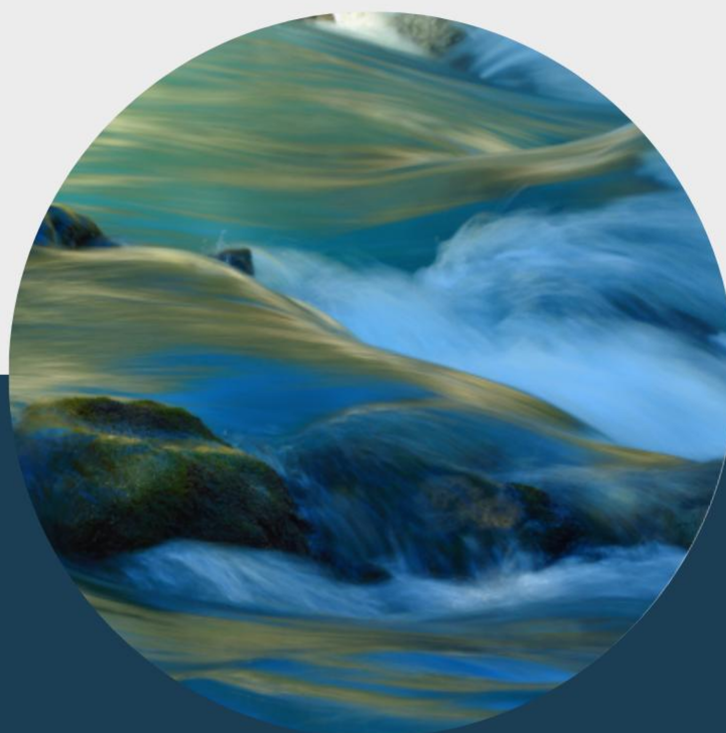
SUBMISSION TO THE NDIS EVIDENCE ADVISORY COMMITTEE

- Early intensive behavioural interventions
- Positive behaviour support for older children and adults
- Social skills training as a disability support for children and young people



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Occupational Therapy Society for Invisible Disability

OTSi Submission to the NDIS Evidence Advisory Committee

28/03/2026

Introduction

The Occupational Therapy Society for Invisible and Hidden Disabilities (OTSi) welcomes the opportunity to the NDS Evidence Advisory Committee. Occupational Therapists (OTs) are health professionals skilled in assessing how people engage in everyday life activities and identifying supports that enhance participation, safety, and independence. We combine clinical reasoning with practical knowledge of assistive technology (AT), environmental modifications, and therapeutic interventions.

From this perspective, we welcome the opportunity to contribute evidence and lived-practice insights to the EAC's review of:

- Early intensive behavioural interventions
- Positive behaviour support for older children and adults
- Social skills training as a disability support for children and young people

Our submission draws on evidence and practice examples provided by OTSi members and the broader community we engage with daily.

About OTSI

OTSI is a national society whose purpose is to enable occupational therapists who work alongside people with invisible and hidden disabilities, to reduce barriers to full participation in our world as active citizens of Australia.

Our focus is ensuring access to resources, opportunities, and supports for people with invisible disabilities of all ages, including access to occupational therapy. OTSI has a strong voice in systemic advocacy and policy direction, as well as enabling individuals to build better lives.

Conceptual and Process Clarity

OTSi respectfully asks for further consideration of conceptual clarity, as this work progresses. We note a dearth of conceptual clarity within the consultation papers and survey, across the varied range of interventions that are listed without: clear taxonomy; clear focus and scope; clear theory of change; clear population definition; or clarity of desired outcome. NDIS participant-representative and advocacy groups have further raised concerns regarding the accessibility of the material provided through the consultation process. [1]

We must ensure any new models being proposed are reflective of current consumer, carer and community expectations, and contemporary research. A potential systemic bias towards historical, or dated, interventions, must be acknowledged. This bias may be understandable if there is a prevailing perception of administrative ease through reverting to historical models, though these remain unproven in terms of government return on

[1] Every Australian Counts, 27 March 2026 https://www.linkedin.com/posts/every-australian-counts-4683b1353_

investment. While there may be cost-drivers and administrative convenience in reverting to previous models, solid process, genuine co-design, and rigor in model development is imperative to ensure fitness for purpose. Conceptual considerations cannot be short-cut in the development of contemporary models.

Further, it would be helpful for the consultation process to provide clarity on where particular interventions are envisioned to 'sit' across the spectrum of care (population health, primary care, through to NDIS) and across the lifespan. We note the scope of Evidence of the Evidence Advisory Committee is to advise on interventions funded by the NDIS[2]

The relationship of this consultation process and the Thriving Kids concept, remains unclear. The Thriving Kids (TK**)** model, developed by Professor Frank Oberklaid and colleagues at the Murdoch Children's Research Institute, has been framed as a national approach to early intervention for children with autism and developmental delay. A close examination of the model, and its roots in Oberklaid's 2021 National Children's Mental Health and Wellbeing Strategy, raises two significant concerns for policymakers, practitioners, and families.

The first issue relates to w**hether a model originally designed for child mental health can easily translate to children with developmental delay or autism**. Oberklaid's professional focus has been overwhelmingly in child mental health: supporting social, emotional, and behavioural development, upskilling educators to identify and manage difficulties, and addressing early psychosocial risk. In this context, interventions are often targeted at social determinants and population-level prevention — areas that can influence mental health outcomes across a broad cohort of children.

Autism and other developmental delays, however, operate differently. While early intervention can mitigate long-term functional impairment, these conditions are less responsive to population health levers. Many interventions are highly individualised, require specialist support, and must be tailored to a child's specific developmental profile. Framing neurodiversity primarily as "social, emotional or behavioural difficulties," as Oberklaid's previous work sometimes appears to do, blurs the lines between mental health and developmental needs. If the same model is applied without adaptation, there is a real risk that children with autism or complex developmental delays may not receive the tailored support they require, and that their outcomes could be compromised.

The second concern relates to **the relationship between population health models and service delivery systems**. Both the 2021 mental health strategy and the TK model are fundamentally population health approaches: they emphasise broad policy, prevention, and support delivered in mainstream settings rather than through an individualised service model like the NDIS. TK even proposes replacing parts of the existing service system with a population health approach. This is problematic because population health budgets and service delivery budgets should remain separate. Population health is measured by population-level indicators (prevalence, wellbeing, reduced hospitalisations), whereas service delivery is evaluated through individual outcomes and utilisation. A single, merged budget will make it difficult to track effectiveness. Population health initiatives involve multiple sectors (health, education, housing), while service delivery sits in defined systems like the NDIS. Separation clarifies accountability and reduces cost-shifting between agencies.

In practice, coordination is essential, but **population health approaches cannot substitute for individualised service delivery**. The risk of merging TK with the NDIS or other individualised systems is the creation of service gaps. Children who require targeted therapy, occupational support, or developmental interventions may be left with only broad, low-intensity population programs that cannot meet their complex needs.

In conclusion, Thriving Kids is an important population health initiative, and early intervention and cross-sector collaboration are laudable objectives. But policymakers, funders, and practitioners must be cautious in two key areas:

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[2] Terms of reference – National Disability Insurance Scheme (NDIS) Evidence Advisory Committee (EAC) | Australian Government Department of Health, Disability and Ageing

1. **Mental health models do not automatically translate to developmental and autism interventions**. Without careful adaptation, children with complex needs may be underserved.
2. **Population health programs should complement, not replace, individualised service systems**. Merging these budgets or models risks creating unacceptable gaps in care, undermining the very children the program intends to support.

