Bonorigo

Alliance 20
A BETTER NDIS

# Report

## Client-led Home & Living Arrangements

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# Executive Summary

Alliance20 (A20) brings together some of Australia's largest disability service providers from across the country to develop initiatives to strengthen the National Disability Insurance Scheme (NDIS) and deliver better services and outcomes for participants.

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission, 2023) recommended the phasing out of "group homes" within 15 years. The NDIS review (2023) identified that people who required 24x7 supports would be generally funded at a 1:3 ratio. To date, most innovation in relation to Home & Living supports has focused on people who can live independently.

In recognition of the fact that the largest number of people in need of 24x7 support will share supports with two other people, the Alliance intends to show leadership through a review of contemporary practice and research, and the development of a set of principles for client-led approaches to quality shared home and living supports. This review particularly focuses on people with moderate to profound intellectual disability, and/or with significant complexity who are the most common groups to have lived in group homes.

The review was directed by representatives of organisations who are invested in client-led approaches to home and living. Client-led approaches to Home & Living were defined by this group as: "co-designed supports which recognise home as the place of stability, self-expression, and connection. The supports provided adapt to each person's changing preferences, goals, and aspirations, promoting choice and active engagement in life, community and work."

A literature review, considering both academic and industry sources, identified contemporary evidence-based practice. Through survey and interview, practices within Alliance20 organisations were also identified and evaluated. Drawing on this, in context of the Disability Housing Outcomes Framework, a set of principles were developed which are organised into four key pillars:

This review concluded that client-led home and living services are services that:

- Ensure the person leads every decision
- Are co-designed
- Respect and respond to choices
- Promote engagement and inclusion in life.

The report provides:

- an overview of the relevant literature, with a focus on how contemporary practice approaches are likely to align with outcomes identified in the Disability Housing Outcomes Framework
- an evaluation of client-led arrangements within the Alliance20, including highlighting key practices which can be shared
- an exploration of the operating model for client-led arrangements and relevant conclusions for implementation
- a target framework for client-led home and living arrangements, including proposed principles, a framework for implementation, key enablers, and considerations for policy makers.

Through the review the author engaged with disability representative organisations (DROs) and sought their input to ensure that the framework was likely to align to the view of the people they represent.

# Introduction and Acknowledgements

This report was commission by Alliance20 in response to a commitment to further leadership in innovation of Home & Living services, primarily for people with an intellectual disability.

A significant proportion of Alliance20 serve a group of people who have long received significant disability supports since prior to the introduction of the NDIS. Many of these people lived in institutions prior to deinstitutionalisation, and most received services directly operated by State Governments until these services were transitioned to the not-for-profit sector over the last 20 years.

Alliance20 recognises this group as a cohort of people with a disability not well understood in context of Home & Living reform. Many of these people cannot communicate to express their choices. Due to their relative complexity, few people within this cohort would have the capacity to live individually without significant support. The nature of their institutionalised experience means they have less family and other natural supports to draw upon. For some people, including those who have a formal guardianship order in place, a long-term support provider may be the only consistent person in their lives.

Different models of physical housing focused on accessibility are unlikely to improve independence for this group given the significant dependence on 24x7 support. Evidence shows this group of people can achieve greater quality of life through high quality shared supports (Bigby, 2019b).

The intent of this report is to explore innovative practices which give the greatest choice and control to these people in how they live their lives. This is unlikely to reflect greater choice and control in terms of living independently of supports. To this end, **client-led** Home & Living arrangements intend to identify how providers can maximise that choice and control in every aspect of service design, governance and delivery to improve outcomes for people with a disability.

## How this review was undertaken

This review was led by a steering group representing A20 members who provide significant Home & Living Supports. The following organisations and individuals were represented in the group:

| | |
|---|---|
| **Sylvanvale** | Leanne Fretten (Chair) |
| **Life Without Barriers** | Cat Lancaster |
| **Minda** | David Panter |
| **Yooralla** | Melissa Cofre |
| **GenU** | Melissa Dunn |
| **Unisson** | Daniella Harrera |
| **Cerebral Palsy Alliance** | Artika Benson |
| **Kanda** | Richard Kreft |
| **Achieve** | Daniel Kyriacou |

All A20 members were invited to participate in survey, and organisations were either nominated or self-nominated to participate in interview.

The survey design, surveys, interviews, research and generation insights and principles were delivered by Bonorigo, a group of consultants including John Rowland, Patrick Tyro-Burns, Nicola Crates, Jon Anning and Cathy Limb. Each of these individuals have been involved in developing and operating Home & Living services or deeply engaged in sector reform.

Engaged in the review to provide insight and feedback was **Inclusion Australia**, **Disability Advocacy Network Australia** and the **Council for Intellectual Disability**.

The review deliverables, including the definition, pillars and principles were endorsed by the steering group and presented to and endorsed by A20.

## Acknowledgements

The authors would like to acknowledge Alliance20 members who participated, disability representative organisations and the various academics who contributed to the research referenced.

# Market and Strategic Positioning of Client-led arrangements for Home & Living

## Environmental scan and literature review

### Introduction

An environmental scan and literature review was commissioned to inform the Alliance20 (A20) initiative on best practice models for Client-led arrangements in disability service delivery. The review is structured around the Disability Housing Outcomes Framework (DHOF, disabilityhousingoutcomes.com), which includes six domains: Independence, Daily Living, Health, Relationships & Community, Rights & Voice, and Stability & Safety.

Client-led approaches have emerged in response to findings from the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2023), which recommended urgent reform of traditional group home models and called for a phased transition toward individualised living and greater client autonomy. These recommendations were endorsed in the NDIS Quality and Safeguarding Commission (NDISQSC)'s Next Steps Report (2024), which identified the need for regulatory reform, better data, separation of Specialist Disability Housing (SDA, the housing aspect of Home & Living) and SIL (Supported Independent Living, the support aspect of Home & Living), and workforce transformation.

### Purpose and Scope

This report synthesises academic and grey literature to:

- Define client-led practice with reference to evidence
- Identify promising and emerging service models aligned to Client-led principles
- Examine the effectiveness of these models across the six DHOF outcomes
- Highlight barriers and enablers for implementation
- Provide considerations for policy and practice.

The review includes both international and Australian research, and reflects lived experience insights, organisational trial data, and evaluations of models such as

Individual Supported Living (ISL), apartment living, Shared Lives, and family-led cluster housing.

In addition, a formal literature review was undertaken. The terms of the review and the resulting literature is summarised in Appendix A: Literature Review.

## Limitations

The following limitations are identified:

- The review is not exhaustive and relies on secondary sources
- Evaluation of new and emerging models is limited by a lack of longitudinal data
- Few standardised outcome measures exist across studies, making comparative analysis difficult (O'Donovan et al., 2021)
- Findings may not fully capture intersectional experiences (e.g. cultural identity, gender, LGBTQIA+)
- A more comprehensive review would involve a systematic evaluation of longitudinal outcomes, comparative cost analyses, and direct engagement with people with disability and their supporters through interviews, surveys, and participatory methods. Within the scope and timeframe of this project, this desktop synthesis reflects the best available evidence that could be obtained and analysed.

## What is Client-led Practice?

Client-led practice refers to service delivery where people with disability are central to decisions that shape their lives. It encompasses:

- Choice over who supports them and how that support is delivered
- Control over where and with whom they live
- Participation in designing routines, planning, governance, and service improvement.

Client-led arrangements are based on principles of supported decision-making, dignity of risk, and meaningful engagement. Rather than a fixed model, client-led practice is a continuum, from understanding to co-design, where individuals

influence the scope, design, and delivery of their services (Orr, 2025; NDIA & Scope, 2023).

## Interaction between housing and services provided in home settings

Client-led models being described in both academic and grey literature also reflect a focus on housing as a primary means to support choice and control. There is conflicting evidence as to whether more individualised housing models improve outcomes, for people with an intellectual disability.

Studies exploring individualised housing models identified greater autonomy, improved choice and control and more independence within the home. There was limited evidence that these settings themselves generated improved outcomes within other life domains, instead reporting that participation and inclusion in society did not improve and in some cases worsened due to isolation. It was determined that people within more individualised models still only interacted with family, paid support roles and other people with a disability, unless there were specific services provided which supported broader engagement.

A detailed discussion of the research reviewed is provided in Appendix B – Environmental Scan Detailed Analysis

## Best Practice Models

### *Individual Supported Living (ISL)*

Described by Thoresen et al. (2022), ISL enables people, including those with high support needs, to live in their own home with tailored supports. Supports are both formal and informal and can be adjusted to individual goals and risk profiles. The model showed positive outcomes in choice and autonomy but limited gains in broader social inclusion.

### *Apartment Living Models*

Carnemolla (2022) evaluated urban apartment living models, finding enhanced autonomy and community proximity. Clients had more say in daily living decisions but also faced barriers in accessing shared outdoor space and finding skilled staff.

### *Shared Lives (UK)*

This model involves carers sharing their home or life with a person with disability. Evaluated by Brookes et al. (2023), it showed high satisfaction and gains in autonomy, emotional health, and stability. However, scalability remains limited.

### *Cluster Housing (Bailey et al., 2024)*

A family-led model with individually occupied homes and shared communal space. Despite initial resistance from funders, the model demonstrated high levels of person-centred support and social connection due to intentional community-building practices.

## Findings Mapped to Disability Housing Outcomes Framework Outcomes

### *Independence*

Models like ISL and Shared Lives enhance autonomy through choice in housing, support workers, and routines. However, systemic defaults (e.g. 1:3 SIL funding) limit real choice, particularly for those needing 24/7 supervision.

### *Daily Living*

Active Support and Practice Leadership are essential. Oliver et al. (2020) found that individualised housing supports domestic tasks and decision-making, but showed no consistent improvement in personal care, suggesting that employee capability is crucial.

### *Health*

Positive health outcomes were noted where clients had access to Comprehensive Health Assessment Program (CHAP) and were supported to co-design their own health plans (Douglas et al., 2022). However, the quality of engagement with health systems varied, especially for those with communication barriers.

### *Relationships & Community*

Housing models alone do not guarantee inclusion. Both ISL and apartment living showed limited community connection without intentional support. Shared Lives and cluster housing models outperformed others by fostering organic social bonds.

### *Rights & Voice*

Tools such as Talking Mats, photovoice (Chinn et al., 2024), and peer advisory committees supported expression and advocacy. However, systemic

guardianship constraints and workforce capability limited genuine rights expression for people with complex needs.

#### *Stability & Safety*

All models reported difficulty in recruiting and retaining skilled employees. Workforce culture, regardless of housing model, was identified as a key risk factor. Practice Leadership close to the frontline (Bigby et al., 2019) and capable environments were repeatedly cited as critical to safety.

## Considerations for Implementation

Embedding Client-led practice into disability service delivery requires more than programmatic change, it involves a cultural, operational, and relational shift across organisations and systems. The literature highlights that even the most promising models will fall short without strong leadership, well-supported employees, flexible funding, and mechanisms to authentically involve people with disability in shaping their own supports. The following considerations offer practical levers to guide implementation at the service and system level.

- Organisational culture must prioritise person-centred values and human rights.
- Investment in frontline leadership, coaching, and reflective supervision is essential.
- Funding models must support 1:1 or 1:2 arrangements where needed.
- Technology and accessible tools are vital for capturing preferences.
- Inclusion efforts must extend beyond the home into the broader community.

## Emerging Principles

From the evidence reviewed, the following principles, while not exhaustive, can inform A20's development of a Client-led framework:

- Every person can lead, if the right supports are provided.
- Choice is active, not just structural; engagement must be fostered.
- Homes should support connection, not isolation.
- Organisations must embed Practice Leadership and reflective systems.

- Client-led services must include those with the most complex disabilities, not only those able to articulate preferences.

## Further research

Within the scope and limitations of this desktop review, the findings offer a foundation for A20 partners to deepen their commitment to Client-led arrangements. However, further longitudinal and participatory research is needed to better understand how housing and support interact to shape long-term outcomes, particularly for those with complex needs and limited informal support networks.

To advance this agenda, A20 could consider forming partnerships with academic and research institutions to:

- Evaluate the impact of Client-led practice across different housing and support models
- Conduct participatory research that includes people with disability as co-researchers
- Build an evidence base for scalable workforce strategies that support authentic decision-making
- Examine cost-effectiveness and sustainability of individualised supports for those with high needs.

Such collaborations could ensure that implementation efforts are continuously informed by rigorous evidence and contribute to sector-wide learning on what truly works in delivering safe, inclusive, and empowering supports for people with disability.

## Conclusion

Client-led practice requires systemic and cultural change. It cannot be achieved solely through funding reform or new housing stock. Rather, it requires coordinated efforts across support practices, leadership, regulation, and advocacy. As the Royal Commission and Next Steps Report highlight, the future of disability support must be built around what people with disability say they want, a life of choice, safety, connection, and meaning.

The environmental scan and literature reviewed affirms that while a range of innovative housing and support models show promise in enhancing autonomy

and engagement, the success of these approaches is heavily dependent on workforce capability, organisational leadership, and intentional support strategies. There is no single model that guarantees success. Instead, the strongest outcomes are achieved when people with disability are supported to lead decisions, and when services commit to ongoing adaptation, co-design, and reflective practice.

