

Independent Review of the place of Art and Music Therapy within Australia's National Disability Insurance Scheme

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Issues in this report

Ensuring art and music therapeutic supports are evidence based

Benefits participants because support more likely to have an impact

Make sure everyone who bills as an art or music therapist is an art or music therapist

Need to make sure smaller participant communities are not unfairly excluded because of poor evidence base

- Researchers may not have developed evidence as it applies to some communities

Benefits community because public money well spent

Need to ensure information about evidence is easily accessible

- Participants and their advisers need to know about the evidence to support participant choices

Need to collect and collate data about outcomes for individual participants to help build the evidence

Key findings and recommendations

- The key finding of this Review is that the literature provides evidence that art and music therapy are effective and beneficial to people in some circumstances, for example where the person has a specific condition and where the therapy is relevant to their seeking to achieve a specific objective or outcome (paragraph 160).
- Art or music therapy should only be included as a funded therapeutic support in a participant's plan if there is generalisable evidence which shows the value of art or music therapy for similar people with these types of goals and these types of conditions. It is the responsibility of the National Disability Insurance Agency (NDIA) to ensure information about the evidence is widely available (paragraph 82).

On evidence

I recommend that the NDIS Evidence Advisory Committee, when established:

- include an assessment of the evidence base for art and music therapy interventions in specific cohorts in its 2025-26 work plan (paragraph 162).
- considers the concept of a minimal clinically important difference in making its recommendations (paragraph 142).
- develop explicit processes for making decisions about provision of therapeutic support in populations where there is a poorly developed evidence base (paragraph 168).

I recommend that the NDIA:

- consider ways in which better information can be provided to participants to assist them make informed choices about whether particular therapeutic supports could be a useful, evidence-based addition to their plans (paragraph 104).
- in messaging about evidence, should emphasise the benefits to a cohort of participants receiving an art or music therapy intervention, distinguishing that from generic advice about any intervention provided by art or music therapists (paragraph 161).
- strengthen its oversight of plans to ensure that all therapeutic support approved, - not only in art or music therapy - has a robust evidence base (paragraph 173).
- systematise its collection of data from providers about the effectiveness and outcomes of therapy interventions for participants, including development of consistent definitions of interventions aligned to a robust participant outcomes framework (paragraph 181).
- ensure that data collected by the NDIA is collated and analysed to ensure that the therapeutic support provided actually achieves a result for the condition for this participant with this provider (paragraph 173).

On payments and payment rates

I recommend that the NDIA:

- set rate maxima for art and music therapists on the basis that these are distinct professions, providing evidence-based therapy, not simply supervising art or music activities (paragraph 214).
- align the maximum payment limit for art and music therapy with the maximum payment limit for counsellors (paragraph 242).
- explore establishing differentials within the allied health professionals' scales to recognise different capacity to provide services and/or to recognise levels of skills and experience (paragraph 248).
- expand its capacity to monitor market dynamics to assess supply of, and the demand for, art and music therapy and therapists (paragraph 229).
- In the medium term, set payment limits for art and music therapy that take account of their labour market monitoring and the need to ensure there is an adequate supply of art and music therapists to meet the requirement for evidence-based provision of art and music therapy (paragraph 235).
- consider alternative methods for funding early intervention services which are consistent with best practice guidelines and any future agreed early childhood intervention best practice frameworks, which encourage holistic evidence-based and outcomes-focused provision consistent with the early childhood approach (paragraph 54).
- consider a different payment and funding approach, particularly for large organisational providers (paragraph 270).
- specify in its Pricing Arrangements and Price Limits, that art and music therapy cannot be claimed under 'other professional' (paragraph 243).
- ensure that funding for art and music therapy as a Therapeutic Support for self-managed participants be limited to supports provided by appropriately trained art and music therapists as defined by NDIA who meet the requirements of NDIS Quality and Safety Commission registration. In other circumstances, art or music activities should be classified as Participation in Community, Social and Civic Activities and funded accordingly (paragraph 251).
- enhance its invoice verification process to ensure that only eligible providers are reimbursed under the art or music therapy item numbers (paragraph 34).

I recommend that the NDIS Quality and Safeguards Commission

- consider introducing an ongoing mechanism to review the verification requirements for recognition as an art or music therapist (paragraph 67).

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Introduction

1. The National Disability Insurance Scheme (NDIS) is one of the most important reforms in social policy in Australia in recent decades.¹ It was developed so that people with disabilities are able to participate in Australian society and be provided with the supports necessary to achieve that.
2. The NDIS was set up to support people with ongoing disabilities (including younger people who would benefit from early intervention).
3. The NDIS arose because of historic – and, unfortunately, continuing – barriers to inclusion as noted in a submission to this review:

The NDIS as a support scheme is not needed solely because people have impairments. It exists equally as an indictment on the chronic inaccessibility of nearly all mainstream spaces and services. It costs a lot of money to include Australians with disability because of serious deficiencies in the skills, knowledge and flexibility of our public services, infrastructures and population. You cannot capacity build disabled individuals out of the barriers they experience when many of those barriers are the result of environmental conditions, not only individual ones.²

4. The premise of the NDIS is facilitative, contributing to participants' achieving their own goals, with both goals and supports articulated in their individual plans. Plans may also include goals and supports which are not provided by the NDIS but are the result of participants' own choices, and broader community services.
5. The supports which can be funded through the NDIS are specified ('NDIS Supports') and are distinct from ordinary costs of living. Approved NDIS supports include 'Therapeutic supports' defined as

Supports that provide evidence-based therapy to help participants improve or maintain their functional capacity in areas such as language and communication, personal care, mobility and movement, interpersonal interactions, functioning (including psychosocial functioning) and community living.

6. To date art and music therapy have been included as therapeutic supports, but a recent policy change - since paused – called these services into question, which was in part a stimulus for this Review.

¹ Buckmaster, Luke and Clark, Shannon (2018), 'The National Disability Insurance Scheme: a chronology', *Research Paper* (Canberra: Parliament of Australia. Department of Parliamentary Services); Miller, Pavla and Hayward, David (2016), 'Social policy 'generosity' at a time of fiscal austerity: The strange case of Australia's National Disability Insurance Scheme', *Critical Social Policy*, 37 (1), 128-47.

² Deafblind Australia Submission to Independent Review of NDIS Art and Music Therapy Supports

7. The policy change was made in the context of a 'rapid review'³ of the evidence about the effectiveness of art and music therapy.⁴ Rapid reviews are legitimate and a well-accepted method of research synthesis and have been described as 'a pragmatic approach to synthesize evidence in a timely manner.'⁵
8. I was asked by the National Disability Insurance Agency (NDIA), which administers the NDIS, to review two aspects of art and music therapy within the NDIS:
 - the NDIA's 'review of evidence', which found that there is limited evidence about the effectiveness of art and music therapy as evidence-based, therapeutic supports for most people with disability; and
 - the pricing of music and art therapy compared with other allied health therapies.
9. This Report then is about the triad of participants, evidence, and the therapies/therapists, and how they interact in the interests of the community, especially participants.
10. Australia has a strong history of ensuring that publicly funded services and supports are evidence-based, starting with the Pharmaceutical Benefits Scheme more than thirty years ago,⁶ and later extending to the Medicare Benefits Schedule. This approach is being extended to the NDIS and so, in the medium term, identifying whether particular interventions work for specific cohorts will be the responsibility of a new Evidence Advisory Committee in the Department of Social Services, as recommended by the NDIS Review.⁷ The new committee will draw on evidence about the benefits, quality, safety and cost-effectiveness of NDIS supports.
11. As part of this review, I invited submissions and received over 600 responses from key provider associations, Disability Representative and Carer Organisations, individual participants receiving these services (and their families/carers/advocates), and service providers.

³ Hamel, Candyce, et al. (2021), 'Defining Rapid Reviews: a systematic scoping review and thematic analysis of definitions and defining characteristics of rapid reviews', *Journal of Clinical Epidemiology*, 129, 74-85.

⁴ National Disability Insurance Agency. Evidence and Practice Leadership Branch (2024), 'Evidence Summary: Art and music therapy', (Canberra: NDIA); <https://dataresearch.ndis.gov.au/research-and-evaluation/decision-making-access-and-planning/evidence-summary-art-and-music-therapy#download-the-evidence-summary>

⁵ Devane, Declan, et al. (2024), 'Key concepts in rapid reviews: an overview', *Journal of Clinical Epidemiology*, 175, 111518.

⁶ Lopert, Ruth and Viney, Rosalie (2014), 'Revolution then evolution: The advance of health economic evaluation in Australia', *Zeitschrift für Evidenz, Fortbildung und Qualität im Gesundheitswesen*, 108 (7), 360-66.

⁷ Independent Review into the National Disability Insurance Scheme (2023), 'Final Report: Working together to deliver the NDIS', (Canberra: The Review).

12. Over a fifth of all submissions were from people who identified themselves as participants or carers. I would like to thank those participants who shared their personal stories and acknowledge the contributions they are making to improving the NDIS.
13. I also met with the three key associations representing providers of art and music therapy: the Australian Music Therapy Association, the Australian, New Zealand and Asian Creative Arts Therapies Association and the College of Creative and Experiential Therapies of the Psychotherapy and Counselling Federation of Australia. I had separate consultations with NDIS participants.
14. The NDIA provided me with data to help me understand the dimensions of the provision of art and music therapy and their review of evidence.⁸
15. I would like to thank all who made submissions and those who participated in consultations, and staff at the NDIS who helped me in analysing submissions and providing data.

Positionality and qualifications

16. My office is on the unceded lands of the Wurundjeri peoples of the Kulin Nation. I acknowledge my debt to First Nations Australians and pay my respects to Elders past and present. I acknowledge that First Nations Australians continue to suffer disadvantage in their access to, and outcomes from, health and disability services. There is a paucity of evidence about therapeutic supports for First Nations Australians, and I regret that this review is not able to make targeted evidence-based recommendations which might improve access or outcomes for First Nations Australians.
17. I am a white male and no one in my immediate family participates in the NDIS. I have attempted to address my positionality by reading carefully all the submissions to this review and listening to the experiences of people with disability as presented to the review.
18. I bring to this Independent Review internationally recognised expertise in pricing of public services, particularly health care, a deep understanding of the way governments and public services operate, a history of management and policy achievements, and a lifelong commitment to equity, efficiency, and quality of service provision.

⁸ National Disability Insurance Agency. Evidence and Practice Leadership Branch (2024), 'Evidence Summary: Art and music therapy', (Canberra: NDIA).

19. My prior experience with disability services and the NDIS has been partly through employment and board roles. In the Victorian Department of Health and Community Services in the early 1990s I had line responsibility for two rural regions at different times and so had responsibility for all Departmental services in the regions, including disability services. As Secretary of the Commonwealth Department of Human Services and Health, also in the 1990s, I had responsibility for aspects of disability services. I am also a former board member of the Brotherhood of St Laurence, which provided local area coordination and early intervention advice under contract to the NDIA. When I was Dean of Health Sciences at La Trobe University, the Faculty included education for art therapy.
20. I have maintained a general interest in aspects of disability policy and services and have co-authored a number of publications on aspects of measurement relating to disability and therapy supports.⁹ I also included a review of disability services in my book on the Australian health care system.¹⁰

⁹ Dyson, M., Allen, F.C.L., and Duckett, S.J. (2000), 'Profiling childhood disability: The reliability of the educational needs questionnaire', *Evaluation and Program Planning*, 23 (2), 177-85; Dyson, M., Duckett, S.J., and Allen, F.C.L. (2000), 'A therapy-relevant casemix classification system for school age children with disabilities', *Archives of Physical Medicine and Rehabilitation*, 81 (May), 634-43; Morris, M., et al. (2005), 'Reliability of the Australian Therapy Outcome Measures for quantifying disability and health', *International Journal of Therapy & Rehabilitation*, 12 (8), 340-46; Perry, Angela, et al. (2004), 'Therapy outcome measures for allied health practitioners in Australia: the AustOMs', *International Journal of Quality in Health Care*, 16 (4), 285-91; Unsworth, Carolyn A., et al. (2004), 'Validity of the AustOM scales: A comparison of the AustOMs and EuroQol-5D', *Health and Quality of Life Outcomes*, 2 (64), 1-12.

¹⁰ Duckett, Stephen (2022), *The Australian Health Care System (6th ed.)* (Melbourne: Oxford University Press).

What are art and music therapy?

21. Art and music therapy are increasingly recognised as important potential contributors to improving the life situation for people across a broad range of conditions.¹¹
22. The Australian, New Zealand and Asian Creative Arts Therapies Association (ANZACATA) describes art therapy as the use of 'art, media and the creative process (drawing, writing, sculpting, drama, clay, sand, dance and movement) to facilitate the exploration of feelings, improve self-awareness and reduce anxiety for clients.'
23. Art therapists are not registered as part of Australia's national system of registering health professionals. However, to provide therapeutic supports funded by the NDIS an art therapist must, among other things, be a 'professional member' of ANZACATA.
24. Professional members of ANZACATA are required to have a master's degree in art therapy approved by ANZACATA.
25. The Australian Music Therapy Association (AMTA) defines music therapy as 'the intentional and therapeutic use of music by registered music therapists (RMTs) to support people to improve their health, functioning and wellbeing'. Aalbers et al. identified two types of music therapy: 'active (where people sing or play music) and receptive (where people listen to music)'.¹²
26. Music therapists are also not registered as part of Australia's national system of registering health professionals, but AMTA is a member of the National Alliance of Self-Regulating Health Professions.
27. To be a registered music therapist endorsed by AMTA, a person must complete a master's degree course approved by AMTA. To provide therapeutic supports funded by the NDIS a music therapist must, among other things, be a 'registered music therapist' with AMTA.

¹¹ World Health Organization. Regional Office for Europe (2023), 'WHO expert meeting on prevention and control of noncommunicable diseases: learning from the arts. Opera House Budapest, Hungary, 15–16 December 2022: meeting report', (Copenhagen: WHO Regional Office for Europe).

¹² Aalbers, Sonja, et al. (2017), 'Music therapy for depression', *Cochrane Database of Systematic Reviews*, 11, CD004517. Davies and Clift make the same distinction about types of arts engagement: Davies, Christina R. and Clift, Stephen (2022), 'Arts and Health Glossary - A Summary of Definitions for Use in Research, Policy and Practice', *Frontiers in Psychology*, 13 (949685), 1-6.

