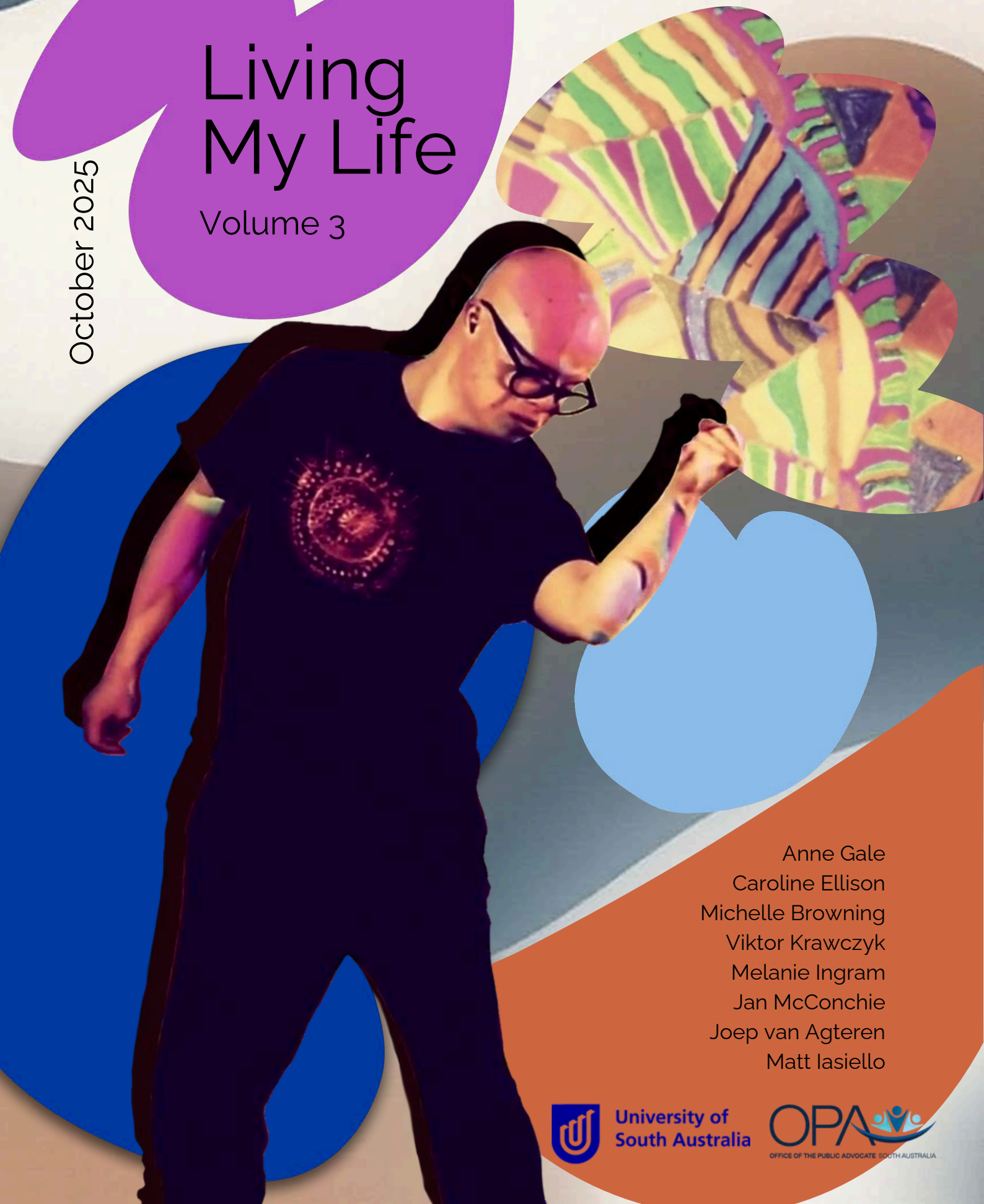
The University of South Australia and Office of the Public Advocate

Living My Life

Volume 3

October 2025



Anne Gale
Caroline Ellison
Michelle Browning
Viktor Krawczyk
Melanie Ingram
Jan McConchie
Joep van Agteren
Matt Iasiello

University of South Australia
OPA
OFFICE OF THE PUBLIC ADVOCATE SOUTH AUSTRALIA

University of South Australia
North Terrace, Adelaide, SA 5001
https://unisa.edu.au

Contact: Jan McConchie, jan.mcconchie@gmail.com
Associate Professor Caroline Ellison, caroline.ellison@unisa.edu.au

Front cover picture: The front cover of this report shows Lorcan Hopper, an artist from Tutti Arts Inc. You can read more about Lorcan and his participation in the project in Section 4 of Living My Life Volume 1

Authors: Anne Gale, Caroline Ellison, Viktor Krawczyk, Michelle Browning, Melanie Ingram, Jan McConchie, Joep van Agteren, Matt Iasiello

Designer: Lilian Choo & Sarah Faulkner

Photos: Tutti Arts Inc and Jan McConchie

Acknowledgement of Country
We acknowledge the traditional Country of the Kaurna people of the Adelaide Plains, where this research was conducted, and pay our respects to Elders past and present. We recognise and respect their cultural heritage, beliefs and relationship with the land, and acknowledge that they are of continuing importance to the Kaurna people living today.

The Living My Life Project received funding from the Australian Government Department of Health, Disability and Ageing

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Acknowledgements

We would like to acknowledge the work of Michelle Browning, who contributed her expertise, thoughtfulness and enthusiasm to the training, videos, webinars and e-learning modules in this project.

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We want to thank Margaret Brown, who has spent many decades educating South Australian health workers and service providers to respect the autonomy of all decision makers, and who generously contributed her wisdom and guidance to this project.

We would especially like to thank the people with disability who shared their lived experience, tested the activities, or helped to create the videos within this project, particularly Sarah Byrne, Ruby Nankivell, Anthony Beazley, Lorcan Hopper and Trish Ferguson.

Above: Sarah Byrne presenting at the SDM training for the OPA

Below: Josh Campton, from the short film, Introduction to Yoga

Grace Lam and Trish Ferguson from the Self Compassion short film

Acknowledgements continued...

We would like to acknowledge new partners established in the final phase of this project, particularly surrounding the completion of this volume.

Thank you to Associate Professor Caroline Ellison and the University of South Australia for supporting the completion of this volume.

Thank you to Melanie Ingram and her Clinical team at Community Living Options continuing the SDM work with Michelle Browning, the Developmental Education Association (DEAI), Tutti Barossa Valley artists, as well as Shutup Sitdown and Watch coordinated by Suzanne Merrell.

Thank you to Be Well Co. a business arm of Orange Toolset, Jessica Frost; Advanced Clinical Educator with SA Health, and Professor Jo Thomas; Clinical Dean of the Adelaide Medical School. Thank you for the ongoing support of Stephanie Searle; SA Intellectual Disability Health Service, and the SACID Inclusion Advisory Group.

Lastly, a special thanks to Eddie Jenkinson and Sarah Byrne for continuing to be the project's Sounding board.

Above: Sarah Byrne and Eddie Jenkinson

Below: Associate Professor Caroline Ellison (UniSA) & John Stokes (CEO of DEAI)

From left to right: Michelle Browning (Decision Agency) Melanie Ingram (Community Living Options), and Margaret Brown UniSA

Glossary of abbreviations

ACT	Acceptance commitment therapy
ALRC	Australian Law Reform Commission
BISA	Brain Injury SA
CBT	Cognitive behavioural therapy
DSS	Department of Social Services
GAA	Guardianship and Administration Act 1993 (SA)
ID:X	Client number X in the OPA project
JFA	Julia Farr Association Purple Orange
MLMW	My Life, My Wishes document
NDIS	National Disability Insurance Scheme
OPA	South Australian Office of the Public Advocate
PPI	Positive psychology interventions
SACAT	South Australian Civil and Administrative Tribunal
SACID	South Australian Council on Intellectual Disability
SAHMRI	South Australian Health and Medical Research Institute
SAIDHS	South Australian Intellectual Disability Health Service
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
SALRI	South Australian Law Reform Institute
DEAI	Developmental Educators Australia
ASID	Australian Society of Intellectual Disability

Glossary of terms

Disability Royal Commission	The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, which was established in 2019, received almost 8000 submissions, and delivered its final report in 2023.
OPA Staff	A South Australian Public Service employee with delegations by the Public Advocate to perform guardianship functions.
Person with a guardianship order	A person subject to a guardianship order under the GAA.
Supported decision making	A process by which a person is supported to make their own decision(s).

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1a Introduction to Volume 3

The Living My Life (LML) Project was conducted by the South Australian Health and Medical Research Institute (SAHMRI) Wellbeing and Resilience Centre in partnership with the South Australian Office of the Public Advocate (OPA) and the Health Department. The LML Project received funding from the Australian Government Department of Health, Disability and Ageing, through an Information, Linkages and Capacity Building grant awarded by the National Disability Insurance Agency in 2020. In 2024 the project funders then offered a further 12-month extension.

Following the commercialisation of the SAHMRI business unit, which provided the initial management oversight, the project was then transferred to one of its partners; the University of South Australia's Justice and Society division under the leadership of Associate Professor Caroline Ellison. The project team remained the same with the Wellbeing researchers also moving from SAHMRI to become foundation members of Be Well Co.[1]

Transitioning the project to the University of South Australia meant that the project could be benefitted by the University's research expertise. As such, formal ethics approval was sought in order to evaluate the efficacy of work conducted by the LML Project. As a result,
three academic papers have been produced:

- ***Public Advocate perceptions and experiences of the use of a holistic environmental framework around supported decision making principles for individuals living with disability as part of the Living Well Project***
- ***Behaviour Support Manager perceptions around the implementation of a holistic supported decision-making framework for individuals living with disability as part of the Living Well Project; and***
- ***Validity of a mental wellbeing measurement for people with living with intellectual disability***

Assets produced by the LML Project have been additionally published by peak body organisations and are available for public use free of charge. These resources include:

- **Supportive Decision Making (SDM) e-learning modules (South Australian Council on Intellectual Disability and Decision Agency)**
- **Wellbeing training tools (Be Well Co. and Tutti Arts); and**
- **SDM forms and videos (SA OPA)**

At the time of this volume's publication, the University of South Australia was in discussion with the Development Educators Australia (DEAI) to publish templates for SDM for the reduction in restrictive practices. SDM training modules produced in an earlier stage of the project are now promoted by the Commonwealth Government and published on their Disability Gateway resource hub[2] and internally by the Victorian Office of Public Advocate as mandatory staff training.

We wish to acknowledge that the work of the last 12 months does not generate any alteration to the conclusions or recommendations as detailed in Volume 1. Indeed our recommendations are now supported by the work of the South Australian Law Reform Institute (SALRI), who further argue for improvements in the current legislation surrounding SDM:[3]

> *After extensive consultation and review of existing laws, the independent South Australian Law Reform Institute (SALRI), based at the University of Adelaide, has found that significant improvements are needed to ensure South Australia's legal system better supports people with impaired decision-making capacity. The report makes 53 recommendations to Parliament aimed at modernising the legal framework, prioritising supported decision-making and aligning South Australian law with contemporary human rights standards*

[1] https://www.bewellco.io
[2] https://www.disabilitygateway.gov.au/sdmhub/training/supporters-training
[3] https://www.adelaide.edu.au/newsroom/news/list/2025/07/24/law-reform-push-to-promote-dignity-autonomy-and-support-in-decision-making

SALRI's findings and recommendations are outlined in its report released on July 25, 2025: 'The Need for New Solutions? Establishing Legal Frameworks for Supported Decision-Making in South Australia' . As part of this report a major review was led by Associate Professor Sylvia Villios, in collaboration with SALRI Director Professor John Williams, Deputy Director and Associate Professor David Plater, Associate Professor Beth Nosworthy, Dr Mark Giancaspro, Dr Peta Spyrou, Emily Conroy, Simon Headland, and Brooke Washusen. Within the report SALRI acknowledged a need to update the current legislation to formally recognise supported decision making without removing a person's own legal authority:

One major proposal is to update the law to formally recognise supported decision-making. For example, adults with disabilities should be able to appoint supporters — trusted people who help them understand options, express preferences, and implement decisions — without removing the person's own legal authority. This push for supported decision-making is influenced by modern disability rights principles that emphasise autonomy and inclusion [i].

This current volume, Volume 3, exists as an addendum to Volume 2 Appendices, as well as to the project report contained in Volume 1. Volume 3 thus contains the following documentation:

- **The Office of Public Advocate SDM pilot extension report;**
- **A report on SDM training for frontline health professionals at the Lyle McEwen Hospital;**
- **SDM and Wellbeing training workshop materials;**
- **SDM and Wellbeing resources now made publicly available as an output of the project work; and,**
- **Formal evaluations undertaken by the University of South Australia**

What follows in this section is a formal background to the following documents included in this Volume that provides critical context to their development, application, and efficacy.

On SDM in the Office of the Public Advocate (OPA)

For their SDM pilot, the Office of Public Advocate (OPA) was able to deepen its work and target new clients (protected persons) in hospitals. The OPA further continued this work by targeting particular individuals to explore what support networks could assist them to make decisions using an SDM approach. An independent evaluation of an SDM Pilot undertaken by the University of South Australia within the OPA provided an opportunity to formally evaluate the efficacy of the Project in practice (see Section 2). As a result of the evaluation, the OPA was provided an opportunity to further update documentation produced by the project and to continue to embed the practice of SDM for and with people under their protection. As noted by the OPA:

Overall, the findings portray a dedicated and values-driven workforce that operates within significant systemic and legislative constraints. While staff may not define or measure success explicitly, their actions consistently reflect a commitment to upholding the human rights, dignity, and autonomy of clients. Supported decision making is already embedded in practice at OPA—though often unacknowledged—and further structural support, internal reflection, and legislative reform would enable it to be implemented more fully and consistently across the organisation.

Conference presenters Eddie Jenkinson and Sarah Byrne

With the final project extension it was then made possible to explore how supported decision might be able to assist people under guardianship, in particular how their NDIS service providers might work with them to reduce any restrictive practices they have in place. Working with service delivery partner Community Living Options (CLO), who are responsible for a range of restrictive practices in place for OPA clients, the project developed a framework for implementing SDM for people with restrictive practices with the intention that the framework would be made available for the broader disability sector for ongoing discussion and potential use.

Project team member Dr. Michelle Browning project, together with clinical lead at CLO Melanie Ingram, ran an SDM workshop entitled 'Increasing agency to reduce restrictive practices for people with complex behaviour support needs'. Continuing professional development was then accredited for developmental educators for a half day training in person or online, with an afternoon case studies workshop that was facilitated to run in-person only. Members of the LML Project further presented the framework work to the National SDM community of practice, ran an Australian Society for Intellectual Disability (ASID) online seminar in October and presented in person at the 2025 ASID conference in Sydney.

On building capacity to practice SDM

As part of training in SDM within the disability sector, the project team worked closely with CLO are engaged to provide disability support to several complex needs clients under OPA guardianship orders. We began by providing SDM training to CLO managers. Building on this training we then worked with CLO's clinical team to develop SDM templates on the management of restrictive practices and the stated policy of the NDIS Commission that could be used by the broader community.[4] The templates can be found in Section 5 of this Volume and are as follows:

- The *Participant Environmental Review* as requested by a PBS practitioner or instigated by the implementing provider. The environmental review explores a participant's environment to better understand their preferences, how they respond to their environment and any elements that may need adjustments.
- A *Decision Making Profile* created when the *Participant Environmental Review* is being done (if there is not one in place already). The decision-making profile captures the support a participant wants and needs when making decisions.
- The *Environmental Review Summary* is completed by the person's PBS practitioner who will identify changes needed to build a more capable and supportive environment for the person. It will outline recommended actions or steps stakeholders can discuss. The summary should inform discussion with the environmental review and the *Risk Mitigation Stakeholder Meeting.*
- The *Environmental Review* and *Risk Mitigation Stakeholder Meeting Template* can be used to record stakeholder discussion of findings of the *Participant Environmental Review* and next steps as suggested by the PBS practitioner.
- Possible changes can be discussed with the participant using the Supported Decision-Making Process Template.
- A *Tier 1 & 2 Action Plan* developed by PBS practitioner outlines the long and short-term goals of the participant and strategies needed to realise them. The action plan outlines a clear path to addressing changes in the person's support and environment that will improve their quality of life.

These documents have been tested with Positive Behaviour Support and Developmental Educators and with clients of CLO. Further, the SDM templates were then formally tested with the SA OPA, internally at CLO, and amongst a series of professionals and experts in complex behaviours. As such, this work has been formally presented to the National SDM Community of Practice and in an online workshop to ASID[5].

Informed by the work conducted with CLO and OPA clients, further SDM training was then delivered to members of the disability sector, as part of Developmental Educators professional development accreditation. Some of the workshop templates and materials are contained in this volume (see Section 7). As part of this workshop the participants were also offered the opportunity to contribute to the review and refinement of the templates. As noted in Section 2, an independent review of the workshop templates have demonstrated early positive findings:

This evaluation demonstrates that implementing a holistic Supported Decision-Making and environmental behaviour support framework has the potential to significantly improve outcomes for individuals with complex disability, particularly in contexts where restrictive practices have traditionally been relied upon. Early adoption within the participating organisation has resulted in meaningful insights and positive behavioural and relational changes, reinforcing the central role of SDM in reducing restrictive practices and promoting human rights.

SDM training was further developed for SA Health frontline staff that targeted professionals in a hospital setting. All training was specifically tailored to the target audience through a collaboration with the University of Adelaide's Dean of Medicine and School Head Professor Josephine Thomas. Furthermore, project team expert Michelle Browning and SA Health co-published a report on the development of this training.

[4]https://www.ndiscommission.gov.au/rules-and-standards/behaviour-support-and-restrictive-practices
[5]https://asid.asn.au

As noted in various testimonials, participating staff enjoyed the opportunity to learn with their colleagues from other disciplines and explore new ideas collaboratively.

A key element to the final stage of the LML Project was developing critical SDM training for frontline health staff to support the transition of patients from hospitals, as well as for disability services to engage in positive behaviour support and increase individual agency in order to reduce the negative impact of restrictive practices experienced by many OPA clients.

"I liked the different approaches discussed and being able to explore SDM within a wider team/discussion."

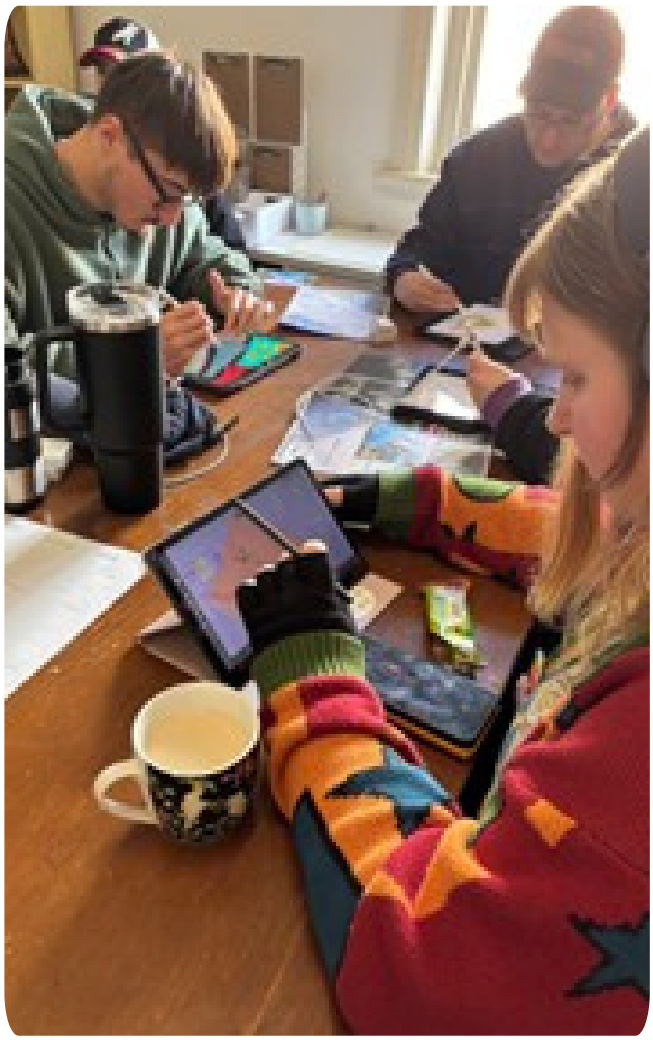
'We feel different pressures, it's good to talk openly about this."

"I liked that the workshop was interactive and interdisciplinary"

"I learned that we can see things through different lenses but still want the same outcome."

On the Be Well Plan: Mental health and wellbeing training

As part of the LML Project, formal training in wellbeing continued to be offered to disability support staff within CLO. In this final year, training was tailored for the audience based on learnings from the earlier stage of the project and co-presented by Be Well Co. and SACID, who promoted the training through their respective media channels. All training materials can be found within this volume in Section 9.



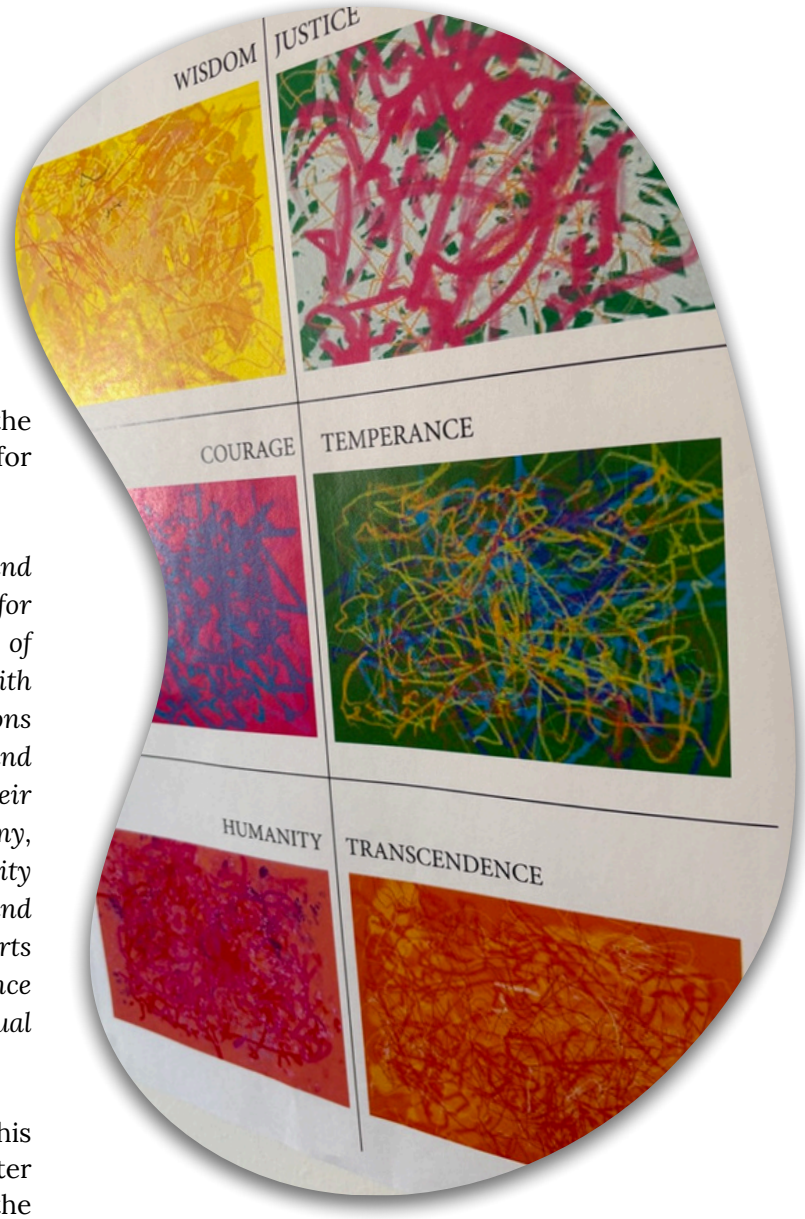
Tutti Artists Austin Greig, Alexander Sotiriou and Brianna Klitscher

Codesign on the foundations of the Be Well Plan

The first codesign project was to evaluate the new wellbeing measure for people with disabilities, developed in a separate but parallel body of work by partner organisation Be Well Co. and SACID. Measuring the impact of the Be Well Plan training exists as a critical outcome of the program. All gathered data will contribute to ongoing research in the field of positive psychology in addition to providing valuable personal information to support those undergoing future training.

Be Well Co., alongside their academic partners, previously developed A Taxonomy of Positive Mental Health.[6] This taxonomy was constructed through a series of studies, including a comprehensive literature review, an initial validation study involving 800 participants from Australia and the United States, as well as a Delphi study with 122 experts from a range of academic fields. The measurement items developed as part of the taxonomy were workshopped with SACID's Community Inclusion Group over two days across three focus groups. An overview of the taxonomy and the research report produced working with SACID under academic ethics approval is contained herein (see Section 8).

[6]https://www.bewellco.io/wp-content/uploads/2025/03/BeWellCo_Taxonomy_of_Positive_Mental_Health-30Sept_compressed.pdf



Artist Gemma Brett

An excerpt from the report notes the value of the measurement tool to enhance the quality of life for individuals living with intellectual disabilities:

In conclusion, this study demonstrates the feasibility and value of a strengths-based wellbeing measure for individuals with intellectual disabilities. The lack of objections to assessing mental wellbeing, combined with practical recommendations for item refinement, positions this tool as a promising resource for both research and practice. By enabling individuals to express their experiences in context, the measure supports autonomy, fosters self-expression, and aligns with the disability sector's evolving emphasis on empowerment and inclusion. This work lays a foundation for future efforts to develop accessible, person-centered tools that enhance the quality of life for individuals with intellectual disabilities.

The second codesign work we facilitated as part of this project focussed on communication of the Character Strength component of the Wellbeing training for the disability community As part of this work, we spent several weeks collaborating with Tutti digital artists living in the Barossa Valley, SA to develop communication tools and language to explain the character strengths concepts. These assets were then built into a day workshop structure with the artists and the Be Well Co researchers in a form that can be used for future training for and by the disability sector. As with the taxonomy the work has a scientific basis, in this case COM-B, a method for characterising and designing behaviour change interventions. The Character strengths and accompanying information can be found in Section 9 of this Volume.

1b Living My Life Project Extension 2024-25 – Office of the Public Advocate component

In 2023 the Office of the Public Advocate (OPA) component of the Living My Life (LML) Project received additional funding to:

1) Evaluate the effectiveness of the My Life My Wishes (MLMW) tool to determine the wishes of Public Advocate (PA) clients.

