Consultation re the new NDIS Support Lists – what’s in and what’s out:

My response to this consultation is informed by my 30 years in the health and disability sectors working as a Registered Nurse, Registered Music Therapist and Rehabilitation Facilitator. Also, I have been a Registered NDIS Provider operating as a sole trader in the scheme since it rolled out in our area. My contribution is also informed by my lived experience as the sister and sister-in-law of a brother and a brother-in-law who have lived most of their adult lives with profoundly complex mental health conditions. In both cases their mental health conditions have significantly and directly impacted every aspect of their health/wellbeing/functioning on a daily basis, as well as the lives of those closest to them e.g. their aging parents. Their obesity and diabetes is a direct result of their long term mental health conditions and the treatment of them. One of these men is on the NDIS the other is not. I am also the mother of a young adult woman living with autism and PTSD. She is not on the NDIS, and I can assure you that despite all our resources as a family, there isn’t a mainstream system (especially not her schools) that has been able to support her appropriately – other than ONE of the GPs we encountered and her private specialist Psychiatrist.

1. Do you think the draft list of NDIS Supports covers the kinds of

disability supports you think should be included?

It does in part, but I do not think it is possible to achieve this comprehensively and to the true intent of the scheme through such a list. The true intent of the NDIS is “Dignity of Risk” – choice and control to support INDIVIDUALISED NEED. How can a black and white list be the right mechanism for this? It is a simplistic and unfortunately lazy option for not addressing the inherent discrimination that sits behind the laws, regulations, structures, systems and/or cultures that have informed the list i.e. exactly the things the NDIS was supposed to transform in our society.

• If not, what changes would you suggest?

Honesty, transparency and a genuine intent to shape the social change promised by the NDIS.

The fundamental problem with the list of “What’s in and What’s out” is that its creation isn’t actually designed for people living with a disability. They are not its purpose. It is for conversations, policy making and the changes recommended in the December 2023 NDIS Review directed at federal, state and territory, and local governments and their relevant sectors i.e. targeted at sectors outside of the NDIS. N.B. The “2023 NDIS Review” was not an NDIS Review. It was a review of how people with a disability are treated/supported across all sectors. This premise should be disclosed in every conversation, communication and consultation.

This is actually a conversation about each level of government taking financial and social responsibility for appropriately looking after people living with a disability in each of their respective jurisdictions, and the third tier of support (i.e. the NDIS – federal government) absolving itself of responsibility if the need is not appropriately meet by the other tiers – tier one and tier two.

The NDIS is an insurance scheme, so, where is the insurance in the “What’s in and What’s Out” list should these first and second line tiers of support fail, or even more specifically fail to meet the person living with a disability’s INDIVIDUALISED NEED as it is defined by the participant and their representative, and not by a list that hopes to have comprehensively considered every confronting, marginalising, traumatic, isolating, excluding scenario a person living with a disability might find themselves in our still imperfect society and across our entire country?

Assessing, identifying, describing, planning for, and supporting individualised need requires significant skills, training, education, years of experience, relevant local and personalised knowledge, and trusted therapeutic relationships – particularly if it is to be able to comprehensively assess this across the vast and complex landscape of the various relevant sectors and how they interact/intersect i.e. health, disability, education, justice, aged care, employment, housing, etc. We still have no insight into the capacities, qualifications and training of the people who are/will be placed at the coal face to support participants in navigating the scheme, and who will have a significant role in making the final decision on their funding needs. This is a profound responsibility, and my fear is the black and white nature of the “What is in and what is out” list is at risk of being applied in a black and white manner, which is completely inappropriate for anyone engaging with people living with a disability and who are highly vulnerable and “at risk”, and should not be necessary if the person in the NDIA supporting people with a disability has the skills and expertise that people living with a disability deserve to be served by. To summarise that the list as missing a “What if?” list highlights just how over-simplified, unsophisticated and therefore potentially offensive the nature of the “What’s in What’s out” list is to people living with a disability.

At its foundation there has been an attempt to build a scheme for the most vulnerable in our society, with the most profoundly complex needs, and have it staffed at every level, (other than the nursing and allied health levels), by people who are completely unqualified – and I am not just referring to the service providers being paid through NDIS participants funds – I am also talking about all the people administering the scheme within the NDIA. Lived experience is important, but it is not enough.

