Reasonable and Necessary Supports

Quick summary: The Australian Government made laws about what we can fund under the NDIS. All supports need to meet the criteria in these laws before we can fund them in your plan. We call these the NDIS funding criteria. For example, supports need to be related to your disability, value for money, effective and beneficial, and most appropriately funded or provided by us. Each support must meet these criteria individually, but the supports must also meet the criteria when considered as a package.

What's on this page?

This page covers:

- What supports can you get?
- What principles do we consider when we decide what supports to include in your plan?
- How do we decide what reasonable and necessary supports to include in your plan?
- Step 1: How do we identify and describe a support in your plan?
- Step 2: How do we work out if an identified and described support meets the NDIS funding criteria?
- Step 3: How do we include the reasonable and necessary supports in your plan?

You may also be interested in:

- Mainstream Supports
- Creating Your Plan
- Reviewing Your Plan
- Reviews of Decisions
- Would we fund it?

What supports can you get?

When we create your plan with you, we'll discuss what supports you need for your disability. We want to help you pursue your goals, increase your independence, and help you work, study and join social activities.

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There are many supports you can get outside the NDIS. Other government and community services provide supports to all Australians, including people with disability. And your friends, family, and other people you know can often be your best supports.

We can fund supports you need for your disability, if they meet certain criteria. These are called ‘reasonable and necessary supports’. Your plan and supports will be just for you, so you have more choice and control over how you use them.

This guideline explains how we decide what reasonable and necessary supports we’ll include in your plan. There are lots of things we have to consider, which we’ll explain in detail.

We also have a Would we fund it guide. It has examples of how we decide whether we fund different types of NDIS supports.

What supports can you get outside the NDIS?

Before we decide what reasonable and necessary supports to fund in your NDIS plan, we’ll first discuss what other supports may be available outside the NDIS. This is an important information-gathering step. For example, there may be mainstream, community and informal supports that suit you.

Mainstream supports are other government services such as employment, education, health and family support services. They are often really helpful, and are available to everyone including people without disability. There are many ways they can help you learn new skills or live as independently as possible.

Community services offer a wide range of supports that may help with your disability support needs. Community supports are things open to everyone in the community, like sporting clubs, community colleges, activity groups, libraries or community gardens. They are often a great way to get involved in your local community, meet new people and learn new skills.

Informal supports, like your family, friends and other people you know in your community, can sometimes be your best supports. They know you and can often help in ways other supports can’t.

Your planner, Local Area Coordinator or Early Childhood Partner will talk with you about what services are available for you outside the NDIS. We can also help link you with these supports, so you don’t have to do it all on your own.

Accessing these supports is a good way to work toward your goals. You get to do it with other people and be involved in your community. Using these supports is part of life for most of us. It’s important you get to access them the same as everyone else.

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When it comes time to talk about what reasonable and necessary supports we can fund, you'll know how mainstream, community and informal supports can help you.

It's important we gather this information and help you access these services before we consider what reasonable and necessary supports we can fund. That way, we can help make sure you're able to access mainstream, community and informal supports wherever possible. This can help you become as independent as possible.

What are reasonable and necessary supports?

An NDIS support is the practical description of how you will be assisted under the NDIS.[1] Supports are the things we provide or fund to help to meet your disability support needs.

NDIS supports are the services, items and equipment we can fund or provide under the NDIS.

There are two types of NDIS supports. We call them 'general supports' and 'reasonable and necessary supports'.[2]

General supports

General supports are the coordination, strategic or referral services and activities we provide, or arrange to be provided, for you.[3] They're how we help you develop your NDIS plan and connect with supports and activities in your community. This includes your mainstream, community and informal supports. Learn more in Creating Your Plan.

Reasonable and necessary supports

Reasonable and necessary supports are the supports we fund in your plan to meet your disability support needs.[4] You can use this funding to buy supports from service providers.

The Australian Government made laws about what we can fund under the NDIS.[5] All supports we fund in a plan need to meet the criteria set out in these laws. We call these the NDIS funding criteria.[6]

To meet the NDIS funding criteria, a support must meet both the following criteria:[7]

- It must not be a type of support the law says we can't fund or provide.[8]
- It must meet the reasonable and necessary criteria.[9]

We call supports that meet the NDIS funding criteria 'reasonable and necessary supports'.

Each individual reasonable and necessary support in your plan must meet the NDIS funding criteria. Your whole plan as a package of supports must also meet the NDIS funding criteria.

We check your overall plan to make sure all your supports make sense together. This means we check that your supports and the amount of supports will complement each other to help you fulfil an ordinary life.[10]

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If you need a new support, which now means your overall package of supports doesn't meet the NDIS funding criteria anymore, we may either:

- not include the new support in your plan
- include the new support in your plan, but also reduce the other supports in your plan.

For example, a home modification may reduce your need for other supports. If we plan to fund a home modification, we will need to take that home modification into account when considering what other supports are reasonable and necessary, such as the amount of care you need at home.

What principles do we consider when we decide what supports to include in your plan?

As far as possible, we have to act according to principles set out in the law for the NDIS.[11] These are the things that guide us when we make decisions about what we fund.

These principles don't override or replace the NDIS funding criteria under the law for the NDIS. They can help us apply the funding criteria, by giving us additional guidance when we decide what supports to approve in your plan.

The principles include the following:

- You have the same right as other Australians to realise your potential for physical, social, emotional and intellectual development.[12]
- You should be supported to take part in and contribute to social and economic life as much as you can.[13]
- You should be supported to make choices about planning and how your supports will be delivered. This includes taking reasonable risks, so that you can pursue your goals.[14]
- You have the same right as other Australians to decide your own best interests. You have the right to be an equal partner in decisions that affect your life to the full extent of your ability.[15]
- Your privacy and dignity should be respected.[16]
- We must make sure the NDIS is financially sustainable.[17]

The principles also tell us that the reasonable and necessary supports we fund should:[18]

- support you to pursue your goals and maximise your independence

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- support you to live independently and to be included in the community as a fully participating citizen
- develop and support your capacity to do things that help you participate in the community and in employment.

Just because a support helps you do these things doesn't mean we'll fund it in your plan. All supports we fund need to meet **all** the NDIS funding criteria.

How do we think about an ordinary life when deciding what supports to include in your plan?

To help guide us in our decision making about reasonable and necessary supports, we took advice from the NDIS Independent Advisory Council.

The Council represents people with disability and carers, bringing their own lived experience and expertise of disability. They give us advice on how the NDIS should work.

The Council advised us that all Australians, including people with disability, should have an 'ordinary life'. They also told us we should think about the idea of an ordinary life when we apply our principles and use the NDIS funding criteria.

An ordinary life is a life where you have the same opportunities as people without a disability. An ordinary life is one that is typical or usual for everyone in modern day Australia. It's a life where you can pursue your potential and participate in society on an equal basis with others.

An ordinary life will be different for different people. We are all different, and come from different cultures and backgrounds. We each have our own values, experiences, beliefs and goals.

But there are some common things that can improve the quality of our lives and help us participate equally. These are the things, such as the following, that make up an ordinary life:

- Positive relationships – with families and informal support networks.
- Individual autonomy – being free and independent, and having the same opportunities as people without disability.
- Active involvement in decision-making – including the ability to make meaningful decisions, and exercise choice and control.
- Using your strengths in ways that provide a challenge and enjoyment.
- A sense of belonging – to our families, friendship networks, communities, workplaces and society.
- Active involvement and contribution to society and your community.

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An ‘ordinary life’ in the context of the NDIS involves supporting you to:

- have and maintain good relationships
- belong and participate in your community
- be involved in making choices about your own life.

One way we can help you have an ordinary life is to support you to access mainstream, community or informal supports wherever possible. These are the usual supports that everyone in the community uses.

When we fund reasonable and necessary supports under the NDIS, we need to make sure they meet the NDIS funding criteria.

When we apply the NDIS funding criteria and make decisions about reasonable and necessary supports, we’re guided by the principles in the law for the NDIS. We also consider how the supports will best help you to live an ordinary life.

How do we decide what reasonable and necessary supports to include in your plan?

What information do we consider to work out what reasonable and necessary supports to fund in your plan?

The most important information we gather about what supports to include in your plan comes from you.

When we create your plan, we will talk with you about:

- your goals and aspirations[19]
- your strengths, capacity and individual circumstances[20]
- any barriers, limitations and restrictions you face in undertaking activities or things that stop you from living an ‘ordinary life’[21]
- your disability support needs[22]
- any risks and safeguards we may need to think about when considering your support needs.[23]

We want to get a good understanding of your disability support needs. We encourage you to involve anyone in the planning process you want to help you.

Learn more about what information we ask for when we create Your Plan.

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We also consider other information we have such as medical or therapy reports, or assessments that you have had.[24]

We may also ask for further information and assessments, if we need them to help us work out your support needs.[25]

To help us work out what supports to consider for people aged 7 years and older, we also use a 'Typical Support Package'.[26] We worked with people with disability, professionals and subject matter experts to develop the Typical Support Package.

It helps us work out the types of supports we'd usually expect to include in your plan. It's based on your situation and support needs.

We then amend the supports suggested by the Typical Support Package to include more, less or different supports if we need to. We may adjust the funding for those supports up or down based on our discussion with you, any reports or other information we have, and when we apply the NDIS funding criteria.

For children younger than 7, we consider the child's current functioning across development areas when we work out the reasonable and necessary supports that should be funded in a child's NDIS plan. Learn more about the Early Childhood Early Intervention approach.

How do we consider your goals when we work out your reasonable and necessary supports?

When we create your plan, you set your goals and tell us what information about your life you want in your plan.[27] Your goals are your own personal desires about what you'd like to do.

You can set any goals you like, even if they're about things we won't fund supports for. You can also change your goals at any time.[28] We consider how your funded supports will help you pursue your goals when we decide to approve your plan.[29]

Reasonable and necessary supports should help you pursue your goals,[30] but you don't need a specific goal for every support in your plan. When we decide if a support will help you pursue your goals, we consider your whole situation.

We look at the disability specific barriers that prevent you from pursuing your goals, and how the support will address your disability support needs.

There are some things to remember when setting goals:

- Setting more and bigger goals doesn't mean we'll fund more and bigger funded supports.
- Setting a goal doesn't mean we have an obligation to fund supports that help you pursue that goal.

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- Setting a goal about an explicit type or amount of support you might want doesn't mean we have an obligation to fund that support or in that amount.

This is because helping you pursue your goals is only one of the NDIS funding criteria.[31] A support must meet all of the NDIS funding criteria to be funded under the NDIS. So not all supports that help you to pursue your goals will be reasonable and necessary supports.

Learn more about setting your goals and how we consider your goals under the NDIS funding criteria.

What if your plan is being reviewed?

If it's not your first plan, we also consider how well the supports funded in your previous plans worked for you.[32] This means we'll ask about how your current plan has worked for you.

This will help us decide whether these supports continue to meet your needs and the NDIS funding criteria. Learn more about plan reviews.

How do we use the information we have to work out what reasonable and necessary supports to fund?

We consider all the information we have gathered to decide what reasonable and necessary supports to fund in your plan.

We use the information you give us and follow the steps below:

- **Step 1**: Identify and describe the supports to be considered. The support will be described either generally (known as 'flexible' funding for supports) or specifically (known as 'stated supports' or 'fixed' supports).[33]
- **Step 2**: Work out if the support identified and described meets the NDIS funding criteria.
- **Step 3**: We include the supports that meet the NDIS funding criteria in your plan.

When we approve your plan we make sure all your supports meet the NDIS funding criteria individually and as a package of supports.[34]

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Step 1: How do we identify and describe a support in your plan?

The first step in deciding what reasonable and necessary supports we can fund is to properly identify and describe the support.[35] This is an important step. We need to be clear on exactly what support we're considering, before we can decide if the support meets the NDIS funding criteria in Step 2.

When we assess your support needs and identify what supports to consider in your plan, we use:

- the information you give us at your planning meeting
- any assessments or other information we have
- the Typical Support Package for people aged 7 years and older.

We identify a support as the service, item or equipment you need to help with your disability support needs. We think about:

- what the outcome of the support will be
- how the support helps with your disability
- whether the support meets the NDIS funding criteria.

How do we describe supports?

We can describe the supports in your plan as one of the following:

- **Flexible**: Under the law for the NDIS, this is when we describe the support generally. You have greater flexibility over what disability supports you can buy within the description of the support.[36]
- **Fixed**: Under the law for the NDIS, this is when we describe the support specifically. It means you must buy the support in the way we have described in your plan.[37] We sometimes call this a 'stated support'.[38]

You must act according to your plan, and buy supports according to how we described them in your plan. This means you can't use the funding in your plan to buy supports that fall outside the description of the support in your plan.[39]

So if we describe the support as fixed, you must comply with how we describe it. This includes how the support is provided. For example, we will sometimes require the support to be provided:

- by a particular service provider

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- by a particular qualified person
- through a particular delivery mode or method, or in a special way.

We describe most supports as flexible when we can. When supports are described as flexible, you will have greater flexibility over the support you can buy that falls within the description of the support in the plan. When supports are described as fixed, you will have less flexibility.

We divide your supports into 3 different budgets:

- **Core Supports** – supports for everyday activities
- **Capacity Building Supports** – supports to help you build your skills and increase your independence
- **Capital Supports** – supports such as assistive technology, vehicle modifications, home modifications and Specialist Disability Accommodation.

Each budget is divided into a number of support categories. Support categories have more detail about what supports you can buy with your funding. When we describe your supports as flexible, you can usually choose what supports you buy within the descriptions for each support category.

Your Core Supports budget is the most flexible. You can usually use your funding across all the support categories except transport in the Core Supports budget if:

- we described the supports as flexible
- you have the same plan management options for your Core Supports.

Learn more about the support budgets and support categories in your plan.

When we decide whether to describe supports as fixed or flexible, we consider:

- how much the support costs[40]
- if the support will help reduce the cost of supports over time,[41] for example providing more supports early so you don't need as many supports later in life
- any risks with supplying the support, for example if the support would create risks to your health and safety or if it doesn't comply with state or territory laws[42]
- if you need a particular support to pursue your goals or to use other supports in your plan effectively[43]
- if you need a specialist support, for example if your support must be delivered by a qualified person, or in a special way[44]
- if you were eligible for the NDIS under the early intervention criteria.[45]

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When do we describe supports as fixed?

We usually describe high-cost supports, or supports with more risk, as fixed. For example, we might describe supports as fixed if you need to use those particular supports to ensure your health and safety. This includes supports such as:

- high-cost assistive technology
- high-cost home modifications
- behaviour support, or supports that involve restrictive practices such as restraint
- Specialist Disability Accommodation.

We will also check if you were eligible for the NDIS through the early intervention criteria.[46] If so, we might decide to describe the supports as fixed for some types of early intervention supports.[47] If you're not sure whether you met the disability criteria or the early intervention criteria, check the letter we sent you when we decided you're eligible.

Example

John just received his first plan. His plan describes support for assistive technology as flexible, including $2,000 of funding. John can choose what assistive technology to buy with this funding. John talks to his occupational therapist about what assistive technology he should buy with this funding. For example, he could buy a shower chair, or low-cost items like a slip-resistant bathmat.

John's plan also has a fixed support for a wheelchair with special features, and funding of $8,000. John will need to use this funding for the specific wheelchair we listed on his plan. He can't use this funding for another support, like a shower chair, instead.

What if you need a specific provider to provide the support?

Sometimes your plan may say who must provide the support. We do this when you need a certain provider to make sure the supports are delivered safely, or to achieve a certain outcome.

For some supports, you must use an NDIS registered provider. These include:

- Specialist Behaviour Supports, if the provider will undertake a behaviour support assessment or develop a behaviour support plan[48]
- supports where it's likely a provider will need to use a regulated restricted practice,[49] either interim or ongoing
- Plan Management[50]
- Specialist Disability Accommodation.[51]

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You must use registered providers for these supports even if your plan doesn't say you need to. You must also use registered providers for these supports, even if you self-manage or plan-manage your funding. Learn more about the different plan management options.

For other supports, we'll decide that the support must be provided by a particular person, provider, or delivered in a certain way.[52] We'll do this if it's the most efficient and effective way to provide the support. This only happens when:

- we have an agreement with a particular provider to provide the support[53]
- we decide you must use an NDIS registered provider due to the risks, for example complex home modifications[54]
- you need support from a particular person with specialist qualifications, for example a health professional[55]
- you need support delivered in a certain way.[56]

Sometimes, we'll arrange the support ourselves, if it's more cost effective than getting another provider to deliver the support. For example, we may bulk buy a support.[57] If so, we will state this in your plan.

What about in-kind supports?

We agreed that state and territory governments will keep providing some supports for a period of time. We call these 'in-kind supports'.

If we fund in-kind supports like specialist school transport or personal care in schools, you will need to use state or territory government providers for these supports. These supports are most efficiently and effectively provided by state and territory government providers.[58] Learn more about Work and study supports.

For most other in-kind supports, you can choose your provider if you don't want to use your in-kind provider anymore. We can let you choose another provider if we consider that the support isn't most effectively and efficiently provided by the in-kind provider.

We usually let you choose another provider if:

- another provider can give you the same support or level of support as the in-kind provider
- the supports with the new provider still meet the NDIS funding criteria, including that they're value for money compared to the in-kind support
- there are no serious risks with changing providers.

Learn more about in-kind supports.

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Step 2: How do we work out if an identified and described support meets the NDIS funding criteria?

To meet the NDIS funding criteria, a support must meet both the following criteria:

- It must not be a type of support the law says we can't fund or provide.[59]
- It must meet the reasonable and necessary criteria.[60]

Each support must be reasonable and necessary individually, but the supports must also be reasonable and necessary when considered as a package of supports.

What types of supports can't be funded or provided under the NDIS?

Under the law for the NDIS, there are things we can't fund or provide.[61] We can't fund or provide supports that:

- are not legal[62]
- are income replacement[63]
- are likely to cause harm to you, or pose a risk to other people[64]
- are not related to your disability[65]
- relate to a 'day-to-day living cost', such as groceries, rent or utilities, that are not attributable to your disability support needs. These are costs that are not caused by or as a result of your disability support needs.[66]
- duplicate other supports provided by the NDIS under alternative funding.[67]

Is the support legal?

We can't fund a support if it does not comply with the law.[68] This includes both:

- **an Australian government law:** a law that applies to all of Australia
- **a State or Territory government law**: a law that only applies in your state or territory.

For example, we won't be able to fund supports involving:

- a restrictive practice where it's not authorised in your state or territory
- assistive technology or home modifications that don't meet Australian laws, such as State and Territory Acts and Regulations, the National Construction Code, and relevant Australian Standards
- supports for illegal activities, such as support for criminal behaviour or illegal drugs.

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While this is one of the NDIS funding criteria, we're not responsible for ensuring your supports are legal. We're not responsible to ensure that all supports in your plan comply with all the relevant legal and administrative requirements. This is your responsibility and your provider's responsibility.

For example, if a support is likely to require the use of a restrictive practice, the provider must be registered with the NDIS Quality and Safeguards Commission.[69] It's the provider's responsibility to ensure they are registered and comply with the conditions of their registration. This includes complying with all laws and seeking the necessary authorisations.[70]

We're not responsible for ensuring the provider is registered and complies with their conditions of registration. You can contact the NDIS Quality and Safeguards Commission if you're concerned about a provider's compliance with legal obligations.

Is the support 'income replacement'?

We don't fund income support or income replacement.[71] This means NDIS funding can't replace or add to money you'd usually earn from working, or income payments you get from Centrelink.

For more information and resources on income support, check out income support payments such as the Disability Support Pension.

If you are interested in getting help to find a job, check out Disability Employment Services or NDIS-funded Work and study supports.

Is the support likely to cause harm?

We can't fund any supports that are likely to either:[72]

- cause harm to you
- be a risk to other people.

We need to consider this for all supports, such as support workers, therapies or equipment. It also means we won't fund supports that involve a regulated restricted practice, such as restraint, unless it follows the requirements of the NDIS Quality and Safeguards Commission.

To help us decide if the support is likely to cause harm, we may need information from a professional. For example, you may need high cost assistive technology, like a powered wheelchair. If so, we would need a report from an occupational therapist to show that it'll be safe for you to use.

Of course everything we do in life comes with some risk. We all make our own choices about how much risk we want to take in our lives. You should also be able to choose how much risk you want to take in your life.

So we try to balance this when we decide what we can and can't fund. We can't fund things that are likely to cause harm. But we will try and balance this with enabling you to make your own choices wherever possible.

While this is one of the NDIS funding criteria, you also have some responsibilities. It's still your responsibility and your provider's responsibility to ensure the supports we fund are:

- used correctly
- safe for you
- safe for other people.

You and your provider will also need to manage any risks of harm that arise. For more information, contact the NDIS Quality and Safeguards Commission.

Is the support related to your disability?

We can't fund a support if it's not related to your disability.[73] This means there must be a direct link or a connection between your disability and the supports we fund.

We look at whether the support addresses your disability support needs. Your disability support needs are those that arise from, or are caused by, your disability.

For example, we wouldn't usually fund things like:

- standard televisions
- standard household furniture such as dining chairs
- upgrades to assistive technology and home modifications that are not related to disability needs, such as marble tiling or leather materials
- flights to go on a holiday
- a car to get to work because there are no public transport options
- a gym membership to get fit
- a swimming pool to relax in summer.

This is because you're unlikely to need these supports as a result of your disability support needs. They are things that all people, with or without disability, might want or need.

Usually, there won't be a direct link or connection between these things and your disability support needs. Having a disability doesn't usually affect whether someone needs or wants these types of things.

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Example

Alan needs some changes to his house, so he can use his bathroom and kitchen in his wheelchair. He also wants to set up an outdoor entertainment area for when his friends visit.

We may be able to fund home modifications so he can access areas of his home such as his bathroom or kitchen. He needs the home modifications because he can't access those areas due to his disability and needing to use a wheelchair. Alan needs the support because of his specific disability support needs.

Alan will need to pay for the outdoor entertainment area, as it's not related to his disability. He doesn't need the entertainment area because of his disability, it's just something he would like so he can have his friends over for a barbecue.

Is the support related to a 'day-to-day living cost'?

We can't fund supports related to day-to-day living costs that everyone has to pay, and aren't caused by or result from your disability support needs.[74] This means we don't fund things like:

- rent
- groceries
- utilities such as electricity, water, gas and internet bills
- the general cost of owning a home, like renovations, mortgage repayments, repairs and maintenance.

In some situations, we can fund supports related to your day-to-day living costs. We can do this if the costs are attributable to, or caused by, your disability support needs.[75] This means we may fund supports that relate to day-to-day living costs where either:

- you have additional living costs that are solely and directly as a result of your disability support needs[76]
- the living costs are connected to another support that is funded or provided in your plan, and you wouldn't incur that cost if it wasn't in your plan.[77]

Example

Nigel has a goal to do his grocery shopping on his own. He needs a shopping basket to attach to his wheelchair to help him carry the items in the supermarket.

Shopping bags and baskets are things we all pay for, whether or not we have a disability. But Nigel only needs this specialised basket for his wheelchair because of his disability support needs.

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If it meets the other NDIS funding criteria, we may fund the shopping basket attachment in his plan.

Does the support duplicate other supports funded through the NDIS?

We can't fund a support if it duplicates other supports delivered under alternative funding through the NDIS.[78]

For example, if we're providing support through your Early Childhood Partner or Local Area Coordinator, we usually won't fund Support Coordination in your plan.

This is because your Early Childhood Partner or Local Area Coordinator is already funded to provide similar supports. If we funded the same Support Coordination, we would be duplicating a support we're already providing you as general supports.

However if you need extra support, we may be able to fund additional Support Coordination in your plan. We may do this if it's above the amount of support your Early Childhood Partner or Local Area Coordinator are able to provide. Your Early Childhood Partner or Local Area Coordinator will work together with the Support Coordinator to help you connect with supports in your community.

Does the support meet the reasonable and necessary criteria?

All NDIS supports need to meet **all** the reasonable and necessary criteria.[79]

This means that before we can include an NDIS support in your plan, we need to be satisfied it meets all the following criteria:

- The support will assist you to pursue your goals in your plan.[80]
- The support will assist you to undertake activities, to facilitate your social and economic participation.[81] This means the support will help you to undertake activities, by reducing the disability-related barriers that prevent you from participating in things such as social outings, recreation, work and study.
- The support represents value for money in that the costs of the support are reasonable relative to both the benefits achieved and the cost of alternative supports.[82] This means we need to consider the costs and benefits of the support, as well as the costs and benefits of alternative supports.
- The support will be, or is likely to be, effective and beneficial for you, having regard to current good practice.[83] This means we consider if there is evidence the support works for someone with similar disability support needs. We won't need an expert report for every support, as we can often rely on other information or evidence. For example, we may have information already about whether the support is widely

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accepted to suit someone with your disability support needs.[84] We also consider your lived experience.

- The funding of the support takes account of what it is reasonable to expect families, carers, informal networks and the community to provide.[85] This means we need to consider what support is reasonable for your family, friends and community to provide.
- The support is most appropriately funded or provided through the NDIS, and is not more appropriately funded or provided through:[86]
  - other general systems of service delivery, or support services offered by a person, agency or body (for example, a State or Territory Statutory Scheme)
  - systems of service delivery or support services offered as part of a universal service obligation (for example, the health or education system)
  - systems of service delivery or support services offered in accordance with reasonable adjustments required under discrimination laws (for example, your employer, or the health or education system).

The law for the NDIS sets out things that we need to consider when we apply the reasonable and necessary criteria.[87]

We must be satisfied that each support is reasonable and necessary individually, but we must also be satisfied that the supports are reasonable and necessary as a package of supports.[88]

For example, a home modification may reduce your need for other supports. If we plan to fund a home modification, we will need to take that home modification into account when considering what other supports are reasonable and necessary, such as the amount of care you need at home.

If the home modification will reduce your care needs, we may need to reduce the amount of care we fund, as a higher amount may not be reasonable and necessary when the whole package of supports is considered.

Does the support help you pursue your goals?

We need to be satisfied that the support will help you pursue the goals, objectives and aspirations in your NDIS plan.[89] This helps us determine if the support is necessary.[90]

While we only fund supports that help you pursue your goals, objectives and aspirations, we understand that different people express themselves in different ways.

You are free to choose your own goals and express them in your own words.

Your goals can be big or small, short term or long term, simple or complex. They can be about anything you want to work towards.

You may express your goals broadly, or you may have specific goals. For example, you may express one of your goals as 'living independently'. Someone else may express their goal as 'to have an accessible bathroom'.

Learn more about setting your goals in Creating Your Plan and the Setting Goals fact sheet.

Reasonable and necessary supports should help you pursue your goals,[91] but you don't need a specific goal for every support in your plan. When we decide if a support will help you pursue your goals, we consider your whole situation.

We look at how a support will address your disability support needs, and the disability specific barriers that prevent you from pursuing your goals.

A support that addresses your disability related support needs is most likely to help you pursue your goals, objectives and aspirations in your plan.

Setting a goal in your plan doesn't mean we'll provide funding to pursue it. For example:

- setting more and bigger goals doesn't mean we have an obligation to fund more and bigger funded supports in your plan
- setting a goal doesn't mean we have an obligation to fund supports that help you pursue that goal
- setting a goal about an explicit type or amount of support you might want doesn't mean we'll fund that support or in that amount.

This is because helping you pursue your goals is only one of the NDIS funding criteria. A support must meet all of the NDIS funding criteria to be funded under the NDIS. So not all supports that help you to pursue your goals will be reasonable and necessary supports.

For example, we only fund reasonable and necessary supports that are value for money,[92] effective and beneficial[93] and relate to disability support needs.[94]

This means that if your goal is to 'live independently', we **may** fund home modifications that address your disability related needs. However, we won't fund supports related to day-to day-living costs like rent or utilities. These costs aren't incurred solely and directly as a result of your disability support needs, so they don't meet other funding criteria.[95]

Also, choosing a different goal 'to have a more accessible home' won't change the supports we could fund in your plan.

Achieving goals usually takes many different kinds of supports. NDIS supports will most likely be just one kind of support that helps you work toward your goals.

Learn more about setting goals.

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Example

Morgan is ready to look for work and she has a goal in her plan to get a job. She has built up her skills and knows what she wants to do. Disability Employment Services are helping Morgan to find work, so we can't fund this support for Morgan.

However, because of her disability, Morgan will need personal care supports to help her get up and ready for work in the morning. We will consider:

- how Morgan's disability support needs relate to her goals
- whether funding supports that address these disability support needs will help Morgan pursue her goals.

Morgan's planner believes the personal care supports meet this criteria. The supports that address her personal care needs will help Morgan to pursue her employment goals.

However, Morgan's planner then needs to look at whether the support meets the other NDIS funding criteria.

We don't fund all the supports that relate to Morgan's employment goals. We only fund the supports we consider are reasonable and necessary – that is, when they meet all the NDIS funding criteria.

Does the support help you do activities that will help your social and economic participation?

We need to be satisfied that the support will help you to do activities, which make it easier for you to participate socially and economically.[96]

Social participation means doing things you enjoy, like going out with friends, playing sport or going on holiday. It also means doing the things you need to do, like going to school or medical appointments.

Economic participation usually means being involved in things that help you work towards getting and keeping a job. This might be things like volunteering, study, learning new skills or trying work experience. Research tells us that work can lead to health benefits and improve our quality of life. Learn more about the Health Benefits of Good Work.

Social and economic participation are important to most people. They are critical to living an ordinary life.

To work out if a support meets this requirement, we look at the purpose of the support and how it will help you.

We fund reasonable and necessary supports that reduce the barriers that prevent you from undertaking activities. This will help you increase your social and economic participation.

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Some supports help economic and social participation directly. There are lots of supports we can fund to directly help with social and economic participation. Learn more about Social and recreation supports and Work and study supports.

Other supports help you to undertake activities like self-care, which indirectly help your economic and social participation.

Example

Sue is going to university next year. She has a vision impairment, and has been working with her Guide Dog Mobility Instructor to decide if a dog guide is right for her. A dog guide can help her leave her home safely and independently, and travel to and from university.

A dog guide could also help her go out with friends and join in other community activities. As long as it meets the other funding criteria, we could fund a dog guide for Sue. It will help her to undertake activities of daily living.

As a result, it'll increase her social and economic participation. For example, the support will help her get to her university so she can study, and will help her social life.

Is the support value for money?

All supports we fund under the NDIS need to be value for money.[97] This means the cost of the support is reasonable, when we consider the benefits of the support and the cost of other supports.

Making sure that your supports are value for money is one of the ways we keep the NDIS financially sustainable. This means we make careful decisions about funding so that we make sure the NDIS exists for future generations. It's also one of our principles.[98]

When we decide if the support is value for money, we consider:

- if other supports would achieve the same result at a substantially lower cost[99] – this means there should be a real or material difference in cost
- if there's evidence that the support will substantially improve your life stage outcomes and benefit you in the long term[100]
- if the support will likely reduce the cost of other supports over time[101]
- how the cost compares to other supports of the same kind in your area[102]
- if the support will make you more independent, and mean you won't need as many supports in future,[103] for example, in some circumstances home modifications may reduce the need for home care.

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When we consider the likely cost of supports, we consider the cost over the long term. We consider if the support will help you to achieve milestones at different ages or stages of your life, and have long term benefits.

For example, some supports such as home modifications may be expensive now, compared to other supports. But getting these supports now may mean you need much less support in a few years, or later in life. Or, it may delay the need for other more costly supports.[104]

When we determine the cost of the support, we consider:

- the prices for NDIS supports in the NDIS Price Guide
- supports suggested by the Typical Support Package
- quotes for specific or high risk supports.

It's important we consider the cost of the support. This will be the level of funding we include in your plan, if we decide the support is reasonable and necessary.

When we fund equipment or modifications, we also need to consider:[105]

- how the cost of buying the equipment or modifications compares against the cost of renting them
- if it's appropriate to fund the equipment or modifications you want, based on your circumstances and any expected changes in technology.

Learn more about how we consider value for money when we fund assistive technology, home modifications and vehicle modifications.

Example

Elias needs a shower commode.

He got an assessment and sent us a quote for one that will suit his needs. As part of the process to work out if we can fund it, his planner considers other similar shower commodes.

There's a second commode that's $5,000 cheaper than the one Elias has asked for. But it won't meet Elias' needs, as it won't provide enough back support. That is, it won't achieve the same result as the one Elias has asked for.

Finally, there's a third commode that's $1,000 cheaper. The planner contacts his occupational therapist who confirms the cheaper commode will meet Elias' needs.

Elias' planner decides to fund the commode that's $1,000 cheaper. It'll deliver the same result at a substantially lower cost.

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Is the support effective and beneficial?

We need to be satisfied that the support will be, or is likely to be, effective and beneficial, when we consider current good practice.

We need to work out if the support is likely to be both:

- **effective** – it will do what you need it to do[106]
- **beneficial** – the support will help you do things you can't otherwise do and meets your support needs.[107]

It can also be effective and beneficial if it will help you maintain your current level of functioning. That is, it will help you keep doing the things you can currently do. And, it'll help you maintain your work, study and social life as much as you can.[108]

When we decide if a support is effective and beneficial, we look at what is current good practice. This means we look at whether there is evidence that the support works for someone with similar disability support needs to you. We won't need an expert opinion or report for every support, as we can often rely on other evidence.

For example:

- We may have information already about whether the support is widely accepted to suit someone with your disability support needs.[109] For example, we could rely on academic research and other literature. This could include university studies on therapies that have been published and refereed in academic journals, evidence based practice resources, or clinical practice guidelines.
- If you or other participants have used the support before, we can consider your experience using the support and the experience of your family members and carers.[110]
- We may consider things we have learnt from other participants in the NDIS with similar support needs to you.[111]

We know you're the expert in your own life, and we use your own experience as much as we can.

For example, we will talk to you about any supports that have helped you do things you can't otherwise do. Or, some supports may have helped maintain your ability to be as independent as possible.

If it's a new support such as new assistive technology, we might fund a trial. This is so we can learn from your experience of using the support, to check if it's likely to do what you need it to.

Your evidence can be particularly useful when it's consistent with other evidence, or if we don't have expert evidence.

We will look at the opinions held by the majority of experts and what they generally agree on.[112] Sometimes we will have to seek expert opinion or report to make a decision.[113]

For example, we may need the views of doctors or health professionals who may be specialists in managing your disability.

Example

Vivek is 12 and has a goal to improve his communication skills. He and his family want him to improve his social skills with the kids in his class.

When he was younger, Vivek's family tried speech therapy, and believe it really helped him improve his communication. His family told his planner about how it helped Vivek learn how to respond to different social settings.

Vivek's speech therapist also believes it could work well for him now, and help him interact with his classmates.

When deciding whether the therapy is effective and beneficial, Vivek's planner will consider:

- how speech therapy has assisted Vivek in the past, including first-hand information from Vivek, his family members and carers
- the views of his speech therapist on the effectiveness and benefits of speech therapy for Vivek
- other information or expert evidence about the effectiveness and benefits of speech therapy, including for a child of the same age, and with the same impairments and functional capacity.

Based on this information and evidence, Vivek's planner decides the speech therapy is effective and beneficial. If it meets the other funding criteria, we will be able to fund speech therapy in Vivek's plan.

Is the support something we would reasonably expect your informal supports, like family or friends, to provide?

We need to be satisfied that funding the support takes into account what is reasonable to expect families, carers, informal networks and the community to provide.[114]

To make sure we understand how disability supports might work for you, we consider:

- the things you're able to do for yourself
- any support you have from others in your network – including family members, relatives, friends and local community services.

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When we fund supports under the NDIS, we have to think about whether it's reasonable to expect your informal supports to provide that support. We can't fund supports that an ordinary person would think is reasonable to expect friends, family or the community to provide for you.[115]

Informal supports are the help and support you get from friends, family and the community. They are called 'informal' because you don't pay for them, and they're not part of a formal agreement. They are the usual things friends and family do for us, and with us.

Most of us get some kind of help and support from friends and family. In our society, we expect that friends, family and our community will support each other and help each other out when they need it.

A good example is families who have young children. In our community, we expect families will provide most of the support a young child needs.[116] They will change a child's nappy, make sure they are safe and drive them around places.

Grandparents, uncles and aunties often have a role to play in supporting young children as well. Neighbours and friends might also help care for the child.

As a child gets older, our society's expectations of the role of the family and community in caring for the child changes. For example, we expect schools to help support the child's learning needs.

We also usually expect the role of family in providing personal care for a child would reduce as they get older and develop new skills and independence. But families are usually still responsible for things like food, emotional support, decision-making and providing a safe home.

It's a similar idea for adults. Our society expects that adults – like family, friends and neighbours – will provide some support to each other. This might be things like taking a friend with you to the football game, or providing emotional support if someone is upset.

NDIS supports won't ever replace the support people like your friends and family provide to you. This support is given freely because people care, and is often quite different to supports bought with NDIS funding.

You have a special bond with your friends and family that's different from your relationship with paid carers. And there are potential risks and problems for you if your friends and families become your paid carers.

To make sure we understand how disability supports might complement your circumstances, we consider:

- the things you are able to do for yourself

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- any support you have from others in your network including family members, relatives, friends and local community services.

We also have to consider the benefits you may get from your informal supports. For example, your family and friends may be more effective at helping you meet other people, or helping to build your social skills, than paid supports can.

We consider if we can help these relationships so that you get the support you need.[117] For example, we may be able to fund training for your informal supports, so they can help you build your skills.

We also think about the capacity of your informal supports to continue caring for you, for example if they're ageing or sick.

There are different things the law for the NDIS says we need to consider for adults and children.

If you're under 18, we consider what support is reasonable to expect parents to provide at your age. It's normal for parents to provide substantial care and support for children.[118] We consider that it's usual for parents to provide almost all the care and support that young children need.

For example, it's reasonable to expect parents to provide transport to and from their child's after-school activities. Of course, the amount of care and support for a child without a disability would typically reduce as they get older.

For children under 18, we consider:

- if your needs are 'substantially greater' because of your disability, compared to other children the same age[119] – that is, you need much more disability support
- any risks to the wellbeing of people providing informal support to you[120]
- if including funding for the support will help build your skills and capacity in the future, or reduce any risks to you.[121]

For example, we consider any health, safety or other impacts resulting from what's involved in meeting your disability support needs.

If you're over 18, we consider:

- if there are any risks to you or your informal supports if you rely on them to provide the support you need[122]
- how much your informal supports would help improve or reduce your independence and other outcomes[123]

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We also consider the suitability of informal supports to provide the supports you need,[124] including:

- how old your carers are and their capacity to provide the support[125]
- if other family members and the community can help your informal supports in their caring role[126]
- the intensity and type of support you need, and if it's appropriate for your informal supports to provide this, based on their age and gender[127]
- any long-term risks to the wellbeing of your informal supports.[128]

When we consider the risks for people over 18, we consider if the supports are sustainable for your informal supports. We consider the health, safety and other impacts on family and carers in the long term.

For example, we wouldn't expect a child to have their schooling affected because they need to provide care. We also wouldn't expect an elderly parent to be responsible for physical activities, if it may result in injury.[129]

We generally don't fund family members to provide supports funded under the NDIS. There are very limited situations where we can consider this. Learn more about Sustaining Informal Supports.

Example 1

Simon is getting his first NDIS plan. For the last 15 years, Simon and his wife Jan's preference was that Jan provide all the physical support he needs at home, such as toileting and showering.

But as Jan is getting older, it's not safe for her to keep lifting Simon. It's becoming risky for her to keep providing this support.

Jan and Simon think it might be best for someone else to provide the personal care support that Simon needs. Their children have moved out of home, and it's not reasonable to expect them to help Simon with personal care.

Based on this information and other evidence, Simon's planner decides that the personal care support meets this criteria. It takes into account what is reasonable for his family and others to provide. If the personal care support meets the other funding criteria, we may fund the personal care support for Simon.

Simon and Jan still prefer Jan to do the other support Simon needs though, such as helping Simon eat his meals. At this time, we wouldn't fund a support worker in Simon's plan to help him eat his meals. It's reasonable to expect Jan to help Simon with this, as it's what they want to do and it's not a safety risk for Jan.

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Example 2

Qing is 14 and wants to join a local footy club. Like most 14 year olds in this situation, she needs someone to drop her off and pick her up from the Saturday matches and the weeknight training sessions.

But unlike most 14 year olds, she needs someone to help her get dressed before she can go to the match. Her parents have been doing this, but as Qing is getting older she no longer wants her family to help her get dressed.

It's reasonable to expect her family or other informal supports to drop Qing to and from the match and training sessions. So we wouldn't fund transport in Qing's plan.

But at age 14, it's not reasonable to expect her family to help her get dressed.

Based on this information and other evidence, Qing's planner finds that the personal care support takes into account what is reasonable for family and others to provide. If it meets the other funding criteria, we may fund personal care support in her plan.

Is the support more appropriately funded or provided through the NDIS, and not through other service systems or support services?

We have to be satisfied that the support is most appropriately funded or provided through the NDIS. This means it's not more appropriately funded or provided through:

- other general systems of service delivery, or support services offered by a person, agency or body (such as a State or Territory Statutory Scheme)
- systems of service delivery or support services offered as part of a universal service obligation (such as the health or education system)
- systems of service delivery or support services offered in accordance with reasonable adjustments required under discrimination laws (such as your employer, or the health or education system).[130]

In short, we won't fund the support if it should be provided by someone else.

We won't fund the support if the support should be provided by someone else, even if the other service system doesn't actually provide it. We're not the funder of last resort, so we don't make up for other organisations and systems that don't provide the supports they should.

The law for the NDIS sets out a number of things we need to consider, when we decide who is most appropriate to fund or provide of the support.[131] There are different things we consider for the following service systems:

(a) Health

(b) Mental health

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(c) Child protection and family support

(d) Early childhood development

(e) School education

(f) Higher education and vocational education and training

(g) Employment

(h) Housing and community infrastructure

(i) Transport

(j) Justice.

How does the NDIS work with other government services?

We call supports provided by other government services, including those provided as part of a universal service obligation, 'mainstream supports'. When we talk about mainstream supports, we mean supports available to everyone in your state or territory, or across Australia, regardless of whether or not you have a disability.

This includes services provided by state and federal governments, like health care, education and mental health services.

You have the same right as all Australians to access these services. There are certain things that mainstream services have to do to make their services accessible for people with disability. Using mainstream supports can also help you be part of your community, or to work or study.

When we fund NDIS supports, we need to check that the support is not more appropriately funded or provided by a mainstream service or system, such as the education system or health system.[132] Under the law for the NDIS, we can't fund supports that should be provided by a mainstream service.

The Australian federal, state and territory governments agreed on responsibilities for funding different types of supports. The law for the NDIS has an outline of funding responsibilities and were developed with the agreement of each State and Territory.[133]

We can only fund supports that are the responsibility of the NDIS. We can't fund supports that are the responsibility of other government services, even if they don't actually fund or provide the support. The law for the NDIS sets out the matters we should consider when we decide who is more appropriate to provide or fund a support.[134]

Learn more about how we decide if the support is best funded or provided by us or another part of government.

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The Applied Principles and Tables of Support also has information on what the governments agreed are the responsibilities of the NDIS and other government services. However, it doesn't override what we consider when we decide if the support is most appropriately funded by the NDIS.[135]

What is reasonable adjustment and why is it important?

People with a disability can sometimes face barriers that make it harder to do the same things as people who don't have a disability. For example, it might be harder to find and keep a job. Or it might be harder to get in and around places, or to get the same services as other people.

It's against the law to discriminate against people with a disability in many areas.[136] This includes in employment, when providing goods and services, and when accessing public places.

This means organisations or people who are responsible for providing these services have to make what are called 'reasonable adjustments'. They have to make sure people with a disability have equal access to the services they provide, as far as is reasonable.

They have to do reasonable things that will make their services equally available to everyone, whether or not you have a disability.

Reasonable adjustments do not mean they have to provide everything you need because of your disability. It means they have to do what's reasonable to make sure you have equal access to employment, public spaces or services. This takes into account what they can afford to do and what is reasonable to expect them to provide in the circumstances.

When we decide what supports to include in your plan, we need to consider what should be provided through reasonable adjustments. Under the law for the NDIS, we can't fund a support if it should be provided by someone else through reasonable adjustments.

What if you're transitioning to the NDIS in Western Australia?

The federal and Western Australian governments made a commitment for people receiving supports before becoming a participant in the NDIS.

They committed that you shouldn't be disadvantaged by your transition to the NDIS. We call this the 'principle of no disadvantage'.

When we create your plan, we must use our best endeavours to follow government agreements.[137] This doesn't mean you'll always have the same level of funding, or that you'll get supports in the same way.

All supports we fund must meet all the NDIS funding criteria. So we may not be able to fund supports you received before the NDIS, if they don't meet the funding criteria.

If we can't fund those supports, we'll see how we can help you meet the same outcomes as you did before the NDIS.

This may mean we include other supports in your plan that address your disability support needs and help you pursue your goals. Or, we could help you connect with other government services that can provide the supports you received before the NDIS.

When we create your plan, we consider whether or not you're disadvantaged overall by joining the NDIS.

What else do you need to know about working out if supports meet the NDIS funding criteria?

From our experience, we learned there are some common misunderstandings about how we work out what supports meet the NDIS funding criteria.

Why don't we always fund what your health professionals recommend?

Although we take expert opinions into account, we can't and don't always fund everything your health professional might recommend. This is because every support we fund needs to meet all the NDIS funding criteria.

For example, your therapist might recommend a piece of equipment on the basis that it will be 'effective and beneficial' for you. But if there is something cheaper that will achieve the same outcome, we won't be able to fund what the therapist recommended.

This is because it won't be value for money. We may be able to fund the cheaper option instead if it meets all the NDIS funding criteria.

Why don't we fund the same supports as your last plan?

We might fund different supports in your next plan. This is because we will fund supports in your plan based on how we use the NDIS funding criteria at that point in time.

Your needs and situation will most likely change over time. This means it's likely your NDIS supports and funding for those supports will change over time.

For example, we may have funded supports to help you build your skills in a particular area. Once you have built those skills, you won't need funding for that any more. So, we probably won't include that funding for those supports in your next plan.

Supports to build your skills may have met the NDIS funding criteria before, but the same supports might not meet the criteria in future.

Or, your disability support needs might increase or decrease over time. This may mean we consider funding more or less supports as a result.

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What happens if you don't use all your funding in your NDIS plan?

We will consider how you have used your NDIS funding to help us work out what supports meet the NDIS funding criteria in your next plans.

If you haven't used all the funding by the end of your plan, it doesn't mean we'll reduce the funding in your next plan. There may be very good reasons why you weren't able to buy the supports we funded.

When we review your plan, we'll talk about any problems you had buying the supports funded in your plan. We'll also see how we can help you use your funding if we need to.

But if you consistently don't buy all the supports we fund and use all of your NDIS funding, we need to think about whether the supports really do meet the NDIS funding criteria. For example, they may not be 'effective and beneficial' for you if you're not actually using them. We will talk to you about this when we review your plan.

Learn more about plan reviews.

Step 3: How do we include the reasonable and necessary supports in your plan?

Once we've identified the supports, and decided they meet the NDIS funding criteria, we can include the description and funding for the support in your plan.

If the support doesn't meet the NDIS funding criteria, we can't include the support in your plan. We may consider if a differently described support meets the NDIS funding criteria instead.

When we approve your plan we will also make sure all your supports are reasonable and necessary when considered as a package of supports.[138]

Sometimes you might not need any supports under the NDIS. For example, your informal supports may meet all your disability support needs. If so, we'll approve a plan with no funded supports.

Learn more about how we create and approve your plan.

Learn more about using the funding in your plan.

What happens if we don't include the supports you want?

If we decide a support doesn't meet the NDIS funding criteria, we can't include the support in your plan. Also, if the amount of support you want doesn't meet the criteria, we can't include that amount in your plan.

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But, we're committed to our principles and helping you live an ordinary life. Even if we can't fund a particular support we may still be able to help.

If the support doesn't meet the NDIS funding criteria, we can consider if a different support meets the NDIS funding criteria. We might be able to consider describing the support differently, or funding a different type of support.

Or, we may be able to connect you to mainstream or community supports that can help. Mainstream and community supports are available to everyone. They can be a good way to connect with your local community, learn new skills and gain independence.

There are lots of ways we might be able to help, so talk to us if you're in this situation. We can do this at any time. We may be able to help before we approve your plan.

We can also give you reasons for our decision to approve your plan. We can put these reasons in writing. You can always contact us.

If you don't agree with the supports we approve in your plan, you can also request an internal review of our decision. Learn more about internal and external review of decisions.

Reference list

[1] *McGarrigle v National Disability Insurance Agency* (2017) 252 FCR 121 at [88].
[2] NDIS Act ss 33(2)(a), 33(2)(b), 33(5)(c), 34.
[3] NDIS Act ss 13, 33(2)(a).
[4] NDIS Act ss 33(2)(b), 34.
[5] NDIS Act and delegated legislation made under the NDIS Act, especially NDIS (Supports for Participants) Rules and NDIS (Plan Management) Rules.
[6] NDIS Act ss 33(2)(b), 34; NDIS (Supports for Participants) Rules.
[7] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules r 5.3.
[8] NDIS (Supports for Participants) Rules pt 5.
[9] NDIS Act s 34(1).
[10] NDIS (Supports for Participants) Rules r 2.4; NDIS Act s 33(5)(c).
[11] NDIS Act ss 4, 31.
[12] NDIS Act s 4(1).
[13] NDIS Act s 4(2).
[14] NDIS Act s 4(4).
[15] NDIS Act s 4(8).
[16] NDIS Act s 4(10).
[17] NDIS Act s 4(17).
[18] NDIS Act s 4(11).
[19] NDIS Act s 33(5)(a); NDIS (Supports for Participants) Rules r 4.1(a).
[20] NDIS (Supports for Participants) Rules r 4.1(a).
[21] NDIS (Supports for Participants) Rules r 4.1(b).
[22] NDIS (Supports for Participants) Rules rr 4.1(b), (d).
[23] NDIS (Supports for Participants) Rules r 4.1(c).
[24] NDIS Act s 33(5)(b).
[25] NDIS Act ss 36, 50.
[26] NDIS (Supports for Participants) Rules rr 4.2-4.6.
[27] NDIS Act s 33(1).
[28] NDIS Act s 47(1).

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[29] NDIS (Supports for Participants) Rules r 4.1(d).
[30] NDIS Act s 34(1)(a).
[31] NDIS Act s 34(1)(a).
[32] NDIS Act s 33(5)(f).
[33] NDIS Act s 33(3) and NDIS (Plan Management) Rules.
[34] NDIS Act s 33(5)(c).
[35] NDIS Act s 33(3).
[36] NDIS Act s 33(3); NDIS (Plan Management) Rules r 6.2.
[37] NDIS Act s 33(3); (NDIS (Plan Management) Rules r 6.3.
[38] NDIS (Plan Management) Rules pt 6.
[39] NDIS Act s 46(1).
[40] NDIS Act (Plan Management) Rules r 6.4(a).
[41] NDIS (Plan Management) Rules r 6.4(b).
[42] NDIS (Plan Management) Rules r 6.4(c).
[43] NDIS (Plan Management) Rules r 6.4(d).
[44] NDIS (Plan Management) Rules r 6.4(e).
[45] NDIS (Plan Management) Rules r 6.4(f).
[46] NDIS (Plan Management) Rules r 6.4(f).
[47] NDIS (Plan Management) Rules r 6.4(f).
[48] NDIS (Provider Registration and Practice Standards) Rules r 7(3).
[49] NDIS (Provider Registration and Practice Standards) Rules r 7(2).
[50] NDIS Act s 42(2)(b).
[51] NDIS (Provider Registration and Practice Standards) Rules r 7(1).
[52] NDIS (Plan Management) Rules rr 6.6-6.7.
[53] NDIS (Plan Management) Rules r 6.6.
[54] NDIS (Plan Management) Rules r 6.7.
[55] NDIS (Plan Management) Rules r 6.7.
[56] NDIS (Plan Management) Rules r 6.7.
[57] NDIS (Plan Management) Rules r 6.5.
[58] NDIS (Plan Management) Rules r 6.6.
[59] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules pt 5.
[60] NDIS Act s 34(1).
[61] NDIS (Supports for Participants) Rules r 5.
[62] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules r 5.3(a).
[63] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules r 5.3(b).
[64] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(a).
[65] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(b).
[66] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(d).
[67] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(c).
[68] NDIS (Supports for Participants) Rules r 5.3(a).
[69] NDIS (Provider Registration and Practice Standards) Rules 2018 r 7(2).
[70] NDIS Act s 73F(2)(a).
[71] NDIS (Supports for Participants) Rules r 5.3(b).
[72] NDIS (Supports for Participants) Rules r 5.1(a).
[73] NDIS (Supports for Participants) Rules r 5.1(b).
[74] NDIS (Supports for Participants) Rules r 5.1(d).
[75] NDIS (Supports for Participants) Rules r 5.1(d).
[76] NDIS (Supports for Participants) Rules r 5.2(a).
[77] NDIS (Supports for Participants) Rules r 5.2(b).
[78] NDIS (Supports for Participants) Rules r 5.1(c).
[79] NDIS Act ss 33(5)(c), 34(1).
[80] NDIS Act s 34(1)(a).
[81] NDIS Act s 34(1)(b).
[82] NDIS Act s 34(1)(c).
[83] NDIS Act s 34(1)(d).
[84] NDIS (Supports for Participants) Rules r 3.2(a).

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[85] NDIS Act s 34(1)(e).
[86] NDIS Act s 34(1)(f).
[87] NDIS (Supports for Participants) Rules pts 3, 4.
[88] NDIS Act s 33(5)(c).
[89] NDIS Act s 34(1)(a).
[90] *McGarrigle v National Disability Insurance Agency* (2017) 252 FCR 121 at [91].
[91] NDIS Act s 34(1)(a).
[92] NDIS Act s 34(1)(c).
[93] NDIS Act s 34(1)(d).
[94] NDIS (Supports for Participants) Rules r 5.1(b).
[95] NDIS (Supports for Participants) Rules r 5.1(d).
[96] NDIS Act s 34(1)(b).
[97] NDIS Act s 34(1)(c).
[98] NDIS Act ss 3(3)(b), 4(17)(b).
[99] NDIS (Supports for Participants) Rules r 3.1(a).
[100] NDIS (Supports for Participants) Rules r 3.1(b).
[101] NDIS (Supports for Participants) Rules r 3.1(c).
[102] NDIS (Supports for Participants) Rules r 3.1(e).
[103] NDIS (Supports for Participants) Rules r 3.1(f).
[104] NDIS (Supports for Participants) Rules r 3.1(c).
[105] NDIS (Supports for Participants) Rules r 3.1(d).
[106] McCutcheon and NDIA [2015] AATA 624 at [34].
[107] McCutcheon and NDIA [2015] AATA 624 at [34].
[108] McCutcheon and NDIA [2015] AATA 624.
[109] NDIS (Supports for Participants) Rules r 3.2(a).
[110] NDIS (Supports for Participants) Rules r 3.2(b).
[111] NDIS (Supports for Participants) Rules r 3.2(c).
[112] NDIS (Supports for Participants) Rules r 3.3.
[113] NDIS (Supports for Participants) Rules r 3.3.
[114] NDIS Act s 34(1)(e).
[115] NDIS Act s 34(1)(e).
[116] NDIS (Supports for Participants) Rules r 3.4(a)(i).
[117] NDIS (Supports for Participants) Rules r 3.4(c).
[118] NDIS (Supports for Participants) Rules r 3.4(a)(i).
[119] NDIS (Supports for Participants) Rules r 3.4(a)(ii); JQJT and National Disability Insurance Agency [2016] AATA 478 at [39].
[120] NDIS (Supports for Participants) Rules r 3.4(a)(iii).
[121] NDIS (Supports for Participants) Rules r 3.4(a)(iv).
[122] NDIS (Supports for Participants) Rules rr 3.4(b)(i), (ii).
[123] NDIS (Supports for Participants) Rules r 3.4(b)(iii).
[124] NDIS (Supports for Participants) Rules r 3.4(b)(ii).
[125] NDIS (Supports for Participants) Rules r 3.4(b)(ii).
[126] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(A).
[127] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(B).
[128] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(C).
[129] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(C).
[130] NDIS Act s 34(1)(f).
[131] NDIS (Supports for Participants) Rules rr 3.5-3.7 and Schedule 1.
[132] NDIS Act s 34(1)(f).
[133] NDIS (Supports for Participants) Rules rr 3.5-3.7, Schedule 1; NDIS Act ss 209(4), (8) item 1.
[134] NDIS (Supports for Participants) Rules rr 3.5-3.7, Schedule 1.
[135] NDIS (Supports for Participants) Rules rr 3.5-3.7, Schedule 1.
[136] Disability Discrimination Act 1992 (Cth); Discrimination Act 1991 (ACT); Anti-Discrimination Act 1977 (NSW); Anti-Discrimination Act 1996 (NT); Anti-Discrimination Act 1991 (Qld); Equal Opportunity Act 1984 (SA); Anti-Discrimination Act 1998 (Tas); Equal Opportunity Act 2010 (Vic); Equal Opportunity Act 1984 (WA).
[137] NDIS Act s 118(2).

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[138] NDIS Act s 33(5)(c).

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Reasonable and Necessary Supports

Quick summary: The Australian Government made laws about what we can fund under the NDIS. All supports need to meet the criteria in these laws before we can fund them in your plan. We call these the NDIS funding criteria. For example, supports need to be related to your disability, value for money, effective and beneficial, and most appropriately funded or provided by us. Each support must meet these criteria individually, but the supports must also meet the criteria when considered as a package.

What's on this page?

This page covers:

- What principles do we follow to create your plan?
- What supports can you get?
- What other principles do we consider when we decide what supports to include in your plan?
- How do we decide what reasonable and necessary supports to include in your plan?
- Step 1: How do we identify and describe a support in your plan?
- Step 2: How do we work out if an identified and described support meets the NDIS funding criteria?
- Step 3: How do we include the reasonable and necessary supports in your plan?

You may also be interested in:

- Mainstream Supports
- Creating Your Plan
- Reviewing Your Plan
- Reviews of Decisions
- Would we fund it?

What principles do we follow to create your plan?

The NDIS was set up as a world first approach to disability support. It puts people with disability at the centre of decision-making, through the principles of reasonable and necessary supports and individual choice and control.

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As an insurance-based scheme, we take a lifetime approach to a participant's support needs. We provide assurance to people with permanent and significant disability or developmental delay, and to people who might acquire disability or developmental delay, that they will get the support they need. Individual funding means we help participants to purchase services and supports from a competitive and consumer-driven marketplace.

What supports can we fund?

NDIS supports should complement, not replace, other supports available to you. That's why we consider:

- the things you're able to do for yourself
- support you have from others in your network, including family members, relatives, friends, local community services and mainstream government services.

One of our aims is to help maximise your independence by working with the local mainstream government and community services that help you live an ordinary life. We all do best when we're connected to our communities.

And as an active consumer, it's important you are able to shop for and access providers who meet your needs. We can help you find providers who meet your needs.

Once we've considered your circumstances, we need to follow the rules determined under the law for the NDIS in our planning decisions.[1] We fund supports that are reasonable and necessary. This means we will only fund a support if it meets **all** of the following criteria:

- the support is related to your disability[2]
- the support will help you pursue your goals and aspirations[3]
- the support will help you undertake activities that will increase your social and economic participation[4]
- the support is value for money,[5] which means that the costs are reasonable:
  - when compared to the benefits to be achieved, for example, whether purchasing the support is likely to reduce the cost of funding other supports in the long term[6]
  - when compared to alternative options that may provide you with the same outcome at a similar or cheaper cost[7]
- the support is likely to be effective and beneficial for you, having regard to good practice and evidence[8]

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- the support is required to complement the informal supports you have available, by taking into account what is reasonable for families, carers, informal networks and the community to provide[9]
- the support is most appropriately funded or provided by the NDIS[10]
- the support is not more appropriately funded by another service system, agency, person or body, such as the education system or the health system.[11] We can't fund a support if it's the responsibility of another service system.

What supports don't we fund?

We do not fund a support if:[12]

- it is likely to **cause harm** to you or others[13]
- it is **not related** to your disability[14]
- it **duplicates** other supports delivered by the NDIS[15]
- it is considered **a day-to-day living cost** (for example, rent, groceries or utility costs like your water bill) that are **not attributable or caused by** your disability support needs[16]
- providing the support would be **against the law**[17]
- it consists of **income replacement**[18]
- it is the **responsibility of other service systems** to provide (for example, your state government, the education system, or the health system).[19] These different systems have different responsibilities, and are designed to complement each other to form a government safety net. Like all Australians, NDIS participants continue to have access to these systems. We can't fund a support if it's the responsibility of another service.

How do we manage the financial sustainability of the NDIS?

The NDIS is an insurance scheme, and one of our core functions is to manage the financial sustainability of the Scheme.[20]

When we make decisions about the supports we fund in your plan, we must also consider our need to ensure the **financial sustainability of the NDIS**.[21] This means we must work within our funding budget, set through agreements between the Australian, and State and Territory governments.

It's also important to know the NDIS is only one part of the broader National Disability Strategy that supports people living with disability. The overall success and sustainability of the National Disability Strategy relies on:

- people accessing their informal support network to get the help they need from day to day
- people using their personal income to pay for their day to day living expenses, as is expected of all Australians
- mainstream and community services being available from state and territory governments, and other federal government programs such as Medicare
- a fair distribution of NDIS supports to those who need them, provided within our funding budget.

Staying within our budget ensures the NDIS will be here to support generations of Australians and their families.

What principles do we use to create your plan?

We use the following 7 principles, to create plans that help you get the reasonable and necessary supports you need, and to make sure the Scheme is financially sustainable:

- Fair for everyone, both today and for future generations
- Fair funding to pursue your goals
- Evidence-based best practice
- Fair early investments
- Fair support across service systems
- Fair supports for your disability needs
- Fair assistance from multiple programs

Fair for everyone, both today and for future generations

While we need to consider your individual circumstances and disability needs, we also need to make consistent decisions and treat people fairly.

This means participants with similar circumstances and disability needs should receive similar amounts of supports in their plans. We also need to ensure the total cost of all participant plans are within the overall NDIS budget set by governments.

We use Typical Support Packages to help us do this. The Typical Support Package give us an indication of what supports we'd usually expect to include in your plan, based on your situation and disability support needs.

Each support in your plan must be reasonable and necessary, but they also need to be reasonable and necessary as a package of supports. We approve your whole plan, not the individual supports in your plan in isolation.[22] The Typical Support Package helps guide this validation process.

The Typical Support Package also helps to guide the consistency of our decision making process. We use these to check your overall plan to make sure that all your supports make sense together, and that your support types and amounts will complement each other to help you fulfil an ordinary life.

We may then increase or decrease the funding in your plan based on:

- our discussion with you
- any reports or other information we have
- applying the NDIS funding criteria.

This helps keep the system fair for everyone, and ensure we remain financially sustainable.

Fair funding to pursue your goals

Goals are important.[23] The supports we fund need to help you increase your independence and pursue your goals.[24] This means your supports should help overcome any disability-specific barriers which may be stopping you pursuing your goals.

This doesn't mean we fund all support costs associated with you pursuing your goals. Also, you may have goals and aspirations we can't fund supports for. This is because helping you pursue your goals is only one of the NDIS funding criteria, so not all supports that help you to pursue your goals will be reasonable and necessary.

Other things to know about when setting your goals:

1. **Setting more goals or bigger goals doesn't mean we'll provide more funding or fund more supports.** For example, if your goal is to live independently in a house with a swimming pool, we may fund home modifications that address your disability related needs. This might be a home modification to make your bathroom accessible.

   We won't fund the swimming pool because this isn't related to your disability support needs. The funding in your plan might be similar to someone else who has a goal of 'to have a more accessible bathroom'.

2. **Setting a goal doesn't mean we have an obligation to fund supports that help you pursue that goal.** For example, if your goal is to get a gym membership to get fit,

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we wouldn't usually fund this. Gym memberships are things that all people, with or without disability, might want or need.

3. **Setting a goal about an explicit type or amount of support you might want doesn't mean we have an obligation to fund that support or provide that amount of funding.** For example, you may tell us your goal is 'to get a top model shower commode' and you show us the one you want costs $4,000.

   If there is a shower commode that costs $3,000, and your occupational therapist confirms this one will meet your needs, we are more likely to fund this one instead because it is likely to deliver the same result at a lower cost. We may also look at alternatives.

Evidence-based best practice

We only fund supports that will be, or are likely to be, effective and beneficial for you, having regard to current good practice.[25] This means we consider if there is evidence that the support is effective and beneficial for someone with similar disability support needs.

We will consider different types of evidence when making decisions and we won't need an expert report for every support, as we can often rely on other information or evidence.

For example, we may already have information about whether the support is widely accepted to suit someone with your disability support needs.[26] The primary source of evidence we rely on, and give the greatest weight to, is evidence from sources that are reliable and widely-recognised. This includes published and refereed literature, and any consensus of expert opinions. If there is no evidence to show a support is reasonable and necessary,[27] we won't fund the support.

You can find the types of evidence we need on our website, and in Our Guidelines.

Fair early investments

Having access to capacity-building supports early in your NDIS journey is considered to be an early investment. This early investment is intended to help increase your independence, and reduce your reliance on NDIS funding over time.

This is an important concept that we consider when we create your plan, and again at future plan reviews. When we review your plan, we reassess all the supports you require to meet your disability support needs at that time.

Over time, your capacity building supports may no longer be reasonable and necessary, in regard to your current functional capacity, the effectiveness of the capacity building supports,[28] and value for money.[29]

If your overall funding level goes down from one plan to the next, it may be because you no longer need the same type or amount of supports, such as capacity building supports. Also,

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if the capacity building investment has been successful at building your independence, then your need for other supports may also decrease, for example core supports.

So other things being equal, you should expect your overall plan value to reduce over time as the benefits of capacity building are realised.

Fair support across service systems

The support you need may be the responsibility of another government service, such as education or health. We don't fund these services, and need to consider the supports you should receive from these services when determining the supports in your plan.

Fair supports for your disability needs

When we make decisions about which supports we can fund, we consider whether a support is reasonable and necessary for you and apply the NDIS funding criteria. Sometimes, you might ask for supports to help with impairments that were not part of your Access eligibility assessment. When this happens, we need to make sure the support will help you address needs that arise from an impairment that meets the same eligibility criteria we consider at Access.

You don't need to make a new Access request if you ask for supports to help with an impairment that was not part of your Access eligibility assessment. We will work out if you need the support you have asked for to address an impairment that would meet our Access criteria. We may ask you to provide evidence to help us work this out. We will decide if the requested support is reasonable and necessary. We will apply the NDIS funding criteria based on the impairments that would meet our Access criteria.

By funding the right disability supports for your permanent impairments that meet our Access criteria, we are ensuring the system is fair for everyone, and that the NDIS remains financially sustainable.

Fair assistance from multiple programs

NDIS funding can't duplicate other funding or supports you may receive due to your disability.

For example, you may have received a lump-sum payment or receive regular payments as a form of compensation for an accident. Or, you may be receiving ongoing supports from another program or insurance scheme, for example, Worksafe or the Transport Accident Commission.

We don't duplicate this funding or these supports. We may reduce the total value of your NDIS plan to account for compensation you receive, or we may not fund certain supports.

What supports can you get?

When we create your plan with you, we'll discuss what supports you need for your disability. We want to help you pursue your goals, increase your independence, and help you work, study and join social activities.

There are many supports you can get outside the NDIS. Other government and community services provide supports to all Australians, including people with disability. And your friends, family, and other people you know can often be your best supports.

We can fund supports you need for your disability, if they meet certain criteria. These are called 'reasonable and necessary supports'. Your plan and supports will be just for you, so you have more choice and control over how you use them.

This guideline explains how we decide what reasonable and necessary supports we'll include in your plan. There are lots of things we have to consider, which we'll explain in detail.

We also have a Would we fund it guide. It has examples of how we decide whether we fund different types of NDIS supports.

What supports can you get outside the NDIS?

Before we decide what reasonable and necessary supports to fund in your NDIS plan, we'll first discuss what other supports may be available outside the NDIS. This is an important information-gathering step. For example, there may be mainstream, community and informal supports that suit you.

Mainstream supports are other government services such as employment, education, health and family support services. They are often really helpful, and are available to everyone including people without disability. There are many ways they can help you learn new skills or live as independently as possible.

Community services offer a wide range of supports that may help with your disability support needs. Community supports are things open to everyone in the community, like sporting clubs, community colleges, activity groups, libraries or community gardens. They are often a great way to get involved in your local community, meet new people and learn new skills.

Informal supports, like your family, friends and other people you know in your community, can sometimes be your best supports. They know you and can often help in ways other supports can't.

Your planner, Local Area Coordinator or Early Childhood Partner will talk with you about what services are available for you outside the NDIS. We can also help link you with these supports, so you don't have to do it all on your own.

Accessing these supports is a good way to work toward your goals. You get to do it with other people and be involved in your community. Using these supports is part of life for most of us. It's important you get to access them the same as everyone else.

When it comes time to talk about what reasonable and necessary supports we can fund, you'll know how mainstream, community and informal supports can help you.

It's important we gather this information and help you access these services before we consider what reasonable and necessary supports we can fund. That way, we can help make sure you're able to access mainstream, community and informal supports wherever possible. This can help you become as independent as possible.

What are reasonable and necessary supports?

An NDIS support is the practical description of how you will be assisted under the NDIS.[30] Supports are the things we provide or fund to help to meet your disability support needs.

NDIS supports are the services, items and equipment we can fund or provide under the NDIS.

There are two types of NDIS supports. We call them 'general supports' and 'reasonable and necessary supports'.[31]

General supports

General supports are the coordination, strategic or referral services and activities we provide, or arrange to be provided, for you.[32] They're how we help you develop your NDIS plan and connect with supports and activities in your community. This includes your mainstream, community and informal supports. Learn more in Creating Your Plan.

Reasonable and necessary supports

Reasonable and necessary supports are the supports we fund in your plan to meet your disability support needs.[33] You can use this funding to buy supports from service providers.

The Australian Government made laws about what we can fund under the NDIS.[34] All supports we fund in a plan need to meet the criteria set out in these laws. We call these the NDIS funding criteria.[35]

To meet the NDIS funding criteria, a support must meet both the following criteria:[36]

- It must not be a type of support the law says we can't fund or provide.[37]
- It must meet the reasonable and necessary criteria.[38]

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We call supports that meet the NDIS funding criteria 'reasonable and necessary supports'.

Each individual reasonable and necessary support in your plan must meet the NDIS funding criteria. Your whole plan as a package of supports must also meet the NDIS funding criteria.

We check your overall plan to make sure all your supports make sense together. This means we check that your supports and the amount of supports will complement each other to help you fulfil an ordinary life.[39]

If you need a new support, which now means your overall package of supports doesn't meet the NDIS funding criteria anymore, we may either:

- not include the new support in your plan
- include the new support in your plan, but also reduce the other supports in your plan.

For example, a home modification may reduce your need for other supports. If we plan to fund a home modification, we will need to take that home modification into account when considering what other supports are reasonable and necessary, such as the amount of care you need at home.

What other principles do we consider when we decide what supports to include in your plan?

As far as possible, we have to act according to principles set out in the law for the NDIS.[40] These are the things that guide us when we make decisions about what we fund.

These principles don't override or replace the NDIS funding criteria under the law for the NDIS. They can help us apply the funding criteria, by giving us additional guidance when we decide what supports to approve in your plan.

The principles include the following:

- You have the same right as other Australians to realise your potential for physical, social, emotional and intellectual development.[41]
- You should be supported to take part in and contribute to social and economic life as much as you can.[42]
- You should be supported to make choices about planning and how your supports will be delivered. This includes taking reasonable risks, so that you can pursue your goals.[43]
- You have the same right as other Australians to decide your own best interests. You have the right to be an equal partner in decisions that affect your life to the full extent of your ability.[44]

- Your privacy and dignity should be respected.[45]
- We must make sure the NDIS is financially sustainable.[46]

The principles also tell us that the reasonable and necessary supports we fund should:[47]

- support you to pursue your goals and maximise your independence
- support you to live independently and to be included in the community as a fully participating citizen
- develop and support your capacity to do things that help you participate in the community and in employment.

Just because a support helps you do these things doesn't mean we'll fund it in your plan. All supports we fund need to meet **all** the NDIS funding criteria.

We consider these principles set out in the law for the NDIS, along with the principles we follow to create your plan.

How do we think about an ordinary life when deciding what supports to include in your plan?

To help guide us in our decision making about reasonable and necessary supports, we took advice from the NDIS Independent Advisory Council.

The Council represents people with disability and carers, bringing their own lived experience and expertise of disability. They give us advice on how the NDIS should work.

The Council advised us that all Australians, including people with disability, should have an 'ordinary life'. They also told us we should think about the idea of an ordinary life when we apply our principles and use the NDIS funding criteria.

An ordinary life is a life where you have the same opportunities as people without a disability. An ordinary life is one that is typical or usual for everyone in modern day Australia. It's a life where you can pursue your potential and participate in society on an equal basis with others.

An ordinary life will be different for different people. We are all different, and come from different cultures and backgrounds. We each have our own values, experiences, beliefs and goals.

But there are some common things that can improve the quality of our lives and help us participate equally. These are the things, such as the following, that make up an ordinary life:

- Positive relationships – with families and informal support networks.
- Individual autonomy – being free and independent, and having the same opportunities as people without disability.

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- Active involvement in decision-making – including the ability to make meaningful decisions, and exercise choice and control.
- Using your strengths in ways that provide a challenge and enjoyment.
- A sense of belonging – to our families, friendship networks, communities, workplaces and society.
- Active involvement and contribution to society and your community.

An ‘ordinary life’ in the context of the NDIS involves supporting you to:

- have and maintain good relationships
- belong and participate in your community
- be involved in making choices about your own life.

One way we can help you have an ordinary life is to support you to access mainstream, community or informal supports wherever possible. These are the usual supports that everyone in the community uses.

When we fund reasonable and necessary supports under the NDIS, we need to make sure they meet the NDIS funding criteria.

When we apply the NDIS funding criteria and make decisions about reasonable and necessary supports, we’re guided by the principles in the law for the NDIS. We also consider how the supports will best help you to live an ordinary life.

How do we decide what reasonable and necessary supports to include in your plan?

What information do we consider to work out what reasonable and necessary supports to fund in your plan?

The most important information we gather about what supports to include in your plan comes from you.

When we create your plan, we will talk with you about:

- your goals and aspirations[48]
- your strengths, capacity and individual circumstances[49]
- any barriers, limitations and restrictions you face in undertaking activities or things that stop you from living an ‘ordinary life’[50]
- your disability support needs[51]

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- any risks and safeguards we may need to think about when considering your support needs.[52]

We want to get a good understanding of your disability support needs. We encourage you to involve anyone in the planning process you want to help you.

Learn more about what information we ask for when we create Your Plan.

We also consider other information we have such as medical or therapy reports, or assessments that you have had.[53]

We may also ask for further information and assessments, if we need them to help us work out your support needs.[54]

To help us work out what supports to consider for people aged 7 years and older, we also use a 'Typical Support Package'.[55] We worked with people with disability, professionals and subject matter experts to develop the Typical Support Package.

It helps us work out the types of supports we'd usually expect to include in your plan. It's based on your situation and support needs.

We then amend the supports suggested by the Typical Support Package to include more, less or different supports if we need to. We may adjust the funding for those supports up or down based on our discussion with you, any reports or other information we have, and when we apply the NDIS funding criteria.

For children younger than 7, we consider the child's current functioning across development areas when we work out the reasonable and necessary supports that should be funded in a child's NDIS plan. Learn more about the Early Childhood Early Intervention approach.

How do we consider your goals when we work out your reasonable and necessary supports?

When we create your plan, you set your goals and tell us what information about your life you want in your plan.[56] Your goals are your own personal desires about what you'd like to do.

You can set any goals you like, even if they're about things we won't fund supports for. You can also change your goals at any time.[57] We consider how your funded supports will help you pursue your goals when we decide to approve your plan.[58]

Reasonable and necessary supports should help you pursue your goals,[59] but you don't need a specific goal for every support in your plan. When we decide if a support will help you pursue your goals, we consider your whole situation.

We look at the disability specific barriers that prevent you from pursuing your goals, and how the support will address your disability support needs.

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There are some things to remember when setting goals:

- Setting more and bigger goals doesn't mean we'll fund more and bigger funded supports.
- Setting a goal doesn't mean we have an obligation to fund supports that help you pursue that goal.
- Setting a goal about an explicit type or amount of support you might want doesn't mean we have an obligation to fund that support or in that amount.

This is because helping you pursue your goals is only one of the NDIS funding criteria.[60] A support must meet all of the NDIS funding criteria to be funded under the NDIS. So not all supports that help you to pursue your goals will be reasonable and necessary supports.

Learn more about setting your goals and how we consider your goals under the NDIS funding criteria.

What if your plan is being reviewed?

If it's not your first plan, we also consider how well the supports funded in your previous plans worked for you.[61] This means we'll ask about how your current plan has worked for you.

This will help us decide whether these supports continue to meet your needs and the NDIS funding criteria. Learn more about plan reviews.

How do we use the information we have to work out what reasonable and necessary supports to fund?

We consider all the information we have gathered to decide what reasonable and necessary supports to fund in your plan.

We use the information you give us and follow the steps below:

- **Step 1**: Identify and describe the supports to be considered. The support will be described either generally (known as 'flexible' funding for supports) or specifically (known as 'stated supports' or 'fixed' supports).[62]
- **Step 2**: Work out if the support identified and described meets the NDIS funding criteria.
- **Step 3**: We include the supports that meet the NDIS funding criteria in your plan.

When we approve your plan we make sure all your supports meet the NDIS funding criteria individually and as a package of supports.[63]

Step 1: How do we identify and describe a support in your plan?

The first step in deciding what reasonable and necessary supports we can fund is to properly identify and describe the support.[64] This is an important step. We need to be clear on exactly what support we're considering, before we can decide if the support meets the NDIS funding criteria in Step 2.

When we assess your support needs and identify what supports to consider in your plan, we use:

- the information you give us at your planning meeting
- any assessments or other information we have
- the Typical Support Package for people aged 7 years and older.

We identify a support as the service, item or equipment you need to help with your disability support needs. We think about:

- what the outcome of the support will be
- how the support helps with your disability
- whether the support meets the NDIS funding criteria.

How do we describe supports?

We can describe the supports in your plan as one of the following:

- **Flexible**: Under the law for the NDIS, this is when we describe the support generally. You have greater flexibility over what disability supports you can buy within the description of the support.[65]
- **Fixed**: Under the law for the NDIS, this is when we describe the support specifically. It means you must buy the support in the way we have described in your plan.[66] We sometimes call this a 'stated support'.[67]

You must act according to your plan, and buy supports according to how we described them in your plan. This means you can't use the funding in your plan to buy supports that fall outside the description of the support in your plan.[68]

So if we describe the support as fixed, you must comply with how we describe it. This includes how the support is provided. For example, we will sometimes require the support to be provided:

- by a particular service provider

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- by a particular qualified person
- through a particular delivery mode or method, or in a special way.

We describe most supports as flexible when we can. When supports are described as flexible, you will have greater flexibility over the support you can buy that falls within the description of the support in the plan. When supports are described as fixed, you will have less flexibility.

We divide your supports into 3 different budgets:

- **Core Supports** – supports for everyday activities
- **Capacity Building Supports** – supports to help you build your skills and increase your independence
- **Capital Supports** – supports such as assistive technology, vehicle modifications, home modifications and Specialist Disability Accommodation.

Each budget is divided into a number of support categories. Support categories have more detail about what supports you can buy with your funding. When we describe your supports as flexible, you can usually choose what supports you buy within the descriptions for each support category.

Your Core Supports budget is the most flexible. You can usually use your funding across all the support categories except transport in the Core Supports budget if:

- we described the supports as flexible
- you have the same plan management options for your Core Supports.

Learn more about the support budgets and support categories in your plan.

When we decide whether to describe supports as fixed or flexible, we consider:

- how much the support costs[69]
- if the support will help reduce the cost of supports over time,[70] for example providing more supports early so you don't need as many supports later in life
- any risks with supplying the support, for example if the support would create risks to your health and safety or if it doesn't comply with state or territory laws[71]
- if you need a particular support to pursue your goals or to use other supports in your plan effectively[72]
- if you need a specialist support, for example if your support must be delivered by a qualified person, or in a special way[73]
- if you were eligible for the NDIS under the early intervention criteria.[74]

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When do we describe supports as fixed?

We usually describe high-cost supports, or supports with more risk, as fixed. For example, we might describe supports as fixed if you need to use those particular supports to ensure your health and safety. This includes supports such as:

- high-cost assistive technology
- high-cost home modifications
- behaviour support, or supports that involve restrictive practices such as restraint
- Specialist Disability Accommodation.

We will also check if you were eligible for the NDIS through the early intervention criteria.[75] If so, we might decide to describe the supports as fixed for some types of early intervention supports.[76] If you're not sure whether you met the disability criteria or the early intervention criteria, check the letter we sent you when we decided you're eligible.

Example

John just received his first plan. His plan describes support for assistive technology as flexible, including $2,000 of funding. John can choose what assistive technology to buy with this funding. John talks to his occupational therapist about what assistive technology he should buy with this funding. For example, he could buy a shower chair, or low-cost items like a slip-resistant bathmat.

John's plan also has a fixed support for a wheelchair with special features, and funding of $8,000. John will need to use this funding for the specific wheelchair we listed on his plan. He can't use this funding for another support, like a shower chair, instead.

What if you need a specific provider to provide the support?

Sometimes your plan may say who must provide the support. We do this when you need a certain provider to make sure the supports are delivered safely, or to achieve a certain outcome.

For some supports, you must use an NDIS registered provider. These include:

- Specialist Behaviour Supports, if the provider will undertake a behaviour support assessment or develop a behaviour support plan[77]
- supports where it's likely a provider will need to use a regulated restricted practice,[78] either interim or ongoing
- Plan Management[79]
- Specialist Disability Accommodation.[80]

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You must use registered providers for these supports even if your plan doesn't say you need to. You must also use registered providers for these supports, even if you self-manage or plan-manage your funding. Learn more about the different plan management options.

For other supports, we'll decide that the support must be provided by a particular person, provider, or delivered in a certain way.[81] We'll do this if it's the most efficient and effective way to provide the support. This only happens when:

- we have an agreement with a particular provider to provide the support[82]
- we decide you must use an NDIS registered provider due to the risks, for example complex home modifications[83]
- you need support from a particular person with specialist qualifications, for example a health professional[84]
- you need support delivered in a certain way.[85]

Sometimes, we'll arrange the support ourselves, if it's more cost effective than getting another provider to deliver the support. For example, we may bulk buy a support.[86] If so, we will state this in your plan.

What about in-kind supports?

We agreed that state and territory governments will keep providing some supports for a period of time. We call these 'in-kind supports'.

If we fund in-kind supports like specialist school transport or personal care in schools, you will need to use state or territory government providers for these supports. These supports are most efficiently and effectively provided by state and territory government providers.[87] Learn more about Work and study supports.

For most other in-kind supports, you can choose your provider if you don't want to use your in-kind provider anymore. We can let you choose another provider if we consider that the support isn't most effectively and efficiently provided by the in-kind provider.

We usually let you choose another provider if:

- another provider can give you the same support or level of support as the in-kind provider
- the supports with the new provider still meet the NDIS funding criteria, including that they're value for money compared to the in-kind support
- there are no serious risks with changing providers.

Learn more about in-kind supports.

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Step 2: How do we work out if an identified and described support meets the NDIS funding criteria?

To meet the NDIS funding criteria, a support must meet both the following criteria:

- It must not be a type of support the law says we can't fund or provide.[88]
- It must meet the reasonable and necessary criteria.[89]

Each support must be reasonable and necessary individually, but the supports must also be reasonable and necessary when considered as a package of supports.

What types of supports can't be funded or provided under the NDIS?

Under the law for the NDIS, there are things we can't fund or provide.[90] We can't fund or provide supports that:

- are not legal[91]
- are income replacement[92]
- are likely to cause harm to you, or pose a risk to other people[93]
- are not related to your disability[94]
- relate to a 'day-to-day living cost', such as groceries, rent or utilities, that are not attributable to your disability support needs. These are costs that are not caused by or as a result of your disability support needs.[95]
- duplicate other supports provided by the NDIS under alternative funding.[96]

Is the support legal?

We can't fund a support if it does not comply with the law.[97] This includes both:

- **an Australian government law:** a law that applies to all of Australia
- **a State or Territory government law**: a law that only applies in your state or territory.

For example, we won't be able to fund supports involving:

- a restrictive practice where it's not authorised in your state or territory
- assistive technology or home modifications that don't meet Australian laws, such as State and Territory Acts and Regulations, the National Construction Code, and relevant Australian Standards
- supports for illegal activities, such as support for criminal behaviour or illegal drugs.

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While this is one of the NDIS funding criteria, we're not responsible for ensuring your supports are legal. We're not responsible to ensure that all supports in your plan comply with all the relevant legal and administrative requirements. This is your responsibility and your provider's responsibility.

For example, if a support is likely to require the use of a restrictive practice, the provider must be registered with the NDIS Quality and Safeguards Commission.[98] It's the provider's responsibility to ensure they are registered and comply with the conditions of their registration. This includes complying with all laws and seeking the necessary authorisations.[99]

We're not responsible for ensuring the provider is registered and complies with their conditions of registration. You can contact the NDIS Quality and Safeguards Commission if you're concerned about a provider's compliance with legal obligations.

Is the support 'income replacement'?

We don't fund income support or income replacement.[100] This means NDIS funding can't replace or add to money you'd usually earn from working, or income payments you get from Centrelink.

For more information and resources on income support, check out income support payments such as the Disability Support Pension.

If you are interested in getting help to find a job, check out Disability Employment Services or NDIS-funded Work and study supports.

Is the support likely to cause harm?

We can't fund any supports that are likely to either:[101]

- cause harm to you
- be a risk to other people.

We need to consider this for all supports, such as support workers, therapies or equipment. It also means we won't fund supports that involve a regulated restricted practice, such as restraint, unless it follows the requirements of the NDIS Quality and Safeguards Commission.

To help us decide if the support is likely to cause harm, we may need information from a professional. For example, you may need high cost assistive technology, like a powered wheelchair. If so, we would need a report from an occupational therapist to show that it'll be safe for you to use.

Of course everything we do in life comes with some risk. We all make our own choices about how much risk we want to take in our lives. You should also be able to choose how much risk you want to take in your life.

So we try to balance this when we decide what we can and can't fund. We can't fund things that are likely to cause harm. But we will try and balance this with enabling you to make your own choices wherever possible.

While this is one of the NDIS funding criteria, you also have some responsibilities. It's still your responsibility and your provider's responsibility to ensure the supports we fund are:

- used correctly
- safe for you
- safe for other people.

You and your provider will also need to manage any risks of harm that arise. For more information, contact the NDIS Quality and Safeguards Commission.

Is the support related to your disability?

We can't fund a support if it's not related to your disability.[102] This means there must be a direct link or a connection between your disability and the supports we fund.

We look at whether the support addresses your disability support needs. Your disability support needs are those that arise from, or are caused by, your disability.

For example, we wouldn't usually fund things like:

- standard televisions
- standard household furniture such as dining chairs
- upgrades to assistive technology and home modifications that are not related to disability needs, such as marble tiling or leather materials
- flights to go on a holiday
- a car to get to work because there are no public transport options
- a gym membership to get fit
- a swimming pool to relax in summer.

This is because you're unlikely to need these supports as a result of your disability support needs. They are things that all people, with or without disability, might want or need.

Usually, there won't be a direct link or connection between these things and your disability support needs. Having a disability doesn't usually affect whether someone needs or wants these types of things.

Example

Alan needs some changes to his house, so he can use his bathroom and kitchen in his wheelchair. He also wants to set up an outdoor entertainment area for when his friends visit.

We may be able to fund home modifications so he can access areas of his home such as his bathroom or kitchen. He needs the home modifications because he can't access those areas due to his disability and needing to use a wheelchair. Alan needs the support because of his specific disability support needs.

Alan will need to pay for the outdoor entertainment area, as it's not related to his disability. He doesn't need the entertainment area because of his disability, it's just something he would like so he can have his friends over for a barbecue.

Is the support related to a 'day-to-day living cost'?

We can't fund supports related to day-to-day living costs that everyone has to pay, and aren't caused by or result from your disability support needs.[103] This means we don't fund things like:

- rent
- groceries
- utilities such as electricity, water, gas and internet bills
- the general cost of owning a home, like renovations, mortgage repayments, repairs and maintenance.

In some situations, we can fund supports related to your day-to-day living costs. We can do this if the costs are attributable to, or caused by, your disability support needs.[104] This means we may fund supports that relate to day-to-day living costs where either:

- you have additional living costs that are solely and directly as a result of your disability support needs[105]
- the living costs are connected to another support that is funded or provided in your plan, and you wouldn't incur that cost if it wasn't in your plan.[106]

Example

Nigel has a goal to do his grocery shopping on his own. He needs a shopping basket to attach to his wheelchair to help him carry the items in the supermarket.

Shopping bags and baskets are things we all pay for, whether or not we have a disability. But Nigel only needs this specialised basket for his wheelchair because of his disability support needs.

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If it meets the other NDIS funding criteria, we may fund the shopping basket attachment in his plan.

Does the support duplicate other supports funded through the NDIS?

We can't fund a support if it duplicates other supports delivered under alternative funding through the NDIS.[107]

For example, if we're providing support through your Early Childhood Partner or Local Area Coordinator, we usually won't fund Support Coordination in your plan.

This is because your Early Childhood Partner or Local Area Coordinator is already funded to provide similar supports. If we funded the same Support Coordination, we would be duplicating a support we're already providing you as general supports.

However if you need extra support, we may be able to fund additional Support Coordination in your plan. We may do this if it's above the amount of support your Early Childhood Partner or Local Area Coordinator are able to provide. Your Early Childhood Partner or Local Area Coordinator will work together with the Support Coordinator to help you connect with supports in your community.

Does the support meet the reasonable and necessary criteria?

All NDIS supports need to meet **all** the reasonable and necessary criteria.[108]

This means that before we can include an NDIS support in your plan, we need to be satisfied it meets all the following criteria:

- The support will assist you to pursue your goals in your plan.[109]
- The support will assist you to undertake activities, to facilitate your social and economic participation.[110] This means the support will help you to undertake activities, by reducing the disability-related barriers that prevent you from participating in things such as social outings, recreation, work and study.
- The support represents value for money in that the costs of the support are reasonable relative to both the benefits achieved and the cost of alternative supports.[111] This means we need to consider the costs and benefits of the support, as well as the costs and benefits of alternative supports.
- The support will be, or is likely to be, effective and beneficial for you, having regard to current good practice.[112] This means we consider if there is evidence the support works for someone with similar disability support needs. We won't need an expert report for every support, as we can often rely on other information or evidence. For example, we may have information already about whether the support is widely

accepted to suit someone with your disability support needs.[113] We also consider your lived experience.

- The funding of the support takes account of what it is reasonable to expect families, carers, informal networks and the community to provide.[114] This means we need to consider what support is reasonable for your family, friends and community to provide.
- The support is most appropriately funded or provided through the NDIS, and is not more appropriately funded or provided through:[115]
  - other general systems of service delivery, or support services offered by a person, agency or body (for example, a State or Territory Statutory Scheme)
  - systems of service delivery or support services offered as part of a universal service obligation (for example, the health or education system)
  - systems of service delivery or support services offered in accordance with reasonable adjustments required under discrimination laws (for example, your employer, or the health or education system).

The law for the NDIS sets out things that we need to consider when we apply the reasonable and necessary criteria.[116]

We must be satisfied that each support is reasonable and necessary individually, but we must also be satisfied that the supports are reasonable and necessary as a package of supports.[117]

For example, a home modification may reduce your need for other supports. If we plan to fund a home modification, we will need to take that home modification into account when considering what other supports are reasonable and necessary, such as the amount of care you need at home.

If the home modification will reduce your care needs, we may need to reduce the amount of care we fund, as a higher amount may not be reasonable and necessary when the whole package of supports is considered.

Does the support help you pursue your goals?

We need to be satisfied that the support will help you pursue the goals, objectives and aspirations in your NDIS plan.[118] This helps us determine if the support is necessary.[119]

While we only fund supports that help you pursue your goals, objectives and aspirations, we understand that different people express themselves in different ways.

You are free to choose your own goals and express them in your own words.

Your goals can be big or small, short term or long term, simple or complex. They can be about anything you want to work towards.

You may express your goals broadly, or you may have specific goals. For example, you may express one of your goals as 'living independently'. Someone else may express their goal as 'to have an accessible bathroom'.

Learn more about setting your goals in Creating Your Plan and the Setting Goals fact sheet.

Reasonable and necessary supports should help you pursue your goals,[120] but you don't need a specific goal for every support in your plan. When we decide if a support will help you pursue your goals, we consider your whole situation.

We look at how a support will address your disability support needs, and the disability specific barriers that prevent you from pursuing your goals.

A support that addresses your disability related support needs is most likely to help you pursue your goals, objectives and aspirations in your plan.

Setting a goal in your plan doesn't mean we'll provide funding to pursue it. For example:

- setting more and bigger goals doesn't mean we have an obligation to fund more and bigger funded supports in your plan
- setting a goal doesn't mean we have an obligation to fund supports that help you pursue that goal
- setting a goal about an explicit type or amount of support you might want doesn't mean we'll fund that support or in that amount.

This is because helping you pursue your goals is only one of the NDIS funding criteria. A support must meet all of the NDIS funding criteria to be funded under the NDIS. So not all supports that help you to pursue your goals will be reasonable and necessary supports.

For example, we only fund reasonable and necessary supports that are value for money,[121] effective and beneficial[122] and relate to disability support needs.[123]

This means that if your goal is to 'live independently', we **may** fund home modifications that address your disability related needs. However, we won't fund supports related to day-to day-living costs like rent or utilities. These costs aren't incurred solely and directly as a result of your disability support needs, so they don't meet other funding criteria.[124]

Also, choosing a different goal 'to have a more accessible home' won't change the supports we could fund in your plan.

Achieving goals usually takes many different kinds of supports. NDIS supports will most likely be just one kind of support that helps you work toward your goals.

Learn more about setting goals.

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Example

Morgan is ready to look for work and she has a goal in her plan to get a job. She has built up her skills and knows what she wants to do. Disability Employment Services are helping Morgan to find work, so we can't fund this support for Morgan.

However, because of her disability, Morgan will need personal care supports to help her get up and ready for work in the morning. We will consider:

- how Morgan's disability support needs relate to her goals
- whether funding supports that address these disability support needs will help Morgan pursue her goals.

Morgan's planner believes the personal care supports meet this criteria. The supports that address her personal care needs will help Morgan to pursue her employment goals.

However, Morgan's planner then needs to look at whether the support meets the other NDIS funding criteria.

We don't fund all the supports that relate to Morgan's employment goals. We only fund the supports we consider are reasonable and necessary – that is, when they meet all the NDIS funding criteria.

Does the support help you do activities that will help your social and economic participation?

We need to be satisfied that the support will help you to do activities, which make it easier for you to participate socially and economically.[125]

Social participation means doing things you enjoy, like going out with friends, playing sport or going on holiday. It also means doing the things you need to do, like going to school or medical appointments.

Economic participation usually means being involved in things that help you work towards getting and keeping a job. This might be things like volunteering, study, learning new skills or trying work experience. Research tells us that work can lead to health benefits and improve our quality of life. Learn more about the Health Benefits of Good Work.

Social and economic participation are important to most people. They are critical to living an ordinary life.

To work out if a support meets this requirement, we look at the purpose of the support and how it will help you.

We fund reasonable and necessary supports that reduce the barriers that prevent you from undertaking activities. This will help you increase your social and economic participation.

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Some supports help economic and social participation directly. There are lots of supports we can fund to directly help with social and economic participation. Learn more about Social and recreation supports and Work and study supports.

Other supports help you to undertake activities like self-care, which indirectly help your economic and social participation.

Example

Sue is going to university next year. She has a vision impairment, and has been working with her Guide Dog Mobility Instructor to decide if a dog guide is right for her. A dog guide can help her leave her home safely and independently, and travel to and from university.

A dog guide could also help her go out with friends and join in other community activities. As long as it meets the other funding criteria, we could fund a dog guide for Sue. It will help her to undertake activities of daily living.

As a result, it'll increase her social and economic participation. For example, the support will help her get to her university so she can study, and will help her social life.

Is the support value for money?

All supports we fund under the NDIS need to be value for money.[126] This means the cost of the support is reasonable, when we consider the benefits of the support and the cost of other supports.

Making sure that your supports are value for money is one of the ways we keep the NDIS financially sustainable. This means we make careful decisions about funding so that we make sure the NDIS exists for future generations. It's also one of our principles.[127]

When we decide if the support is value for money, we consider:

- if other supports would achieve the same result at a substantially lower cost[128] – this means there should be a real or material difference in cost
- if there's evidence that the support will substantially improve your life stage outcomes and benefit you in the long term[129]
- if the support will likely reduce the cost of other supports over time[130]
- how the cost compares to other supports of the same kind in your area[131]
- if the support will make you more independent, and mean you won't need as many supports in future,[132] for example, in some circumstances home modifications may reduce the need for home care.

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When we consider the likely cost of supports, we consider the cost over the long term. We consider if the support will help you to achieve milestones at different ages or stages of your life, and have long term benefits.

For example, some supports such as home modifications may be expensive now, compared to other supports. But getting these supports now may mean you need much less support in a few years, or later in life. Or, it may delay the need for other more costly supports.[133]

When we determine the cost of the support, we consider:

- the prices for NDIS supports in the NDIS Price Guide
- supports suggested by the Typical Support Package
- quotes for specific or high risk supports.

It's important we consider the cost of the support. This will be the level of funding we include in your plan, if we decide the support is reasonable and necessary.

When we fund equipment or modifications, we also need to consider:[134]

- how the cost of buying the equipment or modifications compares against the cost of renting them
- if it's appropriate to fund the equipment or modifications you want, based on your circumstances and any expected changes in technology.

Learn more about how we consider value for money when we fund assistive technology, home modifications and vehicle modifications.

Example

Elias needs a shower commode.

He got an assessment and sent us a quote for one that will suit his needs. As part of the process to work out if we can fund it, his planner considers other similar shower commodes.

There's a second commode that's $5,000 cheaper than the one Elias has asked for. But it won't meet Elias' needs, as it won't provide enough back support. That is, it won't achieve the same result as the one Elias has asked for.

Finally, there's a third commode that's $1,000 cheaper. The planner contacts his occupational therapist who confirms the cheaper commode will meet Elias' needs.

Elias' planner decides to fund the commode that's $1,000 cheaper. It'll deliver the same result at a substantially lower cost.

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Is the support effective and beneficial?

We need to be satisfied that the support will be, or is likely to be, effective and beneficial, when we consider current good practice.

We need to work out if the support is likely to be both:

- **effective** – it will do what you need it to do[135]
- **beneficial** – the support will help you do things you can't otherwise do and meets your support needs.[136]

It can also be effective and beneficial if it will help you maintain your current level of functioning. That is, it will help you keep doing the things you can currently do. And, it'll help you maintain your work, study and social life as much as you can.[137]

When we decide if a support is effective and beneficial, we look at what is current good practice. This means we look at whether there is evidence that the support works for someone with similar disability support needs to you. We won't need an expert opinion or report for every support, as we can often rely on other evidence.

For example:

- We may have information already about whether the support is widely accepted to suit someone with your disability support needs.[138] For example, we could rely on academic research and other literature. This could include university studies on therapies that have been published and refereed in academic journals, evidence based practice resources, or clinical practice guidelines.
- If you or other participants have used the support before, we can consider your experience using the support and the experience of your family members and carers.[139]
- We may consider things we have learnt from other participants in the NDIS with similar support needs to you.[140]

We know you're the expert in your own life, and we use your own experience as much as we can.

For example, we will talk to you about any supports that have helped you do things you can't otherwise do. Or, some supports may have helped maintain your ability to be as independent as possible.

If it's a new support such as new assistive technology, we might fund a trial. This is so we can learn from your experience of using the support, to check if it's likely to do what you need it to.

Your evidence can be particularly useful when it's consistent with other evidence, or if we don't have expert evidence.

We will look at the opinions held by the majority of experts and what they generally agree on.[141] Sometimes we will have to seek expert opinion or report to make a decision.[142]

For example, we may need the views of doctors or health professionals who may be specialists in managing your disability.

Example

Vivek is 12 and has a goal to improve his communication skills. He and his family want him to improve his social skills with the kids in his class.

When he was younger, Vivek's family tried speech therapy, and believe it really helped him improve his communication. His family told his planner about how it helped Vivek learn how to respond to different social settings.

Vivek's speech therapist also believes it could work well for him now, and help him interact with his classmates.

When deciding whether the therapy is effective and beneficial, Vivek's planner will consider:

- how speech therapy has assisted Vivek in the past, including first-hand information from Vivek, his family members and carers
- the views of his speech therapist on the effectiveness and benefits of speech therapy for Vivek
- other information or expert evidence about the effectiveness and benefits of speech therapy, including for a child of the same age, and with the same impairments and functional capacity.

Based on this information and evidence, Vivek's planner decides the speech therapy is effective and beneficial. If it meets the other funding criteria, we will be able to fund speech therapy in Vivek's plan.

Is the support something we would reasonably expect your informal supports, like family or friends, to provide?

We need to be satisfied that funding the support takes into account what is reasonable to expect families, carers, informal networks and the community to provide.[143]

To make sure we understand how disability supports might work for you, we consider:

- the things you're able to do for yourself
- any support you have from others in your network – including family members, relatives, friends and local community services.

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When we fund supports under the NDIS, we have to think about whether it's reasonable to expect your informal supports to provide that support. We can't fund supports that an ordinary person would think is reasonable to expect friends, family or the community to provide for you.[144]

Informal supports are the help and support you get from friends, family and the community. They are called 'informal' because you don't pay for them, and they're not part of a formal agreement. They are the usual things friends and family do for us, and with us.

Most of us get some kind of help and support from friends and family. In our society, we expect that friends, family and our community will support each other and help each other out when they need it.

A good example is families who have young children. In our community, we expect families will provide most of the support a young child needs.[145] They will change a child's nappy, make sure they are safe and drive them around places.

Grandparents, uncles and aunties often have a role to play in supporting young children as well. Neighbours and friends might also help care for the child.

As a child gets older, our society's expectations of the role of the family and community in caring for the child changes. For example, we expect schools to help support the child's learning needs.

We also usually expect the role of family in providing personal care for a child would reduce as they get older and develop new skills and independence. But families are usually still responsible for things like food, emotional support, decision-making and providing a safe home.

It's a similar idea for adults. Our society expects that adults – like family, friends and neighbours – will provide some support to each other. This might be things like taking a friend with you to the football game, or providing emotional support if someone is upset.

NDIS supports won't ever replace the support people like your friends and family provide to you. This support is given freely because people care, and is often quite different to supports bought with NDIS funding.

You have a special bond with your friends and family that's different from your relationship with paid carers. And there are potential risks and problems for you if your friends and families become your paid carers.

To make sure we understand how disability supports might complement your circumstances, we consider:

- the things you are able to do for yourself

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- any support you have from others in your network including family members, relatives, friends and local community services.

We also have to consider the benefits you may get from your informal supports. For example, your family and friends may be more effective at helping you meet other people, or helping to build your social skills, than paid supports can.

We consider if we can help these relationships so that you get the support you need.[146] For example, we may be able to fund training for your informal supports, so they can help you build your skills.

We also think about the capacity of your informal supports to continue caring for you, for example if they're ageing or sick.

There are different things the law for the NDIS says we need to consider for adults and children.

If you're under 18, we consider what support is reasonable to expect parents to provide at your age. It's normal for parents to provide substantial care and support for children.[147] We consider that it's usual for parents to provide almost all the care and support that young children need.

For example, it's reasonable to expect parents to provide transport to and from their child's after-school activities. Of course, the amount of care and support for a child without a disability would typically reduce as they get older.

For children under 18, we consider:

- if your needs are 'substantially greater' because of your disability, compared to other children the same age[148] – that is, you need much more disability support
- any risks to the wellbeing of people providing informal support to you[149]
- if including funding for the support will help build your skills and capacity in the future, or reduce any risks to you.[150]

For example, we consider any health, safety or other impacts resulting from what's involved in meeting your disability support needs.

If you're over 18, we consider:

- if there are any risks to you or your informal supports if you rely on them to provide the support you need[151]
- how much your informal supports would help improve or reduce your independence and other outcomes[152]

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We also consider the suitability of informal supports to provide the supports you need,[153] including:

- how old your carers are and their capacity to provide the support[154]
- if other family members and the community can help your informal supports in their caring role[155]
- the intensity and type of support you need, and if it's appropriate for your informal supports to provide this, based on their age and gender[156]
- any long-term risks to the wellbeing of your informal supports.[157]

When we consider the risks for people over 18, we consider if the supports are sustainable for your informal supports. We consider the health, safety and other impacts on family and carers in the long term.

For example, we wouldn't expect a child to have their schooling affected because they need to provide care. We also wouldn't expect an elderly parent to be responsible for physical activities, if it may result in injury.[158]

We generally don't fund family members to provide supports funded under the NDIS. There are very limited situations where we can consider this. Learn more about Sustaining Informal Supports.

Example 1

Simon is getting his first NDIS plan. For the last 15 years, Simon and his wife Jan's preference was that Jan provide all the physical support he needs at home, such as toileting and showering.

But as Jan is getting older, it's not safe for her to keep lifting Simon. It's becoming risky for her to keep providing this support.

Jan and Simon think it might be best for someone else to provide the personal care support that Simon needs. Their children have moved out of home, and it's not reasonable to expect them to help Simon with personal care.

Based on this information and other evidence, Simon's planner decides that the personal care support meets this criteria. It takes into account what is reasonable for his family and others to provide. If the personal care support meets the other funding criteria, we may fund the personal care support for Simon.

Simon and Jan still prefer Jan to do the other support Simon needs though, such as helping Simon eat his meals. At this time, we wouldn't fund a support worker in Simon's plan to help him eat his meals. It's reasonable to expect Jan to help Simon with this, as it's what they want to do and it's not a safety risk for Jan.

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Example 2

Qing is 14 and wants to join a local footy club. Like most 14 year olds in this situation, she needs someone to drop her off and pick her up from the Saturday matches and the weeknight training sessions.

But unlike most 14 year olds, she needs someone to help her get dressed before she can go to the match. Her parents have been doing this, but as Qing is getting older she no longer wants her family to help her get dressed.

It's reasonable to expect her family or other informal supports to drop Qing to and from the match and training sessions. So we wouldn't fund transport in Qing's plan.

But at age 14, it's not reasonable to expect her family to help her get dressed.

Based on this information and other evidence, Qing's planner finds that the personal care support takes into account what is reasonable for family and others to provide. If it meets the other funding criteria, we may fund personal care support in her plan.

Is the support more appropriately funded or provided through the NDIS, and not through other service systems or support services?

We have to be satisfied that the support is most appropriately funded or provided through the NDIS. This means it's not more appropriately funded or provided through:

- other general systems of service delivery, or support services offered by a person, agency or body (such as a State or Territory Statutory Scheme)
- systems of service delivery or support services offered as part of a universal service obligation (such as the health or education system)
- systems of service delivery or support services offered in accordance with reasonable adjustments required under discrimination laws (such as your employer, or the health or education system).[159]

In short, we won't fund the support if it should be provided by someone else.

We won't fund the support if the support should be provided by someone else, even if the other service system doesn't actually provide it. We're not the funder of last resort, so we don't make up for other organisations and systems that don't provide the supports they should.

The law for the NDIS sets out a number of things we need to consider, when we decide who is most appropriate to fund or provide of the support.[160] There are different things we consider for the following service systems:

(a) Health

(b) Mental health

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(c) Child protection and family support

(d) Early childhood development

(e) School education

(f) Higher education and vocational education and training

(g) Employment

(h) Housing and community infrastructure

(i) Transport

(j) Justice.

How does the NDIS work with other government services?

We call supports provided by other government services, including those provided as part of a universal service obligation, 'mainstream supports'. When we talk about mainstream supports, we mean supports available to everyone in your state or territory, or across Australia, regardless of whether or not you have a disability.

This includes services provided by state and federal governments, like health care, education and mental health services.

You have the same right as all Australians to access these services. There are certain things that mainstream services have to do to make their services accessible for people with disability. Using mainstream supports can also help you be part of your community, or to work or study.

When we fund NDIS supports, we need to check that the support is not more appropriately funded or provided by a mainstream service or system, such as the education system or health system.[161] Under the law for the NDIS, we can't fund supports that should be provided by a mainstream service.

The Australian federal, state and territory governments agreed on responsibilities for funding different types of supports. The law for the NDIS has an outline of funding responsibilities and were developed with the agreement of each State and Territory.[162]

We can only fund supports that are the responsibility of the NDIS. We can't fund supports that are the responsibility of other government services, even if they don't actually fund or provide the support. The law for the NDIS sets out the matters we should consider when we decide who is more appropriate to provide or fund a support.[163]

Learn more about how we decide if the support is best funded or provided by us or another part of government.

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The Applied Principles and Tables of Support also has information on what the governments agreed are the responsibilities of the NDIS and other government services. However, it doesn't override what we consider when we decide if the support is most appropriately funded by the NDIS.[164]

What is reasonable adjustment and why is it important?

People with a disability can sometimes face barriers that make it harder to do the same things as people who don't have a disability. For example, it might be harder to find and keep a job. Or it might be harder to get in and around places, or to get the same services as other people.

It's against the law to discriminate against people with a disability in many areas.[165] This includes in employment, when providing goods and services, and when accessing public places.

This means organisations or people who are responsible for providing these services have to make what are called 'reasonable adjustments'. They have to make sure people with a disability have equal access to the services they provide, as far as is reasonable.

They have to do reasonable things that will make their services equally available to everyone, whether or not you have a disability.

Reasonable adjustments do not mean they have to provide everything you need because of your disability. It means they have to do what's reasonable to make sure you have equal access to employment, public spaces or services. This takes into account what they can afford to do and what is reasonable to expect them to provide in the circumstances.

When we decide what supports to include in your plan, we need to consider what should be provided through reasonable adjustments. Under the law for the NDIS, we can't fund a support if it should be provided by someone else through reasonable adjustments.

What if you're transitioning to the NDIS in Western Australia?

The federal and Western Australian governments made a commitment for people receiving supports before becoming a participant in the NDIS.

They committed that you shouldn't be disadvantaged by your transition to the NDIS. We call this the 'principle of no disadvantage'.

When we create your plan, we must use our best endeavours to follow government agreements.[166] This doesn't mean you'll always have the same level of funding, or that you'll get supports in the same way.

All supports we fund must meet all the NDIS funding criteria. So we may not be able to fund supports you received before the NDIS, if they don't meet the funding criteria.

If we can't fund those supports, we'll see how we can help you meet the same outcomes as you did before the NDIS.

This may mean we include other supports in your plan that address your disability support needs and help you pursue your goals. Or, we could help you connect with other government services that can provide the supports you received before the NDIS.

When we create your plan, we consider whether or not you're disadvantaged overall by joining the NDIS.

What else do you need to know about working out if supports meet the NDIS funding criteria?

From our experience, we learned there are some common misunderstandings about how we work out what supports meet the NDIS funding criteria.

Why don't we always fund what your health professionals recommend?

Although we take expert opinions into account, we can't and don't always fund everything your health professional might recommend. This is because every support we fund needs to meet all the NDIS funding criteria.

For example, your therapist might recommend a piece of equipment on the basis that it will be 'effective and beneficial' for you. But if there is something cheaper that will achieve the same outcome, we won't be able to fund what the therapist recommended.

This is because it won't be value for money. We may be able to fund the cheaper option instead if it meets all the NDIS funding criteria.

Why don't we fund the same supports as your last plan?

We might fund different supports in your next plan. This is because we will fund supports in your plan based on how we use the NDIS funding criteria at that point in time.

Your needs and situation will most likely change over time. This means it's likely your NDIS supports and funding for those supports will change over time.

For example, we may have funded supports to help you build your skills in a particular area. Once you have built those skills, you won't need funding for that any more. So, we probably won't include that funding for those supports in your next plan.

Supports to build your skills may have met the NDIS funding criteria before, but the same supports might not meet the criteria in future.

Or, your disability support needs might increase or decrease over time. This may mean we consider funding more or less supports as a result.

What happens if you don't use all your funding in your NDIS plan?

We will consider how you have used your NDIS funding to help us work out what supports meet the NDIS funding criteria in your next plans.

If you haven't used all the funding by the end of your plan, it doesn't mean we'll reduce the funding in your next plan. There may be very good reasons why you weren't able to buy the supports we funded.

When we review your plan, we'll talk about any problems you had buying the supports funded in your plan. We'll also see how we can help you use your funding if we need to.

But if you consistently don't buy all the supports we fund and use all of your NDIS funding, we need to think about whether the supports really do meet the NDIS funding criteria. For example, they may not be 'effective and beneficial' for you if you're not actually using them. We will talk to you about this when we review your plan.

Learn more about plan reviews.

Step 3: How do we include the reasonable and necessary supports in your plan?

Once we've identified the supports, and decided they meet the NDIS funding criteria, we can include the description and funding for the support in your plan.

If the support doesn't meet the NDIS funding criteria, we can't include the support in your plan. We may consider if a differently described support meets the NDIS funding criteria instead.

When we approve your plan we will also make sure all your supports are reasonable and necessary when considered as a package of supports.[167]

Sometimes you might not need any supports under the NDIS. For example, your informal supports may meet all your disability support needs. If so, we'll approve a plan with no funded supports.

Learn more about how we create and approve your plan.

Learn more about using the funding in your plan.

What happens if we don't include the supports you want?

If we decide a support doesn't meet the NDIS funding criteria, we can't include the support in your plan. Also, if the amount of support you want doesn't meet the criteria, we can't include that amount in your plan.

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But, we're committed to our principles and helping you live an ordinary life. Even if we can't fund a particular support we may still be able to help.

If the support doesn't meet the NDIS funding criteria, we can consider if a different support meets the NDIS funding criteria. We might be able to consider describing the support differently, or funding a different type of support.

Or, we may be able to connect you to mainstream or community supports that can help. Mainstream and community supports are available to everyone. They can be a good way to connect with your local community, learn new skills and gain independence.

There are lots of ways we might be able to help, so talk to us if you're in this situation. We can do this at any time. We may be able to help before we approve your plan.

We can also give you reasons for our decision to approve your plan. We can put these reasons in writing. You can always contact us.

If you don't agree with the supports we approve in your plan, you can also request an internal review of our decision. Learn more about internal and external review of decisions.

Reference list

[1] NDIS Act and delegated legislation made under the NDIS Act, especially NDIS (Supports for Participants) Rules and NDIS (Plan Management) Rules.
[2] NDIS (Supports for Participants) Rules r 5.1(b).
[3] NDIS Act s 34(1)(a).
[4] NDIS Act s 34(1)(b).
[5] NDIS Act s 34(1)(c).
[6] NDIS (Supports for Participants) Rules r 3.1(c).
[7] NDIS Act s 34(1)(c); NDIS (Supports for Participants) Rules r 3.1(a).
[8] NDIS Act s 34(1)(d).
[9] NDIS Act s 34(1)(e).
[10] NDIS Act s 34(1)(f).
[11] NDIS Act s 34(1)(f).
[12] NDIS (Supports for Participants) Rules part 5.
[13] NDIS (Supports for Participants) Rules r 5.1(a).
[14] NDIS (Supports for Participants) Rules r 5.1(b).
[15] NDIS (Supports for Participants) Rules r 5.1(c).
[16] NDIS (Supports for Participants) Rules r 5.1(d).
[17] NDIS (Supports for Participants) Rules r 5.3(a).
[18] NDIS (Supports for Participants) Rules r 5.3(b).
[19] NDIS Act s 34(1)(f).
[20] NDIS Act s 118(1)(b).
[21] NDIS Act s 4(17)(b).
[22] NDIS Act s 33(2).
[23] NDIS Act s 33(5)(a).
[24] NDIS Act s 34(1)(a).
[25] NDIS Act s 34(1)(d).
[26] NDIS (Supports for Participants) Rules r 4.1(d).
[27] NDIS Act s 34(1).
[28] NDIS Act s 34(1)(d); NDIS (Supports for Participants) Rules, rr 3.2-3.3.

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[29] NDIS Act s 34(1)(c); NDIS (Supports for Participants) Rules r 3.1.
[30] *McGarrigle v National Disability Insurance Agency* (2017) 252 FCR 121 at [88].
[31] NDIS Act ss 33(2)(a), 33(2)(b), 33(5)(c), 34.
[32] NDIS Act ss 13, 33(2)(a).
[33] NDIS Act ss 33(2)(b), 34.
[34] NDIS Act and delegated legislation made under the NDIS Act, especially NDIS (Supports for Participants) Rules and NDIS (Plan Management) Rules.
[35] NDIS Act ss 33(2)(b), 34; NDIS (Supports for Participants) Rules.
[36] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules r 5.3.
[37] NDIS (Supports for Participants) Rules pt 5.
[38] NDIS Act s 34(1).
[39] NDIS (Supports for Participants) Rules r 2.4; NDIS Act s 33(5)(c).
[40] NDIS Act ss 4, 31.
[41] NDIS Act s 4(1).
[42] NDIS Act s 4(2).
[43] NDIS Act s 4(4).
[44] NDIS Act s 4(8).
[45] NDIS Act s 4(10).
[46] NDIS Act s 4(17).
[47] NDIS Act s 4(11).
[48] NDIS Act s 33(5)(a); NDIS (Supports for Participants) Rules r 4.1(a).
[49] NDIS (Supports for Participants) Rules r 4.1(a).
[50] NDIS (Supports for Participants) Rules r 4.1(b).
[51] NDIS (Supports for Participants) Rules rr 4.1(b), (d).
[52] NDIS (Supports for Participants) Rules r 4.1(c).
[53] NDIS Act s 33(5)(b).
[54] NDIS Act ss 36, 50.
[55] NDIS (Supports for Participants) Rules rr 4.2-4.6.
[56] NDIS Act s 33(1).
[57] NDIS Act s 47(1).
[58] NDIS (Supports for Participants) Rules r 4.1(d).
[59] NDIS Act s 34(1)(a).
[60] NDIS Act s 34(1)(a).
[61] NDIS Act s 33(5)(f).
[62] NDIS Act s 33(3) and NDIS (Plan Management) Rules.
[63] NDIS Act s 33(5)(c).
[64] NDIS Act s 33(3).
[65] NDIS Act s 33(3); NDIS (Plan Management) Rules r 6.2.
[66] NDIS Act s 33(3); (NDIS (Plan Management) Rules r 6.3.
[67] NDIS (Plan Management) Rules pt 6.
[68] NDIS Act s 46(1).
[69] NDIS Act (Plan Management) Rules r 6.4(a).
[70] NDIS (Plan Management) Rules r 6.4(b).
[71] NDIS (Plan Management) Rules r 6.4(c).
[72] NDIS (Plan Management) Rules r 6.4(d).
[73] NDIS (Plan Management) Rules r 6.4(e).
[74] NDIS (Plan Management) Rules r 6.4(f).
[75] NDIS (Plan Management) Rules r 6.4(f).
[76] NDIS (Plan Management) Rules r 6.4(f).
[77] NDIS (Provider Registration and Practice Standards) Rules r 7(3).
[78] NDIS (Provider Registration and Practice Standards) Rules r 7(2).
[79] NDIS Act s 42(2)(b).
[80] NDIS (Provider Registration and Practice Standards) Rules r 7(1).
[81] NDIS (Plan Management) Rules rr 6.6-6.7.
[82] NDIS (Plan Management) Rules r 6.6.
[83] NDIS (Plan Management) Rules r 6.7.

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[84] NDIS (Plan Management) Rules r 6.7.
[85] NDIS (Plan Management) Rules r 6.7.
[86] NDIS (Plan Management) Rules r 6.5.
[87] NDIS (Plan Management) Rules r 6.6.
[88] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules pt 5.
[89] NDIS Act s 34(1).
[90] NDIS (Supports for Participants) Rules r 5.
[91] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules r 5.3(a).
[92] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules r 5.3(b).
[93] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(a).
[94] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(b).
[95] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(d).
[96] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(c).
[97] NDIS (Supports for Participants) Rules r 5.3(a).
[98] NDIS (Provider Registration and Practice Standards) Rules 2018 r 7(2).
[99] NDIS Act s 73F(2)(a).
[100] NDIS (Supports for Participants) Rules r 5.3(b).
[101] NDIS (Supports for Participants) Rules r 5.1(a).
[102] NDIS (Supports for Participants) Rules r 5.1(b).
[103] NDIS (Supports for Participants) Rules r 5.1(d).
[104] NDIS (Supports for Participants) Rules r 5.1(d).
[105] NDIS (Supports for Participants) Rules r 5.2(a).
[106] NDIS (Supports for Participants) Rules r 5.2(b).
[107] NDIS (Supports for Participants) Rules r 5.1(c).
[108] NDIS Act ss 33(5)(c), 34(1).
[109] NDIS Act s 34(1)(a).
[110] NDIS Act s 34(1)(b).
[111] NDIS Act s 34(1)(c).
[112] NDIS Act s 34(1)(d).
[113] NDIS (Supports for Participants) Rules r 3.2(a).
[114] NDIS Act s 34(1)(e).
[115] NDIS Act s 34(1)(f).
[116] NDIS (Supports for Participants) Rules pts 3, 4.
[117] NDIS Act s 33(5)(c).
[118] NDIS Act s 34(1)(a).
[119] *McGarrigle v National Disability Insurance Agency* (2017) 252 FCR 121 at [91].
[120] NDIS Act s 34(1)(a).
[121] NDIS Act s 34(1)(c).
[122] NDIS Act s 34(1)(d).
[123] NDIS (Supports for Participants) Rules r 5.1(b).
[124] NDIS (Supports for Participants) Rules r 5.1(d).
[125] NDIS Act s 34(1)(b).
[126] NDIS Act s 34(1)(c).
[127] NDIS Act ss 3(3)(b), 4(17)(b).
[128] NDIS (Supports for Participants) Rules r 3.1(a).
[129] NDIS (Supports for Participants) Rules r 3.1(b).
[130] NDIS (Supports for Participants) Rules r 3.1(c).
[131] NDIS (Supports for Participants) Rules r 3.1(e).
[132] NDIS (Supports for Participants) Rules r 3.1(f).
[133] NDIS (Supports for Participants) Rules r 3.1(c).
[134] NDIS (Supports for Participants) Rules r 3.1(d).
[135] McCutcheon and NDIA [2015] AATA 624 at [34].
[136] McCutcheon and NDIA [2015] AATA 624 at [34].
[137] McCutcheon and NDIA [2015] AATA 624.
[138] NDIS (Supports for Participants) Rules r 3.2(a).
[139] NDIS (Supports for Participants) Rules r 3.2(b).

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[140] NDIS (Supports for Participants) Rules r 3.2(c).
[141] NDIS (Supports for Participants) Rules r 3.3.
[142] NDIS (Supports for Participants) Rules r 3.3.
[143] NDIS Act s 34(1)(e).
[144] NDIS Act s 34(1)(e).
[145] NDIS (Supports for Participants) Rules r 3.4(a)(i).
[146] NDIS (Supports for Participants) Rules r 3.4(c).
[147] NDIS (Supports for Participants) Rules r 3.4(a)(i).
[148] NDIS (Supports for Participants) Rules r 3.4(a)(ii); JQJT and National Disability Insurance Agency [2016] AATA 478 at [39].
[149] NDIS (Supports for Participants) Rules r 3.4(a)(iii).
[150] NDIS (Supports for Participants) Rules r 3.4(a)(iv).
[151] NDIS (Supports for Participants) Rules rr 3.4(b)(i), (ii).
[152] NDIS (Supports for Participants) Rules r 3.4(b)(iii).
[153] NDIS (Supports for Participants) Rules r 3.4(b)(ii).
[154] NDIS (Supports for Participants) Rules r 3.4(b)(ii).
[155] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(A).
[156] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(B).
[157] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(C).
[158] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(C).
[159] NDIS Act s 34(1)(f).
[160] NDIS (Supports for Participants) Rules rr 3.5-3.7 and Schedule 1.
[161] NDIS Act s 34(1)(f).
[162] NDIS (Supports for Participants) Rules rr 3.5-3.7, Schedule 1; NDIS Act ss 209(4), (8) item 1.
[163] NDIS (Supports for Participants) Rules rr 3.5-3.7, Schedule 1.
[164] NDIS (Supports for Participants) Rules rr 3.5-3.7, Schedule 1.
[165] Disability Discrimination Act 1992 (Cth); Discrimination Act 1991 (ACT); Anti-Discrimination Act 1977 (NSW); Anti-Discrimination Act 1996 (NT); Anti-Discrimination Act 1991 (Qld); Equal Opportunity Act 1984 (SA); Anti-Discrimination Act 1998 (Tas); Equal Opportunity Act 2010 (Vic); Equal Opportunity Act 1984 (WA).
[166] NDIS Act s 118(2).
[167] NDIS Act s 33(5)(c).

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Reasonable and Necessary Supports

Quick summary: The Australian Government made laws about what we can fund under the NDIS. All supports need to meet the criteria in these laws before we can fund them in your plan. We call these the NDIS funding criteria. For example, supports need to be related to your disability, value for money, effective and beneficial, and most appropriately funded or provided by us. Each support must meet these criteria individually, but the supports must also meet the criteria when considered as a package.

What's on this page?

This page covers:

- What principles do we follow to create your plan?
- What supports can you get?
- What other principles do we consider when we decide what supports to include in your plan?
- How do we decide what reasonable and necessary supports to include in your plan?
- Step 1: How do we identify and describe a support in your plan?
- Step 2: How do we work out if an identified and described support meets the NDIS funding criteria?
- Step 3: How do we include the reasonable and necessary supports in your plan?

You may also be interested in:

- Mainstream Supports
- Creating Your Plan
- Changing your plan
- Reviewing our decisions
- Would we fund it?

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What principles do we follow to create your plan?

The NDIS was set up as a world first approach to disability support. It puts people with disability at the centre of decision-making, through the principles of reasonable and necessary supports and individual choice and control.

As an insurance-based scheme, we take a lifetime approach to a participant's support needs. We provide assurance to people with permanent and significant disability or developmental delay, and to people who might acquire disability or developmental delay, that they will get the support they need. Individual funding means we help participants to purchase services and supports from a competitive and consumer-driven marketplace.

What supports can we fund?

NDIS supports should complement, not replace, other supports available to you. That's why we consider:

- the things you're able to do for yourself
- support you have from others in your network, including family members, relatives, friends, local community services and mainstream government services.

One of our aims is to help maximise your independence by working with the local mainstream government and community services that help you live an ordinary life. We all do best when we're connected to our communities.

And as an active consumer, it's important you are able to shop for and access providers who meet your needs. We can help you find providers who meet your needs.

Once we've considered your circumstances, we need to follow the rules determined under the law for the NDIS in our planning decisions.[1] We fund supports that are reasonable and necessary. This means we will only fund a support if it meets **all** of the following criteria:

- the support is related to your disability[2]
- the support will help you pursue your goals and aspirations[3]
- the support will help you undertake activities that will increase your social and economic participation[4]
- the support is value for money,[5] which means that the costs are reasonable:
  - when compared to the benefits to be achieved, for example, whether purchasing the support is likely to reduce the cost of funding other supports in the long term[6]
  - when compared to alternative options that may provide you with the same outcome at a similar or cheaper cost[7]

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- the support is likely to be effective and beneficial for you, having regard to good practice and evidence[8]
- the support is required to complement the informal supports you have available, by taking into account what is reasonable for families, carers, informal networks and the community to provide[9]
- the support is most appropriately funded or provided by the NDIS[10]
- the support is not more appropriately funded by another service system, agency, person or body, such as the education system or the health system.[11] We can't fund a support if it's the responsibility of another service system.

What supports don't we fund?

We do not fund a support if:[12]

- it is likely to **cause harm** to you or others[13]
- it is **not related** to your disability[14]
- it **duplicates** other supports delivered by the NDIS[15]
- it is considered **a day-to-day living cost** (for example, rent, groceries or utility costs like your water bill) that are **not attributable or caused by** your disability support needs[16]
- providing the support would be **against the law**[17]
- it consists of **income replacement**[18]
- it is the **responsibility of other service systems** to provide (for example, your state government, the education system, or the health system).[19] These different systems have different responsibilities, and are designed to complement each other to form a government safety net. Like all Australians, NDIS participants continue to have access to these systems. We can't fund a support if it's the responsibility of another service.

How do we manage the financial sustainability of the NDIS?

The NDIS is an insurance scheme, and one of our core functions is to manage the financial sustainability of the Scheme.[20]

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When we make decisions about the supports we fund in your plan, we must also consider our need to ensure the **financial sustainability of the NDIS**.[21] This means we must work within our funding budget, set through agreements between the Australian, and State and Territory governments.

It's also important to know the NDIS is only one part of the broader National Disability Strategy that supports people living with disability. The overall success and sustainability of the National Disability Strategy relies on:

- people accessing their informal support network to get the help they need from day to day
- people using their personal income to pay for their day to day living expenses, as is expected of all Australians
- mainstream and community services being available from state and territory governments, and other federal government programs such as Medicare
- a fair distribution of NDIS supports to those who need them, provided within our funding budget.

