

12. Participants aged 25 and over: overview of results

12.1 Key findings

Box 12.1: Key findings for participants aged 25 and over

- In the longitudinal analysis, significant improvements were observed across a number of indicators, including the percentage participating in a community group in the last 12 months, which increased by 5.0%, from 36.4% to 41.4%. A number of other participation indicators have improved significantly. More participants expressed a desire for greater choice and control (an increase of 8.5%, from 66.1% to 74.6%).
- However, the percentage in a paid job has not changed significantly, being 26.6% at baseline and 26.2% at review.
- NDIS participants tend to have poorer baseline health and wellbeing outcomes than Australians overall. 48% of participants 25 and over rated their health as good, very good or excellent, compared to 87% of Australians aged 25 to 64 overall⁴⁷. NDIS participants also express lower overall life satisfaction than the general population, with 52% saying they felt “delighted”, “pleased” or “mostly satisfied” with their life, compared to 77% of Australians aged 25 to 64 overall⁴⁸. 41% of adult participants had been to hospital in the last 12 months, compared to 11% of Australians aged 25 to 64⁴⁹. Moreover, 56% of those who had been to hospital had had multiple visits, compared to a population figure of 23% for Australians aged 25 to 64⁴⁹.
- 33% of participants said they had experienced some difficulty in getting health services. The most common reason cited was access issues (10%), however 6% said it was because of the attitudes and/or expertise of health professionals.
- 17% of adult participants said they currently smoked, and this is similar to a 2014-15 population figure for 25 to 64 year olds of 18%⁴⁷. However, there is considerable variation in smoking rates by disability. At 50%, the percentage of participants with a psychosocial disability who smoke is almost four times the percentage for other disabilities combined (13%). At the other extreme, none of the participants with Down syndrome surveyed said that they smoke.
- The impact of disability type on other outcomes varies by domain. For example, at baseline, participants with intellectual disability or autism experience lower levels of choice and control, and those with a sensory disability or multiple sclerosis experience higher levels. However participants with multiple sclerosis have the poorest self-rated health and are more likely to go to hospital. As for the younger adult cohort, participants with a visual impairment are much more likely to volunteer (22% versus 13% overall).
- Baseline and longitudinal outcomes vary with participant level of function. Participants with higher level of function tend to have better baseline outcomes and exhibit higher rates of improvement than those with lower level of function.

⁴⁷ ABS National Health Survey (NHS) 2014-15.

⁴⁸ ABS General Social Survey (GSS) 2010. For GSS 2014 the question changed from using seven descriptive categories to a rating on a 0 to 10 scale.

⁴⁹ ABS Patient Experience Survey (PES) 2016-17.

Box 12.1: Key findings for participants aged 25 and over (continued)

- Results by remoteness were mixed. For example, overall life satisfaction improved with increasing remoteness, as did levels of volunteering and the likelihood of knowing people in the community. However difficulties in accessing health services tended to increase with remoteness, and participants in major cities were more likely to have a paid job.
- Results by CALD status were also mixed, being slightly better for some baseline choice and control indicators but poorer on some health and wellbeing indicators. CALD participants were less likely to smoke.
- At baseline, SF choice and control indicators for Indigenous participants tend to be slightly worse than for non-Indigenous participants. However Indigenous participants are more likely to have someone outside the home to call on for help. Indigenous participants were less happy with their home, were less likely to feel safe at home and in their community, and had poorer health outcomes. Indigenous participants were much more likely to smoke (30% compared to 17% overall).
- Deeper analysis of employment outcomes suggests that participants looking for paid work are more likely to be successful when they have a university degree, when their health improves, and when they have a work goal or employment funding in their plan.
- For participants who are not involved in a community group at baseline but would like to be, factors increasing the likelihood of success include volunteering, having a paid job, and participating in education or training in a class for students with disability at baseline.
- For participants 25 and over, opinions on whether the NDIS has helped tend to be slightly more optimistic than for the young adult cohort, apart from lifelong learning and work, but generally reflect a similar pattern by domain. The percentage who think the NDIS has helped is highest for daily activities (71%), followed by choice and control (67%). Percentages are lowest for home (30%) and work (20%). Higher baseline plan utilisation is a strong predictor of a positive response across all eight domains. Perceptions also tended to improve with plan cost. Participants from QLD and WA tended to be more positive, and those from TAS and VIC less positive.