Importantly, the review highlights that Client-led practice is not determined by the physical housing model alone. Group homes, apartment-based living, and cluster housing may all be compatible with Client-led principles if implemented with the right values, supports, and governance structures. Conversely, even individualised housing arrangements can fall short if support models fail to promote autonomy, inclusion, or voice. This distinction between the housing model and the support model is critical, true Client-led arrangements are defined by the degree of control and influence individuals have over their supports, not simply by where they live.

We note that our review identified that the body of scholarly research on which to draw conclusions about best practice approaches is limited. We identify this as a significant gap in shaping future practice and encourage increased research in this area.

# A20 Member survey and interviews

## Purpose

The A20 Client-led Survey and Interviews are key data collection tools within a broader Alliance20 (A20) project to define, measure, and strengthen Client-led service models. The tools are designed to capture both current practice and future aspirations across six domains of participant outcomes, enabling A20 members to assess maturity, identify barriers and enablers, and inform practical, evidence-based reforms.

## Objectives

1. Develop a shared, practice-informed definition of Client-led models.
2. Map current practice across six DHOF Outcomes Domains:
    a. Independence
    b. Daily Living
    c. Health
    d. Relationships & Community
    e. Rights & Voice
    f. Stability & Safety
3. Assess implementation maturity, workforce models, and organisational alignment.
4. Identify current and emerging enablers, barriers, and innovations.
5. Support the development of guiding principles that are measurable, aspirational, and grounded in real-world practice.

## Survey design

The survey comprised 24 questions, including:

- Multi-part Likert scale questions with custom 5-point scales
- Open-text insight questions
- Foresight-oriented questions on future aspirations and change-readiness
- Domain-level self-assessment questions (0–10 current state and future goals).

Questions were aligned with:

- The Disability Housing Outcomes Framework
- Thematic Codes (e.g., Health Literacy, Participant Co-Design, Advocacy Access)
- Implementation Maturity and Future Intent

The survey was structured to take approximately 35–40 minutes to complete.

The survey design is included as Appendix C: Survey design

## Interviews

In-depth, semi-structured interviews were conducted with 8 respondents from 5 providers to:

- Explore survey responses in greater detail
- Capture organisational examples and case studies
- Understand leadership intent, cultural change, and systems enablers
- Validate and challenge emerging guiding principles.

Interview insights complemented survey data and assisted with the identification of key practices to share between the Alliance.

## Participants

Each A20 member was encouraged to nominate up to two survey respondents:

- One strategic/operational leader (e.g. Executive, GM of Services)
- One practice/service delivery lead with deep knowledge of Client-led implementation.

Fourteen individual responses were provided, balanced between strategic and operational leadership, and practice or service delivery focus.

## Survey results

The following charts provide a high-level summary of survey responses across DHOF Outcome domains. Overall, results indicate that while most organisations have foundational practices in place, consistency of implementation varies significantly. Complexity of client needs appears to reduce the consistency with which practices are applied. See Appendix D: Survey Results for more detail.

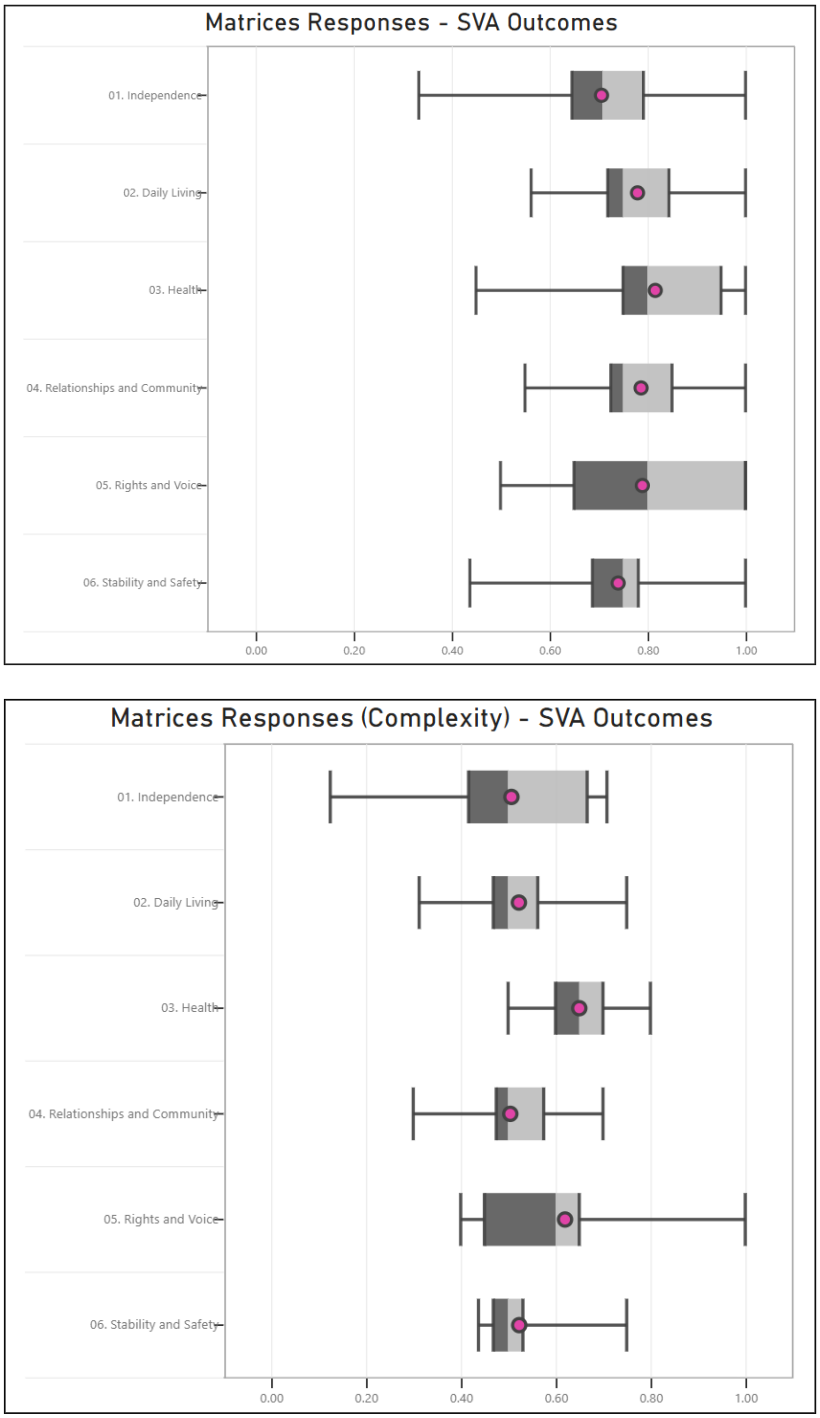



*Figure 1: Survey Results from A20 Members*

## Interpretation

It is important to note when interpreting these results that this is based on self-rating of the implementation of practices and not based on observation of the outcomes associated with each domain.

Respondents were provided with guidance around what “Sometimes”, “Most of the time” and “All of the time” mean in context of practice, where “Sometimes” represents an intended outcome with limited evidence, and “All of the time” represents consistent application with evidence.

## General Observations

**Majority high complexity**: 71% of respondents serve high complexity clients.

**Practice maturity varies by domain**: Most outcome domains have results which cluster around "Sometimes" to "Most of the time", indicating partial to regular practice adoption, but not yet consistently embedded or evidenced measurement of implementation.

**Complexity impacts consistency**: Adding complexity as a lens generally lowers the consistency of implementation (i.e. the mean scores drop in multiple domains).

## Insights mapped to the Disability Housing Outcomes Framework

### *1. Independence*

- Overall: **Mean = Most of the time**, with a wide range from just below **Sometimes** to **All the time**.
- **With complexity**: Mean drops to **Sometimes**, with a wider range from **below Not much** to **Most of the time**.

Indicates strong practice foundations, but challenges in sustaining them with higher complexity.

### *2. Daily Living*

- Overall: **Most of the time**, with a good spread (**Sometimes** to **All the time**).
- **When considering complexity**, mean drops to **Sometimes**, and range widens to **Not much** to **Most of the time**.
- Implies services to high-complexity clients struggle with consistent delivery of daily living supports.

### *3. Health*

- Overall: **Mean = Most of the time**, range from **Sometimes** to **All the time**.
- **With complexity**: Mean lowers slightly (between **Sometimes** and **Most of the time**) but range narrows.
- Practices are somewhat consistent, with less variability than other domains.

### *4. Relationships and Community*

- Overall: Stronger performance, mean = **Most of the time**, with a tight interquartile range.
- With complexity: Mean drops to **Sometimes**, and range drops to **Not much** to **Most of the time**.
- Points to solid strategies in general, but high-complexity environments face unsurprising challenges in delivering on relational/community goals.

### *5. Rights and Voice*

- Overall: **Mean = Most of the time**, with a range from **Sometimes** to **All the time**.
- **With complexity**: Mean drops slightly (below **Most of the time**), but range remains reasonably steady but interquartile range narrows significantly to hover around **Sometimes**.
- Demonstrates moderate consistency, but a need for reinforcement in complex settings.

### *6. Stability and Safety*

- Overall: Mean = **Most of the time**, range between **Sometimes** and **All of the time**.
- With complexity: Mean drops to **Sometimes**, but interquartile range narrows to just either side of **Sometimes**.
- Indicates foundational practices are present but not yet embedded consistently in complex environments.

## Summary Themes

- **High baseline, lower consistency under complexity**: Across all domains, the average score sits around “Most of the time”, suggesting generally

strong organisational intent and frameworks. However, once complexity is considered, every domain shows a decline in the mean, reinforcing the strain complexity places on practice consistency.

- **Independence and Daily Living most impacted by complexity**: These domains showed the most pronounced drop in mean scores and the broadest ranges, indicating greater variability in how well these supports are embedded and delivered for complex cohorts.
- **Health and Stability more consistent**: While complexity lowers the mean slightly in these domains, their narrower interquartile ranges suggest that practices here are more consistently applied, possibly due to clearer compliance or procedural frameworks.
- **Relational and rights-based domains show fragility**: Despite strong scores overall, Relationships, Community, and Rights and Voice experienced a noticeable drop in performance with complexity, indicating that person-centred and empowerment-based practices may be harder to maintain in more challenging contexts.
- **Narrower ranges under complexity indicate stratification**: For several domains, complexity reduced the variability (interquartile range) even as the mean dropped. This may suggest a clearer divide between services that have adapted to complexity and those that have not.

## Interviews

Five (5) interviews were conducted with A20 members. Interviewees had the option to self-nominate or were approached based on practices being identified through the survey process for further exploration. In some interviews there were multiple respondents, while others had only one person.

A standardised interview design was adopted, with adaptation based on what was already described through survey responses, and areas of particular interest to be further explored.

### Themes

Within interviews there were common threads which were explored by each organisation:

***1. People with disability are at the centre***

All organisations are describing deliberate focus on person centred supports.

***2. Employees need the right tools and support***

Each provider recognises that to enable client-led practice, employees must be trained, supported, and supervised, not just told. Coaching, training in decision making, and practice frameworks are all used.

***3. Clear roles help everyone work better***

Whether it's separating housing and support (Sylvanvale) or defining board responsibilities (Minda), having clear roles prevents confusion and builds trust with clients.

***4. Risk is a part of real choice***

Each interview talked about dignity of risk; specifically, how true choice includes letting people make decisions even when they involve risk. This was especially strong in Yooralla's health approach, but visible across all.

***5. Culture Change Is Key***

Client-led practice isn't just a set of practices - it's a shift in how people think and work. All organisations highlighted the need for or experience of organisational change, not just individual effort.

## Transferable practices

There were a range of transferable practices identified through interview. The key practices are identified here:

| Practice | Organisation | Outcomes |
|---|---|---|
| Use of Storypark to enhance two-way communication | Sylvanvale | Real-time updates and shared planning strengthen connection between clients and families. |
| Co-designed Service Excellence Framework | Minda | Standards reflect what people with disability value – it is used across the whole organisation. |
| Coaching and reflective practice to shift employee culture | genU | Helps employees support choice with confidence; moves beyond compliance. |
| Approach to client-led decision-making in health | Yooralla | Clients make informed choices about health, even when risks are involved. |
| 'Not About Me Without Me' rights statement | Life Without Barriers | This co-designed statement is used to guide all planning and decision-making. |

*Table 1: key transferable practices identified from A20 members*

## Organisational highlights

### *genU – Building a Strong Practice Approach*

genU is building a Practice Framework to help employees support people better. It is based on rights, understanding trauma, and helping people make their own choices. They support employees through coaching, not just rules or checklists.

**Practice Framework with Clear Principles**: The framework is based on rights, trauma-informed care, and client-led decision-making, guiding how staff work every day.

**Coaching and Reflection for Support Workers**: Employees are supported through coaching and reflective practice, helping them understand and apply the framework, not just follow rules.

**Shared Language Across the Organisation**: genU uses simple, shared terms so that everyone, from support workers to leaders, can talk about support in the same way.

**Focus on Culture, Not Just Compliance**: Instead of ticking boxes, genU is changing how people think and work by building a culture that supports choice.

**Supportive Leadership**: Leaders actively back the changes and help employees keep improving, making the shift more than just a one-off project.

**Key Idea:**
*Helping employees grow and change by using coaching and shared ways of working.*

### *Life Without Barriers – Intentional Commitment, structures and practices*

Life Without Barriers described significant work in developing a co-designed rights statement which embedded a rights-based approach to service design. An annual survey informs which areas are most relevant to people and has led to a specific focus on relationships, intimacy and sexuality. The organisation has reshaped its leadership structure to give greater representation to people with a lived experience of disability.