How is it possible that we are in 2024 and there is not a disability specialty in medicine? This is a profound failing that needs to be addressed. It can no longer be ignored because it is too hard. A paediatrician looks after healthy children, an obstetrician looks after healthy pregnant women. How is it that people living with a disability do not have access to a medical practitioner who specialises in disability i.e. for people whose disability has reached a relatively “stable point” and who have ongoing complex needs. This is beyond the remit of GPs in this current landscape, and there are glaring widespread omissions. If you want to make the link between sectors more seamless, and increase the professionalism and minimum standards of the scheme and its administration you need to start here. Simple, but hard because it has been avoided and ignored for an eternity. However, that it has come to our attention is a good outcome of the scheme. It has shone a light on glaring omissions.

Take for example, I have a number of people who attend my service for music therapy who are only mobile in wheelchairs due to their profound physical disabilities. They are also predominantly non-verbal and live in supported independent living. It is clear to me through their level of participation and persistence in sessions that they absolutely love the experiences of music therapy for freeing their movement through the progressive and responsively timed priming of their neural pathways (See Professor Michael Thaut’s research for literature – and leader of the Neurologic Music Therapy evidence base) , as well as the experience of shared mutual engagement and expression through music, which is so absent for them in our world that prioritises and rewards verbal communication and thinking in words rather than sound and other options.

Through my combined skills as a specialist Registered Nurse and the understanding I have developed of their unique communication style through my therapeutic relationship with them as a Registered Music Therapist, I regularly find myself asking their attending support worker if they have been given any pain relief when they are responding in a manner different to what we would typically see from them in the context e.g. they might at times appear frustrated, or be grimacing when performing movements that usually would not trouble them, or they may have had a seizure the day before and still not be quite themselves, or after a hospitalisation and large seizures there may be a residual change that becomes the norm, all of which could indicate, and be the only means of identifying the participant is experiencing acute pain, or worse still, chronic pain. Consistently, the support worker/s answer is “no”. This is because disability support workers do not have specialised training in pain management, and worse still – more broadly - there isn’t training in the management of chronic pain for people with profound physical disabilities who cannot talk. This is beyond astounding. If you want people to reach their full potential in any and all areas of daily living how about getting real about pain management for people with profoundly complex physical disabilities who are also non-verbal and living in supported independent living environments where the people caring for them are under-skilled and the staff turn-over is high i.e. so their familiarity with the nuances of the participant/s non-verbal communication style is not understood or prioritised in the rush of performing basic cares.

How about we get honest and serious about addressing the core points of multi-sector (including the NDIS) discrimination through this reform? Irrespective of whether this “what’s in/what’s out” document is a transitional instrument or not it sets a precedent – so how about this time let’s get the precedent right from the ground up, and at every point? Reform is needed, but if it isn’t done properly there is no point in doing it at all. There isn’t a quick fix. This is a big job.

For example, you reference evidence-based therapies. So, how are you going to make sure that the person doing the final sign off on a participants plan knows that the music therapy services being provided to the participant are being delivered by a music therapist registered with the AMTA? How are you going to ensure that the person doing the final sign off has the skills and qualifications to know what is directly-related to the participants disability? For example, just this week I have had a participant in his thirties who I have been working with for 10 years who lives with ASD and PTSD associated with profound early childhood trauma have his plan pulled out from under him by a person at the NDIA granted the “power” to do so, and in this process the continuation of his music therapy services declined because this person at the NDIA stated that emotional regulation was not related to his disabilities. This man is one of the most vulnerable in our society, because his disability is “invisible”. Now, because of this erroneous decision made by someone in the NDIA with unqualified “power” this man’s life is at risk. Would this person with unqualified “power” have considered it their place to do the same thing for a pharmacological therapy such as a mood stabilising agent like lithium?

There is a potentially catastrophic situation very much alive here that needs to be addressed immediately. Not just for this man, but for so many others. This man’s condition was not only stable prior to this appalling decision, his life was blossoming into places he hadn’t known his whole life through his experiences and sense of safety and confidence in the music therapy space and the various long-term relationships he has developed through it - which has been well documented for years. This action by the NDIA has undone all of that, not just for this man, but the shock impacts for all the other members of his long-term group program. This failure in the NDIA’s duty of care puts this man’s life at risk, and casts a shadow of uncertainty, apprehension and distrust that reaches many others. At the end of the day it is completely unprofessional, without evidence, and worst of all, without any minimum standard of due process and procedure on the part of the NDIA. How is this unqualified actor held to account for not meeting practice standards, duty of care, following evidence, and ensuring the delivering of person-centred care in the way that regulated professions operating in the scheme and other sectors are? There is no transparency or known plan whatsoever regarding this.