Staying within our budget ensures the NDIS will be here to support generations of Australians and their families.

What principles do we use to create your plan?

We use the following 7 principles, to create plans that help you get the reasonable and necessary supports you need, and to make sure the Scheme is financially sustainable:

- Fair for everyone, both today and for future generations
- Fair funding to pursue your goals
- Evidence-based best practice
- Fair early investments
- Fair support across service systems
- Fair supports for your disability needs
- Fair assistance from multiple programs

Fair for everyone, both today and for future generations

While we need to consider your individual circumstances and disability needs, we also need to make consistent decisions and treat people fairly.

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This means participants with similar circumstances and disability needs should receive similar amounts of supports in their plans. We also need to ensure the total cost of all participant plans are within the overall NDIS budget set by governments.

We use Typical Support Packages to help us do this. The Typical Support Package give us an indication of what supports we'd usually expect to include in your plan, based on your situation and disability support needs.

Each support in your plan must be reasonable and necessary, but they also need to be reasonable and necessary as a package of supports. We approve your whole plan, not the individual supports in your plan in isolation.[22] The Typical Support Package helps guide this validation process.

The Typical Support Package also helps to guide the consistency of our decision making process. We use these to check your overall plan to make sure that all your supports make sense together, and that your support types and amounts will complement each other to help you fulfil an ordinary life.

We may then increase or decrease the funding in your plan based on:

- our discussion with you
- any reports or other information we have
- applying the NDIS funding criteria.

This helps keep the system fair for everyone, and ensure we remain financially sustainable.

Fair funding to pursue your goals

Goals are important.[23] The supports we fund need to help you increase your independence and pursue your goals.[24] This means your supports should help overcome any disability-specific barriers which may be stopping you pursuing your goals.

This doesn't mean we fund all support costs associated with you pursuing your goals. Also, you may have goals and aspirations we can't fund supports for. This is because helping you pursue your goals is only one of the NDIS funding criteria, so not all supports that help you to pursue your goals will be reasonable and necessary.

Other things to know about when setting your goals:

1. **Setting more goals or bigger goals doesn't mean we'll provide more funding or fund more supports.** For example, if your goal is to live independently in a house with a swimming pool, we may fund home modifications that address your disability related needs. This might be a home modification to make your bathroom accessible.

We won't fund the swimming pool because this isn't related to your disability support needs. The funding in your plan might be similar to someone else who has a goal of 'to have a more accessible bathroom'.

2. **Setting a goal doesn't mean we have an obligation to fund supports that help you pursue that goal.** For example, if your goal is to get a gym membership to get fit, we wouldn't usually fund this. Gym memberships are things that all people, with or without disability, might want or need.
3. **Setting a goal about an explicit type or amount of support you might want doesn't mean we have an obligation to fund that support or provide that amount of funding.** For example, you may tell us your goal is 'to get a top model shower commode' and you show us the one you want costs $4,000.

   If there is a shower commode that costs $3,000, and your occupational therapist confirms this one will meet your needs, we are more likely to fund this one instead because it is likely to deliver the same result at a lower cost. We may also look at alternatives.

Evidence-based best practice

We only fund supports that will be, or are likely to be, effective and beneficial for you, having regard to current good practice.[25] This means we consider if there is evidence that the support is effective and beneficial for someone with similar disability support needs.

We will consider different types of evidence when making decisions and we won't need an expert report for every support, as we can often rely on other information or evidence.

For example, we may already have information about whether the support is widely accepted to suit someone with your disability support needs.[26] The primary source of evidence we rely on, and give the greatest weight to, is evidence from sources that are reliable and widely-recognised. This includes published and refereed literature, and any consensus of expert opinions. If there is no evidence to show a support is reasonable and necessary,[27] we won't fund the support.

You can find the types of evidence we need on our website, and in Our Guidelines.

Fair early investments

Having access to capacity-building supports early in your NDIS journey is considered to be an early investment. This early investment is intended to help increase your independence, and reduce your reliance on NDIS funding over time.

This is an important concept that we consider when we create your plan, and again at future plan reassessments. When we reassess your plan, we reassess all the supports you require to meet your disability support needs at that time.

Over time, your capacity building supports may no longer be reasonable and necessary, in regard to your current functional capacity, the effectiveness of the capacity building supports,[28] and value for money.[29]

If your overall funding level goes down from one plan to the next, it may be because you no longer need the same type or amount of supports, such as capacity building supports. Also, if the capacity building investment has been successful at building your independence, then your need for other supports may also decrease, for example core supports.

So other things being equal, you should expect your overall plan value to reduce over time as the benefits of capacity building are realised.

Fair support across service systems

The support you need may be the responsibility of another government service, such as education or health. We don't fund these services, and need to consider the supports you should receive from these services when determining the supports in your plan.

Fair supports for your disability needs

When we make decisions about which supports we can fund, we consider whether a support is reasonable and necessary for you and apply the NDIS funding criteria. Sometimes, you might ask for supports to help with impairments that were not part of your Access eligibility assessment. When this happens, we need to make sure the support will help you address needs that arise from an impairment that meets the same eligibility criteria we consider at Access.

You don't need to make a new Access request if you ask for supports to help with an impairment that was not part of your Access eligibility assessment. We will work out if you need the support you have asked for to address an impairment that would meet our Access criteria. We may ask you to provide evidence to help us work this out. We will decide if the requested support is reasonable and necessary. We will apply the NDIS funding criteria based on the impairments that would meet our Access criteria.

By funding the right disability supports for your permanent impairments that meet our Access criteria, we are ensuring the system is fair for everyone, and that the NDIS remains financially sustainable.

Fair assistance from multiple programs

NDIS funding can't duplicate other funding or supports you may receive due to your disability.

For example, you may have received a lump-sum payment or receive regular payments as a form of compensation for an accident. Or, you may be receiving ongoing supports from

another program or insurance scheme, for example, Worksafe or the Transport Accident Commission.

We don't duplicate this funding or these supports. We may reduce the total value of your NDIS plan to account for compensation you receive, or we may not fund certain supports.

What supports can you get?

When we create your plan with you, we'll discuss what supports you need for your disability. We want to help you pursue your goals, increase your independence, and help you work, study and join social activities.

There are many supports you can get outside the NDIS. Other government and community services provide supports to all Australians, including people with disability. And your friends, family, and other people you know can often be your best supports.

We can fund supports you need for your disability if they meet certain criteria. These are called 'reasonable and necessary supports'. Your plan and supports will be just for you, so you have more choice and control over how you use them.

This guideline explains how we decide what reasonable and necessary supports we'll include in your plan. There are lots of things we have to consider, which we'll explain in detail.

We also have a Would we fund it guide. It has examples of how we decide whether we fund different types of NDIS supports.

What supports can you get outside the NDIS?

Before we decide what reasonable and necessary supports to fund in your NDIS plan, we'll first discuss what other supports may be available outside the NDIS. This is an important information-gathering step. For example, there may be mainstream, community and informal supports that suit you.

Mainstream supports are other government services such as employment, education, health and family support services. They are often really helpful, and are available to everyone including people without disability. There are many ways they can help you learn new skills or live as independently as possible.

Community services offer a wide range of supports that may help with your disability support needs. Community supports are things open to everyone in the community, like sporting clubs, community colleges, activity groups, libraries or community gardens. They are often a great way to get involved in your local community, meet new people and learn new skills.

Informal supports, like your family, friends and other people you know in your community, can sometimes be your best supports. They know you and can often help in ways other supports can't.

Your planner, local area coordinator or early childhood partner will talk with you about what services are available for you outside the NDIS. We can also help link you with these supports, so you don't have to do it all on your own.

Accessing these supports is a good way to work toward your goals. You get to do it with other people and be involved in your community. Using these supports is part of life for most of us. It's important you get to access them the same as everyone else.

When it comes time to talk about what reasonable and necessary supports we can fund, you'll know how mainstream, community and informal supports can help you.

It's important we gather this information and help you access these services before we consider what reasonable and necessary supports we can fund. That way, we can help make sure you're able to access mainstream, community and informal supports wherever possible. This can help you become as independent as possible.

What are reasonable and necessary supports?

An NDIS support is the practical description of how you will be assisted under the NDIS.[30] Supports are the things we provide or fund to help to meet your disability support needs.

NDIS supports are the services, items and equipment we can fund or provide under the NDIS.

There are two types of NDIS supports. We call them 'general supports' and 'reasonable and necessary supports'.[31]

General supports

General supports are the coordination, strategic or referral services and activities we provide, or arrange to be provided, for you.[32] They're how we help you develop your NDIS plan and connect with supports and activities in your community. This includes your mainstream, community and informal supports. Learn more in Creating your plan.

Reasonable and necessary supports

Reasonable and necessary supports are the supports we fund in your plan to meet your disability support needs.[33] You can use this funding to buy supports from service providers.

The Australian Government made laws about what we can fund under the NDIS.[34] All supports we fund in a plan need to meet the criteria set out in these laws. We call these the NDIS funding criteria.[35]

To meet the NDIS funding criteria, a support must meet both the following criteria:[36]

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- It must not be a type of support the law says we can't fund or provide.[37]
- It must meet the reasonable and necessary criteria.[38]

We call supports that meet the NDIS funding criteria 'reasonable and necessary supports'.

Each individual reasonable and necessary support in your plan must meet the NDIS funding criteria. Your whole plan as a package of supports must also meet the NDIS funding criteria.

We check your overall plan to make sure all your supports make sense together. This means we check that your supports and the amount of supports will complement each other to help you fulfil an ordinary life.[39]

If you need a new support, which now means your overall package of supports doesn't meet the NDIS funding criteria anymore, we may either:

- not include the new support in your plan
- include the new support in your plan, but also reduce the other supports in your plan.

For example, a home modification may reduce your need for other supports. If we plan to fund a home modification, we will need to take that home modification into account when considering what other supports are reasonable and necessary, such as the amount of care you need at home.

What other principles do we consider when we decide what supports to include in your plan?

As far as possible, we have to act according to principles set out in the law for the NDIS.[40] These are the things that guide us when we make decisions about what we fund.

These principles don't override or replace the NDIS funding criteria under the law for the NDIS. They can help us apply the funding criteria, by giving us additional guidance when we decide what supports to approve in your plan.

The principles include the following:

- You have the same right as other Australians to realise your potential for physical, social, emotional and intellectual development.[41]
- You should be supported to take part in and contribute to social and economic life.[42]
- You should be supported to make choices about planning and how your supports will be delivered. This includes taking reasonable risks, so that you can pursue your goals.[43]
- You have the same right as other Australians to decide your own best interests. You have the right to be an equal partner in decisions that affect your life.[44]

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- Your privacy and dignity should be respected.[45]
- We must make sure the NDIS is financially sustainable.[46]

The principles also tell us that the reasonable and necessary supports we fund should:[47]

- support you to pursue your goals and maximise your independence
- support you to live independently and to be included in the community as a fully participating citizen
- develop and support your capacity to do things that help you participate in the community and in employment.

Just because a support helps you do these things doesn't mean we'll fund it in your plan. All supports we fund need to meet **all** the NDIS funding criteria.

We consider these principles set out in the law for the NDIS, along with the principles we follow to create your plan.

How do we think about an ordinary life when deciding what supports to include in your plan?

To help guide us in our decision making about reasonable and necessary supports, we took advice from the NDIS Independent Advisory Council.

The Council represents people with disability and carers, bringing their own lived experience and expertise of disability. They give us advice on how the NDIS should work.

The Council advised us that all Australians, including people with disability, should have an 'ordinary life.' They also told us we should think about the idea of an ordinary life when we apply our principles and use the NDIS funding criteria.

An ordinary life is a life where you have the same opportunities as people without a disability. An ordinary life is one that is typical or usual for everyone in modern day Australia. It's a life where you can pursue your potential and participate in society on an equal basis with others.

An ordinary life will be different for different people. We are all different, and come from different cultures and backgrounds. We each have our own values, experiences, beliefs and goals.

But there are some common things that can improve the quality of our lives and help us participate equally. These are the things, such as the following, that make up an ordinary life:

- Positive relationships – with families and informal support networks.
- Individual autonomy – being free and independent, and having the same opportunities as people without disability.

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- Active involvement in decision-making – including the ability to make meaningful decisions, and exercise choice and control.
- Using your strengths in ways that provide a challenge and enjoyment.
- A sense of belonging – to our families, friendship networks, communities, workplaces and society.
- Active involvement and contribution to society and your community.

An ‘ordinary life’ in the context of the NDIS involves supporting you to:

- have and maintain good relationships
- belong and participate in your community
- be involved in making choices about your own life.

One way we can help you have an ordinary life is to support you to access mainstream, community or informal supports wherever possible. These are the usual supports that everyone in the community uses.

When we fund reasonable and necessary supports under the NDIS, we need to make sure they meet the NDIS funding criteria.

When we apply the NDIS funding criteria and make decisions about reasonable and necessary supports, we’re guided by the principles in the law for the NDIS. We also consider how the supports will best help you to live an ordinary life.

How do we decide what reasonable and necessary supports to include in your plan?

What information do we consider to work out what reasonable and necessary supports to fund in your plan?

The most important information we gather about what supports to include in your plan comes from you.

When we create your plan, we will talk with you about:

- your goals and aspirations[48]
- your strengths, capacity and individual circumstances[49]
- any barriers, limitations and restrictions you face in undertaking activities or things that stop you from living an ‘ordinary life’[50]
- your disability support needs[51]

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- any risks and safeguards we may need to think about when considering your support needs.[52]

We want to get a good understanding of your disability support needs. We encourage you to involve anyone in the planning process you want to help you.

Learn more about what information we ask for when we create your plan.

We also consider other information we have such as medical or therapy reports, or assessments that you have had.[53]

We may also ask for further information and assessments, if we need them to help us work out your support needs.[54]

To help us work out what supports to consider for people aged 7 years and older, we also use a 'Typical Support Package'.[55] We worked with people with disability, professionals and subject matter experts to develop the Typical Support Package.

It helps us work out the types of supports we'd usually expect to include in your plan. It's based on your situation and support needs.

We then amend the supports suggested by the Typical Support Package to include more, less or different supports if we need to. We may adjust the funding for those supports up or down based on our discussion with you, any reports or other information we have, and when we apply the NDIS funding criteria.

For children younger than 7, we consider the child's current functioning across development areas when we work out the reasonable and necessary supports that should be funded in a child's NDIS plan. Learn more about the Early Childhood Early Intervention approach.

How do we consider your goals when we work out your reasonable and necessary supports?

When we create your plan, you set your goals and tell us what information about your life you want in your plan.[56] Your goals are your own personal desires about what you'd like to do.

You can set any goals you like, even if they're about things we won't fund supports for. You can also change your goals at any time.[57] We consider how your funded supports will help you pursue your goals when we decide to approve your plan.[58]

Reasonable and necessary supports should help you pursue your goals,[59] but you don't need a specific goal for every support in your plan. When we decide if a support will help you pursue your goals, we consider your whole situation.

We look at the disability specific barriers that prevent you from pursuing your goals, and how the support will address your disability support needs.

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There are some things to remember when setting goals:

- Setting more and bigger goals doesn't mean we'll fund more and bigger funded supports.
- Setting a goal doesn't mean we have an obligation to fund supports that help you pursue that goal.
- Setting a goal about an explicit type or amount of support you might want doesn't mean we have an obligation to fund that support or in that amount.

This is because helping you pursue your goals is only one of the NDIS funding criteria.[60] A support must meet all of the NDIS funding criteria to be funded under the NDIS. So not all supports that help you to pursue your goals will be reasonable and necessary supports.

Learn more about setting your goals and how we consider your goals under the NDIS funding criteria.

What if your plan is being reassessed?

If it's not your first plan, we also consider how well the supports funded in your previous plans worked for you.[61] This means we'll ask about how your current plan has worked for you.

This will help us decide whether these supports continue to meet your needs and the NDIS funding criteria. Learn more about changing your plan.

How do we use the information we have to work out what reasonable and necessary supports to fund?

We consider all the information we have gathered to decide what reasonable and necessary supports to fund in your plan.

We use the information you give us and follow the steps below:

- **Step 1**: Identify and describe the supports to be considered. The support will be described either generally (known as 'flexible' funding for supports) or specifically (known as 'stated supports' or 'fixed' supports).[62]
- **Step 2**: Work out if the support identified and described meets the NDIS funding criteria.
- **Step 3**: We include the supports that meet the NDIS funding criteria in your plan.

When we approve your plan we make sure all your supports meet the NDIS funding criteria individually and as a package of supports.[63]

Step 1: How do we identify and describe a support in your plan?

The first step in deciding what reasonable and necessary supports we can fund is to properly identify and describe the support.[64] This is an important step. We need to be clear on exactly what support we're considering, before we can decide if the support meets the NDIS funding criteria in Step 2.

When we assess your support needs and identify what supports to consider in your plan, we use:

- the information you give us at your planning meeting
- any assessments or other information we have
- the Typical Support Package for people aged 7 years and older.

We identify a support as the service, item or equipment you need to help with your disability support needs. We think about:

- what the outcome of the support will be
- how the support helps with your disability
- whether the support meets the NDIS funding criteria.

How do we describe supports?

We can describe the supports in your plan as one of the following:

- **Flexible**: Under the law for the NDIS, this is when we describe the support generally. You have greater flexibility over what disability supports you can buy within the description of the support.[65]
- **Fixed**: Under the law for the NDIS, this is when we describe the support specifically. It means you must buy the support in the way we have described in your plan.[66] We sometimes call this a 'stated support'.[67]

You must act according to your plan, and buy supports according to how we described them in your plan. This means you can't use the funding in your plan to buy supports that fall outside the description of the support in your plan.[68]

So if we describe the support as fixed, you must comply with how we describe it. This includes how the support is provided. For example, we will sometimes require the support to be provided:

- by a particular service provider

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- by a particular qualified person
- through a particular delivery mode or method, or in a special way.

We describe most supports as flexible when we can. When supports are described as flexible, you will have greater flexibility over the support you can buy that falls within the description of the support in the plan. When supports are described as fixed, you will have less flexibility.

We divide your supports into 3 different budgets:

- **Core Supports** – supports for everyday activities
- **Capacity Building Supports** – supports to help you build your skills and increase your independence
- **Capital Supports** – supports such as assistive technology, vehicle modifications, home modifications and Specialist Disability Accommodation.

Each budget is divided into a number of support categories. Support categories have more detail about what supports you can buy with your funding. When we describe your supports as flexible, you can usually choose what supports you buy within the descriptions for each support category.

Your Core Supports budget is the most flexible. You can usually use your funding across all the support categories except transport in the Core Supports budget if:

- we described the supports as flexible
- you have the same plan management options for your Core Supports.

Learn more about the support budgets and support categories in your plan.

When we decide whether to describe supports as fixed or flexible, we consider:

- how much the support costs[69]
- if the support will help reduce the cost of supports over time,[70] for example providing more supports early so you don't need as many supports later in life
- any risks with supplying the support, for example if the support would create risks to your health and safety or if it doesn't comply with state or territory laws[71]
- if you need a particular support to pursue your goals or to use other supports in your plan effectively[72]
- if you need a specialist support, for example if your support must be delivered by a qualified person, or in a special way[73]
- if you were eligible for the NDIS under the early intervention criteria.[74]

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When do we describe supports as fixed?

We usually describe high-cost supports, or supports with more risk, as fixed. For example, we might describe supports as fixed if you need to use those particular supports to ensure your health and safety. This includes supports such as:

- high-cost assistive technology
- high-cost home modifications
- behaviour support, or supports that involve restrictive practices such as restraint
- Specialist Disability Accommodation.

We will also check if you were eligible for the NDIS through the early intervention criteria.[75] If so, we might decide to describe the supports as fixed for some types of early intervention supports.[76] If you're not sure whether you met the disability criteria or the early intervention criteria, check the letter we sent you when we decided you're eligible.

Example

John just received his first plan. His plan describes support for assistive technology as flexible, including $2,000 of funding. John can choose what assistive technology to buy with this funding. John talks to his occupational therapist about what assistive technology he should buy with this funding. For example, he could buy a shower chair, or low-cost items like a slip-resistant bathmat.

John's plan also has a fixed support for a wheelchair with special features, and funding of $8,000. John will need to use this funding for the specific wheelchair we listed on his plan. He can't use this funding for another support, like a shower chair, instead.

What if you need a specific provider to provide the support?

Sometimes your plan may say who must provide the support. We do this when you need a certain provider to make sure the supports are delivered safely, or to achieve a certain outcome.

For some supports, you must use an NDIS registered provider. These include:

- Specialist Behaviour Support, if the provider will undertake a behaviour support assessment or develop a behaviour support plan[77]
- supports where it's likely a provider will need to use a regulated restricted practice,[78] either interim or ongoing
- Plan Management[79]
- Specialist Disability Accommodation.[80]

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You must use registered providers for these supports even if your plan doesn't say you need to. You must also use registered providers for these supports, even if you self-manage your funding or use a registered plan manager. Learn more about the different plan management options.

For other supports, we'll decide that the support must be provided by a particular person, provider, or delivered in a certain way.[81] We'll do this if it's the most efficient and effective way to provide the support. This only happens when:

- we have an agreement with a particular provider to provide the support[82]
- we decide you must use an NDIS registered provider due to the risks, for example complex home modifications[83]
- you need support from a particular person with specialist qualifications, for example a health professional[84]
- you need support delivered in a certain way.[85]

Sometimes, we'll arrange the support ourselves, if it's more cost effective than getting another provider to deliver the support. For example, we may bulk buy a support.[86] If so, we will state this in your plan.

What about in-kind supports?

We agreed that state and territory governments will keep providing some supports for a period of time. We call these 'in-kind supports'.

If we fund in-kind supports like specialist school transport or personal care in schools, you will need to use state or territory government providers for these supports. These supports are most efficiently and effectively provided by state and territory government providers.[87] Learn more about Work and study supports.

For most other in-kind supports, you can choose your provider if you don't want to use your in-kind provider anymore. We can let you choose another provider if we consider that the support isn't most effectively and efficiently provided by the in-kind provider.

We usually let you choose another provider if:

- another provider can give you the same support or level of support as the in-kind provider
- the supports with the new provider still meet the NDIS funding criteria, including that they're value for money compared to the in-kind support
- there are no serious risks with changing providers.

Learn more about in-kind supports.

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Step 2: How do we work out if an identified and described support meets the NDIS funding criteria?

To meet the NDIS funding criteria, a support must meet both the following criteria:

- It must not be a type of support the law says we can't fund or provide.[88]
- It must meet the reasonable and necessary criteria.[89]

Each support must be reasonable and necessary individually, but the supports must also be reasonable and necessary when considered as a package of supports.

What types of supports can't be funded or provided under the NDIS?

Under the law for the NDIS, there are things we can't fund or provide.[90] We can't fund or provide supports that:

- are not legal[91]
- are income replacement[92]
- are likely to cause harm to you, or pose a risk to other people[93]
- are not related to your disability[94]
- relate to a 'day-to-day living cost', such as groceries, rent or utilities, that are not attributable to your disability support needs. These are costs that are not caused by or as a result of your disability support needs.[95]
- duplicate other supports provided by the NDIS under alternative funding.[96]

Is the support legal?

We can't fund a support if it does not comply with the law.[97] This includes both:

- **an Australian government law:** a law that applies to all of Australia
- **a State or Territory government law**: a law that only applies in your state or territory.

For example, we won't be able to fund supports involving:

- a restrictive practice where it's not authorised in your state or territory
- assistive technology or home modifications that don't meet Australian laws, such as State and Territory Acts and Regulations, the National Construction Code, and relevant Australian Standards
- supports for illegal activities, such as support for criminal behaviour or illegal drugs.

While this is one of the NDIS funding criteria, we're not responsible for ensuring your supports are legal. We're not responsible to ensure that all supports in your plan comply with

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all the relevant legal and administrative requirements. This is your responsibility and your provider's responsibility.

For example, if a support is likely to require the use of a restrictive practice, the provider must be registered with the NDIS Quality and Safeguards Commission.[98] It's the provider's responsibility to ensure they are registered and comply with the conditions of their registration. This includes complying with all laws and seeking the necessary authorisations.[99]

We're not responsible for ensuring the provider is registered and complies with their conditions of registration. You can contact the NDIS Quality and Safeguards Commission if you're concerned about a provider's compliance with legal obligations.

Is the support 'income replacement'?

We don't fund income support or income replacement.[100] This means NDIS funding can't replace or add to money you'd usually earn from working, or income payments you get from Centrelink.

For more information and resources on income support, check out income support payments such as the Disability Support Pension.

If you are interested in getting help to find a job, check out Disability Employment Services or NDIS-funded Work and study supports.

Is the support likely to cause harm?

We can't fund any supports that are likely to either:[101]

- cause harm to you
- be a risk to other people.

We need to consider this for all supports, such as support workers, therapies or equipment. It also means we won't fund supports that involve a regulated restricted practice, such as restraint, unless it follows the requirements of the NDIS Quality and Safeguards Commission.

To help us decide if the support is likely to cause harm, we may need information from a professional. For example, you may need high cost assistive technology, like a powered wheelchair. If so, we would need a report from an occupational therapist to show that it'll be safe for you to use.

Of course everything we do in life comes with some risk. We all make our own choices about how much risk we want to take in our lives. You should also be able to choose how much risk you want to take in your life.

So we try to balance this when we decide what we can and can't fund. We can't fund things that are likely to cause harm. But we will try and balance this with enabling you to make your own choices wherever possible.

While this is one of the NDIS funding criteria, you also have some responsibilities. It's still your responsibility and your provider's responsibility to ensure the supports we fund are:

- used correctly
- safe for you
- safe for other people.

You and your provider will also need to manage any risks of harm that arise. For more information, contact the NDIS Quality and Safeguards Commission.

Is the support related to your disability?

We can't fund a support if it's not related to your disability.[102] This means there must be a direct link or a connection between your disability and the supports we fund.

We look at whether the support addresses your disability support needs. Your disability support needs are those that arise from, or are caused by, your disability.

For example, we wouldn't usually fund things like:

- standard televisions
- standard household furniture such as dining chairs
- upgrades to assistive technology and home modifications that are not related to disability needs, such as marble tiling or leather materials
- flights to go on a holiday
- a car to get to work because there are no public transport options
- a gym membership to get fit
- a swimming pool to relax in summer.

This is because you're unlikely to need these supports as a result of your disability support needs. They are things that all people, with or without disability, might want or need.

Usually, there won't be a direct link or connection between these things and your disability support needs. Having a disability doesn't usually affect whether someone needs or wants these types of things.

Example

Alan needs some changes to his house, so he can use his bathroom and kitchen in his wheelchair. He also wants to set up an outdoor entertainment area for when his friends visit.

We may be able to fund home modifications so he can access areas of his home such as his bathroom or kitchen. He needs the home modifications because he can't access those areas due to his disability and needing to use a wheelchair. Alan needs the support because of his specific disability support needs.

Alan will need to pay for the outdoor entertainment area, as it's not related to his disability. He doesn't need the entertainment area because of his disability, it's just something he would like so he can have his friends over for a barbecue.

Is the support related to a 'day-to-day living cost'?

We can't fund supports related to day-to-day living costs that everyone has to pay, and aren't caused by or result from your disability support needs.[103] This means we don't fund things like:

- rent
- groceries
- utilities such as electricity, water, gas and internet bills
- the general cost of owning a home, like renovations, mortgage repayments, repairs and maintenance.

In some situations, we can fund supports related to your day-to-day living costs. We can do this if the costs are attributable to, or caused by, your disability support needs.[104] This means we may fund supports that relate to day-to-day living costs where either:

- you have additional living costs that are solely and directly as a result of your disability support needs[105]
- the living costs are connected to another support that is funded or provided in your plan, and you wouldn't incur that cost if it wasn't in your plan.[106]

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Example

Nigel has a goal to do his grocery shopping on his own. He needs a shopping basket to attach to his wheelchair to help him carry the items in the supermarket.

Shopping bags and baskets are things we all pay for, whether or not we have a disability. But Nigel only needs this specialised basket for his wheelchair because of his disability support needs.

If it meets the other NDIS funding criteria, we may fund the shopping basket attachment in his plan.

Does the support duplicate other supports funded through the NDIS?

We can't fund a support if it duplicates other supports delivered under alternative funding through the NDIS.[107]

For example, if we're providing support through your early childhood partner or local area coordinator, we usually won't fund Support Coordination in your plan.

This is because your early childhood partner or local area coordinator is already funded to provide similar supports. If we funded the same Support Coordination, we would be duplicating a support we're already providing you as general supports.

However if you need extra support, we may be able to fund additional Support Coordination in your plan. We may do this if it's above the amount of support your early childhood partner or local area coordinator are able to provide. Your early childhood partner or local area coordinator will work together with the Support Coordinator to help you connect with supports in your community.

Does the support meet the reasonable and necessary criteria?

All NDIS supports need to meet **all** the reasonable and necessary criteria.[108]

This means that before we can include an NDIS support in your plan, we need to be satisfied it meets all the following criteria:

- The support will assist you to pursue your goals in your plan.[109]
- The support will assist you to undertake activities, to facilitate your social and economic participation.[110] This means the support will help you to undertake activities, by reducing the disability-related barriers that prevent you from participating in things such as social outings, recreation, work and study.

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- The support represents value for money in that the costs of the support are reasonable relative to both the benefits achieved and the cost of alternative supports.[111] This means we need to consider the costs and benefits of the support, as well as the costs and benefits of alternative supports.
- The support will be, or is likely to be, effective and beneficial for you, having regard to current good practice.[112] This means we consider if there is evidence the support works for someone with similar disability support needs. We won't need an expert report for every support, as we can often rely on other information or evidence. For example, we may have information already about whether the support is widely accepted to suit someone with your disability support needs.[113] We also consider your lived experience.
- The funding of the support takes account of what it is reasonable to expect families, carers, informal networks and the community to provide.[114] This means we need to consider what support is reasonable for your family, friends and community to provide.
- The support is most appropriately funded or provided through the NDIS, and is not more appropriately funded or provided through:[115]
    - other general systems of service delivery, or support services offered by a person, agency or body (for example, a State or Territory Statutory Scheme)
    - systems of service delivery or support services offered as part of a universal service obligation (for example, the health or education system)
    - systems of service delivery or support services offered in accordance with reasonable adjustments required under discrimination laws (for example, your employer, or the health or education system).

The law for the NDIS sets out things that we need to consider when we apply the reasonable and necessary criteria.[116]

We must be satisfied that each support is reasonable and necessary individually, but we must also be satisfied that the supports are reasonable and necessary as a package of supports.[117]

For example, a home modification may reduce your need for other supports. If we plan to fund a home modification, we will need to take that home modification into account when considering what other supports are reasonable and necessary, such as the amount of care you need at home.

If the home modification will reduce your care needs, we may need to reduce the amount of care we fund, as a higher amount may not be reasonable and necessary when the whole package of supports is considered.

Does the support help you pursue your goals?

We need to be satisfied that the support will help you pursue the goals, objectives and aspirations in your NDIS plan.[118] This helps us determine if the support is necessary.[119]

While we only fund supports that help you pursue your goals, objectives and aspirations, we understand that different people express themselves in different ways.

You are free to choose your own goals and express them in your own words.

Your goals can be big or small, short term or long term, simple or complex. They can be about anything you want to work towards.

You may express your goals broadly, or you may have specific goals. For example, you may express one of your goals as 'living independently'. Someone else may express their goal as 'to have an accessible bathroom'.

Learn more about setting your goals in Creating Your Plan and the Setting Goals fact sheet.

Reasonable and necessary supports should help you pursue your goals,[120] but you don't need a specific goal for every support in your plan. When we decide if a support will help you pursue your goals, we consider your whole situation.

We look at how a support will address your disability support needs, and the disability specific barriers that prevent you from pursuing your goals.

A support that addresses your disability related support needs is most likely to help you pursue your goals, objectives and aspirations in your plan.

Setting a goal in your plan doesn't mean we'll provide funding to pursue it. For example:

- setting more and bigger goals doesn't mean we have an obligation to fund more and bigger funded supports in your plan
- setting a goal doesn't mean we have an obligation to fund supports that help you pursue that goal
- setting a goal about an explicit type or amount of support you might want doesn't mean we'll fund that support or in that amount.

This is because helping you pursue your goals is only one of the NDIS funding criteria. A support must meet all of the NDIS funding criteria to be funded under the NDIS. So not all supports that help you to pursue your goals will be reasonable and necessary supports.

For example, we only fund reasonable and necessary supports that are value for money,[121] effective and beneficial[122] and relate to disability support needs.[123]

This means that if your goal is to 'live independently', we **may** fund home modifications that address your disability related needs. However, we won't fund supports related to day-to

day-living costs like rent or utilities. These costs aren't incurred solely and directly as a result of your disability support needs, so they don't meet other funding criteria.[124]

Also, choosing a different goal 'to have a more accessible home' won't change the supports we could fund in your plan.

Achieving goals usually takes many different kinds of supports. NDIS supports will most likely be just one kind of support that helps you work toward your goals.

Learn more about setting goals.

Example

Morgan is ready to look for work and she has a goal in her plan to get a job. She has built up her skills and knows what she wants to do. Disability Employment Services are helping Morgan to find work, so we can't fund this support for Morgan.

However, because of her disability, Morgan will need personal care supports to help her get up and ready for work in the morning. We will consider:

- how Morgan's disability support needs relate to her goals
- whether funding supports that address these disability support needs will help Morgan pursue her goals.

Morgan's planner believes the personal care supports meet this criteria. The supports that address her personal care needs will help Morgan to pursue her employment goals.

However, Morgan's planner then needs to look at whether the support meets the other NDIS funding criteria.

We don't fund all the supports that relate to Morgan's employment goals. We only fund the supports we consider are reasonable and necessary – that is, when they meet all the NDIS funding criteria.

Does the support help you do activities that will help your social and economic participation?

We need to be satisfied that the support will help you to do activities, which make it easier for you to participate socially and economically.[125]

Social participation means doing things you enjoy, like going out with friends, playing sport or going on holiday. It also means doing the things you need to do, like going to school or medical appointments.

Economic participation usually means being involved in things that help you work towards getting and keeping a job. This might be things like volunteering, study, learning new skills or trying work experience. Research tells us that work can lead to health benefits and improve our quality of life. Learn more about the Health Benefits of Good Work.

Social and economic participation are important to most people. They are critical to living an ordinary life.

To work out if a support meets this requirement, we look at the purpose of the support and how it will help you.

We fund reasonable and necessary supports that reduce the barriers that prevent you from undertaking activities. This will help you increase your social and economic participation.

Some supports help economic and social participation directly. There are lots of supports we can fund to directly help with social and economic participation. Learn more about Social and recreation supports and Work and study supports.

Other supports help you to undertake activities like self-care, which indirectly help your economic and social participation.

Example

Sue is going to university next year. She has a vision impairment, and has been working with her Guide Dog Mobility Instructor to decide if a dog guide is right for her. A dog guide can help her leave her home safely and independently, and travel to and from university.

A dog guide could also help her go out with friends and join in other community activities. As long as it meets the other funding criteria, we could fund a dog guide for Sue. It will help her to undertake activities of daily living.

As a result, it'll increase her social and economic participation. For example, the support will help her get to her university so she can study, and will help her social life.

Is the support value for money?

All supports we fund under the NDIS need to be value for money.[126] This means the cost of the support is reasonable, when we consider the benefits of the support and the cost of other supports.

Making sure that your supports are value for money is one of the ways we keep the NDIS financially sustainable. This means we make careful decisions about funding so that we make sure the NDIS exists for future generations. It's also one of our principles.[127]

When we decide if the support is value for money, we consider:

- if other supports would achieve the same result at a substantially lower cost[128] – this means there should be a real or material difference in cost
- if there's evidence that the support will substantially improve your life stage outcomes and benefit you in the long term[129]
- if the support will likely reduce the cost of other supports over time[130]

- how the cost compares to other supports of the same kind in your area[131]
- if the support will make you more independent, and mean you won't need as many supports in future,[132] for example, in some circumstances home modifications may reduce the need for home care.

When we consider the likely cost of supports, we consider the cost over the long term. We consider if the support will help you to achieve milestones at different ages or stages of your life, and have long term benefits.

For example, some supports such as home modifications may be expensive now, compared to other supports. But getting these supports now may mean you need much less support in a few years, or later in life. Or, it may delay the need for other more costly supports.[133]

When we determine the cost of the support, we consider:

- the prices for NDIS supports in the NDIS Price Guide
- supports suggested by the Typical Support Package
- quotes for specific or high risk supports.

It's important we consider the cost of the support. This will be the level of funding we include in your plan, if we decide the support is reasonable and necessary.

When we fund equipment or modifications, we also need to consider:[134]

- how the cost of buying the equipment or modifications compares against the cost of renting them
- if it's appropriate to fund the equipment or modifications you want, based on your circumstances and any expected changes in technology.

Learn more about how we consider value for money when we fund assistive technology, home modifications and vehicle modifications.

Example

Elias needs a shower commode.

He got an assessment and sent us a quote for one that will suit his needs. As part of the process to work out if we can fund it, his planner considers other similar shower commodes.

There's a second commode that's $5,000 cheaper than the one Elias has asked for. But it won't meet Elias' needs, as it won't provide enough back support. That is, it won't achieve the same result as the one Elias has asked for.

Finally, there's a third commode that's $1,000 cheaper. The planner contacts his occupational therapist who confirms the cheaper commode will meet Elias' needs.

Elias' planner decides to fund the commode that's $1,000 cheaper. It'll deliver the same result at a substantially lower cost.

Is the support effective and beneficial?

We need to be satisfied that the support will be, or is likely to be, effective and beneficial, when we consider current good practice.

We need to work out if the support is likely to be both:

- **effective** – it will do what you need it to do[135]
- **beneficial** – the support will help you do things you can't otherwise do and meets your support needs.[136]

It can also be effective and beneficial if it will help you maintain your current level of functioning. That is, it will help you keep doing the things you can currently do. And, it'll help you maintain your work, study and social life as much as you can.[137]

When we decide if a support is effective and beneficial, we look at what is current good practice. This means we look at whether there is evidence that the support works for someone with similar disability support needs to you. We won't need an expert opinion or report for every support, as we can often rely on other evidence.

For example:

- We may have information already about whether the support is widely accepted to suit someone with your disability support needs.[138] For example, we could rely on academic research and other literature. This could include university studies on therapies that have been published and refereed in academic journals, evidence based practice resources, or clinical practice guidelines.
- If you or other participants have used the support before, we can consider your experience using the support and the experience of your family members and carers.[139]
- We may consider things we have learnt from other participants in the NDIS with similar support needs to you.[140]

We know you're the expert in your own life, and we use your own experience as much as we can.

For example, we will talk to you about any supports that have helped you do things you can't otherwise do. Or, some supports may have helped maintain your ability to be as independent as possible.

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If it's a new support such as new assistive technology, we might fund a trial. This is so we can learn from your experience of using the support, to check if it's likely to do what you need it to.

Your evidence can be particularly useful when it's consistent with other evidence, or if we don't have expert evidence.

We will look at the opinions held by the majority of experts and what they generally agree on.[141] Sometimes we will have to seek expert opinion or report to make a decision.[142]

For example, we may need the views of doctors or health professionals who may be specialists in managing your disability.

Example

Vivek is 12 and has a goal to improve his communication skills. He and his family want him to improve his social skills with the kids in his class.

When he was younger, Vivek's family tried speech therapy, and believe it really helped him improve his communication. His family told his planner about how it helped Vivek learn how to respond to different social settings.

Vivek's speech therapist also believes it could work well for him now, and help him interact with his classmates.

When deciding whether the therapy is effective and beneficial, Vivek's planner will consider:

- how speech therapy has assisted Vivek in the past, including first-hand information from Vivek, his family members and carers
- the views of his speech therapist on the effectiveness and benefits of speech therapy for Vivek
- other information or expert evidence about the effectiveness and benefits of speech therapy, including for a child of the same age, and with the same impairments and functional capacity.

Based on this information and evidence, Vivek's planner decides the speech therapy is effective and beneficial. If it meets the other funding criteria, we will be able to fund speech therapy in Vivek's plan.

Is the support something we would reasonably expect your informal supports, like family or friends, to provide?

We need to be satisfied that funding the support takes into account what is reasonable to expect families, carers, informal networks and the community to provide.[143]

To make sure we understand how disability supports might work for you, we consider:

- the things you're able to do for yourself
- any support you have from others in your network – including family members, relatives, friends and local community services.

When we fund supports under the NDIS, we have to think about whether it's reasonable to expect your informal supports to provide that support. We can't fund supports that an ordinary person would think is reasonable to expect friends, family or the community to provide for you.[144]

Informal supports are the help and support you get from friends, family and the community. They are called 'informal' because you don't pay for them, and they're not part of a formal agreement. They are the usual things friends and family do for us, and with us.

Most of us get some kind of help and support from friends and family. In our society, we expect that friends, family and our community will support each other and help each other out when they need it.

A good example is families who have young children. In our community, we expect families will provide most of the support a young child needs.[145] They will change a child's nappy, make sure they are safe and drive them around places.

Grandparents, uncles and aunties often have a role to play in supporting young children as well. Neighbours and friends might also help care for the child.

As a child gets older, our society's expectations of the role of the family and community in caring for the child changes. For example, we expect schools to help support the child's learning needs.

We also usually expect the role of family in providing personal care for a child would reduce as they get older and develop new skills and independence. But families are usually still responsible for things like food, emotional support, decision-making and providing a safe home.

It's a similar idea for adults. Our society expects that adults – like family, friends and neighbours – will provide some support to each other. This might be things like taking a friend with you to the football game, or providing emotional support if someone is upset.

NDIS supports won't ever replace the support people like your friends and family provide to you. This support is given freely because people care, and is often quite different to supports bought with NDIS funding.

You have a special bond with your friends and family that's different from your relationship with paid carers. And there are potential risks and problems for you if your friends and families become your paid carers.

To make sure we understand how disability supports might complement your circumstances, we consider:

- the things you are able to do for yourself
- any support you have from others in your network including family members, relatives, friends and local community services.

We also have to consider the benefits you may get from your informal supports. For example, your family and friends may be more effective at helping you meet other people, or helping to build your social skills, than paid supports can.

We consider if we can help these relationships so that you get the support you need.[146] For example, we may be able to fund training for your informal supports, so they can help you build your skills.

We also think about the capacity of your informal supports to continue caring for you, for example if they're ageing or sick.

There are different things the law for the NDIS says we need to consider for adults and children.

If you're under 18, we consider what support is reasonable to expect parents to provide at your age. It's normal for parents to provide substantial care and support for children.[147] We consider that it's usual for parents to provide almost all the care and support that young children need.

For example, it's reasonable to expect parents to provide transport to and from their child's after-school activities. Of course, the amount of care and support for a child without a disability would typically reduce as they get older.

For children under 18, we consider:

- if your needs are 'substantially greater' because of your disability, compared to other children the same age[148] – that is, you need much more disability support
- any risks to the wellbeing of people providing informal support to you[149]
- if including funding for the support will help build your skills and capacity in the future, or reduce any risks to you.[150]

For example, we consider any health, safety or other impacts resulting from what's involved in meeting your disability support needs.

If you're over 18, we consider:

- if there are any risks to you or your informal supports if you rely on them to provide the support you need[151]
- how much your informal supports would help improve or reduce your independence and other outcomes[152]

We also consider the suitability of informal supports to provide the supports you need,[153] including:

- how old your carers are and their capacity to provide the support[154]
- if other family members and the community can help your informal supports in their caring role[155]
- the intensity and type of support you need, and if it's appropriate for your informal supports to provide this, based on their age and gender[156]
- any long-term risks to the wellbeing of your informal supports.[157]

When we consider the risks for people over 18, we consider if the supports are sustainable for your informal supports. We consider the health, safety and other impacts on family and carers in the long term.

For example, we wouldn't expect a child to have their schooling affected because they need to provide care. We also wouldn't expect an elderly parent to be responsible for physical activities, if it may result in injury.[158]

We generally don't fund family members to provide supports funded under the NDIS. There are very limited situations where we can consider this. Learn more about Sustaining Informal Supports.

Example 1

Simon is getting his first NDIS plan. For the last 15 years, Simon and his wife Jan's preference was that Jan provide all the physical support he needs at home, such as toileting and showering.

But as Jan is getting older, it's not safe for her to keep lifting Simon. It's becoming risky for her to keep providing this support.

Jan and Simon think it might be best for someone else to provide the personal care support that Simon needs. Their children have moved out of home, and it's not reasonable to expect them to help Simon with personal care.

Based on this information and other evidence, Simon's planner decides that the personal care support meets this criteria. It takes into account what is reasonable for his family and others to provide. If the personal care support meets the other funding criteria, we may fund the personal care support for Simon.

Simon and Jan still prefer Jan to do the other support Simon needs though, such as helping Simon eat his meals. At this time, we wouldn't fund a support worker in Simon's plan to help him eat his meals. It's reasonable to expect Jan to help Simon with this, as it's what they want to do and it's not a safety risk for Jan.

Example 2

Qing is 14 and wants to join a local footy club. Like most 14 year old's in this situation, she needs someone to drop her off and pick her up from the Saturday matches and the weeknight training sessions.

But unlike most 14 year old's, she needs someone to help her get dressed before she can go to the match. Her parents have been doing this, but as Qing is getting older she no longer wants her family to help her get dressed.

It's reasonable to expect her family or other informal supports to drop Qing to and from the match and training sessions. So we wouldn't fund transport in Qing's plan.

But at age 14, it's not reasonable to expect her family to help her get dressed.

Based on this information and other evidence, Qing's planner finds that the personal care support takes into account what is reasonable for family and others to provide. If it meets the other funding criteria, we may fund personal care support in her plan.

Is the support more appropriately funded or provided through the NDIS, and not through other service systems or support services?

We have to be satisfied that the support is most appropriately funded or provided through the NDIS. This means it's not more appropriately funded or provided through:

- other general systems of service delivery, or support services offered by a person, agency or body (such as a State or Territory Statutory Scheme)
- systems of service delivery or support services offered as part of a universal service obligation (such as the health or education system)
- systems of service delivery or support services offered in accordance with reasonable adjustments required under discrimination laws (such as your employer, or the health or education system).[159]

In short, we won't fund the support if it should be provided by someone else.

We won't fund the support if the support should be provided by someone else, even if the other service system doesn't actually provide it. We're not the funder of last resort, so we don't make up for other organisations and systems that don't provide the supports they should.

The law for the NDIS sets out a number of things we need to consider, when we decide who is most appropriate to fund or provide of the support.[160] There are different things we consider for the following service systems:

(a) Health

(b) Mental health

(c) Child protection and family support

(d) Early childhood development

(e) School education

(f) Higher education and vocational education and training

(g) Employment

(h) Housing and community infrastructure

(i) Transport

(j) Justice.

How does the NDIS work with other government services?

We call supports provided by other government services, including those provided as part of a universal service obligation, 'mainstream supports'. When we talk about mainstream supports, we mean supports available to everyone in your state or territory, or across Australia, regardless of whether or not you have a disability.

This includes services provided by state and federal governments, like health care, education and mental health services.

You have the same right as all Australians to access these services. There are certain things that mainstream services have to do to make their services accessible for people with disability. Using mainstream supports can also help you be part of your community, or to work or study.

When we fund NDIS supports, we need to check that the support is not more appropriately funded or provided by a mainstream service or system, such as the education system or health system.[161] Under the law for the NDIS, we can't fund supports that should be provided by a mainstream service.

The Australian federal, state and territory governments agreed on responsibilities for funding different types of supports. The law for the NDIS has an outline of funding responsibilities and were developed with the agreement of each State and Territory.[162]

We can only fund supports that are the responsibility of the NDIS. We can't fund supports that are the responsibility of other government services, even if they don't actually fund or provide the support. The law for the NDIS sets out the matters we should consider when we decide who is more appropriate to provide or fund a support.[163]

Learn more about how we decide if the support is best funded or provided by us or another part of government.

The Applied Principles and Tables of Support also has information on what the governments agreed are the responsibilities of the NDIS and other government services. However, it doesn't override what we consider when we decide if the support is most appropriately funded by the NDIS.[164]

What is reasonable adjustment and why is it important?

People with a disability can sometimes face barriers that make it harder to do the same things as people who don't have a disability. For example, it might be harder to find and keep a job. Or it might be harder to get in and around places, or to get the same services as other people.

It's against the law to discriminate against people with a disability in many areas.[165] This includes in employment, when providing goods and services, and when accessing public places.

This means organisations or people who are responsible for providing these services have to make what are called 'reasonable adjustments'. They have to make sure people with a disability have equal access to the services they provide, as far as is reasonable.

They have to do reasonable things that will make their services equally available to everyone, whether or not you have a disability.

Reasonable adjustments do not mean they have to provide everything you need because of your disability. It means they have to do what's reasonable to make sure you have equal access to employment, public spaces or services. This takes into account what they can afford to do and what is reasonable to expect them to provide in the circumstances.

When we decide what supports to include in your plan, we need to consider what should be provided through reasonable adjustments. Under the law for the NDIS, we can't fund a support if it should be provided by someone else through reasonable adjustments.

What if you're transitioning to the NDIS in Western Australia?

The federal and Western Australian governments made a commitment for people receiving supports before becoming a participant in the NDIS.

They committed that you shouldn't be disadvantaged by your transition to the NDIS. We call this the 'principle of no disadvantage'.

When we create your plan, we must use our best endeavours to follow government agreements.[166] This doesn't mean you'll always have the same level of funding, or that you'll get supports in the same way.

All supports we fund must meet all the NDIS funding criteria. So we may not be able to fund supports you received before the NDIS, if they don't meet the funding criteria.

If we can't fund those supports, we'll see how we can help you meet the same outcomes as you did before the NDIS.

This may mean we include other supports in your plan that address your disability support needs and help you pursue your goals. Or, we could help you connect with other government services that can provide the supports you received before the NDIS.

When we create your plan, we consider whether or not you're disadvantaged overall by joining the NDIS.

What else do you need to know about working out if supports meet the NDIS funding criteria?

From our experience, we learned there are some common misunderstandings about how we work out what supports meet the NDIS funding criteria.

Why don't we always fund what your health professionals recommend?

Although we take expert opinions into account, we can't and don't always fund everything your health professional might recommend. This is because every support we fund needs to meet all the NDIS funding criteria.

For example, your therapist might recommend a piece of equipment on the basis that it will be 'effective and beneficial' for you. But if there is something cheaper that will achieve the same outcome, we won't be able to fund what the therapist recommended.

This is because it won't be value for money. We may be able to fund the cheaper option instead if it meets all the NDIS funding criteria.

Why don't we fund the same supports as your last plan?

We might fund different supports in your next plan. This is because we will fund supports in your plan based on how we use the NDIS funding criteria at that point in time.

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Your needs and situation will most likely change over time. This means it's likely your NDIS supports and funding for those supports will change over time.

For example, we may have funded supports to help you build your skills in a particular area. Once you have built those skills, you won't need funding for that any more. So, we probably won't include that funding for those supports in your next plan.

Supports to build your skills may have met the NDIS funding criteria before, but the same supports might not meet the criteria in future.

Or, your disability support needs might increase or decrease over time. This may mean we consider funding more or less supports as a result.

What happens if you don't use all your funding in your NDIS plan?

We will consider how you have used your NDIS funding to help us work out what supports meet the NDIS funding criteria in your next plans.

If you haven't used all the funding by the end of your plan, it doesn't mean we'll reduce the funding in your next plan. There may be very good reasons why you weren't able to buy the supports we funded.

When we reassess your plan, we'll talk about any problems you had buying the supports funded in your plan. We'll also see how we can help you use your funding if we need to.

But if you consistently don't buy all the supports we fund and use all of your NDIS funding, we need to think about whether the supports really do meet the NDIS funding criteria. For example, they may not be 'effective and beneficial' for you if you're not actually using them. We will talk to you about this when we reassess your plan.

Learn more about changing your plan

Step 3: How do we include the reasonable and necessary supports in your plan?

Once we've identified the supports, and decided they meet the NDIS funding criteria, we can include the description and funding for the support in your plan.

If the support doesn't meet the NDIS funding criteria, we can't include the support in your plan. We may consider if a differently described support meets the NDIS funding criteria instead.

When we approve your plan we will also make sure all your supports are reasonable and necessary when considered as a package of supports.[167]

Sometimes you might not need any supports under the NDIS. For example, your informal supports may meet all your disability support needs. If so, we'll approve a plan with no funded supports.

Learn more about how we create and approve your plan.

Learn more about using the funding in your plan.

What happens if we don't include the supports you want?

If we decide a support doesn't meet the NDIS funding criteria, we can't include the support in your plan. Also, if the amount of support you want doesn't meet the criteria, we can't include that amount in your plan.

But, we're committed to our principles and helping you live an ordinary life. Even if we can't fund a particular support we may still be able to help.

If the support doesn't meet the NDIS funding criteria, we can consider if a different support meets the NDIS funding criteria. We might be able to consider describing the support differently, or funding a different type of support.

Or, we may be able to connect you to mainstream or community supports that can help. Mainstream and community supports are available to everyone. They can be a good way to connect with your local community, learn new skills and gain independence.

There are lots of ways we might be able to help, so talk to us if you're in this situation. We can do this at any time. We may be able to help before we approve your plan.

We'll give you the reasons for our decision to approve your plan in writing.[168] You can contact us if you'd like more detail about the reasons for our decision.

If you don't agree with the supports we approve in your plan, you can ask for an internal review of our decision.[169] You'll need to ask for an internal review within 3 months of getting your plan.[170] [171]Learn more about internal and external review of decisions.

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Reference List

[1] NDIS Act and delegated legislation made under the NDIS Act, especially NDIS (Supports for Participants) Rules and NDIS (Plan Management) Rules.
[2] NDIS (Supports for Participants) Rules r 5.1(b).
[3] NDIS Act s 34(1)(a).
[4] NDIS Act s 34(1)(b).
[5] NDIS Act s 34(1)(c).
[6] NDIS (Supports for Participants) Rules r 3.1(c).
[7] NDIS Act s 34(1)(c); NDIS (Supports for Participants) Rules r 3.1(a).
[8] NDIS Act s 34(1)(d).
[9] NDIS Act s 34(1)(e).
[10] NDIS Act s 34(1)(f).
[11] NDIS Act s 34(1)(f).
[12] NDIS (Supports for Participants) Rules part 5.
[13] NDIS (Supports for Participants) Rules r 5.1(a).
[14] NDIS (Supports for Participants) Rules r 5.1(b).
[15] NDIS (Supports for Participants) Rules r 5.1(c).
[16] NDIS (Supports for Participants) Rules r 5.1(d).
[17] NDIS (Supports for Participants) Rules r 5.3(a).
[18] NDIS (Supports for Participants) Rules r 5.3(b).
[19] NDIS Act s 34(1)(f).
[20] NDIS Act s 118(1)(b).
[21] NDIS Act s 4(17).
[22] NDIS Act s 33(2).
[23] NDIS Act s 33(5)(a).
[24] NDIS Act s 34(1)(a).
[25] NDIS Act s 34(1)(d).
[26] NDIS (Supports for Participants) Rules r 4.1(d).
[27] NDIS Act s 34(1).
[28] NDIS Act s 34(1)(d); NDIS (Supports for Participants) Rules, rr 3.2-3.3.
[29] NDIS Act s 34(1)(c); NDIS (Supports for Participants) Rules r 3.1.
[30] *McGarrigle v National Disability Insurance Agency* (2017) 252 FCR 121 at [88].
[31] NDIS Act ss 33(2)(a), 33(2)(b), 33(5)(c), 34.
[32] NDIS Act ss 13, 33(2)(a).
[33] NDIS Act ss 33(2)(b), 34.
[34] NDIS Act and delegated legislation made under the NDIS Act, especially NDIS (Supports for Participants) Rules and NDIS (Plan Management) Rules.
[35] NDIS Act ss 33(2)(b), 34; NDIS (Supports for Participants) Rules.
[36] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules r 5.3.
[37] NDIS (Supports for Participants) Rules pt 5.
[38] NDIS Act s 34(1).
[39] NDIS (Supports for Participants) Rules r 2.4; NDIS Act s 33(5)(c).
[40] NDIS Act ss 4, 31.
[41] NDIS Act s 4(1).
[42] NDIS Act s 4(2).
[43] NDIS Act s 4(4).
[44] NDIS Act s 4(8).
[45] NDIS Act s 4(10).
[46] NDIS Act s 4(17).
[47] NDIS Act s 4(11).
[48] NDIS Act s 33(5)(a); NDIS (Supports for Participants) Rules r 4.1(a).
[49] NDIS (Supports for Participants) Rules r 4.1(a).
[50] NDIS (Supports for Participants) Rules r 4.1(b).

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[51] NDIS (Supports for Participants) Rules rr 4.1(b), (d).
[52] NDIS (Supports for Participants) Rules r 4.1(c).
[53] NDIS Act s 33(5)(b).
[54] NDIS Act ss 36, 50.
[55] NDIS (Supports for Participants) Rules rr 4.2-4.6.
[56] NDIS Act s 33(1).
[57] NDIS Act s 47(1).
[58] NDIS (Supports for Participants) Rules r 4.1(d).
[59] NDIS Act s 34(1)(a).
[60] NDIS Act s 34(1)(a).
[61] NDIS Act s 33(5)(f).
[62] NDIS Act s 33(3) and NDIS (Plan Management) Rules.
[63] NDIS Act s 33(5)(c).
[64] NDIS Act s 33(3).
[65] NDIS Act s 33(3); NDIS (Plan Management) Rules r 6.2.
[66] NDIS Act s 33(3); (NDIS (Plan Management) Rules r 6.3.
[67] NDIS (Plan Management) Rules pt 6.
[68] NDIS Act s 46(1).
[69] NDIS Act (Plan Management) Rules r 6.4(a).
[70] NDIS (Plan Management) Rules r 6.4(b).
[71] NDIS (Plan Management) Rules r 6.4(c).
[72] NDIS (Plan Management) Rules r 6.4(d).
[73] NDIS (Plan Management) Rules r 6.4(e).
[74] NDIS (Plan Management) Rules r 6.4(f).
[75] NDIS (Plan Management) Rules r 6.4(f).
[76] NDIS (Plan Management) Rules r 6.4(f).
[77] NDIS (Provider Registration and Practice Standards) Rules r 7(3).
[78] NDIS (Provider Registration and Practice Standards) Rules r 7(2).
[79] NDIS Act s 42(2)(b).
[80] NDIS (Provider Registration and Practice Standards) Rules r 7(1).
[81] NDIS (Plan Management) Rules rr 6.6-6.7.
[82] NDIS (Plan Management) Rules r 6.6.
[83] NDIS (Plan Management) Rules r 6.7.
[84] NDIS (Plan Management) Rules r 6.7.
[85] NDIS (Plan Management) Rules r 6.7.
[86] NDIS (Plan Management) Rules r 6.5.
[87] NDIS (Plan Management) Rules r 6.6.
[88] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules pt 5.
[89] NDIS Act s 34(1).
[90] NDIS (Supports for Participants) Rules r 5.
[91] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules r 5.3(a).
[92] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules r 5.3(b).
[93] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(a).
[94] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(b).
[95] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(d).
[96] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(c).
[97] NDIS (Supports for Participants) Rules r 5.3(a).
[98] NDIS (Provider Registration and Practice Standards) Rules 2018 r 7(2).
[99] NDIS Act s 73F(2)(a).
[100] NDIS (Supports for Participants) Rules r 5.3(b).
[101] NDIS (Supports for Participants) Rules r 5.1(a).
[102] NDIS (Supports for Participants) Rules r 5.1(b).
[103] NDIS (Supports for Participants) Rules r 5.1(d).
[104] NDIS (Supports for Participants) Rules r 5.1(d).

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[105] NDIS (Supports for Participants) Rules r 5.2(a).
[106] NDIS (Supports for Participants) Rules r 5.2(b).
[107] NDIS (Supports for Participants) Rules r 5.1(c).
[108] NDIS Act ss 33(5)(c), 34(1).
[109] NDIS Act s 34(1)(a).
[110] NDIS Act s 34(1)(b).
[111] NDIS Act s 34(1)(c).
[112] NDIS Act s 34(1)(d).
[113] NDIS (Supports for Participants) Rules r 3.2(a).
[114] NDIS Act s 34(1)(e).
[115] NDIS Act s 34(1)(f).
[116] NDIS (Supports for Participants) Rules pts 3, 4.
[117] NDIS Act s 33(5)(c).
[118] NDIS Act s 34(1)(a).
[119] *McGarrigle v National Disability Insurance Agency* (2017) 252 FCR 121 at [91].
[120] NDIS Act s 34(1)(a).
[121] NDIS Act s 34(1)(c).
[122] NDIS Act s 34(1)(d).
[123] NDIS (Supports for Participants) Rules r 5.1(b).
[124] NDIS (Supports for Participants) Rules r 5.1(d).
[125] NDIS Act s 34(1)(b).
[126] NDIS Act s 34(1)(c).
[127] NDIS Act ss 3(3)(b), 4(17).
[128] NDIS (Supports for Participants) Rules r 3.1(a).
[129] NDIS (Supports for Participants) Rules r 3.1(b).
[130] NDIS (Supports for Participants) Rules r 3.1(c).
[131] NDIS (Supports for Participants) Rules r 3.1(e).
[132] NDIS (Supports for Participants) Rules r 3.1(f).
[133] NDIS (Supports for Participants) Rules r 3.1(c).
[134] NDIS (Supports for Participants) Rules r 3.1(d).
[135] McCutcheon and NDIA [2015] AATA 624 at [34].
[136] McCutcheon and NDIA [2015] AATA 624 at [34].
[137] McCutcheon and NDIA [2015] AATA 624.
[138] NDIS (Supports for Participants) Rules r 3.2(a).
[139] NDIS (Supports for Participants) Rules r 3.2(b).
[140] NDIS (Supports for Participants) Rules r 3.2(c).
[141] NDIS (Supports for Participants) Rules r 3.3.
[142] NDIS (Supports for Participants) Rules r 3.3.
[143] NDIS Act s 34(1)(e).
[144] NDIS Act s 34(1)(e).
[145] NDIS (Supports for Participants) Rules r 3.4(a)(i).
[146] NDIS (Supports for Participants) Rules r 3.4(c).
[147] NDIS (Supports for Participants) Rules r 3.4(a)(i).
[148] NDIS (Supports for Participants) Rules r 3.4(a)(ii); JQJT and National Disability Insurance Agency [2016] AATA 478 at [39].
[149] NDIS (Supports for Participants) Rules r 3.4(a)(iii).
[150] NDIS (Supports for Participants) Rules r 3.4(a)(iv).
[151] NDIS (Supports for Participants) Rules rr 3.4(b)(i), (ii).
[152] NDIS (Supports for Participants) Rules r 3.4(b)(iii).
[153] NDIS (Supports for Participants) Rules r 3.4(b)(ii).
[154] NDIS (Supports for Participants) Rules r 3.4(b)(ii).
[155] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(A).
[156] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(B).
[157] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(C).

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[158] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(C).
[159] NDIS Act s 34(1)(f).
[160] NDIS (Supports for Participants) Rules rr 3.5-3.7 and Schedule 1.
[161] NDIS Act s 34(1)(f).
[162] NDIS (Supports for Participants) Rules rr 3.5-3.7, Schedule 1; NDIS Act ss 209(4), (8) item 1.
[163] NDIS (Supports for Participants) Rules rr 3.5-3.7, Schedule 1.
[164] NDIS (Supports for Participants) Rules rr 3.5-3.7, Schedule 1.
[165] Disability Discrimination Act 1992 (Cth); Discrimination Act 1991 (ACT); Anti-Discrimination Act 1977 (NSW); Anti-Discrimination Act 1996 (NT); Anti-Discrimination Act 1991 (Qld); Equal Opportunity Act 1984 (SA); Anti-Discrimination Act 1998 (Tas); Equal Opportunity Act 2010 (Vic); Equal Opportunity Act 1984 (WA).
[166] NDIS Act s 118(2).
[167] NDIS Act s 33(5)(c).
[168] NDIS Act s100(1).
[169] NDIS Act s100.
[170] NDIS Act s100(2).

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Reasonable and Necessary Supports

Quick summary: The Australian Government made laws about what we can fund under the NDIS. All supports need to meet the criteria in these laws before we can fund them in your NDIS plan. We call these the NDIS funding criteria. For example, supports need to relate to your disability, be value for money and effective and beneficial. We also need to make sure all supports are most appropriately funded or provided by us. Each support must meet these criteria individually, but the supports must also meet the criteria when considered as a package.

Note: when we say 'your plan' we mean your NDIS plan. If you're looking for information about your community connections plan, go to Our Guideline – Community Connections.

If you're looking for information about your child's early connections plan, go to Our Guideline – Early Connections.

What's on this page?

This page covers:

- What principles do we follow to create your plan?
- What supports can you get?
- What other principles do we consider when we decide what supports to include in your plan?
- How do we decide what reasonable and necessary supports to include in your plan?
- Step 1: How do we describe a support in your plan?
- Step 2: How do we work out if an identified and described support meets the NDIS funding criteria?
- Step 3: How do we include the reasonable and necessary supports in your plan?

You may also be interested in:

- Mainstream Supports
- Creating Your Plan
- Changing your plan
- Reviewing our decisions

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- Would we fund it?

What principles do we follow to create your plan?

The NDIS was set up as a world first approach to disability support. It puts people with disability at the centre of decision-making, through the principles of reasonable and necessary supports and individual choice and control.

As an insurance-based scheme, we take a lifetime approach to a participant's support needs. We provide assurance to people with permanent and significant disability or developmental delay, and to people who might acquire disability or developmental delay, that they will get the support they need. Individual funding means we help participants to purchase services and supports from a competitive and consumer-driven marketplace.

What supports can we fund?

NDIS supports should complement, not replace, other supports available to you. That's why we consider:

- the things you're able to do for yourself
- support you have from others in your network, including family members, relatives, friends, local community services and mainstream government services.

One of our aims is to help maximise your independence by working with the local mainstream government and community services that help you live an ordinary life. We all do best when we're connected to our communities.

And as an active consumer, it's important you are able to shop for and access providers who meet your needs. We can help you find providers who meet your needs.

Once we've considered your circumstances, we need to follow the rules determined under the law for the NDIS in our planning decisions.[1] We fund supports that are reasonable and necessary.

This means we will only fund a support if it meets **all** of the following criteria:

- the support is related to your disability[2]
- the support will help you pursue your goals and aspirations[3]
- the support will help you undertake activities that will increase your social and economic participation[4]
- the support is value for money,[5] which means that the costs are reasonable:

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- when compared to the benefits to be achieved, for example, whether purchasing the support is likely to reduce the cost of funding other supports in the long term[6]
- when compared to alternative options that may provide you with the same outcome at a similar or lower cost[7]

- the support is likely to be effective and beneficial for you, having regard to good practice and evidence[8]
- the support is required to complement the informal supports you have available, by considering what is reasonable for families, carers, informal networks and the community to provide[9]
- the support is most appropriately funded or provided by the NDIS[10]
- the support is not more appropriately funded by another service system, agency, person, or body, such as the education system or the health system.[11] We can't fund a support if it's the responsibility of another service system.

What supports don't we fund?

We do not fund a support if:[12]

- it is likely to **cause harm** to you or others[13]
- it is **not related** to your disability[14]
- it **duplicates** other supports delivered by the NDIS[15]
- it is considered **a day-to-day living cost** (for example, rent, groceries or utility costs like your water bill) that are **not attributable or caused by** your disability support needs[16]
- providing the support would be **against the law**[17]
- it consists of **income replacement**[18]
- it is the **responsibility of other service systems** to provide (for example, your state government, the education system, or the health system).[19] These different systems have different responsibilities and are designed to complement each other to form a government safety net. Like all Australians, NDIS participants continue to have access to these systems. We can't fund a support if it's the responsibility of another service.

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How do we manage the financial sustainability of the NDIS?

The NDIS is an insurance scheme, and one of our core functions is to manage the financial sustainability of the Scheme.[20]

When we make decisions about the supports we fund in your plan, we must also consider our need to ensure the **financial sustainability of the NDIS**.[21] This means we must work within our funding budget, set through agreements between the Australian, and State and Territory governments.

It's also important to know the NDIS is only one part of the broader National Disability Strategy that supports people living with disability. The overall success and sustainability of the National Disability Strategy relies on:

- people accessing their informal support network to get the help they need from day-to-day
- people using their personal income to pay for their day-to-day living expenses, as is expected of all Australians
- mainstream and community services being available from state and territory governments, and other federal government programs such as Medicare
- a fair distribution of NDIS supports to those who need them, provided within our funding budget.

Staying within our budget ensures the NDIS will be here to support generations of Australians and their families.

What principles do we use to create your plan?

We use the following 7 principles, to create plans that help you get the reasonable and necessary supports you need, and to make sure the Scheme is financially sustainable:

- Fair for everyone, both today and for future generations
- Fair funding to pursue your goals
- Evidence-based best practice
- Fair early investments
- Fair support across service systems
- Fair supports for your disability needs
- Fair assistance from multiple programs

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Fair for everyone, both today and for future generations

While we need to consider your individual circumstances and disability needs, we also need to make consistent decisions and treat people fairly.

This means participants with similar circumstances and disability needs should receive similar amounts of supports in their plans. We also need to ensure the total cost of all participant plans are within the overall NDIS budget set by governments.

Each support in your plan must be reasonable and necessary. They also need to be reasonable and necessary as a package of supports. We approve your whole plan, not the individual supports in your plan in isolation.[22] Information about what supports we'd usually include in your plan helps guide this process.

This information also helps to guide the consistency of our decision-making process. We use it to check your overall plan and make sure all your supports make sense together. We'll check your support types and amounts will complement each other to help you fulfil an ordinary life.

We may then increase or decrease the funding in your plan based on:

- information you share with us
- any reports or other information we have
- applying the NDIS funding criteria.

This helps keep the system fair for everyone, and ensure we remain financially sustainable.

Fair funding to pursue your goals

Goals are important.[23] The supports we fund need to help you maximise your independence and pursue your goals.[24] This means your supports should help overcome any disability-specific barriers which may be stopping you from pursuing your goals.

This doesn't mean we fund all support costs associated with you pursuing your goals. Also, you may have goals and aspirations we can't fund supports for. This is because helping you pursue your goals is only one of the NDIS funding criteria, so not all supports that help you to pursue your goals will be reasonable and necessary.

Other things to know about when setting your goals:

1. **Setting more goals or bigger goals doesn't mean we'll provide more funding or fund more supports.** For example, if your goal is to live independently in a house with a swimming pool, we may fund home modifications that address your disability-related needs. This might be a home modification to make your bathroom accessible.

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We won't fund the swimming pool because this isn't related to your disability support needs. The funding in your plan might be similar to someone else who has a goal of 'to have a more accessible bathroom'.

2. **Setting a goal doesn't mean we have an obligation to fund supports that help you pursue that goal.** For example, if your goal is to get a gym membership to get fit, we wouldn't usually fund this. Gym memberships are things that all people, with or without disability, might want or need.
3. **Setting a goal about an explicit type or amount of support you might want doesn't mean we have an obligation to fund that support or provide that amount of funding.** For example, you may tell us your goal is 'to get a top model shower commode' and you show us the one you want costs $4,000.

   If there is a shower commode that costs $3,000, and your occupational therapist confirms this one will meet your needs, we are more likely to fund this one instead because it is likely to deliver the same result at a lower cost. We may also look at alternatives.

Evidence-based best practice

We only fund supports that will be, or are likely to be, effective and beneficial for you, having regard to current good practice.[25] This means we consider if there is evidence that the support is effective and beneficial for someone with similar disability support needs.

For example, we may already have information about whether the support is widely accepted to suit someone with your disability support needs.[26] The primary source of evidence we rely on, and give the greatest weight to, is evidence from sources that are reliable and widely recognised. This includes published and refereed literature, and any consensus of expert opinions. If there is no evidence to show a support is reasonable and necessary,[27] we won't fund the support.

You can find the types of evidence we need on our website, and in Our Guidelines.

Fair early investments

Having access to capacity-building supports early in your NDIS journey is considered to be an early investment. This early investment is intended to help increase your independence and reduce your reliance on NDIS funding over time.

This is an important concept we consider when we create your plan, and again at future plan reassessments. When we reassess your plan, we reassess all the supports you require to meet your disability support needs at that time.

Over time, your capacity building supports may no longer be reasonable and necessary, in regard to any of the following:

- your current functional capacity
- the effectiveness of the capacity building supports[28]
- value for money.[29]

When we say functional capacity we mean the things you can and can't do for yourself.

Your overall funding amount could go down from one plan to the next. This may be because you no longer need the same type or amount of supports, such as capacity building supports. Also, if the capacity building investment has been successful at building your independence, then your need for other supports may also decrease. For example, as you develop your skills you may not need as many Core supports.

So other things being equal, you should expect your overall plan value to reduce over time as the benefits of capacity building are realised.

Fair support across service systems

The support you need may be the responsibility of another government service, like education or health. We don't fund these services. We need to think about the supports you should receive from these services when we determine the supports in your plan.

Fair supports for your disability needs

When we make decisions about which supports we can fund, we consider whether a support is reasonable and necessary for you and apply the NDIS funding criteria. Sometimes, you might ask for supports to help with impairments that were not part of your Access eligibility assessment. When this happens, we need to make sure the support will help you address the needs that arise from an impairment that meets the same eligibility requirement we consider at Access.

You don't need to make a new Access request if you ask for supports to help with an impairment which was not part of your Access eligibility assessment. We'll work out if you need the support to address an impairment which would meet our eligibility requirements. We may ask you to provide evidence to help us work this out. We will decide if the requested support is reasonable and necessary. We'll apply the NDIS funding criteria based on the impairments which meet our eligibility criteria.

We fund the right disability supports for your permanent impairments which meet our eligibility criteria. By doing this we make sure the system is fair for everyone, and the NDIS remains financially sustainable.

Fair assistance from multiple programs

NDIS funding can't duplicate other funding or supports you may receive due to your disability.

For example, you may have received a lump-sum payment or receive regular payments as a form of compensation for an accident. Or, you may be receiving ongoing supports from another program or insurance scheme, for example Work safe, Lifetime Care and Support or the Transport Accident Commission.

We don't duplicate this funding, or these supports. We may reduce the total value of your NDIS plan to account for compensation you receive, or we may not fund certain supports.

What supports can you get?

When we create your plan with you, we'll discuss what supports you need for your disability. We want to help you pursue your goals, increase your independence, and help you work, study and join social activities.

There are many supports you can get outside the NDIS. Other government and community services provide supports to all Australians, including people with disability. And your friends, family, and other people you know can often be your best supports.

We can fund supports you need for your disability if they meet certain criteria. These are called 'reasonable and necessary supports'. Your plan and supports will be just for you, so you have more choice and control over how you use them.

This guideline explains how we decide what reasonable and necessary supports we'll include in your plan. There are lots of things we have to consider, which we'll explain in detail.

We also have a Would we fund it guide. It has examples of how we decide whether we fund different types of NDIS supports.

What supports can you get outside the NDIS?

Before we decide what reasonable and necessary supports to fund in your NDIS plan, we'll first discuss what other supports may be available outside the NDIS. This is an important information-gathering step. For example, there may be mainstream, community and informal supports that suit you.

Mainstream supports are other government services such as employment, education, health and family support services. They are often really helpful, and are available to

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everyone including people without disability. There are many ways they can help you learn new skills or live as independently as possible.

Community services offer a wide range of supports that may help with your disability support needs. Community supports are things open to everyone in the community, like sporting clubs, community colleges, activity groups, libraries or community gardens. They are often a great way to get involved in your local community, meet new people and learn new skills.

Informal supports, like your family, friends and other people you know in your community, can sometimes be your best supports. They know you and can often help in ways other supports can't.

Your my NDIS contact or support coordinator will talk with you about what services are available for you outside the NDIS. We can also help link you with these supports, so you don't have to do it all on your own.

Accessing these supports is a good way to work toward your goals. You get to do it with other people and be involved in your community. Using these supports is part of life for most of us. It's important you get to access them the same as everyone else.

When it comes time to talk about what reasonable and necessary supports we can fund, you'll know how mainstream, community and informal supports can help you.

It's important we gather this information and help you access these services before we consider what reasonable and necessary supports we can fund. That way, we can help make sure you're able to access mainstream, community and informal supports wherever possible. This can help you become as independent as possible.

What are reasonable and necessary supports?

An NDIS support is the practical description of how you will be assisted under the NDIS.[30] Supports are the things we provide or fund to help to meet your disability support needs.

NDIS supports are the services, items and equipment we can fund or provide under the NDIS.

There are two types of NDIS supports we can include in your NDIS plan. We call them 'general supports' and 'reasonable and necessary supports'.[31]

General supports

General supports are the coordination, strategic or referral services and activities we provide, or arrange to be provided, for you.[32] They're how we help you develop your NDIS

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plan and connect with supports and activities in your community. This includes your mainstream, community and informal supports. Learn more in Creating your plan.

Reasonable and necessary supports

Reasonable and necessary supports are the supports we fund in your plan to meet your disability support needs.[33] You can use this funding to buy supports from service providers.

The Australian Government made laws about what we can fund under the NDIS.[34] All supports we fund in a plan need to meet the criteria set out in these laws. We call these the NDIS funding criteria.[35]

To meet the NDIS funding criteria, a support must meet both the following criteria:[36]

- It must not be a type of support the law says we can't fund or provide.[37]
- It must meet the reasonable and necessary criteria.[38]

We call supports that meet the NDIS funding criteria 'reasonable and necessary supports'.

Each individual reasonable and necessary support in your plan must meet the NDIS funding criteria. Your whole plan as a package of supports must also meet the NDIS funding criteria.

We check your overall plan to make sure all your supports make sense together. This means we check that your supports and the amount of supports will complement each other to help you fulfil an ordinary life.[39] Learn more about reasonable and necessary supports.

If you need a new support, which now means your overall package of supports doesn't meet the NDIS funding criteria anymore, we may either:

- not include the new support in your plan
- include the new support in your plan, but also reduce the other supports in your plan.

For example, a home modification may reduce your need for other supports. If we plan to fund a home modification, we will need to take that home modification into account when considering what other supports are reasonable and necessary, such as the amount of care you need at home.

What other principles do we consider when we decide what supports to include in your plan?

As far as possible, we have to act according to principles set out in the law for the NDIS.[40] These are the things that guide us when we make decisions about what we fund.

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These principles don't override or replace the NDIS funding criteria under the law for the NDIS. They can help us apply the funding criteria, by giving us additional guidance when we decide what supports to approve in your plan.

The principles include the following:

- You have the same right as other Australians to realise your potential for physical, social, emotional and intellectual development.[41]
- You should be supported to take part in and contribute to social and economic life.[42]
- You should be supported to make choices about planning and how your supports will be delivered. This includes taking reasonable risks, so that you can pursue your goals.[43]
- You have the same right as other Australians to decide your own best interests. You have the right to be an equal partner in decisions that affect your life.[44]
- Your privacy and dignity should be respected.[45]
- We must make sure the NDIS is financially sustainable.[46]

The principles also tell us that the reasonable and necessary supports we fund should:[47]

- support you to pursue your goals and maximise your independence
- support you to live independently and to be included in the community as a fully participating citizen
- develop and support your capacity to do things that help you participate in the community and in employment.

Just because a support helps you do these things doesn't mean we'll fund it in your plan. All supports we fund need to meet **all** the NDIS funding criteria.

We consider these principles set out in the law for the NDIS, along with the principles we follow to create your plan.

How do we think about an ordinary life when deciding what supports to include in your plan?

To help guide us in our decision making about reasonable and necessary supports, we took advice from the NDIS Independent Advisory Council.

The Council represents people with disability and carers, bringing their own lived experience and expertise of disability. They give us advice on how the NDIS should work.

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The Council advised us that all Australians, including people with disability, should have an 'ordinary life'. They also told us we should think about the idea of an ordinary life when we apply our principles and use the NDIS funding criteria.

An ordinary life is a life where you have the same opportunities as people without a disability. An ordinary life is one that is typical or usual for everyone in modern day Australia. It's a life where you can pursue your potential and participate in society on an equal basis with others.

An ordinary life will be different for different people. We are all different, and come from different cultures and backgrounds. We each have our own values, experiences, beliefs and goals.

But there are some common things that can improve the quality of our lives and help us participate equally. These are the things, such as the following, that make up an ordinary life:

- Positive relationships – with families and informal support networks.
- Individual autonomy – being free and independent, and having the same opportunities as people without disability.
- Active involvement in decision-making – including the ability to make meaningful decisions, and exercise choice and control.
- Using your strengths in ways that provide a challenge and enjoyment.
- A sense of belonging – to our families, friendship networks, communities, workplaces and society.
- Active involvement and contribution to society and your community.

An 'ordinary life' in the context of the NDIS involves supporting you to:

- have and maintain good relationships
- belong and participate in your community
- be involved in making choices about your own life.

One way we can help you have an ordinary life is to support you to access mainstream, community or informal supports wherever possible. These are the usual supports that everyone in the community uses.

When we fund reasonable and necessary supports under the NDIS, we need to make sure they meet the NDIS funding criteria.

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When we apply the NDIS funding criteria and make decisions about reasonable and necessary supports, we're guided by the principles in the law for the NDIS. We also consider how the supports will best help you to live an ordinary life.

How do we decide what reasonable and necessary supports to include in your plan?

What information do we consider to work out what reasonable and necessary supports to fund in your plan?

The most important information we gather about what supports to include in your plan comes from you.

When we create your plan, we will talk with you about:

- your goals and aspirations[48]
- your strengths, capacity and individual circumstances[49]
- any barriers, limitations and restrictions you face in undertaking activities or things that stop you from living an 'ordinary life'[50]
- your disability support needs[51]
- any risks and safeguards we may need to think about when considering your support needs.[52]

We use this information to create your plan with you. Generally, we'll discuss this information before you become an NDIS participant. We'll continue to discuss it when we check-in with you once you have your plan. Learn more about check-ins in Our Guideline – Your plan.

We want to get a good understanding of your disability support needs. We know you're the expert in your own life, and we use your lived experience as much as we can. When we ask for information from you, we encourage you to involve anyone you want to help you give us this information.

We'll also think about other information we have such as medical or therapy reports, or assessments you've had.[53]

We look at different types of evidence for different types of supports. We may need a report or assessment from your doctor or health professional who specialises in helping you manage your disability.

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Reports and assessments may tell us why you need the support and how the support relates to your disability support needs. For example, an occupational therapist may send us a letter about why you need a specific type of wheelchair.

When we create a new plan for you during a reassessment we think about the supports in your current plan. We'll check if you need any changes to these supports to help you pursue your goals in your next plan. We use information from your providers to let us know how the supports they are providing have helped you work towards your goals.

We'll look at the evidence we get to make sure we have enough information to decide if the support meets the NDIS funding criteria. Sometimes we may ask for further information and assessments, if we need them to help us work out your support needs when we approve your plan.[54]

Learn more about the types of evidence we can use when we create your plan.

To help us work out what supports to consider for people aged 9 years and older we also use a 'Typical Support Package'. [55] We worked with people with disability, professionals and subject matter experts to develop the Typical Support Package.

It helps us work out the types of supports we'd usually expect to include in your plan. It's based on your situation and support needs.

We then amend the supports suggested by the Typical Support Package to include more, less or different supports if we need to. We may adjust the funding for those supports up or down based on our discussion with you, the information you share with us

any reports or other information we have, and when we apply the NDIS funding criteria.

For children younger than 9, we consider the child's current functioning across development areas when we work out the reasonable and necessary supports that should be funded in a child's NDIS plan. Learn more about the Early Childhood Early Intervention approach.

How do we consider your goals when we work out your reasonable and necessary supports?

Before we create your plan, we'll discuss your current goals and personal details, including things like your living arrangements and current supports. We'll include this information in your plan.[56] Your goals are your own personal desires about what you'd like to do.

You can set any goals you like, even if they're about things we won't fund supports for. You can also change your goals at any time.[57] We consider how your funded supports will help you pursue your goals when we decide to approve your plan.[58]

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Reasonable and necessary supports should help you pursue your goals,[59] but you don't need a specific goal for every support in your plan. When we decide if a support will help you pursue your goals, we consider your whole situation.

We look at the disability specific barriers that prevent you from pursuing your goals, and how the support will address your disability support needs.

There are some things to remember when setting goals:

- Setting more and bigger goals doesn't mean we'll fund more and bigger funded supports.
- Setting a goal doesn't mean we have an obligation to fund supports that help you pursue that goal.
- Setting a goal about an explicit type or amount of support you might want doesn't mean we have an obligation to fund that support or in that amount.

This is because helping you pursue your goals is only one of the NDIS funding criteria.[60] A support must meet all of the NDIS funding criteria to be funded under the NDIS. So not all supports that help you to pursue your goals will be reasonable and necessary supports.

Learn more about setting your goals and how we consider your goals under the NDIS funding criteria.

What if your plan needs to change?

If it's not your first plan, we also consider how well the supports funded in your previous plans worked for you.[61] This means we'll ask about how your current plan has worked for you. We look at the supports in your current plan and see whether any changes need to be made to these to help you pursue your goals in your next plan.

This will help us decide whether these supports continue to meet your needs and the NDIS funding criteria. Learn more about changing your plan.

How do we use the information we have to work out what reasonable and necessary supports to fund?

We consider all the information we have gathered to decide what reasonable and necessary supports to fund in your plan.

We use the information you give us and follow the steps below:

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- **Step 1**: Identify and describe the supports to be considered. The support will be described either generally (known as 'flexible' funding for supports) or specifically (known as 'stated supports' or 'fixed' supports).[62]
- **Step 2**: Work out if the support identified and described meets the NDIS funding criteria.
- **Step 3**: We include the supports that meet the NDIS funding criteria in your plan.

When we approve your plan we make sure all your supports meet the NDIS funding criteria individually and as a package of supports.[63]

Step 1: How do we describe the types of supports in your plan?

Sometimes we need to describe a specific support to be included in your plan. Or we might include funding more generally within a support category[64]. Where we have included funding in a support category, you can generally choose which supports you buy from that category to meet your disability-related support needs.

Supports we describe generally or specifically must meet the NDIS funding criteria.

We look at all the evidence of your support needs to help us identify what supports to consider in your plan. We use:

- the information you give us when you apply for the NDIS, during a check-in or when you contact us
- any assessments or other information we have

For reassessments we'll look at the supports in your previous plan and check how well they are working for you. For your first plan we use the Typical Support Package to think about what supports we'd usually expect to include in your plan based on your situation and disability support needs.

When we say support we mean funding for a service, item or equipment you need to help with your disability support needs.

We think about:

- what the outcome of the support will be
- how the support helps with your disability
- whether the support meets the NDIS funding criteria.

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- whether we need to specifically describe the supports in your plan.

How do we describe support in your plan?

We divide your supports into 4 different budgets:

- **Core supports**

  These supports help you with everyday activities, like help to take part in activities in the community. This budget is mostly flexible so you can use funding from one support category to pay for something in another support category.

- **Capacity building supports**

  These supports help you build your skills and increase your independence and reduce the need for the same level of support in the future. Your progress and outcomes from these supports will be shared at each plan reassessment. Capacity building supports are stated so you won't be able to use funding from one support category to pay for something in another support category.

- **Capital supports**

  Includes high-cost assistive technology, equipment, vehicle modifications, home modifications and specialist disability accommodation. Capital supports are stated. You can only use this funding to buy approved individual supports in this support category.

- **Recurring supports**

  These supports are paid by us on a regular basis, so you don't need to claim for these. Your funding for your recurring supports will be paid regularly to your nominated bank account. This funding is not included anywhere else in your budget and includes mainly transport supports.

Each budget is divided into a number of support categories. Support categories have more detail about what supports you can buy with your funding. We can describe the support categories in your plan as one of the following:

- **Flexible**: Under the law for the NDIS, this is when we describe supports in a category generally. You have greater flexibility over what disability supports you can buy within the description of the support. When we describe your support categories as flexible, you can usually choose what supports you buy within the descriptions for each support category.

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- **Stated**: Under the law for the NDIS, this is when we describe the supports in a support category specifically. It means you must buy supports in the way we have described in your plan.[65] We sometimes call this a fixed support in your plan.

You must act according to your plan, and buy supports according to how we described them in your plan. This means you can't use the funding in your plan to buy supports that fall outside the description of the support in your plan.[66]

We describe most support categories as flexible when we can. You have greater flexibility over the support you can buy in your flexible budgets. When support categories are described as stated, you have less flexibility.

If we describe a support category as stated, you must use the funding in your plan to buy the supports exactly how we describe them. This includes how the support is provided. For example, we will sometimes require the support to be provided:

- by a particular service provider
- by a particular qualified person
- through a particular delivery mode or method, or in a special way.

Your Core supports budget is the most flexible. You can usually use your funding across all the support categories in the Core Supports budget if:

- we described the supports as flexible
- you have the same plan management options for your Core Supports.

When we decide whether to describe supports as stated or flexible, we think about:

- how much the support costs[67]
- if the support will help reduce the cost of other supports over time,[68] for example providing more supports early so you don't need as many supports later in life
- any risks with supplying the support, for example if the support would create risks to your health and safety or if it doesn't comply with state or territory laws[69]
- if you need a particular support to pursue your goals or to use other supports in your plan effectively[70]
- if you need a specialist support, for example if your support must be delivered by a qualified person, or in a special way[71]
- if you are eligible for the NDIS under the early intervention criteria.[72]

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When do we describe supports as stated?

We usually describe high-cost supports, or supports with more risk, as stated. For example, we might describe supports as stated if you need to use those particular supports to ensure your health and safety. This includes supports such as:

- high-cost assistive technology
- complex home modifications
- behaviour support, or supports that involve restrictive practices such as restraint
- Specialist Disability Accommodation.

We will also check if you were eligible for the NDIS through the early intervention criteria.[73] If so, we might decide to describe the supports as stated for some types of early intervention supports.[74] If you're not sure whether you met the disability criteria or the early intervention criteria, check the letter we sent you when we decided you're eligible.

Example

John just received his first plan. His plan describes support for assistive technology as flexible, including $2,000 of funding. John can choose what assistive technology to buy with this funding. John talks to his occupational therapist about what assistive technology he should buy with this funding. For example, he could buy a shower chair, or low-cost items like a slip-resistant bathmat.

John's plan also has a fixed support for a wheelchair with special features, and funding of $8,000. John will need to use this funding for the specific wheelchair we listed on his plan. He can't use this funding for another support, like a shower chair, instead.

What if you need a specific provider to provide the support?

Sometimes your plan may say who must provide the support. We do this when you need a certain provider to make sure the supports are delivered safely, or to achieve a certain outcome.

For some supports, you must use an NDIS registered provider. These include:

- Specialist Behaviour Support, if the provider will undertake a behaviour support assessment or develop a behaviour support plan[75]
- supports where it's likely a provider will need to use a regulated restricted practice,[76] either interim or ongoing
- Plan Management

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- Specialist Disability Accommodation.

You must use registered providers for these supports even if your plan doesn't say you need to. You must also use registered providers for these supports, even if you self-manage your funding or use a registered plan manager. Learn more about the different plan management options.

For other supports, we'll decide that the support must be provided by a particular person, provider, or delivered in a certain way.[77] We'll do this if it's the most efficient and effective way to provide the support. This only happens when:

- we have an agreement with a particular provider to provide the support[78]
- we decide you must use an NDIS registered provider due to the risks, for example complex home modifications[79]
- you need support from a particular person with specialist qualifications, for example a health professional[80]
- you need support delivered in a certain way.[81]

Sometimes, we'll arrange the support ourselves, if it's more cost effective than getting another provider to deliver the support. For example, we may bulk buy a support.[82] If so, we will state this in your plan.

What about in-kind supports?

We agreed that state and territory governments will keep providing some supports for a period of time. We call these 'in-kind supports'.

If we fund in-kind supports like specialist school transport or personal care in schools, you will need to use state or territory government providers for these supports. These supports are most efficiently and effectively provided by state and territory government providers.[83] Learn more about Work and study supports.

For most other in-kind supports, you can choose your provider if you don't want to use your in-kind provider anymore. We can let you choose another provider if we consider that the support isn't most effectively and efficiently provided by the in-kind provider.

We usually let you choose another provider if:

- another provider can give you the same support or level of support as the in-kind provider
- the supports with the new provider still meet the NDIS funding criteria, including that they're value for money compared to the in-kind support

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- there are no serious risks with changing providers.

Learn more about in-kind supports.

Step 2: How do we work out if an identified and described support meets the NDIS funding criteria?

To meet the NDIS funding criteria, a support must meet both the following criteria:

- It must not be a type of support the law says we can't fund or provide.[84]
- It must meet the reasonable and necessary criteria.[85]

Each support must be reasonable and necessary individually, but the supports must also be reasonable and necessary when considered as a package of supports.

What types of supports can't be funded or provided under the NDIS?

Under the law for the NDIS, there are things we can't fund or provide.[86] We can't fund or provide supports that:

- are not legal[87]
- are income replacement[88]
- are likely to cause harm to you, or pose a risk to other people[89]
- are not related to your disability[90]
- relate to a 'day-to-day living cost', such as groceries, rent or utilities, that are not attributable to your disability support needs. These are costs that are not caused by or as a result of your disability support needs.[91]
- duplicate other supports provided by the NDIS under alternative funding.[92]

Is the support legal?

We can't fund a support if it does not comply with the law.[93] This includes both:

- **an Australian government law:** a law that applies to all of Australia
- **a State or Territory government law**: a law that only applies in your state or territory.

For example, we won't be able to fund supports involving:

- a restrictive practice where it's not authorised in your state or territory

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- assistive technology or home modifications that don't meet Australian laws, such as State and Territory Acts and Regulations, the National Construction Code, and relevant Australian Standards
- supports for illegal activities, such as support for criminal behaviour or illegal drugs.

While this is one of the NDIS funding criteria, we're not responsible for ensuring your supports are legal. We're not responsible to ensure that all supports in your plan comply with all the relevant legal and administrative requirements. This is your responsibility and your provider's responsibility.

For example, if a support is likely to require the use of a restrictive practice, the provider must be registered with the NDIS Quality and Safeguards Commission.[94] It's the provider's responsibility to ensure they are registered and comply with the conditions of their registration. This includes complying with all laws and seeking the necessary authorisations.[95]

We're not responsible for ensuring the provider is registered and complies with their conditions of registration. You can contact the NDIS Quality and Safeguards Commission if you're concerned about a provider's compliance with legal obligations.

Is the support 'income replacement'?

We don't fund income support or income replacement.[96] This means NDIS funding can't replace or add to money you'd usually earn from working, or income payments you get from Centrelink.

For more information and resources on income support, check out income support payments such as the Disability Support Pension.

If you are interested in getting help to find a job, check out Disability Employment Services or NDIS-funded Work and study supports.

Is the support likely to cause harm?

We can't fund any supports that are likely to either:[97]

- cause harm to you
- be a risk to other people.

We need to consider this for all supports, such as support workers, therapies or equipment. It also means we won't fund supports that involve a regulated restricted practice, such as restraint, unless it follows the requirements of the NDIS Quality and Safeguards Commission.

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To help us decide if the support is likely to cause harm, we may need information from a professional. For example, you may need high cost assistive technology, like a powered wheelchair. If so, we would need a report from an occupational therapist to show that it'll be safe for you to use.

Of course everything we do in life comes with some risk. We all make our own choices about how much risk we want to take in our lives. You should also be able to choose how much risk you want to take in your life.

So we try to balance this when we decide what we can and can't fund. We can't fund things that are likely to cause harm. But we will try and balance this with enabling you to make your own choices wherever possible.

While this is one of the NDIS funding criteria, you also have some responsibilities. It's still your responsibility and your provider's responsibility to ensure the supports we fund are:

- used correctly
- safe for you
- safe for other people.

You and your provider will also need to manage any risks of harm that arise. For more information, contact the NDIS Quality and Safeguards Commission.

Is the support related to your disability?

We can't fund a support if it's not related to your disability.[98] This means there must be a direct link or a connection between your disability and the supports we fund.

We look at whether the support addresses your disability support needs. Your disability support needs are those that arise from, or are caused by, your disability.

For example, we wouldn't usually fund things like:

- standard televisions
- standard household furniture such as dining chairs
- upgrades to assistive technology and home modifications that are not related to disability needs, such as marble tiling or leather materials
- flights to go on a holiday
- a car to get to work because there are no public transport options
- a gym membership to get fit

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- a swimming pool to relax in summer.

This is because you're unlikely to need these supports as a result of your disability support needs. They are things that all people, with or without disability, might want or need.

Usually, there won't be a direct link or connection between these things and your disability support needs. Having a disability doesn't usually affect whether someone needs or wants these types of things.

Example

Alan needs some changes to his house, so he can use his bathroom and kitchen in his wheelchair. He also wants to set up an outdoor entertainment area for when his friends visit.

We may be able to fund home modifications so he can access areas of his home such as his bathroom or kitchen. He needs the home modifications because he can't access those areas due to his disability and needing to use a wheelchair. Alan needs the support because of his specific disability support needs.

Alan will need to pay for the outdoor entertainment area, as it's not related to his disability. He doesn't need the entertainment area because of his disability. It's just something he would like so he can have his friends over for a barbecue.

Is the support related to a 'day-to-day living cost'?

We can't fund supports related to day-to-day living costs that everyone has to pay, and aren't caused by or result from your disability support needs.[99] This means we don't fund things like:

- rent
- groceries
- utilities such as electricity, water, gas and internet bills
- the general cost of owning a home, like renovations, mortgage repayments, repairs and maintenance.

In some situations, we can fund supports related to your day-to-day living costs. We can do this if the costs are attributable to, or caused by, your disability support needs.[100] This means we may fund supports that relate to day-to-day living costs where either:

- you have additional living costs that are solely and directly as a result of your disability support needs[101]
- the living costs are connected to another support that is funded or provided in your plan, and you wouldn't incur that cost if it wasn't in your plan.[102]

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Example

Nigel has a goal to do his grocery shopping on his own. He needs a shopping basket to attach to his wheelchair to help him carry the items in the supermarket.

Shopping bags and baskets are things we all pay for, whether or not we have a disability. But Nigel only needs this specialised basket for his wheelchair because of his disability support needs.

If it meets the other NDIS funding criteria, we may fund the shopping basket attachment in his plan.

Does the support duplicate other supports funded through the NDIS?

We can't fund a support if it duplicates other supports delivered under alternative funding through the NDIS.[103]

For example, if we're providing support through your early childhood partner or local area coordinator, we usually won't fund Support Coordination in your plan.

This is because your early childhood partner or local area coordinator is already funded to provide similar supports. If we funded the same Support Coordination, we would be duplicating a support we're already providing you as general supports.

However if you need extra support, we may be able to fund additional Support Coordination in your plan. We may do this if it's above the amount of support your early childhood partner or local area coordinator are able to provide. Your early childhood partner or local area coordinator will work together with the Support Coordinator to help you connect with supports in your community.

Does the support meet the reasonable and necessary criteria?

All NDIS supports need to meet **all** the reasonable and necessary criteria.[104]

This means that before we can include an NDIS support in your plan, we need to be satisfied it meets all the following criteria:

- The support will assist you to pursue your goals in your plan.[105]
- The support will assist you to undertake activities, to facilitate your social and economic participation.[106] This means the support will help you to undertake activities, by reducing the disability-related barriers that prevent you from participating in things such as social outings, recreation, work and study.

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- The support represents value for money in that the costs of the support are reasonable relative to both the benefits achieved and the cost of alternative supports.[107] This means we need to consider the costs and benefits of the support, as well as the costs and benefits of alternative supports.
- The support will be, or is likely to be, effective and beneficial for you, having regard to current good practice.[108] This means we consider if there is evidence the support works for someone with similar disability support needs. We won't need an expert report for every support, as we can often rely on other information or evidence. For example, we may have information already about whether the support is widely accepted to suit someone with your disability support needs.[109] We also consider your lived experience.
- The funding of the support takes account of what it is reasonable to expect families, carers, informal networks and the community to provide.[110] This means we need to consider what support is reasonable for your family, friends and community to provide.
- The support is most appropriately funded or provided through the NDIS, and is not more appropriately funded or provided through:[111]
    - other general systems of service delivery, or support services offered by a person, agency or body (for example, a State or Territory Statutory Scheme)
    - systems of service delivery or support services offered as part of a universal service obligation (for example, the health or education system)
    - systems of service delivery or support services offered in accordance with reasonable adjustments required under discrimination laws (for example, your employer, or the health or education system).

The law for the NDIS sets out things that we need to consider when we apply the reasonable and necessary criteria.[112]

We must be satisfied that each support is reasonable and necessary individually, but we must also be satisfied that the supports are reasonable and necessary as a package of supports.[113]

For example, a home modification may reduce your need for other supports. If we plan to fund a home modification, we will need to take that home modification into account when considering what other supports are reasonable and necessary, such as the amount of care you need at home.

If the home modification will reduce your care needs, we may need to reduce the amount of care we fund, as a higher amount may not be reasonable and necessary when the whole package of supports is considered.

Does the support help you pursue your goals?

We need to be satisfied that the support will help you pursue the goals, objectives and aspirations in your NDIS plan.[114] This helps us determine if the support is necessary.[115]

While we only fund supports that help you pursue your goals, objectives and aspirations, we understand that different people express themselves in different ways.

You are free to choose your own goals and express them in your own words.

Your goals can be big or small, short term or long term, simple or complex. They can be about anything you want to work towards.

You may express your goals broadly, or you may have specific goals. For example, you may express one of your goals as 'living independently'. Someone else may express their goal as 'to have an accessible bathroom'.

Learn more about setting your goals in Creating Your Plan and the Setting Goals fact sheet.

Reasonable and necessary supports should help you pursue your goals,[116] but you don't need a specific goal for every support in your plan. When we decide if a support will help you pursue your goals, we consider your whole situation.

We look at how a support will address your disability support needs, and the disability specific barriers that prevent you from pursuing your goals.

A support that addresses your disability related support needs is most likely to help you pursue your goals, objectives and aspirations in your plan.

Setting a goal in your plan doesn't mean we'll provide funding to pursue it. For example:

- setting more and bigger goals doesn't mean we have an obligation to fund more and bigger funded supports in your plan
- setting a goal doesn't mean we have an obligation to fund supports that help you pursue that goal
- setting a goal about an explicit type or amount of support you might want doesn't mean we'll fund that support or in that amount.

This is because helping you pursue your goals is only one of the NDIS funding criteria. A support must meet all of the NDIS funding criteria to be funded under the NDIS. So not all supports that help you to pursue your goals will be reasonable and necessary supports.

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For example, we only fund reasonable and necessary supports that are value for money,[117] effective and beneficial[118] and relate to disability support needs.[119]

This means that if your goal is to 'live independently', we **may** fund home modifications that address your disability related needs. However, we won't fund supports related to day-to day-living costs like rent or utilities. These costs aren't incurred solely and directly as a result of your disability support needs, so they don't meet other funding criteria.[120]

Also, choosing a different goal 'to have a more accessible home' won't change the supports we could fund in your plan.

Achieving goals usually takes many different kinds of supports. NDIS supports will most likely be just one kind of support that helps you work toward your goals.

Learn more about setting goals.

Example

Morgan is ready to look for work and she has a goal in her plan to get a job. She has built up her skills and knows what she wants to do. Disability Employment Services are helping Morgan to find work, so we can't fund this support for Morgan.

However, because of her disability, Morgan will need personal care supports to help her get up and ready for work in the morning. We will consider:

- how Morgan's disability support needs relate to her goals
- whether funding supports that address these disability support needs will help Morgan pursue her goals.

Morgan's planner believes the personal care supports meet this criteria. The supports that address her personal care needs will help Morgan to pursue her employment goals.

However, Morgan's planner then needs to look at whether the support meets the other NDIS funding criteria.

We don't fund all the supports that relate to Morgan's employment goals. We only fund the supports we consider are reasonable and necessary – that is, when they meet all the NDIS funding criteria.

Does the support help you do activities that will help your social and economic participation?

We need to be satisfied that the support will help you to do activities, which make it easier for you to participate socially and economically.[121]

Social participation means doing things you enjoy, like going out with friends, playing sport or going on holiday. It also means doing the things you need to do, like going to school or medical appointments.

Economic participation usually means being involved in things that help you work towards getting and keeping a job. This might be things like volunteering, study, learning new skills or trying work experience. Research tells us that work can lead to health benefits and improve our quality of life. Learn more about the Health Benefits of Good Work.

Social and economic participation are important to most people. They are critical to living an ordinary life.

To work out if a support meets this requirement, we look at the purpose of the support and how it will help you.

We fund reasonable and necessary supports that reduce the barriers that prevent you from undertaking activities. This will help you increase your social and economic participation.

Some supports help economic and social participation directly. There are lots of supports we can fund to directly help with social and economic participation. Learn more about Social and recreation supports and Work and study supports.

Other supports help you to undertake activities like self-care, which indirectly help your economic and social participation.

Example

Sue is going to university next year. She has a vision impairment, and has been working with her Guide Dog Mobility Instructor to decide if a dog guide is right for her. A dog guide can help her leave her home safely and independently, and travel to and from university.

A dog guide could also help her go out with friends and join in other community activities. As long as it meets the other funding criteria, we could fund a dog guide for Sue. It will help her to undertake activities of daily living.

As a result, it'll increase her social and economic participation. For example, the support will help her get to her university so she can study, and will help her social life.

Is the support value for money?

All supports we fund under the NDIS need to be value for money. This means the cost of the support is reasonable, when we consider the benefits of the support and the cost of other supports.

Making sure that your supports are value for money is one of the ways we keep the NDIS financially sustainable. This means we make careful decisions about funding so that we make sure the NDIS exists for future generations. It's also one of our principles.[122]

When we decide if the support is value for money, we consider:

- if other supports would achieve the same result at a substantially lower cost[123] – this means there should be a real or material difference in cost
- if there's evidence that the support will substantially improve your life stage outcomes and benefit you in the long term[124]
- if the support will likely reduce the cost of other supports over time[125]
- how the cost compares to other supports of the same kind in your area[126]
- if the support will make you more independent, and mean you won't need as many supports in future, for example, in some circumstances home modifications may reduce the need for home care.

When we consider the likely cost of supports, we consider the cost over the long term. We consider if the support will help you achieve milestones at different ages or stages of your life and have long term benefits.

For example, some supports such as home modifications may be expensive now, compared to other supports. But getting these supports now may mean you need much less support in a few years, or later in life. Or, it may delay the need for other more costly supports.[127]

When we determine the cost of the support, we consider:

- the prices for NDIS supports in the NDIS Pricing Arrangements and Price Limits supports suggested by the Typical Support Package
- quotes for specific or high risk supports.

It's important we consider the cost of the support. This will be the level of funding we include in your plan, if we decide the support is reasonable and necessary.

When we fund equipment or modifications, we also need to consider:[128]

- how the cost of buying the equipment or modifications compares against the cost of renting them
- if it's appropriate to fund the equipment or modifications you want, based on your circumstances and any expected changes in technology.

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Learn more about how we consider value for money when we fund assistive technology, home modifications and vehicle modifications.

Example

Elias needs a shower commode.

He got an assessment and sent us a quote for one that will suit his needs. As part of the process to work out if we can fund it, his planner considers other similar shower commodes.

There's a second commode that's $5,000 cheaper than the one Elias has asked for. But it won't meet Elias' needs, as it won't provide enough back support. That is, it won't achieve the same result as the one Elias has asked for.

Finally, there's a third commode that's $1,000 cheaper. The planner contacts his occupational therapist who confirms the cheaper commode will meet Elias' needs.

Elias' planner decides to fund the commode that's $1,000 cheaper. It'll deliver the same result at a substantially lower cost.

Is the support effective and beneficial?

We need to be satisfied that the support will be, or is likely to be, effective and beneficial, when we consider current good practice.

We need to work out if the support is likely to be both:

- **effective** – it will do what you need it to do[129]
- **beneficial** – the support will help you do things you can't otherwise do and meets your support needs.[130]

It can also be effective and beneficial if it will help you maintain your current level of functioning. That is, it will help you keep doing the things you can currently do. And, it'll help you maintain your work, study and social life as much as you can.[131]

When we decide if a support is effective and beneficial, we look at what is current good practice. This means we look at whether there is evidence that the support works for someone with similar disability support needs to you. We won't need an expert opinion or report for every support, as we can often rely on other evidence.

For example:

- We may have information already about whether the support is widely accepted to suit someone with your disability support needs.[132] For example, we could rely on academic research and other literature. This could include university studies on

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therapies that have been published and refereed in academic journals, evidence based practice resources, or clinical practice guidelines.

- If you or other participants have used the support before, we can consider your experience using the support and the experience of your family members and carers.[133]

We may consider things we have learnt from other participants in the NDIS with similar support needs to you.[134] We know you're the expert in your own life, and we use your own experience as much as we can.

For example, we will talk to you about any supports that have helped you do things you can't otherwise do. Or, some supports may have helped maintain your ability to be as independent as possible.

If it's a new support such as new assistive technology, we might fund a trial. This is so we can learn from your experience of using the support. To check if it's likely to do what you need it to.

Your evidence can be particularly useful when it's consistent with other evidence, or if we don't have expert evidence.

We'll look at the opinions held by the majority of experts and what they generally agree on.[135] Sometimes we will have to seek expert opinion or report to make a decision.[136]

Example

Vivek is 12 and has a goal to improve his communication skills. He and his family want him to improve his social skills with the kids in his class.

When he was younger, Vivek's family tried speech therapy, and believe it really helped him improve his communication. His family told his planner about how it helped Vivek learn how to respond to different social settings.

Vivek's speech therapist also believes it could work well for him now, and help him interact with his classmates.

When deciding whether the therapy is effective and beneficial, Vivek's planner will consider:

- how speech therapy has helped Vivek in the past, including first-hand information from Vivek, his family members and carers
- the reports or assessments from his speech therapist on the effectiveness and benefits of speech therapy for Vivek

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- other information or expert evidence about the effectiveness and benefits of speech therapy, including for a child of the same age, and with the same impairments and functional capacity.

Based on this information and evidence, Vivek's planner decides the speech therapy is effective and beneficial. If it meets the other funding criteria, we will be able to fund speech therapy in Vivek's plan.

Is the support something we would reasonably expect your informal supports, like family or friends, to provide?

We need to be satisfied that funding the support takes into account what is reasonable to expect families, carers, informal networks and the community to provide.[137]

To make sure we understand how disability supports might work for you, we consider:

- the things you're able to do for yourself
- any support you have from others in your network – including family members, relatives, friends and local community services.

When we fund supports under the NDIS, we have to think about whether it's reasonable to expect your informal supports to provide that support. We can't fund supports that an ordinary person would think is reasonable to expect friends, family or the community to provide for you.[138]

Informal supports are the help and support you get from friends, family and the community. They are called 'informal' because you don't pay for them, and they're not part of a formal agreement. They are the usual things friends and family do for us, and with us.

Most of us get some kind of help and support from friends and family. In our society, we expect that friends, family and our community will support each other and help each other out when they need it.

A good example is families who have young children. In our community, we expect families will provide most of the support a young child needs.[139] They will change a child's nappy, make sure they are safe and drive them around places.

Grandparents, uncles and aunties often have a role to play in supporting young children as well. Neighbours and friends might also help care for the child.

As a child gets older, our society's expectations of the role of the family and community in caring for the child changes. For example, we expect schools to help support the child's learning needs.

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We also usually expect the role of family in providing personal care for a child would reduce as they get older and develop new skills and independence. But families are usually still responsible for things like food, emotional support, decision-making and providing a safe home.

It's a similar idea for adults. Our society expects that adults – like family, friends and neighbours – will provide some support to each other. This might be things like taking a friend with you to the football game, or providing emotional support if someone is upset.

NDIS supports won't ever replace the support people like your friends and family provide to you. This support is given freely because people care, and is often quite different to supports bought with NDIS funding.

You have a special bond with your friends and family that's different from your relationship with paid carers. And there are potential risks and problems for you if your friends and families become your paid carers.

To make sure we understand how disability supports might complement your circumstances, we consider:

- the things you are able to do for yourself
- any support you have from others in your network including family members, relatives, friends and local community services.

We also have to consider the benefits you may get from your informal supports. For example, your family and friends may be more effective at helping you meet other people, or helping to build your social skills, than paid supports can.

We consider if we can help these relationships so that you get the support you need.[140] For example, we may be able to fund training for your informal supports, so they can help you build your skills.

We also think about the capacity of your informal supports to continue caring for you, for example if they're ageing or sick.

There are different things the law for the NDIS says we need to consider for adults and children.

If you're under 18, we consider what support is reasonable to expect parents to provide at your age. It's normal for parents to provide substantial care and support for children.[141] We consider that it's usual for parents to provide almost all the care and support that young children need.

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For example, it's reasonable to expect parents to provide transport to and from their child's after-school activities. Of course, the amount of care and support for a child without a disability would typically reduce as they get older.

For children under 18, we consider:

- if your needs are 'substantially greater' because of your disability, compared to other children the same age[142] – that is, you need much more disability support
- any risks to the wellbeing of people providing informal support to you[143]
- if including funding for the support will help build your skills and capacity in the future, or reduce any risks to you.[144]

For example, we consider any health, safety or other impacts resulting from what's involved in meeting your disability support needs.

If you're over 18, we consider:

- if there are any risks to you or your informal supports if you rely on them to provide the support you need[145]
- how much your informal supports would help improve or reduce your independence and other outcomes.[146]

We also consider the suitability of informal supports to provide the supports you need,[147] including:

- how old your carers are and their capacity to provide the support[148]
- if other family members and the community can help your informal supports in their caring role[149]
- the intensity and type of support you need, and if it's appropriate for your informal supports to provide this, based on their age and gender[150]
- any long-term risks to the wellbeing of your informal supports.[151]

When we consider the risks for people over 18, we consider if the supports are sustainable for your informal supports. We consider the health, safety and other impacts on family and carers in the long term.

For example, we wouldn't expect a child to have their schooling affected because they need to provide care. We also wouldn't expect an elderly parent to be responsible for physical activities, if it may result in injury.[152]

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We generally don't fund family members to provide supports funded under the NDIS. There are very limited situations where we can consider this.

Learn more about Sustaining Informal Supports.

Example 1

Simon is getting his first NDIS plan. For the last 15 years, Simon and his wife Jan's preference was that Jan provide all the physical support he needs at home, such as toileting and showering.

But as Jan is getting older, it's not safe for her to keep lifting Simon. It's becoming risky for her to keep providing this support.

Jan and Simon think it might be best for someone else to provide the personal care support that Simon needs. Their children have moved out of home, and it's not reasonable to expect them to help Simon with personal care.

Based on this information and other evidence, Simon's planner decides that the personal care support meets this criteria. It takes into account what is reasonable for his family and others to provide. If the personal care support meets the other funding criteria, we may fund the personal care support for Simon.

Simon and Jan still prefer Jan to do the other support Simon needs though, such as helping Simon eat his meals. At this time, we wouldn't fund a support worker in Simon's plan to help him eat his meals. It's reasonable to expect Jan to help Simon with this, as it's what they want to do and it's not a safety risk for Jan.

Example 2

Qing is 14 and wants to join a local footy club. Like most 14 year old's in this situation, she needs someone to drop her off and pick her up from the Saturday matches and the weeknight training sessions.

But unlike most 14 year old's, she needs someone to help her get dressed before she can go to the match. Her parents have been doing this, but as Qing is getting older she no longer wants her family to help her get dressed.

It's reasonable to expect her family or other informal supports to drop Qing to and from the match and training sessions. So we wouldn't fund transport in Qing's plan.

But at age 14, it's not reasonable to expect her family to help her get dressed.

Based on this information and other evidence, Qing's planner finds that the personal care support takes into account what is reasonable for family and others to provide. If it meets the other funding criteria, we may fund personal care support in her plan.

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Is the support more appropriately funded or provided through the NDIS, and not through other service systems or support services?

We have to be satisfied that the support is most appropriately funded or provided through the NDIS. This means it's not more appropriately funded or provided through:

- other general systems of service delivery, or support services offered by a person, agency or body (such as a State or Territory Statutory Scheme)
- systems of service delivery or support services offered as part of a universal service obligation (such as the health or education system)
- systems of service delivery or support services offered in accordance with reasonable adjustments required under discrimination laws (such as your employer, or the health or education system).[153]

In short, we won't fund the support if it should be provided by someone else.

We won't fund the support if the support should be provided by someone else, even if the other service system doesn't actually provide it. We're not the funder of last resort, so we don't make up for other organisations and systems that don't provide the supports they should.

The law for the NDIS sets out a number of things we need to consider, when we decide who is most appropriate to fund or provide of the support.[154] There are different things we consider for the following service systems:

(a) Health

(b) Mental health

(c) Child protection and family support

(d) Early childhood development

(e) School education

(f) Higher education and vocational education and training

(g) Employment

(h) Housing and community infrastructure

(i) Transport

(j) Justice.

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How does the NDIS work with other government services?

We call supports provided by other government services, including those provided as part of a universal service obligation, 'mainstream supports'. When we talk about mainstream supports, we mean supports available to everyone in your state or territory, or across Australia, regardless of whether or not you have a disability.

This includes services provided by state and federal governments, like health care, education and mental health services.

You have the same right as all Australians to access these services. There are certain things that mainstream services have to do to make their services accessible for people with disability. Using mainstream supports can also help you be part of your community, or to work or study.

When we fund NDIS supports, we need to check that the support is not more appropriately funded or provided by a mainstream service or system, such as the education system or health system.[155] Under the law for the NDIS, we can't fund supports that should be provided by a mainstream service.

The Australian federal, state and territory governments agreed on responsibilities for funding different types of supports. The law for the NDIS has an outline of funding responsibilities and were developed with the agreement of each State and Territory.[156]

We can only fund supports that are the responsibility of the NDIS. We can't fund supports that are the responsibility of other government services, even if they don't actually fund or provide the support. The law for the NDIS sets out the matters we should consider when we decide who is more appropriate to provide or fund a support.[157]

Learn more about how we decide if the support is best funded or provided by us or another part of government.

The Applied Principles and Tables of Support also has information on what the governments agreed are the responsibilities of the NDIS and other government services. However, it doesn't override what we consider when we decide if the support is most appropriately funded by the NDIS.[158]

What is reasonable adjustment and why is it important?

People with a disability can sometimes face barriers that make it harder to do the same things as people who don't have a disability. For example, it might be harder to find and keep a job. Or it might be harder to get in and around places, or to get the same services as other people.

It's against the law to discriminate against people with a disability in many areas.[159] This includes in employment, when providing goods and services, and when accessing public places.

This means organisations or people who are responsible for providing these services have to make what are called 'reasonable adjustments'. They have to make sure people with a disability have equal access to the services they provide, as far as is reasonable.

They have to do reasonable things that will make their services equally available to everyone, whether or not you have a disability.

Reasonable adjustments do not mean they have to provide everything you need because of your disability. It means they have to do what's reasonable to make sure you have equal access to employment, public spaces or services. This takes into account what they can afford to do and what is reasonable to expect them to provide in the circumstances.

When we decide what supports to include in your plan, we need to consider what should be provided through reasonable adjustments. Under the law for the NDIS, we can't fund a support if it should be provided by someone else through reasonable adjustments.

What else do you need to know about working out if supports meet the NDIS funding criteria?

From our experience, we learned there are some common misunderstandings about how we work out what supports meet the NDIS funding criteria.

Why don't we always fund what your health professionals recommend?

Although we take expert opinions into account, we can't and don't always fund everything your health professional might recommend. This is because every support we fund needs to meet all the NDIS funding criteria.

For example, your therapist might recommend a piece of equipment on the basis that it will be 'effective and beneficial' for you. But if there is something cheaper that will achieve the same outcome, we won't be able to fund what the therapist recommended.

This is because it won't be value for money. We may be able to fund the cheaper option instead if it meets all the NDIS funding criteria.

Why don't we fund the same supports as your last plan?

We might fund different supports in your next plan. This is because we will fund supports in your plan based on how we use the NDIS funding criteria at that point in time.

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Your needs and situation will most likely change over time. This means it's likely your NDIS supports and funding for those supports will change over time.

For example, we may have funded supports to help you build your skills in a particular area. Once you have built those skills, you won't need funding for that anymore. So, we probably won't include that funding for those supports in your next plan.

Supports to build your skills may have met the NDIS funding criteria before, but the same supports might not meet the criteria in future.

Or, your disability support needs might increase or decrease over time. This may mean we consider funding more or less supports as a result.

What happens if you don't use all your funding in your NDIS plan?

We will consider how you have used your NDIS funding to help us work out what supports meet the NDIS funding criteria in your next plans.

If you haven't used all the funding by the end of your plan, it doesn't mean we'll reduce the funding in your next plan. There may be very good reasons why you weren't able to buy the supports we funded.

When we reassess your plan, we'll talk about any problems you had buying the supports funded in your plan. We'll also see how we can help you use your funding if we need to.

But if you consistently don't buy all the supports we fund and use all of your NDIS funding, we need to think about whether the supports really do meet the NDIS funding criteria. For example, they may not be 'effective and beneficial' for you if you're not actually using them. We will talk to you about this when we reassess your plan.

Learn more about changing your plan

Step 3: How do we include the reasonable and necessary supports in your plan?

Once we've identified the supports, and decided they meet the NDIS funding criteria, we can include the description and funding for the support in your plan.

If the support doesn't meet the NDIS funding criteria, we can't include the support in your plan. We may consider if a differently described support meets the NDIS funding criteria instead.

When we approve your plan we will also make sure all your supports are reasonable and necessary when considered as a package of supports.[160]

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Sometimes you might not need any supports under the NDIS. For example, your informal supports may meet all your disability support needs. If so, we'll approve a plan with no funded supports.

Learn more about how we create and approve your plan.

Learn more about using the funding in your plan.

What happens if we don't include the supports you want?

If we decide a support doesn't meet the NDIS funding criteria, we can't include the support in your plan. Also, if the amount of support you want doesn't meet the criteria, we can't include that amount in your plan.

But, we're committed to our principles and helping you live an ordinary life. Even if we can't fund a particular support we may still be able to help.

If the support doesn't meet the NDIS funding criteria, we can consider if a different support meets the NDIS funding criteria. We might be able to consider describing the support differently, or funding a different type of support.

Or, we may be able to connect you to mainstream or community supports that can help. Mainstream and community supports are available to everyone. They can be a good way to connect with your local community, learn new skills and gain independence.

There are lots of ways we might be able to help, so talk to us if you're in this situation. We can do this at any time. We may be able to help before we approve your plan.

We'll give you the reasons for our decision to approve your plan in writing.[161] You can contact us if you'd like more detail about the reasons for our decision.

If you don't agree with the supports we approve in your plan, you can ask for an internal review of our decision.[162] You'll need to ask for an internal review within 3 months of getting your plan.[163] [164]Learn more about internal and external review of decisions.

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Reference List

[1] NDIS Act and delegated legislation made under the NDIS Act, especially NDIS (Supports for Participants) Rules and NDIS (Plan Management) Rules.
[2] NDIS (Supports for Participants) Rules r 5.1(b).
[3] NDIS Act s34(1)(a).
[4] NDIS Act s34(1)(b).
[5] NDIS Act s34(1)(c).
[6] NDIS (Supports for Participants) Rules r 3.1(c).
[7] NDIS Act s34(1)(c); NDIS (Supports for Participants) Rules r 3.1(a).
[8] NDIS Act s34(1)(d).
[9] NDIS Act s34(1)(e).
[10] NDIS Act s34(1)(f).
[11] NDIS Act s34(1)(f).
[12] NDIS (Supports for Participants) Rules part 5.
[13] NDIS (Supports for Participants) Rules r 5.1(a).
[14] NDIS (Supports for Participants) Rules r 5.1(b).
[15] NDIS (Supports for Participants) Rules r 5.1(c).
[16] NDIS (Supports for Participants) Rules r 5.1(d).
[17] NDIS (Supports for Participants) Rules r 5.3(a).
[18] NDIS (Supports for Participants) Rules r 5.3(b).
[19] NDIS Act s34(1)(f).
[20] NDIS Act s118(1)(b).
[21] NDIS Act s4(17)
[22] NDIS Act s33(2).
[23] NDIS Act s33(5)(a).
[24] NDIS Act s34(1)(a).
[25] NDIS Act s34(1)(d).
[26] NDIS (Supports for Participants) Rules r 4.1(d).
[27] NDIS Act s34(1).
[28] NDIS Act s34(1)(d); NDIS (Supports for Participants) Rules, r 3.2-3.3.
[29] NDIS Act s34(1)(c); NDIS (Supports for Participants) Rules r 3.1.
[30] *McGarrigle v National Disability Insurance Agency* (2017) 252 FCR 121 at [88].
[31] NDIS Act ss 33(2)(a), 33(2)(b), 33(5)(c), 34.
[32] NDIS Act ss 13, 33(2)(a).
[33] NDIS Act ss 33(2)(b), 34.
[34] NDIS Act and delegated legislation made under the NDIS Act, especially NDIS (Supports for Participants) Rules and NDIS (Plan Management) Rules.
[35] NDIS Act ss 33(2)(b), 34; NDIS (Supports for Participants) Rules.
[36] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules r 5.3.
[37] NDIS (Supports for Participants) Rules pt 5.
[38] NDIS Act s 34(1).
[39] NDIS (Supports for Participants) Rules r 2.4; NDIS Act s 33(5)(c).
[40] NDIS Act ss 4, 31.
[41] NDIS Act s 4(1).
[42] NDIS Act s 4(2).
[43] NDIS Act s 4(4).
[44] NDIS Act s 4(8).
[45] NDIS Act s 4(10).
[46] NDIS Act s 4(17).
[47] NDIS Act s 4(11).

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[48] NDIS Act s 33(5)(a); NDIS (Supports for Participants) Rules r 4.1(a).
[49] NDIS (Supports for Participants) Rules r 4.1(a).
[50] NDIS (Supports for Participants) Rules r 4.1(b).
[51] NDIS (Supports for Participants) Rules rr 4.1(b), (d).
[52] NDIS (Supports for Participants) Rules r 4.1(c).
[53] NDIS Act s 33(5)(b).
[54] NDIS Act ss 36, 50.
[55] NDIS (Supports for Participants) Rules rr 4.2-4.6.
[56] NDIS Act s 33(1).
[57] NDIS Act s 47(1).
[58] NDIS (Supports for Participants) Rules r 4.1(d).
[59] NDIS Act s 34(1)(a).
[60] NDIS Act s 34(1)(a).
[61] NDIS Act s 33(5)(f).
[62] NDIS Act s 33(3) and NDIS (Plan Management) Rules.
[63] NDIS Act s 33(5)(c).
[64] NDIS Act s 33(3).
[65] NDIS Act s 33(3); (NDIS (Plan Management) Rules r 6.3.
[66] NDIS Act s 46(1).
[67] NDIS Act (Plan Management) Rules r 6.4(a).
[68] NDIS (Plan Management) Rules r 6.4(b).
[69] NDIS (Plan Management) Rules r 6.4(c).
[70] NDIS (Plan Management) Rules r 6.4(d).
[71] NDIS (Plan Management) Rules r 6.4(e).
[72] NDIS (Plan Management) Rules r 6.4(f).
[73] NDIS (Plan Management) Rules r 6.4(f).
[74] NDIS (Plan Management) Rules r 6.4(f).
[75] NDIS (Provider Registration and Practice Standards) Rules r 7(3).
[76] NDIS (Provider Registration and Practice Standards) Rules r 7(2).
[77] NDIS (Plan Management) Rules rr 6.6-6.7.
[78] NDIS (Plan Management) Rules r 6.6.
[79] NDIS (Plan Management) Rules r 6.7.
[80] NDIS (Plan Management) Rules r 6.7.
[81] NDIS (Plan Management) Rules r 6.7.
[82] NDIS (Plan Management) Rules r 6.5.
[83] NDIS (Plan Management) Rules r 6.6.
[84] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules pt 5.
[85] NDIS Act s 34(1).
[86] NDIS (Supports for Participants) Rules r 5.
[87] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules r 5.3(a).
[88] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules r 5.3(b).
[89] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(a).
[90] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(b).
[91] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(d).
[92] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(c).
[93] NDIS (Supports for Participants) Rules r 5.3(a).
[94] NDIS (Provider Registration and Practice Standards) Rules 2018 r 7(2).
[95] NDIS Act s 73F(2)(a).
[96] NDIS (Supports for Participants) Rules r 5.3(b).
[97] NDIS (Supports for Participants) Rules r 5.1(a).
[98] NDIS (Supports for Participants) Rules r 5.1(b).
[99] NDIS (Supports for Participants) Rules r 5.1(d).