12.1 Results overview – participants aged 25 and over

12.1.1 Outcomes framework questionnaire domains

Employment is also an important area for the older adult cohort, with the older members of this cohort also starting to transition to retirement. For both young and older adults, choice and control is a normal part of everyday life.

The LF contains a number of extra questions for the adult cohorts, across all domains, but particularly in the health and wellbeing domain.

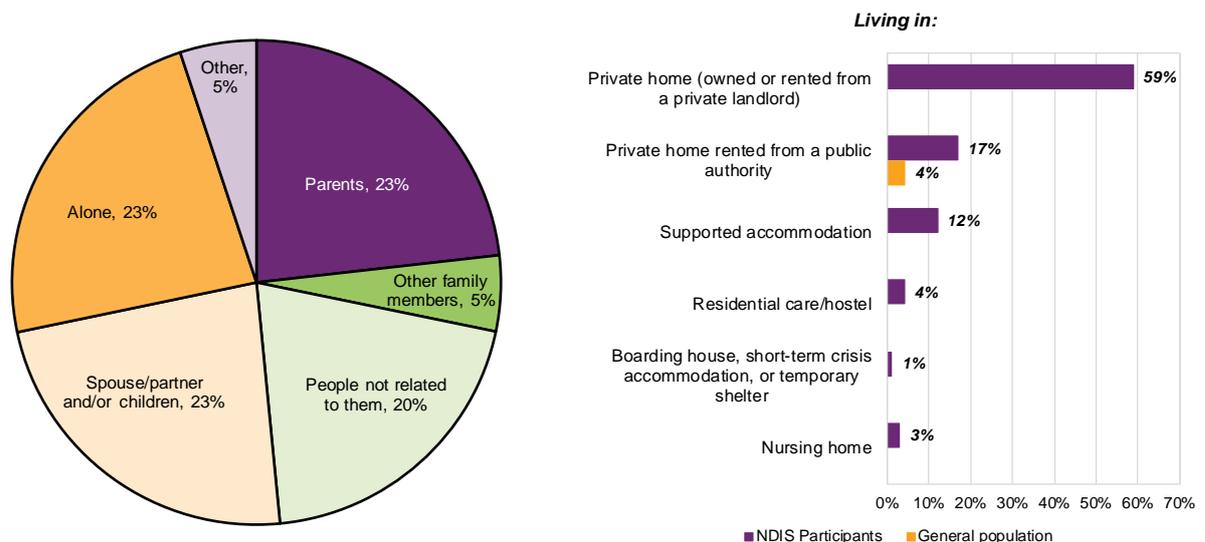
12.1.2 Participant living arrangements

By comparison with the younger adult cohort, participants aged 25 and over are more likely to live alone (23%), or with a spouse/partner and/or children (also 23%), or with people not related to them (20%). However 23% still live with their parents and 5% live with other family members.

For participants aged 25 and over, the percentage in a private home either owned or rented from a private landlord is 59%. 17% of the older adult cohort live in a private home rented from a public authority. 12% are in supported accommodation, 4% in residential care or a hostel and a further 1% in a boarding house, short-term crisis accommodation, or a temporary shelter. 3% live in a nursing home.

The ABS Census of Population and Housing 2016 found that 3.6% of *households* were in public housing (rented from State/Territory governments) and 4.2% were in some form of social housing (including public housing supplied by the government, and community housing supplied by non-government organisations). Although not directly comparable to these household-based percentages, the percentages of participants who say they live in public housing (8%, 10%, 12% and 17% for the four age cohorts) appears higher than the general population.

Figure 12.1 Participant living arrangements – 25 years and over



12.1.3 Baseline indicators – aggregate

Choice and control

More participants chose, or had a say in, what they do each day (90%) and how they spend their free time (89%) than in who supports them (79%), where they live (70%) or who they

live with (53%). The majority (57%) said they made most of the decisions about their lives, with 31% saying their family did, and 7% that their service providers did. 82% said they had someone who supports them to make decisions. Overall, 75% said they would like more choice and control in their life.

Daily living

Support for daily living was most needed for domestic tasks (88%) and travel and transport (81%), and least needed for personal care (55%) and reading or writing (57%). Where support was needed, it was most often received for personal care, domestic tasks, and finances/money (76%-82%), and least often received for using technology (47%). For those receiving support, generally low percentages (ranging from 34%, for getting out of the house, to 76%, for finances/money) felt that it met their needs. 23% of participants needed support in all of the eight areas surveyed.

