Every Australian Counts submission on

Supported Independent Living (SIL) Commissioning

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Introduction

Every Australian Counts (EAC) welcomes the opportunity to contribute to the Australian Government's consultation on the future of Supported Independent Living (SIL).

Every Australian Counts is the grassroots campaign that fought for the introduction of the National Disability Insurance Scheme (NDIS). Launched in 2011, EAC brings together people with disability, families, carers, supporters and others committed to ensuring people with disability have the support they need to live ordinary lives with choice, control and dignity.

EAC continues to advocate for an NDIS that delivers on its original promise to people with disability.

For people who rely on SIL, this consultation is not simply about commissioning, markets or service models. **It is about home.**

It is about who you live with, who comes into your home, who supports you to get out of bed, eat, shower and participate in your community, what happens when something goes wrong, and whether you have genuine power over the decisions that shape your everyday life.

That must be the starting point for this reform.

EAC's position

The NDIS was established to move away from a disability service system in which funding and decision-making power largely sat with governments and service providers. The disability rights movement worked for decades to challenge block-funded and provider-controlled models that too often left people with disability with little practical choice about their supports or daily lives.

The promise of the NDIS was different. Funding would be individualised and portable. People with disability would have greater power to choose who supported them and, importantly, to take their funding elsewhere when a provider did not meet their needs.

Those principles are fundamental to the NDIS and must be protected in any reform to SIL.

EAC supports stronger government stewardship, market development and oversight where there is poor quality, unacceptable risk, inadequate safeguards or limited service availability. However, **greater government oversight must not mean greater government control over the lives of people with disability.**

EAC does not support commissioning as a general, preferred or default model for SIL.

Commissioning would be acceptable only where no quality provider is available to meet a participant's needs, and only as a provider-of-last-resort response.

Before commissioning is used, Government should demonstrate that other measures to build or improve the market have been pursued and are not capable of meeting the person's needs. This should include investment in workforce capacity, support for existing providers, development of new entrants and support for small, specialist, local, culturally responsive and participant-led organisations.

Where commissioning is necessary, it should be strictly targeted to the identified service gap, used only for as long as that gap remains, subject to regular review, and designed to preserve individualised and portable funding.

Commissioning must not transfer participant funding and power back to contracted organisations in a way that makes people dependent on provider decisions or provider service models.

The principle should be simple:

More accountability for governments and providers. More choice and control for participants.

People with disability, particularly people with direct experience of SIL, and their representative organisations must have formal roles in the design, implementation, governance, monitoring and evaluation of any commissioning arrangements.

Nothing about SIL should be designed without the people whose homes and lives will be affected.

Question 1: Which SIL participants could benefit most from additional government oversight of planning, delivering and monitoring of SIL supports?

Additional government oversight should be targeted at **situations where participants face the greatest risk of limited choice, inadequate safeguards, poor-quality support or significant power imbalances**, rather than defining particular groups of people with disability as inherently vulnerable.

This distinction matters. Vulnerability is often created or increased by systems, environments and power imbalances, not by disability itself.

EAC cautions against using disability type, diagnosis, demographic characteristics or participant “cohorts” as a proxy for risk. Oversight should follow demonstrated risk, service failure and market conditions, rather than assumptions about a person's capacity or vulnerability based on disability.

Priority circumstances may include where:

- a participant has limited or no meaningful choice of provider;
- one organisation exercises significant control over both a person's housing and daily supports;
- a participant may lose their home, or reasonably fear losing their home, if they challenge or change their support provider;
- participants rely heavily on shared supports and have limited control over staffing ratios or rosters;
- there are repeated complaints, incidents, restrictive practices or other indicators of poor quality;
- a participant experiences communication barriers or does not have access to effective supported decision-making;
- people have limited access to independent advocacy or trusted informal supports;
- participants live in regional, rural or remote communities or other thin markets with very limited provider choice;
- culturally safe and appropriate services are unavailable;
- participants are transitioning from hospital, residential aged care or other institutional settings and have limited alternatives; or
- participants have complex or very high support needs requiring consistent and skilled support.