A careful, dual-track approach, population health investment alongside robust, individualised service provision, is essential to ensure that all children, whether at risk or already experiencing disability, receive the support they need to thrive.

Recommendations to the NDIS Evidence Advisory Committee

Conceptual and Process Recommendations

1. Ensure greater conceptual clarity across consultation materials by requiring a clear taxonomy, defined scope, articulated theory of change, specified target populations, and explicit intended outcomes for all interventions, while also clearly communicating how these align with the purpose of the consultation and how evidence will be used in decision making.
2. Improve accessibility of consultation materials to support meaningful engagement from participants, families, and advocacy groups through clear language, structured formats, and transparent explanations of key concepts.
3. Ensure all proposed models are grounded in contemporary research and models and reflect current lived experience perspectives of consumers, carers, and the broader community, while actively addressing potential systemic bias toward historical or legacy intervention models that may persist due to administrative convenience rather than demonstrated effectiveness.
4. Require model development processes to demonstrate methodological rigour, transparency, and genuine co design with people with disability and their families, and ensure that conceptual development is not abbreviated for administrative purposes but is sufficiently robust to ensure models are fit for purpose.
5. Provide clear guidance on where interventions sit across the continuum of care, including population health, primary care, and NDIS funded supports, and across the lifespan, and clarify the relationship between this consultation and broader reform initiatives including Thriving Kids and foundational supports for psychosocial disability.
6. Ensure policy frameworks clearly distinguish between population health approaches and individualised service delivery, recognising that autism and developmental disabilities require tailored, specialist, and individualised supports, and ensuring that population level initiatives complement rather than replace individualised services.

Early Intervention

7. Develop and apply a clear taxonomy of early intervention approaches that outlines definitions, mechanisms of change, and intended outcomes, and ensure these outcomes align with contemporary frameworks including participation, quality of life, autonomy, emotional safety, and identity development.
8. Ensure alignment between consultation materials, survey design, and national policy frameworks including PRECI and the National Autism Strategy, and clarify the rationale for inclusion of interventions that sit outside current or future NDIS funded supports.

9. Ensure all interventions align with neurodiversity affirming, trauma informed, and strengths based practice, and avoid deficit based or normalisation focused framing, particularly where this targets core characteristics of neurodivergence.
10. Recognise the role of sensory processing and environmental fit in both outcomes and intervention design, and ensure these are embedded within intervention frameworks.
11. Embed co design and lived experience across all stages of evidence review and policy development, including active incorporation of Disabled People's Organisation perspectives, while addressing consultation fatigue through use of existing evidence and equitable representation.
12. Apply consistent and transparent evidence appraisal standards that consider conflicts of interest, methodological quality, representativeness, and long term outcomes including generalisation to real world contexts, and avoid privileging interventions based on volume or historical dominance where evidence quality is low.
13. Require that any large scale implementation is supported by robust and generalisable evidence, including pilot testing, transparent methodology, and co designed evaluation, and avoid national scaling where evidence is limited or populations are not representative.
14. Ensure interventions with differing theoretical foundations are not treated as equivalent, and that comparisons are methodologically appropriate and clearly define whether outcomes relate to behaviour change or functional participation.
15. Recognise and address potential harms including psychological distress, masking, identity suppression, and fatigue, and ensure ethical safeguards including consent, assent, and impact on family relationships are embedded in all intervention evaluation.
16. Support multidisciplinary approaches that address communication, sensory, physical, psychological, and environmental factors, including the needs of non speaking individuals and those with complex profiles such as Pathological Demand Avoidance.
17. Recognise environmental modification, parent coaching, and capacity building within daily routines as core intervention strategies, and avoid artificial distinctions between intensive programs and individual therapies in order to reflect integrated real world practice.
18. Protect participant and family choice by maintaining access to a range of intervention approaches and avoiding policy settings that privilege a single model, while ensuring initiatives such as Thriving Kids complement rather than replace individualised supports and do not create service gaps.
19. Evaluate interventions for real world feasibility across cultural, socioeconomic, and geographic contexts to ensure equitable access and relevance.

Social Skills Training

20. Develop a clear and differentiated definition of social skills training that specifies purpose, population, mechanisms of change, and intended outcomes, and disaggregate this into therapy based, program based, and participation focused supports.
21. Avoid treating diverse populations as a single cohort and clearly distinguish between skill acquisition models, participation based approaches, and relational or connection based supports.
22. Ensure all approaches align with neurodiversity affirming, trauma informed, and strengths based frameworks, and avoid framing social skills as behaviours to be normalised, recognising instead that social interaction is reciprocal and context dependent.

23. Ensure interventions prioritise autonomy, authentic communication, inclusion, belonging, and wellbeing, particularly for autistic individuals, and exclude or critically evaluate compliance based models that promote masking or conformity.
24. Clearly define the role of the NDIS in funding social participation supports and ensuring disability specific supports remain within scope.
25. Recognise both one to one and group based approaches as valid and ensure funding flexibility, acknowledging that group formats may not be accessible or appropriate for all individuals.
26. Prioritise multidisciplinary, interventions that address communication, sensory, interoceptive cognitive, emotional, and environmental factors, and avoid approaches that focus solely on teaching discrete behaviours in isolation.
27. Expand outcome frameworks to include adolescence and young adulthood, including relationships, education, employment, consent, safety, identity, and management of social risk, and focus evaluation on real world participation and sustained engagement.
28. Ensure comparisons between interventions are based on functionally equivalent goals and include existing NDIS supports, with evaluation of long term outcomes, generalisation, and participant experience.
29. Recognise the complexity of psychosocial disability and avoid positioning social skills training as a universal intervention, ensuring supports are individualised, capacity informed, and inclusive of diverse preferences including alternatives to models such as clubhouse programs.
30. Ensure safeguards are in place to identify and mitigate harms including trauma, family fragmentation, identity suppression, disengagement, and reduced self esteem, while maintaining participant choice and control.
31. Explicitly recognise occupational therapy approaches that are occupation based, contextual, and focused on meaningful participation and social inclusion.

Positive Behaviour Support

32. Broaden the scope of Positive Behaviour Support to reflect contemporary multidisciplinary and cross sector approaches, recognising variation across disability cohorts and service contexts.
33. Reframe behaviours of concern as expressions of distress, unmet need, or environmental mismatch, and shift the focus from behaviour reduction to understanding and addressing underlying causes.
34. Incorporate findings from the Royal Commission including the emphasis on addressing “environments of concern” and acknowledge the limited and inconclusive evidence base for PBS, avoiding its positioning as a default or gold standard approach.
35. Expand interventions to include systems level and organisational approaches, including leadership, workforce capability, data informed practice, and environmental design, and require organisation wide implementation.
36. Integrate sensory modulation and trauma informed approaches as core components of behaviour support, supported by comprehensive sensory and environmental assessment and individualised regulation strategies.