Relationships

Looking at relationships, 24% of participants said they had no-one outside their home to call on for practical assistance, 24% had no-one to call on for emotional assistance, and 21% had no-one to call on in a crisis. By comparison, the ABS General Social Survey (GSS) asks “Are you able to get support in times of crisis from persons living outside the household?”, and the proportion of 25 to 64 year olds who said they were unable to get support was 5% for the 2014 survey.

Whilst only 14% of respondents said they provided care for others, 72% of these said they needed help to continue caring, and only 15% said they received enough help.

28% of participants said they did not have any friends apart from family or paid staff. Overall, 83% were happy with their relationships with staff. 20% said they often feel lonely.

Home

76% of adult participants were happy with their current home, however 17% said they would not want to live there in five years' time, with 8% saying this was because they wanted to choose their future home, 3% for reasons related to support needs, and 6% another reason. 31% cited lack of support as a barrier to living in a home of their choice, with 28% citing lack of affordable housing. 76% said they felt very safe or safe in their home.

Health and wellbeing

People with disability generally rate their health as poorer than other Australians⁵⁰, and this holds true for NDIS participants. 48% of the adult cohort rated their health as good, very good or excellent, compared to 87% of Australians aged 25 to 64 overall⁵¹. NDIS participants also express lower overall life satisfaction than the general population. When asked to think about their life now and in the future, on a seven-point scale from “delighted” to “terrible”, 52% of adult participants responding to the LF said they felt either “delighted”, “pleased” or “mostly satisfied”, compared to 77% of Australians aged 25 to 64 overall⁵².

NDIS participants are also more likely to go to hospital than Australians generally. 41% of adult participants had been to hospital in the last 12 months, compared to 11% of

⁵⁰ Australian Institute of Health and Welfare (AIHW) (2018) Australia's Health 2018.

⁵¹ ABS National Health Survey (NHS) 2014-15.

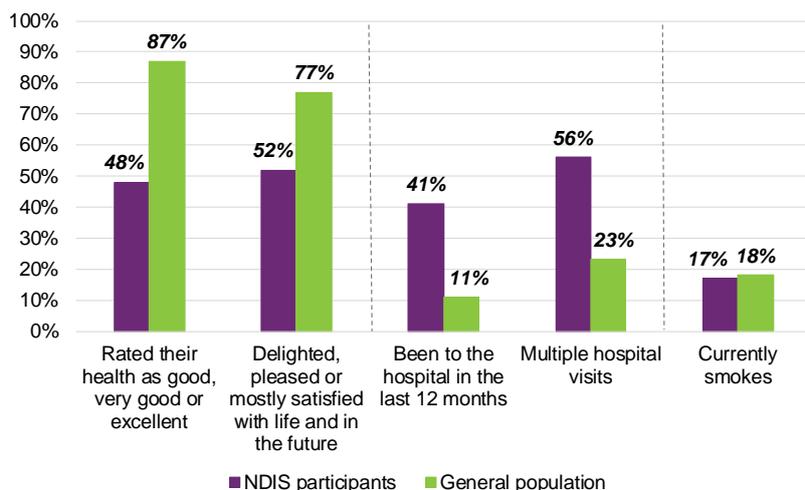
⁵² ABS General Social Survey (GSS) 2010. For GSS 2014 the question changed from using seven descriptive categories to a rating on a 0 to 10 scale.

Australians aged 25 to 64⁵³. Moreover, 56% of those who had been to hospital had had multiple visits, compared to a population figure of 23% for Australians aged 25 to 64⁴³.

33% of the adult cohort said they had experienced some difficulty in getting health services. The most common reason cited was access issues (10%), however 6% said it was because of the attitudes and/or expertise of health professionals.

17% of adult participants said they currently smoked, and this is similar to a 2014-15 population figure for 25 to 64 year olds of 18%⁵⁴.

Figure 12.2 Health and wellbeing indicators for NDIS participants compared with the general population



Lifelong learning

Regarding education and training, 35% said there was a course or training they wanted to do but were unable to do in the last 12 months.