Further to this case example, as it relates the exclusion of somatic therapies, unqualified actors and the notion of a “what’s in/what’s out” list. How are you going to ensure that the person doing the final sign off on a someone’s plan understands that all therapies, and particularly psychology, trauma-informed therapies, the arts therapies, animal-assisted therapies and even speech therapies have a somatic element to them when it is relevant to the participant. Supporting people’s mind-body connection and foregrounding awareness is a significant part of all therapeutic processes for all ages and a range of needs. For example, it is critical for the man in case study above. How can we, as evidence-based professions, be confident that when describing outcomes from the therapeutic process that simply the use of the word “somatic” will not lead the unqualified person with the “power” to sign off on someone’s plan to immediately discount a critical and lifesaving therapy? At this point, and based on this man’s example, we cannot have that confidence at all, and that is a problem on the NDIA side not on ours in terms of “evidence-base”, knowledge, qualifications, standards, regulation, etc.

Similarly, on the point of home schooling. All the participants I see who are home schooled – there is no way they could participate in any main stream school as they (the schools) stand at the moment – for their own safety and the safety of others, and I mean “safety” in every sense of the word. So, how can we as evidence-based professions be confident that the unqualified person with the “power” to sign off on someone’s plan won’t immediately discount a critical therapy, potentially the only experience their parents can get them to participate in beyond the home, that references and describes links between a participant’s therapeutic outcomes and educational outcomes? Again, based on the above case example and the simplistic nature of the “What’s In/What’s Out” list, we can’t. Surely we want these outcomes learning/therapeutic to be accessible to as many people as possible in as many contexts as possible, surely we want the connections between the sectors to be seamless.

There has been a trend of late of the NDIA requesting reports for Occupational Therapists (OT) for participants who don’t even have an OT on their team. What exactly is the evidence base for giving this kind of hierarchy to occupational therapy in the pool of health professions, teachers and allied health professions – similarly for variably qualified “Behaviour Support Practitioners” (BSP) in the NDIS. I have had a BSP attend a session of one of my adult female participants living with Level 3 autism. This BSP had no qualifications besides lived experience. She treated the participant like she was a baby, it was so appalling I had to ring the participants mother immediately after the session and tell her to disengage this BSP immediately. BSP services were imposed on this participant and her mother by the NDIA. Further, the participant was already seeing an excellent local expert clinical psychologist, and none of the existing long-term team were consulted on the matter. This is not an evidence-based approach, and it is certainly not participant-centred. The standard of evidence-based needs to go both ways.

2. Are there goods or services on the exclusion list that you think

shouldn’t be there?

There are many points of exclusion that shouldn’t be there. Unless it is in current practice **(i.e. as per the participants experience and locality)** covered by another tier/sector, and it is consistent with the participants needs, goals, ambitions and aspirations, and their access to it is restricted by their disability – whether it be through functional, social and/or economic limitations, then it should be included. In a nutshell, the NDIS should cover every need not met by the other tiers – in practice – not in theory. The participants of the scheme and their representatives are not theoretical. They are real, and their needs, vulnerabilities, ambitions and aspirations are real. Why have the terms aspirations and ambitions disappeared from the rhetoric?

While musical goals are not a necessity for people accessing music therapy services (i.e. it has a primary focus on non-musical goals) its capability to do so happens to be one of the profession’s strong “value for money” points in the context of the NDIS’s reasonable and necessary criteria, because the specialist musical and creative skills of registered music therapists mean the participants musical and creative sensibilities (N.B. also sensory {physical} & cognitive functioning) are simultaneously developing and expanding while working on functional, independence and participation goals (i.e. non-musical goals), and in ways that don’t feel overtly clinical and impairment focussed, but rather strengths, preference and productivity focussed.