28. A consequence of neither art nor music therapy being nationally registered professions is that there is no protection of those titles, so anybody can call themselves an ‘art therapist’ or a ‘music therapist’. However, as indicated above, the NDIS rules prescribe who ought to be able to claim the relevant item numbers.

29. In 2023-24 about 13,400 people were supported by the NDIS for one of these services, and 600 who received both.

Table 1: Number of art and music therapy participants and providers, 2023-24

	Art therapy	Music therapy
Number of participants	6,788	7,217
Number of providers	1,672	1,405
Total payments	\$ 13.4m	\$ 16.3m

Source: NDIA administrative data provided to this review; Note: Data in this table (and in subsequent tables and figures) may not include full information about supports provided to self-managed participants.

30. There is some evidence that people receiving music therapy tend to be younger than those receiving art therapy. About one in five people receiving music therapy are under 9, compared to one in seven receiving art therapy (21% v 14%). Conversely, about 37% of those receiving art therapy are 35 or over compared to 30% of those receiving music therapy. However, the NDIS data does not allow for the identification of usage of art and music therapy for under 7s as those services are claimed under a general therapy code.

31. Again, subject to the issue about under 7s above, about two thirds of people who receive art therapy are women or girls. The gender balance is reversed for music therapy: 40% of people who receive music therapy are women or girls.¹³

32. The number of separate art or music therapy providers paid under the NDIS appears to be larger than the membership base of the relevant associations.¹⁴

33. Art or music *therapy* are not the same as art or music *activities*:

- *Art or music therapy*: Supports that formally implement elements of art or music as therapeutic techniques alongside or instead of psychotherapy, physiotherapy, speech therapy and rehabilitation. To be considered art or music therapy, a service must meet all the following criteria: Art or music therapy is delivered by a

¹³ I was not provided with data on the number of non-binary participants.

¹⁴ The data on number of providers is based on number of unique ABN codes. It is possible that a therapist may bill using two or more ABNs, for example, to distinguish sites of care.

qualified art or music therapist (typically prepared at master's level); implements a clearly defined and scientifically valid mechanism of action; and aims at an identified and measurable outcome beyond leisure, such as psychosocial functioning, physical capacity or communication.

- *Art or music activities:* Services that involve art or music but do not meet all of the criteria of art or music therapy, even if delivered by a qualified art or music therapist or involve therapeutic techniques. These are mainly aimed at leisure or use art or music to facilitate other benefits such as social interactions or movement.

34. *I recommend that the NDIA enhance its invoice verification process to ensure that only eligible providers are reimbursed under the art or music therapy item numbers.*

Early intervention services

35. There are two pathways into the NDIS – early intervention for younger people and the general permanent disability stream. Most of what I have to say in this report relates to the larger element of the NDIS, permanent disability and supports for this group of participants.
36. The purpose of early intervention is to mitigate the impact of a person's impairment upon their long-term functional capacity by providing support at the earliest possible stage. Early intervention support is also intended to benefit a person by reducing their future need for supports and by strengthening the sustainability of their informal supports, e.g. building the capacity of their carer(s).¹⁵
37. A draft National Best Practice Framework for the provision of early childhood intervention, drawing on an extensive literature review and a review of best practice, is currently being developed.¹⁶ A major theme of the best practice framework for early intervention is the importance of being child-and family-centred and outcomes-focused.
38. The draft Framework applies across all areas of early childhood intervention and so is not NDIS-specific. If the Framework is seen as relevant and useful by stakeholders, there would be merit in its being used to shape NDIS provision.
39. Best practice early childhood intervention identifies the desired outcomes and then the most effective interventions consistent with the principles that underpin the framework. The key questions are: What are the likely gains in function and meaningful participation in everyday settings of childhood? Are the gains greater than alternative interventions or are the gains sufficiently effective in combination with other interventions so as to be attractive? If the therapy is used but does not lead to improved functioning and meaningful participation in the child, it should not continue to be used.
40. In terms of my commission, to examine the evidence base for art and music therapy, the review of best practice points to how art and music therapy ought to be provided as part of early childhood intervention services, namely in the context of implementation of this (draft) evidence-based National Best Practice Framework.

¹⁵ Imms, Christine, et al. (2024), 'Review of best practice in early childhood intervention: Desktop review full report.' (Melbourne: The University of Melbourne).

¹⁶ The Framework is being developed by a broad group including a number of stakeholders. It was commissioned by the Department of Social Services. The University of Melbourne (2025), 'Review of best practice in early childhood intervention: Draft Practice Framework v2.0', (Melbourne: The University of Melbourne).

41. However, there are elements of the overall funding design of the NDIS which may militate against the implementation of the themes of the (draft) National Best Practice Framework.
42. The current funding arrangements for provision of paediatric speech and language were reported in a recent study as not consistent with the evidence, although the relevant papers did not explore the nature of the inconsistency, nor point to specific directions for reform.¹⁷
43. A small qualitative study conducted in the early stages of the implementation of the NDIS, identified several themes about its then negative impact on early childhood intervention services. It identified that sometimes the parents felt disempowered compared to previous systems and emphasised the importance of good information for families.¹⁸ It also concluded that the NDIS funding arrangements – essentially fee-for-service – may have inhibited good service provision.
44. Use of a ‘key worker’ to coordinate services may address some of the problems identified with early childhood intervention services,¹⁹ however, involvement of a key worker is not universal.
45. This Review cannot address all of the issues involved in the development of early childhood intervention policy. However, my observation is that the atomised approach, based on separate funding for separate therapeutic supports is not conducive to encourage the policy directions set out in the draft National Best Practice Framework, and hence does not facilitate evidence-based provision in this context.
46. In the health sector there is increasing recognition of the importance of multidisciplinary teams in the provision of health care, especially for older people. The same is true for early intervention for all people with disability. In the health sector, the response is to recognise the limitations of fee-for-service payments and to encourage holistic payments which encourage continuity of care and the right mix of services being provided to the person in need.²⁰

¹⁷ Nickless, Tristan, et al. (2023), 'Public purse, private service: The perceptions of public funding models of Australian independent speech-language pathologists', *International Journal of Speech-Language Pathology*, 25 (3), 462-78; Nickless, Tristan, et al. (2024), 'Aligned or misaligned: Are public funding models for speech-language pathology reflecting recommended evidence? An exploratory survey of Australian speech-language pathologists', *Health Policy OPEN*, 6, 100117.

¹⁸ Gavidia-Payne, Susana (2020), 'Implementation of Australia's National Disability Insurance Scheme: Experiences of Families of Young Children with Disabilities', *Infants & Young Children*, 33 (3), 184-94.

¹⁹ Young, Dana, et al. (2021), 'Understanding key worker experiences at an Australian Early Childhood Intervention Service', *Health & Social Care in the Community*, 29 (6), e269-e78.

²⁰ Strengthening Medicare Taskforce (2023), 'Report', (Canberra: Department of Health and Aged Care).

47. The same principles might apply for early intervention services. Here one might see payment for a multidisciplinary team, with the expectation that the multidisciplinary team provides holistic support to achieve agreed outcomes for a specified number of people in the early intervention stream for a defined time. e.g., a year. People should have the right to change providers to ensure appropriate accountability and responsiveness with a specified notice period.
48. Such a holistic approach might be more difficult to organise in rural and remote Australia, where the numbers involved are small, but it might be possible to link up with local community services who are able to provide support, especially with remote guidance to those teams provided virtually. This was recommended by the NDIS Review.²¹
49. Provision of early childhood intervention services in this model might also be through a procurement approach, where potential providers respond to an open invitation to participate based on their capabilities and ability to provide services consistent with the National Best Practice Framework when finalised and as updated from time to time.
50. It is important to note that the draft National Best Practice Framework is just that, a draft. It has not yet been adopted as policy and may not be. But if it is adopted, then it is important that funding and policy aspirations are aligned, lest the Framework simply be another statement of unimplemented aspirations.
51. Funding of multi-disciplinary teams is not simple valorising use of a 'multi-disciplinary team' item. It is about facilitating a service which involves true teamwork, on an ongoing basis, in the interest of the participant, with appropriate accountabilities.²²
52. What I am pointing to here is not a return to block funding, which was associated with a lack of accountability to clients, but rather that existing fee-for-service funding arrangements do not serve participants well and may stymie implementation of a new National Best Practice Framework if adopted.
53. In this model, perhaps termed 'team funding', participants would be empowered by being able to move between teams/providers if their needs were not being met. Under this arrangement the NDIA would augment its existing oversight by monitoring participant reported experience measures, and tracking outcomes.
54. ***I recommend that the NDIA consider alternative methods for funding early intervention services which are consistent with best practice guidelines and any***

²¹ Independent Review into the National Disability Insurance Scheme (2023), 'Final Report: Working together to deliver the NDIS', (Canberra: The Review).

²² Katzenbach, Jon R and Smith, Douglas K (2005), 'The discipline of teams', *Harvard business review*, 83 (7/8), 162-71.

future agreed early childhood intervention best practice frameworks, which encourage holistic evidence-based and outcomes-focused provision consistent with the early childhood approach. In the interim, the NDIA should continue to fund early childhood intervention supports in a flexible budget which promotes a best practice approach consistent with best practice guidelines in early childhood intervention.

55. As part of foundational supports, states might give consideration to professional development for teachers and early childhood educators to work with music and art therapists to build their capability and confidence in provision of programs which draw on art or music therapy evidence.²³
56. Unless otherwise specified, the remainder of this report does not consider the evidence base for, or pricing of, early intervention services for children or other groups.

²³ Ng, Siu-Ping, et al. (2024), 'Impact of online professional development on Hong Kong kindergarten teachers' confidence: An experimental study', *Australian Journal of Music Education*, 56 (2), 52-64.

The evidence bases for art and music therapy

57. A number of stakeholders, including the three main provider associations provided comprehensive submissions highlighting the evidence base for art or music therapy. As discussed below, I received more than 150 submissions from participants and/or carers, many of them recounting their personal experience of the benefits of art or music therapy. Some of these also pointed to relevant literature for me to consider.

AMTA submission

58. AMTA provided a comprehensive submission (including appendices directing me to relevant studies). AMTA identified from the literature a number of areas where music therapy might be of benefit:

- *Functioning (including psychosocial functioning)*: Here AMTA concluded that ‘A range of music therapy methods, techniques and interventions are examined in the research literature, including therapeutic singing and instrument play, rhythmic cueing, music assisted storytelling, dyadic improvisations, receptive methods, therapeutic song writing and composition, music and movement, and musical play. Research evidence shows a range of outcomes relevant to this domain across various focus areas that relate to functioning, including global cognition, attention, memory, recall, auditory discrimination, music engagement, depression, anxiety, mood, and apathy’;
- *Language and communication*: AMTA noted that ‘Music therapy evidence demonstrates improvements in a range of functional language and communication domains. Improvements for people who will be able to develop or recover language are obviously more amenable to quantitative measurement. This is seen by significant improvements in people with aphasia after music therapy as demonstrated through meta-analysis’;
- *Interpersonal Interactions*: AMTA identified that in this field ‘participants with primary impairments of either neurological or psychosocial types are the most common (18 and 16 citations respectively), and research with children and adolescents is prominent (32 citations). There are 19 systematic reviews or meta-analyses that are relevant to this area; and
- *Mobility and movement*: The AMTA summary showed ‘A total of 26 citations exploring the role of music therapy in improving movement and mobility functional capacity have been selected for this summary. These studies explore music therapy movement interventions for people experiencing impairments in the NDIA-related domains of neurological functioning (18 citations), physical functioning (5 citations) and cognitive functioning (3 citations)’.

59. AMTA also noted that music therapy can offer benefits relating to *community living* but the evidence base overlaps other areas.

60. The AMTA analysis is structured according to functional domains. Within each of these functional domains, systematic reviews look at specific conditions such as aphasia.²⁴ The critical issue for establishing an evidence based is therefore the interaction of the condition and the functional domain.

ANZACATA submission

61. Although grouped together in this Review, art and music therapy have both similarities and differences. The definition of music therapy cited above highlights the use of music as an intervention. In contrast, the definition of art therapy highlights arts as a medium which allows the intervention which is the exploration of feelings.

62. The ANZACATA submission therefore drew my attention to the evidence base for the psychological literature as published by the Australian Psychological Society,²⁵ with the assumption being that art therapists use the relevant range of psychological interventions.

63. ANZACATA also provided a survey of the literature relating to art therapy specifically.²⁶

64. Again, both the general and specific literature is structured according to the evidence for specific conditions, with literature for one functional domain – cognition – identified in the art therapy specific literature review.

PACFA CCET submission

65. The College of Creative and Experiential Therapists of the Psychotherapy and Counselling Federation of Australia (PACFA CCET) also made a submission. The evidence table of their submission covered much the same ground as AMTA's and ANZACATA's.

66. PACFA CCET also argued that accreditation through their processes should be recognised under the NDIS arrangements.

67. ***I recommend that the NDIS Quality and Safeguards Commission consider introducing an ongoing mechanism to review the verification requirements for recognition as an art or music therapist.***

²⁴ Liu, Qingqing, et al. (2022), 'The effect of music therapy on language recovery in patients with aphasia after stroke: a systematic review and meta-analysis', *Neurological Sciences*, 43 (2), 863-72.

²⁵ Australian Psychological Society (2024), 'Evidence-based psychological interventions in the treatment of mental disorders: A literature review', (Melbourne: APS).

²⁶ Gray, Deanne (2022), 'The Proven Efficacy of Creative Arts Therapies: What the Literature Tells Us', (North Brighton: ANZACATA).

Disability Representative and Carer Organisations

68. Several Disability Representative and Carer Organisations made helpful submissions to this review and also provided evidence of the benefit of art or music therapy for participants with specific conditions.²⁷

Towards a learning organisation

69. The NDIA should strive to be a learning organisation. This is not just jargon but is a guiding principle that strives to both improve care provided and contribute to the body of evidence on which care is based. A learning organisation is 'an organization skilled at creating, acquiring, and transferring knowledge, and at modifying its behaviour to reflect new knowledge and insights'.²⁸

70. The world around us is changing and new knowledge is being created all the time. It is critical that NDIS participants benefit from that new knowledge as quickly as possible, whether it is knowledge about new interventions which have been shown to make a difference and so need to become available to all participants, or knowledge about old practices which have been shown not to make a difference and need to be discarded as giving false hope and costing money.