2) Trial the MLMW tool with people in hospital who have recently had the Public Advocate appointed as their guardian (target 30 clients)

The MLMW tool has been in use at the OPA since mid-2023. As of 1 October 2025, 1,280 out of 2,402 Public Advocate guardianship clients held a MLMW[1] record. This project extension provided a timely opportunity to review the application of the MLMW tool and to determine its applicability in capturing the wishes and preferences of people in hospital who have recently had the Public Advocate appointed as their guardian.

This report focuses on experiences with trialling the MLMW tool with people in hospital who have recently had the Public Advocate appointed as their guardian. A more broad evaluation of the effectiveness of the MLMW tool across the OPA is detailed in a separate independent report by the University of South Australia (see Section 2 in this Volume).

Trialling the MLMW tool with people in hospital who have recently had the Public Advocate appointed as their guardian.

The initial project extension to trial the MLMW tool for people in hospital occurred from 1 January to 30 June 2025 (Trial 1). Whilst an initial 30 clients were targeted to participate in this trial, the OPA inevitably used the MLMW Tool with 31 newly appointed PA clients. An additional trial ran from 1 July to 31 August 2025, which had a stronger focus on identifying and involving supporters for newly appointed PA clients in hospital (Trial 2). The OPA exceeded their initial target of 10 individuals by including 15 clients in the second phase of this trial.

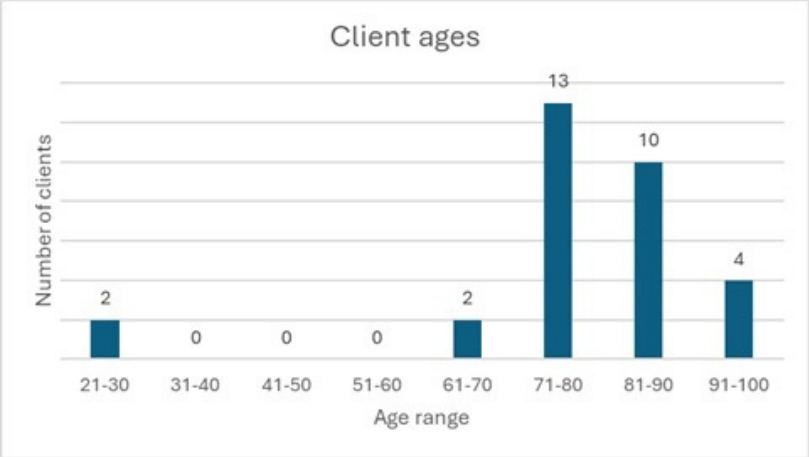
The two trials involved a total of 46 clients and resulted in 34 MLMW documents recorded in the Felix computer system.

Factors that contributed to the MLMW not being completed for all OPA clients included:

- SACAT order expiring (short length of time the SACAT order was in place);
- a client passing away;
- health and cognitive ability of the client preventing engagement;
- a clients' clinical presentation e.g. psychosis preventing engagement; and
- a lack of supporters and lack of available information in the hospital.

In some instances, the OPA client also had an existing and current Advance Care Directive that prevented their engagement in this trial.

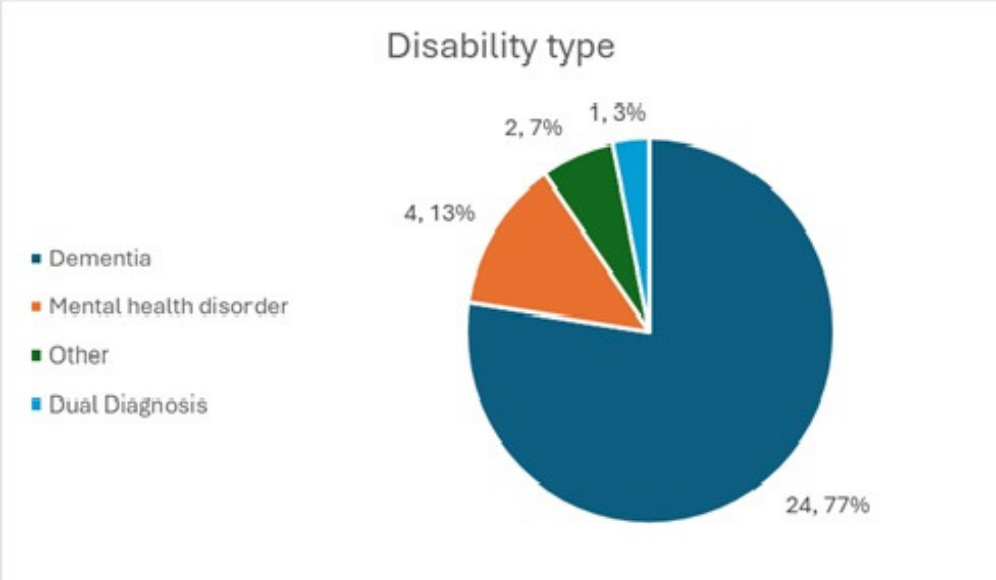
[1] This number does not include where a client has had more than one MLMW record completed or those completed for people who are no longer clients.



The ages of participants in Trial 1 ranged from 25-97 with an average age of 77.3 years.

Trial 1 Client demographics – 31 clients in hospital

Gender – Male 18 (58%) and Female 13 (42%)



In Trial 1, 77% of clients had a primary diagnosis of dementia and 13% of clients were noted as having a mental health disorder.

Trial 2 Client demographics – 15 clients in hospital

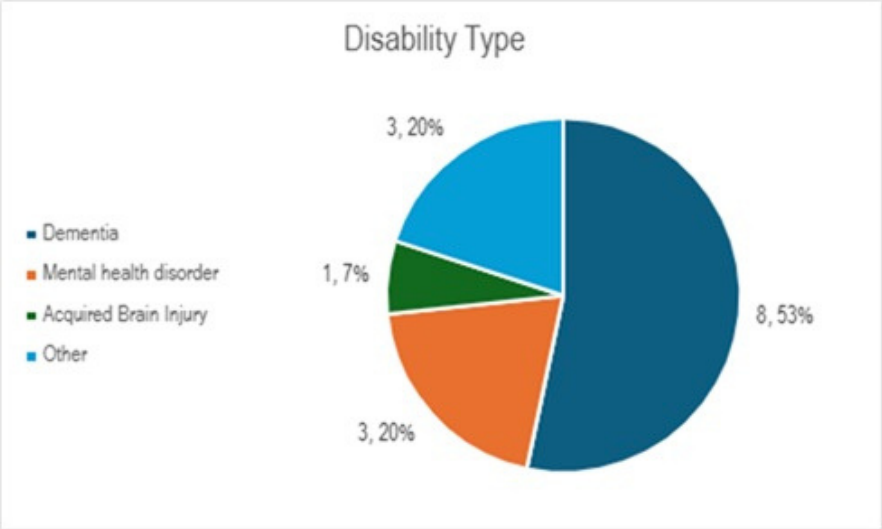
15 people were included in Trial 2 with all identified as being in hospital or step-down units. All participants were deemed clinically stable for discharge and were awaiting placement.

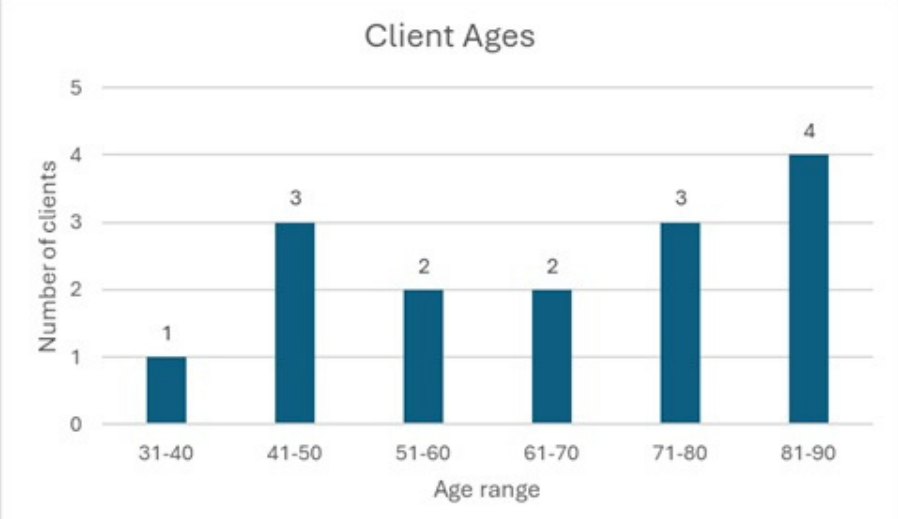
Accommodation and end of life wishes was gathered for 12 of the 15 participants with the MLMW record being completed as best as possible. Of the remaining 3, 1 was in a psychotic state and required substitute decision-making for a specific procedure and 2 already had supporters for decision making and so it was not possible to collect information regarding decision-making capacity for the MLMW document.

Of the 15 participants:

- 1 person was unable to make decisions related to a potentially major physical injury;
- 4 people had family or supportive friends who became guardians;
- 2 people had family who became joint guardians;
- 2 people were homeless when admitted to hospital - the SACAT orders were time-limited and expired within the timeframe of the project; and
- 6 people had ongoing SACAT orders, all of whom were able to have their wishes known via verbal, gestural or augmentative communication systems. Several also had their wishes known via supporters or from other hospital documentation.

In Trial 2, people with dementia (53%) represented the highest proportion of clients followed by clients with a mental health disorder (20%). As in Trial 1, the data indicated that it was the younger clients in hospital who presented with a mental health disorder and older clients with dementia.





Gender – Male 14 (93%) and Female 1 (7%).

Findings

The OPA team leader for newly appointed clients manages the intake process for new clients, including those in hospital. This team made great efforts to ensure that they followed standard practice guidelines and engaged with the individual, families, supported decision makers and service providers within a timely period.

Other observations

- As of November 2025 12 of the 46 clients in both Trials no longer have the Public Advocate appointed as their guardian. For the majority of these 12 clients, the OPA was appointed as guardian for less than 6-weeks.
- It was noted that the MLMW form is lengthy to use and takes significant time to populate. An average of 2-3 hours at minimum
- It was noted that the MLMW form could benefit from a section to identify where information was sourced, if not from the person themselves, and whether there was a support person present, as well as a section for observations.
- During the Trials some clients were noted as asking the question: 'Why do you want all this information?'. Guardians therefore need to inquire about all arrangements currently in place and take time to get to know the person as well as possible.
- It was noted that people involved appreciate visits from guardians, but often expressed that they did not want to feel like they were being interrogated.
- Information that was able to be gathered from the person about their life was often not relevant to Public Advocate decision-making and their current situation (i.e. historical).
- It was noted that the majority of people from diverse cultures, e.g. Greek and Italian people, did not want to talk about end of life.
- At times it was difficult to identify supporters, but this is not surprising as the Public Advocate is typically appointed when no other suitable person is available to assist with decisions.
- It was noted that trial participants often did not nominate support people or want them present.

Further work following the MLMW Project Report June 2024

Living My Life – Volume 1- 2024 details ten findings that have since been reinforced by further work conducted by this Project extension and subsequent projects undertaken by the OPA. There is thus further work that still needs to be done in order to meet the requirements and future needs acknowledged by these findings.

These 10 findings include:

Finding 1: Skilled staff/supporters require the allocation of sufficient time to assist people with a guardianship order to complete the My Life, My Wishes document.

Finding 2: My Life, My Wishes should be enhanced over time, include individual adaptations, be regularly updated and encourage ongoing provision of decision-specific support.

Finding 3: Priority support should be provided to highly vulnerable people with a guardianship order, including those who are hard to reach/difficult to engage, have no 'good support relationships', or no-one who knows them well.

Finding 4: The OPA should continue to advocate for funding entitlements for supported decision making from relevant Commonwealth and state agencies, such as the NDIS and My Aged Care, it could request supported decision making as best practice from all providers servicing people with a guardianship order.

Finding 5: The OPA should continue to provide advocacy and sector leadership in supported decision making through the community/ sector education.

Finding 6: The OPA should continue to strive to uphold supported decision- making processes in the face of urgency and external pressure (e.g. hospital discharge delay, medical treatment) where practical.

Finding 7: The OPA should continue to promote the legal autonomy of people with a guardianship order by supporting a person's own decision wherever possible, whilst remaining consistent with the Guardianship and Administration Act (GAA) and recording processes.

Finding 8: The legal autonomy of people with a guardianship order could be promoted by enabling positive risk to the greatest extent possible under the GAA.

Finding 9: Consultation with Aboriginal people, communities and representatives should inform best practice approaches to decision making within the guardianship context.

Finding 10: Regional and remote partnerships could be explored to provide visitation referrals and cultural advice.

Culturally Safe Supported Decision- Making

From 1 April 2023 to 30 June 2024, the OPA undertook a separate project to explore Culturally Safe Supported Decision-Making (CSSDM), which was funded through the Australian Department of Social Services.

The CSSDM project focused on understanding culturally important issues and how to more respectfully support First Nations clients. This project thus aligns with Australia's Disability Strategy objectives 3.2 and 3.3 and also addresses Finding 9 from the Supported Decision-Making Pilot Project undertaken by the OPA.

Supported Decision- Making in Residential Aged Care

From 1 July 2024 to 30 June 2024, the OPA has also trialled the MLMW tool with people living in residential aged care through the Supported Decision-Making in Residential Aged Care project. This project was a collaboration between the Office of the Public Advocate (OPA) and the Office for Ageing Well (OFAW)and focused on older people in RAC who have the Public Advocate appointed as their guardian. The goal of this trial was to explore how best to support older people in Residential Aged Care (RAC) to express their wishes and maintain choice and control over their lives, in line with the National Decision-Making Principles. Whilst the findings of this trial are still being reviewed, we hope that the insights gained and further assist supported decision-making in aged care settings.

Conclusion

Overall, we found that the MLMW is a valuable tool to determine the wishes and preferences for people who cannot create an Advance Care Directive. The MLMW is a living document that can be updated at client visits and if the person's wishes change. The MLMW does not replace the need for Public Advocate staff to discuss substitute decisions with clients, rather it supports an understanding of the person's wishes and can help facilitate that conversation.

Reccomendations

Based on findings presented in the Trials conducted we provide the following recommendations. We recommend:

1) That the MLMW tool is regularly reviewed and updated to ensure it remains current and fit for purpose.

2) That the MLMW process is undertaken as soon as possible after the appointment of the Public Advocate as guardian.

3) That the OPA intake team prioritises the MLMW process for all newly appointed clients.

4) That the MLMW record be updated at each client visit or when client wishes change.

5) That the OPA develop fact sheets and guidelines to support private guardians to follow the principles of supported decision-making.

6) That the MLMW process gathers detailed information relevant to the decisions the Public Advocate can make in accordance with the SACAT order and makes general enquiries about other areas to get to know the person and if there are other needs e.g. if there is no “health” order from SACAT, then enquire about their general health and what arrangements are in place for making health decisions. This enquiry will assist in determining if an application for orders covering “health” is required.

7) That Advance Care Directives continue to be promoted by the OPA.

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Report on Implementing of Supported Decision-Making Principles: A Review of The My Life My Wishes Tool for the Office of the Public Advocate.

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Researchers

Associate Professor Caroline Ellison (Justice and Society, UniSA)
Dr Victor Krawczyk (Justice and Society, UniSA)
Ms Jan McConchie (Justice and Society, UniSA)
Dr Sarah Faulkner (Justice and Society, UniSA)

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Abstract

This report explores the implementation and impact of the My Life My Wishes (MLMW) Tool within the Office of the Public Advocate (OPA) South Australia, which was designed to embed supported decision-making principles into standard OPA work-place practice. Through qualitative interviews with OPA staff (n=15) across various roles, the study investigates perceptions, experiences, and challenges associated with implementing the MLMW Tool. Findings reveal broad engagement with supported decision-making principles and the MLMW Tool. Staff reported varying degrees of formal training and highlighted tensions between using the MLMW Tool and building rapport with the people being supported. Further barriers included integration with the client software system FELIX, time constraints, and complexities in engaging protected persons. Despite inconsistencies in its application,the MLMW Tool was valued by OPA staff, particularly for documenting the will and preferences of individuals being supported. This study argues that there is a need to enhance system integration, to standardise supportive-decision making training, to clarify the purpose of the MLMW Tool, and to allocate sufficient time for the MLMW tool's successful implementation. Overall, the MLMW Tool was seen as a valuable mechanism to promote autonomy and improve person-centred outcomes for protected persons in South Australia.

Evaluation Purpose

- Explore the implementation and operationalisation of the My Life My Wishes (MLMW) supported decision-making Tool into the practice of OPA SA Delegated Guardians.
- Review the impact of the introduction of the MLMW Tool in OPA SA over the past 3 years.
- Identify recommendations for changes and developments to the MLMW Tool to improve OPA SA practitioner experience and future implementation.
- Identify recommendations for future supported decision-making training and professional development for continuous improvement around implementation of the MLMW Tool into the practices of OPA SA Delegated Guardians.

Introduction

The aim of this research is to evaluate the perceptions and experiences of staff working for the Office of the Public Advocate (OPA) around the implementation of supported decision-making principles within the historical practice of substitute decision-making; particularly focusing on the development and application of a My Life My Wishes Tool (MLMW). The MLMW Tool was developed as part of the Living My Life Project (Gale et al., 2024a; 2024b) to facilitate OPA staff incorporating supported decision-making principles into their everyday work practice. The MLMW was produced following a series of workshops where co-design opportunities were facilitated with Dr Michelle Browning who built on the work conducted with the OPA around Advance Care Directives by Dr Margaret Brown, a widely renowned human services advocate and consultant. The Tool Guide was developed for use by OPAto provide a tangible way to embed supported decision-making principles as standard work-place practice.

This report focuses on OPA staff (i.e., Delegated Guardians, Senior Delegated Guardians, Guardianship Support Officers, and Team Leaders) perceptions and experiences of implementing the MLMW Tool. It explores if and how using the MLMW Tool has shaped their work practices with protected persons under orders—providing a better understanding of their experiences and perceptions (c.f., Casey et al., 2023). In South Australia, being under orders of the OPA means that a person's decision-making is legally supported or substituted because they are considered unable to make certain decisions independently. The South Australian Civil and Administrative Tribunal (SACAT) may appoint the Public Advocate as a guardian to make decisions about health care, accommodation, or lifestyle matters in the person's best interests. These orders aim to protect the individual's rights and wellbeing while ensuring decisions are made with respect for their preferences and dignity.

UniSA were approached to conduct the research for this report because the University were 1) not involved in the supported decision-making training; nor (2) in the implementation of supported decision-making principles within OPA. The findings presented in this evaluation report demonstrate OPA's professional practices around decision making with an ethos of enabling and not just making decisions on behalf of individuals under protective orders.

Background and supporting literature

Supported decision-making has been gaining traction as a means by which vulnerable persons can have more choice and control in their lives, such as individuals with disabilities (Browning et al., 2014, 2021; Gordon, 2000; Gudelytė et al., 2024). Supported decision-making has been defined as the "processes and approaches that assist people to make a decision, including… giving them the tools they need to make the decision for themselves" (Commonwealth of Australia, 2023, p. 7). Article 12 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) recognises that persons with disabilities have the right to be treated equally before the law (United Nations, 2006). It establishes that all people, regardless of disability, have legal capacity—the right to make decisions about their own lives—on an equal basis with others. States are thus required to provide the necessary supports to help people exercise this right, e.g through developing and providing supported decision-making frameworks. Importantly, supports for supportive decision making must respect the person's will and preferences, include safeguards against abuse, and be regularly reviewed to protect against undue influence. In practice, Article 12 of the UNCRPD thereby shifts the focus from substitute decision-making (where others make choices on behalf of a person) to empowering individuals to make their own decisions with appropriate assistance.

A recent report published by the South Australian Law Reform Institute (SALRI), The Need for New Solutions? Establishing Legal Frameworks for Supported Decision-Making in South Australia (Villios et al, 2025) explored if and how supported decision-making principles can be effectively incorporated into new or existing South Australian frameworks to ensure individuals with decision-making support needs can make their own decisions about their lives (Villios et al., 2025). The SALRI report further outlined a supported decision- making framework that dictates the need for persons with disability to have an equal right to make decisions for themselves, that their dignity, autonomy and independence is respected, and that they are supported to make decisions on their own, where such support is necessary. The findings of the SALRI report are further supported by recommendations within the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Royal Commission 2023), which aims to reform guardianship and administration laws nationwide so that decision-making supports the autonomy, will, and preferences of people with disability wherever possible. The 2023 Royal Commission subsequently calls for clearer definitions and objects within legislations, embedding supported decision-making principles, using representatives only as a last resort, recognising decision-making ability, and making processes more accessible, fair and respectful of dignity (Royal Commission 2023).

Under the Guardianship and Administration Act 1993 (SA), SACAT may appoint a guardian if a person has mental incapacity and needs help with major personal decisions (health, accommodation, lifestyle (The Act 1993). The Public Advocate can be appointed as guardian (often of last resort) when there is no suitable private person (such as a friend or family member) available (Legal Services Commission 2025). Under guardianship, the guardian (whether the Public Advocate or a delegated guardian) is legally bound to act according to certain principles, including consideration of the person's past and present wishes, using the least restrictive option, and ensuring the person's proper care and protection. As Australian state and federal governments consider changes to legislation to increase access to supported decision-making for protected persons, rather than substitute decision-making, it is critical that we engage OPA staff about their experiences implementing supported decision-making practices as dictated under the current legislation. Understanding the facilitators, challenges and barriers to extensive implementation of the MLMW Tool among OPA staff thus encourages the continuing development of strategies that will support the OPA to work towards increased access to supported decision-making for individuals under orders.

Method

This report is a qualitative evaluation (Newcomer et al., 2015; Patton, 2015; Russ-Eft et al., 2024) focused on collecting interview data from OPA staff. OPA staff interviewed represented a diverse range of experiences, backgrounds and roles within the OPA, including both long-term and more recent appointments, as well as those from professional and academic backgrounds. Data collection consisted of a once off, one-to-one interview with staff (n=15) who had participated in formal or informal training and/or in workshops associated with the development of the MLMW Tool. The interviews were guided with a semi-structured interview schedule (see Appendix A for the list of questions). Interviews lasted between 40 minutes and 1-hour with participants interviewed in private meeting rooms on the ground floor of the GHD Building, 211 Victoria Square, Adelaide, South Australia. The interviews were audio-recorded and were transcribed verbatim, or detailed field notes were developed for coding. Transcripts were produced for subsequent thematic analysis (Braun & Clarke, 2021). Analysis involved coding with subsequent agreement between the three researchers. Any discrepancies were discussed until unanimous agreement was achieved. This study has ethics approval from the UniSA Human Research Ethics Committee: Number 206783. All participants had access to an invitation to participate using purposive sampling with their experience of the MLMW Tool. Participants were given the participant information sheet and signed an approved consent form, after which a time for the interview was set.

Findings and discussion

As noted previously, this report focuses on OPA staff's experiences with implementing the MLMW Tool, including its benefits and challenges. The MLMW Tool was developed as a critical process by the OPA to document and organise a protected person's will and preferences (i.e., wishes). At the time of this report the MLMW Tool was not fully integrated into the current client software system being used by the OPA, FELIX CRM.. What was evident from the interviews conducted was that OPA staff across the various roles, levels of experience and backgrounds, had a strong working knowledge around supported decision-making principles as based on the current legislation, regardless of their confidence in implementing the MLMW Tool. Key themes that emerged from the interviews are identified and discussed within this section of the report. Key themes include the need for formal and informal training; updating and reviewing the MLMW Tool; issues with developing rapport with the protected person; improving the MLMW Tool; finding information to complete and verify the MLMW tool; engaging supporters for the protected person; negotiating questions about death; the effectiveness of the MLMW Tool after hours; and using the MLMW Tool with target groups.

Formal and informal training

All interviewed OPA participants experienced some level of formal or informal training on how to use the MLMW Tool, with several having been involved in the MLMY Tool's development. Whilst the supported decision-making training for a few participants took on a more structured approach, for other's it was something they learnt during their work-place induction, when learning about their role or while carrying out the duties related to their core work. A number of staff interviewed had been with OPA during the MLMY Tool's development and roll out (in 2022). Such staff reported that there was more formal training around how the MLMY Tool was to be used with protected persons in this earliest phase of the project, and that this provided an opportunity to 'do a refresher' in supported decision-making training.

A few staff members expressed that they felt they did not require additional formal training around the purpose and implementation of the MLMY Tool due to their involvement in its development. For example, OPA Staff member Barbara commented: "it wasn't really relevant to me because I was part of the creation of that document". Other OPA staff, particularly newer members to the OPA that did not have the same opportunity to engage in formal training with the MLMY Tool, but experienced their training through more informal means, such as "buddy visits". For those with more informal training they acknowledged limitations in implementing the MLMY Tool during their standard work-place practice. The lack of formal training to apply the MLMY Tool inevitably impacted these staff members ability to confidently implement it when in the field. For example, participant Max stated:

I don't think I did any formal training on how to use the document....like when I was doing buddy visits, sometimes it was used and so I could follow it through and then other times it wasn't. And then I tried to do some with myself and found it hindered some of the conversations. So, I kind of just put it to one side.

While no staff explicitly stated that they had experienced inadequate training or support on implementing the MLMY tool, none also questioned why supported decision-making was discussed. There was, however, a broad understanding that the MLMW Tool was implemented in the office as part of a broader consideration of supported decision-making practice.

Several OPA staff did have questions around the interpretation of their legislation with respect to supported decision-making, which often linked to their belief that they felt a lot of their work was substitute decision-making. Staff in several interviews reflected on their ability under the current legislation to implement SDM in a way that could be of most benefit to individuals. However, a holistic analysis of their practices suggest that they could be underrating the contribution of their pre-decision-making discussions and the ethos of supported decision-making. It is therefore recommended that the OPA consider continuing profession al development around the ethos and purpose of the MLMY to better facilitate supported decision-making.

Updating and reviewing the MLMW Tool

Various levels of staff engagement were noted with the MLMY Tool. Overall, the OPA staff interviewed reported a level of continued engagement with the MLMY Tool, mainly to ensure that information around each protected person's will and preferences was kept current and up to date. One staff member pointed out that a review of the MLMW tool generally occurs on a yearly basis even if there has been no or limited contact with a protected person in the previous 12 months. OPA protocol stipulates a need to contact the protected persons at least once a year even if there has been no issues or need for decision-making involving the OPA. Staff member Pat expressed that it is this lack of regular engagement with the protected person can limit the application of the MLMY Tool:

I don't see it as a Tool that's used every day, and especially not by guardians, because we're not having contact with the person every day, we're not responsible for all the little things in their life every day. So yeah, I'm not sure how it could be made like a primary document.