Work

7% said they were currently working in an unpaid job, whilst 25% were working in a paid job. Of those not currently working in a paid job, 30% said they would like one and 70% said they didn't want one. From the LF, 61% of adult participants said they had not had a job in the previous 12 months, 36% had had one job, and 4% more than one. 13% had done some casual work in the previous 12 months.

Also from the LF, 81% of participants currently in a paid job had held that job for more than two years and 6% for less than six months. 93% found their job suitable and 92% said they received the support needed to do their job. For those working in an ADE, 25% could see a pathway to open employment. For those not currently in a paid job, 90% had not applied for any jobs in the previous three months, 5% had applied for one or two jobs, and 5% for three or more.

The LF also attempts to uncover reasons why participants do not have a paid job, and the kinds of assistance that would help them find a job. 26% of participants specified lack of support as the main reason they did not currently have a job, with 8% saying they couldn't

⁵³ ABS Patient Experience Survey (PES) 2016-17.

⁵⁴ ABS National Health Survey (NHS) 2014-15.

find a job, and 7% saying travel was difficult, however the majority (59%) chose the “other” response option. Only a small number of participants provided extra information as to what that other reason was, however those who did mainly cited poor health. Similarly, when asked what assistance would help them get a job, 39% said more support, 10% said help with travel, 9% having a mentor, 5% educating employers, and 3% getting work experience, however 35% chose the “other” response option. The small number who gave extra information mainly said that better health, or a mixture of some/all of the fixed category responses, would help them get a job.

Only 16% of adult participants responding to the LF said they had started planning for retirement, and 72% of these said they made all of the decisions or made the important decisions with help from others.

Social, civic, community participation

13% of participants said they currently volunteered, and a further 23% expressed an interest in volunteering. 36% had been involved in a community, cultural or religious group in the last 12 months, with 90% of LF respondents feeling a sense of belonging to the group. Also from the LF, 25% said they had had negative experiences in their community in the past 12 months.

The GSS asks “How safe or unsafe do you feel walking alone in your local area after dark?”, with responses on a five-point scale from “Very safe” to “Very unsafe”. The LF also asks this question, however with an additional response option “I never go out alone”, which was chosen by 66% of respondents. Of those who do go out alone, 57% said they felt safe or very safe whereas 31% said they felt unsafe or very unsafe. From the 2014 GSS, the corresponding figures for 25 to 64 year olds were 68% and 17%.

NDIS participants were also less likely to feel able to have a say within the community on important issues: 23% of participants felt able to have a say all of the time or most of the time, 12% some of the time, and 66% a little of the time or none of the time. From the 2014 GSS, the corresponding figures for 25 to 64 year olds were 25%, 30% and 45%.

47% of participants felt able to have a say with their support providers either all of the time or most of the time, however 26% were only able to have a say a little of the time or not at all.

12.1.4 Baseline indicators – participant characteristics

Key findings based on one-way analyses are summarised here.

- **Level of function**

Baseline outcomes tend to be better for participants with higher level of function, and those with lower cost plans. However the percentage who feel happy about relationships with staff is higher for higher cost plans, and for participants with low level of function. These participants are also more likely to want to live in their home in five years’ time, and are more likely to have a regular doctor and to have had health/dental check-ups in the previous 12 months.

- **Culturally and linguistically diverse backgrounds**

Results by CALD status tend to be more mixed than for the young adult cohort, for example, being slightly better for some choice and control indicators. CALD participants are more likely to provide care for others (18% compared to 13% for non-CALD participants), more likely to have no friends other than family or paid staff (34% versus 27%), and less likely to feel safe in their home and in the community. Some health and wellbeing outcomes tend to be worse for CALD participants, for example they have poorer self-rated health and are more likely to have difficulty accessing

health services, however they are less likely to smoke than non-CALD participants (10% versus 18%). Many of the participation indicators are also worse for CALD participants: they are less likely to spend free time doing activities that interest them, to volunteer, to know people in their community, and to have a say with service providers. However they are slightly more likely to be involved in a community group.