**'Not About Me Without Me' Rights Statement**: This co-designed statement is used to guide all planning and decision-making.

**Planning Conversations Focused on the Person**: Conversations are guided by what matters most to the person—not just what services can offer.

**Reflective Practice and Review**: Support teams regularly check how things are going with the person and adjust support based on their feedback.

**Learning from What Works**: Stories and successes are shared across teams to help others understand how to do client-led practice well.

**Lived Experience in Leadership**: People with disability are involved in leadership, advisory groups, and service reviews.

**Key Idea:**
*A commitment to co-design needs to be embedded and reflected in how the organisation is led and what areas of practice are prioritised for attention.*

### *Minda – Setting Clear Standards with People with Disability*

Minda works closely with people with disability to decide what good support looks like. They have a Service Excellence Framework that includes clear measures and standards. People with disability help shape how things are run, from the board level to day-to-day services.

**Service Excellence Framework Co-Designed with Clients**: Minda worked with people with disability to create a clear set of standards for good support, ensuring they had a say in what "good" looks like.

**Client Involvement at All Levels**: People with disability are included not just in individual planning, but also in shaping how services and governance are run.

**Clear Measures of Quality**: The framework includes ways to check if the support is meeting the standards, making it easier to track progress and improve.

**Organisation-Wide Commitment**: The framework isn't just for one team—it's used across the whole organisation to guide consistent, client-led practice.

**Lived Experience Embedded in Leadership**: Minda ensures people with disability are part of leadership and decision-making, not just consulted after decisions are made.

**Key Idea:**
*Letting people with disability define and measure what good support means.*

### *Sylvanvale – Clear Roles, Working Together*

Sylvanvale makes sure the way people are supported is shaped by them. They keep tenancy and support clearly separate. This helps avoid confusion. They empower frontline leaders to lead planning, so people in homes can decide how things work day-to-day.

**Separation of Tenancy and Support Roles**: Housing issues are handled by one team, and daily support is managed by another, avoiding mixed messages and power imbalances.

**Frontline Facilitation of Support Planning**: Sylvanvale empowers their own frontline leaders to lead planning of Home & Living services, which helps ensure service decisions reflect the person's goals, not organisational convenience.

**Support Design in Shared Living**: Even in shared settings, Sylvanvale enables each person to influence how services are delivered—such as routines, rosters, and relationships.

**Consistency and Clarity in Communication**: Defined roles and responsibilities help everyone (clients, employees, families) know who to speak to and what to expect.

**Focus on Practical Client Choice**: The organisation focuses on how supports are delivered, not just what's written in a plan, ensuring real-world alignment with each person's preferences

**Key Idea:**
*Working together well by making sure everyone knows their role.*

### *Yooralla – Real Choice in Health Decisions*

Yooralla focuses on making sure people are in control of their health decisions. This includes explaining risks and helping them choose what's right for them. They are also training employees to support this better. They aim to make "dignity of risk" real, especially in health context.

**Client Involvement in Health Planning**: Clients are supported to take part in medical decisions, with clear explanations of choices and risks.

**Dignity of Risk in Practice**: Yooralla encourages people to make their own choices, even if it means accepting some risk.

**Training for Support Workers**: Employees are learning how to support clients in these discussions, not just leave it to clinicians.

**Strong Links with Health Services**: Yooralla works with hospitals to make sure health plans match what clients want, especially during discharge planning.

**Balancing Safety and Choice**: Yooralla manages complex risks while still keeping the person's voice at the centre.

**Key Idea:**

*Supporting people to make informed choices about their health, even when it involves some risk.*

## Insights

The following insights were determined from the interview process

- There is a need for a clear and unambiguous commitment to person centred design as part of any model of service delivery. This could include explicit declaration of rights or commitment to principles through a practice framework. This should describe how services are planned and delivered, and how people are involved in service governance.
- Whilst all providers described and were able to detail a commitment to co-design, the results in this area had the greatest variability. In discussion with providers many were challenged in how to balance a commitment to co-design with the inherent limits which exist in relation to funding, regulation and the role of substitute decision makers.
- To be client-led in how they operate, services must respond to the choices of people. This was clear in the context of health-related supports. There is an intent by providers to ensure people accessing services can be enabled to take risks, and to respect the dignity of risk.
- There is a need to focus on measuring tangible outcomes. There was a direct relationship between organisations which measure outcomes, and the extent to which they can demonstrate they are client-led.

# Operating model for client-led Home & Living services

## How client-led arrangements are delivered

Through survey and interview we have determined the ways in which client-led arrangements are achieved:

1. **Organisations make specific investments in areas of practice focus given their vision and purpose.**

Most organisations describe client-led practices in areas which they have expertise or have a focus enshrined in their values. For example:

- Yooralla, which has a commitment to and expertise in providing services to people with complex health needs, invests in resources to support people to make informed choices and deliver safe health related disability supports.
- Sylvanvale has a significant investment and a commitment to providing SDA housing. It has invested in the separation between Housing and Service roles to ensure people lead housing decisions.
- LWB, adopts a right-based approach to client-led practice, consistent with its commitment to human rights.

In each case the investment is made consciously and *without* explicit funding under the NDIS Pricing Arrangements and Price Limits.

2. **Co-design of services is dedicated activity, limited to specific trials, cohorts or areas of the organisation with dedicated resources.**

Providers described that there are significant barriers to co-design of services at scale, including appropriate support funding (services find it difficult to balance funded support ratios with individual choices) and the broader regulatory environment in relation to balancing dignity of risk and safeguarding. There are lots of isolated examples – but each involved the distinct investment of resources (either a dedicated team, or the discretionary effort of a particular leader). Minda specifically called out the choice to resource activities to enable supported decision making for people who usually have decisions made by substitute decision makers.

3. **Organisations that report improved client-led outcomes achieve this through the implementation of practice frameworks alongside coaching and supervision.**

Many providers described a framework or commitment to a set of practices. Some have further invested in coaching and practice leadership to see those practices come to life. Minda had invested in a measurement framework which allowed them to identify client-led outcomes were being achieved consistently. Whilst all providers were able to recognise and describe a commitment to practices, those that were achieving more were those that implemented strategies to embed and measure them. Where people are making a deliberate decision to focus on implementation this is a time limited investment.

4. **Active Support, Positive Behaviour Support and Trauma Informed Practice are key elements of client-led practice.**

Most providers described the implementation of these frameworks as a key aspect of their operating model. Many described this as being currently in an implementation phase. Each provider interviewed recognised these practices as "not new" but identified that they have had a relatively lesser focus during the implementation of the NDIS due to competing demands, particularly billing and reporting obligations.

5. **Funding is an inhibitor to client-led approaches**

Providers recognise that the NDIS approach to Home and Living funds inputs, specifically the housing and the hours of support provided within the service. Client-led practices require specific and dedicated resources, but there is no value attributed to these approaches. In fact, client-led approaches empower choices which often include greater individualisation – where services are funded on the basis that they are shared. The cost of co-design and developing responsiveness in services are borne by the provider, often in context of decreased efficiency through lower economy of scale. There is some work happening between the NDIA, DSS, Providers and people with a disability to co-design new models for funding – but is unclear at this stage whether they will recognise the cost associated with client-led practices.

6. **There are limited adoption of technology and systems to improve efficiency and effectiveness**

There were limited examples of people using technology as part of their service model. Sylvanvale had a notable example of using technology to ensure a person's circle of support were aware of and contributing to setting and celebrating goals. It is identified that most client-led practices are novel or led by people with significant theoretical expertise. There are limited examples of organisations being able to "systemise" client-led arrangements at scale. Minda's Service Excellence Framework is an example of a systemised approach, but its implementation is still reliant on manual record keeping and reporting at this point.

7. **Implementation is compounded by workforce supply factors**

There is an acknowledgement by providers that inherent workforce challenges facing the sector at large compound issues for implementation of client-led approaches. This is because client-led approaches require additional training, practice support and coaching for people delivering supports, and because additional capacity is required to deliver some aspects of the model, particularly co-design, supported decision making, and providing expert advice to support decision making in areas which require expertise such as health.

8. **A major barrier is balancing the explicit requirements for safeguarding against the decisions of a person with a disability to accept risk.**

Providers report a desire to support client-led decision making where there is risk involved. Specifically, some providers engage specialist expertise, e.g. health or behavioural practitioners, to support decisions which accept risk. Examples were provided where people have chosen to accept some risk to achieve desired outcomes. This may include greater independence (less dependence on formal supports) or participation in activities which deliver quality of life.

The greatest inhibiting factor in supporting these decisions was reported as the perceived risk of negative consequences from the NDIS Quality and Safeguarding Commission (NDISQSC). This manifests in providers limiting decisions, either because they perceive they are not meeting a duty of care (as they understand it from the regulatory posture of the NDISQSC), or because the steps required to mitigate risk to a reasonable level are out of the scope of an individual's funding, resources or capability.

## 9. The goal for client-led services needs to consider whether home feels like home

Feedback was consistently provided from representative organisations and providers that the test for whether people were truly able to make choices in life could be seen and experienced in context of how the home "felt" and responded to choices in the moment. "The difference between home and a group home is the ability to get up at 3am and make a toasted cheese sandwich", captures the sentiment which gives a direction to what client-led Home & Living should look like. Home should be a place where a person can behave the way they want to meet your needs and desires. It should also reflect those needs and desires, in terms of who and what is present, how it looks and feels. This means the person with a disability controls every aspect of their own home. A client-led service would occur in a home that seems like it belongs to the person who lives there and is not a facility or service delivery location.

## Conclusions about the NDIS operating model for Client-Led Arrangements

We conclude the current NDIS funding mechanism does currently not promote or enable client-led practices. Whilst we find that A20 providers are committed to client-led practices in principle, the reality is that each provider is needing to allocate resources from within a limited pool of overhead funding to develop employee skills to implement these approaches, and to resource their operation on an ongoing basis. There is also a limited capacity for employees to be available for training within the current cost model.

In considering an operating model the following factors are relevant: The model needs to recognise:

- transitionary cost associated with developing the current workforce to have sufficient knowledge and skills to deliver a client-led approach. This is likely to mean investment in a range of training and practice development initiatives in active support, positive behaviour support, trauma informed practice and supported decision making.
- transitionary cost associated with organisational development, design to incorporate people with disability in service governance, design and review. This cost is both internal (managing change and developing policies and procedures and ways of work) and external (gaining expert advice and guidance). It is noted that DROs have identified that they may be in a position to assist with expert advice and guidance, subject to ongoing funding.
- costs associated with maintaining, embedding and developing this capacity, including:
    - ensuring there is adequate day to day practice leadership to embed the model
    - ensuring there is sufficient capacity to train new workers, and ensure workers receive ongoing upskilling as required
    - the cost of roles to support the implementation of the client-led practice as distinct from day-to-day line supervision – many organisations use “practice coaches” or similar roles which provide professional supervision to both direct support workers and supervisors in how to deliver and supervise client-led approaches.

    - the cost of systems and approaches to enable and monitor this implementation
- costs associated with specific capacity to support client-led decision making which requires expertise, such as:
    - the inclusion of people with lived experience in service governance, design and review
    - to facilitate supported decision making (which could be either within the organisation or in partnership with DROs)
    - to facilitate expert advice in context of client-led decisions in areas with complexity such as health, mental health, complexity and comorbidity (including behaviours of concern).
- costs and/or risks associated with recognising the dignity of risk of people with a disability:
    - providers are inhibited in implementing client-led approaches when the regulatory posture of the NDISQSC leads to the perception that safeguarding against harm is more important that enabling clients to make decisions that present a safeguarding risk.
    - recognise the cost of additional work to mitigate the risk associated with some decisions.
- that the treatment of a home as a place of work for support providers inherently creates responsibilities which need to be carefully managed.

# Target framework for Client-led Home & Living services

## Definition

Through thematic analysis of A20 member surveys and interviews and the environmental and literature review, the following definition was adopted through review and feedback with the steering group.

> "Client-led home and living services are co-designed supports which recognise home as the place of safety, stability, self-expression, and connection. The supports provided adapt to each person's changing preferences, goals, and aspirations, promoting choice and active engagement in life, community and work."

## Generation of principles

A significant deliverable in this review is the generation of principles which underpin the delivery of client-led Home & Living arrangements. In developing these principles several frameworks and iterations were generated.

At a high level the following streams were used to generate a set of principles:

- Thematic analysis of Alliance20 member surveys and interviews, and the environmental and literature review
- Coded analysis of insights against the Disability Housing Outcomes Framework
- Generation of specific principles in response to feedback from Alliance20 members and Disability Representative Organisations.

The process to develop the principles took the following approach:

- The development of four high level principles, which subsequently evolved through engagement with Alliance20 members.

- The adoption of the high-level principles as pillars, with further supporting principles developed to more closely align to the Disability Housing Outcome framework and in response to feedback from Disability Representative Organisations.
- Refinement of the pillars with Disability Representative Organisations based on the views of advocates and people with a disability.
- Final endorsement by representative Alliance20 members.

## Engagement with Disability Representative Organisations

In considering these principles we engaged with Disability Representative Organisations (DROs) to ensure the principles were aligned to their policy position and were likely to be aligned with the view of the people they represent.