37. Ensure behaviours supports are delivered within a multidisciplinary framework and includes functional, participation based assessment, recognising the role of occupational therapy in addressing person environment interactions.
38. Require behaviour support to be individualised, proactive, and preventative, addressing physical, communication, interoceptive, cognitive, sensory, and trauma related factors, and avoiding reliance on standardised plans without adaptation.
39. Prioritise elimination of restrictive practices through human rights based approaches, supported by clear strategies, monitoring, and reporting of outcomes and participant experience.
40. Invest in workforce development to support trauma informed, sensory aware, and neurodiversity affirming practice, ensuring staff are skilled in non compliance and non confrontational and relational approaches.
41. Evaluate behavoiur supports using holistic outcomes including quality of life, participation, autonomy, and wellbeing, with attention to long term outcomes, generalisation, and participant reported experience.
42. Ensure behaviour support frameworks uphold dignity, autonomy, and human rights, avoid compliance driven approaches, and require informed consent and participant involvement.
43. Invest in high quality research that addresses current evidence gaps and includes lived experience and co design, and ensure policy does not narrow intervention approaches or reinforce restrictive practices.
44. Adopt a whole of system approach that recognises the interaction between service design, funding, workforce, and environment, and align behaviour support reform with NDIS objectives of inclusion, participation, and choice and control.

Intensive Behavioural Interventions

Introduction to Intensive Behavioural Interventions

(As per EAC survey description)
Early Intensive Behavioural Interventions are programs that aim to help young children develop a range of skills including communication, social skills, and daily living skills.

The EAC assessment documentation reports that the scope of these interventions focus on more than one outcome. These include:

- Behavioural interventions, such as intensive Applied Behavioural Analysis (ABA) and variants, Early Intensive Behavioural Treatment, and Murdoch Early Intervention Program (MEIP).
- Naturalistic developmental behavioural interventions (NDBIs), such as Early Start Denver Model (ESDM), Pivotal Response Treatment (PRT), and Learning Experiences Alternative Program (LEAP).
- Developmental interventions, such as Developmental Individual-Difference Relationship-Based (DIR)/Floortime.
- Treatment and Education of Autistic and related Communication-handicapped Children (TEACCH).

The rationale for needing to focus on more than one outcome has not been provided and these interventions are then compared to interventions with a more focused scope.

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Aligning Early Intensive Behavioural Interventions with Key national policy frameworks

The assessment of Early Intensive Behavioural Interventions must be explicitly aligned with key national policy frameworks, including the National Best Practice Framework for Early Childhood Intervention (PRECI) and the National Autism Strategy. In its current form, the survey includes a number of questions and underlying assumptions that appear inconsistent with these frameworks. In particular, elements of the survey reflect deficit-based and normalisation-oriented approaches that are not aligned with the principles of participation, inclusion, family-centred practice, and neurodiversity affirmation outlined in these national guidelines. This misalignment raises concerns about the validity of the assessment and the risk that resulting recommendations may not reflect established best practice in early childhood intervention in Australia.

Codesign with people with disabilities.

Co-design with people with disability must be a central component of this assessment process. The current consultation represents only one of several consultations in 2026 to date, placing significant demands on the time, capacity, and resources of the disability community. As a result, there is a real risk that lived experience perspectives are underrepresented, particularly when compared to submissions from well-resourced organisations with dedicated policy staff. It is therefore critical that the Evidence Advisory Committee proactively engages with the disability community, existing lived experience literature and position statements to ensure a balanced and representative evidence base. This should include key contributions such as the Autistic Self Advocacy Network position statement, *For Better or For Worse: A Position Statement on Autism Interventions* (2021), https://linktr.ee/banabatherapy, as well as other Disabled People's Organisations (DPOs) and academic critiques. Without this deliberate effort, there is a risk that the assessment will privilege institutional perspectives over those of the individuals and communities most directly impacted.

Applied Behaviour Analysis

Applied Behavior Analysis (ABA) has been critiqued for methodological quality of research, cost, time of intervention, long-term effectiveness, and negative psychological outcomes.

The U.S. Department of Defense (DoD) has tracked thousands of children receiving ABA. In their 2020 and 2021 reports to Congress, the DoD found that after a year of intensive ABA, 76% of beneficiaries showed no change in symptom presentation, and 9% actually worsened. The report concluded that there is a lack of "statistically significant" correlation between the number of ABA hours received and the improvement in outcomes, challenging the industry standard that "more is better" (often 20–40 hours per week).

The quality of the research that labels ABA the "gold standard" has been criticised. A 2020 study by Bottema-Beutel et al found found that 84% of ABA studies included at least one author with a conflict of interest (e.g., they owned an ABA clinic or provided ABA training), yet only 2% of these studies disclosed those conflicts. The Cochrane Library has conducted systematic reviews of Early Intensive Behavioral Interventions (EIBI), the most common form of ABA and reviews have consistently rated the "strength" of the evidence for ABA as low to very low. (Reichow et al 2018) This low evidence has been due to most studies having small sample sizes, lacking proper control groups, and failing to use standardised "blind" outcome measures. Since the therapist is often the one recording the data on the child's progress, there is a high risk of observer bias, where the researcher unconsciously records more positive results to prove the intervention works. Gitimoghaddam et al 2022 found there is little evidence it improves overall quality of life or long-term independence in a real life setting. Children who have learnt skills in ABA have been found to not generalise to the real world. Eg A child might learn to point to a picture of an apple in a quiet therapy room to get a reward (Discrete Trial Training), but research suggests they often cannot apply those same skills in a noisy classroom or at home without the specific "prompt" and "reward" used in the clinic.

Kupferstein et al (2018) study found that nearly half (46%) of autistic people exposed to ABA met the diagnostic criteria for PTSD. One of the core mechanisms of ABA is compliance-based training which teaches children to suppress their natural coping mechanisms (like stimming) and ignore their own internal signals. This can lead to learned helplessness" and long-term psychological distress including PTSD.

Parents need a choice to not engage in ABA and to have choices in engaging in Early Intensive Bheavioural Interventions.

Early Intensive Behavioural Interventions Survey Questions response

The current survey description of Early Intensive Behavioural Interventions groups together a range of approaches, including behavioural models such as Applied Behaviour Analysis, developmental approaches such as DIR/Floortime, and hybrid models such as Early Start Denver Model, as though they are theoretically equivalent, when they differ substantially in their underlying assumptions, mechanisms of change, and definitions of successful outcomes.

The proposed outcomes reflect a predominantly deficit-focused and normalisation-oriented framework rather than a neurodiversity-affirming approach and is contrary to the National Autism Strategy. The inclusion of 'diagnostic characteristics (features of the disability) as an intended outcome implies these characteristics may be targets for modification or reduction, which raises important ethical and neurodiversity-affirming considerations. This framing risks positioning core aspects of neurodivergent identity as inherently undesirable. In addition, there is limited emphasis on outcomes that are widely recognised as critical within contemporary practice, including autonomy, self-determination, emotional safety, and meaningful participation in everyday life.
A recent article on Sensory-processing informed autism practice for child-centred therapists (Daniel et al) includes points on fostering meaningful connection without compromising the child's agency. [3]
(1) create sensory-stable spaces for their clients, (2) adapt their basic use of voice and body, (3) consider cross-neurotype differences of emotional experience and employ behavioural observations at the heart of empathic processes, (4) facilitate interoceptive awareness and support personalised connections between sensations and regulatory actions, and (5) support the development of individually tailored vocabularies of feelings. The strategies presented in this paper offer a practical roadmap to address each autistic child's sensory needs, reducing dysregulation and fostering meaningful connection without compromising the child's agency.

The representation of sensory experience is also inconsistent, as sensory processing is included as an outcome while sensory-based interventions are excluded from consideration.