- **Indigenous**

- Choice and control indicators for the SF tend to be slightly worse for Indigenous participants, who are more likely to want more choice and control in their life. However from the LF, Indigenous participants are more likely to say they chose where they lived (71% versus 55%, $p=0.03$).
- Indigenous participants are more likely to want to see family and friends more often, however from the LF, they are more likely to have someone outside their home to call on for practical support (91% versus 76%, $p=0.01$) and emotional support (87% versus 75%, $p=0.06$) and someone to call on in a crisis (92% versus 78%, $p=0.02$).
- Indigenous participants are less happy with their home (now and in five years' time), and less likely to feel safe in their home and in the community.
- Health indicators also tend to be worse for Indigenous participants, and from the LF, they are much more likely to smoke than non-Indigenous participants (30% versus 17%, $p=0.01$).
- Indigenous participants are less likely to get opportunities to learn new things (34% versus 43%), less likely to participate in education or training (11% versus 14%), and much less likely to have a paid job (14% versus 26%).
- Indigenous participants are more likely to know people in their community (67% versus 62%), but less likely to feel able to have a say with support services (42% versus 47%).

- **Age**

Choice and control indicators tend to improve with age. The percentage who would like to see their family more often increases with age, from 29% for those under 35 to 47% for those 55 or over. Older participants are more likely to think their home will be suitable in five years' time. As expected, self-reported health deteriorates with age, and the percentage who have been to hospital in the last 12 months increases. Older participants are more likely to have a regular doctor and to have had a health check-up in the last 12 months. Opportunities to learn new things, and participation in education or training, become less widespread with age, and the percentage in a paid job declines as participants approach retirement. Involvement in hobbies/interests and opportunities to try new things decline with age. However older participants are more likely to feel able to have a say with support services.

- **Disability**

- Participants with intellectual disability or autism experience lower levels of choice and control, and those with a sensory disability or multiple sclerosis exhibit higher levels. Despite experiencing lower levels of choice and control, participants with an intellectual disability are the least likely to express a desire for more choice and control.
- Overall, 14% of participants provide care for others, but this percentage is much higher for participants with hearing loss or another sensory/speech disability (39%), multiple sclerosis (30%), or visual impairment (28%). Compared to an overall figure of 28%, participants with autism (42%), a psychosocial disability (40%) or an ABI (35%) are more likely to say they have no friends other than family or paid staff, and those with a sensory disability or multiple sclerosis less likely.

- Participants with hearing loss or another sensory/speech disability and those with a psychosocial disability are the least likely to feel safe or very safe in their home (66-67% compared to 76% overall), and those with an intellectual disability are the most likely (84%).
- Participants with multiple sclerosis have the poorest self-rated health and are the most likely to have been to hospital in the previous 12 months. Those with a psychosocial disability are the most likely to have experienced difficulties accessing health services and those with an intellectual disability the least likely. Participants with visual impairment and those with a psychosocial disability are the least likely to feel safe getting out in their community.
- Participants with autism are much more likely to participate in education or training, although this may partly reflect their younger age.
- Participants with ABI, cerebral palsy or another neurological disorder, or a psychosocial disability are the least likely to have a paid job (13-16% compared to 25% overall), whereas participants with hearing loss or another sensory/speech disability are the most likely (60%).
- Participants with hearing loss or another sensory/speech disability are also the most likely to have been involved in a community group in the last 12 months, whereas those with a psychosocial disability are the least likely. Participants with a sensory disability and those with multiple sclerosis are more likely to feel able to have a say with support services, whereas those with autism or an intellectual disability are the least likely. As for the younger adult cohort, participants with a visual impairment are much more likely to volunteer (22% versus 13% overall).
- From the LF, 17% of adult participants smoke, however this varies considerably by disability. At 50%, the percentage of participants with a psychosocial disability who smoke is almost four times the percentage for other disabilities combined (13%). At the other extreme, none of the participants with Down syndrome say they smoke. Age differences do not appear to explain this difference, since the average age for participants with a psychosocial disability is 47 and for those with Down syndrome is 44.

- **Geography**

SF choice and control indicators tend to be fairly similar for participants in major cities and more remote areas, however some of the LF indicators appear worse for participants in inner regional areas compared to either major cities or more remote areas. For relationships, participants from major cities are less likely to want to see their family more but slightly more likely to have no friends other than family or paid staff. From the LF, participants from major cities were more likely to often feel lonely (23% compared to 16% for those in inner regional areas and 10% for those in more remote areas), and less likely to feel happy with relationships with staff (78% versus 90%-92% for more remote locations). The percentage who had difficulty accessing health services tended to increase with remoteness, and the percentage feeling safe in their community tended to increase slightly. Overall life satisfaction also increased with remoteness, with the percentage feeling delighted, pleased, or mostly satisfied increasing from 41% for participants in major cities, to 47% for those in inner regional areas, and 51% for those in more remote areas. Participants from major cities were more likely to have a paid job. The percentage volunteering, and knowing people in their community, increased with remoteness.