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[100] NDIS (Supports for Participants) Rules r 5.1(d).
[101] NDIS (Supports for Participants) Rules r 5.2(a).
[102] NDIS (Supports for Participants) Rules r 5.2(b).
[103] NDIS (Supports for Participants) Rules r 5.1(c).
[104] NDIS Act ss 33(5)(c), 34(1).
[105] NDIS Act s 34(1)(a).
[106] NDIS Act s 34(1)(b).
[107] NDIS Act s 34(1)(c).
[108] NDIS Act s 34(1)(d).
[109] NDIS (Supports for Participants) Rules r 3.2(a).
[110] NDIS Act s 34(1)(e).
[111] NDIS Act s 34(1)(f).
[112] NDIS (Supports for Participants) Rules pts 3, 4.
[113] NDIS Act s 33(5)(c).
[114] NDIS Act s 34(1)(a).
[115] *McGarrigle v National Disability Insurance Agency* (2017) 252 FCR 121 at [91].
[116] NDIS Act s 34(1)(a).
[117] NDIS Act s 34(1)(c).
[118] NDIS Act s 34(1)(d).
[119] NDIS (Supports for Participants) Rules r 5.1(b).
[120] NDIS (Supports for Participants) Rules r 5.1(d).
[121] NDIS Act s 34(1)(b).
[122] NDIS Act ss 3(3)(b), 4(17).
[123] NDIS (Supports for Participants) Rules r 3.1(a).
[124] NDIS (Supports for Participants) Rules r 3.1(b).
[125] NDIS (Supports for Participants) Rules r 3.1(c).
[126] NDIS (Supports for Participants) Rules r 3.1(e).
[127] NDIS (Supports for Participants) Rules r 3.1(c).
[128] NDIS (Supports for Participants) Rules r 3.1(d).
[129] McCutcheon and NDIA [2015] AATA 624 at [34].
[130] McCutcheon and NDIA [2015] AATA 624 at [34].
[131] McCutcheon and NDIA [2015] AATA 624.
[132] NDIS (Supports for Participants) Rules r 3.2(a).
[133] NDIS (Supports for Participants) Rules r 3.2(b).
[134] NDIS (Supports for Participants) Rules r 3.2(c).
[135] NDIS (Supports for Participants) Rules r 3.3.
[136] NDIS (Supports for Participants) Rules r 3.3.
[137] NDIS Act s 34(1)(e).
[138] NDIS Act s 34(1)(e).
[139] NDIS (Supports for Participants) Rules r 3.4(a)(i).
[140] NDIS (Supports for Participants) Rules r 3.4(c).
[141] NDIS (Supports for Participants) Rules r 3.4(a)(i).
[142] NDIS (Supports for Participants) Rules r 3.4(a)(ii); JQJT and National Disability Insurance Agency [2016] AATA 478 at [39].
[143] NDIS (Supports for Participants) Rules r 3.4(a)(iii).
[144] NDIS (Supports for Participants) Rules r 3.4(a)(iv).
[145] NDIS (Supports for Participants) Rules rr 3.4(b)(i), (ii).
[146] NDIS (Supports for Participants) Rules r 3.4(b)(iii).
[147] NDIS (Supports for Participants) Rules r 3.4(b)(ii).
[148] NDIS (Supports for Participants) Rules r 3.4(b)(ii).
[149] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(A).
[150] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(B).

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[151] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(C).
[152] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(C).
[153] NDIS Act s 34(1)(f).
[154] NDIS (Supports for Participants) Rules rr 3.5-3.7 and Schedule 1.
[155] NDIS Act s 34(1)(f).
[156] NDIS (Supports for Participants) Rules rr 3.5-3.7, Schedule 1; NDIS Act ss 209(4), (8) item 1.
[157] NDIS (Supports for Participants) Rules rr 3.5-3.7, Schedule 1.
[158] NDIS (Supports for Participants) Rules rr 3.5-3.7, Schedule 1.
[159] Disability Discrimination Act 1992 (Cth); Discrimination Act 1991 (ACT); Anti-Discrimination Act 1977 (NSW); Anti-Discrimination Act 1996 (NT); Anti-Discrimination Act 1991 (Qld); Equal Opportunity Act 1984 (SA); Anti-Discrimination Act 1998 (Tas); Equal Opportunity Act 2010 (Vic); Equal Opportunity Act 1984 (WA).
[160] NDIS Act s 33(5)(c).
[161] NDIS Act s100(1).
[162] NDIS Act s100.
[163] NDIS Act s100(2).

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Reasonable and Necessary Supports

Quick summary: The Australian Government made laws about what we can fund under the NDIS. All supports need to meet the criteria in these laws before we can fund them in your NDIS plan. We call these the NDIS funding criteria. For example, supports need to relate to your disability, be value for money and effective and beneficial. We also need to make sure all supports are most appropriately funded or provided by us. Each support must meet these criteria individually, but the supports must also meet the criteria when considered as a package.

Note: when we say 'your plan' we mean your NDIS plan. If you're looking for information about community connections, go to Our Guideline – Community Connections.

If you're looking for information about your child's early connections, go to Our Guideline – Early Connections.

What's on this page?

This page covers:

- What principles do we follow to create your plan?
- What supports can you get?
- What other principles do we consider when we decide what supports to include in your plan?
- How do we decide what reasonable and necessary supports to include in your plan?
- Step 1: How do we describe a support in your plan?
- Step 2: How do we work out if an identified and described support meets the NDIS funding criteria?
- Step 3: How do we include the reasonable and necessary supports in your plan?

You may also be interested in:

- Mainstream Supports
- Creating Your Plan
- Changing your plan
- Reviewing our decisions
- Would we fund it?

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What principles do we follow to create your plan?

The NDIS was set up as a world first approach to disability support. It puts people with disability at the centre of decision-making, through the principles of reasonable and necessary supports and individual choice and control.

As an insurance-based scheme, we take a lifetime approach to a participant's support needs. We provide assurance to people with permanent and significant disability or developmental delay, and to people who might acquire disability or developmental delay, that they will get the support they need. Individual funding means we help participants to purchase services and supports from a competitive and consumer-driven marketplace.

What supports can we fund?

NDIS supports should complement, not replace, other supports available to you. That's why we consider:

- the things you're able to do for yourself
- support you have from others in your network, including family members, relatives, friends, local community services and mainstream government services.

One of our aims is to help maximise your independence by working with the local mainstream government and community services that help you live an ordinary life. We all do best when we're connected to our communities.

And as an active consumer, it's important you are able to shop for and access providers who meet your needs. We can help you find providers who meet your needs.

Once we've considered your circumstances, we need to follow the rules determined under the law for the NDIS in our planning decisions.[1] We fund supports that are reasonable and necessary.

This means we will only fund a support if it meets **all** of the following criteria:

- the support is related to your disability[2]
- the support will help you pursue your goals and aspirations[3]
- the support will help you undertake activities that will increase your social and economic participation[4]
- the support is value for money,[5] which means that the costs are reasonable:
    - when compared to the benefits to be achieved, for example, whether purchasing the support is likely to reduce the cost of funding other supports in the long term[6]

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- when compared to alternative options that may provide you with the same outcome at a similar or lower cost[7]

- the support is likely to be effective and beneficial for you, having regard to good practice and evidence[8]
- the support is required to complement the informal supports you have available, by considering what is reasonable for families, carers, informal networks and the community to provide[9]
- the support is most appropriately funded or provided by the NDIS[10]
- the support is not more appropriately funded by another service system, agency, person, or body, such as the education system or the health system.[11] We can't fund a support if it's the responsibility of another service system.

What supports don't we fund?

We do not fund a support if:[12]

- it is likely to **cause harm** to you or others[13]
- it is **not related** to your disability[14]
- it **duplicates** other supports delivered by the NDIS[15]
- it is considered **a day-to-day living cost** (for example, rent, groceries or utility costs like your water bill) that are **not attributable or caused by** your disability support needs[16]
- providing the support would be **against the law**[17]
- it consists of **income replacement**[18]
- it is the **responsibility of other service systems** to provide (for example, your state government, the education system, or the health system).[19] These different systems have different responsibilities and are designed to complement each other to form a government safety net. Like all Australians, NDIS participants continue to have access to these systems. We can't fund a support if it's the responsibility of another service.

How do we manage the financial sustainability of the NDIS?

The NDIS is an insurance scheme, and one of our core functions is to manage the financial sustainability of the Scheme.[20]

When we make decisions about the supports we fund in your plan, we must also consider our need to ensure the **financial sustainability of the NDIS**.[21] This means we must work within our funding budget, set through agreements between the Australian, and State and Territory governments.

It's also important to know the NDIS is only one part of the broader National Disability Strategy that supports people living with disability. The overall success and sustainability of the National Disability Strategy relies on:

- people accessing their informal support network to get the help they need from day-to-day
- people using their personal income to pay for their day-to-day living expenses, as is expected of all Australians
- mainstream and community services being available from state and territory governments, and other federal government programs such as Medicare
- a fair distribution of NDIS supports to those who need them, provided within our funding budget.

Staying within our budget ensures the NDIS will be here to support generations of Australians and their families.

What principles do we use to create your plan?

We use the following 7 principles, to create plans that help you get the reasonable and necessary supports you need, and to make sure the Scheme is financially sustainable:

- Fair for everyone, both today and for future generations
- Fair funding to pursue your goals
- Evidence-based best practice
- Fair early investments
- Fair support across service systems
- Fair supports for your disability needs
- Fair assistance from multiple programs

Fair for everyone, both today and for future generations

While we need to consider your individual circumstances and disability needs, we also need to make consistent decisions and treat people fairly.

This means participants with similar circumstances and disability needs should receive similar amounts of supports in their plans. We also need to ensure the total cost of all participant plans are within the overall NDIS budget set by governments.

Each support in your plan must be reasonable and necessary. They also need to be reasonable and necessary as a package of supports. We approve your whole plan, not the individual supports in your plan in isolation.[22] Information about what supports we'd usually include in your plan helps guide this process.

This information also helps to guide the consistency of our decision-making process. We use it to check your overall plan and make sure all your supports make sense together. We'll check your support types and amounts will complement each other to help you fulfil an ordinary life.

We may then increase or decrease the funding in your plan based on:

- information you share with us
- any reports or other information we have
- applying the NDIS funding criteria.

This helps keep the system fair for everyone, and ensure we remain financially sustainable.

Fair funding to pursue your goals

Goals are important.[23] The supports we fund need to help you maximise your independence and pursue your goals.[24] This means your supports should help overcome any disability-specific barriers which may be stopping you from pursuing your goals.

This doesn't mean we fund all support costs associated with you pursuing your goals. Also, you may have goals and aspirations we can't fund supports for. This is because helping you pursue your goals is only one of the NDIS funding criteria, so not all supports that help you to pursue your goals will be reasonable and necessary.

Other things to know about when setting your goals:

1. **Setting more goals or bigger goals doesn't mean we'll provide more funding or fund more supports.** For example, if your goal is to live independently in a house with a swimming pool, we may fund home modifications that address your disability-related needs. This might be a home modification to make your bathroom accessible.

   We won't fund the swimming pool because this isn't related to your disability support needs. The funding in your plan might be similar to someone else who has a goal of 'to have a more accessible bathroom'.

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2. **Setting a goal doesn't mean we have an obligation to fund supports that help you pursue that goal.** For example, if your goal is to get a gym membership to get fit, we wouldn't usually fund this. Gym memberships are things that all people, with or without disability, might want or need.
3. **Setting a goal about an explicit type or amount of support you might want doesn't mean we have an obligation to fund that support or provide that amount of funding.** For example, you may tell us your goal is 'to get a top model shower commode' and you show us the one you want costs $4,000.

   If there is a shower commode that costs $3,000, and your occupational therapist confirms this one will meet your needs, we are more likely to fund this one instead because it is likely to deliver the same result at a lower cost. We may also look at alternatives.

Evidence-based best practice

We only fund supports that will be, or are likely to be, effective and beneficial for you, having regard to current good practice.[25] This means we consider if there is evidence that the support is effective and beneficial for someone with similar disability support needs.

For example, we may already have information about whether the support is widely accepted to suit someone with your disability support needs.[26] The primary source of evidence we rely on, and give the greatest weight to, is evidence from sources that are reliable and widely recognised. This includes published and refereed literature, and any consensus of expert opinions. If there is no evidence to show a support is reasonable and necessary,[27] we won't fund the support.

You can find the types of evidence we need on our website, and in Our Guidelines.

Fair early investments

Having access to capacity-building supports early in your NDIS journey is considered to be an early investment. This early investment is intended to help increase your independence and reduce your reliance on NDIS funding over time.

This is an important concept we consider when we create your plan, and again at future plan reassessments. When we reassess your plan, we reassess all the supports you require to meet your disability support needs at that time.

Over time, your capacity building supports may no longer be reasonable and necessary, in regard to any of the following:

- your current functional capacity
- the effectiveness of the capacity building supports[28]
- value for money.[29]

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When we say functional capacity we mean the things you can and can't do for yourself.

Your overall funding amount could go down from one plan to the next. This may be because you no longer need the same type or amount of supports, such as capacity building supports. Also, if the capacity building investment has been successful at building your independence, then your need for other supports may also decrease. For example, as you develop your skills you may not need as many Core supports.

So other things being equal, you should expect your overall plan value to reduce over time as the benefits of capacity building are realised.

Fair support across service systems

The support you need may be the responsibility of another government service, like education or health. We don't fund these services. We need to think about the supports you should receive from these services when we determine the supports in your plan.

Fair supports for your disability needs

When we make decisions about which supports we can fund, we consider whether a support is reasonable and necessary for you and apply the NDIS funding criteria. Sometimes, you might ask for supports to help with impairments that were not part of your Access eligibility assessment. When this happens, we need to make sure the support will help you address the needs that arise from an impairment that meets the same eligibility requirement we consider at Access.

You don't need to make a new Access request if you ask for supports to help with an impairment which was not part of your Access eligibility assessment. We'll work out if you need the support to address an impairment which would meet our eligibility requirements. We may ask you to provide evidence to help us work this out. We will decide if the requested support is reasonable and necessary. We'll apply the NDIS funding criteria based on the impairments which meet our eligibility criteria.

We fund the right disability supports for your permanent impairments which meet our eligibility criteria. By doing this we make sure the system is fair for everyone, and the NDIS remains financially sustainable.

Fair assistance from multiple programs

NDIS funding can't duplicate other funding or supports you may receive due to your disability.

For example, you may have received a lump-sum payment or receive regular payments as a form of compensation for an accident. Or, you may be receiving ongoing supports from another program or insurance scheme, for example Work safe, Lifetime Care and Support or the Transport Accident Commission.

We don't duplicate this funding, or these supports. We may reduce the total value of your NDIS plan to account for compensation you receive, or we may not fund certain supports.

What supports can you get?

When we create your plan with you, we'll discuss what supports you need for your disability. We want to help you pursue your goals, increase your independence, and help you work, study and join social activities.

There are many supports you can get outside the NDIS. Other government and community services provide supports to all Australians, including people with disability. And your friends, family, and other people you know can often be your best supports.

We can fund supports you need for your disability if they meet certain criteria. These are called 'reasonable and necessary supports'. Your plan and supports will be just for you, so you have more choice and control over how you use them.

This guideline explains how we decide what reasonable and necessary supports we'll include in your plan. There are lots of things we have to consider, which we'll explain in detail.

We also have a Would we fund it guide. It has examples of how we decide whether we fund different types of NDIS supports.

What supports can you get outside the NDIS?

Before we decide what reasonable and necessary supports to fund in your NDIS plan, we'll first discuss what other supports may be available outside the NDIS. This is an important information-gathering step. For example, there may be mainstream, community and informal supports that suit you.

Mainstream supports are other government services such as employment, education, health and family support services. They are often really helpful, and are available to everyone including people without disability. There are many ways they can help you learn new skills or live as independently as possible.

Community services offer a wide range of supports that may help with your disability support needs. Community supports are things open to everyone in the community, like sporting clubs, community colleges, activity groups, libraries or community gardens. They are often a great way to get involved in your local community, meet new people and learn new skills.

Informal supports, like your family, friends and other people you know in your community, can sometimes be your best supports. They know you and can often help in ways other supports can't.

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Your my NDIS contact or support coordinator will talk with you about what services are available for you outside the NDIS. We can also help link you with these supports, so you don't have to do it all on your own.

Accessing these supports is a good way to work toward your goals. You get to do it with other people and be involved in your community. Using these supports is part of life for most of us. It's important you get to access them the same as everyone else.

When it comes time to talk about what reasonable and necessary supports we can fund, you'll know how mainstream, community and informal supports can help you.

It's important we gather this information and help you access these services before we consider what reasonable and necessary supports we can fund. That way, we can help make sure you're able to access mainstream, community and informal supports wherever possible. This can help you become as independent as possible.

What are reasonable and necessary supports?

An NDIS support is the practical description of how you will be assisted under the NDIS.[30] Supports are the things we provide or fund to help to meet your disability support needs.

NDIS supports are the services, items and equipment we can fund or provide under the NDIS.

There are two types of NDIS supports we can include in your NDIS plan. We call them 'general supports' and 'reasonable and necessary supports'.[31]

General supports

General supports are the coordination, strategic or referral services and activities we provide, or arrange to be provided, for you.[32] They're how we help you develop your NDIS plan and connect with supports and activities in your community. This includes your mainstream, community and informal supports. Learn more in Creating your plan.

Reasonable and necessary supports

Reasonable and necessary supports are the supports we fund in your plan to meet your disability support needs.[33] You can use this funding to buy supports from service providers.

The Australian Government made laws about what we can fund under the NDIS.[34] All supports we fund in a plan need to meet the criteria set out in these laws. We call these the NDIS funding criteria.[35]

To meet the NDIS funding criteria, a support must meet both the following criteria:[36]

- It must not be a type of support the law says we can't fund or provide.[37]
- It must meet the reasonable and necessary criteria.[38]

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We call supports that meet the NDIS funding criteria 'reasonable and necessary supports'.

Each individual reasonable and necessary support in your plan must meet the NDIS funding criteria. Your whole plan as a package of supports must also meet the NDIS funding criteria.

We check your overall plan to make sure all your supports make sense together. This means we check that your supports and the amount of supports will complement each other to help you fulfil an ordinary life.[39] Learn more about reasonable and necessary supports.

If you need a new support, which now means your overall package of supports doesn't meet the NDIS funding criteria anymore, we may either:

- not include the new support in your plan
- include the new support in your plan, but also reduce the other supports in your plan.

For example, a home modification may reduce your need for other supports. If we plan to fund a home modification, we will need to take that home modification into account when considering what other supports are reasonable and necessary, such as the amount of care you need at home.

What other principles do we consider when we decide what supports to include in your plan?

As far as possible, we have to act according to principles set out in the law for the NDIS.[40] These are the things that guide us when we make decisions about what we fund.

These principles don't override or replace the NDIS funding criteria under the law for the NDIS. They can help us apply the funding criteria, by giving us additional guidance when we decide what supports to approve in your plan.

The principles include the following:

- You have the same right as other Australians to realise your potential for physical, social, emotional and intellectual development.[41]
- You should be supported to take part in and contribute to social and economic life.[42]
- You should be supported to make choices about planning and how your supports will be delivered. This includes taking reasonable risks, so that you can pursue your goals.[43]
- You have the same right as other Australians to decide your own best interests. You have the right to be an equal partner in decisions that affect your life.[44]
- Your privacy and dignity should be respected.[45]
- We must make sure the NDIS is financially sustainable.[46]

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The principles also tell us that the reasonable and necessary supports we fund should:[47]

- support you to pursue your goals and maximise your independence
- support you to live independently and to be included in the community as a fully participating citizen
- develop and support your capacity to do things that help you participate in the community and in employment.

Just because a support helps you do these things doesn't mean we'll fund it in your plan. All supports we fund need to meet **all** the NDIS funding criteria.

We consider these principles set out in the law for the NDIS, along with the principles we follow to create your plan.

How do we think about an ordinary life when deciding what supports to include in your plan?

To help guide us in our decision making about reasonable and necessary supports, we took advice from the NDIS Independent Advisory Council.

The Council represents people with disability and carers, bringing their own lived experience and expertise of disability. They give us advice on how the NDIS should work.

The Council advised us that all Australians, including people with disability, should have an 'ordinary life'. They also told us we should think about the idea of an ordinary life when we apply our principles and use the NDIS funding criteria.

An ordinary life is a life where you have the same opportunities as people without a disability. An ordinary life is one that is typical or usual for everyone in modern day Australia. It's a life where you can pursue your potential and participate in society on an equal basis with others.

An ordinary life will be different for different people. We are all different, and come from different cultures and backgrounds. We each have our own values, experiences, beliefs and goals.

But there are some common things that can improve the quality of our lives and help us participate equally. These are the things, such as the following, that make up an ordinary life:

- Positive relationships – with families and informal support networks.
- Individual autonomy – being free and independent, and having the same opportunities as people without disability.
- Active involvement in decision-making – including the ability to make meaningful decisions, and exercise choice and control.
- Using your strengths in ways that provide a challenge and enjoyment.

A sense of belonging – to our families, friendship networks, communities, workplaces and society.

- Active involvement and contribution to society and your community.

An ‘ordinary life’ in the context of the NDIS involves supporting you to:

have and maintain good relationships

belong and participate in your community

- be involved in making choices about your own life.

One way we can help you have an ordinary life is to support you to access mainstream, community or informal supports wherever possible. These are the usual supports that everyone in the community uses.

When we fund reasonable and necessary supports under the NDIS, we need to make sure they meet the NDIS funding criteria.

When we apply the NDIS funding criteria and make decisions about reasonable and necessary supports, we’re guided by the principles in the law for the NDIS. We also consider how the supports will best help you to live an ordinary life.

How do we decide what reasonable and necessary supports to include in your plan?

What information do we consider to work out what reasonable and necessary supports to fund in your plan?

The most important information we gather about what supports to include in your plan comes from you.

When we create your plan, we will talk with you about:

- your goals and aspirations[48]
- your strengths, capacity and individual circumstances[49]
- any barriers, limitations and restrictions you face in undertaking activities or things that stop you from living an ‘ordinary life’[50]
- your disability support needs[51]
- any risks and safeguards we may need to think about when considering your support needs.[52]

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We use this information to create your plan with you. Generally, we'll discuss this information before you become an NDIS participant. We'll continue to discuss it when we check-in with you once you have your plan. Learn more about check-ins in Our Guideline – Your plan.

We want to get a good understanding of your disability support needs. We know you're the expert in your own life, and we use your lived experience as much as we can. When we ask for information from you, we encourage you to involve anyone you want to help you give us this information.

We'll also think about other information we have such as medical or therapy reports, or assessments you've had.[53]

We look at different types of evidence for different types of supports. We may need a report or assessment from your doctor or health professional who specialises in helping you manage your disability.

Reports and assessments may tell us why you need the support and how the support relates to your disability support needs. For example, an occupational therapist may send us a letter about why you need a specific type of wheelchair.

When we create a new plan for you during a reassessment we think about the supports in your current plan. We'll check if you need any changes to these supports to help you pursue your goals in your next plan. We use information from your providers to let us know how the supports they are providing have helped you work towards your goals.

We'll look at the evidence we get to make sure we have enough information to decide if the support meets the NDIS funding criteria. Sometimes we may ask for further information and assessments, if we need them to help us work out your support needs when we approve your plan.[54]

Learn more about the types of evidence we can use when we create your plan.

To help us work out what supports to consider for people aged 9 years and older we also use a 'Typical Support Package'. [55] We worked with people with disability, professionals and subject matter experts to develop the Typical Support Package.

It helps us work out the types of supports we'd usually expect to include in your plan. It's based on your situation and support needs.

We then amend the supports suggested by the Typical Support Package to include more, less or different supports if we need to. We may adjust the funding for those supports up or down based on our discussion with you, the information you share with us

any reports or other information we have, and when we apply the NDIS funding criteria.

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For children younger than 9, we consider the child's current functioning across development areas when we work out the reasonable and necessary supports that should be funded in a child's NDIS plan. Learn more about the Early Childhood Early Intervention approach.

How do we consider your goals when we work out your reasonable and necessary supports?

Before we create your plan, we'll discuss your current goals and personal details, including things like your living arrangements and current supports. We'll include this information in your plan.[56] Your goals are your own personal desires about what you'd like to do.

You can set any goals you like, even if they're about things we won't fund supports for. You can also change your goals at any time.[57] We consider how your funded supports will help you pursue your goals when we decide to approve your plan.[58]

Reasonable and necessary supports should help you pursue your goals,[59] but you don't need a specific goal for every support in your plan. When we decide if a support will help you pursue your goals, we consider your whole situation.

We look at the disability specific barriers that prevent you from pursuing your goals, and how the support will address your disability support needs.

There are some things to remember when setting goals:

- Setting more and bigger goals doesn't mean we'll fund more and bigger funded supports.
- Setting a goal doesn't mean we have an obligation to fund supports that help you pursue that goal.
- Setting a goal about an explicit type or amount of support you might want doesn't mean we have an obligation to fund that support or in that amount.

This is because helping you pursue your goals is only one of the NDIS funding criteria.[60] A support must meet all of the NDIS funding criteria to be funded under the NDIS. So not all supports that help you to pursue your goals will be reasonable and necessary supports.

Learn more about setting your goals and how we consider your goals under the NDIS funding criteria.

What if your plan needs to change?

If it's not your first plan, we also consider how well the supports funded in your previous plans worked for you.[61] This means we'll ask about how your current plan has worked for you. We look at the supports in your current plan and see whether any changes need to be made to these to help you pursue your goals in your next plan.

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This will help us decide whether these supports continue to meet your needs and the NDIS funding criteria. Learn more about changing your plan.

How do we use the information we have to work out what reasonable and necessary supports to fund?

We consider all the information we have gathered to decide what reasonable and necessary supports to fund in your plan.

We use the information you give us and follow the steps below:

- **Step 1**: Identify and describe the supports to be considered. The support will be described either generally (known as 'flexible' funding for supports) or specifically (known as 'stated supports' or 'fixed' supports).[62]
- **Step 2**: Work out if the support identified and described meets the NDIS funding criteria.
- **Step 3**: We include the supports that meet the NDIS funding criteria in your plan.

When we approve your plan we make sure all your supports meet the NDIS funding criteria individually and as a package of supports.[63]

Step 1: How do we describe the types of supports in your plan?

Sometimes we need to describe a specific support to be included in your plan. Or we might include funding more generally within a support category[64]. Where we have included funding in a support category, you can generally choose which supports you buy from that category to meet your disability-related support needs.

Supports we describe generally or specifically must meet the NDIS funding criteria.

We look at all the evidence of your support needs to help us identify what supports to consider in your plan. We use:

- the information you give us when you apply for the NDIS, during a check-in or when you contact us
- any assessments or other information we have

For reassessments we'll look at the supports in your previous plan and check how well they are working for you. For your first plan we use the Typical Support Package to think about what supports we'd usually expect to include in your plan based on your situation and disability support needs.

When we say support we mean funding for a service, item or equipment you need to help with your disability support needs.

We think about:

- what the outcome of the support will be
- how the support helps with your disability
- whether the support meets the NDIS funding criteria.
- whether we need to specifically describe the supports in your plan.

How do we describe support in your plan?

We divide your supports into 4 different budgets:

- **Core supports**

  These supports help you with everyday activities, like help to take part in activities in the community. This budget is mostly flexible so you can use funding from one support category to pay for something in another support category.

- **Capacity building supports**

  These supports help you build your skills and increase your independence and reduce the need for the same level of support in the future. Your progress and outcomes from these supports will be shared at each plan reassessment. Capacity building supports are stated so you won't be able to use funding from one support category to pay for something in another support category.

- **Capital supports**

  Includes high-cost assistive technology, equipment, vehicle modifications, home modifications and specialist disability accommodation. Capital supports are stated. You can only use this funding to buy approved individual supports in this support category.

- **Recurring supports**

  These supports are paid by us on a regular basis, so you don't need to claim for these. Your funding for your recurring supports will be paid regularly to your nominated bank account. This funding is not included anywhere else in your budget and includes mainly transport supports.

Each budget is divided into a number of support categories. Support categories have more detail about what supports you can buy with your funding. We can describe the support categories in your plan as one of the following:

- **Flexible**: Under the law for the NDIS, this is when we describe supports in a category generally. You have greater flexibility over what disability supports you can buy within the description of the support. When we describe your support categories as flexible, you can usually choose what supports you buy within the descriptions for each support category.
- **Stated**: Under the law for the NDIS, this is when we describe the supports in a support category specifically. It means you must buy supports in the way we have described in your plan.[65] We sometimes call this a fixed support in your plan.

You must act according to your plan, and buy supports according to how we described them in your plan. This means you can't use the funding in your plan to buy supports that fall outside the description of the support in your plan.[66]

We describe most support categories as flexible when we can. You have greater flexibility over the support you can buy in your flexible budgets. When support categories are described as stated, you have less flexibility.

If we describe a support category as stated, you must use the funding in your plan to buy the supports exactly how we describe them. This includes how the support is provided. For example, we will sometimes require the support to be provided:

- by a particular service provider
- by a particular qualified person
- through a particular delivery mode or method, or in a special way.

Your Core supports budget is the most flexible. You can usually use your funding across all the support categories in the Core Supports budget if:

- we described the supports as flexible
- you have the same plan management options for your Core Supports.

When we decide whether to describe supports as stated or flexible, we think about:

- how much the support costs[67]
- if the support will help reduce the cost of other supports over time,[68] for example providing more supports early so you don't need as many supports later in life
- any risks with supplying the support, for example if the support would create risks to your health and safety or if it doesn't comply with state or territory laws[69]
- if you need a particular support to pursue your goals or to use other supports in your plan effectively[70]

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- if you need a specialist support, for example if your support must be delivered by a qualified person, or in a special way[71]
- if you are eligible for the NDIS under the early intervention criteria.[72]

When do we describe supports as stated?

We usually describe high-cost supports, or supports with more risk, as stated. For example, we might describe supports as stated if you need to use those particular supports to ensure your health and safety. This includes supports such as:

- high-cost assistive technology
- complex home modifications
- behaviour support, or supports that involve restrictive practices such as restraint
- Specialist Disability Accommodation.

We will also check if you were eligible for the NDIS through the early intervention criteria.[73] If so, we might decide to describe the supports as stated for some types of early intervention supports.[74] If you're not sure whether you met the disability criteria or the early intervention criteria, check the letter we sent you when we decided you're eligible.

Example

John just received his first plan. His plan describes support for assistive technology as flexible, including $2,000 of funding. John can choose what assistive technology to buy with this funding. John talks to his occupational therapist about what assistive technology he should buy with this funding. For example, he could buy a shower chair, or low-cost items like a slip-resistant bathmat.

John's plan also has a fixed support for a wheelchair with special features, and funding of $8,000. John will need to use this funding for the specific wheelchair we listed on his plan. He can't use this funding for another support, like a shower chair, instead.

What if you need a specific provider to provide the support?

Sometimes your plan may say who must provide the support. We do this when you need a certain provider to make sure the supports are delivered safely, or to achieve a certain outcome.

For some supports, you must use an NDIS registered provider. These include:

- Specialist Behaviour Support, if the provider will undertake a behaviour support assessment or develop a behaviour support plan[75]
- supports where it's likely a provider will need to use a regulated restricted practice,[76] either interim or ongoing

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- Plan Management
- Specialist Disability Accommodation.

You must use registered providers for these supports even if your plan doesn't say you need to. You must also use registered providers for these supports, even if you self-manage your funding or use a registered plan manager. Learn more about the different plan management options.

For other supports, we'll decide that the support must be provided by a particular person, provider, or delivered in a certain way.[77] We'll do this if it's the most efficient and effective way to provide the support. This only happens when:

- we have an agreement with a particular provider to provide the support[78]
- we decide you must use an NDIS registered provider due to the risks, for example complex home modifications[79]
- you need support from a particular person with specialist qualifications, for example a health professional[80]
- you need support delivered in a certain way.[81]

Sometimes, we'll arrange the support ourselves, if it's more cost effective than getting another provider to deliver the support. For example, we may bulk buy a support.[82] If so, we will state this in your plan.

What about in-kind supports?

We agreed that state and territory governments will keep providing some supports for a period of time. We call these 'in-kind supports'.

If we fund in-kind supports like specialist school transport or personal care in schools, you will need to use state or territory government providers for these supports. These supports are most efficiently and effectively provided by state and territory government providers.[83] Learn more about Work and study supports.

For most other in-kind supports, you can choose your provider if you don't want to use your in-kind provider anymore. We can let you choose another provider if we consider that the support isn't most effectively and efficiently provided by the in-kind provider.

We usually let you choose another provider if:

- another provider can give you the same support or level of support as the in-kind provider
- the supports with the new provider still meet the NDIS funding criteria, including that they're value for money compared to the in-kind support

- there are no serious risks with changing providers.

Learn more about in-kind supports.

Step 2: How do we work out if an identified and described support meets the NDIS funding criteria?

To meet the NDIS funding criteria, a support must meet both the following criteria:

- It must not be a type of support the law says we can't fund or provide.[84]
- It must meet the reasonable and necessary criteria.[85]

Each support must be reasonable and necessary individually, but the supports must also be reasonable and necessary when considered as a package of supports.

What types of supports can't be funded or provided under the NDIS?

Under the law for the NDIS, there are things we can't fund or provide.[86] We can't fund or provide supports that:

- are not legal[87]
- are income replacement[88]
- are likely to cause harm to you, or pose a risk to other people[89]
- are not related to your disability[90]
- relate to a 'day-to-day living cost', such as groceries, rent or utilities, that are not attributable to your disability support needs. These are costs that are not caused by or as a result of your disability support needs.[91]
- duplicate other supports provided by the NDIS under alternative funding.[92]

Is the support legal?

We can't fund a support if it does not comply with the law.[93] This includes both:

- **an Australian government law:** a law that applies to all of Australia
- **a State or Territory government law**: a law that only applies in your state or territory.

For example, we won't be able to fund supports involving:

- a restrictive practice where it's not authorised in your state or territory
- assistive technology or home modifications that don't meet Australian laws, such as State and Territory Acts and Regulations, the National Construction Code, and relevant Australian Standards

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- supports for illegal activities, such as support for criminal behaviour or illegal drugs.

While this is one of the NDIS funding criteria, we're not responsible for ensuring your supports are legal. We're not responsible to ensure that all supports in your plan comply with all the relevant legal and administrative requirements. This is your responsibility and your provider's responsibility.

For example, if a support is likely to require the use of a restrictive practice, the provider must be registered with the NDIS Quality and Safeguards Commission.[94] It's the provider's responsibility to ensure they are registered and comply with the conditions of their registration. This includes complying with all laws and seeking the necessary authorisations.[95]

We're not responsible for ensuring the provider is registered and complies with their conditions of registration. You can contact the NDIS Quality and Safeguards Commission if you're concerned about a provider's compliance with legal obligations.

Is the support 'income replacement'?

We don't fund income support or income replacement.[96] This means NDIS funding can't replace or add to money you'd usually earn from working, or income payments you get from Centrelink.

For more information and resources on income support, check out income support payments such as the Disability Support Pension.

If you are interested in getting help to find a job, check out Disability Employment Services or NDIS-funded Work and study supports.

Is the support likely to cause harm?

We can't fund any supports that are likely to either:[97]

- cause harm to you
- be a risk to other people.

We need to consider this for all supports, such as support workers, therapies or equipment. It also means we won't fund supports that involve a regulated restricted practice, such as restraint, unless it follows the requirements of the NDIS Quality and Safeguards Commission.

To help us decide if the support is likely to cause harm, we may need information from a professional. For example, you may need high cost assistive technology, like a powered wheelchair. If so, we would need a report from an occupational therapist to show that it'll be safe for you to use.

Of course everything we do in life comes with some risk. We all make our own choices about how much risk we want to take in our lives. You should also be able to choose how much risk you want to take in your life.

So we try to balance this when we decide what we can and can't fund. We can't fund things that are likely to cause harm. But we will try and balance this with enabling you to make your own choices wherever possible.

While this is one of the NDIS funding criteria, you also have some responsibilities. It's still your responsibility and your provider's responsibility to ensure the supports we fund are:

- used correctly
- safe for you
- safe for other people.

You and your provider will also need to manage any risks of harm that arise. For more information, contact the NDIS Quality and Safeguards Commission.

Is the support related to your disability?

We can't fund a support if it's not related to your disability.[98] This means there must be a direct link or a connection between your disability and the supports we fund.

We look at whether the support addresses your disability support needs. Your disability support needs are those that arise from, or are caused by, your disability.

For example, we wouldn't usually fund things like:

- standard televisions
- standard household furniture such as dining chairs
- upgrades to assistive technology and home modifications that are not related to disability needs, such as marble tiling or leather materials
- flights to go on a holiday
- a car to get to work because there are no public transport options
- a gym membership to get fit
- a swimming pool to relax in summer.

This is because you're unlikely to need these supports as a result of your disability support needs. They are things that all people, with or without disability, might want or need.

Usually, there won't be a direct link or connection between these things and your disability support needs. Having a disability doesn't usually affect whether someone needs or wants these types of things.

Example

Alan needs some changes to his house, so he can use his bathroom and kitchen in his wheelchair. He also wants to set up an outdoor entertainment area for when his friends visit.

We may be able to fund home modifications so he can access areas of his home such as his bathroom or kitchen. He needs the home modifications because he can't access those areas due to his disability and needing to use a wheelchair. Alan needs the support because of his specific disability support needs.

Alan will need to pay for the outdoor entertainment area, as it's not related to his disability. He doesn't need the entertainment area because of his disability. It's just something he would like so he can have his friends over for a barbecue.

Is the support related to a 'day-to-day living cost'?

We can't fund supports related to day-to-day living costs that everyone has to pay, and aren't caused by or result from your disability support needs.[99] This means we don't fund things like:

- rent
- groceries
- utilities such as electricity, water, gas and internet bills
- the general cost of owning a home, like renovations, mortgage repayments, repairs and maintenance.

In some situations, we can fund supports related to your day-to-day living costs. We can do this if the costs are attributable to, or caused by, your disability support needs.[100] This means we may fund supports that relate to day-to-day living costs where either:

- you have additional living costs that are solely and directly as a result of your disability support needs[101]
- the living costs are connected to another support that is funded or provided in your plan, and you wouldn't incur that cost if it wasn't in your plan.[102]

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Example

Nigel has a goal to do his grocery shopping on his own. He needs a shopping basket to attach to his wheelchair to help him carry the items in the supermarket.

Shopping bags and baskets are things we all pay for, whether or not we have a disability. But Nigel only needs this specialised basket for his wheelchair because of his disability support needs.

If it meets the other NDIS funding criteria, we may fund the shopping basket attachment in his plan.

Does the support duplicate other supports funded through the NDIS?

We can't fund a support if it duplicates other supports delivered under alternative funding through the NDIS.[103]

For example, if we're providing support through your early childhood partner or local area coordinator, we usually won't fund Support Coordination in your plan.

This is because your early childhood partner or local area coordinator is already funded to provide similar supports. If we funded the same Support Coordination, we would be duplicating a support we're already providing you as general supports.

However if you need extra support, we may be able to fund additional Support Coordination in your plan. We may do this if it's above the amount of support your early childhood partner or local area coordinator are able to provide. Your early childhood partner or local area coordinator will work together with the Support Coordinator to help you connect with supports in your community.

Does the support meet the reasonable and necessary criteria?

All NDIS supports need to meet **all** the reasonable and necessary criteria.[104]

This means that before we can include an NDIS support in your plan, we need to be satisfied it meets all the following criteria:

- The support will assist you to pursue your goals in your plan.[105]
- The support will assist you to undertake activities, to facilitate your social and economic participation.[106] This means the support will help you to undertake activities, by reducing the disability-related barriers that prevent you from participating in things such as social outings, recreation, work and study.

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- The support represents value for money in that the costs of the support are reasonable relative to both the benefits achieved and the cost of alternative supports.[107] This means we need to consider the costs and benefits of the support, as well as the costs and benefits of alternative supports.
- The support will be, or is likely to be, effective and beneficial for you, having regard to current good practice.[108] This means we consider if there is evidence the support works for someone with similar disability support needs. We won't need an expert report for every support, as we can often rely on other information or evidence. For example, we may have information already about whether the support is widely accepted to suit someone with your disability support needs.[109] We also consider your lived experience.
- The funding of the support takes account of what it is reasonable to expect families, carers, informal networks and the community to provide.[110] This means we need to consider what support is reasonable for your family, friends and community to provide.
- The support is most appropriately funded or provided through the NDIS, and is not more appropriately funded or provided through:[111]
    - other general systems of service delivery, or support services offered by a person, agency or body (for example, a State or Territory Statutory Scheme)
    - systems of service delivery or support services offered as part of a universal service obligation (for example, the health or education system)
    - systems of service delivery or support services offered in accordance with reasonable adjustments required under discrimination laws (for example, your employer, or the health or education system).

The law for the NDIS sets out things that we need to consider when we apply the reasonable and necessary criteria.[112]

We must be satisfied that each support is reasonable and necessary individually, but we must also be satisfied that the supports are reasonable and necessary as a package of supports.[113]

For example, a home modification may reduce your need for other supports. If we plan to fund a home modification, we will need to take that home modification into account when considering what other supports are reasonable and necessary, such as the amount of care you need at home.

If the home modification will reduce your care needs, we may need to reduce the amount of care we fund, as a higher amount may not be reasonable and necessary when the whole package of supports is considered.

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Does the support help you pursue your goals?

We need to be satisfied that the support will help you pursue the goals, objectives and aspirations in your NDIS plan.[114] This helps us determine if the support is necessary.[115]

While we only fund supports that help you pursue your goals, objectives and aspirations, we understand that different people express themselves in different ways.

You are free to choose your own goals and express them in your own words.

Your goals can be big or small, short term or long term, simple or complex. They can be about anything you want to work towards.

You may express your goals broadly, or you may have specific goals. For example, you may express one of your goals as 'living independently'. Someone else may express their goal as 'to have an accessible bathroom'.

Learn more about setting your goals in Creating Your Plan and the Setting Goals fact sheet.

Reasonable and necessary supports should help you pursue your goals,[116] but you don't need a specific goal for every support in your plan. When we decide if a support will help you pursue your goals, we consider your whole situation.

We look at how a support will address your disability support needs, and the disability specific barriers that prevent you from pursuing your goals.

A support that addresses your disability related support needs is most likely to help you pursue your goals, objectives and aspirations in your plan.

Setting a goal in your plan doesn't mean we'll provide funding to pursue it. For example:

- setting more and bigger goals doesn't mean we have an obligation to fund more and bigger funded supports in your plan
- setting a goal doesn't mean we have an obligation to fund supports that help you pursue that goal
- setting a goal about an explicit type or amount of support you might want doesn't mean we'll fund that support or in that amount.

This is because helping you pursue your goals is only one of the NDIS funding criteria. A support must meet all of the NDIS funding criteria to be funded under the NDIS. So not all supports that help you to pursue your goals will be reasonable and necessary supports.

For example, we only fund reasonable and necessary supports that are value for money,[117] effective and beneficial[118] and relate to disability support needs.[119]

This means that if your goal is to 'live independently', we **may** fund home modifications that address your disability related needs. However, we won't fund supports related to day-to

day-living costs like rent or utilities. These costs aren't incurred solely and directly as a result of your disability support needs, so they don't meet other funding criteria.[120]

Also, choosing a different goal 'to have a more accessible home' won't change the supports we could fund in your plan.

Achieving goals usually takes many different kinds of supports. NDIS supports will most likely be just one kind of support that helps you work toward your goals.

Learn more about setting goals.

Example

Morgan is ready to look for work and she has a goal in her plan to get a job. She has built up her skills and knows what she wants to do. Disability Employment Services are helping Morgan to find work, so we can't fund this support for Morgan.

However, because of her disability, Morgan will need personal care supports to help her get up and ready for work in the morning. We will consider:

- how Morgan's disability support needs relate to her goals
- whether funding supports that address these disability support needs will help Morgan pursue her goals.

Morgan's planner believes the personal care supports meet this criteria. The supports that address her personal care needs will help Morgan to pursue her employment goals.

However, Morgan's planner then needs to look at whether the support meets the other NDIS funding criteria.

We don't fund all the supports that relate to Morgan's employment goals. We only fund the supports we consider are reasonable and necessary – that is, when they meet all the NDIS funding criteria.

Does the support help you do activities that will help your social and economic participation?

We need to be satisfied that the support will help you to do activities, which make it easier for you to participate socially and economically.[121]

Social participation means doing things you enjoy, like going out with friends, playing sport or going on holiday. It also means doing the things you need to do, like going to school or medical appointments.

Economic participation usually means being involved in things that help you work towards getting and keeping a job. This might be things like volunteering, study, learning new skills or trying work experience. Research tells us that work can lead to health benefits and improve our quality of life. Learn more about the Health Benefits of Good Work.

Social and economic participation are important to most people. They are critical to living an ordinary life.

To work out if a support meets this requirement, we look at the purpose of the support and how it will help you.

We fund reasonable and necessary supports that reduce the barriers that prevent you from undertaking activities. This will help you increase your social and economic participation.

Some supports help economic and social participation directly. There are lots of supports we can fund to directly help with social and economic participation. Learn more about Social and recreation supports and Work and study supports.

Other supports help you to undertake activities like self-care, which indirectly help your economic and social participation.

Example

Sue is going to university next year. She has a vision impairment, and has been working with her Guide Dog Mobility Instructor to decide if a dog guide is right for her. A dog guide can help her leave her home safely and independently, and travel to and from university.

A dog guide could also help her go out with friends and join in other community activities. As long as it meets the other funding criteria, we could fund a dog guide for Sue. It will help her to undertake activities of daily living.

As a result, it'll increase her social and economic participation. For example, the support will help her get to her university so she can study, and will help her social life.

Is the support value for money?

All supports we fund under the NDIS need to be value for money. This means the cost of the support is reasonable, when we consider the benefits of the support and the cost of other supports.

Making sure that your supports are value for money is one of the ways we keep the NDIS financially sustainable. This means we make careful decisions about funding so that we make sure the NDIS exists for future generations. It's also one of our principles.[122]

When we decide if the support is value for money, we consider:

- if other supports would achieve the same result at a substantially lower cost[123] – this means there should be a real or material difference in cost
- if there's evidence that the support will substantially improve your life stage outcomes and benefit you in the long term[124]
- if the support will likely reduce the cost of other supports over time[125]

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- how the cost compares to other supports of the same kind in your area[126]
- if the support will make you more independent, and mean you won't need as many supports in future, for example, in some circumstances home modifications may reduce the need for home care.

When we consider the likely cost of supports, we consider the cost over the long term. We consider if the support will help you achieve milestones at different ages or stages of your life and have long term benefits.

For example, some supports such as home modifications may be expensive now, compared to other supports. But getting these supports now may mean you need much less support in a few years, or later in life. Or, it may delay the need for other more costly supports.[127]

When we determine the cost of the support, we consider:

- the prices for NDIS supports in the NDIS Pricing Arrangements and Price Limits supports suggested by the Typical Support Package
- quotes for specific or high risk supports.

It's important we consider the cost of the support. This will be the level of funding we include in your plan, if we decide the support is reasonable and necessary.

When we fund equipment or modifications, we also need to consider:[128]

- how the cost of buying the equipment or modifications compares against the cost of renting them
- if it's appropriate to fund the equipment or modifications you want, based on your circumstances and any expected changes in technology.

Learn more about how we consider value for money when we fund assistive technology, home modifications and vehicle modifications.

Example

Elias needs a shower commode.

He got an assessment and sent us a quote for one that will suit his needs. As part of the process to work out if we can fund it, his planner considers other similar shower commodes.

There's a second commode that's $5,000 cheaper than the one Elias has asked for. But it won't meet Elias' needs, as it won't provide enough back support. That is, it won't achieve the same result as the one Elias has asked for.

Finally, there's a third commode that's $1,000 cheaper. The planner contacts his occupational therapist who confirms the cheaper commode will meet Elias' needs.

Elias' planner decides to fund the commode that's $1,000 cheaper. It'll deliver the same result at a substantially lower cost.

Is the support effective and beneficial?

We need to be satisfied that the support will be, or is likely to be, effective and beneficial, when we consider current good practice.

We need to work out if the support is likely to be both:

- **effective** – it will do what you need it to do[129]
- **beneficial** – the support will help you do things you can't otherwise do and meets your support needs.[130]

It can also be effective and beneficial if it will help you maintain your current level of functioning. That is, it will help you keep doing the things you can currently do. And, it'll help you maintain your work, study and social life as much as you can.[131]

When we decide if a support is effective and beneficial, we look at what is current good practice. This means we look at whether there is evidence that the support works for someone with similar disability support needs to you. We won't need an expert opinion or report for every support, as we can often rely on other evidence.

For example:

- We may have information already about whether the support is widely accepted to suit someone with your disability support needs.[132] For example, we could rely on academic research and other literature. This could include university studies on therapies that have been published and refereed in academic journals, evidence based practice resources, or clinical practice guidelines.
- If you or other participants have used the support before, we can consider your experience using the support and the experience of your family members and carers.[133]

We may consider things we have learnt from other participants in the NDIS with similar support needs to you.[134] We know you're the expert in your own life, and we use your own experience as much as we can.

For example, we will talk to you about any supports that have helped you do things you can't otherwise do. Or, some supports may have helped maintain your ability to be as independent as possible.

If it's a new support such as new assistive technology, we might fund a trial. This is so we can learn from your experience of using the support. To check if it's likely to do what you need it to.

Your evidence can be particularly useful when it's consistent with other evidence, or if we don't have expert evidence.

We'll look at the opinions held by the majority of experts and what they generally agree on.[135] Sometimes we will have to seek expert opinion or report to make a decision.[136]

Example

Vivek is 12 and has a goal to improve his communication skills. He and his family want him to improve his social skills with the kids in his class.

When he was younger, Vivek's family tried speech therapy, and believe it really helped him improve his communication. His family told his planner about how it helped Vivek learn how to respond to different social settings.

Vivek's speech therapist also believes it could work well for him now, and help him interact with his classmates.

When deciding whether the therapy is effective and beneficial, Vivek's planner will consider:

- how speech therapy has helped Vivek in the past, including first-hand information from Vivek, his family members and carers
- the reports or assessments from his speech therapist on the effectiveness and benefits of speech therapy for Vivek
- other information or expert evidence about the effectiveness and benefits of speech therapy, including for a child of the same age, and with the same impairments and functional capacity.

Based on this information and evidence, Vivek's planner decides the speech therapy is effective and beneficial. If it meets the other funding criteria, we will be able to fund speech therapy in Vivek's plan.

Is the support something we would reasonably expect your informal supports, like family or friends, to provide?

We need to be satisfied that funding the support takes into account what is reasonable to expect families, carers, informal networks and the community to provide.[137]

To make sure we understand how disability supports might work for you, we consider:

- the things you're able to do for yourself
- any support you have from others in your network – including family members, relatives, friends and local community services.

When we fund supports under the NDIS, we have to think about whether it's reasonable to expect your informal supports to provide that support. We can't fund supports that an ordinary person would think is reasonable to expect friends, family or the community to provide for you.[138]

Informal supports are the help and support you get from friends, family and the community. They are called 'informal' because you don't pay for them, and they're not part of a formal agreement. They are the usual things friends and family do for us, and with us.

Most of us get some kind of help and support from friends and family. In our society, we expect that friends, family and our community will support each other and help each other out when they need it.

A good example is families who have young children. In our community, we expect families will provide most of the support a young child needs.[139] They will change a child's nappy, make sure they are safe and drive them around places.

Grandparents, uncles and aunties often have a role to play in supporting young children as well. Neighbours and friends might also help care for the child.

As a child gets older, our society's expectations of the role of the family and community in caring for the child changes. For example, we expect schools to help support the child's learning needs.

We also usually expect the role of family in providing personal care for a child would reduce as they get older and develop new skills and independence. But families are usually still responsible for things like food, emotional support, decision-making and providing a safe home.

It's a similar idea for adults. Our society expects that adults – like family, friends and neighbours – will provide some support to each other. This might be things like taking a friend with you to the football game, or providing emotional support if someone is upset.

NDIS supports won't ever replace the support people like your friends and family provide to you. This support is given freely because people care, and is often quite different to supports bought with NDIS funding.

You have a special bond with your friends and family that's different from your relationship with paid carers. And there are potential risks and problems for you if your friends and families become your paid carers.

To make sure we understand how disability supports might complement your circumstances, we consider:

- the things you are able to do for yourself
- any support you have from others in your network including family members, relatives, friends and local community services.

We also have to consider the benefits you may get from your informal supports. For example, your family and friends may be more effective at helping you meet other people, or helping to build your social skills, than paid supports can.

We consider if we can help these relationships so that you get the support you need.[140] For example, we may be able to fund training for your informal supports, so they can help you build your skills.

We also think about the capacity of your informal supports to continue caring for you, for example if they're ageing or sick.

There are different things the law for the NDIS says we need to consider for adults and children.

If you're under 18, we consider what support is reasonable to expect parents to provide at your age. It's normal for parents to provide substantial care and support for children.[141] We consider that it's usual for parents to provide almost all the care and support that young children need.

For example, it's reasonable to expect parents to provide transport to and from their child's after-school activities. Of course, the amount of care and support for a child without a disability would typically reduce as they get older.

For children under 18, we consider:

- if your needs are 'substantially greater' because of your disability, compared to other children the same age[142] – that is, you need much more disability support
- any risks to the wellbeing of people providing informal support to you[143]
- if including funding for the support will help build your skills and capacity in the future, or reduce any risks to you.[144]

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For example, we consider any health, safety or other impacts resulting from what's involved in meeting your disability support needs.

If you're over 18, we consider:

- if there are any risks to you or your informal supports if you rely on them to provide the support you need[145]
- how much your informal supports would help improve or reduce your independence and other outcomes.[146]

We also consider the suitability of informal supports to provide the supports you need,[147] including:

- how old your carers are and their capacity to provide the support[148]
- if other family members and the community can help your informal supports in their caring role[149]
- the intensity and type of support you need, and if it's appropriate for your informal supports to provide this, based on their age and gender[150]
- any long-term risks to the wellbeing of your informal supports.[151]

When we consider the risks for people over 18, we consider if the supports are sustainable for your informal supports. We consider the health, safety and other impacts on family and carers in the long term.

For example, we wouldn't expect a child to have their schooling affected because they need to provide care. We also wouldn't expect an elderly parent to be responsible for physical activities, if it may result in injury.[152]

We generally don't fund family members to provide supports funded under the NDIS. There are very limited situations where we can consider this.

Learn more about Sustaining Informal Supports.

Example 1

Simon is getting his first NDIS plan. For the last 15 years, Simon and his wife Jan's preference was that Jan provide all the physical support he needs at home, such as toileting and showering.

But as Jan is getting older, it's not safe for her to keep lifting Simon. It's becoming risky for her to keep providing this support.

Jan and Simon think it might be best for someone else to provide the personal care support that Simon needs. Their children have moved out of home, and it's not reasonable to expect them to help Simon with personal care.

Based on this information and other evidence, Simon's planner decides that the personal care support meets this criteria. It takes into account what is reasonable for his family and others to provide. If the personal care support meets the other funding criteria, we may fund the personal care support for Simon.

Simon and Jan still prefer Jan to do the other support Simon needs though, such as helping Simon eat his meals. At this time, we wouldn't fund a support worker in Simon's plan to help him eat his meals. It's reasonable to expect Jan to help Simon with this, as it's what they want to do and it's not a safety risk for Jan.

Example 2

Qing is 14 and wants to join a local footy club. Like most 14 year old's in this situation, she needs someone to drop her off and pick her up from the Saturday matches and the weeknight training sessions.

But unlike most 14 year old's, she needs someone to help her get dressed before she can go to the match. Her parents have been doing this, but as Qing is getting older she no longer wants her family to help her get dressed.

It's reasonable to expect her family or other informal supports to drop Qing to and from the match and training sessions. So we wouldn't fund transport in Qing's plan.

But at age 14, it's not reasonable to expect her family to help her get dressed.

Based on this information and other evidence, Qing's planner finds that the personal care support takes into account what is reasonable for family and others to provide. If it meets the other funding criteria, we may fund personal care support in her plan.

Is the support more appropriately funded or provided through the NDIS, and not through other service systems or support services?

We have to be satisfied that the support is most appropriately funded or provided through the NDIS. This means it's not more appropriately funded or provided through:

- other general systems of service delivery, or support services offered by a person, agency or body (such as a State or Territory Statutory Scheme)
- systems of service delivery or support services offered as part of a universal service obligation (such as the health or education system)
- systems of service delivery or support services offered in accordance with reasonable adjustments required under discrimination laws (such as your employer, or the health or education system).[153]

In short, we won't fund the support if it should be provided by someone else.

We won't fund the support if the support should be provided by someone else, even if the other service system doesn't actually provide it. We're not the funder of last resort, so we don't make up for other organisations and systems that don't provide the supports they should.

The law for the NDIS sets out a number of things we need to consider, when we decide who is most appropriate to fund or provide of the support.[154] There are different things we consider for the following service systems:

(a) Health

(b) Mental health

(c) Child protection and family support

(d) Early childhood development

(e) School education

(f) Higher education and vocational education and training

(g) Employment

(h) Housing and community infrastructure

(i) Transport

(j) Justice.

How does the NDIS work with other government services?

We call supports provided by other government services, including those provided as part of a universal service obligation, 'mainstream supports'. When we talk about mainstream supports, we mean supports available to everyone in your state or territory, or across Australia, regardless of whether or not you have a disability.

This includes services provided by state and federal governments, like health care, education and mental health services.

You have the same right as all Australians to access these services. There are certain things that mainstream services have to do to make their services accessible for people with disability. Using mainstream supports can also help you be part of your community, or to work or study.

When we fund NDIS supports, we need to check that the support is not more appropriately funded or provided by a mainstream service or system, such as the education system or health system.[155] Under the law for the NDIS, we can't fund supports that should be provided by a mainstream service.

The Australian federal, state and territory governments agreed on responsibilities for funding different types of supports. The law for the NDIS has an outline of funding responsibilities and were developed with the agreement of each State and Territory.[156]

We can only fund supports that are the responsibility of the NDIS. We can't fund supports that are the responsibility of other government services, even if they don't actually fund or provide the support. The law for the NDIS sets out the matters we should consider when we decide who is more appropriate to provide or fund a support.[157]

Learn more about how we decide if the support is best funded or provided by us or another part of government.

The Applied Principles and Tables of Support also has information on what the governments agreed are the responsibilities of the NDIS and other government services. However, it doesn't override what we consider when we decide if the support is most appropriately funded by the NDIS.[158]

What is reasonable adjustment and why is it important?

People with a disability can sometimes face barriers that make it harder to do the same things as people who don't have a disability. For example, it might be harder to find and keep a job. Or it might be harder to get in and around places, or to get the same services as other people.

It's against the law to discriminate against people with a disability in many areas.[159] This includes in employment, when providing goods and services, and when accessing public places.

This means organisations or people who are responsible for providing these services have to make what are called 'reasonable adjustments'. They have to make sure people with a disability have equal access to the services they provide, as far as is reasonable.

They have to do reasonable things that will make their services equally available to everyone, whether or not you have a disability.

Reasonable adjustments do not mean they have to provide everything you need because of your disability. It means they have to do what's reasonable to make sure you have equal access to employment, public spaces or services. This takes into account what they can afford to do and what is reasonable to expect them to provide in the circumstances.

When we decide what supports to include in your plan, we need to consider what should be provided through reasonable adjustments. Under the law for the NDIS, we can't fund a support if it should be provided by someone else through reasonable adjustments.

What else do you need to know about working out if supports meet the NDIS funding criteria?

From our experience, we learned there are some common misunderstandings about how we work out what supports meet the NDIS funding criteria.

Why don't we always fund what your health professionals recommend?

Although we take expert opinions into account, we can't and don't always fund everything your health professional might recommend. This is because every support we fund needs to meet all the NDIS funding criteria.

For example, your therapist might recommend a piece of equipment on the basis that it will be 'effective and beneficial' for you. But if there is something cheaper that will achieve the same outcome, we won't be able to fund what the therapist recommended.

This is because it won't be value for money. We may be able to fund the cheaper option instead if it meets all the NDIS funding criteria.

Why don't we fund the same supports as your last plan?

We might fund different supports in your next plan. This is because we will fund supports in your plan based on how we use the NDIS funding criteria at that point in time.

Your needs and situation will most likely change over time. This means it's likely your NDIS supports and funding for those supports will change over time.

For example, we may have funded supports to help you build your skills in a particular area. Once you have built those skills, you won't need funding for that anymore. So, we probably won't include that funding for those supports in your next plan.

Supports to build your skills may have met the NDIS funding criteria before, but the same supports might not meet the criteria in future.

Or, your disability support needs might increase or decrease over time. This may mean we consider funding more or less supports as a result.

What happens if you don't use all your funding in your NDIS plan?

We will consider how you have used your NDIS funding to help us work out what supports meet the NDIS funding criteria in your next plans.

If you haven't used all the funding by the end of your plan, it doesn't mean we'll reduce the funding in your next plan. There may be very good reasons why you weren't able to buy the supports we funded.

When we reassess your plan, we'll talk about any problems you had buying the supports funded in your plan. We'll also see how we can help you use your funding if we need to.

But if you consistently don't buy all the supports we fund and use all of your NDIS funding, we need to think about whether the supports really do meet the NDIS funding criteria. For example, they may not be 'effective and beneficial' for you if you're not actually using them. We will talk to you about this when we reassess your plan.

Learn more about changing your plan

Step 3: How do we include the reasonable and necessary supports in your plan?

Once we've identified the supports, and decided they meet the NDIS funding criteria, we can include the description and funding for the support in your plan.

If the support doesn't meet the NDIS funding criteria, we can't include the support in your plan. We may consider if a differently described support meets the NDIS funding criteria instead.

When we approve your plan we will also make sure all your supports are reasonable and necessary when considered as a package of supports.[160]

Sometimes you might not need any supports under the NDIS. For example, your informal supports may meet all your disability support needs. If so, we'll approve a plan with no funded supports.

Learn more about how we create and approve your plan.

Learn more about using the funding in your plan.

What happens if we don't include the supports you want?

If we decide a support doesn't meet the NDIS funding criteria, we can't include the support in your plan. Also, if the amount of support you want doesn't meet the criteria, we can't include that amount in your plan.

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But, we're committed to our principles and helping you live an ordinary life. Even if we can't fund a particular support we may still be able to help.

If the support doesn't meet the NDIS funding criteria, we can consider if a different support meets the NDIS funding criteria. We might be able to consider describing the support differently, or funding a different type of support.

Or, we may be able to connect you to mainstream or community supports that can help. Mainstream and community supports are available to everyone. They can be a good way to connect with your local community, learn new skills and gain independence.

There are lots of ways we might be able to help, so talk to us if you're in this situation. We can do this at any time. We may be able to help before we approve your plan.

We'll give you the reasons for our decision to approve your plan in writing.[161] You can contact us if you'd like more detail about the reasons for our decision.

If you don't agree with the supports we approve in your plan, you can ask for an internal review of our decision.[162] You'll need to ask for an internal review within 3 months of getting your plan.[163] [164]Learn more about internal and external review of decisions.

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Reference List

[1] NDIS Act and delegated legislation made under the NDIS Act, especially NDIS (Supports for Participants) Rules and NDIS (Plan Management) Rules.
[2] NDIS (Supports for Participants) Rules r 5.1(b).
[3] NDIS Act s34(1)(a).
[4] NDIS Act s34(1)(b).
[5] NDIS Act s34(1)(c).
[6] NDIS (Supports for Participants) Rules r 3.1(c).
[7] NDIS Act s34(1)(c); NDIS (Supports for Participants) Rules r 3.1(a).
[8] NDIS Act s34(1)(d).
[9] NDIS Act s34(1)(e).
[10] NDIS Act s34(1)(f).
[11] NDIS Act s34(1)(f).
[12] NDIS (Supports for Participants) Rules part 5.
[13] NDIS (Supports for Participants) Rules r 5.1(a).
[14] NDIS (Supports for Participants) Rules r 5.1(b).
[15] NDIS (Supports for Participants) Rules r 5.1(c).
[16] NDIS (Supports for Participants) Rules r 5.1(d).
[17] NDIS (Supports for Participants) Rules r 5.3(a).
[18] NDIS (Supports for Participants) Rules r 5.3(b).
[19] NDIS Act s34(1)(f).
[20] NDIS Act s118(1)(b).
[21] NDIS Act s4(17)
[22] NDIS Act s33(2).
[23] NDIS Act s33(5)(a).
[24] NDIS Act s34(1)(a).
[25] NDIS Act s34(1)(d).
[26] NDIS (Supports for Participants) Rules r 4.1(d).
[27] NDIS Act s34(1).
[28] NDIS Act s34(1)(d); NDIS (Supports for Participants) Rules, r 3.2-3.3.
[29] NDIS Act s34(1)(c); NDIS (Supports for Participants) Rules r 3.1.
[30] *McGarrigle v National Disability Insurance Agency* (2017) 252 FCR 121 at [88].
[31] NDIS Act ss 33(2)(a), 33(2)(b), 33(5)(c), 34.
[32] NDIS Act ss 13, 33(2)(a).
[33] NDIS Act ss 33(2)(b), 34.
[34] NDIS Act and delegated legislation made under the NDIS Act, especially NDIS (Supports for Participants) Rules and NDIS (Plan Management) Rules.
[35] NDIS Act ss 33(2)(b), 34; NDIS (Supports for Participants) Rules.
[36] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules r 5.3.
[37] NDIS (Supports for Participants) Rules pt 5.
[38] NDIS Act s 34(1).
[39] NDIS (Supports for Participants) Rules r 2.4; NDIS Act s 33(5)(c).
[40] NDIS Act ss 4, 31.
[41] NDIS Act s 4(1).
[42] NDIS Act s 4(2).
[43] NDIS Act s 4(4).
[44] NDIS Act s 4(8).
[45] NDIS Act s 4(10).
[46] NDIS Act s 4(17).
[47] NDIS Act s 4(11).
[48] NDIS Act s 33(5)(a); NDIS (Supports for Participants) Rules r 4.1(a).
[49] NDIS (Supports for Participants) Rules r 4.1(a).
[50] NDIS (Supports for Participants) Rules r 4.1(b).

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[51] NDIS (Supports for Participants) Rules rr 4.1(b), (d).
[52] NDIS (Supports for Participants) Rules r 4.1(c).
[53] NDIS Act s 33(5)(b).
[54] NDIS Act ss 36, 50.
[55] NDIS (Supports for Participants) Rules rr 4.2-4.6.
[56] NDIS Act s 33(1).
[57] NDIS Act s 47(1).
[58] NDIS (Supports for Participants) Rules r 4.1(d).
[59] NDIS Act s 34(1)(a).
[60] NDIS Act s 34(1)(a).
[61] NDIS Act s 33(5)(f).
[62] NDIS Act s 33(3) and NDIS (Plan Management) Rules.
[63] NDIS Act s 33(5)(c).
[64] NDIS Act s 33(3).
[65] NDIS Act s 33(3); (NDIS (Plan Management) Rules r 6.3.
[66] NDIS Act s 46(1).
[67] NDIS Act (Plan Management) Rules r 6.4(a).
[68] NDIS (Plan Management) Rules r 6.4(b).
[69] NDIS (Plan Management) Rules r 6.4(c).
[70] NDIS (Plan Management) Rules r 6.4(d).
[71] NDIS (Plan Management) Rules r 6.4(e).
[72] NDIS (Plan Management) Rules r 6.4(f).
[73] NDIS (Plan Management) Rules r 6.4(f).
[74] NDIS (Plan Management) Rules r 6.4(f).
[75] NDIS (Provider Registration and Practice Standards) Rules r 7(3).
[76] NDIS (Provider Registration and Practice Standards) Rules r 7(2).
[77] NDIS (Plan Management) Rules rr 6.6-6.7.
[78] NDIS (Plan Management) Rules r 6.6.
[79] NDIS (Plan Management) Rules r 6.7.
[80] NDIS (Plan Management) Rules r 6.7.
[81] NDIS (Plan Management) Rules r 6.7.
[82] NDIS (Plan Management) Rules r 6.5.
[83] NDIS (Plan Management) Rules r 6.6.
[84] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules pt 5.
[85] NDIS Act s 34(1).
[86] NDIS (Supports for Participants) Rules r 5.
[87] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules r 5.3(a).
[88] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules r 5.3(b).
[89] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(a).
[90] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(b).
[91] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(d).
[92] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(c).
[93] NDIS (Supports for Participants) Rules r 5.3(a).
[94] NDIS (Provider Registration and Practice Standards) Rules 2018 r 7(2).
[95] NDIS Act s 73F(2)(a).
[96] NDIS (Supports for Participants) Rules r 5.3(b).
[97] NDIS (Supports for Participants) Rules r 5.1(a).
[98] NDIS (Supports for Participants) Rules r 5.1(b).
[99] NDIS (Supports for Participants) Rules r 5.1(d).
[100] NDIS (Supports for Participants) Rules r 5.1(d).
[101] NDIS (Supports for Participants) Rules r 5.2(a).
[102] NDIS (Supports for Participants) Rules r 5.2(b).
[103] NDIS (Supports for Participants) Rules r 5.1(c).
[104] NDIS Act ss 33(5)(c), 34(1).

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[105] NDIS Act s 34(1)(a).
[106] NDIS Act s 34(1)(b).
[107] NDIS Act s 34(1)(c).
[108] NDIS Act s 34(1)(d).
[109] NDIS (Supports for Participants) Rules r 3.2(a).
[110] NDIS Act s 34(1)(e).
[111] NDIS Act s 34(1)(f).
[112] NDIS (Supports for Participants) Rules pts 3, 4.
[113] NDIS Act s 33(5)(c).
[114] NDIS Act s 34(1)(a).
[115] *McGarrigle v National Disability Insurance Agency* (2017) 252 FCR 121 at [91].
[116] NDIS Act s 34(1)(a).
[117] NDIS Act s 34(1)(c).
[118] NDIS Act s 34(1)(d).
[119] NDIS (Supports for Participants) Rules r 5.1(b).
[120] NDIS (Supports for Participants) Rules r 5.1(d).
[121] NDIS Act s 34(1)(b).
[122] NDIS Act ss 3(3)(b), 4(17).
[123] NDIS (Supports for Participants) Rules r 3.1(a).
[124] NDIS (Supports for Participants) Rules r 3.1(b).
[125] NDIS (Supports for Participants) Rules r 3.1(c).
[126] NDIS (Supports for Participants) Rules r 3.1(e).
[127] NDIS (Supports for Participants) Rules r 3.1(c).
[128] NDIS (Supports for Participants) Rules r 3.1(d).
[129] McCutcheon and NDIA [2015] AATA 624 at [34].
[130] McCutcheon and NDIA [2015] AATA 624 at [34].
[131] McCutcheon and NDIA [2015] AATA 624.
[132] NDIS (Supports for Participants) Rules r 3.2(a).
[133] NDIS (Supports for Participants) Rules r 3.2(b).
[134] NDIS (Supports for Participants) Rules r 3.2(c).
[135] NDIS (Supports for Participants) Rules r 3.3.
[136] NDIS (Supports for Participants) Rules r 3.3.
[137] NDIS Act s 34(1)(e).
[138] NDIS Act s 34(1)(e).
[139] NDIS (Supports for Participants) Rules r 3.4(a)(i).
[140] NDIS (Supports for Participants) Rules r 3.4(c).
[141] NDIS (Supports for Participants) Rules r 3.4(a)(i).
[142] NDIS (Supports for Participants) Rules r 3.4(a)(ii); JQJT and National Disability Insurance Agency [2016] AATA 478 at [39].
[143] NDIS (Supports for Participants) Rules r 3.4(a)(iii).
[144] NDIS (Supports for Participants) Rules r 3.4(a)(iv).
[145] NDIS (Supports for Participants) Rules rr 3.4(b)(i), (ii).
[146] NDIS (Supports for Participants) Rules r 3.4(b)(iii).
[147] NDIS (Supports for Participants) Rules r 3.4(b)(ii).
[148] NDIS (Supports for Participants) Rules r 3.4(b)(ii).
[149] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(A).
[150] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(B).
[151] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(C).
[152] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(C).
[153] NDIS Act s 34(1)(f).
[154] NDIS (Supports for Participants) Rules rr 3.5-3.7 and Schedule 1.
[155] NDIS Act s 34(1)(f).
[156] NDIS (Supports for Participants) Rules rr 3.5-3.7, Schedule 1; NDIS Act ss 209(4), (8) item 1.
[157] NDIS (Supports for Participants) Rules rr 3.5-3.7, Schedule 1.

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[158] NDIS (Supports for Participants) Rules rr 3.5-3.7, Schedule 1.
[159] Disability Discrimination Act 1992 (Cth); Discrimination Act 1991 (ACT); Anti-Discrimination Act 1977 (NSW); Anti-Discrimination Act 1996 (NT); Anti-Discrimination Act 1991 (Qld); Equal Opportunity Act 1984 (SA); Anti-Discrimination Act 1998 (Tas); Equal Opportunity Act 2010 (Vic); Equal Opportunity Act 1984 (WA).
[160] NDIS Act s 33(5)(c).
[161] NDIS Act s100(1).
[162] NDIS Act s100.
[163] NDIS Act s100(2).

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Reasonable and Necessary Supports

Quick summary: There are new laws about what we can and can't fund under the NDIS. All supports need to meet each of the reasonable and necessary criteria before we can fund them in your plan. For example, your supports need to relate to the impairments you meet the disability or early intervention requirements for, be value for money, and effective and beneficial. We also need to make sure each support is an NDIS support. This means it is a service, item, or equipment that can be funded by the NDIS. Examples of NDIS supports include support with personal daily living tasks and accessing the community, therapeutic supports, and personal mobility equipment.

Note:

- When we say 'your plan' we mean your NDIS plan.
- When we say 'disability support needs', we mean supports you need for the impairments that meet the disability or early intervention requirements, or both.
- If you're aged between 9 and 65 years and are looking for information about community connections, go to Our Guideline – Community Connections.
- If your child is younger than 9 and you're looking for information about early connections, go to Our Guideline – Early Connections.
- As part of the recent changes to the NDIS laws we are moving towards a new framework for planning. Rules need to be developed for this new framework. We're working on how and when we'll introduce these changes.

  Until then, the information in this Our Guideline is about our 'old framework' for planning, which include the legislative changes that become operational when the law commences. All current plans will be known as 'old framework' plans, and we will continue to develop these until all participants have transitioned to the new framework.

What's on this page?

This page covers:

- What are reasonable and necessary supports?
- How do we make decisions about what is reasonable and necessary?
- How do we include the reasonable and necessary supports in your plan?

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- What if you don't agree with our decision?

You may also be interested in:

- Mainstream supports
- Creating your plan
- Changing your plan
- Reviewing our decisions
- Would we fund it?

What are reasonable and necessary supports?

The National Disability Insurance Scheme (NDIS) was set up as a world first approach to disability support. It puts people with disability at the centre of decision-making, through the principles of reasonable and necessary supports and individual choice and control.

We provide funding for reasonable and necessary supports to people with a permanent and significant disability or developmental delay.

Reasonable and necessary supports are the supports we fund in your plan to meet your disability needs. All supports we fund in your plan need to meet the criteria set out in law for the NDIS of what we can and can't fund.[1] For information on what is an NDIS support and what is not, go to NDIS support.

NDIS supports should complement, not replace, other supports available to you. That's why we consider:

- the things you're able to do for yourself
- support you have from others in your network, including family members, relatives, friends, local community services and mainstream government services.

Once we've considered your situation, we need to follow the rules determined under the law for the NDIS in our planning decisions.[2]

This guideline explains how we decide what reasonable and necessary supports must consider, which we'll explain in detail.

When creating your plan, we also follow these principles.

We also have Would we fund it guides. They have examples of how we decide if we fund different types of supports.

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How do we make decisions about what is reasonable and necessary?

When we create your plan with you, we'll discuss what supports you need for the impairments that meet the disability or early intervention requirements.[3] We want to help you pursue your goals, increase your independence, and help you work, study and join social activities.

The NDIS will only fund a support if it meets **all** the reasonable and necessary criteria. We also won't fund a support if the law says we can't fund it. We explain the reasonable and necessary criteria in more detail further down.

What supports can you get outside the NDIS?

Before we decide what reasonable and necessary supports to fund in your plan, we'll first discuss what other supports may be available outside the NDIS. This is an important information-gathering step. For example, there may be mainstream, community and informal supports that suit you.

There are many supports you can get outside the NDIS. Other government and community services provide supports to all Australians, including people with disability. And your friends, family, and other people you know can often be your best supports.

To find out more about supports you can get outside the NDIS, go to Creating your plan.

It's important we gather this information and help you access these services before we consider what reasonable and necessary supports we can fund. That way, we can help make sure you're able to access mainstream, community, and informal supports wherever possible.

For more information, go to Mainstream and community supports.

What types of supports may be included in your plan?

Your plan may include 'general supports' and 'reasonable and necessary supports'.[4]

General supports

General supports are the coordination, strategic or referral services and activities we provide or arrange to be provided, for you.[5] They're how we help you develop your plan and connect with support and activities in your community. This includes the support you get from your early childhood coordinator or local area coordinator to connect to mainstream, community, and informal supports. You don't need to pay for your general supports from your plan as the NDIS pays for them directly.

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Reasonable and necessary supports

Reasonable and necessary supports are the NDIS supports we fund or provide in your plan to meet your disability support needs.[6] NDIS supports need to be for your impairments that meet the disability or early intervention requirements, or both.[7] NDIS supports are the services, items, and equipment we can fund or provide under the NDIS.[8] For information on what supports are considered NDIS supports, go to NDIS supports.

The laws for the NDIS tell us what we can fund in your plan.[9] All supports we fund in a plan need to meet all the criteria set out in these laws. We call these the NDIS funding criteria.

- We'll check your support types and amounts of support will complement each other to help you fulfil an ordinary life.[10] Any funded supports must be an NDIS support[11] that is right for you.
- It must not be a type of support the law says we can't fund or provide.[12]

Each support must be reasonable and necessary individually, but the supports must also be reasonable and necessary when considered as a package of supports.

Does the support meet the reasonable and necessary criteria?

We can only include supports in your plan if they meet **all** the reasonable and necessary criteria.[13]

This means that before we can include a funded support in your plan, we need to be satisfied it meets all the following criteria:

- The support is for the impairments you meet the disability or early intervention requirements for, or both.[14]
- The support will help you to pursue your goals in your plan.[15]
- The support will help you to undertake activities, to facilitate your social and economic participation.[16] This means the support will help you join in social outings, recreation, work and study by reducing the disability-related barriers that prevent you from participating.
- The support represents value for money. This means we need to consider the costs and benefits of the support, as well as the costs and benefits of alternative supports.[17]
- The support will be, or is likely to be, effective and beneficial for you, having regard to current good practice.[18] This means we consider if there is evidence the support works for someone with similar disability support needs. We won't need an expert report for every support, as we can often rely on other information or evidence. For example, we may have information already about whether the support is widely

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accepted to suit someone with your disability support needs.[19] We also consider your lived experience.

- The funding of the support takes account of what it is reasonable to expect families, carers, informal networks and the community to provide.[20] This means we need to consider what support is reasonable for your family, friends and community to provide.
- The support is an NDIS support for you.[21]

The law for the NDIS sets out things that we need to consider when we apply the reasonable and necessary criteria.[22]

For example, funding a vehicle modification may reduce your need for other supports. By funding a vehicle modification in your plan, we'll look at whether you need less support to access the community.

If the vehicle modification will reduce your support needs, we might reduce the amount of support we fund for you to access the community. This is because the same amount of support might not be reasonable and necessary when the whole package of supports is considered.

Is the support related to the impairments you meet disability or early intervention requirements for, or both?

We'll only fund a support if it relates to the impairments you meet the disability or early intervention requirements for, or both.[23] This means there must be a direct link between your disability support needs and the NDIS supports we fund.

We consider if the support addresses your disability support needs. Your disability support needs are those that come from, or are caused by, your disability.

For example, we don't fund things like flights to go on a holiday or a gym membership to get fit.

This is because you're unlikely to need these supports because of your disability support needs. They are things that all people, with or without disability, might want or need.

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Example

Alan uses a wheelchair and needs some changes to their house. They need to be able to independently use their bathroom and kitchen. They also want to set up an outdoor entertainment area for when their friends visit.

We may be able to fund home modifications so Alan can access areas of their home, including their bathroom and kitchen. They need the home modification because they can't access those areas due to their disability.

Alan will need to pay for the outdoor entertainment area, as it's not related to their disability.

Does the support help you pursue your goals?

We need to be satisfied that the support will help you pursue the goals, objectives and aspirations in your plan.[24] This helps us determine if the support is necessary.[25]

While we only fund supports that help you pursue your goals, objectives and aspirations, we understand that different people express themselves in different ways.

Reasonable and necessary supports should help you pursue your goals,[26] but you don't need a specific goal for every support in your plan. When we decide if a support will help you pursue your goals, we consider your whole situation.

We look at how a support will address your disability support needs, and the disability specific barriers that prevent you from pursuing your goals.

A support that addresses your disability related support needs is most likely to help you pursue your goals, objectives and aspirations in your plan.

This means that if your goal is to 'live independently', we **may** fund home modifications that address your disability related needs. However, we won't fund supports that aren't NDIS supports, including day-to day-living costs like rent or utilities. These costs aren't incurred solely and directly because of your disability support needs, so they don't meet other funding criteria.[27]

Also, choosing a different goal 'to have a more accessible home' won't change the supports we could fund in your plan.

Achieving goals usually takes many different kinds of supports. NDIS supports will most likely be just one kind of support that helps you work toward your goals.

Learn more about setting your goals in Creating Your Plan and the Setting Goals fact sheet.

Example

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Morgan is ready to look for work and they have a goal in their plan to get a job. They have built up their skills and know the type of work they want to do. Disability Employment Services are helping Morgan find work, so we can't fund this support for Morgan.

However, because of their disability, Morgan will need personal care supports to help them get ready for work in the morning. We will consider:

- how Morgan's disability support needs relate to their goals
- if funding NDIS supports that address these disability support needs will help Morgan pursue their goals.

Morgan's planner determines the personal care supports meet this criteria. The supports that address their personal care needs will help Morgan to pursue their employment goals.

Morgan's planner then needs to look at if the support meets the other NDIS funding criteria. In this case Morgan does get personal care in their plan. Morgan doesn't have a job yet but will need personal care support to help them get ready to look for work. Morgan will also be able to use these supports when they get a job.

We don't fund all the supports that relate to Morgan's employment goals. We only fund the supports we consider are reasonable and necessary – that is, when they meet all the NDIS funding criteria.

Does the support help you do activities that will help your social and economic participation?

We need to be satisfied that the support will help you to do activities, which make it easier for you to participate socially and economically.[28]

Social participation means doing things you enjoy, like going out with friends, playing sport or going out into the community. It also means doing the things you need to do, like going to school or medical appointments.

Economic participation usually means being involved in things that help you work towards getting and keeping a job. This might be things like volunteering, study, learning new skills or trying work experience. Research tells us that work can lead to health benefits and improve our quality of life. Learn more about the Health Benefits of Good Work.

Social and economic participation are important to most people. They are critical to living an ordinary life.

To work out if a support meets this criteria, we look at the purpose of the support and how it will help you.

We fund reasonable and necessary supports that reduce the barriers that prevent you from doing activities. This will help you increase your social and economic participation.

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Some supports help economic and social participation directly. There are lots of supports we can fund to directly help with social and economic participation. Learn more about Social and recreation supports and Work and study supports.

Other supports help you do activities like self-care, which indirectly help your economic and social participation.

Example

Sue is going to university next year. She has a vision impairment and has been working with her Guide Dog Mobility Instructor to decide if a Dog Guide is right for her. A Dog Guide can help her leave her home safely and independently, and travel to and from university.

A Dog Guide could also help her go out with friends and join in other community activities. As long as it meets the other funding criteria, we could fund a Dog Guide for Sue. It will help her with activities of daily living.

In Sue's case, a Dog Guide will also increase her social and economic participation. Having a Dog Guide will help her get to her university independently where she studies and also has lots of friends.

Is the support value for money?

All supports we fund under the NDIS need to be value for money. This means the cost of the support is reasonable when we consider the benefits of the support and the cost of other supports.

Making sure your supports are value for money is one of the ways we keep the NDIS financially sustainable. This means we make careful decisions about funding so that we make sure the NDIS exists for future generations. It's also one of our principles.[29]

When we decide if the support is value for money, we consider:

- if other supports would achieve the same result at a substantially lower cost.[30] This means there should be a real or material difference in cost
- if there's evidence that the support will substantially improve your life stage outcomes and benefit you in the long term[31]
- if the support will likely reduce the cost of other supports over time[32]
- how the cost compares to other supports of the same kind in your area[33]
- if the support will make you more independent and mean you won't need as many supports in the future. For example, in some situations home modifications may reduce the need for support in your home.

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When we consider the likely cost of supports, we consider the cost over the long term. We consider if the support will help you achieve milestones at different ages or stages of your life and have long term benefits.

For example, some supports like home modifications may be expensive now, compared to other supports. But getting these supports now may mean you need much less support in a few years, or later in life. Or it may delay the need for other more costly supports.[34]

When determining if the cost of the support is value for money, we consider:

- the prices for NDIS supports in the NDIS Pricing Arrangements and Price Limits
- quotes for specific or high risk supports.

It's important we consider the cost of the support. This will be the level of funding we include in your plan, if we decide the support is reasonable and necessary.

When we fund equipment or modifications, we also need to consider:[35]

- how the cost of buying the equipment or modifications compares to the cost of renting them
- if it's appropriate to fund the equipment or modifications you want, based on your situation and any expected changes in technology.

Learn more about how we consider value for money when we fund assistive technology, home modifications and vehicle modifications.

Example

Elias needs a shower commode.

He got an assessment and sent us a quote for one that will suit his needs. As part of the process to work out if this meets the reasonable and necessary criteria, his planner considers other similar shower commodes.

There's another commode that's $5,000 cheaper than the one Elias has asked for. It won't meet Elias' needs, as it doesn't provide enough support for his back. That means, it won't achieve the same result as the one Elias has asked for.

Elias's planner finds a commode that's $1,000 cheaper. The planner contacts Elias's occupational therapist who confirms this commode will meet Elias' needs.

Elias' planner decides to fund the commode that's $1,000 cheaper. This has the same features and will have the same benefits for Elias at a substantially lower cost.

Is the support effective and beneficial?

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We need to be satisfied that the support will be, or is likely to be, effective and beneficial, when we consider current good practice.

We need to work out if the support is likely to be both:

- **effective** – it will do what you need it to do[36]
- **beneficial** – the support will help you do things you can't otherwise do and meets your support needs.[37]

It can also be effective and beneficial if it will help you maintain your current level of functioning. That is, it will help you keep doing the things you can currently do. And it'll help you maintain your work, study and social life as much as you can.[38]

When we decide if a support is effective and beneficial, we look at what is current good practice. This means we look at if there is evidence that the support works for someone with similar disability support needs to you. We won't need an expert opinion or report for every support, because we can often rely on other evidence.

For example:

- We may have information already about whether the support is widely accepted to suit someone with your disability support needs.[39] For example, we could rely on academic research and other literature. This could include university studies on therapies that have been published and referred in academic journals, evidence based practice resources, or clinical practice guidelines.
- If you or other participants have used the support before, we can consider your experience and the experience of your family members and carers.[40]

We may consider things we have learnt from other participants in the NDIS with similar support needs to you.[41] We know you're the expert in your own life, and we use your own experience as much as we can.

For example, we will talk to you about any supports that have helped you do things you can't otherwise do. Or some supports may have helped maintain your ability to be as independent as possible.

If it's a new support such as new assistive technology, we might fund a trial. This is so we can learn from your experience of using the support to check if it's likely to do what you need it to.

Your evidence can be particularly useful when it's consistent with other evidence, or if we don't have expert evidence.

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We'll look at the opinions held by the majority of experts and what they generally agree on.[42] Sometimes we will have to seek expert opinion or report to make a decision.[43]

Example

Vivek is 12 and has a goal to improve his communication skills. He and his family want him to improve his social skills with the kids in his class.

When he was younger, Vivek's family tried speech therapy, and believe it really helped him improve his communication. His family told his planner about how it helped Vivek learn how to respond to different social settings.

Vivek's speech therapist also believes it could work well for him now and help him interact with his classmates.

When deciding if the therapy is effective and beneficial, Vivek's planner will consider:

- how speech therapy has helped Vivek in the past, including first-hand information from Vivek, his family members, and carers
- the reports or assessments from his speech therapist on the effectiveness and benefits of speech therapy for Vivek
- other information or expert evidence about the effectiveness and benefits of speech therapy, including for children of the same age, with the same impairments and functional capacity.

Based on this information and evidence, Vivek's planner decides the speech therapy is effective and beneficial. If it meets the other funding criteria, we will be able to fund speech therapy in Vivek's plan.

Is the support something we would reasonably expect your informal supports, like family or friends, to provide?

We need to be satisfied that funding the support takes into account what is reasonable to expect families, carers, informal networks and the community to provide.[44]

To make sure we understand how disability supports might work for you, we consider:

- the things you're able to do for yourself
- any support you have from others in your network – including family members, relatives, friends and local community services.

When we fund supports under the NDIS, we need to consider if it's reasonable to expect your informal supports to provide that support. We can't fund supports that an ordinary person would think is reasonable to expect friends, family or the community to provide for you.[45]

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Informal supports are the help and support you get from friends, family and the community. They are called ‘informal’ because you don’t pay for them, and they’re not part of a formal agreement. They are the usual things friends and family do for us, and with us.

Most of us get some kind of help and support from friends and family. In our society, we expect that friends, family and our community will support each other and help each other out when they need it.

A good example is families who have young children. In our community, we expect families will provide most of the support a young child needs.[46] They will care for the child, make sure they are safe and drive them around places.

Grandparents, uncles and aunties often have a role to play in supporting young children as well. Neighbours and friends might also help care for the child.

As a child gets older, our society’s expectations of the role of the family and community in caring for the child changes. For example, we expect schools to provide a child’s learning needs.

We also usually expect the role of family in providing personal care for a child would reduce as they get older and develop new skills and independence. But families are usually still responsible for things like food, emotional support, decision-making and providing a safe home.

It’s a similar idea for adults. Our society expects that adults – like family, friends and neighbours – will provide some support to each other. This might be things like taking a friend with you to the football game, or providing emotional support if someone is upset.

NDIS supports won’t ever replace the support people like your friends and family provide to you. This support is given freely because people care and is often quite different to supports bought with NDIS funding.

You have a special bond with your friends and family that’s different from your relationship with paid carers. And there are potential risks and problems for you if your friends and families become your paid carers.

We also must consider the benefits you may get from your informal supports. For example, your family and friends may be better at helping you meet other people, or helping to build your social skills, than paid supports.

We consider if we can help these relationships so that you get the support you need.[47] For example, we may be able to fund training for your informal supports, so they can help you build your skills.

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We also think about the capacity of your informal supports to continue caring for you, for example if they're ageing or sick.

There are different things the law for the NDIS says we need to consider for adults and children.

If you're under 18, we consider what support is reasonable to expect parents to provide at your age. It's normal for parents to provide substantial care and support for children.[48] We consider that it's usual for parents to provide almost all the care and support that young children need.

For example, it's reasonable to expect parents or other family members to provide transport to and from their child's after-school activities. Of course, the amount of care and support for a child without a disability would typically reduce as they get older.

For children under 18, we consider:

- if your needs are substantially greater because of your disability, compared to other children the same age.[49] This means you need much more disability support
- any risks to the wellbeing of people providing informal support to you[50]
- if including funding for the support will help build your skills and capacity in the future or reduce any risks to you.[51]

For example, we consider any health, safety or other impacts resulting from what's involved in meeting your disability support needs.

If you're over 18, we consider:

- if there are any risks to you or your informal supports if you rely on them to provide the support you need[52]
- how much your informal supports would help improve or reduce your independence and other outcomes.[53]

We also consider the suitability of informal supports to provide the supports you need,[54] including:

- how old your carers are and their capacity to provide the support[55]
- if other family members and the community can help your informal supports in their caring role[56]
- the intensity and type of support you need, and if it's appropriate for your informal supports to provide this, based on their age and gender[57]
- any long-term risks to the wellbeing of your informal supports.[58]

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When we consider the risks for people over 18, we consider if the supports are sustainable for your informal supports. We consider the health, safety and other impacts on family and carers in the long term.

For example, we wouldn't expect a child to have their schooling affected because they need to provide care. We also wouldn't expect an elderly parent to be responsible for physical activities, if it may result in injury.[59]

We generally don't fund family members to provide supports funded under the NDIS. There are very limited situations where we can consider this.

Learn more about Sustaining Informal Supports.

Example 1

Simon is getting his first plan. For the last 15 years, Simon and his wife Jan's preference was that Jan provide all the physical support he needs at home, such as toileting, showering and dressing.

But as Jan is getting older, it's not safe for her to do this. It's becoming risky for both Jan and Simon to keep providing this support informally.

Jan and Simon think it might be best for someone else to provide the personal care support that Simon needs. Their children have moved out of home, and it's not reasonable to expect them to help Simon with personal care.

Based on this information and other evidence, Simon's planner decides that the personal care support meets this criteria. It takes into account what is reasonable for his family and others to provide. If the personal care support meets the other funding criteria, we may fund the personal care support for Simon.

Simon and Jan still prefer Jan to do the other support Simon needs though, such as helping Simon eat his meals. At this time, we wouldn't fund a support worker in Simon's plan to help him eat his meals. It's reasonable to expect Jan to help Simon with this, because it's what they want to do and it's not a safety risk for Jan or Simon.

Example 2

Qing is 14 and wants to join a local chess club. Like most 14-year-olds in this situation, she needs someone to drop her off and pick her up from the mid-week and weekend gatherings.

But unlike most 14-year-olds, she needs someone to help her get dressed before she can go to the chess club. Her parents have been doing this, but as Qing is getting older, she no longer wants her family to help her get dressed.

It's reasonable to expect her family or other informal supports to drop Qing to and from the match and training sessions. So, we wouldn't fund transport in Qing's plan.

But at age 14, it's not reasonable to expect her family to help her get dressed.

Based on this information and other evidence, Qing's planner finds that the personal care support considers what is reasonable for family and others to provide. If it meets the other funding criteria, we may fund personal care support in her plan.

Is the support an NDIS support for you?

A support will only be an NDIS support for you if either:

- the Rules say that the support is a NDIS support for everyone, or
- the Rules say that the support is only for a specific group of people, and you are part of that group.[60]

NDIS supports are the services, items, and equipment that can be funded under the NDIS.

Remember, we can only fund a support if it is:

- an NDIS support for you
- necessary for your impairments that meet the disability or early intervention requirements, or both.[61]

Go to NDIS supports to find more information on what is and isn't an NDIS support.

Example

Max has a spinal cord injury and uses a manual wheelchair to move around. His home has a carport at the front. The path from the carport to the front door is too narrow for his wheelchair and the uneven ground makes it unsafe for him to use his wheelchair on his own.

In Max's planning meeting, he requests the installation of a pathway from the carport to the front door to enable safe access to his home.

Max's planner checks that the home modifications are an NDIS support.

Because Max needs a pathway to access his house safely, the planner decides that the home modifications are an NDIS support.

What types of supports can't be funded or provided under the NDIS?

Under the law for the NDIS, there are things we can't fund or provide.[62] We can't fund goods and services that are not NDIS supports.[63] For example, we can't fund or provide supports that:

- consist of sexual services and sex work, alcohol, or drugs[64]
- are not legal[65]

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- are income replacement[66]
- are likely to cause harm to you, or pose a risk to other people[67]
- relate to a 'day-to-day living cost', like groceries, rent or utilities[68]
- duplicate other supports provided by the NDIS under alternative funding[69]
- include tickets to events or the cost of going on a holiday.[70]

For more information on what we can't fund, go to NDIS supports.

What else do you need to know about deciding if supports meet the NDIS funding criteria?

From our experience, we learned there are some common misunderstandings about how we work out what supports meet the NDIS funding criteria.

Why don't we always fund what your health professionals recommend?

Although we take expert opinions into account, we can't and don't always fund everything your health professional might recommend. This is because every support we fund needs to meet all the NDIS funding criteria.

For example, your therapist might recommend a piece of equipment on the basis that it will be 'effective and beneficial' for you. But if there is something cheaper that will achieve the same outcome, we won't be able to fund what the therapist recommended.

This is because it may not be value for money. We may be able to fund the cheaper option instead if it meets all the NDIS funding criteria.

Why don't we fund the same supports as your last plan?

We might fund different supports in your next plan. This is because we will fund supports in your plan based on how we use the NDIS funding criteria at that point in time.

Your needs and situation will most likely change over time. This means it's likely your NDIS supports and needs for those supports will change over time.

For example, we may have funded supports to help you build your skills in a particular area. Once you have built those skills, you won't need funding for that anymore. So, we probably won't include that funding for those supports in your next plan.

Supports to build your skills may have met the NDIS funding criteria before, but the same supports might not meet the criteria in the future.

Or, your disability support needs might increase or decrease over time. This may mean we consider funding more or less supports as a result.

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What else do we consider when deciding what to include in your plan?

As far as possible, we have to act according to principles set out in the law for the NDIS.[71] These principles guide us when we make decisions about what we can fund.

These principles don't override or replace the NDIS funding criteria under the law for the NDIS. They can help us apply the funding criteria, by giving us more guidance when we decide what supports to approve in your plan.

The principles include the following:

- You have the same right as other Australians to realise your potential for physical, social, emotional, and intellectual development.[72]
- You should be supported to take part in and contribute to social and economic life.[73]
- You should be supported to make choices about planning and how your supports will be delivered. This includes taking reasonable risks, so you can pursue your goals.[74]
- You have the same right as other Australians to decide your own best interests. You have the right to be an equal partner in decisions that affect your life.[75]
- Your privacy and dignity should be respected.[76]
- We must make sure the NDIS is financially sustainable.[77]

The principles also tell us that the reasonable and necessary supports we fund should:[78]

- support you to pursue your goals and maximise your independence
- support you to live independently and to be included in the community as a fully participating citizen
- develop and support your capacity to do things that help you participate in the community and employment.

Just because a support helps you do these things doesn't mean we'll fund it in your plan. All supports we fund need to meet all the NDIS funding criteria.

We consider these principles set out in the law for the NDIS, along with the principles we follow to create your plan.

How do we think about an ordinary life when deciding what supports to include in your plan?

To help guide us in our decision-making about reasonable and necessary supports, we took advice from the NDIS Independent Advisory Council (The Council).

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The Council represents people with disability and carers, bringing their own lived experience and expertise of disability. They give us advice on how the NDIS should work.

The Council advised us that all Australians, including people with disability, should have an 'ordinary life'. They also told us we should think about the idea of an ordinary life when we apply our principles and use the NDIS funding criteria.

An ordinary life is a life where you have the same opportunities as people without a disability. An ordinary life is one that is typical or usual for everyone in modern day Australia. It's a life where you can pursue your potential and participate in society on an equal basis with others.

An ordinary life will be different for different people. We are all different and come from different cultures and backgrounds. We each have our own values, experiences, beliefs, and goals.

But there are some common things that can improve the quality of our lives and help us participate equally. These are the things, such as the following, that make up an ordinary life:

- Positive relationships with families and informal support networks.
- Individual autonomy. This means being free and independent, and having the same opportunities as people without disability.
- Active involvement in decision-making including the ability to make meaningful decisions, and exercise choice and control.
- Using your strengths in ways that provide a challenge and enjoyment.
- A sense of belonging to our families, friendship networks, communities, workplaces and society.
- Active involvement and contribution to society and your community.

An 'ordinary life' in the context of the NDIS involves supporting you to:

- have and maintain good relationships
- belong and participate in your community
- be involved in making choices about your own life.

One way we can help you have an ordinary life is to support you to access mainstream, community, or informal supports wherever possible. These are the usual supports that everyone in the community uses.

When we fund reasonable and necessary supports under the NDIS, we need to make sure they meet the NDIS funding criteria.

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When we apply the NDIS funding criteria and make decisions about reasonable and necessary supports, we're guided by the principles in the law for the NDIS. We also consider how the supports will best help you to live an ordinary life.

What other services or systems are responsible for providing supports?

We have to be satisfied that the support is considered an NDIS support which means the support is something that can be funded or provided through the NDIS. Some supports are not considered an NDIS support because they're more appropriately funded or provided through:

- other service systems or supports offered by a person, agency or body (like a State or Territory Statutory Scheme)
- services or supports offered as part of a universal service obligation (like the health or education system)
- services or supports offered in line with reasonable adjustments required under discrimination laws (like your employer, or the health or education system).[79]

We won't fund the support if the support should be provided by someone else, even if the other service system doesn't actually provide it. We don't make up for other organisations and systems that don't provide the supports they should.

The list of goods and services that are not NDIS supports includes supports that are considered the responsibility of service systems such as:

- Health
- Mental health
- Child protection and family support
- Early childhood development
- School education
- Higher education and vocational education and training
- Employment
- Housing and community infrastructure
- Transport
- Justice.

For more information, go to Mainstream and community supports.

How does the NDIS work with other government services?

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We call supports provided by other government services, including those provided as part of a universal service obligation, 'mainstream supports'. When we talk about mainstream supports, we mean supports available to everyone in your state or territory, or across Australia, regardless of if you have a disability.

This includes services provided by state and federal governments, related to health care, education and mental health services.

You have the same right as all Australians to access these services. There are certain things that mainstream services have to do to make their services accessible for people with disability. Using mainstream supports can also help you be part of your community, or to work or study.

When we fund NDIS supports, we won't fund supports that are not considered NDIS supports because the support is more appropriately funded or provided by a mainstream service or system, such as the education system or health system.[80] Under the law for the NDIS, we can't fund supports that should be provided by a mainstream service.

The Australian federal, state and territory governments agreed on responsibilities for funding different types of supports. The law for the NDIS has an outline of funding responsibilities and were developed with the agreement of each State and Territory.[81]

Learn more about who is responsible for the supports you need.

What is reasonable adjustment and why is it important?

People with a disability can sometimes face barriers that make it harder to do the same things as people who don't have a disability. For example, it might be harder to find and keep a job. Or it might be harder to get in and around places, or to get the same services as other people.

It's against the law to discriminate against people with a disability in many areas.[82] This includes in employment, when providing goods and services, and when accessing public places.

This means organisations or people who are responsible for providing these services have to make what are called 'reasonable adjustments'. They have to make sure people with a disability have equal access to the services they provide, as far as is reasonable.

They have to do reasonable things that will make their services equally available to everyone, whether or not you have a disability.

Reasonable adjustments do not mean they have to provide everything you need because of your disability. It means they have to do what's reasonable to make sure you have equal

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access to employment, public spaces or services. This takes into account what they can afford to do and what is reasonable to expect them to provide in the circumstances.

When we decide what supports to include in your plan, we need to consider what should be provided through reasonable adjustments. Under the law for the NDIS, we can't fund a support if it should be provided by someone else through reasonable adjustments.

What about in-kind supports?

We agreed that state and territory governments will keep providing some supports for a period of time. We call these 'in-kind supports'.

If we fund in-kind supports like specialist school transport or personal care in schools, you will need to use state or territory government providers for these supports. These supports are most efficiently and effectively provided by state and territory government providers.[83] Learn more about Work and study supports.

For most other in-kind supports, you can choose your provider if you don't want to use your in-kind provider anymore. We can let you choose another provider if we consider that the support isn't most effectively and efficiently provided by the in-kind provider.

We usually let you choose another provider if:

- another provider can give you the same support or level of support as the in-kind provider
- the supports with the new provider still meet the NDIS funding criteria, including that they're value for money compared to the in-kind support
- there are no serious risks with changing providers.

Learn more about in-kind supports.

How do we include the reasonable and necessary supports in your plan?

Once we've identified the supports, and decided they meet the NDIS funding criteria, we can include the description and funding for the NDIS support in your plan.

If the support doesn't meet the NDIS funding criteria, we can't include the support in your plan. We may consider if a differently described support meets the NDIS funding criteria instead.

When we approve your plan, we'll also make sure all your supports are reasonable and necessary when considered as a package of supports.[84]

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Sometimes you might not need any supports under the NDIS. For example, your informal supports may meet all your disability support needs. If so, we'll approve a plan with no funded supports.

Learn more about how we create and approve your plan.

Learn more about using the funding in your plan.

Learn more about changing your plan.

What happens if we don't include the supports you want?

If we decide a support doesn't meet the NDIS funding criteria, we can't include the support in your plan. Also, if the amount of support you want doesn't meet the criteria, we can't include that amount in your plan.

But, we're committed to our principles and helping you live an ordinary life. Even if we can't fund a particular support, we may still be able to help.

If the support doesn't meet the NDIS funding criteria, we can consider if a different support meets the NDIS funding criteria. We might be able to consider describing the support differently or funding a different type of support.

Or we may be able to connect you to mainstream or community supports that can help. Mainstream and community supports are available to everyone. They can be a good way to connect with your local community, learn new skills and gain independence.

There are lots of ways we might be able to help, so talk to us if you're in this situation. We can do this at any time. We may be able to help before we approve your plan.

We'll give you the reasons for our decision to approve your plan in writing.[85] You can contact us if you'd like more detail about the reasons for our decision.

What happens if I want to replace a support for something else?

We fund NDIS supports in your plan. NDIS laws set out what we can and can't fund.[86]

Sometimes, we may agree that you can spend your funding on supports that are not NDIS supports. We call this a 'replacement support'. Go to Your plan for more information. For more information about replacement supports, go to NDIS supports.

What if you don't agree with our decision?

If we decide the supports you requested don't meet our NDIS funding criteria, we can't include them in your plan.

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If you'd like more details about the supports that make up your plan's total funding amount, we can send this to you. You can contact us and ask for a Budget Breakdown.

We'll give you written reasons why we made the decision. You can contact us if you'd like more detail about the reasons for our decision.

If you don't agree with a decision we make about what supports to include in your plan, you can ask for an internal review of our decision.[87]

You'll need to ask for an internal review within 3 months of getting your plan.[88]

Learn more about reviewing our decisions.

Reference List

[1] NDIS Act s 34(1)(aa).
[2] NDIS Act and delegated legislation made under the NDIS Act, especially NDIS (Supports for Participants) Rules and NDIS (Plan Management) Rules.
[3] NDIS Act s 34 (1)(aa).
[4] NDIS Act ss 33(2)(a), 33(2)(b), 33(5)(c), 34.
[5] NDIS Act ss 13, 33(2)(a).
[6] NDIS Act s 34 (1).
[7] NDIS Act s 34 (1) (aa).
[8] NDIS Act s 10.
[9] NDIS Act and delegated legislation made under the NDIS Act, especially NDIS (Supports for Participants) Rules and NDIS (Plan Management) Rules.
[10] NDIS (Supports for Participants) Rules r 2.4; NDIS Act s 33(5)(c).
[11] NDIS Act s 34(1)(f).
[12] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules pt 5.
[13] NDIS Act ss 33(5)(c), 34(1).
[14] NDIS Act s 34(1)(aa).
[15] NDIS Act s 34(1)(a).
[16] NDIS Act s 34(1)(b).
[17] NDIS Act s 34(1)(c).
[18] NDIS Act s 34(1)(d).
[19] NDIS (Supports for Participants) Rules r 3.2(a).
[20] NDIS Act s 34(1)(e).
[21] NDIS Act s 34(1)(f).
[22] NDIS (Supports for Participants) Rules pts 3, 4.
[23] NDIS (Supports for Participants) Rules r 5.1(b), NDIS Act s 34(1)(aa).
[24] NDIS Act s 34(1)(a).
[25] *McGarrigle v National Disability Insurance Agency* (2017) 252 FCR 121 at [91].
[26] NDIS Act s 34(1)(a).
[27] NDIS (Supports for Participants) Rules r 5.1(d).
[28] NDIS Act s 34(1)(b).
[29] NDIS Act ss 3(3)(b), 4(17).
[30] NDIS (Supports for Participants) Rules r 3.1(a).
[31] NDIS (Supports for Participants) Rules r 3.1(b).
[32] NDIS (Supports for Participants) Rules r 3.1(c).

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[33] NDIS (Supports for Participants) Rules r 3.1(e).
[34] NDIS (Supports for Participants) Rules r 3.1(c).
[35] NDIS (Supports for Participants) Rules r 3.1(d).
[36] McCutcheon and NDIA [2015] AATA 624 at [34].
[37] McCutcheon and NDIA [2015] AATA 624 at [34].
[38] McCutcheon and NDIA [2015] AATA 624.
[39] NDIS (Supports for Participants) Rules r 3.2(a).
[40] NDIS (Supports for Participants) Rules r 3.2(b).
[41] NDIS (Supports for Participants) Rules r 3.2(c).
[42] NDIS (Supports for Participants) Rules r 3.3.
[43] NDIS (Supports for Participants) Rules r 3.3.
[44] NDIS Act s 34(1)(e).
[45] NDIS Act s 34(1)(e).
[46] NDIS (Supports for Participants) Rules r 3.4(a)(i).
[47] NDIS (Supports for Participants) Rules r 3.4(c).
[48] NDIS (Supports for Participants) Rules r 3.4(a)(i).
[49] NDIS (Supports for Participants) Rules r 3.4(a)(ii); JQJT and National Disability Insurance Agency [2016] AATA 478 at [39].
[50] NDIS (Supports for Participants) Rules r 3.4(a)(iii).
[51] NDIS (Supports for Participants) Rules r 3.4(a)(iv).
[52] NDIS (Supports for Participants) Rules rr 3.4(b)(i), (ii).
[53] NDIS (Supports for Participants) Rules r 3.4(b)(iii).
[54] NDIS (Supports for Participants) Rules r 3.4(b)(ii).
[55] NDIS (Supports for Participants) Rules r 3.4(b)(ii).
[56] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(A).
[57] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(B).
[58] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(C).
[59] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(C).
[60] NDIS Act s 34(1)(f).
[61] NDIS (Supports for Participants) Rules r 5.1(b), NDIS Act s 34(1)(aa).
[62] NDIS (Supports for Participants) Rules r 5.
[63] NDIS Act s 10.
[64] NDIS Act s 10.
[65] NDIS Act s 10.
[66] NDIS Act s 10.
[67] NDIS Act s 10.
[68] NDIS Act s 10.
[69] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(c).
[70] NDIS Act s 10.
[71] NDIS Act ss 4, 31.
[72] NDIS Act s 4(1).
[73] NDIS Act s 4(2).
[74] NDIS Act s 4(4).
[75] NDIS Act s 4(8).
[76] NDIS Act s 4(10).
[77] NDIS Act s 4(17).
[78] NDIS Act s 4(11).
[79] NDIS Act s 34(1)(f).
[80] S10(b1) -(3).
[81] NDIS (Supports for Participants) Rules rr 3.5-3.7, Schedule 1; NDIS Act ss 209(4), (8) item 1.
[82] Disability Discrimination Act 1992 (Cth); Discrimination Act 1991 (ACT); Anti-Discrimination Act 1977 (NSW); Anti-Discrimination Act 1996 (NT); Anti-Discrimination Act 1991 (Qld); Equal Opportunity Act 1984 (SA); Anti-Discrimination Act 1998 (Tas); Equal Opportunity Act 2010 (Vic); Equal Opportunity Act 1984 (WA).

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[83] NDIS (Plan Management) Rules r 6.6.
[84] NDIS Act s 33(5)(c).
[85] NDIS Act s100(1).
[86] NDIS Act s 10.
[87] NDIS Act s 100.
[88] NDIS Act s 100(2).

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Reasonable and Necessary Supports

Quick summary: there are new laws about what we can and can't fund under the NDIS. All NDIS supports need to meet each of the reasonable and necessary criteria before we can fund them in your plan. For example, supports need to relate to your disability support needs, be value for money, and effective and beneficial. We also need to make sure each support is an NDIS support. This means it's a service, item, or equipment that can be funded by the NDIS. Examples of NDIS supports include support with personal daily living tasks and accessing the community, therapeutic supports, and personal mobility equipment.

Note:

- When we say 'your plan' we mean your NDIS plan.
- When we say 'disability support needs', we mean supports you need because of your disability.
- If you're aged between 9 and 65 years and are looking for information about community connections, go to Our Guideline – Community Connections.
- If your child is younger than 9 and you're looking for information about early connections, go to Our Guideline – Early Connections.
- As part of the recent changes to the NDIS laws we are moving towards a new framework for planning. Rules need to be developed for this new framework. We're working on how and when we'll introduce these changes.

  Until then, the information in this Our Guideline is about our 'old framework' for planning, which include the legislative changes that become operational when the law commences. All current plans will be known as 'old framework' plans, and we will continue to develop these until all participants have transitioned to the new framework.

What's on this page?

This page covers:

- What are reasonable and necessary supports?
- How do we make decisions about what is reasonable and necessary?
- How do we include the reasonable and necessary supports in your plan?
- What if you don't agree with our decision?

You may also be interested in:

- Mainstream supports
- Creating your plan
- Changing your plan
- Reviewing our decisions
- Would we fund it?

What are reasonable and necessary supports?

The National Disability Insurance Scheme (NDIS) was set up as a world first approach to disability support. It puts people with disability at the centre of decision-making, through the principles of reasonable and necessary supports and individual choice and control.

We provide funding for reasonable and necessary supports to people with a permanent and significant disability or developmental delay.

Reasonable and necessary supports are the supports we fund in your plan to meet your disability needs. All NDIS supports we fund in your plan need to meet the criteria set out in law for the NDIS of what we can and can't fund.[1] For information on what is an NDIS support and what is not, go to NDIS support.

NDIS supports should complement, not replace, other supports available to you. That's why we consider:

- the things you're able to do for yourself
- support you have from others in your network, including family members, relatives, friends, local community services and mainstream government services.

Once we've considered your situation, we need to follow the rules determined under the law for the NDIS in our planning decisions.[2]

This guideline explains how we decide what reasonable and necessary supports must consider, which we'll explain in detail.

When creating your plan, we also follow these principles.

We also have Would we fund it guides. They have examples of how we decide if we fund different types of supports.

How do we make decisions about what is reasonable and necessary?

When we create your plan with you, we'll discuss your disability support needs.[3] We want to help you pursue your goals, increase your independence, and help you work, study and join social activities.

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The NDIS will only fund a support if it meets **all** the reasonable and necessary criteria. We also won't fund a support if the law says we can't fund it. We explain the reasonable and necessary criteria in more detail further down.

What supports can you get outside the NDIS?

Before we decide what reasonable and necessary supports to fund in your plan, we'll first discuss what other supports may be available outside the NDIS. This is an important information-gathering step. For example, there may be mainstream, community and informal supports that suit you.

There are many supports you can get outside the NDIS. Other government and community services provide supports to all Australians, including people with disability. And your friends, family, and other people you know can often be your best supports.

To find out more about supports you can get outside the NDIS, go to Creating your plan.

It's important we gather this information and help you access these services before we consider what reasonable and necessary supports we can fund. That way, we can help make sure you're able to access mainstream, community, and informal supports wherever possible.

For more information, go to Mainstream and community supports.

What types of supports may be included in your plan?

Your plan may include 'general supports' and 'reasonable and necessary supports'.[4]

General supports

General supports are the coordination, strategic or referral services and activities we provide or arrange to be provided, for you.[5] They're how we help you develop your plan and connect with support and activities in your community. This includes the support you get from your early childhood coordinator or local area coordinator to connect to mainstream, community, and informal supports. You don't need to pay for your general supports from your plan as the NDIS pays for them directly

Reasonable and necessary supports

Reasonable and necessary supports are the NDIS supports we fund or provide in your plan to meet your disability support needs.[6] NDIS supports are the services, items, and equipment we can fund or provide under the NDIS.[7] For information on what supports are considered NDIS supports, go to NDIS supports.

The laws for the NDIS tell us what we can fund in your plan.[8] All NDIS supports we fund in a plan need to meet all the criteria set out in these laws. We call these the NDIS funding criteria.

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- We'll check your support types and amounts of support will complement each other to help you fulfil an ordinary life.[9] Any funded supports must be an NDIS support[10] that is right for you.
- It must not be a type of support the law says we can't fund or provide.[11]

Each NDIS support must be reasonable and necessary individually, but the supports must also be reasonable and necessary when considered as a package of supports.

Does the support meet the reasonable and necessary criteria?

We can only include NDIS supports in your plan if they meet **all** the reasonable and necessary criteria.[12]

This means that before we can include an NDIS support in your plan, we need to be satisfied it meets all the following criteria:

- The support is related to your disability[13].
- The support will help you to pursue your goals in your plan.[14]
- The support will help you to undertake activities, to facilitate your social and economic participation.[15] This means the support will help you join in social outings, recreation, work and study by reducing the disability-related barriers that prevent you from participating.
- The support represents value for money. This means we need to consider the costs and benefits of the support, as well as the costs and benefits of alternative supports.[16]
- The support will be, or is likely to be, effective and beneficial for you, having regard to current good practice.[17] This means we consider if there is evidence the support works for someone with similar disability support needs. We won't need an expert report for every support, as we can often rely on other information or evidence. For example, we may have information already about whether the support is widely accepted to suit someone with your disability support needs.[18] We also consider your lived experience.
- The funding of the support takes account of what it is reasonable to expect families, carers, informal networks and the community to provide.[19] This means we need to consider what support is reasonable for your family, friends and community to provide.
- The support is an NDIS support for you.[20]

The law for the NDIS sets out things that we need to consider when we apply the reasonable and necessary criteria.[21]

For example, funding a vehicle modification may reduce your need for other supports. By funding a vehicle modification in your plan, we'll look at whether you need less support to access the community.

If the vehicle modification will reduce your support needs, we might reduce the amount of support we fund for you to access the community. This is because the same amount of support might not be reasonable and necessary when the whole package of supports is considered.

Is the support related to your disability?

We'll only fund a support if it relates to your disability.[22] This means there must be a direct link between your disability support needs and the NDIS supports we fund.

We consider if the support addresses your disability support needs. Your disability support needs are those that come from, or are caused by, your disability.

For example, we don't fund things like flights to go on a holiday or a gym membership to get fit.

This is because you're unlikely to need these supports because of your disability support needs. They are things that all people, with or without disability, might want or need.

Example

Alan uses a wheelchair and needs some changes to their house. They need to be able to independently use their bathroom and kitchen. They also want to set up an outdoor entertainment area for when their friends visit.

We may be able to fund home modifications so Alan can access areas of their home, including their bathroom and kitchen. They need the home modification because they can't access those areas due to their disability.

Alan will need to pay for the outdoor entertainment area, as it's not related to their disability.

Does the support help you pursue your goals?

We need to be satisfied that the support will help you pursue the goals, objectives and aspirations in your plan.[23] This helps us determine if the support is necessary.[24]

While we only fund supports that help you pursue your goals, objectives and aspirations, we understand that different people express themselves in different ways.

Reasonable and necessary supports should help you pursue your goals,[25] but you don't need a specific goal for every support in your plan. When we decide if a support will help you pursue your goals, we consider your whole situation.

We look at how a support will address your disability support needs, and the disability specific barriers that prevent you from pursuing your goals.

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A support that addresses your disability support needs is most likely to help you pursue your goals, objectives and aspirations in your plan.

This means that if your goal is to 'live independently', we **may** fund home modifications that address your disability support needs. However, we won't fund supports that aren't NDIS supports, including day-to day-living costs like rent or utilities. These costs aren't incurred solely and directly because of your disability support needs, so they don't meet other funding criteria.[26]

Also, choosing a different goal 'to have a more accessible home' won't change the supports we could fund in your plan.

Achieving goals usually takes many different kinds of supports. NDIS supports will most likely be just one kind of support that helps you work toward your goals.

Learn more about setting your goals in Creating Your Plan and the Setting Goals fact sheet.

Example

Morgan is ready to look for work and they have a goal in their plan to get a job. They've built up their skills and know the type of work they want to do. Disability Employment Services are helping Morgan find work, so we can't fund this support for Morgan.

However, because of their disability, Morgan will need personal care supports to help them get ready for work in the morning. We will consider:

- how Morgan's disability support needs relate to their goals
- if funding NDIS supports that address these disability support needs will help Morgan pursue their goals.

Morgan's planner determines the personal care supports meet this criteria. The supports that address their personal care needs will help Morgan to pursue their employment goals.

Morgan's planner then needs to look at if the support meets the other NDIS funding criteria. In this case Morgan does get personal care in their plan. Morgan doesn't have a job yet but will need personal care support to help them get ready to look for work. Morgan will also be able to use these supports when they get a job.

We don't fund all the supports that relate to Morgan's employment goals. We only fund the supports we consider are reasonable and necessary – that is, when they meet all the NDIS funding criteria.

Does the support help you do activities that will help your social and economic participation?

We need to be satisfied that the support will help you to do activities, which make it easier for you to participate socially and economically.[27]

Social participation means doing things you enjoy, like going out with friends, playing sport or going out into the community. It also means doing the things you need to do, like going to school or medical appointments.

Economic participation usually means being involved in things that help you work towards getting and keeping a job. This might be things like volunteering, study, learning new skills or trying work experience. Research tells us that work can lead to health benefits and improve our quality of life. Learn more about the Health Benefits of Good Work.

Social and economic participation are important to most people. They're critical to living an ordinary life.

To work out if a support meets this criteria, we look at the purpose of the support and how it will help you.

We fund reasonable and necessary supports that reduce the barriers that prevent you from doing activities. This will help you increase your social and economic participation.

Some supports help economic and social participation directly. There are lots of supports we can fund to directly help with social and economic participation. Learn more about Social and recreation supports and Work and study supports.

Other supports help you do activities like self-care, which indirectly help your economic and social participation.

Example

Sue is going to university next year. She has a vision impairment and has been working with her Guide Dog Mobility Instructor to decide if a Dog Guide is right for her. A Dog Guide can help her leave her home safely and independently, and travel to and from university.

A Dog Guide could also help her go out with friends and join in other community activities. As long as it meets the other funding criteria, we could fund a Dog Guide for Sue. It will help her with activities of daily living.

In Sue's case, a Dog Guide will also increase her social and economic participation. Having a Dog Guide will help her get to her university independently where she studies and also has lots of friends.

Is the support value for money?

All supports we fund under the NDIS need to be value for money. This means the cost of the support is reasonable when we consider the benefits of the support and the cost of other supports.

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Making sure your supports are value for money is one of the ways we keep the NDIS financially sustainable. This means we make careful decisions about funding so that we make sure the NDIS exists for future generations. It's also one of our principles.[28]

When we decide if the support is value for money, we consider:

- if other supports would achieve the same result at a substantially lower cost.[29] This means there should be a real or material difference in cost
- if there's evidence that the support will substantially improve your life stage outcomes and benefit you in the long term[30]
- if the support will likely reduce the cost of other supports over time[31]
- how the cost compares to other supports of the same kind in your area[32]
- if the support will make you more independent and mean you won't need as many supports in the future. For example, in some situations home modifications may reduce the need for support in your home.

When we consider the likely cost of supports, we consider the cost over the long term. We consider if the support will help you achieve milestones at different ages or stages of your life and have long term benefits.

For example, some supports like home modifications may be expensive now, compared to other supports. But getting these supports now may mean you need much less support in a few years, or later in life. Or it may delay the need for other more costly supports.[33]

When determining if the cost of the support is value for money, we consider:

- the prices for NDIS supports in the NDIS Pricing Arrangements and Price Limits
- quotes for specific or high risk supports.

It's important we consider the cost of the support. This will be the level of funding we include in your plan, if we decide the support is reasonable and necessary.

When we fund equipment or modifications, we also need to consider:[34]

- how the cost of buying the equipment or modifications compares to the cost of renting them
- if it's appropriate to fund the equipment or modifications you want, based on your situation and any expected changes in technology.

Learn more about how we consider value for money when we fund assistive technology, home modifications and vehicle modifications.

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Example

Elias needs a shower commode.

He got an assessment and sent us a quote for one that will suit his needs. As part of the process to work out if this meets the reasonable and necessary criteria, his planner considers other similar shower commodes.

There's another commode that's $5,000 cheaper than the one Elias has asked for. It won't meet Elias' needs, as it doesn't provide enough support for his back. That means, it won't achieve the same result as the one Elias has asked for.

Elias's planner finds a commode that's $1,000 cheaper. The planner contacts Elias's occupational therapist who confirms this commode will meet Elias' needs.

Elias' planner decides to fund the commode that's $1,000 cheaper. This has the same features and will have the same benefits for Elias at a substantially lower cost.

Is the support effective and beneficial?

We need to be satisfied that the support will be, or is likely to be, effective and beneficial, when we consider current good practice.

We need to work out if the support is likely to be both:

- **effective** – it will do what you need it to do[35]
- **beneficial** – the support will help you do things you can't otherwise do and meets your support needs.[36]

It can also be effective and beneficial if it will help you maintain your current level of functioning. That is, it will help you keep doing the things you can currently do. And it'll help you maintain your work, study and social life as much as you can.[37]

When we decide if a support is effective and beneficial, we look at what is current good practice. This means we look at if there is evidence that the support works for someone with similar disability support needs to you. We won't need an expert opinion or report for every support, because we can often rely on other evidence.

For example:

- We may have information already about whether the support is widely accepted to suit someone with your disability support needs.[38] For example, we could rely on academic research and other literature. This could include university studies on therapies that have been published and referred in academic journals, evidence-based practice resources, or clinical practice guidelines.

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- If you or other participants have used the support before, we can consider your experience and the experience of your family members and carers.[39]

We may consider things we've learnt from other participants in the NDIS with similar support needs to you.[40] We know you're the expert in your own life, and we use your own experience as much as we can.

For example, we'll talk to you about any supports that have helped you do things you can't otherwise do. Or some supports may have helped maintain your ability to be as independent as possible.

If it's a new support such as new assistive technology, we might fund a trial. This is so we can learn from your experience of using the support to check if it's likely to do what you need it to.

Your evidence can be particularly useful when it's consistent with other evidence, or if we don't have expert evidence.

We'll look at the opinions held by the majority of experts and what they generally agree on.[41] Sometimes we'll have to seek expert opinion or report to make a decision.[42]

Example

Vivek is 12 and has a goal to improve his communication skills. He and his family want him to improve his social skills with the kids in his class.

When he was younger, Vivek's family tried speech therapy, and believe it really helped him improve his communication. His family told his planner about how it helped Vivek learn how to respond to different social settings.

Vivek's speech therapist also believes it could work well for him now and help him interact with his classmates.

When deciding if the therapy is effective and beneficial, Vivek's planner will consider:

- how speech therapy has helped Vivek in the past, including first-hand information from Vivek, his family members, and carers
- the reports or assessments from his speech therapist on the effectiveness and benefits of speech therapy for Vivek
- other information or expert evidence about the effectiveness and benefits of speech therapy, including for children of the same age, with the same disability and functional capacity.

Based on this information and evidence, Vivek's planner decides the speech therapy is effective and beneficial. If it meets the other funding criteria, we will be able to fund speech therapy in Vivek's plan.

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Is the support something we would reasonably expect your informal supports, like family or friends, to provide?

We need to be satisfied that funding the support takes into account what is reasonable to expect families, carers, informal networks and the community to provide.[43]

To make sure we understand how disability supports might work for you, we consider:

- the things you're able to do for yourself
- any support you have from others in your network – including family members, relatives, friends and local community services.

When we fund supports under the NDIS, we need to consider if it's reasonable to expect your informal supports to provide that support. We can't fund supports that an ordinary person would think is reasonable to expect friends, family or the community to provide for you.[44]

Informal supports are the help and support you get from friends, family and the community. They are called 'informal' because you don't pay for them, and they're not part of a formal agreement. They're the usual things friends and family do for us, and with us.

Most of us get some kind of help and support from friends and family. In our society, we expect that friends, family and our community will support each other and help each other out when they need it.

A good example is families who have young children. In our community, we expect families will provide most of the support a young child needs.[45] They will care for the child, make sure they're safe and drive them around places.

Grandparents, uncles and aunties often have a role to play in supporting young children as well. Neighbours and friends might also help care for the child.

As a child gets older, our society's expectations of the role of the family and community in caring for the child changes. For example, we expect schools to provide a child's learning needs.

We also usually expect the role of family in providing personal care for a child would reduce as they get older and develop new skills and independence. But families are usually still responsible for things like food, emotional support, decision-making and providing a safe home.

It's a similar idea for adults. Our society expects that adults – like family, friends and neighbours – will provide some support to each other. This might be things like taking a friend with you to the football game or providing emotional support if someone is upset.

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NDIS supports won't ever replace the support people like your friends and family provide to you. This support is given freely because people care and is often quite different to supports bought with NDIS funding.

You have a special bond with your friends and family that's different from your relationship with paid carers. And there are potential risks and problems for you if your friends and families become your paid carers.

We also must consider the benefits you may get from your informal supports. For example, your family and friends may be better at helping you meet other people, or helping to build your social skills, than paid supports.

We consider if we can help these relationships so that you get the support you need.[46] For example, we may be able to fund training for your informal supports, so they can help you build your skills.

We also think about the capacity of your informal supports to continue caring for you, for example if they're ageing or sick.

There are different things the law for the NDIS says we need to consider for adults and children.

If you're under 18, we consider what support is reasonable to expect parents to provide at your age. It's normal for parents to provide substantial care and support for children.[47] We consider that it's usual for parents to provide almost all the care and support that young children need.

For example, it's reasonable to expect parents or other family members to provide transport to and from their child's after-school activities. Of course, the amount of care and support for a child without a disability would typically reduce as they get older.

For children under 18, we consider:

- if your needs are substantially greater because of your disability, compared to other children the same age.[48] This means you need much more disability support
- any risks to the wellbeing of people providing informal support to you[49]
- if including funding for the support will help build your skills and capacity in the future or reduce any risks to you.[50]

For example, we consider any health, safety or other impacts resulting from what's involved in meeting your disability support needs.

If you're over 18, we consider:

- if there are any risks to you or your informal supports if you rely on them to provide the support you need[51]

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- how much your informal supports would help improve or reduce your independence and other outcomes.[52]

We also consider the suitability of informal supports to provide the supports you need,[53] including:

- how old your carers are and their capacity to provide the support[54]
- if other family members and the community can help your informal supports in their caring role[55]
- the intensity and type of support you need, and if it's appropriate for your informal supports to provide this, based on their age and gender[56]
- any long-term risks to the wellbeing of your informal supports.[57]

When we consider the risks for people over 18, we consider if the supports are sustainable for your informal supports. We consider the health, safety and other impacts on family and carers in the long term.