Amongst interviewed participants it was found that the updating and/or reviewing of the MLMW Tool often occurs in the context of other work the OPA staff were conducting, and that despite other pressing matters staff were generally aware of the need to update and/or review the MLMW tool. For example, one staff member noted that:

I do update those forms [i.e., MLMW Tool] and sometimes not just after a visit, it depends on the circumstance that if something significant changes and I've got the breathing space... then I do update it in between

Several OPA staff reported using the Tool during the face-to-face meetings with the protected person, yet reported challenges using the MLMY Tool when linking it to their client software platform FELIX. One noted challenge was that the MLMW document was not prepopulated from FELIX: requiring all information to be manually entered by the person completing the form. This then raised concerns around the MLMY Tool creating some duplication of effort with already stressed workloads. In addition, one staff member stated that they always make a new MLMW Tool, rather than one that has been pre-populated, as they were not comfortable having their name associated with a prepopulated tool for reasons of legal responsibility. Several staff noted that they take the opportunity to fill in parts of the MYMW Tool before the meeting with the protected person. For example, participant Cameron stated:

When I do plan to use it, I do pre-fill it... when I have gone out with a particular person that I feel is going to be receptive to this, or I could use this then to perpetuate conversations in a specific direction, then, yeah, I pre-filled it with names, information, orders, all that kind of stuff. But then again, I also take a paper copy so I can show and write, and I've got to re-put that back onto a computer.

Regardless, several staff expressed that it was often worth the level of in-depth time it took to populate the MLMY Tool, in order to enhance supported-decision making with the protected person. Thus, embedding the MLMW Tool within the existing software can assist in the time it takes OPA staff to complete.

Issues with developing rapport

A number of OPA staff noted that using the MLMW Tool during a face-to-face meeting with a protected person risked impacting the development of good rapport or created a perception that staff members lacked experience. For example, participant Terry spoke about their limited confidence using the tool and how the presence of a large piece of paper during a meeting created a sense of concern with the protected person:

When I've tried to focus on getting through the categories in the document, I've found it sometimes really hindering the flow of the conversation or the person [i.e. protected person] has been concerned that I've got a piece of paper there because I can't remember all the categories because I don't use the Tool enough

Some OPA staff did not always see the Tool as useful to bring to a meeting with a protected person. One Delegated Guardian explained in detail their reservations with bringing in the Tool into a face-to-face meeting with a protected person as a result of their government position:

I often want interviews with a protected person to be as informal as possible....because there is this stranger coming, you know, with a name tag, and saying I'm your guardian....Someone from the government, you know, which particularly with people from certain ethnic backgrounds could be quite, you know, concerning issue. So, I try to make it as informal as possible. So, I wouldn't be pulling out [the MLMW Tool].... I will take a notebook and make some notes, and I will say, because..., ...what you are telling me is important, and I want to make sure that I got it. But, I wouldn't be pulling out the form and going through [it with] them.

The Delegated Guardian here highlights that a level of power differentials exist between the OPA staff member and the protected person, in which the formality of the MLMW Tool can create a sense of unease for the protected person. This sense of unease can in turn limit the quality of information gathered and inevitably compromise the ability to implement supported decision-making principles with the protected person. This Delegated Guardian is therefore more likely to take a notebook and jot down notes during their meeting, which they will then use to populate the MLMW Tool at a later stage.

Thus, it was sometimes the level of formality and structure provided by the MLMW Tool in combination with the OPA staff members government position that had the potential to affect the rapport and relationship established with the protected person.

Improving the MLMW Tool

Generally interviewed OPA staff noted that the Tool was easy to use but there were practical suggestions on how it could be improved. Several Delegated Guardians and line managers expressed that they wanted the MLMW Tool to have a section where they could provide some contextual data, particularly when gathering information about the protected person's will and preferences. For instance, one Team Leader Max stated:

It's important that when you go, you actually make comments, general comments about the person's room, interactions with others, you know, during your visit..... there's no space where you could say, the context.

Other participants noted that the MLMW Tool is not well incorporated in the current client software management system, known as FELIX. Staff member Pat recommended 'pinning' the MLMY Tool into their actual software or creating it as a visible primary document:

Maybe if it was pinned in our actual software, so that it was really accessible on the front page...But if it's there as a visible front page, maybe, I don't know, but that would mean a whole different software system.

Overall, staff participants noted that turning the MLMW Tool into a primary document and embedding it within their current software create more prominence within the current software system or better incorporate it into a new system. OPA staff also provided concrete suggestions to improve its level of efficiency and practicality when using it as part of their everyday practice.

Difficulty finding information to complete Tool and verify it

Expressed by all staff participants was the sentiment that completing the MLMW Tool was not a straightforward process and sourcing the relevant information was often difficult and time-consuming. On the struggles to source the relevant information required by the MLMW Tool, one staff member Sam stated:

Sometimes finding that information [for the Tool] can take a while. You might have to contact other stakeholders. And then you have to wait for responses. That waiting time needs to be considered in order to...do a sufficiently comprehensive job. Or can you imagine when you have a family with seven children? And should you get, you know, information from each of them? If a person, if a protected person has limited abilities to actually express himself, you know. So it's very hard, for example, to get the wishes and the client wishes. Or their preferences, their history.

A common response among participating staff was that the MLMW Tool does require quite a few hours of work for it to be useful in documenting and improving the understanding of the protected person's will and preferences, but that this was still a worthwhile endeavor. Staff member Cameron noted how it was the 'nature of the beast' that the information required by the MLMW Tool was time-consuming, 'if you want to do it properly':

I think it [i.e., the MLMW Tool] is user-friendly. It's just the nature of the beast that...It's very time-consuming...I know that it can take hours, actually, to do them.. if you want to do it properly. Because the underlying principle is you want the next person to have a quick access to information and be equipped and make a decision as quickly as possible.

The majority of participating staff reported that subsequent visits with protected persons to add missing information or a follow-up visit to verify what has been documented on the MLMW Tool was something worth doing. However, resource and time constraints often created obstacles to achieving this. For example, staff member Perry commented:

I mean, realistically, I don't think that we will go and do another visit because we forgot to ask a question, to be honest.... In the ideal world, would it be nice to do a follow-up visit.

Staff consistently reported that completing the Tool requires a level of quality engagement with the protected person — each with their own unique set of circumstances and capacity — along with other stakeholders and/or supporters. However, the protected person does not always have the opportunity to confirm their will and preferences in a timely manner during follow-up visits with a Delegated Guardian or other OPA staff. As a result, a number of staff reported that they are not clear if individuals even get to see or access their own MLMW Tool, which raises issues around transparency and accountability.

Engaging supporters for the protected person

There was congruence in interviewed OPA staff reporting that many protected persons are largely socially isolated, which complicates completion of the MLMW Tool. In instances where a protected person has limited capacity to communicate, there is a need to engage supporters who can provide additional valuable insights into the protected person. Supporters can be both paid or informal, and include family members, friends, advocates, and individuals who support or know the person. For instance, OPA staff member Max spoke about the gratitude they feel when they can find a supporter who can adequately express and protect the persons wishes:

I think if we are able to identify a close person, a family member, a friend, who truly represents the protected person's wishes, you know, understands the person, doesn't have any of their own agenda, you know, we actually are extremely grateful, you know.

When asked how they can ensure supporters have the best interest of the protected person in mind, staff member Max highlights a series of considerations that they make in such instances and which is largely a 'judgement call':

You gather as much information as you can and you make a judgement who you should listen and who you shouldn't, you know... that's the best answer I can give you. And you compromise sometimes who you contact. Or you will pick up a family member who seems to be...it's a judgement call, seems to be most objective.... Most, have most insight or less self-interest to actually be a communicator with other family members.

Engaging with supporters to further develop the MLMW Tool as part of a collaborative codesign process could facilitate a better profile of the protected person, but it is not without its challenges. There is also need to develop adequate protocol to ensure the views of supporters does not render obsolete those of the individual. It was such considerations around the presence and role of supporters that was raised by OPA staff in this regard.

Negotiating questions about death

As part of the MLMW Tool there is a section about "my dying wishes" that provided OPA staff a framework to approach the concepts of life, death and dying. During the application of this framework, OPA staff reported that they often considered the protected person's capacity to understand concepts around end of life, death and dying, as is illustrated by staff member Vic:

Depending on the person's level of understanding...I will start with simple questions like, what do you think, if something happens to you? Like your heart stops beating, you know? What would you like a doctor to do?

Some OPA staff note that such questions may not be easily answered and larger amounts of time are sometimes required by the protected person to consider them thoughtfully. For example, staff member Karen spoke about the explanation and time they give to help the person think through the concepts:

{I] Just to start off by just saying we need this information purely because if you [i.e., protected person] are unconscious you're not going to be able to be asked these questions...You don't feel pressure to give me an answer and you can say I need time to think about it and explore with you what are your wishes

OPA staff generally expressed that some groups of people are more receptive to answering questions about their dying wishes. However, other staff, like Max, noted cases where it can be difficult to obtain a comprehensive expression of a protected person's dying wish as even asking such questions using current strategies could trigger a negative response that can compromise the individual's wellbeing:

Other people, I've found like more the middle-aged people have been more receptive [to discussing their dying wishes] because it's like, okay, you know, we understand that, let's put it down. And then other people have just been so offended or confused because they think then they're dying. So, yeah, that can be a tricky part. And I have left that off quite a few documents because there's just been no safe way to bring it up to prevent escalation or distress as well.

There are also cases where protected persons might refuse to answer questions about death and dying, as OPA staff member Tina experienced, in which cases having developed a strong rapport and positive working relationship is key:

Aboriginal clients have asked me not to talk about it...it's been completely shut down. But again, rapport, because I've had one of my 19-year-old young Aboriginal man tell me everything about what he wants to happen when he dies. So, yeah, different person, different rapport.

In such instances where the Public Advocate is not the guardian of health decisions, interviewed OPA staff reported that they did not ask about dying wishes unless there is reason to believe the person is close to death. Staff member Cameron spoke about avoiding this topic if it was outside of their 'role':

If it's not part of our role, it's not part of our role. I've got lots of other things to get on with that are part of my role, that's what I do, so with probably rare exceptions, where it might be, where the writing is kind of on the wall, that this will become part of our role.

Amongst the majority of OPA staff interviewed, asking a person about their dying wishes is a topic that was often approached cautiously and in a sensitive manner; noting though that some protected persons may experience a strong or negative reaction.

Effectiveness of MLMW Tool after hours

Some staff working after hours reported a lack of clarity around the responsibility for which OPA staff need to complete the MLMW Tool and to what level they can trust the currency of the information populated. Several staff further outlined an expectation that the MLMW Tool should have been completed prior to their after-hours engagement. Amongst several OAP staff, it was also noted that the effectiveness of using the MLMW Tool to help make supported decisions depends on how up to date and accurate the information is, a factor that could particularly compromise its applicability for staff who are working after hours. The effectiveness of the information provided is noted by staff member Keri who states:

It doesn't help with what's happening currently with the current...some of these documents [i.e., filled in MLMW Tools] would have been updated about a year ago and the situations and circumstances would have changed in a duty setting.

One Delegated Guardian, Cameron, noted that using the MLMW Tool is useful after hours but for matters that are more pressing, such as matters related to health and death.

My Life, My Wishes after hours is for health decisions, you know, things like end-of-life decisions, because otherwise I'm not going to make accommodation decisions after hours...I'm not going to do any of that. So, really, it's just for... end-of-life decisions that it's very useful.

Regardless, matters related to the death of the protected person are also recorded in another section of the FELIX system, which suggests that the MLMW Tool may not be entirely useful in this regard. As a result, OPA staff member perry noted that they often 'forget it exists':

I've never used it on duty. I think I've used it once after hours. So not particularly helpful. I forget it exists....If I do have end-of-life decisions on after hours, then I'll search end-of-life, not My Life, My Wishes. Because usually there's another entry for end-of-life wishes.

What the interviews seem to indicate is that the MLMW Tool may not necessarily receive significant engagement by OPA staff who work out of hours if the information collected is not kept up to date or if similar information can be easily elsewhere on the FELIX system.

Applicability of using the MLMW Tool with target groups

The OPA sought to explore if there were potential challenges or concerns with using MLMW Tools for target groups under their protection, specifically: Aboriginal and Torres Strait Islander peoples, people in residential aged care, and National Disability Insurance Scheme (NDIS) participants.

Several interviewed staff did not express any issues with the form when used with Aboriginal and Torres Strait Islander peoples, whilst others acknowledged that they have not worked with this target group for some time. There is notably a designated group in OPA that worked with Aboriginal and Torres Strait Islander protected persons, which inevitably limited our findings in this regard.

Amongst the other two target groups, interviewed staff did not identify specific issues with the MLMW Tool, but articulated that there were differences in acquiring the necessary information to populate the MLMW Tool depending on the target group. For example, there was a consensus among interviewed staff that populating the MLMW Tool was more straightforward amongst protected persons in residential aged care. The ease for which to acquire the information for this target group was expressed by worker Karen:

It's actually relatively easy...to get information from residential care than from people....Because this document is not only about persons' wishes...but also it's a tool where you can put factual information. So, you know, like diagnosis, level of functioning. So it's easier when there is form of support in place, you know, to get information from residential care, because you ask for a care plan, you have your support plan, you know what to ask, because they have to document everything. It's more complicated when people live in a community...you know, in their private residence.

In relation to protected persons that were NDIS participants, there could be a greater degree of complexity, which often meant more time was required to populate the MLMW Tool. The complexity of documenting these individuals was acknowledged by OPA staff member Liv, who also commented on the MLMW Tool's usefulness in this regard:

NDIS participants, they can have six providers. They can have one half-million package. So it's a lot of information. I can see this document being particularly useful when you have to navigate this labyrinth of services. And I think it's a major challenge to keep our record up-to-date with changing providers, changing services. So I think probably it would be more complex and more time-consuming because you have speech pathologists, you may have OT [i.e., Occupational Therapist], you may have social workers, you may have a psychologist, you may have a day option. You may have five or six service providers, NDIS, and you want this document to capture what people are getting. So I would say probably more time-consuming.

Whilst it could not be ascertained whether there were any challenges or concerns about the usage of the MLMW Tool with Aboriginal and Torres Strait Islander peoples, there are often sufficient supports and evidence available to populate the MLMW Tool with protect persons in residential aged care.Notably, information related to protected persons with complex NDIS packages can take longer to populate within the MLMW Tool provided.

Summary of Findings Criteria for Success in Implementing Supported Decision Making (SDM) and Working within Current Legislation

Interview findings revealed that OPA staff do not typically frame their work in terms of "success." Instead, their focus and reflective mechanism lies in fulfilling their duties as effectively as possible within the constraints of time, workload, and legislation. Their approach remains largely guided by compliance with legislative requirements rather than by explicit outcome measures. While staff demonstrate strong professional commitment and capability, the current legislative framework presents significant barriers to implementing supported decision making (SDM) in a consistent and comprehensive way. Several OPA staff members noted the limitations of their current practice as a result of the current legislation. These statements are reflected in comments made by participants like Vik, Cameron, and Sam:

There are certain boundaries...There are limitations of supported decision-making and the legislation gives us an option of actually being quite restrictive, an option of acting against the person's wishes which would be in conflict with supported decision-making. It's consistent with the principles of the legislation which established the Public Advocate Office.
-Vik

Our legislation doesn't support substitute [supported] decision making...it is our role to make the decisions with the legislation requires us to make a substitute decisions and doesn't really allow the supported decision.
-Cameron

Unfortunately I find the act is written in a substitute position making model.. That's the tension I struggle with....because whenever we try to implement supportive decision-making, we get a lot of pushback.
-Sam

Despite these challenges, there is a clearly articulated ethos of supported decision making embedded across the professional practices of interviewed OPA SA staff. Staff consistently demonstrate an understanding of SDM principles, often incorporating them into their day-to-day work even when these actions are not explicitly recognised as SDM. Examples include encouraging dialogue, ensuring that individuals are consulted, and delaying substitute decisions to allow people more opportunity to participate in decision-making processes. This ethos has been strengthened through past and current projects, reflecting a gradual cultural shift toward a rights-based, autonomy-focused model of practice. Human rights, legislative and SDM ethos were reported during interviews as providing a reflective mechanism—with staff expressing continually ask themselves whether they have "done right" by the person under their guardianship and whether they have facilitated SDM as much as possible within legislative and practical limits. In this context, "success" is not defined by outcomes, but by the extent to which staff can create space and flexibility for individuals to make their own decisions, even when those decisions involve uncertainty or risk. This marks an important shift from traditional paternalistic substitute decision making toward enabling self-determination and human rights.

However, findings also highlight that staff often face emotional and ethical complexity in their roles. They must constantly balance duty of care obligations with respect for the individual's right to take risks and make autonomous choices. This tension is compounded by the reputational challenges of being perceived externally as "the bad guys" who make difficult or unpopular decisions. Staff navigate this emotional labour by drawing on professional judgement, empathy, and peer support, though there is recognition that more structured opportunities for reflection and shared learning would strengthen practice.
Interview findings also identified a diverse range of knowledge, skills, and capabilities among staff in relation to supported decision making. This diversity points to the need for dedicated opportunities for collective reflection, where staff can explore what "success" means within their specific operational context, share strategies, and align their practice more closely with SDM principles under current legislation. Such reflection could also inform OPA's contribution to shaping future legislative reform, including recommendations that make SDM central—rather than secondary—to its statutory role and decision-making processes.

Overall, the findings portray a dedicated and values-driven workforce that operates within significant systemic and legislative constraints. While staff may not define or measure success explicitly, their actions consistently reflect a commitment to upholding the human rights, dignity, and autonomy of clients. Supported decision making is already embedded in practice at OPA—though often unacknowledged—and further structural support, internal reflection, and legislative reform would enable it to be implemented more fully and consistently across the organisation.

Limitations and further explanation

This research has limitations as it does not investigate interactions between various areas of the OPA. The researchers interviewed members of staff whose role is to generally work directly with protected persons. There is therefore an incomplete picture of how the MLMW Tool helps to embed supported decision-making principles in the office because senior management and policy officers at the OPA were not interviewed for this evaluation. Further, the staff interviewed self-reported their perceptions and experiences of using the MLMW Tool with protected persons for the purposes of supported decision-making. No research was conducted with protected persons to investigate their perceptions and experiences of how the MLMW Tool was used in meetings with Delegated Guardians. A more nuanced account of the operations of the MLMW Tool could be better achieved if the researchers could triangulate interview data from: (1) OPA staff that work directly with protected persons, (2) the protected persons themselves and (3) OPA senior management and policy officers. It would also be worth considering the sub-group of OPA staff that specifical work with Aboriginal Torres Strait Islander peoples in this triangulation as well.

Conclusion

This study outlines staff views which demonstrate that there is inherent value in the MLMW Tool. However, there are several aspects surrounding the implementation of the MLMW Tool that would benefit from a more consistent approach from the OPA. After three years of the OPA engaging with this project, this study suggests there is enough value in the MLMW Tool to further refine and formally embed it into the FELIX platform. Only two staff interviewed notably expressed a dislike of the MLMW Tool, mainly as a result of having to prioritise their time to its application and due its absence on the FELIX platform. Next steps for the MLMW Tool centre around establishing strategies to facilitate its implementation more consistently into practice, as well as creating clearer protocols and expectations of staff across roles in the OPA.This report outlines a variety of ways OPA staff operate and use the MLMW Tool, at times to varying degrees of success. We therefore recommend that the OPA establish a clear purpose for the MLMW Tool in relation to the legislated responsibilities of Delegated Guardians, to define with clarity the purpose of the MLMW Tool, and ensure that subsequent professional development and training includes how the MLMW Tool is to be used and by whom There are notable aspects where the discretion of individual Delegated Guardian should continue. This review mainly highlighted the professional approach of OPA staff and their intention to provide the best outcome for individuals under orders within the OPA. This includes the way they work with supporters and diverse cohorts of protected persons, including those with diverse and specific needs. In 2025 there is increasing knowledge about supported decision making, individual wishes and future planning in the NDIS services than other health and human service areas. This review reinforced the OPA staff's view of a positive working approach to their responsibilities to best engage in support decision-making as Delegated Guardians to some of the most vulnerable and invisible individuals in South Australia.

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Reccomendations and future directions

Recommendation One: Upgrade or adapt the FELIX system so Delegated Guardians can access accurate information within the MLMW Tool without the need to search for other documents. Delegated Guardians did express that they attempt to pre-complete some of the MLMW Tool, but this is often time consuming and somewhat repetitive.

Recommendation Two: Continued professional development around the application and ethos surrounding supported decision-making and how the MLMW Tool was designed to facilitate it. This is necessary to ensure that staff's understandings of supported decision-making are well aligned and consistent to OPA approaches.

Recommendation Three: A more consistent approach to support the implementation and commonality surrounding the completion of the MLMW Tool. This includes the need to review and update the MLMW Tool at any change of circumstances of the protected person's needs.

Recommendation Four: Delegated Guardians to be trained in current end of life planning discussions with vulnerable people and refer to any Advance Care Directive documentation associated documentation

Recommendation Five: Delegated Guardians need consistent access to time and workload to complete and implement the MLMW Tool with individuals under protection orders

Recommendation Six: The information from the MLMW Tool documentation is not generally shared/verified with protected persons under orders. This has the potential to compromise the quality of information within the MLMW Tool.

Recommendation Seven: The MLMW tool needs some revisions, such as the inclusion of a section that provides contextual information on where the interview with the protected person took place.

Recommendation Eight: Develop a protocol to ensure views of supporters can be verified with protected persons to ensure the best information is available to facilitate supported decision-making.

Recommendation Nine: To achieve a more systematic evaluation of the qualitative scope and practices of supported decision-making, at a stage when it is deemed most appropriate for OPA, a follow-up evaluation can be conducted that can triangulate the perceptions and experiences of OPA staff that work directly with protected persons, the protected persons themselves, and senior management and policy officers. This triangulation would be best embedded within an organisational ethnographic research project, which would then be able to identify patterns and processes in how supported decision-making operates within OPA.

Criteria for Success Recommendations and Future Directions

Recommendations: Implementing Supported Decision Making (SDM) and Strengthening Practice within Legislative Frameworks

1. Legislative Reform to Embed Supported Decision Making as Central Practice

Amend current guardianship legislation to explicitly prioritise supported decision making as the primary approach in all decision-making processes. Legislative reform should move beyond allowing SDM as an optional or secondary consideration and instead make it a mandated first step before substitute decision making is considered. Clear statutory language and guidelines should affirm the rights of individuals to participate in decisions affecting their lives, aligning with Australia's obligations under the UN Convention on the Rights of Persons with Disabilities (UNCRPD).

2. Establish Organisational Reflection and Learning Forums

Develop structured opportunities for OPA staff to reflect collectively on their practice, share strategies, and articulate what "success" means in implementing supported decision making within the current legislative context. These forums should facilitate peer learning, professional dialogue, and problem-solving around ethical dilemmas such as balancing duty of care with respect for autonomy. Embedding reflective practice sessions into regular professional development would strengthen consistency and confidence in SDM application.

3. Build Capability and Professional Development in Supported Decision Making

Implement a comprehensive capability-building framework across OPA to enhance staff understanding, skills, and confidence in applying SDM principles. Training should include case-based learning, role-play, and critical reflection on real-world challenges. A competency framework could outline expected knowledge and behaviours for staff at different levels, helping ensure that SDM principles are consistently integrated into daily decision-making practices and client interactions.

4. Develop Organisational Measures and Indicators of SDM "Success"

Create a set of practice-based indicators and reflective tools to help OPA define and assess what "success" looks like in the context of supported decision making. These measures should focus on qualitative outcomes—such as the extent of client participation, informed choice, and autonomy—rather than quantitative compliance metrics. This shift would align performance assessment with OPA's human rights–based ethos, ensuring that staff efforts to promote supported decision making are recognised and valued within organisational reporting and accountability structures.

These recommendations collectively aim to strengthen the systemic, legislative, and cultural foundations for supported decision making within OPA. Legislative reform would provide the necessary structural change, while internal reflection, capability building, and practice-based evaluation would support sustainable, rights-based implementation across all levels of the organisation.

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Appendix A

The Overarching Questions for Office of Public Advocate (OPA) Interview Schedule

Biographic Details

1.What is your education and background in working in the human services sector?
2.How long have you worked for the OPA?
3.Can you tell me about some of your experiences working with individuals with complex needs under the guardianship order appointed by the Public Advocate? For example, how are clients allocated to you, what kinds of clients do you work with, what are common things that you do in your work with clients, are there any reoccurring challenges?

Supported Decision Making Principles within OPA Organisational Context

1.How were you introduced to the principles of Supported Decision Making?
2.Can you tell me about any training you had about Supported Decision Making?
3.Have you carried out any self-directed study/education about Supported Decision Making beyond any potential training you had?
4.Considering your work within OPA, how would you explain what Supported Decision Making means within this organisational context?
5.How have the principles of Supported Decision Making been introduced into OPA's work? Can you provide examples?
6.Does the My Life Why Wishes (MLMW) Form act as a means by which to better incorporate the principles of Supported Decision Making? Why or why not?

My Life My Wishes Form

1.What training have you received on using the My Life My Wishes form?
2.Do you use/review the MLMW form on every visit? If not, why not?
3.What would make the MLMW process more user-friendly?
4.What do you think should be added to, or removed from, the form, and why?
5.Do you prefill parts of the form before the visit? Why or why not?
6.How easy is it to find the information needed to complete the form, and how much post-visit follow-up is required?
7.Describe your experience with supporters (for the person under guardianship) when using the form. For example, do you seek support for the person, and how have supporters interacted and responded?
8.On the MLMY form there is a section on 'my dying wishes'. How do you initiate and guide conversations with the person under guardianship about their end-of-life wishes? Do you discuss end-of-life wishes if the Public Advocate is not guardian for health decisions?
9.How helpful is the MLMW form to you in your work, particularly during duty/after hours? What additional information would be useful?
10. Are there any concerns or challenges you have observed when using the form with Aboriginal and Torres Strait Islander peoples? What could be done to improve the form in this regard?
11. Are there any concerns or challenges you have observed when using the form with people living in residential aged care? What could be done to improve the form in this regard?
12. Are there any concerns or challenges you have observed when using the form with NDIS participants? What could be done to improve the form in this regard?

Impact of Supported Decision-Making Principles

1.Broadly, do you perceive that using the principles of Supported Decision Making has or is making a positive difference to the lives of individuals with complex needs under the guardianship order appointed by the Public Advocate? Could you outline examples on the types of changes or outcomes you have seen - being positive, negative, or no noticeable change to outcomes?'

2.Has the implementation of the principles of Supported Decision Making changed or is changing your practice as a delegated guardian for OPA? If so, are you able to outline some of the changes you believe it has made to your practice? If not, are you able to outline your views on why it is not making any changes?

Tension and Future Directions

1.Are there any significant tensions for you between implementation of the principles of Supported Decision Making and your role in the life of an individual with complex needs under the guardianship order appointed by the Public Advocate?