71. The NDIA should become more adept at gathering data – including data on the experience of NDIS participants – and using data to inform the plan development and approval process. It should be at the forefront of synthesising evidence to inform its decisions and is a theme of this review.

²⁷ e.g., Dementia Australia Independent Review of NDIS art and music therapy supports: A Dementia Australia Submission

²⁸ Garvin, David A (1993), 'Building a Learning Organization', *Harvard Business Review*, 71 (4), 78-91.

What is evidence?

72. Section 3.2 of the *National Disability Insurance Scheme (Supports for Participants) Rules 2013* states that

In deciding whether the support will be, or is likely to be, effective and beneficial for a participant, having regard to current good practice, the CEO (of the NDIA) is to consider the available evidence of the effectiveness of the support for others in like circumstances. That evidence may include:

- published and refereed literature and any consensus of expert opinion;
- the lived experience of the participant or their carers; or
- anything the Agency has learnt through delivery of the NDIS.

73. Further, published NDIS guidance, states that

Therapeutic supports under the NDIS are limited to 'supports that provide *evidence-based* therapy' (emphasis added).

74. The NDIS Quality and Safeguards Commission has produced an 'Evidence Informed Practice Guide' which portrays evidence informed practice as being shaped by the rights and perspectives of the person with disabilities; best research and evaluation evidence; clinical and provider expertise; and information from the implementing or practice context.²⁹

75. Schalock defined evidence-based practices as 'practices for which there is a demonstrated relation between specific practices and measured outcomes.'³⁰ I will return to the meaning of 'demonstrated relation' later.

76. What is critical is how do the different types of knowledge and evidence interact? It is appropriate to use different types of evidence at different stages of a participant's plan development and implementation journey, making the way the NDIS Guidance and the Schalock definition are phrased somewhat problematic.

77. Firstly, what is regarded as 'evidence' needs to be considered from the perspective of both the system and the individual.

78. In my view, to meet the evidence criterion in the NDIS definition there should be rigorous studies which show that for this type of client, the support (art or music therapy) achieves a measurable result. As art and music therapy in Australia is influenced by developments

²⁹ NDIS Quality and Safeguards Commission (2023), 'Evidence-Informed Practice Guide', (Penrith, NSW: The Commission).

³⁰ Schalock, Robert L., et al. (2017), 'Evidence and Evidence-Based Practices: Are We There Yet?', *Intellectual and Developmental Disabilities*, 55 (2), 112-19. page 115

internationally in these professions, the evidence synthesis of the effectiveness of these therapies should draw on international replicable evidence.

79. For an individual participant, this approach to the use of evidence is prospective, that is, as a participant's plan is being developed, there is research evidence available which shows that art or music therapy has the potential to benefit this individual. This then can inform the plan for the participant.
80. What is important here is that the evidence being considered is reproducible,³¹ both in the sense that another study looking at the same issue will most likely come to the same conclusion, but also that given this study, we can presume that this NDIS participant will likely benefit from this intervention.³²
81. That is, synthesis of the research evidence will enable the Department of Social Services and the NDIA, on the advice of the new NDIS Evidence Advisory Committee, to form a view about the effectiveness of that intervention for that participant cohort group with similar goals. There will always be a judgement here, as the population in research studies may never mirror exactly the NDIS participant population, but what is critical is that participants know what is likely to work for them, based on the best available evidence, and so how their packages should be used. Similarly, sustainability of the NDIS means that it is important that the NDIA knows what is likely to have a beneficial effect for participants.
82. Specifically, subject to the caveats discussed later, ***art or music therapy should only be included as a funded therapeutic support in a participant's plan if there is generalisable evidence which shows the value of art or music therapy for similar people with these types of goals and these types of conditions. It is the responsibility of the NDIA to ensure information about the evidence is widely available***, an issue to which I will return.
83. *In addition*, therapists should monitor a person's progress in response to the therapy provided to ensure that, *in this instance*, a measurable and meaningful result is being achieved. That is, if the therapist's proposed treatment plan is implemented, the literature will show (prospectively) that art or music therapy may benefit this individual because of the experience of providing these supports in the past to others in a similar situation. What we now need to know retrospectively is whether the support works as provided by

³¹ Foley, Thomas and Horwitz, Leora I. (2025) Learning Health Systems [online text], Cambridge University Press, page 6

³² Relatively new UK guidance is useful here: Skivington, Kathryn, et al. (2021), 'A new framework for developing and evaluating complex interventions: update of Medical Research Council guidance', *BMJ*, 374, n2061.

this therapist to *this* person in *this* context. 'Result' here would be outcomes as contemplated in an individual's goals and would be different from the person's previous situation and trajectory.

84. This type of evidence is retrospective. That is, only after a participant has received therapeutic supports is it possible to measure the impact of those supports.
85. Although there are common measures of outcomes of provision of therapeutic support, both covering multiple therapies³³ and discipline specific, each clinician has autonomy in determining which measures to use, and how often.
86. Overtime there should be more systematisation of how information on a participant's progress and outcomes are collected, collated, and analysed. This will help build an evidence base where none exists today and is a key component of building a learning organisation.³⁴ I will return to this issue of reporting later.
87. Other types of evidence, such as professional judgement, might also be considered but that itself must be evidence based, supported by the literature. Again, the clinician or technical advisor has autonomy to determine what they might recommend as the best art or music therapy intervention for this person at this time. The clinician or technical advisor here would draw on their own professional experience and knowledge of the evidence and their understanding of the participant's situation and goals.
88. During this review, I received many personal testimonies from people with disabilities, their carers, or advocates, which attest to the benefit to those individuals of art or music therapy.³⁵ Similarly, I received many submissions from therapists who recounted appropriately anonymised stories about the benefits of the therapy they provided. I also saw several anonymised professional reports produced by art or music therapists documenting the progress made while individual participants were receiving these therapies. Stakeholders also provided me with vignettes showing the benefits of the art or music therapeutic supports provided to individual participants. There are also published papers describing case studies of the outcomes of art and music therapy.³⁶
89. One cannot but be moved by these stories.

³³ Perry, Angela, et al. (2004), 'Therapy outcome measures for allied health practitioners in Australia: the AustOMs', *International Journal of Quality in Health Care*, 16 (4), 285-91.

³⁴ Foley, Thomas and Horwitz, Leora I. (2025) *Learning Health Systems* [online text], Cambridge University Press.

³⁵ I also heard stories where music therapy was not useful, indeed said to be detrimental.

³⁶ Thompson, Grace A. and McFerran, Katrina Skewes (2015), 'Music therapy with young people who have profound intellectual and developmental disability: Four case studies exploring communication and engagement within musical interactions', *Journal of Intellectual & Developmental Disability*, 40 (1), 1-11.

90. I heard firsthand of the difference art or music therapy can make in those individual circumstances, not only to the person with disabilities but also to those around them. Unfortunately, support for people with disabilities is still quite gendered in Australia: in 2022 6.1 per cent of women were primary carers, compared to 3 per cent of men,³⁷ so there is a gender equity issue at play here too.
91. The personal statements in submissions and in the consultations address the second limb of my proposed approach to 'evidence-based'.
92. That we see change in participants associated with provision of therapeutic supports is really no surprise. There is now a substantial – and growing³⁸ – literature, including systematic reviews, and in the case of music therapy, summaries of,³⁹ and systematic reviews of, systematic reviews,⁴⁰ which outline the benefit of art or music therapy in specific circumstances, or for people with specific conditions.
93. Although the individual stories shared with me show that there was generally a benefit to those individuals, they don't show *in a systematic way* whether an alternative support (or alternative supports) might have provided the same benefit, or whether a different approach to art or music therapy (e.g. facilitating the carer) might have achieved the same (or lesser or greater) benefit. Of course, there were some stories which described how all these other therapies had been tried but no progress was being made until art or therapy was provided. But it is hard to put these together in a systematic pattern to make an evaluative assessment.
94. These stories, of prior failure and subsequent progress, raise the question of why art or music therapy was not provided earlier? If there is evidence that art or music therapy is beneficial, why was it not part of the original package right from the start?
95. This may not be an issue unique to art or music therapy. But the therapeutic supports considered in this review are provided by professions which are relatively small compared to other allied health disciplines, and so the local area coordinator or other places where participants may gather information, may not be aware of whether these

³⁷ Australian Bureau of Statistics (2024), *Disability, Ageing and Carers, Australia: Summary of Findings* (Canberra: ABS). The data are for people supporting both older people and younger people with disabilities.

³⁸ Rodriguez Novo, Natalia, et al. (2021), 'Trends in Research on Art Therapy Indexed in the Web of Science: A Bibliometric Analysis', *Frontiers in Psychology*, 12 (752026), 1-10.

³⁹ Kamioka, Hiroharu, et al. (2014), 'Effectiveness of music therapy: a summary of systematic reviews based on randomized controlled trials of music interventions', *Patient Preference and Adherence*, 8 (null), 727-54.

⁴⁰ Wu, Jiaming, Zhang, Qing, and Wu, Aihong (2024), 'Functioning, health and developmental benefits of music interventions for children and adolescents with intellectual and developmental disabilities: a systematic review of systematic reviews', *Chinese Journal of Rehabilitation Theory and Practice*, 543-53.

therapeutic supports might make a difference in these cases, or even of the existence of these therapeutic supports at all.

96. The essence of the NDIS is that participants should have choice and control over what mix of supports will best help them achieve their goals, so goal setting is fundamental. But so too is identifying what therapeutic support will help in achieving those goals, and good information about what is likely to be effective is necessary for this purpose.
97. A defining characteristic of a market – where they exist – is that consumers in that market have enough information to choose among the products on offer. Imbalance in the knowledge of consumers vis-à-vis providers, is referred to as ‘information asymmetry’ and leads to market failure.⁴¹
98. Information asymmetry is not the only reason for market failure, for example, in parts of Australia there may not be an adequate supply of professionals and other staff to meet needs, a situation sometimes described as ‘thin markets’.⁴²
99. All this points to the need for active ‘market stewardship’ rather than simple market regulation,⁴³ or hoping that markets will work their magic without any superintendence. There is thus an important role of ‘market stewards’,⁴⁴ such as the NDIA and the NDIS Commission, including in ensuring there is adequate information to participants to make informed choices.⁴⁵
100. There is known to be a long gap – measured in years but estimates and methods for estimating the length of the gap vary – between new knowledge about treatments in

⁴¹ Giza, Wojciech (2024), 'Asymmetric information as a market failure in retrospect The Elgar Companion to Information Economics', in Daphne R. Włodarczyk Raban, Julia (ed.), *The Elgar Companion to Information Economics* (Cheltenham, UK: Edward Elgar Publishing), 106-17.

⁴² Reiders, Daniel, et al. (2019), 'Market Capacity Framework: An approach for identifying thin markets in the NDIS', (Sydney: Centre for Social Impact:).

⁴³ Carey, Gemma, et al. (2018), 'The Vexed Question of Market Stewardship in the Public Sector: Examining Equity and the Social Contract through the Australian National Disability Insurance Scheme', *Social Policy & Administration*, 52 (1), 387-407.

⁴⁴ Independent Review into the National Disability Insurance Scheme (2023), 'Final Report: Working together to deliver the NDIS', (Canberra: The Review).

⁴⁵ In the longer term, market regulation in the NDIS needs to reconcile the individualistic/personalism view of participants in a market and the contemporary public policy concept of co-design and co-creation, see, for example, Ongaro, Edoardo, Rubalcaba, Luis, and Solano, Ernesto (2025 (in press)), 'The ideational bases of public value co-creation and the philosophy of personalism: Why a relational conception of person matters for solving public problems', *Public Policy and Administration*, 0 (0), 09520767251318127.

health care and implementation in practice.⁴⁶ Inclusion of research syntheses in published guidelines helps but is not a panacea.⁴⁷

101. There also appears to be a research-practice gap in disability.⁴⁸ An essential step in addressing the gap is that the new Evidence Advisory Committee, as part of its determination of the evidence and formulating its recommendations, develop a 'plain language' synthesis/summary of its conclusions.⁴⁹
102. However, mere publication of the evidence of what works, even in a plain language version, will not be enough to ensure that participants know when to include art or music therapy in their plans, and art or music therapists know what the latest available evidence-based interventions are.
103. Again, it is in the best interests of participants and the sustainability of the NDIS, to ensure good advice is available to help participants, their carers, and their advocates make informed decisions about what is likely to make a difference. Evidence updates might also be provided to therapists.
104. ***I recommend that the NDIA consider ways in which better information can be provided to participants to assist them make informed choices about whether particular therapeutic supports could be a useful, evidence-based addition to their plans.***
105. Ideally, information would be made available in a tailored way, specifying in plain language that for this type of domain and for a person with this condition, whether there is evidence that art or music therapy can help achieve their goals.⁵⁰
106. In a quite different context,⁵¹ the University of York has a good website which provides information about potential outcomes of some types of surgery, taking into

⁴⁶ Evensen, Ann E., et al. (2010), 'Trends in publications regarding evidence-practice gaps: A literature review', *Implementation Science*, 5 (11), 1-5.; Hanney, Stephen R., et al. (2015), 'How long does biomedical research take? Studying the time taken between biomedical and health research and its translation into products, policy, and practice', *Health Research Policy and Systems*, 13 (1), 1-18.

⁴⁷ Freitas de Mello, Nicole, et al. (2024), 'Models and frameworks for assessing the implementation of clinical practice guidelines: a systematic review', *Implementation Science*, 19 (59), 1-15.

⁴⁸ Dew, Angela and Boydell, Katherine M. (2017), 'Knowledge translation: bridging the disability research-to-practice gap', *Research and Practice in Intellectual and Developmental Disabilities*, 4 (2), 142-57.

⁴⁹ I use 'plain language' throughout this Report rather than 'plain English' to recognise the need for materials in languages other than English.