We engaged with:

- Disability Advocacy Network Australia (DANA)
- Inclusion Australia
- Centre for Intellectual Disability

### Areas of emphasis

**Supported decision making** was emphasised. It was identified that whilst it requires specific resourcing and expertise, it is the determining factor in ensuring client-led decisions especially to achieve co-design. There is some concern that substitute decision making may be recognised as client-led, when often the person with a disability has not been involved in decision making. This was recognised broadly by A20 providers, with several explicitly mentioning employing supported decision making, and others recognising the limitation that some people have with substitute decision makers who do not enable client-led decisions.

**Choice requires a range of experience**. It is unreasonable to assume that a person who has only lived in a specific Home & Living context to make reasonably informed decisions without sufficient experience of alternatives. Therefore, to be client-led, services must enable access to those experiences as part of ongoing decision making. This is particularly relevant for people with a history of institutionalisation and people who have needed to advocate to receive home

and living supports, who may perceive trying alternative approaches as putting their existing services at risk.

**A sense of home and homeliness** was explicitly identified by one representative organisation. This was identified as a core outcome as part of recent co-design work which was facilitated by DSS related to innovative funding models for Home and Living. This aligns to how the service respects and responds to individual choices – and is called out as a specific principle.

**Working together** was emphasised as an opportunity to deliver client-led approaches. Some DROs recognised they already have capability to support providers specifically in the areas of inclusive governance, co-design and supported decision making. An example of this in practice is the VALID8 program which is peer-led service review approach used by people with disability to support self-advocacy and client-led decision making which is operated by Victorian DRO VALID.

**Conflict of interest** was raised, specifically in context of organisations which play multiple roles, especially roles which support decision making such as Support Coordinators. This was highlighted as a particular issue in rural and remote services. Representatives identified that some conflicts are hard to avoid, but that they must be managed.

**Relationship to affordable housing** was also identified. Whilst this report focuses on home and living supports rather than specialist disability housing (SDA), the lack of affordable and suitable housing for people not eligible for SDA or who are only approved for Legacy SDA represents a significant issue. Representatives acknowledged the impact that the lack of housing provides on the ability to genuinely explore choices. This represents a conflict of interest whereby support providers with access to housing present a potential conflict of interest to people with a disability with limited other choices.

**Measurement should focus on achievement** rather than focusing on measuring the supports received. “It’s not what people are receiving, but what they are achieving”. This is not to say that people should be forced to set goals or be in a constant state of striving, it is fine just to “be” – but when people choose to work towards something – the achievement is celebrated rather than the supports.

## Framework for implementation

Through the completion of this review there were significant learnings gathered around how organisations are implementing client-led arrangements. We considered these learnings in context of four essential elements:

- Structure
- Process
- Relationships
- Practice

The following table describes how a client-led approach would be represented in these elements of the organisation.

| | | |
|---|---|---|
| **Structure** | Client-led structure ensures governance, leadership, and service models embed client autonomy and human rights as foundational.<br><br>Policies, role design, and system architecture actively support clients to lead decisions, not just be included. | **Client-led structural alignment** exists when support, housing, health, and family systems are coordinated around the individual—not around organisational silos. Separation of roles (e.g., SDA/SIL) is clear, yet collaborative. |
| **Process** | Client-led processes place clients at the centre of decision-making through embedded planning cycles, consistent documentation, and co-designed routines.<br><br>Frontline staff and managers are accountable for enabling real-time choice and responsiveness. | **Client-led process integration** means cross-team workflows (planning, communication, scheduling) support client preferences, even where services intersect or impact others. Flexibility and negotiation are embedded. |

| | | |
|---|---|---|
| **Relationships** | Client-led relationships are built on trust, respect, and presumption of capacity.<br><br>Clients lead their own decisions, and professionals (incl. plan nominees) defer to their will and preference wherever possible. | **Client-led relational networks** involve clear, structured roles between support teams, families, and stakeholders that prioritise the client's goals and communication needs above all others. Relationships are transparent and collaborative. |
| **Practice** | Client-led practice means everyday actions by employees reflect the belief that every client can grow, decide, and lead aspects of their life.<br><br>Practice leadership, coaching, and supervision reinforce these values through observation and feedback. | **Client-led practices across teams** are evidenced by shared language (e.g., goals, routines), universal responsibility for engagement, and consistent adaptation of support to match client style, context, and voice. |

*Table 2: Framework for implementation of client-led approaches*

Through completing the review, we have maintained an index of structures, processes, relationships and practices which will be relevant to the implementation of client-led principles.

Given what we learned about the challenges faced by organisations in prioritising different client-led approaches we did not want to enshrine any specific elements into the principles – however the following table presents a summary of the different structures, processes, relationships and practices which are identified through research or practice to respond to the principles developed in this process.

# Proposed Pillars and Principles

## Pillars

The final product represents four pillars each of which are supported by three principles. The pillars exist to capture the key differences between client-led arrangements and traditional group homes which adopt institutional thinking and approaches. The intent for these pillars is to be able to be used by people with a disability and their families and advocates, policy makers and providers to identify what shared home and living services which represent client choice and control look like.

**Client-led home and living services are services that...**

| Pillars | … ensure the person leads *every* decision | …are co-designed | …respect & respond to choices | …promote engagement & inclusion in life |
|---|---|---|---|---|
| | Services ensure people with disability lead every decision about their health, relationships, home, and how they share it. | Services are co-designed in response to people's rights, goals & needs and in context of their resources and environment. | Services are designed to be responsive, so that supports are continuously adapted to respect the choices and control of people living in their own home | Services promote people actively shaping their lives & relationships, making both everyday choices & decisions aligned with their goals |

### *Services that ensure the person leads every decision*

There was significant evidence from providers that an organisational commitment to client leadership through leadership in decision making was an essential element of client-led arrangements. This relates to the governance and leadership of the organisation's operations, and the development and implementation of services. There is a specific focus in this pillar on how to enable this behaviour which is explored in the principles. Representation of people with a disability is a significant focus and recommendation of the Disability Royal Commission.

| | |
|---|---|
| **Flagship Practice** | **Supported decision making** is identified as a flagship practice in research with a strong evidence-base and was an area of emphasis for representatives. |

### *Services that are co-designed*

A key difference in client-led home and living arrangements is that the design of the arrangement is contextualised to the people receiving or sharing the services. This means specifically that the service is designed around the people, rather than the people choosing to fit in with the existing service model. There was significant exploration of the various elements that enable and constrain the ability for services to respond to individual choices, specifically funding limitations and provider obligations under NDIS Practice Standards and workplace regulations. It is recognised that there is the potential for providers to hold differential power in how services are designed, and they must carefully consider how their role in design may limit choices, especially when providers play multiple roles (e.g. Home & Living supports combined with SDA, support coordination or behaviour support).

| | |
|---|---|
| **Flagship Practice** | **Facilitators** are identified as a flagship practice in emerging research identifying this approach as a way of supported decision making for people sharing supports that is independent from the home and living service provision. |

### *Services that respect and respond to choices*

There was significant evidence, both in practice and literature, about the importance of services to respect and respond to the choices of people receiving home and living supports. There is strong evidence for positive behaviour support and emerging evidence for trauma informed practice. Providers are innovating in how to better engage and respond to the choices of people with a disability around their health. There is also a strong focus on dignity of risk, ensuring services balance the reasonable expectation that services support people to be safe, whilst not constraining people's right to make choices that include some risk (some providers refer to this as "risk enablement"). Finally, there is a clear expectation of people with a disability for services to respond to their choices of what makes home feel like home, rather than home being defined by the housing and services provided.

| | |
|---|---|
| **Flagship Practice** | **Positive Behaviour Support and Trauma Informed Practice** are identified as a flagship practices, providing people with advanced skills in responding to complex situations and improving choice and control through understanding |

### *Services that promote engagement & inclusion in life*

There is a clear view that home and living services are broader than the provision of in-home supports for people to live safely at home. Providers of home and living services play a broader role in supporting people participate in other aspects of their lives in the way they choose, both in everyday choices like how to spend time, but also in broader choices like how to engage with friends and family, community and work. There is significant research evidence supporting person-centred active support and practice leadership as an approach to deliver these outcomes.

| | |
|---|---|
| **Flagship Practice** | **Active Support and Practice Leadership** have a strong evidence base in achieving quality of life. This practice specifically responds to the needs of people with an intellectual disability, which is the largest cohort of users of supported independent living supports. |

## Principles

Developed in context of the four pillars, the principles are intended to describe how providers of home and living arrangements can deliver supports which are client-led.

The following principles were developed:

| | |
|---|---|
| **Services that ensure the person leads every decision** | 1. Embed client leadership in how services are planned, delivered, and reviewed. |
| | 2. Involve people in governance and service design to shape how services evolve. |
| | 3. Use supported decision making and include people who know the person and can help them raise their voice |
| **Services that are co-designed** | 4. Help people understand their options, resources, and environment so they can make informed decisions. |
| | 5. Design supports with each person, based on their rights, preferences, and goals |
| | 6. Recognise and respond to how conflict of interest and substitute decision makers can influence choices |
| **Services that respect and respond to choices** | 7. Support people to make informed health decisions that reflect their goals and respond effectively to those decisions. |
| | 8. Provide consistent, trauma-informed, and flexible support that people can shape to feel safe and supported. |
| | 9. Respect the choices and boundaries with people's homes and recognise their right to live their way. |
| **Services that promote engagement & inclusion in life** | 10. Support people to build and grow meaningful relationships and valued roles in life and community. |
| | 11. Enable people to lead their daily routines, roles and responsibilities with the support they choose |
| | 12. Support people to recognise and celebrate outcomes |

*Table 3: Principles for providers of client-led approaches to Home and Living*

Each principle is explored in detail in the following section, with exploration of the structures, processes, relationships and practices which underpin the principle as demonstrated in evidence.

### *How principles were derived*

We determined principles through the following means:

- Deconstruction of the broader pillars agreed by A20 members which define client-led home and living
- Considering the Disability Housing Outcomes Framework and what elements are likely to lead to those outcomes
- Giving focus to elements supported by research evidence, are working in practice
- Elements which support choice and control as identified by representatives of people with a disability.

## Services that ensure the person leads every decision

### *1. Embed client leadership in how services are planned, delivered, and reviewed.*

| | |
|---|---|
| **Structure** | Organisations embed opportunities for participation in how services are planned, delivered and reviewed. |
| **Process** | Processes are adapted to support people to be able to play a genuine role in service planning, delivery and review. |
| **Relationships** | People with disability who access services are directly involved in their planning, delivery and review. |
| **Practice(s)** | VALID8 Peer-led review process |

### *2. Involve people in governance and service design to shape how services evolve.*

| | |
|---|---|
| **Structure** | Clients are represented in governance and leadership structures |
| **Process** | Processes are adapted to support people to be able to play a genuine role in governance and design. |
| **Relationships** | People with disability have genuine and valued roles in decision making. |
| **Practice(s)** | Inclusive Governance |

### *3. Use supported decision making and include people who know the person and can help them raise their voice*

| | |
|---|---|
| **Structure** | Organisations embed or retain skilled people who can facilitate supported decision making. |
| **Process** | The entire client lifecycle from intake, assessment, planning, delivery and review considers where supported decision making (SDM) will allow people to make informed choices. The strengths of the person should be the starting point with a focus on building networks and capacity (and informal supports) for SDM in the future. |
| **Relationships** | People who know the person are involved in supporting decision making, this may include family or friends, or paid supports who have worked directly with the person for a significant time. |
| **Practice(s)** | Supported Decision Making |

## Services that are co-designed

### *4. Help people understand their options, resources, and environment so they can make informed decisions.*

| | |
|---|---|
| **Structure** | Organisations ensure people are presented with options which provide choice about how they leverage their resources and environment. |
| **Process** | As part of planning services, clients are supported to understand their choices in context of their resources and environment. |
| **Relationships** | People have access to independent people to support them understand their choices. |
| **Practice(s)** | Independent Facilitation |

### *5. Design supports with each person, based on their rights, preferences, and goals*

| | |
|---|---|
| **Structure** | Services are co-designed with people |
| **Process** | Priority is given to the “desirability” of solutions, with “feasibility” and “viability” being considered as constraints. |
| **Relationships** | People with disability play the role of expert in their needs. |
| **Practice(s)** | Co-design<br>Person Centred Planning |

### *6. Recognise and respond to how conflict of interest and substitute decision makers can influence choices*

| | |
|---|---|
| **Structure** | There is appropriate separation between structures and roles where people exert control or are conflicted in ways that limit choice. |
| **Process** | Roles are clearly delineated, and independent support is incorporated when conflict exists. |
| **Relationships** | Where potential or actual conflicts exist people with a disability are supported to engage independently with each aspect of their support network. |
| **Practice(s)** | Role separation<br>Independent Advocacy |

## Services that respect and respond to choices

### *7. Support people to make informed health decisions that reflect their goals and respond effectively to those decisions.*

| | |
|---|---|
| **Structure** | People have independent access to health advice to make decisions. |
| **Process** | People are supported to make informed decisions, and those decisions are incorporated into how the service responds to support people in their health at home. |
| **Relationships** | The person with a disability makes health decisions. The health provider responds to those decisions. |
| **Practice(s)** | Specialist advisors who support Health decisions |

### *8. Provide consistent, trauma-informed, and flexible support that people can shape to feel safe and supported.*

| | |
|---|---|
| **Structure** | Organisations adopt a practice framework which defines practices that provide flexible and responsive supports. |
| **Process** | A practice framework defines the theoretical model for supports and describes how they are trained, embedded, supported and monitored. |
| **Relationships** | People providing support are trained and receive coaching and feedback. |
| **Practice(s)** | Practice Leadership<br>Positive Behaviour Support<br>Trauma Informed Practice |