Oversight should also focus strongly on provider and service-level risk. Providers with repeated complaints, high staff turnover, poor incident management, inappropriate restrictive practices or persistent quality concerns should attract greater scrutiny regardless of the characteristics of the people they support.

Importantly, **additional oversight is not the same thing as commissioning**.

Government has a range of tools available to improve quality and safeguards, including regulation, monitoring, enforcement, workforce development, market stewardship and provider development. Commissioning should be considered only where those mechanisms cannot ensure that a quality provider is available to meet a participant's needs.

Oversight should follow risk. Commissioning should be reserved for provider-of-last-resort circumstances.

Question 2: What do high-quality SIL supports look like?

Good SIL gives people with disability the support they need to live the lives they choose. Quality must be judged by the participant's experience of daily life, including whether they feel safe, are listened to and have genuine control over their home and support.

High-quality SIL should include the following.

Control over everyday life. Participants should be able to decide when to get up, what to eat, who visits and how they spend their time. Support should adapt to the person's preferences, culture, identity, communication and individual routines. A person's home should feel like their own, with privacy and dignity, including during personal care. Provider routines and staffing convenience must not determine how people live.

Workers people choose and trust. Participants should have a meaningful say in selecting, matching, training and changing the workers who support them. Workers need the skills, values and knowledge to meet individual needs, including health, communication and complex support needs. Continuity matters because trusted relationships take time to build. Rosters should reflect participant needs and preferences, with reliable backup arrangements when a worker is unavailable.

Support for an individual life. SIL should enable people to maintain relationships, pursue interests and participate in their chosen community. Shared staffing must not force people into the same activities or prevent someone from going out or pursuing their own goals. People must not be pressured into shared living arrangements, unwanted housemates or support ratios that do not meet their needs.

Decisions that are supported and respected. Participants must receive accessible information, sufficient time and supported decision-making where required. Communication differences must never be treated as an absence of preferences or decision-making capacity. Providers should listen directly to the participant and involve family, advocates and trusted supporters where the participant wants this. Support should enable people to exercise their rights, make choices and take reasonable risks.

Safety and accountability in practice. Participants must be able to raise concerns privately, access independent advocacy and have complaints addressed promptly without retaliation. Workers must respond appropriately to signs of harm and follow individual safeguarding arrangements. Service agreements, charges and shared staffing arrangements should be clear and transparent. Providers should act on

participant feedback and be accountable for explaining what has changed as a result.

The freedom to change. High-quality SIL includes the practical ability to choose another provider without losing a home or experiencing a gap in essential support. Providers should plan transitions with the participant and cooperate with the participant's chosen alternative. Nobody should be trapped with a provider because their housing, essential support or funding depends on staying.

Shared support must never mean shared lives. People living in the same house may have different goals, routines, cultures, relationships, interests and preferences. Shared staffing arrangements must preserve those differences rather than requiring people to live according to a common provider schedule.

Quality should be reviewed with the participant against the life they want to live, including safety, wellbeing, relationships, community participation, independence, choice and control. Government should also use regular, accessible and independent participant-reported measures to determine whether these outcomes are actually being achieved.

Quality should ultimately be visible in a person's life, not just in a provider's records.

Question 3: How should SIL supports protect the safety, health, wellbeing and rights of participants?

Safety and rights cannot be separated.

A system that keeps someone physically safe while denying them choice, privacy, dignity or control over their life is not delivering quality support.

Choice alone cannot prevent abuse or neglect. Government must enforce standards, investigate concerns promptly and ensure participants can raise complaints privately and without retaliation.

Strong safeguards should include:

- accessible information about rights and complaints;
- access to independent advocacy;
- supported decision-making appropriate to each participant's communication needs;
- clear separation between housing or tenancy arrangements and support provision wherever possible;
- strong protections against retaliation when participants complain or seek to change providers;

- effective incident reporting, investigation and follow-up;
- strong oversight of restrictive practices;
- appropriate worker screening, training, supervision and professional development;
- continuity of skilled workers where participants have complex support needs;
- proactive identification of patterns of incidents, complaints and workforce problems;
- reliable backup arrangements when a service or worker is unavailable; and
- independent mechanisms for checking participant wellbeing, particularly where people are isolated or have limited informal supports.