⁵⁰ Perhaps a matrix format could be used, but this might be challenging to develop in a plain language format.

⁵¹ The point of this paragraph is to draw attention to a user-friendly way of presenting data to facilitate an informed choice. Unlike the example used, which is about acute care, participants in the disability stream have permanent disabilities. That is not to say, of course, that outcome measures are not relevant.

account the characteristics of the individual.⁵² The data behind the pictorial display used is drawn from before and after Patient Reported Outcome Measures completed by patients who have had that type of surgery. I am not aware of anything similar to this to help people develop their plans under the NDIS. If it were, participants could have advice specific to their situation to answer the critical question: If art or music therapy (or any other therapy for that matter) were added to my plan, what might I expect? This type of analysis could also be developed using data both from the literature and analysis of individual participant reports submitted to the NDIA, potentially following revision to standard templates for therapists' reports on participant progress.⁵³

107. The second problematic element of the phrasing of 'evidence based' is that one might infer that art or music therapy is provided out of an overall therapeutic context of the participant.
108. The point of art and music therapy is to contribute to achieving the functional outcomes and goals established by and for the individual receiving those services. They should not be conceived of as part of a smorgasbord approach to achieving goals (one of those, and one of those), but rather as an integrated, holistic approach.
109. The emphasis of the NDIS is, and should be, that supports in combination are to achieve the individual's goals. Art or music therapy may, subject to the evidence, be appropriate contributions linked logically, and in an evidence-based way, to a particular goal or goals for an individual. The emphasis of the NDIS is appropriately on the holistic combination of supports that together provide support to meet the individual's goals. So, it is the cluster of supports which leads to achievement of a cluster of goals. Evaluating the contribution of any one intervention is often difficult to disentangle.
110. I have raised the issue of holistic provision above, in the context of early intervention, but the same issues apply to all aspects of the NDIS to a greater or lesser degree. Unfortunately, the literature mostly only focuses on evaluating each therapeutic support in isolation.
111. The third problematic element in the literature base is that the research evidence in any field rarely says something is always beneficial or always not, rather, the critical question is almost always how much and in what circumstances.

⁵² <https://www.york.ac.uk/che/patient-outcome-tool/>

⁵³ Wallace, Jacqueline (2022), 'An Arts Therapists Guide to NDIS Therapy Report Writing', (North Brighton: ANZACATA). The NDIA also provides guidance on reporting.

112. Phrased more formally, the key policy question is *in prospect, in what cases is art or music therapy a reasonable and necessary therapeutic support as an alternative to art or music activities*. Possible factors may include, among others:
- Diagnoses and complexity (e.g., level of verbal communication)
 - Treatment goals and outcomes (e.g., music activities are not a reasonable alternative to some forms of therapy such as neurological music therapy)
 - How much music therapy is reasonable and necessary in key scenarios.
113. As I have argued above, these factors can be assessed in prospect. For people like the participant, is there rigorous evidence that art or music therapy might make a difference in achieving their functional outcomes?
114. If art or music therapy were then added to the participant's plan, progress might be measured concurrently (or in retrospect). That is, given the specific circumstances of this participant, working with this therapist, we see a trajectory of change from before the support was provided until now, with reports to the NDIA being able to identify any incremental benefit compared to the cost of the support.
115. Over time, the NDIA could use this data set to supplement the published literature to identify, standardised for the type of participant, what expected trajectories might be, and whether specific therapists are associated with better or worse trajectories for the participant.
116. Public provision of provider- or team-specific information about impact⁵⁴ would assist participants to choose amongst providers/teams, consistent with effecting the NDIS goal about choice and control.⁵⁵
117. Returning to the question of 'what is evidence?', at minimum 'evidence' is about systematic, controlled studies. By 'controlled' here I mean studies that compare the use of art or music therapy with usual services, or with art or music activities not under the guidance of an art or music therapist.

⁵⁴ Information about names, locations and other attributes (e.g., languages spoken) of therapists is readily available, but no information is provided about therapist quality.

⁵⁵ The evidence about public provision of comparative quality data in health care is mixed; see Metcalfe, D., et al. (2018), 'Impact of public release of performance data on the behaviour of healthcare consumers and providers', *Cochrane Database of Systematic Reviews*, (9). There may also be perverse effects, as providers may distort data provision. That said, if choice and control is to be effected, it is important that participants, carers and advocates are as fully informed as possible when selecting among potential providers.

118. Although randomisation of groups to receiving or not receiving these supports or not is ideal, other methods of control – such as case control studies – may yield comparable information.⁵⁶ The point here is that there needs to be good evidence that the supports achieve benefits in specific circumstances, in addition to reports of individual stories, for a support to meet the threshold of ‘evidence based’ contemplated in the NDIS definition.⁵⁷
119. A further weakness of the literature of the effectiveness of art and music therapy is that the definition of art or music therapy used in the evaluations is often not as clear as it could be, and so the conclusions from the literature are not always easily able to be translated into policy. There are exceptions, of course, Hu et al.’s review of art therapy has a table describing the treatment for each of the key articles reviewed.⁵⁸
120. Even when the interventions are well described, they might be quite heterogenous. One systematic review noted that ‘the nature of music interventions ... varied largely across the studies.’⁵⁹
121. The Cochrane Review of music therapy in autism spectrum disorders described the included studies thus:

The majority of studies included in this review examined music therapy in an individual (i.e. one-to-one) setting (n = 13). In eight trials, music therapy was delivered in a group setting. One study reported that music therapy was delivered either individually or in small groups of up to three people, (another) applied a family-based setting where parents or other family members were also involved in therapy sessions. In four studies, it was unclear whether music therapy sessions were conducted in an individual or group setting. The frequency of music therapy sessions ranged from daily to weekly. In seven studies music therapy was provided daily, all with a very short duration of one or two weeks. Of the studies that provided music therapy over a longer time period, it was provided weekly in nine studies, twice weekly in six studies, and in the remaining studies three, four, or six times per week. One study randomised to either one or three session per week. The duration of sessions ranged from 10 to 60 minutes with a median of 30 minutes.⁶⁰

⁵⁶ Benson, Kjell and Hartz Arthur, J. 'A Comparison of Observational Studies and Randomized, Controlled Trials', *New England Journal of Medicine*, 342 (25), 1878-86.; Concato, John, Shah, Nirav, and Horwitz Ralph, I. 'Randomized, Controlled Trials, Observational Studies, and the Hierarchy of Research Designs', *New England Journal of Medicine*, 342 (25), 1887-92.; Pocock Stuart, J. and Elbourne Diana, R. 'Randomized Trials or Observational Tribulations?', *New England Journal of Medicine*, 342 (25), 1907-09.

⁵⁷ The NDIS Quality and Safeguards Commission discusses the concept of an evidence hierarchy in its *Evidence-Informed Practice Guide*, see pages 4 +.

⁵⁸ Hu, Jingxuan, et al. (2021), 'Art Therapy: A Complementary Treatment for Mental Disorders', *Frontiers in Psychology*, 12 (686006), 1-9.

⁵⁹ Jordan, Catherine, Lawlor, Brian, and Loughrey, David (2022), 'A systematic review of music interventions for the cognitive and behavioural symptoms of mild cognitive impairment (non-dementia)', *Journal of Psychiatric Research*, 151, 382-90.

⁶⁰ Geretsegger, Monika, et al. (2022), 'Music therapy for autistic people', *Cochrane Database of Systematic Reviews*, (5), CD004381. Page 21

122. Other reviews have made similar comments about the heterogeneity of what an art or music therapy intervention might be. Ideally, as mentioned above, we should be able to address the *how much* question: we should be able to compare the effects of a one-on-one intervention compared to a group session compared to no art or music therapy.
123. Similarly, it was often not clear what was the marginal benefit of an additional session: should the therapy intervention be eight sessions with a therapist or ten? How long should each session be to achieve the benefit?
124. Most importantly, there is also the question of who should provide each service?
125. There is an increasing expectation of health and disability professionals that they should be able to work to their full scope of practice, using all the skills and knowledge they acquired in their professional training.⁶¹ The corollary is that when those skills are not needed, the support/activity could be done by someone without those skills and for a lesser cost.
126. Specifically, should the role of the professional therapist be to design a program for the person, with implementation the responsibility of the carer providing the support in an integrated participant and carer-centred way? For example, the music therapist might write a song which the parents sing and teach the participant to sing, to help with undertaking hand washing⁶² or other everyday activities. The therapist might also train a schoolteacher in appropriate techniques.⁶³ Or should the therapist delegate some of a program to an assistant professional? In NDIS parlance, this might mean that the therapist designs, and the next few sessions are art or music activities rather than art or music therapy, with the therapist having another session later to monitor progress.
127. The reverse is also true: the art or music therapist might work with other therapists to design an integrated multi-disciplinary program which the art or music therapist implements on behalf of the whole team.
128. However, all this presupposes a truly multi-disciplinary way of working, easier in organisational settings than in the home or a therapist's rooms is in solo practice. As one music therapist reflected to this review:

But we have lost the transdisciplinary ways of working that are often a signature of organisation-based music therapy practice, particularly because music therapists can

⁶¹ Scope of Practice Review (Reviewer: Mark Cormack) (2024), 'Unleashing the Potential of our Health Workforce: Final Report', (Canberra: The Review).

⁶² This is a real example provided in the submission from AMTA

⁶³ Bentley, Laura A, et al. (2023), 'A translational application of music for preschool cognitive development: RCT evidence for improved executive function, self-regulation, and school readiness', *Developmental Science*, 26 (5), e13358.

create motivating and rewarding conditions for people to rehearse and maintain skills so we often support goals of our colleagues, as well as focusing on creative, expressive, psychosocial emotional goals.

129. Finally, to what extent should art or music therapy be seen as time-limited, designed to build capacity so that participants and their families/carers can use the techniques they have learned (e.g., calming music) in an ongoing way without the presence of the therapist?
130. Unfortunately, the published literature does not provide definitive answers to these questions, pointing to a gap in the literature and a potential research agenda.

The quality of the literature

131. As evidenced in the submissions and from my own analysis, there is a growing literature about the benefits of art and music therapy,⁶⁴ and a number of systematic reviews. Systematic reviews and meta-analyses look across a number of studies, or combine a number of studies, to get an overall picture of what is happening in a field and can more precisely measure effect size. By combining studies one can be more certain of their generalisability.
132. A systematic review generally assesses the quality of included studies.⁶⁵ For both art and music therapy, much of the literature is still weak – poor quality designs, low numbers – probably a sign that the fields are still developing. A recent systematic review of music therapy had this to say about the quality of the literature:

The literature had a number of limitations including small sample sizes, lack of control group, lack of randomisation and lack of double blinding in (randomised controlled trial) studies.⁶⁶

133. Nevertheless, despite these limitations, the overall pattern is that both art and music therapy can make a meaningful difference in goal achievement for people with some conditions.

⁶⁴ Australian Music Therapy Association (2024), 'Music therapy Disability evidence summary 2024: Person-first language', (Beaumaris, Vic: AMTA).

⁶⁵ Grades of Recommendation, Assessment, Development, and Evaluation (GRADE) Working Group, (2004), 'Grading quality of evidence and strength of recommendations', *BMJ*, 328 (7454), 1490-94.; Guyatt, Gordon H., et al. (2008), 'What is "quality of evidence" and why is it important to clinicians?', *BMJ*, 336 (7651), 995-98.

⁶⁶ Jordan, Catherine, Lawlor, Brian, and Loughrey, David (2022), 'A systematic review of music interventions for the cognitive and behavioural symptoms of mild cognitive impairment (non-dementia)', *Journal of Psychiatric Research*, 151, 382-90.

134. It is important to emphasise that not all systematic reviews are themselves of good quality. Indeed, there are now tools to assess the quality of systematic reviews (e.g. risk of bias).⁶⁷
135. The literature essentially examines the *clinical benefit* of the interventions, with almost no studies of the *cost-effectiveness* of the interventions,⁶⁸ whether increased investment in the therapy would yield additional benefits, or whether reduced investment could achieve the same benefit.
136. There was only one study of art therapy reported in the Tufts cost effectiveness registry, and this related to non-psychotic mental health disorders.⁶⁹ This systematic review cautioned about drawing definitive conclusions, given the heterogeneity of the studies, risk of bias, and generally poor quality.
137. ANZACATA also drew my attention to an economic impact study about art therapy.⁷⁰
138. The Tufts cost effectiveness registry included only two studies related to music, neither directly related to music therapy with people with disabilities.⁷¹ Neither study allows one to make definitive conclusions about the cost effectiveness of music therapy for people with disabilities generally.
139. This paucity of evidence about cost-effectiveness of both modalities is unfortunate to the say the least, and the NDIA might consider commissioning research to address this gap.

⁶⁷ Shea, Beverley J., et al. (2017), 'AMSTAR 2: a critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both', *BMJ*, 358 (j4008), 1-9.

⁶⁸ The Tufts cost-effectiveness registry is the accepted registry of such studies: Thorat, Teja, Cangelosi, Michael, and Neumann, Peter J. (2012), 'Skills of the Trade: The Tufts Cost-Effectiveness Analysis Registry', *Journal of Benefit-Cost Analysis*, 3 (1), 1-9.

⁶⁹ Uttley, Lesley, et al. (2015), 'The clinical and cost effectiveness of group art therapy for people with non-psychotic mental health disorders: a systematic review and cost-effectiveness analysis', *BMC Psychiatry*, 15 (151), 1-13.

⁷⁰ Bowen, Henry, et al. (2024), 'Social value of culturally informed art therapy for military and emergency services', *International Journal of Art Therapy*, 29 (4), 205-14.

⁷¹ One on community singing with older people (Coulton, Simon, et al. (2015), 'Effectiveness and cost-effectiveness of community singing on mental health-related quality of life of older people: randomised controlled trial', *British Journal of Psychiatry*, 207 (3), 250-5.) and one on sound therapy for tinnitus (Newman, Craig W. and Sandridge, Sharon A. (2012), 'A comparison of benefit and economic value between two sound therapy tinnitus management options', *Journal of the American Academy of Audiology*, 23 (2), 126-38.)