For example, we wouldn't expect a child to have their schooling affected because they need to provide care. We also wouldn't expect an elderly parent to be responsible for physical activities, if it may result in injury.[58]

We generally don't fund family members to provide supports funded under the NDIS. There are very limited situations where we can consider this.

Learn more about Sustaining informal supports.

Example 1

Simon is getting his first plan. For the last 15 years, Simon and his wife Jan's preference was that Jan provide all the physical support he needs at home, such as toileting, showering and dressing.

But as Jan is getting older, it's not safe for her to do this. It's becoming risky for both Jan and Simon to keep providing this support informally.

Jan and Simon think it might be best for someone else to provide the personal care support that Simon needs. Their children have moved out of home, and it's not reasonable to expect them to help Simon with personal care.

Based on this information and other evidence, Simon's planner decides that the personal care support meets this criteria. It takes into account what is reasonable for his family and others to provide. If the personal care support meets the other funding criteria, we may fund the personal care support for Simon.

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Simon and Jan still prefer Jan to do the other support Simon needs though, such as helping Simon eat his meals. At this time, we wouldn't fund a support worker in Simon's plan to help him eat his meals. It's reasonable to expect Jan to help Simon with this, because it's what they want to do and it's not a safety risk for Jan or Simon.

Example 2

Qing is 14 and wants to join a local chess club. Like most 14-year-olds in this situation, she needs someone to drop her off and pick her up from the mid-week and weekend gatherings.

But unlike most 14-year-olds, she needs someone to help her get dressed before she can go to the chess club. Her parents have been doing this, but as Qing is getting older, she no longer wants her family to help her get dressed.

It's reasonable to expect her family or other informal supports to drop Qing to and from the match and training sessions. So, we wouldn't fund transport in Qing's plan.

But at age 14, it's not reasonable to expect her family to help her get dressed.

Based on this information and other evidence, Qing's planner finds that the personal care support considers what is reasonable for family and others to provide. If it meets the other funding criteria, we may fund personal care support in her plan.

Is the support an NDIS support for you?

A support will only be an NDIS support for you if either:

- the Rules say that the support is a NDIS support for everyone, or
- the Rules say that the support is only for a specific group of people, and you are part of that group.[59]

NDIS supports are the services, items, and equipment that can be funded under the NDIS.

Remember, we can only fund a support if it is:

- an NDIS support for you
- necessary for your disability.[60]

Go to NDIS supports to find more information on what is and isn't an NDIS support.

Example

Max has a spinal cord injury and uses a manual wheelchair to move around. His home has a carport at the front. The path from the carport to the front door is too narrow for his wheelchair and the uneven ground makes it unsafe for him to use his wheelchair on his own.

In Max's planning meeting, he requests the installation of a pathway from the carport to the front door to enable safe access to his home.

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Max's planner checks that the home modifications are an NDIS support.

Because Max needs a pathway to access his house safely, the planner decides that the home modifications are an NDIS support.

What types of supports can't be funded or provided under the NDIS?

Under the law for the NDIS, there are things we can't fund or provide.[61] We can't fund goods and services that are not NDIS supports.[62] For example, we can't fund or provide supports that:

- consist of sexual services and sex work, alcohol, or drugs[63]
- are not legal[64]
- are income replacement[65]
- are likely to cause harm to you, or pose a risk to other people[66]
- relate to a 'day-to-day living cost', like groceries, rent or utilities[67]
- duplicate other supports provided by the NDIS under alternative funding[68]
- include tickets to events or the cost of going on a holiday.[69]

For more information on what we can't fund, go to NDIS supports.

What else do you need to know about deciding if supports meet the NDIS funding criteria?

From our experience, we learned there are some common misunderstandings about how we work out what supports meet the NDIS funding criteria.

Why don't we always fund what your health professionals recommend?

Although we take expert opinions into account, we can't and don't always fund everything your health professional might recommend. This is because every support we fund needs to meet all the NDIS funding criteria.

For example, your therapist might recommend a piece of equipment on the basis that it will be 'effective and beneficial' for you. But if there is something cheaper that will achieve the same outcome, we won't be able to fund what the therapist recommended.

This is because it may not be value for money. We may be able to fund the cheaper option instead if it meets all the NDIS funding criteria.

Why don't we fund the same supports as your last plan?

We might fund different supports in your next plan. This is because we will fund supports in your plan based on how we use the NDIS funding criteria at that point in time.

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Your needs and situation will most likely change over time. This means it's likely your NDIS supports and needs for those supports will change over time.

For example, we may have funded supports to help you build your skills in a particular area. Once you have built those skills, you won't need funding for that anymore. So, we probably won't include that funding for those supports in your next plan.

Supports to build your skills may have met the NDIS funding criteria before, but the same supports might not meet the criteria in the future.

Or your disability support needs might increase or decrease over time. This may mean we consider funding more or less supports as a result.

What else do we consider when deciding what to include in your plan?

As far as possible, we have to act according to principles set out in the law for the NDIS.[70] These principles guide us when we make decisions about what we can fund.

These principles don't override or replace the NDIS funding criteria under the law for the NDIS. They can help us apply the funding criteria, by giving us more guidance when we decide what supports to approve in your plan.

The principles include the following:

- You have the same right as other Australians to realise your potential for physical, social, emotional, and intellectual development.[71]
- You should be supported to take part in and contribute to social and economic life.[72]
- You should be supported to make choices about planning and how your supports will be delivered. This includes taking reasonable risks, so you can pursue your goals.[73]
- You have the same right as other Australians to decide your own best interests. You have the right to be an equal partner in decisions that affect your life.[74]
- Your privacy and dignity should be respected.[75]
- We must make sure the NDIS is financially sustainable.[76]

The principles also tell us that the reasonable and necessary supports we fund should:[77]

- support you to pursue your goals and maximise your independence
- support you to live independently and to be included in the community as a fully participating citizen
- develop and support your capacity to do things that help you participate in the community and employment.

Just because a support helps you do these things doesn't mean we'll fund it in your plan. All supports we fund need to meet all the NDIS funding criteria.

We consider these principles set out in the law for the NDIS, along with the principles we follow to create your plan.

How do we think about an ordinary life when deciding what supports to include in your plan?

To help guide us in our decision-making about reasonable and necessary supports, we took advice from the NDIS Independent Advisory Council (The Council).

The Council represents people with disability and carers, bringing their own lived experience and expertise of disability. They give us advice on how the NDIS should work.

The Council advised us that all Australians, including people with disability, should have an 'ordinary life'. They also told us we should think about the idea of an ordinary life when we apply our principles and use the NDIS funding criteria.

An ordinary life is a life where you have the same opportunities as people without a disability. An ordinary life is one that is typical or usual for everyone in modern day Australia. It's a life where you can pursue your potential and participate in society on an equal basis with others.

An ordinary life will be different for different people. We are all different and come from different cultures and backgrounds. We each have our own values, experiences, beliefs, and goals.

But there are some common things that can improve the quality of our lives and help us participate equally. These are the things, such as the following, that make up an ordinary life:

- Positive relationships with families and informal support networks.
- Individual autonomy. This means being free and independent, and having the same opportunities as people without disability.
- Active involvement in decision-making including the ability to make meaningful decisions, and exercise choice and control.
- Using your strengths in ways that provide a challenge and enjoyment.
- A sense of belonging to our families, friendship networks, communities, workplaces and society.
- Active involvement and contribution to society and your community.

An 'ordinary life' in the context of the NDIS involves supporting you to:

- have and maintain good relationships
- belong and participate in your community

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- be involved in making choices about your own life.

One way we can help you have an ordinary life is to support you to access mainstream, community, or informal supports wherever possible. These are the usual supports that everyone in the community uses.

When we fund reasonable and necessary supports under the NDIS, we need to make sure they meet the NDIS funding criteria.

When we apply the NDIS funding criteria and make decisions about reasonable and necessary supports, we're guided by the principles in the law for the NDIS. We also consider how the supports will best help you to live an ordinary life.

What other services or systems are responsible for providing supports?

We have to be satisfied that the support is considered an NDIS support which means the support is something that can be funded or provided through the NDIS. Some supports are not considered an NDIS support because they're more appropriately funded or provided through:

- other service systems or supports offered by a person, agency or body (like a State or Territory Statutory Scheme)
- services or supports offered as part of a universal service obligation (like the health or education system)
- services or supports offered in line with reasonable adjustments required under discrimination laws (like your employer, or the health or education system).[78]

We won't fund the support if the support should be provided by someone else, even if the other service system doesn't actually provide it. We don't make up for other organisations and systems that don't provide the supports they should.

The list of goods and services that are not NDIS supports includes supports that are considered the responsibility of service systems such as:

- Health
- Mental health
- Child protection and family support
- Early childhood development
- School education
- Higher education and vocational education and training
- Employment

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- Housing and community infrastructure
- Transport
- Justice.

For more information, go to Mainstream and community supports.

How does the NDIS work with other government services?

We call supports provided by other government services, including those provided as part of a universal service obligation, 'mainstream supports'. When we talk about mainstream supports, we mean supports available to everyone in your state or territory, or across Australia, regardless of if you have a disability.

This includes services provided by state and federal governments, related to health care, education and mental health services.

You have the same right as all Australians to access these services. There are certain things that mainstream services have to do to make their services accessible for people with disability. Using mainstream supports can also help you be part of your community, or to work or study.

When we fund NDIS supports, we won't fund supports that are not considered NDIS supports because the support is more appropriately funded or provided by a mainstream service or system, such as the education system or health system.[79] Under the law for the NDIS, we can't fund supports that should be provided by a mainstream service.

The Australian federal, state and territory governments agreed on responsibilities for funding different types of supports. The law for the NDIS has an outline of funding responsibilities and were developed with the agreement of each State and Territory.[80]

Learn more about who is responsible for the supports you need.

What is reasonable adjustment and why is it important?

People with a disability can sometimes face barriers that make it harder to do the same things as people who don't have a disability. For example, it might be harder to find and keep a job. Or it might be harder to get in and around places, or to get the same services as other people.

It's against the law to discriminate against people with a disability in many areas.[81] This includes in employment, when providing goods and services, and when accessing public places.

This means organisations or people who are responsible for providing these services have to make what are called 'reasonable adjustments'. They have to make sure people with a disability have equal access to the services they provide, as far as is reasonable.

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They have to do reasonable things that will make their services equally available to everyone, whether or not you have a disability.

Reasonable adjustments do not mean they have to provide everything you need because of your disability. It means they have to do what's reasonable to make sure you have equal access to employment, public spaces or services. This takes into account what they can afford to do and what is reasonable to expect them to provide in the circumstances.

When we decide what supports to include in your plan, we need to consider what should be provided through reasonable adjustments. Under the law for the NDIS, we can't fund a support if it should be provided by someone else through reasonable adjustments.

What about in-kind supports?

We agreed that state and territory governments will keep providing some supports for a period of time. We call these 'in-kind supports'.

If we fund in-kind supports like specialist school transport or personal care in schools, you will need to use state or territory government providers for these supports. These supports are most efficiently and effectively provided by state and territory government providers.[82] Learn more about Work and study supports.

For most other in-kind supports, you can choose your provider if you don't want to use your in-kind provider anymore. We can let you choose another provider if we consider that the support isn't most effectively and efficiently provided by the in-kind provider.

We usually let you choose another provider if:

- another provider can give you the same support or level of support as the in-kind provider
- the supports with the new provider still meet the NDIS funding criteria, including that they're value for money compared to the in-kind support
- there are no serious risks with changing providers.

Learn more about in-kind supports.

How do we include the reasonable and necessary supports in your plan?

Once we've identified the supports, and decided they meet the NDIS funding criteria, we can include the description and funding for the NDIS support in your plan.

If the support doesn't meet the NDIS funding criteria, we can't include the support in your plan. We may consider if a differently described support meets the NDIS funding criteria instead.

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When we approve your plan, we'll also make sure all your supports are reasonable and necessary when considered as a package of supports.[83]

Sometimes you might not need any supports under the NDIS. For example, your informal supports may meet all your disability support needs. If so, we'll approve a plan with no funded supports.

Learn more about how we create and approve your plan.

Learn more about using the funding in your plan.

Learn more about changing your plan.

What happens if we don't include the supports you want?

If we decide a support doesn't meet the NDIS funding criteria, we can't include the support in your plan. Also, if the amount of support you want doesn't meet the criteria, we can't include that amount in your plan.

But, we're committed to our principles and helping you live an ordinary life. Even if we can't fund a particular support, we may still be able to help.

If the support doesn't meet the NDIS funding criteria, we can consider if a different support meets the NDIS funding criteria. We might be able to consider describing the support differently or funding a different type of support.

Or we may be able to connect you to mainstream or community supports that can help. Mainstream and community supports are available to everyone. They can be a good way to connect with your local community, learn new skills and gain independence.

There are lots of ways we might be able to help, so talk to us if you're in this situation. We can do this at any time. We may be able to help before we approve your plan.

We'll give you the reasons for our decision to approve your plan in writing.[84] You can contact us if you'd like more detail about the reasons for our decision.

What happens if I want to replace a support for something else?

We fund NDIS supports in your plan. NDIS laws set out what we can and can't fund.[85]

Sometimes, we may agree that you can spend your funding on supports that are not NDIS supports. We call this a 'replacement support'. Go to Your plan for more information. For more information about replacement supports, go to NDIS supports.

What if you don't agree with our decision?

If we decide the supports you requested don't meet our NDIS funding criteria, we can't include them in your plan.

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If you'd like more details about the supports that make up your plan's total funding amount, we can send this to you. You can contact us and ask for a Budget Breakdown.

We'll give you written reasons why we made the decision. You can contact us if you'd like more detail about the reasons for our decision.

If you don't agree with a decision we make about what supports to include in your plan, you can ask for an internal review of our decision.[86]

You'll need to ask for an internal review within 3 months of getting your plan.[87]

Learn more about reviewing our decisions.

Reference List

[1] NDIS Act s 34(1)(aa).
[2] NDIS Act and delegated legislation made under the NDIS Act, especially NDIS (Supports for Participants) Rules and NDIS (Plan Management) Rules.
[3] NDIS Act s 34 (1)(aa); NDIS (Supports for Participants) Rules r 5.1(b).
[4] NDIS Act ss 33(2)(a), 33(2)(b), 33(5)(c), 34.
[5] NDIS Act ss 13, 33(2)(a).
[6] NDIS Act s 34 (1).
[7] NDIS Act s 10.
[8] NDIS Act and delegated legislation made under the NDIS Act, especially NDIS (Supports for Participants) Rules and NDIS (Plan Management) Rules.
[9] NDIS (Supports for Participants) Rules r 2.4; NDIS Act s 33(5)(c).
[10] NDIS Act s 34(1)(f).
[11] NDIS Act ss 33(5)(d), 35(1)(b); NDIS (Supports for Participants) Rules pt 5.
[12] NDIS Act ss 33(5)(c), 34(1).
[13] NDIS Act s 34(1)(aa); NDIS (Supports for Participants) Rules r 5.1(b).
[14] NDIS Act s 34(1)(a).
[15] NDIS Act s 34(1)(b).
[16] NDIS Act s 34(1)(c).
[17] NDIS Act s 34(1)(d).
[18] NDIS (Supports for Participants) Rules r 3.2(a).
[19] NDIS Act s 34(1)(e).
[20] NDIS Act s 34(1)(f).
[21] NDIS (Supports for Participants) Rules pts 3, 4.
[22] NDIS (Supports for Participants) Rules r 5.1(b), NDIS Act s 34(1)(aa).
[23] NDIS Act s 34(1)(a).
[24] *McGarrigle v National Disability Insurance Agency* (2017) 252 FCR 121 at [91].
[25] NDIS Act s 34(1)(a).
[26] NDIS (Supports for Participants) Rules r 5.1(d).
[27] NDIS Act s 34(1)(b).
[28] NDIS Act ss 3(3)(b), 4(17).
[29] NDIS (Supports for Participants) Rules r 3.1(a).
[30] NDIS (Supports for Participants) Rules r 3.1(b).
[31] NDIS (Supports for Participants) Rules r 3.1(c).
[32] NDIS (Supports for Participants) Rules r 3.1(e).
[33] NDIS (Supports for Participants) Rules r 3.1(c).
[34] NDIS (Supports for Participants) Rules r 3.1(d).
[35] McCutcheon and NDIA [2015] AATA 624 at [34].

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[36] McCutcheon and NDIA [2015] AATA 624 at [34].
[37] McCutcheon and NDIA [2015] AATA 624.
[38] NDIS (Supports for Participants) Rules r 3.2(a).
[39] NDIS (Supports for Participants) Rules r 3.2(b).
[40] NDIS (Supports for Participants) Rules r 3.2(c).
[41] NDIS (Supports for Participants) Rules r 3.3.
[42] NDIS (Supports for Participants) Rules r 3.3.
[43] NDIS Act s 34(1)(e).
[44] NDIS Act s 34(1)(e).
[45] NDIS (Supports for Participants) Rules r 3.4(a)(i).
[46] NDIS (Supports for Participants) Rules r 3.4(c).
[47] NDIS (Supports for Participants) Rules r 3.4(a)(i).
[48] NDIS (Supports for Participants) Rules r 3.4(a)(ii); JQJT and National Disability Insurance Agency [2016] AATA 478 at [39].
[49] NDIS (Supports for Participants) Rules r 3.4(a)(iii).
[50] NDIS (Supports for Participants) Rules r 3.4(a)(iv).
[51] NDIS (Supports for Participants) Rules rr 3.4(b)(i), (ii).
[52] NDIS (Supports for Participants) Rules r 3.4(b)(iii).
[53] NDIS (Supports for Participants) Rules r 3.4(b)(ii).
[54] NDIS (Supports for Participants) Rules r 3.4(b)(ii).
[55] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(A).
[56] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(B).
[57] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(C).
[58] NDIS (Supports for Participants) Rules r 3.4(b)(ii)(C).
[59] NDIS Act s 34(1)(f).
[60] NDIS (Supports for Participants) Rules r 5.1(b), NDIS Act s 34(1)(aa).
[61] NDIS (Supports for Participants) Rules r 5.
[62] NDIS Act s 10.
[63] NDIS Act s 10.
[64] NDIS Act s 10.
[65] NDIS Act s 10.
[66] NDIS Act s 10.
[67] NDIS Act s 10.
[68] NDIS Act ss 33(5)(d), 35(1)(a); NDIS (Supports for Participants) Rules r 5.1(c).
[69] NDIS Act s 10.
[70] NDIS Act ss 4, 31.
[71] NDIS Act s 4(1).
[72] NDIS Act s 4(2).
[73] NDIS Act s 4(4).
[74] NDIS Act s 4(8).
[75] NDIS Act s 4(10).
[76] NDIS Act s 4(17).
[77] NDIS Act s 4(11).
[78] NDIS Act s 34(1)(f).
[79] S10(b1) -(3).
[80] NDIS (Supports for Participants) Rules rr 3.5-3.7, Schedule 1; NDIS Act ss 209(4), (8) item 1.
[81] Disability Discrimination Act 1992 (Cth); Discrimination Act 1991 (ACT); Anti-Discrimination Act 1977 (NSW); Anti-Discrimination Act 1996 (NT); Anti-Discrimination Act 1991 (Qld); Equal Opportunity Act 1984 (SA); Anti-Discrimination Act 1998 (Tas); Equal Opportunity Act 2010 (Vic); Equal Opportunity Act 1984 (WA).
[82] NDIS (Plan Management) Rules r 6.6.
[83] NDIS Act s 33(5)(c).
[84] NDIS Act s100(1).
[85] NDIS Act s 10.
[86] NDIS Act s 100.
[87] NDIS Act s 100(2).

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Therapy supports

Quick summary: Therapy supports are evidence-based supports to help you build or maintain your skills and independence. These supports are delivered by allied health professionals to help you manage everyday activities at school or work, in your home and community. They can help you to build skills to increase your independence and take part in social and community activities. They can also help you pursue work or study goals, if you want to.

This guideline is for participants to learn more about different types of therapy supports and how they might work for you. We talk about how you can get therapy supports in your NDIS plan for the first time and when you change your plan.

Note:

When we say:

- 'your plan', we mean your NDIS plan
- ‘therapist’ we mean an allied health professional who delivers your NDIS therapy supports
- ‘therapy assistant’, we mean an allied health assistant with the skills to help their supervising therapist deliver parts of your therapy support program. To learn more, go to Who can deliver therapy supports?
- multidisciplinary team, we mean a team of people with different skills, working together to help you build your skills and independence and work towards your NDIS goals.

If you’re aged between 9 and 65 years and are looking for information about community connections, go to Our Guideline – Community connections.

If your child is younger than 9 and you’re looking for information about our early childhood approach, go to Our Guideline – Early childhood approach.

What’s in this guideline?

This guideline covers:

- What do we mean by therapy supports?
- Who can deliver therapy supports?

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- What therapy supports can we fund?
- What therapy supports can't we fund?
- How can you get therapy supports in your plan?
- What happens when you get therapy supports in your plan?
- What if you don't agree with our decision?

You might also be interested in:

- Mainstream and community supports
- Disability-related health supports
- Behaviour support

What do we mean by therapy supports?

Therapy supports can be either for capacity building to help you build new skills, or for maintenance, when therapy supports can help to slow the loss of existing skills. They're also known as therapeutic supports. They're evidence-based supports delivered by a therapist to help you build or maintain your skills and independence, in areas such as:

- language and communication, like conversation and social skills
- personal care, like getting washed and dressed
- mobility and movement, like walking and moving around your home
- interpersonal interactions, like social and relationship skills at school or work
- functioning (including psychosocial functioning), like problem-solving and decision-making
- community living, like using public transport.

What is 'evidence-based' therapy support?

For a therapy support to be evidence-based, we need to make sure it uses current best-practice evidence or is from the highest quality research. Current best-practice evidence helps us to understand how well the therapy works for you.

When we decide which therapy supports are evidence-based, we think about:

- the most up-to-date and reliable research studies

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- the data we've collected from you about how you've used them to pursue your goals and meet your desired outcomes
- expert best-practice advice from therapists
- information we've received from the disability community and peak bodies
- if it's value for money compared to the supports available from other mainstream systems, like health or education
- feedback about other schemes in Australia and overseas.

We need to be sure there's enough evidence this type of therapy is effective and beneficial to improve or maintain your skills and independence. This could be for someone with similar disability support needs to you, or for all NDIS participants. All therapy supports must be safe and use current best practice.

If we decide a therapy support is evidence-based, you'll still need to provide evidence from your allied health professional to show that these therapy supports are right for you. Learn more in What information do we need if you don't have therapy supports in your plan?

What are capacity building therapy supports?

Capacity building therapy supports aim to build your skills and independence. They can help you do everyday activities in your home, community, at school or work. They have specific goals and outcomes, with a timeframe to achieve them. You may need them for a short time or a longer time, depending on your individual situation.

You may need capacity building therapy supports at different times or stages in your life, such as:

- at a developmental stage, like childhood to adolescence
- at specific life stage transitions. For example, leaving school, moving out of your family home or getting a job
- after a recent diagnosis once health-based rehabilitation is finished, for example motor neurone disease
- when you've had a change in your situation, such as a decline in your functional capacity or skills
- where you want to learn a new life skill, for example when learning to catch a bus.

As your capacity and independence grow, it's likely you'll need less capacity building therapy supports over time. Your therapy supports may also reduce your need for core supports like assistance with daily life or social, economic and community participation If your condition is

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progressive, you might change over to using maintenance therapy supports once your capacity has improved. For some people, a mix of capacity building therapy supports and maintenance therapy supports might be suitable. If you need capacity building therapy supports, your therapist will assess your disability support needs and work with you to create a therapy plan or program. This includes strategies and supports to help you build your skills. They may also recommend things for you to practice at home with your informal supports like family and friends.

In your therapy plan, the therapist will need to show how their approach and your goals will be measured. Before your plan reassessment, we may ask you to provide us with evidence from your therapist. This is to show us the progress you are making towards your goals and any measurable outcomes. Your therapists will need to provide evidence on progress towards your goals and let us know how the therapy supports are working for you.

Learn more about capacity building support budgets in your plan.

Example

Shae is 21 and lives at home with her family. Shae lives with Down Syndrome and needs support with some everyday tasks because of her disability. She wants to develop her personal care skills so she can get ready on her own before work.

Shae uses her NDIS supports to work with an occupational therapist (OT). Together they develop a therapy plan to help build her independence to get ready for work. Her OT explains the therapy plan to her family and support workers too as they'll help her follow it.

Shae's therapy plan says that she'll meet regularly with her OT for the next 6 months. In these sessions the OT will help Shae learn new skills, measure progress and support her to overcome any challenges. The OT will work with Shae to make sure the supports and strategies in her therapy plan are effective in helping her build her independence. If needed they'll change them.

Before her plan reassessment date, Shae will check in with her OT to work out if she needs ongoing therapy supports in her plan. If she does, we'll ask for a progress report from the OT to decide if Shae needs ongoing funding for this type of therapy support.

What are maintenance therapy supports?

You may need this type of therapy support to help you maintain your current functional capacity. When we say functional capacity, we mean the things you can and can't do because of your disability. Maintenance therapy supports can also help prevent or delay your functional capacity from getting worse. They may help you achieve modest improvements over time, adapt the skills you already have to different environments or maintain your

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current level of functional capacity. For example, stretching programs to stop someone with muscle spasticity from losing a range of movement.

When you have a recent diagnosis or change in your skills or function, you may need time-limited, capacity building therapy supports before moving to therapy supports for maintenance.

You may need ongoing maintenance therapy if your function is likely to change or get worse over time without intervention. For example, if you have cerebral palsy you might need ongoing therapy support to maintain a level of independence to do daily tasks for and with muscle strength, balance and movement activities to prevent your physical function from getting worse.

Example

Hassan has several chronic conditions, including Parkinson's disease, steady weight loss and diabetes. He frequently sees a speech therapist to help him communicate more effectively with his family, friends and support workers. This therapy also helps deal with Hassan's difficulty with swallowing.

Together, Hassan and his speech therapist set some therapy goals. This will help him improve his food and nutritional intake and communicate more effectively. These goals also recognise Hassan's expected decline in function. For example, Hassan's informal supports can help by reducing background noise and speaking more slowly, to help his verbal communication. He could also start using an augmented or alternative communication (AAC) system to improve communication for when his verbal communication skills decline more in the future.

This maintenance program can be followed by his family, friends or support worker. As his condition progresses, the program may need to be re-evaluated. The maintenance therapy supports help with Hassan's changing needs. They also give him the support he needs to keep participating in the things that are important to him.

What are therapy supports for children and young people?

This guideline outlines how we make decisions about therapy supports for children who are aged 9 years and older. To learn more about how we support children younger than 9 and their families, visit Our Guideline – Early childhood approach.

What if your child has been getting early childhood supports and is turning 9?

If your child has been getting early childhood supports as part of their plan before they turn 9, they may transition to other types of capacity building supports, including therapy supports when their plan is reassessed.

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Early childhood supports should draw on best-practice principles that follow the National Best Practice Framework for Early Childhood Intervention. This includes early childhood intervention for professionals working together as a team to deliver early childhood supports to your child and family.

When your child turns 9, the way the NDIS funds therapy is different. It may mean your child's plan includes individual therapy supports rather than a multidisciplinary team approach. To find NDIS registered providers, you can search the Provider Finder, or when you are on the my NDIS portals or app. You can also talk to your my NDIS contact or support coordinator.

As your child's independence and functional capacity grows, their therapy support needs may reduce or change. We'll check in with you regularly about any changes to your child's disability-related support needs as they grow and develop. We'll fund therapy supports as well as other support types to meet your child's disability support needs.

Supports for families and carers to help you with everyday activities

Good therapy is delivered in collaboration with the participant and their support network, leading to the most valuable outcomes.

Some family members, carers, support workers and community organisations may need training so they can help you do your everyday activities. We can fund your therapist to help you implement these strategies. This might involve training your informal supports so they can also help you build your independence or help with your maintenance supports. For example, we may fund an occupational therapist to train your family members how to safely use your support equipment, such as a chair lift.

Who can deliver therapy supports?

NDIS therapy supports can only be delivered by qualified allied health professionals. We sometimes refer to them as therapists. They may also deliver other NDIS supports to you such as disability-related health supports.

To learn more about the allied health professionals who can deliver NDIS therapy supports, go to NDIS Pricing Arrangements and Price Limits.

Allied health professionals are also expected to:

- comply with the NDIS Code of Conduct
- comply with the NDIS Practice Standards if they're NDIS registered providers

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- take part in ongoing professional development to provide the best and most current evidence-based therapy supports
- deliver specialised therapy supports to help with your individual disability-related needs
- help you work towards your specific therapy goals and pursue your NDIS goals
- behave ethically, in line with their duty of care and in your best interests
- deliver therapy supports and invoice in line with the NDIS Pricing Arrangements and Price Limits.

Depending on your needs and goals, you might get therapy supports from more than one allied health professional when you're working towards different goals. For example, you might be starting a job. You may need an occupational therapist to help you improve your skills to travel to new places and manage the changes in your life. You may also need a speech pathologist to help build your social and communication skills so you can communicate confidently with others. It may be important for your therapists to work together so they can coordinate the therapy supports they deliver to get the best outcomes for you. Talk to your allied health professionals if you want more coordination of your therapies.

Therapists are qualified allied health professionals, who are registered with the Australian Health Practitioner Regulation Agency (AHPRA) for regulated professions or accredited by a relevant peak body for self-regulated professions. Ask your provider about their qualifications and professional registration to make sure they're able to provide the right supports for you.

Allied health professionals and providers who are not qualified or registered with the relevant professional body can't be funded as therapy.

What is the role of therapy assistants?

Some therapy supports can be delivered by a therapy assistant. Therapy assistants are sometimes called allied health assistants. They have the skills to perform specific tasks or deliver therapy support programs under the supervision or delegation of an allied health professional. They usually hold relevant TAFE qualifications and can be members of the Allied Health Assistants' National Association Ltd (AHANA).

There are 2 levels of therapy assistant:

- level 1 must always work under the direct supervision of the allied health professional
- level 2 can work under the delegation, without direct supervision of the allied health professional. The use of an assistant can be a cost-effective way to deliver therapy outcomes which means your therapy funding will last longer.

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The main benefit of using a therapy assistant is they can practise these skills with you in natural environments like your home, community or school.

You can use your therapy budget flexibly for a mix of allied health therapy supports. This may include a therapy assistant if your allied health professional agrees this is suitable for you. For example, they can help you with activities to practise daily living skills like personal care and speech programs. Usually when we fund a therapy assistant, we expect that sessions with them will replace some of the sessions normally provided by the supervising allied health professional.

Provisional psychologists or allied health students on placement or internship may deliver specific tasks and supports to you under supervision, with your consent. You need to make sure they are covered by the supervising allied health professional's insurance. As this is an unpaid learning role for they won't be able to claim from your plan for delivering support to you. Instead, the cost of supervision and support delivered by the supervising therapist can be claimed from your plan, with your agreement.

To learn more about claiming for therapy supports, go to the NDIS Pricing Arrangements and Price Limits.

What therapy supports can we fund?

NDIS laws determine what we can and can't fund. We can only fund therapy supports that meet all the NDIS funding criteria. This includes that it's an NDIS support we can fund. To learn more, go to What is an NDIS support?

Here you'll find general descriptions and examples to help you understand the type of therapy supports we can fund and who can deliver them. When we describe the different therapies, we've included any professional bodies the therapist must be part of and what the therapy might help you achieve.

We may also be able to fund other types of therapists if they meet the requirements in NDIS Pricing Arrangements and Price Limits.

Art therapy

Art therapy can support you to explore and regulate your feelings and emotions, improve self-awareness and develop your communication skills. The focus of art therapy as an individual therapy support is the creative process of making art, not the final product. It can be delivered in different ways, like through painting, drawing, sculpting, dance and movement. Art therapy is not the same as art lessons. Art supplies used to deliver art therapy should be included in the cost of the therapy session.

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To provide therapy supports funded by the NDIS, an art therapist must be a professional member of the Australian New Zealand and Asian Creative Arts Therapies Association (ANZACATA). ANZACATA requires art therapists to have a master's degree in art therapy.

Example

Tahnee is 18 years old. She is a participant from the lands of the Gimuy Walubara Yidinji peoples of Far North Queensland. She has cerebral palsy and is autistic. Tahnee has good evidence that working with an art therapist every fortnight for 6 months will help improve her functional capacity.

Tahnee's mother found a registered therapist who uses art and storytelling as part of her practice. The therapist will deliver art therapy as a culturally appropriate, family-centred approach. This means Tahnee can go to therapy sessions with her mother or grandmother if she wants to. We fund art therapy for Tahnee because there is evidence this type of therapy can help improve her overall functional abilities. Importantly, this support will help Tahnee work towards her goal of being more independent.

Audiology

Audiologists are experts in hearing loss at any age. They can help you to maximise hearing function or improve balance and provide counselling, aural rehabilitation and communication training. This can involve the use of hearing aids and other assistive technology to improve your ability to communicate.

Audiology therapies include treatments for hearing and balance disorders like hearing tests, tinnitus management and vestibular rehabilitation. Audiologists must either be currently certified as an Audiology Australia Accredited Audiologist by Audiology Australia (AudA) or as a full member of the Australian College of Audiology (ACAud).

Counselling

Counsellors can help by providing a safe space to explore your emotions, develop resilience, learn skills to communicate positively and set clear goals. They can help you to identify personal and societal barriers related to disability and learn ways to manage or overcome them. For example, they can support you to develop a personal plan to learn coping and well-being strategies to adapt to a new disability diagnosis and build your resilience. Any equipment or supplies used to deliver counselling should be included in the cost of the therapy session, such as sand trays or fidget tools.

A counsellor must be a member of the Australian Counselling Association, or registered with the Psychotherapy and Counselling Federation of Australia or a provisionally registered

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psychologist working towards full registration with Australian Health Practitioner Regulation Agency (AHPRA).

Example

Paul is autistic and has asked for therapy supports to help him build his skills to have conversations with his friends. Paul feels nervous about talking with a counsellor, especially about his friendships and the skills he wants to improve. He wants to work with a counsellor who includes a therapy dog in their sessions as he thinks this will make it easier for him to feel relaxed. He finds a counsellor who uses a therapy dog. This helps Paul to relax, regulate his emotions and talk to the counsellor without feeling anxious during therapy.

We can fund animal-assisted counselling therapy for Paul because it meets the NDIS funding criteria. It will help Paul increase his skills in areas related to his disability. For Paul, who has some difficulty with social communication, funding a counsellor will help him improve his skills to make and keep friends. The counsellor can include a therapy dog to help them work with Paul if they don't charge him any additional fees for using the dog.

Developmental education

Developmental education is a therapy support to help you build skills, independence and quality of life, often in childhood or adolescence. Developmental educators have expertise in developmental or acquired disabilities. They can also implement strategies from other therapists with children under the age of 18. For example, they may support you to navigate life stage transitions such as leaving school. They can work with you to develop social and emotional regulation strategies. A developmental educator must hold a bachelor's degree or higher and be a current full member of Developmental Educators Australia Incorporated.

Example

Stephanie is 13 years old and autistic. She lives at home with her mother. Stephanie is starting high school next year and wants to learn how to be more organised and get ready for school. She also wants to learn to build her social skills so she can tell her friends and teachers what she needs and prefers.

Stephanie uses the NDIS supports in her plan to work with a developmental educator. Stephanie, her mother and her developmental educator have put together a therapy plan. The strategies in the plan will help her learn personal care, planning and organisational skills and increase her independence. She also wants to learn self-advocacy skills. Stephanie's developmental educator explains how to carry out the therapy plan and gives a copy to her school as part of her individual learning plan.

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Stephanie's current plan includes regular meetings with her developmental educator for the next 3 months, before she starts at her new school. This is to make sure the supports and strategies are effective in helping her build her independence and pursue her goals. Her developmental educator will also work out what future supports Stephanie may need.

Dietary support

Dietetics and dietary support can help you to learn new ways to manage the dietary and eating needs that relate to your disability. Dietitians provide evidence-based nutrition services, dietary counselling and therapy. For example, they can help you create a personalised mealtime plan or implement eating and swallowing strategies. They can work with you to make sure the food you are eating is safe and healthy for you. They can also review and update mealtime plans and strategies, as needed.

Dietitians must be an Accredited Practising Dietitian with Dietitians Australia.

You can also learn more about disability-related dietary supports in Our Guideline – Nutrition supports including meal preparation.

Exercise physiology

Exercise physiology is a therapy support to help you work out the best clinical exercises, that work for you and implement them, to help you pursue your goals. The use of exercise-based therapies can help you learn more about muscle strength and physical activity related to your disability. Exercise physiologists can also support needs that result from your disability. For example, they can help a person with multiple sclerosis using a walker to maintain muscle strength and independence. This might mean they don't need a support worker to help them as often, and they can move about more independently.

Exercise physiologists must be an Accredited Exercise Physiologist (AEP) with Exercise and Sports Science Australia.

Music therapy

Music therapy can support you to explore and regulate your feelings and emotions, build skills in memory, movement and sequencing. The focus of music therapy as an individual therapy support is the therapeutic impact of music on the brain, mind and body. For example, music therapy can help improve communication, self-expression, coordination and mobility. Music therapy can be delivered in many ways, such as listening to music, songwriting, music making and as an assisted relaxation strategy. It is not the same as music lessons.

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Registered Music Therapists (RMTs) can help people in areas like communication, motor skills, mobility, mood, emotions, cognitive capacity, identity and self-confidence. RMTs have a university degree in music therapy and must be registered with the Australian Music Therapy Association.

Occupational therapy

Occupational therapy can help you build skills and confidence to take part in everyday activities, with more independence. An occupational therapist works with you to create a personalised plan to explore and implement practical solutions at home or in your community, at school or work. For example, this might include learning strategies to manage change and make informed decisions, like planning and organisation. It might also include practical skills you can use to stay safe around your home and community, so you can live more independently. They can also help you learn new skills or find different ways of doing things that are safe and works for you, such as using equipment to cook, dress or shower.

Occupational therapists must have a current Australian Health Practitioner Regulation Agency (AHPRA) registration as an occupational therapist.

Example

Trey is 37 years old. Just over a year ago, Trey was involved in an accident that resulted in a spinal cord injury. He had treatment for his injury, followed by rehabilitation in hospital for 10 months. The hospital occupational therapist did an assessment of Trey's home before he left hospital. During his rehabilitation, he applied for NDIS disability-related supports for when he got home. He lives with his sister and has a goal to work from home.

Trey uses his NDIS funding for an occupational therapist. He develops a transfer and position plan for Trey to reduce the risk of falls and pressure injuries. This includes regular training for his support workers and sister. His occupational therapist also identifies strategies and equipment to help him with showering, dressing and preparing meals.

His occupational therapist will review and update Trey's maintenance plan and adjust it to meet his support needs. As he makes progress towards his goals, he may need less support or his support needs may change.

Orthoptist

Orthoptists help adults and children with vision difficulties. They work with you if you have vision loss, double vision, an eye movement disorder or neurological condition that makes it hard to understand what you see. Orthoptists can help you learn and understand how your vision works and deliver therapy supports to improve your vision, manage symptoms and optimise how you use your vision. They can teach you about what supports you may need,

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for example assistive technology and visual aids, to help you improve your functional vision for everyday activities.

Orthoptists must have current registration with the Australian Orthoptic Board.

Physiotherapy

Physiotherapy as a therapy support can help you build or maintain movement, function and independence. Physiotherapists can assess, treat and manage a wide range of disabilities and impairments that limit brain, muscular, joint, heart and breathing functions. These include cerebral palsy, stroke, Parkinson's Disease, spinal cord injury, pain and stiffness. Physiotherapists also work with you to prevent any loss of mobility and keep you safe from falls or accidents. As part of your therapy plan, they may focus on evidence-based exercise, manual therapy, functional training, carer education or assistive technology, as long as it relates to your disability.

Physiotherapists must have current AHPRA registration as a physiotherapist.

Podiatry

Podiatrists are healthcare professionals who diagnose, treat, and prevent conditions of your feet, ankles, and lower limbs. They can support you to manage musculoskeletal challenges, skin and nail conditions. They might also deliver diabetic foot care, prescribe orthotics or give footwear advice. Podiatrists will develop a therapy plan with you to improve or maintain a level of mobility that works for you and give you strategies to reduce pain. The focus of a podiatrist is to help you build independence and improve your overall quality of life.

Podiatrists must be registered with the Podiatry Board AHPRA.

Psychology

Psychology as a therapy support can help you build your capacity to do things in your everyday life and join in with your community. We can only fund sessions with psychologists whose focus is to build or maintain your capacity to engage in everyday activities or increase your independence.

Psychologists can assess and deliver tailored supports to help you pursue your individual goals. This could be in your personal or social life, at work or school. For example, they might work with you, and your family, to improve your quality of life, develop new skills and adjust to changes in your life, that relate to your disability. They can also help you manage behaviours and emotions in different settings, like the way you engage in relationships.

If you need support from a psychologist for a mental health diagnosis or treatment, this is the responsibility of the health system and not the NDIS.

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Psychologists must have current AHPRA registration as a psychologist.

If you have behaviours of concern, you may require behaviour support instead of, or as well as, therapy supports. To learn more, go to Our Guidelines – Behaviour support.

Rehabilitation and vocational counselling

Rehabilitation and vocational counselling can help people with a disability or chronic illness pursue their work and study goals in areas like education, employment or community living. These specialist counsellors provide assessments, counselling, case management and service coordination. They can assess your functional capacity and help you pursue goals like finding and keeping a job. Rehabilitation counsellors are tertiary-educated therapists who are members of Australian Society of Rehabilitation Counsellors (ASORC).

Social work

The main focus of social work as a therapy support is to maintain and maximise your social functioning and overall quality of life. Social workers use a holistic approach to understand how your individual factors and social environment might impact your therapy. For example, social workers may support you with individual, family and group work and strategies to adjust to disability and associated lifestyle changes. They can provide therapy supports to help you deal with emotional aspects of life transitions and improve wellbeing. Social workers must be a member of the Australian Association of Social Workers (AASW).

Speech pathology or therapy

Speech pathology or therapy is a therapy support that can help with your communication and swallowing disability support needs. A speech therapist can support you to build the skills you need to receive, send, process and understand information that is spoken, non-spoken and signed. They can also support you to implement the use of picture and graphic symbols.

Speech therapists support you if you have difficulties with speaking, listening, hearing, reading or writing. They can help you to understand language and learning. They can also work with you to improve the different ways you communicate using speech, sign language, assistive technology and other alternative and augmentative communication methods. They can help if you have difficulties with eating, drinking or swallowing.

To provide NDIS supports, speech pathologists must be a Certified Practising Speech Pathologist (CPSP) as approved by Speech Pathology Australia.

Learn more about how they can help with swallowing difficulties in Our Guideline - Dysphagia supports.

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What therapy supports can't we fund?

Under the laws for the NDIS, there are things we can't fund or provide. We also can't fund goods and services that are not NDIS supports[1]. To learn more, go to What is not an NDIS support?

We can't fund a therapy support if there isn't enough evidence to show that it has good functional outcomes for people with disability, even if the service provider is an allied health professional.

Supports we can't fund as therapy include:

- **Alternative and complementary therapies** like cuddle therapy, crystal therapy or aromatherapy. This also includes therapies that focus on balancing the body's energy fields.
- **Animal therapy**, such as canine or equine therapy. Recreational, sporting or social activities involving animals could also be called 'animal therapy'. This type of animal therapy isn't an NDIS therapy support because the outcome is for you to have a positive experience with an animal. This is different to an animal being used as a therapy tool to help you achieve your therapy goals. Animal therapy may be funded under social and community participation.
- **Energy and health practices**, such as practices about lifestyle choices, including exercise physiology for general fitness, weight loss and exercise. These are not specifically disability-related practices.
- **Gymnasium or swimming pool memberships**. A physiotherapist or exercise physiologist may want you to do an exercise program at a gym or in a pool. We may fund supports to help you at the gym or pool, for example a support worker to help you access and use the facilities. We won't fund the cost to access the gym, pool or any memberships. This is a cost everyone across Australia would have to pay, whether or not they have a disability.
- **Massage therapy**. Massage that's delivered to you by someone who isn't an allied health professional is not an NDIS support. This includes remedial massage and general massage used for relaxation. We can't fund this type of massage even when it's been recommended by an allied health professional. We also can't fund massage therapists to deliver massage if they work under supervision of an allied health professional. This is because massage therapists are not allied health professionals or therapy assistants.

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- **Personal training**. We can't fund a personal trainer as a therapy support. If it meets the NDIS funding criteria, we may fund an appropriately qualified personal trainer as a support in your capacity building - health and wellbeing funding, but not as therapy.
- **Social group programs which include strategies described as 'therapy'**. We can't fund group programs or activities where there's not enough evidence they are an effective therapy support. This includes things like 'Lego therapy' or activities such as yoga, art and music lessons and drama groups. We can fund a support worker to help you get ready for and take part in social and community activities, but we can't fund the cost of the activity or the class. This is because they're costs for everyone, including people with disability.
- **Therapy in a box**, also known as therapy kits or therapy-at-home programs. They are once-off or ongoing subscriptions, sometimes put together and posted out by an allied health practice. Because they're not individually tailored or evidence-based programs, we can't fund this type of therapy support. They're also not overseen or delivered by a qualified therapist with a measurable outcome.
- **Wellness and coaching therapies**, such as general good health practices that focus on improving general wellbeing and making positive lifestyle changes. Some are labelled therapies but aren't recognised by the NDIS because they're not directly disability related.

Mainstream and community support

There are many systems that work alongside the NDIS to provide supports and services. We call these systems mainstream and community supports, and they're available to everyone across Australia. Mainstream supports are the services you can get from other government funded systems like health, mental health and education[2]. For example, the education system is responsible for supports to help you learn, study and pursue your educational goals. This includes adjusting teaching methods and providing you with learning assistance and aids.

There are also many support services available through community organisations, like youth mentoring programs, neighbourhood cooperatives, religious groups and supports from local councils. We call these community supports. Ask your my NDIS contact for help to get in touch with them if you need it.

Learn more about mainstream and community supports on our website.

How can you get therapy supports in your plan?

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For a therapy support to be included in your plan, it must meet all the NDIS funding criteria. Some therapy supports are not NDIS supports. When you ask for therapy supports to be included in your plan, you need to give us an assessment or report from your therapist. It needs to include recommendations for supports you need, how often and the reasons you need them. Allied health professionals can also provide the same information in a letter of recommendation for you to submit as part of your evidence. We call this the evidence you need to give us before we create or change your plan.

We will think about the most effective and beneficial options for you. We won't fund two therapists to work with you on the same therapy goal. However, we can fund a team of allied health professionals to work together as part of a multidisciplinary team approach to help you pursue your NDIS goals.

To learn more about how we decide what therapy supports we can fund, go to the principles we follow to create your plan.

What information do we need if you don't have therapy supports in your plan?

If you haven't had therapy supports before, it may be helpful for you to give us information[3] from your treating professional about:

- the type of therapy support you need and why you need it
- the therapy approach that will be used and who might provide it
- what outcome the support aims to give you
- how long and how often you'll need the support to achieve the expected outcome
- evidence of previous treatments you've had and what the results were.

Sometimes we need more information to help us decide if your request for therapy supports meets the NDIS funding criteria. If we do, we may ask you to have an assessment and give us a report.[4]

If we ask you to have a therapy assessment, we'll include funding in your plan to pay for the assessment and a report from your therapist. We'll let you know the information we need in the assessment. For example:

- how your informal, community and mainstream supports will help you to pursue your goals
- how the therapy support will increase or maintain your independence

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- how the therapy support will help you pursue your goals and take part in your community, work, and study
- how your gains or expected outcomes will be measured, including how long you will need to achieve the outcome of the therapy support
- the NDIS contact person to forward the information to.

If you need help getting the evidence, or you're not sure what evidence is needed, talk to your my NDIS contact. Learn more about what happens in your planning conversation and what information we need before your planning meeting.

What happens when we have all the information we need?

When we have all the information and evidence we need, we'll make a decision about funding therapy supports in your plan. If they meet the NDIS funding criteria, we'll include the funding for therapy supports in your NDIS plan.

If we decide some or all the therapy supports recommended in the evidence you provide don't meet the NDIS funding criteria, we can't include them in your plan. We'll give you written reasons for our decision[5] about the supports we have or haven't included in your plan. This decision is a reviewable decision, which means if you don't agree with our decision, you can ask us to review it.

What happens when you get therapy supports in your plan?

Your plan may include some therapy supports which are funded by us and some by another service, such as the health system. When you have funding for therapy supports in your plan, you can use your funding to get the NDIS supports you need, in line with your plan. If you need help to use your funding, talk to your my NDIS contact, support coordinator or recovery coach.

All therapy supports are stated supports. You must use your funding in the way we describe in your plan. This means as long as you use your therapy funding on therapy supports that are NDIS supports, delivered by an appropriately qualified professional and delivering similar therapeutic outcomes, you can choose the type of therapy and how the supports are delivered.

You can't use your therapy support funding flexibly to pay for other types of supports in your plan. For example you can't use your therapy funding to pay for other supports in the capacity building support category .[6] Learn more about how we describe supports in your plan.

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You can choose if you want to spend your therapy funding on:

- individual or group sessions
- intensive blocks of therapy, or therapy at regular intervals
- a particular therapy, or combination of therapies, that will be most effective in meeting your needs at a certain time.

Learn more about how to start using your plan in Our Guideline – Your plan.

How will your therapist work with you?

Your therapist will assess your support needs and develop a therapy plan or program for you. Your plan or program will have strategies and recommended supports to help you build your skills to do things or maintain the things you can already do. Your therapist will teach you how to complete your therapy program and will review it regularly to make sure it is still working.

You might want to share your therapy strategies with your other providers and your informal supports. This way, they can also help you with the strategies in between sessions with your therapist.

What information do we need if you're getting therapy supports?

We'll have regular check-ins with you where we'll talk with you to make sure your therapy supports are working for you. We may also talk about how they're working if you have a plan reassessment meeting. This helps us see if your plan is meeting your individual support needs. As your capacity and independence build, we may talk to you about changing your plan.

We may ask your therapist to give us progress reports if we need to reassess your plan. This helps us check that you're making progress towards the goals you set for therapy, and your skills and independence are being improved or maintained. It also helps us understand if you need to continue to receive therapy supports in your next plan, what type of therapy supports you need and the outcomes you want to achieve.

A progress report should include:

- a summary of the supports you're getting
- your experience with how therapy supports have helped you with your disability in the past[7]
- how the support has helped you pursue your goals

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- how the support has helped you increase or maintain your independence
- any measurable, functional gains you've made since receiving therapy supports
- if relevant, details of how your therapy supports are being coordinated with other therapists
- how you've been linked to additional informal, community or mainstream supports to help you take part in social, work or study activities
- any barriers to using your supports or getting them provided, and how these have been resolved
- any risks to you or others
- best-practice recommendations for ongoing therapy, if relevant.

If your situation changes, or your NDIS-funded therapy supports are not meeting your needs, you can ask us to change your plan.[8] Learn more about changing your plan.

What if you don't agree with our decision?

If we decide therapy supports don't meet all our NDIS funding criteria, we can't include them in your plan.

We'll give you written reasons why we made the decision.[9] You can contact us if you'd like more detail about the reasons for our decision.

If you don't agree with a decision we've made about therapy supports, you can ask for an internal review of our decision.[10]

You'll need to ask for an internal review within 3 months of getting your plan.[11]

Learn more about reviewing our decisions.

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Reference list

[1] NDIS (Getting the NDIS Back on Track No. 1)(NDIS Supports) Transitional Rules 2024 sch 2
[2] NDIS (Getting the NDIS Back on Track No. 1)(NDIS Supports) Transitional Rules 2024 sch 2 item 16 and item 17
[3] NDIS Act 2013 s 36(2)(a).
[4] NDIS Act 2013 s 36(2)(b)(i).
[5] NDIS Act s 100(1).
[6] NDIS Act 2013 s 33(3); NDIS (Getting the NDIS Back on Track No. 1)(NDIS Supports) Transitional Rules 2024.
[7] NDIS (Support for Participants) Rules r3.2(b).
[8] NDIS Act Scheme Amendment Act 2022 s 48(2).
[9] NDIS Act s 100(1).
[10] NDIS Act s 100.
[11] NDIS Act s 100(2).

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Therapy supports

Quick summary: Therapy supports are evidence-based supports to help you build or maintain your skills and independence. These supports are delivered by allied health professionals to help you manage everyday activities at school or work, in your home and community. They can help you to build skills to increase your independence and take part in social and community activities. They can also help you pursue work or study goals, if you want to.

This guideline is for participants to learn more about different types of therapy supports and how they might work for you. We talk about how you can get therapy supports in your NDIS plan for the first time and when you change your plan.

Note:

When we say:

- 'your plan', we mean your NDIS plan
- ‘therapist’ we mean an allied health professional who delivers your NDIS therapy supports
- ‘therapy assistant’, we mean an allied health assistant with the skills to help their supervising therapist deliver parts of your therapy support program. To learn more, go to Who can deliver therapy supports?
- multidisciplinary team, we mean a team of people with different skills, working together to help you build your skills and independence and work towards your NDIS goals.

If you’re aged between 9 and 65 years and are looking for information about community connections, go to Our Guideline – Community connections.

If your child is younger than 9 and you’re looking for information about our early childhood approach, go to Our Guideline – Early childhood approach.

What’s in this guideline?

This guideline covers:

- What do we mean by therapy supports?
- Who can deliver therapy supports?

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- What therapy supports can we fund?
- What therapy supports can't we fund?
- How can you get therapy supports in your plan?
- What happens when you get therapy supports in your plan?
- What if you don't agree with our decision?

You might also be interested in:

- Mainstream and community supports
- Disability-related health supports
- Behaviour support

What do we mean by therapy supports?

Therapy supports can be either for capacity building to help you build new skills, or for maintenance, when therapy supports can help to slow the loss of existing skills. They're also known as therapeutic supports. They're evidence-based supports delivered by a therapist to help you build or maintain your skills and independence, in areas such as:

- language and communication, like conversation and social skills
- personal care, like getting washed and dressed
- mobility and movement, like walking and moving around your home
- interpersonal interactions, like social and relationship skills at school or work
- functioning (including psychosocial functioning), like problem-solving and decision-making
- community living, like using public transport.

What is 'evidence-based' therapy support?

For a therapy support to be evidence-based, we need to make sure it uses current best-practice evidence or is from the highest quality research. Current best-practice evidence helps us to understand how well the therapy works for you.

When we decide which therapy supports are evidence-based, we think about:

- the most up-to-date and reliable research studies

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- the data we've collected from you about how you've used them to pursue your goals and meet your desired outcomes
- expert best-practice advice from therapists
- information we've received from the disability community and peak bodies
- if it's value for money compared to the supports available from other mainstream systems, like health or education
- feedback about other schemes in Australia and overseas.

We need to be sure there's enough evidence this type of therapy is effective and beneficial to improve or maintain your skills and independence. This could be for someone with similar disability support needs to you, or for all NDIS participants. All therapy supports must be safe and use current best practice.

If we decide a therapy support is evidence-based, you'll still need to provide evidence from your allied health professional to show that these therapy supports are right for you. Learn more in What information do we need if you don't have therapy supports in your plan?

What are capacity building therapy supports?

Capacity building therapy supports aim to build your skills and independence. They can help you do everyday activities in your home, community, at school or work. They have specific goals and outcomes, with a timeframe to achieve them. You may need them for a short time or a longer time, depending on your individual situation.

You may need capacity building therapy supports at different times or stages in your life, such as:

- at a developmental stage, like childhood to adolescence
- at specific life stage transitions. For example, leaving school, moving out of your family home or getting a job
- after a recent diagnosis once health-based rehabilitation is finished, for example motor neurone disease
- when you've had a change in your situation, such as a decline in your functional capacity or skills
- where you want to learn a new life skill, for example when learning to catch a bus.

As your capacity and independence grow, it's likely you'll need less capacity building therapy supports over time. Your therapy supports may also reduce your need for core supports like assistance with daily life or social, economic and community participation If your condition is

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progressive, you might change over to using maintenance therapy supports once your capacity has improved. For some people, a mix of capacity building therapy supports and maintenance therapy supports might be suitable. If you need capacity building therapy supports, your therapist will assess your disability support needs and work with you to create a therapy plan or program. This includes strategies and supports to help you build your skills. They may also recommend things for you to practice at home with your informal supports like family and friends.

In your therapy plan, the therapist will need to show how their approach and your goals will be measured. Before your plan reassessment, we may ask you to provide us with evidence from your therapist. This is to show us the progress you are making towards your goals and any measurable outcomes. Your therapists will need to provide evidence on progress towards your goals and let us know how the therapy supports are working for you.

Learn more about capacity building support budgets in your plan.

Example

Shae is 21 and lives at home with her family. Shae lives with Down Syndrome and needs support with some everyday tasks because of her disability. She wants to develop her personal care skills so she can get ready on her own before work.

Shae uses her NDIS supports to work with an occupational therapist (OT). Together they develop a therapy plan to help build her independence to get ready for work. Her OT explains the therapy plan to her family and support workers too as they'll help her follow it.

Shae's therapy plan says that she'll meet regularly with her OT for the next 6 months. In these sessions the OT will help Shae learn new skills, measure progress and support her to overcome any challenges. The OT will work with Shae to make sure the supports and strategies in her therapy plan are effective in helping her build her independence. If needed they'll change them.

Before her plan reassessment date, Shae will check in with her OT to work out if she needs ongoing therapy supports in her plan. If she does, we'll ask for a progress report from the OT to decide if Shae needs ongoing funding for this type of therapy support.

What are maintenance therapy supports?

You may need this type of therapy support to help you maintain your current functional capacity. When we say functional capacity, we mean the things you can and can't do because of your disability. Maintenance therapy supports can also help prevent or delay your functional capacity from getting worse. They may help you achieve modest improvements over time, adapt the skills you already have to different environments or maintain your

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current level of functional capacity. For example, stretching programs to stop someone with muscle spasticity from losing a range of movement.

When you have a recent diagnosis or change in your skills or function, you may need time-limited, capacity building therapy supports before moving to therapy supports for maintenance.

You may need ongoing maintenance therapy if your function is likely to change or get worse over time without intervention. For example, if you have cerebral palsy you might need ongoing therapy support to maintain a level of independence to do daily tasks for and with muscle strength, balance and movement activities to prevent your physical function from getting worse.

Example

Hassan has several chronic conditions, including Parkinson's disease, steady weight loss and diabetes. He frequently sees a speech therapist to help him communicate more effectively with his family, friends and support workers. This therapy also helps deal with Hassan's difficulty with swallowing.

Together, Hassan and his speech therapist set some therapy goals. This will help him improve his food and nutritional intake and communicate more effectively. These goals also recognise Hassan's expected decline in function. For example, Hassan's informal supports can help by reducing background noise and speaking more slowly, to help his verbal communication. He could also start using an augmented or alternative communication (AAC) system to improve communication for when his verbal communication skills decline more in the future.

This maintenance program can be followed by his family, friends or support worker. As his condition progresses, the program may need to be re-evaluated. The maintenance therapy supports help with Hassan's changing needs. They also give him the support he needs to keep participating in the things that are important to him.

What are therapy supports for children and young people?

This guideline outlines how we make decisions about therapy supports for children who are aged 9 years and older. To learn more about how we support children younger than 9 and their families, visit Our Guideline – Early childhood approach.

What if your child has been getting early childhood supports and is turning 9?

If your child has been getting early childhood supports as part of their plan before they turn 9, they may transition to other types of capacity building supports, including therapy supports when their plan is reassessed.

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Early childhood supports should draw on best-practice principles that follow the National Best Practice Framework for Early Childhood Intervention. This includes early childhood intervention for professionals working together as a team to deliver early childhood supports to your child and family.

When your child turns 9, the way the NDIS funds therapy is different. It may mean your child's plan includes individual therapy supports rather than a multidisciplinary team approach. To find NDIS registered providers, you can search the Provider Finder, or when you are on the my NDIS portals or app. You can also talk to your my NDIS contact or support coordinator.

As your child's independence and functional capacity grows, their therapy support needs may reduce or change. We'll check in with you regularly about any changes to your child's disability-related support needs as they grow and develop. We'll fund therapy supports as well as other support types to meet your child's disability support needs.

Supports for families and carers to help you with everyday activities

Good therapy is delivered in collaboration with the participant and their support network, leading to the most valuable outcomes.

Some family members, carers, support workers and community organisations may need training so they can help you do your everyday activities. We can fund your therapist to help you implement these strategies. This might involve training your informal supports so they can also help you build your independence or help with your maintenance supports. For example, we may fund an occupational therapist to train your family members how to safely use your support equipment, such as a chair lift.

Who can deliver therapy supports?

NDIS therapy supports can only be delivered by qualified allied health professionals. We sometimes refer to them as therapists. They may also deliver other NDIS supports to you such as disability-related health supports.

To learn more about the allied health professionals who can deliver NDIS therapy supports, go to NDIS Pricing Arrangements and Price Limits.

Allied health professionals are also expected to:

- comply with the NDIS Code of Conduct
- comply with the NDIS Practice Standards if they're NDIS registered providers

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- take part in ongoing professional development to provide the best and most current evidence-based therapy supports
- deliver specialised therapy supports to help with your individual disability-related needs
- help you work towards your specific therapy goals and pursue your NDIS goals
- behave ethically, in line with their duty of care and in your best interests
- deliver therapy supports and invoice in line with the NDIS Pricing Arrangements and Price Limits.

Depending on your needs and goals, you might get therapy supports from more than one allied health professional when you're working towards different goals. For example, you might be starting a job. You may need an occupational therapist to help you improve your skills to travel to new places and manage the changes in your life. You may also need a speech pathologist to help build your social and communication skills so you can communicate confidently with others. It may be important for your therapists to work together so they can coordinate the therapy supports they deliver to get the best outcomes for you. Talk to your allied health professionals if you want more coordination of your therapies.

Therapists are qualified allied health professionals, who are registered with the Australian Health Practitioner Regulation Agency (AHPRA) for regulated professions or accredited by a relevant peak body for self-regulated professions. Ask your provider about their qualifications and professional registration to make sure they're able to provide the right supports for you.

Allied health professionals and providers who are not qualified or registered with the relevant professional body can't be funded as therapy.

What is the role of therapy assistants?

Some therapy supports can be delivered by a therapy assistant. Therapy assistants are sometimes called allied health assistants. They have the skills to perform specific tasks or deliver therapy support programs under the supervision or delegation of an allied health professional. They usually hold relevant TAFE qualifications and can be members of the Allied Health Assistants' National Association Ltd (AHANA).

There are 2 levels of therapy assistant:

- level 1 must always work under the direct supervision of the allied health professional
- level 2 can work under the delegation, without direct supervision of the allied health professional. The use of an assistant can be a cost-effective way to deliver therapy outcomes which means your therapy funding will last longer.

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The main benefit of using a therapy assistant is they can practise these skills with you in natural environments like your home, community or school.

You can use your therapy budget flexibly for a mix of allied health therapy supports. This may include a therapy assistant if your allied health professional agrees this is suitable for you. For example, they can help you with activities to practise daily living skills like personal care and speech programs. Usually when we fund a therapy assistant, we expect that sessions with them will replace some of the sessions normally provided by the supervising allied health professional.

Provisional psychologists or allied health students on placement or internship may deliver specific tasks and supports to you under supervision, with your consent. You need to make sure they are covered by the supervising allied health professional's insurance. As this is an unpaid learning role for they won't be able to claim from your plan for delivering support to you. Instead, the cost of supervision and support delivered by the supervising therapist can be claimed from your plan, with your agreement.

To learn more about claiming for therapy supports, go to the NDIS Pricing Arrangements and Price Limits.

What therapy supports can we fund?

NDIS laws determine what we can and can't fund. We can only fund therapy supports that meet all the NDIS funding criteria. This includes that it's an NDIS support we can fund. To learn more, go to What is an NDIS support?

Here you'll find general descriptions and examples to help you understand the type of therapy supports we can fund and who can deliver them. When we describe the different therapies, we've included any professional bodies the therapist must be part of and what the therapy might help you achieve.

We may also be able to fund other types of therapists if they meet the requirements in NDIS Pricing Arrangements and Price Limits.

Art therapy

Art therapy can support you to explore and regulate your feelings and emotions, improve self-awareness and develop your communication skills. The focus of art therapy as an individual therapy support is the creative process of making art, not the final product. It can be delivered in different ways, like through painting, drawing, sculpting, dance and movement. Art therapy is not the same as art lessons. Art supplies used to deliver art therapy should be included in the cost of the therapy session.

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To provide therapy supports funded by the NDIS, an art therapist must be a professional member of the Australian New Zealand and Asian Creative Arts Therapies Association (ANZACATA). ANZACATA requires art therapists to have a master's degree in art therapy.

Example

Tahnee is 18 years old. She is a participant from the lands of the Gimuy Walubara Yidinji peoples of Far North Queensland. She has cerebral palsy and is autistic. Tahnee has good evidence that working with an art therapist every fortnight for 6 months will help improve her functional capacity.

Tahnee's mother found a registered therapist who uses art and storytelling as part of her practice. The therapist will deliver art therapy as a culturally appropriate, family-centred approach. This means Tahnee can go to therapy sessions with her mother or grandmother if she wants to. We fund art therapy for Tahnee because there is evidence this type of therapy can help improve her overall functional abilities. Importantly, this support will help Tahnee work towards her goal of being more independent.

Audiology

Audiologists are experts in hearing loss at any age. They can help you to maximise hearing function or improve balance and provide counselling, aural rehabilitation and communication training. This can involve the use of hearing aids and other assistive technology to improve your ability to communicate.

Audiology therapies include treatments for hearing and balance disorders like hearing tests, tinnitus management and vestibular rehabilitation. Audiologists must either be currently certified as an Audiology Australia Accredited Audiologist by Audiology Australia (AudA) or as a full member of the Australian College of Audiology (ACAud).

Counselling

Counsellors can help by providing a safe space to explore your emotions, develop resilience, learn skills to communicate positively and set clear goals. They can help you to identify personal and societal barriers related to disability and learn ways to manage or overcome them. For example, they can support you to develop a personal plan to learn coping and well-being strategies to adapt to a new disability diagnosis and build your resilience. Any equipment or supplies used to deliver counselling should be included in the cost of the therapy session, such as sand trays or fidget tools.

A counsellor must be a member of the Australian Counselling Association, or registered with the Psychotherapy and Counselling Federation of Australia or a provisionally registered

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psychologist working towards full registration with Australian Health Practitioner Regulation Agency (AHPRA).

Example

Paul is autistic and has asked for therapy supports to help him build his skills to have conversations with his friends. Paul feels nervous about talking with a counsellor, especially about his friendships and the skills he wants to improve. He wants to work with a counsellor who includes a therapy dog in their sessions as he thinks this will make it easier for him to feel relaxed. He finds a counsellor who uses a therapy dog. This helps Paul to relax, regulate his emotions and talk to the counsellor without feeling anxious during therapy.

We can fund animal-assisted counselling therapy for Paul because it meets the NDIS funding criteria. It will help Paul increase his skills in areas related to his disability. For Paul, who has some difficulty with social communication, funding a counsellor will help him improve his skills to make and keep friends. The counsellor can include a therapy dog to help them work with Paul if they don't charge him any additional fees for using the dog.

Developmental education

Developmental education is a therapy support to help you build skills, independence and quality of life, often in childhood or adolescence. Developmental educators have expertise in developmental or acquired disabilities. They can also implement strategies from other therapists with children under the age of 18. For example, they may support you to navigate life stage transitions such as leaving school. They can work with you to develop social and emotional regulation strategies. A developmental educator must hold a bachelor's degree or higher and be a current full member of Developmental Educators Australia Incorporated.

Example

Stephanie is 13 years old and autistic. She lives at home with her mother. Stephanie is starting high school next year and wants to learn how to be more organised and get ready for school. She also wants to learn to build her social skills so she can tell her friends and teachers what she needs and prefers.

Stephanie uses the NDIS supports in her plan to work with a developmental educator. Stephanie, her mother and her developmental educator have put together a therapy plan. The strategies in the plan will help her learn personal care, planning and organisational skills and increase her independence. She also wants to learn self-advocacy skills. Stephanie's developmental educator explains how to carry out the therapy plan and gives a copy to her school as part of her individual learning plan.

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Stephanie's current plan includes regular meetings with her developmental educator for the next 3 months, before she starts at her new school. This is to make sure the supports and strategies are effective in helping her build her independence and pursue her goals. Her developmental educator will also work out what future supports Stephanie may need.

Dietary support

Dietetics and dietary support can help you to learn new ways to manage the dietary and eating needs that relate to your disability. Dietitians provide evidence-based nutrition services, dietary counselling and therapy. For example, they can help you create a personalised mealtime plan or implement eating and swallowing strategies. They can work with you to make sure the food you are eating is safe and healthy for you. They can also review and update mealtime plans and strategies, as needed.

Dietitians must be an Accredited Practising Dietitian with Dietitians Australia.

You can also learn more about disability-related dietary supports in Our Guideline – Nutrition supports including meal preparation.

Exercise physiology

Exercise physiology is a therapy support to help you work out the best clinical exercises, that work for you and implement them, to help you pursue your goals. The use of exercise-based therapies can help you learn more about muscle strength and physical activity related to your disability. Exercise physiologists can also support needs that result from your disability. For example, they can help a person with multiple sclerosis using a walker to maintain muscle strength and independence. This might mean they don't need a support worker to help them as often, and they can move about more independently.

Exercise physiologists must be an Accredited Exercise Physiologist (AEP) with Exercise and Sports Science Australia.

Music therapy

Music therapy can support you to explore and regulate your feelings and emotions, build skills in memory, movement and sequencing. The focus of music therapy as an individual therapy support is the therapeutic impact of music on the brain, mind and body. For example, music therapy can help improve communication, self-expression, coordination and mobility. Music therapy can be delivered in many ways, such as listening to music, songwriting, music making and as an assisted relaxation strategy. It is not the same as music lessons.

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Registered Music Therapists (RMTs) can help people in areas like communication, motor skills, mobility, mood, emotions, cognitive capacity, identity and self-confidence. RMTs have a university degree in music therapy and must be registered with the Australian Music Therapy Association.

Occupational therapy

Occupational therapy can help you build skills and confidence to take part in everyday activities, with more independence. An occupational therapist works with you to create a personalised plan to explore and implement practical solutions at home or in your community, at school or work. For example, this might include learning strategies to manage change and make informed decisions, like planning and organisation. It might also include practical skills you can use to stay safe around your home and community, so you can live more independently. They can also help you learn new skills or find different ways of doing things that are safe and works for you, such as using equipment to cook, dress or shower.

Occupational therapists must have a current Australian Health Practitioner Regulation Agency (AHPRA) registration as an occupational therapist.

Example

Trey is 37 years old. Just over a year ago, Trey was involved in an accident that resulted in a spinal cord injury. He had treatment for his injury, followed by rehabilitation in hospital for 10 months. The hospital occupational therapist did an assessment of Trey's home before he left hospital. During his rehabilitation, he applied for NDIS disability-related supports for when he got home. He lives with his sister and has a goal to work from home.

Trey uses his NDIS funding for an occupational therapist. He develops a transfer and position plan for Trey to reduce the risk of falls and pressure injuries. This includes regular training for his support workers and sister. His occupational therapist also identifies strategies and equipment to help him with showering, dressing and preparing meals.

His occupational therapist will review and update Trey's maintenance plan and adjust it to meet his support needs. As he makes progress towards his goals, he may need less support or his support needs may change.

Orthoptist

Orthoptists help adults and children with vision difficulties. They work with you if you have vision loss, double vision, an eye movement disorder or neurological condition that makes it hard to understand what you see. Orthoptists can help you learn and understand how your vision works and deliver therapy supports to improve your vision, manage symptoms and optimise how you use your vision. They can teach you about what supports you may need,

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for example assistive technology and visual aids, to help you improve your functional vision for everyday activities.

Orthoptists must have current registration with the Australian Orthoptic Board.

Physiotherapy

Physiotherapy as a therapy support can help you build or maintain movement, function and independence. Physiotherapists can assess, treat and manage a wide range of disabilities and impairments that limit brain, muscular, joint, heart and breathing functions. These include cerebral palsy, stroke, Parkinson's Disease, spinal cord injury, pain and stiffness. Physiotherapists also work with you to prevent any loss of mobility and keep you safe from falls or accidents. As part of your therapy plan, they may focus on evidence-based exercise, manual therapy, functional training, carer education or assistive technology, as long as it relates to your disability.

Physiotherapists must have current AHPRA registration as a physiotherapist.

Podiatry

Podiatrists are healthcare professionals who diagnose, treat, and prevent conditions of your feet, ankles, and lower limbs. They can support you to manage musculoskeletal challenges, skin and nail conditions. They might also deliver diabetic foot care, prescribe orthotics or give footwear advice. Podiatrists will develop a therapy plan with you to improve or maintain a level of mobility that works for you and give you strategies to reduce pain. The focus of a podiatrist is to help you build independence and improve your overall quality of life.

Podiatrists must be registered with the Podiatry Board AHPRA.

Psychology

Psychology as a therapy support can help you build your capacity to do things in your everyday life and join in with your community. We can only fund sessions with psychologists whose focus is to build or maintain your capacity to engage in everyday activities or increase your independence.

Psychologists can assess and deliver tailored supports to help you pursue your individual goals. This could be in your personal or social life, at work or school. For example, they might work with you, and your family, to improve your quality of life, develop new skills and adjust to changes in your life, that relate to your disability. They can also help you manage behaviours and emotions in different settings, like the way you engage in relationships.

If you need support from a psychologist for a mental health diagnosis or treatment, this is the responsibility of the health system and not the NDIS.

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Psychologists must have current AHPRA registration as a psychologist.

If you have behaviours of concern, you may require behaviour support instead of, or as well as, therapy supports. To learn more, go to Our Guidelines – Behaviour support.

Rehabilitation and vocational counselling

Rehabilitation and vocational counselling can help people with a disability or chronic illness pursue their work and study goals in areas like education, employment or community living. These specialist counsellors provide assessments, counselling, case management and service coordination. They can assess your functional capacity and help you pursue goals like finding and keeping a job. Rehabilitation counsellors are tertiary-educated therapists who are members of Australian Society of Rehabilitation Counsellors (ASORC).

Social work

The main focus of social work as a therapy support is to maintain and maximise your social functioning and overall quality of life. Social workers use a holistic approach to understand how your individual factors and social environment might impact your therapy. For example, social workers may support you with individual, family and group work and strategies to adjust to disability and associated lifestyle changes. They can provide therapy supports to help you deal with emotional aspects of life transitions and improve wellbeing. Social workers must be a member of the Australian Association of Social Workers (AASW).

Speech pathology or therapy

Speech pathology or therapy is a therapy support that can help with your communication and swallowing disability support needs. A speech therapist can support you to build the skills you need to receive, send, process and understand information that is spoken, non-spoken and signed. They can also support you to implement the use of picture and graphic symbols.

Speech therapists support you if you have difficulties with speaking, listening, hearing, reading or writing. They can help you to understand language and learning. They can also work with you to improve the different ways you communicate using speech, sign language, assistive technology and other alternative and augmentative communication methods. They can help if you have difficulties with eating, drinking or swallowing.

To provide NDIS supports, speech pathologists must be a Certified Practising Speech Pathologist (CPSP) as approved by Speech Pathology Australia.

Learn more about how they can help with swallowing difficulties in Our Guideline - Dysphagia supports.

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What therapy supports can't we fund?

Under the laws for the NDIS, there are things we can't fund or provide. We also can't fund goods and services that are not NDIS supports[1]. To learn more, go to What is not an NDIS support?

We can't fund a therapy support if there isn't enough evidence to show that it has good functional outcomes for people with disability, even if the service provider is an allied health professional.

Supports we can't fund as therapy include:

- **Alternative and complementary therapies** like cuddle therapy, crystal therapy or aromatherapy. This also includes therapies that focus on balancing the body's energy fields.
- **Animal therapy**, such as canine or equine therapy. Recreational, sporting or social activities involving animals could also be called 'animal therapy'. This type of animal therapy isn't an NDIS therapy support because the outcome is for you to have a positive experience with an animal. This is different to an animal being used as a therapy tool to help you achieve your therapy goals. Animal therapy may be funded under social and community participation.
- **Energy and health practices**, such as practices about lifestyle choices, including exercise physiology for general fitness, weight loss and exercise. These are not specifically disability-related practices.
- **Gymnasium or swimming pool memberships**. A physiotherapist or exercise physiologist may want you to do an exercise program at a gym or in a pool. We may fund supports to help you at the gym or pool, for example a support worker to help you access and use the facilities. We won't fund the cost to access the gym, pool or any memberships. This is a cost everyone across Australia would have to pay, whether or not they have a disability.
- **Massage therapy**. Massage that's delivered to you by someone who isn't an allied health professional is not an NDIS support. This includes remedial massage and general massage used for relaxation. We can't fund this type of massage even when it's been recommended by an allied health professional. We also can't fund massage therapists to deliver massage if they work under supervision of an allied health professional. This is because massage therapists are not allied health professionals or therapy assistants.

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- **Personal training**. We can't fund a personal trainer as a therapy support. If it meets the NDIS funding criteria, we may fund an appropriately qualified personal trainer as a support in your capacity building - health and wellbeing funding, but not as therapy.
- **Social group programs which include strategies described as 'therapy'**. We can't fund group programs or activities where there's not enough evidence they are an effective therapy support. This includes things like 'Lego therapy' or activities such as yoga, art and music lessons and drama groups. We can fund a support worker to help you get ready for and take part in social and community activities, but we can't fund the cost of the activity or the class. This is because they're costs for everyone, including people with disability.
- **Therapy in a box**, also known as therapy kits or therapy-at-home programs. They are once-off or ongoing subscriptions, sometimes put together and posted out by an allied health practice. Because they're not individually tailored or evidence-based programs, we can't fund this type of therapy support. They're also not overseen or delivered by a qualified therapist with a measurable outcome.
- **Wellness and coaching therapies**, such as general good health practices that focus on improving general wellbeing and making positive lifestyle changes. Some are labelled therapies but aren't recognised by the NDIS because they're not directly disability related.

Mainstream and community support

There are many systems that work alongside the NDIS to provide supports and services. We call these systems mainstream and community supports, and they're available to everyone across Australia. Mainstream supports are the services you can get from other government funded systems like health, mental health and education[2]. For example, the education system is responsible for supports to help you learn, study and pursue your educational goals. This includes adjusting teaching methods and providing you with learning assistance and aids.

There are also many support services available through community organisations, like youth mentoring programs, neighbourhood cooperatives, religious groups and supports from local councils. We call these community supports. Ask your my NDIS contact for help to get in touch with them if you need it.

Learn more about mainstream and community supports on our website.

How can you get therapy supports in your plan?

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For a therapy support to be included in your plan, it must meet all the NDIS funding criteria. Some therapy supports are not NDIS supports. When you ask for therapy supports to be included in your plan, you need to give us an assessment or report from your therapist. It needs to include recommendations for supports you need, how often and the reasons you need them. Allied health professionals can also provide the same information in a letter of recommendation for you to submit as part of your evidence. We call this the evidence you need to give us before we create or change your plan.

We will think about the most effective and beneficial options for you. We won't fund two therapists to work with you on the same therapy goal. However, we can fund a team of allied health professionals to work together as part of a multidisciplinary team approach to help you pursue your NDIS goals.

To learn more about how we decide what therapy supports we can fund, go to the principles we follow to create your plan.

What information do we need if you don't have therapy supports in your plan?

If you haven't had therapy supports before, it may be helpful for you to give us information[3] from your treating professional about:

- the type of therapy support you need and why you need it
- the therapy approach that will be used and who might provide it
- what outcome the support aims to give you
- how long and how often you'll need the support to achieve the expected outcome
- evidence of previous treatments you've had and what the results were.

Sometimes we need more information to help us decide if your request for therapy supports meets the NDIS funding criteria. If we do, we may ask you to have an assessment and give us a report.[4]

If we ask you to have a therapy assessment, we'll include funding in your plan to pay for the assessment and a report from your therapist. We'll let you know the information we need in the assessment. For example:

- how your informal, community and mainstream supports will help you to pursue your goals
- how the therapy support will increase or maintain your independence

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- how the therapy support will help you pursue your goals and take part in your community, work, and study
- how your gains or expected outcomes will be measured, including how long you will need to achieve the outcome of the therapy support
- the NDIS contact person to forward the information to.

If you need help getting the evidence, or you're not sure what evidence is needed, talk to your my NDIS contact. Learn more about what happens in your planning conversation and what information we need before your planning meeting.

What happens when we have all the information we need?

When we have all the information and evidence we need, we'll make a decision about funding therapy supports in your plan. If they meet the NDIS funding criteria, we'll include the funding for therapy supports in your NDIS plan.

If we decide some or all the therapy supports recommended in the evidence you provide don't meet the NDIS funding criteria, we can't include them in your plan. We'll give you written reasons for our decision[5] about the supports we have or haven't included in your plan. This decision is a reviewable decision, which means if you don't agree with our decision, you can ask us to review it.

What happens when you get therapy supports in your plan?

Your plan may include some therapy supports which are funded by us and some by another service, such as the health system. When you have funding for therapy supports in your plan, you can use your funding to get the NDIS supports you need, in line with your plan. If you need help to use your funding, talk to your my NDIS contact, support coordinator or recovery coach.

We include therapy supports in your plan as a stated support under the Improved Daily Living Skills support category. This means you can only use this funding for therapy. You can't use your therapy funding flexibly to pay for other capacity building supports.[6] Learn more about how we describe supports in your plan.

Your plan may include funding for therapy supports without describing a specific therapy type. This means you have the flexibility to choose your provider, and where appropriate, the type of therapy that suits your needs. This gives you greater choice and control over the therapy type you choose, and who delivers the therapy.

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You can choose if you want to spend your therapy funding on:

- individual or group sessions
- intensive blocks of therapy, or therapy at regular intervals
- a particular therapy, or combination of therapies, that will be most effective in meeting your needs at a certain time.

In some plans we may include extra details, such as a specific stated therapy type or a measurable outcome you want to achieve. When we do this, you must use your funding in the way we describe in your plan. This helps make sure you use the funding for its intended purpose.

Learn more about how to start using your plan in Our Guideline – Your plan.

How will your therapist work with you?

Your therapist will assess your support needs and develop a therapy plan or program for you. Your plan or program will have strategies and recommended supports to help you build your skills to do things or maintain the things you can already do. Your therapist will teach you how to complete your therapy program and will review it regularly to make sure it is still working.

You might want to share your therapy strategies with your other providers and your informal supports. This way, they can also help you with the strategies in between sessions with your therapist.

What information do we need if you're getting therapy supports?

We'll have regular check-ins with you where we'll talk with you to make sure your therapy supports are working for you. We may also talk about how they're working if you have a plan reassessment meeting. This helps us see if your plan is meeting your individual support needs. As your capacity and independence build, we may talk to you about changing your plan.

We may ask your therapist to give us progress reports if we need to reassess your plan. This helps us check that you're making progress towards the goals you set for therapy, and your skills and independence are being improved or maintained. It also helps us understand if you need to continue to receive therapy supports in your next plan, what type of therapy supports you need and the outcomes you want to achieve.

A progress report should include:

- a summary of the supports you're getting

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- your experience with how therapy supports have helped you with your disability in the past[7]
- how the support has helped you pursue your goals
- how the support has helped you increase or maintain your independence
- any measurable, functional gains you've made since receiving therapy supports
- if relevant, details of how your therapy supports are being coordinated with other therapists
- how you've been linked to additional informal, community or mainstream supports to help you take part in social, work or study activities
- any barriers to using your supports or getting them provided, and how these have been resolved
- any risks to you or others
- best-practice recommendations for ongoing therapy, if relevant.

If your situation changes, or your NDIS-funded therapy supports are not meeting your needs, you can ask us to change your plan.[8] Learn more about changing your plan.

What if you don't agree with our decision?

If we decide therapy supports don't meet all our NDIS funding criteria, we can't include them in your plan.

We'll give you written reasons why we made the decision.[9] You can contact us if you'd like more detail about the reasons for our decision.

If you don't agree with a decision we've made about therapy supports, you can ask for an internal review of our decision.[10]

You'll need to ask for an internal review within 3 months of getting your plan.[11]

Learn more about reviewing our decisions.

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Reference list

[1] NDIS (Getting the NDIS Back on Track No. 1)(NDIS Supports) Transitional Rules 2024 sch 2
[2] NDIS (Getting the NDIS Back on Track No. 1)(NDIS Supports) Transitional Rules 2024 sch 2 item 16 and item 17
[3] NDIS Act 2013 s 36(2)(a).
[4] NDIS Act 2013 s 36(2)(b)(i).
[5] NDIS Act s 100(1).
[6] NDIS Act 2013 s 33(3); NDIS (Getting the NDIS Back on Track No. 1)(NDIS Supports) Transitional Rules 2024.
[7] NDIS (Support for Participants) Rules r3.2(b).
[8] NDIS Act Scheme Amendment Act 2022 s 48(2).
[9] NDIS Act s 100(1).
[10] NDIS Act s 100.
[11] NDIS Act s 100(2).

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Research Request – Neurofeedback Therapy

Brief	AAT case – request for a literature review on the efficacy of Neurofeedback therapy for a 14 year old with Autism Spectrum Disorder.
Date	10 September 2019
Requester	Katrin S22(1)(a)(ii)-irrelevant material & Kylie S22(1)(a)(ii)-irrelevant material
Researcher	Aanika Droste

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Definition of Neurofeedback Therapy

Neurofeedback therapy is considered an alternative therapy. Based on provider websites it is commonly used for the treatment of ADD/ADHD, epilepsy, brain injuries, post-traumatic stress disorder, sleep issues, stroke, and alcoholism and drug abuse, stress and anxiety.

Neurofeedback therapy is a treatment method that uses a sound-based biofeedback technology to help retrain the brain to self-regulate and function optimally. The computer-based program uses sound or visual signals to retrain or reorganize these brain signals. By responding to this process, the clients then learn to regulate and improve their brain function and to help alleviate the symptoms related to various neurological and mental health disorders[1].

Nuerofeedback therapy and ASD

Neurofeedback refers to training in self-regulation aiming to achieve control over cortical electrical activity. The aim of neurofeedback training is to teach children with ASD to adapt their neurophysiological profile so that it matches those of typically developing children, resulting in subsequent improvement in symptoms. The self-regulation of cortical activity is realized through a process of operant learning using real-time representation of electroencephalographic (EEG) parameters[2].

Published TAT advice in HPRM

The TAT have published five advices relating to reasonable and necessary support requests for neurofeedback therapy. These advices were all for participants with Autism Spectrum Disorder whose ages ranged between 10 to 24 years.

All TAT five advices concluded that: **There is limited evidence currently available that supports the efficacy of neurofeedback therapy in the treatment of Autism. The request for funding for Neurofeedback therapy does not meet the criteria for Reasonable and Necessary and should be declined at this time.**

Research identified in these advices has been collated below.

Literature Review for Neurofeedback

There is very little quality and reliable evidence to support the use of neurofeedback therapy in the treatment of Autism. The only sources of information that were in support of neurotherapy as a practice were active providers (Brain Training Centre and Neurodevelopment Centre) and the information these providers used to substantiate the treatment were not reliable. This is examined below.

There was very little research discussing the use of neurofeedback in adults with ASD.

[1] Natural Therapy Pages, 'What is Neurofeedback Therapy?', <https://www.naturaltherapypages.com.au/energetic_medicine/neurofeedback>, accessed 10 September 2019.

[2] Holtmann, M et al, 'Neurofeedback in autism spectrum disorders', Developmental Medicine & Child Neurology, 14 July 2011, vol. 53, no. 11, pp.986-93, <https://www.researchgate.net/publication/51488393_Neurofeedback_in_autism_spectrum_disorder>, accessed 10 September 2019, p.986.

Review of Current Studies

The most credible source of information available is a 2011 review of current studies on the effectiveness of neurofeedback as a method of treatment of the core symptoms of autism spectrum disorders[3]. This review found that "the existing evidence does not support the use of neurofeedback in the treatment of ASD. Studies with outcomes in favour of neurofeedback might be showing an improvement in comorbid attention-deficit–hyperactivity disorder symptoms rather than a true improvement in core ASD symptoms[4].

The review recommends that significant further research is required to determine the link between ASD and neurofeedback therapy, stating that: "A multitude of methodological limitations will have to be addressed in future studies on neurofeedback in ASD. The use of criterion standard diagnostic instruments and blinded multiple informants using standardized instruments for parents, teachers, and specialists is warranted. The comorbidity of ASD and ADHD needs to be carefully addressed"[5].

Raising Children Website

The Australian parenting website Raising Children Network has established a therapies guide related to Autism. The guide identified neurotherapy as unrateable – (not yet reviewed by our research sources) using the rating system based on National Standards Project- National Autism Center 2009 and the Cochrane Collection[6].

The Raising Children website also states "More high-quality research is needed to determine whether neurofeedback works for people with autism spectrum disorder (ASD) [and] Some research suggests that positive results in treating ASD might be because neurofeedback improves ADHD symptoms – which many people with ASD have – rather than ASD symptoms. But well-designed and controlled research is also needed to determine whether neurofeedback is effective for people with ADHD"[7].

The National Institute for Health and Care Excellence (NICE)

The National Institute for Health and Care Excellence (NICE) guidelines make evidence - based recommendations on a wide range of topics for use by public health and social care practitioners in England.

These guidelines are made public[8]. The PTSD, anxiety, depression, adult ADHD NICE guidelines do not list Neurofeedback as an evidence based treatment. Any other specific condition can be searched on the NICE website to determine if Neurofeedback is an evidence based treatment for that specific condition. In fact the NICE Guideline for autism spectrum disorder in under 19s: support

[3] Holtmann, loc cit.
[4] Ibid.
[5] Holtmann et al., p.992.
[6] Raising Children, 'Parent Guide to Therapies for ASD: FAQs', <https://raisingchildren.net.au/autism/therapies-guide/guide-to-therapies-for-asd>, accessed 10 September 2019.
[7] Raising Children, 'Neurofeedback: Therapy at a glance', <https://raisingchildren.net.au/autism/therapies-guide/neurofeedback>, accessed 10 September 2019.
[8] The National Institute for Health and Care Excellence, 2019, <https://www.nice.org.uk/About/What-we-do/Our-Programmes/NICE-guidance/NICE-guidelines>, accessed 10 September 2019.

and management says 'do not use neurofeedback to manage speech and language problems in children and young people with autism'[9].

Neurodevelopment Centre (US)

The Neurodevelopment centre is a progressive neurotherapy provider in the US. The approach to therapy at this centre is as follows:

> "At the NeuroDevelopment Center, we closely follow the research on these promising approaches. We recognize the need for scientific evidence, and carefully evaluate the research on new therapy methods**. But we also realize that it takes decades to compile conclusive scientific proof. You may not want to wait until the research is conclusive**. So we offer neurofeedback and Cogmed working memory training and even our Preschool ADHD LEAP program – research supported treatments that harness the brain's capacity for change through brain exercise and training"[10].

The Neurodevelopment Centre states that "Early studies have provided research support for neurofeedback as a treatment of the symptoms of autism spectrum disorders (ASD) including Autism, Asperger's Disorder, and Pervasive Developmental Disorder (PDD). As of 2011, nine studies have been completed, showing significant improvements in social, emotional, and behavioral functioning with neurofeedback.

However, the Neurodevelopment centre also acknowledges that "More research needs to be done, particularly more studies employing random assignment of subjects to a neurofeedback and to a good comparison or control group"[11].

The Brain Training Centre

The Brain Training Centre is a provider of neurotherapy based in ACT, Australia.

The website states that:

> Autism is a neurodevelopmental disorder. Symptoms include lack of social interaction, challenged communication, lack of appropriate eye contact and expression, and a narrow range of repetitive behaviours. The sufferer's brain is not operating as it should in a number of different regions. Some areas are 'talking to each other' too much while other brain regions aren't interacting at all. Neurofeedback is all about working with the brain. It makes sense therefore, that it can help with reducing symptoms in a brain challenged with ASD.
>
> During brain training you receive real time feedback on the training activity in your brain. The activity is measured with electrodes placed on your scalp. Don't worry, you don't feel a thing! These electrodes provide feedback to the stimuli of a video or game on a television screen. If the brain activity changes in the desired direction, you receive a positive 'reward'. If it doesn't change or changes in an undesired direction, you receive no feedback or negative response. When we are talking about rewards etc. we are referring to a change of

[9] The National Institute for Health and Care Excellence, Autism spectrum disorder in under 19s: support and management, August 2013, https://www.nice.org.uk/guidance/cg170/chapter/1-Recommendations#interventions-for-autism-that-should-not-be-used

[10] The Neurodevelopment Centre, 2019, <https://neurodevelopmentcenter.com/> accessed 10 September 2019.

[11] The Neurodevelopment Centre, 2019, <https://neurodevelopmentcenter.com/psychological-disorders/autism-spectrum-disorder/neurofeedback-for-autism/>, accessed 10 September 2019.

pitch in the sounds through the earphones, or a light snowing/blurring/lightening of the image on the screen[12].

The Brain Training Centre website provides an extensive list of evidence based research for the effectiveness of neurotherapy for ADD/ADHD, learning and developmental disabilities, and academic cognitive enhancement to back up the use of neurotherapy as a treatment. However, this reference list is misleading as the majority of these references relate to ADHD and **none of them are clearly linked to ASD studies**, which is in line with the 2011 review findings (Holtmann et al.).

ADHD and neurofeedback therapy – clinical trials

In 2017 a group of medical experts published a journal article on a concurrent, triple-blind, randomised, controlled trial using authorised deception in adults with ADHD to determine the effectiveness of neurofeedback as a therapy, compared to sham neurofeedback, and cognitive-behavioural group therapy in adults.

Contrary to the Brain Training Centre claims that neurofeedback is effective for the treatment of ADHD, the controlled trial suggested that:"neurofeedback training is not superior to a sham condition or group psychotherapy. All three treatments were equivalently effective in reducing ADHD symptoms. This first randomised, sham-controlled trial did not show any specific effects of neurofeedback on ADHD symptoms in adults"[13].

In 2016, a meta-analyses of randomized controlled trials to examine the effects of neurofeedback on attention-deficit/hyperactivity disorder (ADHD) symptoms and neuropsychological deficits in children and adolescents with ADHD. This publication concluded that "Evidence from well-controlled trials with probably blinded outcomes currently fails to support neurofeedback as an effective treatment for ADHD. Future efforts should focus on implementing standard neurofeedback protocols, ensuring learning, and optimizing clinically relevant transfer"[14].

International Society for Neurofeedback and Research

The International Society for Neurofeedback & Research (ISNR) is a membership organization comprised of people from many countries and various professional disciplines doing neurotherapy, neurofeedback training and research.

The ISRN provides information on guidelines for neurofeedback therapy and training and credentials required by the website also states that these "are voluntary and help demonstrate to the public that a neurofeedback provider is able to provide ethical and competent training [and] Regulations regarding licensure and scope of practice are determined and enforced by various governmental agencies, depending on state, country, or province. Consumers should ascertain that the practitioner has appropriate credentials, training, experience, and licensure to treat their problem, or is supervised by someone who does"[15].

[12] The Brain Training Centre, 'Autism Spectrum Disorder', 2014, <https://www.braintrainingcentre.com.au/autism-spectrum-disordern> accessed 10 September 2019.
[13] https://www.sciencedirect.com/science/article/pii/S2215036617302912
[14] Cortese, S, et al, 'Neurofeedback for Attention-Deficit/Hyperactivity Disorder: Meta-Analysis of Clinical and Neuropsychological Outcomes From Randomized Controlled Trials', *Journal of the American Academy of Child and Adolescent Psychiatry*, 2016, vol.55, no.6, 444-55, <https://www.ncbi.nlm.nih.gov/pubmed/27238063>, accessed 10 September 2019.
[15] https://www.isnr.org/guidelines-for-practice

Research Request – Updated Literature Review: Sensory products/ weighted items for participants with Autism

Date	May 14, 2020
Requester	Karyn S22(1)(a)(ii)-irrelevant material (Director - TAB)
Researchers	Jane S22(1)(a)(ii)-irrelevant material (Research Team Leader)

Research Brief

Perform literature search to confirm that published TAT advice titled - *Sensory devices and toys to assist with sleep and calming for participant who has Autism* is current and effective.

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Please note:

The research and literature reviews collated by our TAB Research Team are not to be shared external to the Branch. These are for internal TAB use only and are intended to assist our advisors with their reasonable and necessary decision making.

Delegates have access to a wide variety of comprehensive guidance material. If Delegates require further information on access or planning matters they are to call the TAPS line for advice.

The Research Team are unable to ensure that the information listed below provides an accurate & up-to-date snapshot of these matters.

1. Summary

The current TAT digest states Ayres Sensory Integration (SIT) has 'weak to insufficient evidence that the intervention can improve outcomes.' However, evidence supporting the use of Ayres Sensory Integration Therapy (SIT) as an intervention for Autism Spectrum Disorder (ASD) is building.

- A recent systematic review [1] concludes that Ayres SIT is an evidence based practice for children with ASD between the ages of four and 12. However, the intervention delivered must be consistent with the principles described by Ayres and operationalized in the Ayres Sensory Integration Fidelity Measure (ASIFM) [2-6].
- Interventions that utilise isolated sensory stimuli do not adhere to these principles and are not recommended.
- This review included two Randomised Controlled Trials (RCT's). Both indicated statistically significant group differences favouring the Ayres SIT group across Goal Attainment Scale (GAS) outcomes, care giver assistance using the Paediatric Evaluation of Disability Inventory (PEDI) for self-care and social activities scale.
- It should be noted that only one of these RCT's achieved an effect size that would be considered an important intervention effect (≥0.25). Therefore, results should be interpreted with caution.

There is weak evidence to support the use of SIT that doesn't adhere to principles outlined by Ayres or Sensory Based Interventions (SBI) (both single and multi-sensory). Generalisability of results is not possible as many reviews included peer reviewed literature which was of ***low quality***, had ***small sample*** sizes or ***lacked any statistical comparison***. The majority of studies were classified as negative due to a lack of patient benefit, especially weighted vests and/or blankets. In some cases, SIT may have increased problem behaviour [7]. Studies that found positive outcomes were often rated as 'suggestive' evidence due to major methodological limitations.

Single and multi-sensory interventions investigated included: sensory objects, toys, special seating, eye shields, noise cancelling head set, brushes, lotion, books, games, mats, swing,

climbing walls, tubes, ball pit, weighted vests, fine motor activities and Snoezelen equipment.

2. Sensory Integration Therapy Research Evidence

2.1 Systematic reviews utilising the principles of Ayres Sensory Integration Therapy

Ayres Sensory Integration Therapy (SIT) is one of the most highly utilised interventions for autism spectrum disorder (ASD), however, a lack of consensus exists regarding its evidence base. One reason for this is that many studies included in existing systematic reviews and meta-analyses report on sensory-based interventions which are not consistent with the principles of Ayres SIT as described by Ayres [2-5], and operationalized in the Ayres Sensory Integration Fidelity Measure (ASIFM) [6]. Instead, many reviews and meta-analyses include studies of interventions that use isolated sensory stimuli as the active ingredient of the intervention (hereafter referred to as sensory-based interventions (SBI)) and do not adhere to the core principles of Ayres SIT. These sensory-based interventions are largely characterized as protocols that are passively applied to the child and have been found to have few positive effects [8]. They lack many of the key ingredients of the ASI such as **individual-tailoring, active engagement of the child, the establishment of a therapeutic alliance between the child and therapist, targeting the just right challenge and provided within the context of play** [1].

A recent systematic review conducted by **Schaaf, Dumont, Arbesman, and May-Benson (2018)** [9] only included studies where *the intervention approach adhered to the principles of ASI.*

Summary

1) *Research question/purpose/objective*
   - What is the efficacy of occupational therapy using Ayres SIT to support functioning and participation as defined by the International Classification of Functioning, Disability and Health for persons with challenges in processing and integrating sensory information that interfere with everyday life participation?
2) *Methodology*

- Only studies of level I, II and III were included.
- NHMRC level of evidence hierarchy = **Level III-2**
- Comprehensive search strategy

3) *Results/conclusion*
   - 5 included studies (3 RCT's, 1 retroactive analysis and 1 single subject A-B-A design)
   - Included participants were mostly male and ranged in age from 4 – 9 years
   - **Strong evidence** that Ayres SIT intervention demonstrates positive outcomes for improving individually generated goals of functioning and participation as measured by Goal Attainment Scaling (GAS)
   - **Moderate evidence** supported improvements in impairment-level outcomes of improvement in autistic behaviours and skills-based outcomes of reduction in caregiver assistance with self-care activities
   - **Insufficient evidence** for outcomes in play, sensory–motor, and language skills and reduced caregiver assistance with social skills

A further systematic review with far stricter inclusion criteria to establish whether ASI is an evidence based practice was published in 2019 by **Schoen, Lane, Mailloux, May-Benson, Parham, Smith Roley and Schaaf** [1]. The authors of this review identified 'major concerns' with previous reviews which investigate the effectiveness of Ayres SIT such as;

1) Sensory integration interventions described were not consistent with the principles of Ayres SIT and were instead a sensory-based intervention.
2) Fail to provide an adequate description of the phenotypic characteristics of participants.
3) Do not present a replicable description of the intervention, or document intervention fidelity throughout the intervention period using a quantitative measure.
4) Outcomes measured in existing studies vary widely and may not be sensitive to the changes expected following Ayres SIT intervention.

Summary

1) *Research question/purpose/objective*

- Does ASI intervention meet the Council for Exceptional Children (CEC) criteria for an evidence-based practice for children with ASD?

2) *Methodology*
   - Comprehensive strategy which included 3 stages: (1) electronic database search, (2) selection of studies using well defined inclusion criteria and (3) evaluation of included studies using CEC standards.
   - NHMRC level of evidence hierarchy = **Level III-2** (this is because one study included was a retrospective record review and non-randomisation)
   - Quality indicator rating and data extraction was performed by 7 highly experienced OT's (>34 years clinical and academic experience)

3) Results/conclusion
   - 3 studies met inclusion criteria
   - Authors state that "*Ayres SIT is an evidence based practice is supported by the finding of two methodologically sound group comparison studies with random group assignment, positive outcomes, and a collective total of >60 participants.*"
   - Only one study achieved a combined effect size of >0.25 (see effect size interpretation below)
   - The justification and conclusion that ASI is an evidence based practice and provides positive outcomes needs to be interpreted with caution. Although two studies found statistically significant results (<0.05) only the study by Schaaf et al. (2014) [10] achieved effect sizes that would be considered clinically effective. GAS (p = 0.003, d = 1.2), measures of caregiver assistance in self-care (p = 0.008

Effect size interpretation: Measures either the sizes of associations or the sizes of differences.

It is standard practice to use effect size in experimental group comparisons rather than statistical significance to evaluate the strength of the findings, since statistical significance is influenced by the sample size. Effect size is preferable because it takes into account the meaningfulness of the outcomes for the population being studied.

The Schoen et al (2019) [8] paper used the guideline that an effect size ≥0.25 is deemed a substantively important intervention effect and <0.25 is not a substantively important effect. This means that if two groups' means don't differ by 0.25 standard deviations or more, the difference is trivial, even if it is statistically significant.

d = 0.9) and socialization (p = 0.04, d = 0.7) compared to the usual care group (control).

2.2 Systematic Reviews – combined Sensory Integration Therapy and Sensory Based Interventions

Description of Sensory-Based Interventions

Sensory-based interventions (SIB's) typically occur in the child's natural environment and consist of applying adult-directed sensory modalities to the child with the aim of producing a short-term effect on self-regulation, attention, or behavioural organization Common individual SBIs include weighted vests, brushing, bouncing on a ball, and adapted seating devices that allow motion. These modalities may be provided in a systematic manner throughout the child's day or as needed in response to the child's self-regulation and are often combined into what is called a sensory diet.

Lang R, O'Reilly M, Healy O, Rispoli M, Lydon H, Streusand W, Davis T, Kang S, Sigafoos J, Lancioni G, Didden R. Sensory integration therapy for autism spectrum disorders: A systematic review. Research in Autism Spectrum Disorders. 2012 Jul 1;6(3):1004-18 [7].

Summary

1) *Research question/purpose/objective*
   - To systematically identify, analyse, and summarize research involving the use of SIT in the education and treatment of individuals with ASD.
2) *Methodology*
   - Multiple research databases searched
   - Studies had to include at least on participant with ASD and implement some form of SIT
   - No restriction on level of evidence included.
   - NHMRC level of evidence hierarchy = **Level III-2**
   - No differentiation between Ayres SIT and SBI
3) *Results/conclusion*
   - Included studies investigated weighted vests, blanket or body sock, swinging, brushing, joint compressions or stretching, alternative seating, playing with

water or sand sensory table, chewing on a rubber tube, playing with textured toys sensory diets, and vestibular or proprioceptive intervention

- 25 included studies provided SIT intervention to a total of 217 individuals with ASD (*some studies included other diagnoses)
- 14 studies were classified as negative as there was no benefit to the patient. Of these, four suggested that SIT may have increased problem behaviour. Eight studies showed mixed results and three were positive. All three positive studies were rated as 'suggestive' evidence which is the lowest rating due to major methodological limitations.
- SIT had no consistently positive effect as a treatment for children with ASD.

Watling R, Hauer S. Effectiveness of Ayres Sensory Integration® and sensory-based interventions for people with autism spectrum disorder: A systematic review. American Journal of Occupational Therapy. 2015 Sep 1;69 (5):6905180030p1-2 [11].

Summary

1) *Research question/purpose/objective*
   - What is the evidence for SIT and SBIs within the scope of occupational therapy practice to improve performance in daily life activities and occupations for children with autism spectrum disorders?
2) *Methodology*
   - Multiple research databases searched
   - Studies included in the review are Level I, II, and III evidence. Level IV evidence was included only when higher level evidence on a given topic was not found
   - NHMRC level of evidence hierarchy = **Level III-2**
3) *Results*
   - 23 articles met inclusion criteria
   - 506 participants ranging in age from 2 to 39 years. Majority were male
   - Level I SIT studies included significant improvement in individualized goals, improved sleep, decreased autism mannerisms, and reduced caregiver burden

- Level I SIB studies found that active participation in multisensory experiences in home or clinic settings led to significant improvements in autism symptoms and behaviours as well as improved scores in cognitive and vocabulary testing
- Level II SIB studies reported a significant improvement in motor proficiency and sensory functioning after clinic-based multisensory intervention that included enhanced vestibular, proprioceptive, and tactile sensory experiences. Increases in sustained focus, decreases in self-injurious behaviour, and increased perceived relaxation and happiness were found after independent participation in a multisensory centre.
- Level IV SIB study found no effect on self-injurious behaviour, challenging behaviour, or cortisol levels as a result of uniformly designed sensory diets.
- Studies which investigated single SBI's found no effects

4) *Conclusion*
   - Moderate evidence was found to support the use of Ayres SIT. The results for sensory-based methods were mixed. Recommendations include performing higher level studies with larger samples, using the Fidelity Measure in studies of Ayres SIT, and using carefully operationalized definitions and systematic methods in examination of SBIs.

Bodison SC, Parham LD. Specific sensory techniques and sensory environmental modifications for children and youth with sensory integration difficulties: A systematic review. American Journal of Occupational Therapy. 2018 Jan 1; 72(1):7201190040p1-1 [12].

Summary

1) *Research question/purpose/objective*
   - What is the effectiveness of occupational therapy interventions that use specific sensory techniques or sensory environmental modifications to support function and participation of children and youth who have sensory integration difficulties
2) *Methodology*
   - Multiple research databases searched

- Included interventions: cognitive, parent or teacher coaching, and occupation-based interventions; specific sensory techniques; and sensory environmental modifications
- Levels I, II, and III studies included
- NHMRC level of evidence hierarchy = **Level III-2**

3) *Results*
   - 8 articles met inclusion criteria and interventions included weighted vests, Qigong massage, slow linear swinging and sensory environmental techniques
   - Qigong massage had 3 high level 3 RCTs which concluded that all reporting positive outcomes
   - Limited support for weighted vests
   - Insufficient evidence for the effectiveness of slow linear swinging in producing improved on-task behaviour
4) *Conclusion*
   - The evidence is insufficient to draw conclusions regarding slow linear swinging and incorporation of multisensory activities into preschool settings. Although Qigong massage provided positive results all RCT's were conducted by the same research group which is of concern. Further independent studies are required.

Case-Smith J, Weaver LL, Fristad MA. A systematic review of sensory processing interventions for children with autism spectrum disorders. Autism. 2015 Feb; 19(2):133-48 [13].

1) *Research question/purpose/objective*
   - What is the effectiveness of SIT and SBIs for children with ASD and co-occurring sensory processing problems on self-regulation and behaviour?
2) *Methodology*
   - Thorough search strategy
   - Inclusion criteria: (a) peer reviewed studies published in English, (b) participants were youth aged 3–21 years, (c) an SIT or SBI was studied, (d) participants were diagnosed with ASD, and (e) the intervention systematically (i.e. was based on stated goals) targeted self-regulation and arousal state.
   - NHMRC level of evidence hierarchy = **Level III-2**

3) *Results*
   - 19 studies included. 5 SIT and 14 SIB
   - SIB - Among the seven single-subject studies that applied a weighted vest, only one demonstrated positive effects. Although these studies provide low-level evidence, findings suggest that wearing a weighted vest does not result in improved behaviour (e.g. decreased stereotypic behaviours, improved joint attention, or reduced distractibility). The evidence for children sitting on balls or for multisensory stimulation is limited and inconclusive.
   - SIT – Two RCT's found that SIT is associated with positive effects as measured by the child's performance on Goal Attainment Scaling, decreased autistic mannerisms and improved self-care and social function
4) *Conclusion*
   - SIT for children with ASD and sensory processing problems demonstrates positive effects on the child's individualized goals; however, additional studies are needed to confirm these results. Randomized trials using blinded evaluation and larger samples are needed. SBIs have almost no evidence of positive effects.

2.2.1 Weighted vests

Taylor CJ, Spriggs AD, Ault MJ, Flanagan S, Sartini EC. A systematic review of weighted vests with individuals with autism spectrum disorder. Research in Autism Spectrum Disorders. 2017 May 1; 37:49-60 [14].

1) *Research question/purpose/objective*
   - The purpose of the study was to evaluate the current literature on the use of weighted vests with individuals with autism spectrum disorder
2) *Methodology*
   - Thorough search strategy
   - Inclusion criteria: (a) use of a group design or single case research design; (b) inclusion of at least one individual with ASD; (c) examination of the effects of weighted vests on a particular dependent variable (e.g., aggressive behaviour,

attention to task); and (d) publication in English in a peer-refereed journal in the past 25 years.

- NHMRC level of evidence hierarchy = **Level III-2**
- Utilised validated data extraction criteria

3) *Results*
   - 32 studies met inclusion criteria
   - Relatively small sample sizes across studies. Poor levels of evidence/quality
   - 13 were rated as **meets evidence standards** and four were rated as **meets evidence standards with reservations** and fifteen studies were rated as **does not meet evidence standards**.
   - A total of 13 children (4–10 years) with ASD participated in the studies rated as meeting evidence standards or meeting evidence standards with reservations.
   - No effect on engagement, stereotypic behaviour, or problem behaviour as meets evidence standards with reservations
4) *Conclusion*
   - The information from this review indicates that the use of weighted vests with children with ASD is not an evidence-based practice. Practitioners should be aware of the literature examining weighted vests when designing interventions for children with ASD

Gee BM, Peterson TG, Buck A, Lloyd K. Improving sleep quality using weighted blankets among young children with an autism spectrum disorder. International Journal of Therapy and Rehabilitation. 2016 Apr 2; 23(4):173-81 [15].

1) *Research question/purpose/objective*
   - to explore the efficacy of weighted blankets with children with an autism spectrum disorder and sleep disturbances using a single case, multiple baseline design
2) *Methodology*
   - Case study (pilot)
   - NHMRC level of evidence hierarchy = **Level IV (lowest level)**

- Inclusion criteria: (a) Diagnosis of ASD, (b) evidence of sleep disturbance according to the Child Sleep Habits Questionnaire, (c) struggle with sensory over-reactivity as evidenced by achieving a threshold score on the Sensory Processing Measure (d) age between 3 and 6, (e) fluent in English, (f) Have internet access, (g) able to willingly implement the weight vest.
- Intervention: 9 days of no weighted blanket (baseline), 14 days of weighted blanket (intervention) and 7 days of no weighted blanket (withdrawal)

3) *Results*
   - The overall findings demonstrated minimal improvement of the measured constructs related to sleep quality in the two participants.
   - Weak evidence shown for total amount of sleep per night and decrease in the time to fall asleep
   - The findings provide a foundation for the justification of further single subject designs, using more rigorous designs and measurement.
4) *Conclusion*
   - There is need for additional research related to improving the quality of sleep in children with an ASD and sensory over-responsivity, using more robust single subject design methodology and measurement resources.

2.2.2 Systematic reviews of sensory integration therapy non-specific to ASD

Two systematic reviews investigating SIT have been conducted that investigate disabilities other than ASD. Their results and conclusion will be covered for reference.

Leong HM, Carter M, Stephenson J. Systematic review of sensory integration therapy for individuals with disabilities: Single case design studies. Research in developmental disabilities. 2015 Dec 1; 47:334-51 [16].

1) *Results*
   - 17 single case design studies on sensory integration therapy for people with, or at-risk of, a developmental or learning disability, disorder or delay.

- Interventions included: Ayres SIT, vestibular stimulation, tactile stimulation, proprioceptive stimulation, sensory diet, weighted vest, Wilbarger, joint compression
- Based on limited comparative evidence, functional analysis-based interventions for challenging behaviour were more effective that SIT.

2) *Conclusion*
   - Overall the studies do not provide convincing evidence for the efficacy of sensory integration therapy. Given the findings of the present review and other recent analyses it is advised that the use of SIT be limited to experimental contexts

Barton EE, Reichow B, Schnitz A, Smith IC, Sherlock D. A systematic review of sensory-based treatments for children with disabilities. Research in Developmental Disabilities. 2015 Feb 1; 37:64-80 [17].

1) *Results*
   - Thirty studies involving 856 participants met our inclusion criteria and were included
   - Interventions included: Sensory objects, toys, pool, special seating, eye shields, noise cancelling head set, brushes, lotion, books, games, mats, swing, climbing walls, tubes, ball pit, weighted vests, Vestibular, tactile, and proprioceptive-based activities, fine motor activities, Snoezelen equipment,
   - Considerable heterogeneity was noted across studies in implementation, measurement, and study rigor. The research on sensory-based treatments is limited due to insubstantial treatment outcomes, weak experimental designs, or high risk of bias.

2) *Conclusion*
   - Based on the analysis, sensory-based treatments are more likely to be ineffective than effective for children with disabilities

3. Reference List

1. Schoen SA, Lane SJ, Mailloux Z, May-Benson T, Parham LD, Smith Roley S, Schaaf RC. A systematic review of Ayres Sensory Integration intervention for children with autism. Autism Research. 2019 Jan;12(1):6-19.
2. Ayres AJ. Sensory integration and learning disorders. Western Psychological Services; 1972.
3. Ayres AJ. Sensory integration and learning disorders, Western Psychological Services. Los Angeles, CA. 1972.
4. Ayres AJ. Sensory integration and praxis tests (SIPT). Western Psychological Services (WPS); 1996.
5. Ayres AJ, Robbins J. Sensory integration and the child: Understanding hidden sensory challenges. Western Psychological Services; 2005.
6. Parham LD, Cohn ES, Spitzer S, Koomar JA, Miller LJ, Burke JP, Brett-Green B, Mailloux Z, May-Benson TA, Roley SS, Schaaf RC. Fidelity in sensory integration intervention research. American Journal of Occupational Therapy. 2007 Mar 1;61(2):216-27.
7. Lang R, O'Reilly M, Healy O, Rispoli M, Lydon H, Streusand W, Davis T, Kang S, Sigafoos J, Lancioni G, Didden R. Sensory integration therapy for autism spectrum disorders: A systematic review. Research in Autism Spectrum Disorders. 2012 Jul 1;6(3):1004-18.
8. Case-Smith J, Weaver LL, Fristad MA. A systematic review of sensory processing interventions for children with autism spectrum disorders. Autism. 2015 Feb;19(2):133-48.
9. Schaaf RC, Dumont RL, Arbesman M, May-Benson TA. Efficacy of occupational therapy using Ayres Sensory Integration®: A systematic review. American Journal of Occupational Therapy. 2018 Jan 1;72(1):7201190010p1-0.
10. Schaaf RC, Benevides T, Mailloux Z, Faller P, Hunt J, Van Hooydonk E, Freeman R, Leiby B, Sendecki J, Kelly D. An intervention for sensory difficulties in children with autism: A randomized trial. Journal of autism and developmental disorders. 2014 Jul 1;44(7):1493-506.

11. Watling R, Hauer S. Effectiveness of Ayres Sensory Integration® and sensory-based interventions for people with autism spectrum disorder: A systematic review. American Journal of Occupational Therapy. 2015 Sep 1;69(5):6905180030p1-2.
12. Bodison SC, Parham LD. Specific sensory techniques and sensory environmental modifications for children and youth with sensory integration difficulties: A systematic review. American Journal of Occupational Therapy. 2018 Jan 1;72(1):7201190040p1-1.
13. Case-Smith J, Weaver LL, Fristad MA. A systematic review of sensory processing interventions for children with autism spectrum disorders. Autism. 2015 Feb;19(2):133-48.
14. Taylor CJ, Spriggs AD, Ault MJ, Flanagan S, Sartini EC. A systematic review of weighted vests with individuals with autism spectrum disorder. Research in Autism Spectrum Disorders. 2017 May 1;37:49-60.
15. Gee BM, Peterson TG, Buck A, Lloyd K. Improving sleep quality using weighted blankets among young children with an autism spectrum disorder. International Journal of Therapy and Rehabilitation. 2016 Apr 2; 23(4):173-81.
16. Leong HM, Carter M, Stephenson J. Systematic review of sensory integration therapy for individuals with disabilities: Single case design studies. Research in developmental disabilities. 2015 Dec 1;47:334-51.
17. Barton EE, Reichow B, Schnitz A, Smith IC, Sherlock D. A systematic review of sensory-based treatments for children with disabilities. Research in Developmental Disabilities. 2015 Feb 1;37:64-80.

NDIA Research Paper: Sexual Activity Supports

Purpose of paper:

This research paper has been developed to provide guidance on;

- Definitions and terminology used for various sexual activity supports
- Evidence around expected experience, training and qualifications of service providers
- Domestic and International policy and/or guidelines relevant to delivering sexual activity supports to people with a disability
- Existing disability sexual activity supports
- Information relating frequency of sexual activity in the community and benefits (physical or mental) of sex or sexuality
- Sexuality and disability
- Viewpoint of advocacy groups

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World Health Organisation definitions of sexual health

The World Health Organisation (WHO) has developed working definitions of key terms relating to sexual health [1]. These terms are used extensively throughout this document and are provided for reference.

Sexual health

According to the current working definition, sexual health is:
"…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." [2]

Sex

Sex refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females. *In general use in many languages, the term sex is often used to mean "sexual activity", but for technical purposes in the context of sexuality and sexual health discussions, the above definition is preferred.*

Sexuality

Sexual health cannot be defined, understood or made operational without a broad consideration of sexuality, which underlies important behaviours and outcomes related to sexual health. The working definition of sexuality is:
"…a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors." [2]

Sexual rights

There is a growing consensus that sexual health cannot be achieved and maintained without respect for, and protection of, certain human rights. The working definition of sexual rights given below is a contribution to the continuing dialogue on human rights related to sexual health.

"The fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled." Sexual rights embrace certain human rights that are already recognized in international and regional human rights documents and other consensus documents and in national laws. Rights critical to the realization of sexual health include:

- the rights to equality and non-discrimination
- the right to be free from torture or to cruel, inhumane or degrading treatment or punishment
- the right to privacy
- the rights to the highest attainable standard of health (including sexual health) and social security

- the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage
- the right to decide the number and spacing of one's children
- the rights to information, as well as education
- the rights to freedom of opinion and expression, and
- the right to an effective remedy for violations of fundamental rights.

Disability Specific Terminology, Definitions and Services

The search strategy utilised to identify evidence can be found in Appendix A.

Table 1 provides a list of professionals who provide disability specific sexual activity supports. This includes their roles, definition, services provided and the country of origin.

Table 2 provides a comparison of services provided by each identified provider.

Table 3 is a comprehensive list of organisations that provide sexual activity support to PWD.

Table 1

	Role	Definition	Services	Countries	References which identify term
1.	Sexual assistant (Sexualbegleiterin)	Sexual assistants (SA) was defined as a person who provides sexual assistance to physically and/or intellectually disabled people. By sexual assistance we mean one or more of these activities: sexual intercourse, oral sex, massage therapy including erotic massage, masturbatory acts, and discussion of sexuality, contraception, and the appropriate use of sex toys [3] p.2. SA do not provide standardised services, rather differentiated services take into account disability and emotional and sexual expectations of the client [4].	SA provide limited 'touching' services through non-profit organisations [5]; however Limoncin (2014) [3] notes that a SA may provide oral sex, sex, erotic massage, masturbation, conversation about sexuality and appropriate use of sex toys. SAs explicitly discuss what kind of practices might improve the relationship quality, communication and intimacy for clients with disabilities; 'preliminary meeting' – a non-sexual encounter, ideally in person or on Skype, allowing the potential client and the assistant to see each other and discuss their expectations and boundaries. SAs are trained to relate to the client's team of personal assistants and family carers. Embrace a discourse of reciprocity with the clients, including around aspects of pleasure [6]. A team of specialists (including, but not limited to, psychologists, sexologists, physiotherapists, the sexual assistant and the client) determine the number of required sessions (no more than twelve in Italy per therapeutic plan), when physical contact will occur (i.e. after the 5th session), and the content of the sessions [4, 7]. **Skills required include** [4]: • Distinguish between own emotional and psychological projections and the emotional needs and welfare of the client • Adhere to privacy and confidentiality of their clients and the sessions • Professionalism including mutual respect and the intimacy of the sessions • Skills linked to the concept of 'holding' whereby the assistant supports the person both physically and psychologically or emotionally. • Knowledge about safe transfers and body manipulation **Difference from sex work** [4]: • Greater emphasis on intimacy which may or may not include sexual activity • Goal is therapeutic • Aims to facilitate confidence of the person with social and physical relationships and overcoming anxiety and fears	Germany, The Netherlands, Denmark, Switzerland, UK, Italy, Sweden.	[4, 5, 6, 7, 8, 9, 10, 11, 12, 13]

			• In a triadic relationship with the therapist, psychologist or physiotherapist, (PWD-surrogate-therapist) • A therapist (as point above) mediates and supervises the relationship between the assistant and the client • Relationship only occurs within the confines of the sessions • Includes sex and sexuality education [3, 4] • More emphasis on relaxation activities [3, 4, 7] • May have rehabilitation aspects such as increasing confidence and sexual and social skill development [8].		
2.	Voluntary non-profit relationship	Charitable non-profit organisations, whose members would voluntarily and freely provide sexual pleasure (proposed model).	N/A	N/A	[14]
3.	Sexual surrogacy	Sex Surrogates (sometimes referred to as surrogate partners), are trained in addressing issues of intimacy and sexuality.	Surrogate's primary aim is to resolve sexual issues, therapists are involved in the process through regular check-ins (triadic relationship PWD-surrogate-therapist) [15]; Surrogacy for PWD is rooted in therapeutic approaches to address sexual dysfunctions, rather than in PWD's interventions [9]. Sex surrogacy can be a contested term because of "the implication that the only people who will want to, or are able to, have sex with PWD are professionals who have undergone special therapeutic training or New Age consciousness-raising. Another problem with the term is that it carries a suggestion that sex surrogates are somehow better than sex workers. Sex surrogates, the label seems to say, are more healing, more involved, more professional…" [10]. In rehabilitation contexts, the surrogate will work with a sex therapist or psychologist who is trained in rehabilitation [16]. Sexual aspects that a surrogate may address include social, intimacy, sensual, and sexual skills. They need to be able to empathise, set limits, and provide encouragement and tenderness [16].	N/A	[9, 10, 15-17]
4.	Sex worker (provides specialised services to PWD)	A sex worker who provides specialised services to clients with disability is another way in which disabled (and non-disabled) people can affirm and express their sexuality.	In the UK prostitution is not in itself illegal. However, if staff are aware that patients or service users are using the services of prostitutes on their premises, this may give rise to a charge of keeping, or managing or acting to assist in the management of, a brothel. Assisting a PWD or service user in obtaining the services of a prostitute could be illegal under s.53A of the Sexual Offences Act 2003 [17].	NSW (Australia), UK	[9, 15, 18]

			Sex workers who are experienced in working with PWD still exchange sexual services, performances or products for material compensation. This includes activities of direct physical contact between buyers and sellers as well as indirect sexual stimulation. The not-for-profit organisation in Australia, Touching Base, links PWD up with sex workers who are experienced in providing specialised services.		
5.	Sexual advisors (seksualvejledere)	Initiatives which promote forms of access to sensual and sexual experiences with professionals, for PWD [9].	Sexual advisors may counsel PWD about their options, making sure that they understand consent, exploitation and coercion, and non-violent approach [10].	Denmark	[9, 10]
6.	Sexual facilitators	N/A	Sexual facilitation or facilitated sex (sexuality) is a highly contested term. Facilitated sexuality - it appears that nurses may be expected to become adjuncts to the sex industry or even a part of it, by directly 'sexually facilitating' men with disabilities themselves [18]. 'Facilitated sex' can range from 'the provision of accessible information and advice to the organisation of sexual surrogacy' [18] pg. 437. It might include assistance to 'negotiate the price when using the services of a prostitute' [18] pg. 437. More specifically, a person might be required to 'facilitate sexual intercourse between two or more individuals, to undress them for such a purpose, or to masturbate them when no other form of sexual relief is available'… One problem here is that carers might be able to use the justification of facilitated sex for sexually abusing PWD in their care. The major problem is that expecting carers to sexually service men is just another form of sexual exploitation [19]. **Sexual facilitators may perform the following** [11]: • Provide accessible information • Foster environments that allow for sexual intimacy • Supports social interaction • Procurement of sexual goods • Arrange for paid sexual services • Facilitate masturbation or sexual intercourse with another person (positioning, handing of aids (such as removing catheter, undressing etc.) [11, 12] Barriers may include: • Lack of guidelines for support workers/personal assistants around facilitating sexuality from organisations • Undertaking risk management for the person and the support worker/personal assistants	Sweden	[11, 12, 19, 20]
7.	Sexual companion		Some authors use this term in reference to surrogacy		[10]

(Sexualbegleiter)

8.	Sex therapist/ Psychosexual therapist (not disability specific profession)	Sex therapists provide a specialized form of professional counselling that focuses on addressing the sexual concerns, sexual functioning and sexual expression of human beings. The Society of Australian Sexologists uses the term *Psychosexual Therapist* for accredited members who must meet stringent educational standard.	Therapeutic counselling (talk therapy) may be provided within specialist areas in the field including sexual development over the lifespan (child, adolescent and ageing sexuality), sexual relationships, sexual behaviour and activity, sexual identity and orientation, and also with groups (cultures, people with disability, adolescents, sex in older age). The International Society for Sexual Medicine and Society of Australian Sexologists clearly state that sex therapy **does not involve physical contact or sexual activity among clients and therapists.**	Definitions/services provided by Lisa Torney (National Chairperson – Society of Australian Sexologists)

Table 2

Model	Services												
	Providing specialised services to PWD	Formal/non formal education, peer training	Sex Ed for people with disabilities	Affirming and expressing sexuality	Trained to relate with PWDs personal assistant/carers	Peer supervision (experience sharing, discussions about enhancing relationship/intimacy	Resolving sexual issues	Overcoming obstacles in sex lives	Facilitating of the erotic life (incl. safe transfers and body manipulation)	Limited touching' services	'Preliminary meeting' to discuss expectations and boundaries	Addressing sexual dysfunctions	Triadic relationship with a therapist
Sex Work	x	x		x									
Sexual assistant	x	x	x	x	x	x		x	x	x	x		x

Voluntary non-profit relationship	x			x									
Sexual surrogacy	x	x					x	x	x			x	
Sexual advisors	x	x	x										
Sexual facilitation	x	x							x	x			x

Table 3.