The process for comparing Early Intensive Behavioural Interventions with other interventions is unclear and would require a different methodological approach if the aim is to determine which interventions most effectively result in a child's behaviour changing. This would also require clearly stating that this is the purpose of the consultation and explicitly inviting input on alternative approaches. Any comparison must be broad and inclusive, incorporating cultural considerations, the needs of children with diverse disabilities, multidisciplinary team models, and frameworks such as PRECI. (Professionals & researchers in early childhood intervention).

The distinction drawn between intensive programs and individual therapies does not reflect real-world practice, where integrated and interdisciplinary models of care are standard. In addition, the framework does not adequately consider ecological and family-centred approaches, such as parent coaching, capacity-building within daily routines, and environmental modification.

[3] Sensory Processing informed autism practice for child-centred therapists

In addition, it is essential to recognise that parental choice is critical, and that access to a range of intervention options, rather than a single prescribed approach, is fundamental to delivering appropriate and individualised support. There are significant risks associated with the current frame of this assessment. There is a risk of privileging a single paradigm, particularly behavioural approaches such as Applied Behaviour Analysis, which may marginalise other evidence-based disciplines, narrow funding pathways, and reduce clinical choice. There is also a risk of harm associated with the intensity and compliance-focused nature of some interventions, particularly when delivered at very high levels of intensity, which may override children's natural rhythms, increase stress and fatigue, and prioritise compliance over autonomy.

When considering the reasons a child may require behaviour support, it is recommended that a comprehensive multidisciplinary assessment is undertaken to identify potential physical, communication, psychological, sensory, and medical contributing factors. Interventions or manualised programs that do not incorporate this level of assessment may be ineffective, as they risk failing to address the underlying cause of the behaviour. For example, if a child is dysregulated in a classroom and a behavioural approach is used to have them sit in a quiet corner, this may not address a possible sensory sensitivity to a specific sound or a trauma response. In such cases, there is a missed opportunity to identify and appropriately support the child's underlying needs.

There are also system-level risks, including potential impacts on the allied health workforce and reduced access to multidisciplinary care if funding and policy decisions become overly aligned with a single intervention model. There is also a risk that highly intensive, clinic-based interventions may not generalise effectively to everyday environments and may not be feasible or appropriate for many families, particularly when cultural, contextual, and environmental factors are considered. Missing a window of opportunity for early intervention can require additional funding later.

Case example: Inklings Program

A program that has not been explicitly classified as an Early Intensive Behavioural Intervention, yet has received government endorsement, is the Inklings Program. An OTSI member has undertaken a detailed critical analysis of this program, the findings of which are directly relevant to this submission, and summarised here. Importantly, the issues identified are not isolated and reflect broader concerns that apply across many intensive behavioural intervention models.

The Inklings program has been proposed for young children identified as having lower to middle support needs, including those who are autistic or have an intellectual disability. The iBASIS-VIPP intervention research model is underpinning the program, and a critical appraisal raises significant methodological, ethical, and conceptual issues.

A primary concern is that the program appears to be extended to a broad population of children with diverse developmental profiles, despite the underlying study being conducted with a small and specific cohort of infants identified as being with likelihood of autism. The extrapolation of findings from a limited and narrowly defined sample to a national, heterogeneous population is not justified by the available evidence and raises serious questions regarding validity and appropriateness.

The evidence base itself is limited in both scale and rigour. The iBASIS-VIPP study is based on a relatively small sample, with approximately 89 children completing the final three-year assessment. Despite this, the findings are being positioned as sufficient to inform large-scale implementation. The study draws on literature that is, in part, outdated and does not reflect contemporary neurodiversity-

affirming or trauma-informed frameworks. Refer to [A statement from The Kids Research Institute Australia in support of Inklings] for more information.

The intervention is also insufficiently described. While it is reported to involve approximately ten sessions over five months using video feedback, there is limited detail regarding what parents are asked to do, which behaviours are being targeted, how clinicians are trained, or how fidelity is maintained. The comparison condition, described as "usual care," lacks specificity, with no clear account of the type, intensity, or quality of services received. This lack of transparency limits the ability to replicate the study, evaluate its validity, or meaningfully interpret its findings.

There are also significant concerns regarding sampling bias. The intervention group demonstrated higher levels of maternal education and household income compared to the usual care group. These differences were not adequately controlled for or addressed in the analysis, despite their potential to influence outcomes. In a study of this size, such disparities can have a substantial impact on results and limit generalisability.

The reporting of outcomes raises further concerns. In several domains, including infant positive affect and caregiver satisfaction, the usual care group performed as well as or better than the intervention group. However, these findings were not given equivalent weight in the interpretation of results. This selective emphasis introduces the risk of reporting bias and undermines confidence in the conclusions drawn, particularly when the study is being used to support policy decisions at a national level.

More broadly, the conceptual framing of the intervention reflects a deficit-based model of development. The study positions autism primarily in terms of traits to be reduced or modified, without sufficient consideration of strengths, identity, or the long-term implications of such an approach. There is limited attention to the potential impacts of masking, identity suppression, or relational strain. The assumption that certain forms of communication or interaction are inherently superior reflects a normative framework that is not aligned with contemporary neurodiversity-affirming practice.

The intervention also does not adequately account for environmental and contextual factors that significantly influence development. Many challenges experienced by neurodivergent children arise from mismatches between the individual and their environment, including sensory demands, social expectations, and the inclusivity of educational settings. These factors are not meaningfully addressed within the study, which instead focuses on modifying child and parent behaviour.

Additional ethical concerns arise from the framing of caregiving relationships. The study places a strong emphasis on maternal behaviour, with limited recognition of diverse family structures. This risks reinforcing outdated and potentially harmful assumptions about caregiver responsibility. Furthermore, the use of video-based intervention raises questions regarding consent, comfort, and the relational impact of observation, which are not adequately explored.

Taken together, these issues point to significant limitations in the evidence base supporting the Inklings program. The study demonstrates constraints in sample size, diversity, transparency, and conceptual alignment with current best practice. It also raises broader ethical concerns regarding the goals of early intervention and the potential for unintended harm.

Further concerns arise regarding the transparency of the program's selection and policy positioning. The Inklings program appears to have been introduced into the reform landscape without a clearly articulated rationale, selection process, or comparative evaluation against alternative approaches.

This lack of transparency limits the ability to assess its appropriateness, evidentiary basis, and alignment with national frameworks.

While it has been indicated that Inklings is subject to ongoing research and is distinct from broader reform initiatives such as the Thriving Kids model, there remains a clear conceptual and research lineage. The Thriving Kids approach appears to draw on similar underlying principles, including brief, low-intensity, non-clinical intervention delivered over a limited number of sessions. This raises concerns regarding the translation of a narrowly evidenced, small-scale intervention model into broader policy reform, particularly where the evidence base is not yet sufficiently robust, generalisable, or independently validated.

Additional concerns relate to the characterisation of the approach as neurodiversity-affirming. While language used within the model may reflect contemporary terminology, the underlying framework continues to rely on developmental norm expectations. In practice, this may function to encourage children toward neurotypical communication patterns, rather than supporting authentic, individualised forms of communication and participation.

There is also a notable absence of meaningful co-design with neurodivergent individuals, which is a core requirement of contemporary best practice. Without this, claims of neurodiversity affirmation are difficult to substantiate.

Given these factors, there is a risk that programs of this nature may be prematurely elevated within policy settings, potentially displacing more comprehensive, individualised, and multidisciplinary approaches that are better aligned with current evidence and practice.