### *9. Respect the choices and boundaries with people's homes and recognise their right to live their way.*

| | |
|---|---|
| **Structure** | The home is a place controlled by the people who live in it. |
| **Process** | All decisions about the home are made by the people that live there, including who, when and how others access and use the home. |
| **Relationships** | The person with a disability controls their home. People who provide support fulfill those supports in context of their decisions. |
| **Practice(s)** | Capable Environments (for people who cannot communicate their decisions to have control of their environment) |

## Services that promote engagement & inclusion in life

### *10. Support people to build and grow meaningful relationships and valued roles in life and community.*

| | |
|---|---|
| **Structure** | Home and living services are a whole of life support, responding to a person's choices in life in addition to supporting them to be safe at home. |
| **Process** | Home and living services respond considering the connection between home and community. |
| **Relationships** | The person with a disability makes decisions about relationships and roles inside and outside the home. People who provide support are active in how they respond to those choices. |
| **Practice** | Practice Leadership<br>Active support |

### *11. Enable people to lead their daily routines, roles and responsibilities with the support they choose*

| | |
|---|---|
| **Structure** | Home and living services are active supports extending beyond functional support to meet immediate safeguarding needs. |
| **Process** | Practice leadership is adopted to support people to recognise the opportunity for choice and control in every moment. |
| **Relationships** | The person with a disability makes decisions in every moment. People who provide support are active in how they respond to those choices. |
| **Practice** | Practice Leadership<br>Active support |

### *12. Support people to recognise and celebrate outcomes*

| | |
|---|---|
| **Structure** | Organisations adopt frameworks to set goals (if people choose to), monitor goals (if people choose to) or recognise achievements, and celebrate them. |
| **Process** | If people choose to set goals, these are captured and monitored. People are encouraged to recognise and celebrate achievements in the way they choose. |
| **Relationships** | People choose who in their life they want to recognise and celebrate achievements with. |
| **Practice** | Goal Setting<br>Outcomes measurement |

## Notes on the principles:

**Principle 6: Recognise and respond to how conflict of interest and substitute decision makers can influence choices** specifically considers the roles and responsibilities in establishing and maintaining a service, and the conflicts that can exist between different roles including support coordination, specialised disability and mainstream accommodation, home and living supports. This principle is called out to give focus to recognising and responding to those conflicts as opposed to stating a specific position in relation to whether people should be limited from choosing multiple supports from one provider. It was recognised by providers that to be client-led, where such conflicts arise, providers have an obligation to ensure their structures, processes, roles and practices specifically recognise and respond to those conflicts so that clients are not limited in their choices.

There is a range of practice approaches, some with an emerging evidence base, to support sound management of these conflicts. These include acknowledging and managing the conflict of interest by taking clear and deliberate steps to separate structures, processes and relationships, through to leveraging independent third parties who focus on facilitation of co-tenancy (see Enliven Community). This principle recognises that providers should commit to adopt an approach that effectively responds to any conflicts present.

**Principle 10: Support people to build and grow meaningful relationships and valued roles in life and community** is not intended to identify that client-led home and living services are responsible to respond to goals with specific supports outside the scope of the services. If a goal is important to the person, that person can choose to have it incorporated in their NDIS plan which may then be supported explicitly by another service or provider. This principle instead suggests that within the scope of home and living supports providers should be responsive to enable those goals through active supports. This may be by supporting the development of relevant skills or routines at home.

It also reflects that for many people the home and living service is disproportionately present in people's lives and therefore has a role to encourage choices in all areas of life – even if they are not actively participating in the achievement of those goals.

# Mapping to Disability Housing Outcomes Framework

## Enablers

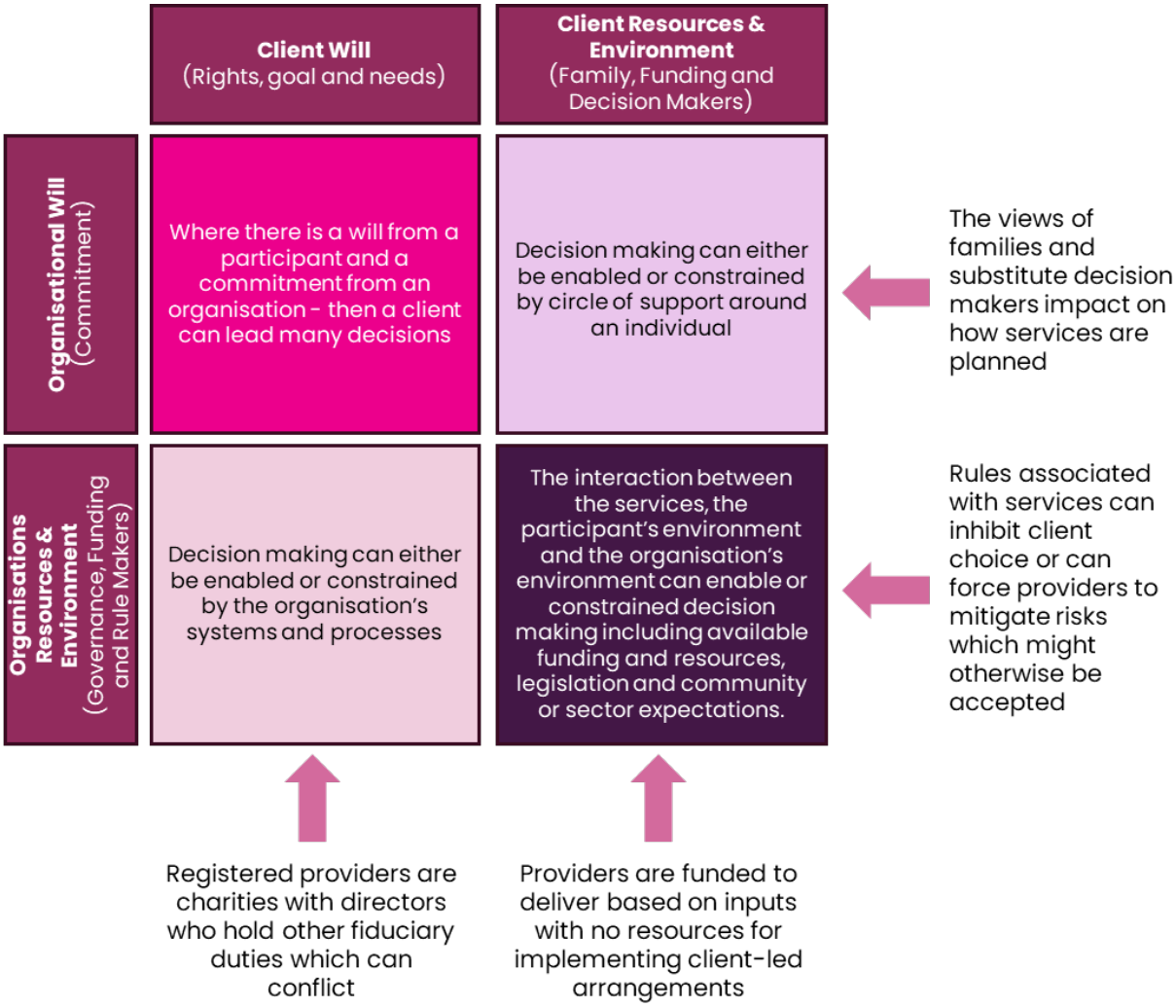
In addition to establishing principles, a range of underpinning enablers were identified. These enablers were determined as essential to ensure the broader intent of client-led arrangements could occur. Many enablers were identified by A20 members who were seeking to implement client-led arrangements in these organisations. Further enablers were identified in research, often as limitations. Finally, enablers were identified by representative organisations.

| | |
|---|---|
| **Commitment to client-led approaches** | Many providers reported adopting a specific commitment to client-led practice, through their stated mission or vision, values, practice framework or an explicit statement of client rights. These commitments are characterised by describing how client-led approaches are expressed in structure, process, relationships and practices. Organisations which made these commitments reported higher levels of client-led outcomes. |
| **Practice framework** | Several providers had in place a published practice framework which documented and explained the connection between a commitment to client-led approaches and the adoption specific practices that enable them such as active support, practice leadership, positive behaviour support and trauma informed support. We recognise that a practice framework which specifically details how the organisation develops, coaches and mentors support workers is likely to have a positive impact on enabling client-led practice. |
| **Capability & Culture** | We identified that the organisations that had made the most progress in embedding of client-led practice in everyday service delivery were those who had invested in the capability of people providing supports and had specifically developed a culture which recognised the value of these practices. Those cultures generally incorporated regular practice supervision and coaching. |
| **Outcome measurement** | The organisations that reported the highest levels of outcomes had taken steps to measure outcomes as an indicator of client-led approaches. In some organisations this was completed as part of an external academic study. In one organisation regular monthly outcome measurement was implemented from a service to whole of organisational levels. This organisation reported the highest outcomes of any organisation in the survey sample. Providers should strongly consider the benefit of outcome measurement in seeing positive change in relation to client-led approaches. |

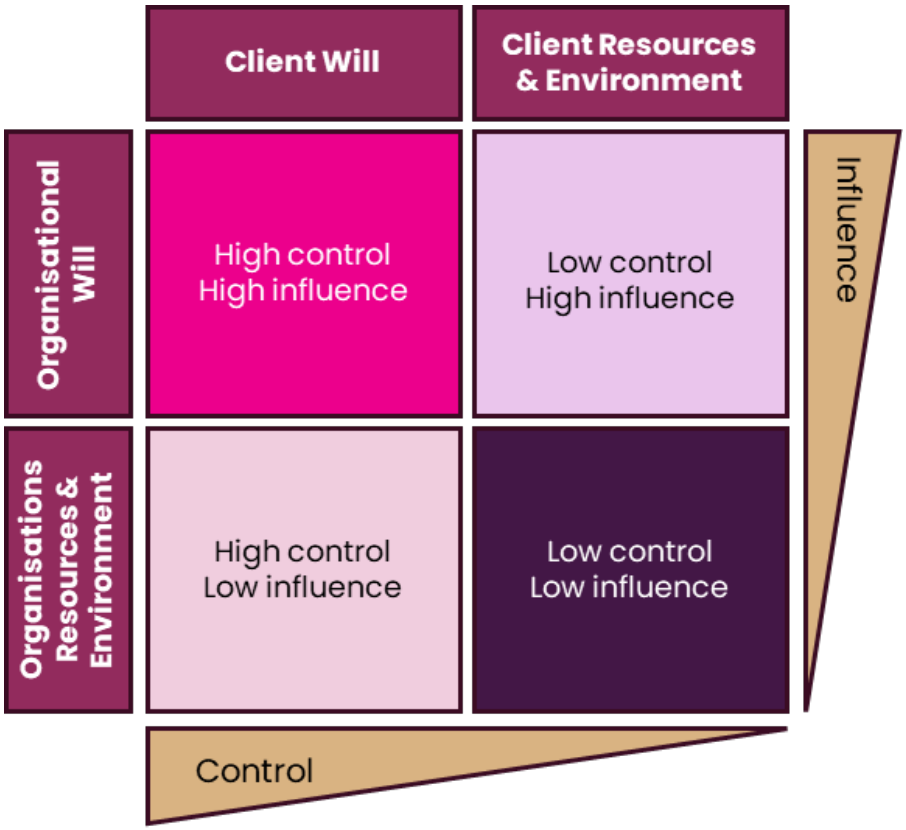
# Considerations for policy to enable client-led home and living arrangements

## Environment for client-led decision making

A significant barrier identified by Alliance20 members in developing and delivering client-led approaches was factors where they had limited influence or control. The following diagram represents the challenge as it is understood from a provider perspective.




There is a broader context for client-led arrangements which depends on the people surrounding the person being supported, and the funding and regulatory environment to enable the approach.




## Role of family substitute decision makers

Providers recognise that whilst they can exert some influence in relation to families and substitute decision makers, that in some cases those decision makers will make decisions which directly contradict decisions of people with a disability. During this review, organisations have given examples of where decision makers prioritise safeguarding over risk taking or make decisions which align to the family member or decision makers own values but contradict the choices of a person with a disability (e.g. gender identity, sexual preference).

In some cases, providers will engage independent advocacy to support people with a disability in the case where they are not able to make choices due to a substitute decision maker. Whilst in some cases this has led to successful outcomes, it has also led to situations where substitute decision makers decisions remain unchanged, and significant conflict is created between the provider and the decision maker. Providers gave examples of where this conflict has led to substitute decision makers deciding to move to other services who are more compliant with their wishes, likely to organisations who have a lesser or no commitment to client-led decision making.

## Duty of care and regulatory obligations of providers

The regulatory environment has become increasingly complex for providers of home and living supports. In addition to industrial and workplace safety legislation, the evolving application of the NDIS Quality and Safeguarding Framework has a significant impact on how home and living services operate. Whilst providers determine their own policies and procedures in response to their duties and specifically the NDIS Practice standards, organisations need to weigh their own tolerance for risk, against their desire to support client-led approaches.

## Regulatory and funding environment

In addition to providers considering how they respond to obligations under the practice standards, the NDIS Quality and Safeguards Commission has increased directive guidance to providers through complaints and serious incident investigations, enforcements and practice alerts (which often determine specific responses to situations – especially relating to areas which present risk to safeguards like disability related health conditions). Providers are required to consider how client choices impact explicit and implicit guidance from the regulator.