Independent monitoring must hear directly from participants, using their preferred communication methods.

Participants must have safe ways to speak about what is happening in their home **without their provider controlling the conversation**. Communication support, interpreters, independent advocates and trusted supporters should be available where required and have open access to the participant.

Oversight should respond to evidence of harm, conflicts of interest, service failure and poor provider practice. It should not depend on assumptions about particular disability groups or participant cohorts.

There must also be consequences when poor practice is identified. Participants should not repeatedly report the same problems while responsibility is passed between providers, the NDIA, the NDIS Quality and Safeguards Commission and other agencies.

Any future arrangements must establish clear escalation pathways, responsibilities and timeframes for responding to serious or repeated concerns.

Importantly, strengthening safeguards must not be used as a justification for concentrating greater power in providers.

Concentrating more power in a provider that someone cannot leave can deepen the very dependency that safeguards are intended to address.

Safeguarding must also not become paternalism. People with disability have the same right as anyone else to make choices, take reasonable risks, have relationships, make mistakes and decide how they live.

The goal must be **safety with rights, not safety instead of rights**.

Question 4: How can innovation by SIL providers enhance the quality of SIL supports and outcomes for SIL participants?

For too long, innovation in disability support has sometimes meant asking people with disability to fit into a new service model rather than asking how services can fit around people's lives.

Real innovation starts with participants.

Innovation could include:

- more flexible and individualised approaches to shared support;
- self-management, self-direction and participant-led workforce models;
- direct employment and greater participant involvement in selecting, training and directing workers;
- better use of assistive technology where the participant wants it;
- technology that increases independence without increasing surveillance;
- flexible rostering based on individual routines and goals;
- stronger pathways between SIL and other home and living options;
- models that support transition from hospital or residential aged care into a home in the community;
- new approaches to reliable support in regional, rural and remote communities;
- culturally safe service models designed with local communities; and
- partnerships that improve access to mainstream services and community participation.

Innovation should not be defined simply as reducing paid support or achieving lower costs.

No participant should be required to accept technology, shared staffing arrangements or a new support model as a substitute for existing support merely because it is cheaper.

Innovation should be voluntary, based on informed choice and demonstrably improve outcomes identified by the participant.

Government should keep pathways open for new and different approaches shaped by people with disability.

Self-management, direct employment, self-direction and other individualised living and support arrangements must remain available to both existing and new participants.

A need for 24-hour support must not force a person into a commissioned service.

Commissioning arrangements should not create closed markets that favour only large organisations with significant procurement and administrative capacity.

Small, local, specialist, culturally responsive, participant-led and community-controlled providers can be important sources of innovation and diversity.

Government should support innovation by creating the conditions in which these providers and participant-led models can enter, develop and grow.

Most importantly, people with disability should be **co-designers and decision-makers.**

Question 5: How can effective participant choice and control be enhanced, including in regions with smaller populations?

Choice is only meaningful when there are real options available.

Keep the power to choose and change providers

Individualised and portable funding is a foundation of participant power.

It enables people to direct support towards their own needs and priorities and to replace a provider that does not listen or does not provide appropriate support.

Returning control of funding to contracted organisations risks making participants dependent on provider decisions and requiring them to fit within the provider's service model.

An exit right is meaningful only when people can actually use it.

Funding must follow the individual, including outside any commissioned provider or provider panel.

Participants need accessible information about their options, supported decision-making where required, access to independent advocacy, uninterrupted essential support while changing providers, and practical assistance to move from one provider to another.

Nobody should have to prove provider failure before choosing to leave.

Housing and support should also be separated wherever possible.