140. Another weakness of the literature is often the effect demonstrated is quite small, so although the result in the initial trial, or as revealed in a meta-analysis, is *statistically significant*, it may make no real difference to a person in their everyday life.; The concept of the '*minimal clinically important difference*',⁷² has been developed in the wider literature to address this issue and better studies are beginning to discuss this.
141. Although there are still methodological issues about identifying what is a clinically important difference,⁷³ the concept is an important one, especially in the context of public funding and in the absence of reliable cost effectiveness measures.
142. Inclusion in a plan of supports which do not meet a threshold of a clinically important difference also comes at an opportunity cost, that is including this support may mean another support which might make a bigger difference is not included in a participant's plan. There are wider opportunity cost issues too, as including a support which does not reach a minimal threshold means the therapist time spent on that is not available for other participants, and there is a cost to the public as well. ***It is recommended that the new Evidence Advisory Committee considers the concept of a minimal clinically important difference in making its recommendations.***
143. The concept of the minimal clinically important difference also raises issues of measurement error and reproducibility.⁷⁴ So for an individual, any measurement of their functioning or outcomes has an inherent measurement error – and this is why most clinicians will measure multiple times, to minimise the risk of treating ordinary variation as being something of clinical importance.
144. The effect size found in many of the systematic reviews and meta-analyses is quite small, but in some cases, it is quite reasonable.⁷⁵
145. Finally, the academic evidence relies on academics (and/or practitioners) having time, funding, and an interest in researching an area. This results in gaps and contradictions in the literature beyond methodological or study-design issues.

⁷² Hays, Ron D. and Woolley, J. Michael (2000), 'The Concept of Clinically Meaningful Difference in Health-Related Quality-of-Life Research', *PharmacoEconomics*, 18 (5), 419-23.

⁷³ Mouelhi, Yosra, et al. (2020), 'How is the minimal clinically important difference established in health-related quality of life instruments? Review of anchors and methods', *Health and Quality of Life Outcomes*, 18 (136), 1-17.; Carrasco-Labra, Alonso, et al. (2021), 'Minimal important difference estimates for patient-reported outcomes: A systematic survey', *Journal of Clinical Epidemiology*, 133, 61-71.

⁷⁴ Dvir, Zeevi (2015), 'Difference, significant difference and clinically meaningful difference: The meaning of change in rehabilitation', *Journal of Exercise Rehabilitation*, 11 (2), 67-73.

⁷⁵ A good preprint review has a helpful table of effect sizes: de Witte, Martina, et al. (2025 (preprint)), 'The Effects of Arts-Based Interventions in the Treatment and Management of Non-Communicable Diseases: An Umbrella Review and Meta-Analyses', *Natureportfolio*.

Where to from here?

146. Creative activities, in and of themselves, benefit all of us,⁷⁶ and there has been a number of studies that identify physiological mechanisms and paths associated with music.⁷⁷ The issue to be considered in this Review is the evidence base for a *therapeutic* intervention, compared to the ordinary life course with a person's existing set of interventions, and the relative benefit of therapy over *participation* in art or music *activities*.

147. As I have discussed above, there are many issues involved in weighing up evidence, including what evidence to consider. I started this consideration of evidence citing a definition of evidence-based practices as 'practices for which there is a demonstrated relation between specific practices and measured outcomes.'⁷⁸ Importantly and usefully, the authors go on to clarify that *demonstrated relation* here can be inferred if:

(a) there is substantial evidence that the outcome is caused by the practice, (b) it has been demonstrated that the intervention clearly leads to the desired outcome, or (c) there is a significant correlation between a specific practice and the measured outcome (page 115).

148. This would be useful framing for the new Evidence Advisory Committee to adopt.

149. A recent very comprehensive 'umbrella review and meta-analysis' of arts-based interventions in non-communicable disease was published as a preprint (that is, it has not yet been peer reviewed).⁷⁹ It included findings about mental health and neurological conditions:

- **Mental health conditions** We found a medium overall effect of arts-based interventions on health outcomes in people with mental health conditions (0.53, 95% CI 0.39–0.67, 78 ES, 30 SRs).⁸⁰ Most ES were related to music (51 ES, 17 SRs), followed by mixed arts (7 ES, 2 SRs), visual arts (6 ES, 5 SRs), drama/theatre (6 ES, 2 SRs), dance (4 ES, 4 SRs), and poetry/expressive writing (4 ES, 11 3 SRs). The overall effect for psychological outcomes was medium. The effect for physical outcomes was large but accompanied by a wide CI. We found

⁷⁶ Daykin, Norma, et al. (2017), 'What works for wellbeing? A systematic review of wellbeing outcomes for music and singing in adults', *Perspectives in Public Health*, 138 (1), 39-46.

⁷⁷ Fancourt, Daisy, Ockelford, Adam, and Belai, Abi (2014), 'The psychoneuroimmunological effects of music: A systematic review and a new model', *Brain, Behavior, and Immunity*, 36, 15-26. Sittler, Mareike C., et al. (2021), 'Psychobiological mechanisms underlying the health-beneficial effects of music in people living with dementia: A systematic review of the literature', *Physiology & Behavior*, 233, 113338.

⁷⁸ Schalock, Robert L., et al. (2017), 'Evidence and Evidence-Based Practices: Are We There Yet?', *Intellectual and Developmental Disabilities*, 55 (2), 112-19. page 115

⁷⁹ de Witte, Martina, et al. (2025 (preprint)), 'The Effects of Arts-Based Interventions in the Treatment and Management of Non-Communicable Diseases: An Umbrella Review and Meta-Analyses', *Nature portfolio*; Finn, Saoirse and Fancourt, Daisy (2018), 'The biological impact of listening to music in clinical and nonclinical settings: A systematic review', in Julia F. Christensen and Antoni Gomila (eds.), *Progress in Brain Research* (237: Elsevier), 173-200.

⁸⁰ CI=Confidence interval; ES=Effect size; SR=Systematic review; QoL=Quality of life

a small effect for the QoL domain. The effect for cognitive functioning was imprecise.

- *Neurological conditions:* We identified a small-to-medium overall effect of arts-based interventions for people with neurological conditions (0.40, 95% CI 0.30–0.50, 276 ES, 67 SRs). Most eligible ES were related to dance (138 ES, 31 SRs), followed by music (119 ES, 33 SRs), mixed arts (13 ES, 2 SRs), art (5 ES, 3 SRs), and drama/theatre (1 ES, 1 SR), with none for poetry/expressive writing. The overall effect for physical outcomes was medium. Across the psychological, cognitive, and QoL outcome domains, the effects were small.

150. As pointed out above, and as this latest preprint shows, the overall pattern in the literature is quite variable.

The NDIA's review of evidence

151. I was commissioned to consider 'the NDIA's 'review of evidence', which found that there is limited evidence about the effectiveness of art and music therapy as evidence-based'.

152. My view is that the conclusion explicit in my terms of reference, namely that there is 'limited evidence' about the effectiveness of art and music therapy is correct. It is also the case that, for some conditions, there is insufficient evidence that art or music therapy works to the extent necessary to meet any reasonable criterion for funding. But it is not my view that limited evidence and no evidence are synonyms.

153. The NDIA's evidence summary concluded:

This rapid review shows that there is some evidence which supports the use of art and music therapy for certain disability groups (e.g. art therapy for children with autism, music therapy for people with multiple sclerosis and people who have had a stroke). Overall, the identified evidence was not conclusive in supporting art and music therapy as evidence-based, therapeutic supports for all disability groups.

154. I agree with that conclusion.

155. The rapid review went on to conclude about art therapy that there was/were:

- Some evidence for the benefit of art therapy for children with autism across a range of outcomes (mobility and movement, interpersonal interactions, and other outcomes such as hyperactivity and inattention).

- Limited but positive indications for the benefit of art therapy across some outcomes for adults with learning disabilities (on interpersonal interactions and psychosocial functioning outcomes), children with cerebral palsy (on language and communication outcomes), people with PTSD (on psychosocial functioning outcomes), and people with anxiety and depression (on psychosocial functioning outcomes).
 - Limited evidence which indicated mixed and unclear benefit for people with eating disorders and people with non-psychotic mental disorders.
 - Limited evidence which indicated that art therapy may not provide any benefit for children with learning disabilities and people with schizophrenia.
156. And with respect to music therapy the rapid review concluded that there was/were
- Some evidence for the benefit of music therapy for people with multiple sclerosis and people who have had a stroke on mobility and movement outcomes.
 - Limited but positive indications for the benefit of music therapy for people living with Parkinson's disease (on communication, mobility and movement and psychosocial functioning outcomes), and people with depression and anxiety (on interpersonal interactions and psychosocial functioning outcomes).
 - Limited evidence which indicated mixed and unclear benefits for people with autism, people with schizophrenia, people with PTSD, children with epilepsy, and children with an intellectual disability and auditory processing disorder
157. There are three conclusions that one can draw from these findings. Firstly, one cannot unequivocally say that either art or music therapy are always beneficial for every person. Secondly, nor can one say that art or music therapy are not effective for anyone.
158. Thirdly, and more importantly, the conclusions are nuanced. That is, for both art and music therapy, the benefits are contingent; both art and music therapy have been shown to be effective and beneficial for some conditions and for some functional outcomes. In summary, the literature shows that effectiveness occurs at the intersection of the condition and the functional outcome.
159. The NDIA's rapid review summarises the literature using an example of what I would call a matrix to show the condition-outcome pairs where art or music therapy are effective.
160. Taking the evidence that I have reviewed, the submissions from stakeholders and the NDIA's own rapid review into account, the **key finding of this Review is that the literature provides evidence that art and music therapy are effective and beneficial to people in some circumstances, for example where the person has a specific condition and where the therapy is relevant to their seeking to achieve a specific objective or outcome.**
161. It is a corollary of this that not every intervention provided by an art or music therapist will necessarily be of benefit to a particular participant. **It is recommended that the NDIA, in messaging about evidence, should emphasise the benefits to a cohort of**

participants receiving an art or music therapy intervention, distinguishing that from generic advice about any intervention provided by art or music therapists.

162. It is beyond the scope of this review and inconsistent with the timelines I was given to specify precisely what combination of conditions or diagnoses and for what functional limitations is the literature sufficiently strong to demonstrate effectiveness. ***It is recommended that the new NDIS Evidence Advisory Committee should include an assessment of the evidence base for art and music therapy interventions in specific cohorts in its 2025-26 work plan.*** This assessment should focus on identifying the goals and cohorts and dosage for which art or music therapy is likely to be more valuable than only participation in art and music as an activity.
163. Information in plain language should be provided, possibly in a table/matrix showing in what circumstances the literature shows a benefit should be produced and placed in the public domain. The table should only include studies which demonstrate a minimally clinically important difference. This should inform the plan approval process. That is, therapeutic support should not be included in plans unless consistent with the evidence.
164. The evidence table should be supplemented by an interactive guide to help participants, and their carers, advisors, and advocates, to identify what therapeutic supports are likely to benefit them to achieve their goals, given their conditions.
165. Assessment of evidence – and development of evidence-based guidelines – is a non-trivial task,⁸¹ especially in the context of some groups being historically excluded from being participants in research studies. As the Deafblind Association argued:
- gatekeeping the use of funds in this way risks participants from lesser understood cohorts being denied effective supports on the basis that they have been historically excluded from academic research.⁸²
166. There is an old research adage that ‘absence of evidence is not evidence of absence’. Accordingly, in considering guidance about the evidence base for small cohorts, especially those who might have additional layers of disempowerment,⁸³ weaker evidence should be considered for inclusion, and logical links accepted that this

⁸¹ Knaapen, Loes (2013), 'Being 'evidence-based' in the absence of evidence: The management of non-evidence in guideline development', *Social Studies of Science*, 43 (5), 681-706.

⁸² Deafblind Australia Submission to Independent Review of NDIS Art and Music Therapy Supports

⁸³ Crenshaw, Kimberlé W (1989), 'Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics', *University of Chicago Legal Forum*, 1989 (8), 139-67.; evidence-based decision making needs to incorporate equity issues more: Hirsch, Bomi Kim, et al. (2025), 'Centering Equity in Evidence-Informed Decision Making: Theoretical and Practical Considerations', *The Milbank Quarterly*, 103 (1), 11-31.

therapeutic support works with this group, therefore, even though there is no published evidence, it seems reasonable that it might work with another group.

167. In other settings, processes have been developed to support funding of an intervention while the evidence is being developed, perhaps even from the cohort being funded.⁸⁴ The recent review of methods for health technology assessment in Australia made a number of recommendations about strengthening the use of 'real world evidence'.⁸⁵
168. ***I recommend that the new NDIS Expert Advisory Committee develop explicit processes for making decisions about provision of therapeutic support in populations where there is a poorly developed evidence base.***
169. As the Royal Commission into Violence, Abuse, Neglect, and Exploitation of People with Disability showed, 'First Nations peoples' understanding of disability does not easily align with Western concepts of disability...'⁸⁶ One consequence of this is that the Expert Advisory Committee may have to develop very different processes for assessing evidence relevant to provision of specific supports for First Nations Australians.
170. However, subject to the small cohort issue discussed above, providing therapeutic support where there is no evidence base is, in my view, unethical.
171. Participation in therapy comes at a cost to the participant of their time, sometimes also travel to meet the therapist, and in the opportunity cost of not doing something else. Sometimes costs for the parent or carer can be added to these. Given therapists are in limited supply, if one person sees an art or music therapist for a condition for which there is no evidence base, it precludes another person seeing that therapist for a condition where there is a positive evidence base, creating a net loss in potential benefits to the community. There is also a cost to the public in paying the therapist.

⁸⁴ Federici, Carlo, et al. (2021), 'Coverage with evidence development schemes for medical devices in Europe: characteristics and challenges', *The European Journal of Health Economics*, 22 (8), 1253-73.; Stafinski, Tania, McCabe, Christopher J., and Menon, Devidas (2010), 'Funding the Unfundable', *PharmacoEconomics*, 28 (2), 113-42.

⁸⁵ Health Technology Assessment Policy and Methods Review (2024), 'Accelerating access to the best medicines for Australian now and into the future. A review of Australia's health technology assessment policies and methods for the Australian Government', (Canberra: Department of Health and Aged Care). Chapter 7.