The National Disability Insurance Agency (NDIA) is similarly evolving their approach to funding home and living supports. Despite a policy intent to increase individualisation in how services are delivered, since the introduction of the scheme the NDIS has transitioned from a highly individualised approach to determining a home and living budget based on quotation to a system with a far greater focus on consistency, in terms of how services are priced, the amount of services provided and how they are shared. Providers identify that whilst the NDIA promote client-led approaches as best practice, the approach to funding increasingly constrain the ability to co-design services.

# Glossary

| | |
|---|---|
| Client-led | An approach to service delivery focus on ensuring people with disability make decisions about their supports |
| Home & Living | A group of supports which when combined provide what is reasonable and necessary for a person with a disability to live safely |
| Supported Independent Living (SIL) | The direct and wrap around support provided to an individual along with other Home & Living supports |
| Specialist Disability Accommodation (SDA) | The housing supports provided to a person with a disability who has specialist housing needs which require adaption to form and design |
| Disability Representative Organisations (DRO) | Organisations which represent people with a disability in advocacy and public policy |
| Alliance20 (A20) | Organisation of Australia's largest disability service providers which develop initiatives to strengthen the National Disability Insurance Scheme (NDIS) and deliver better services and outcomes for participants. |
| Comprehensive Health Assessment Program (CHAP) | Evidence-based tool for conducting annual health assessments for people with intellectual disability in Australia |
| Disability Housing Outcomes Framework (DHOF) | The Disability Housing Outcomes Framework (DHOF) Tool helps providers of disability housing and support to understand their outcomes through regular surveys of the people in their homes. |

# Appendix A: Literature Review

A literature search was conducted using the PsycINFO, PubMed, Social Sciences Citation Index, and Scopus databases.

Searches were limited to journal articles and book chapters written in English from 1990 and later to reflect the time of deinstitutionalisation in Australia onwards.

A total of *N* = 3,577 papers and chapters were located using the keywords:

- "client-led" AND "housing AND (health OR "daily living" OR relationships OR transitions OR inclusion OR "decision making")
- codesign AND housing AND (health OR "daily living" OR relationships OR transitions OR inclusion OR "decision making")
- coproduction AND housing AND (health OR "daily living" OR relationships OR transitions OR inclusion OR "decision making")
- "intellectual disab*" AND "client voice"; "intellectual disab*" AND "client voice" AND "human rights"
- "intellectual disab*" AND codesign AND (health OR "daily living" OR relationships OR transitions OR inclusion OR "decision making")
- "intellectual disab*" AND "decision making"
- "intellectual disab*" AND "client-led" AND housing
- "intellectual disab*" AND codesign AND housing.

After duplicate items were removed, a total of *N* = 2,135 papers and book chapters remained.

2,088 articles were deemed not to be relevant to the review.

68 articles were reviewed and did not include evidence or relevant material to the review.

21 articles/chapters were relevant to client-led home and living supports.

5 articles/chapters were identified as potentially relevant but were not fully reviewed due to time constraints.

# Appendix B: Environmental Review Detailed Analysis

## Background

This review was conducted based on the working definition of Client-led arrangements:

"A service model where people with disability are central to decision-making across their housing and support, including who supports them, how, when, and where that support is delivered and how their environment and services reflect their values, identity, and goals."

The review also considered the Disability Housing Outcome Framework developed by Social Ventures Australia with the sector. In completing the review academic search approaches, the authors knowledge of literature and desktop search approaches to identify sources as referenced were used.

## Introduction

Traditional shared accommodation supports, typically described as group homes in the literature, are currently regarded, by the National Disability Insurance Scheme, as not being best practice or client-led. This follows negative assessment of group homes by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability 2023 (Royal Commission), which made strong recommendations for interim reform of group homes, that is homes where 4 to 6 people with disability live together and share support, specifically:

- Recommendation 7.41 was to separate Supported Independent Living (SIL) and SDA arrangements and to strengthen models of practice such as Active Support and Practice Leadership.
- Recommendation 7.53 was for the longer term phasing out of group homes within 15 years and no new development of 4-6 bed group home accommodation.

The Next Steps Report, National Disability Insurance Scheme Quality and Safeguarding Commission (2024) cited the following as the key outcomes from the Royal Commission (2023) report to be actioned.

"There is a need for specific regulation of group home settings to enhance the quality and safety of these settings for people with disability:

- Greater engagement with people living in group homes is required to support their exercise of choice and control
- The attitude and aptitude of the workforce drives a high number of the issues evident in group home settings
- The interaction of SIL and SDA arrangements impacts the ability of people with disability in supported accommodation to make changes to their living arrangements
- The NDIS Commission needs to better understand the supported accommodation market and how people interact with it, including by improving the collection, monitoring and analysing relevant data
- The interface with health and the supported accommodation system is not effective for many people living in these settings."

Kendrick, M. (2017) celebrates the move in Canada and internationally to individualised funding and to the choice, when available, to live individually or with one or two others which is consistent with the NDIS funding approach adopted in Australia.

While the Royal Commission recommends the move away from group homes the allocation of "individual funding" for people requiring support to live their life at home is typically, the default funding ratio of 1:3 of Supported Independent Living (SIL) Funding. This means that while a person may use this money flexibly a 1:3 funding allocation, they will need to share some supports or leverage informal supports if the person both requires 24x7 support and prefers to live alone.

Another barrier to choosing to move away from traditional "group homes" is identified in the NDIA / SCOPE Having a Go Report 2023 which found that having information to choose and understanding the available Home and Living Options was a barrier to making choices both for people with disability and their supporters. This is reflected in the allocation of funds for the 2025 round of home and living research projects which substantially focus on home and living roadmaps and decision making.

While a focus on choice of home and support provider is an important step it is only an initial step if, as recommended in Next Steps (2024), greater engagement to ensure choice and control is to be achieved throughout a person's life.

## Innovative Approaches and their Outcomes

Client-led models being described in both academic and grey literature also reflect a focus on housing as a primary means to support choice and control.

The option of apartment style living where persons with disability live alone or with a friend and may share support with persons living in other apartments was evaluated by Carnemolla (2022). They noted that "despite social policy narrative little is known about what influences outcomes in individual settings and how they compare with other models such as group homes." The rationale for apartment living is that it provides improved access to community supports and activity in urban settings when compared to new builds located in outer suburbs where land is more affordable, but services and activities are thin. Participants in this study reported greater ownership of and autonomy within their home, improved choice and control about how they live within the space and more independence within their home. Due to complexity of accessing buildings and way finding to shared outdoor spaces, it was identified that less time was spent outside than previously when people lived in housing with direct access to outdoor space, further the challenges associated with finding sufficient, suitably skilled support workers was reported as a significant, an going challenge consistent with broader sector workforce and practice governance challenges within the sector.

An AHURI review of Independent Supported Living (ISL), Thoresen et al., (2022) described ISL as "an approach to support persons with intellectual disabilities, including persons with high support needs, to live lives of their choosing in their own homes. This may take different forms. It is not focussed solely on the physical housing setting, as the nature of supports available to the individual is central to the model. ISL may include a mix of formal and informal supports, as well as opportunities for individual growth and development across a range of social and community roles tailored to the needs, preferences, strengths, vulnerabilities, and ambitions of the individual.

"The ISL Framework is built around three fundamental assumptions:

- all adults with disabilities can live in an ISL arrangement if they are provided with the appropriate supports

- persons with disabilities do not have to live together
- persons with disabilities in an ISL arrangement do not have to live alone or independently."

This review showed that many challenges were articulated within this model including the support needs of the people with disability and the challenges associated with finding "suitable and sufficient staff to provide quality care including behaviour intervention". The major benefit was participants "having more choices and being happier." In this cohort the pathway to these arrangements was moving out of the family home with support and advocacy from family to access this pathway or following a break down in other accommodation models. The key benefits identified were that access to appropriate physical space improved choice and control and supported ability to make own decisions. It was also found that people with disability within this support model were still limited to contact with family members, paid support providers and other people with disability and that this arrangement had not led to greater inclusion or connection with community.

Oliver et al., (2020) conducted a scoping review of outcomes of individualised housing for people with disability and complex needs. They defined individualised housing as "Housing options that are life stage appropriate, where people with disability have choice regarding where and with whom they live, the support they receive and day to day activities."

This review found a positive association between individualised living and self-determination, choice and autonomy and favourable outcomes in relation to domestic tasks, social relationships, challenging behaviour and mood. Outcomes relating to self-care, adaptive behaviour, scheduled activities and safety showed no difference or less favourable outcomes than group homes.

While these examples reflect the outcomes of living individually with sufficient support there are barriers to all people with disability enjoying these arrangements, the cost for people who require constant access to support due to their needs and who are unable to independently call for assistance are unlikely to be funded by government given the current climate of reducing funding and pressure on government to reduce NDIS costs. Further they show that while individual living arrangements increase choice and control within the personal living environment another key issue highlighted by the Royal Commission, specifically increased relationships, participation and inclusion within society did

not improve. Consistent with the Next Steps (2024) report aptitude of the workforce continued to be identified as a barrier despite the individualised setting.

Adult "foster care" type arrangements have been advocated for by the Grattan Institute as an alternative to group homes due to their cost and the reported satisfaction of people utilising these arrangements. The example cited is Shared Lives, a service in the United Kingdom offering support through people sharing their lives and in some cases their home. The Shared Lives website reports that in 2020, 12,800 people were supported either during the daytime through shared activity or overnight for short- or long-term accommodation. Brookes et al (2023) reported that in 2022 it was estimated that over 5717 of arrangements were used by adults with learning disabilities (United Kingdom Terminology for Intellectual Disability) and that they report high levels of satisfaction with the scheme.

A report by Mitchell-Smith et al., (2020) examined the outcomes for 65 young people (16+) leaving care who moved to Shared Lives arrangements. Young people involved in the pilot reported greater choice, autonomy, consistency and stability and improvements were reported on outcomes related to self-risk management, emotional health, and increased integration with family and community. Within this pilot recruitment of carers was identified as a major challenge with one area unable to find any carers despite extensive recruitment. Given a population of 67.08 million in the UK and 12,800 placements currently this is likely to be a difficult option to operate at scale in Australia. There is a further lack of clarity as to whether the Australian industrial relations environment will support such arrangements.

Support for choice and control by independent facilitators is an area of emerging innovation. In this model independent support is provided prior to the establishment of new SDA and SIL arrangements by facilitating co-design conversations individually and between clients about how they wish to live and be supported. An evaluation of the pilot project (Summer Foundation, 2025) found that people with disability were more satisfied over time, showing that the model helped them feel more in control, connected, and empowered through shared support. People with disability said they felt listened to, learned about their rights, built community ties, and made small changes, though group dynamics and housing challenges mean ongoing facilitation is still needed.

Self-advocacy organisation, VALID have developed a peer led service quality review process where clients provide feedback about the services they are

experiencing for providers to respond to. This model is funded by the Victorian Government for accommodation services previously delivered by government disability services and VALID also provide a report to Government incorporating provider responses.

## Considerations for Innovation

This review has primarily considered how can client-led services be achieved within the practical constraint of a 1:3 support ratio for people who require 24x7 supports. The primary focus of innovation in Home and Living is individual living for people who have a sufficient level of capacity to live alone. We conclude that that if people can call for assistance and to wait for assistance to arrive, living individually while supported collectively will likely be a favourable option. We recognise for people with more pervasive support needs, including those who need others to notice and respond to their needs and who can't call for help, that further innovation is required.

In both individual and shared accommodation models the need for appropriate staff support utilising practices that foster skills and respond to the people they support so that they can take the lead in their own lives is highlighted as a key issue. While housing and particularly individual living arrangements have a significant impact on everyday choices about how people live their life within that same environment for other areas of their life such as self-care, time outside their home, developing relationships and participating in community life they are still reliant on access to support practices that deliver these outcomes.

Bailey et al (2024) examined a family led cluster housing model in which 15 residents lived in individual homes with a communal space for social activity modelled on an intentional housing community. This development met considerable resistance from government funding representatives who expressed concern that this congregate setting would recreate an institution. The study suggested that any housing was "institution-like if it creates barriers to the critical elements of community participation, social connection, person-centred support and individual choice regarding private and shared spaces".

The cluster-designed homes were specifically chosen and designed by families who knew their children well and both the buildings and support models were chosen to improve those critical elements. An intentional focus equal to that placed on the housing and the support was placed on building social

relationships. Specific actions included inviting neighbours outside the cluster to information meetings and to celebrate key milestones in the development and the use of a communal space with dining room, jukebox and BBQ area for people living within the cluster accommodation to hold celebrations of people such as Birthdays. This study showed that while individual housing can improve choice and control intentional support of relationships is central to building social relationships and inclusion in community.

The Grattan Institute (2024) highlights the risks people living in "group homes" face. While living in individualised settings addresses two of these, client to client violence and choice over key aspects of home life, who they live with, where they live, and who provides support; the other risks are as likely to be present in new models of support as they are in some group homes.

Specifically, the risks identified were:

- Isolation and limited contact with people outside the residence.
- Large numbers of staff providing support to residents.
- A lack of valued interpersonal relationships between residents and staff providing care, and
- A service culture that puts the needs of staff first.

Figure 1 in the Next Steps Project suggests 6 factors that are integral to a good home life for people sharing their home and supports. Three relate to how providers organise and deliver services:

- Worker Safety is Paramount
- Appropriately Trained and Assessed Staff, and
- Privacy

All impact significantly on participant experience while three more directly focus on how clients are engaged.