Changing a support provider must not threaten a person's tenancy or force them to leave their home, community or relationships. Provider or commissioning contracts must not pressure participants to accept unwanted housemates, shared support arrangements or routines designed around staffing convenience.

Making better alternatives possible

In regional, rural and remote communities, the first response to a thin market should be to **build the market, not remove participant choice**.

Government should invest in workforce development, local organisations, additional supply and measures that support quality providers to establish and remain in undersupplied communities.

Large tenders and long exclusive contracts risk favouring established organisations with significant procurement resources while excluding smaller, local, culturally responsive and participant-led providers before participants have an opportunity to choose them.

This can entrench existing service models and reduce pressure on providers to improve.

Government should keep market entry open and actively support alternative and participant-led models.

Commissioning should be confined to a provider-of-last-resort response where no quality provider is available to meet the participant's needs.

Government must demonstrate that gap, protect individualised alternatives and regularly review whether commissioning remains necessary.

Where commissioning is used, it should extend only as far as necessary to address the identified service gap. Individualised and portable funding must be retained, participants should retain choice wherever more than one suitable option exists, and participants must be able to leave when an appropriate quality alternative becomes available.

Government intervention must not turn a thin market into a permanent **single-provider market**.

Commissioning must not displace quality providers or become the default model for SIL.

Question 6: What is needed to ensure that SIL providers are sustainable?

Provider sustainability matters because participants need reliable support today, tomorrow and into the future.

But sustainability cannot mean protecting every existing business model regardless of the quality of support delivered.

The goal must be **sustainable high-quality support, not simply sustainable providers**.

Good providers need funding arrangements that reflect the real cost of delivering safe, skilled and reliable support. This includes fair wages and employment conditions, appropriate training and supervision, workforce development and retention, higher costs associated with rural, regional and remote delivery, specialist skills required for participants with complex support needs, adequate governance and safeguarding systems, and genuine participant engagement.

Government should use market stewardship, workforce initiatives and provider-development measures to improve sustainability before turning to commissioning.

Large tenders and long exclusive contracts can favour established organisations with substantial procurement capacity.

Small, local, specialist, culturally responsive, community-controlled and participant-led providers may be excluded before people have the opportunity to choose them.

This risks entrenching existing service models, reducing provider diversity and weakening the pressure on providers to improve.

Government must also avoid structuring commissioning arrangements in a way that effectively guarantees providers participants, occupancy or market share. Provider viability should not depend on participants being locked into services or pressured to accept unwanted housemates or shared support arrangements.

Evidence-based pricing and targeted investment should recognise the genuine costs of delivering high-quality support, particularly in thin markets and where participants have complex support needs.

Any provider-of-last-resort commissioning arrangement should be proportionate to the service gap being addressed, avoid exclusive or unnecessarily long-term contracts, maintain opportunities for new providers to enter

the market, avoid concentrating excessive market power, recognise the higher costs of operating in thin markets, and be regularly reviewed to determine whether commissioning remains necessary.

Government also needs clear arrangements for provider failure and service continuity.

Where a provider fails, withdraws from the market or is no longer able or permitted to deliver SIL supports, alternative support must be put in place quickly and safely.

Participants must not be required to accept an unsuitable provider, housemate or living arrangement simply to maintain essential support.

Participants with high support needs cannot be expected to carry the risk of provider or market failure.

Transition and implementation

If Government proceeds with any form of provider-of-last-resort commissioning, implementation must protect existing participants and support arrangements.

No participant should be required to move home solely because commissioning is introduced.

Nor should a participant be required to leave a quality provider, chosen workers, funding management arrangement or existing self-directed support merely because government changes how parts of the SIL market are managed.

There should be **no disruption simply to fit a person into a new commissioning contract**.

Participation in any commissioned arrangement should require active and informed agreement. Participants must retain the right to decline or leave without penalty where another suitable arrangement is available.

Before any transition, participants must receive accessible information explaining why commissioning is being proposed, the evidence that no quality provider is otherwise available, what the arrangement means for them, what choices remain available, how their funding will operate, how they can challenge or leave the arrangement, and when the need for commissioning will be reviewed.