2.How would you improve, change, adapt or build on the principles of Supported Decision Making with the individuals you support to increase likelihood of positive change?

3. 3 Toolset review at Community Living Options (CLO) by Associate Professor Caroline Ellison, UniSA

Perceptions of a Behaviour Support Manager: The initial implementation of a Supported Decision-Making Framework with Individuals Living with Complex Disability within a disability support agency in South Australia

Authors

Associate Professor Caroline Ellison
Ms Jan McConchie
Dr Sarah Faulkner

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The Toolkit and Environmental Framework were developed by Dr Michelle Browning from Decision Agency and Ms Melanie Ingram from CLO as an extension of the initial work of the ILC Living My Life Project.

Abtract

This evaluation explores the early implementation of a holistic supported decision-making (SDM) toolkit of resources and environmental behaviour support framework within a South Australian disability service organisation, Community Living Options (CLO). CLO participated in the Living My Life (LML) ILC Project. Using a qualitative case study design, three semi-guided interviews were conducted with CLO's Positive Behaviour Support (PBS) Manager to capture the manager's perceptions of staff adoption, reported outcomes, and emerging impact of the framework on restrictive practices of individuals with complex disability and under guardianship orders supported by CLO. Findings indicate significant variation in the understanding of SDM across workforce groups within CLO, following training across levels of the organisation's leadership, professional and frontline staff. Initial findings suggest tertiary trained practitioners demonstrated stronger engagement in SDM principles linked to their education and professional experience than less experienced frontline staff with Certificate IV–level qualifications engaging with SDM concepts for the first time. Staff confidence, fear, trauma-informed barriers, and risk-averse cultures were reported as key challenges to SDM implementation, while leadership endorsement, reflective practice, and integration of SDM with Positive Behaviour Supports served as enablers. This evaluation highlights the importance of embedding SDM expectations across organisational systems, providing protected time for education, training, assessment, and strengthening workforce capability through foundational understanding of trauma-informed, assumed ability and empathy-based capacity building. The findings of this evaluation can contribute to broader policy discourse across disability, aged care and mental health services sectors to reduce restrictive practices through human rights-based, capability-focused frameworks, underscoring the potential for system-level adoption across human services.

Introduction

According to Dr Michelle Browning, supported decision making (SDM) has the main aims of facilitating an individual living with cognitive disabilities to exercise their right to will and preference(s), as well as to determine the direction of their own lives (Browning, Bigby and Douglas, 2021). The South Australian Office of the Public Advocate (OPA) outlines SDM as the process of assisting "individuals with impaired decision-making abilities by enhancing their skills, and knowledge, alongside those of their family and supporters" (OPA(a), 2025). SDM and having the equal right to make decisions that affects one's own life is a fundamental right as recognised by the United Nations Convention of the Rights of Persons with Disabilities (CRPD) (UN, 2016) and thus has been legally adopted as an obligation by the Australian Government (OPA (a) 2025). Over the past ten years there has been an increased focus in the development, evolution, and application of SDM as an alternative to substitute decision-making; a process of making decisions for individuals if they lack the capacity to make decisions for themselves (OPA(b), 2025; Shogren et al. 2019).

The implementation of SDM reflects the inherent rights of people with disabilities to exert their own level of self-determination and the direction of their own lives. When an individual exercises more self-determination, it has been widely shown that they have a demonstrably better quality of life (Shogren et al. 2019). Thus, increasing the application of SDM for individuals receiving support, particularly those who are at increased risk of restrictive practices, was a key goal of the Living My Life (LML) ILC Project.

In order to provide an approach that could be implemented across human service practice, thereby supporting the formal application and efforts to implement SDM practices to reduce the use of restrictive practices for individuals, Dr Michelle Browning and Ms Melanie Ingram through the LML ILC Project developed an SDM environmental framework and resource toolkit to formally guide practitioners and human services to increase the agency for individuals and therefore reduce the need for restrictive practices. According to Dr Browning SDM within an environmental framework is foundational to increasing agency, choice and control, and facilitating will and preference(s) for individual's with complex needs, which will lead to a reduction in the need for restrictive practices. SDM is a mechanism by which supports can facilitate an individual to have more choice and control by actively involving them in decision making and the direction of their own lives (Browning et al, 2021).

Within the SDM environmental framework and resources toolkit, identifying and understanding what the individual wants and who they are is central to the approach. Notably, if individuals have a good life that reflects their will and preference(s) there will be less need for an individual to communicate through behaviours considered challenging or inappropriate. Professional supports can become overly reactive to such behaviours. Thus, the SDM environmental framework and resource toolkit aims to steer professional responses away from being reactive by encouraging supports to take a more proactive approach.

Dr. Michelle Browning and Melanie Ingram developed the SDM environmental framework and resource toolkit by drawing on their rich and extensive theoretical and professional experience in behaviour support, along with a contemporary review of the literature. ..(continued on page 41)

Applying a human rights lens, Browning and Ingram identified and reviewed current positive behaviour support frameworks and models, such as the Alinka Fischer models, tiered models of positive behaviour support (PBS), and the Inclusion Australia Framework, alongside SDM literature. They notably identified a gap between extension theory and the reality of trying to make the theory come to life for support services at the frontline. As such Browning and Ingram developed a SDM environmental framework and resource toolkit that was accessible at service delivery levels.

Consequently, the LML ILC Project enabled the development of a framework that integrated key SDM principles, an environmental review, and personal goal setting into the PBS process in order to reduce behaviours of concern and the use of restrictive practices for people with intellectual disability. The creation of these tools aim to support practitioners and support teams to:

- Understand a person's environment and supports
- Make adjustments to support a more individualised approach
- Set goals that reflect what the person wants and needs
- Reduce behaviours of concern; and
- Reduce or avoid the use of restrictive practices

Formal implementation and training of the framework and toolkits were undertaken across a range of health and advocacy areas following their development. However, this evaluation looks at the initial trial implementation of the SBM environmental framework and resource toolkit within disability support provider, Community Living Options (CLO), in order to identify potential enablers and barriers to its implementation.

Aim of research

To explore the perceptions of a PBS Manager on the initial adoption, impact and reported outcomes (from their team) on the practice and implementation of a holistic environmental framework that includes SDM and behaviour support strategies to reduce the experience of restrictive practices for individuals living with complex support needs.

Research Questions

- What outcomes do behaviour support staff report that are linked to the implementation of a holistic environmental behaviour support and SDM framework?
- What outcomes do staff working with people living with complex disability identify and report around reconsidering tier 1 daily living environments in order to reduce needs for tier 2 and 3 restrictive practices?
- What examples of positive, unchanged, or negative impacts on individuals living with complex disability have behaviour support staff reported due to implementing the behaviour support and SDM framework?
- How do behaviour support staff determine the success, or lack of success, of the holistic environmental behaviour support and SDM framework, particularly in its ability to reduce restrictive practices in an individual's life?
- How can this evaluation contribute to the delivery of human services more broadly, in order to influence policy and practice around reducing the experience of restrictive practices for individuals living with complex disability?

Rationale

This evaluation seeks to identify the potential contribution that a broader implementation and adoption of a holistic environmental framework for SDM (Browning, Bigby and Douglas, 2014; Browning, Bigby and Douglas, 2021; Fisher & Kelly, 2025) and a range of behaviour support strategies (Fisher and Kelly, 2024) have on the delivery of human services for individuals living with complex disability. Particularly, individuals with guardianship orders. Critically, the findings of this study seek to influence policy and practice around reducing the experience of restrictive practice for individuals living with complex disability (Penzenstadler, Molodynski & Khazaa, 2020) and particularly those with a complex intersectionality of needs (Browning, Bigby & Douglas, 2021). A marked reduction in the use of restrictive practices and increase in positive outcomes for individuals with complex needs as a result of implementing the SDM framework is likely to support a broad application of formal SDM and behaviour support strategies by governments and human services. Some of the most vulnerable individuals in our communities who live with significant tier 1 and tier 2 restrictive practices are supported by practitioners who have undergone training in providing a holistic environmental SDM and behaviour support framework. Any noted outcomes and changes to practitioner practices thus need evaluating for continuous improvement and to better understand the next steps required to increase choice and control and reduce restrictive practices. Such outcomes would inevitably improve individuals quality of life and restore access to human rights currently being minimised by substitute decision making and restrictive practices.

Method

This research followed ethics protocols as stipulated by UniSA's HREC Ethics (approval number 206828). This study involved three 1.5 hour monthly semi guided interviews following purposive sampling with the PBS Manager of CLO, an Adelaide based human service organisation. The interview focused on their observations and discussions with staff supporting individuals with complex needs; many of whom are under orders from the OPA. Semi-guided interviews explored the outcomes following staff's training and initial implementation of a holistic SDM framework with the aim to reduce restrictive practices.

Over a period of 5 months the Chief Investigator, Associate Professor Caroline Ellison, met three times on teams with the PBS Manager from CLO. The PBS Manager meets and debriefs with a team of up to 15 professional staff, all of whom have completed SDM framework and toolkit training in 2024 and early 2025. A semi-structured interview approach was undertaken to ensure consistency and depth in data collection. The questions remained open-ended and explored implementation processes, organisational support and practitioner experiences. Reflexive thematic analysis was then used to identify patterns, themes, & meanings in the interview data (Braun and Clarke, 2024; Braun and Clarke, 2022).

The PBS Managers perceptions were based on the outcomes reported by their PBS staff during regular and ongoing routine debriefs. The semi guided interviews focused on the impact of training and initial implementation of holistic SDM toolkit of resources and environmental behaviour support framework as part of the 12-month extension of the LML ILC Project. While the experiences, views and perceptions of CLO's PBS manager form the data, no actual names were used in the interviews or recordings to ensure any information stored did not directly identify any staff or individual's receiving supports. The PBS Manager was given the opportunity to review all transcription and review the initial analysis to prevent any misinterpretation of comments, views or feedback during the interviews.

Results of Interview-Findings

This section synthesises insights from three in-depth interviews with the PBS Manager of CLO. The findings reveal a complex interplay of organisational culture, workforce capability, and perceived risk that significantly influenced initial adoption of the holistic SDM toolkit of resources and environmental behaviour support framework. While CLO demonstrates strong structural and leadership commitment to SDM, considerable variability exists in how different staff groups understand, value, and apply SDM principles.

1. Variability in SDM Understanding Across Workforce Groups

A consistent theme across both interviews was the marked disparity in SDM comprehension and confidence between professional groups. Practitioners with higher-level qualifications, such as PBS practitioners, Developmental Educators, and trained Allied Health staff responding positively to SDM concepts and valued the structured, capability focused approach of the framework. In contrast, team leaders and support coordinators (often qualified in Cert IV in Disability Support) struggled to interpret foundational SDM concepts into practice. This group frequently expressed resistance, uncertainty, or a belief that SDM was "not possible" for certain individuals. The disparity created inconsistency in practice and highlighted the need for differentiated training and organisational scaffolding.

2. Staff Fear and Trauma-Informed Barriers to SDM Engagement

A significant barrier identified in the second interview was staff fear. Many support workers reported apprehension that engaging participants in SDM activities, such as exploring preferences or asking reflective questions, might "trigger" participant distress or behaviours of concern from individuals. This fear exhibited by staff appears rooted in previous negative experiences and a trauma-informed response from staff themselves. Thus, a level of uncertainty or lack of confidence can inevitably contribute to risk-averse practice, limited opportunities for individual autonomy and reinforce staff's deficit-oriented view of individuals.

3. Tendency to Conceptualise Participants Through Deficit-Based Lenses

Interviews highlight that when describing individuals, staff often default to behaviour and risk-focused narratives, rather than strengths-based descriptions. An exercise in the framework, in which staff rewrote participant descriptions from a strengths-based perspective, revealing profound shifts in understanding, empathy, and professional orientation. This underscores the need for more reflective practices integrated into training and supervision to reshape organisational narratives and promote a capability-focused culture.

4. Environmental Assessment Tools (Part 1) Are Effective but Time-Intensive

The transcripts confirm that Part 1 of the SDM Environmental Assessment an individual directed exploration of wants preferences, environment, identity, and support needs, is a powerful tool. Staff reported that the tool facilitated new insights into individual's goals and identity, often generating deep and meaningful engagement. However, the process was described as time-intensive, emotionally demanding, and requiring multiple sessions, sometimes spanning several months. Without organisational systems to allocate time and supervision, frontline staff were unlikely to sustain the practice.

5. Early Evidence of Positive Participant Outcomes

Implementation of the SDM framework has already resulted in early positive outcomes for several highly complex individuals supported by CLO. One case example involved an individual with a complex disability and behavioural background. After having engaged with SDM processes, this participant experienced reduced behavioural severity, increased staff stability, improvements in daily regulation, and enhanced motivation that stemmed from identifying and achieving clearly defined and personally meaningful goals. These early indicators suggest that SDM contributes to improved quality of life and decreased reliance on restrictive practices as the more an individual's life aligns with their aspirations there is a reduced need to communicate via what can appear as dis-regulated actions.

6. Relationship Between SDM and Positive Behaviour Support (PBS)

Interview data emphasises that SDM and PBS are mutually reinforcing rather than separate practices. SDM-driven foundational supports, particularly, those addressing wants, environment, sensory needs, and daily decision-making can directly reduce behaviours of concern and a reliance on restrictive practices. Integrating SDM into PBS processes was viewed as essential to achieving sustainable practice change.

7. Organisational Culture and Leadership as Key Implementation Enablers

CLO's organisational alignment emerged as a strong enabler. The CEO, executive team, and senior operational staff all participated in the holistic SDM toolkit of resources and environmental behaviour support framework SDM training, creating coherence between organisational intentions and practice expectations. CLO is exploring policy revisions, training frameworks, and job description updates to embed SDM across all roles. This leadership engagement positions CLO favourably for whole-of-organisation SDM implementation. The organisational leadership also supported collaboration with Decision Agency, UniSA and engagement in professional development webinars and the sharing of experiences around the development at impactful conferences.

Summary Table: Enablers and Barriers Across Both Interviews

Theme	Enablers Identified	Barriers Identified
Workforce Capability & Skills	• Highly trained practitioners (PBS, DE, allied health) strongly engage with SDM	• Cert IV–qualified staff struggle with SDM concepts
	• Staff value structured tools and case-based learning	• Limited theoretical grounding in trauma, rights, and capability
	• Strengths-based description exercises shift thinking	• Staff fear of "triggering" participants inhibits practice
Organisational Culture & Leadership	• Strong executive and leadership endorsement	• Uneven adoption across middle leadership
	• Willingness to integrate SDM into policy, job descriptions, and HR systems	• Operational pressures limit reflective practice
	• Commitment to whole-of-organisation implementation	
Tools & Processes	• Environmental Assessment Tool (Part 1) generates deep insights	• Part 1 is time-intensive and complex
	• CLO developing decision-making profiles for all participants	• Frontline staff lack confidence to administer tools
	• Role-play and case study exercises effective for learning	• Limited time allocated to SDM practice
Participant Outcomes	• Reduced severity of behaviours of concern	• Historical restrictive practices and risk culture limit new opportunities
	• Increased staff stability and confidence	• Participants often have limited prior opportunity for autonomy, requiring slow change
	• Improved participant purpose, motivation, and autonomy	
Risk, Safety & Trauma	• Recognition that autonomy and risk can safely co-exist	• Staff trauma and anxiety drive avoidance
	• PBS + SDM integration supports a balanced approach	• "Risk-first" culture suppresses autonomy
	• Modelling from practitioners influences entire teams	• Behaviour-focused narratives reinforce deficit views
Training & Learning Systems	• Case-based training, modelling, and role-play are effective	• Training alone insufficient without structural support
	• Simulation (VR/AI avatars) provides safe practice environments	• Supervisors vary in ability to coach SDM in practice
	• DE and PBS backgrounds complement SDM adoption	

Discussion

The findings from this evaluation add to growing evidence supporting SDM a foundational component of ethical and effective disability support, particularly for individuals with complex behavioural presentations and long histories of restrictive practices. The implementation of a holistic SDM toolkit of resources in this organisation reveals several important insights on the interplay between workforce capability, organisational culture, and individual outcomes.

A central theme emerging from the interviews was the substantial variation in staff understanding of SDM. With the majority of PBS practitioners, Developmental Educators, and Allied Health staff embracing the framework's focus on capability, identity and environment, frontline and middle-management staff demonstrated discomfort, confusion, or resistance. This disparity reflects broader challenges within the disability sector, where variation in qualifications and professional training can create inconsistent practice with SDM implementation. Such findings reinforce the need for ongoing coaching, reflective practice(s), and organisational scaffolding when shifting from substitute decision-making to rights-based, capability-focused approaches that highlights the importance of the toolkit of resources and environmental framework.

Staff fear and trauma also emerged as significant implementation barriers. The interviews demonstrated how workers, particularly those newer to the sector or with limited theoretical grounding, may avoid engaging participants in reflective or preference-driven conversations due to perceived risks of "triggering" behaviours of concern. This fear-based approach, often shaped by historical incidents, mirrors patterns described by Browning et al. (2021) and Penzenstadler et al. (2020), where trauma-informed support is required not only for participants but also for staff. Addressing this requires trauma-sensitive supervision, opportunities for positive risk-taking, and organisational endorsement that autonomy and risk can safely co-exist.

Despite these barriers, the evaluation provides compelling early evidence that the framework fosters meaningful improvements in quality of life and reductions in restrictive practices. Individual's life outcomes described by the PBS Manager included improved regulation, reduced behaviour severity, and increased purpose in daily activities and life in general, demonstrating that SDM can act as a protective factor when embedded within person-centred environments. These outcomes support arguments from Fisher and Kelly (2024) that foundational environmental adjustments, rather than restrictive interventions, are often the key drivers of behavioural change.

Organisational leadership also emerged as a critical enabler. With the CEO, senior executives, and operational leads participating in training, the organisation has created a culture where rights-based practice is both expected and supported. This strategic alignment strengthens the sustainability of implementing the holistic SDM toolkit of resources and environmental behaviour support framework as best practice for system-level change across human services.

Finally, the findings highlight the need for practical tools, time allocation, and integration of SDM within existing PBS processes. Staff require accessible, environment-focused tools and structured guidance to incorporate SDM into daily practice. The Environmental Assessment Tool (Part 1), while powerful, requires protected time and reflective space that is often incompatible with NDIS-driven operational pressures. The findings suggest that embedding SDM in job descriptions, KPIs, supervision agendas, and organisational policies will be essential to long-term sustainability. Overall, this evaluation supports the need for a broader adoption of approaches such as the SDM toolkit of resources and environmental behaviour support framework across human services and provides important considerations for policy, training, and organisational reform.

Recommendations

1. Strengthen Workforce Capability Through Structured, Empathy-Building Training

Training should be tiered and tailored to different staff groups. A core focus should be reducing staff fear and building confidence in exploring participant preferences. Training should integrate trauma-informed principles, rights-based frameworks, capability vs competency distinctions, and strengths-based language. Regular reflective exercises such as rewriting behaviour-focused descriptions, should be embedded into supervision and team reviews.

2. Embed SDM Expectations into Organisational Systems and Job Roles

For SDM to be sustainable, expectations must be incorporated into job descriptions, induction programs, competency frameworks, and performance reviews. This includes clear indicators for: supporting everyday decision-making, applying environmental assessments, and using strengths-based and capability-oriented support approaches. Organisational policies should explicitly articulate SDM as a standard of practice.

3. Allocate Protected Time and Supervision Structures for SDM Implementation

Given the depth of engagement required for Part 1 of the SDM Environmental Assessment, CLO should ensure frontline workers have protected time to complete assessments, reflect, and review findings. Supervision should include coaching from PBS practitioners and DEs to support workers in navigating complex conversations, balancing risk with autonomy, and maintaining professional confidence.

4. **Integrate SDM Within the Broader PBS Framework**

SDM should be positioned as foundational to effective PBS. Environmental and preference-based insights from SDM must inform PBS strategies, behaviour hypotheses, and recommendations. Developing a standardised process for this integration will reduce reliance on restrictive practices and strengthen the alignment between support delivery and participant aspirations.

5. Implement Organisational Tools That Support Everyday SDM Practice

This includes:

- decision-making profiles for every participant,
- simplified Tier 1 SDM tools for frontline teams,
- visual communication supports,
- templates for documenting participant preferences, identity, and sensory/communication needs
- tools should be accessible, practical, and embedded into day-to-day support routines.

6. Foster a Culture of Balanced Risk and Autonomy

Staff require organisational endorsement to take reasonable risks that support participant autonomy. Training and supervision should focus on understanding contributors to risk, differentiating between risk and fear, and developing strategies that allow autonomy while maintaining safety. Emphasis should be placed on the principle that autonomy and risk can co-exist and that eliminating all risk undermines skill development and quality of life.

7. Expand Implementation to All Participants Over Time

While initial implementation has focused on the most complex participants, broader rollout will reinforce that SDM is everyone's right, not a specialised intervention. CLO's adoption of decision-making profiles for all participants is an important first step and should be further integrated into planning and review processes.

8. Develop Safe Learning Environments Using Simulation Technologies

Given staff fear and trauma around previous incidents, simulation-based learning (VR scenarios, AI-powered avatars, practice de-escalation environments) should be incorporated into training opportunities in collaboration with tertiary institutions such UniSA and into the future Adelaide University where there are plans to have the assets from the LML ILC Project publicly available. AI Avatars and other innovations in education tools allow staff to practice without fear of harming real clients, make mistakes safely, and develop empathy and confidence before applying skills in practice. This collaboration has begun and extends beyond the LML ILC Project and is a valuable legacy of the project.

9. Strengthen Interdisciplinary Collaboration and Modelling

PBS practitioners, DEs, and allied health professionals should continue to model SDM-consistent interactions, language, and decision-making during team meetings, case discussions, and joint sessions. Modelling has been shown to create a "trickle-down" effect that shifts staff attitudes, reduces fear, and improves consistency across teams.

Conclusion

This evaluation demonstrates that implementing a holistic SDM toolkit of resources and environmental behaviour support framework has the potential to significantly improve outcomes for individuals with complex disability, particularly in contexts where restrictive practices have traditionally been relied upon. Early adoption within CLO as a participating organisation has resulted in meaningful insights and positive behavioural and relational changes, reinforcing the central role of SDM in reducing restrictive practices and promoting individual human rights.
The findings of this initial and limited review emphasises that while the framework is effective, its success depends on organisational readiness, leadership commitment, and workforce capability. Variation in staff background, previous education, formal qualifications, trauma-informed barriers, and operational constraints present challenges that must be addressed through structured training, protected time, and policy alignment. The positive outcomes observed, such as increased autonomy, reductions in behaviours of concern, and enhanced staff confidence indicate that the framework is both impactful and scalable.

Moving forward, embedding the holistic SDM toolkit of resources and environmental behaviour support framework into organisational systems, strengthening interdisciplinary collaboration, and integrating SDM components within PBS processes is essential for sustaining changes. Consequently, the results of this evaluation have broader implications for human services and provide a foundation for system-level policy reform aimed at reducing restrictive practices and expanding choice and control for individuals living with complex disability. The LML ILC Project demonstrates that with the right structures, training, and leadership engagement, a rights-based, capability-focused approach to providing support can transform practice(s) and significantly enhance the lives of those most impacted by restrictive environments.

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Appendix

Semi Guided Interview Questions

Interview One – Exploring Process and First Phases of Implementation

1. Background and Role Context:
- As a Behaviour Support Manager, can you describe your role in supporting staff and overseeing the implementation of behaviour support strategies?
- What are the roles and responsibilities of staff who participated in the professional development on holistic environmental behaviour support and supported decision-making, as presented by Dr. Michelle Browning?
- How long ago did staff undertake this professional development? Could you provide an overview of the program, including its duration and key concepts?

2. Initial Outcomes:
- Based on staff feedback, what outcomes have they reported so far regarding the implementation of the framework following their professional development with Dr. Browning?
- Have staff observed a reduction in restrictive practices experienced by individuals they support as a result of implementing the framework? Could you share any specific examples?

3. Environmental Adjustments:
- In what ways have staff reported modifying their practice or service approach after engaging with the holistic behaviour support and supported decision-making framework?
- Have staff identified any specific changes in tier one daily living environments that have contributed to reducing the need for tier two and three restrictive practices?

4. Barriers & Enablers:
- What challenges or barriers have staff reported in trying to implement the framework?
- Have staff shared any specific conditions, resources, or organisational factors that have contributed to the successful implementation of the framework?

5. Measuring Success:
- Can you share examples of staff-reported experiences—whether positive, unchanged, or negative—regarding the impact of the framework on individuals with complex disabilities?
- When discussing outcomes with you, what criteria or indicators do staff use to assess whether the implementation of the framework has been successful in reducing restrictive practices?

6. Training Effectiveness:
- Have staff provided any feedback on what could improve the framework's implementation to better support their practice?
- Are there any additional training, resources, or support mechanisms that staff feel would enhance the effectiveness of the framework?

Interview Two – Deepening Understanding & Exploring Initial Trends

1. Refinement of Outcomes:
o Since our last discussion, have there been any changes or new insights into the outcomes staff report regarding the framework's impact on restrictive practices?
2. Environmental Adjustments:
o Can you provide further examples of how adjustments to tier one environments have influenced the need for restrictive practices at tiers two and three?
3. Decision-Making Practices:
o Have staff shared any additional examples of how supported decision-making has influenced individual outcomes compared to substitute decision-making?
4. Barriers & Enablers:
o Since our last discussion, have new challenges or facilitators emerged in implementing the framework, and how are staff responding to these?
5. Measuring Success:
o Have staff refined or changed the criteria they use to evaluate the success of the framework?
6. Training Effectiveness:
o What aspects of training continue to be effective or require further enhancement based on staff experiences?
7. Unintended Consequences:
o Have staff reported any new or unexpected consequences—either positive or negative—arising from the framework's implementation?
8. Policy & Practice Implications:
o Based on staff reflections, are there any emerging recommendations for broader human services policy and practice?

Interview Three – Identifying Patterns & Refining Strategies

1. Consistency of Outcomes:
   - Are there any trends or consistencies in staff-reported outcomes across different settings or individuals?
2. Sustainability of Changes:
   - Have the initial environmental modifications remained effective over time, or have adjustments been required?
3. Impact on Restrictive Practices:
   - Can you provide examples of cases where restrictive practices have been fully eliminated or significantly reduced?
4. Adaptation of Support Strategies:
   - How have staff adapted their approaches over time based on their experiences with the framework?
5. Training Gaps & Needs:
   - Are there areas where staff feel additional training or support is necessary to improve framework implementation?
6. Influencing Broader Practice:
   - What emerging insights could be translated into broader policy or practice recommendations?
7. Long-Term Commitment & Buy-In:
   - How are staff perceptions and engagement with the framework evolving?
8. Future Research or Development Needs:
   - Are there areas where further research or modifications to the framework are needed?