	Organisation	Type of service	Country	Website
1	European Platform for Sexual Assistance (EPSA)	EPSA is a platform for non-profit organisations who are active in providing sexual assistance to people with disability. It have seven organisation partners across Europe.	EU	http://www.epseas.eu/en/
2	BodyUnity	BodyUnity operates legally in its not-for-profit activities of peer training and peer supervision of sexual assistants, as well as its not-for-profit mediation between potential clients, their carers and institutions, and sexual assistants (Garofalo Geymonat 2019).	Switzerland	N/A
3	TouchingBase	Assists people with disability and sex workers to connect with each other.	NSW, AU	https://www.touchingbase.org/
4	The Danish Association for Sexuality Advisors (DASA)	The association consists of around 200 members who all have gone through training as sexuality advisors. Members work in many different fields, such as mental disability, physical disability, vocational training, etc. They are all qualified to: • Teach staff about disability and sexual abuse. • Teach staff about disability and sexuality – Responsibilities and liabilities. • Facilitate processes on how to create a policy for sexuality. • Give courses for couples with disabilities – Learning how to act in a relationship. • Teach and advise people with a disability.	Denmark	https://www.seksualvejlederforeningen.dk/in-english/

		• Provide guidance in sexuality – for singles and couples.		
5	TLC Trust	The TLC Trust are a non-profit organisation who strive to promote sexual services for disabled people in a safe, fun and responsible way. Having access to intimate experiences is a basic human right.	UK	https://tlc-trust.org.uk/
6	Sexual Health and Disability Alliance (SHADA)	SHADA aims to support those professionals who include the sexual and relationship aspects of their disabled clients in their holistic care.	UK	https://shada.org.uk/
7	Equitable and Accessible Sexual Expression (EASE)	Disability Rights group that partners with sex workers and the sex industry.	Canada	N/A
8	Sensual Solutions (registered as an escort agency by the City of Vancouver)	Sensual Solutions is an escort agency that provides sexual services to people with physical disability through Sensual Coaches who provide a range of services.	Canada	http://www.sensualsolutions.ca/whats-a-coach/
9	Para-Doxies	A not for profit Sexual enabling service for all people with disability or terminal illness	UK	https://twitter.com/para_doxies?lang=en
10	The Outsiders	The Outsiders Trust is a social, peer support and dating club. It also offers support on relationships, sexuality, dating and sexual services, to all disabled people and a wide range of their therapists and health and social care professionals	UK	https://www.outsiders.org.uk/outsidersclub/
11	Basel-based Welfare Group Disabled and Sexuality Fachstelle Behinderung und Sexualität (Fabs)	'Fabs' arranges erotic massages, but has recently campaigned to extend the service to provide full sex acts for heterosexual and gay people with impairments.	Switzerland	https://web.archive.org/web/20061206220439/http://aiha-zemp.com/de/fabs
12	IPSA International Professional Surrogates Assn	IPSA supports a worldwide community of professionals in the field of surrogate partner therapy, which includes surrogate partners, therapists, and individuals in need of and supportive of surrogate partner therapy.	US	https://www.surrogatetherapy.org/
13	White Hands	White Hands is a Japanese organisation that provides training to people with disability and other people including those working in the sex industry.	Japan	https://white-hands.jp/
14	Handisex	Handisex is an organisation that offers services to people with disability including: assessment of sexual needs, sexual guidance, sexual training, sexual education, intercourse and masturbation assistance and sensual massage	Denmark	https://handisex.dk/om-os/?lang=en
15	Institute for Self-Determination of Disabled People (Institut zur	Sexual counseling and sexual accompaniment outside of prostitution	Germany	http://www.isbbtrebel.de/

	SelbstBestimmung Behinderter)			
16	Stichting Alternatieve Relatiebemiddeling (Foundation for Alternative Relationship Mediation)	A foundation that mediates between sex workers and people with disability. Includes Introductory meeting (in which PWD discusses possibilities, limitations and sexual wishes) and, if desired, a one hour Visit (tailored to person's needs and wants). If help is needed getting in and out of bed, getting out and getting dressed, the SAR asks the PWD to arrange this.	Netherlands	https://www.stichtingsar.nl/English/index.html
17	Love Giver	An Italian committee created to promote sexual assistance in Italy	Italy	www.lovegiver.it
18	The Federation of Youth with Mobility Impairments	"A Secret Known by Everyone" was a project to challenge negative attitudes to sexual facilitation	Sweden	N/A

Training and Qualifications

Sexual Assistant

Training and Certification Overview

The training program for sexual assistants was originally developed in Switzerland. Although training programs vary from one country to another, they are generally similar to the program delivered in Switzerland [7, 21, 22].

To be accepted into a training program candidates must undergo a rigorous selection process to ensure the purity of their intentions (professionalism) and their ability to practice this profession. Candidates must be:

- At least 30 years old
- Have a stable relationship status
- Give evidence of the necessary human qualities (e.g., active listening skills, good knowledge of their own personal limitations, excellent sense of touch, being comfortable with their own sexuality, balanced personality)

Candidates must then submit an application including:

- A letter of motivation
- Résumé
- Proof of employment
- Criminal record check
- Proof of payment of the registration fees

They are then contacted by telephone, after which they have an interview with a sex educator and an individual with experiential knowledge related to disabilities. Finally, the selection process ends with the administration of a questionnaire covering the candidates' knowledge of sexuality in people with disabilities, the people close to them, their education and profession, their knowledge of disabilities in general, their health, and their expectations regarding the training.
The training program takes 1-year (300 hours) and covers the following topics:

- Specific knowledge of different disabilities
- Legal knowledge
- Sexuality and sexology related to disabilities
- Knowledge of and initiation into bodily approaches (body language and eroticism)
- Institutional contexts and the role of accompanying persons, and ethics

At the end of the program, the new sexual assistants are sometimes supervised by an experienced worker, while at other times peer support groups are set up for supervision. Since the profession of sexual assistant is a difficult one, this kind of follow-up makes it possible to ensure that a new sexual assistant is maintaining his/ her mental health.

Voluntary non-profit relationship

We are unable to locate any qualification/training criteria.

Sex Surrogate/Surrogate Partner

The *International Professional Surrogates Association* (IPSA) [23] provides training and accreditation to become a professional surrogate partner. The profession follows a code of ethics, however, it is

not a **regulated** profession. In the USA, sex surrogacy falls within a legal grey area. There is no law against providing the service, but there are no laws that stipulate that it is ok. The use of sex surrogates is relatively uncommon. The IPSA website lists only 22 certified surrogate partners globally.

Training and Certification Overview

- No specific academic degrees or courses are required as prerequisite to IPSA's Professional Surrogate Partner training program.
- Emotional maturity developed via a combination of life experiences and academic exposure is essential (unclear how this is assessed).
- IPSA offers a 100-hour didactic course which is considered the 'first phase' at a cost of $2,000 (USD) and covers:
    - Intimacy and Human Sexuality
    - Sex Therapy (Clinical Sexology) (in this section reference is made to "working with the differently-abled")
    - Surrogate Partner Therapy
    - Professional Issues
- Following successful completion of 'phase one' applicants are recommended for Internship. This includes;
    - Working with real clients under the supervision of experienced therapists (normally the clients primary therapist) and a surrogate partner mentor
    - The internship continues until the IPSA training staff are satisfied the intern is ready to continue as a professional surrogate partner. This is based on periodic progress evaluations made by mentors *(*unclear what needs to be achieved, appears to be subjective assessment)*
- Certification and Full-membership to IPSA requires:
    - Letter of interest and intent
    - Description of training (length of training, certificates, IPSA trainees must complete a list of training dates and mentors)
    - Personal evolution essay
    - Two letters of recommendation
- To maintain certification, members must engage in continuing education, "honour the letter and spirit" of the IPSA Code of Ethics, and undergo periodic peer review.
- Membership in IPSA must be maintained on an annual basis to retain IPSA certification status. If membership in IPSA lapses, certification will also lapse.

Australia

Currently within Australia, there is no governing or educational criteria for working as a sex surrogate, and sex surrogacy is a term that can be used interchangeably for sex workers who have experience or training in disability, sex therapy or other relevant field [24].
https://www.goodvibesclinic.com.au/sex-surrogacy

Sex Worker

Training and Certification Overview

There are no minimum training or qualification requirements for sex workers in Australia.

The not-for-profit organisation, Touching Base provides *Professional Disability Awareness Training* [25] for sex workers. Lack of specific awareness or training for sex workers providing services to clients with a disability was a major reason for the development of the course.
To be eligible sex workers must have been providing sex services for a minimum of 3 months.
Goals of the course include:

- Progress the concept of professional training being made available to sex workers and sex industry staff who wish to gain greater awareness and skills in working with clients who have a range of special needs
- Assist sex workers and sex industry staff to challenge myths and prejudices they or their workplace may have regarding clients with disability
- Inform participants of the diverse sexuality of people with disability
- Educate participants on how discrimination may create barriers for people with disability to access the sexual lifestyles of their choice – including accessing sex workers and sex services premises
- Inform on better practice for providing accessible services to people with disability
- Inform on how to arrange services through a third party (personal care attendant, family member or friend of client, etc)

Outcomes/Objectives

- Participants will gain knowledge and skills on how to increase the accessibility of their services/premises to people with disability
- Participants will gain skills in working with clients with various disabilities – including mobility and communication impairments
- Increased awareness and skills on a range of Occupational, Health and Safety issues
- Increased awareness of the sexual rights of people with disability
- Increased recognition of the rights of sex workers to have access to courses for professional development
- Sex workers and people with disability will be empowered through their vital collaboration in the development and presentation of this training programme
- Increase of the numbers of sex workers available for referrals through the Touching Base database of sex workers who have completed the Professional Disability Awareness Training (PDAT)
- Increased networking and support for sex workers who see clients with disability

Evaluation

On completion of the training programme sex workers will receive a Certificate of Attendance from Touching Base Inc. Certificates are available to participants in their working and/or personal names, allowing sex workers to safeguard their anonymity.

Sexual Advisors

We are unable to locate any qualification/training criteria.

Sexual Facilitators

We were unable to locate any qualification/training criteria for sexual facilitators. The literature suggests that ‘personal assistants’ or ‘nurses’ could act as a sexual facilitators [12, 13, 19 20]. In

Sweden, 'personal assistants' (similar to disability support worker in Australia) often work alone in the service user's home; there are no formal requirements for education or training; they rarely receive formal supervision or meet with colleagues to discuss their work during work hours; the work is highly individualized; there is an absence of regulatory body/professional [12].

The role of a sexual facilitator does not exist in Australia [26]. The book *Sexual Citizenship and Disability: Understanding Sexual Support in Policy, Practice and Theory* [26] provides interviews with a representative from Touching Base to question the use of the term/service in their *Sexuality and Relationships Policy*. Their response to this was;

"We've often spoken about this new role – a facilitated sexual assistant – you know, probably perfectly suited for a lot of sex workers who are wanting to retire. And quite frankly, if I was providing services to a client and they needed positioning, if I know that person was an ex-sex worker, then, you know, you just don't care, you feel more [at ease]. … The recognition of the different roles that sex workers can play is really understated." [Chapter 6, Pg 26.)

Furthermore, a representative from People with a Disability Australia was also interviewed and asked about the possibility of creating the role of a facilitated sexual assistant.

"A particular type of disability support worker, rather than a sex worker, who would be involved in that whole kind of continuum of activities that didn't include having sex with the person. … but all of the stuff about, you know, accessing pornography, positioning, putting on condoms, etcetera … It was this sort of concept about whether the disability support worker industry would find that palatable to have this kind of new role, but it was really just describing a role that some support workers were very comfortable with and were doing, and just kind of acknowledging that, giving it a framework, so that they were supported, and that there were particular sort of skills or competencies, and safeguards, and accountabilities." [Chapter 6, pg. 27]

Sex Therapist and Sex Educator

Training and Certification Overview

In Australia, sex therapy is not regulated yet by the government. This means untrained and inexperienced people can call themselves sex therapists.
The Society of Australian Sexologists Ltd (SAS) is Australia's leading peak body for the regulation and accreditation of psychosexual therapy and sexuality education. SAS has therefore developed a system of accreditation [27] to ensure the public is protected with trained, qualified and experienced therapists and educators providing professional psychosexual therapy and sexuality education in Australia. Table 4 provides the criteria for becoming a clinical and provisional psychosexual therapist.

Table 4.

Clinical Psychosexual Therapist *(this term is used for accredited Sex Therapists)*	Supervision and Client Hours Minimum of 1000 client-contact hours, with a minimum of 80 supervision hours; consisting of a minimum of 50 hours individual supervision, with a maximum of 20 hours group supervision and a maximum of 10 hours of peer supervision. All hours except the first 200 hours MUST be sex therapy oriented. Proof of registration with approved professional association AHPRA (those that are not appropriate for registration as a psychosexual therapist include dentistry, podiatry, chiropractic , optometry, osteopathy and pharmacy) Psychotherapy and Counselling Federation of Australia

	Australian Counselling Association Australian Association of Social Workers *International Applicants: Applicants from countries other than Australia seeking accreditation as a Psychosexual Therapist will need to meet this criterion as appropriate to their national registration standards. Proof of registration with the respective professional body will need to be supplied* <u>Proof of professional indemnity</u> Proof of National police check (and/or working with children's check where appropriate) <u>Sexological Education</u> Minimum of 216 hours is required covering the following content areas: Overview of the discipline of sexology (including historical and contemporary approaches to psychosexual therapy and sexuality research) Socio-Cultural Aspects of Sex, Sexuality, and Gender (including sexual and gender diversity/identity, spirituality/religion, ethnicity/race, ability, sexual subcultures) Sexual Function and Dysfunction (including diagnosis, testing/assessment, intervention) Sexual and reproductive anatomy and physiology (including models of sexual response cycles) Developmental sexuality across the lifespan Knowledge of sexually transmitted infections and safer sex practices Knowledge of atypical sexual behaviours (including rape and sexual assault, paraphilias, and fetishes) Familiarity of current research in psychosexual therapeutic and sexuality-related (broad) research <u>Attitudes and Values Training Experience</u> A minimum of 12 hours is required in: A Society of Australian Sexologists Ltd. approved Attitudes and Values training experience (e.g. SAR); consisting of a process oriented exploration of the applicant's own feelings, attitudes, values, and beliefs regarding human sexuality and sexual behaviour. Such training is not to be construed as personal psychotherapy or as an academic experience in which the primary emphasis is on cognitive information. The applicant will submit a one page comprehensive statement of his/her professional philosophy and goals of psychosexual therapy including how the SAR affected that philosophy.
Provisional Psychotherapist	<u>Supervision and Client Hours</u> A minimum of 200 client-contact hours with a minimum of 50 supervision hours; consisting of a minimum of 30 hours individual supervision with maximum 20 hours group supervision. The supervisor needs to be approved by Society of Australian Sexologists Ltd. <u>Proof of Registration with Approved Professional Association</u> *Same as for Clinical Psychotherapist* **Proof of Professional Indemnity Insurance** *Same as for Clinical Psychotherapist* **Sexological Education** *Same as for Clinical Psychotherapist* **Attitudes and Values Training Experience**

	Same as for Clinical Psychotherapist

Apart from sexological education, sexuality educators have specific training in education, teaching and assessment and provide education in a variety of areas including schools and community organisations. Table 5 provides the requirements for membership to the SAS.

Table 5.

Clinical Sexuality Educator	**Teaching/Training Practice Hours** A minimum of 216 training/teaching hours in sexuality or a cognisant area A minimum of 24 hours mentorship by SAS clinical sexuality educator or SAS approved (by Accreditation Committee) mentor These must be formal training hours and not adjunct to another role or therapy **Training and Education Provision** Minimum Certificate IV Training and Assessment (or equivalent, or RPL), or Diploma/Advanced Diploma/Bachelor/Graduate Certificate/Graduate Diploma and Masters in a cognate area (Education, teaching, training) **Proof of Professional Indemnity Insurance** Proof of National Police Check (and/or Working with Children's Check where appropriate) **Sexological Education** A minimum of 216 hours (or RPL equivalent) is required covering the following content areas: Overview of the discipline of sexology (including historical and contemporary approaches to psychosexual therapy and sexuality research) Socio-Cultural Aspects of Sex, Sexuality, and Gender (including sexual and gender diversity/identity, spirituality/religion, ethnicity/race, ability, sexual subcultures) Sexual Function and Dysfunction (including diagnosis, testing/assessment, intervention) Sexual and reproductive anatomy and physiology (including models of sexual response cycles) Developmental sexuality across the lifespan Knowledge of sexually transmitted infections and safer sex practices Knowledge of atypical sexual behaviours (including rape and sexual assault, paraphilias, and fetishes) Familiarity of current research in psychosexual therapeutic and sexuality-related (broad) research. **Attitudes and Values Training Experience** A minimum of 12 hours is required in: A Society of Australian Sexologists Ltd. approved Attitudes and Values training experience (e.g. SAR); consisting of a process oriented exploration of the applicant's own feelings, attitudes, values, and beliefs regarding human sexuality and sexual behaviour. Such training is not to be construed as personal psychotherapy or as an academic experience in which the primary emphasis is on cognitive information.

	The applicant will submit a one page comprehensive statement of his/her professional philosophy and goals of psychosexual therapy including how the SAR affected that philosophy.
Provisional Sexuality Educator	**Teaching/Training Practice Hours** A minimum of 72 training/teaching hours in sexuality or a cognisant area. These must be formal training hours and not adjunct to another role or therapy **Training and Education Provision** Same as for Clinical Sexuality Educator **Proof of Professional Indemnity Insurance** Same as for Clinical Sexuality Educator **Sexological Education** Same as for Clinical Sexuality Educator **Attitudes and Values Training Experience** Same as for Clinical Sexuality Educator

Policy and Guidelines on Sexual Activity Supports – Domestic and International

The media and various academic writings refer to sexual activity supports (i.e. sex workers) being provided as part of Government funding arrangements for PWD. Attempts were made to contact various domestic compensation schemes such as Department of Veterans Affairs, Transport Accident Commission, WorkSafe and iCare to identify any public facing documents which outline policy or guidelines as to what is covered, however, we were unsuccessful in obtaining any guidance. The following section will summarise the resources which describe different funding arrangements and potentially packages of support both overseas and domestically.

Northcott Sexuality and Relationship Policy

The NSW not-for-profit organisation Northcott has developed a policy [28] to assist PWD who require assistance with exploring sexuality and creating positive relationships.

This policy states that support will be provided if:
Under NSW Crimes Act 1900, the person/s is over 16 – unless assessed as not having the capacity to consent or if one of the person's holds a supervisory role under care.

- In NSW to have capacity to consent the person needs to understand the nature of a sexual act and understand the difference between sexual touch and non-sexual touch.
- If there is uncertainty about the person's capacity to consent to sexual activity a team approach including staff who know the person well, psychologists and a medical practitioner can be adopted. It is not the role of an individual staff member to decide if a person has capacity to consent.
- In NSW it is an offence for any person to sexuality engage another person under his or her special care who is aged 16 or 17 years. That supervisory role would include teachers, religious leaders, support staff etc.

- All people involved consent to the sexual act. This consent does not need to be communicated verbally
- All people involved have been offered sexual health information, for example, advice on contraception and safe sex
- A private and safe space for the sexual act has been agreed
- A safe space for staff has been agreed. *Note: Staff should never be in the same room or waiting at the door, they should be in a completely separate room*
- A minimum of two staff must work together for this process to ensure staff and person/'s safety. This does not apply for masturbation, one staff member can set up or give the person/s the sex aids or toys they require to independently masturbate
- Staff have had Manual Handling training for people that need Medium Level help

Level of support

- Low Level – Access to space only.
- Medium Level – The person/s need support to undress and be positioned in location e.g. on bed, set up correct aids and equipment. They can have sex or masturbate without physical help e.g. positioning during sex.
- High level – The person/s need physical help during sex or masturbation and putting on/insertion of contraception. At this level a sex worker or sex facilitator is required. Refer to Page 6 for more information on Guidelines for staff supporting people to a Sex Worker

Expectations

Support workers **can** help the person/s with a disability to:

- Get to/onto the place that they would like to have sex on (e.g. transfer the person/s on the bed referring to standard Manual Handling procedures)
- Undress
- Set up/give the person/s the sex aids, sex toys or contraception they need (e.g. hand the person/s a dam, put vibrating underwear on a person – must be off when staff are in the room)

Support workers **cannot** help the person/s with a disability to:

- Position them sexually (Transfers must refer to standard Manual Handling procedures)
- Help with penetration of any opening (e.g. put a penis inside an anus)
- Physically assist with masturbation (e.g. physically guide someone's hand to masturbate)
- Be in the room during the sexual act
- Put on/insert contraception or sex toys that need to be inserted (e.g. put a condom on a person's penis or insert a dildo into a vagina)

NSW Government, Family and Community Services Guidelines on Sexuality and Relationships

The following section is based on the NSW Government, Family and Community Services: Ageing, Disability and Home Care guidelines [29] on sexuality and relationships.

The Sexuality and Relationship Guidelines are written **for any person** who is supporting a PWD to explore and express their sexuality. The Guidelines are intended to provide direction about the roles and responsibilities of all supporters to enhance opportunities for people while exercising their duty of care to avoid harm. The guidelines focus particularly on the importance of providing access to information and education to people, and decreasing their vulnerability to abuse and exploitation.

Education

Workers who support PWD have a role to inform and educate people about their rights in relation to sexuality and relationships. A skilled workforce is needed to achieve this, and requires the full support of service providers to offer opportunities for the professional development of their workers in the area of sexuality and developing relationships. Negative myths and stereotypes about disability and sexuality contribute to contribute to the lack of sexuality education provided to people with disability.

In a service environment supporters must be able to:

- Assist people to understand sex and relationships, and help them to address their reproductive and sexual health needs
- Assist people to understand gender identify, sexual identity, sexual orientations, informed consent and self-advocacy skills
- Understand their responsibilities to the person and the limitations and boundaries related to their role
- Identify what sexual behaviours are legal and illegal, and to fulfil their obligations to support the person and respond appropriately.

For example, Family Planning NSW, Family Planning Victoria and other states run regular courses on sexuality for service providers, support workers and health professionals to build their skills in providing education and support to people with disability.

Respecting diversity

Supporters should be educated to inform people that they have a **gender identity**, that is, they identify as being a man, a woman or transgender. People can have different gender identities and should be supported to understand that it is possible and acceptable to identify as being the opposite gender to the sex they were born. Education also informs people that they have a **sexual identity** which is about how they identify and feel about themselves, in relation to their sexual orientation and who they are attracted to. People can have different **sexual orientations** and should be supported to understand that it is possible and acceptable to be attracted to the opposite sex, the same sex or both.

Providing opportunity

It is with the scope of a support worker to enable PWD to form friendships. Finding friends can be harder for people who need support to undertake activities of daily living or who have mobility and communication difficulties. They require thoughtful and sensitive support to overcome barriers to developing social networks.

Sexual and non-sexual relationships help in the development of social skills. Skill building could include:

- Increasing lifestyle opportunities to form relationships that are equal and balanced for both people
- Building capacity to recognise and interpret non-verbal cues and unwanted behaviour, and to give or withhold consent based on an understanding of the behaviour
- Providing opportunities to make choices and communicating these choices in a variety of life areas, including who they want to spend time with
- Learning conversation and communication styles, for example, taking turns, being part of a group conversation, maintaining comfortable physical distance between people and acceptable touching of other people.

In relation to sexual activity, support workers should consider;

- Promoting opportunities for sexual activity to happen
- Providing privacy to make phone calls or have space for sexual activity
- Be supported to access items such as condoms and lubrication

Sex workers (based on previous NSW legislation)
In a service environment, support workers have an active, legal and legitimate role to support people to access a sex worker. This may include contacting an organisation for information about sex workers, or driving the person to see the sex worker. Touching Base Inc is one organisation that people with disability can contact for access to information about sex services and providers.

It is recognised that *"Engaging a sex worker is one of a range of available options to satisfy the sexual needs of a person, but* ***should not be the first strategy for meeting a person's need for intimacy****. Nor is it an appropriate strategy to satisfy a person's identified need for developing friendships" [p.19].*

Sex Aids
Support workers cannot be expected to provide physical assistance with masturbation and sexual positioning. Visual aids and resources are available from recognised organisations, and supporters may assist people to contact suppliers for advice if they want more information. *Further information on sex aids will be provided in the assistive technology section.*

Specialised sexuality education for people with a disability
All young people need access to and can find benefit from sexual health information. However, programs delivered to people with a disability need to be modified in order to allow for information to be understood and learned in a way that is meaningful to them.

A child's sexuality education comes from a range of sources, including their parents, teachers and friends. Sexual health education is delivered in Australian schools, however, no specific mention is made relating to sexual health and relationships education in the *Disability Standards for Education 2005*. In addition to general sexual health education, people with cognitive disability also require education that:

- Teaches them that people with disability can have fulfilling sex lives
- Covers age-appropriate sexual issues that may be associated with their particular disability
- Explains social rules, such as telling the difference between private and public behaviours
- Is delivered in a way that a person with cognitive disability can understand.

Some adults with cognitive disability may have received adequate sexuality education at school, while others may have missed out. Those who have received adequate education may need follow-up information that is suitable for an adult of their level of ability and literacy. For those who have missed out, it is important to start at the beginning, no matter how old they are.

One-on-one education programs can be accessed through external agencies or not-for-profit organisations. These are delivered by experienced disability and community educators.
For example, Family Planning Victoria delivers the following courses which are designed specifically for those with a cognitive disability:

- Safer Sex: Contraception and Sexually Transmitted Infections
- Consent and the law
- Anatomy and conception
- Sex and Sexual decision making

- Dating and respectful relationships

A report from Sexual Health and Family Planning Australia lists additional 'Good Practice Programs' which deliver sexual health and education programs (Table 6).

Table 6.

Name	Description
SoSAFE	Sexual Health and Family Planning ACT and Family Planning Tasmania offer training to education disability services sectors in the SoSAFE! Program. Designed by teachers with extensive experience in education of students with disabilities, and based on demonstrated sound teaching practices, SoSAFE! is a set of visual and conceptual tools designed to facilitate sexuality education, social safety and social skills training. The program was designed specifically to the common learning needs of students with moderate-severe intellectual disability and autism spectrum disorders, and makes use of high levels of visual learning and system and explicit instruction.
Every Body Needs to Know	Family Planning Queensland produces and distributes the Every Body Needs to Know education resource. The resource has been developed in response to the need expressed by educators and workers in the disability field for a teaching/learning package addressing the specific needs of their group, and can be used in conjunction with the sexuality components of Health and Physical Education (HPE), Studies of Society and Environment (SOSE) and Science curricula.
DASHING - Disability and Sexual Health Information Networking Guide	DASHING is a sexual health and relationship resource for professionals working in the education, health and disability sectors who work with young people with intellectual and/or learning disabilities or acquired brain injury. Developed by Family Planning Tasmania, it contains information and recommendations on best practice and refers to resources and articles from other service providers that can be used to complement the DASHING resource.
Family Planning Tasmania (FPT) Disability Education Service	FPT Disability Education Service is a comprehensive Relationships and Sexuality Education Service delivering education to people living with disability, their families and professionals working in the disability field. FPT Disability Education Service provides individual and small group education sessions to people living with disability. These education sessions are delivered according to the principles of best practice in teaching and learning and Sexuality and Relationships Education. Educators provide a tailored education program to each client to promote knowledge, skills and attitudes to support the client in establishing and maintaining healthy and respectful relationships at all stages of life.
Rules About Sex Getting Them Right	Sexual health information networking and education SA, provide a training module and a resource which aims to assist workers in the disability sector communicate effectively with people with adults and young people with border-line and mild-moderate intellectual disabilities about problematic socio-sexual behaviours, personal rights and responsibilities, private sexual behaviours and sexual safety. This resource specifically references legal and ethical considerations as outlined in SA law and interprets these in plain English. It is distinctive in that the visual materials can be combined and layered electronically to help create tailored and personalized visual communication sets.

Creating Conversations	The Creating Conversations project worked to build the confidence of Central Queensland parents and carers to discuss topics such as relationships and decision making, bodies and puberty changes as well as personal safety skills. The project provided opportunities for parents and carers to practice having conversations with their child using multimedia, visual and activity based resources.
Sexuality and Relationships Forums for parents and carers	Family Planning NSW has delivered over 12 forums for parents and carers of people with intellectual disability across NSW. The forums aim to address many of the concerns and information needs of parents and carers regarding the sexuality of the person they are caring for. Topics include relationships and dating, puberty, decision making and safety, sexual health and safe sex, contraception and more. Evaluations have shown that participants are more prepared and resourced to support their family member's sexuality and personal development in a positive way.

Hard copy and online disability related resources

Family Planning NSW has a wide range of online and hard copy resources developed for PWD and their supporters. All resources are available for loan from the Disability Resource Collection. The Disability Resource Collection covers puberty, health and hygiene, self-protection skills, social skills and relationships, sex and relationships, pregnancy and parenting and sex work produced by Family Planning NSW, as well as resources sourced from across the world. A membership fee applies for borrowing from this collection.

International models of sexual activity supports

A number of countries have been identified as having set up Government sanctioned funding arrangements to assist with paid sexual services for people with disability. Most notably are the Netherlands and Denmark. While reports about the Netherlands indicate that state funded sexual assistance has been provided for over 30 years [30], it has not been possible to find further information about either country or their subsidies for people with disability.

Media headlines appeared to have sensationalised the concept of PWD paying for sexual services. In reality, these countries may have implemented person-centred policy approaches, allowing people to choose to pay for whatever services they wanted.

The article by Ward (2014) [31] referring to the Netherlands reports that there is no direct "sex grant" per se, the benefits citizens with disabilities receive can be spent however they like. Some reports indicate that they can use these benefits to access sex services 12 times a year, but information on the specifics is elusive.

News articles by the Telegraph and Life Site News claim that in Denmark social services pay for sex workers up to twice a month for disabled men, and that in the town of Aarhus residents can visit a brothel or have a sex worker visit their home and be reimbursed up to £300.

The peer reviewed article by Mannino (2017) [4] provides an brief description of how the type and frequency of services are provided. *"The way in which this service is given is determined case by case, after a series of meetings, which involve these subjects: the person with disability, the sex worker and a psychologist. The team of specialists will establish with the client the number of*

*sessions of the sexual assistance, which **must not exceed twelve (per year)**. Physical contact between the client and the sexual assistant can take place only after the fifth session contact. Regardless of the type of performance required, the encounters between the client and the sexual assistant will be **1 h each in duration**."*

Overview of disability policy – The Netherlands

This overview has been taken from the book *Sexual Citizenship and Disability Understanding Sexual Support in Policy, Practice and Theory (Chapter 5)* [26].

The Netherlands has developed comprehensive and state-funded work around sexuality, and there is the existence of some disability-specific 'sex care' organisations.

The discourse around the **commercial prostitution industry** is paradoxical. It is a legalised system but still stigmatised. Its legalised status may be one reason for the relatively easy development of sex care organisations, but at the same time the stigma around traditional sex work leads the sex care actors to wanting to distance themselves from it, while sex workers feel denigrated.

Framework for Disability Support

The Long-Term Care Act (2014) along with the Social Support Act (2015), and Health Insurance Act (2006) (Zorgverzekeringswet, Zvw) make up the framework for care and support provision for adults with 'permanent disabilities and chronic conditions'

The Social Support Act aims to promote independence and participation through personalisation and 'less complex support' and is provide d by municipalities. The Netherlands still has the highest expenditure for long-term care in the EU and the OECD, one reason being the provision of institutional living and support arrangements rather than independent/community ones. This has also affected disabled people's general participation in society [32]. Furthermore, the complexity of the newly developed support scheme has led to blind spots for people who have 'cross domain needs' due to input from different levels of authority [33].

Developments in the care system "need to be understood against the background of a new liberal and responsibilisation approach to health care under the new model of '**Positive Health'**. This research based concept has been adopted by the Government along with a new framework for health policy which includes collaboration in a network of governmental and corporate organisations. **Positive Health** conceptualises health as 'the ability to adapt and to self-manage, in the face of social, physical and emotional challenges' [34] (p. 1).

The **Positive Health** approach has been criticised by rehabilitation sexologist Egbert Kruijver (2018) [35] for not including aspects of neither disability nor sexual health. Kruijver contrasts the model with the WHO's newly updated approach to sexual health promotion which incorporates aspects relating to policy, culture, social norms and inequalities. He concludes that for marginalised populations it may not be possible to 'take control if you do not have equal opportunities' [35] (p. 31).

Sexuality Support Context

As concerns sexuality in disability policy and legislation, the only place where such issues are mentioned is in a sub-section of the Social Support Act: 'violence in the provision of a facility'.

It is stated that: sexual penetration of the body or fornication with a client, as well as physical and mental violence against a client, by a professional person or by another client with whom the client is staying … is illegal. (Article 1.1.1, point 18). In other words, although the protection from sexual violence and abuse is very important, there are no mentions of how to support disabled people in the positive sides of sexual life.

In June 2019 the Central Appeals Board ruled that municipalities are not obliged under the Social Support Act to pay for sexual services because sex is not seen as part of so-called 'daily living activities' such as eating, toileting, showering, sports and hobbies. Furthermore, the Board stated that the requested support is neither aimed at self-reliance and participation in society, nor are his 'sexual limitations' restrictions on self-reliance or participation as referred to in the Social Support Act. This judgement ended a lawsuit of a disabled man in the village Peel en Maas against his municipality [36].

Overview of disability policy – Sweden

This overview has been taken from the book *Sexual Citizenship and Disability Understanding Sexual Support in Policy, Practice and Theory (Chapter 3)* [26]. The author explored disabled people's experiences of sexual facilitation within the context of personal assistance services in Sweden, as well as personal assistants', managers' and policy stakeholders' perspectives. She suggests that disability and sexuality is largely a neglected issue:

- There are currently no laws, policies or guidelines that regulate sexual facilitation in Sweden.
- Neither has the broader disability movement advocated for sexual rights in general nor the right to sexual support in particular [26, p. 68].

Framework for Disability Support

In Sweden, the main disability policy is the Act concerning support and service for persons with certain functional impairments. (SFS 1993:387), (LSS). Among the ten available services, personal assistance is the most popular and most debated. The LSS law aims for personal assistance to make it possible for service users 'to live as normal a life as possible', 'under good living conditions' and on the same terms as non-disabled citizens.

To be eligible, applicants must prove that they have 'profound and lasting disabilities', which fall within specified categories and that cause them to require assistance in fulfilment of their 'basic needs' for a minimum of 20 hours per week. Basic needs mean help such as managing hygiene and meals, dressing and undressing, and communicating with others. Eligible service users can also apply for assistance with 'personal needs', for example household duties, leisure activities and assistance at work or with studies – in order to 'counter isolation and passivity'.

Disability rights organisations worked closely together with governmental bodies to develop the personal assistance scheme. They championed the Independent Living (IL) ideology, visible in the law's guiding principles: autonomy, integrity and self-determination for service users. The aim of the ideology was to empower service users to direct their own individualised home-based services.

The Swedish Penal Code (SFS 1962:700), which makes it illegal to purchase sexual services, further complicates issues around sexual facilitation. Since personal assistance services are funded by the state or the municipality, some fear that sexual facilitation could be interpreted as an indirect purchase of sexual services [10]. Even though such fear is unfounded, the Swedish anti prostitution/ sex work discourse has a strong influence in interpreting and handling sexual situations. The

background to this discourse lies in the process of criminalising the demand for prostitution, as advocated by the women's movement and social workers. Their understanding is based on a view of prostitution constituting gender-based violence in a patriarchal society where women can never consent to selling sex [37].

Sexuality Support Context

Sexual facilitation is an unregulated issue in Swedish personal assistance services. It is therefore up for negotiation among service users and personal assistants, or for managers to provide instructions. No policies, regulations or other types of advisory materials exist concerning sexual facilitation issued by national authorities [26, p. 71].

Among all concerned parties there is insecurity in how sexual needs and sexual facilitation should be conceptualised and handled in practice [26, p. 92]. Sweden ratified the Convention on the Rights of Persons with Disabilities (CRPD) in 2008, however, implementation has not been a priority. **Concerning sexuality and disability specifically**, neither the Swedish Agency for Participation nor the Public Health Agency of Sweden have included disabled people's sexuality or sexual health in recent reports.

In a policy submission to a governmental inquiry on increasing equality and efficacy in accessing aids, one of the main points argued is the right to sexuality and sexual health. While the inquiry suggests that the right to aids should include those needed for sexuality, the Agency argues that they should not be regarded as aids for 'recreational purposes' but for 'daily life'.

When it comes to sexual facilitation, neither the LSS law nor the preparatory works mention anything related to sexuality. The National Board of Health and Welfare, an agency under the Ministry of Health and Social Affairs responsible for guidelines and regulations, does not mention sexuality in their regulation about knowledge requirements for those working in disability services (SOSFS 2014:2) [26, p 71].

Assistive Technology, Allied Health and Medical Professional Sexual Activity Supports

Assistive Technology

The majority of assistive technology (AT) described in this section have been taken from *"Pleasure ABLE – Sexual Device Manual for Persons with Disabilities"* [38] and "The MA+ Guide: A Guide to more Accessible Sexuality-Related Assistive Technology" [39] Many of these devices are commonly used by people without a disability. Below is a description of potential AT devices. Table 7 lists the suitability of devices based on physical/functional categories.

Wahl Massager: Total body massager that is ergonomically designed with a long handle.

Universal Cuff: Leather cuff with elastic strap can hold a variety of objects including sexual devices such as dildos and vibrators. Adjustable for hand size and has a plastic extender available for self/partner penetration.

Hitachi Magic Wand: an AC-powered wand vibrator. It was originally manufactured for relieving tension and relaxing sore muscles, but is most famous for its use as a sex toy.

Fleshlight: Realistic penetration device. Made with Real Feel Superskin, also known as cyberskin (non-allergenic, no latex, no silicone). Easy to grip with one or two hands

Butt seriously: silicone anal dildo + vibrator can be used by men or women
MHP tongue vibrator: attaches to your tongue or any other body part with one of the elastic silicone bands provided

Finger vibrator: Finger vibrators allow users to turn their fingers (or toes…or anything else they may fit onto) into a vibrator, without the need to continually hold onto it.

Fukuoko 5 Finger Massage glove: Waterproof stretch fabric glove, with small vibrating units at the tip of each finger

The Strapper: Leather harness for dildo, worn around pelvis to use with a partner

Aslan Men's harness: Leather harness for dildo, designed specifically for men. Pouch safely and comfortably allows room for genitals.

Thigh rider: Leather harness for dildo, worn around thigh to use with a partner.

Furniture harness: Nylon harnesses to hold dildos; can be attached to anything from chairs and beds to a washer or dryer.

Intimate rider: Designed by a person with C6-7 quadriplegia to facilitate positions for sexual activities and to aid with thrusting and sexual movement. A small seat glides on precision bearings to produce a natural, fluid motion. Movement occurs with minimal upper body motion

Body bouncer: Steel frame, soft rubber seat. Slight flexing of thighs will cause bouncing movement.

Liberator shapes: Soft-core foam positioning pillows that can be used in a variety of ways during sexual activities. Wedge, ramp, and rocking pillows are available.

Love bumpers: Soft-core foam positioning pillows that can be used in a variety of ways during sexual activities. Iceberg Love Bumpers are pillows with openings to accommodate Vibrators.

Thigh sling: This sling fits around the neck (padded neck brace) and has adjustable leg straps (padded loops) that hold thighs in an elevated and open position for easy contact.

Vibrating underwear: Commonly, a bullet vibrator is placed within the underwear and a remote is used to turn on and change settings.

Hands free kit: Designed to enable "hands free" vibrator stimulation to assist persons with spinal cord injuries. Includes metal grab bar (and hardware to attach to wall), the 'Lean On Me link', and a two-speed Homedics plug-in massager.

Suction based toys: Suction based toys are available in two types and allow hands free use for solo or couple play. Suction based vibrators are designed for external use. Suction based dildos are available in both vibrating and non-vibrating styles and designed for penetration by both males and female. Some suction toys are one piece, with the suction cup built in to the bottom of the toy.

Others are two-piece, with a detachable double sided suction cup allowing use with a range of toys. Suction based toys may be fastened to the floor, wall or smooth furniture

Table 7

	Limited Hand Function	No Hand Function	Set-up by caregiver (if not hand function)	Limited strength in upper extremities	Limited flexibility for positioning
Wahl Massager	√				
Universal cuff + dildo	√				
Universal cuff + vibrator		√	√	√	
Hitachi Magic Wand	√			√	
Fleshlight	√			√	
Butt Seriously (rectal vibrator)	√				
MHP Tongue Vibrator	√	√	√	√	
Finger Vibrator	√			√	
Fukuoko 5 Finger Massage glove	√			√	
Thigh rider hardness + dildo	√	√	√	√	
Furniture harness	√	√	√	√	
The Strapper or Aslan Men's harness + dildo		√	√	√	
Vibrating underwear (female)	√	√	√	√	
Suction based toys	√	√	√	√	√
Hands free kit		√	√		√
Positioning products			√	√	
Intimate rider					√
Love bumpers					√
Thigh sling					√
Body bouncer					√
Liberator shapes					√

Continence

Purpose designed bed protection is available that stays and feels warm and dry, even when handling large amounts of fluid.

Liberator Fascinator Throe (Liberator): A moisture proof blanket which is microfiber or plush on one side and satin on the other. The blanket is machine washable and has a moisture barrier contained within.

Connie Mate Bedpad: Bed pads consisting of a soft polyester top layer, highly absorbent core and a breathable PUL waterproof backing. They are available with or without tuck-ins and are designed to keep the skin feeling dry. Able to absorb 2L of fluid over an 8hr period.

Nursing

A recent systematic review [40] investigating the factors that influence nurses' provision of sexual health care of patients has found that nurses have a key role in teaching patients about sexual health care. However, it is evident that sexual healthcare information is not widely addressed by nurses. This is due to a lack of knowledge, attitudes and beliefs, and perceived barriers such as scope of practice, responsibility, lack of time and privacy). It has been concluded that professional societies should publish guidelines and white papers on expectations for nursing programmes as well as practicing nurses and clinicians.
The role that nurses can play in acknowledging and facilitating the sexual needs of PWD within a holistic framework are listed below in Table 8 [19].

Table 8.

Roles	Examples
Providing accessible information, advice and services	Arranging for information to be available in Braille, large print and audio-tape
Fostering an environment which allows intimacy	Acceptance and acknowledgement of patient's sexual needs
Offering and observing need for privacy	Closing doors, providing curtains
Encouraging and enabling social interaction	Arranging suitable transportation
The procurement of sexual goods	Purchasing or arranging the purchase of pornographic magazines
Arranging paid-for sexual services	Assistance with arranging, or information on how to arrange, paid-for-sex; willingness to discuss this as an option for the patient
Facilitation of sexual intercourse with another party	Undressing, or helping to undress, patient
Facilitation of masturbation	Assisting patient with positioning and technique
Sexual surrogacy	Assistance with arranging, or information on how to arrange a sexual surrogate

Physiotherapy

Physiotherapists are trained to provide treatment to restore function, improve mobility, relieve pain, and prevent or limit permanent physical disabilities of patients suffering from injuries or disease. Despite the holistic intention of physiotherapy, sexual health has historically received insufficient attention by physiotherapists. There are several areas where physiotherapists can assist in improving sexual health [41, 42]:

- Increasing physical activity to improve general health and physical capacity
    - Promoting greater involvement in active leisure time pursuits, including physical exercise, decreases feelings of pain and fatigue, and may indirectly improve a person's sexual health

- Increase the choice of possible positions for sexual intercourse by increasing joint mobility and muscle strength, and patients' knowledge of their own physical abilities
- Pelvic floor rehabilitation for patients with gynaecological and urological problems, erectile dysfunction and premature ejaculation
    - Utilise a range of treatment tools, including manual therapy, therapeutic exercise, biofeedback, electrical stimulation and heat/cold modalities. Present literature on the efficacy of such techniques on the treatment of sexual dysfunction in both men and women reveals that physiotherapists are integral members of the healthcare team involved in the improvement of sexual health.

Occupational Therapy

The American *Occupational Therapy Practice Framework: Domain and Process, 2nd Edition* [43] lists sexual activity as an activity of daily living (ADL). As such, sexual activity falls under the scope of practice of occupational therapists and should be included as part of a routine evaluation of clients, and address this area in occupational therapy interventions.

Occupational therapy is seen as a safe place for addressing sexuality, allowing the client to express fears and concerns, and offering assistance with problem solving. Empathy, sensitivity, and openness are necessary aspects of the therapeutic relationship, the foundation of occupational therapy, and are used in addressing sexuality. Partners are often included in occupational therapy interventions to achieve goals of mutual concern, such as sexual expression and satisfaction.

The following are types of interventions offered by occupational therapy practitioners [44, 45].

Remediation:

This is the first approach to take if possible. It consists of restoring skills, such as range of motion to make more positions available, increasing endurance for longer sessions of sexual activity, or increasing strength to be able to support a partner, effective communication, and social engagement, as part of meeting sexual needs. For example, a person with multiple sclerosis is likely going to need energy conservation strategies. A person with cerebral palsy may need alternate positioning suggestions. A person with a spinal cord injury may need to use a vibrator for masturbation when previously they were able to do so by hand.

Treatment methods can also be cognitive and relate to health promotion – like providing education on contraceptive use for teenagers with intellectual disability, sexual abuse prevention training for children who have trouble communicating, stress relieving activities or working on relationship/social skills for adults with mental illness.

A behavioural approach is also applicable. Many individuals with autism or other social disorders often exhibit challenging behaviours during puberty such as public masturbation, unwanted touching of others, or inappropriate conversations. Social Stories can be a great resource for teaching appropriate behaviour, and paired with healthy outlets to explore this part of their lives, these teens may stop maladaptive behaviours entirely.

Modification:

This approach consists of changing the environment or routine to allow for sexual activity. Examples include resting prior to sexual activity for those with poor endurance; placing pillows under stiff or painful joints or preceding sexual activity with a warm bath; learning new positions to compensate for amputated limbs, using positions that incorporate weight bearing to compensate for tremors or compensating for decreased sensation with the use of sex toys.

Intensive therapy is outside the scope of usual OT practice, and includes referral to or intervention by specialized clinicians including but not limited to the areas of: sexual medicine, gynecology, urology, psychology, etc.

Talk Therapy

Sex Therapy

Definition, qualification and services provided by a sex therapist have been provided above. In relation to PWD, a sex therapist may:

- Discuss things like attitudes towards sex
- Provide sexual education or practical advice, or
- Recommend activities that can help people achieve their sexual goals that are otherwise not possible due to their disability.

Sexuality Education/Counselling

Sexuality educators apart from sexological education have specific training in education, teaching and assessment and provide education in a variety of areas including schools and community organisations.
For example, Family Planning NSW and Family Planning Victoria delivers best practice education and training in reproductive and sexual health for PWD.

Not-for-profit organisations such as Sexuality Education Counselling and Consultancy Agency (SECCA) also provide specialist counselling services in the area of human relationships and sexuality to people who have a disability, their family and significant carers. Counsellors have extensive experience in both sexuality and disability issues. Counselling is conducted on a one-to-one basis, allowing for tailor-made sessions specifically to suit the needs, age and ability of the individual.

Psychology

Various clinical psychologists specialise in sexual psychology and have advanced training in this area which sets them apart from sex therapists. They can help to learn what drives sexual problems in addition to helping:

- Understand your diagnosis
- Manage depression and anxiety
- Manage anger
- Work on your emotional wellbeing
- Understand and communicate your feelings
- Express your needs and wants
- Recognise emotions in others
- Increase your confidence
- Learn how to manage stress
- Help you learn and remember information
- Develop social skills
- Build relationships
- Improve your quality of life

Mainstream Medical Support Options

General Practitioner (GP)

Attending to sexual health is a core part of general practice in Australia and is relevant to patients across the lifecycle [46]. General practice management of sexual health covers physical, emotional, mental and social wellbeing in relation to sexuality, and not merely the absence of disease, dysfunction or infirmity.

Sexual and reproductive health presentations are common in Australian general practice. According to the Bettering the Evaluation and Care of Health (BEACH) activity data, out of every 100 patient encounters in general practice, 4.7 were for issues regarding the female genital system, 3.0 were for pregnancy and family planning issues, 2.8 were urological, and 1.2 for the male genital system [46].This does not include encounters for relationship counselling or other sexual health concerns.

The Royal Australian College of General Practitioners (RACGP) require GP's to be "competent and comfortable discussing sex with a wide range of people including those of different ages, gender (male, female, transgender or intersex), sexual preference, culturally and linguistically diverse backgrounds, and people with disabilities [46]."

People with physical disabilities have higher rates of female sexual dysfunction, erectile dysfunction (ED), and low desire [47-49]. In some cases these may be due solely to medical conditions; in others, psychological distress may contribute as well. GP's can assist with maximizing sexual physiology and reducing the medical issues that often interfere with sexual interest and activities e.g. medications, pain, bladder and bowel continence, autonomic dysreflexia, and spasm. Other physicians (urologist, gynecologist, neurologist, etc) may also have valuable expertise. These physicians can refer clients to other health care professionals as needed [47-49]..

Medication support

Medications commonly used to treat secondary conditions like depression, heart disease, and chronic pain among PWD have known sexual side effects [50]. If sexual dysfunction is associated with specific medications, it may be practical for the consulting GP or specialist to consider alternative medications [50].

Other medications that can affect sexual function are beta blockers, thiazides and anti-androgens. Alternatives to beta blockers and thiazides are plenty, including calcium channel blockers and angiotensin converting enzyme inhibitors, which do not carry the same risk to sexual function as the aforementioned medications [51].
If a patient has significant pain associated with their disability, they should be encouraged to use analgesics approximately 30 minutes before sexual activity. These can include nonsteroidal anti-inflammatory medications, acetaminophen, or opioids. If there are limitations from positioning, a muscle relaxant, such as baclofen, cyclobenzaprine, and methocarmamol, can assist with lower extremity spasticity [51].

Erectile Dysfunction

WorkSafe [53] and TAC [54] both have policy for the provision of medication to treat erectile dysfunction.

TAC: Erectile dysfunction medication in oral or injectable form, up to a maximum of 8 intermittent use tablets or injections per month, or low dosage daily use tablets.

WorkSafe: The quantity of erectile dysfunction medication that the Agent can pay for is restricted to the reasonable costs of:

- a maximum of eight intermittent use tablets or injections per month, or
- low dosage daily use tablets (where the medication is indicated for low dose daily use) in circumstances where clinically justified and where written clinical rationale is provided by the appropriate prescribing medical practitioner, as outlined in this policy

Who can prescribe erectile dysfunction medication?

The diagnosis and initial prescription of erectile dysfunction medication must be made:

- by a medical specialist such as a Urologist, Endocrinologist, Rehabilitation Physician or Neurologist where the cause of the erectile dysfunction is physical, e.g. urological, neurological, hormonal or vascular damage
- by a Psychiatrist where the cause of the erectile dysfunction is psychogenic, or
- by the treating medical practitioner or a medical specialist where the cause of the erectile dysfunction is considered to be a direct side-effect of medication used to treat another work-related injury or illness. In these cases, payment for medications for erectile dysfunction will be limited to the period of time the causative medication is required.

Inappropriate sexual behaviours

When educational and behavioural interventions have failed to reduce inappropriate sexual behaviours, pharmacological intervention can be used [52]. A review of the literature on pharmacological treatments for such behaviors especially in children and youth with ASD showed the interventions to be effective, however, only single case studies were included meaning the results have limited generalisability. The medications prescribed included;

- Leuprolide (injectable)
- Estrogen (oral)
- Mirtazapine (oral)
- Propranolol (oral)

The use of Androgen depleting drugs (cyproterone acetate, medroxyprogesterone acetate and luteinising hormone releasing hormone agonists) and psychotropic drugs (serotonin specific reuptake inhibitors and antipsychotics) are two major categories of medications used in the treatment of inappropriate sexual behaviours for people who have committed serious sexual offences [52]. Most trials indicated beneficial effects including reduction in sexually deviant fantasies and behaviours, however, few included people with intellectual disability [52].

Sexual Activity of Australians

The Australian Study of Health and Relationships is conducted once a decade and gives a snapshot of the sexual health and wellbeing of the Australian population. Between October 2012 and November 2013 20,094 men and women aged 16-69 were interviewed. Key findings from the published literature [55-60] are summarised below.

First times

- Approximately 50% of people had intercourse for the first time between the ages of 15 and 17
- Men (39%) were more likely than women (19%) to have first intercourse with a casual partner
- 88% of men and 86% of women have experienced oral sex

Sexual Practices

Masturbation

- 72% of men and 42% of women had masturbated in the past year

- Men who masturbated did so more often (6 times in past 4 weeks) than women (3 times in past 4 weeks)

At the most recent sexual encounter

- 73% had sex with a live in partner, 17% with a regular partner who they didn't live with and 8% with a casual partner

In the past year

- 63% of men and 20% of women looked at pornography (print, film or online)
- 15% of men and 21% of women had used a sex toy such as a vibrator or dildo

Homosexual experience and recent homosexual encounters

- Women were significantly more likely than men to report lifetime same-sex experience (13.5% vs 6.5%, $P < 0.001$).
- Among people who reported same-sex experience, the median number of same-sex partners was four for men and one for women and the mean was 63.1 for men and 3.7 for women

Sexual relationships and satisfaction

Sex and satisfaction

- On average, people in regular relationships had sex about 1.4 time a week in the past 4 weeks
- Most people said they would ideally like to have sex about 2-4 times a week

Attitudes

- Most Australians have positive attitudes toward premarital sex, abortion and homosexual behaviour
- Over the last decade there has been a shift towards less tolerance of sex outside a committed relationship

Sexual Coercion

- 4% of men and 22% of women had ever been forced or frightened into doing something sexual that they didn't want to do: 2% of men and 12% of women reported that this happened before they turned 17

Paying for sex

- Among men, 16.7% had ever paid for sex; only 0.3% of women had done this ($P < 0.001$)
    - In the year before being interviewed, 2.3% of men had paid for sex (rates are similar to surveys performed in Britain)
    - No relationship between states where sex work is legal
- Very few people reported that they had ever been paid to have sex with someone: 1.3% of men and 1.0% of women ($P = 0.27$).

Benefits of sex

"Sexuality is an integral part of human life. It carries the awesome potential to create new life. It can foster intimacy and bonding as well as shared pleasure in our relationships. It fulfils a number of personal and social needs, and we value the sexual part of our being for the pleasures and benefits it affords us…. Sexual health is inextricably bound to both physical and mental health" [61, p. 1].

Historically, there has been the presumption that the only health-relevant aspect of sexuality concerns its potential for risk. Study into the morbidity and mortality of HIV and STD's is extensive. In comparison, we know very little about the health benefits of regular, satisfying sexual activity (beyond simple replacement of the species). More recently, researchers have shifted the focus and are attempting to determine the potential health benefits of regular, positive sexual functioning [62].

Large-scale observational research emphatically suggests that individuals who engage in regular sexual activity have better health [63]. Early studies found greater longevity among men with more frequent sexual activity. Among women, greater enjoyment of sexual activity predicted longevity [64, 65].

More recently, two large studies with long follow-up periods have yielded even more compelling evidence for the health-promoting qualities of sexual behaviour. Men who reported a greater frequency of orgasm at baseline had a lower all-cause mortality over the 10-year follow-up [66]. Chen, Tsend, Wu, Lee, and Chen [67] reported findings from a 14-year prospective study of Taiwanese individuals over the age of 65. Being sexually active at baseline was negatively associated with all-cause mortality over the next 14 years for both men and women.

The following positive outcomes have also been attributed to sexual activity:

- Protective effect on cardiovascular health, especially in women [68].
    - Lower risk of cardiac events later in life
    - Women who expressed sexual satisfaction had lower blood pressure
- Increased effectiveness of the immune system
    - People who had frequent sex (1-2 times per week) had more immunoglobin A (IgA) in their system than others [69].
- Reducing prostate cancer
    - Those who ejaculated more than 21 times per month had a lower risk of prostate cancer than men who only ejaculated 4–7 times per month [70].
- Relieving stress and improving sleep
    - Expressions of intimacy, whether sexual or not, helped to bring cortisol levels in both males and female back within normal range [71].
    - Sexual activity has hormonal benefits for sleep
- Sexual health is a highly important aspect of quality of life and wellbeing [71].

Sexuality and disability

The lived experience of PWD in relation to their sexual lives has not been well documented in Australia. Johnson et al. [73] are of the opinion that the failure to take account of how this group of people see their lives has led to the continuation of stereotypical views of people with intellectual disabilities and their sexuality. Sexual activity statistics of people with a disability are rare. However, research among those with a disability has indicated that being able to express one's sexuality is an important dimension in the construction of a good life [11, 74, 75]. A survey in England reported that most people with a mild/moderate intellectual disability have had sexual intercourse by the age of 19/20 (slightly higher than the Australian average) and were more likely to have unsafe sex [76].

An investigation into the frequency and satisfaction of sexual activity of PWD has shown that'

- Women with physical disabilities have significantly more positive feelings about their sexuality and significantly more frequent mutual sexual experiences than their male counterparts
- Frequency of oral sex and nude cuddling were significant predictors of sexual satisfaction in men
- Frequency of deep kissing predicted sexual satisfaction in women

Unfortunately, these results don't assist with making comparison to the general community/able bodied population.

A review of the social and empirical evidence on disability and (a)sexuality, conducted in 2001 [77], highlighted that people with disabilities tend to face disproportionate levels of difficulty in leading fulfilling sexual lives compared to people without disabilities, despite possessing the same sexual needs and desires. The review identified that people with disabilities tend to encounter several barriers when expressing their sexuality and accessing sexual and reproductive healthcare, located at the individual (e.g. poor body image), societal (e.g. negative attitudes), and structural (e.g. inaccessible environments) levels.

A more recent review [78] of the sexuality issues and voices of adults with intellectual disabilities identified 5 themes regarding the experiences, perceptions and needs of individuals regarding the expression of their sexuality. These include;

1) Autonomy v's risk of harm
    a. The balance and tensions between protection from harm within a relationship, autonomy, and the right to make independent decisions regarding relationships
2) Knowledge and sexuality
    a. The need for education regarding sexuality and relationships
3) Relationships and intimacy
    a. A wish and desire for relationships and for some, this may be sexual; for others, there was a desire for intimacy and friendship
4) Self-determination and taking control
    a. Some men and women with intellectual disabilities want to have, and be able to talk about, loving relationships; they seek passion, romance and intimacy. They want influence over forming and maintaining intimate personal relationships
5) Encouragement and supports
    a. Central to the expression of their sexuality, both men and women with intellectual disabilities want to know that they are being listened to and their wishes and needs are regarded and respected

Sex Workers who provide services to clients with disability in NSW

In 2016, Rachel Wotton carried out a substantial study of sex workers who provide services to clients with disability in New South Wales, Australia [79]. Her research is an exploratory study with the aim to identify the nature and extent of such activities to produce empirical data to support anecdotal evidence and recent emerging research in this field.

The research method was an exploratory online survey of sex workers. Ages ranged from 21 to 61 years, with 65 respondents being 55 female, 9 male and one transgender sex worker. They were asked to share their experiences of providing services to clients with disability. This included:

- The frequency, type and range of services provided,
- Location of service delivery and how clients made contact.
- Third party assistance and the identification of any barriers or challenges faced by sex workers.

Reasons why some sex workers would not provide their service to PWD

Seven survey participants suggested they did not provide services to PWD for the reasons such as 'never been asked/approached by a client with a disability (n = 5), 'never had any training' (n = 1), 'brothel/parlour/premises I work in is not disability accessible' (n = 1) or 'would feel uncomfortable seeing clients with a disability' (n = 1).

Number of PWD client's serviced by the sex workers

Out of the 57 survey participants who gave absolute numbers, the total number of clients seen ranged between 1,301 and 1,535. This is because a few respondents answered with approximations such as 160-250 or 20-30. Other responses including no idea - it's only a few a year, approx. 2 - 3 per month, don't know and many.

As this has never been asked to a cohort of sex workers before there is no way to currently determine if these figures are representative but it challenges the notion that clients with disability never seek the services of sex workers in NSW or that it is a rare occurrence.

Gender

From all respondents:

- 100% identified as having ***male*** clients with disability
- Seven (11.29%) had provided services to ***female*** clients, and
- Three (4.84%) had prior bookings with clients with disability who are ***transgender***.

Identifying the range of disabilities / impairments that clients presented with

Participants were asked to identify the specific name or type of disability/s their clients had presented with. Answers were derived from 50 respondents with a wide range of disabilities mentioned spanning both physical and cognitive disabilities, as well as acquired and congenital disabilities as detailed in the list below in order of frequency.
In assessing the results:

- The researcher noted that over a third of the nominated disabilities had a degree of cognitive impairment (See Appendix B for a list of disabilities). The research suggesting that this is important to acknowledge and identify specifically due to the ongoing discourse around the ability for people living with an intellectual disability to give informed consent, which prompted Touching Base Inc. to produce educational booklets aimed at this cohort.

- It is anticipated that further research in this area could include an analysis of how and why the client with disability decided to see a sex worker and what support and educational tools were utilised to reach such a decision. These findings also substantiate that there is no specific 'type' of person with disability who has sought the services of a sex worker.

- Given that people with disability are constantly experiencing stigma and discriminatory attitudes, it appears that there is substantial acceptance of the diversity of clients to whom sex workers are more than willing to provide services. Consequently, this data can be used to support further discussions within the disability sector about peoples' sexual expression, no matter what their disability may be.

Frequency of client visits

- Out of the 62 respondents 90% had seen their clients with disability more than once suggesting that their clients were satisfied with their services and chose to return regularly to the same sex worker.

- Participants were asked to identify how often your clients with a disability come back to visit. The responses are in the table below with the most common response was only when they can afford to see me.

- The paper suggests that the frequency of bookings is consistent with previous research done in Australia about clients in general [80]

Answer Choices		Responses	
Onlywhen theycan afford to see me	Responses	60.42%	29
No set pattern	Responses	58.33%	28
Once a month	Responses	47.92%	23
Once every 3 months	Responses	39.58%	19
Once a fortnight	Responses	27.08%	13
Once a week	Responses	22.92%	11
Once every 2 months	Responses	20.83%	10
Once every 6 months	Responses	20.83%	10
Once a year	Responses	14.58%	7
Once every 4 months	Responses	6.25%	3

Location of work place

The research also aimed to identify where the service delivery took place. Results are in the table below. The paper notes that:

- The results indicated that at least some clients with disability in NSW had an awareness of the range of options available to them.

- The increased accessibility of communication devices such as computers, tablets and mobile phones has allowed the internet to enrich the lives of some people with disability by becoming less reliant on others for information and options available to them.

Answer Choices	Responses	
their private home	59.65%	34
full service brothel	45.61%	26
in a hotel	33.33%	19
rented work premises	31.58%	18
my home	26.32%	15
nursing home	14.04%	8
group home - supported accommodation	14.04%	8
BDSM parlour	12.28%	7
massage parlour	8.77%	5
safe house	5.26%	3
hospital room	5.26%	3
Other, please specify	5.26%	3
Car	3.51%	2

Sexual services provided to clients with disability

Results regarding the types of sexual services provided to PWD are in the table below. The paper noted that:

- The range of services paid for by clients with disability reflect the broad range of desires and sexual activity enjoyed by the general population within Australia. These include both physical and emotional services as reflected by the additional comments pertaining to personal intimacy, cuddling and conversation and company.

- These also reflect current empirical literature where the sex workers interviewed clearly identified that, alongside sexual activities, services offered to clients included many therapeutic and emotional dimensions.

Answer Choices	Responses	
hand relief	96.43%	54
blow job/ French/ oral sex (client receiving)	80.36%	45
Massage	76.79%	43
blow job/ French/ oral sex (client giving)	57.14%	32
vaginal sex(client giving)	55.36%	31
Striptease	50.00%	28
toys – vibrators	48.21%	27
fantasy	42.86%	24
vaginal sex (client receiving)	30.36%	17
Spanish	30.36%	17
doubles (2 workers, 1 client)	28.57%	16
BDSM	25.00%	14
strap ons	25.00%	14
anal sex (client receiving)	23.21%	13
anal sex (client giving)	16.07%	9
Other, please specify	8.93%	5
doubles (1 worker, 2 clients with a disability)	5.36%	3
doubles (1 worker, 1 client with a disability, 1 client without a disability)	5.36%	3

Challenges and barriers in sex workers communicating with PWD

Common barriers were 'the client wanted me to lower my price' (n = 18, 60%), 'my workplace was not suitably accessible – so had to see them somewhere else (n = 14, 46.67%), 'I couldn't understand the client on the phone' (n = 13, 43.33%), 'they kept changing the time of the appointment' (n = 11, 36.67%), 'they rang everyday' (n = 10, 33.33%), 'other' (n = 9, 30%), 'I had to borrow equipment (ie ramp) to make workplace accessible (n = 2, 6.67%) and 'management won't make specific appointment times for my client to see me (n = 2, 6.67%).

The nine responses that were given in the 'other' option were:

- service had unrealistic low price expectations
- carer won't take them
- Couldn't talk to client directly on the phone
- my limited sign language, a parlour receptionist being cruel

- client asked to speak to me directly
- difficulty negotiating through the disability
- A time when both carer & client were free.
- very worried about access prior to 1st apt
- Carers', parents' values/judgements, other apts

See Appendix C for 'Third party difficulties'

Prevalence of sexual abuse and psychological impact among individuals with an intellectual disability

A recent narrative review [81] investigated the prevalence of sexual abuse among individuals with an intellectual disability, well-known risk factors and the psychological effects of sexual abuse. The findings confirmed that children and adults with an intellectual disability are at a higher risk of sexual abuse than nondisabled peers. Despite the heterogeneity of included studies, prevalence rates are between 14% and 32% for children with an intellectual disability [82] and 7% and 34% for adults with an intellectual disability [83, 84]. Table 9 displays the results of 8 studies which investigated prevalence of abuse.

A global review [85] of violence against women with disabilities found that women with disability, regardless of age, ethnicity, sexual orientation or class are subjected to double the rate of exploitation, violence and abuse, including domestic and family violence as experienced by women without disability. More than a quarter of rape cases reported by females are perpetrated against women with disability [86].

Risk factors for sexual abuse

Attempts have been made to highlight the risk factors that may increase the likelihood of sexual abuse occurring [81]. These include;

1) Being a woman or younger child
2) Having a disability that severely impacts activities of daily living
3) Increased language difficulties
4) Lack of sexual education. Briggs (2006) [87] reported that 20% of children in their study thought that sex between an adult and a child was "OK" or did not know.
    a. This suggests that those with an intellectual disability have difficulties distinguishing between appropriate and non-appropriate touching

Psychological effects of sexual abuse

Individuals with an intellectual disability who have experienced sexual abuse have a similar range of psychological disturbances as the general population, especially regarding depressive and traumatic symptoms. Included studies rely on informant accounts of the effect of trauma rather than firsthand accounts of the abuse. Table 10 summaries the results of studies included in the narrative review by Byrne [81]

Table 9.

Author (year and publication)	Sample	Objectives	Results
Haydon et al. (2011)	A nationally representative sample of men and women (n = 11, 878, age range 26– 32)	Examined associations between unwanted sexual experiences and both physical disability and cognitive performance in a nationally representative sample of young adults	Thirteen percent of respondents with cognitive scores less than 70 experienced unwanted sex compared to 11% of those with scores between 70 and 90 and 14% of scores between 91 and 110
Kvam (2000)	n = 1293, 83 disabled, 20 with intellectual disability	To investigate if the prevalence of sexual abuse among Norwegian children with an intellectual disability	Severely disabled children constituted 1.7% of the examined children. Children with disability were more often assessed as probably assaulted than nondisabled
McCabe et al. (1994)	n = 80, 30 individuals intellectual disability, 50 nondisabled	Compare level of sexual knowledge and experience among those with an ID and people without ID	Lower level of sexual knowledge among people with a disability but no difference between groups in terms of incidents of incest and other unwanted sexual activities
Cambridge et al. (2011)	n = 6, 146 referrals, 1857 individuals with an ID	Examine referrals for alleged sexual abuse for people with ID to identify patterns of risk	Over a fifth (397) of referrals related to alleged sexual abuse, two-thirds for women. Sexual abuse confirmed in just over a quarter of cases
Mitra et al. (2011)	n = 25,756 survey respondents (21% of men and 14% of women reported having disability, which included ID)	Examine the prevalence of victimization among me with a disability	The prevalence of lifetime sexual violence was 13.9% among those with a disability compared to 3.7% for men without a disability. Men with disabilities four times more likely to report lifetime and past-year victimization compared to men without disabilities
Spencer et al. (2005)	n = 119,729 children of who 1067 had a learning disability	Examine the relationship between various disabling conditions and registration for child abuse and neglect in a 19-year population birth cohort	Children with moderate/severe ID eight times increased risk for sexual abuse
Khalifeh et al. (2013)	Nationally representative cross-sectional study n	Study the relationship between a range of disabilities and incidents of violence	No association between violence and learning disability

	= 35,361 of which 9037 had a disability (170, 2.7% learning disability		
Pan (2007)	n = 336, 232 caregivers of individuals with ID and 104 individuals with ID	Explore prevalence and of sexual abuse among individuals with ID in Taiwan	Eighteen of the 336 individual (5.4%) reported being victim of sexual abuse. Nine (7.4%) had mild ID, 6 (5.7%) had mod ID, 3 (3%) had severe, 0 profound

Table 10.

Author (year and publication)	Sample	Objectives	Results
Firth et al. (2001)	n = 43 cases, 21 victims only 22 perpetrators of which 16 victims 44% mild, 37% mod, and 7% severe ID	Extent of PTSD in sample of children with ID who have experienced sexual abuse	One case met criteria for PTSD. Among 21 victims, only two reported uncontrollable intrusive imagery. Limited relationship between sexual abuse victimization and PTSD
O'Callaghan et al. (2003)	n = parents of 18 individual with an ID who were abused (three case studies sexual abuse)	Interview parents to collect information about the effects of abuse on their children	Impact on the survivors of abuse and their families appear to have profound and long-lasting ramifications
Murphy et al. (2007)	Eighteen individuals with severe ID	Describe the consequences of abuse and changes in behaviour	Adaptive behaviour change across time in multiple areas including socialization, independent functioning, self-abuse, and sexual behaviour. Few problems or difficulties reported at Time 1, major changes at Time 2, and some recovery at Time 3.
Mansell et al. (1998)	n = 86 (43 with ID and 43 without referred for treatment of sexual abuse)	Do those with ID share the same range of vulnerabilities as individuals with ID	Compared to non-ID group, ID group had significant more difficulties in the areas of personal safety, withdrawal into fantasy, and withdrawal at school
Solyu et al. (2013)	n = 256 children and adolescents (102 with ID and 154 without)	Compare the frequency of post abuse psychological disorders among the two groups as well as characteristics of abuse	No significant differences found between the two groups in PTSD and major depressive disorder. Those with ID higher risk of developing conduct disorder
Sequeira et al. (2003)	Matched case control study comparing 54 adults who experienced sexual abuse and 54 with no reported history of abuse	To identify symptoms of psychological disturbances among adults with an ID with and without a history of sexual abuse	Sexual abuse associated with increased rates of mental health difficulties and behavioural problems. Abused group showed significantly more symptoms of social withdrawal, hyperactivity, PTSD, and depression

Roswell et al. (2013)	An informant interview with family members and caregivers of 18 individuals with ID and who experienced alleged abuse (n = 15 who suffered alleged sexual abuse)	The psychological impact of alleged abuse on males and females with severe intellectual disability, using a specific PTSD framework	Marked increases in the frequency and severity of a range of emotional, physiological, and behavioural symptoms following alleged abuse

Position of Advocacy Groups in Australia

It appears that there is overwhelming community support for the NDIS to support funding for sexual activity and the development of a comprehensive sexual activity supports policy.

No oppositional statements could be found from religious groups

One oppositional statement could be found from a feminist advocacy group

It appears that there are two prominent Australian disability groups leading and advocating for policy changes in sexual activity supports. Disabled People's Organisations Australia is an alliance of four national peak organisations made up of, led and governed by people with disability. The alliance members are People with Disability Australia (PWDA), Women With Disabilities Australia (WWDA), National Ethnic Disability Alliance (NEDA) and First Peoples Disability Network (Australia) (FPDN). Touching Base Inc developed out of the need to assist people with disability and sex workers to connect with each other, focusing on access, discrimination, human rights and legal issues and attitudinal barriers

See Appendix D for the joint position statement from Disabled People's Organisations Australia and Touching Base Inc, Family Planning NSW and Project Respect.

Appendix

Appendix A – Search Strategy

Search string
"sex therapy" OR "sex assistan*" OR "sex work" OR "Sex* surrogacy" OR "sex* advisor*" OR "Sex* facilitation" OR "prostitut*" OR "surrogate partner"

AND

disabil* OR "people with disabil*" OR pwd OR "disabled people" OR disabilit* OR "people with disabilit*" OR PWD

Limiters
Keywords found in Title and Abstract

Type of publication: peer reviewed article

Year of publication: 2005-present

Language: English

Databases:
CINHAL, PsycInfo, Cochrane, Medline, Scopus and ProQuest: Consumer Health Database Health & Medical Collection; Healthcare Administration Database; Nursing & Allied Health Database; Psychology Database; Public Health Database; Social Science Database; Sociology Database (1985 - current); International Bibliography of the Social Sciences (IBSS) (1951 - current)

Number of references:
Database search 115

Hand search 17

Included 23

Data extraction
Data was extracted for Author/s, Year, Terminology/role, Services (role), Education, Organisation, Type of service (organisation), Country/ies and Webpage

Appendix B – List of disabilities and impairments of PWD who have sought a sex worker in NSW

Paraplegia/quadriplegia (28),
Schizophrenia/Bipolar (27),
Cerebral Palsy (25),
Deafness / hearing impaired (17)
Multiple Sclerosis (13)
Blindness (10)
Autism / Asperger's (9)
Amputees (9)
Anxiety disorders (8)
Parkinson's (7)
Acquired Brain Injury (6)
Obsessive compulsive disorder (4)
Depression (4)
Use of colostomy bags (4)
Spinal cord injuries (4)
Down syndrome (4)
Post Traumatic Stress Disorder (3)
Stroke survivor (3)
Morbid obesity (3)
Degenerative disorders of the spine (including spina bifida, severe scoliosis) (3)
Wheelchair bound (3)
Severe burns (3)
HIV (3)
Intellectually disabled (2)
Muscular Dystrophy (2)
Mute (2)
Physical disabilities / birth deformities (2)
Tourette's (2)
Polio (2)
Agoraphobia (1)
Haemocromotosis (1)
Psoriasis (1)
Born with no limbs (1)
Diabetes (1)
Heart Disease (1)
Frail aged (1)
ADHD (1)
Bone disorder (1)
Prostate cancer survivor (1)
Liver cancer (1)
Elephantitis (1)
Epilepsy (1)
Degenerative disorder of the feet (1)

Answer Choices	Responses	
client in wheelchair	73.77%	45
client needed assistance with dressing and undressing	59.02%	36
client needed assistance with walking	57.38%	35
client in bed already and could not move much	54.10%	33
client was very shaky / had tremours	54.10%	33
client had a skin condition	52.46%	32
client was hearing impaired / deaf	47.54%	29
client had a brain injury	44.26%	27
client spoke but hard to understand	44.26%	27
client could not pick things up with his hands	42.62%	26
client used a walking cane	42.62%	26
client was missing a limb	42.62%	26
client repeats the same conversation/ sentences with me	37.70%	23
client had a colostomy bag	36.07%	22
client had slurred speech	36.07%	22
client was on crutches	34.43%	21
client had a catheter	34.43%	21
client was vision impaired / blind	29.51%	18
client could not speak at all	27.87%	17
client used a communication board	27.87%	17
client could not move arms	26.23%	16
client can't remember me from one time to the next	26.23%	16
Other, please specify Responses	26.23%	16
client was in a plaster cast	22.95%	14
client had short term memory loss	19.67%	12
client communicated through sign language	18.03%	11
client had more than one bag attached to them	9.84%	6

Appendix C – Third party difficutlies identifed by sex workers in NSW

Third party difficulties

- The values and judgements imparted by carers and other third parties can negatively impede upon the enjoyment level of a booking and can create further barriers for the person with disability wanting subsequent bookings with a sex worker. This situation places sex workers in a precarious position between respecting their client's wishes of privacy and their own right to be paid for the range of services they provide.

- A large proportion of respondents spoke about how carers would not take the client to their appointment, with others reflective upon the lack of privacy given to the sex worker and their client including mentioning that the carers entered room/knocked/talked through door

- The worst example of crossing professional and ethical boundaries was exemplified by one respondent's statement that the carer [was] overprotective but wanted to touch me also. These kind of actions are extremely inappropriate and unethical and can be ameliorated by the development of supportive organisational policy and procedure guidelines to clearly communicate the rights and responsibilities of staff.

- The creation of clear communication pathways between the disability and sex worker communities will also strengthen the confidence of sex workers to know that they can speak up and report such incidences without fear of reprisal, possibly where the client is denied future access to the sex worker or the organisation / carer refuses to coordinate other clients to see this sex worker.

Appendix D – Position statements from advocacy groups

Joint Position Statement: A call for a rights-based framework for sexuality in the NDIS (2019)
A joint position statement in 2019 from Disabled People's Organisations Australia and Touching Base Inc. [3] and endorsed by 45 community advocacy groups and organisations, emanates from concerns that:

- The NDIS need to develop a clear and comprehensive sexuality policy for NDIS participants that encompasses and supports individual sexual needs and goals at all life and development stages.

An NDIS policy should encompass and support the types and range of professional support some people with disability may need to use to express their sexuality, and to have the opportunity for fulfilling sexual experiences in life.

The NDIS policy should include a broad range of goals an NDIS participant may seek to include in their NDIS plan. These goals might include:

- Appropriate disability-inclusive sexuality and relationships education;
- Information and resources to support individual learning needs;
- Support for dating and social sexual engagements;
- Access to adaptive sex toys;
- Access to sex therapy or
- Utilising sexual services from sex workers.

The benefits of sexual expression for people with disability
The position statement suggests that the benefits of sexual expression for people with disability:
Fulfil sexual needs and goals can positively contribute to the overall quality of life and self-esteem for individuals

Meets a range of other emotional, psychological, physical and social needs.

That some people with disability are in need of specific support to learn about their sexuality and sexual capacity after a significant injury, illness or sexual assault

Increase their experience, knowledge and acceptance about changes in their own bodies and abilities

Gain confidence and social skills to enjoy a positive sexuality.

Professional Services
The position statement suggests that:
The professional services of a wide range of educators, including allied health professionals and sex therapists, can play an integral role in supporting an individual's capacity to develop life skills necessary to engage in healthy and consenting sexual and romantic relationships.

Sex workers who can and do provide mutually consenting physical contact. While accessing services of sex workers may not be for everyone, this option should not be denied nor dismissed on the basis of disability, or the moral beliefs of third parties.

Sex workers, especially within Australia, have already been recognised as being able to provide professional sexual services for a wide range of people with disability. Their skill-set can complement

sex education and sex therapy and allow an individual to practice, experience and enjoy a range of activities in a safe and supportive environment. *(Statement quotes: Wotton, R. (2016), Sex workers who provide services to clients with disability in New South Wales, Australia. University of Sydney, Sydney, Australia, retrieved from: https://ses.library.usyd.edu.au/bitstream/2123/16875/1/Wotton_RW_thesis.pdf)*

Giving people with disability the right to exercise choice and control over the supports they need to achieve the goals they've identified is the primary objective the community expects the NDIS to deliver on.

Community Support

The position statement is supported by the following advocacy groups and organisations wanting ***"the NDIA to develop a comprehensive sexuality policy to allow for all levels of sexual education and support to be provided, according to our individual needs and goals".***

ACON (NSW)
ACT Council of Social Service
Advocacy for Inclusion
AIDS Action Council of the ACT
Australian Centre for Disability Law
Australian Federation of AIDS Organisations
Australian Society of Sex Educators, Researchers and Therapists NSW
Family Advocacy
Family Planning NSW
Migrant Women's Lobby Group (SA)
Multicultural Disability Advocacy Association of NSW
National Council of Single Mothers and their Children Inc.
National LGBTI Health Alliance
Northcott
Northern Territory AIDS and Hepatitis Council
NSW Council of Intellectual Disability
People with Disabilities WA
Physical Disability Council of NSW
Public Health Association of Australia
Queensland Advocacy Inc.
Queensland AIDS Council
Queensland Voice for Mental Health Inc.
Respect Inc. (QLD)
Scarlett Alliance, Australian Sex Workers Association
Self Advocacy Sydney Inc.
Sex Work, Education, Advocacy & Rights Western Australia
Sex Workers Outreach Program, Northern Territory
Sex Workers Outreach Project Inc. (NSW)
Sex Workers Reference Group, Northern Territory
Sexual Health and Family Planning ACT Inc.
SHINE SA
SHQ and People First Program (WA)
SIN (SA)
Society of Australian Sexologists
Tasmanian Council on AIDS, Hepatitis and Related Diseases
Thorne Harbour Health (VIC)
True Relationships & Reproductive Health (QLD)

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Vixen Collective (Victoria's peer only sex worker organisation)
WA AIDS Council
WA Council of Social Service
Women in Adult and Vocational Education
Women with Disabilities ACT
Women's Electoral Lobby Inc. Australia
Working It Out (TAS)
YWCA Australia

Family Planning NSW

Family Planning NSW is the state's leading provider of reproductive and sexual health services. The organisation has been delivering targeted services to people with disability and those who support them for over 35 years, including health promotion, education and training. Family Planning NSW is also a registered provider under the National Disability Insurance Scheme (NDIS), and provide services under the following NDIS support areas:

- Specialised assessment of skills, abilities and needs
- Therapeutic supports

In April 2019 Family Planning NSW made a submission to the Joint Standing Committee on the National Disability Insurance Scheme [8] regarding 'General issues around the implementation and performance of the NDIS'. Their recommendations are detailed below. The submission reiterates issues raised in their August 2017 submission [9] to the Committee regarding 'Transitional arrangements for the NDIS', where many of the issues they raised have been resolved.

Recommendations
Family Planning NSW recommends that:
Mechanisms be introduced to allow more responsive changes to plans so that participants' sexuality support needs can be met in a timely fashion.

Sexuality support requirements be considered as a standard inclusion for all participant plans, including puberty support for children and adolescents.

The NDIS website and associated materials provide clearer guidance about the kinds of services that can be obtained as part of sexuality support, in the form of an NDIA policy or procedure document.

Adequate funding be provided for professional learning of NDIA representatives, including in the areas of sexuality and relationships.

Opposition to NDIS funding Sexual Services

Project Respect

Project Respect is a "non-profit, feminist, community-based organisation". They operate a support and referral service for "women trafficked for sexual exploitation and women in the sex industry". They assist women one-on-one, create a safe community and advocate for women's rights. They believe the sex industry is deeply gendered, and that the majority of people in the industry are female, and the majority of clients are male. As a feminist organisation, they "believe that gender based inequality exists, and that the sex industry strengthens and reinforces this inequality". [4]
Position Statement: Accessing sexual services through the NDIS
Project Respect produced a position statement [5] in 2019 with asserting following key points:

The National Disability Insurance Agency (NDIA) has made an official statement that it 'does not cover sexual services, sexual therapy or sex workers in a participant's NDIS plan. We believe the NDIA has made the right decision not to 'fund sexual services' as part of the NDIS.

This position paper aims to unpack the arguments for including sexual services on the NDIS and argues against this inclusion.

We need to acknowledge that this is a deeply gendered issue. Hiding beneath gender neutral language proponents are fighting for the rights of mostly men with disability to access sexual services provided by mostly women.

When proponents argue for sexual services to be included on the NDIS because it is an essential need and a human right, they are arguing for men's needs and rights. The belief that men have a right to sex is based on regressive gender roles and entrenched ideas of masculinity and male sexual entitlement which have been recognised as major drivers of violence against women.

Another unstated assumption proponents of including sexual services on the NDIS make is that men with disability all, or mostly all, want sexual services in the first place. This stems from the belief that men "need" sex and assumes that all or mostly all men with a disability want to participate in commercial sexual encounters.

There are concerns that some men with disability who may not be able to give meaningful consent will have sexual services decided for them as part of their NDIS plan.

It may be difficult for the woman providing the commercial sexual service to negotiate what is being consented to. This raises obvious concerns for men with disability being assumed to want to participate in commercial sex when they may not want that service.

In concluding their statement Project Respect asserts:

We believe the NDIA has made the right decision not to 'fund sexual services' as part of the NDIS.

We urge the government to instead provide information and programs about rights and health in sex and relationships for PWD, as many disability advocates have recommended.

We have argued that sexual services are not an essential service, a necessity or a human right and therefore should not be included on the NDIS.

The ideas that underpin the arguments for commercial sex to be included on the NDIS are based on male sexual entitlement, which contributes to a culture of sexism and violence against women already prevalent in Australia.

Men's perceived needs are privileged above women's human rights, as seen in the very different ways women with disability are treated, and though the complete lack of concern for the women in the sex industry expected to provide these services.

We argue against men's right to buy sexual access to women on the grounds of women's human rights and gender equality. This includes men with disability.

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Appendix E – Informed consent, culture and linguist diversity

Informed consent means that the person understands what they are consenting to, and is able to make informed decisions. Supporters have a role to create opportunities that increase a person's decision making skills and confidence. This can be done by improving communication systems, supporting the person to understand the decision making process, and providing opportunities to practice making decisions.
People have the legal right to consent to having sexual relations in Australia if they:

- Are 16 years of age (for males and females, and whether heterosexual or homosexual) in ACT, NSW, NT, QLD, VIC and WA, and 17 years of age in TAS and SA.

Four areas of knowledge are required in order to give consent: understanding of what the physical act(s) involve, their meaning, society's laws and cultural norms, and possible consequences [88]. According to theoretical and practical understandings of consent, those key elements include:

- transparency about what is being proposed (not being tricked or fooled);
- that all parties possess similar cultural knowledge about standards of behaviour;
- that all parties are similarly aware of possible consequences, such as pregnancy or disease;
- having respect for agreement or disagreement without repercussion; and
- that consent is freely given, and that all parties have the legal competence to freely give consent (being in possession of decision-making capacity and unaffected by intoxication)

Anyone providing support to a person with cognitive impairment has a duty of care to ensure that the person with cognitive impairment:

- Has the capacity to give consent to sexual activity
- Has freely consented to sexual activity with another person
- Understands what that consent means for them and the other person.

There are many other situations where the person's consent is required, for example:

- Using a contraceptive and the method
- Having a pap test
- Choosing whether to have a date with a person.

A Capacity Toolkit exists which acts as a guide to assessing a person's capacity to make legal, medical, financial and personal decisions. The Capacity Toolkit was created in response to requests from lawyers, medical professionals, health workers, carers and advocates who required more information about capacity, some general capacity principles and guidelines on assessing a person's capacity to make decisions.

Culture
Sexual expression may be viewed differently within cultural groups. Before starting conversations about sexuality, supporters and others should first learn what topics and behaviours are sensitive for discussion in other cultures.
Aboriginal and Torres Strait Islander people
Sensitivity to cultural norms is important in discussions about sexuality and relationships with Aboriginal and Torres Strait Islander people. While the person's right to make decisions about their own life must be upheld, the following culturally sensitive matters are fundamental for consideration when supporting Aboriginal or Torres Strait Islander people to explore and express their sexuality:

- Recognise that acknowledging the person's culture is a way of acknowledging and valuing the person's identity
- Acknowledge the history of difficult relationships between governments and Aboriginal people
- Recognise family, kinship and friend relationships and the person's connection to community and the land
- Determine who in the family or community should be approached for discussions about sexuality and relationships
- Ask the person or family if they wish to choose who would provide sexual health services, Aboriginal or mainstream providers.

Sexual issues are personal and sensitive and discussion with some people is taboo. The person and family or carers should be consulted to learn what sexual matters are sensitive. Identify the family member or carer to speak to about matters of sexuality and relationships, and record the information in the person's records.
Understanding cultural sensitivity includes understanding the person's individual history, experiences and choices. A high degree of sensitivity is required to support the person and family with a history of sexual abuse. Sexual health can be a private matter and is often discussed within gender groups. Shame can be a barrier to people accessing health services and being tested for sexually transmissible infections. People face other barriers such as location of services and issues of confidentiality, especially in small remote communities, and willingness to access health services to discuss sexual health matters.

Cultural and Linguistic Diversity
People may still retain their values, beliefs and experiences, even when they no longer live in the culture where they learned them. The person and family's behaviour, attitudes, preferences and decisions about sexuality and relationships, are influenced by culture and religious practices.
The person and family or carer's cultural and religious beliefs about sexuality and relationships should be understood before starting a conversation with the person about exploring and expressing their sexuality.
Demonstrate respect and sensitivity to their culture by considering:

- The person and the family or carer's perspective on sexuality and relationships
- The person and the family or carer's views about Western sexuality and relationship practices
- The role of spiritual and religious beliefs and practices in sexual development
- How the person and the family or carer communicate, for instance, through an interpreter
- The person's own role in problem solving and decision making.

It is important to acknowledge that some people may choose to adopt practices, values and attitudes that are different from those of their parents or family. Supporters need to be aware of this and provide support according to the person's wishes.

References

1. World Health Organisation. (2020). Defining sexual health. Retrieved from https://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/
2. World Health Organisation. (2006). Defining sexual health: Report of a technical consultation on sexual health, 28–31 January 2002. Geneva, World Health Organization. https://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf
3. Limoncin, E., et al. (2014). "The psychosexual profile of sexual assistants: an internet-based explorative study." PLoS ONE [Electronic Resource] 9(2): e98413.
4. Mannino, G., et al. (2017). "Psychodynamics of the Sexual Assistance for Individuals with Disability." Sexuality & Disability 35(4): 495-506
5. Appel, J. M. (2010). Sex rights for the disabled? Journal of Medical Ethics, 36(3), 152–154. https://doi.org/10.1136/jme.2009.033183
6. Geymonat, G.G., Macioti, P.G. (2016). Ambivalent professionalisation and autonomy in workers' collective projects: The cases of sex worker peer educators in Germany and sexual assistants in Switzerland Sociological Research Online, 21 (4), art. no. 10, .
7. Morales E, Quattrini F, Auger C, Gauthier V. What Sexual Assistants Want and Need: Creating a Toolkit and New Solutions to Help Them Better Perform Their Work with Individuals with Disabilities. Sexuality and Disability. 2020 Jan 24:1-1.
8. Gammino et al (2016) "Sexual Assistance in Italy: An Explorative Study on the Opinions of People with Disabilities and Would-Be Assistants." Sexuality & Disability 34(2): 157-170.
9. Giulia Garofalo Geymonat (2019) Disability Rights Meet Sex Workers' Rights: the Making of Sexual Assistance in Europe Sexuality Research and Social Policy (2019) 16:214–226 https://doi.org/10.1007/s13178-019-0377-x
10. Kulick, D., Rydström , Jens, 2015) ProQuest, Ebooks Corporation, & Duke University Press. (Loneliness and its opposite : sex, disability, and the ethics of engagement.
11. Bahner (2012), "Legal Rights or Simply Wishes? The Struggle for Sexual Recognition of People with Physical Disabilities Using Personal Assistance in Sweden." Sexuality & Disability 30(3): 337-356.
12. Bahner (2015), "Sexual professionalism: for whom? The case of sexual facilitation in Swedish personal assistance services." Disability & Society 30(5): 788-801.
13. Bahner (2016), "Risky business? Organizing sexual facilitation in Swedish personal assistance services." Scandinavian Journal of Disability Research 18(2): 164-175.
14. Di Nucci, E. (2010). Sexual rights and disability. Journal of Medical Ethics, 37(3), 158–161. https://doi.org/10.1136/jme.2010.036723
15. Fritsch, K., Heynen, R., Ross, A.N., van der Meulen, E. (2106) Disability and sex work: developing affinities through decriminalization (2016) Disability and Society, 31 (1), pp. 84-99.
16. De Boer Tracy (2014) Disability and Sexual Inclusion First published: 23 September 2014 https://doi.org/10.1111/hypa.12118
17. Aloni, R., Keren, O., & Katz, S. (2007). Sex therapy surrogate partners for individuals with very limited functional ability following traumatic brain injury. Sexuality and Disability, 25(3), 125-134.
18. Dewson, H., Rix, K., & Choong, K. (2018). Sexual rights, mental disorder and intellectual disability: practical implications for policy makers and practitioners. BJPsych Advances, 24(6), 386–397. https://doi.org/10.1192/bja.2018.40

19. Earle, Sarah (2001). Disability, facilitated sex and the role of the nurse. Journal of Advanced Nursing, 36(3), 433−440
20. Jeffreys, S. (2008). Disability and the male sex right. Women's Studies International Forum, 31(5), 327–335. https://doi.org/10.1016/j.wsif.2008.08.001
21. Chatton, D.: Assistance sexuelle, assistance au développement sexuel? Reliance 3(29), 62–65 (2008). https://doi.org/10.3917/reli.029.0062
22. Kessler S. Mais qui sont-ils? La sélection des candidats qui se destinent à l'assistance sexuelle. Reliance. 2008(3):53-7. https://doi.org/10.3917/reli.029.0053 10.
23. International Professional Surrogates Assocaition. (2020). *Training*. Retrieved from https://www.surrogatetherapy.org/training/
24. Good Vibes Clinic. (ND). Sex Surrogacy – get the facts. Retrieved from https://www.goodvibesclinic.com.au/sex-surrogacy
25. Touching Base. (2020). Professional Disability Awareness Training (PDAT) for sex workers. Retrieved from https://www.touchingbase.org/workshops-and-training/pdat/
26. Bahner J. Sexual Citizenship and Disability: Understanding Sexual Support in Policy, Practice and Theory. Routledge; 2019 Dec 5.
27. Society of Australian Sexologists. (2020). Accreditation with the Society of Australian Sexologists Ltd (SAS). Retrieved from https://societyaustraliansexologists.org.au/membership/accreditation/
28. Northcott. Sexuality and Relationships Policy. Retrieved from https://northcott.com.au/wp-content/uploads/2016/08/Sexuality-and-Relationships-Policy1.pdf
29. Family & Community Services. (2016). *Sexuality and Relationship Guidelines*. Sydney, NSW: NSW Government. Retrieved from https://www.facs.nsw.gov.au/__data/assets/pdf_file/0008/590660/117-Sexuality_and_Relationship_Guidelines-accessible.pdf
30. Sanders, T. (2007) The politics of sexual citizenship: Commercial sex and disability Disability and Society, 22 (5), pp. 439-455.
31. Ward, M. (2014). The Surprising Way the Netherlands Is Helping Its Disabled Have Sex. Retrieved from https://mic.com/articles/85201/the-surprising-way-the-netherlands-is-helping-its-disabled-have-sex#.8t8MN8umR
32. van Hees, Suzanne, Oldenkamp, Marloes, de Putter, Iris, van der Hoek, Lucas & Boeije, Hennie (2016). *Participatiemonitor 2008-2016: Deelname aan de samenleving van mensen met een beperking en ouderen [Participation Monitor 2008–2016: Participation in Society by People with Disabilities and the Elderly]*. Utrecht: Nivel.
33. Hilberink, Sander R. & Cardol, Mieke (2019). Citizenship according to the UNCRPD and in practice: a plea for a broader view. *Disability & Society*, 34(2), pp. 326–331.
34. Huber, M., van Vliet, M., Giezenberg, M., Winkens, B., Heerkens, Y., Dagnelie, P.C. & Knottnerus, J.A. (2016). Towards a 'patient-centred' operationalisation of the new dynamic concept of health: a mixed methods study. *BMJ Open*, 6(1), p. e010091.
35. Kruijver, Egbert (2018). De Rozet versus het Spinnenweb [The Rosette versus the Spider Web]. *Tijdschrift voor Seksuologie*, 42(1), pp. 25–34.
36. Willen, Sjoerd (2019). Rechter: Betaalde seks niet verplicht [Judge: Paid Sex Is Not Mandatory]. *Binnenlands Bestuur*, 17 June 2019.
37. Svanström, Yvonne (2017) From contested to consensus. Swedish politics on prostitution and trafficking. In Ward, E. & Wylie, G. (eds.) *Feminism, prostitution and the state. The politics of neo-abolitionism*. London and New York: Routledge, pp. 29–45.

38. MacHattie, E., Naphtali, K., Disabilities Health Research Network. (2009). Pleasure-Able: Sexual device manual for persons with a disability. Retrieved from https://facingdisability.com/resource/pleasure-able-sexual-device-manual-for-persons-with-disabilities
39. Higson, N. (2012). The MA+ Guide: A guide to more accessible sexuality-related assistive technology. Retrieved from https://ilc.com.au/wp-content/uploads/2013/08/the_ma__guide.pdf
40. Fennell R, Grant B. Discussing sexuality in health care: A systematic review. Journal of clinical nursing. 2019 Sep;28(17-18):3065-76.
41. *Areskoug-Josefsson K, Gard G. Physiotherapy as a promoter of sexual health. Physiotherapy theory and practice. 2015 Aug 18;31(6):390-5.*
42. *Rosenbaum TY. The role of physiotherapy in sexual health: Is it evidence based. Journal of the Association of Chartered Physiotherapists in Women's Health. 2006;99:1-5.*
43. American Occupational Therapy Association. Occupational therapy practice framework: Domain and process. Am J Occup Ther. 2002;56:609-39.
44. American Occupational Therapy Association. (2013). Occupational Therapy's Role with Sexuality: Fact Sheet. Retrieved from https://www.aota.org/~/media/Corporate/Files/AboutOT/Professionals/WhatIsOT/RDP/Facts/Sexuality.pdf
45. Northcott. (2016). 10 ways Occupational Therapists can help people with disability express their sexuality. Retrieved from https://northcott.com.au/10-ways-occupational-therapists-can-help-people-with-disability-express-their-sexuality/
46. Royal Australian College of General Practitioners. (2020). SH16- Sexual and Reproductive Health Contextual Unit. Retrieved from https://www.racgp.org.au/education/education-providers/curriculum/contextual-units/presentations/sh16-sexual-and-reproductive-health
47. *McCabe MP, Taleporos G. Sexual esteem, sexual satisfaction, and sexual behavior among people with physical disability. Arch Sex Behav 2003;32:359–69.*
48. *Basson R. Sexual health of women with disabilities. CMAJ 1998;159:359–62.*
49. *Rowen TS, Stein S, Tepper M. Sexual health care for people with physical disabilities. The journal of sexual medicine. 2015 Mar;12(3):584-9.*
50. *Giuliano F, Droupy S. Sexual side effects of pharmacological treatments. Prog Urol 2013;23:804–10*
51. *Rowen TS, Stein S, Tepper M. Sexual health care for people with physical disabilities. The journal of sexual medicine. 2015 Mar;12(3):584-9.*
52. *Sajith SG, Morgan C, Clarke D. Pharmacological management of inappropriate sexual behaviours: a review of its evidence, rationale and scope in relation to men with intellectual disabilities. Journal of Intellectual Disability Research. 2008 Dec;52(12):1078-90.*
53. Worksafe Victoria. Policy for Erectile Dysfunction Medication: Guidelines for erectile dysfunction medication for injured workers. Retrieved from https://content.api.worksafe.vic.gov.au/sites/default/files/2018-06/ISBN-Erectile-dysfunction-medication-for-injured-workers-policy-2013-06.pdf
54. Transport Accident Commission. (ND). Medication guidelines. Retrieved from https://www.tac.vic.gov.au/providers/working-with-tac-clients/guidelines/provider-guidelines/medication-guidelines
55. Rissel C, Heywood W, de Visser RO, Simpson JM, Grulich AE, Badcock PB, Smith AM, Richters J. First vaginal intercourse and oral sex among a representative sample of Australian adults:

the Second Australian Study of Health and Relationships. Sexual Health. 2014 Nov 7;11(5):406-15.
56. Richters J, Altman D, Badcock PB, Smith AM, de Visser RO, Grulich AE, Rissel C, Simpson JM. Sexual identity, sexual attraction and sexual experience: the Second Australian Study of Health and Relationships. Sexual Health. 2014 Nov 7;11(5):451-60.
57. Rissel C, Badcock PB, Smith AM, Richters J, de Visser RO, Grulich AE, Simpson JM. Heterosexual experience and recent heterosexual encounters among Australian adults: the Second Australian Study of Health and Relationships. Sexual health. 2014 Nov 7;11(5):416-26.
58. Rissel C, Richters J, De Visser RO, McKee A, Yeung A, Caruana T. A profile of pornography users in Australia: Findings from the second Australian study of health and relationships. The Journal of Sex Research. 2017 Feb 12;54(2):227-40.
59. de Visser RO, Badcock PB, Simpson JM, Grulich AE, Smith AM, Richters J, Rissel C. Attitudes toward sex and relationships: the Second Australian Study of Health and Relationships. Sexual health. 2014 Nov 7;11(5):397-405.
60. Richters J, de Visser RO, Badcock PB, Smith AM, Rissel C, Simpson JM, Grulich AE. Masturbation, paying for sex, and other sexual activities: the Second Australian Study of Health and Relationships. Sexual health. 2014 Nov 7;11(5):461-71.
61. Satcher, D. (2001). The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior. Washington, DC: U.S. Department of Health and Human Serviceso.
62. Diamond LM, Huebner DM. Is good sex good for you? Rethinking sexuality and health. Social and Personality Psychology Compass. 2012 Jan;6(1):54-69.)
63. Lindau, S. T., & Gavrilova, N. (2010). Sex, health, and years of sexually active life gained due to good health: evidence from two US population based cross sectional surveys of ageing. British Medical Journal, 340, c810.
64. Palmore, E. B. (1982). Predictors of the longevity difference: A 25-year follow-up. The Gerontologist, 22, 513.
65. Persson, G. (1981). Five-year mortality in a 70-year-old urban population in relation to psychiatric diagnosis, personality, sexuality and early parental death. Acta Psychiatrica Scandinavica, 64, 244–253.
66. Davey Smith, G. (1997). Sex and death: are they related? Findings from the Caerphilly Cohort Study. BMJ: British Medical Journal, 315, 1641.
67. Chen, H. K., Tsend, C. D., Wu, S. C., Lee, T. K., & Chen, H. H. (2007). A prospective cohort study on the effect of sexual activity, libido and widowhood on mortality among the elderly people: 14-year follow-up of 2453 elderly Taiwanese. International Journal of Epidemiology, 36, 1136–1142.)
68. Liu H, Waite LJ, Shen S, Wang DH. Is sex good for your health? A national study on partnered sexuality and cardiovascular risk among older men and women. Journal of health and social behavior. 2016 Sep;57(3):276-96.
69. Charnetski CJ, Brennan FX. Sexual frequency and salivary immunoglobulin A (IgA). Psychological reports. 2004 Jun;94(3):839-44.
70. Leitzmann MF, Platz EA, Stampfer MJ, Willett WC, Giovannucci E. Ejaculation frequency and subsequent risk of prostate cancer. Jama. 2004 Apr 7;291(13):1578-86
71. Ditzen B, Germann J, Meuwly N, Bradbury TN, Bodenmann G, Heinrichs M. Intimacy as related to cortisol reactivity and recovery in couples undergoing psychosocial stress. Psychosomatic Medicine. 2019 Jan 1;81(1):16-25.

72. Flynn KE, Lin L, Bruner DW, Cyranowski JM, Hahn EA, Jeffery DD, Reese JB, Reeve BB, Shelby RA, Weinfurt KP. Sexual satisfaction and the importance of sexual health to quality of life throughout the life course of US adults. The journal of sexual medicine. 2016 Nov 1;13(11):1642-50.
73. Johnson K, Hillier L, Harrison L, Frawley P. Living safer sexual lives: Final report. Melbourne, Australian research Centre in Sex, health & Society, La Trobe University. 2001
74. Sakellariou D. If not the disability, then what? Barriers to reclaiming sexuality following spinal cord injury. Sexuality and disability. 2006 Jun 1;24(2):101-11.
75. Sakellariou D. Sexuality and disability: A discussion on care of the self. Sexuality and Disability. 2012 Jun 1;30(2):187-97.
76. Baines S, Emerson E, Robertson J, Hatton C. Sexual activity and sexual health among young adults with and without mild/moderate intellectual disability. BMC public health. 2018 Dec 1;18(1):667.
77. Milligan MS, Neufeldt AH. The myth of asexuality: a survey of social and empirical evidence. Sex Disabil. 2001;19:91–109.
78. Brown M, McCann E. Sexuality issues and the voices of adults with intellectual disabilities: A systematic review of the literature. Research in developmental disabilities. 2018 Mar 1;74:124-38.
79. Wotton, R. Sex Workers Who Provide Services to Clients with Disability in New South Wales, Australia. Sept. 2016. ses.library.usyd.edu.au. https://ses.library.usyd.edu.au/handle/2123/16875
80. Perkins, R. "'How Much Are You, Love?' the Customer in the Australian Sex Industry." Social Alternatives, vol. 18, no. 3, July 1999, p. 38. https://search.informit.com.au/documentSummary;dn=200001967;res=IELAPA;type=pdf
81. Byrne G. Prevalence and psychological sequelae of sexual abuse among individuals with an intellectual disability: A review of the recent literature. Journal of Intellectual Disabilities. 2018 Sep;22(3):294-310.
82. Balogh R, Bretherton K, Whibley S, et al. (2001) Sexual abuse in children and adolescents with intellectual disability. Journal of Intellectual Disability Research 45: 194–201. DOI: 10.1046/ j.1365-2788.2001.00293.x.
83. Lin LP, Yen CF, Kuo FY, et al. (2009) Sexual assault of people with disabilities: results of a 2002–2007 national report in Taiwan. Research in Developmental Disabilities 30: 969–975. DOI: 10.1016/j.ridd. 2009.02.001
84. Mitra M, Mouradian VE and Diamond M (2011) Sexual violence victimization against men with disabilities. American Journal of Preventive Medicine 41: 494–497. DOI: 10.1016/j.amepre.2011.07.014
85. Dowse, L. (2007). Forgotten Sisters: Recognising and Responding to Domestic Violence in the Lives of Women with Disabilities. Retrieved from http://wwda.org.au/issues/viol/viol2006/dowsedv07/
86. Women with Disabilities Australia. (2011). Submission to the UN Analytical Study on Violence against Women With Disabilities. Retrieved from http://wwda.org.au/wp-content/uploads/2013/12/WWDASubUNStudyViolenceWWDDec2011.pdf
87. Briggs F (2006) Safety issues in the lives of children with learning disabilities. Social Policy Journal of New
Zealand 29: 43–59.
88. McCarthy, M., & Thompson, D. (2004). People with learning disabilities: Sex, the law and consent. In M. Cowling. & P. Reynolds (Eds.), *Making sense of sexual consent* (pp. 227-242). Burlington: Ashgate.

Research – Treatment of Advanced Osteoarthritis, Spinal Stenosis and Functional Neurological Disorder

	AAT Matter – Access s11c - Personal Privacy - Unsuitable for the disclosure log
Brief	[redacted] What are the known available and strokappropriate evidence based clinical, medical or other treatments/interventions for each impairment listed above?
Date	September 16, 2020
Requester	Naomi [redacted] (Senior Technical Advisor – TAB/AAT)
Researcher	Craig [redacted] (Tactical Research Advisor – TAB/AAT)

Please note:

The research and literature reviews collated by our TAB Research Team are not to be shared external to the Branch. These are for internal TAB use only and are intended to assist our advisors with their reasonable and necessary decision-making.

Delegates have access to a wide variety of comprehensive guidance material. If Delegates require further information on access or planning matters they are to call the TAPS line for advice.

The Research Team are unable to ensure that the information listed below provides an accurate & up-to-date snapshot of these matters.

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NED19/326570: RES HWB Functional Neurological Disorder & CRPS 2019/0060 ADO283 (Research to assist Assessors from NAWM with their decisions for access requests relating to these specific conditions).

Summary

Research indicates that all three conditions are best treated by a multi-disciplinary approach.

Treatment for Advanced Osteoarthritis (Left Hip)

Multi-disciplinary approach is taken with treatment which includes physical activity, weight management, medication, and nondrug pain relief techniques to control pain and complementary and alternative therapies. Australian GPs generally demonstrate a conservative approach, where non-pharmacological interventions were not given the importance suggested by clinical practice guidelines.

Treatment for Spinal Stenosis

Multi-disciplinary approach to treatment which may include medication, physiotherapy, steroids injections, and laminectomy surgery as a last resort (where clinical treatment fails or neurological symptoms worsen).

Treatment for Functional Neurological Disorder

Comprehensive multi-disciplinary team approach involving neurology, neuro-psychiatry, physical therapy, occupational therapy, and Neuro-psychology.

Definitions

Advanced Osteoarthritis (Left Hip)

Osteoarthritis (AO) is the most common form of arthritis. It occurs when the protective cartilage that cushions the ends of your bones wears down over time. Although osteoarthritis can damage any joint, the disorder most commonly affects joints in hands, knees, hips and spine. [1] Advanced and terminal stage hip OA causes severe restriction of hip range of motion and hip pain. [2]

Spinal Stenosis

Spinal stenosis, or spinal canal stenosis, is a narrowing of the canal in which the spinal cord sits. The narrowing can put pressure on the nerves in the back, which can cause pain and weakness in the arms or legs.

Spinal stenosis is usually caused by arthritis. Some people are born with a narrowed spinal canal, which puts them at greater risk. Spinal stenosis can happen after a disc prolapse (a 'slipped disc', or a problem with the spongy discs between the bones of the spine).

Spinal stenosis can also be caused when a thickened ligament bulges into the spinal cord, by a tumour, or by an injury to the back.

The most common form of spinal stenosis is in the lower back (called a lumbar stenosis). It can also happen at the top of the spine (called a cervical stenosis). [3]

Functional Neurological Disorder

Functional neurologic disorders is a newer and broader term that includes what some people call conversion disorder. It feature nervous system (neurological) symptoms that can't be explained by a neurological disease or other medical condition. However, the symptoms are real and cause significant distress or problems functioning.

Signs and symptoms vary, depending on the type of functional neurologic disorder, and may include specific patterns. Typically these disorders affect movement of the senses, such as the ability to walk, swallow, see or hear. Symptoms can vary in severity and may come and go or be persistent. However, the patient can't intentionally produce or control the symptoms.

The cause of functional neurologic disorders is unknown. The condition may be triggered by a neurological disorder or by a reaction to stress or psychological or physical trauma, but that's not always the case. Functional neurologic disorders are related to how the brain functions, rather than damage to the brain's structure (such as from a stroke, multiple sclerosis, infection or injury). [4]

Treatment

Advanced Osteoarthritis (Left Hip)

It appears a multi-disciplinary approach is taken with treatment. The Australian Institute of Health and Welfare (AIHW) suggests that at present, there is no cure for osteoarthritis (OA) and the disease is long-term and progressive. [5] The Institute suggests treatment for OA aims to manage symptoms, increase mobility and maximise quality of life. General practitioners (GPs) are usually the first point of contact with the health care system for people with OA and are ideally placed to play the role of care coordinator to ensure treatment continuity. GP management of OA may include assessment and diagnosis, referral to other health services, prescribing medication and providing education about the condition.

Treatment options [5] for OA include:

- physical activity
- weight management
- medication
- joint replacement surgery

Other sources [6] also suggest the following inclusions in treatment plans:

- Rest and joint care
- Use of a Crutches, Canes, and Walkers to take weight off the affected hip
- Nondrug pain relief techniques to control pain
- Complementary and alternative therapies

It would appear that the severity of the OA would determine the likely treatment protocol. A 2016 study [7] looked at International evidence-based guidelines for the management of patients with hip and knee OA which recommend to start with a combination of non-surgical treatments, and using surgical intervention only if a patient does not respond sufficiently to non-surgical treatment options. Despite the recommendations, there are strong indications that nonsurgical treatments are not optimally used in orthopaedic practice.

In Australia, a 2015 survey study set out to examine opinions about the management of OA by Australian GPs following the release of the Royal Australian College of General Practitioners Guideline for the non-surgical management of hip and knee. The study concluded that Australian GPs generally demonstrated a conservative approach to the treatment of OA, and non-pharmacological interventions were not given the importance that is suggested by clinical practice guidelines. [8]

The Royal Australian College of General Practitioners Guideline for the non-surgical management of hip and knee best practice [9], for long term and advanced stage management are:

Long term management of OA

Best practice management of chronic conditions:

- optimal use of medicines
- non-pharmacological management

- care and referral pathways
- patient self-management education
- patient psychosocial support requirements

Treatment and management in advanced stages of OA

Best practice management to optimise quality of life:

- optimal use of medicines
- non-pharmacological management
- care and referral pathways
- patient self-management education
- patient psychosocial support requirements
- Carer support and information

Physical Activity/Exercise

Exercise is an important and effective component in both management and prevention of OA. Exercise helps improve symptoms (especially pain and joint stiffness) and quality of life by increasing range of motion (the ability to move joints through their full motion), strengthening muscles around affected joints, assists in weight control and reduces risk of other chronic diseases (e.g. diabetes and cardiovascular disease). Exercise is also beneficial for other comorbidities and overall health. A GP or Exercise Physiologist should be consulted before undertaking an exercise program. [5]

Weight Management

Being overweight increases the risk of developing OA, due to the increased load on weight bearing joints and increased stress on cartilage. Weight management is strongly recommended for people with knee and/or hip OA who are overweight or obese. For people with existing OA and who are overweight or obese, weight loss can help reduce symptoms. Weight loss should be combined with exercise for the greatest benefits. A GP or Dietitian can be consulted to discuss weight loss/management strategies. [5]

Medications

Treatment of OA with medication aims to relieve pain, reduce inflammation and improve functioning and quality of life. Analgesics, or pain medications, are commonly used to manage the pain of OA. Analgesics include paracetamol, non-steroidal anti-inflammatory drugs (NSAIDs) and opioid analgesics. For those with hip and/or knee OA requiring pain relief, it may be reasonable to trial the use of paracetamol or NSAIDs for a short period and then discontinue use if it is not effective. Corticosteroid injections may also be recommended for short term pain relief for hip and/or knee OA if appropriate. Opioids are not recommended for the treatment of hip and/or knee OA. [5]

Spinal Stenosis

Research indicates a multi-disciplinary approach to treatment which may include:

- Medication (for pain management)
- Physiotherapy (build strength, flexibility and balance)
- Steroids injections (reduce pain and inflammation)
- Laminectomy surgery (where other treatments don't work) [10]

Medication

In a 2016 literature review [11], suggest that drug treatment does not offer many possibilities. The indiscriminate and frequent use of anti-inflammatory medications for chronic lumbar pain does not have a proven satisfactory response and may be associated with gastrointestinal and renal complications. Its use should be very restricted and avoided in elderly patients with narrow lumbar spinal canal syndrome.

Simple painkillers, muscle relaxants, and opioids may be of value. They are indicated for treating and controlling the pain but have no effect on the treatment of neurogenic claudication. [11] Gabapentin has been shown to be a safe medication; it may be taken orally and has a positive effect on patients with neurogenic claudication and the sensory alterations, which are very common in this cohort of patients [11]. Corticosteroids are also used indiscriminately. The idea is that there is an inflammatory process associated with the mechanical compression that could benefit from the medication, but this theory was not proven. [11]

Physiotherapy

Physiotherapy, or more broadly rehabilitation is a non-surgical approach. Manual therapy, stretching, and muscular strengthening play an important role, in addition to the exercises. Patients who suffer from canal stenosis have, in addition to pain, a significant muscle loss, which severely limits their activities and progressively worsens their clinical condition, which leads to further impairments. [12] [13]

The recommended activities include manual therapy, strengthening, and walking training, as well as exercises that improves proprioception. In addition, weight loss is important, because obese patients have been described to have a worse prognosis. [14]. Cycling is a very much recommended activity, not only because patients tolerate it well, but it also allows them to improve their conditioning and does not impact other joints that may also be degenerated, such as the hip and the knee. [15]

Steroid Injections

Peridural corticosteroids (Steroid injections) are another type of non-surgical treatment for narrow lumbar spinal canal syndrome, as opposed to oral corticosteroids, which were shown to be ineffective for this condition. [14]

Peridural corticosteroids have some advantages. There are several possibilities for their administration, with or without radioscopy, as well as several techniques: interlaminar, caudal, and transforaminal. Despite their limited benefits, their use may have lasting efficacy in many patients. [15]

Laminectomy Surgery

Surgical treatment is considered the last resort for patients with treating lumbar canal stenosis. Because surgery is performed in patients over 65 years of age, there is significant morbidity and mortality, which increase with associated diseases and patient age, making it mandatory to assess the risks and benefit of the surgery.

Surgical treatment is indicated when clinical treatment fails or neurological symptoms worsen. There are several different surgical techniques.

- The classical technique is laminectomy, performed by an incision along the midline followed by decompression, removing up to 50% of facets.

- Interspinous spacers have been recently included in the surgical arsenal for canal stenosis, but studies are still under way, and there are no studies yet evaluating for an adequate follow-up period.

For this reason, the actual benefit of this kind of surgery is not yet well established. However, it is known that it does offer some advantages, such as short hospitalization periods and limited bleeding. [16]

Functional Neurological Disorder (FND)

Research indicates that FND is best treated within a comprehensive multi-disciplinary team involving [17] [18]:

- Neurology
- Neuro-psychiatry
- Physical therapy
- Occupational therapy and,
- Neuro-psychology
- Speech pathology
- Physiotherapists

Patients with physical symptoms (gait disturbance, weakness, paralysis, dystonia, etc.) will often need physical treatment. Allied health professionals including: speech pathologist, occupational therapists and physiotherapists then becomes integral to the patient's recovery process. [18]

Patients who have early access to an FND specialised multi-disciplinary treatment program with specialist FND knowledge, have the best chance of improved outcomes and potential for recovery. When patients were able to access specialised treatment there were noticeable positive benefits. [19]

Neuro-psychiatry & Neuro-psychology

Around one third of patients with FND have a comorbid psychiatric condition [18]. Some patients experience depression and anxiety as a result of having their functional symptoms. For others, a history of trauma or adverse childhood experiences can make them vulnerable to developing FND. Psychologists and psychiatrists can assist in the management of comorbid mental health conditions and in the treatment of FND. Cognitive behavioural therapy (CBT) is an evidenced based psychological approach for treating FND. This can include exploring the symptoms and identifying behaviours and cognitions (thoughts) that maintain or exacerbate the symptoms to increase the patient's awareness of their symptoms. A range of CBT strategies can be taught to the patient to assist them manage their FND and mood symptoms to maximise their everyday function. [18]

Physical therapy

Neuro-physiotherapists can offer education, movement retraining and self-management strategies. Recent research has demonstrated marked improvements in functional motor symptoms in patients who work closely with physiotherapists. [18]

Occupational therapy

Occupational therapists are able to build good rapport with patients and help them with self explorations to understand what they can/can't do, as well as, determining and addressing the specific blockages for their normal everyday functioning. This is done through a wide range of activities and relaxation techniques. [18]

Medications

Generally, pharmacological therapy for FND is avoided when possible. In the clinical practice, their use may not be welcomed by many patients due to psychiatric stigma, perception of addictive and harmful properties, and side effects. Antidepressants have demonstrated benefits even in those who do not have comorbid mental disorders. Tricyclics are helpful in those with insomnia and pain. Serotonin reuptake inhibitors are good for hypersomnia but not so good in pain management. Neuropathic analgesia such as gabapentin or pregabalin are used in chronic pain. Patients are often explained to that they can get better without the tablets but they are worth trying for those who are looking to explore every therapeutic avenue. [18]

References

1 Mayo Clinic. Osteoarthritis - Symptoms and causes [Internet]. 2020 [cited 15 September 2020]. Available from: https://www.mayoclinic.org/diseases-conditions/osteoarthritis/symptoms-causes/syc-20351925

2 Teramoto Y, Fukushima K, Koyama T, Ohashi Y, Uchiyama K, Takahira N et al. Impact of Jiggling Exercise as Conservative Treatment for Hip Osteoarthritis: A Report of Two Cases. Case Reports in Orthopedics. 2020;2020:1-5.

3 Healthdirect.gov.au. Spinal stenosis [Internet]. 2020 [cited 15 September 2020]. Available from: https://www.healthdirect.gov.au/spinal-stenosis

4 Mayo Clinic. Functional neurologic disorders/conversion disorder - Symptoms and causes [Internet]. 2020 [cited 15 September 2020]. Available from: https://www.mayoclinic.org/diseases-conditions/conversion-disorder/symptoms-causes/syc-20355197

5 Osteoarthritis, Treatment & management - Australian Institute of Health and Welfare [Internet]. Australian Institute of Health and Welfare. 2020 [cited 15 September 2020]. Available from: https://www.aihw.gov.au/reports/chronic-musculoskeletal-conditions/osteoarthritis/contents/treatment-management

6 WebMD. Hip Osteoarthritis (Degenerative Arthritis of the Hip) [Internet]. 2020 [cited 15 September 2020]. Available from: https://www.webmd.com/osteoarthritis/hip-osteoarthritis-degenerative-arthritis-hip

7 Hofstede S, Marang-van de Mheen P, Vliet Vlieland T, van den Ende C, Nelissen R, van Bodegom-Vos L. Barriers and Facilitators Associated with Non-Surgical Treatment Use for Osteoarthritis Patients in Orthopaedic Practice. PLOS ONE. 2016;11(1):e0147406.

8 Basedow M, Williams H, Shanahan E, Runciman W, Esterman A. Australian GP management of osteoarthritis following the release of the RACGP guideline for the non-surgical management of hip and knee osteoarthritis. BMC Research Notes. 2015;8(1).

9 Royal Australian College of General Practitioners, Guideline for the non-surgical management of hip and knee osteoarthritis [Internet]. Racgp.org.au. 2009 [cited 15 September 2020]. shorturl.at/efrR2

10 Healthdirect.gov.au. Spinal stenosis [Internet]. 2020 [cited 16 September 2020]. Available from: https://www.healthdirect.gov.au/spinal-stenosis

11 Rodrigues L. Lumbar Spinal Stenosis, Clinical Presentation, Diagnosis, and Treatment. 2016. DOI: 10.5772/63920

12 Rittemberg JD, Ross AE. Functional rehabilitation for degenerative lumbar spina stenosis. Phys Med Rehabil Clin N Am (14);111–120, 2003.

13 Whtiman JM. Flyn TW, Frotz JM. Nonsurgical management of patients with lumbar

spine stenosis: a literature review and a case series of three patients managed with physical therapy. Phys Med Rehabil Clin N Am;14(1):77–101, 2003.

14 Rodrigues LC, Natour J. A double-blind, randomized controlled, prospective trial assessing the effectiveness of oral corticoids in the treatment of symptomatic lumbar canal stenosis. J Negat Results Bioemed;13:13, 2014.

15 Whitman JM, Flym TW, Chids JD, Wainer RS et al. A comparassion between two physical therapy treatment programs for patients with lumbar spinal stenosis: a randomized clinical trial. Spine;31(2):2541–2549, 2006.

16 Zucherman JF, Hsu KY, Hartjen CA, et al. A prospective randomized multicenter study for the treatment of lumbar spinal stenosis with the X stop interspinous implant: 1-year results. Eur Spine J;13:22–31, 2004.

17 FND Treatment Australia. FND Australia Support Services [Internet]. Fndaus.org.au. 2020 [cited 16 September 2020]. Available from: https://fndaus.org.au/fnd-treatment-australia/

18 Mater Centre for Neuro Sciences. Functional Neurological Disorder (FND) Learning guide [Internet]. Fndaustralia.com.au. 2020 [cited 16 September 2020]. Available from: https://fndaustralia.com.au/resources/FND-Learning-guide-for-nurses.pdf

19 Mentalhealthcommission.gov.au. Consumer and Carer Experiences of fnd/Cd in Australia [Internet]. 2019 [cited 16 September 2020]. Available from: https://www.mentalhealthcommission.gov.au/getmedia/8ac49bb8-556e-42dc-b946-a175149fb57d/Consumer-and-Carer-Experiences-of-FND-CD-in-Australia-FND-Support-Services-Inc

Research – Length of High Intensity Intervention for ABI, SCI and Amputees

Brief	In order to develop business rules for the amount of funding to include as a capacity building support within the Participant Budget Model, the following information will assist us: • For the following disability groups: Acquired Brain injury, including Traumatic Brain Injury (TBI), stroke, brain tumour AND spinal injury AND amputations as separate groups. • What is considered best practice in terms of: a) The length of time for which high intensity therapy supports are considered effective after onset? b) How long does high intensity rehab continue post spinal cord injury or amputation? There is a period of time (previously termed 'spontaneous recovery') when it is considered that the brain is more amenable to learning new information/skills after a brain injury. In the past it was accepted that this period of relatively rapid learning would then be followed by a plateau, when limited new learning was possible. c) What is the current thinking regarding: i) whether there is a plateau; and ii) when this point is reached for brain injuries? We are considering the possibility of 5 years as an appropriate time to cease high intensity rehabilitation, and "switch" to maintenance/monitoring supports for brain injuries; and 2 years for spinal cord injuries or amputations. d) Is there any research evidence for this? e) Does this align with research and length of time for improvement post acquired injury?
Date	09/07/2021
Requester(s)	Jane [redacted] – Assistant Director (TAB) Jeán [redacted] - Senior Technical Advisor (TAB)
Researcher	Jane [redacted] - Research Team Leader (TAB)
Cleared	N/A

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The contents of this document are OFFICIAL

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2 Summary

- Because randomised controlled trials (RCTs) often have limited funding, interventions are rarely delivered past the 12 month mark. Because of this, we can only make assumptions about the effectiveness of rehabilitation for TBI past these timeframes.
    - The consensus is, the earlier intervention occurs the better.
    - The timeline and level of recovery differs between patients. Therefore, the length of rehabilitation should be guided by the patient's needs.
- Most commonly, the plateau for TBI improvement is around the 2 year mark. However, various studies have put the range anywhere from 6 months to 2 years.

- Most spinal cord injury (SCI) cases reach a plateau by 9 months after injury. However, additional recovery may occur up to 12–18 months.
- There is no agreement on duration and intensity of intervention in the acute and post-acute phases of SCI
    - Most studies implement intervention over 6 to 12 weeks.
    - Rehabilitation should be implemented when patients are medically stable and can tolerate the required intensity.

- Unable to determine a timeframe for plateau in relation to amputees, however, the time needed to progress through rehabilitation phases is consistently reported to be between 12 and 18 months.

3 Traumatic Brain Injury

3.1 Length of time high therapy supports are effective

Systematic reviews investigating intensive multidisciplinary rehabilitation (in the post-acute stage) on average implement the intervention for less than 6 months and follow up study participants anywhere between 6-24 months. Refer to Table 1 for more details.

The length of time over which rehabilitation may have its effects (always many months and usually several years) is usually longer than any funded research project [1].

Benefits of neurological rehabilitation typically accrue over several years, rather than over weeks or months. RCTs are typically conducted over a much shorter time. Definitive RCTs in this area should be funded to include follow-up over three to five years but this is rarely possible under existing funding programmes. Furthermore, studies with long follow up periods tend to have high dropout rates, leading to less meaningful results due to smaller sample [2].

For patients engaged in rehabilitation, intervention should be offered as intensively as possible and should begin as early as possible, although the balance between intensity and cost-effectiveness has yet to be determined [2].

3.2 Recovery Plateau

Review of the existing TBI cognitive recovery literature indicates that recovery does indeed occur after TBI and that recovery curves are likely to be differentially sensitive to both recovery domain and time [3]. Most studies have employed global measures of functional outcome including: vocational status, Glasgow Outcome Scale, the Disability Rating Scale, the Community Integration Questionnaire, and the Functional Independence Measure [3].

Recovery is detectable, asymptotic (when more than 3 points are measured), and commonplace after TBI. Studies remain ambiguous about the pace of change over time and the point at which a plateau in recovery is achieved [3]. Expressly, some studies observe continued recovery as late as **2 years** post injury [4-6] while others note no further recovery after **1 year** [3, 7], while still others indicate full recovery as early as **6 months** post injury [8, 9]. The discrepancies between findings may be attributable to the disparity across studies with regard to both study design and outcome measures [10].

Longer term longitudinal studies investigating post injury outcomes have shown mixed results. Newcombe [11] found that veterans who had had a head injury in the showed no

evidence of deterioration many years after injury. This might have been due to the expert and systematic care they received very soon after the injury. But other researchers found that a proportion of patients deteriorated when assessed 10-20 years later. In contrast, Dams-O'Connor, Ketchum [12] found a decline in functioning and decreased independence 5 years post injury. Similar results were also found by Millar, Nicoll [13] and Olver, Ponsford [14], however, a percentage of patients did make improvements. Furthermore, Ponsford, Downing [2] assessed patients at 2, 5 and 10 years post injury and found that problems that were evident at two years post-injury persisted until 10 years post-injury.

Rate of improvement varies from person to person. Currently, we don't know the exact reason why the rate is different between people. However, age, pre-injury health, abilities and severity of injury have an impact on recovery.

3.3 Impairment two years after brain injury

Research from the TBI Model System program offers information about recovery from a moderate to severe TBI at 2 years after injury [15].

- About 30% of people need some amount of assistance from another person.
    - This may be during the day, at night, or both. Over time, most people can move around again without help.
- Trouble with thinking is common.
    - This includes how fast a person can think. It also includes forming new memories. The severity of these problems varies.
- About 25% of people have major depression.
    - In some cases, it's caused directly by the brain injury. In addition, people with TBI are also dealing with major changes in their lives caused by the trauma, including changes in employment, driving, and living circumstances.
- Just over 90% of people live in a private home.
    - Of those who were living alone when they were injured, almost half go back to living alone.
- About 50% of people can drive again, but there may be changes in how often they drive or when.
- About 30% of people have a job, but it may not be the same job they had before the injury.

4 Spinal Cord Injury

4.1 Length of time high therapy supports are effective

A systematic review by Burns, Marino [16] sought to answer various questions relating the type and timing of acute and subacute SCI. The results found that the evidence base is limited for many fundamental questions related to rehabilitation following acute and subacute SCI and there is no agreement in relation to timing, intensity and response [16]. These knowledge gaps include the timing of rehabilitation, nature of rehabilitation (specific interventions), therapeutic dose (intensity, frequency, and duration), role and impact of patient and injury characteristics, cost-effectiveness and efficiency of alternative interventions [16].