⁸⁶ Royal Commission into Violence, Abuse, Neglect, and Exploitation of People with Disability (2023), 'Final Report. Volume 9: First Nations people with disability', (Sydney: The Royal Commission)., page 34

172. I heard stories from participants' families where music therapy was not beneficial. It is not clear whether these were instances where the evidence base for music therapy is weak.
173. ***I recommend the NDIA strengthen its oversight of plans to ensure that all therapeutic support approved - not only in art or music therapy - has a robust evidence base. The NDIA should ensure that data collected by the NDIA is collated and analysed to ensure that the therapeutic support provided actually achieves a result for the condition for this participant with this provider.*** Such a data set could also be used to build evidence where it is currently lacking.
174. An exception to the plan approval process being limited to where the evidence is already existing should be made where the program involves research for which ethics approval has been obtained, or for very small participant cohorts where research has not been conducted. Such an exception would be on a time-limited basis while the research is conducted.
175. Strengthening oversight of plans would be facilitated by systematising reporting.
176. I was privileged to receive a number of anonymised reports submitted to the NDIA reporting on participant progress. These were all submitted as narrative reports, in line with the broad guidance provided by the NDIA.⁸⁷ All the reports included information about treatments and about the participant's progress on relevant metrics, but how they did this varied significantly.
177. Preparation of narrative reports allows provision of rich and nuanced data about the participant's progress, but they are expensive for professionals to prepare. They are also hard for the NDIA to collate, even with use of artificial intelligence, as there is often inconsistency in what measures are included in reports and how interventions are described.⁸⁸ It will be recalled that systematic reviews of the value of art or music therapy bemoaned the heterogeneity of the interventions involved in the reviews, and how they were described.
178. Both description of interventions and measures used should be standardised. Ideally both would cover multiple therapies, perhaps in the case of interventions using the

⁸⁷ <https://www.ndis.gov.au/providers/working-provider/connecting-participants/reporting-and-participant-plan-reviews>

⁸⁸ The use of 'AI scribes' is growing as part of reducing the cost of preparing clinical notes and reports, see e.g., Tierney Aaron, A., et al. 'Ambient Artificial Intelligence Scribes to Alleviate the Burden of Clinical Documentation', *NEJM Catalyst*, 5 (3), CAT.23.0404. AI scribes can allow user-specific formatting, and this might be developed for NDIA reporting.

relatively new Rehabilitation Treatment Specification System.⁸⁹ Generic outcome measures, such as the Australian Therapy Outcome Measures (Aus-TOMs),⁹⁰ or the EQ-5D⁹¹ might form the basis for reporting across a range of types of supports. The latter is an interval-level measure and is widely used in economic evaluation.

179. The World Health Organization has supported the development of another measure based on the International Classification of Functioning,⁹² the World Health Organization Disability Assessment Schedule 2.0,⁹³ and this is also used widely.⁹⁴ Therapy- or diagnosis-specific tools might be used as an alternative or in addition to generic measures, but these have variable psychometric properties.⁹⁵
180. Systematising description and collection of both interventions and outcomes could lead to a major reduction in the time taken by providers to provide data on treatments and their outcomes and also improve efficiency within the NDIA. It will also help, in the longer term, to address one of the problems of developing appropriate payment design.⁹⁶

⁸⁹ Van Stan, Jarrad H., et al. (2023), 'Rehabilitation Treatment Specification System: Identifying Barriers, Facilitators, and Strategies for Implementation in Research, Education, and Clinical Care', *Archives of Physical Medicine and Rehabilitation*, 104 (4), 562-68.; Van Stan, Jarrad H., et al. (2021), 'Rehabilitation Treatment Specification System: Methodology to Identify and Describe Unique Targets and Ingredients', *Archives of Physical Medicine and Rehabilitation*, 102 (3), 521-31.; Zanca, Jeanne M., et al. (2019), 'Advancing Rehabilitation Practice Through Improved Specification of Interventions', *Archives of Physical Medicine and Rehabilitation*, 100 (1), 164-71.

⁹⁰ Morris, M., et al. (2005), 'Reliability of the Australian Therapy Outcome Measures for quantifying disability and health', *International Journal of Therapy & Rehabilitation*, 12 (8), 340-46.; Perry, Angela, et al. (2004), 'Therapy outcome measures for allied health practitioners in Australia: the AusTOMs', *International Journal of Quality in Health Care*, 16 (4), 285-91.; Unsworth, Carolyn A., et al. (2004), 'Validity of the AusTOM scales: A comparison of the AusTOMs and EuroQol-5D', *Health and Quality of Life Outcomes*, 2 (64), 1-12.

⁹¹ Feng, You-Shan, et al. (2021), 'Psychometric properties of the EQ-5D-5L: a systematic review of the literature', *Quality of Life Research*, 30 (3), 647-73.

⁹² World Health Organization (2001), *International classification of functioning, disability and health* (Geneva: WHO).; although one should acknowledge critiques of the ICF: Imrie, Rob (2004), 'Demystifying disability: a review of the International Classification of Functioning, Disability and Health', *Sociology of Health & Illness*, 26 (3), 287-305.

⁹³ Üstün, T Bedirhan, et al. (2010), 'Developing the World Health Organization disability assessment schedule 2.0', *Bulletin of the World Health Organization*, 88, 815-23.

⁹⁴ Federici, Stefano, et al. (2017), 'World Health Organization disability assessment schedule 2.0: An international systematic review', *Disability and Rehabilitation*, 39 (23), 2347-80.

⁹⁵ Kumar, Mrityunjai, et al. (2024), 'Outcome Measures in intellectual disability: A Review and narrative synthesis of validated instruments', *International Journal of Social Psychiatry*, 71 (2), 239-53

⁹⁶ Chalkley, Martin and Malcomson, James M. (2000), 'Government purchasing of health services', in Anthony. J. Culyer and Joseph P. Newhouse (eds.), *Handbook of health economics: Volume 1A* (Amsterdam: Elsevier), 847-90.

181. ***I recommend that the NDIA systematise its collection of data from providers about the effectiveness and outcomes of therapy interventions for participants, including development of consistent definitions of interventions aligned to a robust participant outcomes framework.***

Pricing and rate setting

182. My terms of reference listed pricing first and the evidence base second, I have reversed the order in this report as price is only relevant for evidence-based services. That is, a therapy support should not be paid for if it is not likely to achieve a clinically important outcome for participants.
183. In this section I use the term ‘payment rate’ to describe what is paid to providers under the NDIS; generally, I reserve the term ‘price’ for market interactions.⁹⁷
184. Ideally, the payment rate for art and music therapy would reflect the value to the user of the service. This would mirror the approach in an ordinary unregulated market, where the consumer is willing to pay what they think the product is worth to them.⁹⁸
185. In the NDIS, the price to the recipient of the service is zero, that is, the full payment for the service is made by the NDIA (or the self-managed participant) to the provider.
186. However, in most circumstances, a recipient’s NDIS allocation is essentially fungible, that is, if money is not spent on one therapeutic support, it is available to be spent on another. This means there is an ‘opportunity cost’ to the person with disability: what they spend on art or music therapy is not available to be spent on something else. This is the case for all participants irrespective of how their plans are managed, but it is transparently so for self-managed participants.
187. But even so, apart from self-managed participants, the recipient does not completely determine what is paid to the provider, as the payment is covered by the NDIS’ *Pricing Arrangements and Price Limits* (PAPL).
188. The PAPL sets a payment rate maximum, and providers can charge less than that. The PAPL describes ‘pricing’ thus:
- The NDIA does not set the prices that providers charge participants. Each provider must agree the price for each support with each participant, subject to the price limits and pricing arrangements that are imposed by the NDIA.
 - Providers should not indicate in any way to participants that the prices that they charge are set by the NDIA.
 - In general, providers should not charge NDIS participants more for a support than they would charge anyone else for the same support. If the price a provider offers to a NDIS participant is different to that which they would offer to a person who was not an NDIS participant, then the provider should ensure that the participant is aware of this difference and the reasons for the difference (page 9).

⁹⁷ I acknowledge that ‘administrative pricing’ is occasionally used in the literature.

⁹⁸ The actual price paid in an unregulated market is determined by the intersection of what the consumer is willing to pay and what price the provider/seller is willing to sell for.

189. In effect, then, the NDIS oversees payment rates and, through the PAPL, sets a maximum rate. This is essentially what I have been asked to review.
190. Because the payment for art and music therapy is made by the NDIS, and there is no out-of-pocket cost to the participant, there is no effective market in that consumers are not asked to make an individual valuation of what the service is worth to them and pay accordingly.
191. In these circumstances, payment rates should reflect average benefit to the average consumer.⁹⁹
192. Technically, payment should reflect the marginal benefit, and in the longer term, with standardised information collected from providers, it will be possible to track incremental improvements and calculate the average of those incremental benefits to inform payment policy.
193. There is extensive theoretical literature about measuring benefits, and so, if data were available, it would be possible to set a fair payment rate relative to the average benefit achieved. However, although the literature on measuring benefits is longstanding,¹⁰⁰ it is still controversial in the disability field.¹⁰¹
194. As I have concluded earlier, there is evidence that art and music therapy work in certain circumstances, but the literature does not adduce estimates of the incremental or average benefit of the proven interventions to be used in price setting.
195. Accordingly, setting aside the controversy about measurement, there is no reliable data to set a payment rate based on average (or marginal) benefit.
196. The NDIS approach to setting rates or what is sometimes referred to as prices, is to set rate maxima. The PAPL sets the following rate maxima:

⁹⁹ Newhouse provides a useful review of pricing issues in health care, many of which are relevant to disability services: Newhouse, Joseph P. (2002), *Pricing the priceless. A health care conundrum* (Cambridge, Massachusetts: MIT Press).

¹⁰⁰ Chen, Ariel, et al. (2015), 'The evolution of the disability-adjusted life year (DALY)', *Socio-Economic Planning Sciences*, 49 (March), 10-15.

¹⁰¹ Andrade, Gabriel (2024), 'Quality-Adjusted Life Years and Disability', in Gabriel Bennett and Emma Goodall (eds.), *The Palgrave Encyclopedia of Disability* (Cham: Springer), 1-8.

Table 2: Current rate maxima for selected services, per hour

Item Number	Item Name and Notes	Maximum rate
15_610_0128_1_3	Assessment Recommendation Therapy or Training - Art Therapist	\$193.99
15_615_0128_1_3	Assessment Recommendation Therapy or Training - Music Therapist	\$193.99
15_054_0128_1_3	Assessment Recommendation Therapy or Training - Psychologist	\$222.99
15_056_0128_1_3	Assessment Recommendation Therapy or Training - Other Professional	\$193.99
043_0128_1_3	Assessment Recommendation Therapy or Training - Counsellor	\$156.16
15_052_0128_1_3	Therapy Assistant - Level 1 Support must be delivered by a therapy assistant working under the delegation and direct supervision at all times of a therapist.	\$56.16
15_053_0128_1_3	Therapy Assistant - Level 2 Support must be delivered by a therapy assistant working under the delegation and supervision of a therapist, where the therapist is satisfied that the therapy assistant is able to work independently without direct supervision at all times.	\$86.79

Note: Rate maxima shown are for NSW, Victoria, Queensland and ACT, non-rural, non-remote. Other areas have higher maxima.

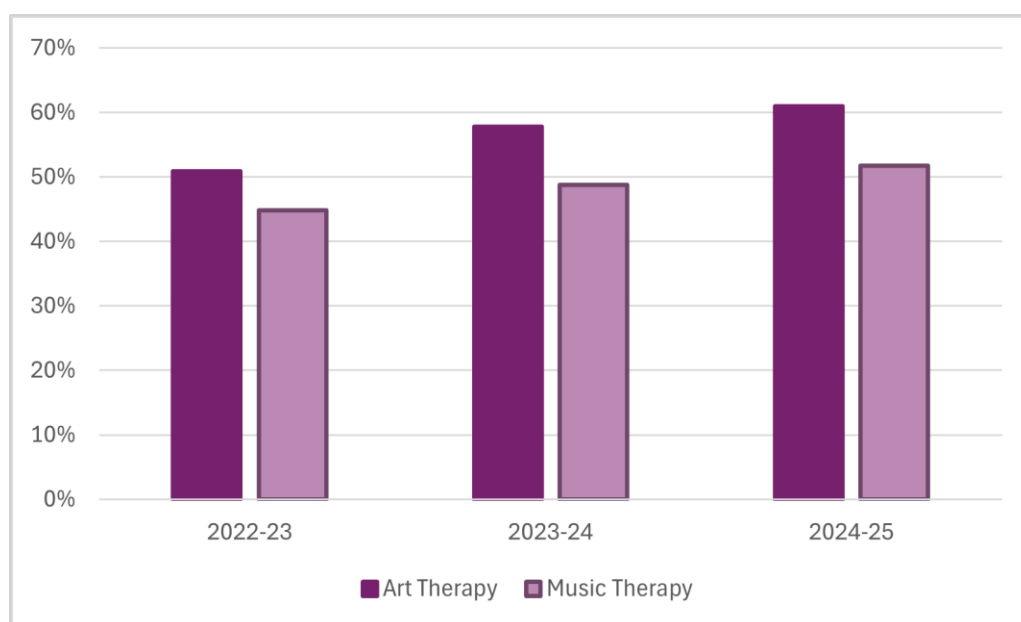
197. The maximum payment rate for art and music therapists in the current PAPL (2023-24) is the same as that for nationally regulated professions such as speech and occupational therapy, below that for psychologists, and above that for counsellors, who are not nationally regulated. Maximum rates for therapy supports, other than psychology, have not increased since 2019 as until recently most claims were at rates below the maximum.

198. Although the PAPL makes clear that the specified rates are the maximum that the NDIS will pay, there is no incentive on a provider to charge under the cap, or on participants to see a provider who charges under the maximum.¹⁰²

¹⁰² Theoretically, the participant has a financial allocation, and they should have an incentive to shop around to get best value for money. However, they can also ask for their allocation to be reviewed and increased if it is fully expended which somewhat mitigates the incentive.