I have NDIS participants of all ages who aspire to be musicians or active in a range of creative and performing arts fields. This cannot be achieved this if they (adults and children with a disability alike) have no financial capacity to access instruments, performance/recording experiences, experiences of production, exposure to production and related areas, production support, and apps that are suited to their unique needs and skills sets. In cases such as these, for example, they may not need specifically made instruments, but simply the capacity to purchase an instrument (which may not be accessible through any other means other than the NDIS) and be supported in how to use it according to their unique set of skills. Further, those supporting them need support to come to understand how this might be possible.

This takes time and is the remit of an AMTA registered music therapist. The importance of the quality of instrument and sound in supporting engagement, and the adapted methods of using instruments to achieve both musical and non-musical goals, are throughout the music therapy literature and can be traced back to the seminal works and writings of giants in our field such as Nordoff and Robbins, and Ken Bruscia. If we consider that it can take decades for a person living without a disability and without obstacle to become a master of their chosen field/instrument (whether it be musical or non-musical), we need to recognise at least the same need and length of time for a person living with a disability to develop proficiency in their chosen area of goals, ambition and aspiration.

Two examples (out of many) below represent cases that have led to important physical, psychological, social and economic outcomes for my participants. The third case example is a microanalysis I did of clinical improvisation work Nordoff and Robbins did with a young girl called Audrey living with impaired speech. It was an assessment piece during my Masters program for which I received full marks. It depicts two points in Audrey’s music therapy process. The background and the follow up information from this process are important for it was this work with Audrey that identified she has been homed in an inappropriate institution and that her communication capacities and cognitive capacities were far greater than anyone had realised. As a result, Audrey was moved and years later, when she was in her early twenties, she contacted Nordoff and Robbins and thanked them for changing her life. The microanalysis, which is very technical from the music knowledge and theory perspective, highlights the role music can play in supporting meaningful interactions and allowing critical insights into the capacities and potential of people living with a disability when used through the music therapy process – particularly for people who are predominantly non-verbal and engage well with music. Given more than 90% of our (humans) communication is non-verbal (Alex Kelly, 2019) – these types of insights and interactions are critical to ensuring non-verbal NDIS participants who engage strongly with music have the opportunity of expressing their voice and representing their true self through the music therapy process.

1. The mother of a five year old boy living with Down Syndrome who I have been working with since he was 8 months old sent me a text from her hospital bed the other day in response to my invitation to participate in this consultation. She was excited to tell me that he was just offered a job to be in Big W’s latest series of commercials. When this boy started attending sessions at 8 months he could not move or hold himself up. It was all he could do to watch me and breathe. Now he comes into sessions, directs them from start to finish, talks, signs, dances, plays a range of instruments, beats everyone at Just Dance, and has participated in a number of group original music videos in celebration of International Day Of People With Disability, as well as international Couch Choir (by Pub Choir) productions and recordings. His mother, who is mother to six children, clearly states that the only therapy worth bringing him to from such a young age was music therapy. He has had many “firsts” from a developmental point of view in this space and in the contexts of the aforementioned music-based, therapist-supported experiences. The music production apps that we have used throughout his music therapy course have been essential, and his current trajectory suggests we can certainly expect that having access to being able to purchase instruments and production apps in the future is likely to be important in him having access to the same opportunities at all stages of his life as his peers without disabilities. But the greatest achievement of all here is – at this point in time this boy does not see or know his future as limited or any different to his typically developing peers. This promise by the NDIS has delivered for this boy and his family so far. We need to make sure the limited, over-simplified and non-individualised “what’s in and what’s out” list isn’t the thing that brings this to his attention.
2. Another participant in her mid-20s who has been attending music therapy with me since just before she left school is a multi-media genius. Her works are prolific, and her interest in new ways of applying her skills and creativity is insatiable, but as a woman who lives with Level 3 autism her capacity to share her gifts in the way that she wants to requires heavy support and specialist knowledge, not just of ways to support her non-musical functional skills, but also technical elements of her musical skills. Without the later, no-one would have any way of knowing what this amazing woman is capable of, or how to support her in navigating any kind of context involving another – such as in a regular music production experiences/apps/studios. Further, the musical production space through experiences such as using the acapella app to collaborate with others has offered a safe space for both this woman, and others with similar interests to connect and share their gifts. As behavioural and emotional regulation can interfere with successful social experiences for this woman, and therefore in turn shared face-to-face group music making experiences - unless she has two familiar professionals supporting her i.e. two-on-one therapists. Collaborative music production apps have been essential for supporting her in sharing her music therapy experiences, productions and collaboration with others i.e. the group experiences she longs for. Further to this point of steadily supporting her progress to successfully participating in shared face-to-face group experiences, she recently was part of a group of participants for whom I arranged a group trip to the theatre to see Beauty and The Beast. This was the first time she had ever seen anything like this, and we met up for lunch with a number of other participants and their families and support workers who she knew before going into the show. The participants all paid for their tickets independently, but they were all adults, and had no means of paying for these themselves as an adult their age typically would i.e so their parents paid for them, which is actually not what would typically occur for a person their age. This performing arts world should be accessible to people such as this woman who see a future for themselves in creative and performing arts fields – “if you can see it - you can be it”. Where is that in this country for our aspiring performing artists living with disabilities? Sports people with a disability have the paralympics to aspire to. Where is the equivalent in the performing/creative/visual arts worlds in this country – and throughout the world. They are excluded by omission. This is discriminating/marginalising. I can assure you I do not have a family I see who would want to take their participant to such a production/performance if it wasn’t relevant to the participants/or the participants family’s world. The associated challenges would seem insurmountable.