Interview Four – Consolidation & Future Directions

1. Final Reflections on Outcomes:
    - Looking back on the entire process, what are the strongest reported outcomes from the implementation of the framework?
2. Sustained vs. Short-Term Impact:
    - What framework elements seem most sustainable, and which require continuous reinforcement or change?
3. Evolving Views on Decision-Making:
    - Have staff perspectives on supported versus substitute decision-making shifted over time?
4. Key Learnings from Implementation:
    - What are the most significant lessons staff have learned through this process?
5. Scaling the Approach:
    - How applicable do staff feel the framework is to different settings, and what modifications (if any) would improve broader adoption?
6. Policy & Systemic Change Recommendations:
    - If staff could suggest one or two key policy or practice changes based on their experiences, what would they be?
7. Future Support Needs:
    - What supports would be most valuable for staff to continue applying the framework effectively?
8. Final Takeaways:
    - Is there anything else staff feel is important to share about the impact of the framework?

Building Capacity to Practice Supported Decision-Making

The Living My Life Project

July2025

CONTENTS

INTRODUCTION

Between 2020 and mid-2024 the Living My Life Project provided a program of activities aimed at building capacity within the healthcare sector to practise supported decision-making. This work was inspired by the evidence put before the Disability Royal Commission that highlighted people with cognitive disability are subject to systemic neglect in the Australian health system1. The Commission found health services are not designed for people with disability and health workers do not have sufficient disability knowledge and skills. To change this, they recommended building the capability of the health workforce to understand and respond to the different needs of people with disability2. The Living My Life Project has sought to address a lack of knowledge in how to support people with disability to make important decisions about their health care.

The Living My Life Project has provided supported decision-making training to the Office of the Public Advocate, social workers at Royal Adelaide Hospital, specialist health services (South Australian Intellectual Disability Health Service), community based health professionals (general practitioners) and four community mental health teams (including forensic mental health specialists). Feedback from these activities was overwhelmingly positive and highlighted the importance of engaging frontline staff in the important work of culture change.

In mid-2024, the Living My Life Project received additional funding to extend it's reach further. UniSA reengaged Dr Michelle Browning to facilitate interdisciplinary supported decision-making training in the acute and subacute hospital environment. Resourcing and time constraints had made it difficult to include a broader range of professions including doctors and nurses in the project's prior activities. Supported decision-making training was offered to SA Health and accepted by staff at Lyell McEwin Hospital.

[1] Royal Commission into Violence, Abuse, Neglect and Exploitation. Final Report (2023). Volume 6: Enabling Autonomy and Access, p.10.

[2] Royal Commission into Violence, Abuse, Neglect and Exploitation. Final Report (2023). Volume 6: Enabling Autonomy and Access, p.321.

Context

The Lyell McEwin Hospital is a major tertiary hospital located north of Adelaide, South Australia that provides medical, surgical, diagnostic, emergency and support services. It is part of the Northern Adelaide Local Health Network (NALHN),which delivers services to a population of more than 400,000 people living in Adelaide's north and north-eastern suburbs.

Supported Decision Making Expertise

Dr Michelle Browning is a nationally recognised supported decision-making expert. In 2010 she explored the emerging concept of supported decision-making in the United Kingdom and Canada on a Churchill Fellowship investigation. She went onto conduct doctoral research focused on the practice in Canada which was completed in 2018. She has been involved in eight pilot projects across Australia (NSW, VIC, QLD, WA &SA)which have explored support for decision making in a diverse range of contexts(e.g. volunteer supporters matched with isolated decision makers, supporting the decision making of people with complex communication access needs)and using different practice frameworks(e.g. La Trobe Support for Decision Making Framework, WAiS Framework, CID Framework).

Michelle works with government and non-government organisations to produce supported decision-making resources, policy and practice guidelines. She regularly facilitates training, practice groups and supervision for supporters wanting to build their confidence as practitioners. She also provides training for decision makers wanting to understand more about decision making and their rights. For more information about Michelle please visit her website www.decisionagency.com.au.

Allied Health Educator and Co-facilitator

Dr Browning collaborated with Ms. Jessica Frost, Allied Health Advanced Clinical Educator NAHLN, to organise and facilitate two full days of interprofessional training.

Jessica is a Physiotherapist and Advanced Allied Health Clinical Educator and has worked for NALHN for 17 years. She worked clinically as an acute care clinician and held the role of Senior Clinical Educator for acute care physiotherapy students for 12 years. In the past 8 years, she has held the position of Allied Health Clinical Educator, where she is responsible for scoping, designing, developing, and delivering allied health education and training programs to the NALHN Allied Health, OPD and Spiritual Care Division, as well as allied health professionals and allied health assistants across NALHN. She is a member of NALHN Interprofessional Education Team and works collaboratively with Nursing and Midwifery Education, Medical Education and People and Culture Division. Jessica is passionate about clinical

education and facilitating allied health professionals to reach their full potential, clinically and professionally to ensure a workforce that is capable to meet the complex care needs of the NALHN community.

Lived Experience Expert

All supported decision-making training provided in the Living My Life Project has involved people with lived experience of the decision support being explored. This interdisciplinary training included a contribution from Ms Libby Crawford who shared her experience being supported with decision making while in an acute hospital in Adelaide.

Libby has extensive experience as a self-advocate through her work with Our Voice SA as a Peer Mentor, Purple Orange, and the South Australia Council on Intellectual Disability (SACID) Redress Support Service. Libby identifies as a person with an intellectual disability who is passionate about furthering the rights of all people with disability.

Interdisciplinary Learning

Michelle and Jessica recognised the potential for challenges to arise in an interdisciplinary learning environment such as conflict and power imbalances. To address these concerns, they sought guidance from Professor Josephine Thomas – Dean of Medicine and Head of School Adelaide School of Medicine, University of Adelaide.

Professor Jo (Josephine) Thomas is a Specialist General Physician, Clinical Pharmacologist and Educator. She is the Dean of Medicine and Head of Adelaide Medical School. She has a long term involvement in education and training, with strong connections across SA and nationally. Her PhD in Medical Education completed in 2020, focused on interprofessional education research. She is a passionate clinician educator with a commitment to high-quality teaching, training, and clinical service delivery.

Interdisciplinary Supported Decision-Making Training

The two interdisciplinary supported decision-making training sessions took place on Wednesday 18 and Thursday 19 June 2025.

The first workshop on Wednesday 18 June was held at the Cancer Centre Conference Room, Playford Hub and was attended by 12 health professionals which included:

- Nurse Consultant – Cardiology

- Nurse Educator – Modbury Acute
- Nurse – Geriatrics in the Home
- Clinical Nurse – Short Stay
- Speech Pathologist – Acute Medical
- Speech Pathologist – Acute Stroke
- Occupational Therapist – Acute Stroke
- Physiotherapist – Geriatrics in the Home
- Occupational Therapist – Allied Health Complex Care
- Social Worker – Acute Medical
- Social Worker – Community Geriatrics
- Social Worker – Senior Disability Coordinator

The second workshop on Thursday 19 June 2025 held at Lyell McEwen Education Room was attended by 21 health professionals including:

- Nurse Consultant – Stroke
- Nurse Educator
- Nurse Educator - Medicine
- Nurse Consultant – Acute Care of the Elderly Ward
- Nurse Consultant – Acute Medical
- Clinical Nurse – Acute Medical
- Nurse – Capacity Manager
- Speech Pathologist – Acute Medical
- Speech Pathologist – Acute Stroke and Medical
- Speech Pathologist – Acute Stroke
- Speech Pathologist – Inpatient Rehabilitation
- Consultant – Geriatrics
- Consultant – General Medicine
- Consultant – Rheumatologist
- Occupational Therapist – General Medical
- Senior Specialist Behaviour Support
- Physiotherapist – Inpatient Rehabilitation
- Social Worker – Acute Medical
- Social Worker – Senior Disability Coordinator
- Social Worker – SACAT Coordinator

FEEDBACK

Feedback from staff attending the workshops was overwhelmingly positive. Staff expressed they found the content helpful and useful.

> *"I really loved how strength and positive driven the content was and how complex and non-verbal communication was included."*
> *"Such a relevant and important topic to health care."*
>
> *"Was very informative and showed a different perspective."*

Staff expressed they enjoyed hearing from the specific presenters and learning from their expertise and experience.

> *"I enjoyed the real-life experience, the use of diagrams/graphics to express complex ideas and Michelle's overall approach to the subject matter/breadth of knowledge and passion."*
>
> *"I liked hearing from Libby's personal experience as it was thought provoking..."*
>
> *"The content presented was relatable. Michelle spoke really well. There were plenty of stretch breaks. The day wasn't boring. I also liked Jess playing devil's advocate between disciplines."*

Staff enjoyed the opportunity to learn with their colleagues from other disciplines and explore new ideas collaboratively.

> *"I liked that the workshop was interactive and interdisciplinary."*
>
> *"I liked the different approaches discussed and being able to explore SDM within a wider team/discussion."*
> *"We all feel different pressures, it's good to talk openly about this."*
>
> *"I learned that we can see things through different lenses but still want the same outcome."*

Staff left the workshop with greater clarity on what good decision support looks like in the acute hospital setting, and how to use support strategies in their specific roles.

> *"I am going to advocate for more MDT meetings to ensure we can all be on the same page and provide an effective decision-making approach. Educate team."*
> *"I will change the language we use i.e. substitute to support and capability. Focus more on the positive."*

"To utilise a more supported decision-making approach vs urgency of substitute decision-making appointment – very different to practice."

See Appendix One for additional information regarding how staff responded to the training and intend to apply the learning in practice.

Reflection of Allied Health Educator and Co-Facilitator

Jessica Frost, Allied Health Advanced Clinical Educator NALHN, reflected on her involvement organising and co-facilitating the training in the following way:

The Supported Decision Making training for health professionals at NALHN was well received by all participants. It prompted insightful discussions on current practices, approaches, and perceptions of decision making for, with, and by consumers within acute and rehabilitation health settings. Participants reflected on the ten strategies that form a supported decision-making approach, identified existing enablers as well as actual and perceived barriers within the system, and began developing strategies to address these challenges. For example, a quality improvement project plan has commenced within the Speech Pathology team regarding communication tools for menus after one of the group discussions.

Delivering the workshops in an interprofessional format expanded the dialogue beyond individual perspectives to team and service level discussions. Participants gained a deeper understanding of each other's roles in care and key decision making moments, recognising how different professions can collaboratively support the application of the supported decision-making approach, particularly when managing risk, a critical consideration in acute and subacute health sectors.

Significant preparation went into creating an interprofessional learning environment that ensured diverse professional representation, balanced experience levels to minimise power imbalances, and fostered a culture of safety, collaboration, and respect—enabling participants to learn from, with, and about each other in the context of supported decision making. This required coordinated efforts from nursing, medical, and allied health education leaders, with guidance from Jo Thomas, Dean of Medicine and Head of Adelaide Medical School, and a valued interprofessional learning advisor to NALHN.

disciplines and how collaboration was the most effective way of addressing the decision support needs of patients.

CONCLUSION

Supported decision-making is an important practice needed to enable the human rights of people with disability. In Australia, health professionals need to be able to provide supported decision-making to ensure they are providing equitable access to health care to all Australians[3].

Given the complex interdisciplinary care patients in hospital receive, providing training in supported decision-making practice greatly benefited from having all professional disciplines together in the same room exploring how to further practice and overcome systemic barriers. It is recommended that future supported decision-making training to professionals in acute and subacute health care settings use an interdisciplinary format that is interactive and provides plenty of opportunities to share professional knowledge and strengthen opportunities to collaborate.

[3] Royal Commission into Violence, Abuse, Neglect and Exploitation. Final Report (2023). Volume 4 Realising the humans rights of people with disability. Recommendation 4.9 (d).

APPENDIX 1: Staff Feedback

Summary of staff feedback (31 participants) obtained at the end of both sessions.

	Strongly disagree	Disagree	Unsure	Agree	Strongly agree
					
Information					
The workshop was helpful.				9	22
I can use the information.			1	8	22
Content and Activities					
An interdisciplinary approach was useful.				8	23
I enjoyed hearing from Libby.				6	25
The scenario added to my understanding.				10	21
Presenter					
Michelle explained things well.				5	26
I liked the training.				5	26

What was something surprising from the workshop?

“Reframing risk to think about what are the good things that can come from it.”

“The concept of holding tension and stretching or sitting within discomfort rather than the natural instinct of avoiding it.”

“Importance of always assuming capability – lack is often assumed.”

“My Health Information tool on SA Health website.”

“My Health Information for when I’m in Hospital Document.”

“Whole decision making approach – step by step.”

“More appropriate language and terminology i.e. more sensitive such as ‘supported’ instead of ‘substitute’. This will hopefully lead to questions being asked.”

“My Health Information Form that is available from SA Health. Shared decision making vs supported decision making principles.”

“Giving people the opportunity to make decisions with support rather than taking away their decision and making it for them.”

“As social workers we feel we do supported decision-making well but after this, there are strategies we could implement to improve – story of son, his view on what’s more uncomfortable.”

“Biases – how others’ biases affect own practice and the implications for patients.”

“Enabling risk – in the context of supported decision making and what we may think that looks like.”

“Being comfortable around risk enablement and ways to mitigate risk – being part of SDM.”

“Assuming capability.”

“Assume capability. Holding tension.”

“Assuming capacity and capability. Concept of supported decision-making.”

“To utilise a more supported decision-making approach vs urgency of substitute decision-making appointment – very different to practice.”

“That it was challenging to reflect on my biases and how much they come into play, even for small decisions like what to order for dinner.”

“Minimise influence – be neutral, mitigate own biases, focus on process not outcome.”

“Focus on enabling risk even with potential adverse outcomes.”

“That it is okay for the decision not to be made in the moment, we can hold tension.”

“Assuming capability. Implement supportive strategies. 10 step process to understand situation and consent. Risk vs benefit.”
“Enabling risk and putting the positives first.”

“Assume capability and starting with the benefits.”

“Capacity assessment is the beginning of the SDM process. Remove bias before assessment.”
“Trust the process.”

“Good process better outcome.”

“Language assessment is routinely done for all stroke patients.”

What did you like?

“I liked that the workshop was interactive and interdisciplinary. Michelle was a great presenter and very knowledgeable.”

“Real life experience, the use of diagrams/graphics to express complex ideas and Michelle’s overall approach to the subject matter/ breadth of knowledge and passion.”

“Such a relevant and important topic to health care.”

“Approach and process of decision making.”

“Explanation of supported decision-making and the process.”

“All the information was very informative. Everything was well explained. Everything was well presented by Michelle.”
“All of it – Michelle’s knowledge is inspiring.”

“How the information was presented to be easily understood. Michelle was very engaging.”

“The content presented was relatable. Michelle spoke really well. There were plenty of stretch breaks. The day wasn’t boring. I also liked Jess playing devil’s advocate between disciplines.”

“Hearing from Libby’s personal experience as it was thought provoking and having a range of disciplines, it was also interactive.”

“The MDT approach – each discipline in room bringing their own knowledge and understanding.”
“I really enjoyed the multi-D attendance and collaboration. The content is so important. Michelle has a very engaging and calm and articulated way of presenting.”

“The steps involved around supported decision-making approach.”

“Going through the process of SDM.”

“I liked the different approaches discussed and being able to explore SDM within a wider team/discussion.”

“I liked the case scenarios.”

“An opportunity to have the discussion of supported decision-making and how interdisciplinary cohesion can support this model of practice.”

“Michelle was calm and respectful, I really loved how strength and positive driven the content was and how complex and non-verbal communication was included.”
“The presentation, the engagement, the content.”

“Strong focus on the person and thinking about how to facilitate their input in decision making.”

“Libby, the way the process was explained in an easy to understand way.”

“Engaging presentation and helped to challenge my thinking. Liked the supported decision-making approach.”

“Interdisciplinary perspectives.”

“Was very informative and showed a different perspective.”

“SDM approach.”

“All of it.”

“IPL approach, easy to understand the difference between substitute and supported decision making concept.”
“The experiences of colleagues, Libby’s story, Michelle’s slides and explanations.”

“Hearing from others problem solving bringing new ideas.”

“Looking at everyone’s opinion/recommendations in the scenarios.”

“The opportunity to hear perspectives from all professions.”

What could have been done better?

“More scenarios and practical session.”

“Exploring different case scenarios within the acute care setting.”

“Handout of the process, maybe activities earlier on.”

“Would have loved to hear about POA and guardianship as well.”

“Managing conflict between potential guardian/substitute decision maker and the wishes that the person is expressing.”

“Nothing.”

“More real life scenarios to work through.”

“Nothing.”

“All content delivered well.”

“Split over two days to allow for more discussion.”

“More case studies.”

“More movement.”

What could be improved to facilitate your learning from, with and about your colleagues?

"It would have been great to have a few participants from medical present to have a more holistic discussion and different perspectives."

"Perhaps a mix of professions i.e. medical staff to give a full MDT picture/viewpoints."

"Addition of medical staff for a true team understanding – realising this is a challenge."

"In service education about Maria's situation."

"In-services about all disciplines."

"Shared case studies and use of SDM principles in these examples."

"Multi-D huddles for complex patients requiring lots of input."

"More regular professional development activities such as this."

"Assuming capability with appropriate supports."

"Potentially re-fresher sessions later down the track or more opportunities for discussion within the interdisciplinary team."

"Sharing with the wider team/colleagues. Making training accessible."

"Interdisciplinary meetings. Team huddles."

"Nothing."

"Discuss with colleagues and a management plan. Encourage SDM and ensure patient is at the centre of care. Take more time."

"More group activities. This should be offered to all NAHLN employees. Great module!"

"Open conversations and willingness for the process."

"More multidisciplinary learning opportunities."

"Activities."

How are you going to put the learning into action?

"Assume capability before questioning capacity. Explore how can speech pathologists better support decision making."

"Trying to be more "positive" rather than automatically being deficit focused – reframing to view positives."
"Work with teams on how we explore and review the gathering of information to ensure will and preferences are included."
"Menu card with food pictures for non-verbal patients."

"Use patients' decision-making capability. 'You don't know unless you ask me.'"

"Using the My Health Information Form. Taking more time on knowing patients' best interests."
"Provide more education to the team. Send out an email about today's learnings. Continue to advocate more for our clients. Continue facilitating CRMs and family meetings."

"Advise the team of My Health Information Form that we can include in our admission packs to distribute to patients with known cognitive impairment."

"Try and advocate for patients who may be able to make their own decisions, rather than assuming they cannot by the medical team."
"Advocate for more MDT meetings to ensure we can all be on the same page and provide an effective decision-making approach. Educate team."
"Change the language we use i.e. substitute to support and capability. Focus more on positive."
"Use the terminology "will and preferences" to more clearly articulate to team members. Spread the word about supported decision making."
"Reflecting on the process – not just the outcome."

"Longitudinal assessment. Process is more important than the outcome."

"Give them more time. Take a neutral approach. Eliminate bias."

"Utilise a supported decision-making approach. Reflect on my own biases."

"Take back the approach to my team (SW) to try and utilise this before SACAT. Undertake Decision Agency online modules with team."

“Support people to create more decision options, remember to assume capability and enable risks. Support others to be confident to enable risks.”

“Put the client’s will and preferences at the centre.”

“Encourage MDT to focus more of the conversation to the patient and get their input even with cognitive difficulties.”

“Formulate an education session for nurses to strengthen their ability to support the decision making of their patients.”

“Engage in supported decision-making. Change way of clinical reasoning and client at the core of care. Discuss with colleagues re the process.”

“Think of the positives first when enabling risk.”

“Review SACAT process and intervene as needed.”

“Give more time for SDM. Assume capability.”

“Look for ability.”

“Listen to everyone’s story.”

“Take time to assess capability/capacity.”

“Focus on process and encourage, challenge others to do the same.”

APPENDIX 2: Workshop Flier

5 5a Introduction

"With interest, our mind is open to seeing what's there, but with curiosity, we've acknowledged a gap in what we know and understand, and our heart and head are both invested in closing that gap."

-Brene Brown, "Atlas of the Heart."

Introduction

In Positive Behaviour Support (PBS), our core focus is improving quality of life by enhancing choice, control, and a person's sense of agency. We've seen that when someone's environment meets their needs, they're less likely to use behaviour to communicate unmet needs. Yet, for people with complex behavioural needs, risk management often takes priority—sometimes at the cost of opportunities to build decision-making skills and personal agency.

We noticed that supported decision making was often introduced only in the context of restrictive practices, rather than being embedded throughout everyday life.

This raised important questions for us:

- How do we truly understand a person's goals, will, and preferences?
- How does their environment shape their behavioural responses?
- How can we manage risk while supporting people to make their own decisions, build skills, and inform guardians of their preferences?
- What tools are available to support behaviour support practitioners to understand a person's supports, environments and their own will and preferences?

.
This framework and these tools have been inspired through asking these curious questions

Creating Agency to Support the Reduction of Restrictive Practices

This project is a federally funded initiative developed through a collaborative partnership between the University of South Australia (UniSA), Decision Agency (led by Dr Michelle Browning), and Community Living Options (CLO)(led by Melanie Ingham).

Commencing in September 2024 and funded through to September 2025, the project aims to create a comprehensive framework to support individuals who present with complex behaviours and are currently subject to restrictive practices.
The overarching goal is to better understand the environments people live in, identify existing Tier 1 supports, understand service gaps and barriers, and assess how these factors influence behavioural outcomes and the continued use of restrictive practices.

The framework is designed to:

- Review and assess a participant's environment and support systems.
- Explore risks and develop mitigation strategies.
- Engage participants through a Supported Decision Making (SDM) approach at multiple stages.
- Co-develop an action plan with all stakeholders and the participants.
- Allow for ongoing adjustment of actions based on participant feedback.
- Progress at a pace aligned with the participant's preferences, needs, and abilities.

Framework for Building More Capable and Supportive Environments

The following information provides a flow chart to guide the process that has been developed through the framework and a description of each component of the process.

Participant Environmental Review Part 1 – direct collaboration with the participant
Initiated by a PBS practitioner or implementing provider, this review explores the participant's environment to understand preferences, responses, and areas needing adjustment.

Participant Environmental Review Part 2 – collaboration with the participant, implementing provider and other stakeholders.
Facilitated by the practitioner, this review explores more in-depth aspects of a person's environment and services to explore health, sensory, service provision, staff approach and broader system's interacting with the participant to understand what is working well, gaps that could be improved and barriers that may impact the person's agency and influence behaviour.

Decision Making Profile
Created alongside the Environmental Review (if not already in place), this profile captures the participant's decision-making support needs and preferences.

Environmental Review Summary
Completed by the PBS practitioner, this summary identifies necessary changes and informs stakeholder discussions.

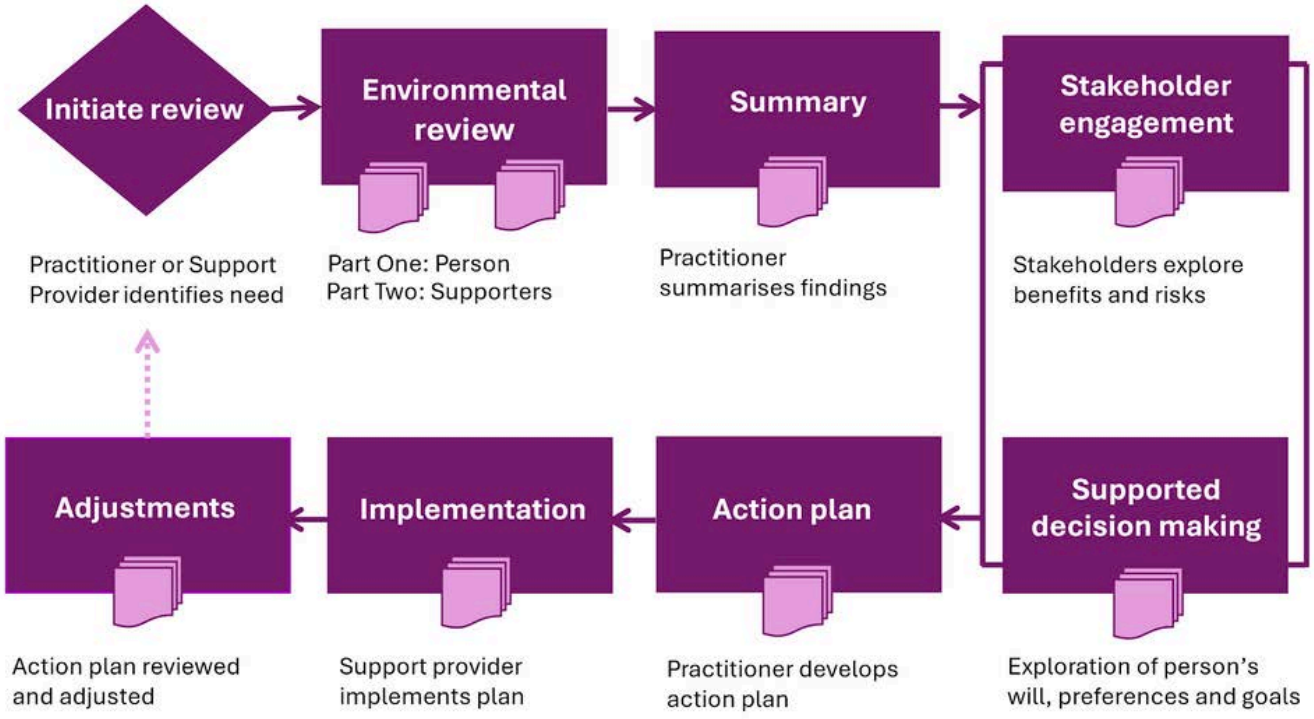
Framework for Building More Capable and Supportive Environments Continued...

Environmental Review and Risk Mitigation Stakeholder Meeting Template
Used to document stakeholder discussions and next steps based on the Environmental Review findings.

Supported Decision-Making Process
Facilitates participant engagement in discussing possible changes.

Action Plan
Developed by the PBS practitioner, this plan outlines participant goals and strategies to enhance support and quality of life.

The following flow chart is the suggested process for using the tools and identifies elements of the process where there is a supporting document/tool to support that part of the process.