Of the studies included in the systematic review, the intervention lasted anywhere from 6 to 12 weeks [16]. This is likely because of similar reasons mentioned above for TBI (i.e. lack of funding for trials). Follow up was up to 12 months.

Recommendations arising from this review include [17, 18]:

- Rehabilitation be offered to patients with acute SCI **when they are medically stable and can tolerate required rehabilitation intensity.** (Grade: Weak Recommendation; No included studies)
- Offer body weight–supported treadmill training as an option for ambulation training in addition to conventional overground walking, dependent on resource availability, context, and local expertise. (Grade: Weak Recommendation; Low Evidence)
- Individuals with acute and subacute cervical SCI be offered functional electrical therapy as an option to improve hand and upper extremity function. (Grade: Weak Recommendation; Low Evidence)
- Based on the absence of any clear benefit, suggest not offering additional training in unsupported sitting beyond what is currently incorporated in standard rehabilitation. (Grade: Weak Recommendation; Low Evidence)

4.2 Recovery Plateau

In the clinical management of spinal cord injury (SCI), neurological outcomes are generally determined at 72 h after injury using American Spinal Cord Injury Association scoring system [19]. This time-point has shown to provide a more precise assessment of neurological impairments after SCI [20]. One important predictor of functional recovery is to determine whether the injury was incomplete or complete. As time passes, SCI patients experience some spontaneous recovery of motor and sensory functions. Most of the functional recovery occurs during the first 3 months and in most cases reaches a plateau by 9 months after injury [19, 21, 22]. However, additional recovery may occur up to 12–18 months post-injury [19, 21, 22]. Long term outcomes of SCI are closely related to the level of the injury, the severity of the primary injury and progression of secondary injury.

5 Amputation

5.1 Length of time high therapy supports are effective

Unable to locate precise intensity and duration of multidisciplinary interventions for amputees. However, the US Department of Veterans Affairs have developed a clinical practice guideline for lower limb amputation [23]. For the purpose of the guideline, the postoperative continuum is separated into “phases”. These include

1) Preoperative phase
2) Immediate postoperative phase
3) Pre-prosthetic rehabilitation phase
4) Prosthetic training phase. A study by Johannesson, Larsson [24] found that 64% of participants obtained good function with their prosthesis within 6 months.
5) Rehabilitation and prosthesis follow up phase

The advancement through these phases is largely individualized, however the time needed to progress is consistently reported to be between **12 and 18 months** [23].

The NSW Agency for Clinical Innovation states that follow-up should occur regularly in the initial period for example, fortnightly/monthly for a few months, then 3-monthly, then 6-monthly [25]. Once the residual limb has stabilised, follow-up should occur, at minimum, on an annual basis. This plan may vary depending on the needs of the person [25].

5.2 Recovery Plateau

Unable to locate any details relating to a recovery plateau for amputees in the literature. It is clear however, the length of time often required before maintenance intervention should be implemented.

Table 1. Studies of rehabilitation following TBI, SCI or amputation

Author	Aim/Objective	Methods	Results	Level & Quality of evidence
Turner-Stokes, Pick [1]	To assess the effects of multi-disciplinary rehabilitation following ABI in adults 16 to 65 years of age.	**Systematic Review** RCTs comparing multi-disciplinary rehabilitation versus routinely available local services or lower levels of intervention; or trials comparing an intervention in different settings, of different intensities or of different timing of onset. 16 to 65 years of age, with ABI from any cause.	19 studies involving 3480 people. Mild brain injury: information and advice were usually more appropriate than intensive rehabilitation. Variable intervention length. Often less than 6 months. 6-12 months was the most common length of study/follow-up period. Patients with moderate to severe brain injury who received more intensive rehabilitation showed earlier improvement, and that earlier rehabilitation was better than delayed treatment. Strong evidence supports the provision of cognitive rehabilitation in an environment in which patients receive predominantly group-based rehabilitation alongside a peer group of others who are facing similar challenges. Rehabilitation for brain injury is such an individualised and long-term process that research studies do not necessarily facilitate general conclusions.	Level: 1 Quality: High Rehabilitation for brain injury is an individualised and long term process that research studies do not necessarily facilitate general conclusions.

Table 1. Studies of rehabilitation following TBI, SCI or amputation

Author	Aim/Objective	Methods	Results	Level & Quality of evidence
Königs, Beurskens [26]	Review evidence on the effects of timing and intensity of neuro-rehabilitation on the functional recovery of patients with moderate to severe TBI.	**Systematic Review and Meta-analysis** Prospective controlled clinical trials Eleven articles were included Two independent authors performed data extraction and risk of bias analysis using the Cochrane Collaboration tool Patients with moderate to severe TBI compared with usual care.	6 RCTs, 1 quasi-randomized trial, and 4 controlled trials revealed consistent evidence for a beneficial effect of early onset neuro-rehabilitation in the trauma centre and intensive neuro-rehabilitation in the rehabilitation facility on functional outcome compared with usual care. Meta-analytic quantification revealed a large-sized positive effect for early onset rehabilitation programs (d =1.02; P<.001) and a medium-sized positive effect for intensive Neuro-rehabilitation programs (d= 0.67; P<.001) compared with usual care. Intervention duration was a maximum of 6 months. Intensity was at least 20 therapy hours per week (i.e., 4-5 therapy hours per day, during 4-5d/week).	Level: I Quality: Moderate Early onset neuro-rehabilitation in the trauma centre and more intensive neuro-rehabilitation in the rehabilitation facility have beneficial effects on the functional recovery of patients with TBI compared with usual care. ***Optimal timing and intensity of neuro-rehabilitation remains unknown.*** More research is needed to determine the gain of early and intensive neuro-rehabilitation in younger patients, with greater potential for neural plasticity and functional recovery and a longer period for return on personal, societal, and economic investment.
Ponsford, Downing [2]	To examine aspects of function, previously shown to be affected following TBI, over a span of 10 years.	**Longitudinal Follow up Study** All participants (moderate to severe TBI) received inpatient rehabilitation, during which they typically received 3–5 h daily of physiotherapy, occupational therapy and speech therapy, neuropsychological	141 patients with TBI were assessed at two, five, and 10 years post-injury. Fatigue and balance problems were the most common neurological symptoms, with reported rates decreasing only slightly during the 10-year period.	Level: II Quality: Moderate There is a need for rehabilitation programs to put a greater focus on the cognitive, behavioural, psychological, and social problems

Table 1. Studies of rehabilitation following TBI, SCI or amputation

Author	Aim/Objective	Methods	Results	Level & Quality of evidence
		assessment, and social work services. This was generally followed by outpatient or community based rehabilitation, with continuing therapy as needed. Therapy services were received over an average **9 month period**, although there was considerable variability according to individual needs. The Structured Outcome Questionnaire was used to assess participant outcomes.	Mobility outcomes were good in more than 75% of patients, with few participants requiring aids for mobility. Changes in cognitive, communication, behavioural, and emotional functions were reported by approximately 60% of the sample at all-time points. Levels of independence in activities of daily living were high during the 10-year period, and as many as 70% of subjects returned to driving. Nevertheless, approximately 40% of patients required more support than before their injury. Only half the sample returned to previous leisure activities and fewer than half were employed at each assessment time post-injury. Older age at injury did not substantially alter the pattern of changes over time, except in employment. Overall, problems that were evident at two years post-injury persisted until 10 years post-injury.	that impede community participation.
Khan, Amatya [27]	To assess the effectiveness of multidisciplinary rehabilitation in people after primary brain tumour treatment, especially the types of approaches that	**Systematic Review** Adults aged 18 years and older. Confirmed diagnosis of brain tumour, regardless of time of onset or disease stage according to the WHO	Only a single study included. N = 106 (with gliomas): treatment group = 53, control group= 53 Treatment group: individualised high-intensity outpatient multidisciplinary rehabilitation programme, up to 3 one-hour sessions of interrupted therapy/week, comprising half-hour	Level: II Quality: Moderate

Table 1. Studies of rehabilitation following TBI, SCI or amputation

Author	Aim/Objective	Methods	Results	Level & Quality of evidence
	are effective (settings, intensity).	classification of tumours of the central nervous system. All RCTs and controlled clinical trials. Only multidisciplinary interventions were included. Timing of outcome measures The time points for outcome assessments and follow-up were: Short term (immediately after intervention or up to three months) and Long term (greater than three months) from the start of the intervention.	blocks of therapy sessions (occupational, social, psychological, and physiotherapy), 2 to 3 times per week for 6 to 8 weeks. Assessment time points: baseline, 3 months, and 6 months 'Low-level' evidence to support high-intensity ambulatory (outpatient) multidisciplinary rehabilitation in reducing short- and long-term motor disability (continence, mobility and locomotion, cognition), when compared with standard outpatient care.	

6 References

1. Turner-Stokes L, Pick A, Nair A, Disler PB, Wade DT. Multi-disciplinary rehabilitation for acquired brain injury in adults of working age. Cochrane Database of Systematic Reviews. 2015(12).
2. Ponsford JL, Downing MG, Olver J, Ponsford M, Acher R, Carty M, et al. Longitudinal Follow-Up of Patients with Traumatic Brain Injury: Outcome at Two, Five, and Ten Years Post-Injury. Journal of Neurotrauma [Internet]. 2014 2014 Jan 01

2014-09-20; 31(1):[64-77 pp.]. Available from: https://www.liebertpub.com/doi/abs/10.1089/neu.2013.2997.
3. Christensen BK, Colella B, Inness E, Hebert D, Monette G, Bayley M, et al. Recovery of Cognitive Function After Traumatic Brain Injury: A Multilevel Modeling Analysis of Canadian Outcomes. Archives of Physical Medicine and Rehabilitation [Internet]. 2008 2008/12/01/; 89(12, Supplement):[S3-S15 pp.]. Available from: https://www.sciencedirect.com/science/article/pii/S0003999308014986.
4. Hammond FM, Grattan KD, Sasser H, Corrigan JD, Rosenthal M, Bushnik T, et al. Five years after traumatic brain injury: A study of individual outcomes and predictors of change in function. NeuroRehabilitation [Internet]. 2004; 19:[25-35 pp.].
5. Hammond FM, Grattan KD, Sasser H, Corrigan JD, Bushnik T, Zafonte RD. Long-Term Recovery Course After Traumatic Brain Injury: A Comparison of the Functional Independence Measure and Disability Rating Scale. The Journal of Head Trauma Rehabilitation [Internet]. 2001; 16(4). Available from: https://journals.lww.com/headtraumarehab/Fulltext/2001/08000/Long_Term_Recovery_Course_After_Traumatic_Brain.3.aspx.
6. Sbordone RJ, Liter JC, Pettler-Jennings P. Recovery of function following severe traumatic brain injury: A retrospective 10-year follow-up. Brain Injury [Internet]. 1995 1995/01/01; 9(3):[285-99 pp.]. Available from: https://doi.org/10.3109/02699059509008199.
7. Whitlock JA, Hamilton BB. Functional outcome after rehabilitation for severe traumatic brain injury. Archives of Physical Medicine and Rehabilitation [Internet]. 1995 1995/12/01/; 76(12):[1103-12 pp.]. Available from: https://www.sciencedirect.com/science/article/pii/S0003999395801170.
8. Davis Levere N, Levere TE. Recovery of function after brain damage: Support for the compensation theory of the behavioral deficit. Physiological Psychology [Internet]. 1982 1982/06/01; 10(2):[165-74 pp.]. Available from: https://doi.org/10.3758/BF03332932.
9. Choi SC, Barnes TY, Bullock R, Germanson TA, Marmarou A, Young HF. Temporal profile of outcomes in severe head injury. Journal of Neurosurgery [Internet]. 1994 01 Jan. 1994; 81(2):[169-73 pp.]. Available from: https://thejns.org/view/journals/j-neurosurg/81/2/article-p169.xml.
10. Ponsford JL, Olver JH, Curran C. A profile of outcome: 2 years after traumatic brain injury. Brain Injury [Internet]. 1995 1995/01/01; 9(1):[1-10 pp.]. Available from: https://doi.org/10.3109/02699059509004565.
11. Newcombe F. Very Late Outcome After Focal Wartime Brain Wounds. Journal of Clinical and Experimental Neuropsychology [Internet]. 1996 1996/02/01; 18(1):[1-23 pp.]. Available from: https://doi.org/10.1080/01688639608408258.
12. Dams-O'Connor K, Ketchum JM, Cuthbert JP, Corrigan JD, Hammond FM, Haarbauer-Krupa J, et al. Functional Outcome Trajectories Following Inpatient Rehabilitation for TBI in the United States: A NIDILRR TBIMS and CDC Interagency Collaboration. J Head Trauma Rehabil [Internet]. 2020 Mar/Apr PMC6814509]; 35(2):[127-39 pp.].

13. Millar K, Nicoll JAR, Thornhill S, Murray GD, Teasdale GM. Long term neuropsychological outcome after head injury: relation to APOE genotype. Journal of Neurology, Neurosurgery & Psychiatry [Internet]. 2003; 74(8):[1047 p.]. Available from: http://jnnp.bmj.com/content/74/8/1047.abstract.
14. Olver JH, Ponsford JL, Curran CA. Outcome following traumatic brain injury: a comparison between 2 and 5 years after injury. Brain Injury [Internet]. 1996 1996/01/01; 10(11):[841-8 pp.]. Available from: https://doi.org/10.1080/026990596123945.
15. Center MSKT. Understanding TBI: Part 3 - The Recovery Process 2019 [Available from: https://msktc.org/tbi/factsheets/Understanding-TBI/The-Recovery-Process-For-Traumatic-Brain-Injury.
16. Burns AS, Marino RJ, Kalsi-Ryan S, Middleton JW, Tetreault LA, Dettori JR, et al. Type and Timing of Rehabilitation Following Acute and Subacute Spinal Cord Injury: A Systematic Review. Global Spine Journal [Internet]. 2017 2017/09/01; 7(3_suppl):[175S-94S pp.]. Available from: https://doi.org/10.1177/2192568217703084.
17. Fehlings MG, Tetreault LA, Aarabi B, Anderson P, Arnold PM, Brodke DS, et al. A Clinical Practice Guideline for the Management of Patients With Acute Spinal Cord Injury: Recommendations on the Type and Timing of Rehabilitation. Global spine journal [Internet]. 2017; 7(3 Suppl):[231S-8S pp.]. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5684839/.
18. Fehlings MG, Tetreault LA, Wilson JR, Kwon BK, Burns AS, Martin AR, et al. A Clinical Practice Guideline for the Management of Acute Spinal Cord Injury: Introduction, Rationale, and Scope. Global spine journal [Internet]. 2017; 7(3 Suppl):[84S-94S pp.]. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5684846/.
19. Kehr P, Kaech DL. Michael G. Fehlings, Alexander R. Vaccaro, Maxwell Boakye, Serge Rossignol, John F. Ditunno Jr, Anthony S. Burns: Essentials of spinal cord injury: basic research to clinical practice. European Journal of Orthopaedic Surgery & Traumatology. 2014;24(5):837-.
20. Brown PJ, Marino RJ, Herbison GJ, Ditunno JF, Jr. The 72-hour examination as a predictor of recovery in motor complete quadriplegia. Arch Phys Med Rehabil. 1991;72(8):546-8.
21. Alizadeh A, Dyck SM, Karimi-Abdolrezaee S. Traumatic Spinal Cord Injury: An Overview of Pathophysiology, Models and Acute Injury Mechanisms. Frontiers in Neurology [Internet]. 2019 2019-March-22; 10(282). Available from: https://www.frontiersin.org/article/10.3389/fneur.2019.00282.
22. Burns AS, Marino RJ, Flanders AE, Flett H. Chapter 3 - Clinical diagnosis and prognosis following spinal cord injury. In: Verhaagen J, McDonald JW, editors. Handbook of Clinical Neurology. 109: Elsevier; 2012. p. 47-62.
23. The Rehabilitation of Lower Limb Amputation Working Group. Clinical Practice Guideline For Rehabilitation of Lower Limb Amputation. Washington; 2007. Available from: https://www.healthquality.va.gov/guidelines/Rehab/amp/amp_v652.pdf#page=75.
24. Johannesson A, Larsson G-U, Ramstrand N, Lauge-Pedersen H, Wagner P, Atroshi I. Outcomes of a Standardized Surgical and Rehabilitation Program in Transtibial Amputation for Peripheral Vascular Disease: A Prospective Cohort Study. American Journal of Physical Medicine & Rehabilitation [Internet]. 2010; 89(4). Available from: https://journals.lww.com/ajpmr/Fulltext/2010/04000/Outcomes_of_a_Standardized_Surgical_and.4.aspx.
25. NSW Agency for Clinical Innovation. ACI Care of the Person following Amputation: Minimum Standards of Care Australia; 2017. Available from: https://aci.health.nsw.gov.au/__data/assets/pdf_file/0019/360532/The-care-of-the-person-following-amputation-minimum-standards-of-care.pdf.

26. Königs M, Beurskens EA, Snoep L, Scherder EJ, Oosterlaan J. Effects of Timing and Intensity of Neurorehabilitation on Functional Outcome After Traumatic Brain Injury: A Systematic Review and

Meta-Analysis. Archives of Physical Medicine and Rehabilitation [Internet]. 2018 2018/06/01/; 99(6):[1149-59.e1 pp.]. Available from: https://www.sciencedirect.com/science/article/pii/S0003999318300868.
27. Khan F, Amatya B, Ng L, Drummond K, Galea M. Multidisciplinary rehabilitation after primary brain tumour treatment. Cochrane Database of Systematic Reviews. 2015(8).

Ratios of support

The content of this document is OFFICIAL.

Please note:

The research and literature reviews collated by our TAB Research Team are not to be shared external to the Branch. These are for internal TAB use only and are intended to assist our advisors with their reasonable and necessary decision-making.

Delegates have access to a wide variety of comprehensive guidance material. If Delegates require further information on access or planning matters they are to call the TAPS line for advice.

The Research Team are unable to ensure that the information listed below provides an accurate & up-to-date snapshot of these matters.

Research question: Is there research (national and international) available that can inform best practice in applying Ratios of Support to participant care in group programs and supported employment? Are there guidelines available in other insurance type schemes (national and international)?

Date: 14/12/2021

Requestor: Tiffany S22(1)(a)(ii)-irrelevant material

Request endorsed by (EL1): Jane S22(1)(a)(ii)-irrelevant material

Cleared by: Illya S22(1)(a)(ii)-irrelevant material

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2. Summary

Occupational Therapists (OT) use clinical judgement in determining ratios of support required by clients for employment, community and social activities. OTs appeal to a wide variety of considerations covering personal, environmental and institutional factors. No guidelines have been developed by any organisation that offer clear guidance or rules for determining ratios of support. Different assessment tools are used to inform clinical decision making depending on the individual circumstances of the person requiring support.

3. Assessment Tools

Members of Occupational Therapy Australia (OTA) advised that the types of assessments they use to assist with determining support ratios varies between participants. OTs employ their clinical reasoning in determining which assessment tool will provide the best information. Some tools and strategies that were mentioned include:

- informal interview and history taking
- observing and analysing skills of formal and informal supports
- Overt Behaviour Scale
- manual handling plans
- observing rosters and scheduling
- Care and Needs Scale
- Community Integration Questionnaire [7.4 Occupational Therapy Australia].

Previous research completed by the TAB Research Team in March 2021 identifies one systematic review noting that only two assessment tools have been used for both individualised support planning and resource allocation. They are the **Support Intensity Scale**

(SIS) and the **Instrument for the Classification and Assessment of Support Needs** (I-CAN) [1,2,3,4]. These two scales are the most widely researched support needs assessment scales [2]. Both are in use in Australia [2,5]. I-CANS is based on the World Health Organisation's International Classification of Functioning, Disability, and Health. SIS uses the American Association on Intellectual and Developmental Disabilities functioning model [2].

The SIS records frequency, duration and type of support required for specific activities. The assessor rates activities according to the following scales:

FREQUENCY – How frequently is support needed for this activity?

0 = none or less than monthly

1 = at least once a month, but not once a week

2 = at least once a week, but not once a day

3 = at least once a day, but not once an hour

4 = hourly or more frequently

DAILY SUPPORT TIME – On a typical day when support in this area is needed, how much time should be devoted?

0 = none

1 = less than 30 minutes

2 = 30 minutes to less than 2 hours

3 = 2 hours to less than 4 hours

4 = 4 hours or more

TYPES OF SUPPORT: What kind of support should be provided?

0 = none

1 = monitoring

2 = verbal/gestural prompting

3 = partial physical assistance

4 = full physical assistance [6].

The I-CAN records frequency and type of support required on a scale of 0 – 5 to then calculate intensity of supports required:

FREQUENCY – how often support is needed

5 = Continuously

4 = Frequently

3 = Daily

2 = Weekly

1 = Occasionally

0 = Never

TYPE – how much support is needed

5 = Pervasive

4 = Extensive

3 = Moderate

2 = Minor

1 = Managed

0 = Independent

COMBINED SUPPORT INTENSITY – sum of **Frequency** and **Type** scores

10 = Continuous / Pervasive

8 = Frequent/ Extensive

6 = Daily / Moderate

4 = Weekly / Minor

2 = Occasionally / Managed

0 = No support [7].

Paying particular attention to the **Type** scores in both assessment scales, a suitably qualified clinician may be able to interpret these scores in such a way as to suggest ratios of support or at least suggest something about possible ratios of support. For example, a person with a SIS Type score of 1 or 2 (monitoring, verbal/gestural prompting) for community access or employment activities may thrive with a higher ratio environment compared to a person with a SIS score of 4 (full physical assistance). Similarly, a person with an I-CAN **Type** score of 1 or 2 (managed, minor) may benefit from group social activities with a shared support worker while a person with a score of 4 or 5 (extensive, pervasive) may require direct individual support at a 1:1 or 2:1 ratio. However, the assessment tools do not specifically recommend ratios of support and any conclusions about ratios would be significantly based on clinician's expertise or judgement.

It is also worth noting that these assessment tools do not determine support needs but are based on the assessor's observations of support needs. Both tools record support needs based on the assessor's understanding and then quantify and aggregate scores to indicate overall support needs. In that sense, the contribution of these assessment tools to determining ratios of support may be limited.

4. Guidelines

Previous research completed by the TAB Research Team in March 2021 states that there are no available professional or governmental guidelines that can be used to support determining personal care hours required for a range of tasks, disabilities and severity levels [1].

ICARE NSW has produced guidance relevant to people with Spinal Cord Injury. This document estimates support needs for different levels of spinal cord injury. Considerable clinical judgement is required to determine appropriate support hours. Ratios of support are not explicitly mentioned. However, the estimates do appeal to the following scale:

0 = no assistance	person completes the task
X = standby assistance	person completes task with monitoring, supervision
+ = needs some/set-up support	person completes more than 75% of the task
++ = needs moderate support	person completes approximately 25–75% of the task
+++ = needs full support	person completes 25% or less of the task

[8]

As reasoned in 3. Assessment Tools, it may be possible to interpret this scale as implying something about support ratios, however this would need to be done carefully and with individual clinical justification.

I have not found any professional or governmental guidelines that could assist with determining appropriate ratios of support for community access or group social activities. I reached out to 13 professional Occupational Therapy organisations. I received replies from 6. All 6 of the groups (Occupational Therapy Australia, Royal College of Occupational Therapists in the UK, the Icelandic Occupational Therapy Association, American Occupational Therapy Association), Swedish Association of Occupational Therapists, Council of Occupational Therapists for the European Countries) confirmed that there were no overall guidelines and that determination of support ratios occurs at a local or individual level [7. Appendix – Correspondence].

Members of the OTA NDIS reference group have advised:

> Guidelines could be useful. However, information must be triangulated including person's own statement of performance, with observation, other clinical and care information, client environment, and other relevant contextual factors. Any inconsistencies need to be sorted out. Each client's social and community participation levels are different. What is reasonable and ordinary for their age, relationships, skill set and social needs should be considered [7.4 Occupational Therapy Australia].

Sarah Jones, the Professional Practice Advisor from OTA, also referred me to a member of their NDIS Reference group for further advice. Leanne Healey, OT and founder/director of Everyday Independence, is in the process of developing and trialling a support measure aimed

at informing NDIS planning decisions. **Discussions regarding this project are pending** [7.4 Occupational Therapy Australia].

5. Factors that can influence ratios of support

OTA members advised the following factors can influence decisions about determining support ratio:

- level of risk to self, others and property damage
- past incident reports
- manual handling risk plans
- self-report around comfort, confidence
- cognition
- safety risks
- vulnerability within the community
- public transport confidence/ability/ability to be trained
- level of supervision required
- maximum benefit – do they participate/benefit with number of people around
- compatibility with others, e.g. issues participating with other genders precluding group ratios
- opportunities/abilities to learn from others and form natural relationships
- unpredictable or ad hoc support needs such as behavioural support or toileting support [7.4 Occupational Therapy Australia].

Relevant considerations can include personal, environmental and institutional factors. Personal factors can include:

- goals and lifestyle
- physical features of the person (height, weight etc.)
- functional capacity of the person (e.g. capacity to assist with transfers or to self-mobilise)
- the behaviour and personality of the person (e.g. presence of behaviours of concern, how well they get on with the staff)
- the person's capacity to engage in social activities (need for prompting, active inclusion etc.)
- need for assistive technology / availability of assistive technology

Environmental factors can include:

- risk of the activity (e.g. swimming, operating tools/equipment)
- complexity of the activity (e.g. complex employment tasks, navigating crowded event)
- duration of the activity (e.g. travel time, short trip to the shops, day trip out of town)
- risk in the environment (e.g. beach, busy urban streets, crowded events)

Institutional factors can include:

- consideration of the needs of all individuals in a group
- manual handling policy of the organisation
- availability of assistive technology, accessible vehicles etc.
- availability of trained staff
- other staffing needs (e.g. scheduled breaks, support for staff with a disability)
- legislative requirements, codes of practice, professional guidelines

This list is not exhaustive. The complexity and interdisciplinarity of determining support ratios may provide a clue as to why there is very little research directly focussing on the topic.

5.1 Manual Handling

Safe Work Australia and state-based work safety organisations have codes of practice relating to manual handling tasks [9,10,11]. The Safe Work Australia *Code of Practice for Hazardous Manual Tasks* suggests that, to maximise worker safety, transfer equipment should be preferred to team handling. In other words, where possible a single person should assist a patient or client using suitable assistive technology rather than two or more people assisting a patient or client manually. There are of course exceptions for equipment that is designed to be operated by two people [9]. A 2011 Work Safe Victoria guideline suggests that two people may be required to operate an electric hoist where the patient or client is not able to assist [10]. A 2006 manual handling guideline from the NSW Department of Ageing, Disability and Home Care (now the Department of Community and Justice) states that clients with uncontrolled movement may require two carers for personal care tasks. The guideline also recommends the development of a Client Manual Handling plan for risk management and support planning [12].

Phillips, Mellson and Richards emphasise the importance of individual risk assessments rather than just assuming that one or two carers are appropriate for transfers [13]. Thornton observes that two carers are often required for floor hoists, while a single carer is required for ceiling hoists. The latter is safer and generally more cost effective [14]. Determining whether 1:1 or 2:1 is required for transfers depends on the suitability of available equipment with implications for funding of ceiling hoists or floor hoists.

5.2 Behaviours of concern

Behaviours of concern are a frequent reason for requesting higher staff ratios. I could not find any research directly investigating the relationship between staff ratios and behaviours of concern. A 2021 Cochrane review completed by researchers at the NDIS Quality and Safeguard Commission investigated organisational interventions for reducing use of restrictive practices. They listed 11 potential interventions but did not explicitly consider staffing numbers or staff-client ratios as a factor in use of restrictive practices [15]. Correspondence with the author of this review suggested other potential sources (refer to 7.7 NDIS Quality and Safeguards Commission researchers). A 2009 report from the Victorian government summarises the relationship between staffing levels and restrictive practices:

> Staffing factors have been identified as critical, though there is a lack of consensus in the literature as to how best to determine optimum staffing numbers. Higher staffing ratios have been suggested as a means of enabling early intervention and prevention of escalation. However, the availability of higher levels of staff have also been associated with a greater likelihood of staff using physical interventions, if for no other reason than they have the person power available to do so. Similarly, while lower staffing ratios make it practically more difficult to use restraint, lower staffing levels can also contribute to staff feeling anxious and consequently more likely to deploy restrictive practices earlier than they might otherwise do so had they the support (reassurance and security) of other staff close by who could offer assistance if required. Further research into these issues is necessary [16].

Relating specifically to staff-client ratios, the report refers to a study in which the researchers found higher staff to patient ratios resulted in increased use of restrictive practice when the staff in question were nursing assistants. However, there was a decreased use of restrictive practices when the staff in question were registered nurses [16]. This finding could not be corroborated as the reference appears to be incorrect, however it does coincide with other research that suggests training has a greater effect than staff numbers. Singh et al found that training staff with mindfulness techniques reduced staff interventions for aggression and this was true at low, moderate and high staff-client ratios [17].

6. Social service analogues

I looked into the literature related to ratios of support in aged care and childcare. Unfortunately, the literature did not add much to the considerations already raised above.

There is inconsistent evidence that ratios of support affect children's learning and developments in early learning environments. A 2016 study by Iluz, Adi-Japha and Klein found some association between ratios of support and positive peer interactions [18]. A later systematic review found "child-staff ratios for pre-school aged children classrooms have small, if any, associations with concurrent or subsequent child outcomes" [19]. Though ultimately the standard of evidence in the reviewed papers was low.

In the context of aged care, a study by Baker et al found that abuse is more likely to occur in situations where there is not sufficient staff to complete all the work [20]. A study by Karimi-Shahanjarini et al found that insufficient staff in a hospital setting leads to lack of organisation and ‘ad hoc’ shifting of tasks [21]. In both these cases, it is not clear what counts as ‘insufficient staff’. While the findings might be relevant to determining the importance of proper ratios, they do not support planning for what those ratios might be.

7. Appendix – Correspondence

I sent an initial inquiry to 13 professional occupational therapy organisations via email on 30th September 2021 (refer to table below). With minor variations for individual organisations, the message read:

> I am completing some research for the National Disability Insurance Agency, the organisation that administers Australia’s National Disability Insurance Scheme (NDIS). The NDIS provides support to eligible people with intellectual, physical, sensory, cognitive and psychosocial disability.
>
> I am currently compiling existing research on how occupational therapists determine ratios of support for community access and group social activities. I am interested in how this is achieved internationally.
>
> It is common practice for Occupational Therapists to recommend support ratios required by their clients. For example, while one person may require 2:1 direct assistance for certain tasks, another person might thrive with 1:7 supervision for the same task. My questions are:
>
> - What considerations go into determining the appropriate ratio of individual support (i.e. 1:1 or 2:1)?
> - What considerations go into determining a safe and effective ratio of group support (i.e. 1:3 versus 1:7)?
>
> I’m hoping you might be able to provide some information on how your members determine the appropriate ratio of support. If possible can you please provide any:
>
> - recommendations you make to your members regarding ratios of support
> - best practice guidelines you may have developed or refer to in order to determine appropriate ratios of support
> - existing research you appeal to in making recommendations / developing guidelines for ratios of support
> - contacts you believe may be able to assist with my inquiry.
>
> Thank you very much for your time and all the best

Organisation	Email	Replied (Y/N)
Royal College of Occupational Therapy	library@rcot.co.uk	Y
American Occupational Therapy Association	customerservice@aota.org	Y
Icelandic Occupational Therapy Association	thoraleo@bhm.is	Y
Occupational Therapy Australia	info@otaus.com.au	Y
The Association of Occupational Therapists of Ireland	cpd@aoti.ie	N
Norsk Ergoterapeutforbund (Norway)	post@ergoterapeutene.org	N
Ergoterapeutforeningen (Denmark)	etf@etf.dk	N
Sveriges Arbetsterapeuter (Swedish Association of Occupational Therapist)	kansli@arbetsterapeuterna.se	Y
Asia Pacific Occupational Therapists Regional Group	apotrg@gmail.com	N
La Confederación Latinoamericana de Terapeutas Ocupacionales (Latin America)	clatoterapiaocupacional@gmail.com	N
Council of Occupational Therapists for European Countries	info@coteceurope.eu	Y
Occupational Therapy New Zealand - Whakaora Ngangahau Aotearoa	julia@otnz.co.nz	N

Organisation	Email	Replied (Y/N)
Canadian Association of Occupational Therapists	practice@caot.ca	N

7.1 Royal College of Occupational Therapists

From: Library <library@rcot.co.uk>
Sent: Thursday, 7 October 2021 1:04 AM
To: S22(1)(a)(ii)-irrelevant material, Aaron S22(1)(a)(ii)-irrelevant material
Cc: S22(1)(a)(ii)-irrelevant material S22(1)(a)(ii)-irrelevant material
Subject: RE: Research inquiry: best practices for determining ratios of support [SEC=OFFICIAL]

Dear Aaron,

Thank you for your enquiry.

RCOT produced two Member briefings last year that may be of interest: *Workforce planning* and *Managing caseload - workload weighting*. I attach these for your reference. As far as contacts are concerned, you may find the RCOT Independent Practice Specialist Section directory of help. The directory's search page, and links to more information about the Specialist Section, can be found here: https://rcotss-ip.org.uk/.

Moving further afield, an NHS provider directory can be viewed at https://www.england.nhs.uk/publication/nhs-provider-directory/. It gives an overview of all NHS trusts. You may, however, find contacting individual library services a better first step. The Health Library & Information Services Directory (https://www.hlisd.org/libraries/search) would help with this. Keying "foundation", for example, in the 'Library or Organisation Name' box will give many results.

I hope this helps. I'm ccing Anne Keen in here in case she wishes to add anything to the above.

Best wishes,

Alice S22(1)(a)(ii)-irrelevant material (she / her)
Librarian (Collections & Access)
Royal College of Occupational Therapists
S22(1)(a)(ii)-irrelevant material
W: www.rcot.co.uk E: S22(1)(a)(ii)-irrelevant material

From: S22(1)(a)(ii)-irrelevant material
Sent: 01 October 2021 16:43
To: S22(1)(a)(ii)-irrelevant material, Aaron S22(1)(a)(ii)-irrelevant material
Subject: RE: Research inquiry: best practices for determining ratios of support [SEC=OFFICIAL]

Dear S22(1)(a)(ii)-irrelevant material

Thank you for contacting the Royal College of Occupational Therapists (RCOT). RCOT does not provide guidance to its members regarding patient: therapist ratios as this is decided at a local level depending upon the needs of each individual receiving occupational therapy.

I have found the following information, but it is not occupational therapy specific:

Resources NHS evidence search workload weighting
https://www.evidence.nhs.uk/Search?q=workload+weighting
Social Care Institute for Excellence http://www.scie.org.uk/publications/guides/guide01/managing-work/workload.asp

You may wish to contact library@rcot.co.uk to see if my colleagues could assist you further.

Kind regards,

S22(1)(a)(ii)-irrelevant material
Professional Adviser - Professional Practice Enquiries Service
Royal College of Occupational Therapists
S22(1)(a)(ii)-irrelevant material www.rcot.co.uk

7.2 Icelandic Occupational Therapy Association

From: S22(1)(a)(ii)-irrelevant material
Sent: Friday, 1 October 2021 7:56 PM
To: S22(1)(a)(ii)-irrelevant material, Aaron S22(1)(a)(ii)-irrelevant material
Subject: Re: research inquiry: best practices for determining ratios of support [SEC=OFFICIAL]

You are most welcome - best of luck with your project!
S22(1)(a)(ii)-irrelevant material
S22(1)(a)(ii)-irrelevant material
www.ii.is

From: S22(1)(a)(ii)-irrelevant material, Aaron S22(1)(a)(ii)-irrelevant material
Sent: 30 September 2021 22:30
To: S22(1)(a)(ii)-irrelevant material
Subject: RE: research inquiry: best practices for determining ratios of support [SEC=OFFICIAL]

Hi S22(1)(a)(ii)-irrelevant material
Yes it was a very specific request. It sounds like you've understood perfectly. I have found that some OT organisations develop guidelines for use by their members. From your description it sounds like things work at more of a local level in your jurisdiction.
Thanks very much for taking the time to reply. I really appreciate it.
All the best

From: S22(1)(a)(ii)-irrelevant material
Sent: Thursday, 30 September 2021 11:08 PM
To: S22(1)(a)(ii)-irrelevant material, Aaron S22(1)(a)(ii)-irrelevant material
Subject: RE: research inquiry: best practices for determining ratios of support [SEC=OFFICIAL]
Hi Aaron,
I´m not sure if I understand your request – it seems very specific. We, as an association and a union do not have any information on how OT´s decide on support in their different workplaces. People with disabilities are a very diverse group and those decisions are made on multiple levels of the services an mostly within the different municipalities in the country. Although we have laws and procedures on support for people with disabilities but that is measured in a specific way and just for a part of the disabled population.
Sorry for this
Yours sincerely
S22(1)(a)(ii)-irrelevant material OT, MPM
President
Icelandic Occupational Therapy Association
S22(1)(a)(ii)-irrelevant material
erial

7.3 American Occupational Therapy Association

From: S22(1)(a)(ii)-irrelevant material (AOTA Customer Service Support) <customerservice@aota.org>
Sent: Thursday, 7 October 2021 7:39 AM
To: S22(1)(a)(ii)-irrelevant material, AaronS22(1)(a)(ii)-irrelevant material
Subject: [AOTA Customer Service] Re: Research inquiry: Best practice for determining ratios of support [SEC=OFFICIAL]
Hello,
AOTA does not have data or publications regarding this. I would say that clinicians use their clinical and professional reasoning. Typically if AOTA does not have specific knowledge about a topic I refer members to ask questions in CommunOT. Follow the link and feel free to post any questions, concerns, etc.
https://communot.aota.org/home
CommunOT has a general forum, as well as several communities that one can post in, and they may be found here: https://communot.aota.org/communities/allcommunities
Academic Education
Admin and Mgt

AOTA Elections
Children and Youth
COVID 19
Developmental Disabilities
Home and Community Health
Mental Health
Private Practice and Entrepreneurship
Productive Aging
Rehab and Disability
Sensory Integration and Processing
Students
Technology
Work and Industry

Thank you for your email.
AOTA Practice Division

Approved Provider Program

7.4 Occupational Therapy Australia

From: Practice Queries <Practicequeries@otaus.com.au>
Sent: Wednesday, 6 October 2021 5:25 PM
To: S22(1)(a)(ii)-irrelevant material, Aaron S22(1)(a)(ii)-irrelevant material
Subject: RE: Best practice for determining ratios of support [SEC=OFFICIAL]
Hi Aaron,
A few more responses have come through from our reference group which I have collated below.
What factors do you consider when determining ratio of support for community and social activities?

- *Level of risk to self, others and property damage.*
- *Past Incident Reports.*
- *Manual Handling Risk Plans.*
- *Self-Report around comfort, confidence.*
- *Cognition.*
- *Safety risks.*
- *Vulnerability within the community.*
- *Public transport confidence/ability/ability to be trained.*
- *Level of supervision required.*
- *Maximum benefit – do they actually still participate/benefit with number of people around*
- Compatibility with others e.g. issues participating with other genders precluding group ratios
- Opportunities/abilities to learn from others and form natural relationships – would indicate higher group ratio
- Unpredictable or ad hoc support needs i.e. behavioural support or toileting support – that would unsafely leave others in group without direct support for significant period

What assessments would you complete to contribute to decision making, are there any standard assessments that you use?
Responses varied between clinicians- selection of appropriate tools would involve clinical reasoning to ensure the most appropriate assessment is used for the clients needs and to get the most useful information to safely achieve work towards the clients goal, however, some assessments that were mentioned included: Initial interview and history taking. Behavioural scales (Overt Behavioural Scale) for behaviours of concern. Lifting and handling assessments (manual handling plans). Rosters of Care (e.g. from day programs, SIL). CANS. OBS, and writing actual times spent undertaking activities to determine level of care and ratio of supports and number of hours for same. Completion of Community Integration Questionnaires. Analysis of skills of formal and informal supports.
Are there any specific guidelines that you follow when determining ratio of support and how do you consider these? *All responses were No – individually tailored to each individual. Guidelines could be useful. However information must be triangulated including person's own statement of performance, with observation, other clinical and care information, client environment, and other relevant contextual factors. Any inconsistencies need to be sorted out. Each client's social and community participation levels are different. What is reasonable and ordinary for their age, relationships, skill set and social needs should be considered.*

What factors do you consider when recommending hours of support recommended? how might NDIS clients differ from clients accessing other types of funding?
Risk assessments around when, how often, and what time of day the person is out in the community.
Environmental assessments.
Consideration as to when should the supports be reviewed and graded up or down- Reassessment of improved functional capacity using self-reports, WHODAS, self-efficacy scales in social and community participation.
Time taken to complete activities / receive benefit from activities
Comparison to time a person without disability would spend on these activities / opportunities they would have
Person's goals i.e. if they want to go out in community often or not
Tolerance of these activities e.g. if significant disability and fatigue/ medical needs at play
If informal supports are also providing anything
History of accessing supports, importance of meaningful activities, importance of routines e.g. if they have gone to bowling on a Thursday night for ten years would want to keep those hours the same
I hope this helps
Regards,
S22(1)(a)(ii)-irrelevant material
Professional Practice Advisor
Occupational Therapy Australia
S22(1)(a)(ii)-irrelevant material

From: S22(1)(a)(ii)-irrelevant material Healey S22(1)(a)(ii)-irrelevant material
Sent: Wednesday, 6 October 2021 10:32 AM
To: S22(1)(a)(ii)-irrelevant material, Aaron S22(1)(a)(ii)-irrelevant material
Subject: Participation and support needs

Hi Aaron
OTA passed your details onto me.
I was so excited that you reached out to OTA in relation to support needs.
I wanted to share with you the work that I am doing in relation to participation and support needs.
Following years of study and liaison with international experts, I have developed an Everyday Participation and Support Needs Measure. I have worked with a research company, ORIMA, to develop this measure and planning tool.
At Everyday Independence we are starting trial of the tool in the next few weeks and have a MVP (using soft tech) for the trial but intend to build this into an expert management system in the next 6 months that will enable us to do some predictive planning (service bundling of hours of therapy, hours of support to achieve personal goals that reflect the person's values and preferences, but is also based on objective assessment of personal capacity and potential).
Aligned with evidenced based guidelines and "good" practice, the measure is administered and the data gathered using a collaborative approach with the person and their supporters. The measure also has a component of personal capacity assessment, so it is not only a measure using direct observation and self-report. To be honest, this was the key reason for failure of the Independent Assessment model.
As a therapy organisation it is clear to us that we are a long way from being the dominant narrative which underpins support decisions by the NDIA. I want to challenge this. The provision of a budget for supports and services is currently **not based on the person's assessed support needs.** The way the NDIA currently determines support budgets is not aligned with internationally recommended evidence based guidelines and on the ground, the core budget rarely reflects the person's needs, we see a lot of people over supported, and the delivery of support is not aligned with enabling the person to achieve personal outcomes. We are often seeing people NOT achieving their potential and growth due to the core budget and the way supports are delivered. We want to work towards a future where people with a disability can be supported more by community members, colleagues, peers etc – as you and I are. The reality now is that NDIA participants just get 1:1 person to person support when in the community which often prevents the person from building real social capital. Yet as therapist we have no way to influence support budgets. I am very passionate about a person getting the right intensity and type of support and I am concerned about the current state of support allocation and implementation.
This is the sole reason I have embarked on developing this measure – so that people get every chance to build their best life and supports are only there to bridge the gap that may exist when there is a mismatch between the person- task and environment.
I would be very keen to share my work with you. Given that social and community participation is a key component to building a good everyday life, much of the measure is focussed on this area – which is relevant to your study.

Best wishes
S22(1)(a)(ii)-irrelevant material | Founder & Director
Everyday Independence
S22(1)(a)(ii)-irrelevant material
Work days: Monday to Friday
www.everydayind.com.au

From: S22(1)(a)(ii)-irrelevant material Aaron S22(1)(a)(ii)-irrelevant material
Sent: Wednesday, 6 October 2021 9:30 AM
To: Practice Queries <Practicequeries@otaus.com.au>
Subject: RE: Best practice for determining ratios of support [SEC=OFFICIAL]
Hi S22(1)(a)(ii)-irrelevant material
Yes, that would be wonderful if you passed on my details.
Thanks very much.
All the best

From: Practice Queries <Practicequeries@otaus.com.au>
Sent: Wednesday, 6 October 2021 8:57 AM
To: S22(1)(a)(ii)-irrelevant material, Aaron S22(1)(a)(ii)-irrelevant material
Subject: RE: Best practice for determining ratios of support [SEC=OFFICIAL]
Hi Aaron,
Following on from our phone discussion yesterday. A member of our NDIS reference group has been working on an expert management system for the past 12 months to assess and measure participation and support needs. She has done extensive international searches and liaised with every expert in this area. The system has been built and they are entering trial next week.
She is happy to get in contact with you to discuss her work. Are you happy for me to pass on your details to her so she can get in touch?
Kind regards,
S22(1)(a)(ii)-irrelevant material
Professional Practice Advisor
Occupational Therapy Australia
S22(1)(a)(ii)-irrelevant material

From: Harrison, Aaron <Aaron.Harrison@ndis.gov.au>
Sent: Friday, 1 October 2021 11:41 AM
To: Practice Queries <Practicequeries@otaus.com.au>
Subject: RE: Best practice for determining ratios of support [SEC=OFFICIAL]
Hi S22(1)(a)(ii)-irrelevant material
Thanks so much for getting back to me.
It would be great to talk to you next week. We have a public holiday in NSW on Monday but I am free on Tuesday. 1pm would be perfect. You can reach me on 0434 886 465.
Thanks again

From: Practice Queries <Practicequeries@otaus.com.au>
Sent: Friday, 1 October 2021 11:34 AM
To: Harrison, Aaron <Aaron.Harrison@ndis.gov.au>
Subject: FW: Best practice for determining ratios of support [SEC=OFFICIAL]
Hi Aaron,
Thank you for reaching out to OTA to support the research that you are completing. It would be helpful to have some additional context from you before I put this to members. This will help ensure that the information we provide is most useful to you. Is there a time on Monday that would be suitable for me to give you a quick call? I am also available Tuesday after 12.30pm

Hopefully speak with you soon
Kind regards,
S22(1)(a)(ii)-irrelevant material
Professional Practice Advisor
Occupational Therapy Australia
S22(1)(a)(ii)-irrelevant material

From: Occupational Therapy Australia <info@otaus.com.au>
Sent: Thursday, 30 September 2021 11:39 AM
To: Practice Queries <Practicequeries@otaus.com.au>
Subject: FW: Best practice for determining ratios of support [SEC=OFFICIAL]
Hey team,
Please see enquiry from NDIS below.
Kind Regards,
S22(1)(a)(ii)-irrelevant material
Marketing and Membership Administrator
Occupational Therapy Australia
S22(1)(a)(ii)-irrelevant material
| W www.otaus.com.au

From: S22(1)(a)(ii)-irrelevant material, Aaron S22(1)(a)(ii)-irrelevant material
Sent: Thursday, 30 September 2021 11:33 AM
To: Occupational Therapy Australia <info@otaus.com.au>
Subject: Best practice for determining ratios of support [SEC=OFFICIAL]
Good morning
I am currently compiling existing research on how occupational therapists determine ratios of support for community access and group social activities.
It is common practice for Occupational Therapists to recommend support ratios required by their clients. For example, while one person may require 2:1 direct assistance for certain tasks, another person might thrive with 1:7 supervision for the same task. My questions are:

- What considerations go into determining the appropriate ratio of individual support (ie. 1:1 or 2:1)?
- What considerations go into determining a safe and effective ratio of group support (ie. 1:3 versus 1:7)?

I'm hoping you might be able to provide some information on how your members determine the appropriate ratio of support. If possible can you please provide any:

- recommendations you make to your members regarding ratios of support
- best practice guidelines you may have developed or refer to in order to determine appropriate ratios of support
- existing research you appeal to in making recommendations / developing guidelines for ratios of support
- contacts you believe may be able to assist with my inquiry.

Thank you very much for your time and all the best

7.5 Swedish Association of Occupational Therapists

From: S22(1)(a)(ii)-irrelevant material
Sent: Thursday, 4 November 2021 8:27 PM
To: S22(1)(a)(ii)-irrelevant material, Aaron S22(1)(a)(ii)-irrelevant material>
Subject: Sv: Research inquiry: best practices for determining ratios of support [SEC=OFFICIAL]

Dear Aaron,

The Association of Occupational Therapists are not able to provide you with this specific information. But please read about Professional duties for OT's in Sweden. Occupational Therapist in Sweden are trying to follow National Guidelines, provided by The National Board of Health and Welfare.

Hope this was to any kind of help.

Kind regards,
S22(1)(a)(ii)-irrelevant material

S22(1)(a)(ii)-irrelevant material
Educational coordinator and developer
International Secretary
Swedish Association of Occupational Therapists

7.6 Council of Occupational Therapists for the European Countries

From: S22(1)(a)(ii)-irrelevant material
Sent: Saturday, 9 October 2021 11:51 PM
To: S22(1)(a)(ii)-irrelevant material Aaron S22(1)(a)(ii)-irrelevant material
Subject: Re: Research inquiry: best practices for determining ratios of support [SEC=OFFICIAL]

Dear Aaron,

Thank you for your email and please accept our apologies for not replying to you earlier.

Unfortunately, COTEC as an organisation, does not have any published material on this topic. However, we would suggest that you get in touch with our Members who might have some in-house material related to your questions. Their contact details can be found on our website - https://www.coteceurope.eu/membership-2/

Let us know if we can be of any further help,

Kind regards,

S22(1)(a)(ii)-irrelevant material
Office Administration

7.7 NDIS Quality and Safeguards Commission researchers

From: S22(1)(a)(ii)-irrelevant material
Sent: Wednesday, 15 December 2021 4:38 PM
To: S22(1)(a)(ii)-irrelevant material, Aaron S22(1)(a)(ii)-irrelevant material
Subject: RE: Interventions for reducing restrictive practice [SEC=OFFICIAL]

Hi Aaron,

The review about organisational interventions to reduce restrictive practices (or behaviours of concern) showed the lack of studies looking at organisational-level interventions for people with a disability. Almost all the studies in our review looked at staff training.

The categories of interventions we listed were based on some common themes that were mentioned in papers. The paper I've attached is one of the papers the categories are based on and references some studies regarding staff ratios.

I've also attached a report by the Victorian Government that has a section referring to staff ratios, and a section on barriers to reducing restraint. The references they've listed also look relevant.

You might also find some other resources on websites such as

https://restraintreductionnetwork.org/

I hope that's useful and all the best with your project.

Kind regards,

S22(1)(a)(ii)-irrelevant material
Senior Research Officer
Senior Practitioner Division

S22(1)(a)(ii)-irrelevant material
www.ndiscommission.gov.au

From: S22(1)(a)(ii)-irrelevant material
Sent: Wednesday, 15 December 2021 10:02 AM
To: S22(1)(a)(ii)-irrelevant material, Aaron' S22(1)(a)(ii)-irrelevant material
Cc: S22(1)(a)(ii)-irrelevant material
Subject: RE: Interventions for reducing restrictive practice [SEC=OFFICIAL]

HI Aaron,

Apologies on being so slow to get back to you.

S22(1)(a)(ii)-irrelevant material Senior Research Officer here at the Commission, is the Primary author of this review. Michelle may be able to tell you whether this was a consideration in some of the included literature. Michelle will email back to let you know.

Regards
S22(1)(a)(ii)-irrelevant material

S22(1)(a)(ii)-irrelevant material (PhD)
Director Research and Practice Evidence
Senior Practitioner Division

S22(1)(a)(ii)-irrelevant material
www.ndiscommission.gov.au

From: S22(1)(a)(ii)-irrelevant material, Aaron S22(1)(a)(ii)-irrelevant material
Sent: Friday, 10 December 2021 2:17 PM
To: S22(1)(a)(ii)-irrelevant material
Subject: Interventions for reducing restrictive practice [SEC=OFFICIAL]

Hi S22(1)(a)(ii)-irrelevant material

I have just read your Cochrane review of interventions to reduce restrictive practices and was wondering if you can assist me.

I am currently completing a research project for the Technical Advisory Branch of the NDIA looking primarily at best practice for determining ratios of support (staff/carer to participant ratios) for employment activities and social / community participation.

Evidence is pretty thin to support best practice. However, one reason that clinicians often recommend higher ratios for our participants is to assist with managing behaviours of concern or managing risk to the participant, staff or others. I've not been able to find any published research pertaining to this directly. For instance, I did not see staff ratios mentioned as a potential intervention to reduce use of restrictive practices in your review.

Did you come across any consideration of staff ratios in your research? If so, can you point me in the direction of any published research that might inform my project?

Thanks and all the best

Aaron S22(1)(a)(ii)-irrelevant material

Research Officer, Enabling Services
Technical Advisory Branch
Operations and Support Division
National Disability Insurance Agency

8. References

[1] Scheetz J. Resource to Assist with Determining Personal Care Hours. TAB Research Team paper 2021.

[2] Verdugo MA, Aguayo V, Arias VB, García-Domínguez L. A systematic review of the assessment of support needs in people with intellectual and developmental disabilities. Int J Environ Res Public Health. 2020;17(24):9494.

[3] Giné C, Font J, Guàrdia-Olmos J, Balcells-Balcells A, Valls J, Carbó-Carreté M. Using the SIS to better align the funding of residential services to assessed support needs. Res Dev Disabil. 2014;35(5):1144–51.

[4] Arnold SRC, Riches VC, Stancliffe RJ. I-CAN: the classification and prediction of support needs. J Appl Res Intellect Disabil. 2014;27(2):97–111.

[5] International SIS Use [Internet]. American Association on Intellectual and Developmental Disabilities. [cited 2021 Oct 6]. Available from: https://www.aaidd.org/sis/international.

[6] Profile Form. Supports Intensity Scale [Internet]. American Association on Intellectual and Developmental Disabilities. [cited 2021 Oct 6]. Available from: https://www.aaidd.org/docs/default-source/sis-docs/sis_form_do_not_copy.pdf?sfvrsn=2.

[7] I-CAN [Internet]. Centre for Disability Studies. [cited 2021 Oct 6]. Available from: https://www.i-can.org.au/.

[8] Lukersmith S (ed.) ICARE (Insurance and Care NSW). Guidance on the support needs for adults with spinal cord injury. 2017. Sydney, Australia.

[9] Code of Practice for Hazardous Manual Tasks [Internet]. Safe Work Australia. [cited 2021 Oct 6]. Available from: https://www.safeworkaustralia.gov.au/system/files/documents/1905/model-cop-hazardous-manual-tasks.pdf.

[10] A health and safety solution – assisting people who have fallen [Internet]. WorkSafeVictoria. [cited 2021 Oct 6]. Available from: https://content.api.worksafe.vic.gov.au/sites/default/files/2018-06/ISBN-A-health-and-safety-solution-assisting-people-who-have-fallen-2011-05.pdf.

[11] Code of Practice for Hazardous Manual Tasks [Internet]. Safe Work NSW. [cited 2021 Oct 6]. Available from: https://www.safework.nsw.gov.au/__data/assets/pdf_file/0020/50078/Hazardous-manual-tasks-COP.pdf.

[12] Best Practice Guidelines for Manual Handling [Internet]. Department of Ageing, Disability and Home Care. [cited 2021 Oct 6]. Available from: http://disabilitysafe.org.au/sites/default/files/DADHC_Best_Practice_Guidelines_MH.pdf.

[13] Phillips J, Mellson J and Richardson N. It takes two? exploring the manual handling myth. 2014. University of Salford. Available from: http://usir.salford.ac.uk/id/eprint/43619/.

[14] Thornton S. An ergonomics approach to managing transfers from two handed to single handed care [Thesis]. Loughborough University. [cited 2021 Oct 6]. Available from: https://iosh.com/media/4403/sarah-thornton.pdf.

[15] Iffland M, Xu J, Gillies D. Organisational interventions for decreasing the use of restrictive practices with children or adults who have an intellectual or developmental disability. Cochrane Libr [Internet]. 2021; Available from: http://dx.doi.org/10.1002/14651858.cd013840.

[16] McVilly K. Physical restraint in disability services: Current practices, contemporary concerns, and future directions [Report]. State Government of Victoria 2009.

[17] Singh NN, Lancioni GE, Winton ASW, Curtis WJ, Wahler RG, Sabaawi M, et al. Mindful staff increase learning and reduce aggression in adults with developmental disabilities. Res Dev Disabil [Internet]. 2006;27(5):545–58. Available from: http://dx.doi.org/10.1016/j.ridd.2005.07.002.

[18] Iluz R, Adi-Japha E, Klein PS. Identifying child–staff ratios that promote peer skills in childcare. Early Educ Dev [Internet]. 2016;27(7):1077–98. Available from: http://dx.doi.org/10.1080/10409289.2016.1175240.

[19] Perlman M, Fletcher B, Falenchuk O, Brunsek A, McMullen E, Shah PS. Child-staff ratios in early childhood education and care settings and child outcomes: A systematic review and meta-analysis. PLoS One [Internet]. 2017;12(1):e0170256. Available from: http://dx.doi.org/10.1371/journal.pone.0170256.

[20] Baker PRA, Francis DP, Hairi NN, Othman S, Choo WY. Interventions for preventing abuse in the elderly. Cochrane Database Syst Rev [Internet]; 2016(8):CD010321. Available from: http://dx.doi.org/10.1002/14651858.CD010321.pub2.

[21] Karimi-Shahanjarini A, Shakibazadeh E, Rashidian A, Hajimiri K, Glenton C, Noyes J, et al. Barriers and facilitators to the implementation of doctor-nurse substitution strategies in primary care: a qualitative evidence synthesis. Cochrane Database Syst Rev [Internet]. 2019;4:CD010412. Available from: http://dx.doi.org/10.1002/14651858.CD010412.pub2.

9. Version control

Version	Amended by	Brief Description of Change	Status	Date
1.0	AHR908	Research paper to investigate evidence base for determining ratios of support.	Approved	21-12-2021

Virtual Reality as a support tool

The content of this document is OFFICIAL.

Please note:

The research and literature reviews collated by our TAB Research Team are not to be shared external to the Branch. These are for internal TAB use only and are intended to assist our advisors with their reasonable and necessary decision-making.

Delegates have access to a wide variety of comprehensive guidance material. If Delegates require further information on access or planning matters they are to call the TAPS line for advice.

The Research Team are unable to ensure that the information listed below provides an accurate & up-to-date snapshot of these matters

Research question: How can Virtual Reality (VR) be used to implement NDIS supports?

What considerations would go into determining if VR mediated supports are reasonable and necessary?

What are the benefits and risks of VR in different therapeutic / support contexts?

How much does virtual reality equipment cost and are there other associated costs?

Date: 26/04/2022

Requestor: Karen S22(1)(a)(ii)-irrelevant material

Endorsed by (EL1 or above): n/a

Researcher: Aaron S22(1)(a)(ii)-irrelevant material

Cleared by: Stephanie S22(1)(a)(ii)-irrelevant material

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2. Summary

This paper gives an overview of virtual reality (VR), its use for people with disabilities and its potential for use by NDIS participants. VR is a wide-ranging technology that can supplement therapies and support patients in a variety of ways. The effectiveness of VR as a therapeutic medium varies with condition and symptoms targeted.

A frequent barrier cited by systematic reviewers is the difficulty of combining results due to the heterogeneous nature of the technology and ways of implementing the technology in clinical and research settings. Further research is required to say reliably whether and how much benefit is gained by the key features of VR such as immersion and interaction.

Considering the rapidly changing technology and the already expansive literature on the use of virtual reality for people with disabilities, further research focusing on specific cohorts may be beneficial.

3. What is Virtual Reality?

VR is a form of human-computer interaction which reproduces sensory information for a user in the absence of the real object typically associated with the information (Doerner et al, 2022). There is no universally acknowledged definition of VR (Doerner et al, 2022) and there may be

no list of necessary and sufficient criteria by which we can say conclusively that some piece of technology is or is not VR.

However, VR is often distinguished from other presentational or representational media (eg. film, animation, computer games etc.) by its multi-sensory content being three-dimensional and variable in real-time based on life-like bodily movements (Doerner et al, 2022). For example, whereas in a traditional computer game you might adjust the perspective on a two-dimensional display by using a mouse or controller, in a VR environment you would adjust the perspective on a three-dimensional display by turning your own body.

VR systems typically have the goal of maximising immersion and presence. Presence is the user's feeling of actually being in the virtual environment (Doerner et al, 2022). Immersion refers to how well the technical features of the system promote presence. A system is more highly immersive when it:

- limits information from outside the VR system
- includes multiple sense modalities
- has a panoramic rather than narrow or limited display
- has vivid, high resolution, high fidelity displays (Doerner et al, 2022).

Bell et al describe an immersive VR system involving an HMD displaying three-dimensional images on a screen:

> Images are continuously rendered relative to the position of the head and can capture movements of the body, allowing users to explore and interact with objects and avatars (digital agents) in the virtual space. These virtual environments are either programmed using specialist software to create computer-generated, photorealistic images, or filmed with specialized cameras to create 360-degree videos of real-world scenes that can be replayed within VR. Together, these capabilities make it possible for researchers and clinicians to observe and record individuals in highly controlled and near-natural environments, in real time (2020, p.169).

There is some disagreement in the literature about the meaning of immersion and presence. Doerner et al note that head-mounted devices/displays (HMDs) and multi-screen display systems are sometimes called immersive or fully immersive systems. Desktop displays and single screen displays are sometimes called non-immersive or semi-immersive systems (Doerner et al, 2022). Brassel et al. use the term slightly differently so that immersive refers only to HMDs, semi-immersive refers to only projection-based VR and non-immersive refers to screen-based or desktop VR (Brassel, 2021).

The lack of definitional certainty can lead to some borderline cases. For example, there is some ambiguity in the literature about whether exercise game consoles like the Nintendo Wii or XBOX Kinect should count as non-immersive VR or just a regular videogame (Iosa et al, 2022; Fandim et al, 2021; Halldorsson, 2021). While these systems do utilise some responsive bodily movements (e.g swinging your arm to swing a virtual tennis racket), they do not typically

have 3D displays and interaction or responsiveness is prioritised over immersion or presence. Immersion is a key feature of the definition of VR for a lot of researchers (Fandima et al, 2021; Khan et al, 2021; Jin et al, 2022), which makes the idea of non-immersive VR an oxymoron. Borderline cases and variable applications of VR may make synthesis of results difficult when different systems are in play. Iosa et al. argue that misuse of the term “virtual reality” is one limitation in the current literature on use of gaming in neurorehabilitation (Iosa et al, 2022). This problem is meliorated at least partially if researchers make their definition of VR explicit.

A related concept which is becoming quite common is augmented reality (AR). Instead of replacing the real world with a virtual world, AR supplements or integrates virtual elements into reality (Doerner et al, 2022). For example, a pair of AR glasses might integrate with a GPS system and use visual cues to point to user to their destination. Cieslik et al offer this taxonomy:

> Depending on what real and virtual objects are presented in the image, there are four basic categories: (1) Reality, the real world; (2) Augmented Reality, where computer-generated data are merged into a real-world image; (3) Augmented Virtuality, where real-life data are merged into a computer-generated world; and (4) Virtual Reality, where the world has been created entirely by a computer. (2020, p.2)

4. VR Technology

Note: links are provided below to illustrate technologies or products. VR technology is developing quickly with new products entering the market and old products being discontinued. The examples may not be currently commercially available products or the best or most cost effective products.

VR systems can be recognised by typical technological features such as HMDs, stereo-glasses, motion or spatial tracking devices, data gloves or controllers (Bell et al, 2020, p.69; Doerner et al, 2022). Virtual reality can also be implemented by single or multi-screen systems including rooms or domes (Doerner et al, 2022).

Most commercially available VR kits include a headset, controllers, cords and base stations. Examples include Valve Index, HTC Vive Pro and HTC Vive Cosmos Elite. The headset contains the stereoscopic display screen and may also contain motion sensors. The controllers are handheld devices which track hand movements. The base stations are devices which are placed at appropriate points around the room to track movements of the body. Most VR kits require a computer to run. The Valve Index and HTC models recommend minimum specifications for the computer. The headset will be tethered to the computer with a long cord or via some cordless technology. The PlayStation VR has a separate headset which interacts with the PlayStation4 or PlayStation5 console, controllers and camera. The Oculus Quest 2 is a stand-alone system that does not require base stations or a separate computer to run (Greenwald, 2022, The Big Question: Which VR Headset Is the Best?).

Some commercially available VR kits make use of a person's mobile device. The mobile device is fitted into an HMD and may be linked to a controller. For example, a Samsung phone can connect to the Samsung Gear SM-R325 providing some VR features including motion sensing (User Manual SMR325, 2017). This technology is often cheaper than stand-alone VR systems or systems that run using a computer. However, the industry may be moving away from this type of technology and so ongoing support could be a problem (Greenwald, 2022, What happened to phone-based VR?).

4.1 Accessibility of VR technology

VR technology may be able to improve functional capacity of people with disabilities in some settings (refer to 5. Virtual reality as therapy and skills development). It can also make experiences and situations more accessibility for people with disabilities. For example, Shaker et al (2020) have designed a VR tour program that allows people to become familiar with a place before attending it in person, thereby potentially reducing anxieties about novel situations.

However, the technology itself still has some accessibility issues. The content of VR programs are still primarily visual, even though they often include auditory and haptic inputs as well (Mott et al, 2019). This can limit involvement from people with visual impairments. Teofilo et al outline accessibility features that have been added to an example system. They include:

- zoom – giving the user the ability to magnify content
- inverted colours – can allow users to change the display colours to suit their need
- auto-reading – audio information is provided when the user hovers over an element
- captions – transcription of dialogue or description of content (Teofilo et al, 2018).

Microsoft is developing a 'Canetroller' that could render content haptically exactly how a cane user would experience it (Mott et al, 2019).

Other concerns include the way VR systems or software respond to the user's body. VR allows users to do things they wouldn't ordinarily be able to do (eg. fly) but developers also often strive to make the system or program mimic one's own bodily movements as closely as possible. This can potentially duplicate physical barriers from the real to the virtual environment (Mott et al, 2019).

The physical features of the device can also pose barriers. The HMD can be difficult or impossible to wear for people with glasses, hearing aids, cochlear implants (Mott et al, 2019). Most commercially available VR systems depend on a controller, which requires a level of grip strength and manual dexterity to operate (Mott et al, 2019). This can be addressed with integration of other types of interaction device. Examples include voice commands, eye-gaze technology or the Leap Motion Controller, which tracks the movements of the hand and fingers via camera (Aguilera-Rubio, 2022; Mott et al, 2019).

4.2 Cost of some VR devices

	System	Equipment needed	Cost
1	Valve Index	Included: headset and controllers, base stations. Not included: PC with minimum dual-core CPU, Nvidia GeForce GTX 970 or AMD RX 480 GPU.	$2,500 (not including PC)
2	Oculus Quest 2	Included: Headset and controllers Not included: nil	$479
3	HTC Vive Pro full kit	Included: headset Not included: controllers, base stations, PC with Intel Core i5-4590 or AMD FX 8350, equivalent or better and NVIDIA GeForce GTX1060 or AMD Radeon RX480, equivalent or better.	$1899 (not including PC)
4	HTC Vive Cosmos Elite	Included: headset, controllers and base stations Not included: PC with Intel Core i5-4590 or AMD FX 8350 equivalent or better, and NVIDIA GeForce GTX 970 4GB, AMD Radeon R9 290 4GB equivalent or better	$1699 (not including PC)

5. Virtual Reality as therapy and skills development

VR is currently being used for rehabilitation, therapy and skills development targeting pain, physical and motor function, social and vocational skills, and capacity to complete daily activities.

There are several potential benefits of VR based therapies or skills building programs. Many researchers note that VR has the potential to improve user's motivation to take part in therapy or stick to a skills development program (Brassel et al, 2021; Alashram 2019; Demers et al, 2021; Zhao et al, 2020; Cortes-Perez et al, 2021; Aguilera-Rubio et al, 2021; Jin et al, 2022). VR may be especially beneficial for people who live in rural or remote areas with limited

access to allied health services or who otherwise experience barriers to accessing conventional therapies.

VR programs are customisable in a way that might aid in a therapeutic or skills development context. Skills development programs can be specified to progressively adjust difficulty of tasks. Virtual scenarios can be designed to provide low-risk environments to talk with strangers, interview for a job, go shopping or confront fears or anxieties. However, there are mixed results about the transferability of skills gained in a virtual world to their real-world cognates.

This variability in VR programs as well as the multitude of available systems and rapid technological development has led to difficulties in drawing reliable conclusions in the literature. Most of the systematic reviews discussed above include multiple VR systems, with multiple or undisclosed therapy programs with potentially relevant clinical differences. For example, immersion has been shown in a few studies to mediate effect size of treatment, with more immersive systems showing larger effect sizes (Dellazizzio et al, 2020; Zhu et al, 2021; Aguilera-Rubio et al, 2022). However, many studies draw conclusions based on combined results for fully-, semi- and non-immersive VR.

Technological change causes an additional barrier to research and its applications as new VR systems are created and old systems are discontinued. For example, much of the research on low immersive VR exercise games utilises the Ninento Wii or XBOX Kinect. Both systems have been discontinued. It would need to be established that the results achieved for those systems are also achievable by or representative of other systems.

The literature relating to VR use in a medical or therapeutic context is growing rapidly. At the time of writing this research paper, a search of the PubMed database for the phrase “virtual reality” returns 15,926 results since 1991 with 8,120 results from the last 5 years. A search for “virtual reality” AND:

- “disability” returns 633 results, with 326 from the last 5 years
- “autism” returns 182 results with 115 from the last 5 years
- “PTSD” returns 232 results with 96 from the last 5 years
- “cerebral palsy” returns 198 results with 90 from the last 5 years
- “stroke” returns 1,018 results with 501 from the last 5 years.

Due to the volume of available research I have restricted source material to systematic reviews into the use of a variety of VR tools for rehabilitation, therapy and skills development. Discussions of the use of VR for assessment, screening and staff training have been excluded as they are less relevant to the research question. Further targeted research into other clinical uses of VR or into specific conditions or impairments may be beneficial to get a more detailed picture of VR’s use and benefit.

5.1 Autism Spectrum Disorder

Use of VR based therapies for people with Autism Spectrum Disorder (ASD) has theoretical support due to the preference of many people with ASD for computer mediated ways of learning, communicating and relaxing (Valencia et al, 2019; Berenguer et al, 2020). However, the evidence for the effectiveness of VR in improving outcomes for people with ASD is still preliminary (Mesa-Gresa et al, 2018; Dellazizzio et al, 2020).

Two recent systematic reviews found preliminary and non-conclusive support for the effectiveness of VR type technologies in improving outcomes for children and adolescents with ASD (Mesa-Gresa, 2018; Berenguer, 2020). Studies reviewed targeted social interaction, pretended play, communication, emotion, recognition, daily living skills, attention, phobias, motor skills and physical activity (Berenguer, 2020; Mesa-Gresa, 2018). The majority of included studies found positive support for the effectiveness of therapies including VR or AR. Barriers to more reliable conclusions include: low levels of evidence (e.g large number of case studies or single subject designs), small sample sizes, disproportionate representation of boys in samples, lack of longitudinal studies, focus on high functioning ASD, lack of control groups or inappropriate control groups, (Mesa-Gresa, 2018; Berenguer, 2020).

The variety of VR technologies and implementations is of particular relevance as it prevents adequate synthesis of results. Studies used VR driving simulators, HMDs, smartphones, tablets, computers, consoles and smartglasses. Technologies were implemented in various ways as well, including mirror-type experiences where the user could see themselves with different facial expressions or performing different actions, augmented pop-up story books, 3D concept maps overlayed onto movies or games, daily living activity simulators (eg. driving, shopping) or avatar based virtual environments (Mesa-Gresa, 2018; Berenguer, 2020). Reviews did not draw conclusions about dosage or the relevance of immersion or presence.

5.2 Cerebral Palsy

A 2021 systematic review found VR is well-placed to integrate motor learning principles into therapy practice. For example, VR based therapies can be motivating, incorporate regular feedback and gradually increase in complexity or difficulty. However, the actual integration of these principles into current studies is mixed (Demers et al, 2021).

The authors also found generally lower study quality (Poor or Fair on the Downs and Black checklist) (p.4), which seems to be a feature of a body of evidence composed in large part of small pilot or proof-of-concept studies (Demers et al, 2021).

A handful of systematic reviews have returned mixed results. A review into VR motor function interventions for stroke, Parkinson's disease and cerebral palsy found general endorsement of VR techniques, except in the case of cerebral palsy (Amirthalingam et al, 2021). Another found VR therapy improves balance and walking but results were limited by small sample sizes, lack of RCTs and variety of VR technology (Warnier, Lambregts, Van De Port, 2020). A review of

RCTs describing VR treatment for hand function in children with CP found mixed results with 4 studies reporting improvement and 2 studies reporting no improvement (Rathinam et al, 2019).

Fandim et al's 2021 systematic review of VR interventions for children and young adults with CP found mixed results of generally low or very low quality of evidence. The authors found low or very low quality of evidence supporting VR plus conventional therapy in improvement of upper limb function and lower limb strength compared to conventional therapy alone. They also found low or very low quality of evidence showing no benefit to VR plus conventional therapy in improvement of postural control, postural stability, balance and gait (Fandim et al, 2021). Comparing VR with and without conventional therapy, the authors found very low quality evidence that VR improves postural control and balance immediately post intervention and low quality evidence that there is no benefit of VR on these outcomes after a short term follow up. The authors also found low or very low quality evidence showing no improvement with VR in upper limb function, gait speed or functional strength (Fandim et al, 2021).

5.3 Dementia

A 2021 review into use of digital technologies in intervention for people with dementia reviewed only 3 studies including the use of VR tools. One found a positive effect of VR tools in improvement of activities of daily living. One found a positive effect of VR tools for improvement in emotional regulation. One found no statistically significant effects. All studies were of fair study quality (using the NIH assessment tool) (Neal et al, 2021).

Zhu et al (2021) reviewed 11 RCTs of generally high quality targeting domains such as attention, executive function, memory, visuo-spatial ability, global cognition, gait and balance. Analysis showed a significant moderate positive effect on attention, memory, global cognition and balance. The authors found a small positive effect on motor function and no significant effect on visuo-spatial ability or gait (Zhu et al, 2021). The meta-analysis was also able to show that immersion mediates effect size such that fully immersive VR has a greater effect (Zhu et al, 2021). In contrast, a review of studies of exercise games found evidence of improvement to cognitive function for people with dementia (Zhao et al, 2020). Also of note, the authors found that all studies which tracked motivation showed the technology could increase motivation to engage in cognitive and physical exercise (Zhao et al, 2020). This is supported by Clay et al, who reviewed 4 studies using fully immersive VR tools. They found that while there was no reliable evidence of therapeutic benefit, the subjects were motivated to complete the tasks involved in treatment (Clay et al, 2020).

5.4 Down syndrome

Two systematic reviews have addressed the use of virtual reality tool for people with Down syndrome. Boato et al noted improvements in global motor skills, balance, postural control, body layout, spatial organization, visual-motor cognition skills and sensorimotor function after treatment with a non-immersive exercise game (Boato et al, 2022). They conclude that VR-type games have the potential to impact daily living, language, social and learning skills of

people with Down syndrome (Boato et al, 2022). However, the authors did not report the study designs or quality of the studies reviewed and so results are not reliable. More suggestive is the review from Stander et al, who included 6 studies of overall moderate levels of evidence and good study quality. They found use of non-immersive VR in combination with physiotherapy or occupational therapy did not improve motor proficiency though it could improve agility and strength in people with Down syndrome, and balance and coordination in children with Down syndrome (Stander et al, 2021).

5.5 Mental health and psychiatric conditions

Two meta-reviews give a good picture of the current state of evidence for use of VR in the treatment of mental health and psychiatric conditions. Cieslik et al (2020) reviewed 70 systematic reviews reporting on the use of VR in psychiatric disorders. The reviews covered pain perceptions, post-traumatic stress disorder, phobias, attention deficit hyperactivity disorder, psychosis and depression. The results were largely in favour of VR across all categories. 23 systematic reviews agreed that VR could be a useful non-pharmacological technique for the management of pain. 23 systematic reviews agreed that VR could be a good accompaniment to traditional treatments of anxiety and phobias. 17 reviews of various conditions including psychosis, depression, substance disorders, eating disorders, schizophrenia, spatial neglect cognitive impairment and dementia all confirmed the effectiveness of VR compared to conventional treatments. One review stated there was no good quality evidence for using VR for treatment compliance for people with schizophrenia (Cieslik et al, 2020; Dellazizzo et al, 2020).

Despite the overall positive results of the included reviews, Cieslik et al echo a common observation in the literature on VR, that is, the variety of hardware and software used in interventions is often not well reported, which is a barrier to reliable synthesis of results (Cieslik et al, 2020; Skurla et al, 2021). Further, while Cieslik et al claim the majority of included studies are of good methodological quality, they were not able to offer specific meta-analyses of results. When only papers that include meta-analysis were reviewed then assessment of quality is much lower. The meta-review from Dellazizzo et al (2020) into uses of VR in psychiatric disorders focussed on quantitatively evaluable meta-analyses. In general, the meta-analyses reviewed were found to be of very low to moderate quality.

The authors limited their investigation to 11 papers and were able to offer more specific results about effect sizes of VR based treatments. They found that VR therapy showed moderate to large effect sizes in the treatment of anxiety disorders or post-traumatic stress disorder but showed no significant difference with conventional therapy. VR has been shown to reduce symptoms of depression and may improve cognition and emotion in subjects with neurocognitive disorders (Dellazizzo et al, 2020).

Recent evidence into more specific populations or focussing on more specific interventions is mixed. Halldorsson et al. (2021) recommend VR therapies for mental health should not be offered to children and young people until further research is conducted. VR environments

may produce anxiety in children and there is only minimal evidence which focussed on children. In contrast, Kelson et al (2021) recommend VR therapies for reducing psychological distress in adolescents but base this assessment on only 4 RCTs. Jahn et al. (2021) looked specifically at fully immersive VR as a tool for cognitive rehabilitation in people with cognitive impairment, stroke, schizophrenia and ADHD. They found therapies could improve theory of mind, attention, visual working memory and executive function. The largest effect sizes were found in studies that involved training in activities of daily living like cooking or shopping. However, there is very little evidence of a transfer effect from VR training to real life activities. Larger studies are needed to establish conclusions (p.9). In contrast, Schroeder et al (2022) found evidence of transference of skills from virtual to real situations. They noted improvements in real-world social skills, community participation, managing housework, job performance as well as increased likelihood of receiving a job offer. However, they also acknowledge the small sample sizes which may affect the reliability of the results.

5.6 Multiple Sclerosis

A number of systematic reviews have focused on the use of VR tools to improve balance, gait and motor function for people with multiple sclerosis. Webster et al (2021) found conflicting evidence that VR tools could improve upper limb motor function with no consensus about which technology is best placed to achieve outcomes. Truijen et al (2022) found improvement in both treatment and control groups with no significant difference in outcome. They concluded that non-immersive VR type exercise games could be used to prolong physical therapy. Results from Truijen et al are consistent with an earlier review from Casuso-Holgado et al (2018) who found VR training is more effective than no treatment and as effective as conventional therapy in improving balance and gait.

Two 2021 reviews have obtained more positive results. Calafiori et al (2021) reviewed 9 RCTs with a total of 209 participants and concluded that balance can be improved with the use of non-immersive VR type exercise games. Nascimento et al (2021) found VR exercises were no better than conventional exercises in improving functional mobility but may offer greater benefit to fatigue, balance and quality of life.

Of particular interest is a 2021 review from Cortés-Pérez et al who found that VR based therapies can reduce the functional impact of MS. Specifically, VR based therapy can reduce the impact of MS and improve overall quality of life compared to no intervention, can reduce fatigue more than conventional therapy, and when combined with conventional therapy can improve the physical and mental dimensions of quality of life compared with conventional therapy alone (Cortés-Pérez et al, 2021). These results are limited by the number of studies, low sample sizes and medium level quality of the studies reviewed. Also noteworthy, the majority of studies investigated the use of non-immersive exercise games. Results may not generalise for more costly fully or semi-immersive VR tools (Cortés-Pérez et al, 2021).

5.7 Parkinson's disease

An early review of VR tools to improve outcomes in patients with Parkinson's disease found low quality evidence that VR and physiotherapy showed comparable improvements in gait, balance and quality of life and low quality evidence of an improvement in step and stride length in comparison to physiotherapy (Dockx, 2016).

The ambiguous findings from Truijen et al (2022), discussed in 4.6 Multiple Sclerosis also include patients with Parkinson's disease. More positive results were found in Wu et al (2022). The authors found a significant improvement in balance compared to the control groups. In addition they were able to show that specially designed rehabilitation systems were more effective than commercially available systems. These results are consistent with Sevcenko and Lindgren (2022), who show that VR is at least as effective as conventional therapy in patients with Parkinson's when considering balance, gait and function.

5.8 Spinal Cord Injury

Two systematic reviews of studies on pain in patients with spinal cord injury showed reduction in pain and disabling effect of pain. However, both reviews note limitations in the literature including small sample sizes, high risk of bias and general low quality (Ahern et al, 2020; Austin & Siddall, 2021).

Two systematic reviews from Miguel-Rubio et al found there is not enough evidence that VR interventions are more effective than conventional therapy for improving either upper limb motor function or functional performance in patients with spinal cord injury (Miguel-Rubio et al, 2020a; Miguel-Rubio et al, 2020b). However, due to conflicting results in other published studies, more research is required.

The same team did find beneficial effects of VR on balance when combined with conventional physiotherapy (Miguel-Rubio et al, 2020c). Preliminary evidence for effectiveness on balance is supported in the literature (Abou et al, 2020; Alashram et al, 2020). Abou et al found beneficial effects on both sitting and standing balance. However the levels of evidence of the studies that support these controls could be improved for more reliable results.

5.9 Stroke

In their meta-analysis of high quality studies looking at chronic stroke, Gao et al (2021) found significant and large effects of VR therapies on overall cognition, attention, executive function and depressive mood compared to conventional therapy. In addition, they found doses of larger than 20 hours and frequency of over 4 times per week showed larger effects. These findings are inconsistent with other recent reviews, however other reviews do not focus specifically on patients in the chronic phase of stroke. For example, Zhang et al. (2021) find that VR was similar to conventional therapy in improving cognition, but could improve upper and lower limb function, walking ability, balance, gait and completion of daily activities.

Aguilera-Rubio et al (2022) reviewed 6 studies that use the Leap Motion Controller, a hands-free device that enables interaction with a virtual interface without holding a controller or wearing a data-glove. Benefits to upper-limb function were reported in all studies. Jin et al reviewed 40 studies with a total 2018 participants and found an overall small benefit in arm function and completion in daily activities. However, a larger effect is produced for participants with moderately severe or severe arm muscle weakness (compared with low-moderate) and for fully immersive VR systems (compared with semi- or non-immersive systems). However, differences in study design, level of stroke, dosage and frequency, measurement tool and VR system used for treatment make generalising results difficult (Aguilera-Rubio, 2021; Jin et al, 2022). Khan et al (2021) also support the benefit of VR for motor function, finding a majority of studies reporting positive results. However the results of their meta-analysis shows no significant difference with conventional therapies. This indicates VR may be beneficial in contexts where conventional therapy is difficult to achieve.

5.10 Traumatic brain injury

Research into VR based rehabilitation treatments for traumatic brain injury (TBI) has focused on physical and cognitive symptoms of TBI including gait, balance, upper limb function, attention, memory and executive function. Treatments have involved virtual car simulators, virtual activities of daily living such as shopping, and general exercises in a virtual environment (Bassel et al, 2021; Ausilio, Han, Gleuck, 2020; Alashram et al, 2019).

There is mixed evidence for the benefit of virtual reality for rehabilitation after TBI. Three systematic reviews completed between 2019 and 2021 found overall positive results with limited explanatory power due to low levels of evidence, small sample size and risk of bias (Bassel et al, 2021; Ausilio, Han, Gleuck, 2020; Alashram et al, 2019). Meta-analyses in all reviews were not possible due to heterogeneity of studies (Bassel et al, 2021; Ausilio, Han, Gleuck, 2020; Alashram et al, 2019).

The 2019 review found mixed results for improvement in cognition. Two RCTs found positive results for memory and executive function. One RCT found comparable improvement in both treatment and control groups. (Alashram et al, 2019). This is supported by Ausilio, Han and Gleuck (2020) who also found mixed and unreliable support for benefit to cognition. However, they did find moderate support for improvements in balance and gait. Overall studies considered in this review were limited by low levels of evidence, small sample sizes (50% of studies with less than 10 participants) and risk of bias.

Brassel et al (2021) conclude the evidence base for the therapeutic benefit of VR for rehabilitation after TBI is too small to draw any reliable conclusions. This is due to overall low levels of evidence, overall low study quality and heterogeneity of the included studies marked by different measures, severity of TBI and types of VR. The authors were able to draw out some recommendations for future studies from a descriptive consideration of the literature on acquired brain injury (ABI) in general. These recommendations include the importance of co-design in developing the VR tool / intervention, describing barriers and potential safety risks

and ensuring tasks are progressively challenging and customisable. The evidence base for ABI is larger owing significantly to the number of studies looking at stroke. Refer to 5.9 Stroke for more information.

6. Risks of virtual reality use

There may be some risks of virtual reality to children. Many VR companies state that their products are not for children under 12 years old (Virtual Reality, eSafety.gov.au). Immersive VR aims to shut out stimulus outside the VR environment. This means that during play, the user will be less aware of hazards in the real world. Aubrey et al (2018) point out that while the immersive effects of VR can be more powerful for children than adults and the long-term effects of VR use on children is unknown, there is no evidence of harm associated with brief exposure (5-10 minutes) to appropriate content. Tychsen and Foeller (2020) found that after two 30 minute sessions in a fully immersive VR headset, there were no ill effects on visuomotor functions or the vestibule-ocular reflex. In their study, 2 out of 50 children experienced mild motion sickness.

Fully immersive VR may have a negative effect on static balance and cause eye strain or fatigue (Park & Lee, 2020). VR sickness, with symptoms similar to motion sickness, is a recognised problem for the industry (Saredakis et al, 2020). In their systematic review of studies reporting VR sickness, Saredakis et al reviewed 55 papers representing a total of 3016 participants. 15.6% of participants dropped out of the studies due to VR sickness. They find that content of the VR environment is a significant contributing factor to VR sickness which indicates that developers can adjust the content to reduce the likelihood or impact of VR sickness. This is supported by Park and Lee (2020) and Oh and Lee (2021) who argue that moving backgrounds can increase the likelihood of users experiencing VR sickness, so that static backgrounds should be preferred for VR in a rehabilitation or therapeutic setting.

7. Reasonable and necessary considerations

Participants may request funding for VR therapy or skills training or for the purchase or rental of a VR system itself. The following should be considered when determining if a request is reasonable and necessary:

- In many settings, there is good evidence that VR can assist with improving capacity and skills development. However, this varies by population and targeted functional domain.
- Despite the growing literature, researchers are still often tentative about recommending VR as a therapy tool due to limitations in the level and quality of evidence.

- There is no standard or ‘best practice’ therapy program as conclusions about dosage and frequency are more difficult to reach than conclusions about VR’s general effectiveness.
- Beyond a trend in some settings that immersive VR is more effective than semi- or non-immersive VR, there is very little research comparing different systems or evaluating cost-effectiveness of different systems.
- Much of the existing research shows similar effectiveness of VR based therapy and conventional physiotherapy or occupational therapy. This raises questions of the duplication of supports if VR is being requested in addition to regular therapies.
- Most VR systems require hardware beyond the VR kit itself. For example, gaming consoles like the PlayStation or XBOX or above standard PCs designed to accommodate game-play.
- Commercially available VR systems are growing in popularity and may constitute an everyday entertainment device.
- VR therapy may be particularly useful for people in rural or remote areas or who otherwise have difficulties accessing allied health services. However, some programs may require a reliable internet connection to use which could be problematic in some rural or remote settings.
- Much of the existing research demonstrating the effectiveness of VR is in the context of rehabilitation after spinal injury, stroke or other brain injury, funding for which is not the role of NDIS.
- In some cases VR systems may count as therapy tools, funding for which may not be the role of NDIS.
- There are still accessibility issues with some VR systems.
- VR systems are generally not recommended for children under 12.
- While very few studies report adverse effects of VR, some people can succumb to VR sickness when exposed to fully immersive VR environments.

8. References

Abou L, Malala V D, Yarnot R, Alluri A, Rice L A. (2020). Effects of Virtual Reality Therapy on Gait and Balance Among Individuals With Spinal Cord Injury: A Systematic Review and Meta-analysis. *Neurorehabil Neural Repair*, 34(5):375-388. doi: 10.1177/1545968320913515.

Aguilera-Rubio Á, Alguacil-Diego I M, Mallo-López A, Cuesta-Gómez A. (2022) Use of the Leap Motion Controller System in the Rehabilitation of the Upper Limb in Stroke. A Systematic Review. *J Stroke Cerebrovasc Dis*, 31(1):106174. doi: 10.1016/j.jstrokecerebrovasdis.2021.106174.

Ahern MM, Dean LV, Stoddard CC, Agrawal A, Kim K, Cook CE, Narciso Garcia A. (2020). The Effectiveness of Virtual Reality in Patients With Spinal Pain: A Systematic Review and Meta-Analysis. *Pain Pract*, 20(6):656-675. doi: 10.1111/papr.12885.

Alashram A R, Annino G, Padua E, Romagnoli C, Mercuri N B. (2019). Cognitive rehabilitation post traumatic brain injury: A systematic review for emerging use of virtual reality technology. *J Clin Neurosci*. 66:209-219. doi: 10.1016/j.jocn.2019.04.026.

Alashram A R, Padua E, Hammash A K, Lombardo M, Annino G. (2020). Effectiveness of virtual reality on balance ability in individuals with incomplete spinal cord injury: A systematic review. *J Clin Neurosci*. 72:322-327. doi: 10.1016/j.jocn.2020.01.037.

Amirthalingam J, Paidi G, Alshowaikh K, Iroshani Jayarathna A, Salibindla D, Karpinska-Leydier K, Ergin H E. (2021). Virtual Reality Intervention to Help Improve Motor Function in Patients Undergoing Rehabilitation for Cerebral Palsy, Parkinson's Disease, or Stroke: A Systematic Review of Randomized Controlled Trials. *Cureus*, 13(7): e16763. doi: 10.7759/cureus.16763.

Aubrey J S, Robb M B, Bailey J, Bailenson J. (2018) *VIRTUAL REALITY 101: What You Need to Know About Kids and VR*. San Francisco, CA: Common Sense.

Aulisio M C, Han D Y and Glueck A C. (2020). Virtual reality gaming as a neurorehabilitation tool for brain injuries in adults: A systematic review. *Brain Injury*, 34(10), 1322-1330, doi: 10.1080/02699052.2020.1802779

Austin P D, Siddall P J. (2021). Virtual reality for the treatment of neuropathic pain in people with spinal cord injuries: A scoping review. *,* 44(1):8-18. doi:10.1080/10790268.2019.1575554.

Brassel S, Power E, Campbell A, Brunner M, Togher L. (2021). Recommendations for the Design and Implementation of Virtual Reality for Acquired Brain Injury Rehabilitation: Systematic Review. *J Med Internet Res,* 23(7):e26344. doi: 10.2196/26344.

Bell I H, Nicholas J, Alvarez-Jimenez M, Thompson A, Valmaggia L. (2020). Virtual reality as a clinical tool in mental health research and practice. *Dialogues Clin Neurosci*, 22(2):169-177. doi: 10.31887/DCNS.2020.22.2/lvalmaggia.

Berenguer C, Baixauli I, Gómez S, Andrés MEP, De Stasio S. (2020). Exploring the Impact of Augmented Reality in Children and Adolescents with Autism Spectrum Disorder: A Systematic Review. *Int J Environ Res Public Health*, 17(17):6143. doi: 10.3390/ijerph17176143.

Boato E, Melo G, Filho M, Moresi E, Lourenço C, Tristão R. (2022). The Use of Virtual and Computational Technologies in the Psychomotor and Cognitive Development of Children with Down Syndrome: A Systematic Literature Review. *Int J Environ Res Public Health*, 19(5):2955. doi: 10.3390/ijerph19052955.

Calafiore D, Invernizzi M, Ammendolia A, Marotta N, Fortunato F, Paolucci T, Ferraro F, Curci C, Cwirlej-Sozanska A, de Sire A. (2021). Efficacy of Virtual Reality and Exergaming in Improving Balance in Patients With Multiple Sclerosis: A Systematic Review and Meta-Analysis. *Front Neurol*, 12:773459. doi: 10.3389/fneur.2021.773459.

Casuso-Holgado MJ, Martín-Valero R, Carazo AF, Medrano-Sánchez EM, Cortés-Vega MD, Montero-Bancalero FJ. (2018). Effectiveness of virtual reality training for balance and gait rehabilitation in people with multiple sclerosis: a systematic review and meta-analysis. *Clin Rehabil*, 32(9):1220-1234. doi: 10.1177/0269215518768084

Cieślik B, Mazurek J, Rutkowski S, Kiper P, Turolla A, Szczepańska-Gieracha J. (2020) Virtual reality in psychiatric disorders: A systematic review of reviews. *Complement Ther Med*, 52:102480. doi: 10.1016/j.ctim.2020.102480. Epub 2020 Jun 9.

Clay F, Howett D, FitzGerald J, Fletcher P, Chan D, Price A. (2020) Use of Immersive Virtual Reality in the Assessment and Treatment of Alzheimer's Disease: A Systematic Review. *J Alzheimers Dis*. 75(1):23-43. doi: 10.3233/JAD-191218.

Cortés-Pérez I, Sánchez-Alcalá M, Nieto-Escámez FA, Castellote-Caballero Y, Obrero-Gaitán E, Osuna-Pérez MC. (2021). Virtual Reality-Based Therapy Improves Fatigue, Impact, and Quality of Life in Patients with Multiple Sclerosis. A Systematic Review with a Meta-Analysis. *Sensors*. 21(21):7389. doi: 10.3390/s21217389.

Dellazizzo L, Potvin S, Luigi M, Dumais A. (2020). Evidence on Virtual Reality-Based Therapies for Psychiatric Disorders: Meta-Review of Meta-Analyses. *J Med Internet Res*. 22(8):e20889. doi: 10.2196/20889.

Demers M, Fung K, Subramanian SK, Lemay M, Robert MT. (2021). Integration of Motor Learning Principles Into Virtual Reality Interventions for Individuals With Cerebral Palsy: Systematic Review. *JMIR Serious Games*, 9(2):e23822. doi: 10.2196/23822.

Doerner R, Broll W, Grimm P, Jung B (Eds.). (2022). *Virtual and Augmented Reality (VR/AR): Foundations and Methods of Extended Realities (XR)*. Springer: Switzerland.

Dockx K, Bekkers EMJ, Van den Bergh V, Ginis P, Rochester L, Hausdorff JM, Mirelman A, Nieuwboer A. (2016). Virtual reality for rehabilitation in Parkinson's disease. *Cochrane Database of Systematic Reviews*, 12 CD010760. doi: 10.1002/14651858.CD010760.pub2.

Fandim JV, Saragiotto BT, Porfírio GJM, Santana RF. (2021) Effectiveness of virtual reality in children and young adults with cerebral palsy: a systematic review of randomized controlled trial. *Braz J Phys Ther*. 25(4):369-386. doi: 10.1016/j.bjpt.2020.11.003.

Gao Y, Ma L, Lin C, Zhu S, Yao L, Fan H, Gong J, Yan X, Wang T. (2021). Effects of Virtual Reality-Based Intervention on Cognition, Motor Function, Mood, and Activities of Daily Living in Patients With Chronic Stroke: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. *Front Aging Neurosci*. 13:766525. doi: 10.3389/fnagi.2021.766525.

Greenwald, W. (2022). The Best VR Headsets for 2022. PC Mag Australia. https://au.pcmag.com/virtual-reality-1/42713/the-best-vr-headsets

Halldorsson B, Hill C, Waite P, Partridge K, Freeman D, Creswell C. (2021). Annual Research Review: Immersive virtual reality and digital applied gaming interventions for the treatment of mental health problems in children and young people: the need for rigorous treatment development and clinical evaluation. *J Child Psychol Psychiatry*. 62(5):584-605. doi: 10.1111/jcpp.13400.

Iosa M, Verrelli CM, Gentile AE, Ruggieri M, Polizzi A. (2022). Gaming Technology for Pediatric Neurorehabilitation: A Systematic Review. *Front Pediatr*. 10:775356. doi: 10.3389/fped.2022.775356.

Jahn FS, Skovbye M, Obenhausen K, Jespersen AE, Miskowiak KW. (2021). Cognitive training with fully immersive virtual reality in patients with neurological and psychiatric disorders: A systematic review of randomized controlled trials. *Psychiatry Res*. 300:113928. doi: 10.1016/j.psychres.2021.113928.

Jin M, Pei J, Bai Z, Zhang J, He T, Xu X, Zhu F, Yu D, Zhang Z. (2022). Effects of virtual reality in improving upper extremity function after stroke: A systematic review and meta-analysis of randomized controlled trials. *Clin Rehabil*. 36(5):573-596. doi: 10.1177/02692155211066534.

Khan A, Podlasek A, Somaa F. (2021). Virtual reality in post-stroke neurorehabilitation - a systematic review and meta-analysis. *Top Stroke Rehabil*. 1-20. doi: 10.1080/10749357.2021.1990468.

Kelson JN, Ridout B, Steinbeck K, Campbell AJ. (2021). The Use of Virtual Reality for Managing Psychological Distress in Adolescents: Systematic Review. *Cyberpsychol Behav Soc Netw*. 24(10):633-641. doi: 10.1089/cyber.2021.0090.

Mesa-Gresa P, Gil-Gómez H, Lozano-Quilis JA, Gil-Gómez JA. (2018). Effectiveness of Virtual Reality for Children and Adolescents with Autism Spectrum Disorder: An Evidence-Based Systematic Review. *Sensors*, 18(8):2486. doi: 10.3390/s18082486.

De Miguel-Rubio A, Rubio MD, Alba-Rueda A, Salazar A, Moral-Munoz JA, Lucena-Anton D. (2020a). Virtual Reality Systems for Upper Limb Motor Function Recovery in Patients With Spinal Cord Injury: Systematic Review and Meta-Analysis. *JMIR Mhealth Uhealth*. 8(12):e22537. doi: 10.2196/22537.

De Miguel-Rubio A, Rubio MD, Salazar A, Camacho R, Lucena-Anton D. (2020b). Effectiveness of Virtual Reality on Functional Performance after Spinal Cord Injury: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. *J Clin Med.*, 9(7):2065. doi: 10.3390/jcm9072065.

Miguel-Rubio A, Rubio MD, Salazar A, Moral-Munoz JA, Requena F, Camacho R, Lucena-Anton D. (2020b). Is Virtual Reality Effective for Balance Recovery in Patients with Spinal Cord Injury? A Systematic Review and Meta-Analysis. *J Clin Med.* 9(9):2861. doi: 10.3390/jcm9092861.

Mott M, Cutrell E, Franco M G, Holz C, Ofek E, Stoakley R, Ringel Morris, M. (2019) Accessible by Design: An Opportunity for Virtual Reality. *2019 IEEE International Symposium on Mixed and Augmented Reality Adjunct (ISMAR-Adjunct)*, 451-454, doi: 10.1109/ISMAR-Adjunct.2019.00122.

Nascimento AS, Fagundes CV, Mendes FADS, Leal JC. (2021). Effectiveness of Virtual Reality Rehabilitation in Persons with Multiple Sclerosis: A Systematic Review and Meta-analysis of Randomized Controlled Trials. *Mult Scler Relat Disord*, 54:103128. doi: 10.1016/j.msard.2021.103128.

Neal D, van den Berg F, Planting C, Ettema T, Dijkstra K, Finnema E, Dröes RM. (2021). Can Use of Digital Technologies by People with Dementia Improve Self-Management and Social Participation? A Systematic Review of Effect Studies. *J Clin Med.* 10(4):604. doi: 10.3390/jcm10040604.

Oh, Hye Jin, Lee, Gyu Chang. (2021). Feasibility of full immersive virtual reality video game on balance and cybersickness of healthy adolescents. *Neurosci Lett.* 24;760:136063. doi: 10.1016/j.neulet.2021.136063.

Park, So Hu, Lee, Gyu Chang. (2020). Full-immersion virtual reality: Adverse effects related to static balance. *Neurosci Lett.* ;733:134974. doi: 10.1016/j.neulet.2020.134974.

Rathinam C, Mohan V, Peirson J, Skinner J, Nethaji KS, Kuhn I. (2019). Effectiveness of virtual reality in the treatment of hand function in children with cerebral palsy: A systematic review. *J Hand Ther.* 32(4):426-434.e1. doi: 10.1016/j.jht.2018.01.006.

Saredakis, D., Szpak, A., Birckhead, B., Keage, H. A. D., Rizzo, A., & Loetscher, T. (2020). Factors associated with virtual reality sickness in head-mounted displays: A systematic review and meta-analysis. *Frontiers in Human Neuroscience*, *14*, 96. https://doi.org/10.3389/fnhum.2020.00096

Schroeder AH, Bogie BJM, Rahman TT, Thérond A, Matheson H, Guimond S. (2022). Feasibility and Efficacy of Virtual Reality Interventions to Improve Psychosocial Functioning in Psychosis: Systematic Review. *JMIR Ment Health.* 9(2):e28502. doi: 10.2196/28502.

Sevcenko K, Lindgren I. (2022). The effects of virtual reality training in stroke and Parkinson's disease rehabilitation: a systematic review and a perspective on usability. *Eur Rev Aging Phys Act*. 19(1):4. doi: 10.1186/s11556-022-00283-3.

Shaker, A., Lin, X., Kim, D. Y., Kim, J.-H., Sharma, G., & Devine, M. A. (2020). Design of a virtual reality tour system for people with intellectual and developmental disabilities: A case study. *Computing in Science & Engineering*, *22*(3), 7–17. https://doi.org/10.1109/mcse.2019.2961352

Skurla MD, Rahman AT, Salcone S, Mathias L, Shah B, Forester BP, Vahia IV. (2021). Virtual reality and mental health in older adults: a systematic review. *Int Psychogeriatr.* 24:1-13. doi: 10.1017/S104161022100017X.

Stander J, du Preez JC, Kritzinger C, Obermeyer NM, Struwig S, van Wyk N, Zaayman J, Burger M. (2021). Effect of virtual reality therapy, combined with physiotherapy for improving motor proficiency in individuals with Down syndrome: A systematic review. *S Afr J Physiother*. 77(1):1516. doi: 10.4102/sajp.v77i1.1516.

Teofilo, M., Lucena, V. F., Nascimento, J., Miyagawa, T., & Maciel, F. (2018). Evaluating accessibility features designed for virtual reality context. *2018 IEEE International Conference on Consumer Electronics (ICCE)*.

Truijen S, Abdullahi A, Bijsterbosch D, van Zoest E, Conijn M, Wang Y, Struyf N, Saeys W. (2022). Effect of home-based virtual reality training and telerehabilitation on balance in individuals with Parkinson disease, multiple sclerosis, and stroke: a systematic review and meta-analysis. *Neurol Sci.* doi: 10.1007/s10072-021-05855-2.

Tychsen L, Foeller P. (2020). Effects of immersive virtual reality headset viewing on young children: visuomotor function, postural stability, and motion sickness. *Am J Ophthalmol.* 209:151-159. doi: 10.1016/j.ajo.2019.07.020

User Manual SM-R325. (2017). Samsung: Korea. https://www.samsung.com/au/support/model/SM-R325NZVCXSA/

Valencia K, Rusu C, Quiñones D, Jamet E. (2019). The Impact of Technology on People with Autism Spectrum Disorder: A Systematic Literature Review. *Sensors*, 19(20):4485. doi: 10.3390/s19204485.

eSafety Commissioner. *Virtual Reality*. https://www.esafety.gov.au/parents/gift-guide/virtual-reality.

Warnier N, Lambregts S, Port IV. (2020). Effect of Virtual Reality Therapy on Balance and Walking in Children with Cerebral Palsy: A Systematic Review. *Dev Neurorehabil.* 23(8):502-518. doi: 10.1080/17518423.2019.1683907.

Webster A, Poyade M, Rooney S, Paul L. (2021). Upper limb rehabilitation interventions using virtual reality for people with multiple sclerosis: A systematic review. *Mult Scler Relat Disord*. 47:102610. doi: 10.1016/j.msard.2020.102610.

Wu J, Zhang H, Chen Z, Fu R, Yang H, Zeng H, Ren Z. (2022). Benefits of Virtual Reality Balance Training for Patients With Parkinson Disease: Systematic Review, Meta-analysis, and Meta-Regression of a Randomized Controlled Trial. *JMIR Serious Games*. 10(1):e30882. doi: 10.2196/30882.

Zhao Y, Feng H, Wu X, Du Y, Yang X, Hu M, Ning H, Liao L, Chen H, Zhao Y. (2020). Effectiveness of Exergaming in Improving Cognitive and Physical Function in People With Mild Cognitive Impairment or Dementia: Systematic Review. *JMIR Serious Games*. 8(2):e16841. doi: 10.2196/16841.

Zhu S, Sui Y, Shen Y, Zhu Y, Ali N, Guo C, Wang T. (2021). Effects of Virtual Reality Intervention on Cognition and Motor Function in Older Adults With Mild Cognitive Impairment or Dementia: A Systematic Review and Meta-Analysis. *Front Aging Neurosci*. 13:586999. doi: 10.3389/fnagi.2021.586999.

9. Version control

Version	Amended by	Brief Description of Change	Status	Date
1.0	Aaron Harrison	Report on uses, risks and features of VR in an NDIS context	Cleared	26/04/2022

Corticobasal syndrome

The content of this document is OFFICIAL.

Please note:

The research and literature reviews collated by our TAB Research Team are not to be shared external to the Branch. These are for internal TAB use only and are intended to assist our advisors with their reasonable and necessary decision-making.

Delegates have access to a wide variety of comprehensive guidance material. If Delegates require further information on access or planning matters, they are to call the TAPS line for advice. The Research Team are unable to ensure that the information listed below provides an accurate & up-to-date snapshot of these matters

Research question: What is Corticobasal sydrome? How is it diagnosed? What are effective treatments or management path?

Date: 6/7/22

Requestor: Peta-Leanne S22(1)(a)(ii)-irrelevant material

Endorsed by (EL1 or above): Naomi S22(1)(a)(ii)-irrelevant material

Researcher: Stephanie S22(1)(a)(ii)-irrelevant material

Cleared by: Stephanie S22(1)(a)(ii)-irrelevant material

1. Contents

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2. Summary

Corticobasal syndrome (CBS) is a rare, slowly progressive, neurodegenerative disorder. Diagnosis of CBS is made by a neurologist based on clinical signs and symptoms. While pathological changes may be evident on MRI, the absence of changes does not exclude the disorder. Common manifestations of CBS are asymmetric progressive rigidity, apraxia, limb dystonia and frontal-cognitive deficits. CBS progresses to disability and loss of independence, with a poor long-term prognosis – average life expectancy post-diagnosis is 7 years. Death is typically related to complications of being bedridden such as pneumonia aspiration, pulmonary embolus and sepsis infection. There are no effective treatments to stop or slow progression of the disease. Clinical management is aimed at improving functional ability where possible and reducing the life-threatening risks from increasing immobility.

3. Corticobasal syndrome

3.1 Background

Corticobasal syndrome is a rare, progressive neurodegenerative disorder (Mennella & Schub, 2018; Stasio et al, 2019). Prevalence of CBS is estimated to be 4.9-7.3:100,000 (Constantinides et al, 2019; Wilson et al, 2021), and average life expectancy after diagnosis is 7 years (Constantinides et al, 2019; Wilson et al, 2021). Death is typically from complications from being bedridden, such as aspiration pneumonia, pulmonary embolism, or sepsis infection (Mennella & Schub, 2018). Typical age of presentation for CBS is between 50-70 years old (Wilson et al, 2021).

While some literature refers to CBS as corticobasal degeneration (CBD) or cortical basal ganglionic degeneration (Mennella & Schub, 2018), CBS requires a clinical diagnosis whereas CBD has pathological diagnostic criteria (Parmera et al, 2016; Wilson et al, 2021). Another difference is CBD diagnostic criteria has a particular age of onset and excludes anyone with a positive family history or known tau-protein mutation, which is not the case for CBS diagnosis (Constantinides et al, 2019).

CBS is a disorder of movement, cognition and behaviour (Wilson et al, 2021). It has a gradual onset of neurologic symptoms in the absence of stroke or tumour, and progression of the disease is slow (Mennella & Schub, 2018; Wilson et al, 2021). Patients who experience a dramatic presentation or rapid degeneration should have other diagnoses considered, for example Creutzfeldt-Jacob disease or Hashimoto’s encephalitis (Wilson et al, 2021).

Multiple pathologies may underlie CBS, such as CBD, Alzheimer’s disease, frontotemporal degeneration or progressive supranuclear palsy (Constantinides et al, 2021; Wilson et al, 2021). It is believed CBS results from abnormal levels of tau protein accumulating in certain brain cells leading to degeneration (Mennella & Schub, 2018).

3.2 Symptoms

Onset of CBS is gradual. Neurological degeneration manifests in motor, sensory, cognitive and behavioural signs and symptoms (Mannella & Schub, 2018). Presenting symptoms of CBS can vary between individuals as different parts of the brain may be affected (Monash Health, n.d.). Limb symptoms are typically asymmetrical early in the disease course, however eventually progress to the whole body (Mannella & Schub, 2018).

Most common symptoms reported in the literature include:

- Limb apraxia – disorder of skilled movement evident as an inability to execute purposeful movement (Mannella & Schub, 2018); occurs in approximately 70-80% of CBS cases, usually asymmetrical
- Alien-limb – loss of control over a limb such that it seems to have a mind of its own (Mannella & Schub, 2018); occurs in approximately 50% of cases of CBS (Constantinides et al, 2019; Wilson et al, 2021)
- Extrapyramidal dysfunction manifest as focal or asymmetric rigidity or focal or asymmetric limb dystonia early in the disease course (Mannella & Schub, 2018; Wilson et al, 2021); rigidity is evident in over 73% of cases (Wilson et al, 2021)
- Dystonia is present in 40% of cases, with 80% being upper limb; usually presents in first two years of disease course and related to myoclonus (Constantinides et al, 2019)
- Parkinsonism evident as slowed, awkward voluntary movements with additional involuntary movements, generally asymmetrical (Constantinides et al, 2019; Wilson et al, 2021)
- Tremors are typically not present, but if evident they are then usually a positional or action tremor; can be irregular with myoclonic quality (Constantinides et al, 2019)
- Postural instability
- Aphasia – typically non-fluent, slowed, effortful and/or groping apraxia of speech and grammatical errors, sometimes there will be difficulty with word retrieval and sentence repetition (Wilson et al, 2021)
- Cognitive deficits from frontal lobe executive dysfunction (Mannella & Schub, 2018)
- Persistent pain may be a common non-motor symptom (Mannella & Schub, 2018)

3.3 Diagnosis

Diagnosis of CBS is difficult due to overlapping features of other disorders, the lack of diagnostic tests and biological markers to confirm a CBS diagnosis, and the heterogenous presentation of the syndrome (Constantinides et al, 2021; Monash Health, n.d.; Parmera et al, 2016).

Table 1 shows Cambridge clinical criteria for CBS. For a positive diagnosis, patients must display all mandatory criteria, and two of both major and minor criteria (Wilson et al, 2021).

Table 1

Cambridge clinical criteria, modified Bak and Hodges, for CBS diagnosis (Wilson et al, 2021)

Mandatory criteria	Insidious onset
	No sustained response to levodopa treatment
Major criteria	Akinetic rigid syndrome
	Limb apraxia
	Speech and language impairment
Minor criteria	Focal or segmental myoclonus
	Asymmetric dystonia
	Alien limb syndrome
	Cortical sensory loss or dyscalculia
	Frontal executive dysfunction
	Visuospatial defects

3.4 Imaging

It should be noted that CBS diagnosis can be supported, but not refuted, by features of imaging (Wilson et al, 2021). Although cortical and subcortical changes on MRI have been well described in the literature, it is unclear at what stage of the disease these findings have been identified.

Neural changes identified by imaging will depend on the underlying pathology responsible for the CBS (Constantinides et al, 2019). Most commonly, MRI will demonstrate asymmetric cortical changes such as grey matter atrophy or dysfunction evident as hypometabolism or hypoperfusion (Wilson et al, 2021). Changes particularly affect frontal-parietal regions encompassing the premotor, motor and sensory association cortices, and typically develop contralateral to the more affected side of the body (Wilson et al, 2021). Perirolandic patterns of change relate directly to the symptoms of CBS, and the finding of asymmetrical perirolandic atrophy or hypometabolism on imaging supports the clinical diagnosis of CBS (Wilson et al, 2021). (N.b. The perirolandic region of the brain is also known as the central lobe or paracentral area. It incorporates the primary motor cortex, primary somatosensory cortex (the main sensory receptive area) and paracentral lobule (motor and sensory region) (Zuo et al, 2020)).

3.5 Treatment

There are no effective treatments to stop or slow the progression of CBS (Mennella & Schub, 2018; Stasio et al, 2019; Wilson et al, 2021). The goal of treatment is to improve motor and cognitive-behavioural symptoms (Parmera et al, 2016) or reduce the risk of life-threatening complications such as falls, aspiration pneumonia, or sepsis (Mennella & Schub, 2018).

Management options/goals noted in the literature include (Constantinides et al, 2019; Mennella & Schub, 2018; Monash Health, n.d.):

- Botulinum toxin injections to temporarily improve the functionality of the affected limb and decrease pain and cramping or dystonic muscles
- Myoclonus may be helped by medications like clonazepam (tranquiliser)
- Physiotherapy/physical therapy – improve everyday functionality such as walking and balance problems, prevent contractures and improve rigidity, advise on assistive technology to support independence
- Occupational therapy – can advise on positional aides to support posture while eating, drinking, communication; provide home safety advice to minimise risk from falls; assess and advise on pressure relieving equipment such as specialised seating and mattresses
- Speech therapy – assess speech and language decline; swallowing difficulties are common, which can lead to loss of enjoyment of food, poor nutrition, or aspiration therefore support from a speech pathologist may be beneficial
- Dietician for management of nutrition if difficulties occur with swallowing or mood changes prevent the person from eating well
- Depression and anxiety – mood changes can be supported via prescribed medication or a social worker/psychologist
- There is little evidence of effective therapy to improve cognition or prevent cognitive decline

4. References/Bibliography

Constantinides, V. C., Paraskevas, G. P., Paraskevas, P. G., Stefanis, L., & Kapaki, E. (2019). Corticobasal degeneration and corticobasal syndrome: A review. *Clinical Parkinsonism & Related Disorders, 1,* 66-71. https://doi.org/10.1016/j.prdoa.2019.08.005

Di Stasio, F., Suppa, A., Marsili, L., Upadhyay, N., Asci, F., Bologna, M., Colosimo, C., Fabbrini, G., Pantano, P., & Berardelli, A. (2019). Corticobasal syndrome: neuroimaging and neurophysiological advances. *European Journal of Neurology, 26*, 701-710. http://doi:10.1111/ene.13928

Mennella, H. D. A.-B., & Schub, T. B. (2018). Corticobasal syndrome. *CINAHL Nursing Guide.*

Monash Health. (n.d.). Corticobasal degeneration [fact sheet]. Accessed from https://monashhealth.org/services/movement-disorders-program/understanding-movement-disorders/corticobasal-degeneration/

Parmera, J. B., Rodriguez, R. D., Neto, A. S., Nitrini, R., & Dozzi Bruck, S. M. (2016). Corticobasal syndrome: A diagnostic conundrum. *Dementia & Neuropsychologia, 10*(4), 267-275. http://doi: 10.1590/s1980-5764-2016dn1004003

Raypole, C., (2019). *Understanding extrapyramidal symptoms and the medications that cause them.* Healthline. Accessed from https://www.healthline.com/health/symptom/extrapyramidal-symptoms

Wilson, D., Le Heron, C., & Anderson, T. (2021). Corticobasal syndrome: a practical guide. *Practical Neurology, 21*(4), 276-285. http://dx.doi.org/10.1136/practneurol-2020-002835

Zuo, F., Hu, K.,Kong, J., Zhang, Y., & Wan, J. (2020). Surgical management of brain metastases in the perirolandic region. *Frontiers in Oncology, 10*. https://doi.org/10.3389/fonc.2020.572644

5. Version control

Version	Amended by	Brief Description of Change	Status	Date
1.0	SJP131	Document created	Cleared	6/7/22

Research paper

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Dementia supports

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The Research Team are unable to ensure that the information listed below provides an accurate & up-to-date snapshot of these matters

Research question: Are the recommendations in RES 203 regarding dementia therapy interventions still current?

What are the common and uncommon presentations of dementia?

What community and mainstream interventions are available to people diagnosed/living with dementia?

Date: 01/09/2022

Requestor: Naomi S22(1)(a)(ii)-irrelevant material

Endorsed by: n/a

Researcher: Aaron S22(1)(a)(ii)-irrelevant material

Cleared by:

Review date:

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2. Summary

Dementia can present differently in different people. There are multiple causes which are associated with different symptom presentations. Cognitive and behavioural / psychological symptoms are common. Some people may experience physical symptoms such as tremor or rigidity.

Evidence-based supports exist including programs offered by physiotherapists, occupational therapists, psychologists and other allied health. Speech therapists are often consulted for advice on eating and drinking.

There are a variety of publicly funded dementia-specific community services including services provided by Dementia Australia and Dementia Support Australia.

3. Types and presentation of dementia

Dementia presents differently in different people. The Diagnostic and Statistical Manual of Mental Disorders 5th edition uses the term Major Neurocognitive Disorder for dementia. The International Classification of Disease 11th edition retains the name dementia but classifies it as a type of Neurocognitive Disorder. Both classifications include the common subtypes of dementia associated with Alzheimer's disease, frontotemporal lobe degeneration, Lewy body disease, Vascular disease, HIV, Huntington's disease, Parkinson's disease, substance use

and multiple concurrent causes (American Psychiatric Association, 2013; World Health Organisation, 2019).

These sub-types share common features including cognitive and behavioural/psychological symptoms. Cognitive symptoms of dementia can include problems with:

- attention
- processing speed
- planning
- decision making
- memory
- language
- perceptual-motor abilities
- social cognition (American Psychiatric Association, 2013; World Health Organisation, 2019).

Behavioural and psychological symptoms include:

- psychosis
- aggression
- anxiety
- apathy
- agitation
- depression
- delusions
- disinhibition
- wandering
- hallucinations
- sleep disturbances (World Health Organisation, 2019; National Institute for Health and Care Excellence, 2018; Sansoni et al, 2016).

There is some variation among subtypes. People with Alzheimer's disease generally present with initial memory problems and functional decline is gradual. In dementia caused by vascular disease, mood fluctuations may be more evident than memory loss in the initial stages. Personality and mood changes, disinhibition and language problems are common early symptoms of frontotemporal dementia. Dementia associated with Lewy body disease can present with visual hallucinations and physical symptoms such as tremor or rigidity (Guideline Adaptation Committee, 2016).

3.1 Younger Onset Dementia

In the NDIA, we are more likely to encounter younger onset dementia (YOD) due to the age-requirements for access to the NDIS. YOD is diagnosed when symptoms occur before the age of 65 (Dementia Australia, n.d). Also, people are more likely to experience dementia when they have been diagnosed with other conditions for which they may gain access to NDIS, such as severe/profound intellectual disability, Down Syndrome, autism, Parkinson's disease and Huntington's disease, (Lauterescu et al, 2017; Vivanti et al, 2021; Wissing et al, 2022). About 75% of people with Down Syndrome show signs of dementia before the age of 60 (Lauterescu et al, 2017).

YOD is much less common than later onset dementia. In 2021, estimates of all people experiencing dementia in Australia ranged from 386,200 to 472,000, while only about 23,308 people were living with YOD (Australian Institute of Health and Welfare, 2021). Dementia Australia estimates 28,800 people living with YOD in 2022 (Dementia Australia, 2022).

YOD can be caused by any of the common diseases associated with later onset dementia and can present in similar ways (Dementia Australia, n.d; Sansoni et al, 2016). There is evidence of some difference in symptom presentation. For example, memory problems may be less common in the initial stages compared to later onset dementia (Koedam et al, 2010) and YOD may progress faster (Veira et al, 2013).

Because symptoms occur before the age of 65, people with YOD may require different types of supports compared to people for whom symptoms present later in life. In 2021, AIHW estimates 64.7% of people with dementia were living in the community. This rises to 91% when only considering people with YOD. Younger people with dementia are more likely to be employed and still caring for children (Dementia Australia, n.d). This can change the dynamic of care, with caring responsibilities sometimes falling to younger children (Sansoni et al, 2016).

4. Management and treatment

4.1 Clinical guidelines

The Tactical Research Team's 2021 research paper RES 203 Therapy Best Practice described best practice treatments for dementia based on the UK's National Institute for Health and Care Excellence (NICE) 2018 clinical guidelines.

The Guideline Adaptation Committee of Australia's National Health and Medical Research Council (NHMRC) adapted the 2006 version of the NICE guideline for use in Australia. The *Clinical Practice Guidelines and Principles of Care for People with Dementia* was published in 2016 and approved by NHMRC for 5 years (Guideline Adaptation Committee, 2016). Approval is no longer valid. However, the document does not appear to have been either reviewed or rescinded.

The following is a selection of recommendations relating to treatment and management. For more detail and additional recommendations refer to the NICE guideline Dementia:

assessment, management and support for people living with dementia and their carers or the NHMRC's Clinical Practice Guidelines and Principles of Care for People with Dementia.

- Overall health should be monitored and maintained, including:
  - adequate nutrition and hydration (NHMRC 64-65; NICE 104, 131)
  - exercise (NHMRC 68; NICE 104)
  - dental care (NHMRC 65).
- Offer a range of activities to promote wellbeing that are tailored to the person's preferences (NHMRC 66; NICE 82).
- Offer group cognitive stimulation therapy to people living with mild to moderate dementia (NICE 83).
- Consider group reminiscence therapy for people living with mild to moderate dementia (NHMRC 84; NICE 84).
- Consider cognitive rehabilitation or occupational therapy to support functional ability in people living with mild to moderate dementia (NICE 85).
- Explore clinical or environmental causes for distress before starting treatment (NHMRC 77-78; NICE 91-92).
- Consider psychological treatments for people with mild to moderate dementia experiencing mild to moderate depression or anxiety (NHMRC 79; NICE 101).
- Consider sleep hygiene education, exposure to daylight, exercise and personalised activities as treatment for sleep problems (NICE 104).

4.2 Allied health therapies for management of symptoms

People with dementia may require referral to:

- Psychologist or behaviour support practitioner (NHMRC 82-84, 92; NICE 11, 101)
- Speech therapist (NHMRC 64; NICE 132)
- Dietician (NHMRC 64)
- Occupational therapist (NHMRC 67; NICE 85)
- Physiotherapist or exercise physiologist (NHMRC 68)

Other professionals may also be required including dentists, audiologists, orthoptists, podiatrists and social workers (Guideline Adaptation Committee, 2016).

Woods et al found cognitive stimulation therapy could improve cognitive function in people with mild to moderate dementia. The support could be delivered by professionals (speech therapist, occupational therapist, nurse, support worker) or by family caregivers. Median session length

across the studies reviewed was 45 minutes, and the median frequency was 3 times a week, ranging from 1 to 5 times a week. The total possible exposure to the intervention varied dramatically, from 10 to 12 hours to 375 hours in the two-year study. Across the 15 studies, the median exposure time was 30 hours (Woods et al, 2012).

A 2021 meta-analysis showed a multimodal occupational therapy program with a cognition-oriented approach can improve cognitive dysfunction and basic activities of daily living. The effect was achieved with 1 to 3 one-hour sessions per week for at least 16 weeks (Ham et al, 2021). Integrating activities which are tailored to the individual with dementia and activities which involve the carer are likely to reduce behavioural symptoms and improve quality of life for people with mild to moderate dementia (Tan et al, 2022; Mohler et al, 2020). The effect can be obtained with 2 – 8 sessions at 1 - 2 hours delivered face-to-face or over the phone (Mohler et al, 2020).

Cognitive training delivered by a neuropsychologist or both psychologist and occupational therapist together is shown to improve global cognition and verbal semantic fluency when delivered at least once per week. Effect sizes were larger if delivered more than 3 times per week (Bahar-Fuchs, 2019).

One 2022 systematic review found no evidence that exercise programs had a positive effect on cognition or improvement in activities of daily living. However, the authors note that there may be evidence to support the effect of aerobic activity on neuropsychiatric symptoms (Steichele et al, 2022). In contrast, another 2022 review found that when aerobic exercise is included in a multicomponent exercise program of low to moderate intensity, it may improve global cognition for people with dementia. The effect was obtained with 1 to 7 sessions per week of 30 to 90 minutes each session (Venegas-Sanabria et al, 2022).

5. Community and mainstream services

As well as MyAgedCare and Carer's Gateway, people living with dementia may be able to access Medicare subsidised allied health services through their Chronic Disease Management plan.

There are also several community services available for people living with dementia and their carers.

5.1 Dementia Australia

Dementia Australia provides information about dementia and living with dementia on their website as well as:

- in person and online library services
- support to access My Aged Care or NDIS
- counselling
- referrals to supports in the community

- social support groups
- National Dementia Hotline

5.2 Dementia Support Australia

Dementia Support Australia offers:

- educational resources to assist people living with dementia and their carers to understand and manage behaviour changes
- 24-hour helpline
- individual assessments and ongoing support
- referral to medical and allied health services
- Staying at Home program, which includes education and respite for carers and people living with dementia to encourage people to remain living in the community.

5.3 Dementia Alliance International

Dementia Alliance International facilitates online peer-to-peer support groups for people living with dementia.

5.4 Dementia Carers Australia / Dementia Reframes

Dementia Carers Australia / Dementia Reframed provides information resources as well as online workshops for people living with dementia and their carers.

6. References

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Australian Institute of Health and Welfare. (2021). *Prevalence of Dementia in Australia*. https://www.aihw.gov.au/reports/dementia/dementia-in-aus/contents/population-health-impacts-of-dementia/prevalence-of-dementia

Bahar-Fuchs, A., Martyr, A., Goh, A. M. Y., Sabates, J., & Clare, L. (2020). Cognitive training for people with mild to moderate dementia: a Cochrane Review. *BJPsych Advances*, *26*(2), 66–66. https://doi.org/10.1192/bja.2019.74

Dementia Australia. (n.d.). *About younger onset dementia*. Younger Onset Dementia Hub. from https://yod.dementia.org.au/about-younger-onset-dementia

Dementia Australia. (2022). *Dementia Statistics*. https://www.dementia.org.au/statistics

Guideline Adaptation Committee. (2016). *Clinical Practice Guidelines and Principles of Care for People with Dementia*. Sydney. National Health and Medical Research Council

Partnership Centre for Dealing with Cognitive and Related Functional Decline in Older People.

Ham, M.-J., Kim, S., Jo, Y.-J., Park, C., Nam, Y., Yoo, D.-H., & Moon, M. (2021). The effect of a multimodal occupational therapy program with cognition-oriented approach on cognitive function and activities of daily living in patients with Alzheimer's disease: A systematic review and meta-analysis of randomized controlled trials. *Biomedicines*, *9*(12), 1951. https://doi.org/10.3390/biomedicines9121951

Koedam, E. L. G. E., Lauffer, V., van der Vlies, A. E., van der Flier, W. M., Scheltens, P., & Pijnenburg, Y. A. L. (2010). Early-versus late-onset Alzheimer's disease: more than age alone. *Journal of Alzheimer's Disease: JAD*, *19*(4), 1401–1408. https://doi.org/10.3233/JAD-2010-1337

Lautarescu, B. A., Holland, A. J., & Zaman, S. H. (2017). The early presentation of dementia in people with Down syndrome: A systematic review of longitudinal studies. *Neuropsychology Review*, *27*(1), 31–45. https://doi.org/10.1007/s11065-017-9341-9

Möhler, R., Renom, A., Renom, H., & Meyer, G. (2020). Personally tailored activities for improving psychosocial outcomes for people with dementia in community settings. *Cochrane Database of Systematic Reviews*, *8*(8), CD010515. https://doi.org/10.1002/14651858.CD010515.pub2

National Institute for Health and Care Excellence. (2018). Dementia: assessment, management and support for people living with dementia and their carers (NICE guideline NG97. https://www.nice.org.uk/guidance/ng97/evidence/full-guideline-pdf-4852695709

Tan, D. G. H., Boo, B. M. B., Chong, C. S., Tan, M. M. L.-L., & Wong, B.-S. (2022). Effectiveness of home-based, non-exercise interventions for dementia: A systematic review. *Frontiers in Aging Neuroscience*, *14*, 846271. https://doi.org/10.3389/fnagi.2022.846271

Venegas-Sanabria, L. C., Cavero-Redondo, I., Martínez-Vizcaino, V., Cano-Gutierrez, C. A., & Álvarez-Bueno, C. (2022). Effect of multicomponent exercise in cognitive impairment: a systematic review and meta-analysis. *BMC Geriatrics*, *22*(1), 617. https://doi.org/10.1186/s12877-022-03302-1

Vieira, R. T., Caixeta, L., Machado, S., Silva, A. C., Nardi, A. E., Arias-Carrión, O., & Carta, M. G. (2013). Epidemiology of early-onset dementia: a review of the literature. *Clinical Practice and Epidemiology in Mental Health: CP & EMH*, *9*(1), 88–95. https://doi.org/10.2174/1745017901309010088

Vivanti, G., Tao, S., Lyall, K., Robins, D. L., & Shea, L. L. (2021). The prevalence and incidence of early-onset dementia among adults with autism spectrum disorder. *Autism Research: Official Journal of the International Society for Autism Research*, *14*(10), 2189–2199. https://doi.org/10.1002/aur.2590

Wissing, M. B. G., Ulgiati, A. M., Hobbelen, J. S. M., De Deyn, P. P., Waninge, A., & Dekker, A. D. (2022). The neglected puzzle of dementia in people with severe/profound intellectual disabilities: A systematic literature review of observable symptoms. Journal of Applied Research in Intellectual Disabilities: JARID, 35(1), 24–45. https://doi.org/10.1111/jar.12920

Woods, B., Aguirre, E., Spector, A. E., & Orrell, M. (2012). Cognitive stimulation to improve cognitive functioning in people with dementia. *Cochrane Database of Systematic Reviews*, *2*, CD005562. https://doi.org/10.1002/14651858.CD005562.pub2

World Health Organization. (2019). ICD-11: International classification of diseases (11th revision). https://icd.who.int/

Dorsal Root Ganglion Stimulation for Complex Regional Pain Syndrome

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Research question: What is the evidence for the efficacy of dorsal root ganglion stimulation for complex regional pain syndrome? How do the clinical outcomes compare to less invasive and lower cost options?