I was able to organise group tickets and so the costs were a little reduced, though I certainly did not charge for my time in organising the group outing, which was/is considerable.

So, if tickets to theatre/cinemas/concerts are to be excluded from the NDIS, irrespective of whether or not the outcomes of successfully attending are relevant to their goals (e.g. from a sensory processing/regulation/social and community participation point of view, and ambition – perhaps it is very important in their world from a family relationships point of view), how does the government propose to engage with event organisers, national theatre companies and the like to ensure these experiences are economically accessible to people with a disability, such as the woman I described, who have no other means to afford them? This is a significant inclusion issue – that needs to be addressed simultaneously and transparently with any suggestion of exclusion from the NDIS.

3)

**Clinical Improvisation:**

 **An Integrated Analysis of Two Excerpts from Creative Music Therapy (CMT) with Audrey**

The language and approach used to present this analysis of clinical improvisation with Audrey is informed by a synthesis of:

1. the description and audio of Audrey’s case presented in Aigen ([1998](#_ENREF_1))
2. Bruscia’s ([1987](#_ENREF_2)) sixty-four clinical techniques in improvisational music therapy
3. Wigram’s ([2004](#_ENREF_3), [2007](#_ENREF_4)) approach to improvisation and event-based analysis
4. the humanistic and developmental underpinnings of the Nordoff-Robbins approach ([Aigen, 1998](#_ENREF_1); [Bruscia, 1987](#_ENREF_2))
5. the three main work phases within the Nordoff-Robbins approach ([Aigen, 1998](#_ENREF_1); [Bruscia, 1987](#_ENREF_2))

Please note the extended tables of analysis in Appendix A (Excerpt 1) and Appendix B (Excerpt 7) are not exhaustive, but seek to represent salience, process and detail.

**Integrated Analysis of Excerpt 1 (Session 1):**

**What is the client doing?**

This is Audrey’s first individual session and her excitement is both documented and audibly evident in the strong beat she initiates and maintains throughout ([Aigen, 1998](#_ENREF_1)). Further evidence of Audrey’s eagerness is revealed through the presence of “flam” (drumming not in perfect unison) between 00:28 – 00:38 and 01:00 – 01:23. This suggests Audrey is drumming with both hands and using two sticks throughout. Despite various rhythmic figures and chromaticisms, Audrey demonstrates a stable and assured connection to the basic beat (Appendix A time examples: 00:05, 00:14, 00:17). This connection is most conspicuous when Audrey confidently initiates a faster tempo at 00:22, and when she stops playing to reconnect with the basic beat following Nordoff’s ritardando at 00:35. At 00:39 Audrey is able to quickly synchronise rhythmically and move with the accelerando. Audrey’s sense of safety within the client-therapist relationship is revealed through her uninhibited laughter at 00:48 and vocalisation at 01:21. These also depict a release of tension following a climax in the music. In an assured presentation of her intra-musical and inter-musical self, Audrey defines the beginning of the “B” section (00:49 – 01:23) in the improvisation with a change of:

1. timbre (brush on snare)
2. instrumentation (brush on cymbal)
3. dynamic (soft – piano)
4. style of playing (gentle/lightly).