Decision Making Profile

Name: **Date:**

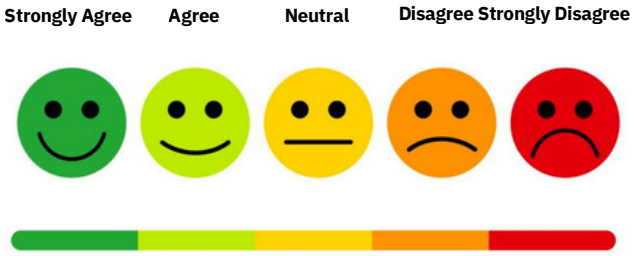
How I communicate my preferences	*Showing people with my body* *Showing people with my eyes* *Showing people with my behaviour* *Using my voice* *Telling people with words* *Using my communication system* *Other ways*
How I like to get information	*Talking about things - asking other people their experiences and what works for them.* *Seeing things – using technology such as the internet, YouTube videos.* *Using images or pictures.* *Using words and pictures together – this could be Easy Read format.* *Written down in words that are easy to understand i.e. plain language.*
How to present choices to me	*In small amounts – breaking things down.* *Using my communication system. Not enough options may be limiting, too many may be overwhelming. Visual supports (e.g. photos of the person doing the activity previously, items to choose from that the person can point to or touch to indicate making the choice). One at a time, don't rush.*
When is the best time for me to make decisions?	*A particular time of the day e.g. in the morning when I have a fresh mind, in the afternoon when I am most alert.* *When I am feeling a certain way e.g. relaxed, focused, confident.*

When is a bad time for me to decide?	*A particular time of the day e.g. not long after I have taken my medication.* *When I am feeling a certain way e.g. when I am overwhelmed and distressed, very tired, feeling pressured.*
Who do I like to help me make decisions?	*Family* *Friends* *Support workers* *People who know about the type of decision I want to make* *People who listen, who respect what I have to stay, people I trust People who know me well, people who care about me.* *People who do not tell me what to do or try to change my mind.* *People who are fun and easy to talk to.*
What decisions do I make on my own?	*What I wear* *What I eat* *How I spend my time during the day*
What decisions do I make with support?	*How to keep myself safe when out in the community* *How to travel to where I want to go.* *Budgeting* *Decisions around my medication*
What decisions do I want to make in the future?	*Living on my own* *Getting married and having a family* *Getting a better job*

Template amended from Helen Sanderson Associates.

Environmental Review Tool – Part 1

Please tell us about what you want and whether you are happy with your home and services. Read each sentence and tick on the scale how you feel about it. If you strongly agree tick in the green section. If you strongly disagree tick in the red section. You can tick anywhere on the scale
to show how you feel about the sentence.
The person helping you go through this review might ask you some questions as you go through it together. They want to understand your answer and what you think should happen or change.



Home

1. I live in a good house; it reflects who I am, and I am proud to have people over to visit.	
2. I have control over what happens in my house.	
3. I feel safe where I live.	
4. I have things that are important to me in my home.	
5. Other people in my home respect those things.	
6. I can access all parts of my home and get around it easily	
7. I have a place in my home where I can go to have quiet time or calm down	
8. From home, it is easy for me to access the places I want to go in my community (e.g shops, library, sport or other activities)	
9. The way my house is set up helps me to do the things I want to do	
10. The way my house is set up helps me to learn new things (e.g. cooking new meals, fixing things, doing things around the house).	
11. My home makes it easy for friends and family to visit. I know my neighbours well, and lots of people know me in my neighbourhood.	

Communication and Connection

12. I can communicate well with the other people in my home (housemates and staff).	
13. The people in my home listen to me and respect what I have to say.	
14. I enjoy spending time with the other people in my home (housemates and staff).	
15. I enjoy spending time with friends, family and other important people in my life.	
16. I get the help I need to stay in touch with friends, family and other important people in my life.	
17. I have opportunities to meet new people when I want to.	
18.Ihave opportunities to be a part of groups where I feel I belong (e.g. cultural, activity focused, spiritual).	
19.Ilike animals and can spend time with them.	

Activities and Participation

20. I choose how I spend my time each day.	
21. I choose when I get up and go to bed.	
22. I am involved in planning my weekly routine.	
23. I am supported to explore my future and set goals.	
24. I am working towards my goals.	
25. I feel I have a meaningful role in my home, and with my friends/ family and in my community.	
26. I am supported to practice my spirituality/faith (e.g. meditation, yoga, church, religion or wellbeing activities such as being in nature).	
27. I am supported to do things from my culture that are important to me (e.g. attending festivals and celebrations, eating certain foods, learning language and spending time with people from the same culture).	

Personal Preferences

28. I feel good about how I look.	
29. I feel good about how I am supported to maintain my appearance (e.g. I like to wear makeup, colour my hair a certain way, wear nail polish).	
30. The clothes I wear reflect what I like.	
31. I feel comfortable in my clothing.	
32. I feel good about the people I get to spend time with regularly (e.g. friends and family).	
33. I feel good about the way staff support me.	
34. I feel good about the other support services in my life (e.g. my doctor, counsellor, mental health worker, NDIS and other services).	

Environmental Review Tool Guide

Part One

Guide to Completing an Environmental Review

Part 1

Introduction

This is a companion document to assist staff completing part one of the Environmental Review Tool. It provides additional information and questions to help staff understand the purpose of each statement being asked of the person.

Set up

When doing the review staff are to meet with the person in a safe space at a time when they are best able to communicate their thoughts and feelings. This review can be done over multiple conversations and visits depending on the person and their support needs.

Rating scale

When assisting the person to rate how they respond to each of the statements some may connect with a scale that uses different faces to help them explore and express how they are feeling. Other people may connect with the words on the scale - strongly agree to strongly disagree. There may be others who relate more to the change in colours that correspond to different feelings. Staff should support the person to use whichever scale is most helpful for them.

Capturing reflections

As the person rates each statement, they might also share their thoughts and feelings about them. Staff should capture these reflections in the spaces provided in this accompanying guide. Circle the pen icon on the Environmental Review Tool to flag comments have been captured. Follow up questions have been included for some statements that might assist staff to go deeper and explore these important ideas further.

My Home

1. I live in a good house; it reflects who I am and I am proud to have people over to visit.

We want to understand if the participant feels they live in a good house. If they feel proud of where they live and whether it reflects who they are.

2. I have control over what happens in my house.

We want to explore how in control the person feels in their home.

Follow up questions – Tell me about when you don't feel you have control. Are there parts of the house you don't feel you have control over? What might help you feel you have more control?

3. I feel safe where I live.

We want to explore whether the person feels safe at home.

Follow up questions – Tell me about when you don't feel safe where you live. What do you think might help you feel safer?

4. I have things that are important to me in my home.

We want to explore whether the person has items at home such as décor, photos and furniture that are important to them.

5. Other people in my home respect those things.

We want to explore whether the person feels other people in their home, whether housemates or staff, respect their belongings.

6. I can access all parts of my home and get around it easily.

We want to explore whether the person can access all parts of their home and get around it easily.

7. I have a place in my home where I can go to have quiet time or calm down.

We want to explore whether the person has somewhere in their home they can go to when needing quiet time or needing to calm down.
Follow up question – Where is it that you go to calm down? Can you think of somewhere we could set aside as a quiet space?

8. From home, it is easy for me to access the places I want to go in my community (e.g. shops, library, sport or other activities).

We want to explore whether the person can access the places they want to go in their community. These places might include local shops, the library, sports clubs, social groups, religious venues etc.
Follow up questions – What makes it hard for you to access the places you want to go? Can you think of how things could be easier?

9. The way my house is set up helps me to do the things I want to do.

We want to explore whether the person feels the way their home is set up supports them to do what they want to do.

10. The way my house is set up helps me to learn new things (e.g. cooking new meals, fixing things, doing things around the house).

We want to explore whether the person feels their house is set up to help them learn new things.

Follow up questions – Are there things you would like to learn to do at home for yourself? Is there anything about the way your house is set up that frustrates you?

11. My home makes it easy for friends and family to visit. I know my neighbours well, and lots of people know me in my neighbourhood.

We want to explore whether the person feels they are able to have people visit their home and whether they feel connected to people in their neighbourhood.

Communication and Connection

12. I can communicate well with the other people in my home (housemates and staff).

We want to explore whether the person feels they can communicate well with their housemates and staff.

Follow up questions – Are there issues with communication? What would work for you?

_____

_____

_____

_____

13. The people in my home listen to me and respect what I have to say.

We want to explore whether the person feels listened to and respected in their home.

Follow up questions – Are there times you didn't feel listened to or respected? What would you want to change?

_____

_____

_____

_____

14. I enjoy spending time with the other people in my home (housemates and staff).

We want to explore whether the person enjoys spending time with their housemates and staff.

_____

_____

_____

_____

15. I enjoy spending time with friends, family and other important people in my life.

We want to explore whether the person spends time with family and other important people in their life.
Follow up questions – Who would you like to be spending more time with? What is stopping you from spending time with them?

_____

_____

_____

_____

Activities and Participation

20. I choose how I spend my time each day.

We want to explore whether the person has control over how they spend their time. *Follow up questions – What do you have a choice over each day? What would you like to have more control over in your day?*

21. I choose when I get up and go to bed.

We want to explore whether the person has control over how they spend their time.

22. I am involved in planning my weekly routine.

We want to explore whether the person is involved in deciding what their week looks like especially if it is shaped by a structured routine.

23. I am supported to explore my future and set goals.

We want to explore how the person sees their future and whether they are being supported to explore what might be possible and set goals towards achieving their desired changes.
Follow up questions – What are your hopes and dreams for the future? Where do you see yourself? What are you doing? How do you feel?

24. I am working towards my goals.

We want to explore whether the person feels they are working towards the goals they have for their future.

Follow up – What do you want to do? What are you working towards? What are your short term goals? What are your long term goals?

25. I feel I have a meaningful role in my home, and with my friends/ family and in my community.

We want to know whether the person feels they contribute to their community and experience the benefits that come from having a valued role.

Follow up questions – how would you like help your friends/family? How would you like to use your gifts and talents in the community? What roles are meaningful to you e.g. being a volunteer, studying or in paid work? Do you have a mentor or someone you look up to that you would like to be like?

26. I am supported to practice my spirituality/faith (e.g. meditation, yoga, church, religion or wellbeing activities such as being in nature).

We want to explore whether the person feels supported to practice their spirituality and/or faith.

27. I am supported to do things from my culture that are important to me (e.g. attending festivals and celebrations, eating certain foods, learning language and spending time with people from the same culture).

We want to explore whether the person feels supported to engage with and practice their culture.

Personal Preferences

28. I feel good about how I look.

We want to explore how the person feels about their appearance.

29. I feel good about how I am supported to maintain my appearance (e.g. I like to wear makeup, colour my hair a certain way, wear nail polish).

We want to explore how the person feels about the support they receive the maintain their appearance.

30. The clothes I wear reflect what I like.

We want to explore whether the person feels how they dress reflects their preferences.

Follow up – Are there clothes you would like to wear that you haven't had the opportunity to try?

31. I feel comfortable in my clothing.

We want to explore whether the person feels physically comfortable in their clothing.

Follow up – What type of clothing do you like and feel most comfortable in? Do you like or need certain textures?

32. I feel good about the people I get to spend time with regularly (e.g. friends and family).

We want to explore whether the person feels good about who they get to see regularly.

Follow up – Is there anyone in your life you don't feel good about? Why? Is there anyone you would like to see that you don't get to regularly?

_____
_____
_____
_____
_____

33. I feel good about the way staff support me.

We want to explore whether the person feels good about the way staff support them.

Follow up – is there anything staff do that you don't like?

_____
_____
_____
_____
_____

34. I feel good about the other support services in my life (e.g. my doctor, counsellor, mental health worker, NDIS and other services).

We want to explore how the person feels about other support services in their life including their doctor, counsellor, mental health worker, NDIS and other services.

_____
_____
_____
_____
_____

Signed:	
Name and position:	
Date completed:	

Environmental Review Tool – Part 2

Name:	
Environment reviewed:	
Person conducting review:	
Purpose of review:	
Date started and finished:	

This tool has been developed for the purpose of reviewing the ecological support within a person's environment. The review aims to better understand the person's preferences and needs, how they respond to their environment and elements that may require review or adjustment.

This resource has been developed for PBS Practitioners to:

- Review foundational (Tier 1) supports.
- Identify areas that may require adjustment to suit the person's needs and quality of life – contributing to choice, control, and furthering their human rights.
- Identify barriers that may prevent goals and preferences being met.
- Inform PBS assessment (FBA), recommendations, NDIS reporting and strategies.
- Inform stakeholder discussion and decision making where a person may not have the opportunity to participate in decisions about aspects of their life (e.g. A guardian has been appointed, professionals need to understand the needs of the person such as Support Coordinators, NDIS planners, Allied health and medical professionals.)

Part 1ofthe Environmental Review is engaging with the person to understand their perspectives, preferences and goals.

Part 2should NOT commence until Part 1 is completed.

***This review should NOT be used to replace other professional assessments (such as Occupational Therapy, Speech Pathology or mental health) however it may provide relevant information for consideration within those assessments.*

The Person's Needs *This section reviews the needs and basic human rights in placeforthe personsuch ascommunication support, sensory needs, medical and health needs. It seeks to understand if the person's environment andservices meet their unique needs.*		
Question	**Comment**	**Issues for further exploration**
Health, Medical, and Sensory Needs		
Hearing – does the person experience any known hearing loss or deafness?		
Does the person wear prescription glasses?		
Any health observations/concerns or diagnosis: Yes/No?		
Does the person have a mental health diagnosis that requires environmental considerations to assist in the management of the condition?		

Environmental and Sensory Accommodation		
Does the person have any known or observed sensory needs?		
Does the environment reflect the stimulation levels preferred by the person?		
Are there any concerns about the cleanliness of parts of the environment that may be impacting the person and their wellbeing? Do the wet areas reflect the needs of the person?		
Are there external noises commonly heard in the environment that impact the person's ability to concentrate or relax?		

Does the person have planned activities that they prefer/choose that occur outside of their daily living tasks?		
Communication and Visual Needs		
Does the person use or need visual items around the environment to function well?		
Are there visual resources, prompts, or supports in place to meet the person's communication needs?		
Does the person need verbal prompts to be paired with visual prompts? (including gestures) for communication?		
Furniture, Comfort and Movement Needs		
Does the person require specific furniture to meet their needs?		

Is the furniture and other household items within the environment appropriate and in reasonable condition?		
Are there items of comfort or emotional regulation available?		
Dietary and Routine Support		
Does the person have any dietary requirements?		
Are there foods available that could negatively impact the person?		
Social needs and advocacy		
Are the staff aware if the person has any cultural or spiritual preferences or needs?		
Does the person have someone who champions their voice when needed?		

Additional Observations		
Any other observations?		

Approach *This section explores how staff and other individuals working with theperson approach providing support. It also explores how aware they are of th person's preferences and needs.*		
Question	**Comment**	**Issues for further exploration**
Staff Awareness and Understanding		
Are staff aware of the person's hopes and dreams?		
Are staff aware of the person's goals (short and long term)?		
Do staff have a positive vision for the person and believe the person is capable of achieving their goals/hopes and dreams?		
Have staff previously been successful in supporting the		

person to achieve their goals (or steps towards any goal)?		
Do staff understand how the environment may cause agitation or a behavioural response from the person?		
What knowledge do staff have of the environmental recommendations that come from assessments for the person, such as an FCA or sensory profile assessment?		
Are staff aware of identified risks and how they may impact or prevent a person working towards their goals?		
Do staff understand what biases are and how they can impact decision making and the provision of support?		
Communication and Interaction		

Do staff appear to be aware and support the social needs as well as other support needs of the person?		
Are all staff trained in the communication needs of the person?		
Do staff adjust their communication to suit the person? E.g., using visual supports.		
Do staff speak to the person in an age-appropriate way?		
Do staff offer the person choices and include them in conversations?		

Staff Approach and Skills Required to Meet Person's Needs		
Are there resources to assist staff to get to know the person and understand all support needs, including social and emotional supports?		
Is there evidence staff understand the strengths of the person, and use this to inform their person centred practice?		
Are staff able to breakdown tasks or information to be able to scaffold support and skill development?		
Do staff collaborate with the person to work through the benefits and risks of different situations and options?		
Do staff provide support for the person to maintain their dignity and personal preferences regarding their appearances?		

Do staff have the opportunity to engage in reflection on their work practice?		
Do staff actively problem solve with the person?		
Do staff appear to encourage or shut down opportunities for the person?		
Staff Planning and Shift Communication		
Do staff create or have a plan prior to starting their shift?		
Do staff clearly communicate shift outcomes (positive) to the next shift?		
Staff Behaviour and Environment		
Do staff present as confident and calm when with the person?		
If relevant: Do staff have a safe area to retreat for safety during a behaviour escalation?		

Do staff talk about the person in front of others?		
Additional Observations		
Any other observations?		

Systems and Organisation *This section explores the systems around the personandhow theyareworking.Itseeksto identify any systems gaps or barriers including environmental pressures that often cannot be controlled through immediate supports, howthe person may experience these and how they are supported to navigate the pressures.*		
Question	**Comment**	**Issues for further exploration**
Broader Environmental and Legal Conditions		
Is the organisation open to exploring preferences involving risk with the person and other stakeholders?		
Are cultural preferences and needs considered and accommodated at an organisational level?		
Are there any legal orders in place such as Special Powers or license conditions that limit access to		

environments or preferred activities?		
How does the person feel about these orders being in place?		
Is there anything within the community that needs to be considered in relation to safety or behaviour?		
Are there barriers that may prevent the person having a pet (policy/housing/legal?)		
2. Funding		
Does the person's funding meet their needs? (NDIS or other sources of funding)		
4. Policies and documentation		
Are there any policies or processes that are reported to impact the person negatively?		

Is there a process to support the person through any staffing changes? Is the plan followed?		
Are there structures and processes for communicating information to person around appointments and visitors?		
Are there individualised considerations in place that reflect the person's specific needs?		

Safeguarding

Doyouhaveany concerns that should be followed up in a timely manner? For example, concerns about the person's safety, human rights or restrictive practice usage.

Actions required	Who	Time frame/date

Environmental Review Tool Guide

Part Two

Guide to Completing an Environmental Review

Part 2

Introduction

This is a companion document to assist people completing part two of the Environmental Review Tool. It provides additional information and questions for deeper consideration when completing each section of the tool.

Being curious

"*With interest, our mind is open to seeing what's there, but with curiosity, we've acknowledged a gap in what we know and understand, and our heart and head are both invested in closing that gap.*"

Brene Brown, "Atlas of the Heart."

Part 2 of the Environmental Review Tool represents an opportunity to move beyond interest, to become curious, which will allow us to better understand the person we support.

Being curious helps us discover the "in-between parts" enabling us to "fill in the gaps". It helps us to understand the person's environment, how they can be better supported and how to ensure the environment supports their safety (psychological and physical). We believe better supporting the person's environment will allow them to grow and develop unhindered.

Responding to the questions

Section 1 - Exploring the person's needs

This section asks questions about the person from the perspective of those who support them, who spend time with them and know them well.

It is important to remember that knowing a person a certain length of time does not guarantee they are known well.

As such, it is important to ensure that all questions are based on observation and genuine knowledge of the person, rather than assumptions or guessing.

It is acknowledged that support teams can fluctuate. In this context, it is even more important to speak to the people who are most familiar with the person. Completing this section of the review with casual workers who are unfamiliar with the person is not recommended.

There may be some items that cannot be answered, this is okay, it is better to have no answer than an assumed or incorrect answer.

Section 2 - Approach

This section looks at what staff know and understand about the person and how they consider the needs of the person within their practice and supports.

This information can be gathered through:

- Staff interview
- Team leader interview
- Reports and assessments
- Direct observation
- Discussion with family and friends.

It is important to identify and record how information has been gathered within the review. This could include other information such as staff support logs, records of direct observations or team meeting discussions.

Section 3 – Systems and organisation

This section explores systems and organisational structures within services. It seeks to understand gaps and barriers as well as what might be working well for the person within these systems and organisational requirements.

The information for this section can be found through:

- Stakeholder discussion
- Reports and other legal documents
- Discussion with a manager or team leader to understand policies and processes that may impact supports
- Understanding of the NDIS or other funding plans
- Legislative requirements for legal orders.

The Person's Needs

The items in this section review the persons health, medical and sensory needs.

Health items include mental and physical health as well as the person's well-being.

Review Question	**Additional Considerations**
Health, Medical and Sensory Needs	
Hearing – does the person experience any known hearing loss or deafness?	Are there concerns or reports that the person may be experiencing hearing loss or difficulties hearing in certain environments?
Does the person wear prescription glasses?	If the person does wear glasses: • When was the last eye check? • Are we confident that their prescription is right? If not, are there any concerns about the person's eyesight? (E.g. bumping into things, moving closer to things to see.)
Any health observations/concerns or diagnosis: Yes/No?	What is observed? Do staff or family have any concerns? For example, with: • Swallowing, • Coughing regularly • Unable to control saliva • Breathing through mouth • Nose (and sinuses) • Breathing • Skin (rashes, bruises, cuts, abrasions) • Oral hygiene • Mobility • Walking Gait • Posture If there are things that have been noticed – are there any barriers that are preventing access to care and support (e.g. difficulties accessing a consistent GP or arranging appointments)? Consider:
Does the person have a mental health diagnosis that requires environmental considerations to assist in the reduction of triggers to better support the condition?	• Trigger words/noises/visual stimuli • Possible trauma history • Staffing preferences such as gender

	• Access to resources within the environment for self/co-emotional regulation and symptom management.
Does the person have any known or observed sensory needs?	If yes, has the person been provided with a sensory assessment? If yes, have there been adjustments to the persons environment or supports that reflect the needs and recommendations of the assessment? Are there clear strategies to support the person's sensory needs?
Does the environment reflect the stimulation levels preferred by the person?	Consider noise levels, ability for movement in the environment, smell, light levels, air movement, temperature. Does the person have control over these factors (e.g. temperature control, access to equipment like a swing, lights, access to quiet space, or headphones) You may want to consider things such as:
Are there any concerns about the cleanliness of parts of the environment that may be impacting the person and their wellbeing?	• Evidence of hoarding items that may cause hazards • Evidence of biological waste in living area • Evidence of mould (on walls, windows, items) • Food hygiene • Bathroom facilities • Clean clothing to wear If something has been identified, consider: • Does this need to be reported to an authority? • What has been tried to remedy the matter? • Are there already attempts to support this person?
Do the wet areas reflect the needs of the person?	Consider: • Bathing preferences • Privacy • Noise control • Safety • Water play

Are there safeguarding items fitted in the wet areas?	Consider: • Taps • Temperature control of water • Slip hazards for mobility
Are there external noises commonly heard in the environment that impact the person's ability to concentrate or relax?	Consider: • Planes, • Sirens and beeping, • TV on in background, • Dog next door, noisy neighbours, • Main road traffic, lawn mowers? Is this avoidable? Does it occur regularly? Can it be predicted and better managed?
Does the person have planned activities that they prefer/choose that occur outside of their daily living tasks?	Consider: • Community activities such as library, local craft groups • Work (paid/volunteer) What activities have meaning for the person?
Does the person use or need visual items around the environment to function well?	Consider: • Prompts and reminders • Calendar or daily schedule • Colour of walls • Photos of family and friends • Artwork • Plants • Preferred items that provide positive memories or feelings • Affirmations
Are there visual resources, prompts, or supports in place to meet the person's communication needs?	Consider: • Communication book • iPad • Photos • Compic • Spelling board • Social Stories Does the person need support to use any communication tools or technology?

Does the person need verbal prompts to be paired with visual prompts? (including gestures) for communication?	Consider: • Simple Sign language • Individual (personal made up) signs and gestures • Photos • Compic
Does the person require specific furniture to meet their needs?	Consider: • A princess chair to support physical needs • Robust furniture to prevent breakage and maintain dignity of possession • Height of benches/chairs/bed • Easy open doors/cupboards • Bedding and mattress for sensory needs Do we know how the person feels about these items?
Is the furniture and other household items within the environment appropriate and in reasonable condition?	Consider: • Broken furniture • Soiled furniture • Age appropriateness of items • Bed size (e.g. Adult male in a single bed that may be too small)
Are there items of comfort or emotional regulation available?	Consider: • Comfort items such as blanket or preferred item • Sensory items • Chew sensory toys • Speakers to play preferred sounds • Bean bags • Weighted items • Balls Is the person supported to access and use these items (co-regulated) when necessary?
Does the person have any dietary requirements?	Consider: • Food texture (sensory) • Ability to chew and swallow • Preferred taste • Food variety

	• Supervision to prevent choking (may eat too quickly)
Are there foods available that could negatively impact the person?	Consider: • Whether the person shares a house with others and has certain allergies • Medical conditions preventing access to certain food and drink • Smells that trigger emotions
Are staff aware if the person has any cultural or spiritual preferences or needs?	Consider: • Cultural heritage and identity • Plans that consider cultural heritage and guidance • Spiritual preferences and whether they are respected and accommodated (e.g. person enjoys meditation or engaging with a faith)
Does the person have someone who champions their voice when needed?	Consider: • Family or friends • Staff members with whom they have good rapport and trust • Someone who knows the person well and understands their will and preferences

Approach

This section explores how staff and other individuals working with the person approach providing support. It also explores how aware they are of the person's preferences and needs.

Review Question	Additional Considerations
Staff Awareness and Understanding	
Are staff aware of the person's hopes and dreams?	Consider: • Responses of "Part 1" of this environmental review • Reflect on times/environments/activities when the person has seemed "relaxed" and "safe" • Reflect on past expressions the person has made of hopes/dreams/goals that may not have been expressed by the person in part 1.
Are staff aware of the person's goals (short and long term)?	Consider: • How staff respond to this question (from their own perspective or the persons') • Personal bias the respondent may be expressing (remember this is often unconscious). • Does the organisation provide staff with the resources needed to meet the goals of the person? • Consider the goals in the NDIS plan and how they may have been determined (directly by the person or on their behalf). • Are these goals part of the person's supports? And do they reflect previous considerations and part 1 of this tool.
Do staff have a positive vision for the person and believe the person is capable of achieving their goals/hopes and dreams?	Consider: • Language used by the respondent (Is it personable?) • Do staff assume the person is capable of achieving their goals? • Do staff use different ways or approaches when supporting goal attainment? • Is there evidence of staff supporting the person to work towards goals? •
Have staff been successful in supporting the person to achieve their goals (or steps towards any goal)?	Consider: If yes • What were the goals? • How long ago? • Did this success help staff to support the person to continue achieving other goals? If no • What are the barriers for this (e.g. staff don't believe it is possible, the guardian does not believe this is possible, has

	there been support to break down the goal into smaller or more short term steps)
Do staff understand how the environment may cause agitation or a behavioural response from the person?	Consider whether staff: • Understand broader more overtly known triggers • Understand less obvious triggers • Take the initiative to explore what might be happening in the environment that might be impacting behaviour. Is there an expectation that only the practitioner will do this?
What knowledge do staff have of the environmental recommendations that come from assessments for the person, such as an FCA or sensory profile assessment?	Consider: • Have staff been trained to enact plans that include environmental recommendations? • Are these recommendations included in support plans they follow? • Staff may not be aware of the reports (as these can be long and detailed) but have the implementing provider considered these and developed support plans that reflect the recommendations?
Are staff aware of identified risks for the person and how they may impact or prevent a person working towards their goals?	Consider: • Have staff been trained to manage these risks? • Does staff knowledge and skills reduce or increase the likelihood the person can achieve the goals? • Do staff contribute to finding solutions? • Is there evidence of staff taking proactive steps to find solutions to overcome these risks?
Do staff understand what biases are and how they can impact decision making and the provision of support?	Consider: • Are staff able to identify the influence that they may be having when supporting the person's decision making? • Can staff name the biases they bring to providing support? E.g. their values, beliefs, goals and priorities and whether they are aligned or misaligned with the person? • Do staff have clear strategies for mitigating their biases when supporting client decision making and goal setting? • If staff make decisions on what they think is right rather than what the person might want.
Communication and Interaction	
Do staff appear to be aware of and support the social needs of the person?	Consider: • Are staff only focused on physical tasks? Do staff recognise the difference between instruction and interaction? • Do staff support the person to facilitate relationships outside of paid supports? (family/friends/neighbours/community)
Are all staff trained in the communication needs of the person?	Consider: • Is there evidence of staff receiving support to understand and implement communication support strategies as outlined in support/care plans?