There is a substantial risk that implementation of this program at scale may displace more individualised, multidisciplinary, and allied health-led supports that are better aligned with contemporary evidence and practice. It may also contribute to a narrowing of intervention approaches toward those that prioritise behavioural or relational modification over participation, autonomy, and environmental adaptation.

Given these concerns, it is recommended that further research be completed that is methodologically robust, inclusive of diverse populations, and grounded in neurodiversity-affirming principles. Future program development should include meaningful co-design with autistic individuals and their families, as well as input from a broad range of allied health professionals. Greater emphasis should also be placed on environmental and systemic interventions, including inclusive education and community-based supports, which are critical to long-term outcomes.

Early intervention policy should prioritise approaches that support children to develop, participate, and communicate in ways that are authentic, safe, and meaningful to them. Without this foundation, there is a risk that well-intentioned programs may contribute to harm, reduce diversity of support options, and fail to meet the needs of the populations they are intended to serve.

Social skills training as a disability support for children and young people

Introduction to Social skills training

Within the NDIS the support of social skills for participants is funded under categories of supports including the development of daily care and life skills (engaging in social activities and improving relationships and social skills), participation in community, social and civic activities, innovative community participation and therapeutic supports. There is not currently a social skills training support listed which makes it hard to respond to the EAC definition, given that the scope of the EAC is to "make recommendations to government on the safety, suitability and value for money of supports for NDIS funding, drawing on the best available evidence."
Currently these support items may be provided by Allied Health professionals (therapeutic supports), recovery coaches and disability support workers.

Survey response to Social Skills training

Definition

EAC survey**: **What:

Social skills training aims to develop social interactions with family, peers and members of the wider community. Social skills training can be delivered as a standalone intervention or included in broader packages of supports. Social skills training may be delivered in a one-to-one format but is usually delivered in groups.

***Where:** Social skills training may be provided across different settings, such as clinical, school, childcare, community or home.**Who provides:** Social skills training may involve participation of allied health professionals, educators, parents, carers and/or peers. Does the description above accurately describe what social skills training as a disability support for children and young people is and how it is used? (please choose one)*

The current description of social skills training is overly broad and lacks sufficient conceptual clarity, which limits its usefulness for meaningful evaluation. While it appropriately identifies that social skills training can occur in one-to-one or group formats and across a range of settings, it does not adequately differentiate between the diverse purposes, populations, and underlying models encompassed within this term. As currently framed, "social skills training" appears to include a wide spectrum of approaches, ranging from developmental teaching of social interaction in educational contexts through to interventions for individuals with social anxiety, intellectual disability, psychosocial disability, and other complex needs. These groups have fundamentally different profiles, goals, and support requirements, and it is not appropriate to consider them within a single, undifferentiated category. For example, evidence indicates social skills training is not an evidence-based approach and therefore not considered contemporary practice, for groups of people living with psychosocial disability[4].

It is recommended that both one-to-one and group formats are retained as equally valid options, rather than implicitly or explicitly privileging group-based delivery. One-to-one approaches are often essential for individuals who require tailored, individualised support, particularly where there is significant communication, sensory, or psychological factors impacting participation. Group-based approaches may be beneficial for some individuals, particularly where peer interaction is a meaningful goal; however, they are not universally appropriate and may be inaccessible or ineffective for others. The current framing risks oversimplifying this distinction and may lead to assumptions that group-based delivery is the preferred or more effective model.

A further concern is that the description frames social skills as a discrete set of abilities that can be "trained" in isolation, without sufficient acknowledgement of the broader factors that underpin social interaction. Social

[4] Social skills programmes for schizophrenia - PMC

participation is not solely determined by an individual's social skill level but is influenced by communication differences, sensory processing, emotional regulation, cognitive factors, and the responsiveness of the environment. Allied health approaches, including occupational therapy and speech pathology, typically address these underlying domains in an integrated and individualised manner. Without recognising this complexity, the current definition risks promoting approaches that focus on surface-level behaviours rather than meaningful participation.

The description also does not reflect contemporary, neurodiversity-affirming understandings of social interaction. It implies a unidirectional model in which individuals are expected to adapt to normative social expectations, rather than recognising social interaction as a reciprocal process that involves mutual understanding and adaptation from all participants. This has important implications for how interventions are designed and evaluated, particularly in relation to outcomes such as inclusion, wellbeing, and identity. Refer to the Reframing autism article on What Traditional Social Skills Courses Get Wrong and What an Affirming Social Skills Course Would Look Like - Reframing Autism

The breadth of the current definition makes it difficult to determine what is actually being assessed or compared within the survey. Without clearer delineation of intervention types, and intended mechanisms of change, there is a significant risk that responses will be inconsistent and that findings will not be interpretable. A more precise and differentiated framework is required to ensure that the assessment reflects the diversity of practice and produces meaningful, actionable conclusions.

NDIS role

The NDIS is legislated to fund reasonable and necessary support that build functional capacity, including therapy supports to develop social engagement skills and disability supports that enable participation in social and civic environments. The inclusion within the Evidence Advisory Committee (EAC) survey of delivery by teachers, childcare workers, and other mainstream roles raises significant policy concerns. These roles sit within foundational and mainstream service systems and are not equivalent to NDIS-funded disability supports. Their inclusion within this assessment blurs the boundary between specialist disability intervention and universal service provision, creating ambiguity regarding the scope of the NDIS and the responsibilities of other service systems.

This framing risks underpinning policy directions that shift responsibility for disability-specific supports away from the NDIS and onto mainstream systems, without adequate consideration of capability, resourcing, or accountability. Such a shift would be inconsistent with the intent of the NDIS to provide targeted, individualised support that address disability-related needs beyond what can reasonably be expected of mainstream services.

It is essential that the assessment explicitly clarifies its underlying assumptions and the intended application of the findings in the context of reform. Without this transparency, there is a risk that the consultation process may inadvertently support policy decisions that dilute access to specialised supports and undermine the integrity of the NDIS as a distinct and necessary component of Australia's disability support system.

OTSi has raised concerns regarding the recent 'Defining Therapy Supports'[5] discussion paper. As a professional body representing occupational therapists working across the lifespan and across disability cohorts, OTSi is committed to ensuring that NDIS policy settings align with the objects and principles of the *National Disability Insurance Scheme Act 2013* (NDIS Act); the *International Classification of Functioning, Disability and Health* (ICF); and contemporary evidence-based allied health practice. OTSi is concerned regarding the proposed categorisation of therapy supports into "general", "social", and "physical and health related" categories, particularly as these categories are proposed to be linked directly to domains identified through the ICAN Support Needs Assessment. Our central concern is that the proposed framework may not be compatible with the NDIS Act, conceptually inconsistent with the ICF, and relies on

[5] Defining Therapy Supports consultation with Allied Health Peak Bodies | Australian Government Department of Health, Disability and Ageing

an assessment tool (ICAN) that has not been validated for the purpose of determining therapy categories or therapy access.

The proposal to divide therapy into "social" and "physical and health related" categories reflects a reductionist separation that does not reflect contemporary disability practice. Therapeutic interventions routinely target transferable skills across multiple domains

The proposed separation of therapy into "social" versus "physical" categories reintroduces a dualistic model that the ICF explicitly rejects. Therapeutic interventions frequently address body functions in order to enable participation outcomes. Similarly, participation-based therapy often influences physical function.

Under the ICF, functioning is dynamic and interdependent. The 'Defining Therapy Support' paper domain-linked therapy categories risk fragmenting that integrated model and incentivising siloed intervention rather than whole-of-person practice.