- **Self management**

Self-management is consistently associated with better choice and control outcomes. Some relationship indicators are also better, for example, participants who self manage are less likely to say they have no friends other than family or paid staff. They are more likely to get opportunities to learn new things and to participate in education/training, and more likely to have a paid job. Some participation indicators are also better for self-managing participants, and they are more likely to feel able to have a say with their support services (67% compared with 45-46% for Agency and Plan managed, and 55% for combination)⁵⁵.

- **Gender**

The SF choice and control indicators tend to be slightly better for females, however from the LF, males are more likely to say they choose how they spend their free time and who they live with. Females are more likely to want to see their family and friends more, but less likely to have no friends other than family or paid staff. Females are twice as likely to provide care for others, and less likely to receive enough assistance to continue caring. Females are also less likely to feel safe in their home and in the community. They have poorer self-rated health, go to hospital more, and are more likely to have had difficulty accessing health services. However they are more likely to have had health and dental check-ups in the previous 12 months, and less likely to smoke. They are less likely to have a paid job.

12.1.5 Longitudinal indicators – aggregate

Longitudinal analysis describes how outcomes have changed for participants during the time they have been in the Scheme. Included here are participants entering the Scheme in the first year of transition (from 1 July 2016 to 30 June 2017) for whom a record of outcomes is available at two time points: at scheme entry and at approximately one year following scheme entry.

As expected during this relatively short period, many indicators have not changed a great deal. For this summary we select indicators based on a combination of statistical significance and magnitude of change^{56,57}.

Table 12.1 summarises changes for the 25 selected indicators.

⁵⁵ Some of these results may reflect other characteristics of self-managing participants, such as education and socio-economic status.

⁵⁶ Since there is much more data available for the SF, with more than 14000 participants contributing to the analysis, statistical testing would identify indicators where the magnitude of change is unimportantly small, so we only consider SF indicators where the absolute magnitude of change in the indicator is greater than 0.02 (all of these changes are statistically significant). For the LF, where the quantity of data is much smaller (around 200 participants), selection is based on statistical significance.

⁵⁷ Note that at least some of the observed change may be attributable to normal ageing, since participants will be one year older at the second time point.

Table 12.1 Selected longitudinal indicators for participants aged 25 and over

SF/LF	Domain	Indicator	Baseline	Review	Change	Improvement/ Deterioration
LF	1	% who say they have someone who supports them to make decisions (or who don't need anyone)	93.4%	98.6%	5.2%	Improvement
LF	3	% who have someone outside their home to call on for practical support	78.3%	87.7%	9.4%	Improvement
LF	3	% who feel happy with their relationships with staff	67.6%	83.8%	16.2%	Improvement
LF	5	% who feel delighted, pleased or mostly satisfied about their life in general now and in the future	37.7%	47.2%	9.4%	Improvement
SF	5	% who have been to the hospital in the last 12 months	40.0%	36.5%	-3.5%	Improvement
SF	6	% who get opportunities to learn new things	46.3%	49.4%	3.1%	Improvement
SF	6	% who currently participate in education, training or skill development	13.8%	15.8%	2.0%	Improvement
SF	6	Of those who currently participate in education, training or skill development in a mainstream class, % who say it's what they want	53.7%	59.0%	5.2%	Improvement
LF	7	% who get the help they need to do their job	78.0%	94.0%	16.0%	Improvement
SF	8	% who spend their free time doing activities that interest them	68.8%	73.5%	4.7%	Improvement
SF	8	% who have been actively involved in a community, cultural or religious group in the last 12 months	36.4%	41.4%	5.0%	Improvement
LF	8	% who have opportunities to try new things and have new experiences	54.7%	69.8%	15.1%	Improvement
LF	8	% eligible to vote at the last federal election	84.9%	89.6%	4.7%	Improvement
LF	8	% able to have a say within the general community on issues that are important to them, all of the time or most of the time	24.6%	32.7%	8.1%	Improvement
LF	8	For those who have participated in leisure activities in the past 12 months, % who feel those activities were enjoyable	88.2%	95.8%	7.6%	Improvement
LF	8	For those who have participated in leisure activities in the past 12 months, % who feel those activities enabled them to spend time with people they liked	84.9%	93.5%	8.5%	Improvement
SF	8	% who know people in their community	59.5%	64.8%	5.3%	Improvement
SF	1	% who want more choice and control in their life	66.1%	74.6%	8.5%	Context dependent
SF	3	% who would like to see their family more often	34.7%	36.8%	2.2%	Context dependent
SF	3	% who would like to see their friends more often	48.1%	50.4%	2.2%	Context dependent
SF	5	% who have a doctor they see on a regular basis	87.8%	92.4%	4.5%	Context dependent
LF	1	% who choose how they spend their free time	87.7%	77.8%	-9.9%	Deterioration
SF	1	% who feel able to advocate (stand up) for themselves	50.0%	47.6%	-2.4%	Deterioration
SF	5	% who rate their health as good, very good or excellent	51.3%	48.7%	-2.6%	Deterioration