Do staff adjust their communication to suit the person? E.g., using visual supports.	Consider expanding this answer to include how different people may do this. Are there some staff who engage in this and some who do not or do not think the person needs it? Provide examples.
Do staff speak to the person in an age-appropriate way?	
Do staff offer the person choices and include them in conversations?	Consider: • Travelling in the car – do interactions include or exclude the person? • Shift change and handover – is the person included in this process?
Staff Approach and Skills Required to Meet Persons' Needs	
Are there resources to assist staff to get to know the person and understand their support needs, including social and emotional support needs?	Yes or no Please provide an example.
Is there evidence staff understand the strengths of the person, and use this to inform their person centred practice?	Provide examples if able.
Are staff able to breakdown tasks or information to scaffold support and skill development?	Consider: • Are there any written examples of this? • Are there some staff who naturally do this as a part of their approach? • Have staff been trained to be able to do this?
Do staff collaborate with the person to work through the benefits and risks of different situations and options?	Consider: • Is the person given options? • How are the options explored? Provide examples of how this happens.
Do staff provide support for the person to maintain their dignity and personal preferences regarding their appearance?	Consider: • To support maintaining dignity (at home and in the community) do staff discreetly prompt the person if they experience difficulties in such areas as: o Managing saliva or running nose o Food consumption "manners" o Clean face after eating and drinking o Odour o Hand Hygiene • Is this practiced at home and approached in a respectful and dignified way?

	• Are the person's "fashion" preferences respected and supported (clothing/hair/other accessories)?
Do staff have the opportunity to reflect on their work practice?	Yes/No, provide examples. Consider: • Team meetings • Scenario discussions and exploring solutions with peers • Supervision with manager.
Do staff actively problem solve with the person?	Consider: • Examples of holding tension to create space to problem solve rather than shutting opportunities down. • Do staff know what to do when tensions between the person and others arise?
Do staff appear to encourage or shut down opportunities for the person?	Consider: • When staff might be encouraging or shutting down opportunities. • Why staff are shutting down opportunities for the person. • There may be varying approaches of difference staff.
Staff Planning and Shift Communication	
Do staff create or have a plan prior to starting their shift?	Consider: • If not, how do they work out what they are meant to do for their shift? • Do the team meet to plan small goals for supporting the person? • Do staff understand that a person requires experience to be able to make choices, and this may mean facilitating experiences to support this?
Do staff clearly communicate shift outcomes (positive) to the next shift?	Consider: • Whether only "incidents" or difficult situations are communicated – are successes and positive experiences communicated? • Is the person involved in this process?
Staff Approach and Environment	
Do staff present as confident and calm when with the person?	Consider: • Staff personal feelings about working at the service • Have you observed interactions with the person and staff? • Do staff actions help the person to feel safe and/or calm?
If relevant: Do staff have a safe area to retreat for safety during a behaviour escalation?	Consider: • Frequency used • Do staff use it at other times? • Is the person isolated from staff during this time? • Is there a plan around retreating and how the person is supported to co-regulate even when staff have retreated?
Do staff talk about the person in front of others?	Yes/no – provide examples. • Is this done in a respectful way? • Is the person included in the conversation or is it as if they are not there?

Systems and Organisation

This section explores the systems around the person and how well they are working. It seeks to identify any systems gaps or barriers including environmental pressures that often cannot be controlled through immediate supports, how the person may experience these and how they are supported to navigate the pressures.

Review Question	Additional Considerations
Broader Environmental and Legal Conditions	
Is the organisation open to exploring preferences involving risk with the person and other stakeholders?	Consider: • The support team's approach to risk and their appetite to try things? • Is dignity of risk understood by staff and stakeholders? How is this considered in decision making?
Are cultural preferences and needs considered and accommodated at an organisational level?	Consider: • Policies that accommodate cultural preferences • Training for staff.
Are there any legal orders in place such as Special Powers or license conditions that limit access to environments or preferred activities?	Yes/No Provide further detail.
How does the person feel about these orders being in place?	Consider: • Are staff aware about how they feel? Are staff trained to support implementing while respecting the feelings of the person?
Is there anything within the community that needs to be considered in relation to safety or behaviour?	Yes/No Provide further information if required. Consider: • Near primary schools, main roads, neighbours, • Noise levels of person that may compromise tenancy.
Are there barriers that may prevent the person having a pet (policy/housing/legal?)	Yes/No Provide further detail.
Funding	
Does the person's funding meet their needs? (NDIS or other sources of funding)	Consider: • Is a lack of funding creating a barrier to an environment where the person can be supported effectively and according to their preferences and needs? • Do support ratios recommended in funding align with professional recommendations?

Are there any policies or processes that are reported to impact the person negatively?	Yes/No Provide further detail.
Is there a process to support the person through any staffing changes?	Yes/No Provide further detail. If not, how is the person supported when this occurs?
Are there structures and processes for communicating information to person around appointments and visitors?	Yes/No Provide further detail. If not, how is the person supported when this occurs?
Are there individualised considerations in place that reflect the person's specific individual needs?	Consider: • Trauma informed support needs • Gender specific supports. • Theoretical models that align with needs such as Good Lives Model. • Are these needs within supports plans? • Are these needs reviewed regularly (e.g. annually)?

Safeguarding

Once the environmental tool is completed it is important to consider any concerns that may require a response to safeguard the person. This may include concerns about the person's safety, human rights, restrictive practice usage or implementation of a restrictive practice that is unauthorised.

When responding to immediate safeguarding concerns it is important that implementing providers and practitioners explore solutions collaboratively and using supported decision-making principles – guided by the will, preferences and rights of the person.

Conclusion

It is impossible to explore every scenario and consideration that may be useful when completing an environmental review. However, it is hoped that the information included in this guide helps expand the thought processes of the person or people conducting the review.

The tool has been developed to encourage curiosity and foster open conversations between the person, their support staff and other stakeholders. It is the start of a process which aims to explore how the person's environment can become more supportive and responsive to their will and preferences. The next step in the process is summarising the findings of this review and meeting with stakeholders to discuss whether risk mitigation may be needed as part of future environmental changes.

It is hoped that through this process the person's sense of agency and autonomy is developed, allowing opportunities for them to reach their goals and dreams.

This tool was developed collaboratively by Dr Michelle Browning (Decision Agency) and Melanie Ingham (Community Living Options) with the support of Jan McConchie and UniSA.

Environmental Review Summary

The aim of this document is to summarise the findings of Part 1 and Part 2 of the Environmental Review Tool. It needs to be completed by the person's Practitioner who is identifying changes needed to build a more capable and supportive environment for the person. This summary should inform discussions with the person and their stakeholders as future goals and actions are explored.

The Person's Preferences

What changes might be needed after considering the person's preferences in Part 1 of the Environmental Review?

Change	**Possible steps to work towards that change**
What change are we trying to achieve?	*What are the tasks or steps that might be needed to achieve the change?*

The Person's Needs

What changes might be needed after considering the person's needs in Part 2 of the Environmental Review?

Change	**Possible steps to work towards that change**
What change are we trying to achieve?	*What are the tasks or steps that might be needed to achieve the change?*

Approach (Staff and Others)

What changes might be needed after considering the approach staff and others take to supporting the person?

Change	**Possible steps to work towards that change**
What change are we trying to achieve?	*What are the tasks or steps that might be needed to achieve the change?*

Systems and Organisation

What changes might be needed after considering the systems and organisational supports around the person?

Change	**Possible steps to work towards that change**
What change are we trying to achieve?	*What are the tasks or steps that might be needed to achieve the change?*

Name (Practitioner who completed this tool):
Signature:
Date completed:

Agenda

What does the person want?

- What has the person identified they are not happy with and would like to see changed?
- What are their big goals for the future?
- Did the person identify any priorities or short term goals?
- Do these priorities or goals need be explored further?
- How might acting on them benefit the person?
- What actions might be needed achieve next steps? Have any steps already taken place towards meeting these goals?

What have we learned from the review?

The implementing provider, guardians and other stakeholders can share their thoughts on what has emerged from the environmental review.

Do they have ideas to improve the service environment?

Is there anything that might make it difficult to make discussed changes?

Are there any safety concerns?

- What are the risks involved in acting on the person's will and preferences?
- What are the risks involved in making service improvements?
- How serious and likely are they?
- How can we collaborate with the person to find ways to mitigate the risks?
- How can we ensure our conversations with the person are safe?

What does the practitioner recommend prioritising and why?

- Recommendations to improve quality of life,
- Ways to support the person's decision-making and increased autonomy,
- Steps to take (short-term and long-term). For example, using a scaffolded approach.

Actions from this meeting:

- Meeting with person to do supported decision making using strategies discussed by stakeholders (if not done already),
- Development of Action Plan that clarifies steps implementing provider and person will take to achieve their short and long-term goals.

Supported Decision Making Tool

When responding to the environmental review, the practitioner and stakeholders, need to be guided by the person's will and preferences1.

A practitioner should meet with the person to discuss the issues identified in the environmental review in a way that is just right for them. Start by exploring what the participant wants changed and why, to clarify their priorities and understand their goals more deeply.
Decision opportunities will emerge in this meeting that need to be explored further. Practitioners can use the following process to unpack the options and risks with the person and support them to decide what actions should be prioritised in their Action Plan.

1. **Look into and understand the decision opportunity** – why is the decision important or needed? What might it mean for the person or others? What are the barriers to exploring this opportunity? What can we do to make exploring this opportunity possible?

[1] A person's will is who they are at a deep level including the vision they have for their life, goals, priorities and values. A person's preferences are what they want to do in the moment, what they like and don't like.

2. **Understand the person's will and preferences** – how does making this decision align with the person's values, goals, previous experiences and how they want their life to be? Initially, what are they saying they want?

3. **Gather information and explore options** – having heard what the person wants how can we find, and go through information about the decision? How can we explore options with the person? What are the possible options? What are the good and bad things that could happen for each option?

4. **Working through the benefits, barriers and risks of the options** – what are the benefits of different options? What are the barriers and how can we overcome them? What are the risks? How can the risks be reduced and managed? What strategies can we use to reduce potential harm that make the least change to the person's will and preferences?

5. **Weigh it all up and make the decision** – have you explored what choosing each option might mean for the person and others? Have you supported the person to weigh up the benefits and risks? What is their final decision?

6. **Support the person to action their decision** – consider how the decision can be included as part of an Action Plan. How will you scaffold the steps necessary to enact the change the person wants?

7. In the future, when reviewing the implementation of the Action Plan, the PBS practitioner will support the person to **reflect on the decision and what happened** – what has been the impact of the decision for the person and others? If the outcome of the decision was not what the person wanted, what are the next steps?

Name (Practitioner who completed this tool):
Signature:
Date of meeting/s:

Increasing agency to reduce restrictive practices:

A pilot project at Community Living Options.

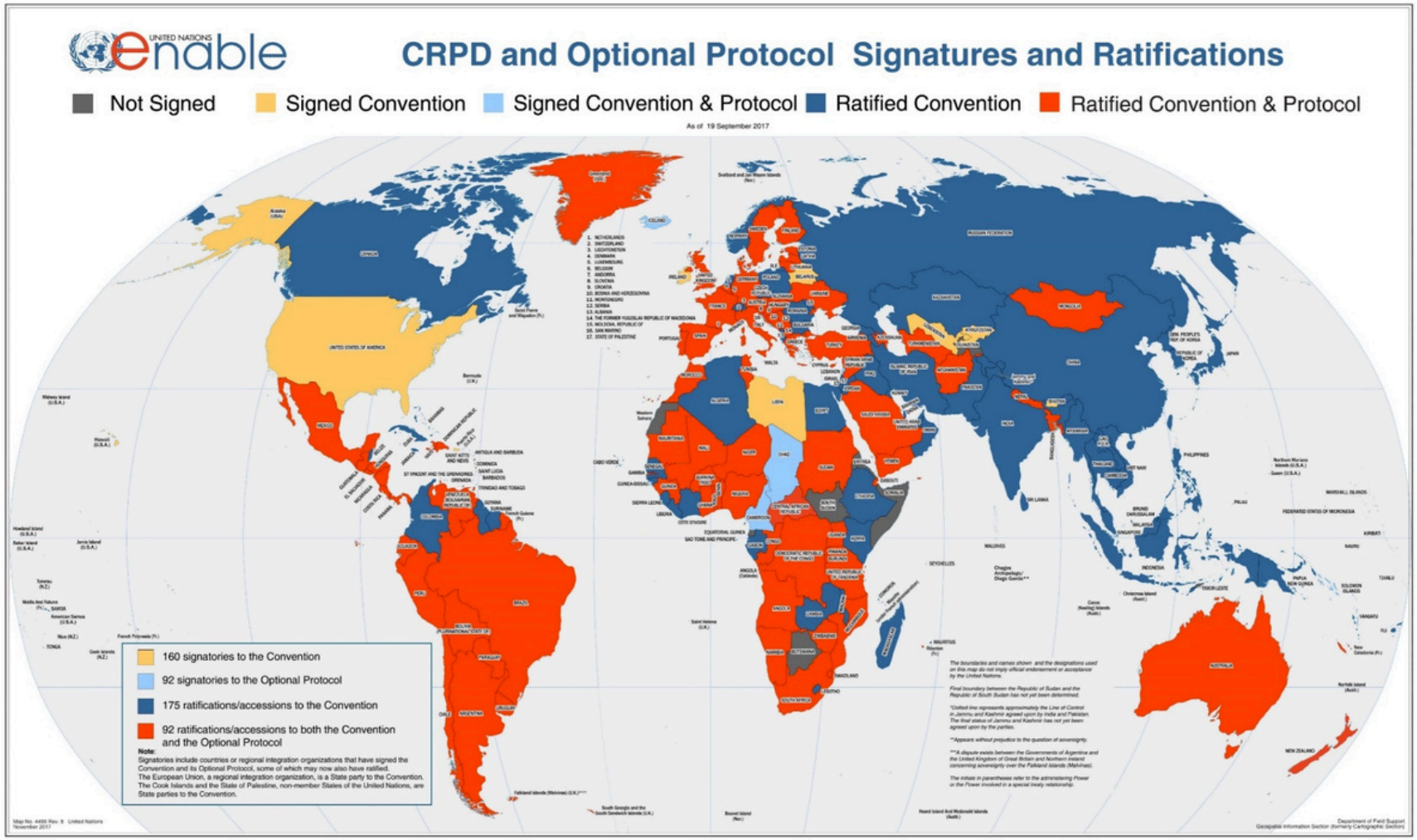
Acknowledgement of Country

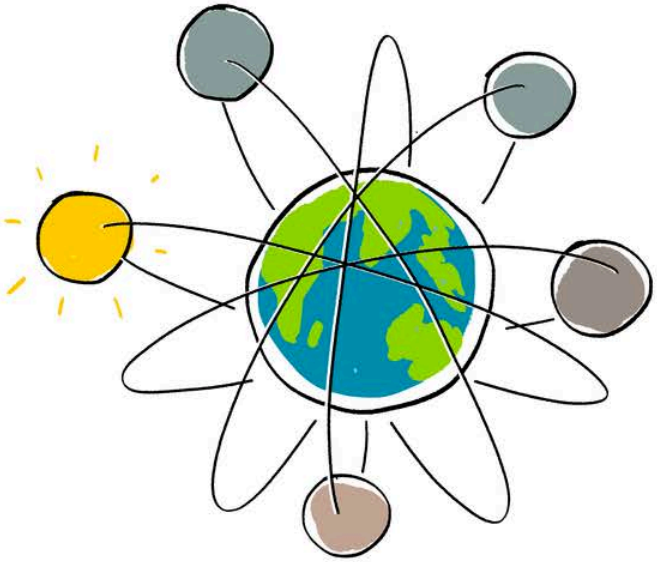
WAiS commissioned artist Gertrina Hayden a Badimia-Yamatji-Noongar woman based in Perth to visually represent supported-decision making.

Summary

- What is SDM and how it relates to PBS
- Using 3 key SDM strategies
- Applying key research in action
- Our process for building agency
- Applying the process in a complex situation

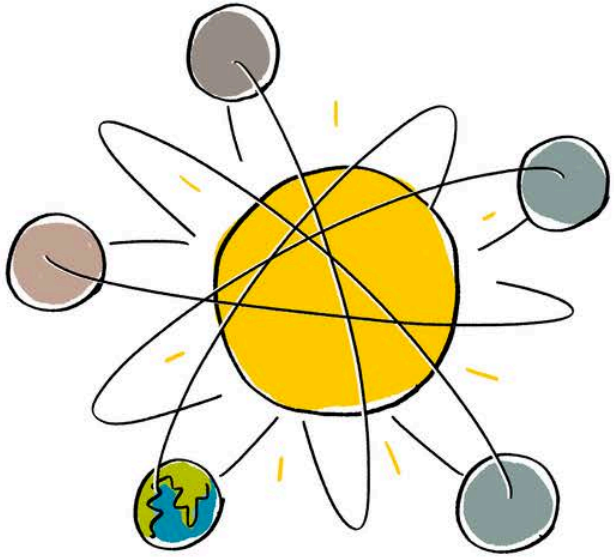
SDM enables important human rights


UNITED NATIONS enable
CRPD and Optional Protocol Signatures and Ratifications
Not Signed
Signed Convention
Signed Convention & Protocol
Ratified Convention
Ratified Convention & Protocol
As of 19 September 2017
160 signatories to the Convention
92 signatories to the Optional Protocol
175 ratifications/accessions to the Convention
92 ratifications/accessions to both the Convention and the Optional Protocol
Note:
Signatories include countries or regional integration organizations that have signed the Convention and its Optional Protocol, some of which may now also have ratified.
The European Union, a regional integration organization, is a State party to the Convention.
The Cook Islands and the State of Palestine, non-member States of the United Nations, are State parties to the Convention.



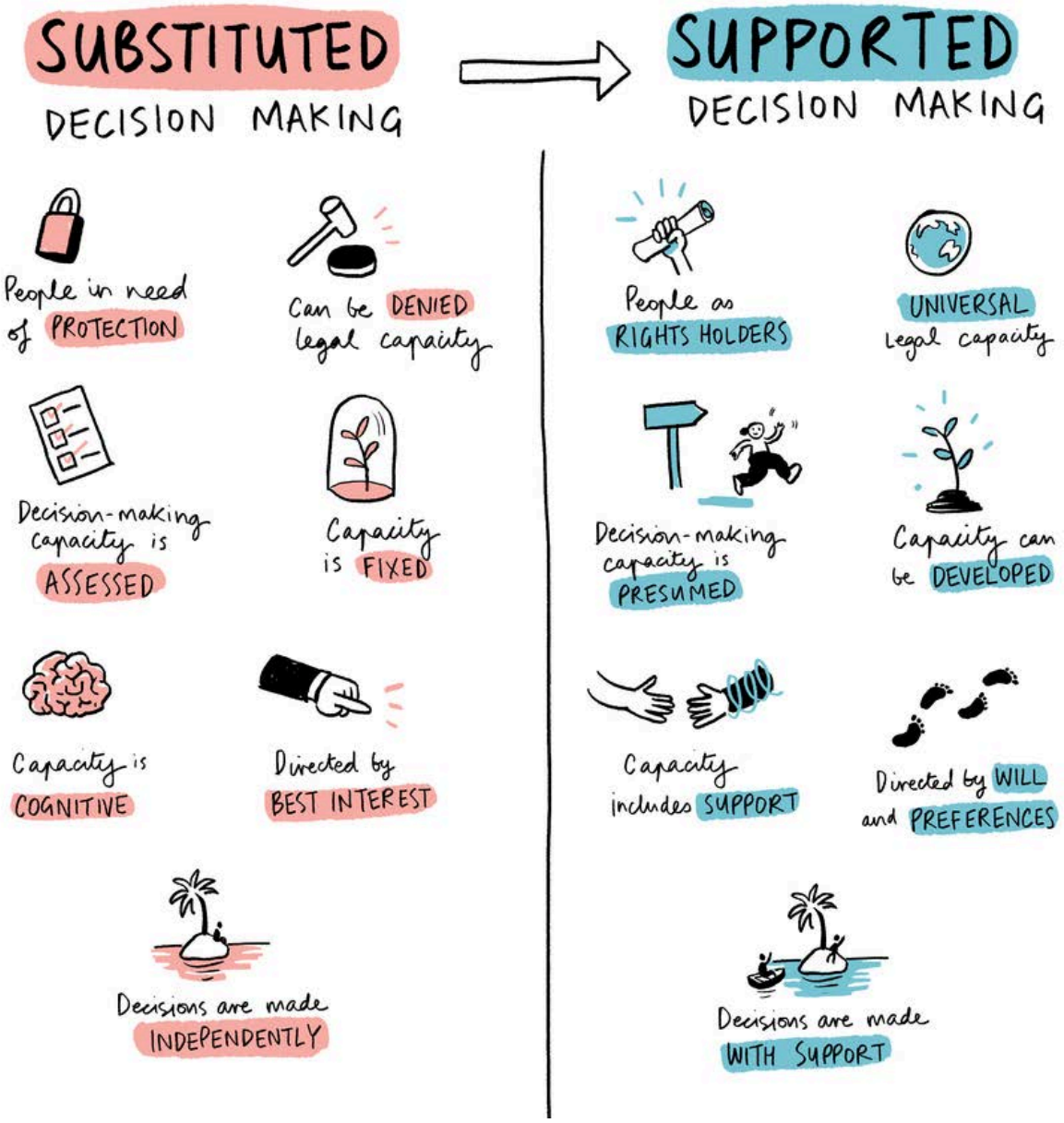
SUBSTITUTED DECISION MAKING

The person's WILL and PREFERENCES are ONE of MANY planets orbiting the decision making universe.



SUPPORTED DECISION MAKING

The person's WILL and PREFERENCES are AT THE CENTRE of the decision making universe.


SUBSTITUTED
DECISION MAKING
SUPPORTED
DECISION MAKING
People in need of PROTECTION
Can be DENIED legal capacity
Decision-making capacity is ASSESSED
Capacity is FIXED
Capacity is COGNITIVE
Directed by BEST INTEREST
Decisions are made INDEPENDENTLY
People as RIGHTS HOLDERS
UNIVERSAL Legal capacity
Decision-making capacity is PRESUMED
Capacity can be DEVELOPED
Capacity includes SUPPORT
Directed by WILL and PREFERENCES
Decisions are made WITH SUPPORT

ability + supports and accommodations

= **decision-making capability**

Think about a person you work with…

How can we shift our thinking about that person to be aligned with SDM instead of substitute decision making?

How can we take an approach that builds decision-making capability when guardianship is in place ?

ASSUMING CAPABILITY

We assume people can make decisions with the right support.

What does it look like to assume capability in PBS practice?

Think about the same person in relation to assuming capability…

Will and preferences

Our will is what drives us and gives our life meaning. Our deeply held **beliefs**, **values** and **commitments**. Our preferences are the things that are **important** to us **in the moment**.

We respect who the decision maker is and what they want when supporting their decision making.

How do we respect will and preferences in PBS practice?

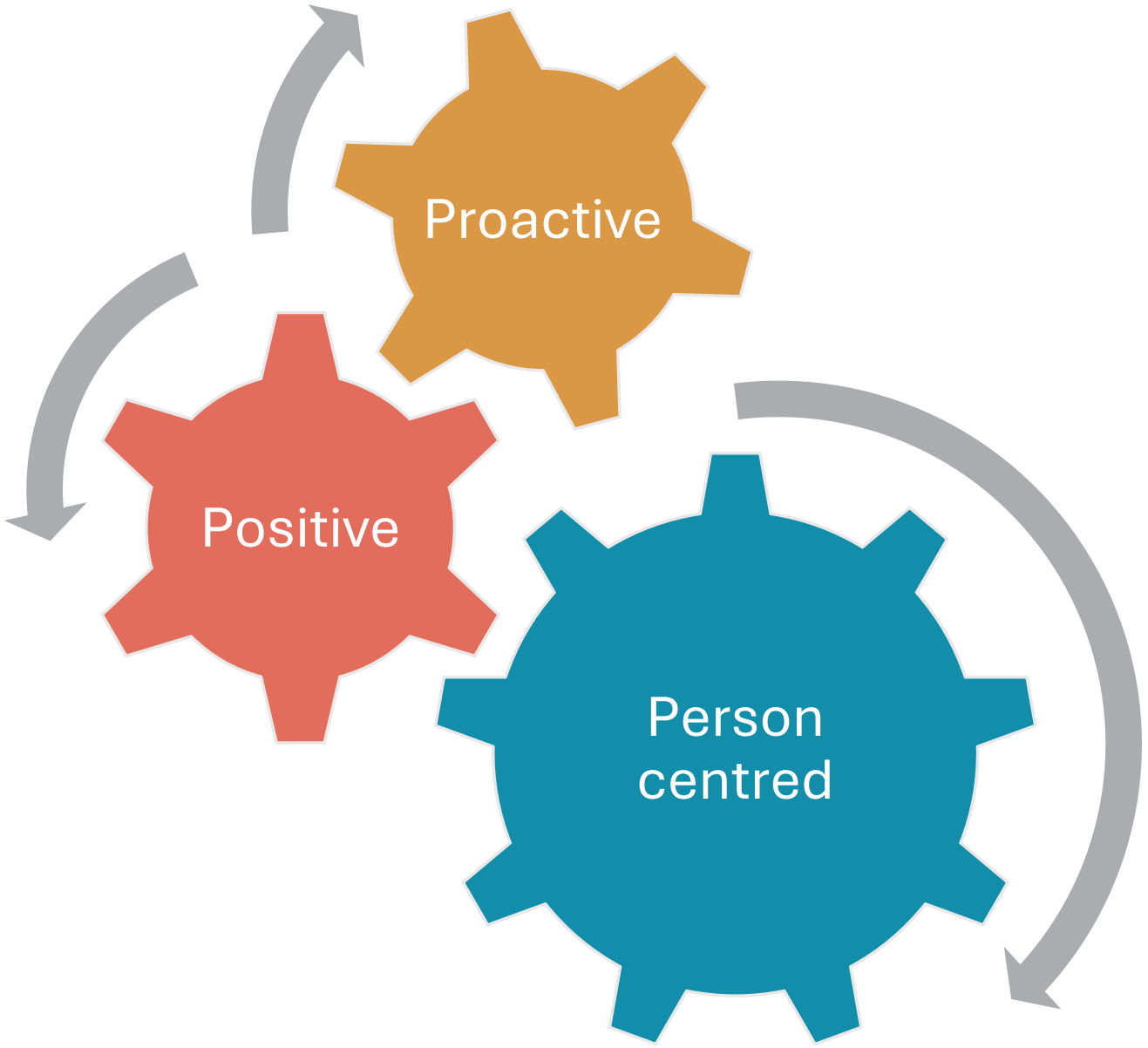
Think about the same person and their will and preferences…

ENABLING RISK

MITIGATING RISK

"It is long past time to rethink risk and vulnerability. Our efforts to minimize or contain these threats can thwart opportunities for those in our care. Living an unfulfilled life carries a greater risk of harm than what may befall someone in the pursuit of their dreams."