In *Sutherland*[6], the Federal Court emphasised that support needs cannot be artificially constrained by administrative interpretations inconsistent with the statutory framework. The Court reinforced that eligibility and support determinations must align with the text and purpose of the NDIS Act.

In *Eastham*[7], the Tribunal considered whether a mobility scooter met the criteria for funding under the Act and Transitional Rules. The decision reinforced that supports must be assessed holistically, in light of real-world functional need and environmental context, rather than by narrow administrative categorisation.

Outcomes

> ***EAC survey**: Based on what we know so far, we think social skills training as a disability support for children and young people aims to help with the following outcomes:*
>
> *Activities and Participation; Communication (core social communication skills); Daily living and community participation (e.g., cooperative play, group activities, classroom integration, imitation); Friendship skills (e.g., initiating play, maintaining peer relationships); Problem-solving and conflict resolution in social settings; Gross motor skills'; Socially interactive movements (moving towards people, personal space); Mobility for interaction (activities that involve social engagement such as dancing, interactive play); Behavioural and emotional adjustment; Social difficulties; Wellbeing of others (e.g., family/carers, peers, educators); Inclusion.*

The outcomes attributed to social skills training as a disability support are difficult to evaluate due to the lack of clarity regarding what is being assessed. It is not specified whether "social skills training" refers to a therapy support, a disability support, or a structured program. This ambiguity is problematic, particularly given the absence of a clear methodology for how these supports will be compared to other interventions. For example, the inclusion of outcomes such as gross motor skills and socially interactive movement raises questions about whether social skills training is intended to be compared with allied health interventions by Occupational Therapists and Physiotherapists, , which are specifically designed to address these domains through assessment-driven, individualised intervention.

The current list of outcomes is also predominantly younger child-focused and does not adequately reflect the developmental trajectory into adolescence and early adulthood. There is limited recognition of the more complex social demands faced by older young people, including the development of meaningful relationships, participation in further education, and navigation of broader social environments. To ensure relevance and completeness, the

[6] Access to NDIS safeguarded by Federal Court win | Victoria Legal Aid
[7] Eastham and Chief Executive Officer of the National Disability Insurance Agency (NDIS) - [2025] ARTA 198 - Case | CaseNote AU

outcomes should be expanded to include areas such as the development of relationships, including romantic and sexual relationships, as well as the capacity to engage in these safely and with appropriate understanding of consent and boundaries. Outcomes should also reflect the ability to participate in age-relevant environments, such as engaging in university tutorials or other post-secondary settings, workplaces, and to manage social risks, including vulnerability to exploitation or harm. Without inclusion of these domains, the assessment risks presenting an incomplete and developmentally limited view of social participation.

The assessment will need to compare how effective social skills training as a disability support for children and young people is at achieving its goals, compared to other supports which might help with the same, or similar things.

Effectiveness Comparison

***EAC survey**: The assessment will need to compare how effective social skills training as a disability support for children and young people is at achieving its goals, compared to other supports which might help with the same, or similar things. Depending on the goal, we think the most relevant supports to compare social skills training for children and young people to are: Different settings (e.g., social skills training provided in a clinic compared to in a school setting); Different approaches to delivering the support (e.g., training delivered by itself, or with involvement of other people in a person's life, such as clinicians, teachers, parents/carers, peers or other support people); Different methods (e.g., training based in a digital/virtual environment or other technology compared to face-to-face training); Delayed training or 'waitlist control' ('waitlist control' is when some people in a study don't get the support immediately so they can be compared to the people who do get the support immediately).*

It is challenging to meaningfully compare the outcomes of social skills training with other effective interventions, given the lack of clarity regarding the nature and scope of the support being assessed. The current framework appears to be weighted toward younger children and does not adequately account for interventions designed for older adolescents or young adults, where the complexity and context of social participation differ significantly. There is a fundamental distinction between approaches that focus on teaching discrete social skills and therapy-based supports that identify and address the underlying barriers an individual may experience. Allied health interventions, such as occupational therapy, typically involve comprehensive assessment and the development of individualised strategies that consider communication, sensory processing, cognition, and environmental factors. This contrasts with models that primarily focus on the acquisition of social knowledge or behaviours in isolation.

A more appropriate comparison would require distinguishing between these different approaches and evaluating outcomes in relation to functional participation and real-world engagement. Consideration could also be given to existing outcome data within current NDIS-funded supports, which may provide a more accurate reflection of how individualised, multidisciplinary interventions contribute to meaningful social participation across different age groups.

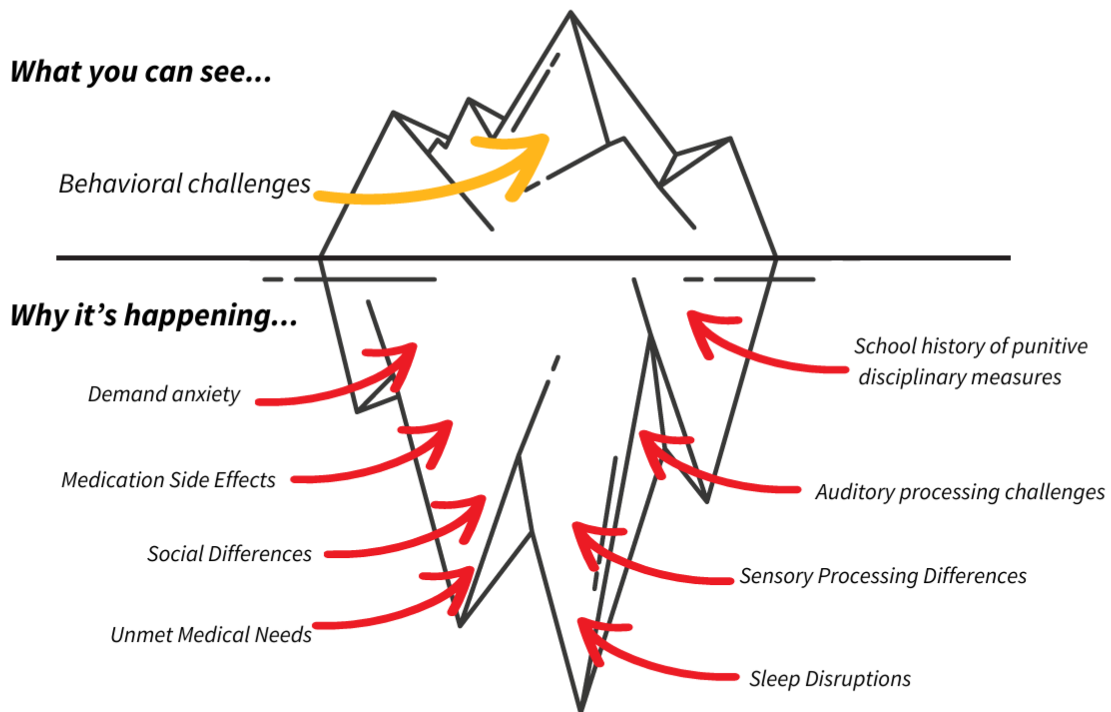
The approach taken to comparison within the social skills training section raises significant concerns, particularly in relation to how allied health interventions are positioned. The proposed comparators focus primarily on variations in delivery format, such as setting, mode of delivery, or timing, rather than comparing fundamentally different types of supports that aim to achieve similar outcomes. This creates a narrow comparison framework that does not reflect real-world clinical practice and limits the ability of the assessment to meaningfully evaluate effectiveness.