Date: 19/9/2022

Requestor: Lynette S22(1)(a)(ii)-irrelevant material

Endorsed by (EL1 or above): Andrea S22(1)(a)(ii)-irrelevant material

Researcher: Stephanie S22(1)(a)(ii)-irrelevant material

Cleared by: Stephanie S22(1)(a)(ii)-irrelevant material

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2. Summary

Complex regional pain syndrome can develop after direct trauma to a limb. Most cases of complex regional pain syndrome will resolve over a few months, however some individuals may experience long-term pain and disability.

Dorsal root ganglion stimulation is one treatment option for complex regional pain syndrome. The efficacy of dorsal root ganglion stimulation appears superior to other neuromodulation techniques such as spinal cord stimulation, however it should be considered one of the last management options after all other pain management techniques have been attempted and failed.

3. Background

3.1 What is complex regional pain syndrome?

Complex regional pain syndrome (CRPS) is characterised by neuropathic pain that typically affects an extremity and develops after direct physical trauma (Pilgrim and Schiebel, 2017). While many cases are mild, in some people the pain can be disproportionately severe compared to the triggering event, with these patients reporting a very low quality of life (Pilgrim and Schiebel, 2017).

Common symptoms of CRPS include (Better Health Channel, 2015; National Institute of Neurological Disorders and Stroke (NINDS), 2020; Pilgrim and Schiebel, 2017):

- Unprovoked or spontaneous pain (e.g., squeezing, burning or pins and needles sensation) that can be constant or fluctuate with activity
- Excess or prolonged pain after use or contact
- Changes in skin temperature, colour or swelling of the limb
- Changes in skin texture
- Abnormal sweating and nail and hair growth
- Stiffness in affected joints
- Wasting away or excess bone growth
- Loss of fine motor control, tremors, spasms or impaired muscle strength due to pain and abnormalities in sensory input that coordinates movement
- Limited range of motion.

CRPS is divided into two subtypes depending on whether nerve damage is present. CRPS I (previously known as reflex sympathetic dystrophy) has no clinically apparent nerve damage, whereas CRPS II (previously called causalgia) has confirmed nerve damage (Pilgrim and Schiebel, 2017).

The exact cause of CRPS is unknown, but NINDS (2020) suggest up to 90% of cases are triggered by nerve trauma or injury to the affected limb that damages the thin sensory and autonomic nerve fibres. It is believed this leads to dysfunction of the sympathetic nervous system and induces an inflammatory response that causes blood vessels to spasm, leading to swelling and pain (NINDS, 2020; Pilgrim and Schiebel, 2017). Injuries that can lead to CRPS include blunt trauma, lacerations, burns, frostbite, fractures and casting, sprains and strains, and surgery-related injury such as knee arthroscopy or carpel tunnel surgery (Better Health Channel, 2015; NINDS, 2020; Pilgrim and Schiebel, 2017).

CRPS only develops in limbs because circulation in extremities is limited. Damage to nerve fibres can compromise vascular flow, impeding delivery of oxygen and nutrients needed for healing (NINDS, 2020). Additionally, conditions such as diabetes or exposure to nerve toxins can make the nerves more vulnerable to damage. The immune system and genetics have also been implicated in some cases (NINDS, 2020).

CRPS is more common in women, reportedly up to three times more likely to be affected than males (Better Health Channel, 2015). The mean age of onset is 36-46 years, however the condition can occur in anyone at any age (Pilgrim and Schiebel, 2017). CRPS is rare in the elderly who have less inflammation after injury, and in young children who heal very quickly and completely (NINDS, 2020). The outcome of CRPS is variable, but most often people experience mild symptoms over a few months as the injured nerve heals (NINDS, 2020). In rare circumstances, some individuals may experience prolonged severe pain and disability despite treatment (Better Health Channel, 2015; NINDS, 2020).

3.2 What is dorsal root ganglion stimulation?

Dorsal root ganglions (DRG) are at each segment level of the spinal cord and lumbosacral spine, laying in the intervertebral foramina where the nerve roots exit the spinal column (Nagpal et al, 2020). They are the first cell body of the sensory pathway from the periphery to the central nervous system (Nagpal et al, 2020). The DRG may have a role in chronic neuropathic pain through hyperexcitability and spontaneous, ectopic firing after peripheral nerve injury as is seen in CRPS I and II and other peripheral nerve injuries (Deer et al, 2019; Nagpal et al, 2020).

Neurostimulation is the application of electricity to the nervous system to achieve a desired therapeutic response, and neurostimulation of the DRG as an interventional treatment for chronic pain was approved in Europe in 2011 and the United States in 2016 (Deer et al, 2019). The DRG is considered an important target for treating neuropathic pain because it transmits sensory input from the peripheral to central nervous system (Deer et al, 2019). DRG stimulation is thought to provide more precise focal coverage of pain as physicians rely on

patient's descriptions of pain distribution patterns to determine lead placement compared to spinal cord stimulation (Deer et al, 2019; Nagpal et al, 2020). As the DRG lays in the epidural space it is amenable to epidural access techniques allowing device leads to be safely implanted (Deer et al, 2019). After a trial period, if DRG stimulation appears to be successful in the reduction of pain and other symptoms, an implantable pulse generator can be placed subcutaneously.

4. What is the evidence for the efficacy of dorsal root ganglion stimulation?

4.1 Literature review for efficacy of dorsal root ganglion stimulation

The primary outcome for DRG stimulation in most studies is a ≥50% reduction in pain, with secondary outcomes relating to concerns such as physical function, mood, quality of life, opioid use and complications (Nagpal et al, 2020).

Results from a systematic literature review (Deer et al., 2020) into the efficacy of DRG stimulation for CRPS or chronic neuropathic pain analysed one randomised control trial and five prospective observational studies and reported:

- Deer et al. (2017): randomised control trial, *N* = 76 – over 80% of participants who had a DRG stimulation device implanted experienced greater than 50% reduction in pain three months after the procedure and 74% at 12 months. The reported relief in pain by the DRG stimulation group was superior to the comparison group who received spinal cord stimulation
- Huygen et al. (2018): observational, *N* = 12 – more than half reported 50% or better pain relief, and the overall average pain relief was 46% at 12 months; improved mood and quality of life was demonstrated
- Morgalla et al. (2018): observational, *N* = 62 – 78% experienced pain reduction at 12 months, 65% at 36 months
- Van Buyten et al. (2015): observational, 8 received implanted device – at 1-month post-procedure the average pain level decreased 62% compared to baseline, at 12 months the overall pain relief was 62% with five participants reporting greater or equal to 50% pain relief. One participant had the device extracted due to unsatisfactory pain relief.
- Liem et al. (2015): observational, 32 received implanted device – at the 12 month follow up 25 participants reported a 56% decrease in pain from baseline levels. Reported quality of life improved and total mood disturbance scores decreased
- Deer et al. (2013): observational, 8 participants provided data for efficacy – 75% experienced reduction in pain at 4 weeks. No further follow up reported.

Multiple case-series observational studies are noted. One particular study, Yang and Hunter (2017), reports the experience of two patients with lower extremity CRPS who had failed a tonic spinal cord stimulation device so proceeded to a DRG stimulation trial. One patient reported a 90% reduction in pain and improvement in gait during the trial so had the spinal cord stimulation device explanted in favour of the DRG stimulator. The second patient had the DRG stimulation device 'piggy back' with the spinal cord stimulation device to trial the technology and reported an immediate improvement in pain; when only the DRG stimulation device was active the pain score was at its lowest. At 8 months both participants had retained the improvement in function and pain relief.

Limitations in the literature noted by Nagpal et al. (2020) and Potter et al. (2022) include the conflict of interest as some studies are funded by industry providers (e.g., St Jude Medical, Spinal Modulation) increasing the risk of bias, limited long term follow up data, and many papers include the same authors so there is a concern some studies have used the same cohort of participants. Finally, the lack of randomised control trials makes it unclear whether the findings are robust and reproducible.

4.2 Recommendations for use of dorsal root ganglion stimulation

The Food and Drug Administration approved dorsal root ganglion stimulation in 2016 (Potter et al, 2022). No information could be found regarding approval by the Therapeutic Goods Administration.

A 2018 literature review by the Neuromodulation Appropriateness Consensus Committee found there was strong evidence for the use of DRG stimulation for patients with CRPS I and II and other chronic pain syndromes of the pelvis and lower extremity (Nagpal et al, 2020). The evidence quality was considered to be level II (based on one randomised control trial and two observational studies) by the committee and was used to provide recommendations around the used of DRG stimulation for different pain conditions (Deer et al., 2019):

- General considerations for patient selection –
    - Be psychologically stable
    - Have a defined pathology
    - Have any issues with addiction under control
    - Have satisfactory anticoagulation management that allows for the safe placement of an epidural lead
    - Have no unaddressed or poorly managed medical conditions that may impact the outcome of the procedure, such as those that relate to infection risk, diabetes, or other systemic disease
    - Have satisfactory access to the target foramen, i.e., no stenosis
    - Be well informed on the device and treatment, having the chance to ask

questions and be offered other options

- Complex regional pain syndrome
    - Based on the one randomised control trial available, the committee recommended DRG stimulation as effective therapy for treatment of CRPS type I or type II of the lower extremity. The trial compare DRG stimulation to tonic spinal cord stimulation, 81.2% of participants who received DRG stimulation achived > 50% pain reduction compared to 55.7% in the other group. This resulted in improved quality of life and psychological disposition, less postural interference from stimulation or parasthesia compared to tonic spinal cord stimulation.
    - The committee recommended further research for DRG stimulation of the upper extremity for CRPS treatment of type I or type II.
- Diabetic peripheral neuropathy
    - There is stronger evidence of efficacy for spinal cord stimulation than DRG stimulation. Due to the limited data regarding efficacy, DRG stimulation should be carefully justified.
- Other peripheral neuropathies
    - More evidence is required before DRG stimulation can be recommended for non-diabetic peripheral neuropathy
- Postsurgical pain
    - There is reportedly a good response to DRG stimulation in patients with post-surgical pain after thoracotomy or mastectomy.
    - The committee recommend use of DRG stimulation in patients with chronic postoperative surgical pain, however decisions should be made on a case-by-case basis (moderate consensus within the committee).
- Pelvic pain
    - Pelvic pain is a non-specific term representing a variety of pathologies that can arise from many causes, such as: pudendal neuralgia, interstitial cystitis, endometriosis, vulvodynia, ilioinguinal neuralgia. Pelvic visceral pain arising from S2, S3 and S4 need to be differentiated from groin pain mediated by T12 and L1. Spinal cord stimulation has only a fair response, with 33% of patients explanting the technology due to loss of therapeutic effect. Additional studies are required to determine the efficacy of DRG stimulation for pelvic pain.
    - The committee recommendation is that DRG stimulation only be used according to strict criteria for pelvic pain, including identification of the

mechanism of injury (surgical or trauma) and related pathology, along with the designation of visceral or somatic. Proceeding with DRG stimulation should be done within a medical team, including a gynaecologist, urologist and psychologist. Patients with significant psychology issues should be excluded or treated prior to DRG stimulation.

- Groin pain
    - Based on a study of 25 patients who had successful trial and proceeded with implantation, the average rating of pain relief achieved was 71% for over 80% of the cohort. Therefore, DRG stimulation is recommended for the treatment of neuropathic groin pain
- Phantom limb and stump pain
    - Further study is needed for patients with phantom limb pain.
- Postherpetic neuralgia
    - The committee advised that DRG stimulation has better evidence than spinal cord stimulation for this condition, but no formal recommendation was listed. It was noted that the level of lead placement for best results was being discussed, therefore further research is needed before the procedure could be recommended.

5. Alternative treatments to DRG stimulation for CRPS

There is no single recommended treatment for CRPS, with the primary goal of treatment being to restore movement and function of the affected limb (Better Health Channel, 2015). CRPS has a broad range of symptoms therefore patients may require management from different clinical specialists, including orthopeadic surgeons, anaesthetists, rheumatologists and rehabilitation specialists (Goh et al, 2017). Treatment is most effective when started early after onset (NINDS, 2020).

Physical and occupational therapy is a key component of rehabilitation for patients with CRPS and is recommended as the first-line treatment (Goh et al, 2017). NINDS (2020) indicate rehabilitation and physical therapy are the single most important treatment for CRPS. Initial strategies to reduce swelling and pain are key to participation in movement therapy (Better Health Channel, 2015). Patients can develop kinesophobia, so therapy is designed to overcome this fear to enable the patient to gain the best use of the limb. Physical and occupational therapy should be individualised to the patient needs, but may include elevation, massage, contrast baths, transcutaneous electrical nerve stimulation, gentle range of motion, isometric strengthening exercise and stress loading of the affected limb along with sufficient analgesia (Goh et al, 2017). An occupational therapist will encourage use of the affected limb in activities of daily living (NINDS, 2020). Specialised garments may reduce oedema and sensory overload of the affected limb (Goh et al, 2017). No time frame was found in the literature regarding when physical or occupational therapy should be ceased, however it was

noted that ongoing rehabilitation can help prevent or reverse secondary spinal cord and brain changes associated with disuse and chronic pain (NINDS, 2020).

Psychological therapy may be warranted for people who suffer a significant impact on their health-related quality of life. People with CRPS may develop secondary depression, situational anxiety and sometimes post-traumatic stress disorder (NINDS, 2020). This may include cognitive behaviour therapy, relaxation skills and biofeedback to facilitate rehabilitation and decrease the intensity of pain (Better Health Channel, 2015; Goh et al, 2017).

Medical management includes corticosteroids and non-steroidal anti-inflammatory drugs to reduce inflammation. However there is evidence these medications do not alleviate symptoms for all patients (Goh et al, 2017). Other medical options include opioid use, but this is more useful in the acute phase of the disorder (Goh et al, 2017). Better Health Channel (2015) indicates medications prescribed for epilepsy or depression can sometimes help manage CRPS, however Goh et al (2017) indicated the long-term efficacy of these drugs was not well researched. NINDS (2020) note that medical management is more effective when taken early in the course of the disorder.

Analgesia therapy includes use of a sympathetic blockade to alleviate sympathetically mediated pain and can be used in combination with botulinum toxin to prolong the effect of the analgesia (Goh et al, 2017). The most commonly used is a sympathetic ganglion block, which involves the use of local anaesthetic to stop some of the nerves in the affected limb from functioning (Better Health Channel, 2015). There is evidence this treatment can provide substantial pain relief and improve functional use, however there is less information about long term effect on CRPS (Goh et al, 2017).

Non-invasive neural stimulation includes repetitive transcranial magnetic stimulation (rTMS) and transcranial direct electrical stimulation (NINDS, 2020). These methods are still being investigated, however a meta-analysis (including one randomised controlled trial and two prospective observational studies) by Chang et al (2020) suggests that while there was not an immediate reduction in pain after one rTMS session, pain was significantly reduced one week post-completion of the entire schedule (5-10 sessions) of rTMS therapy.

Surgical options include neuromodulation, sympathectomy or amputation. Patients who are not responsive to sympathetic blockade may be suitable for neuromodulation to treat CRPS (Goh et al, 2017). A randomised controlled trial cited in Goh et al (2017) reports that spinal cord stimulation and physiotherapy may be more effective at pain relief compared to physiotherapy on its own at 6 months and 2 years follow up. It was noted, though, that effectiveness diminished at the long-term follow up of 5 years. As noted above, DRG stimulation appears to be more effective than spinal cord stimulation for the relief of pain in patients with CRPS. Side effects of having the spinal cord stimulation device implanted, which would be similar for DRG stimulation, include lead displacement, pulse-generator pocket revision, pulse-generator failure and infection (Goh et al, 2017). Better Health Channel (2015) suggests that device implant-therapy should be considered a last resort when all other pain management techniques have failed.

Sympathectomy may be done as an extension of temporary sympathetic blockade in patients who experience satisfactory but transient relief from sympathetic block (Goh et al, 2017). A sympathectomy involves severing the sympathetic chains using chemicals, radiofrequency or

open surgical techniques to prolong analgesia. Chemical sympathectomy may use alcohol or phenyl injections but there is limited evidence to support effectiveness (Goh et al, 2017). Radiofrequency provides a long-lasting pain relief, with 40% patients reporting greater than 50% pain reduction after one year. Complications from sympathectomy are common and include post-sympathectomy neuralgia, anhydrosis (inability to sweat/perspire) and Horner's syndrome (neurological condition affecting the face and eye on one side of the body) (Goh et al, 2017). Therefore this treatment is only considered when all alternative treatment options have failed (Goh et al, 2017; NINDS, 2020).

Amputation may be indicated due to pain, limb dysfunction, gangrene, infections or ulcers. While most patients report relief in pain following amputation, others may experience phantom pain and recurrence in the residual limb (Goh et al, 2017). This should only be performed after consultation from several specialists and psychological counselling (NINDS, 2020).

6. References

Better Health Channel. (2015). *Complex regional pain syndrome (CRPS).* Department of Health, State Government of Victoria. Accessed from https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/complex-regional-pain-syndrome-crps

Chang, M. C., Kwak, S. G., & Park, D. (2020). The effect of rTMS in the management of pain associated with CRPS. *Translational neuroscience*, *11*(1), 363–370. https://doi.org/10.1515/tnsci-2020-0120

Deer, T. R., Grigsby, E., Weiner, R. L., Wilcosky, B., & Kramer, J. M. (2013). A prospective study of dorsal root ganglion stimulation for the relief of chronic pain. *Neuromodulation : journal of the International Neuromodulation Society*, *16*(1), 67–72. https://doi.org/10.1111/ner.12013

Deer, T.R., Levy, R.M., Kramer, J., et al. Dorsal root ganglion stimulation yielded higher treatment success rate for complex regional pain syndrome and causalgia at 3 and 12 months: A randomized comparative trial. *Pain*, 158(4),669–81.

Deer, T. R., Pope, J. E., Lamer, T. J., Grider, J. S., Provenzano, D., Lubenow, T. R., FitzGerald, J. J., Hunter, C., Falowski, S., Sayed, D., Baranidharan, G., Patel, N. K., Davis, T., Green, A., Pajuelo, A., Epstein, L. J., Harned, M., Liem, L., Christo, P. J., & Chakravarthy, K. (2019). The Neuromodulation Appropriateness Consensus Committee on Best Practices for Dorsal Root Ganglion Stimulation. *Neuromodulation, 22*(1), 1–35. https://doi.org/10.1111/ner.12845

Goh, E. L., Chidambaram, S., & Ma, D. (2017). Complex regional pain syndrome: a recent update. *Burns & Trauma, 5.* https://doi.org/10.1186/s41038-016-0066-4

Huygen, F., Liem, L., Cusack, W., & Kramer, J. (2018). Stimulation of the L2-L3 Dorsal Root Ganglia Induces Effective Pain Relief in the Low Back. *Pain practice : the official journal of World Institute of Pain*, *18*(2), 205–213. https://doi.org/10.1111/papr.12591

Liem, L., Russo, M., Huygen, F. J., Van Buyten, J. P., Smet, I., Verrills, P., Cousins, M., Brooker, C., Levy, R., Deer, T., & Kramer, J. (2015). One-year outcomes of spinal cord stimulation of the dorsal root ganglion in the treatment of chronic neuropathic pain. *Neuromodulation: journal of the International Neuromodulation Society*, *18*(1), 41–49. https://doi.org/10.1111/ner.12228

Morgalla, M. H., Fortunato, M., Lepski, G., & Chander, B. S. (2018). Dorsal Root Ganglion Stimulation (DRGS) for the Treatment of Chronic Neuropathic Pain: A Single-Center Study with Long-Term Prospective Results in 62 Cases. *Pain physician*, *21*(4), E377–E387.

Nagpal, A., Clements, N., Duszynski, B., & Boies, B. (2021). The Effectiveness of Dorsal Root Ganglion Neurostimulation for the Treatment of Chronic Pelvic Pain and Chronic

Neuropathic Pain of the Lower Extremity: A Comprehensive Review of the Published Data. *Pain Medicine, 22*(1), 49–59.

National Institute of Neurological Disorders and Stroke. (2020). *Complex regional pain syndrome fact sheet.* Accessed from https://www.ninds.nih.gov/complex-regional-pain-syndrome-fact-sheet

Pilgrim, J. R. B. M., & Schiebel, D. F. (2017). *Complex Regional Pain Syndrome: an Overview.* CINAHL Nursing Guide.

Potter, S. T., Welch, S., Tata, F., Probert, S., & Nagpal, A. (2022). Dorsal Root Ganglion Stimulation. *Physical medicine and rehabilitation clinics of North America*, *33*(2), 359–378.

Van Buyten, J. P., Smet, I., Liem, L., Russo, M., & Huygen, F. (2015). Stimulation of dorsal root ganglia for the management of complex regional pain syndrome: a prospective case series. *Pain practice : the official journal of World Institute of Pain*, *15*(3), 208–216. https://doi.org/10.1111/papr.12170

Yang, A., & Hunter, C. W. (2017). Dorsal Root Ganglion Stimulation as a Salvage Treatment for Complex Regional Pain Syndrome Refractory to Dorsal Column Spinal Cord Stimulation: A Case Series. *Neuromodulation, 20*(7), 703–707. https://doi.org/10.1111/ner.12622

Direct and group supports in schools

The content of this document is OFFICIAL.

Please note:

The research and literature reviews collated by our TAB Research Team are not to be shared external to the Branch. These are for internal TAB use only and are intended to assist our advisors with their reasonable and necessary decision-making.

Delegates have access to a wide variety of comprehensive guidance material. If Delegates require further information on access or planning matters, they are to call the TAPS line for advice.

The Research Team are unable to ensure that the information listed below provides an accurate & up-to-date snapshot of these matters

Research question: What direct and small group supports are available for students with disability in Australian schools? What allied health services are available in schools and funded by State or Territory governments?

Date: 9/5/2024

Requestor: Star S22(1)(a)(ii)-irrelevant material

Endorsed by: Sarah S22(1)(a)(ii)-irrelevant material

Researcher: Aaron S22(1)(a)(ii)-irrelevant material

Cleared by: Aaron S22(1)(a)(ii)-irrelevant material

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2. Summary

All State or Territory departments of education are committed to providing reasonable adjustments to ensure children can access school and learning activities. In practice, services may vary based on school, region and student disability cohort. Most services are either provided free of charge to schools or through funding allocated to schools. In the latter case, schools often have discretion about how the funds are spent.

This paper lists services available for students in early childhood education, primary and secondary schools. The focus is on direct supports available to students. Information is drawn from federal, state and territory government documents and online resources. Other services may be available that are not described in publicly available resources.

3. Previous TAPIB Research

Refer to RES 240 Mainstream interface – education supports for more information on the policy and legislative framework related to disability support in school. This research paper details rights and responsibilities of state, territory and federal government departments and agencies, explains key legislation and introduces state and territory school-based disability support programs.

RES 147 Learning Supports for children with a disability in public and catholic school system provides some detail around specific programs (e.g. Arrowsmith program) that may be provided in mainstream and independent schools to support people with disabilities.

Other research papers that include information relating to mainstream education supports include:

- RES 259 Middle childhood and adolescent development
- RES 260 Sex education and sex therapy services
- RES 339 Auslan and Mandarin interpreting services in NSW.

4. National

The Federal government provides funding to services to support the inclusion of student with disability in the learning environment.

For further information refer to federal Department of Education resources:

- Students with disability (Primary and Secondary)
- Inclusion Support Program (Early Childhood Education and Care)
- Best practice adjustments for Students with Disability.

Positive Partnerships

The Positive Partnerships program provides learning resources and training programs focussed improving outcomes for school-aged autistic people. Resources are aimed at educators, parents and carers and include professional development activities for teachers. The program is funded by the federal Department of Education and delivered by Aspect (Department of Education, 2022; Positive Partnerships, n.d.).

For further information refer to the Positive Partnerships website.

Inclusion Support Program

The Inclusion Support Program provides professional support, specialist equipment and funding to address barriers to inclusion in early childhood education and care settings. Supports are available directly to centre-based day care centres, family day care centres and outside school hours care. Children that services intend to support through the program must also be eligible for Child Care Subsidy (Department of Education, 2020; Department of Education, 2023a).

Professional support is provided by different Inclusion Agencies in each state and territory (Table 1). Services can contact Inclusion Agencies directly (Department of Education, 2020; Department of Education, 2023a-b).

Centre-based day care centres and outside school hours care centres can access a Specialist Equipment Library. This includes equipment such as:

- portable ramps
- standing frames
- hoists, slings, harnesses, change tables, toilet sets or steps, potty chairs, mobile stools and seating or posture aids
- sensory toys
- specialised furniture
- communication cards or charts, including Auslan dictionaries
- books in languages other than English (Department of Education, 2023a).

Funding is provided when equipment or advice does not address the child's barrier to inclusion. Funding can be used for innovative solutions, immediate or time-limited support or to hire additional educators (Department of Education, 2024a).

For further information refer to:

- Inclusion Support Program Fact Sheet
- Inclusion Support Program Guidelines.

Table 1 Inclusions Agencies in each State and Territory (Source: Department of Education, 2023b)

State / Territory	Inclusion Agency	Contact Details
ACT / NSW	KU Children's Services	Website: inclusionagencynswact.org.au Email: inclusionagency@includeme.com.au Phone: 1800 703 382
NT	Early Childhood Australia Northern Territory Branch	Website: ecant.org.au Email: ecant@earlychildhood.org.au Phone: 1800 959 995
QLD	KU Children's Services	Website: inclusionsupportqld.org.au Email: inclusionsupportqld@ku.com.au Phone: 1800 811 039
SA	Gowrie SA	Website: gowriesa.org.au Email: inclusion@gowriesa.org.au Phone: 1800 129 606
TAS	Lady Gowrie Tasmania Inc.	Website: gowrie-tas.com.au Email: inclusion@gowrie-tas.com.au Phone: 1800 647 718
VIC	Community Child Care	Website: viac.com.au Email: via@cccinc.org.au Phone: 1800 177 017
WA	Communicare Inc.	Website: wainclusionagency.org.au

		Email: info@communicare.org.au Phone: 1800 119 247

National Student Wellbeing Program

The National Student Wellbeing Program provides funding to schools to employ a chaplain or wellbeing officer. Chaplains or wellbeing officers may provide pastoral care to students, organise volunteer activities, workshops, excursions or other programs (Department of Education, 2024b).

For further information refer to the National Student Wellbeing Program.

5. State and Territory

5.1 Australian capital territory

The ACT Student Disability Criteria describes how students meet the criteria for eligibility for ACT disability support programs. It also describes evidence required to substantiate eligibility (Education Directorate, 2023).

Primary and Secondary school students are assessed using the Student Centred Appraisal of Need to determine additional supports a student may require (Education Directorate, 2019).

ACT schools may provide specialist staff to assist students with disabilities including:

- Autism support assistant
- Vision support assistant
- Communication support assistant (Education Directorate, n.d.a)

For further information refer to Education Directorate resources:

- Students with Disability
- Students with Learning Difficulties
- Support for Students at School.

School Psychology and Allied Health Services

All schools in the ACT have access to school psychologists. School psychologists may consult with other staff around complex student issues, facilitate training or other professional activities. They may also provide group or individual psychological support to students, conduct assessments and complete referrals.

Schools may request additional support from a multidisciplinary allied health team. Occupational therapists, speech therapists and physiotherapists from the Allied Health Service do not provide direct therapeutic support to students. Instead they may assess students skills and recommend strategies or supports required in the school environment. Social workers in

the Allied Health Service may work directly with students and families to support students participation in learning activities.

Some schools employ youth workers to “help a student develop independence, connectedness, self -efficacy and meaningful participation in society including education”.

School nurses can consult directly with students in health-related matters or provide small group or whole of school health education support (Education Directorate, n.d.b).

For further information refer to School Psychology, Allied Health and school-based supports.

Health Healthcare Access At School Program

The Health Healthcare Access At School Program provides Learning Support Assistants trained to support students with complex or invasive health care needs, such as an enteral feed or tracheostomy management (Education Directorate, 2016).

For further information refer to Healthcare Access at School Frequently Asked Questions.

5.2 New South Wales

The NSW Department of Education has committed to the support of students with disability through their Disability Strategy (Department of Education [NSW], 2022a).

For further information refer to:

- Disability Strategy
- Adjustments in early childhood education
- Adjustments for Primary School Students
- Adjustments for High School Students

Tailored health and wellbeing approaches

NSW Department of Education includes student health and wellbeing in their outcomes framework (Department of Education [NSW], 2022a). Resources and supports available to address student health and wellbeing will vary depending on the approach or combination of approaches that schools choose to implement. Strategies can include:

- school-wide policies and initiatives
- dedicated health and wellbeing or learning support teams
- on-site allied health professionals
- cooperation with other government departments or agencies
- implementing state or federal programs (Department of Education [NSW], 2022b).

Learning and Support staff

Every NSW public school has a learning and support teacher. Schools have access to additional funding for learning and support to assist students with additional learning needs.

This funding will vary by student need and enrolment data (Department of Education [NSW], 2024b).

Students with moderate to severe intellectual disability, physical or psychosocial disability, autism spectrum disorder, hearing or vision impairment may be eligible for additional funding through the Integration funding support program. Funding can be used for additional staffing, training or resources needed to support the student (Department of Education [NSW], 2024d).

A school's learning and support team may provide students access to in-class support staff and specialist staff to support their learning. The team can include:

- Transition support teachers assist students with disability prior to and during their first year at school, or during transition to post-schooling activities.
- Itinerate support teachers work with students with hearing or vision impairment throughout their schooling.
- Specialist Assistant Principals coordinate school programs, professional development activities and complex supports for students with disability.
- Learning support officers assist teachers and students during class.
- Counsellors or psychologists can provide assessments and support for individual students or facilitate skills building workshops or professional development activities (Department of Education [NSW], 2023c).

For more information refer to NSW Department of Education resources:

- Inclusive Learning Support Resources
- Integration funding support
- Getting Ready for School – a guide for parents of a child with disability
- Students with disability and additional learning and support needs.

Inclusive Practice Hub

The Inclusive Practice Hub has been developed with Monash and Deakin universities. It includes teaching strategies, classroom resources and information about professional development or training opportunities (Department of Education [NSW], 2023a).

Disability and Inclusion Program

The Disability and Inclusion Program provides funding for community pre-schools to enable young children with disability to access quality early childhood education. It can include funding for modifications, professional development and training, and learning supports (Department of Education [NSW], 2023b). Pre-schools educating students with high learning support needs can access up to $15,402 – up to 600 hours of support at $25.67/hour – per eligible student per year. Funding can be used for additional staff, specialist support or

professional development. Funding cannot be used for assessments or to engage therapists for the child (Department of Education [NSW], 2024c).

For further information refer to NSW Department of Education resources:

- 2024 High Learning Support Needs Funding Guidelines
- 2024 Inclusive Environments Funding Guidelines
- 2024 Sector Capacity Building Program Guidelines

External programs

The Student Wellbeing external programs catalogue lists programs that have been vetted by the NSW Department of Education. Some programs may be free for schools to adopt, while others incur a fee.

5.3 Northern Territory

Individual learning plans and certain assessments such as routine vision and hearing checks can be conducted with local school resources. Student Wellbeing and Inclusion Programs and Services (SWIPS) provides any additional support required for students with disability, their families and schools. SWIPS can help with:

- assessment, referral and other direct support for eligible students
- connection and coordination of services for eligible students and their families
- managing critical incidents
- staff training and professional development (Department of Education [NT], n.d. a; Department of Education [NT], 2019).

To support access to NDIS, schools will provide families or carers with existing reports and documents. It is at the school's discretion whether further assessments are provided for the sole purpose of support NDIS access applications (Department of Education [NT], n.d. a-b).

The Disability Equipment Funding program can provide funding for necessary equipment including costs associated with prescription and assessment, maintenance and training for when:

- the student is in pre-school, primary or secondary school
- the student has a diagnosed disability
- the equipment is required to access education
- the equipment costs at least $500 (Department of Education [NT], 2023).

For further information refer to:

- Students with disability
- Disability equipment funding program

- Diagnostic-Assessment Guidelines.

5.4 Queensland

Queensland schools receive core funding to support the learning needs of all students. They may also receive addition funding to support students with disability based on the level of need for that school's students (Department of Education [Qld]; 2024a). Direct supports provided by the school may include additional staffing in the classroom or assistance with personal care (Department of Education [Qld]; 2024b).

For general information refer to:

- General information for students with disability
- Specialist Disability Support in Schools Program
- List of Specialist Disability Support in Schools organisations

The Queensland Department of Education has compiled tools, resources and supports for disability cohorts:

- Autism
- Vision impairment
- Deaf or Hard of Hearing
- Health condition
- Intellectual disability
- Learning disabilities
- Neurological conditions
- Physical impairment
- Psychosocial conditions
- Speech, language and communication difficulties.

Early Childhood Development Programs

Children with diagnosed disability may be eligible to receive services from an Early Childhood Development Program (ECDP). ECDP provides intensive, multidisciplinary early intervention to prepare children for schooling (Department of Education [Qld]; 2024b; Department of Education [Qld]; 2021a).

Specialist Disability Support in Schools Program

The Queensland Department of Education provides funding to non-government organisations through the Specialist Disability Support in Schools Program (SDSS) to improve outcomes for students with disability and to address barriers students might experience to access and participation in school and learning.

Students are eligible if the meet the Nationally Consistent Collection of Data on School Students with Disability criteria for supplementary, substantial or extensive adjustments, or if the school requires assistance to address a physical access barrier to the school environment (Department of Education [Qld]; 2023a).

Eligibility criteria and services provided by SDSS organisations may vary. SDSS organisations may provide:

- education support
- allied health support
- equipment and other resources for students
- funding for specialist equipment purchases or rental for schools
- training and professional development (Department of Education [Qld]; 2023b).

State School Nursing Service

The State School Nursing Service provides training and education to schools and support to students who require additional support with health conditions. School nurses can provide support with

- enteral device feeding/medication administration
- urinary catheterisation or urostomy
- airway/breathing, oxygen therapy/oxygen concentrator
- stoma or collection bag/attachment device
- diabetes management
- seizure management and first aid
- complex asthma, allergy and anaphylaxis management (Department of Education [Qld]; 2021b).

For further information refer to the State schools nursing service practice guideline.

5.5 South Australia

Statewide Inclusive Education Services

The South Australian Department of Education provides support for to schools and families to maximise inclusion and outcomes for students with disability through Statewide Inclusive Education Services (SIES). Services available through SIES include:

- Teaching and Learning service
- Early Intervention Service for Deaf/Hard of Hearing
- Conductive Education Service

- Learning Difficulties Service
- Inclusive Technology Service (Department of Education [SA], 2024a; Special Education Resource Unit, n.d. a).

For further information refer to Statewide Inclusive Education Services.

The Teaching and Learning service provides advice and support to families as well as training and resource development aimed at improving inclusive practice in schools (Special Education Resource Unit, n.d. b).

The Early Intervention Service provide support for children and families from birth until school age. This includes support children and staff in early childhood education centres. The service can provide advice and support and programs focussing on developing communication skills including Auslan (Special Education Resource Unit, n.d. c).

The Conductive Education Service is available for students with physical or multiple impairments and focusses on developing mobility, language, social skills and self-care skills (Special Education Resource Unit, n.d. d).

The Inclusive Technology Service provides advice, support and training related to assistive technology in schools. They offer long term equipment loans for students with physical or vision impairments and short-term loans for equipment trial. The service does not provide formal assistive technology assessments (Special Education Resource Unit, n.d. e).

More information on the range of equipment provided can be found:

- Assistive Technology
- Access Equipment catalogue.

The Learning Difficulties Service provides advice and support to families as well as training and resource development aimed at improving inclusive practice in schools for students with learning difficulties (Special Education Resource Unit, n.d. f).

Access Assistant Program

The Access Assistant Program is provided in South Australian schools by 3D Health. The program offers support for children with complex health care needs or a disability to participate in education and care services (Department of Education [SA], 2024b). Registered nurses can assist families and schools to develop health care plans to determine supports required for students. For further information refer to the Access Assistant Program brochure.

5.6 Tasmania

All Tasmanian schools administer by the Department of Education, Children and Young People (DECYP) have a Support Teacher whose role involves supporting students with disability. If students require other supports outside the base level school resources, schools may receive additional funding targeted to support individual students with substantial or

extensive need for adjustments (DECYP, 2023b; DECYP, 2024a). Targeted funding can be used for:

- specialised equipment
- specific planning for access to activities or facilities
- closely monitored playground supervision
- modification to school environments, such as buildings and facilities
- environmental adjustments to support participation in learning
- provision of specialist advice on a regular basis
- support from specialist staff (DECYP, 2021).

For further information refer to the Education Adjustment Descriptor Tool.

School Psychologists

If a student's mental health is affecting their learning and participation in school, parents can request a referral to a school psychologist. Support can include:

- individual or group counselling or therapy
- assessments and referrals
- support and advice for parents and families
- assisting with crisis response (DECYP, 2024b).

Physiotherapy and Occupational Therapy in Schools

Occupational therapists and physiotherapists can assist with professional development and training, resource development and consultation within their scope of practice. They may also provide advice around equipment or modifications (DECYP, 2020).

School Social Workers

Social workers in Tasmanian schools can assist students, their families and schools with:

- counselling, case management and group work
- responding to critical incidents or crises
- home/school liaison with student, parents and school staff
- mediation between home, school and/or other agencies
- referral to, and liaison with, other community agencies
- advice, information and resources
- training and professional development
- limited financial assistance with school uniforms in exceptional circumstances (DECYP, 2024c).

School speech and Language Pathologists

School speech therapists can provide support for students, staff and families around language and communication. Services available include:

- professional development
- whole class programs
- individual or group therapy
- teacher assistant programs
- home programs (DECYP, 2023b).

5.7 Victoria

Program for students with disabilities

Victorian schools are provided funding through the Student Resource funding package. If this funding does not meet the needs of individual students, they may be eligible for the Program for students with disability. This program provides additional funding to be used for:

- learning resources and programs
- teaching staff including education support staff
- specialist and allied health staff
- professional development
- specialist equipment/materials, including assistive technology (Department of Education [Vic], 2024a-b).

Full eligibility criteria for the program are described in the Program for Students with Disabilities operational guidelines.

Language and Learning Disabilities Support Program

Students with severe language impairment that are not eligible for the Program for students with disability may be eligible for the Language and Learning Disabilities Support Program (Department of Education [Vic], 2024b). Funding and resources are provided to schools to enable them to access:

- additional teaching staff including education support staff
- specialist education or allied health staff
- consultancy or professional development
- specialist equipment or materials (Department of Education [Vic], 2024c).

This program is being phased out and by 2025 will be replaced by Disability Inclusion Tier 2 funding (Department of Education [Vic], 2024c).

For further information refer to Language and Learning Disabilities Support Program.

Schoolcare and medical intervention support programs

Students who would not be able to attend school without regular medical procedures and for whom staff need specific training to assist with the support may be eligible for the Schoolcare program The Schoolcare program provides training and support to school staff to assist children with high level medical medical needs. Training includes instruction in procedures such as tube feeding, tracheostomy care, suction, stoma care, ventilation or oxygen therapy (Department of Education [Vic], 2023).

Students who are eligible for the Program for students with disabilities and who require complex medical care during school hours may be eligible for Medical intervention support. This involves access to trained staff to assist students with:

- tube feeding
- mechanical ventilation
- oxygen
- tracheostomy care
- suction
- ostomy management
- management of faecal output (Department of Education [Vic], 2023).

For further information refer to Support for students with high care needs.

5.8 Western Australia

Student-centred funding model

For students with additional learning needs in Western Australian schools, the school sets up a support team. The support team may include the student's parents, teacher, support staff, school psychologist, principal, and other medical or allied health supports. The support team will coordinate and discuss reasonable adjustments, develop learning plans, health plan, consider and implement other supports the student may require (Department of Education [WA], n.d. a).

Schools access funding for students supports through the student-centred funding model. This model allocates resources for schools based on the number and characteristics of students enrolled at the school. There are two components to funding provided for students with disability: the individual disability allocation and the educational adjustment (Department of Education [WA], n.d. b). Specific eligibility criteria for these two funding programs were not found.

The individual disability allocation makes available seven levels of funding provided for students with disability based on disability type, school type, degree of disability and level of

teaching and learning adjustment. Schools with students that have very high support needs may be provided additional funding (Department of Education [WA], n.d. b). Schools determine how best to use the allocated funding. This may be through staffing or other supports (Department of Education [WA], 2018).

The educational adjustment is flexible funding provided to schools based on the proportion of students scoring the lowest 10% on the NAPLAN tests. This additional allocation is intended to fund learning supports and programs for students that may not have a diagnosed disability and may not be eligible for the individual disability allocation (Department of Education [WA], n.d. b). However, there is limited evidence that the funding instrument achieves this goal (Department of Education [WA], 2018).

Schools of Special Education Needs

Schools of Special Education Needs (SSEN) provide specialist educational advice and support, day programs and special schools. SSENs can provide support to mainstream schools and students in mainstream settings in the form of:

- professional development
- consultation and support planning
- direct support for students or staff (Department of Education [WA]; n.d. c-g).

There are four SSEN aimed to support students with disability: Disability, Medical and Mental Health, Sensory, and Behaviour and Engagement.

SSEN: Disability primarily provides professional development, consultation and training. The focus of SSEN: Disability services is building the capacity of school staff to assist them to support students with disability (Department of Education [WA]; n.d. c).

SSEN: Medical and Mental Health primarily provides educational services to students who are unable to attend school due to medical or mental health conditions. This SSEN provides services in hospitals and other facilities, but also provides some transition and outpatient support that may involve liaising with schools (Department of Education [WA]; n.d. d)

SSEN: Sensory provides online resources and professional development opportunities for teachers to support children with additional hearing or vision needs. SSEN: Sensory also provides direct visiting teacher support for students who meet the eligibility criteria:

- hearing loss with a 4-frequency average loss of 30dB or greater in the better ear
- visual acuity of 6/18 or less (in the better eye after correction)
- a constricted visual field of 20 degrees or less
- mild vision impairment associated with a degenerative vision condition (Department of Education [WA]; n.d. e-f).

SSEN: Behaviour and Engagement can provide teaching and learning resources to engage students with behavioural concerns. It can also provide positive behaviour support in schools where required (Department of Education [WA]; n.d. g).

6. References

Department of Education [Cth]. (2020). *Inclusion Support Program Fact Sheet*. Australian Government. https://www.education.gov.au/early-childhood/resources/inclusion-support-program-fact-sheet

Department of Education [Cth]. (2022). *Positive Partnerships*. Australian Government. https://www.education.gov.au/swd/positive-partnerships

Department of Education [Cth]. (2023a). *Inclusion Support Program Guidelines*. Australian Government. https://www.education.gov.au/early-childhood/resources/inclusion-support-program-guidelines

Department of Education [Cth]. (2023b). *Inclusion Agencies*. Australian Government. https://www.education.gov.au/early-childhood/inclusion-support-program/inclusion-agencies

Department of Education [Cth]. (2024a). *Inclusion Support Program*. Australian Government. https://www.education.gov.au/early-childhood/inclusion-support-programs

Department of Education [Cth]. (2024b). *The National Student Wellbeing Program*. Australian Government. https://www.education.gov.au/national-student-wellbeing-program-nswp

Department of Education [NSW]. (2012). *Getting Ready for School – a guide for parents of a child with disability*. New South Wales Government. https://education.nsw.gov.au/content/dam/main-education/going-to-a-public-school/media/documents/translated-documents-/getting-ready-for-school---disability/english_SSD.pdf

Department of Education [NSW]. (2022a). *Disability Strategy*. New South Wales Government. https://education.nsw.gov.au/schooling/school-community/our-disability-strategy/disability-strategy

Department of Education [NSW]. (2022b). *5 Main Approached*. New South Wales Government. https://education.nsw.gov.au/schooling/school-community/tailoring-health-and-wellbeing-approaches-at-your-school/five-approach-snapshots

Department of Education [NSW]. (2023a). *Inclusive education for students with disability*. New South Wales Government. https://education.nsw.gov.au/schooling/school-community/inclusive-education-for-students-with-disability

Department of Education [NSW]. (2023b). *Disability and Inclusion Program*. New South Wales Government. https://education.nsw.gov.au/early-childhood-education/operating-an-

early-childhood-education-service/grants-and-funded-programs/disability-and-inclusion-program

Department of Education [NSW]. (2023c). *Roles and Responsibilities*. New South Wales https://education.nsw.gov.au/schooling/parents-and-carers/inclusive-learning-support/resources/roles-and-responsibilities

Department of Education [NSW]. (2024a). *Student Wellbeing external programs catalogue*. New South Wales Government. https://education.nsw.gov.au/schooling/school-community/external-wellbeing-providers/student-wellbeing-external-programs-catalogue

Department of Education [NSW]. (2024b). *Students with disability and additional learning and support needs*. New South Wales Government. https://education.nsw.gov.au/schooling/parents-and-carers/going-to-school/getting-ready-for-school/starting-primary-school/health-and-wellbeing/students-with-disability-and-additional-learning-and-support-needs

Department of Education [NSW]. (2024c). *2024 High Learning Support Needs Funding Guidelines*. New South Wales Government. https://education.nsw.gov.au/early-childhood-education/operating-an-early-childhood-education-service/grants-and-funded-programs/disability-and-inclusion-program/2024-high-learning-support-needs-funding--guidelines

Department of Education [NSW]. (2024d). *Integration funding support*. New South Wales Government. https://education.nsw.gov.au/schooling/parents-and-carers/inclusive-learning-support/primary-school/how-your-child-can-be-supported-in-primary-school/integration-funding-support

Department of Education [NT]. (n.d. a). *Get school support for your child*. Northern Territory Government. https://nt.gov.au/learning/student-support-services/about-special-education-and-disability

Department of Education [NT]. (n.d. b). *NDIS FAQ*. Northern Territory Government. https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Feducation.nt.gov.au%2F__data%2Fassets%2Fword_doc%2F0005%2F672170%2F10.-NDIS-Frequently-Asked-Questions.DOCX&wdOrigin=BROWSELINK

Department of Education [NT]. (2019). *Students with disability guidelines*. Northern Territory Government. https://education.nt.gov.au/policies/access-equity/students-with-disability

Department of Education [NT]. (2023). *Disability equipment funding program – guidelines and procedures*. Northern Territory Government. https://education.nt.gov.au/__data/assets/pdf_file/0005/1183469/disability-equipment-funding-program-guidelines-and-procedures.pdf

Department of Education [Qld]. (2021a). *Application for Access to Early Childhood Development Programs and Services*. Queensland Government.

https://education.qld.gov.au/student/Documents/access-application-early-childhood-development-programs.DOC

Department of Education [Qld]. (2021b). *State School Nursing Service practice guide*. Queensland Government. https://education.qld.gov.au/student/Documents/state-schools-nursing-service-practice-guideline.pdf#search=nursing%20service

Department of Education [Qld]. (2023a). *Specialist Disability Support in Schools Program*. Queensland Government. https://education.qld.gov.au/about-us/budgets-funding-grants/grants/other-organisations/sdss

Department of Education [Qld]. (2023b). *SDSS information for schools*. Queensland Government. https://education.qld.gov.au/about-us/budgets-funding-grants/grants/other-organisations/sdss/for-schools

Department of Education [Qld]. (2024a). *Students with disability*. Queensland Government. https://education.qld.gov.au/students/students-with-disability

Department of Education [Qld]. (2024b). *General information for students with disability*. Queensland Government. https://education.qld.gov.au/students/students-with-disability/supports-for-students-with-disability/general-information

Department of Education [SA]. (2024a). *Disability support at school*. Government of South Australia. https://www.education.sa.gov.au/parents-and-families/student-health-and-disability-support/disability-support-school

Department of Education [SA]. (2024b). *Access Assistants Program*. Government of South Australia. https://www.education.sa.gov.au/parents-and-families/student-health-and-disability-support/health-and-disability-programs/access-assistant-program-aap-complex-health-care-needs

Department of Education [Vic]. (2023). *Support for students with high care needs*. Victorian Government. https://www.vic.gov.au/support-students-high-care-needs

Department of Education [Vic]. (2024a). *Program for students with disabilities*. Victorian Government. https://www.vic.gov.au/program-students-disabilities-psd

Department of Education [Vic]. (2024b). *Program for students with disabilities operational guidelines*. Victorian Government. https://www.education.vic.gov.au/Documents/parents/2024_PSD_operational_guidelines.docx

Department of Education [Vic]. (2024c). *Language and Learning Disabilities Support Program*. Victorian Government. https://www2.education.vic.gov.au/pal/srp-core-student-learning-allocation/guidance/language-learning-disabilities-support-program

Department of Education [WA]. (n.d. a). *Children with special educational needs*. Government of Western Australia. https://www.education.wa.edu.au/children-with-special-educational-needs

Department of Education [WA]. (n.d. b). *Student-centred funding model*. Government of Western Australia. https://www.education.wa.edu.au/dl/kgonndd

Department of Education [WA]. (2018). *Evaluation of the student-centred funding model*. Government of Western Australia. https://www.education.wa.edu.au/dl/po03l6

Department of Education [WA]. (n.d. c). *School of Special Educational Needs: Disability*. Government of Western Australia. https://www.oneclassroom.wa.edu.au/

Department of Education [WA]. (n.d. d). *School of Special Educational Needs: Medical and Mental Health*. Government of Western Australia. https://ssenmmh.wa.edu.au/our-programs.html

Department of Education [WA]. (n.d. e). *School of Special Educational Needs: Sensory*. Government of Western Australia. https://www.ssens.wa.edu.au/

Department of Education [WA]. (n.d. f). *School of Special Educational Needs: Sensory, Eligibility Criteria*. Government of Western Australia. https://www.ssens.wa.edu.au/schools-educators/eligibility-guidelines-se/

Department of Education [WA]. (n.d. g). *School of Special Educational Needs: Behaviour and Engagement*. Government of Western Australia. https://ssenbe.wa.edu.au/overview-of-service/

Department of Education, Children and Young People. (2020). *Consultative Physiotherapy and Occupational Therapy Program*. Tasmanian Government. https://publicdocumentcentre.education.tas.gov.au/library/Shared%20Documents/2PS-Consultative-Physiotherapy-and-Occupational-Therapy-Program-Information.pdf

Department of Education, Children and Young People. (2021). *Educational Adjustment Descriptor Tool*. Tasmanian Government. https://publicdocumentcentre.education.tas.gov.au/library/Shared%20Documents/Education%20Adjustment%20Descriptor%20Tool%20-%20v11.pdf

Department of Education, Children and Young People. (2023a). *Resourcing to schools to support students with disability*. Tasmanian Government. https://www.decyp.tas.gov.au/learning/supporting-student-need/support-students-disability/students-with-disability-resourcing-to-schools/

Department of Education, Children and Young People. (2023b). *School speech and language pathologists*. Tasmanian Government. https://www.decyp.tas.gov.au/learning/supporting-student-need/school-speech-pathologists/

Department of Education, Children and Young People. (2024a). *Frequently Asked Questions about Educational Adjustments*. Tasmanian Government. https://www.decyp.tas.gov.au/learning/supporting-student-need/educational-adjustments/frequently-asked-questions/

Department of Education, Children and Young People. (2024b). *School Psychology*. Tasmanian Government. https://www.decyp.tas.gov.au/learning/supporting-student-need/school-psychologists/

Department of Education, Children and Young People. (2024c). *School Social Workers*. Tasmanian Government. https://www.decyp.tas.gov.au/learning/supporting-student-need/social-workers/

Education Directorate. (n.d.a). *Casual Administrative and School Support Staff*. Australia Capital Territory Government. https://www.education.act.gov.au/working-with-us/apply-to-teach/casual_employment/casual_administrative_and_school_support_staff

Education Directorate. (n.d.b). *School Psychology, Allied Health and school-based supports*. Australia Capital Territory Government. https://www.education.act.gov.au/support-for-our-students/support-for-students-at-school/school-psychology-and-student-support-teams

Education Directorate. (2016). *Healthcare Access at School Frequently Asked Questions*. Australia Capital Territory Government. https://www.education.act.gov.au/__data/assets/pdf_file/0009/872226/HAAS-Healthcare-Access-at-School-FAQs.pdf

Education Directorate. (2019). *Student Centred Appraisal of Need*. Australia Capital Territory Government. https://www.education.act.gov.au/__data/assets/pdf_file/0012/20127/Student-Centred-Appraisal-of-Need-Booklet.pdf

Education Directorate. (2023). *ACT Student Disability Criteria*. Australia Capital Territory Government. https://www.education.act.gov.au/__data/assets/pdf_file/0009/17829/ACT-Student-Disability-Criteria-Jan-2023.pdf

Positive Partnerships. (n.d.). *What We Do*. https://www.positivepartnerships.com.au/about-us/what-we-do

Special Education Resource Unit. (n.d. a). *Services*. Government of South Australia. https://sies.sa.edu.au/services/

Special Education Resource Unit. (n.d. b). *Teaching and Learning Service*. Government of South Australia. https://sies.sa.edu.au/services/teaching-learning-service/

Special Education Resource Unit. (n.d. c). *Early Intervention Service*. Government of South Australia. https://sies.sa.edu.au/services/early-intervention-service-deaf-hard-of-hearing/

Special Education Resource Unit. (n.d. d). *Conductive Education Service*. Government of South Australia. https://sies.sa.edu.au/services/conductive-education-service/

Special Education Resource Unit. (n.d. e). *Inclusive Technology Service*. Government of South Australia. https://sies.sa.edu.au/services/inclusive-technology-service/

Special Education Resource Unit. (n.d. f). *Learning Difficulties Service*. Government of South Australia. https://sies.sa.edu.au/services/learning-difficulties/

Postural Orthostatic Tachycardia Syndrome

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The TAPIB Research and Capability team take care to ensure the research presented is accurate at the time of writing. Due to the nature of our work, we cannot ensure that all relevant research has been considered in the development of this document or that information remains accurate after publishing.

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2. Summary

Postural orthostatic tachycardic syndrome (POTS) is a type of cardiovascular autonomic disorder with three different phenotypes: hypovolemic, hyperadrenergic and neuropathic. It can cause many symptoms, some of which occur on standing. Standing-related symptoms include tachycardia, weakness, blurred vision, headaches, or fainting. Symptoms not related to standing can include gastrointestinal issues, thermoregulatory issues, pain, sleep problems and brain fog. POTS is associated with comorbidities such as migraines, coeliac disease, irritable bowel syndrome, fibromyalgia, chronic fatigue syndrome and Ehlers-Danlos syndrome. POTS can lead do a high degree of functional impairment and decreased quality of life.

The diagnosis of POTS is typically carried out via an Active Standing Test or a tilt table test but should also include a patient history, physical examination, and 12-lead electrocardiography. The first-line treatment is lifestyle modifications including increased fluid and salt intake, compression garments, graded physical exercise, and the limiting of hot environments and prolonged standing. The consumption of tea, coffee, alcohol, energy drinks and large meals should also be limited. Pharmacology should be considered if lifestyle modifications prove ineffective.

There is evidence that a multidisciplinary team including physicians, psychologists, occupation therapists, physical therapists, nurses, and recreational therapists may positively affect functional ability in adolescents and young adults with POTS. The evidence for single-clinician interventions such as occupational therapy or chiropractic is extremely limited and based only on case studies. We found limited evidence of the efficacy of psychologists in assisting individuals with POTS. While there are recommendations for the involvement of a dietician in the management of POTS, we did not find study-based evidence to this effect.

Physical exercise programs have been shown to improve the heart rate and quality of life of patients with POTS. There is preliminary evidence that supervised, individualised and progressive programs may be more beneficial than those that are unsupervised, standardised, and rigid in timeframes.

3. What is Postural Orthostatic Tachycardia Syndrome

Postural orthostatic tachycardia syndrome (POTS) is a variant of cardiovascular autonomic disorder (Ghazal et al., 2025, p. 1). It causes unpleasant symptoms on standing such as tachycardia (see section 4 for more information) which are resolved once the individual lies down (HealthDirect, 2024). It is predominantly diagnosed in younger (pre-menopausal) women (Zhao & Tran, 2023).

POTS is caused by a problem in the autonomic nervous system and is considered to be a form of dysautonomia (Bryarly et al., 2019, p. 1208; HealthDirect, 2024). When a healthy individual stands up, gravity pulls blood down into the lower part of their body, away from their brain.

Their autonomic nervous system reacts instantly to push the blood back up towards their heart and brain. In individuals with POTS, there is a problem with this process and blood does not get pushed up to brain as it should. This results in the heart beating faster to improve blood flow (HealthDirect, 2024).

There are three distinct phenotypes of POTS: hypovolemic, hyperadrenergic, and neuropathic. Individuals may display characteristics consistent with more than one subtype of POTS (El Hussein & Hewko, 2025, p. 1; Ghazal et al., 2025, p. 1; Lau et al., 2022).

The aetiology of POTS is unclear, although most evidence points to it being heterogeneously complex (Lau et al., 2022; Zhao & Tran, 2023). There are three main hypotheses which include an autoimmune disorder, abnormally increased sympathetic activity and catecholamine excess, and sympathetic denervation leading to central hypovolaemia and reflex tachycardia (Fedorowski, 2019). POTS can occur after a viral infection, such as COVID-19 or infectious mononucleosis and many people with long COVID have POTS. It can also occur after surgery, hormonal changes (pregnancy, the onset of menstruation or menopause), or concussion or other injuries (Australian POTS Foundation, n.d.a; HealthDirect, 2024). People are more likely to have POTS if they also have migraines, coeliac disease, irritable bowel syndrome, fibromyalgia, chronic fatigue syndrome and Ehlers-Danlos syndrome (Australian POTS Foundation, n.d.a; HealthDirect, 2024; Lau et al., 2022).

4. Clinical Presentation

POTS symptoms which can occur on standing (orthostatic symptoms) include dizziness, nausea, light-headedness, brain fog, shakiness, a fast heartbeat (tachycardia), chest pains, weakness, palpitations, fatigue, blurred vision, and headaches. It may also cause the individual to faint when they stand up (Ghazal et al., 2025, p. 2; HealthDirect, 2024; Lau et al., 2022).

Other symptoms can occur that are not related to standing (non-orthostatic symptoms). These include tiredness and sleep problems, difficulty thinking, problems passing urine, bloating, constipation and diarrhoea, sensitivity to light, noise, smell or taste, thermoregulatory disturbance; reduced ability to do intense activities, and pain, especially in the head, neck and shoulders (Australian POTS Foundation, n.d.a; HealthDirect, 2024; Lau et al., 2022). They may also include acrocyanosis, unexplained fever and dry mouth (Raj et al., 2022, p. 381).

Individuals with POTS who have one or more of the above-mentioned non-orthostatic symptoms and one or more associated comorbidity (including hypermobile Ehlers Danlos syndrome, coeliac disease, chronic migraines, hypermobile spectrum disorder, mast cell activation disorder, chronic fatigue syndrome/ME, autoimmune disorder, cerebrospinal fluid leak, mitochondrial mutations disorders, multiple sclerosis) can be said to have POTS plus (Raj et al., 2020, p. 359).

The severity of symptoms can differ widely among individuals with POTS and it is common for individuals to have 'flares' interspersed with periods of relative well-controlled symptoms (Australian POTS Foundation, n.d.a; Lau et al., 2022).

Individuals with POTS may also experience difficulty with movement, anxiety, depression, and difficulty caring for themselves. POTS may also make it difficult to work, study or carry out daily activities, and can lead do a high degree of functional impairment and decreased quality of life (Australian POTS Foundation, n.d.a; HealthDirect, 2024; Lau et al., 2022; Zhao & Tran, 2023).

5. Diagnostic Criteria

The diagnosis of POTS is based on symptomatology (Lau et al., 2022). The diagnostic criteria for POTS include:

- a significant increase in heart rate within the first 10 minutes of standing up (>30 beats heart rate rise from laying to standing for adults, or >120 bpm during the standing test, described below)
- no significant drop in blood pressure upon standing (systolic blood pressure drops by no more than 20 mm Hg) within 3 minutes of standing
- orthostatic intolerance (symptoms like dizziness, light-headedness, or fainting that improve when lying down)
- symptoms lasting for at least 3 months
- no other known illnesses that may be causing the symptoms (Australian POTS Foundation, n.d.a; Lau et al., 2022; Lee Lewis, 2024; Raj et al., 2020, p. 361).

The Canadian Cardiovascular Society's 2020 position statement on POTS provides additional clarifications to these criteria.

The heart rate above threshold should be seen on at least 2 measurements at least 1 minute apart (Raj et al., 2020, p. 361). The patient's supine heart rate should be a minimum rate of 60 beats/min to prevent the diagnosis of POTS being made in a patient with a low resting heart rate that increases to a normal level on standing (Raj et al., 2022, p. 378). If the patient has a low supine resting heart rate (<60 bpm), the threshold will be on the basis of an increase from a resting heart rate of 60 bpm (Raj et al., 2020, p. 361). While the orthostatic tachycardia must occur in the absence of classical orthostatic hypotension, transient initial orthostatic hypotension does not preclude a diagnosis of POTS (Raj et al., 2020, p. 361).

It is normal for orthostatic tachycardia to vary slightly from day to day and the abovementioned hemodynamic criteria do not need to be met at every visit (Raj et al., 2020, p. 361). There may be greater orthostatic tachycardia in the morning compared to later in the day. If a clinician has a high suspicion of POTS, but the patient does not meet the criterion for orthostatic

tachycardia at their initial evaluation, reassessment at a later date is advised, preferably in the morning (Raj et al., 2022, p. 378).

The Active Standing Test can be used to diagnose POTS as described above. The Active Standing test involves a doctor checking an individual's heart rate and blood pressure after they have been lying down for 5 minutes and then again after they stand up. The testing is conducted at regular intervals over a period of 10 minutes. If their heart rate increases by at least 30 beats per minute (or 40 beats per minute for 12-19-year-olds) within 10 minutes of standing up, it might suggest POTS (Australian POTS Foundation, n.d.a; Bryarly et al., 2019, p. 1218; Lau et al., 2022; Steinberg et al., 2023, p. 1). An absolute heart rate of 120 beats per minute or greater at any time during the standing test is also diagnostic (Lau et al., 2022).

The heart rate criteria have been disputed and a negative active standing test does not conclusively exclude POTS. If symptoms suggestive of POTS are present but there is no evidence of orthostatic tachycardia and orthostatic hypotension, the Canadian Consensus Statement suggests a diagnosis of postural symptoms without tachycardia (PSWT) (Raj et al., 2022, p. 359).

Individuals with PSWT who also have one or more comorbidities (including hypermobile Ehlers Danlos syndrome, coeliac disease, chronic migraines, hypermobile spectrum disorder, mast cell activation disorder, chronic fatigue syndrome/ME, autoimmune disorder, cerebrospinal fluid leak, mitochondrial mutations disorders, multiple sclerosis) can be described as having PSWT plus (Raj et al., 2022, p. 359). Postural tachycardia of other causes (PTOC) is a diagnosis used for patients who have the same hemodynamic and clinical criteria as POTS but there is a clear underlying cause for the excessive orthostatic tachycardia such as bedrest, hypovolemia, or medications. The excessive orthostatic tachycardia is expected to resolve with treatment of the underlying cause and the patient should not be diagnosed with POTS (Raj et al., 2020, p. 362).

Tilt tables can also be used to confirm the diagnosis of POTS, particularly if the active standing test is deemed unsafe (Australian POTS Foundation, n.d.a; Lau et al., 2022). However, tilt table testing is not mandatory for the diagnosis of POTS (Australian POTS Foundation, n.d.a).

Other conditions that may cause orthostatic tachycardia should be excluded. These include anaemia, anxiety, fever, pain, infection, dehydration, hyperthyroidism, pheochromocytoma, prolonged bed rest or the use of medications that can increase heart rate (including stimulants, diuretics, and norepinephrine reuptake inhibitors) (Raj et al., 2022, p. 378). Core laboratory investigations should screen for secondary causes of orthostatic tachycardia, including haemoglobin, electrolytes, renal function, ferritin, thyroid-stimulating hormone, and morning cortisol (Raj et al., 2022, p. 382).

In addition to the diagnostic tools mentioned above, clinicians should take a patient history, conduct a physical examination, and order a 12-lead electrocardiography to assess for persistent underlying arrhythmias (Raj et al., 2022, p. 381; Raj et al., 2020, p. 363).

The patient history should focus on possible underlying causes and associated disorders, potential POTS triggers and precipitating events, severity of symptoms, factors that can improve or worsen symptoms, the patient's ability to exercise and how the symptoms affect the patient's quality of life. Clinicians should ask about symptoms that suggest possible signs of autonomic dysfunction, such as gastrointestinal or urinary dysfunction, abnormal sweating, acrocyanosis, dry mouth and unexplained fever. Patient medications should be reviewed as some may worsen symptoms. Salt and water intake should be recorded (Raj et al., 2022, p. 381).

The physical examination should include orthostatic vital signs at regular intervals after standing up with recording of associated symptoms (Raj et al., 2022, p. 381). A 24-hour Holter monitor can be used for detection of the presence of inappropriate sinus tachycardia (Raj et al., 2022, p. 380).

Testing for supine and upright fractionated plasma catecholamines and other hormones involved in regulation of blood pressure and blood volume is sometimes done as part of an advanced evaluation (Raj et al., 2022, p. 382).

The Malmö POTS Score (MAPS) survey is also available. It is a 12-item survey based on self-ratings of patients' symptoms. According to the survey developers, it can be used to assess symptom burden, monitor disease progression, and evaluate pre-test likelihood of disease (Spahic et al., 2022, p. 91).

6. Management

There is no known cure for POTS but there are treatments that can relieve symptoms. First-line therapy is lifestyle modification, including the following:

- drink 2 to 3 litres of water every day
- increase salt intake (10 to 12 grams of salt per day)
- limit tea, coffee, alcohol, energy drinks and large meals
- undertake graded physical exercise
- avoid hot environments and hot showers
- wear compression garments (e.g., for the abdomen and legs)
- avoid prolonged standing
- vagus nerve stimulation
- medications that might exacerbate orthostatic tachycardia may be stopped

(Australian POTS Foundation, n.d.a; HealthDirect, 2024; Lau et al., 2022; Raj et al., 2022, p. 382).

Depending on the symptoms present, individuals with POTS may be referred to specialists such as a POTS specialist or pain physician, neurologist, gastroenterologist, vascular surgeon,

psychologist, or allied health professionals, such as a physiotherapist, occupational therapist, dietician, or exercise physiologist (HealthDirect, 2024; Lau et al., 2022). Orthopaedic, rheumatology, immunology and psychiatry input may also be required (Lau et al., 2022).

Pharmacotherapy has limited evidence but it utilised to reduce symptom burden and improve day-to-day function in those with persistent symptoms who have already tried lifestyle modifications (Australian POTS Foundation, n.d.a; Lau et al., 2022; Zhao & Tran, 2023).

Medications that may be prescribed to help with POTS symptoms include midodrine, ivabradine, fludrocortisone and propranolol. Midodrine helps to constrict blood vessels in the legs and abdomen, helping to improve blood flow to the heart and brain. Ivabradine can lower heart rate. Fludrocortisone can help increase blood volume by promoting salt and fluid retention. Propranolol can help control heart rate and reduce palpitations and tachycardia (Australian POTS Foundation, n.d.a; Lau et al., 2022). Pyridostigmine, which reduces upright heart rate, is generally well tolerated. It can increase colonic motility and should be avoided in patients prone to diarrhea but can be helpful in patients with constipation (Raj et al., 2022, p. 382). Other medications may also be prescribed.

There is currently no pharmacological therapy approved for POTS management in Australia, the USA or Canada (El Hussein & Hewko, 2025, p. 6; Ghazal et al., 2025, p. 4). The medications described above are prescribed “off-label.” The Australian POTS Foundation is currently putting forward Midodrine for repurposing through the Therapeutic Goods Administration program (Australian POTS Foundation, n.d.b). The pharmacological management is mostly considered in patients who do not respond to conservative measures (Ghazal et al., 2025, p. 4).

Patient education and therapy adherence play a key role in successfully managing POTS (Zhao & Tran, 2023). This involves detailed discussions about the syndrome, supported by printed materials, brochures, and trusted online resources. Patients should be informed about symptom-relief strategies, non-pharmacological measures, and long-term outcomes. Education on available treatment options tailored to the individual’s condition is essential, fostering better understanding and adherence to management plans (Ghazal et al., 2025, p. 4).

The treatment of POTS often requires individualised, multimodal approaches. There is ongoing debate about whether treatments should be tailored to specific POTS subtypes or applied uniformly (Ghazal et al., 2025, p. 4). El Hussein and Hewko (2025) give the following suggestions for effective treatments for different POTS subtypes.

For neuropathic POTS, compression garment use, exercise training and midodrine are particularly effective. For hypovolemic POTS, exercise training, increased fluid and sodium intake, fludrocortisone and desmopressin can be effective. For hyperadrenergic POTS, patients should avoid medications that may aggravate the condition such as serotonin-norepinephrine reuptake inhibitors, selective-serotonin reuptake inhibitors, and norepinephrine

reuptake inhibitors. Beta-blockers, pyridostigmine, ivabradine, and central-acting sympatholytic drugs are of value for this subtype (El Hussein & Hewko, 2025, pp. 1-2).

7. Interventions and their Efficacy

POTS is now recognised as a fluctuating condition that can affect individuals for a long time (Australian POTS Foundation, n.d.a). The trajectory of POTS is largely unknown due to a lack of long-term data (Lau et al., 2022). There is evidence that symptoms disappear within 5 years of onset (and mostly within the first 1-2 years) in over 50% of patients (Zhao & Tran, 2023).

In children, orthostatic intolerances may improve over time with treatment, although a longer duration of symptoms before therapy has been associated with poorer long-term outcomes (Raj et al., 2022, p. 379).

7.1 General Multidisciplinary Teams

Several studies have shown the efficacy of interdisciplinary care teams for adolescents and young adults with POTS (see Bruce et al. 2016 and Oetjen et al., 2024). These studies showed the effects of a 3-week intensive program during which adolescents worked with physicians, psychologists, occupation therapists, physical therapists, nurses, and recreational therapists to meet their goals surrounding POTS. In Bruce et al. (2016). 33 adolescents were provided with occupational therapy, physical therapy, cognitive behavioural therapy (CBT) therapy, stress management, wellness instruction and symptom management training. At the end of the program, patients showed a significant increase in overall functional ability and significant reductions in depression and pain catastrophising (as measured by the Functional Disability Index, Centre for Epidemiological Studies-Depression-Child Scale and Pain Catastrophising Scale for Children). In Oetjen et al. (2024), 111 adolescents and young adults underwent the program to improve goals around self-care, school, and leisure. They received medical care and support including increasing and balancing salt and fluid intake, gradually increasing exercise, taking medications as prescribed, practising good sleep hygiene, and returning to school and increasing social support. They also received 1 hour of physical therapy daily which included strength training, upright cardio workouts and return to sports activities. CBT and acceptance and commitment therapy were used for symptom management strategies. Occupational therapists helped them to utilise the learned skills including maintenance of routines despite symptoms. On discharge, patients reported significant positive changes in their Canadian Occupational Performance Measure (COPM) satisfaction, performance, and functional disability scores.

7.2 Occupational Therapy

In 2022, Dochod published a retrospective case report on the effect of occupational therapy in a 37-year-old female patient with POTS and chronic headaches. The intervention involved twice-weekly meetings for 10 weeks and then once-weekly meetings for 6 weeks. Sessions focused on energy conservation and pacing training to improve the patient's ability to complete

daily tasks such as getting ready for the day, grocery shopping and cooking. Positive outcomes from this treatment included an increase in strength and stamina, allowing the patient to begin selling handmade goods online, increases in perception of health, mood energy and social activities and decreases in pain and health interference. Improvements were measured using the Medical Outcomes Survey 36-Item Short-Form (SF-36) and COPM.

7.3 Psychologist

We found a limited amount of information addressing the efficacy of psychological intervention for individuals with POTS.

According to POTS UK (2021), CBT can help to improve recovery, ability to function and quality of life in individuals with POTS.

Raj et al. (2019) described the psychological challenges that individuals with POTS may face including depression symptoms and symptoms of anxiety disorders which can lead to sub-clinical low mood and sleep disturbances. They state that there is a likely role for psychotherapy in helping control adjustment-related issues, and possibly aberrant physiology in individuals with POTS (p. 1).

In 2016, Ralston and Kanzler described a case study which employed elements of CBT including in-vivo exposure and symptom discrimination to treat a patient with POTS. They report that over the course of 10 sessions, the patient learned to discriminate POTS symptoms from anxiety and displayed a significant self-reported decrease in POTS-related functional impairment, resulting in her being able to maintain her employment.

7.4 Nutrition

The Association of UK Dieticians (2023) states that up to 90% of patients with POTS have gut symptoms, and that nutrient deficiencies can occur due to a combination of restrictive diets caused by challenging symptoms and malabsorption. The correction of these issues can improve some of the orthostatic symptoms found in POTS (see Mittal et al., 2021).

According to Ganesh et al. (2020, p. 818), the majority of patients with POTS also experience gastrointestinal (GI) and systemic symptoms and conditions that may contribute to functional debility and poor quality of life. This can lead to significant issues in meeting nutrition and hydration needs. Severe symptoms may prevent sufficient oral intake and may result in weight loss, enteral nutrition or parenteral nutrition support being required The authors also state that a nutritional assessment should be offered to all those with POTS (p. 822). Nutrient deficiency, malnutrition, dehydration, and other potential symptom-generating aetiologies should be explored in patients with POTS (p. 822). The optimal diet for these patients and the role of dietary modification in POTS management requires further study.

According to the Association of UK Dieticians (2023), dietary changes and fluids can help orthostatic and gastrointestinal symptoms, ensuring patients are able to get the nutrients they need whilst minimising symptoms. Individuals with POTS and co-existing conditions may

follow a range of diets, such as the low histamine diet or the low FODMAP diet, which may impact on their nutritional intake further so dietetic support is particularly important if any of these diets are being followed. Practical dietary advice is essential if patients' symptoms make preparing and cooking food challenging without support.

In a not yet peer-reviewed preprint of recent research, time-restricted eating whereby caloric intake was limited to an 8-10 daily window, was tested in 20 patients with POTS over a 12-week period. Post-intervention results showed reduced heart rate increase upon standing and improved quality of life metrics including POTS symptom severity, physical functioning, and energy/fatigue (Dzotsi et al., 2025).

Zha et al. (2023) conducted a retrospective study with 20 patients with POTS and without coeliac disease to determine the effect of a gluten free diet. Based on self-assessments, they reported improvements in patients' orthostatic intolerance, vasomotor and GI symptoms.

A 2020 systematic review and meta-analysis (Loughlin et al.) of studies investigating the effect of salt intake in individuals with POTS found low-quality evidence of short-term improvement in orthostatic intolerance with increased salt intake but noted there are no clinical trials demonstrating the efficacy and safety of increased salt intake on long-term clinical outcomes.

7.5 Chiropractic

There is very preliminary evidence of the efficacy of chiropractic treatment in individuals with POTS (see Chu & Lin, 2022; Jarosz, 2021; Wilson, 2022). The evidence is based on case studies with patient numbers ranging from 1 to 3. While the chiropractic interventions did lead to the resolution or improvement of POTS symptoms including neck pain, dizziness and motor coordination, the evidence is limited and not generalisable.

7.6 Physical Exercise

Exercise training programs are often cited as a key component of POTS management to decrease upright tachycardia and improve symptoms and quality of life. The exercise program must be introduced gradually to avoid aggravating symptoms (Lei et al., 2020, p. 113). Lei et al. (2020, p. 113) recommend slowly progressing from non-upright activities (rowing machines, recumbent cycles) to upright aerobic exercises at a frequency of 4 to 6 times a week. They clarify it can take 4 to 6 weeks of consistent adherence to the program for benefits to begin to take effect and regression may occur if regular physical activity is terminated (p. 113).

Previous evidence has also demonstrated that a 3-month exercise program can help treat the cardiac origins of POTS, with an active lifestyle being key to reducing and eliminating symptoms. The current standard of care includes recommendations for physical therapy and/or aerobic exercise. The recommendation comprises a graded exercise regimen building to a target of 30 minutes per day, 5 days a week starting with recumbent exercises (Wheatley-Guy et al., 2023, p. 660). However, there is criticism in the literature that this format is typically

not personalised, progressive or supervised and can be too rigid for many patients (see Wheatley-Guy et al., 2023, p. 660 and Ziaks et al., 2024, p. 1).

Ziaks et al. (2024) discuss the need for adaptive approaches to exercise rehabilitation in POTS and related autonomic disorders given that current exercise rehabilitation protocols for POTS contain rigid timelines and progression paradigms that negatively affect the tolerability of these programs and the adherence of patients to the programs. Based on existing standards in exercise physiology and rehabilitation science, they suggest 4 key advances to improve autonomic rehabilitation. These include comprehensive evaluation of the patient, individualised program entry and initial exercise prescription, patient-driven criteria, and adaptation to patient needs. The authors cite a novel exercise program called the Utah Autonomic Disorder adaptive Physical Therapy (ADaPT) program which provides patients with a progressive exercise program under the supervision of a physical therapist. The program was undergoing formal clinical evaluation in 2024 and we did not find any publications relating to the program.

A randomised trial by Wheatley-Guy et al. (2023) with 49 participants involved one group of patients receiving the recommended standard of care (described above) for 3 months and a second group receiving an in-person exercise consultation and 8 supervised in-person or virtual exercise sessions, weekly for 1 month and bi-weekly for the remaining 2 months. The supervised exercise sessions comprised three aerobic sessions per week which started with short durations (3 minutes) and progressed by increasing working interval and shortening recovery time, progressing to 30 minutes of continuous exercise at a moderate intensity. The supervised group showed greater improvements in aerobic fitness, orthostatic intolerance and vasomotor, and a greater reduction in heart rate, shortness of breath and bodily pain. There was no difference in symptom severity and functional ability between groups, although the supervised group did demonstrate a trend in the positive direction. The supervised group was more likely to complete at least 2 sessions per week and have fewer weeks with no exercise.

Zeznick Trimble et al. (2024) also provide evidence that patients with POTS, particularly those with severe orthostatic intolerance and fatigue, may benefit from a home-based exercise approach with individualised exercise programs that are delivered remotely by a certified physical therapist. Such programs can be convenient, easily accessible, and safe for patients with POTS who have severe symptoms and may be home- or bedbound.

A 2025 systematic review (Cortez et al.) examined the impact of exercise in the treatment of POTS. It reviewed 7 studies including the 2023 study by Wheatley-Guy et al. described above. The review found improvements in heart rate noted in all studies, with improvements in quality of life and stroke volume found in some but not all studies. The risk of bias was moderate-high in all but one of the studies and the authors underlined the need for additional studies assessing the effect of exercise on symptom burden and daily function.

A 2024 scoping review (Peebles et al.) of the use and effectiveness of exercise for managing POTS in young adults with joint hypermobility and related conditions found evidence in 10 articles that 3 months of endurance exercise followed by resistance exercise, graduating from the horizontal-to-upright position reduced orthostatic symptoms and improved quality of life.

8. References

Australian POTS Foundation. (n.d.a). *What is POTS?* https://potsfoundation.org.au/living-with-pots/

Australian POTS Foundation. (n.d.b). *Therapeutic Goods Administration (TGA) Medication Repurposing.* https://potsfoundation.org.au/therapeutic-goods-administration-repurposing-program/

Bruce, B. K., Harrison, T. E., Bee, S. M., Luedtke, C. A., Porter, C.-B. J., Fischer, P. R., Hayes, S. E., Allman, D. A., Ale, C. M., & Weiss, K. E. (2016). Improvement in Functioning and Psychological Distress in Adolescents With Postural Orthostatic Tachycardia Syndrome Following Interdisciplinary Treatment. *Clinical Pediatrics*, *55*(14), 1300–1304. https://doi.org/10.1177/0009922816638663

Bryarly, M., Phillips, L. T., Fu, Q., Vernino, S., & Levine, B. D. (2019). Postural Orthostatic Tachycardia Syndrome: JACC Focus Seminar. *Journal of the American College of Cardiology*, *73*(10), 1207–1228. https://doi.org/10.1016/j.jacc.2018.11.059

Chu, E. C. P., & Lin, A. F. C. (2022). Relief of postural orthostatic tachycardia syndrome with chiropractic rehabilitation. *Journal of Family Medicine and Primary Care*, *11*(7), 4006–4009. https://doi.org/10.4103/jfmpc.jfmpc_2108_21

Cortez, M. M., Aikins, K., Arnold, A. C., Boris, J. R., Davenport, T. E., Johnson, K., Kattaya, H. S., Kinsella, L., McFarland, M. M., Pelo, R., Powers, C. D., Schiltz, K., Stiles, L. E., Ziaks, L., Chung, T. H., & Dal Molin, C. (2025). Impact of exercise to treat postural orthostatic tachycardia syndrome: a systematic review. *Frontiers in Neurology*, *16*, Article 1567708. https://doi.org/10.3389/fneur.2025.1567708

Dochod, J. R. (2022). Enhancing Health-Related Quality of Life through Occupational Therapy: A Case Report of a Client with Postural Orthostatic Tachycardia Syndrome. *Occupational Therapy in Health Care*, *36*(3), 202–219. https://doi.org/10.1080/07380577.2022.2051218

Dzotsi, M., Strohm, A., Varshney, S., Zuniga-Hertz, J. P., Chitteti, R., Manoogian, E., Sethi, A., Panda, S., Patel, H. H., Doherty, T. A., & Taub, P. (2025). *Time-Restricted Eating Improves Quality of Life, Heart Rate, and Mitochondrial Function in Patients with Postural Orthostatic Tachycardia Syndrome.* MedRxiv. https://doi.org/10.1101/2025.05.29.25328448

El Hussein, M. T., & Hewko, A. (2025). Management of Postural Orthostatic Tachycardia Syndrome: A Canadian Approach. *Journal for Nurse Practitioners*, *21*(1), Article 105258. https://doi.org/10.1016/j.nurpra.2024.105258

Fedorowski, A. (2019). Postural orthostatic tachycardia syndrome: clinical presentation, aetiology and management. *Journal of Internal Medicine*, *285*(4), 352–366. https://doi.org/10.1111/joim.12852

Ganesh, R., Bonnes, S. L. R., & DiBaise, J. K. (2020). Postural Tachycardia Syndrome: Nutrition Implications. *Nutrition in Clinical Practice*, *35*(5), 818–825. https://doi.org/10.1002/ncp.10564

Ghazal, M., Akkawi, A. R., Fancher, A., Oundo, E., Tanzeem, H., Sajjad, L., & Briasoulis, A. (2025). Pathophysiology and management of postural orthostatic tachycardia syndrome (POTS): A literature review. *Current Problems in Cardiology*, *50*(3), Article 102977. https://doi.org/10.1016/j.cpcardiol.2024.102977

HealthDirect. (2024, May). *Postural orthostatic tachycardia syndrome (POTS).* https://www.healthdirect.gov.au/postural-orthostatic-tachycardia-syndrome-pots

Jarosz, B. S. (2021). Postural Orthostatic Tachycardia Syndrome (POTS) and its relevance, and importance, in the management of persistent post-concussive symptoms: A case series. *Chiropractic Journal of Australia (Online)*, *48*(1), 1–22. https://www.cjaonline.com.au/index.php/cja/article/view/279

Lau, D., Gallagher, C., & Seeley M.-C. (2022, November 26). AusDoc. https://www.ausdoc.com.au/therapy-update/postural-orthostatic-tachycardia-syndrome/

Lee Lewis, D. K. (2024, August 11). *What is POTS – and what triggers it?* Harvard Health Publishing. https://www.health.harvard.edu/blog/pots-lightheadedness-and-a-racing-heart-202110012608

Lei, L. Y., Chew, D. S., Sandhu, R. K., Sheldon, R. S., & Raj, S. R. (2020). Non-Pharmacological and Pharmacological Management of Cardiac Dysautonomia Syndromes. *Journal of atrial fibrillation*, *13*(1), 2395. https://doi.org/10.4022/jafib.2395

Loughlin, E. A., Judge, C. S., Gorey, S. E., Costello, M. M., Murphy, R. P., Waters, R. F., Hughes, D. S., Kenny, R. A., O'Donnell, M. J., & Canavan, M. D. (2020). Increased Salt Intake for Orthostatic Intolerance Syndromes: A Systematic Review and Meta-Analysis. *The American Journal of Medicine*, *133*(12), 1471-1478.e4. https://doi.org/10.1016/j.amjmed.2020.05.028

Mittal, N., Portera, A., & Taub, P. (2021). Improvement of hyperadrenergic postural orthostatic tachycardia syndrome (POTS) with methylated B vitamins in the setting of a heterozygous COMT Val158Met polymorphism. *BMJ Case Reports*, *14*(11), Article e245012. https://doi.org/10.1136/bcr-2021-245012

Oetjen, L., Johannsen, A., Bean, J., Sim, L., Harrison, T., Tsai Owens, M., & Harbeck-Weber, C. (2024). The Goals and Outcomes of Adolescent and Young Adults with POTS Attending an Intensive Interdisciplinary Treatment Program. *Occupational Therapy in Health Care*, *ahead-of-print*(ahead-of-print), 1–15. https://doi.org/10.1080/07380577.2022.2116666

Peebles, K. C., Jacobs, C., Makaroff, L., & Pacey, V. (2024). The use and effectiveness of exercise for managing postural orthostatic tachycardia syndrome in young adults with

joint hypermobility and related conditions: A scoping review. *Autonomic Neuroscience*, *252*, Article 103156. https://doi.org/10.1016/j.autneu.2024.103156

POTS UK. (2021). *Cognitive Behavioural Therapy*. https://www.potsuk.org/pots-for-medics/cognitive-behavioural-therapy/

Raj, S. R., Fedorowski, A., & Sheldon, R. S. (2022). Diagnosis and management of postural orthostatic tachycardia syndrome. *Canadian Medical Association Journal (CMAJ)*, *194*(10), E378–E385. https://doi.org/10.1503/cmaj.211373

Raj, S. R., Guzman, J. C., Harvey, P., Richer, L., Schondorf, R., Seifer, C., Thibodeau-Jarry, N., & Sheldon, R. S. (2020). Canadian Cardiovascular Society Position Statement on Postural Orthostatic Tachycardia Syndrome (POTS) and Related Disorders of Chronic Orthostatic Intolerance. *Canadian Journal of Cardiology*, *36*(3), 357–372. https://doi.org/10.1016/j.cjca.2019.12.024

Raj, V., Opie, M., & Arnold, A. C. (2018). Cognitive and psychological issues in postural tachycardia syndrome. *Autonomic Neuroscience*, *215*, 46–55. https://doi.org/10.1016/j.autneu.2018.03.004

Ralston, T. E., & Kanzler, K. E. (2016). Symptom Discrimination and Habituation: A Case Study of Behavioral Treatment for Postural Orthostatic Tachycardia Syndrome (POTS). *Behavioral Medicine*, *42*(1), 57–62. https://doi.org/10.1080/08964289.2014.977765

Spahic, J. M., Hamrefors, V., Johansson, M., Ricci, F., Melander, O., Sutton, R., & Fedorowski, A. (2023). Malmö POTS symptom score: Assessing symptom burden in postural orthostatic tachycardia syndrome. *Journal of Internal Medicine*, *293*(1), 91–99. https://doi.org/10.1111/joim.13566

Steinberg, R. S., Dicken, W., & Cutchins, A. (2023). Narrative Review of Postural Orthostatic Tachycardia Syndrome: Associated Conditions and Management Strategies. *US cardiology*, *17*, e13. https://doi.org/10.15420/usc.2022.35

The Association of UK Dieticians. (2023, August 9). *PoTS: How can a dietitian help to support those with Postural Tachycardia Syndrome?* https://www.bda.uk.com/resource/how-can-a-dietitian-help-to-support-those-with-postural-tachycardia-syndrome.html

Wheatley-Guy, C. M., Shea, M. G., Parks, J. K., Scales, R., Goodman, B. P., Butterfield, R. J., & Johnson, B. D. (2023). Semi-supervised exercise training program more effective for individuals with postural orthostatic tachycardia syndrome in randomized controlled trial. *Clinical Autonomic Research*, *33*(6), 659–672. https://doi.org/10.1007/s10286-023-00970-w

Wilson, J. (2022). Resolution of Chronic Postural Orthostatic Tachycardia Syndrome (POTS) & Dysautonomia Following Chiropractic Care: A Case Study & Review of Literature. *Annals of Vertebral Subluxation Research*, *2022*, 91–96. https://vertebralsubluxationresearch.com/2022/01/23/1783/

Zha, K., Brook, J., McLaughlin, A., & Blitshteyn, S. (2023). Gluten-free diet in postural orthostatic tachycardia syndrome (POTS). *Chronic Illness*, *19*(2), Article 17423953221076984. https://doi.org/10.1177/17423953221076984

Zhao, S. & Tran, V. H. (2023, August 7). *Postural Orthostatic Tachycardia Syndrome*. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK541074/#:~:text=and%20Other%20Issues-,Postural%20orthostatic%20tachycardia%20syndrome%20(POTS)%20is%20a%20common%20form%20of,the%20presence%20of%20orthostatic%20intolerance

Zeznick Trimble, K., Switzer, J. N., & Blitshteyn, S. (2024). Exercise in Postural Orthostatic Tachycardia Syndrome: Focus on Individualized Exercise Approach. *Journal of Clinical Medicine*, *13*(22), Article 6747. https://doi.org/10.3390/jcm13226747

Ziaks, L., Johnson, K., Schiltz, K., Pelo, R., Lamotte, G., Dal Molin, C., Chung, T., & Cortez, M. M. (2024). Adaptive Approaches to Exercise Rehabilitation for Postural Tachycardia Syndrome and Related Autonomic Disorders. *Archives of rehabilitation research and clinical translation*, *6*(4), 100366. https://doi.org/10.1016/j.arrct.2024.100366

24-hour Postural Management Programs

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2. Summary

Research for this paper was originally completed in September 2021. An update was added in August 2025.

24-hour postural management (24PM) programmes are complex and multi-faceted interventions to address a variety of health and functional outcomes. Some good quality evidence exists for certain interventions included in 24PM programmes, though recent research on postural management continues to be rated as low quality and non-generalisable due to small participant numbers, the heterogenous nature of the cohorts under study and other methodological factors. However, the sentiment that randomised, blinded and/or controlled studies may not be suitable for research in this area continues to be expressed by researchers. There are arguments suggesting the quality of evidence is an artefact of the complexity and individuality of 24PM programmes and therefore is not something that can be fixed by further research (refer to 4. Evidence for best practice). Study results do suggest postural management for lying, standing and sitting may provide benefits for some individuals, and there is little evidence that it can cause harm. Research tends to emphasise that postural management systems should be prescribed individually, developed in collaboration with the patient and/or carer and reassessed frequently. There is widespread clinical consensus that 24PM is best practice for the management of postural care needs.

3. 2025 Research Review

Wood and Brown (2022) conducted an exploratory study on the effects of the Symmetrisleep sleep system on sleep quality, pain and carer goals for non-ambulant children and young people with cerebral palsy. 4 children participated in the study over 6 months. Data were collected via the Chailey Sleep Questionnaire, a Sleep Profile, Neutral Zero joint range assessment, the Paediatric Pain profile (PPP), nightly sleep diaries completed by carers and Goal Attainment Scale (GAS) light verbal goals which were agreed upon with carers. Several participants had gaps in data collection due to illness or inability to attend. All participants completed the Chailey Sleep Questionnaire and Sleep Profile while only two fully completed the sleep diaries. Results showed that during the study 3 out of the 4 children reported a decreased number of night time wakings and 2 out of the 4 became less restless and required less turning by their carer. There was no change in pain score on the PPP. GAS goals included maintaining and improving comfort, promoting and supporting good posture and maintaining symmetry and alignment, and all goals showed improvement over the course of the study.

Paleg et al. (2022) provide an overview of studies on postural management for hip health, for individuals with non-ambulant cerebral palsy. Interventions included sleep, standing and seating postural management systems. Results were often found to be inconclusive but there was evidence that postural support may assist in preventing contracture, deformity, pain and asymmetry. The need for postural management systems to be individually prescribed,

developed with the patient and caregiver input and regularly reassessed was also emphasised.

In 2023, McLean et al. conducted a scoping review of supported-standing interventions for children and young adults (25 years old or younger) with non-ambulant cerebral palsy based on over 50 systematic reviews, primary studies and clinical guidelines. High quality evidence showed that interventions impact upon bone mineral density and contracture prevention (range of motion). Low-quality evidence (quasi-experimental designs, case studies etc) indicated an impact on hip migration percentage, bowel function, and participation and activity. Evidence for reduced spasticity was contradictory. The authors conclude that individualised assessment and prescription are essential in order to account for personal and environmental needs, and that standing programmes should be incorporated into age-appropriate and meaningful activities to enhance function, participation and overall health.

A scoping review of the evidence for 24PM was conducted by Osborne et al. in 2023. They found that evidence for 24PM was often of low quality but this was attributed to the complications of carrying out robust research in this area. They found that 24PM may have positive effects in lying, sitting and standing.

In 2024, Kittelson et al. published a longitudinal, quasi-experimental study pilot study on posture care management that was conducted over 2.5 years with 55 participants who had disability-related mobility impairment. The posture care management intervention included positioning support for use when lying down, a personalised training workshop for caregiver teams, and in-home initial and follow-up assessments. Participants' body symmetry was measured using the Goldsmith Indices of Body Symmetry (GIoBS) and pain was measured using the Paediatric Pain Profile (PPP) with measures being taken for pain on a 'good day' and pain on a 'bad day'. Sleep was described using the Pittsburgh Sleep Quality Index (PSQI) or the Children's Sleep Habits Questionnaire (CSHQ) (age-dependent). Results showed that among participants with comparable responses from baseline to follow-up, 55% reported an improvement in 'good day' pain levels, 51% reported an improvement in 'bad day' pain levels, and 69% reported improvement in overall sleep quality. All participants saw improvement on at least one health outcome (body symmetry, pain and sleep) and a majority showed improved body symmetry of which none showed worsening of pain or sleep.

In 2025, the Rehabilitation Engineering and Assistive Technology Association of North America (RESNA), and the Clinician Task Force (CTF) published a position paper on standing devices both attached to and separate from wheelchairs (Masselink et al., 2025). Using a scoping review methodology, the authors identified 42 studies on supported frames. Overall, they found evidence to support engaging consistently in supported standing from nine months of age (or as soon possible after onset of ambulatory disability) in order to maximise benefits. Supported frames may also improve hip and ankle range motion and change the related muscle length, balance and stability outside of the standing device, and can lead to acquisition of mobility skills. It may help to reduce pain and effort with bowel evacuation and lead to a decrease in pressure injuries. However, the paper did not systematically analyse bias in the

studies it reviewed and some claims made by the authors are not supported by the publications they cite.

More recently, in 2025, Kimizu et al. published a case study on one child who was born with spinal muscular atrophy. Physical therapy was conducted twice a week using careful postural management including a seating system and a supine stander to promote motor development in the patient. He was also restricted to sitting without support for 30 mins a day. At age 6, the patient is able to stand with support for several minutes, scoliosis and hip subluxation has not been observed, and neither has progression of spinal deformity. The lumbar hyperlordosis has improved and the Cobb angle has also been maintained.

In 2024, an umbrella systematic review was published by Toohey et al. on the effectiveness of postural interventions in cerebral palsy. The review identified several interventions that were effective for improving movement and preventing deformity. The ranking of each intervention assessed can be found in Tables 1-3 below. Overall, the most effective intervention according to the authors was hip surveillance.

Table 1 Postural control interventions (Source: Toohey et al., 2024, pp. 260/272-273)

Intervention	Lack of effect	Weak/lacking evidence	Some evidence, probably works	Good evidence
Postural control interventions	NeuroDevelopmental therapy (Bobath)	Cuevas Medek exercises (CME) Dynamic movement intervention (DMI) Vojta	Balance training Functional hand splints (e.g. neoprene thumb spica) Hippotherapy via a mechanical horse Sit-to-stand training Taping Transcranial direct current stimulation (tDCS) Virtual reality (VR) Whole body vibration (WBV)	Hippotherapy

Table 2 Interventions for movement improvement and deformity preventions (Source: Toohey et al., 2024, pp. 273-274)

Intervention	Some evidence	Treatments that might work	Treatments that work
Tone management to improve movement and prevent deformity	Baclofen (Oral), Benzodiazepines, gabapentin	Trihexyphenidyl, clonidine and levodopa Deep brain stimulation (DBS)	Botulinumtoxin (BOTOX) for the lower/upper limb Intrathecal baclofen Selective dorsal rhizotomy (SDR)

Table 3 Interventions for posture and deformity prevention (Source: Toohey et al., 2024, p. 274)

Intervention	Might be helpful but consider the risks	What might work	What works
Postural management interventions to support upright posture for function	N/A	Adaptive seating systems Ankle foot orthoses (AFOs)	N/A
Postural management interventions to prevent deformity	Sleep positioning systems Stretching	Non-Functional night hand splints (e.g. resting hand splints) Orthopaedic Surgery (temporary medial hemi-epiphysiodesis of the proximal femur) Orthopaedic surgery (single event multilevel surgery) Orthopaedic surgery (hip or knee joint reconstruction) Orthopaedic surgery (upper limb) Passive range of motion (PROM) Serial casting Spinal orthoses (back brace or spinal brace) Standing frames	Hip surveillance Orthopaedic surgery (scoliosis correction)

4. 24-hour postural management

Postural management is “the use of any technique to minimize postural abnormality and enhance function” (Farley et al., 2003). A postural management programme is “a planned approach encompassing all activities and interventions which impact on an individual’s posture and function.” (Gericke, 2006). 24-hour postural management (24PM), also called 24-hour postural care or 24-hour body positioning, is a treatment or prevention strategy that attempts to maximise a person’s function, comfort, and participation in activities over the whole day (Castle et al., 2014; Crawford & Stinson, 2015; Stinson et al., 2020). The 24-hour approach emphasises that postural support may be required for both night and day and for all activities a person engages in. This approach can be useful for anyone who is not able to reposition themselves (Farley et al., 2003). It needs to be implemented everywhere the person spends time. For example, supports can be implemented at home, school, workplace or care facility.

24PM programmes are individualised (Gericke, 2006). They can include:

- provision of assistive technology such as orthotics, adaptive seating, sleep systems or standing frames
- development of specific handling techniques
- individual therapy sessions
- active exercise
- education and training for all carers including staff, family and allied health (Castle et al., 2014; Crawford & Stinson, 2015; Gericke, 2006).

Postural management can also involve surgery though the 24PM approach is often considered a less invasive alternative to surgery (Poutney et al., 2009).

Poor body position and posture can affect bodily functions such as digestion, breathing and sleep. It can also influence capacity to complete daily activities such as eating, showering, toileting, and mobility. Correcting body position can greatly affect overall health and comfort (Castle et al., 2014; Crawford & Stinson, 2015; Farley et al., 2003). 24PM is perceived to have a positive effect on quality of life (Crawford & Stinson, 2015).

Designing and implementing a 24PM programme is likely to be time consuming and expensive (Blake et al., 2015; Crawford & Stinson, 2015; Gough, 2009). There is no research explicitly focussing on its cost effectiveness. Castle et al. found that although approximately 50% of members of multi-disciplinary teams made referrals for 24PM, most of them did not know the purpose of postural management programmes (Castle et al., 2014).

5. Evidence for best practice

It is generally recognised that the quality of the evidence for the effectiveness of 24PM tends to be low and there are significant gaps in the research (Blake et al., 2015; Kittelson-Aldred & Hoffman, 2017; Pountney et al., 2009; Quintans et al., 2020; Robertson et al., 2016).

An early systematic review found a robust link between abnormalities of posture and physiological function including blood flow and lung capacity. The same study found evidence that physical therapy and equipment improves body position and performance, but the quality of this evidence was low to moderate (Farley et al., 2003). Besides this 2003 systematic review, we did not find any other papers that focus on the benefits of 24PM in general. Rather, the focus is on specific interventions for specific cohorts.

Research into 24PM is difficult for a few reasons. 24PM programmes are individualised and complex, equipment / supports are interdependent and planning makes use of multiple disciplines. Implementation of the programme depends on allied health and medical professionals, the individual, their family, carers, equipment providers and funding bodies. (Kittelson-Aldred & Hoffman, 2017; Quintans et al., 2020; Stephens et al., 2021). For these reasons, randomised control trials are difficult to design and execute (Goodwin et al., 2018).

The lack of high-quality research and the complexity of 24PM programmes means it is difficult to make judgements about best practice (Humphreys, 2019; Quintans et al., 2020; Tinker et al., 2015). The contrast between the level of evidence and the continued practice of scripting 24PM programmes has led to some push back from researchers. For example, Kittelson-Aldred and Hoffman (2017) argue:

> Professionally, the use of evidence-based practice is emphasized strongly, yet there is a paucity of high-level research directly supporting the effectiveness of therapeutic positioning over 24 hours in a day, especially at night. In such situations, however, an evidence-informed approach is useful. …[E]vidence-informed practice incorporates the best available research evidence with theory, client values and choices, and practitioner clinical judgement, into the decision-making process when planning interventions.

Reivonen et al. (2021) also argue that 24PM is not amenable to the particular standard of evidence defined by evidence-based practice guidelines. They suggest Realist review as an alternative that might be better suited to the complexities of 24PM (Quintans et al., 2020; Reivonen et al., 2021).

5.1 An example: Children with Cerebral Palsy

One complexity is the need for research targeted at interventions for specific cohorts. For example, several studies have been conducted investigating the effect of 24PM for children with cerebral palsy. Drawing conclusions even about this specific cohort proves difficult.

In 2006, a group of 23 medical and allied health professionals developed a consensus statement on postural management for children with Cerebral Palsy. They recommend the use of postural management programs from soon after birth (Gericke, 2006).

A 2009 study into the use of Chailey postural management equipment lends some weight to this consensus, finding children that use the equipment have a greater chance of less than 33% hip migration by the age of 5. The authors also found a reduction in need for surgery (Poutney et al., 2009). The research quality is affected by use of a historical control group and inability to control for variables such as changes in surgical practice.

Problematising the consensus is a 2015 Cochrane review into the effect of postural management on hip migration. The authors found no randomised control trials investigating the benefit of sleep positioning systems on hip migration. They found two studies examining the benefits of sleep positioning systems for children with Cerebral Palsy. One study found sleep systems do not affect pain levels. Both studies found sleep systems do not affect sleep quality. However, the quality of both studies was very low on the GRADE scale (Blake et al., 2015.

A 2010 systematic review into the use of standing frames by children with cerebral palsy concludes that there is some limited evidence to support the benefit of standing frame use on bone mineral density, short term changes in muscle tone and improving hip joint development. Though there is little evidence to support physiological or psychosocial benefits (Bush et al. 2010). A 2013 systematic review endorses the beneficial effect of standing programmes for bone mineral density but notes that this may not have a follow-on effect for activity or participation (Paleg et al., 2013).

Goodwin et al. (2018) note there is reason to think that standing frames improve bone structure, function, activity and participation. However they also note that there is little strong evidence for the benefits and little evidence that the benefits outweigh the reported and predicted disadvantages such as pain and discomfort, cost and investment of time for family and carers.

Gough looks at the use of 24PM programmes in the prevention of deformity in children with CP and notes that there is little evidence for the use of specific seating systems and that in general there is little evidence to suggest specialised seating systems improve the child's posture. He argues that the evidence for benefit of 24PM is ambiguous and concludes:

> A continuous physical postural management program aimed at preventing deformity may not be needed for some children with CP and may not be effective in others. We need to define the subgroup of children with CP who may benefit (Gough, 2009).

6. Measuring benefits of 24-hour postural management

In the context of seating interventions, Field and Livingstone argue that an assessment of the overall benefit of 24PM interventions should account for all components of the International Classification of Functioning, Disability and Health (ICF) (Field & Livingstone, 2013). These components include:

- body functions and structures

- activities and participation
- environmental factors
- personal factors (World Health Organisation, 2025).

Field and Livingstone (2013) assessed 19 measurement scales for seating ability using COSMIN checklist and the McMaster rating system. They report poor ratings for most of the scales and note that none of the scales in use address all the components of the ICF.

There is an evidence base for several general tools for assessing posture. Reliability and validity have been demonstrated for The Chailey Levels of Ability (Pountney et al., 1999). The Posture and Postural Ability Scale (PPAS) is based on the Chailey scale, revised and expanded to separate the quality (body shape and alignment) and quantity (ability) of posture. PPAS is a reliable and valid measure of posture in both children and adults (Rodby-Bousquet et al., 2016). Inter- and intra-rater reliability has been demonstrated for Goldsmith indices of body symmetry (Holmes et al., 2021).

7. Literature summary table

Author / Date	Title	Source	Aim / Objective	Methods	Results	Quality of Research
Masselink, Detterbeck, LaBerge, Paleg 2025	RESNA and CTF position on the application of supported standing devices: Current state of the literature	*Assistive Technology The Official Journal of R SNA*	To provide an updated position statement on wheelchair standing devices.	A scoping review methodology was used to identify 42 studies in order to establish an updated, unbiased and comprehensive position. Inclusion criteria were articles published in a peer reviewed journal between January 2000 and November 2020, in the English language.	A recommendation to consistently engage in supported standing from nine months of age, or as soon after onset of ambulatory disability as possible, in order to maximise benefits. Clinical reasoning is required to apply the information in this document to unique individual cases.	LOW. The position paper is based on research studies but did not systematically analyse study bias.
Kimizu, Yokawa, Horibe, Oki, Nakajima, Tominaga, Mogami, Tamura, Yanagihara, 2025	A case of spinal muscular atrophy type 0 treated with nusinersen without progression of early-onset scoliosis – possibility of preventing scoliosis with a rehabilitation program focusing on postural management	*Brain and Development*	To describe a case of SMA type 0 in a patient with 2 copies of SMN2 that was treated with nusinersen, in which the patient's motor function improved and no progression of spinal deformity was observed.	A case study on one patient. Physical therapy was conducted twice a week using careful postural management using a seating system and a supine stander to promote motor development. The patient was restricted to sitting	The patient can stand with support for several minutes and scoliosis has been prevented. No hip subluxation or progression of his spinal deformity has been observed. The lumbar hyperlordosis had improved The Cobb angle was also maintained.	LOW. A case study on 1 patient so results are not generalisable.

Author / Date	Title	Source	Aim / Objective	Methods	Results	Quality of Research
				without support for 30 mins a day		
Toohey, Blatch-Williams, Budini, Ferreira, Griffin, Hines, Jackman, Lind, Massey, Mc Namara, Mitchell, Morgan, Norfolk, Paton, Polyblank, Reedman, Novak, 2024	Effectiveness of postural interventions in cerebral palsy: umbrella systematic review	*Symposium: Cerebral Palsy*	To summarise and evaluate the evidence supporting postural interventions for cerebral palsy published after Gough's review in 2009. Additionally, it aims to provide clinical bottom lines according to Gross Motor Function Classification System or Manual Ability Classification System levels.	Found systematic reviews or population register studies evaluating postural management interventions in people with cerebral palsy using an umbrella systematic review design. Assessed the quality of evidence for each intervention and made recommendations using GRADE (Grading of Recommendation, Assessment, Development, and Evaluation) and the Evidence Alert Traffic Light approaches. 33 unique studies met the inclusion criteria.	Several postural control interventions are effective for improving movement, and several postural management interventions may prevent deformity, with hip surveillance having the best evidence. Many interventions show positive effects on postural outcomes including range of motion, spasticity, pain, hip migration, gross motor function, hand function, gait parameters, muscle strength, balance, and ease of caregiving. The quality of evidence for these interventions and outcomes is mostly low to very low, meaning conclusions and	HIGH.

Author / Date	Title	Source	Aim / Objective	Methods	Results	Quality of Research
					recommendations cannot be made with certainty.	
Kittelson, Kittelson-Aldred, Justad, Hoffman, Coombs 2024	The Montana Postural Care Project: A pilot study implementing posture care management in a rural, low-resource region	*Heliyon*	To determine the feasibility of introducing posture care management to a rural-based, medically complex patient population, evaluate response of body symmetry, and examine its impact on pain and sleep quality.	A longitudinal, quasi-experimental study pilot study over 2.5 years with 55 participants completing the study. The posture care management intervention included positioning support for use when lying down, a personalised training workshop for caregiver teams, and in-home initial and follow-up assessments. The Goldsmith Indices of Body Symmetry (GIoBS) was used to measure body symmetry. Pain was measured using the Paediatric Pain Profile (PPP) with two measures: pain on a 'good day' and pain on a 'bad day'.	All participants saw improvement on at least one health outcome. A majority of participants improved body symmetry.	LOW. There was no control group. Data were collected via self-reporting. There were potential issues with consistency of intervention administration.

Author / Date	Title	Source	Aim / Objective	Methods	Results	Quality of Research
				Sleep was rated using the Pittsburgh Sleep Quality Index (PSQI) or the Children's Sleep Habits Questionnaire (CSHQ).		
Osborne, Gowran, Jackie, 2023	Evidence for 24-hour posture management: A scoping review	*British Journal of Occupational Therapy*	To scope the evidence for a 24-hour posture management approach.	A scoping review was conducted with 44 papers meeting the inclusion criteria including grey literature, scientific studies, and various other literature published between 2003 and 2019 and in English.	There were no random controlled trials and only one quasi-experimental design amongst the included papers. The evidence for 24-hour posture management is often low quality due to the complications of completing robust research in this area. Nevertheless, benefits of posture management in lying, sitting and standing were identified.	LOW. Limited information about the included studies' quality and no indication of possible biases.
Paleg, Livingstone. 2022	Evidence-informed clinical perspectives on postural management for hip health in children and adults with	*Journal of Pediatric Rehabilitation Medicine: An Interdisciplinary Approach*	To provide an overview of the evidence supporting use of postural management to positively influence hip health in individuals	An overview of relevant systematic reviews and experimental research studies.	High-quality experimental research is difficult to carry out in this area and systematic reviews tend to	LOW. The reviews and research studies included in this overview were generally low-level or low-quality.

Author / Date	Title	Source	Aim / Objective	Methods	Results	Quality of Research
	non-ambulant cerebral palsy	*Throughout the Lifespan*	with cerebral palsy, functioning as Gross Motor Classification System (GMFCS) levels IV or V.		produce inconclusive results. More longitudinal or single-subject studies are required. There is limited evidence of harm being caused by postural management devices/programs. Positioning supports can enable participation and function and ease caregiving.	
McLean, Paleg, Livingstone, 2023	Supported-standing interventions for children and young adults with non-ambulant cerebral palsy: A scoping review	*Dev Med Child Neurol*.	To describe the evidence, outcomes, and lived experience of supported standing for children and young adults with cerebral palsy aged 25 years or younger, classified in Gross Motor Function Classification System levels IV and V.	Scoping review methodology including papers from up to 21st February 2022. No limits were placed on design methodology, age range, language, or publication status to ensure that the search was as comprehensive as possible. Primary studies, reviews, and guidelines were all considered for inclusion	Systematic reviews were rated as low-confidence quality or critically low, while bias ranged from low to high. The primary studies' quality ratings and risk of bias ratings ranged from low to high. Evidence from most experimental studies supported the maintenance of bone mineral density and contracture	HIGH.

Author / Date	Title	Source	Aim / Objective	Methods	Results	Quality of Research
					prevention outcomes. Evidence supporting other outcomes was primarily quasi-experimental or descriptive. Evidence suggests that individualised assessment and prescription are essential to match personal and environmental needs.	
Wood, Brown, 2022	An exploratory study: The effects of sleep systems on sleep quality, pain and carer goals for non-ambulant children and young people with cerebral palsy	*Journal of Rehabilitation and Assistive Technologies Engineering*	To investigate the effect of sleep systems on sleep quality and quantity, pain for young people with Cerebral Palsy and outcomes for carers.	Exploratory study conducted over 6 months. 4 children were given the sleep System (Symmetrisleep) to use. Data on sleep quality and quantity, and pain levels were gathered using the Chailey Sleep Questionnaire, a Sleep Profile, sleep diaries the Paediatric Pain Profile and GAS	Pain levels remained static. Improvements in sleep quality and quantity were found and GAS goals achieved. 3 out of 4 children reported decreased number of night time wakings, 2 out of 4 children became less restless and required less turning.	VERY LOW. Small sample size. Gaps in data collection due to participants being ill or unable to attend follow-ups. No blinding or randomisation. Limited information given on several measures including the Sleep Profile and Neutral Zero joint range assessment.

Author / Date	Title	Source	Aim / Objective	Methods	Results	Quality of Research
				Light verbal outcomes.		
Castle, Stubbs, Clayton, Soundy, April 2014	A 24-hour postural care service: Views, understanding and training needs of referring multidisciplinary staff	International Journal of Therapy and Rehabilitation VOL. 21, NO. 3	To consider the views, understanding and training needs of members of a multidisciplinary team (MDT) around 24-hour postural care. These MDT members refer individuals with profound and multiple learning disabilities (PMLD) and postural care needs to a 24-hour postural care service.	Two phase mixed method sequential explanatory design. Phase 1: online survey of 57 multi-disciplinary team members views experiences and understanding of 24 postural support. Phase 2: 14 semi-structured interviews and 3 profession specific focus groups.	Members of multi-disciplinary team generally lacked understanding of 24hr postural management but nevertheless continued to make referrals.	LOW. Small and probably non-representative sample size and the presence of possible bias in selecting study participants.
Gericke, 2006	Postural management for children with cerebral palsy: consensus statement	Developmental Medicine & Child Neurology 2006, 48: 244–244	To provide a consensus statement of the best practice interventions to support posture of children with cerebral palsy including recommendations for further research	NIL	An 8 point consensus statement in which contributors agree to, on the one hand, the benefit of 24 hour postural care for children with CP and on the other hand, the need for more research and greater consensus on standards for assessing postural management programmes.	LOW. While undoubtedly evidenced based and based on clinical experience of 23 professionals, this is a policy statement rather than a clinical study.

Author / Date	Title	Source	Aim / Objective	Methods	Results	Quality of Research
Stinson, Crawford, Madden, June 2021	Current clinical practice in 24-hour postural management and the impact on carers and service users with severe neurodisability	The British Journal of Occupational Therapy; London Vol. 84, Iss. 6,	To investigate the use of 24-hour postural management by occupational therapists and to explore its impact on service users with neurodisability and their carers.	Two phase data gathering: 1. Online survey of 96 Occupational Therapists to get responses relating to understanding and experience of 24hr postural management; 2. Two focus groups of 4 or 5 people comprising people with a neuro-disability and carers of people with a neuro-disability to elicit discussion of understanding and experience of 24hr postural management. Phase 1 data were analysed for correlation between responses. Phase 2 data were coded, themes extrapolated and conclusions drawn.	Occupational therapists' skills in 24-hour postural management improve with frequency of use. Reliance on postural management equipment leads to service user and caregiver frustrations that need to be addressed	LOW. Phase 1 results based on adequate sample size for a population of UK OTs, but may not generalise to AUST or other regions. Phase 2 qualitative results based on small sample and themes may not generalise for other regions.

Author / Date	Title	Source	Aim / Objective	Methods	Results	Quality of Research
Crawford, Stinson 2015	Management of 24 hr-Body Positioning	International Handbook of Occupational Therapy Interventions (Ed. Söderback)	To introduce 24 hr body positioning, its benefits, target patients and evidence base.	Contains sample lit review of 7 items found via database search. Larger narrative review describing the procedure, best practice interventions, additional considerations etc.	24hour positioning is essential to the care of people unable to reposition themselves. Further research is required to determine the long term benefits of the intervention.	LOW. Effectively a narrative review used as a tool to introduce OT students to the subject area.
Field, Livingstone Nov 2013	Clinical tools that measure sitting posture, seated postural control or functional abilities in children with motor impairments: a systematic review	Clinical Rehabilitation; London Vol. 27, Iss. 11	"To identify and critically appraise clinical measurement tools used to assess sitting posture, seated postural control or functional abilities for children with motor impairment who are candidates for seating interventions."	Systematic review	"Evidence supporting reliability and validity varied, with small sample sizes influencing quality ratings. Evidence of the tools' reliability was more prevalent than evidence of the tools' validity. Only four tools reported on responsiveness, an important consideration for evaluating change. Little information on clinical utility was provided. Although a number of tools are available, evidence supporting their use for seating	HIGH

Author / Date	Title	Source	Aim / Objective	Methods	Results	Quality of Research
					interventions is limited, as is the evidence supporting the strength of their measurement properties. Few tools address participation, environmental factors or the child's and family's perspective."	
Robertson et al 2016	Postural care for people with intellectual disabilities and severely impaired motor function: A scoping review	Journal of Applied Research in Intellectual Disability	To map and summarize existing evidence regarding postural care for people with intellectual disabilities and severely impaired motor function	Systematic review. Studies were identified via electronic database searches covering January 1990 to March 2016, and email requests to researcher networks. Results were collated via descriptive numerical summary of studies and thematic analysis.	"The evidence base relating to postural care for people with intellectual disabilities and severely impaired motor function is small and lacking in studies that employ robust methodological designs."	HIGH
Farley et al Oct 2003	What is the evidence for the effectiveness of postural management?	International Journal of Therapy and Rehabilitation. 10/10	To provide an overview of evidence base for the link between postural management and positive health outcomes.	Systematic review organising literature into 8 themes including: physiological function, neonates and children under	Scientific quality of evidence varies according to Sackett's levels. Evidence of link physiological outcomes was	MODERATE. Methodology is reasonably strong but age of the paper means the conclusions may not be reliable,

Author / Date	Title	Source	Aim / Objective	Methods	Results	Quality of Research
				5, progressive muscular disorders, cerebral palsy, ADLs, older people, neuromuscular scoliosis, neurological disorder. Studies were assessed using Sackett's levels of evidence.	stronger than evidence for functional outcomes. However there is some reliable evidence of a benefit from postural support on activities of daily living, possibly mediated by comfort and physical enabling.	especially relating to comments on lack of high quality evidence for certain interventions.
Blake et al 2015	Sleep positioning systems for children with cerebral palsy	Cochrane Database of Systematic Reviews	"To determine whether commercially-available sleep positioning systems, compared with usual care, reduce or prevent hip migration in children with cerebral palsy. Any negative effect of sleep positioning systems on hip migration will be considered within this objective. Secondary objectives were to determine the effect of sleep positioning systems on: (1) number or frequency of hip problems; (2) sleep patterns and quality; (3) quality of life of the	Systematic review of "all randomised controlled trials (RCTs) evaluating whole body sleep positioning systems for children and adolescents (up to18 years of age) with cerebral palsy".	"No randomised controlled trials were found that evaluated the effectiveness of sleep positioning systems to reduce or prevent hip migration." Researchers found two RCTs related to sleep quality of children with CP while using sleep positioning systems. However the "quality of the current evidence regarding the effectiveness of sleep positioning	HIGH

Author / Date	Title	Source	Aim / Objective	Methods	Results	Quality of Research
			child and family; (4) pain; and (5) physical functioning. We also sought to identify any adverse effects from using sleep positioning systems."		systems for children with cerebral palsy is very low and more robust research is needed to help families and professionals make informed decisions about whether to use this intervention."	
Humphreys et al. 2019	Sleep positioning systems for children and adults with a neurodisability: A systematic review	British Journal of Occupational Therapy, VOL 82/1	To identify and summarise studies of people with neurodisability using sleep positioning systems	Systematic review of academic and non-academic literature on sleep positioning use by people with neurodisability. Search results current at Feb 2018.	The review "found some evidence that there are potential benefits in hip stability, improved sleep quality and an improved quality of life for users that can tolerate using a sleep positioning system but the quality of the evidence is very poor. No statistically or clinically significant differences were found in respiratory function in or out of a sleep positioning system."	HIGH

Author / Date	Title	Source	Aim / Objective	Methods	Results	Quality of Research
Stephens, Bartley, Priestly 2018	Evaluation of night time therapeutic positioning system for adults with complex postural problems	University of Salford, monograph	To evaluate the Simple Stuff Works sleep positioning system for effectiveness based on pain, physiological observations, oxygen saturation, nutrition and fluid intake, weight, Waterlow risk score, sleep score, choke risk score, skin integrity, comfort and quality of life.		Sleep system showed beneficial effects on pain, sleep, weight, choke risk, Waterlow score, food/fluid intake, depression score, medication, and analgesia.	LOW. Small sample size and difficult to generalise for the effectiveness of sleep systems as a whole. **So far unpublished**.
Gough 2009	Continuous postural management and the prevention of deformity in children with cerebral palsy: an appraisal	Developmental Medicine and Child Neurology, 51	To assess the evidence for effectiveness of postural management for the prevention of deformity in children with Cerebral Palsy.	Narrative review	Postural management programs require further research. We need to determine which cohorts of children with CP will benefit from postural management and which will not. We need to redirect focus from body shape to function to promote the activity and independence of children with CP.	LOW. Narrative review without stated method or stated criteria for assessing the evidence.

Author / Date	Title	Source	Aim / Objective	Methods	Results	Quality of Research
Goodwin et al. 2018	Standing frames for children with cerebral palsy: a mixed-methods feasibility study	Health Technol Assess. 22(50):1–232	To determine the likelihood of a possible trial of standing equipment for children with cerebral palsy.	Survey of 551 clinicians and parents, focus groups, in depth interviews.	It is not feasible to progress to a full randomised control trial to test the effectiveness of standing frame intervention.	MODERATE. While conclusions depend on qualitative data, the phenomenon they were investigating was apt for that style of investigation. Conclusions are modest.
Holmes, Fredrickson, Brock, Morgan. 2021	The intra- and inter-rater reliability of the Goldsmith indices of body symmetry in non-ambulant adults with cerebral palsy.	Disabil Rehabil. 43(18):2640–6.	To establish intra- and inter-rater reliability of the Goldsmith Indices of Body Symmetry in nonambulant adults with CP.	17 males with CP and 48 young people without CP were tested using the Goldsmith Indices multiple times by a single clinician and multiple times by multiple different clinicians.	Good inter and intra-rater reliability for measuring thoracic shape and symmetry, pelvic orientation and hip range.	MODERATE. Presence of controls but small sample size.
Paleg, Smith, Glickman. 2013	Systematic review and evidence-based clinical recommendations for dosing of pediatric supported standing programs.	Pediatr Phys Ther. 25(3):232–47	To produce evidence based recommendations for dosing of paediatric standing programs.	Systematic review.	“Standing programs 5 days per week positively affect bone mineral density (60 to 90 min/d); hip stability (60 min/d in 30◦ to 60◦ of total bilateral hip abduction); range of motion of hip, knee, and ankle (45 to 60 min/d);	HIGH.

Author / Date	Title	Source	Aim / Objective	Methods	Results	Quality of Research
					and spasticity (30 to 45 min/d)."	
Pountney et al. 1999.	Content and criterion validation of the Chailey levels of ability.	Physiotherapy 85(8):410–6	To validate the Chailey levels of ability scale.	Content validity established by appeal to data set of 38 infants and 85 children with CP. Criterion validity testing was performed by correlating the Chailey scale with Alberta Infant Motor Scale and Gross Motor Function Measure.	The study established content and criterion validity for Chailey scale.	MODERATE. Some discrepancy in establishing criterion validity.
Pountney et al. 2009	Hip subluxation and dislocation in cerebral palsy - a prospective study on the effectiveness of postural management programmes.	Physiother Res Int. 14(2):116–27	To investigate the effectiveness of early postural management programmes on hip subluxation and dislocation in children with CP.	Group of 39 children with CP commenced using postural supports. Xrays of children's hips and 30 and 60 months. Compared with rates of hip problems in control group.	Early use of postural management programmes can assist in reducing number of hip problems and need for treatment in children under 5 years old.	MODERATE. Historical control present but could not control for missing data and changes in surgical practice.
Rodby-Bousquet, Persson-Bunke, Czuba.	Psychometric evaluation of the Posture and Postural Ability	Clin Rehabil. 2016;30(7):697–704	"To evaluate construct validity, internal consistency and inter-rater reliability of the Posture and Postural	29 children with CP were tested by 3 different clinicians using the Posture	"The Posture and Postural Ability Scale shows high psychometric properties for	LOW. Reasonable sample of test subjects but very small number of

Author / Date	Title	Source	Aim / Objective	Methods	Results	Quality of Research
	Scale for children with cerebral palsy.		Ability Scale for children with cerebral palsy".	and Postural Ability Scale.	children with cerebral palsy, as previously seen when evaluated for adults. It enables detection of postural deficits and asymmetries indicating potential need for support and where it needs to be applied"	clinicians testing the measure.