199. Further, the preconditions for effective market functioning are not present – not least because of poor information about quality of different providers and consumers can only judge the quality for them after they have experienced the service.¹⁰³
200. As will be shown below, in 2023-24 the rate maxima for both art and music therapy appear to be above the prevailing rates in the outside market.
201. Setting rate maxima has serious limitations and risks.
202. Firstly, as mentioned above, there is effectively no incentive on providers to charge less than the rate maxima. The PAPL specifies that
- ‘In general, providers should not charge NDIS participants more for a support than they would charge anyone else for the same support’.
203. I have seen no evidence that any provider has been called to account for breaching that specification, despite years of statistical evidence that this is a regular occurrence.
204. Secondly, there is no effective market in art or music therapy within the NDIS, and so there is really no ability of participants or their support people to look to price competition, nor is there any real incentive to do so.
205. It is therefore no surprise that actual payments to art and music therapists are tending toward the regulated maximum: more than half of all claims for art and music therapy are now at or near the rate maxima (see Figure 1).

Figure 1: Proportion of payments at or near hourly rate maxima



¹⁰³ Nelson, Phillip (1970), 'Information and consumer behavior', *Journal of political economy*, 78 (2), 311-29.

Data table for Figure 1

	Art Therapy	Music Therapy
2022-23	51%	45%
2023-24	58%	49%
2024-25	61%	52%

Source: NDIA analysis, 'at or near' defined as \$190-195

206. Thirdly, NDIS rates appear to be influencing the wider market, to the extent there is one. That is, prices charged in the wider market appear to be drifting up to the NDIS rate maxima.

207. Art and music therapy are very small professions and, as the NDIS has grown, it has become the main purchaser of non-salaried art and music therapy. Effectively, the NDIA is becoming a monopsonistic purchaser in these fields.¹⁰⁴

208. It has been argued that art and music therapists should have the same maximum rate as physiotherapists, occupational therapists or speech therapists, essentially because the training programs are somewhat similar. Indeed, my terms of reference directed me to look at the rate maxima for other allied health professions. But there are differences between the professions as well, most notably that art and music therapy are not nationally regulated.

209. The argument for parity is predicated on the assumption that the payment rate for the chosen comparator is fair, and there is parity in all respects. However, in the short time available for this review I cannot determine whether the maximum payment rates for the other therapies are fair or not.

¹⁰⁴ A monopsony is the buyer side parallel to a monopoly: a monopoly exists when there is a single seller or provider, a monopoly exists when there is a single buyer or purchaser. Robinson, Joan (1969), *The economics of imperfect competition* (New York, NY: St Martins Press).; Thornton, Robert J. (2004), 'Retrospectives: How Joan Robinson and B. L. Hallward Named Monopsony', *Journal of Economic Perspectives*, 18 (2), 257-61.

210. But I will go this far, as I have argued above there is good evidence that art and music therapy can make a real difference for participants. Further, the evidence shows that art and music therapy make a difference in some circumstances over and above participation in art and music activities. The corollary of this is that art and music therapy should continue to be paid as therapy rather than as participation in activities. This of course leaves open the question about where precisely that professional rate should be set.
211. Another way of phrasing this is to say that if art or music therapy is included in a participant's plan as an evidence-based stated support, then it should be paid as such, as a therapy, else it should be paid as a participation activity.
212. My assumption here is that art or music therapy are included in a participant's plan as therapeutic supports because the aim is for the therapy to have a clear and defined benefit linked to the participant's needs. As I have said, it should then be paid as a therapy.
213. Participant's may want to accrue other benefits from involvement in art or music: to calm, to engage with others, or generally to benefit as we all do from these activities. These engagements should be paid for as participation in activities, not as therapy.
214. ***I recommend that the NDIA set rate maxima for art and music therapists on the basis that these are distinct professions, providing evidence-based therapy, not simply supervising art or music activities.***
215. As indicated above, in a normal market, a person assesses what the value of the service is to them and is willing to pay commensurately. Importantly, art and music therapists provide services outside the NDIS and so another comparator is how do other users value art and music therapy?
216. Although there are good reasons to compare the prices that users outside the NDIS are prepared to pay for art and music therapy, it is not a perfect comparison, as services provided outside the NDIS may be slightly different from the services provided to people eligible to receive NDIS support. Nevertheless, prices in an ordinary market may provide a useful benchmark in relation to NDIS benchmarks.
217. As part of its annual pricing review, the NDIA analyses what private therapists charge outside the NDIS as reported on their websites. The results for art and music therapists for 2023-24 and all therapists are shown in Table 3.

Table 3: Summary Statistics of Private Billing Rate Sample, by Therapy Type, 2023-24

Type of Therapy	Count	Mean	Standard Deviation	Min	25 th percentile	Median	75 th percentile	Max	NDIS price limit
Art Therapy	26	\$154.5	\$30.6	\$100.0	\$135.0	\$147.5	\$178.8	\$216.0	\$193.99
Music Therapy	39	\$166.0	\$36.7	\$90.4	\$120.0	\$180.8	\$194.0	\$233.3	\$193.99
All therapy supports	1,791	\$195.6	\$56.0	\$85.0	\$158.0	\$194.0	\$230.0	\$396.0	Varies

Source: 2023-24 Annual Pricing Review Report, page 79

218. On average (mean), a session of art therapy in 2023-24 cost a person outside the NDIS about \$40 below the NDIS payment maximum (median: about \$45 below). The price for music therapy outside the NDIS was also on average about \$30 below the NDIS maximum rate (median about \$15 below NDIS maximum). That is, market prices for art therapy were on average 80% of NDIS price caps, and for music therapy, 86% of the maximum NDIS rate.

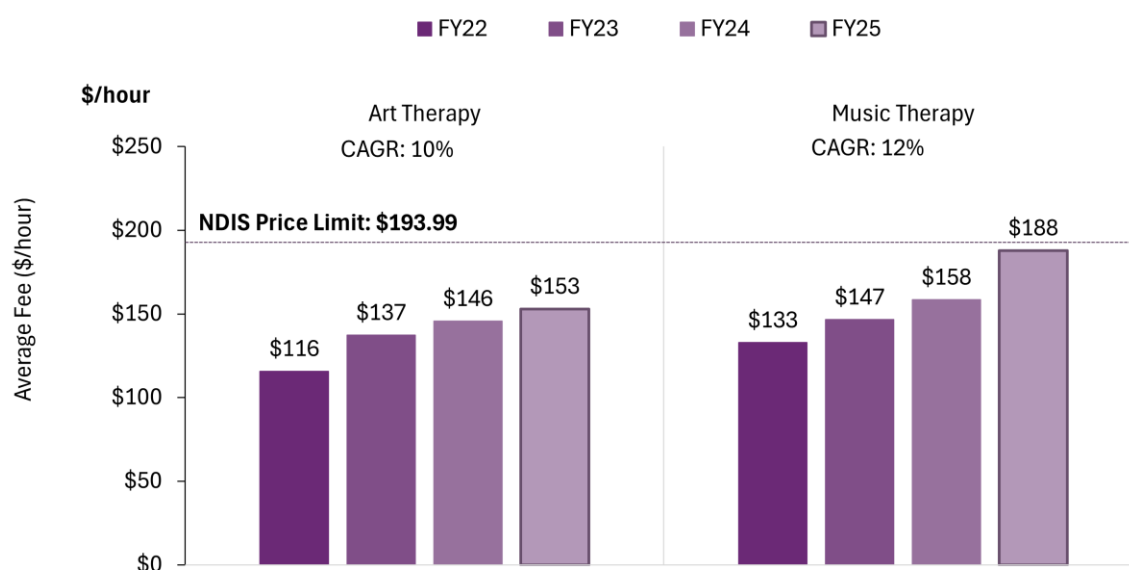
219. I have used the average market price here as the comparator. If one took a tighter standard, say the 25th percentile there is an even bigger disparity between charges to private clients and the NDIS. However given the NDIS's monopsonistic positioning, the mean seems reasonable for the purposes of these comparisons.

220. Although there may be differences between therapy services provided to NDIS and non-NDIS clients, and the reporting associated with service provision, the magnitude of the payment differences seen in 2023-24 is hard to explain, other than the effect of NDIS maximum rate setting.

221. My conclusion is the NDIS maximum rate for both art and music therapy for 2023-24 was too high and potentially facilitated faster rate increases than was warranted e.g., relative to inflation. A fairer rate maximum for both art and music therapy would have been the rate maximum for counsellors.

222. Figure 2 shows that average prices charged outside the NDIS have drifted up to the NDIS maximum rate over the last four years. The 10%-12% cumulative annual growth rate (CAGR) seen is well in excess of the effect of inflation: the Consumer Price Index showed a 3.5% cumulative annual growth rate over this period.

Figure 2: Average charge to clients outside the NDIS, recent years



Data table for Figure 2

	FY22	FY23	FY24	FY25
Art Therapy	\$116	\$137	\$146	\$153
Music Therapy	\$133	\$147	\$158	\$188

Source: NDIA, website scraping data

223. The shift in prevailing payment rates from 2023-24 to the present shows that the NDIS rate maximum is an asymptote for prevailing prices. Importantly this is the case both for NDIS services and for services provided outside the NDIS.
224. This illustrates my earlier point about NDIA market dominance: that the NDIA has essentially become a monopsonistic purchaser, setting prices for both NDIS services and for services outside the NDIA's purview.
225. The NDIA payment rate has therefore become the pricing benchmark for all other services, such as public community and mental health services. To the extent that salaries of art and music therapists employed in these settings have not kept pace with movements in the effective payment rate under the NDIS, the high NDIA payment rate leads to a 'crowding out' effect. This means that other public services may not be competitive in attracting art or music therapists and so art and music therapy become less available in these other settings. This may lead to an overall reduction in societal utility, as people not covered by the NDIS can no longer get access to evidence-based art or music therapy.

226. Another effect of the NDIA's dominant role in the broader rate/price setting for art and music therapy is that looking to the private market for benchmarking is somewhat circular - the NDIA rate setting affects those prices as well.
227. How then might the NDIA set rate maxima? The simple answer is what is best for participants and the public. Ideally the payment rate should reflect marginal value, but we don't have the evidence to do that.
228. The next best approach is for the NDIA to become a more sophisticated market steward as contemplated in the NDIS Review.¹⁰⁵
229. ***I recommend that the NDIA expand its capacity monitor market dynamics to assess supply of, and the demand for, art and music therapy and therapists.***
230. Demand for art and music therapists is dominated by the public sector, particularly the NDIS, as most users of art and music therapy are NDIS participants. Other public sector payers – such as state governments for mental health services – could easily be captured in evaluations of demand.
231. Supply of art and music therapists is affected by entry and exits, the former constrained by the number of approved education programs for these professions. The NDIA or the Department of Social Services could foreshadow to educational providers its estimates of future demand to assist them in planning the size of their intakes.
232. A potential constraint on supply is the availability of placements for art and music therapy students. Although this was only raised with me in this Review in passing, the issue of finding placements for students is a perennial one, exacerbated in professions which are predominantly private, one: one provision, with fee-for-service remuneration, all characteristics of art and music therapy. In the medium term, strategies may need to be considered to facilitate or fund placements through additional payments to providers of art or music therapy to supervise students on placement.
233. Another critical variable in estimating supply is the response of therapists to change in payment rates: if the NDIA rate is too low, therapists might choose leisure or alternative work rather than support NDIS participants. Assuming that all future NDIS provision is evidence-based in line with my recommendations, a level of supply that is less than the level of demand would involve a net loss in societal welfare.

¹⁰⁵ Independent Review into the National Disability Insurance Scheme (2023), 'Final Report: Working together to deliver the NDIS', (Canberra: The Review). The Department of Social Services already undertakes demand mapping: <https://caresectordemandmap.dss.gov.au/map/ndis/postcode>

234. The objective of workforce analysis would be to ensure that there are sufficient art and music therapists so that evidence-based art and music therapy is available to all NDIS participants if it is included in their plans. Demand outside the NDIS also needs to be considered. Any workforce analysis would also benefit by being segmented by geography, to ensure access for people in rural and remote Australia.
235. ***I recommend that in the medium term the NDIA, set payment limits for art and music therapy that take account of their labour market monitoring and the need to ensure there is an adequate supply of art and music therapists to meet the requirement for evidence-based provision of art and music therapy.***
236. But a payment rate maximum for each of the relevant professions needs to be set in the meantime while the longer-term strategy is addressed.
237. Due to the circularity involved in the interaction between the NDIA rate maxima and the private market, unfortunately there is no other basis for setting a rate maximum currently.
238. I have seen no evidence that the increase in charges for art and music therapy seen in the last few years is associated with improvements in outcomes. Rather, I think it is simply the outworkings of the drift upwards in charging in the absence of an effective market for these services.
239. Accordingly, I think the evidence about the relationship between NDIA rate maxima, charges by therapists to the NDIA, and external market pricing, as shown in the previously published NDIA market review should be the basis for rate maxima.
240. However, as recommended above, it is not my view that art or music therapy is simply another form of art and music activity, so rate maxima for these services should be aligned with professional, rather than participation in an activity, rates.
241. The previous NDIS pricing review showed that there was alignment in the marketplace of the rate for both art and music therapy with the rate maximum for counsellors.
242. ***I recommend that the NDIA align the maximum payment limit for art and music therapy with the maximum payment limit for counsellors.*** To be explicit, this recommendation applies to the separate rates established for early intervention services.
243. The PAPL schedule includes a rate maximum for 'other professionals'. A potential risk of this recommendation is that art and music therapists might use that item, which has a higher maximum, rather than the existing art and or music therapy code which would have a newer rate maximum. To avoid this perverse consequence, ***I recommend that***

the NDIA specify in its Pricing Arrangements and Price Limits, that art and music therapy cannot be claimed under 'other professional'.