**What the therapist is doing?**

Nordoff and Robbin’s first work phase involves the exploration of Audrey’s connection to music ([Aigen, 1998](#_ENREF_1); [Bruscia, 1987](#_ENREF_2)). Chromatic motifs through ascending registers (middle of piano upwards) underpin the salient and overlapping clinical improvisation techniques of empathy, structuring, elicitation and redirection (See Appendix A time examples: 00:10 – 00:22, 00:30 – 00:35, 00:43 – 00:45) ([Bruscia, 1987](#_ENREF_2)). While empathetic techniques are audible throughout, two key examples occur at 00:03 and 00:22. In both cases Audrey determines the beat and Nordoff imitates within the second (time unit) then synchronises rhythmically with Audrey. Nordoff also matches her playing intensity, thereby offering Audrey reflection and acceptance of her music and character, as well as companionship (See Appendix A: pacing and reflecting). From 00:10 the second work phase dominates, as Nordoff explores Audrey’s capacity to control, produce and organise musical ideas ([Aigen, 1998](#_ENREF_1); [Bruscia, 1987](#_ENREF_2)). From 00:14 – 00:21 the elicitation technique of intervening prevails as Nordoff challenges Audrey’s connection to the basic beat through a number of rhythmic figure variations using chromatic octaves on D natural & E flat. From this point the use of exaggerating through chromatic, rhythmic and register variations aims to enhance Audrey’s awareness of her connection to the music, particularly at points of challenge, initiation or transition (See Appendix A time examples: 00:38 – 00:45, 00:49, 00:55, 00:99 – 1:05). This technique is bound to the elicitation technique of extending, and the redirection technique of intensifying. Nordoff’s repeated use of progressive rhythmic figure variations, exaggerated by ascending chromatic motifs, models and offers structure and form (Section A = 00:00 – 00:45; Section B = 00:49 – 01:23). The prevailing outcome of these integrated techniques is a sense of building intensity in each section which supports Audrey’s enduring connection to the music and the music therapist. This connection is clearly audible in the mutual release of tension through laughter at 00:46.

**Integrated Analysis of Excerpt 7 (Session 16):**

**What is the client doing?**

Aigen ([1998](#_ENREF_1)) informs us Audrey comes to this 16th session requesting to play Cinderella, a role she has demonstrated resistance towards. Audrey’s choice of a classical, operatic style of singing matches and facilitates measured development of the regal theme. While Audrey references Nordoff’s harmonic accompaniment throughout (See Appendix B time examples: 00:01 – 00:07, 00:08, 00:28, 00:45, 1:07, 01:22, 01:35, 01:48), close analysis reveals she selectively differentiates herself musically and interpersonally through melody, lyrics, and rhythm. A breath-taking example of this occurs in what Aigen ([1998](#_ENREF_1)) refers to as the first verse (00:01 – 01:04). At 00:44 Audrey challenges the natural movement of the harmony to the tonic (E flat) to close the phrase by singing and sustaining an F natural (interrupted cadence) on a new and symbolic lyric - “fly”. And fly she does. In a stunning presentation of musicality following Nordoff’s responsive treble A flat (00:45), Audrey soars into the closing phrase of the verse and determines her own time to close with the tonic (perfect cadence). A similar example occurs in the first development (01:04-02:23) following Nordoff’s introduction of a High G to the harmony through a broken, second inversion, E flat major chord (01:22). As if stopping to think, Audrey rests for a bar then launches into a dramatic three phrase melody over a tenth range (E flat – High G) wherein the High G dominates. Audrey is seven years old. Towards the end of the second development (02:23-03:33) Audrey’s assertive singing directs the accompaniment to a strong, marching style. Once this is in place, as if thinking again, Audrey rests for two bars (02:55 – 03:00). Then, in an exquisitely creative integration of organised thought and musicality, Audrey leads a coda summarising focal points of each development and the original verse (2nd - marching “Li-sten!”, “Li-sten!”; 1st – High Gs; gentle, vulnerable, legato – “I cry”).