8. References

Blake, S. F., Logan, S., Humphreys, G., Matthews, J., Rogers, M., Thompson-Coon, J., Wyatt, K., & Morris, C. (2015). Sleep positioning systems for children with cerebral palsy. *Cochrane Database of Systematic Reviews*, *2015*(11), Article CD009257. https://doi.org/10.1002/14651858.CD009257.pub2

Castle, D., Stubbs, B., Clayton, S., & Soundy, A. (2014). A 24-hour postural care service: Views, understanding and training needs of referring multidisciplinary staff. *International Journal of Therapy and Rehabilitation*, *21*(3), 132–139. https://doi.org/10.12968/ijtr.2014.21.3.132

Crawford, S., & Stinson, M. (2015). Management of 24hr-Body Positioning. In: I. Söderback (Ed.). *International Handbook of Occupational Therapy Interventions* (pp. 189 – 204). Springer. https://doi.org/10.1007/978-3-319-08141-0

Farley, R., Clark, J., Davidson, C., Evans, G., MacLennan, K., Michael, S., Morrow, M., & Thorpe, S. (2003). What is the evidence for the effectiveness of postural management? *International Journal of Therapy and Rehabilitation*, *10*(10), 449–455. https://doi.org/10.12968/bjtr.2003.10.10.13476

Field, D., & Livingstone, R. (2013). Clinical tools that measure sitting posture, seated postural control or functional abilities in children with motor impairments: a systematic review. *Clinical Rehabilitation*, *27*(11), 994–1004. https://doi.org/10.1177/0269215513488122

Gericke, T. (2006). Postural management for children with cerebral palsy: consensus statement. *Developmental Medicine and Child Neurology*, *48*(4), 244–244. https://doi.org/10.1017/S0012162206000685

Goodwin, J., Lecouturier, J., Basu, A., Colver, A., Crombie, S., Smith, J., Howel, D., McColl, E., Parr, J. R., Kolehmainen, N., Roberts, A., Miller, K., & Cadwgan, J. (2018). Standing frames for children with cerebral palsy: a mixed-methods feasibility study. *Health Technology Assessment (Winchester, England)*, *22*(50), 1–232. https://doi.org/10.3310/hta22500

Gough, M. (2009). Continuous postural management and the prevention of deformity in children with cerebral palsy: an appraisal. *Developmental Medicine and Child Neurology*, *51*(2), 105–110. https://doi.org/10.1111/j.1469-8749.2008.03160.x

Holmes, C., Fredrickson, E., Brock, K., & Morgan, P. (2021). The intra- and inter-rater reliability of the Goldsmith indices of body symmetry in non-ambulant adults with cerebral palsy. *Disability and Rehabilitation*, *43*(18), 2640–2646. https://doi.org/10.1080/09638288.2019.1708979

Humphreys, G., King, T., Jex, J., Rogers, M., Blake, S., Thompson-Coon, J., & Morris, C. (2019). Sleep positioning systems for children and adults with a neurodisability: A

systematic review. *The British Journal of Occupational Therapy*, *82*(1), 5–14. https://doi.org/10.1177/0308022618778254

Kittelson-Aldred, T., & Hoffman, L. A. (2017). 24-Hour Posture Care Management: Supporting People Night and Day: The relationship between lying posture and function in sitting and standing, as well as the forces of gravity, are key among this evidence-informed approach to therapeutically limit or avoid body shape distortions. *Rehab Management*, *30*(6), S14. https://rehabpub.com/conditions/neurological/cerebral-palsy/24-hour-posture-care-management-supporting-people-night-day/

National Disability Insurance Scheme Act 2013 (Aus). https://www.austlii.edu.au/cgi-bin/viewdoc/au/legis/cth/consol_act/ndisa2013341/s34.html

Paleg, G. S., Smith, B. A., & Glickman, L. B. (2013). Systematic Review and Evidence-Based Clinical Recommendations for Dosing of Pediatric Supported Standing Programs. *Pediatric Physical Therapy*, *25*(3), 232–247. https://doi.org/10.1097/PEP.0b013e318299d5e7

Pountney, T. E., Cheek, L., Green, E., Mulcahy, C., & Nelham, R. (1999). Content and Criterion Validation of the Chailey Levels of Ability. *Physiotherapy*, *85*(8), 410–416. https://doi.org/10.1016/S0031-9406(05)65499-5

Pountney, T. E., Mandy, A., Green, E., & Gard, P. R. (2009). Hip subluxation and dislocation in cerebral palsy - a prospective study on the effectiveness of postural management programmes. *Physiotherapy Research International : The Journal for Researchers and Clinicians in Physical Therapy*, *14*(2), 116–127. https://doi.org/10.1002/pri.434

Quintans, J. R., Yonekura, T., Trapé, C. A., & Soares, C. B. (2020). Realist evaluation for programs and services in the health area: an integrative review of the theoretical and methodological literature. *Revista Latino-Americana de Enfermagem*, *28*, Article 3255. https://doi.org/10.1590/1518-8345.3933.3255

Reivonen, S., Sim, F., Bulley, C., Kinsella, E. A., Groven, K. S., Anjum, R. L., & Nicholls, D. A. (2021). Learning from biology, philosophy, and sourdough bread – challenging the evidence-based practice paradigm for community physiotherapy. In D. A. Nicholls, K. S. Groven, E. Kinsella & R. Anjum (Eds.). *Mobilizing Knowledge in Physiotherapy* (pp. 83–96). Routledge. https://doi.org/10.4324/9780367855338-7

Robertson, J., Baines, S., Emerson, E., & Hatton, C. (2018). Postural care for people with intellectual disabilities and severely impaired motor function: A scoping review. *Journal of applied research in intellectual disabilities: JARID*, *31 Suppl 1*, 11–28. https://doi.org/10.1111/jar.12325

Rodby-Bousquet, E., Persson-Bunke, M., & Czuba, T. (2016). Psychometric evaluation of the Posture and Postural Ability Scale for children with cerebral palsy. *Clinical Rehabilitation*, *30*(7), 697–704. https://doi.org/10.1177/0269215515593612

Stephens, M., Bartley, C., Priestley, C. (2018). *Evaluation of night time therapeutic positioning system for adults with complex postural problems*. University of Salford. http://usir.salford.ac.uk/id/eprint/48470/1/Simple%20Stuff%20Works%20Final%20Report%20Sept%202018%20amended%20version%20for%20SSW%20%28002%29.pdf

Stinson, M., Crawford, S., & Madden, E. (2021). Current clinical practice in 24-hour postural management and the impact on carers and service users with severe neurodisability. *The British Journal of Occupational Therapy*, *84*(6), Article 0308022620944739. https://doi.org/10.1177/0308022620944739

Tinker, J., Bettany-Saltikov, J., Gressman, M. (2015, October 16-17). *The 24 hour Management and Protection of Body Shape for Adults with a Profound Intellectual and Multiple Disability (PIMD) and body shape distortion: A Delphi consensus study exploring physiotherapists' perceptions of practice.* Physiotherapy UK 2015 Liverpool, United Kingdom. google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjN-aX96N6OAxV_3jQHHcDKOAwQFnoECBkQAQ&url=https%3A%2F%2Fwww.csp.org.uk%2Fsystem%2Ffiles%2Fdocuments%2F2018-10%2Fpost_mgmnt_consensus_statement_october_2015.docx&usg=AOvVaw16p323WNMWPXncLgI5ZNAw&opi=89978449

World Health Organisation. (2025). *International Classification of Functioning, Disability and Health.* https://apps.who.int/classifications/icfbrowser/

Orthoses for people with Autism Spectrum Disorder

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2. Summary

Research for this paper was originally completed in November 2021. An update was added in August 2025.

There is a lack of evidence for the effectiveness of foot orthoses for people with Autism Spectrum Disorder (ASD). However, there is some indication that foot orthoses can assist in

treating and managing conditions associated with ASD. Foot orthoses may help reduce toe-walking. There is very little evidence that orthoses can assist with mobility in people diagnosed with Developmental Coordination Disorder (DCD), a condition associated with ASD. However, there is evidence that foot orthoses assist with the management of pain and associated function for a variety of other conditions such as flat feet, high arches, bunions, juvenile idiopathic arthritis, rheumatoid arthritis and knee pain. Quality of studies vary.

2.1 2025 Research Review

The prevalence of motor impairments in individuals with ASD is confirmed in recent research. These impairments can affect gait and balance among other things. There is also evidence that these impairments correlate with other symptoms of ASD such as impairments in social skills and language and functional delays. It remains unclear whether the motor impairments experienced by those with DCD have the same underlying sensorimotor mechanisms as the motor impairments experience by those with ASD. Toe-walking also continues to be reported as prevalent in individuals with ASD. However, studies on the functional impact of toe-walking produce contradictory results. In terms of ASD, the DSM-5-TR mentions odd gait, clumsiness, and other abnormal motor signs (e.g., walking on tiptoes).

Studies on the effectiveness of foot orthoses show improvements in gait-related parameters in individuals with various neuromuscular and musculoskeletal impairments. However, generalisability of these results is affected by small sample sizes, high risk of bias and low study quality. Current studies on the effect of orthotics on individuals with ASD have focused on resolving toe-walking. These studies often combine orthotics with another intervention such as serial casting or Botox injections. Results often show a decrease in toe-walking. Sample sizes are often small and blinding and randomisation are not used, making it difficult to generalise results.

3. Motor difficulties for people with Autism Spectrum Disorder

2025 update: Research continues to confirm high rates of motor impairment in individuals with ASD, and motor impairments are a core feature of ASD according to research and peak and community bodies such as Embrace Autism, the Autism Research Institute, and the National Autistic Society (UK). The prevalence of motor impairments in individuals with ASD has been estimated to be between 35% and 95% (da Silva et al., 2025, p. 1; Miller et al., 2024, p. 2). In 2025, da Silva et al. published a scoping review of motor impairments in individuals with ASD looking at 19 studies of fair to good quality. Results showed that individuals with ASD may have a range of motor impairments including a reduction in stride, a lower cadence, greater variation in stride width, and a change in the ankle joint during the pre-swing phase. Cho et al. (2022) conducted an exploratory pilot study on 82 individuals with ASD which showed greater mediolateral deviation while walking, greater sway during normal, tandem, and single leg stance, a reduced walking speed and cadence, a greater arrhythmicity during jumping jack

tasks and an impaired manual dexterity during finger tapping tasks compared to healthy controls. However, regarding motor impairments in individuals with ASD, the DSM-5-TR (2022) only mentions odd gait, clumsiness, and other abnormal motor signs (e.g., walking on tiptoes).

Studies also purport the high functional impactful of motor problems in individuals with ASD including its correlation with repetitive behaviour severity, language and functional delays, limited ability to engage in self-care behaviours, and current and future daily living skills (Bhat, 2023; Cho et al., 2022; Miller, 2024). A recent systematic review with two meta analyses also found that gross motor skills were moderately but significantly associated with social skills in children with ASD. The authors also explain that more research is needed to understand causality and directionality of the relationship (Wang et al., 2022). The 21 studies included in this meta-analysis had a mean total quality rating of 9.95 out of 13. A similar correlation was also found in a SPARK dataset analysis of 13,887 children by Bhat (2023).

Miller et al. (2024) call for motor impairments to be recognised as a feature of autism and for uniform structure to the assessment and treatment of motor problems in autism. They question whether a cooccurring diagnosis of DCD is the best approach for individuals with ASD and DCD-like symptoms and call for more research to understand whether motor impairments in individuals with ASD and motor impairments in individuals with DCD stem from the same or different underlying sensorimotor mechanisms (Miller et al., 2024).

Toe-walking continues to be reported as prevalent in individuals with ASD (Chapek & Kessler, 2025; Valagussa et al., 2024). Studies on its impact on quality of life have produced contradictory results. Caserta et al. (2022) found that the 27 participants with idiopathic toe-walking in their study exceeded Australian recommendations for physical activity but did not meet recommendations for screen time amounts or sleep times. On the other hand, Morrow et al. (2024) found that the 157 children in their study showed significant reductions in physical, school and play, and emotional domain scores using the Oxford Ankle Foot Questionnaire for Children (OXAFQ_C) when compared to healthy controls.

Original 2021 paper: ASD is a neurodevelopmental disorder characterised by difficulties in social interaction and social communication, including restrictive, repetitive, and inflexible patterns of behaviour (American Psychiatric Association, 2013; World Health Organisation, 2019).

DSM 5 notes that people with ASD can often also experience motor deficits such as clumsiness and problems with gait (American Psychiatric Association, 2013). Motor deficits are included as ‘additional features supporting diagnosis,’ though there is a growing body of evidence supporting the idea that motor deficits are a core feature of ASD (American Psychiatric Association, 2013; Bhat, 2020; Ming et al., 2007; Zampella et al., 2021).

In a study of 11,814 participants, Bhat et al. find 86.9% of children with ASD are at risk of motor impairments. Zampella et al. report that up to 76% of children with ASD meet the diagnostic criteria for Developmental Coordination Disorder (DCD). DCD is a motor disorder characterised by motor skills substantially below what is expected at a person’s age (Zampella

et al., 2021). People with ASD are also at greater risk of low muscle tone (hypotonia) and apraxia (Ming et al., 2007; Shetreat-Klein et al., 2014).

Of particular interest is the prevalence of motor deficits that can affect gait. An earlier study on the prevalence of motor deficits in children with ASD finds 19% present with toe-walking, 9% with a gross motor delay and 2% with reduced ankle mobility (see Table 1). A later study finds 68% of children with ASD have some form of gait abnormality (see Table 2).

Children with ASD are at higher risk of toe-walking (Caserta et al., 2019; Ming et al., 2007; Shetreat-Klein et al., 2014). Estimates of the prevalence of toe walking in people with ASD range from 9% (Leyden et al., 2019) to 20% (Barrow et al., 2011; Ming et al., 2007; Valagussa et al., 2019). A 2015 review found considerable disagreement over the specifics of a pattern of gait in people with ASD, concluding that deviations in gait are a common symptom of ASD (Kindregan et al., 2015). This heterogeneity is echoed by Dufek et al. (2017), who observe that the participants in their study displayed varied patterns of gait but generally showed an increase in gait abnormalities.

Table 1 The prevalence of motor deficits in ASD (Source: Ming et al., 2007)

Motor deficits	Age groups (years)	Hypotonia	Apraxia	Toe-walking	Reduced ankle mobility	Gross motor delay
Presence	All	79 (51%)	53 (34%)	30 (19%)	4 (2%) (all children had history of toe-walking)	14 (9%)
	2-6	52 (63%)	34 (41%)	21 (25%)	2 (2%)	10 (12%)
	7-18	27 (38%)	19 (27%)	9 (13%)	2 (3%)	4 (6%)
Absence	All	75 (49%)	101 (66%)	124 (81%)	150 (98%)	140 (91%)
	2-6	31 (37%)	49 (59%)	62 (75%)	81 (98%)	73 (88%)
	7-8	44 (62%)	52 (73%)	62 (87%)	69 (97%)	67 (94%)

Table 2 Gait abnormalities in children with Autism and their typically developing matched peers (percent) (Source: Shetreat-Klein et al., 2014)

Gait Abnormalities	Children with autism (n=38)	Peers (n=38)
Wide-based	33	0

Gait Abnormalities	Children with autism (n=38)	Peers (n=38)
Apraxic	33	0
Posturing	25	11
Clumsy	20	0
Any abnormality (except toe-walking)	58	11
Toe-walking (observed on video only)	33	3
Any toe-walking (in office or on video)	45	3
Any gait abnormality (including any toe-walking)	68	13

Motor deficits in children can impact social interaction and communication (Zampella et al., 2021). However, the presence of motor deficits in individuals with ASD does not indicate that these individuals necessarily experience the deficit as an impairment or that they require a specific kind of support. As shown in Table 1, prevalence of motor deficits tends to reduce with age, although this is likely not the case for people diagnosed with DCD (Harris et al., 2015). Dietz and Khunsree argue that evidence for the harm of toe-walking is lacking and that beyond social stigma, toe-walking may ultimately be a benign condition (Dietz & Khunsree, 2012). On the contrary, Herrin and Geil argue that there are short and long term harms to toe-walking including:

- decreased walking velocity due to decreased stride length and cadence
- greater risks for falling
- greater effort than normal gait
- contracted Achilles tendon
- equinus position of the foot/ankle complex
- lumbar spine hyperlordosis
- deformities of bones and soft tissues in the feet
- abnormal adult gait (Herrin & Geil, 2016).

Leyden et al. (2019) note that some biomechanical and gait changes have been noted in people with toe-walking for years, though they temper this with the observation that long term consequences of toe-walking are generally unknown. In one study, participants walking barefoot displayed toe-walking behaviour in 36% of steps (Michalitsis et al., 2019). We did not

find research to link frequency of toe-walking behaviour with real functional impact (i.e. research linking percentage of toe-walking footfalls with substantial mobility deficits).

While it is clear from the evidence that people with ASD experience problems with gait and motor skills at a higher rate than people without ASD, they do not receive treatment at a higher rate and continue to be under-diagnosed with motor impairments and DCD (Ming et al., 2007).

4. Effectiveness of foot orthoses

4.1 What are foot orthoses?

An orthosis or orthotic device is an “externally applied device used to compensate for impairments of the structure and function of the neuro-muscular and skeletal systems” (International Standards Organisation, 2020). Common lower limb orthoses include:

- toe – designed to wedge in between toes
- insoles – able to slip inside shoes, available custom made or prefabricated, can be heel, ¾ length or full length
- sub malleolar – covers the whole foot but stopping below the ankle
- supra malleolar – covers the whole foot and ankle
- ankle-foot – covers all or part of the foot, the ankle and stops just below the knee, can be articulated or solid, lined or padded and with or without a sole
- knee – covers knee joint and stops above the ankle and below the hip, can be custom moulded or prefabricated
- knee-ankle-foot – covers all or part of the foot, over the ankle and knee and stops just below the hip joint, can be articulated at ankle or knee, fully or partly custom moulded
- hip – usually covering lower back and hip joint stopping before the knee, custom moulded or prefabricated
- knee-hip-ankle-foot – covers all or part of the foot, over the ankle, knee and hip but should not obstruct movement of the spine (Black et al., 2010; Queensland Health, 2014).

4.2 Effectiveness of treatment

2025 Update: Caldeira Quaresma and McMonagle (2025) conducted a systematic review on the efficacy of lower limb orthoses on quality of life, well-being, and participation in individuals with stroke. Based on the 10 articles reviewed, the relationship between lower limb orthoses and quality of life is inconsistent, while the relationship between the use of orthoses and

psychological well-being and participation is mostly positive. However, the level of evidence was low to acceptable for most studies with only two receiving a rating of high. The authors present information based on other studies that lower limb orthoses improve mobility, ambulation, gain, energy costs, balance and walking speed in people with stroke (Caldeira Quaresma & McMonagle, 2025, p. 388). Faccioli et al. (2025) conducted a systematic review and meta-analysis on the role of ankle-foot orthoses in improving gait in children and adolescents with neuromotor disability. The meta-analysis component, which focused only on 5 randomised controlled trials of individuals with cerebral palsy, showed ankle-foot orthoses are effective in increasing stride length, ankle dorsiflexion at initial contact and peak ankle dorsiflexion in stance while reducing cadence and the energy cost of walking. In terms of risk of bias, these studies showed only 'some concerns' according to Faccioli et al. Another systematic review (Pollen et al., 2025) explored the efficacy of 3D-printed ankle-foot orthoses on gait in patient with neuromuscular and/or musculoskeletal ankle impairments. 10 studies of fair to good quality were reviewed and included gait parameter outcome measures such as kinematics, kinetics, plantar pressure/force, and spatiotemporal data. Results showed a myriad of changes including increased gait velocity and cadence (see pp. 296-298 for more details). Bollepalli et al.'s 2025 systematic review of orthoses for in-toeing and out-toeing found that foot orthotics may be appropriate for mild gait abnormality management. The majority of studies included in this review were at low risk of bias while the remaining studies were at moderate risk of bias.

Various recent studies have shown that different types of orthoses may produce positive results for some populations. These include those with unilateral drop foot associated with multiple sclerosis (Pourhoseingholi & Tafti, 2025), plantar flexor weakness post-stroke (Skigen et al., 2024), patellofemoral knee pain (Simon et al., 2024) and hip osteoarthritis (King et al., 2024). However, these studies typically have small participant numbers (<30). Other complicating factors discussed in 5.2.1 also persist such as the different styles, design and manufacture methods of various orthoses and the variety and combination of materials used in orthoses under study. These variations make it difficult to compare studies, and difficult for results to be generalisable.

Original 2021 paper: Foot orthoses are a commonly prescribed treatment and management technique for a variety of lower body pain and functional/mobility issues. Orthoses, prescription footwear and physical therapy are often called 'conservative' treatments to contrast these with surgical interventions (Martikyan et al., 2018).

A 2008 Cochrane review of 11 randomised control trials found evidence that custom made insoles can reduce the pain associated with high arches (pes cavus), juvenile idiopathic arthritis, rheumatoid arthritis and bunions (hallux valgus). The review found mixed evidence that custom insoles reduce pain of plantar fasciitis (Hawke et al., 2008).

Results were mixed for different conditions. Use of custom insoles for at least 3 months decreases pain associated with high arches, improves function and quality of life (Burns et al., 2007; Hawke et al., 2008). Children experiencing juvenile idiopathic arthritis can benefit from

custom insoles or prefabricated neoprene insoles. Both interventions were more effective than supportive footwear at reducing pain and disability and improving function. After 3 months of use, pain reduction was seen for patients with rear-foot pain associated with rheumatoid arthritis, but no change after 3 years compared with placebo. Improvements to function between treatment and control were not statistically significant. Custom insoles did not reduce pain in the metatarsophalangeal joint associated with rheumatoid arthritis any more than supportive shoes or non-custom orthoses. Custom insoles can help reduce pain associated with bunions. Surgery may be more effective at reducing pain though no statistically significant difference in function was found between the two treatments (Hawke et al., 2008).

A 2011 Cochrane review into use of foot orthoses to treat knee pain found some evidence for a reduction in pain in the short term (6 weeks) but also an increase in problems like blisters and rubbing. There was no statistically significant difference in pain for patients treated with orthoses and those treated with physiotherapy. The patients who had physiotherapy scored higher on functional outcomes. However, the standard of evidence of the reviewed studies was VERY LOW on the GRADE scale (Hossain et al., 2011).

A 2010 Cochrane review into the use of non-surgical treatments for children with flat feet (pes planus) found some evidence that custom made orthoses could assist with the reduction in pain. However the quality of the evidence was compromised by small sample sizes, risk of bias and difficulty comparing data of the included studies. The authors note there is a lack of high quality evidence on the topic (Rome et al., 2010). A later study found some evidence that foot orthoses can improve knee alignment in people with flat feet (Jafarnezhadgero et al., 2018). However, the sample size of this randomly controlled trial was quite small at 15 participants.

Foot orthoses, either insoles, full foot or ankle-foot, are often used to treat toe-walking in people with good ankle range of motion and who are deemed capable of gait re-education (Caserta et al., 2019). Herrin et al. found use of ankle-foot orthoses controls toe walking but the effects do not last after treatment. The insole does not work as well as the ankle-foot orthosis but it is less restrictive and there is more uptake by children and their parents (Herrin & Geil, 2016). The quality of this randomly controlled trial suffers from lack of masking of any kind and stopping the study at 6 weeks instead of 6 months as originally stipulated (Caserta et al., 2019; Herrin & Geil, 2016). The authors argue their preliminary evidence supports a ‘sequential orthotic treatment’, where less restrictive orthoses (insoles) are trialled first and the patient can progressively move to more restrictive orthoses (ankle-foot) as required (Herrin & Geil, 2016).

4.2.1 Difficulties with determining effectiveness of foot orthoses

Even when high quality studies can be found on the benefits or harms associated with types of foot orthoses, it can still be difficult to draw conclusions about the effectiveness of foot orthoses in general. Orthoses designed for the same purpose come in different styles, use different design and manufacture methods and can be made from a variety and combination of materials including plastic, foam rubber, leather, cork, carbon fibre, and metal (Queensland

Health, 2014). For example, results for one type of custom moulded carbon fibre insole may not generalise to other types of insole. Many studies do not specify the type of foot orthosis used (Dars et al., 2018). Available research uses different measures of effectiveness, making findings difficult to aggregate. Much of the research focusses on pain reduction and only secondarily on functional outcomes and quality of life. Much of the research on the effectiveness of orthoses involves children. We know that children often outgrow their podiatric issues even without treatment. This means long term studies should contend with age and development as a confounding variable (Meyr & Sansosti, 2020).

Also of note, much of the available research is designed to assess orthoses as a time-limited treatment option (Herrin & Geil, 2016). One study focussing on the long term effects of foot orthoses on walking kinematics limit the time-frame of the study to just 4 months (Jafarnezhadgero et al., 2018). I have not been able to find much research relevant to ongoing management of functional deficits (an exception is Hawke et al., 2008).

4.3 Foot orthoses for people with ASD

2025 update: A systematic review by Luginsland et al. (2024) focused on biomechanical gait interventions for individuals with ASD including orthopaedic interventions such as serial casting and/or ankle/foot orthoses. Only three studies in the review focused on orthoses. Participants with toe-walking who underwent both serial casting and foot orthoses showed improved overall kinematic and spatiotemporal parameters during gait. More specifically, participants who underwent serial casting followed by foot orthoses in two studies showed an increase in ankle dorsiflexion, while participants in another study who used just foot orthoses showed an increase in peak force of the hallux and first metatarsal heat and a reduction of plantar pressures. In terms of study quality and bias, none of the studies used randomisation, or blinding and all showed a low risk of reporting bias.

Wilder et al. (2022) evaluated shoe inserts in two children with ASD and toe-walking. Toe-walking was heavily reduced in one child via the use of shoe inserts. The second child also showed reduced toe-walking with the shoe inserts, but his toe-walking was further reduced by the hand-on-shoulder technique which involved one of the researchers placing gentle pressure on the participant's shoulder if the participant began toe-walking. During follow-up probes, the levels of toe-walking in both participants did increase slightly compared to levels during the active intervention (insoles) phase but did not return to initial levels. It is worth noting that one of the participants had previously been treated with ankle orthotics without success (Wilder et al., 2022, p. 756).

A 2022 study by Manfredi et al. discusses treatment of toe-walking in individuals with ASD using the "Cast and Go" protocol. This protocol involves a botulinum toxin injection, serial casting and orthoses associated with physiotherapy to achieve ankle neutral position. 22 children underwent treatment via this protocol with the outcome being the correction of the ankle dorsiflexion angle. Initially, the injection is performed and then casting is applied 4-7 days thereafter. Allied health professionals are then engaged to assist with plaster walking.

Orthoses are used only nightly after plaster removal. Multiple consecutive casts could be employed for a maximum of 35-40 days. The whole protocol could be repeated after one year if the ankle dorsiflexion angle remained at more than 90 degrees, but the protocol could not be repeated more than 3 times (Manfredi et al., 2022, p. 4). In this study neutral angle position was achieved in all participants, with the maximum length of treatment being 50 months, and the average length 13 months.

In the 2023 response of the Australian Podiatry Association (APodA) to the draft version of the updated National Guideline for the Assessment and Diagnosis of Autism in Australia, APodA state that by prescribing appropriate orthotic devices, they can address motor challenges, improve motor function and enhance the overall quality of life for individuals with ASD. APodA also states that through the utilisation of devices such as shoe inserts and ankle-foot orthoses, podiatrists can help individuals with ASD manage sensory sensitivities and promote better mobility and balance. However, no recommendations regarding podiatry or orthoses are included in the National Guideline for the Assessment and Diagnosis of Autism (2023).

Original 2021 paper: We did not find any literature specifically focussing on prescription of foot orthoses for people with ASD. Valagussa et al (2018) mention only 2 studies that look at treatment of toe-walking in people with ASD. We found 3 papers that mention foot orthoses as a treatment option for people with ASD and none of them look at this option in depth (Ming et al., 2007; Valagussa et al., 2019; Martikyan et al., 2018).

A summary of evidence-based treatments for ASD endorsed by the European Society of Child and Adolescent Psychiatry only briefly mentions motor deficits and notes only occupational therapy as a possible treatment (Fuentes et al., 2021). Martikyan, Kaur, and Patel point out that consideration of the particularities of ASD which might complicate treatment of toe-walking are absent from the current literature (Martikyan et al., 2018). For example, Leyden, Frung and Frick conclude:

> current [idiopathic toe-walking] treatment guidelines do not include specific recommendations for patients with comorbid conditions like ASD, and nonoperative treatments may be more challenging in patients with ASD if the patient has difficulty complying with instructions, sensitivity to tactile foot sensations/manipulation or is disturbed by the noise of cast saws. Medical treatment decisions should consider family preference, severity of the patient's condition, as well as any comorbid conditions (Leyden et al., 2019).

As shown in 3. Motor difficulties for people with Autism Spectrum Disorder, people with ASD are at a much higher risk of DCD (Zampella et al., 2021). Podiatrists in Australia tend to think foot orthoses will be a viable treatment option for people with DCD. However, according to one analysis, podiatrists more familiar with DCD are less likely to prescribe orthoses (Smith et al., 2019). There is very little evidence to suggest foot orthoses will have positive outcomes for people with DCD.

5. References

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders: DSM-5-TR* (5th edition). American Psychiatric Association Publishing. https://www.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5 (R)*. (5th edition). American Psychiatric Association Publishing. Diagnostic and statistical manual of mental disorders _ DSM-5 (PDFDrive.com).pdf

Australian Podiatry Association. (2023). *2023 Draft version of the (updated) National Guideline for the Assessment and Diagnosis of Autism in Australia Response by Australian Podiatry Association (APodA).* https://www.podiatry.org.au/documents/item/2953

Barrow, W. J., Jaworski, M., & Accardo, P. J. (2011). Persistent Toe Walking in Autism. *Journal of Child Neurology*, *26*(5), 619–621. https://doi.org/10.1177/0883073810385344

Bhat, A. (2023). Multidimensional motor performance in children with autism mostly remains stable with age and predicts social communication delay, language delay, functional delay, and repetitive behavior severity after accounting for intellectual disability or cognitive delay: A SPARK dataset analysis. *Autism Research*, *16*(1), 208–229. https://doi.org/10.1002/aur.2870

Bhat, A. N. (2020). Is Motor Impairment in Autism Spectrum Disorder Distinct From Developmental Coordination Disorder? A Report From the SPARK Study. *Physical Therapy*, *100*(4), 633–644. https://doi.org/10.1093/ptj/pzz190

Black J. A., & Matheson, I. (2010). Orthoses. In: P. Frowen, M. O'Donnell, J. Gordon Burrow, D. L. Lorimer (Eds.). *Neale's disorders of the foot clinical companion*. (pp. 435-451). Elsevier. https://www.google.com.au/books/edition/Neale_s_Disorders_of_the_Foot_Clinical_C/v4zWDf1fso4C?hl=en&gbpv=1&dq=Neale%E2%80%99s+disorders+of+the+foot+clinical+companion&pg=PA37&printsec=frontcover

Bollepalli, H., White, C. J. K., Kodra, J. D., & Liu, X.-C. (2025). An Evaluation of Orthotics on In-Toeing or Out-Toeing Gait. *Healthcare (Basel)*, *13*(5), 531. https://doi.org/10.3390/healthcare13050531

Burns, J., Landorf, K. B., Ryan, M. M., Crosbie, J., & Ouvrier, R. A. (2007). Interventions for the prevention and treatment of pes cavus. *Cochrane Database of Systematic Reviews*, *2010*(12), CD006154. https://doi.org/10.1002/14651858.CD006154.pub2

Caldeira Quaresma, D., & McMonagle, C. (2025). The efficacy of lower limb orthoses on quality of life, well-being, and participation following stroke: A systematic review. *Prosthetics and Orthotics International*, *49*(4), 388–399. https://doi.org/10.1097/PXR.0000000000000389

Caserta, A., Reedman, S., Morgan, P., & Williams, C. M. (2022). Physical activity and quality of life in children with idiopathic toe walking: a cross sectional study. *BMC Pediatrics*, *22*(1), Article 544. https://doi.org/10.1186/s12887-022-03583-w

Caserta, A. J., Pacey, V., Fahey, M. C., Gray, K., Engelbert, R. H., & Williams, C. M. (2019). Interventions for idiopathic toe walking. *Cochrane Database of Systematic Reviews*, *2019*(10), CD012363. https://doi.org/10.1002/14651858.CD012363.pub2

Chapek, M., & Kessler, J. (2025). The Prevalence of Persistent Toe Walking in Children With and Without Autism Spectrum Disorder and the Odds of Subsequent Surgery. *The Journal of Foot and Ankle Surgery*, *64*(1), 16–20. https://doi.org/10.1053/j.jfas.2024.08.005

Cho, A. B., Otte, K., Baskow, I., Ehlen, F., Maslahati, T., Mansow-Model, S., Schmitz-Hübsch, T., Behnia, B., & Roepke, S. (2022). Motor signature of autism spectrum disorder in adults without intellectual impairment. *Scientific Reports*, *12*(1), Article 7670. https://doi.org/10.1038/s41598-022-10760-5

da Silva, S. H., Felippin, M. R., de Oliveira Medeiros, L., Hedin-Pereira, C., & Nogueira-Campos, A. A. (2025). A scoping review of the motor impairments in autism spectrum disorder. *Neuroscience and Biobehavioral Reviews*, *169*, Article 106002. https://doi.org/10.1016/j.neubiorev.2025.106002

Dars, S., Uden, H., Banwell, H. A., & Kumar, S. (2018). The effectiveness of non-surgical intervention (Foot Orthoses) for paediatric flexible pes planus: A systematic review: Update. *PloS One*, *13*(2), e0193060. 1-17. https://doi.org/10.1371/journal.pone.0193060

Dietz, F., & Khunsree, S. (2012). Idiopathic toe walking: to treat or not to treat, that is the question. *The Iowa Orthopaedic Journal*, *32*, 184–188. https://pmc.ncbi.nlm.nih.gov/articles/PMC3565400/

Dufek, J., Eggleston, J., Harry, J., & Hickman, R. (2017). A Comparative Evaluation of Gait between Children with Autism and Typically Developing Matched Controls. *Medical Sciences (Basel)*, *5*(1), 1-11. https://doi.org/10.3390/medsci5010001

Faccioli, S., Tonini, G., Vinante, E., Ehsani, A., Pellarin, E., Cassanelli, G., Malvicini, F., Perazza, S., Venturelli, F., Guida, A., & Sassi, S. (2025). The Role of Ankle–Foot Orthoses in Improving Gait in Children and Adolescents with Neuromotor Disability: A Systematic Review and Meta-Analysis. *Prosthesis (Basel, Switzerland)*, *7*(1), 13. https://doi.org/10.3390/prosthesis7010013

Fuentes, J., Hervás, A., & Howlin, P. (2021). ESCAP practice guidance for autism: a summary of evidence-based recommendations for diagnosis and treatment. *European Child & Adolescent Psychiatry*, *30*(6), 961–984. https://doi.org/10.1007/s00787-020-01587-4

Harris, S. R., Mickelson, E. C. R., & Zwicker, J. G. (2015). Diagnosis and management of developmental coordination disorder. *Canadian Medical Association Journal (CMAJ)*, *187*(9), 659–665. https://doi.org/10.1503/cmaj.140994

Hawke, F., Burns, J., Radford, J. A., & du Toit, V. (2008). Custom-made foot orthoses for the treatment of foot pain. *Cochrane Database of Systematic Reviews*, *2010*(1), CD006801. https://doi.org/10.1002/14651858.CD006801.pub2

Herrin, K., & Geil, M. (2016). A comparison of orthoses in the treatment of idiopathic toe walking: A randomized controlled trial. *Prosthetics and Orthotics International*, *40*(2), 262–269. https://doi.org/10.1177/0309364614564023

Hossain, M., Alexander, P., Burls, A., & Jobanputra, P. (2011). Foot orthoses for patellofemoral pain in adults. *Cochrane Database of Systematic Reviews*, *2011*(1), CD008402. https://doi.org/10.1002/14651858.CD008402.pub2

International Standards Organisation. (2020). *ISO 8549-1:2020(en) Prosthetics and orthotics — Vocabulary — Part 1: General terms for external limb prostheses and external orthoses*. https://www.iso.org/obp/ui/#iso:std:iso:8549:-1:ed-2:v1:en

Jafarnezhadgero, A., Madadi-Shad, M., Alavi-Mehr, S. M., & Granacher, U. (2018). The long-term use of foot orthoses affects walking kinematics and kinetics of children with flexible flat feet: A randomized controlled trial. *PloS One*, *13*(10), e0205187, 1-19. https://doi.org/10.1371/journal.pone.0205187

Kindregan, D., Gormley, J., Gallagher, L., & Berman, R. F. (2015). Gait Deviations in Children with Autism Spectrum Disorders: A Review. *Autism Research and Treatment*, *2015*(2015), 105–112. https://doi.org/10.1155/2015/741480

King, M. G., Hon, R., Roughead, E., Kemp, J. L., Pizzari, T., Wong, J., Menz, H. B., Taylor, N. F., Harms, A., McClelland, J. A., & Semciw, A. I. (2024). Prefabricated contoured foot orthoses to reduce pain and increase physical activity in people with hip osteoarthritis: A randomised feasibility trial. *Physiotherapy Research International: The Journal for Researchers and Clinicians in Physical Therapy*, *29*(4), e2118-n/a. https://doi.org/10.1002/pri.2118

Laurie, C. (2022, November 4). *Autistic Children and Motor Skills*. National Autistic Society. https://www.autism.org.uk/advice-and-guidance/professional-practice/motor-skills

Leyden, J., Fung, L., & Frick, S. (2019). Autism and toe-walking: Are they related? Trends and treatment patterns between 2005 and 2016. *Journal of Children's Orthopaedics*, *13*(4), 340–345. https://doi.org/10.1302/1863-2548.13.180160

Luginsland, L. A., Haegele, J. A., Laverdure, P. A., & Bennett, H. J. (2024). Biomechanical Gait Interventions in Persons with Autism Spectrum Disorder: A Scoping Review. *World Scientific Annual Review of Biomechanics*, *2*. https://doi.org/10.1142/S2810958924300026

MacDonald, M., & McClelland, M. (2024, May 7). *Motor Skills and Executive Function in Autism*. Autism Research Institute. https://autism.org/motor-cognitive-development/

Manfredi, F., Riefoli, F., Coviello, M., & Dibello, D. (2022). The Management of Toe Walking in Children with Autism Spectrum Disorder: "Cast and Go." *Children (Basel)*, *9*(10), 1477. https://doi.org/10.3390/children9101477

Martikyan, S., Kaur, K., & Patel, O. (2018). Autism and Toe-walking – a review of the current literature. *Extremitas*. 5: 26-30.

Meyr, A. J., & Sansosti, L. E. (2020). Flatfoot Deformity. In: Tower, D. E. (Ed). *Evidence-based podiatry: A clinical guide to diagnosis and management*. Springer. https://doi.org/10.1007/978-3-030-50853-1

Michalitsis, J., Murphy, A. T., Rawicki, B., Haines, T. P., & Williams, C. (2019). Full length foot orthoses have an immediate treatment effect and modify gait of children with idiopathic toe walking. *Gait & Posture*, *68*(NA), 227–231. https://doi.org/10.1016/j.gaitpost.2018.11.022

Miller, H. L., Licari, M. K., Bhat, A., Aziz-Zadeh, L. S., Van Damme, T., Fears, N. E., Cermak, S. A., & Tamplain, P. M. (2024). Motor problems in autism: Co-occurrence or feature? *Developmental Medicine and Child Neurology*, *66*(1), 16–22. https://doi.org/10.1111/dmcn.15674

Ming, X., Brimacombe, M., & Wagner, G. C. (2007). Prevalence of motor impairment in autism spectrum disorders. *Brain & Development (Tokyo. 1979)*, *29*(9), 565–570. https://doi.org/10.1016/j.braindev.2007.03.002

Morrow, E., Harris, J., Gelfer, Y., Cashman, J., & Kothari, A. (2024). Health-related Quality of Life in Idiopathic Toe Walkers: A Multicenter Prospective Cross-sectional Study. *Journal of Pediatric Orthopaedics*, *44*(4), e357–e360. https://doi.org/10.1097/BPO.0000000000002620

Pollen, T. N., Jor, A., Munim, F., He, Y., Daryabor, A., Gao, F., Lam, W.-K., & Kobayashi, T. (2025). Effects of 3D-printed ankle-foot orthoses on gait: a systematic review. *Assistive Technology*, *37*(4), 287–303. https://doi.org/10.1080/10400435.2024.2411563

Pourhoseingholi, E., & Tafti, N. (2025). The efficacy of the Novel Hybrid Passive Spring Damper Ankle Foot Orthosis regard to kinetic and kinematic parameters of patients with Multiple Sclerosis: An intervention study. *Assistive Technology*, *37*(4), 248–256. https://doi.org/10.1080/10400435.2024.2392657

Queensland Health. (2014, June 01). *Orthoses glossary*. Queensland Government. https://www.health.qld.gov.au/mass/prescribe/orthoses/glossary

Rome, K., Ashford, R. L., & Evans, A. (2010). Non-surgical interventions for paediatric pes planus. *Cochrane Database of Systematic Reviews*, *2012*(11), CD006311. https://doi.org/10.1002/14651858.CD006311.pub2

Shetreat-Klein, M., Shinnar, S., & Rapin, I. (2014). Abnormalities of joint mobility and gait in children with autism spectrum disorders. *Brain & Development (Tokyo. 1979)*, *36*(2), 91–96. https://doi.org/10.1016/j.braindev.2012.02.005

Silvertant, E. (2024, February 29). *Autism & motor control*. Embrace Autism. https://embrace-autism.com/autism-and-motor-control/

Skigen, J. T., Koller, C. A., Nigro, L., Reisman, D. S., McKee, Z., Pinhey, S. R., Henderson, A., Wilken, J. M., & Arch, E. S. (2024). Customized passive-dynamic ankle–foot orthoses can improve walking economy and speed for many individuals post-stroke. *Journal of Neuroengineering and Rehabilitation*, *21*(1), Article 126. https://doi.org/10.1186/s12984-024-01425-7

Smith, M., Banwell, H. A., Ward, E., & Williams, C. M. (2019). Determining the clinical knowledge and practice of Australian podiatrists on children with developmental coordination disorder: a cross-sectional survey. *Journal of Foot and Ankle Research*, *12*(1), 1-9. https://doi.org/10.1186/s13047-019-0353-y

Valagussa, G., Purpura, G., Balatti, V., Trentin, L., Signori, A., & Grossi, E. (2024). Quantitative assessment of tip-toe behavior in individuals with autism spectrum disorder and intellectual disability: A cross-sectional study. *Autism Research*, *17*(2), 311–323. https://doi.org/10.1002/aur.3072

Valagussa, G., Trentin, L., Signori, A., & Grossi, E. (2018). Toe Walking Assessment in Autism Spectrum Disorder Subjects: A Systematic Review. *Autism Research*, *11*(10), 1404–1415. https://doi.org/10.1002/aur.2009

Wang, L. A. L., Petrulla, V., Zampella, C. J., Waller, R., & Schultz, R. T. (2022). Gross Motor Impairment and Its Relation to Social Skills in Autism Spectrum Disorder: A Systematic Review and Two Meta-Analyses. *Psychological Bulletin*, *148*(3–4), 273–300. https://doi.org/10.1037/bul0000358

Wilder, D. A., Ingram, G., & Hodges, A. C. (2022). Evaluation of shoe inserts to reduce toe walking in young children with autism. *Behavioral Interventions*, *37*(3), 754–765. https://doi.org/10.1002/bin.1860

World Health Organization. (2019). *Autism Spectrum Disorder*. https://www.who.int/news-room/fact-sheets/detail/autism-spectrum-disorders

Zampella, C. J., Wang, L. A. L., Haley, M., Hutchinson, A. G., & de Marchena, A. (2021). Motor Skill Differences in Autism Spectrum Disorder: a Clinically Focused Review. *Current Psychiatry Reports*, *23*(10), Article 64. 1-11. https://doi.org/10.1007/s11920-021-01280-6

Rehabilitation after Selective Dorsal Rhizotomy for children with Cerebral Palsy

The content of this document is OFFICIAL.

Please note:
The research and literature reviews collated by our TAB Research Team are not to be shared external to the Branch. These are for internal TAB use only and are intended to assist our advisors with their reasonable and necessary decision-making.
Delegates have access to a wide variety of comprehensive guidance material. If Delegates require further information on access or planning matters they are to call the TAPS line for advice.
The Research Team are unable to ensure that the information listed below provides an accurate & up-to-date snapshot of these matters

Research question: When is the post SDR specific intensive rehabilitation period considered to have ceased i.e., 6 weeks, 12 weeks, 6 months etc.?

Date: 15/10/2021

Requestor: Shane S22(1)(a)(ii)-irrelevant material

Endorsed by (EL1 or above): Julie S22(1)(a)(ii)-irrelevant material

Cleared by:

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2. Summary

Selective Dorsal Rhizotomy (SDR) is a neurosurgical technique that aims to improve lower limb spasticity in people with cerebral palsy (CP) by selectively cutting the nerve fibres in the spine responsible for aberrant signals to the limbs. Extensive rehabilitation is required after the procedure. There is little consensus about the most appropriate rehabilitation protocols. Duration of rehabilitation varies between 6 and 24 months. There can be considerable overlap between therapies and supports required for rehabilitation and therapies that children with CP would tend to receive even without the surgery. This creates some difficulty in determining reasonable and necessary supports to include in a participant's plan.

3. Selective Dorsal Rhizotomy in Australia

SDR surgery in Australia began in 2003. Australian neurosurgeons have performed this surgery 44 times between 2003 and 2019, though as of 2021 there are at least 70 children currently registered as having had the surgery and living in Australia [2,3]. Here SDR is currently only performed on children, though adults may receive the surgery overseas [4]. Some children also travel overseas to have the surgery if they do not meet the selection criteria at any Australian institution. Three hospitals in Australia can perform the surgery:

- Children's Hospital at Westmead
- Royal Melbourne Children's Hospital
- Queensland Children's Hospital in Brisbane [2,3]

According to Lewis et al, surgeons at these hospitals were trained to perform SDR by a visiting surgeon affiliated with Gillette Children's Specialty Healthcare and The Shriners Hospitals for Children, Minnesota. Surgical and rehabilitative protocols in use in Australia are based on those in use at these institutions [2,5].

Typically the procedure is only performed on children with CP who are ambulatory, however some have argued for expansion to children with greater mobility difficulties [6,7]. Selection criteria vary between institutions but may include:

- diagnosed with cerebral palsy
- spasticity in lower limbs
- levels I, II or III on Gross Motor Function Classification Scale (GMFCS)
- able to engage in intense rehabilitation programme
- no previous orthopaedic surgeries
- lack of severe contractures
- no excessive weakness of antigravity muscles

- no other movement disorders [2,5].

4. Rehabilitation after SDR

4.1 In hospital rehabilitation

Shortly after surgery, a period of intensive rehabilitation begins. Rehabilitation can start as early as the day after surgery. Time that the child spends in hospital will vary depending on the child, any post-surgery complications and the policy of the particular institution [8,Table 1]. Children's Hospital at Westmead recommends exercises begin at 4 days post-surgery and intensive in-hospital rehabilitation continue for 4 – 6 weeks [9]. Queensland Children's Hospital generally discharges after 4 weeks [1]. Gillette Children's Speciality Healthcare in USA recommends rehabilitation commence around the third day post-surgery and continue for 4-6 weeks [5]. Leeds Children's Hospital commences rehabilitation at around day 4 and usually discharges the child on the same day. The child returns to the hospital for daily physiotherapy for 3 weeks at which point the child continues with an exercise and therapy program [10].

4.2 Post-discharge rehabilitation

After discharge there is an extensive period of rehabilitation required to improve the patient's mobility. Rehabilitation can include physiotherapy, hydrotherapy, prescription of ankle-foot orthoses and encouragement to engage in regular daily activities [8,11]. Veerbeek et al note that a focus on functional mobility can improve chances of positive long term outcomes for the patient [12].

The recommended length of this period of rehabilitation varies. There is still debate about the best rehabilitation protocols [2,8,13,14]. The latest guidelines from the National Institute for Health and Clinical Excellence (NICE) suggest that rehabilitation is given for "several months" post-surgery [15]. The previous version of this guidance offered a more specific "three months to one year" [16]. This indicates increased contestation around rehabilitation protocols. Leeds Children's Hospital recommends physiotherapy for up to 2 years [10]. Queensland Children's hospital advises that improvements can be seen with rehabilitation up to 2 years after surgery [1].

After their review of the literature, Colvin and Thomas describe current practice as between 9 and 24 months post-operative therapy [14]. Cawker and Aquilina confirm that evidence supports intensive rehabilitation period of up to 2 years [13]. Lewis et al argue that it is difficult to settle on a recommended rehabilitation period as extant research varies in rehabilitation protocol and duration [2]. Nicolini-Panisson et al suggest post-operative rehabilitation generally lasts around one year, though their research shows a spread of between 6 months and 2 years [8,Table 1].

The Academy of Paediatric Physical Therapy, part of the American Physical Therapy Association, is currently developing a clinical practice guideline for physical/occupational

therapies for children with CP who have SDR. This is not due for publication until 2024. The project lead for the development of this guideline advised me that even after publication "the line between rehabilitation and habilitation can be blurry" [6. Correspondence].

Table 1. Characteristics of physiotherapy protocols after SDR [8]

Study	PT start (day)	Length of hospital stay	Physical therapy frequency
Graubert et al.[6]	--		4 weeks de terapia:10 hours/week + 5 months: 4-5 hours/ week + 6 months: 1-3 hours/week
Wright et al.[12]	2nd or 3rd	6 weeks	6 weeks: 45 minutes/day of physical therapy e 2 sessions/week (45 minutes of occupational therapy); after discharge, up to 1 year: 2 sessions/week (120 minutes)
McLaughlin et al.[14]	4th a 6th	1 month	1st month: 2 hours/day for 5 days/week; following 5 months: 3-5 hours/week; 6th month: normal therapy
McLaughlin et al.[11]	2nd	1 month	4 weeks: 2 hours/day for 5 days/week (40 hours) + 5 months:1 hour/ day for 4-5 days/week + 6 months: 1 hour/day for 1-4 days/week
Josenby et al.[22]	1st	–	6 months: twice/week (1 hour); 6th-18th month: once/week and physical activities
Chan et al.[7]	2nd	4 weeks	4 weeks: 5 hours/day for 5 times/week; 2nd -12th month: 3-6 hours/week
Engsberg et al.[10]	5th	1 week	5th day-8th month: 4 times/week; 8th -16th month: 3 times/week
Engsberg et al.[4]	--	–	8 months: 4 times/week + 12 months: 3 times/week
Schie et al.[16]	1st	1 week	5th day: sitting on WC and therapy 3 times/day (1 hour); 6th day: orthostasis and, when possible, gait with GRO; 3 months: 5 times/ week (1 hour); 3rd-6th month: 4 times/week (1 hour); 6th -12th month: 3 times/week (30 minutes)
Engsberg et al.[31]	3rd	1 week	1st week: twice/day + 8 months: 4-5 times/week; after 8th month: 3-4 times/week
Buckon et al.[27]	4th	1 month	1st month: twice/day + occupational therapy: 1time/day; 2th -6th month: 3-4 times/week, occupational therapy: 1-2 times/ week; 6th mês-1 year: 1-2 times/week
Steinbok et al.[13]	--	–	3 months: 3 times/week + 6 months: twice/week (9 months pre- and post-operative periods)
Engsberg et al.[15]	3rd	–	Post-operative period, 6 months: twice/week; 3rd day post-operative period: 3 times/day; up to 6 months: 4-5 times/week; 6th -8th month: 3-4 times/week
Hodgkinson et al.[19]	--	–	6 months: once/day
Dudgeon et al.[20]	--	4 weeks	4 weeks: 2 hours/day, 5 times/week; occupational therapy: 3-5 hours/week + 5 months: 4-5 hours/week
Josenby et al.[23]	1st	–	6 months: 1 hour/2 times/week; up to 18 months: once/week and physical activities.
Nordmark et al.[5]	5th	3-5 days ICU	1st week: 45 minutes/twice/day; 2nd -3rd week: 45 minutes/3 times/day; 2nd-6th month: 1 hour/twice/week; 6 months: 1 hour/once/week
Steinbok et al.[8]	2nd	6 days	6th day: weight support while standing up; 2nd week: gait; 3 months: 3 times/week + 6 months: 2 times/week

PT: physical therapy; WC: wheelchair; GRO: ground-reaction orthosis. ICU: intensive care unit.

5. Reasonable and necessary

According to the Disability Related Health Support Operational Guideline, NDIS will not fund post-acute services defined as "follow-up care after a person's hospital stay, often by allied health services, and can include admitted or community-based rehabilitation". NDIS will also not fund time-limited health supports that are not required on an ongoing basis.

Physiotherapy following SDR would appear to satisfy the definition of post-acute care and non-ongoing health supports. Therapy following SDR is an essential aspect of the treatment protocol [13]. Even if the precise duration of the therapy is not possible to specify in advance, it is time-limited, lasting anywhere between 6 months and 2 years. In this case, it would seem clear that SDR rehabilitation does not satisfy s34.1(f) as post-acute time limited therapies are the responsibility of the health system.

However, there are a few issues which demonstrate how “the line between rehabilitation and habilitation can be blurry”. Firstly, the surgery is often performed on very young children who are still growing and developing physically. Without SDR, these children may be eligible for early intervention therapies that aim to assist them to approach the level of mobility of their peers. This is something that NDIS may fund. Further, some rehabilitation protocols prescribe Ankle-Foot orthoses. However, children with CP may require AFOs for the ongoing management of their disability.

The SDR treatment guide for Gillette Children’s Speciality Healthcare states:

> If, before the rhizotomy, your child was having occupational therapy, speech therapy, or therapy related to emotional or behavioral functioning, recommendations for those therapies usually don’t change as a result of the surgery. After returning home, your child can resume these therapies at the same frequency as before the surgery [5].

A few studies have described occupational therapy, hydrotherapy, or hippotherapy as aspects of the post-surgical rehabilitative care protocols [8,11].

These three examples show that supports may be both an expected part of a child’s ongoing care and also a prescribed feature of their rehabilitation program. Ultimately it may be difficult to distinguish between supports required to: i) support a child to develop age appropriate capacities; and ii) realise the gains made possible by SDR. In fact, the same supports might be aimed towards both goals.

6. Correspondence

From: S22(1)(a)(ii)-irrelevant material

Sent: Thursday, 14 October 2021 11:35 AM

To: S22(1)(a)(ii)-irrelevant material, Aaron S22(1)(a)(ii)-irrelevant material

Subject: RE: Duration of physical therapy after SDR [SEC=OFFICIAL]

Hi Aaron-

What seems like it might be an easy project, certainly does not have a straightforward answer! I’m learning a lot about the process of writing clinical practice guidelines. Our group is making

slow progress but we're a long way away from having and recommendations to share or publish.

This is a recent reference that summarizes rehabilitation protocols following SDR, but it is not very detailed:

DOI: 10.1590/1984-0462/;2018;36;1;00005

Something that you might also consider is that most children who undergo SDR are still developing and have not reached a plateau in their mobility or ADL function prior to surgery. Although you might be able to use measures to identify when a child returns to their prior level of function after SDR, for many children the long-term goal after SDR is to exceed their baseline level of function. So, the line between rehabilitation and habilitation can be blurry.

Best of luck to you as you tackle this project!

S22(1)(a)(ii)-irrelevant material, PT

Physical Therapist and Clinical Educator

Board-certified in Neurologic Physical Therapy

Gillette Children's Specialty Healthcare

S22(1)(a)(ii)-irrelevant material

From: S22(1)(a)(ii)-irrelevant material, Aaron
Sent: Wednesday, 13 October 2021 12:17 PM
To: S22(1)(a)(ii)-irrelevant material
Subject: Duration of physical therapy after SDR [SEC=OFFICIAL]

Hi S22(1)(a)(ii)-irrelevant material

I hope you don't mind my reaching out to you. I noticed you are the contact for the development of the APTA clinical guideline on physical and occupational therapy for children with CP who have had selective dorsal rhizotomy.

I am currently completing a short research project for the National Disability Insurance Agency, the organisation that administers Australia's National Disability Insurance Scheme.

I've been asked to look into duration of the rehabilitation period after SDR. From what I have seen so far, duration of physical therapy tends to vary between 6 months and 2 years. Current NICE guidelines suggest "several months" but do not specify.

Are you able to point me to any recent research that might suggest how long the post-operative rehabilitation period might last? I understand it is likely to vary with individuals as well, so I am also curious how rehabilitation therapists might determine when a patient has reached their post-operative baseline.

Any advice would be very much appreciated.

Thanks and all the best

Aaron S22(1)(a)(ii)-irrelevant material

Research Officer

National Disability Insurance Agency

Email S22(1)(a)(ii)-irrelevant material

7. References

[1] Children's Health Queensland. Selective dorsal rhizotomy fact sheet [Internet]. Queensland Government: Brisbane. 2018 [cited 2021 Oct 14]. Available from: https://www.childrens.health.qld.gov.au/fact-sheet-selective-dorsal-rhizotomy/

[2] Lewis J, Bear N, Baker F, Fowler A, Lee O, McLennan K, et al. Australian children undergoing selective dorsal rhizotomy: protocol for a national registry of multidimensional outcomes. BMJ Open. 2019;9(4):e025093.

[3] The Australian Selective Dorsal Rhizotomy Registry. Report 2019-2020. ASDRR: Sept 2020. [cited 2021 Oct 14]. Available from: https://www.ausacpdm.org.au/wp-content/uploads/2020/10/The-Australian-SDR-Registry-Report-2019-2020.pdf

[4] Park TS, Dobbs MB, Cho J. Evidence supporting selective dorsal rhizotomy for treatment of spastic cerebral palsy. Cureus. 2018;10(10):e3466.

[5] Gillette Children's Specialty Healthcare. Selective Dorsal Rhizotomy (SDR) Surgery [Internet]. Gillette Children's Specialty Healthcare: St Paul Minnesota. Nov 2019. [cited 2021 Oct 14]. Available from: https://www.gillettechildrens.org/conditions-care/selective-dorsal-rhizotomy-sdr-surgery/what-is-rhizotomy-or-sdr-surgery

[6] Wach J, Yildiz ÖC, Sarikaya-Seiwert S, Vatter H, Haberl H. Predictors of postoperative complications after selective dorsal rhizotomy. Acta Neurochir. 2021;163(2):463–74

[7] Davidson B, Fehlings D, Milo-Manson G, Ibrahim GM. Improving access to selective dorsal rhizotomy for children with cerebral palsy. CMAJ. 2019;191(44):E1205–6.

[8] Nicolini-Panisson RD, Tedesco AP, Folle MR, Donadio MVF. Selective dorsal rhizotomy in cerebral palsy: Selection criteria and postoperative physical therapy protocols. Rev Paul Pediatr. 2018;36(1):9.

[9] Children's Hospital at Westmead. Selective Dorsal Rhizotomy: Patient Management [Practice Guideline]. The Sydney Children's Hospital Network: Sydney NSW. [cited 2021 Oct 14]. Available from: https://www.schn.health.nsw.gov.au/_policies/pdf/2016-6000.pdf

[10] Leeds Children's Hospital. SDR Post-Operative Information for Physiotherapists. The Leeds Teaching Hospitals: Leeds, UK. April 2019. [cited 2021 Oct 14]. Available from: https://www.leedsneurosurgery.com/sdr/resources/SDR%20Info%20for%20PT%20updated%202019-04.pdf

[11] Oudenhoven LM, van der Krogt MM, Romei M, van Schie PEM, van de Pol LA, van Ouwerkerk WJR, et al. Factors associated with long-term improvement of gait after selective dorsal rhizotomy. Arch Phys Med Rehabil. 2019;100(3):474–80.

[12] Veerbeek BE, Lamberts RP, Fieggen AG, Verkoeijen PPJL, Langerak NG. Daily activities, participation, satisfaction, and functional mobility of adults with cerebral palsy more than 25 years after selective dorsal rhizotomy: a long-term follow-up during adulthood. Disabil Rehabil. 2021;43(15):2191–9.

[13] Cawker S, Aquilina K. Selective dorsal rhizotomy (the perspective of the neurosurgeon and physiotherapist). Paediatr Child Health. 2016;26(9):395–9.

[14] Colvin C, Thomas M. An Evidence-Based Review of Physical Therapy Intervention for Individuals Who Have Undergone a Selective Dorsal Rhizotomy. Paper presented at: American Academy for Cerebral Palsy and Development Medicine 72nd Annual Meeting; Oct 9-13; Cincinnati, Ohio. [cited 2021 Oct 14]. Available from: http://www.aacpdm.org/UserFiles/file/handouts/am18/bsh/BRK4-An-Evidence-based-Review-of-Physical-Therapy-.pdf

[15] National Institute for Health and Care Excellence (NICE). Selective Dorsal Rhizotomy for spasticity in cerebral palsy [Practice Guideline]. NICE. Dec 2010. [cited 2021 Oct 14]. Available from: https://www.nice.org.uk/guidance/ipg373

[16] National Institute for Health and Care Excellence (NICE). Selective Dorsal Rhizotomy for spasticity in cerebral palsy [Practice Guideline]. NICE. Dec 2010. [cited 2021 Oct 14]. Available from: https://www.nice.org.uk/guidance/ipg373/documents/selective-dorsal-rhizotomy-for-spasticity-in-cerebral-palsy-interventional-procedure-consultation-document

8. Version control

Version	Amended by	Brief Description of Change	Status	Date
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0.2				
0.3				
1.0				

Post-COVID syndrome

The content of this document is OFFICIAL.

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The TAPIB Research team take care to ensure the research presented is accurate at the time of writing. Due to the nature of our work, we cannot ensure that all relevant research has been considered in the development of this document or that information remains accurate after publishing.

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2. Summary

Update (October, 2025): The symptoms of post-COVID syndrome have diverse trajectories. While evidence is emerging that some symptoms may last for 2 years or more, many symptoms do attenuate over time. Understanding of symptom trajectory is limited by a lack of long-term studies that include symptom measures before the onset of COVID-19.

Post-COVID syndrome is not diagnosed via a single test. It requires symptoms to be present for at least 12 weeks (although some consider 4 weeks sufficient), the patient's functioning to be impacted and alternative diagnoses to be excluded. Additionally, a patient's medical history should be taken, their symptoms considered and a variety of test run e.g., x-rays, blood tests. Treatment is based on the symptoms present in the patient and is therefore highly individualised. There is no pharmacological treatment for post-COVID syndrome although symptoms can be treated with medication. There is limited evidence that therapy and exercise may improve some symptoms.

There is evidence that female gender, a longer hospital stay during COVID-19 infection, no COVID-19 vaccination, multiple COVID-19 infections, increased number and severity of symptoms during the infection, intensive care admission, older age, prior comorbidities and elevated Body Mass Index may be associated with post-COVID syndrome, although some sources disagree about the role of multiple infections and hospitalisation. Sources do agree that a multidisciplinary team should be involved in the rehabilitation process of post-COVID syndrome and the services of a multidisciplinary team should be offered any time from 4 weeks after the start of acute COVID-19 if rehabilitation is required.

Individuals with post-COVID syndrome often report decreased smell and taste, hair loss, rash and respiratory issues. These symptoms are less common in individuals with myalgic encephalomyelitis/chronic fatigue syndrome. Research is still underway to determine the exact relationship between these two conditions.

Psychological support, mindfulness-based approaches, peer support groups, antidepressants and, if safe, physical exercise training may be recommended for managing the long-term mental health symptoms of post-COVID syndrome based on their effectiveness in treating mental health symptoms in other conditions. The efficacy of these interventions in treating mental health symptoms in post-COVID syndrome is supported by a small amount of low-quality non-generalisable evidence.

Update (September, 2023): Heterogeneity of research data is still a significant barrier to determining the prevalence and incidence of post-COVID syndrome, the persistence of disability associated with post-COVID syndrome and any effective treatment and management techniques. Estimates of activity limitation for people with post-COVID syndrome vary between 16% and 80%. Estimates of prevalence vary considerably, though studies coalesce around estimates in the range of either 10%-20% or 40%-55%. The evidence base for treatment and management techniques is growing with some evidence supporting physical therapy,

multimodal and personalised approaches. No pharmacological or non-pharmacological technique has emerged as a preferred pathway.

Post-COVID syndrome-19 is a collection of symptoms that persist after the initial acute phase of COVID-19 infection. While some consider 4 weeks the start of prolonged symptomology, 12 weeks is emerging as the point where post-COVID syndrome-19 can be diagnosed. The prevalence of post-COVID syndrome-19 is difficult to determine due to heterogeneity in the research data, however it is suggested to effect between 10-20% of people who survive a COVID-19 infection.

Management of post-COVID syndrome-19 will likely follow the management protocols for other post-viral syndromes, such as myalgic encephalitis/chronic fatigue syndrome, or critical illness recovery paths, for example post-intensive care syndrome.

Permanence of post-COVID syndrome-19 is difficult to determine at this point as the disease is in its infancy, however most people are expected to make a recovery over many months. Nonetheless, it is expected some people will continue to have physical and/or mental impairment that significantly impacts their functional capacity. As a consequence, the United States Department of Health and Human Services advises that post-COVID syndrome-19 can be considered a disability after patients complete an individualised assessment that indicates they have severely impaired functional capacity.

3. Review, October 2025

Long COVID is also known post-acute sequelae of COVID-19 (PASC), post-COVID-19 condition (PCC) and post-COVID syndrome (PCS). For the purpose of this review the term post-COVID syndrome will be used.

3.1 The Trajectory of Post-COVID Syndrome

NSW Health states that a small number of people may have symptoms of post-COVID syndrome for 12 or more months (2025, p. 2). A Queensland Health living evidence summary on Long COVID states it is very rare that lingering symptoms do not resolve. It reports a study in Victoria showing that 2% of hospitalised and 0.09% of non-hospitalised adults with COVID-19 develop post-COVID syndrome (2024b, pp. 5/10). It also references data from the Centre for Disease Control (CDC) published in 2023 which found that the persistence of symptoms at 12 months was not statistically significant different between COVID test-positive and COVID test-negative participant groups. It reports that 1,288 COVID-positive participants completed the full 12 months of the study including all quarterly surveys, and 18.3% of COVID–positive participants reported persistent symptoms of any type through the 12 months.

According to the living evidence summary, many studies are poorly designed and overestimate the threat of post-COVID syndrome (2024b, p. 10). It is also acknowledged that there is a lack of large studies on post-COVID syndrome symptoms with symptom measures before the onset of COVID-19, resulting in post-COVID syndrome still being poorly defined (Ellingjord-Dale et

al., 2024; Santoro et al., 2025). Recent longitudinal studies have shown mixed results, and the trajectory appears to be highly individual, varying for different symptoms in different people.

A 2024 Norwegian study compared persistent symptoms in COVID-positive and COVID-negative adults. The study found higher levels of persistent symptoms such as memory- and concentration problems, anosmia and dysgeusia, dyspnoea, fatigue and self-assessed worsening of overall health in COVID-positive patients. The cognitive symptoms and self-assessed worsening of overall health did not attenuate over time, with the symptoms of memory and concentration problems persisting for at least 22 months (the time of the final follow-up in the study) while other symptoms peaked during the acute phase and then exhibited a downward trend. These results held true even when correcting for symptoms before the onset of COVID-19 (Ellingjord-Dale et al., 2024). Another study comparing COVID-positive and COVID-negative individuals A 2025 study by Yeung et al. compared COVID-positive and COVID-negative patients in majority English-speaking countries. They found that, over a 9 month period, non-cognitive symptoms improved but cognitive and neurological symptoms and memory function did not change significantly in their study's participants. For COVID-positive participants, symptoms of ongoing gastrointestinal/autoimmune/fatigue and mood symptoms appeared to reduce and cardiopulmonary symptoms also improved compared to the COVID-negative group.

Santoro et al. (2025) found evidence that, while many symptoms attenuated over time, some participants continued to experience symptoms for 2 years or longer. Predominant long-term symptoms include fatigue, respiratory sequalae and brain fog (Santoro et al., 2025, p. 6). Becker et al. (2025) found that cognitive measures of attention, working memory, processing speed, executive function and verbal learning and memory improved progressively through 42 months post-COVID. However, the measures of processing speed and executive functioning still remained below the normative mean at the end of the study (Becker et al., 2025, p. 1). Fischer et al. (2025) also identified elevated and persisting symptoms in individuals for up to 24 months after COVID infection. They identified that individual symptoms have multiple possible trajectories including remaining at a low level, increasing over time, and decreasing over time (Fischer, 2025). The variety of trajectories for each symptom is also shown by Badinlou et al. (2024). They report that most symptoms (mental functions, sensory functions, pain and body system functions) decrease over time, with a slight increase or stabilisation towards the end of the study, 12 months after infection. However, the quality of these studies is affected by the lack of control groups, different durations and follow-up time points, and decreasing number of participants with each follow-up.

3.2 Diagnosing Post-COVID Syndrome

According to the National Institute for Health and Care Excellent (NICE) Rapid Guidelines, the CDC and the World Health Organisation (WHO), post-COVID syndrome may be suspected if the person's symptoms have not resolved 12 weeks after the start of acute COVID-19 (Queensland Health, 2024b, p. 3; NICE, 2024, p. 9). However, some consider that ongoing

health issues 4 weeks after COVID-19 constitutes post-COVID syndrome e.g., the UK Office of National Statistics. Some also refer to an intermediary phase called ongoing symptomatic COVID for symptoms lasting between 4 and 12 weeks e.g., the NICE Rapid Guidelines (Queensland Health, 2024b, p. 3).

According to Queensland Health, to meet the criteria for post-COVID syndrome, symptoms must meet the duration criteria described above and must:

- be unable to be explained by an alternative diagnosis
- impact on the patient's function (i.e. affecting their ability to perform everyday functions) (Queensland Health, 2024a).

However, there is currently no one test that can be used to diagnose post-COVID syndrome. Diagnosis is performed by a doctor based on symptoms, medical history and tests which may include:

- blood pressure checks
- heart rate checks
- blood tests
- exercise tests — including a one-minute sit-to-stand test
- x-rays
- lung function tests
- an electrocardiogram (ECG) (HealthDirect, 2024).

For people with ongoing symptomatic COVID-19 or suspected post-COVID syndrome, the NICE Rapid Guidelines (2024) recommend a comprehensive clinical history and appropriate examination that involves assessing physical, cognitive, psychological and psychiatric symptoms, as well as functional abilities.

The comprehensive clinical history should include the following:

- history of acute COVID-19 (suspected or confirmed)
- the nature and severity of previous and current symptoms
- timing and duration of symptoms since the start of acute COVID-19
- history of other health conditions
- exacerbation of pre-existing conditions (NICE 2024, p. 13).

The NICE Rapid Guidelines also recommend offering tests and investigations tailored to patients' signs and symptoms to rule out acute or life-threatening complications and to determine if symptoms are likely to be caused by ongoing symptomatic COVID-19, post-COVID syndrome or a new, unrelated diagnosis (NICE, 2024, p. 15).

Queensland Health's living evidence summary (2024, p. 9) for Long COVID recommends *The Post COVID Functional Scale (PCFS)* and *the Post-Covid-19 Yorkshire Rehabilitation Screen (C19-YRS)* for the assessment and management of post-COVID syndrome (Queensland Health, 2024b, p. 9).

3.3 Treating Post-COVID Syndrome

There is no single treatment for post-COVID syndrome. Treatment aims to manage symptoms and any complications (NSW Health, 2025). As such, the treatment for post-COVID syndrome depends on the symptoms experienced by the patient. Treating doctors may refer patients to a variety of allied health specialists including:

- a respiratory specialist
- a cardiologist
- a physiotherapist
- an occupational therapist
- a dietitian
- a speech pathologist
- a psychologist (HealthDirect, 2024).

There are currently no recommended medicines for treating post-COVID syndrome (HealthDirect, 2024). However, medications may be prescribed for symptomatic relief as needed (WHO, 2025b). General advice includes:

- eat a healthy diet
- stay well hydrated by drinking plenty of fluids
- keep your social connections — reach out to family and friends
- practise mindfulness techniques, such as breathing exercises and meditation
- quit smoking or vaping
- reduce how much alcohol you drink (HealthDirect, 2024).

According to HealthDirect (2024), treatments that are currently showing positive results for people with post-COVID syndrome are:

- physical activity
- inspiratory muscle training and pulmonary rehabilitation (types of breathing exercises)
- hyperbaric oxygen therapy
- physical and mental health rehabilitation programs.

The 3 Ps are also recommended:

Pace: save your energy by breaking up your daily activities into smaller, more manageable tasks. Rest often.

Plan: spread activities that need more energy, such as gardening, food shopping and laundry, across the whole week. Plan for plenty of rest in between these tasks. If you can, ask family members or friends to help you. Consider other options like grocery delivery services.

Prioritise: only do essential tasks and activities. If you can, ask a family member or friend to help with these tasks (HealthDirect, 2024).

At the present time, there remains limited research on treatments and a lack of large studies to understand the most effective treatments. However, doctors and their patients may make individualised treatment decisions based on knowledge from similar medical conditions (WHO, 2025b).

A WHO Guideline Development Group is currently working on guidelines on diagnosis, treatment and rehabilitation in post-COVID syndrome (WHO, 2025b). A living guideline for the clinical management of COVID-19 is available and includes information about rehabilitating post-COVID syndrome (WHO, 2025a). It provides conditional recommendations for managing symptoms such as post-exertional symptom exacerbation, arthralgia, breathing impairment, cognitive impairment, fatigue, mental health, olfactory impairment, orthostatic intolerance, swallowing impairment and voice impairment. See the living guideline for more information (WHO, 2025a, pp. 81 – 92).

The current NICE Rapid Guidelines for managing the long-term effects of COVID-19 emphasise the role of self-management, a personalised rehabilitation and management plan and a multidisciplinary approach to rehabilitation including physical, psychological and psychiatric aspects (NICE, 2024, pp. 20-22).

A living systematic review by Zeraatkar et al. (2024) investigates the interventions for managing post-COVID syndrome. Results show that cognitive behavioural therapy (CBT) and physical and mental health rehabilitation are likely effective for the treatment of post-COVID syndrome with moderate certainty evidence. In particular, CBT may reduce fatigue and improve concentration, while combined programmes of physical and mental health may increase the proportion of patients who experience recovery or important improvements, and may improve quality of life and reduce symptoms of depression. However, no such evidence for physical and cognitive function, anxiety, fatigue, pain or dyspnoea was found. Moderate-certainty evidence also showed that intermittent aerobic exercise probably improves physical function compared with continuous aerobic exercise. Other interventions included pharmacological treatments (vortioxetine, leronlimab, a synbiotic (SIM01), coenzyme Q10, amygdala and insula retraining, combined L-arginine and vitamin C), inspiratory muscle training, transcranial direct current stimulation, hyperbaric oxygen, and a mobile application providing education on post-COVID syndrome (telerehabilitation mobile app). Evidence for these treatments was of low or very low certainty.

Greenhalgh et al. (2024) include in their clinical update of post-COVID syndrome information on recommended approaches for symptom-specific treatment. It includes information on fatigue, breathing issues, chest pain, throat and voice symptoms, orthostatic intolerance, neurocognitive dysfunction, pain, poor sleep, mental health and more (see pp. 715-716 for more information).

3.4 The Prognostic Indicators for Post-COVID Syndrome

There is evidence that female gender, a longer hospital stay during COVID-19 infection, no COVID-19 vaccination, multiple COVID-19 infections, increased number and severity of symptoms during the infection, intensive care admission, older age, prior comorbidities and elevated Body Mass Index may be associated with post-COVID syndrome (Allard et al., 2022; Fischer et al., 2025, p. 1; NSW Health, 2025, p. 20; Santoro et al., 2025, p. 2). Badinlou et al. (2024, p. 1) report that initial infection severity, education and work status were significantly associated with post-COVID syndrome impairment levels in their participants in Sweden, with those with lower levels of education and those who were not employed at baseline more likely to experience a deterioration of post-COVID impairments over time (p. 4).

Importantly, Queensland Health (2024b, p. 6) report that risk of post-COVID syndrome decreases with subsequent infections, and the NICE Rapid Guidelines advise not to predict whether a person is likely to develop post-COVID syndrome based on whether they had certain symptoms (or clusters of symptoms) or were in hospital during acute COVID-19 (NICE, 2024, p. 14).

QLD Health discuss the effects of negative messaging and the media, and their implication on the recovery from post-COVID syndrome. They present the argument that negative public health messaging has induced fear of post-COVID syndrome in the population which has increased risks of functional somatic symptom disorders and of the ‘nocebo effect’ whereby “the expectation of a negative future outcome causes the very physiologic negative outcome to occur.” What is more, the hypervigilance caused by negative messaging also causes hyper-attentiveness to symptoms which further delays recovery (2024b, p. 10).

We did not find any information regarding the expected duration of post-COVID syndrome beyond what is discussed in section 3.1 above.

3.5 The Multidisciplinary Team and Post-COVID Syndrome

Multidisciplinary teams are consistently recommended in the management of post-COVID syndrome (Allard et al., 2022; NICE, 2024, pp. 21-22 WHO, 2025a, pp. 77).

As discussed above in section 3.2 patients may be referred to a variety of clinicians depending on the symptoms they are experiencing. The Australian Guidelines for the Clinical Care of People with COVID-19 state that patients with persistent symptoms or functional impairment following COVID-19 should begin rehabilitation as soon as possible in a way that is appropriate to their circumstance, setting and tolerance. Where appropriate, treatment may

involve physical and occupational therapy, speech and language therapy, vocational therapy, as well as neurological rehabilitation and dietary intervention (National Clinical Evidence Taskforce, 2023, pp. 451/456).

The NICE Rapid Guidelines state that after ruling out acute or life-threatening complications and alternative diagnoses, practitioners should consider referring people to an appropriate service, such as an integrated multidisciplinary assessment service, any time from 4 weeks after the start of acute COVID-19 (p. 17). They recommend providing integrated, multidisciplinary rehabilitation services, based on local need and resources. According to the guidelines, healthcare professionals should have a range of specialist skills, with expertise in managing fatigue and respiratory symptoms (including breathlessness). They go on to explain that additional expertise may be needed depending on the age and symptoms of the person. The core team may include, but should not be limited to, the following specialist areas:

- occupational therapy
- physiotherapy
- clinical psychology and psychiatry
- rehabilitation medicine (NICE, 2024, p. 27).

The WHO living guidelines (2025a, p. 75) state that multidisciplinary rehabilitation professionals, mental health and psychosocial providers should be included in the national (local), coordinated care pathways for individuals who have had suspected or confirmed COVID-19 (of any disease severity) who have persistent, new, or changing symptoms. A workforce for the rehabilitation of adults with post COVID-19 condition may include but is not limited to physiotherapists, occupational therapists, nurses, psychologists, speech and language therapists, physicians, social workers and community health care workers depending on local needs (WHO, 2025a, p. 81).

A 2023 randomised controlled study with 96 ICU patients found that the intervention group, who had received medical, nursing, physiotherapy and occupational therapy interventions, had significantly better muscular strength and respiratory capacity, and significantly fewer days of hospitalisation, than the control group who received care as usual (Carvalho et al., 2023).

3.6 Post-COVID Syndrome and Chronic Fatigue

Myalgic encephalomyelitis/chronic fatigue syndrome (ME-CFS) often follows an “infectious-like” illness. Post-COVID syndrome, by definition, follows in the wake of acute infection with SARS-CoV-2 (Komaroff & Lipkin, 2023, p. 3).

Some individuals with post-COVID syndrome may have symptoms similar to those reported by individuals with ME-CFS (CDC, 2025). It has been theorised that, given the similarities between ME-CFS and post-COVID syndrome in their post-viral clinical course, overlapping symptoms, and idiopathic aetiology, post-COVID syndrome may represent another post-viral

example of ME-CFS (Dehlia & Guthridge, 2024, p. 2). Research in this area is ongoing with no definitive answer available at this time.

A systematic review and meta-analysis conducted by Dehlia and Guthridge in 2024 revealed that 51% of patients with post-COVID syndrome satisfied ME-CFS diagnostic criteria, with fatigue, sleep disruption, and muscle/joint pain being the most common symptoms. Importantly, post-COVID syndrome patients also experienced post-exertional malaise (PEM) which is a hallmark symptom of ME-CFS. Similar findings are reported in other studies (Goldenberg, 2024).

Individuals with post-COVID syndrome frequently report decreased smell and taste, hair loss, rash and respiratory issues, which are not as common in ME-CFS (Komaroff & Lipkin, 2023, p. 4; Moneer, 2024). On the other hand, individuals with ME-CFS frequently report painful lymph nodes, chemical sensitivities and tinnitus. These symptoms are rarely reported in individuals with post-COVID syndrome (Komaroff & Lipkin, 2023, p. 4).

The recommendations for managing post-COVID syndrome are discussed above section 3.3. The TAPIB research paper RES 338 ME/CFS discusses treatment for ME/CFS.

Similarities in treating the two conditions include symptom management, lifestyle changes (scheduling activities and rest, ensuring good sleep hygiene and appropriate diet), pacing, CBT, personalised exercise programs.

3.7 Psychosocial Impairments of Post-COVID Syndrome

Common complications of post-COVID syndrome include anxiety, depression and post-traumatic stress disorder. These complications may be from post-COVID syndrome or from the stress of having a chronic illness (HealthDirect, 2024; Santoro et al., 2025).

For the clinical rehabilitation management of anxiety and depression in adults with post-COVID syndrome, the WHO living guidelines include a condition recommendation for using psychological support and, in the absence of post-exertional symptom exacerbation (PESE), physical exercise training. In addition, mindfulness-based approaches and peer support groups may be useful to reduce distress in some people with post-COVID syndrome when managing long-term symptoms (p. 87). In addition, antidepressants (e.g. amitriptyline, fluoxetine) may be considered for depression in consultation with the individual and considering personal preferences, age, concurrent medical conditions, mental health conditions (e.g. bipolar disorder) and side-effects (p. 87). The interventions in the recommendation have been proposed considering evidence for interventions for rehabilitation of anxiety and depression in other health conditions and therefore their effectiveness for post-COVID syndrome is not stated (p. 88).

Greenhalgh et al. (2024) recommend whole-person care, talking therapy, meditation, and medication (if indicated) for depression, anxiety and PTSD associated with post-COVID syndrome (p. 716).

A 2024 systematic review of interventions for mental health, cognition and psychological well-being in post-COVID syndrome included seven studies on psychosocial interventions including CBT, cognitive processing therapy, acceptance and commitment therapy and more (Hawke et al.). The RCTs included in this review showed differences in resilience and components of quality of life in the intervention group compared to the control group. However, this study did not control for pre-test scores. Another RCT found that fewer people in the intervention group reported psychological distress, post-traumatic stress disorder and anxiety at post-treatment compared with the control group. Other non-RCT studies showed significant effects on symptoms such as anxiety, rumination, social connection and mental well-being, and a reduction in post-traumatic stress disorder, depression and anxiety, an increase in quality of life and daily functional improvements. However, the results of these studies are unable to be generalised due to small participant numbers and lack of control groups (pp. 3-4). Overall, the review's results show that interventions are highly heterogeneous and findings are inconclusive to date (Hawke et al., 2024, p. 1).

Another systematic review (Schurr et al., 2025) found 12 studies which included psychotherapeutic interventions. Interventions included CBT, Eye Movement Desensitisation and Reprocessing, psychoeducation, cognitive training, stress management and more. While most studies showed an improvement in a range of post-COVID syndrome symptoms (depression, anxiety, quality of life, fatigue, pain, memory and others) it is not possible to draw general conclusions regarding the efficacy of these interventions due to the nature of the studies (non-randomised, non-controlled).

4. Review, September 2023

4.1 Prolonged disability

Estimates of prevalence and incidence of post-COVID syndrome, and estimates of the presence of impairment or activity limitation still vary widely. Centers for Disease Control and Prevention found approximately one quarter of adults with post-COVID syndrome report significant activity limitations (Ford et al, 2023). Reviewing 35 studies, Oliveira-Almeida et al (2023) found activity limitations in between 16% and 80% of subjects.

The World Health Organisation still endorses a prevalence estimate of 10-20% (WHO, 2022). Woodrow et al (2023) reviewed 73 studies and found prevalence estimates between 0% and 93%. An international systematic review considered 194 studies including 735,006 participants and found 45% of COVID-19 survivors experience ongoing symptoms at 4 months (O'Mahoney et al, 2022). In a review involving 120,970 patients, Di Gennaro et al (2023) found an incidence of 56.9%. In contrast, 10 longitudinal studies from the UK found continuation of symptoms after 12 weeks in 8-17% of cases (Hallek et al, 2023). Hallek et al (2023) found 15% of unvaccinated adults infected with SARS-CoV-2 met criteria for post-COVID syndrome, with lower incidence among vaccinated COVID-19 survivors. Evidence from the US also supports the rate of around 15%. Between 14% and 16% of respondents to the Household

Pulse Survey report experiencing post-COVID syndrome (National Centre for Health Statistics, 2023).

Centers for Disease Control and Prevention found approximately 16% of adults with COVID-like symptoms reported ongoing symptoms after 12 months (Montoy et al, 2023). In contrast, Woodrow et al (2023) found prevalence estimate of 48.5% after 12 months. Woodrow et al conclude that the way in which post-COVID syndrome is defined and measured affects prevalence estimates. Estimates are lower in studies using routine health records (13.6%) compared with self-report studies (43.9%). The highest estimates were found in studies systematically investigating pathology (51.7%).

4.2 Treatment and management

No pharmacological or non-pharmacological treatment or management strategy has emerged as the favoured method among researchers or clinicians (Chandon et al, 2023; Chee et al, 2023; Fawzy et al, 2023; Marshall-Andon et al, 2023; Hallek et al, 2023).

In their review of 37 practice guidelines, Marshall-Andon et al (2023) found some consensus around education, shared decision making and personalised care for patients with post-COVID syndrome, including tailoring the modality and setting of treatment or management to the patient's situation.

A recent review of 12 studies found physical therapy (especially, moderate exercise and interventions related to respiratory muscles) was associated with a significant improvement in fatigue, dyspnea and quality of life in patients with post-COVID syndrome (Sánchez-García et al, 2023).

5. What is post-COVID syndrome-19?

There is no internationally agreed definition of post-COVID syndrome-19, however signs and symptoms beyond 4 weeks is considered ongoing COVID-19 (Molhave et al, 2022). The World Health Organisation (WHO) recognised the existence of continuing symptoms and effects of COVID-19 after the initial infection period in September 2020, stating post-COVID syndrome-19 is:

> an illness that occurs in people who have a probable or confirmed SARS-CoV-2 infection; usually within 3 months of onset of the infection, with symptoms and effects that last for at least 3 months. These symptoms and effects cannot be explained by an alternative diagnosis (WHO, 2021a).

In the United States, Centers for Disease Control and Prevention (CDC) advise that post-COVID-19 conditions can be identified at least 4 weeks after the initial COVID-19 diagnosis (CDC, 2022). In the United Kingdom, the National Institute for Health Care and Excellence (NICE) proposes that 'acute COVID-19' is the period up to 4 weeks post infection diagnosis, 'COVID in progress' is the experience of signs and symptoms between 4-12 weeks post infection diagnosis, and post-COVID syndrome are signs and symptoms that continue for more

than 12 weeks after the initial infection and are not attributable to another diagnosis (NICE, 2022). A formal definition of post-COVID syndrome-19 by the Australian Health Department could not be found.

The CDC suggests post-COVID syndrome-19 is more common for people who had severe symptoms of COVID-19 during their initial infection (CDC, 2022), however the WHO advise there is no clear evidence of a relationship between initial severity of COVID-19 infection and the likelihood of developing post-COVID syndrome-19 (WHO, 2021b). What is known, is people can suffer post-COVID syndrome-19 regardless of whether they had mild or severe symptoms with the initial COVID-19 infection (Berger et al, 2021).

While research is continuing to try to identify those most at risk of post-COVID syndrome-19, some risk factors may include (Berger et al, 2021; CDC, 2022):

- people who were in intensive care units during their initial COVID-19 infection
- people who have underlying health conditions prior to the infection including diabetes, heart failure, asthma, hypertension and epilepsy
- demographics with health inequities such as ethnic minority groups and people with disability
- people unvaccinated against COVID-19
- adults appear more vulnerable to post-COVID syndrome-19 than children.

6. What is the prevalence of post-COVID syndrome-19?

Despite the body of research emerging around post-COVID syndrome-19, the prevalence is difficult to determine due to differences in study methodology, different outcome definitions and time frames, and different symptoms and levels of severity surveyed (Emecen et al, 2022). Additionally, prevalence is influenced by social determinants, such as poverty, racism and disability (Berger et al, 2021), therefore there is considerable inconsistency in the literature depending on participant demographics.

In one United Kingdom study, 18.2% of participants reported at least one symptom 6 months post initial COVID-19 infection (Emecen et al, 2022). This is in line with the WHO (2021b) estimate that around 10-20% of COVID-19 survivors experience mid- and long-term effects after the acute phase of illness has passed. However, a systematic review cited by Maglietta et al (2022), involving 57 studies and over 250,000 survivors of COVID-19, demonstrated more than half of these survivors experienced post-acute symptoms at 6 months post initial infection. I was unable to source clear data for the persistence of symptoms beyond this time point.

Further complicating prevalence data is the influence of different variants on recovery from COVID-19. Research from the United Kingdom comparing the Delta and Omicron variants

suggests an increased risk of ongoing symptoms at 4 weeks post infection with Delta infection (10.8% participants) than an Omicron infection (4.5% participants) (Antonelli et al, 2022).

7. What are the most common symptoms of post-COVID syndrome-19?

It has been noted that symptoms of post-COVID syndrome-19 are similar to other post-viral fatigue syndromes such as myalgic encephalitis/chronic fatigue syndrome (Boaventrua et al, 2022; CDC, 2022), although the multisystem complications from post-COVID syndrome-19 maybe broader and more intense than other post-viral syndromes (Boaventrua et al, 2022).

The most common symptoms of post-COVID syndrome-19 reported in the literature include (Berger et al, 2021; CDC, 2022; Maglietta et al, 2022; Scordo et al, 2021; WHO, 2021b):

- Physical and mental fatigue that interferes with daily life
- Shortness of breath
- Memory and concentration problems (‘brain fog’)
- Headache
- Mental health impairment (e.g., anxiety, depression, mood swings)
- Abdominal pains
- Muscle weakness and joint pain
- Palpitations and chest pain
- Dizziness
- Gastrointestinal issues (e.g., diarrhea, stomach pain)
- Sleep problems
- Change in smell and/or taste
- Pins and needles feeling
- Skin lesions similar to chilblains

Post-COVID syndrome-19 may affect people differently as different organ systems become involved, and an individual’s symptoms may fluctuate or relapse over time (Berger et al, 2021; WHO, 2021b).

Figure 1 below, an excerpt from research by Yong and Liu (2021), highlights the different organ systems that may be affected by post-COVID syndrome-19:

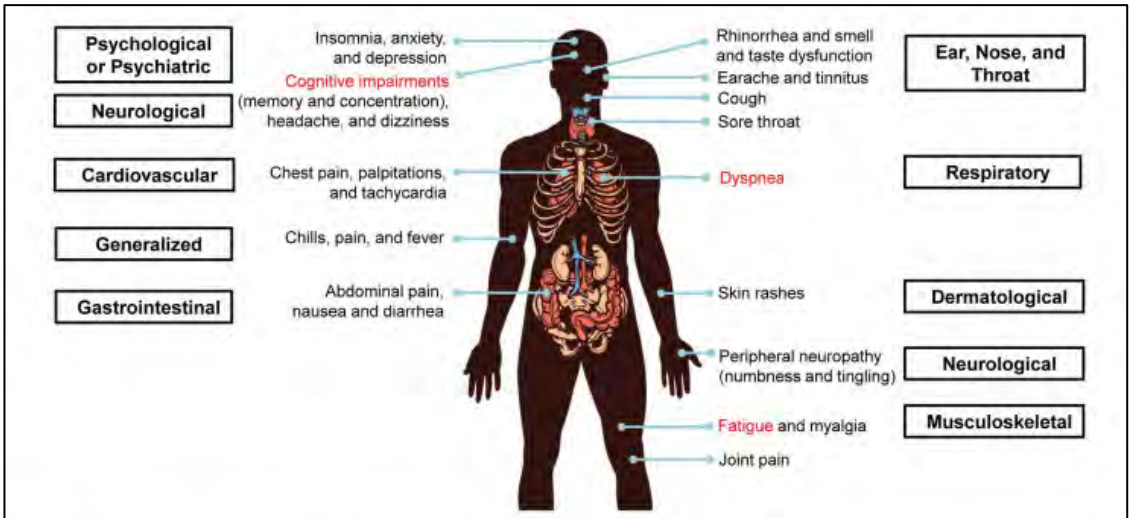

FIGURE 1 Symptoms of the post-COVID-19 syndrome (PCS). Multiple organ systems are affected, such as psychological or psychiatric (insomnia, anxiety and depression), neurological (cognitive impairments involving memory and concentration, headache, dizziness and peripheral neuropathy), ear, nose, and throat (rhinorrhoea, smell and taste alterations, earache, tinnitus, cough, and sore throat), respiratory (dyspnoea and cough), cardiovascular (chest pain, palpitations and tachycardia), gastrointestinal (abdominal pain, nausea and diarrhoea), generalised (chills, pain and fever) and musculoskeletal (fatigue, myalgia and joint pain). Dyspnoea, fatigue, and cognitive impairments are among the topmost common PCS symptoms (references in Table 1), as reviewed in Shah et al.,[3] Nasserie et al.,[10] Michelen et al.[11] and Lopez-Leon et al[19]. (The human body vector was licenced from Freepik.com.)

8. What is the current management for post-COVID syndrome-19?

There is no documented specific medication to treat post-COVID syndrome-19 (Molhave et al, 2022) and much of the current literature describes medical management of post-COVID syndrome-19. Effective management of post-COVID syndrome-19 involves symptom relief and rehabilitation (Molhave et al, 2022; WHO, 2021b), and involvement of a multidisciplinary team for patients with multiple organ systems impacted may be required (Berger et al, 2021; Kokhan et al, 2022; Molhave et al, 2022; Scordo et al, 2021; Sundar Srethstha & Love, 2021).

Particular rehabilitation programs mentioned in the literature include physical rehabilitation to improve respiratory and cardiovascular function, which is best performed within 2 months of initial diagnosis of COVID-19 (Kokhan et al, 2022; Molhave et al, 2022). Also, cognitive therapy has been shown to be effective for patients with mental fatigue (Molhave et al, 2022).

As the existence of post-COVID syndrome-19 is in its infancy, there is speculation, for example by Dr Anthony Fauci of the National Institute of Allergy and Infectious Diseases, that post-COVID syndrome-19 may have a similar aetiology to other post-infectious conditions such as myalgic encephalomyelitis/chronic fatigue syndrome (Scordo et al, 2021; Sundar Shrestha & Love, 2021). Therefore, exploring the aetiology and management of myalgic encephalomyelitis/chronic fatigue syndrome may give some insight into post-COVID syndrome-19 syndrome (Scordo et al, 2021). Current literature indicates cognitive behaviour therapy and graded exercise therapy are important in the management of myalgic encephalitis/chronic fatigue syndrome (Sharpe et al, 2021; Snook & Slowman, 2019).

Cognitive behaviour therapy focusses on challenging fatigue related cognitions and planning social and occupational rehabilitation, while graded exercise therapy involves determining baseline ability and slowly increasing intensity and duration without exacerbating symptoms (Sharpe et al, 2021; Snook & Slowman, 2019).

Another significant medical condition that may be relevant to the understanding and management of post-COVID syndrome-19 is post-intensive care syndrome (PICS) - the presence of health problems common to patients who have recovered from critical illness in intensive care units (Parker et al, 2021). Similar to post-COVID syndrome-19, cognitive impairment ('brain fog'), extreme fatigue, muscle weakness, and shortness of breath are among the most common symptoms of PICS (Parker et al, 2021). Parker et al (2021) suggests applying the PICS post-acute phase framework to post-COVID syndrome-19 patients could involve:

- Occupational therapy – provide energy conservation and work simplification strategies; address impact of cognitive impairments on work performance; monitor for residual impairment in gross and fine motor function, sensory integration or pain related to positioning (such as prolonged proning in ICU); strengthening and fine motor training using writing aids or assistive technology.
- Physical therapy – ICU acquired weakness can persist for years after the acute illness has resolved, therefore physical therapy can be beneficial to improve strength and physical function.
- Speech therapy – intubation injuries can extend from the voice and airway to dysphagia; dysphagia can persist for months, but most patients will recover with support.
- Social workers – many patients report persistent symptoms that impact their ability to return to work. Social workers can connect patients with job resources, conduct screening for mental health impairments, and provide psychoeducation and referrals.
- Primary health care – primary health practitioners should provide aftercare and care coordination for post-COVID syndrome-19 patients.

9. Permanence of post-COVID syndrome-19

For most people, the natural history of post-COVID syndrome-19 appears to be a gradual improvement of symptoms over many months (Berger et al, 2021; CDC, 2022; WHO, 2021b). However, the long-term prognosis for some people is unknown, as it is not known whether damaged organ systems will fully recover or if there will be lasting effects (Berger et al, 2021; Scordo et al, 2021). Unfortunately, it appears some people with post-COVID syndrome-19 will continue to have long-term organ compromise, long-term complex immune and homeostatic dysfunction with disabling symptoms and impaired functional levels (Sundar Srethstha & Love, 2021).

In July 2021, post-COVID syndrome-19 became a recognised disability under the Americans with Disabilities Act, Section 504 and Section 1557 (CDC, 2022; United States Department of Health and Human Services, 2021). In the United States, as post-COVID syndrome-19 causes physical and/or mental impairment, it can be considered a disability if it substantially limits one or more major life activities such as caring for oneself, performing manual tasks, eating, walking or concentrating. Table 1 summarises further information from the United States Department of Health and Human Services (2021) regarding post-COVID syndrome-19 as a disability.

However, whether post-COVID syndrome-19 can be considered a permanent disability requires an individualised assessment to determine if the post-COVID syndrome-19 symptoms and effects substantially impact the individual's functional capacity (United States Department of Health and Human Services, 2021).

Table 1

*Information regarding post-COVID syndrome-19 as a disability (*United States Department of Health and Human Services, 2021)

ADA, Section 504, and Section 1557 if it substantially limits one or more major life activities. These laws and their related rules define a person with a disability as an individual with a physical or mental impairment that substantially limits one or more of the major life activities of such individual ("actual disability"); a person with a record of such an impairment ("record of"); or a person who is regarded as having such an impairment ("regarded as"). A person with post-COVID syndrome has a disability if the person's condition or any of its symptoms is a "physical or mental" impairment that "substantially limits" one or more major life activities.

a. Post-COVID syndrome is a physical or mental impairment.

A physical impairment includes any physiological disorder or condition affecting one or more body systems, including, among others, the neurological, respiratory, cardiovascular, and circulatory systems. A mental impairment includes any mental or psychological disorder, such as an emotional or mental illness.

Post-COVID syndrome is a physiological condition affecting one or more body systems. For example, some people with post-COVID syndrome experience:

- Lung damage
- Heart damage, including inflammation of the heart muscle
- Kidney damage
- Neurological damage
- Damage to the circulatory system resulting in poor blood flow
- Lingering emotional illness and other mental health conditions

Accordingly, post-COVID syndrome is a physical or mental impairment under the ADA, Section 504, and Section 1557.

b. Post-COVID syndrome can substantially limit one or more major life activities

"Major life activities" include a wide range of activities, such as caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, writing, communicating, interacting with others, and working. The term also includes the operation of a major bodily function, such as the functions of the immune system, cardiovascular system, neurological system, circulatory system, or the operation of an organ.

The term "substantially limits" is construed broadly under these laws and should not demand extensive analysis. The impairment does not need to prevent or significantly restrict an individual from performing a major life activity, and the limitations do not need to be severe, permanent, or long-term. Whether an individual with post-COVID syndrome is substantially limited in a major bodily function or other major life activity is determined without the benefit of any medication, treatment, or other measures used by the individual to lessen or compensate for symptoms. Even if the impairment comes and goes, it is considered a disability if it would substantially limit a major life activity when the impairment is active.

Post-COVID syndrome can substantially limit a major life activity. The situations in which an individual with post-COVID syndrome might be substantially limited in a major life activity are diverse. Among possible examples, some include:

- A person with post-COVID syndrome who has lung damage that causes shortness of breath, fatigue, and related effects is substantially limited in respiratory function, among other major life activities
- A person with post-COVID syndrome who has symptoms of intestinal pain, vomiting, and nausea that have lingered for months is substantially limited in gastrointestinal function, among other major life activities
- A person with post-COVID syndrome who experiences memory lapses and "brain fog" is substantially limited in brain function, concentrating, and/or thinking.

10. References

Allard, N., Miller, A., Morgan, M., & Chakraborty, S. (2022). Post-COVID-19 syndrome/condition or long COVID: Persistent illness after acute SARS-CoV-2 infection. Australian Journal of General Practice, 51(12), 952–957. https://doi.org/10.31128/AJGP-05-22-6429

Antonelli, M., Pujol, J. C., Spector, T. D., Ourselin, S., & Steves, C. J. (2022). Risk of post-COVID syndrome associated with delta versus omicron variants of SARS-CoV-2. *Lancet (London, England)*, *399*(10343), 2263–2264. https://doi.org/10.1016/S0140-6736(22)00941-2

Badinlou, F., Abzhandadze, T., Rahimian, F., Jansson-Fröjmark, M., Hedman-Lagerlöf, M., & Lundgren, T. (2024). Investigating the trajectory of post-COVID impairments: a longitudinal study in Sweden. *Frontiers in Psychology*, *15*, 1402750. https://doi.org/10.3389/fpsyg.2024.1402750

Becker, J. H., Li, J., Lin, J. J., Federman, A., Bagiella, E., Kale, M. S., Fierer, D., Bartram, L., & Wisnivesky, J. P. (2025). Neurocognitive trajectories in long COVID: Evidence from longitudinal analyses. *Brain, Behavior, & Immunity. Health*, *48*, Article 101093. https://doi.org/10.1016/j.bbih.2025.101093

Berger, Z., Altiery de Jesus, V., Assoumou, S. A. & Greenhalgh, T. (2021). Post-COVID syndrome and health inequities: The role of primary care. *The Milbank Quarterly, 99*(2), 519-541. https://doi.org/10.1111%2F1468-0009.12505

Boaventura, P., Macedo, S., Ribeiro, F., Jaconiano, S., & Soares, P. (2022). Post-COVID-19 condition: where are we now? *Life, 12*(4), 517. https://doi.org/10.3390/life12040517

Carvalho, A. C., Moreira, J., Cubelo, P., Cantista, P., Aguiar Branco, C., & Guimarães, B. (2023). Multidisciplinary rehabilitation in intensive care for COVID-19: randomised controlled trial. *ERJ open research*, *9*(1), 00350-2022. https://doi.org/10.1183/23120541.00350-2022

Centre for Disease Control and Prevention. (2025, July 24). *Long COVID Basics.* https://www.cdc.gov/long-covid/about/index.html

Centre for Disease Control and Prevention. (2022). *Post-COVID syndrome or Post-COVID Conditions*. Accessed from https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/index.html

Chandan, J. S., Brown, K. R., Simms-Williams, N., Bashir, N. Z., Camaradou, J., Heining, D., Turner, G. M., Rivera, S. C., Hotham, R., Minhas, S., Nirantharakumar, K., Sivan, M., Khunti, K., Raindi, D., Marwaha, S., Hughes, S. E., McMullan, C., Marshall, T., Calvert, M. J., Haroon, S., … TLC Study (2023). Non-Pharmacological Therapies for Post-Viral Syndromes, Including Post-COVID syndrome: A Systematic Review. *International*

journal of environmental research and public health, *20*(4), 3477. https://doi.org/10.3390/ijerph20043477

Chee, Y. J., Fan, B. E., Young, B. E., Dalan, R., & Lye, D. C. (2023). Clinical trials on the pharmacological treatment of post-COVID syndrome: A systematic review. *Journal of medical virology*, *95*(1), e28289. https://doi.org/10.1002/jmv.28289

Dehlia, A., & Guthridge, M. A. (2024). The persistence of myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) after SARS-CoV-2 infection: A systematic review and meta-analysis. *The Journal of Infection*, *89*(6), Article 106297. https://doi.org/10.1016/j.jinf.2024.106297

de Oliveira Almeida, K., Nogueira Alves, I. G., de Queiroz, R. S., de Castro, M. R., Gomes, V. A., Santos Fontoura, F. C., Brites, C., & Neto, M. G. (2023). A systematic review on physical function, activities of daily living and health-related quality of life in COVID-19 survivors. *Chronic illness*, *19*(2), 279–303. https://doi.org/10.1177/17423953221089309

Ellingjord-Dale, M., Nygaard, A. B., Støer, N. C., Bø, R., Landrø, N. I., Brunvoll, S. H., Istre, M., Kalleberg, K. T., Dahl, J. A., Geng, L., Tsilidis, K., Riboli, E., Ursin, G., & Søraas, A. (2024). Temporal trajectories of long-COVID symptoms in adults with 22 months follow-up in a prospective cohort study in Norway. *International Journal of Infectious Diseases*, *149*, Article 107263. https://doi.org/10.1016/j.ijid.2024.107263

Emecen, A. N., Keskin, S., Turunc, O., Suner, A. F., Siyve, N., Basoglu Sensoy, E., Dinc, F., Kilinc, O., Avkan Oguz, V., Bayrak, S., & Unal, B. (2022). The presence of symptoms within 6 months after COVID-19: a single-center longitudinal study. *Irish Journal of Medical Science,* 1–10. https://doi.org/10.1007/s11845-022-03072-0

Fawzy, N. A., Abou Shaar, B., Taha, R. M., Arabi, T. Z., Sabbah, B. N., Alkodaymi, M. S., Omrani, O. A., Makhzoum, T., Almahfoudh, N. E., Al-Hammad, Q. A., Hejazi, W., Obeidat, Y., Osman, N., Al-Kattan, K. M., Berbari, E. F., & Tleyjeh, I. M. (2023). A systematic review of trials currently investigating therapeutic modalities for post-acute COVID-19 syndrome and registered on WHO International Clinical Trials Platform. *Clinical microbiology and infection*, *29*(5), 570–577. https://doi.org/10.1016/j.cmi.2023.01.007

Fischer, A., Zhang, L., Elbéji, A. *et al.* Trajectories of persisting Covid- 19 symptoms up to 24 months after acute infection: findings from the Predi-Covid cohort study. *BMC Infect Dis* 25, 603 (2025). https://doi.org/10.1186/s12879-025-11023-0

Ford N.D., Slaughter D., Edwards D., Dalton, A., {errine, C., Vahratian, A., & Saydah, S. (2023). Post-COVID syndrome and Significant Activity Limitation Among Adults, by Age — United States, June 1–13, 2022, to June 7–19, 2023. *Morbidity and Mortality Weekly Report*, *72*(32), 866–870. http://dx.doi.org/10.15585/mmwr.mm7232a3

Goldenberg, D. L. (2024). How to understand the overlap of long COVID, chronic fatigue syndrome/myalgic encephalomyelitis, fibromyalgia and irritable bowel syndromes.

Seminars in Arthritis and Rheumatism, *67*, Article 152455. https://doi.org/10.1016/j.semarthrit.2024.152455

Greenhalgh, T., Sivan, M., Perlowski, A., & Nikolich, J. Ž. (2024). Long COVID: a clinical update. *The Lancet (British Edition)*, *404*(10453), 707–724. https://doi.org/10.1016/S0140-6736(24)01136-X

Hallek, M., Adorjan, K., Behrends, U., Ertl, G., Suttorp, N., & Lehmann, C. (2023). Post-COVID Syndrome. *Deutsches Arzteblatt international*, *120*(4), 48–55. https://doi.org/10.3238/arztebl.m2022.0409

Hawke, L. D., Nguyen, A. T. P., Wang, W., Brown, E. E., Xu, D., Deuville, S., Goulding, S., Ski, C. F., Rossell, S. L., Thompson, D. R., Rodak, T., Strudwick, G., & Castle, D. (2024). Systematic review of interventions for mental health, cognition and psychological well-being in long COVID. *BMJ Mental Health*, *27*(1), e301133. https://doi.org/10.1136/bmjment-2024-301133

HealthDirect. (2024, November). *Long COVID*. Department of Health and Aged Care. https://www.healthdirect.gov.au/long-covid#treated

Kokhan, S., Vlasava, S., Kolokoltsev, M., Bayankin, O., Kispayev, T., Tromfimova, N., Suslina, I., & Romanova, E. (2022). Postcovid physical rehabilitation at the sanatorium. *Journal of Physical Education and Sport, 22*(3), Art 76, 607-613. DOI:10.7752/jpes.2022.03076

Komaroff, A. L., & Lipkin, W. I. (2023). ME/CFS and Long COVID share similar symptoms and biological abnormalities: road map to the literature. *Frontiers in Medicine*, *10*, 1187163. https://doi.org/10.3389/fmed.2023.1187163

Maglietta, G., Diodati, F., Puntoni, M., Lazzarelli, S., Marcomini, B., Patrizi, L., & Caminiti, C. (2022). Prognostic Factors for Post-COVID syndrome: A Systematic Review and Meta-Analysis. *Journal of clinical medicine*, *11*(6), 1541. https://doi.org/10.3390/jcm11061541

Marshall-Andon, T., Walsh, S., Berger-Gillam, T., & Pari, A. A. A. (2023). Systematic review of post-COVID syndrome rehabilitation guidelines. Integrated healthcare journal, 4(1), e000100. https://doi.org/10.1136/ihj-2021-000100

Mølhave, M., Agergaard, J., & Wejse, C. (2022). Clinical Management of COVID-19 Patients - An Update. *Seminars in nuclear medicine*, *52*(1), 4–10. https://doi.org/10.1053/j.semnuclmed.2021.06.004

Montoy, J. C. C. (2023). Prevalence of Symptoms≤ 12 Months After Acute Illness, by COVID-19 Testing Status Among Adults—United States, December 2020–March 2023. *Morbidity and Mortality Weekly Report*, *72*(32), 859-865. https://www.cdc.gov/mmwr/volumes/72/wr/mm7232a2.htm

National Centre for Health Statistics. (2023). Post-COVID syndrome – Household Pulse Survey 2022-2023. US Census Bureau. https://www.cdc.gov/nchs/covid19/pulse/long-covid.htm

National Clinical Evidence Taskforce. (2023). *Australian guidelines for the clinical care of people with COVID-19*. https://app.magicapp.org/#/guideline/L4Q5An/section/jDJJJQ

National Institute for Health and Care Excellence. (2024, January 25). *COVID-19 rapid guideline: managing the long-term effects of COVID-19*. https://www.nice.org.uk/guidance/ng188/resources/covid19-rapid-guideline-managing-the-longterm-effects-of-covid19-pdf-66142028400325

National Institute for Health and Care Excellence. (2022). *COVID-19 rapid guideline: managing the long-term effects of COVID-19.* Accessed from https://www.nice.org.uk/guidance/ng188/resources/covid19-rapid-guideline-managing-the-longterm-effects-of-covid19-pdf-51035515742

NSW Health. (2025, September). *Long COVID.* NSW Government. https://www.health.nsw.gov.au/Infectious/factsheets/Factsheets/long-covid-english.pdf

O'Mahoney, L. L., Routen, A., Gillies, C., Ekezie, W., Welford, A., Zhang, A., Karamchandani, U., Simms-Williams, N., Cassambai, S., Ardavani, A., Wilkinson, T. J., Hawthorne, G., Curtis, F., Kingsnorth, A. P., Almaqhawi, A., Ward, T., Ayoubkhani, D., Banerjee, A., Calvert, M., Shafran, R., … Khunti, K. (2022). The prevalence and long-term health effects of Post-COVID syndrome among hospitalised and non-hospitalised populations: A systematic review and meta-analysis. *EClinicalMedicine*, 55, 101762. https://doi.org/10.1016/j.eclinm.2022.101762

Parker, A. M., Brigham, E., Connolly, B., McPeake, J., Agranovich, A. V., Kenes, M. T., Casey, K., Reynolds, C., Schmidt, K., Kim, S. Y., Kaplin, A., Sevin, C. M., Brodsky, M. B., & Turnbull, A. E. (2021). Addressing the post-acute sequelae of SARS-CoV-2 infection: a multidisciplinary model of care. *The Lancet. Respiratory medicine*, *9*(11), 1328–1341. https://doi.org/10.1016/S2213-2600(21)00385-4

Queensland Health. (2024a, April 4). *COVID-19 recovery and Long COVID-19*. Queensland Government. https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/novel-coronavirus-qld-clinicians/covid-19-recovery-and-long-covid-19

Queensland Health. (2024b, July 17). *“Long COVID” Living Evidence Summary*. Queensland Government. https://www.qld.gov.au/__data/assets/pdf_file/0023/380741/long-covid-living-evidence-summary.pdf

Sánchez-García, J. C., Rentero Moreno, M., Piqueras-Sola, B., Cortés-Martín, J., Liñán-González, A., Mellado-García, E., & Rodriguez-Blanque, R. (2023). Physical Therapies in the Treatment of Post-COVID Syndrome: A Systematic Review. *Biomedicines*, *11*(8), 2253. https://doi.org/10.3390/biomedicines11082253

Santoro, A., Bai, F., Greco, M. F., Rovito, R., Sala, M., Borghi, L., Piscopo, K., Vegni, E., de Morais Caporali, J. F., Marinho, C. C., Leite, A. S., Santoro, M. M., Silberstein, F. C., Iannetta, M., Juozapaite, D., Strumiliene, E., Almeida, A., Toscano, C., Quinones, J. A. R., … Marchetti, G. (2025). Short and long-term trajectories of the post COVID-19

condition: Results from the EuCARE POSTCOVID study. *BMC Infectious Diseases*, *25*(1), Article 625. https://doi.org/10.1186/s12879-025-10805-w

Schurr, M., Graf, J., Junne, F., & Giel, K. E. (2025). Psychotherapy in patients with long/post-COVID – A systematic review on the feasibility, acceptability, safety, and efficacy of available and emerging interventions. *Journal of Psychosomatic Research*, *190*, Article 112048. https://doi.org/10.1016/j.jpsychores.2025.112048

Scordo, K. A., Richmond, M. M., & Munro, N. (2021). Post-COVID syndrome: Theoretical Basis, Identification, and Management. *AACN advanced critical care*, *32*(2), 188–194. https://doi.org/10.4037/aacnacc2021492

Sharpe, M., Chalder, T., & White, P. D. (2022). Evidence-Based Care for People with Chronic Fatigue Syndrome and Myalgic Encephalomyelitis. *Journal of general internal medicine*, *37*(2), 449–452. https://doi.org/10.1007/s11606-021-07188-4

Snook, A., & Slowman, L. (2019). Chronic Fatigue Syndrome: Occupational Therapy. *CINAHL Rehabilitation Guide.*

Sundar Shrestha, D., & Love, R. (2021). Post-COVID syndrome Patient Symptoms and its Evaluation and Management. *JNMA; journal of the Nepal Medical Association*, *59*(240), 823–831. https://doi.org/10.31729/jnma.6355

United States Department of Health and Human Services. (2021). *Guidance on "Post-COVID syndrome" as a disability under the ADA., Section 504, and Section 1557*. United States of America Government. Accessed from https://www.hhs.gov/civil-rights/for-providers/civil-rights-covid19/guidance-long-covid-disability/index.html#footnote10_0ac8mdc

Woodrow, M., Carey, C., Ziauddeen, N., Thomas, R., Akrami, A., Lutje, V., Greenwood, D. C., & Alwan, N. A. (2023). Systematic Review of the Prevalence of Post-COVID syndrome. *Open forum infectious diseases*, *10*(7), ofad233. https://doi.org/10.1093/ofid/ofad233

World Health Organisation. (2025a, June). *Clinical management of COVID-19*. https://iris.who.int/server/api/core/bitstreams/d1021eff-f570-4c22-b630-a44bf4267a6c/content

World Health Organisation. (2025b, February 26). *Post COVID-19 condition (long COVID).* https://www.who.int/news-room/fact-sheets/detail/post-covid-19-condition-(long-covid)

World Health Organisation. (2022, December). Post COVID-19 condition (Post-COVID syndrome) [Fact sheet]. https://www.who.int/europe/news-room/fact-sheets/item/post-covid-19-condition

World Health Organisation. (2021a). *A clinical case definition of post COVID-19 condition by a Delphi consensus, 6 October 2021*. Accessed from https://www.who.int/publications/i/item/WHO-2019-nCoV-Post_COVID-19_condition-Clinical_case_definition-2021.1

World Health Organisation. (2021b). *Coronavirus disease (COVID-19): Post COVID-19 condition*. Accessed from https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-(covid-19)-post-covid-19-condition

Yeung, S. P., Guo, P., Adlard, F. L., Zhang, S. R., Bhagat, V., Cho, J., Curtis, L., Kaser, M., Haggard, M. P., & Cheke, L. G. (2025). COVCOG 3—Trajectory of Long COVID: Longitudinal Changes in Symptoms and Cognitive Impairment. A Third Publication From the COVID and Cognition Study. *Applied Cognitive Psychology*, *39*(2). https://doi.org/10.1002/acp.70040

Yong, S. J., & Liu, S. (2022). Proposed subtypes of post-COVID syndrome (or long-COVID) and their respective potential therapies. *Reviews in Medical Virology, 32*(4), e2315. https://doi.org/10.1002/rmv.2315

Zeraatkar, D., Ling, M., Kirsh, S., Jassal, T., Shahab, M., Movahed, H., Talukdar, J. R., Walch, A., Chakraborty, S., Turner, T., Turkstra, L., McIntyre, R. S., Izcovich, A., Mbuagbaw, L., Agoritsas, T., Flottorp, S. A., Garner, P., Pitre, T., Couban, R. J., & Busse, J. W. (2024). Interventions for the management of long covid (post-covid condition): living systematic review. *BMJ (Online)*, *387*, e081318. https://doi.org/10.1136/bmj-2024-081318

Contracture management for spinal muscular atrophy

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2. Summary

Contractures are common for people with Spinal Muscular Atrophy (SMA). There is minimal research evidence related to the management of contractures for people with SMA. Recent developments in gene therapy are changing the typical disease progression of SMA for those treated, which means different symptoms management options are being now being considered or re-evaluated.

Contracture management strategies that are supported by consensus-based recommendations include:

- passive or active stretching supported by a physiotherapist or occupational therapist
- assistive technology such as orthoses, braces and standing frames
- serial casting.

3. Spinal Muscular Atrophy

SMA is a progressive neuromuscular condition that impacts motor function and can lead to hypotonia, muscle weakness, and difficulties with breathing, speaking and eating (Shin, 2024; Aponte Ribero et al, 2023; SMA, n.d.). SMA is caused by a genetic mutation in chromosome 5 that interferes with the production of a protein necessary for the functioning of motor neurons (MDA, n.d.a). It occurs in 1 in 10,000 births in Australia (Aponte Ribero et al, 2023; SMA, n.d.). Diagnosis is based on medical and family history, physical and neurological examinations, a blood test and genetic testing (NINDS, 2024; MDA, n.d.d).

SMA is categorised into five types based on age of onset and childhood motor skills:

- Type 0 – also called prenatal onset or arthrogryposis multiplex congenital SMA; symptoms are evident at birth; usually results in death of the infant
- Type 1 – also called infantile SMA or Werdnig-Hoffman disease; symptoms usually develop at 3 – 9 months; child generally unable to sit or walk unsupported and may experience skeletal weakness, hypotonia and respiratory impairments; life expectancy varies based on treatment
- Type 2 – also called intermediate SMA or chronic childhood SMA; symptoms usually appear around 7 – 19 months of age; child may be able to sit but unlikely to pull themselves up to stand or walk; life expectancy varies based on treatment
- Type 3 – also called juvenile SMA or Kugelberg-Welander disease; symptoms usually appear by 2 – 7 years of age; child may learn to walk but ambulation may decrease if untreated; life expectancy is unaffected

- Type 4 – also called adult onset SMA; symptoms are less severe than other types and can appear from puberty to late adulthood; life expectancy is unaffected (Aponte Ribero et al, 2023; SMA, n.d.; MDA, n.d.b).

With the widespread use of new disease modifying treatments, the typical symptom progression associated with these types is changing (Shin, 2024). As stated in Schorling et al (2020):

> Since the introduction of new drug treatments for SMA, we have observed disease trajectories that differ significantly from the known natural history of the disease. These new phenotypes now also cross the traditional subtypes of SMA. For example, patients with onset before six months of age (typical for SMA type 1) might achieve independent sitting (SMA type 2 by definition) if treatment is initiated early. It is now more appropriate to rely on a combination of age of onset, number of *SMN2* copies, and age at start of drug treatment rather than the traditional subtypes to define a clinical phenotype of SMA (Schorling et al, 2020, p.7).

Three medications are now available in Australia which can limit the progression of symptoms:

- Spinraza for types 1, 2 and 3 under the age of 19
- Risdiplam for adults
- Zolgensma for children under 2 (SMA, n.d.; MDA, n.d.c).

If left untreated, it is very likely that symptoms of SMA will progress across all types. There is some disagreement about whether these medications may affect a cure for SMA (Shin, 2024; Schorling et al, 2020). In some cases, treated patients may be asymptomatic, though for most cases people will still experience symptoms, but with reduced severity, slower progression and longer lifespan (Shin, 2024; Aponte Ribero et al, 2023; Schorling et al, 2020; SMA, n.d.; MDA, n.d.c).

4. Allied health symptom management

People with SMA may benefit from ongoing symptom management with speech therapy, physiotherapy or occupational therapy, mobility aids, and attention to diet (NINDS, 2024d). According to the *National Guideline for Newborn Screening in Spinal Muscular Atrophy in Australia and Aotearoa New Zealand* “all children diagnosed with SMA should be referred for multidisciplinary allied therapy interventions aligning with international standards of care” (National Committee, 2024, p.183).

4.1 SMA Guidelines

The international standards of care referred to in the *National Guideline for Newborn Screening in Spinal Muscular Atrophy* are the 2018 *Diagnosis and management of spinal*

muscular atrophy, Parts 1 and 2 (SMA guidelines) (National Committee, 2024; Finkel et al, 2018; Mercuri et al, 2018).

The SMA Guidelines recommend care from a multidisciplinary team incorporating expertise in neuromuscular and musculoskeletal rehabilitation, nutrition, gastrointestinal support, pulmonary treatment, medication and psychology. The care team should be coordinated by a qualified professional, usually a neurologist (Mercuri et al, 2018, p.106).

The SMA Guidelines recommend management strategies for different levels of functional capacity, classified as non-sitters, sitters and walkers.

Non-sitters

Primary goals: optimise function; minimise impairment; optimise tolerance to various positions.

- Stretching using orthoses and splints, active-assistive and passive manual techniques, supported supine/standing frames and serial casting.
- Seating systems and postural supports for sitting and lying.
- Recline/tilt options to be included in strollers and wheelchairs.
- Assistive technology to provide an opportunity for mobility, exercise and play.
- Chest physiotherapy to promote airway clearance and management.
- Conduct feeding and swallowing assessment.
- Dietician should advise about nutritional requirements with focus on bone health and hydration.

Sitters

Primary goals: prevent contractures and scoliosis; maintain, restore or promote function and mobility.

- Stretching using orthoses and splints, active-assistive and passive manual techniques, supported supine/standing frames and serial casting.
- Stretching should be supervised or performed by a physiotherapist or occupational therapist. Family and carers may be instructed in stretching techniques.
- Static, dynamic and functional orthoses for positioning, supported standing and walking.
- Power wheelchairs with custom postural support and light-weight manual or power assist chairs for people with higher levels of upper limb strength and mobility.

- Regular exercise including aquatic therapy, aerobic exercise and general conditioning exercise with and without resistance.
- Chest physiotherapy to promote airway clearance and management.
- Conduct feeding and swallowing assessment.
- Dietician should advise about nutritional requirements with focus on bone health and hydration.

Walkers

Primary goals: maintain, restore or promote function, mobility, and adequate joint range; improve balance and endurance.

- Regular exercise including aquatic therapy, aerobic exercise and general conditioning exercise with and without resistance, dynamic and static balance exercises.
- Focus on active-assistive and passive manual stretching techniques. Lower limb orthoses may also be used.
- Light-weight manual or power assist wheelchairs or electric scooters may be used when endurance is limited.
- Dietician should advise about nutritional requirements with focus on bone health and caloric intake.

4.2 Limitations of current guidelines

The 2018 guidelines were completed only two years after the first disease-modifying treatment became available. This means the guidelines have not taken into account the modified disease progression seen after the widespread use and effectiveness of treatment (Shin, 2024; Mercuri et al, 2018). As of 2024, Shin notes that effective treatments have still been available for less than 10 years and so there is limited evidence and no clinical consensus on the most effective management protocols for people with SMA who have received effective treatment. Shin suggests the following may be considered:

- for hip instability, modify protocols for cerebral palsy to suit presentation of individual with SMA (e.g. postural management, neuromotor treatment, spasticity management and preventive or reconstructive soft tissue or bone surgery)
- for bone health, bone density monitoring, administering biophosphates, weight bearing activities such as standing or gait training
- aerobic exercise (such as arm cycle ergometry) and progressive resistance training may improve fitness and prevent muscle deterioration

- prescription of orthoses for postural support or gait training
- regular monitoring of swallowing ability, nutritive and non-nutritive sucking trials should begin immediately after birth
- ventilation and the use of cough augmentation, mucus mobilisation and postural drainage techniques should be considered.

4.3 Contracture management

Contractures are common for people with SMA and may occur in almost all cases. Contractures can lead to pain and inhibit mobility and daily functioning (Brown et al, 2025; Lansink et al, 2024; Shin, 2024; Mercuri et al, 2018).

There is limited evidence for the efficacy of surgical management of contractures, though it is recommended for consideration in the SMA Guidelines if the contractures cause pain or impair function (Shin, 2024; Mercuri et al, 2018).

Non-surgical management of joint contractures should vary based on the capacity of the individual, but may include passive or active stretching and the use of orthoses and splints. Use of a stranding frame may assist with preventing lower limb joint contractures. Range-of-motion exercises should be performed 3 – 5 times per week for non-sitters and walkers, and 5 – 7 times per week for sitters. Orthoses should be worn for periods of between 60 minutes and overnight. Bracing should occur at least 5 times per week. For sitters supported standing should occur 5 – 7 times per week for up to 60 minutes per session (Shin, 2024; Mercuri et al, 2018; 4.1 SMA Guidelines).

A recent interview-based study of 14 adolescents with SMA (types 2 or 3) (Lansink et al, 2024), found that participants viewed contracture management delivered by a physiotherapist favourably as an additional form of comfort. However, participants reported viewing the use of orthoses and standing frames as uncomfortable and unnecessary in contracture management.

Serial casting has also been recommended as a treatment for contractures in SMA. This recommendation is based on the evidence for its efficacy in other neuromuscular conditions:

> There is no direct evidence to support serial casting in SMA, however casting has been used to treat joint contractures present in other neuromuscular diagnoses such as Duchenne's muscular dystrophy and Charcot Marie Tooth Disease and a general evidence-based care guideline for management of serial casting for those with cerebral palsy, traumatic brain injury, Duchenne's muscular dystrophy , and idiopathic toe walking and spasticity has been published (Brown et al, 2025, p.7).

5. References

Aponte Ribero, V., Martí, Y., Batson, S., Mitchell, S., Gorni, K., Gusset, N., Oskoui, M., Servais, L., & Sutherland, C. S. (2023). Systematic Literature Review of the Natural

History of Spinal Muscular Atrophy: Motor Function, Scoliosis, and Contractures. *Neurology*, *101*(21), e2103–e2113. https://doi.org/10.1212/WNL.0000000000207878

Brown, L., Hoffman, K., Corbo-Galli, C., Kelley, C., Carry, T., Civitello, M., Coratti, G., DeSanctis, R., Duong, T., Driscoll, B., Flickinger, J., Glanzman, A. M., Jones, J., Maczek, E., Moat, D., Montes, J., Muni-Lofra, R., Nelson, L., Pasternak, A., Valle, M., … Krosschell, K. J. (2025). Serial casting for contractures in SMA: consensus derived guidelines for treatment. *Frontiers in neurology*, *16*, 1502495. https://doi.org/10.3389/fneur.2025.1502495

Finkel, R. S., Mercuri, E., Meyer, O. H., Simonds, A. K., Schroth, M. K., Graham, R. J., Kirschner, J., Iannaccone, S. T., Crawford, T. O., Woods, S., Muntoni, F., Wirth, B., Montes, J., Main, M., Mazzone, E. S., Vitale, M., Snyder, B., Quijano-Roy, S., Bertini, E., Davis, R. H., … SMA Care group (2018). Diagnosis and management of spinal muscular atrophy: Part 2: Pulmonary and acute care; medications, supplements and immunizations; other organ systems; and ethics. *Neuromuscular disorders : NMD*, *28*(3), 197–207. https://doi.org/10.1016/j.nmd.2017.11.004

Mercuri, E., Finkel, R. S., Muntoni, F., Wirth, B., Montes, J., Main, M., Mazzone, E. S., Vitale, M., Snyder, B., Quijano-Roy, S., Bertini, E., Davis, R. H., Meyer, O. H., Simonds, A. K., Schroth, M. K., Graham, R. J., Kirschner, J., Iannaccone, S. T., Crawford, T. O., Woods, S., … SMA Care Group (2018). Diagnosis and management of spinal muscular atrophy: Part 1: Recommendations for diagnosis, rehabilitation, orthopedic and nutritional care. *Neuromuscular disorders : NMD*, *28*(2), 103–115. https://doi.org/10.1016/j.nmd.2017.11.005

Muscular Dystrophy Association. (n.d.a). *Spinal Muscular Atrophy*. https://www.mda.org/disease/spinal-muscular-atrophy

Muscular Dystrophy Association. (n.d.b). *Types of Spinal Muscular Atrophy*. https://www.mda.org/disease/spinal-muscular-atrophy/types

Muscular Dystrophy Association. (n.d.c). *Medical Management - Spinal Muscular Atrophy*. https://www.mda.org/disease/spinal-muscular-atrophy/medical-management

Muscular Dystrophy Association. (n.d.d). *Diagnosis*. https://www.mda.org/disease/spinal-muscular-atrophy/diagnosis

National Committee for Newborn Screening in Spinal Muscular Atrophy (Australia and New Zealand). (2024). *National Guideline for Newborn Screening in Spinal Muscular Atrophy in Australia and Aotearoa New Zealand*. https://www.unsw.edu.au/content/dam/pdfs/medicine-health/clinical-medicine/research-reports/2024-08-nbs-for-sma/2024-11-Technical-report-NBS-for-SMA-06_11_2024.pdf

National Institute of Neurological Disorders and Stroke. (2024). *Spinal Muscular Atrophy*. https://www.ninds.nih.gov/health-information/disorders/spinal-muscular-atrophy

Oude Lansink, I. L. B., Gorter, J. W., van der Pol, W. L., Bartels, B., & Beelen, A. (2024). Impact of contractures on daily functioning in adolescents with spinal muscular atrophy: a qualitative study. *Disability and rehabilitation*, *46*(12), 2593–2599. https://doi.org/10.1080/09638288.2023.2227953

Shin H. I. (2024). Rehabilitation Strategies for Patients With Spinal Muscular Atrophy in the Era of Disease-Modifying Therapy. *Annals of rehabilitation medicine*, *48*(4), 229–238. https://doi.org/10.5535/arm.240046

Schorling, D. C., Pechmann, A., & Kirschner, J. (2020). Advances in Treatment of Spinal Muscular Atrophy - New Phenotypes, New Challenges, New Implications for Care. *Journal of neuromuscular diseases*, *7*(1), 1–13. https://doi.org/10.3233/JND-190424

Spinal Muscular Atrophy Australia Inc. (n.d.). *What is SMA?* https://smaaustralia.org.au/what-is-sma/

Ulusaloglu, A. C., Asma, A., Shrader, M. W., Scavina, M. T., Mackenzie, W. G., Erb, A., & Howard, J. J. (2024). Hip Displacement in Spinal Muscular Atrophy: The Influences of Genetic Severity, Functional Level, and Disease-modifying Treatments. *Journal of pediatric orthopedics*, *44*(3), e226–e231. https://doi.org/10.1097/BPO.0000000000002595