SF/LF	Domain	Indicator	Baseline	Review	Change	Improvement/ Deterioration
SF	8	% who wanted to do certain things in the last 12 months, but could not	59.8%	65.4%	5.6%	Deterioration

Key findings from Table 12.1 include:

- There is considerable overlap with the younger adult age group, with 12 of the 16 indicators highlighted for the 15 to 24 group also appearing in the above table.
- Improvements were observed for seven of the eight participation indicators where a change has been noted.
- As for the younger adult cohort, there has been a considerable increase in the percentage who are happy with their relationships with staff⁵⁸.
- As also observed for the younger adult cohort, whilst self-rated health has deteriorated, more participants have a regular doctor, and fewer have been to hospital in the past year.

12.1.6 Longitudinal indicators – participant characteristics

Analysis by participant characteristics has been examined in two ways:

1. A simple comparison of the percentage meeting the indicator at review with the percentage meeting the indicator at baseline. The difference (review-baseline) is compared for different subgroups.
2. Multiple regression analyses modelling improvement in the indicator. That is, for the subset without the indicator at baseline, the probability of meeting the indicator at review is modelled as a function of participant characteristics. For some indicators, deterioration has been modelled in a similar way.

It should be noted that these two analyses can produce different results, particularly where there is a large difference in the indicator at baseline between subgroups.

For the logistic regression modelling, we have combined data from the 15 to 24 and 25 and over cohorts (adjusting for age in the regressions), so results from that analysis are for participants aged 15 and over.

Some key features of the analyses for selected indicators are summarised below.

Overall, are you happy with your relationships with staff? (LF indicator, overall improvement of 0.162)

One-way analysis suggests that the extent of improvement is greater for participants with an intellectual disability or Down syndrome, but less for those with cerebral palsy or another neurological disorder. Participants in NSW experience greater improvement, as do new entrants to the Scheme.

Do you know people in your community? (SF indicator, overall improvement of 0.053)

Multiple regression modelling reveals the following key findings:

- Improvement is less likely for participants with autism and more likely for those with Down syndrome.

⁵⁸ This may partly reflect participants without staff at baseline responding “no” at baseline then subsequently changing their answer to “yes” once they have staff and are happy with them, at review. For future collections, an option “I don’t have any staff” has been added.

- Improvement is more likely for those living in the Northern Territory and Queensland, and less likely for those living in Victoria. Participants from regional and remote locations are more likely to experience improvement than those in major cities.
- Self-managing participants (fully or partly) are more likely to improve.
- Participants living in an Aboriginal or Torres Strait Islander community residence are more likely to start to know people in their community, whereas those in supported accommodation or a nursing home are less likely.
- Participants who have support from family and friends, and those who feel safe getting out and about in the community, are more likely to improve.

Do you want more choice and control in your life? (SF indicator, went up by 0.085, interpretation is mixed)

Multiple regression modelling reveals the following key findings:

- The likelihood of starting to want more choice and control is lower for participants with lower level of function, and decreases between ages 16-25, and again between ages 41-56.
- Participants who need support with domestic tasks or for getting out of the house are more likely to start seeking more choice and control.
- Participants looking for a paid job are more likely to start wanting more choice and control.
- Participants who are happy with how often they see their friends are less likely to start wanting more choice and control.
- Participants who are involved in a community groups, as well as those who are not involved but would like to be, are more likely to start seeking more choice and control.