- Focus on Human Rights,
- Participant Centred, and
- Harmonious House Dynamic

These three factors could be considered as integral to a "Client-led" service and there are evidence-based practices shown to deliver these outcomes as listed below.

***Focus on Human Rights***

- Knowing the person well
- Supported Decision Making
- Active Support
- Positive Behaviour Support
- VALID8 Quality Project
- Talking Mats
- Chinn et al, 2024 describe a research methodology for capturing opinions of people with disability about what home looks like using photovoice (photo elicitation), a research methodology that could be used in practice for capturing client-led decisions and preferences of people with severe and profound disability.

***Participant centred***

- Person Centred Planning
- Active Support
- Positive Behaviour Support
- VALID My Home My Plan workshops
- Capable Environments

***Harmonious House Dynamic***

- Enliven Community project using the "Facilitator" role.
- Active Support group-based strategies specifically promote cooperation and participation to complete daily tasks.
- Capable Environments.

All of these practices rely on implementation on a day-to-day basis by disability support workers supported by frontline leaders. Organisational commitment and Practice Leadership to support employees tasked with utilising these approaches to delivering valued outcomes will be critical to embedding any client-led practices

Current evidence indicates that the challenges identified in implementing quality services in group homes will also be experienced in client-led individual arrangements and in arrangements where people share their homes.

O'Donovan et al (2022) in a review examining strategies to support people with disabilities to move from group homes and congregate care found that

- Interventions that enable transition exist at policy (flexible funding, adequate housing stock), organisational (staff training, provision of specialist services, person centred values), community (technology, outreach supports), interpersonal (staff support and informal networks and supports) and individual levels (involvement and skill development). Barriers to transition also exist at each of these levels

The difficulties in changing practices in group homes are highlighted by Bigby and others (2019a) who found that embedding active support was hard even when organisations had committed to do so and particularly hard when serving people with high support needs. Factors identified as most significant in changing practice by Bigby (2019b) were "a strong culture of support for practice amongst senior leaders combined with structuring practice leadership so that it is close to frontline service delivery and that tasks are aligned with those of line management." Bigby (2019a) also found that widely spread support needs of people being supported in group homes led to poorer quality of support as disability support workers are shown to find it more difficult to support people with severe and profound disability and that this challenge is exacerbated when there are people with lower support needs being supported in the same house by the same team. This factor should be considered and researched further in arrangements where people live individually, and share supports.

The VALID PS Report demonstrated that people who had previously lived in institutions and did not have family connections had lower scores on the VALID "Good Life Scale." Bailey and (2024) reported on a housing innovation and support approach that was family driven and the AHURI (2022) indicated that pathways into Individual Supported Living were driven by family advocacy or self-advocacy through behaviours of concern leading to accommodation breakdown. This suggests a focus on innovation through choosing where to live, who to live with and who to have provide supports is least likely to impact on the people most at risk and experiencing the greatest disadvantage within the current funding and service system.

Organisational leadership and commitment, to support the implementation of Practice Leadership in the application of client-led support practices is not only the most likely approach to succeed but also an approach that will ensure that those with severe and profound intellectual disability, particularly those without family supports are not left behind.

There are multiple descriptions and definitions of client-led. The MIND practice framework conceptualises a continuum of client leadership recognising that people will choose the level to which they are engaged even if the system offers opportunities at every level.

Currently evidence is not consistently collected across the sector to demonstrate what is occurring and what is working. There are two key areas for consideration.

***Measurement of process*** where actions to implement good practice are recorded demonstrating that the action is being taken, for example introducing two monthly observation and feedback for direct support workers and setting this as a Key Performance Indicator for Frontline Leaders and

***Measurement of Outcomes*** in order to evaluate the effectiveness of the action being taken, for example use of the Social Ventures Outcome Scale or the Observing Practice Quality Tool.

Given the limited data available to demonstrate outcomes with both shared and individual settings, providers should prioritise efforts to collaborate with academics and drive practice improvement that is achievable within current environments and constraints.

Strategic collection of data can be used to demonstrate where services are client-led, and quality of life is improving. This evidence could then be used to provide accountability to clients and others choosing services, position services to make decisions based on a stronger body of evidence as well as demonstrating that organisations are leading innovation and delivering pre-emptively on Next Steps recommendations.

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# Appendix C: Survey Design

The intention of the questions is to understand whether organisations have identified relevant practice, whether it is embedded in training or practice approach, and whether it is consistently applied.

The following rating scale is used:

| | |
|---|---|
| **Not at all** | We have not identified any specific practice or approach OR we are planning to do something but have not started. |
| **Not much** | We have identified the appropriate practice or approach and communicate our intent to follow it through broad direction. Some employees would be unaware. |
| **Sometimes** | It is part of our standard practice, training or induction and most employees would recognise the approach. |
| **Most of the time** | It is compulsory practice, training, and we have strategies in place to assess its implementation |
| **All of the time** | It is core to our practice, and we ensure it occurs consistently and can demonstrate this with evidence. |

We are interested to understand how the level of complexity of supports impacts Client-led arrangements. For each question respondents can elect to provide additional detail if they believe there are differences in how these services operate:

*Does the complexity of support impact how Client-led arrangements are implemented (eg. for non-verbal people with disability, people with behaviours of concern, people with no family or responsible person)?*

*YES/NO*

If YES, the matrix will appear a second time.

If YES, an additional question will appear.

*Provide detail about how this is different for this cohort?*

# Demographics

1. How many **FTE staff** (approx.) does you organisation employ?

| | | | |
|---|---|---|---|
| Fewer than 100 | 100-500 | 501-1000 | 10001+ |

2. How many **NDIS participants** does your organisation support in Home and Living services?

| | | | | |
|---|---|---|---|---|
| 1-50 | 51-200 | 201-500 | 500-1000 | 1001+ |

3. What are the main types of Home and Living supports you deliver?
   - SIL
   - ILO
   - SDA
   - Other (please specify)

4. What best describes your current role?
   - CEO / Executive Leader
   - Operations Manager
   - Practice Lead / Service Designer
   - Quality / Safeguards / Risk
   - Frontline Manager / Team Leader
   - Policy / Strategy Advisor
   - Other (please specify)

5. How would you describe the overall complexity of your Home and Living service delivery?

(Please consider the diversity of models, participant needs, staffing requirements, and regulatory demands.)

- Low – Single model, relatively consistent participant profiles, minimal complexity
- Moderate – Mix of models and/or moderate diversity in participant needs
- High – Multiple models, high diversity in participant needs, complex staffing and risk profiles
- Not sure / Prefer not to say

# Survey

**Definition**

| 6. What does ‘Client-led’ mean to you? |
| --- |
| *Open-ended text-based answer.* |

**Independence**

7. In our services, people with disability….

| | Not at all | Not much | Sometimes | Most of the time | All of the time |
|---|---|---|---|---|---|
| …make everyday decisions about their lives (eg, work, religion) | | | | | |
| …lead or influence decisions about where and with whom they live? | | | | | |
| …set their own goals for independence and track progress | | | | | |
| …understand and can influence the way their supports are delivered? (who, where, when, how) | | | | | |
| …can transition to more or other self-directed supports or independent living options when ready or requested? | | | | | |
| … regularly engage someone independent of their SIL and SDA provider to explore their living arrangements | | | | | |

*Does the complexity of support impact how Client-led arrangements are implemented.*

*YES/NO*

If YES, the matrix will appear a second time.
If YES, an additional question will appear.
Provide detail about how this is different for this cohort?

| 8. What are the key elements of your support model that promote the independence of the people you serve? |
|---|
| *Open-ended text-based answer.* |

**Daily Living**

9. In our services, people with disability….

| | Not at all | Not much | Sometimes | Most of the time | All of the time |
|---|---|---|---|---|---|
| …choose or co-design the daily living skill-building activities (e.g., cooking, budgeting, self-care)? | | | | | |
| …set or adjust their own daily routines (e.g., mealtimes, sleep/wake cycles, use of space)? | | | | | |
| …make daily decisions based on preference rather than routine (e.g., what to wear, when to eat, what activities to do)? | | | | | |
| …choose to develop and track skills that respond to their daily preferences? | | | | | |

*Does the complexity of support impact how any of these Client-led arrangements are implemented?*

*YES/NO*

If YES, the matrix will appear a second time.
If YES, an additional question will appear.
Provide detail about how this is different for this cohort?

| 10. What helps or hinders people with disability in making choices about their daily routines, tasks, or skill-building activities? |
|---|
| *Open-ended text-based answer.* |

| 11. Do you capture evidence which demonstrates the quality of day-to-day support provision (eg. Active Support)? |
|---|
| *Yes/No with provide details if Yes.* |

**Health**

12. In our services, people with disability….

| | Not at all | Not much | Sometimes | Most of the time | All of the time |
|---|---|---|---|---|---|
| … are supported to make their own decisions about health and wellbeing goals | | | | | |
| … are supported to understand their health needs and make informed choices (e.g., using tools like CHAP)? | | | | | |
| … participate in the coordination of health services (e.g., allied health, therapies)? | | | | | |
| … review and adjust their health supports over time based on changing preferences or goals? | | | | | |
| … regularly engage someone independent of their SIL and SDA provider to explore their Health and Wellbeing | | | | | |

*Does the complexity of support impact how any of these Client-led arrangements are implemented?*

*YES/NO*

If YES, the matrix will appear a second time.
If YES, an additional question will appear.
Provide detail about how this is different for this cohort?

| 13. What strategies does your organisation use to promote client-led health decisions and continuity of care? |
|---|
| *Open-ended text-based answer.* |

**Relationships and Community**

14. In our services, people with disability….

| | Not at all | Not much | Sometimes | Most of the time | All of the time |
|---|---|---|---|---|---|
| … decide how their social and community connections are supported (e.g., peers, cultural groups, shared interests)? | | | | | |
| … lead their involvement in peer connection and mutual support opportunities (e.g., groups, mentoring, lived experience sharing)? | | | | | |
| … set goals around cultural identity, language, or participation in their chosen community settings or events? | | | | | |
| … choose when and how they engage with social or community activities (e.g., scheduling, location, type of activity | | | | | |
| … spend time with people **not** paid to provide services (including services available to community eg. Hairdresser) | | | | | |

*Does the complexity of support impact how any of these Client-led arrangements are implemented?*

*YES/NO*

If YES, the matrix will appear a second time.
If YES, an additional question will appear.
Provide detail about how this is different for this cohort?

| 15. How does your organisation support people with disability to form and sustain meaningful social connections or community roles? |
|---|
| *Open-ended text-based answer.* |

**Rights and Voice**

16. People with disability….

| | Not at all | Not much | Sometimes | Most of the time | All of the time |
|---|---|---|---|---|---|
| … are supported to understand their rights and express concerns (e.g., through advocacy, complaints processes, or peer networks)? | | | | | |
| … are supported to make decisions in ways that reflect their preferences and communication styles | | | | | |
| … are involved in learning about their rights (e.g., workshops, lived-experience facilitation, NDIS Code of Conduct education)? | | | | | |
| … influence service improvements, governance, or advocate for their own rights? | | | | | |
| … are supported by an independent advocate and/or are empowered to self-advocate | | | | | |

*Does the complexity of support impact how any of these Client-led arrangements are implemented?*

*YES/NO*

If YES, the matrix will appear a second time.
If YES, an additional question will appear.
Provide detail about how this is different for this cohort?

| 17. What formal or informal processes do you have in place to encourage and enable people with disability to influence service improvements, governance, or advocate for their own rights? |
|---|
| *Open-ended text-based answer.* |

**Stability and Safety**

18. People with disability….

| | Not at all | Not much | Sometimes | Most of the time | All of the time |
|---|---|---|---|---|---|
| … receive support from familiar staff who understand their needs and preferences? | | | | | |
| … involved in planning for major transitions (e.g. hospital discharge, relocation, provider changes)? | | | | | |
| … in developing their own safety and risk management plans (e.g., emergency management, personal risk preferences, behaviour support, medication)? | | | | | |
| … have flexibility to make choices about their supports during unexpected events or crises (e.g. illness, family emergency, critical incidents)? | | | | | |

*Does the complexity of support impact how any of these Client-led arrangements are implemented?*

*YES/NO*

If YES, the matrix will appear a second time.
If YES, an additional question will appear.
*Provide detail about how this is different for this cohort?*

| 19. What factors most affect your organisation's ability to provide consistent, stable, and safe supports? |
|---|
| *Open-ended text-based answer.* |

**General**

| 20. What, if anything, is your organisation currently doing to make your services more informed and directed by people with disability? |
|---|
| *Open-ended text-based answer.* |

21. How confident are you in your organisation's ability to deliver consistent, safe, and participant-directed supports? Rate on a scale from 1 to 10.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|

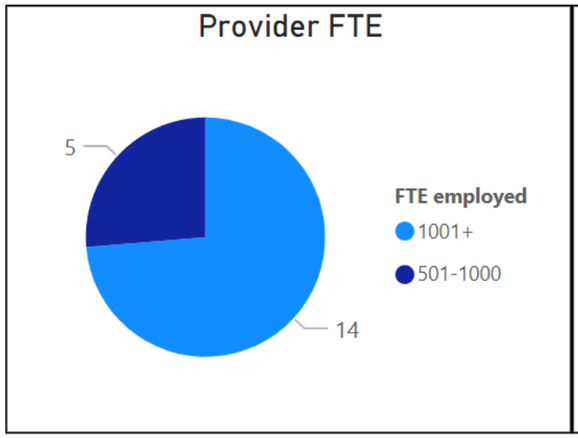
22. Where do you expect this to be in two years, based on current activity and plans?