Independent advocacy and supported decision-making should be available where required.

Essential supports must continue throughout any transition.

Any commissioning model should initially be **voluntary, time-limited and independently evaluated before broader use**.

Government should publish the findings of any pilot or evaluation, including participant outcomes, costs, rights impacts, competition impacts and whether commissioning remains necessary.

Governance and co-design

People with disability, particularly people with direct experience of SIL, must have formal roles in the design, implementation, governance, monitoring and evaluation of any provider-of-last-resort commissioning arrangements.

This must include people with intellectual disability, people with communication support needs, First Nations people, culturally and linguistically diverse communities and people living in regional, rural and remote areas.

Consultation alone is not enough.

People with disability must be involved in deciding the options, safeguards and implementation arrangements **before a preferred model is selected**.

They should also have an ongoing role in determining whether commissioning remains necessary and whether arrangements are achieving better outcomes.

What Government must commit to

Government must honour the promise of the NDIS through the following commitments, reflected in published policy and any commissioning contracts.

1. Protect consent and continuity.
Require active and informed agreement before a participant enters a commissioned arrangement. Guarantee the right to decline or leave without penalty. Preserve chosen workers, providers, funding management arrangements and self-directed supports wherever possible, with no disruption simply to fit a new commissioning contract. Essential supports must continue throughout any transition.

2. Protect individualised funding and participant control.
Reject any return to provider-controlled block funding, compulsory allocation or exclusive provider panels. Funding must remain individualised, portable and directed by the participant. People must retain the practical right to choose and change

providers without losing their housing, funding or essential support. Nobody should have to prove provider failure before choosing to leave.

3. Strengthen independent safeguards.
Fund independent advocacy, supported decision-making and independent monitoring. Provide accessible external complaints pathways, protection from retaliation and timely investigation and enforcement. Independent monitoring must hear directly from participants using their preferred communication methods. Quality must be assessed through participant experience and outcomes, not provider compliance alone.

4. Invest in a diverse and reliable supply of support.
Keep pathways open for new, small, specialist, local, culturally responsive, community-controlled and participant-led providers, as well as self-managed, direct-employment and other individualised models. Address workforce shortages and genuine delivery costs through evidence-based pricing and targeted investment. Government should not guarantee providers participants, occupancy or market share, and commissioning arrangements should not create permanent local monopolies.

5. Share power over reform.
Co-design any future model with people receiving SIL, including people with intellectual disability, people with communication support needs, First Nations people, culturally and linguistically diverse communities and people living in regional, rural and remote areas. People with disability must be involved in deciding the options, safeguards and implementation arrangements before a preferred model is selected, and must have formal roles in ongoing governance, monitoring and evaluation.

6. Limit commissioning to a provider-of-last-resort response.
Permit commissioning only where evidence demonstrates that no quality provider is available to meet a participant's needs and other market stewardship, workforce and provider-development measures have not resolved the gap. Government should publish the evidence supporting that decision, including costs, rights impacts, competition impacts and participant protections. Any pilot must be voluntary, time-limited and independently evaluated, with findings published. The need for commissioning must be reviewed regularly and the arrangement should end when quality alternatives become available.

Final comments

Every Australian Counts supports action to address longstanding problems in Supported Independent Living.

But reform must begin with what people with disability have been saying for years.

People with disability want safe and reliable support. We want skilled workers who know them. We want to decide who enters their home. We want to choose who they live with. We want support to participate in their community and pursue their own goals. We want somewhere independent to turn when things go wrong. And they want to be able to change providers without risking their home or essential support.

These are not unreasonable expectations. They are the foundations of choice, control, dignity and an ordinary life.

The NDIS was won through the determination of people with disability and families to gain greater control over their lives.

We have learned the lessons of block-funded and provider-controlled disability services.

Government must protect individualised and portable funding and preserve the choice and control that people with disability fought for.

Commissioning must remain a narrow provider-of-last-resort response. It must never become the default model for SIL.

We must not go back.

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