Social skills training programs have historically been criticised for not being neurodiversity affirming or trauma informed. Some programs have been changing but this is not always reflected in the literature. Programs selected for Australian reform need to reflect contemporary best practice rights-based approaches rather than relying on the degree of evidence.

Autism and social skills training

Many traditional approaches for Autism are based on teaching neurodivergent individuals to conform to neurotypical social norms, such as maintaining eye contact, suppressing natural movements, or following scripted interactions, rather than supporting authentic, reciprocal communication. This can place the burden of adaptation solely on the neurodivergent person and overlook the role of the environment and communication partners in facilitating inclusion. For social skills training to be considered neurodiversity-affirming, it must shift away from compliance-based models and instead prioritise autonomy, mutual understanding, flexibility in communication styles, and participation in meaningful social contexts. Without these safeguards, social skills training may improve observable behaviours while inadvertently compromising wellbeing and authenticity, resulting in trauma and/or further costs for government schemes down the track.
The needs of children and adults with Pathological Demand Avoidance also need to be considered in program development, access and research.

Tolerance VS Demand - looking under the iceberg:
Behavioral challenges are the "tip" of the iceberg, and the answers to helping individuals are often found below the surface of behaviors. The tip of the iceberg will tell us "what" is happening, but not the "why".



From: PDA North America

Psychosocial Disability, Mental illness and social skills training

Given the lack of clarity within the survey regarding the distinction between clinical social skills programs and broader capacity-building supports, it is important to highlight several approaches that may fall within scope, even where their inclusion may not be appropriate or intended.

We highlight the need for the NDIS reform implementation to recognise the profound impact psychosocial disability has on daily lives. The profound impact persists between acute episodes and is not adequately addressed by systems outside the NDIS. Further, potential risks due to the development of the ecosystem and introduction of the foundational supports, must be explored to mitigate the risk of creating further barriers to accessing disability support.

There are very significant and under-recognised complexities experienced by those who live with substantial psychosocial disability, that contribute to reduced lifespan of 20 years compared to the average Australian . For example, current research highlights the high rates of persistent disability experienced by the cohort identifying with an impairment of schizophrenia, which includes two-thirds with a cognitive impairment; 24% experience hearing impairment; 26-70% of people experiencing vision, or visual processing, difficulties with functional impact, impacting literacy and social engagement; motor skills and gait difficulties; and a 2.5 fold increase in lifetime risk of developing early-onset dementia. An individual experiencing one or a combination of these issues will be inappropriately placed within a social skills group; structured group groups; or a Clubhouse, for example, without at the very least, prior recognition and accommodation of functional capacity; and addressing a range of disability support needs.[8]

Clubhouse Model

The clubhouse model, as implemented by organisations such as Clubhouse International, is often presented as social skills training for people with psychosocial disability. While it has some popularity, it is not suitable as a primary approach for all people with psychosocial disability. Its effectiveness is highly dependent on individual preference, readiness, and the specific needs of the person, and it should not be positioned as a universal or default model for developing social participation, particularly for individuals under 25 years of age. Mixed-age environments, where younger people engage alongside older adults with psychosocial disabilities, may not be developmentally or socially appropriate and are not considered youth-sensitive.

Contemporary approaches to inclusion increasingly emphasise participation based on individual interests, activities, and naturally occurring peer connections, rather than grouping individuals solely on the basis of shared diagnosis or mental health status. While peer-based environments can provide valuable opportunities for connection, they represent only one option within a broader spectrum of supports. In the context of social skills or participation-focused funding, it is important that such models are offered as part of a diverse range of choices, with recognition that many individuals may prefer alternative pathways to social inclusion.

Available data also suggests that uptake of clubhouse models may be limited relative to the broader population of people with psychosocial disability. For example, an evaluation of a Brisbane-based clubhouse reported 135 members joining over a 12-month period (Fjeldsoe et al., 2025). This relatively modest engagement, despite the program being freely accessible, indicates that such models may not align with the preferences or needs of a large proportion of the target population. This further reinforces the need for a flexible, individualised approach to social participation supports, rather than reliance on a single service model.

Other social skills training

The broader literature on social skills for psychosocial disability includes a range of manualised social skills interventions, such as Dialectical Behaviour Therapy (DBT), Social Cognition and Interaction Training (SCIT), and other

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[8] Howes, O. D., Bukala, B. R., & Beck, K. (2023). Cognitive impairment in schizophrenia: aetiology, pathophysiology, and treatment | Molecular Psychiatry (nature.com)
Saperstein, A. M., Meyler, S., & Medalia, A. (2023). Hearing Loss Among People With Schizophrenia: Implications for Clinical Practice. Psychiatric Services (Washington, D.C.), 74(5), 543–546. https://doi.org/10.1176/appi.ps.20220226

The Phenomenology and Neurobiology of Visual Distortions and Hallucinations in Schizophrenia: An Update - PubMed (nih.gov) (Retrieved Jan 2023)

Petrescu, Petrescu, et al (2022). Neurological Soft Signs in Schizophrenia, a Picture of the Knowledge in the Last Decade: A Scoping Review.
Feldman, Ron & Schreiber, Shaul & Pick, Chaim & Been, Ella. (2020). Gait, Balance and Posture in Major Mental Illnesses: Depression, Anxiety and Schizophrenia.
Psychotic disorders may increase the risk of dementia (healtheuropa.com)

structured programs developed within clinical mental health settings. These interventions are typically delivered within specialised clinical contexts and are not widely implemented as NDIS-funded supports. If such programs are being considered within the scope of this assessment, further clarification is required regarding their relevance, delivery context, and evidence base in disability settings.
The survey also appears to assume that social interaction can be improved through the training of discrete skills, such as initiating conversation, maintaining eye contact, or adhering to social rules. This reflects a more behaviourally oriented model and does not align with contemporary understandings of social interaction as a reciprocal, context-dependent process. For individuals with psychosocial disability, social participation is often influenced by factors such as mental health status, confidence, executive functioning, sensory processing, environmental safety, and opportunities for meaningful engagement, rather than solely by the acquisition of specific skills.

Peer models may provide valuable social connection and peer relationships, however these outcomes are distinct from skill-development approaches.

Potential Harms
There are also potential risks associated with some forms of social skills training. Approaches that emphasise conformity to social norms may lead individuals to suppress authentic communication styles, which can negatively impact self-esteem, identity, and engagement with supports. There is evidence that such approaches may contribute to disengagement or dropout, particularly where participants do not experience the intervention as relevant or respectful of their lived experience. These potential harms should be explicitly considered within the assessment and choice for participants is essential.

Occupational Therapy models of social skills training.

Occupational therapy models offer a trauma informed and contemporary approach to supporting social participation and should be explicitly included in this review. These approaches are typically grounded in functional, participation-based frameworks and may include occupation-based groups, core skill development embedded within meaningful activity, and social inclusion approaches such as social prescribing. These models focus on enabling participation in real-world contexts, addressing environmental and personal barriers, and supporting individuals to engage in ways that are meaningful and sustainable, rather than training social behaviours in isolation.

Occupation Based Groups

Occupational therapy has long utilised activity-based groups as a fundamental approach to assist individuals improve their social participation. In the field of occupational therapy, "occupation" doesn't just refer to paid employment or traditional jobs. Instead, it encompasses a wide range of activities that people engage in to fulfill their roles and responsibilities in life. This includes activities such as bathing, cooking, socialising, playing, and other tasks that contribute to one's overall functioning and quality of life. Occupation is so core to Occupational Therapy that it is part of our name.