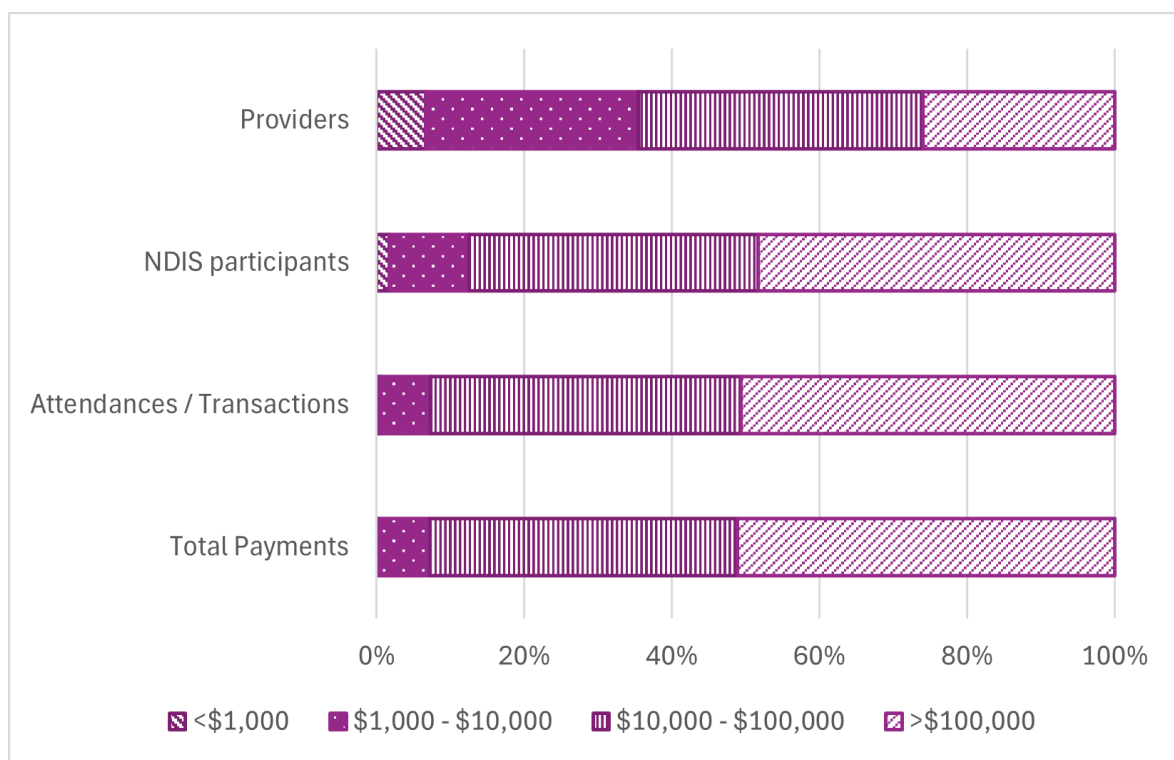
244. The current PAPL sets a single payment rate for each class of allied health professional, including art and music therapists, so a new graduate and a therapist with years of experience can claim the same rate.
245. Patently, therapists might differ in their skills based on their experience and further study. One would typically expect to see a large variation in rates charged to the NDIA to reflect this. We don't. Rather what we see as exhibited in Figure 1 more than half of claimed rates are close to the rate maximum.
246. Overtime, it might also be useful to recognise specialisation and advanced skills within allied health professions, including art and music therapy. This would help to ensure that the most skilled therapists are appropriately remunerated for dealing with participants with more complex needs.
247. The PAPL already provides for two rates for therapy assistants.
248. ***I recommend that the NDIA explore establishing differentials within the allied health professionals' scales to recognise different capacity to provide services and/or to recognise levels of skills and experience.***
249. Payments by self-managed participants are not regulated by the PAPL. However, self-managed participants can only spend under their plan budgets in line with NDIS guidelines, that is, the therapeutic support provided must be evidence based.
250. Appropriately, self-managed participants have freedom to choose who provides therapeutic support. This freedom is not unconstrained, as what is provided must be consistent with the definition of therapeutic support. This suggests that the person providing the therapeutic support should be appropriately qualified and understands what evidence-based support is and what it is not.
251. ***I recommend that the NDIA ensure that funding for art and music therapy as a Therapeutic Support for self-managed participants be limited to supports provided by appropriately trained art and music therapists as defined by NDIA who meet the requirements of NDIS Commission registration. In other circumstances, art or music activities should be classified as Participation in Community, Social and Civic Activities and funded accordingly.***
252. The provision of art and music therapy, and payment arrangements, reflect a 'professional' model of provision involving fee-for-service payment. Essentially, a

hallmark of professions is that expertise is institutionalised in an individual profession,¹⁰⁶ with payment between the professional and the client, typically paid as a fee-for-service. Traditionally there were no third-party payers.

253. The NDIS is a third-party payer which potentially calls into question whether the historic fee-for-service model continues to be fit-for-purpose.

254. Many art and music therapists see only a few NDIS clients and so the fee-for-service model may continue to be appropriate here, but in both fields, there are large providers with a quite different service model.

Figure 3: Provision of art therapy, by size of provider in terms of total NDIS payments, 2023-24



¹⁰⁶ Abbott, Andrew (1988), *The system of professions: An essay on the division of expert labor* (Chicago: University of Chicago Press).

Data table for Figure 3

	<\$1,000	\$1,000 - \$10,000	\$10,000 - \$100,000	>\$100,000
Total Payments	0.0443	0.92073	5.57791	6.83243
Attendances / Transactions	289	4714	28594	34515
NDIS participants	121	754	2722	3367
Providers	111	482	644	435

Source: NDIA, data provided to review. Note: Payments are total NDIS payment to the provider, not just for art therapy. Providers could claim other therapies, or other NDIS supports (e.g., disability support workers), noting that NDIS provider is not equivalent to the actual therapist who provided the service

255. About one quarter of providers who have claimed for art therapy received more than \$100,000 of total NDIS revenue in 2023-24 (defined here as a large provider), but these large providers have claimed almost half the art services (called attendances/transactions in the figure) and received more than half the total art therapy payments.

256. Compared to the smallest providers, the largest providers of art therapy:

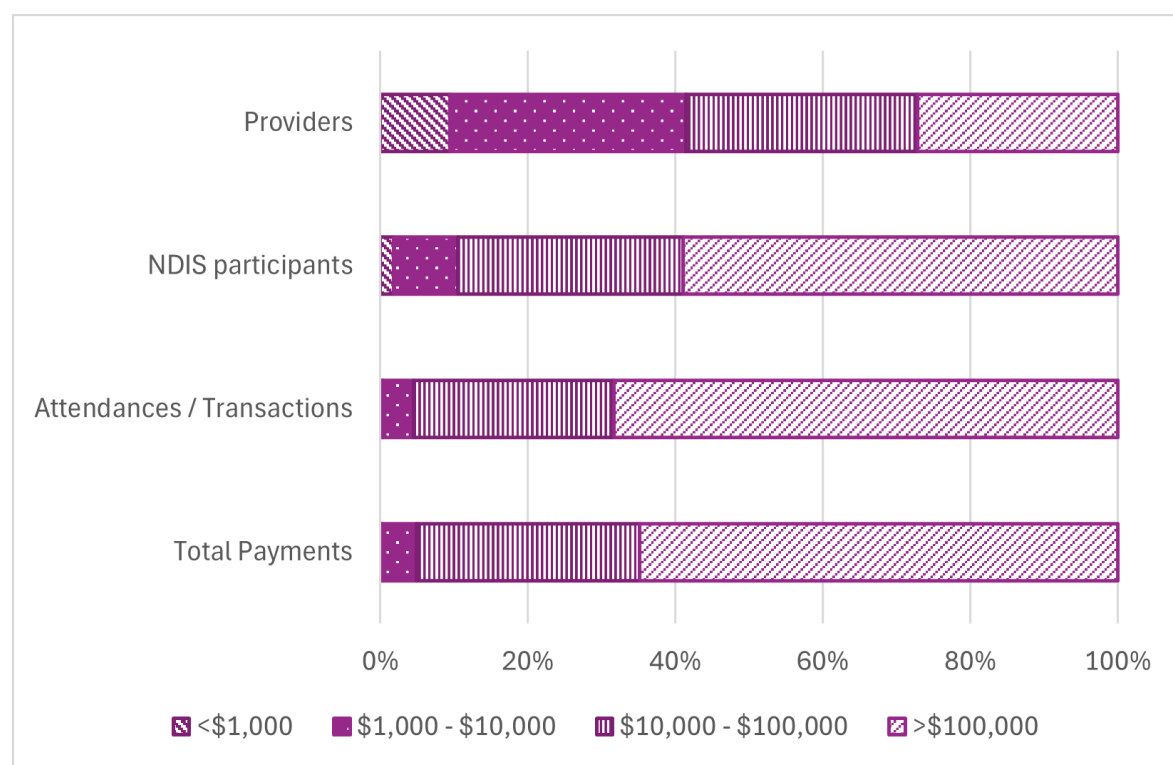
- Received higher average payments per service (\$198 v \$152)
- Claimed more for each NDIS participant treated (\$2029 v \$364)
- Saw participants more frequently (average 10.3 services per participant v 2.4).¹⁰⁷

257. The data provided to me does not enable me to assess whether participants seen by the largest providers are more complex (so justifying some more visits), achieve better outcomes (again potentially justifying more visits), or whether this simply reflects provider and/or participant preferences.¹⁰⁸

¹⁰⁷ I also looked at providers in the \$1,000 - \$10,000 range. They also saw participants less frequently (6.3 vs 10.3 for largest providers).

¹⁰⁸ The economics literature refers to this concept as 'moral hazard', although the concept is under challenge see Grignon, Michel, et al. (2018), 'Moral Hazard in Health Insurance', *OEconomia. History, Methodology, Philosophy*, (8-3), 367-405. Where the variation in use is driven by provider choices it is referred to as supplier- or provider-induced demand. Various hypotheses have been advanced for the phenomenon including income maximisation and professional uncertainty.

Figure 4: Provision of music therapy, by size of provider in terms of total NDIS payments, 2023-24



Data table for Figure 4

	<\$1,000	\$1,000 - \$10,000	\$10,000 - \$100,000	>\$100,000
Total Payments	0.04714	0.74591	4.89062	10.4954
Attendances / Transactions	390	4550	29990	75498
NDIS participants	133	640	2246	4331
Providers	132	450	442	381

Source: NDIA, data provided to review. Note: Payments are total NDIS payment to the provider, not just for music therapy. Providers could claim other therapies, or other NDIS supports (e.g., disability support workers), noting that NDIS provider is not equivalent to the actual therapist who provided the service.

258. We see a similar pattern of claiming with music therapy providers. The largest providers (those with total NDIS revenue in 2023-24 of more than \$100,000) account for just over one quarter of all providers who claimed music therapy. Similar to art therapy, almost 60% of participants who received music therapy, used one of the largest providers. The largest providers claimed for more than two thirds of the services and received almost two thirds of the music therapy payments.

259. Compared to the smallest providers, the largest music providers:

- Received higher average payments per service (\$139 v \$121)
- Claimed more for each NDIS participant treated (\$2423 v \$353)
- Saw participants more frequently (average 17.4 services per participant v 2.9).

260. Again, we cannot make any definitive conclusions about the different practice patterns.

261. The largest providers of both art and music therapy use company or trust structures (79% of the largest art therapy providers and 85% of the largest music therapy providers are companies or trusts) compared to the smaller providers who tend to be unincorporated individuals or partnerships (85% of small art therapy providers and 95% of small music therapy providers have adopted these structures).

262. Service provision by larger providers is different from the smaller providers and warrants a different approach from the NDIA, including consideration of whether fee-for-service is the best way of paying for their services

263. Normal business practice involves different bases for payment, including commercial or relational contracts. Here, there may be elements of fee-for-service, but the contract may be on a different basis more suitable to share benefits, say, of economies of scale and to introduce payment models more appropriate for a regulated market.¹⁰⁹

264. In the case of art and music therapy, the NDIS might be able to articulate different and/or greater expectations for the larger providers. For example, larger providers might be expected to have a greater share of their provision in group work;¹¹⁰ may have greater expectations about training the next generations of therapists; or have greater

¹⁰⁹ Laffont, Jean-Jacques and Tirole, Jean (1993), *A theory of incentives in procurement and regulation* (Cambridge, MA: MIT Press).

¹¹⁰ It is important to note that group sessions are not appropriate for every participant: it may take time for a participant to be comfortable in a group setting, or they might upset other people in the group. I also heard stories of NDIS participants looking forward to group activities, building their skills there, and learning how to make friends through participation in therapy sessions.

expectations about more sophisticated quality improvement practises; and better measurement of the outcomes of their services.

265. The NDIA's payment framework for these larger providers should consider the full range of service benefits that are linked to participant needs over the short, medium and long term. The framework should consider the most efficient and effective ways to set payment limits for these services and the best payment arrangements that can ensure their delivery.
266. Differential payment for larger providers has been canvassed previously, based in part on arguments about different complexity of their clients, greater roles in workforce development, and stronger mechanisms for quality improvement.¹¹¹
267. For larger providers, payment for training and research might be a supplement to service provision payments.¹¹²
268. As outlined in the discussion on early interventions services, client choice and control would be maintained by their ability to 'exit' – their ability to move between providers should not be constrained, perhaps with the exception of a specified notice period.
269. A key challenge in establishing a robust payment regime in the NDIS is the range of cost structures and benefits delivered across a broad range of providers. Large providers probably accrue all the benefits of economies of scale and other efficiencies, with no explicit or apparent sharing of those benefits with participants or in improving NDIS sustainability. What needs to be considered is how the NDIA might develop payment and funding approaches that facilitate better collaboration among participants to extract value from the larger providers.
270. ***I recommended that the NDIA consider a different payment and funding approach, particularly for large organisational providers.***

¹¹¹ Deloitte - Access Economics (2023), 'NDIS Therapy Pricing Structures – Options Analysis', (Canberra: Deloitte - Access Economics).

¹¹² In the health sector these services are recognised as distinct additional roles which need to be paid for, with distinct additional payments not built into a higher payment cap for larger providers

Conclusion

271. It is clear from my review of the literature, that art or music therapy can be valuable contributions to helping participants achieve their goals. But these therapeutic supports are only likely to do this if there is good evidence to support this use of art or music therapy from the experience of people with similar conditions and similar goals as revealed in replicable research.
272. It is a waste of money to incorporate any therapeutic support in a plan in the absence of good prospective evidence.
273. More information needs to be available to participants so that they are aware of what works and what doesn't. Better information, and tighter linking of evidence and plans, will be helpful to both participants and the overall sustainability of the NDIS. I hope my recommendations go some way to achieving this.
274. I would again like to thank all those who participated in this review, and those who supported the review.