**What is the therapist doing?**

Nordoff initiates the music with E flat major broken chords and incorporates a lilting sixth voicing. Nordoff plays in a legato style with a mezzo piano (mp) dynamic (00:01) ([Aigen, 1998](#_ENREF_1)). This represents referential (fairy-tale), procedural (experimenting), empathetic (reflection), and elicitation (modelling) clinical improvisation techniques ([Bruscia, 1987](#_ENREF_2)). With her initial melody Audrey allocates Nordoff’s musical role to supportive accompaniment (00:07). From this point the techniques of structuring, redirection, and emotional exploration ([Bruscia, 1987](#_ENREF_2)) are also integrated through the harmony and accompaniment style. Through timely harmonic, melodic and rhythmic cueing ([Wigram, 2004](#_ENREF_3)) Nordoff helps to gently shape and contain Audrey’s spontaneous, emotional singing (See Appendix B time examples: 00:01 – 00:07, 00:08, 00:28, 00:45, 00:52, 01:01, 1:07, 01:22, 01:24, 01:35, 01:48, 01:57, 02:26, 02:45). For example, at 01:01 Nordoff incorporates use of the lower bass register to ground and exaggerate the perfect cadence inferred by Audrey’s melody. From 01:35 Nordoff’s descending thirds in the treble offer Audrey’s melody and phrasing direction following her ascension to the High G. Similarly, Nordoff then offers a rising treble line (01:48). Audrey accepts and engages in further melodic exploration around High G. In support, Nordoff repeats upper register E flat major notes (01:57). An outcome of this empathetic improvising ([Wigram, 2004](#_ENREF_3)) is Audrey’s emphatic expression: “…somebody wake me up!” (02:03). A prominent example of rhythmic cueing occurs at 02:26 when Nordoff incorporates the contrasting, light and detached, dance-style accompaniment ([Aigen, 1998](#_ENREF_1)). This is a reflective and grounding response to Audrey’s new staccato style of singing at 02:23. From this point, Nordoff’s role is purely supportive. Apart from remaining within the key of E flat major, Audrey abandons cues and shapes a spectacular, highly integrated and organised coda. Nordoff’s musical and extra-musical role in facilitating Audrey’s self-actualising experience cannot be overlooked.

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• If yes, please list in order of importance

 - what an absurd notion – if this is an individualised scheme, which is what it is supposed to be, the order of importance will be different for each person.

3. Do you have any further feedback or concerns with the draft NDIS

support lists?

Given the scenarios I have depicted here from personal and professional experience, and the many more I work with everyday, I would like to know the level of knowledge, skills & expertise that the people synthesising each participants information have to discern what is a disability-related support and/or a “disability-related health support”? Like the “What’s in/What’s out” list, this is a grossly over-simplified notion. Nothing is simple here. Marriage counselling is out – Why? What could possibly be the rationale for that? Can’t people living with a disability be married? Can’t issues in a marriage be associated with a disability? Why has “disability-related health supports” been reduced to a limited list of physical items – as if psychological, social and economic health matters aren’t health matters? These are very narrow and uninformed attempts to take care of something other than participants – who are supposed to be at the centre of the scheme…..remember?

Why are standard toys excluded – would the scheme rather pay for expensive specialty toys when a participant may derive the same benefit from a standard toy they have shown a particular preference for through the therapeutic process? For example, I have a family who have been attending music therapy with me since their child was two. This child is now 12. All through this child’s therapy process he/she has taken to a variety of instruments, toys, books and other props I have used in the space. When these preferences have become well established the family have purchased these so they can transfer these skills to the home, and other important relationships in their child’s world. Therapists can especially design resources from what exists – they don’t necessarily always have to be specialty or expensive. They just need to be functional for their intended purpose.

The matter of sex workers… is this not a basic human need – fundamental to our existence in fact? So does the law stand in the way here – is that the problem? If so, is the “What’s in/What’s Out” list just a “head in the sand” way of ignoring it – again? How about the nationwide multi-sector reform that the “2023 NDIS Review” recommended trigger an initiative to address the law, if there is a law that stands in the way of this? Because let’s face it, this is an opportunity to create safety in this space for people with a disability and sex workers alike through proper regulation.

How about the NDIA and all levels of governments have the courage of their convictions regarding disability reform in this country?

Also, why wasn’t this consultation process, and the various others, issued to participants in the same way as Minister Shorten’s mail out to all NDIS participants about provider fraud earlier this year?

What are the inclusive measures/mechanisms of this consultation process, and others?