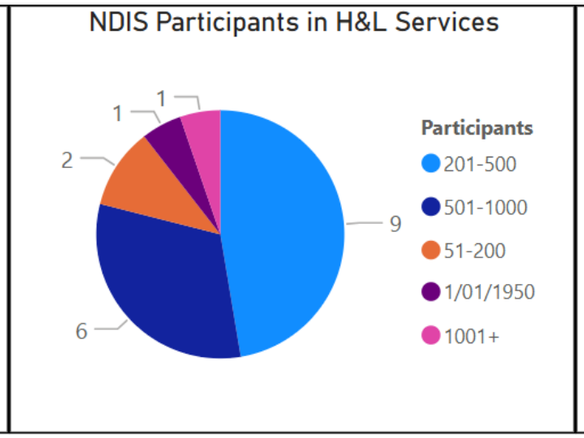
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|

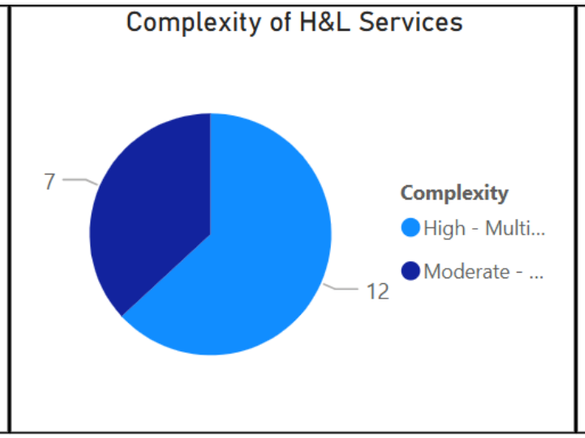
**Looking to the future**

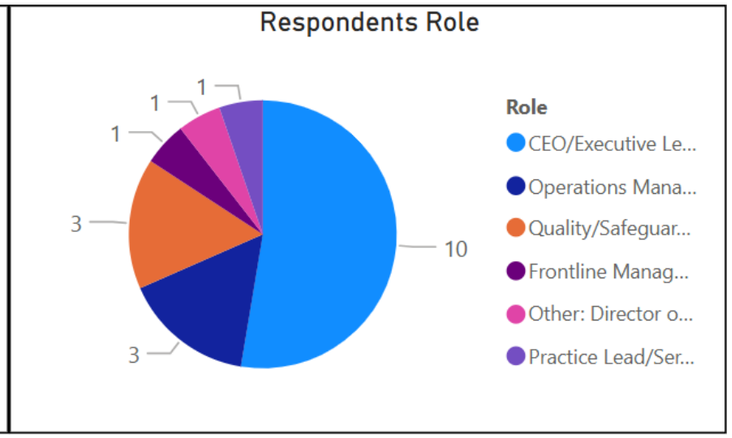
| 23. What would a truly Participant Led model look like in your organisation five years from now? |
|---|
| *Open-ended text-based answer.* |
| 24. What changes or innovations would most strengthen your organisation's ability to deliver Participant Led supports in the future? |
| *Open-ended text-based answer.* |
| 25. What system-level changes (e.g., funding, policy, workforce) would most enable your organisation to scale or deepen Participant Led practice? |
| *Open-ended text-based answer.* |

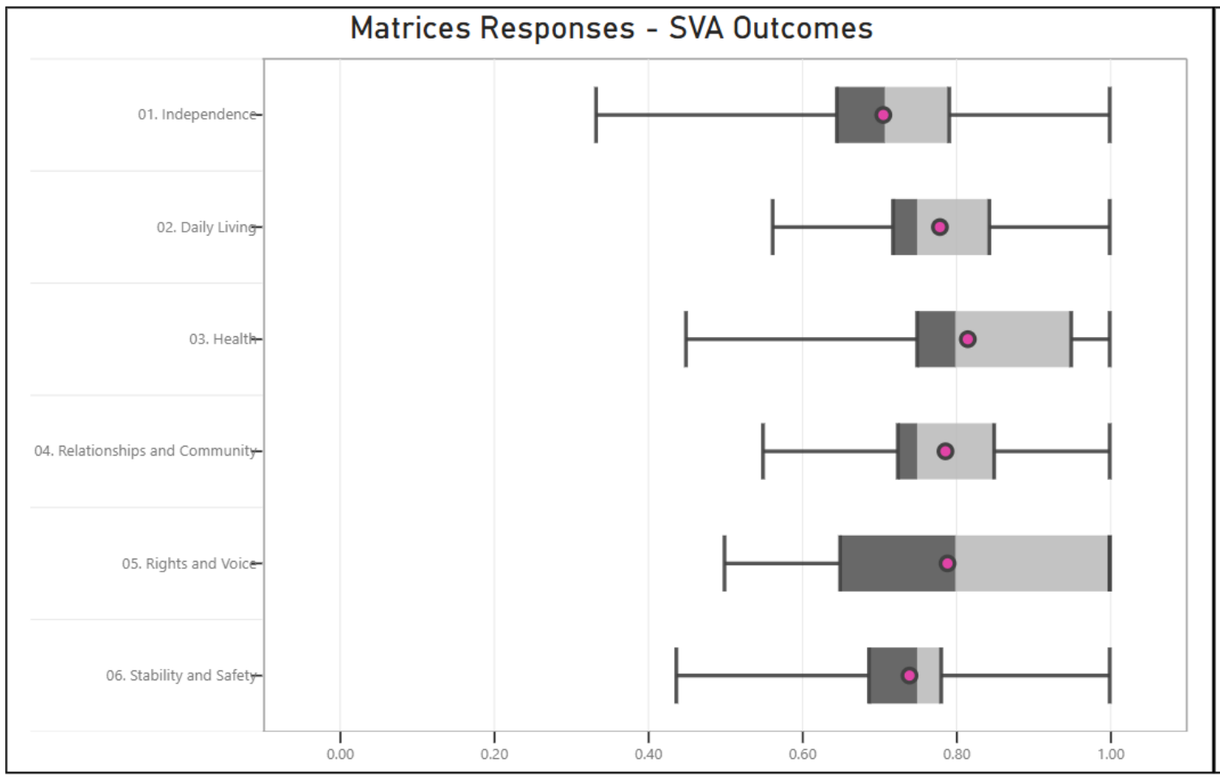
# Appendix D: Survey Results

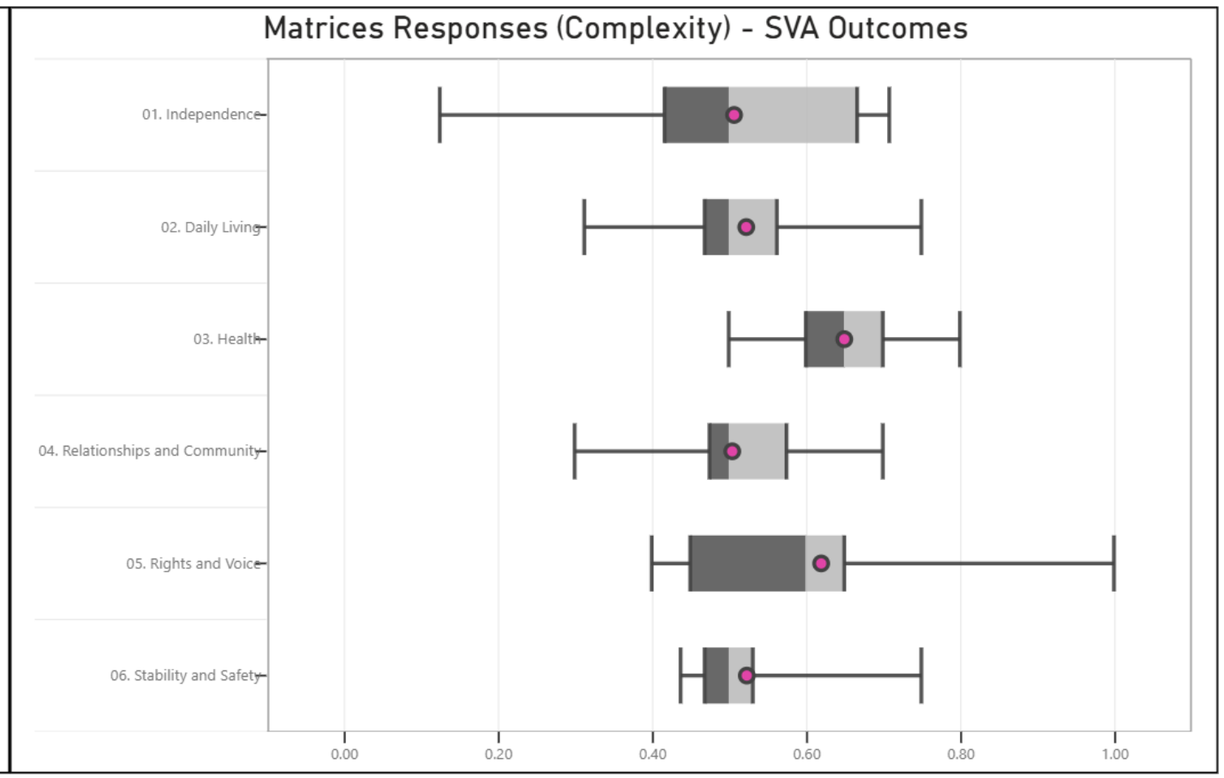


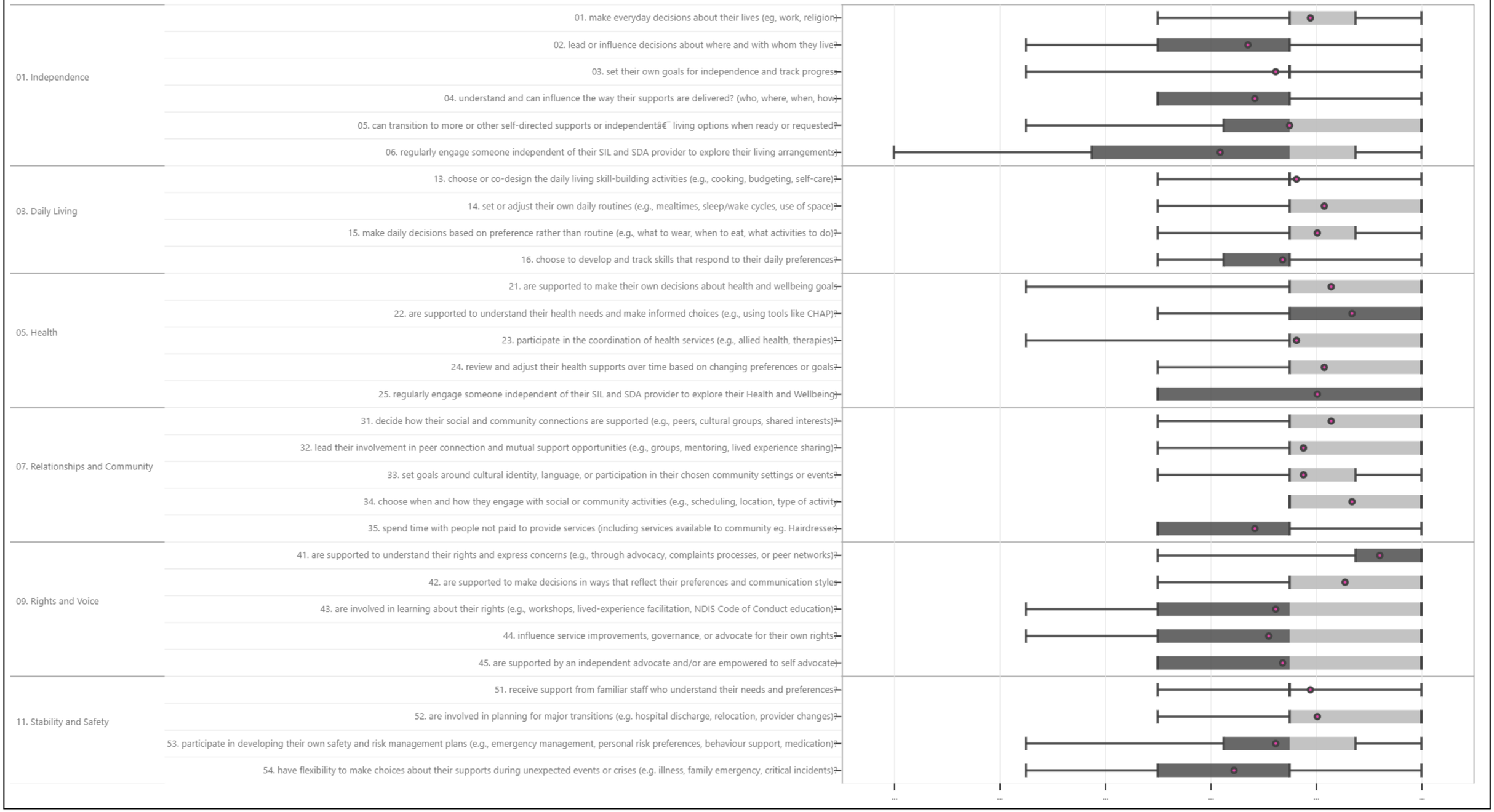



## Matrices Responses - Per Question



## Matrices Responses (Complexity) - Per Question