2


Proactive
Positive
Person centred

Collaborative

How can we make it work?

Questions to guide us

What is the decision?
We want to be clear about the decision – what it is and why it is needed.

What does the person want?
What does the decision mean to them? Why is it important?

What are their options?
We want to creatively explore options with the person.

What are the good things that could happen? (for all options)
Putting positives first.

What are the bad things that could happen? (for all options)
How serious are the risks? How likely are they to happen?

What can we do to reduce the risks and possible harm?
How can we make the risks less likely to happen?
How can we reduce their seriousness?
Brainstorm the strategies you could use.

Which option stays most true to what the person wants?
Which strategies does the person like the most?
Which align most with their will and preferences [1]?

If they understand the risks and still want to go ahead – this is an informed decision.

We support the person to act on their decision knowing they have the right to take risks that may lead to harm. We can support and encourage them to consider implementing the strategies to reduce harm but ultimately it is up to them.

Guided by least change to preferences principle

If they don't understand the risks how can we support their decision, staying true to what they want but reducing harm?

We use our knowledge of the person's will and preferences to help them find ways to make the bad things that could happen less serious or likely. The strategies developed must be guided by a "least change to preferences" principle [2].

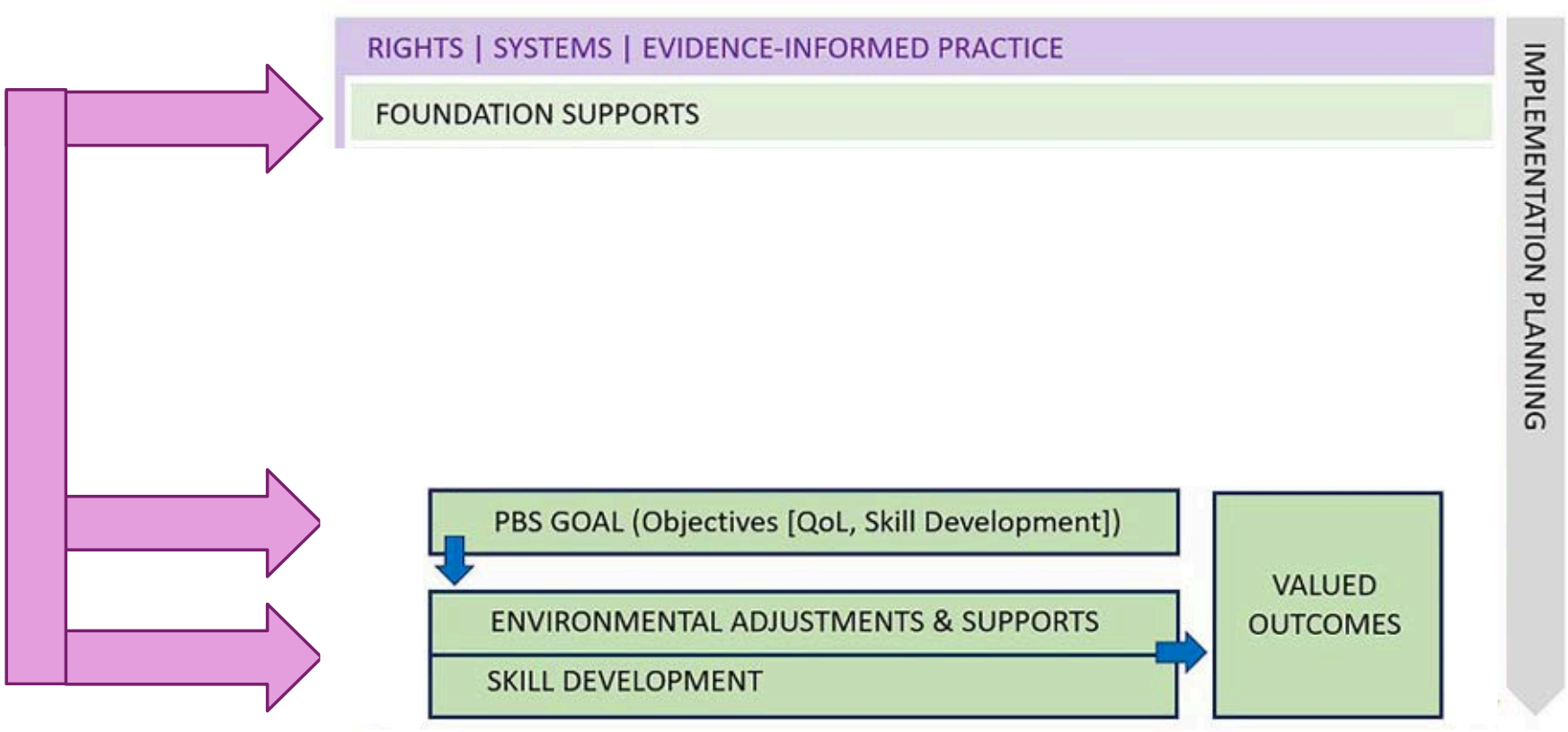
For example, Ari communicates he wants to travel overseas alone, and his supporters are concerned he will have difficulty managing his money and become confused by people speaking in another language. When working through the risks, if the main purpose of the trip for Ari is to travel alone, changing plans to explore Australia independently would reduce the seriousness of the risks and still respect his preference to travel alone. But if visiting the Eiffel Tower in Paris is the main purpose of the trip, taking a friend will greatly reduce the likelihood of the risks and still respect his preference to travel overseas.

We best support people to take risks by understanding who they are, what is important to them, and working with them to find ways to reduce harm that make the least change to their preferences.

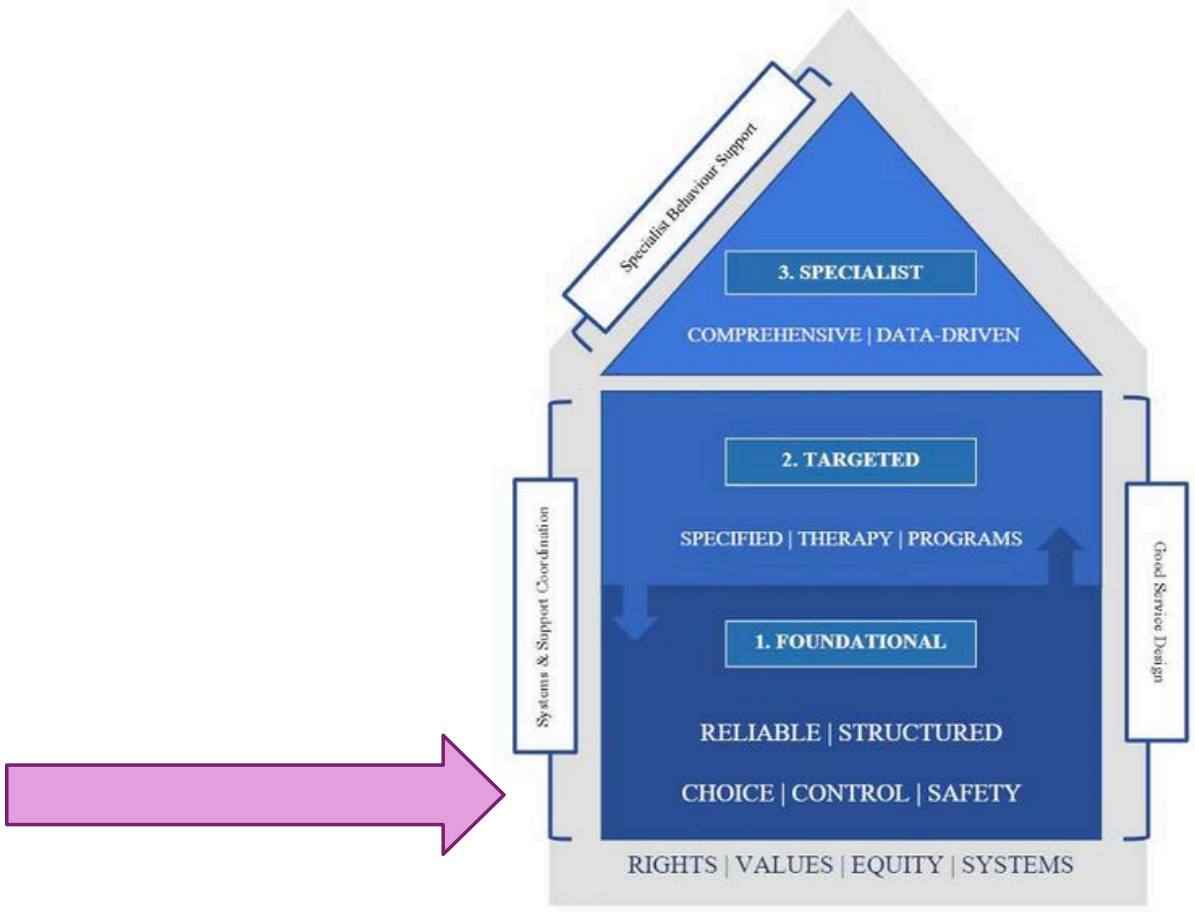
What does risk enablement look like in PBS practice?


Person-led
Quality of life
Meeting needs
Rights & respect

Putting the research into practice



Alinka Fisher, Kymberly Louise, Monika Dobek, Jo McRae, Maverick Clissold, Katrina Reschke, Russell Fox, Erin Leif, Maria Vassos, Jane Ellis, Katharine Annear, Sessina Figueiredo, Lee Cubis, Sau Chi Cheung, Matthew Spicer, Karen Nankervis, Keith McVilly & Rachel Freeman (17 Sep 2024): **A positive behaviour support practice framework for disability and community services in Australia that prioritises human rights and evidence-based practices**, Disability and Rehabilitation, DOI: 10.1080/09638288.2024.2402079



Fisher, A., & Kelly, G. (2024). **Positive behaviour supports in disability and community services (PBS-DCS): a tiered model for foundational, targeted, and specialist supports.** *Disability and Rehabilitation*, *47*(10), 2693–2702. https://doi.org/10.1080/09638288.2024.2398778

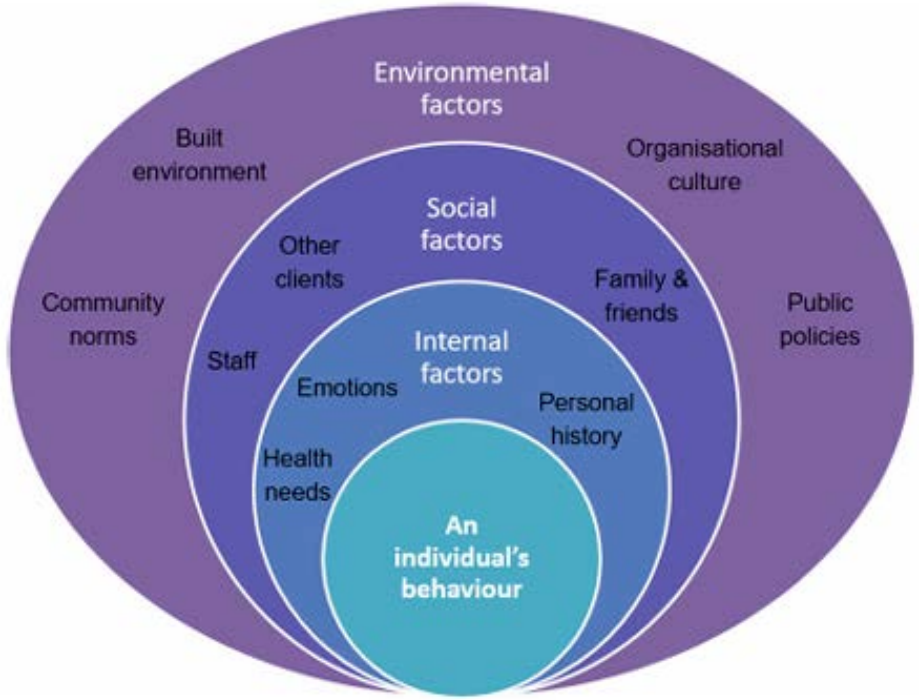
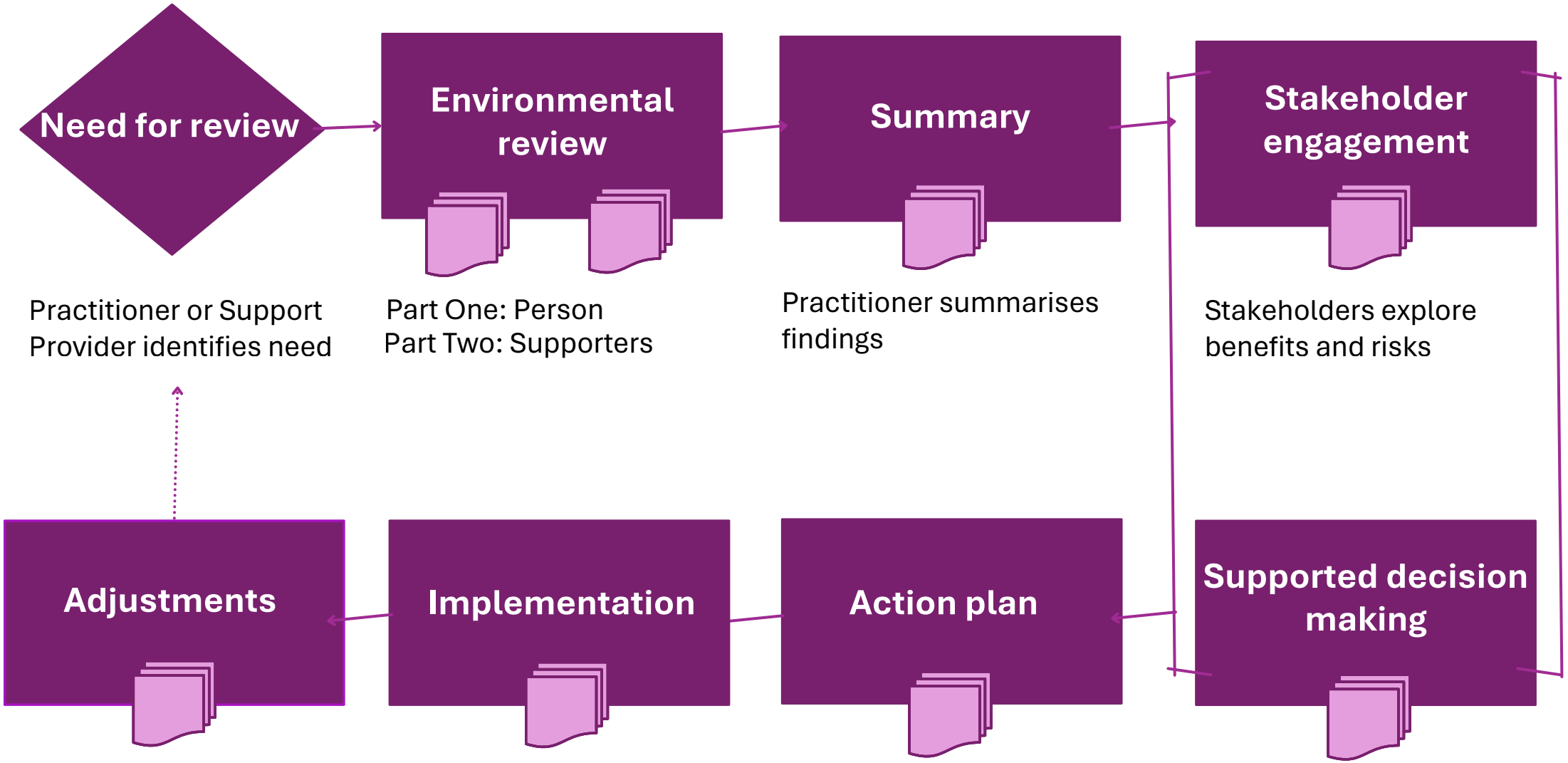


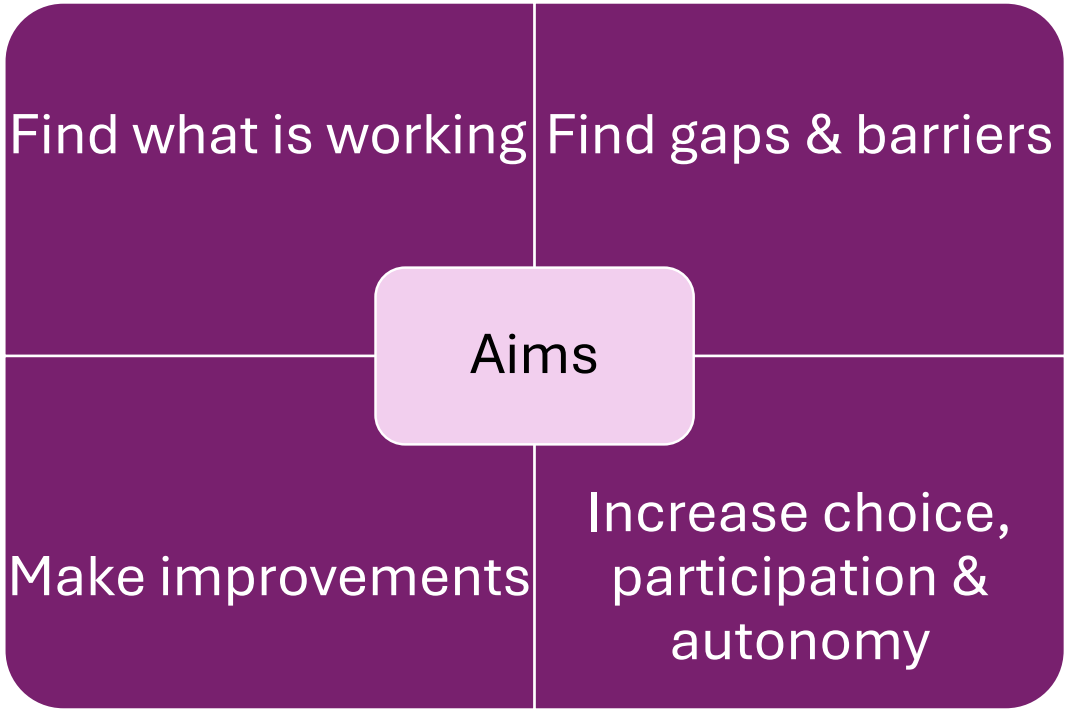
Figure 1. A social-ecological model adapted for behaviour.

Mikaela Jorgensen, Karen Nankervis & Jeffrey Chan (2023): **Environments of concern: reframing challenging behaviour within a human rights approach**, International Journal of Developmental Disabilities, DOI:10.1080/20473869.2022.2118513

Inclusion Australia (June 2024): A model for eliminating the use of restrictive practices against people with an intellectual disability.


Morning Tea


Need for review
Environmental review
Summary
Stakeholder engagement
Practitioner or Support Provider identifies need
Part One: Person
Part Two: Supporters
Practitioner summarises findings
Stakeholders explore benefits and risks
Adjustments
Implementation
Action plan
Supported decision making
Action plan reviewed and adjusted
Support provider implements plan
Practitioner develops action plan
Exploration of person's will, preferences and goals


Find what is working
Find gaps & barriers
Aims
Make improvements
Increase choice, participation & autonomy

Environmental review

Environmental Review Tool – Part 1

Please tell us about what you want and whether you are happy with your home and services.

Read each sentence and tick on the scale how you feel about it.

If you strongly agree tick in the green section. If you strongly disagree tick in the red section. You can tick anywhere on the scale to show how you feel about the sentence.

The person helping you go through this review might ask you some questions as you go through it together. They want to understand your answer and what you think should happen or change.

Home

1. I live in a good house; it reflects who I am, and I am proud to have people over to visit.	
2. I have control over what happens in my house.	
3. I feel safe where I live.	
4. I have things I own that are important to me at home.	
5. Other people in my home respect those things.	
6. I can access all parts of my home and get around it easily.	
7. I have a place in my home where I can go to have quiet time or calm down.	
8. From home, it is easy for me to access the places I want to go in my community (e.g. shops, library, sport or other activities).	
9. The way my house is set up helps me to do the things I want to do.	

Environmental review

Environmental Review Tool – Part 2

Name:	
Environment reviewed:	
Person conducting review:	
Purpose of review:	
Date started and finished:	

This tool has been c
to better understan
review or adjustmer

Approach *This section explores how staff and other individuals working with the person approach providing support. It also explores how aware they are of the person's preferences and needs.*		
Question	**Comment**	**Issues for further exploration**
Staff Awareness and Understanding		
Are staff aware of the person's hopes and dreams?		
Are staff aware of the person's goals (short and long term)?		
Do staff have a positive vision for the person and believe the person is capable of achieving their goals/hopes and dreams?		
Have staff previously been successful in supporting the		

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Supported decision making

Supported Decision Making Tool

When responding to the environmental review, the practitioner and stakeholders, need to be guided by the person's will and preferences[1].

A practitioner should meet with the person to discuss the issues identified in the environmental review in a way that is just right for them. Start by exploring what the participant wants changed and why, to clarify their priorities and understand their goals more deeply.

Decision opportunities will emerge in this meeting that need to be explored further. Practitioners can use the following process to unpack the options and risks with the person and support them to decide what actions should be prioritised in their Action Plan.

1. **Look into and understand the decision opportunity** – why is the decision important or needed? What might it mean for the person or others? What are the barriers to exploring this opportunity? What can we do to make exploring this opportunity possible?

Stakeholder engagement

Stakeholder Engagement Tool

When responding to the environmental review we need to engage with stakeholders to discuss the potential benefits and risks of making environmental changes and acting on the person's will and preferences.

Practitioners will need to assess whether exploring benefits and risks with stakeholders should occur before or after engaging with the person directly. A supported decision-making approach is always guided by the person and helps ensure their will and preferences are informed. We would only delay involving the person if there were concerns about their wellbeing and safety discussing certain topics without adequate stakeholder support. And if the seriousness warranted risk mitigation strategies being developed prior to exploring options with the person directly.

This tool has been designed to help practitioners facilitate stakeholder meetings where the benefits and risks of making environmental changes can be proactively explored.

Stakeholder Meeting Details

Date:	
Time:	

Action plan

Action Plan

We develop and implement an Action Plan to build a more capable and supportive environment for the person.

Practitioners collaborate with the person, their implementing provider and other important supporters, to plan how to increase their choice, participation, access and autonomy.

The Action Plan is developed after completing an Environmental Review and supporting exploration of the person's will, preferences and goals. All stakeholders are involved in collaborating with the person to identify and mitigate risks that might prevent them from achieving their goals.

Immediate actions for safeguarding

These actions were identified as part of the Environmental Review. They are included here to ensure they are considered when developing recommended actions and thinking about short and long-term priorities.

Recommendation	Acti
What are you trying to achieve?	*Wha steps char*

Long Term Priorities

This section outlines the long-term actions the support team will focus on to improve the person's environment and support over the next few years. Actions are prioritised based on the person's values and what is important and meaningful to them. Changes should be focused on increasing their choice, participation, access and autonomy as well as meeting their long-term support needs and preferences.

Priority One	Actions required	Who is responsible	Time frame/date
What change are you trying to achieve?	*What are the detailed tasks or steps needed to achieve the change?*	*Who will do them?*	*When and how will you monitor progress?*

Priority Two	Actions required	Who is responsible	Time frame/date
What change are you trying to achieve?	*What are the detailed tasks or steps needed to achieve the change?*	*Who will do them?*	*When and how will you monitor progress?*

Priority Three	Actions required	Who is responsible	Time frame/date
What change are you trying to achieve?	*What are the detailed tasks or steps needed to achieve the change?*	*Who will do them?*	*When and how will you monitor progress?*

Decision Making Profile

Name: **Date:**

How I communicate my preferences	*Showing people with my body* *Showing people with my eyes* *Showing people with my behaviour* *Using my voice* *Telling people with words* *Using my communication system* *Other ways*
How I like to get information	*Talking about things - asking other people their experiences and what works for them.* *Seeing things – using technology such as the internet, YouTube videos.* *Using images or pictures.* *Using words and pictures together – this could be Easy Read format.* *Written down in words that are easy to understand i.e. plain language.* *In small amounts – breaking things down.* *Using my communication system.*
How to present choices to me	*Not enough options may be limiting, too many may be overwhelming.* *Visual supports (e.g. photos of the person doing the activity previously, items to choose from that the p* *or touch to indicate making the choice).* *One at a time, don't rush.*
When is the best time for me to make decisions?	*A particular time of the day e.g. in the morning when I have a fresh mind, in the afternoon when I am* *When I am feeling a certain way e.g. relaxed, focused, confident.*
When is a bad time for me to decide?	*A particular time of the day e.g. not long after I have taken my medication.* *When I am feeling a certain way e.g. when I am overwhelmed and distressed, very tired, feeling pressured.*
Who do I like to help me make decisions?	*Family* *Friends* *Support workers* *People who know about the type of decision I want to make* *People who listen, who respect what I have to stay, people I trust* *People who know me well, people who care about me.* *People who do not tell me what to do or try to change my mind.* *People who are fun and easy to talk to.*
What decisions do I make on my own?	*What I wear* *What I eat* *How I spend my time during the day*
What decisions do I make with support?	*How to keep myself safe when out in the community* *How to travel to where I want to go.* *Budgeting* *Decisions around my medication*
What decisions do I want to make in the future?	Living on my own Getting married and having a family Getting a better job

Please read about Alex's Situation

What are the risks in this situation?

What are Alex's will and preferences?

What are the environmental constraints, barriers and gaps?

Let’s act out a stakeholder meeting

How did we support Alex's involvement in goal setting?