There is a fundamental difference between someone engaging in an activity, such as playing a video game, lego or loose parts play and then a qualified Occupational Therapist who is utilising the activity to achieve goals of increasing functional capacity in social participation. In Occupational Therapy the games and activities are part of a strategy to achieve the goal.

The concept of social skills training does not make this distinction clear and we are aware of the need for NDIS workforce to understand that activity based groups are considered best practice by Occupational Therapists (and other qualified professionals) and a fun and engaging, non threatening strategy to achieve goals by participants with disabilities.

Some of the activities that have been utilised by Occupational Therapists to increase functional activities include lego, gaming, dungeons and dragons, art, craft, cooking, creative writing, Loose parts play.
Occupational Therapists plan the most suitable environment for an activity to achieve the goal of increased functional capacity. This can include outdoors and nature based activities such as gardening, bushwalking, and outdoor play. Animal assisted therapy may be indoors or outdoors but involve the additional utilisation of animals to achieve the desired goal. The overall plan would be to utilise the environment or animals in order to achieve the goals to increase social participation. For OTs the nature is not the focus but the means to achieving the skills development.

CORE Approach

The Capabilities, Opportunities, Resources, and Environments (CORE) Approach is an evidence-based framework used in occupational therapy and related fields to understand and address the factors that influence an individual's ability to engage in meaningful activities, as well as promoting social inclusion. This approach is designed to comprehensively assess, reflect upon, and support a person's occupational performance, values, interests, goals and aspirations, by focusing on multiple dimensions of their life. Put simply, "the CORE approach aims to amplify a person or group's *voice* and advocacy of their *choices*; respect their *journey*, and celebrate their *life* through a direct and collaborative pursuit of authentic outcomes, and possibilities for social inclusion" (Pereira & Brown, 2023).

The components include:

1. Capabilities:
   - Definition: Refers to the individual's intrinsic abilities, skills, and potential. This includes physical, cognitive, and emotional capabilities. As a key driver of social inclusion, capabilities also consider extrinsic and contextual factors such as those conditions, abilities, possibilities, and freedoms, that enable an individual to say, and do and believe that "I can" and that "I matter" in the world (Pereira & Brown, 2023). Capabilities capture what an individual is capable of doing and being so that they can live a life that they have reason to value.
   - Focus: Assessing what the person can do and what skills they have developed, as well as identifying any gaps or areas for development and potential for flourishing.
2. Opportunities:
   - Definition: Involves the external factors and conditions that facilitate or hinder participation in desired activities. This includes opportunities for engagement in various occupations.
   - Focus: Understanding how available opportunities (e.g., social networks, community programs) influence the person's ability to participate in activities.
3. Resources:
   - Definition: Pertains to the tools, supports, and assets available to the individual that can aid in achieving their goals. Resources can be both tangible (e.g., adaptive equipment, financial resources) and intangible (e.g., social support, knowledge).
   - Focus: Identifying what resources the person has access to and how these resources can be utilised to enhance their occupational performance.
4. Environments:
   - Definition: Encompasses the physical, social, and cultural contexts in which activities occur. This includes the individual's home, workplace, community, and broader societal factors.

  - Focus: Examining how the environment influences the person's ability to participate in activities and identifying potential modifications to improve accessibility and support.

Application of the CORE Approach:

- Assessment: The CORE Approach is used to conduct a thorough assessment by evaluating each of these four areas, as well as the enablement strategies that can facilitate authentic outcomes. This helps in identifying barriers and facilitators to occupational performance.
- Intervention: Interventions are then designed based on the assessment to address deficits in capabilities (including unpacking contextual factors for enablement), enhance opportunities, leverage resources, and modify environments as needed.
- Holistic View: By considering all these components, the CORE Approach provides a comprehensive view of the factors affecting a person's ability to engage in meaningful activities, leading to more effective, personalised, values-based and authentic intervention strategies.

Overall, the CORE Approach is valuable for creating a holistic understanding of the factors influencing an individual's occupational performance and for developing targeted interventions to support their participation in daily life. . Due to being resourceful in nature this permits sustainability and economic efficiency in government programs, whilst promoting a sense of self, and safe environments.

Occupational Therapy and Social Inclusion

Advocating for Meaningful, Social Inclusion

1. Promoting Social Well-Being:

- Role of OTs: OTs understand that meaningful social occupations—activities that provide a sense of purpose and connection—are crucial for health (physical, social, mental, and spiritual) and overall well-being. They advocate for engaging in activities that are not only enjoyable but also align with personal values and interests.
- Impact: By encouraging individuals to participate in activities that promote social interaction and community involvement, OTs help combat feelings of isolation, enhance self-esteem, and improve quality of life. Social inclusion is an end goal of occupational therapy, going beyond occupational outcomes, towards being and feeling included in one's community.

2. Customising Interventions:

- Role of OTs: OTs tailor interventions to fit the individual's unique social needs, preferences, and goals. They use client-centered approaches to design activities and social roles that resonate with the individual's sense of identity and purpose.
- Impact: Customised interventions ensure that social activities are meaningful and engaging, which increases the likelihood of sustained participation and positive outcomes.

3. Addressing Barriers:

- Role of OTs: OTs identify and address barriers to social participation, such as physical limitations, social anxiety, or environmental challenges such as noise, bright lights or movement. They work to remove these barriers through adaptive techniques, environmental modifications, and therapeutic support.
- Impact: Overcoming barriers enables individuals to engage more fully in social occupations, fostering a greater sense of belonging and inclusion.

4. Advocacy for Social Inclusion:

- Role of OTs: OTs advocate for the inclusion of individuals in community life by promoting accessibility and social equity. They may work with communities, organisations, and policymakers to ensure that social programs and activities are inclusive and supportive.
- Impact: Advocacy efforts lead to more inclusive communities where everyone has the opportunity to participate in meaningful social occupations.

Integrating Social Prescribing into Occupational Therapy

1. Holistic Approach to Health:

- Opportunity for OTs: Social prescribing complements the holistic approach of occupational therapy by addressing non-medical factors that influence health and well-being. It allows OTs to provide a more comprehensive form of care that goes beyond traditional therapy, to highlight an individual’s capabilities to do, be, become, belong, connect and flourish.
- Impact: Integrating social prescribing in their work enables OTs to support clients in accessing a broader range of resources that can enhance their social participation and overall health.

2. Connecting to Community Resources:

- Opportunity for OTs: Through social prescribing, OTs can connect clients with community resources such as social groups, volunteer opportunities, and recreational activities that align with their interests and needs, as well as highlighting the power of occupations for health, wellbeing, quality of life, and social inclusion.
- Impact: These connections can lead to increased social engagement, improved mental health, identity development or reconnection, and a stronger sense of community belonging.

3. Enhancing Client Empowerment:

- Opportunity for OTs: Social prescribing empowers clients to take an active role in managing their health and well-being by exploring and engaging with community resources.
- Impact: Empowered clients are more likely to develop and maintain healthy social habits, leading to long-term benefits in their social and emotional lives.

4. Expanding the Role of OTs:

- Opportunity for OTs: Integrating social prescribing into occupational therapy practice allows OTs to expand their role in promoting well-being. It positions them as key facilitators in helping clients access and engage with meaningful social occupations.
- Impact: This expanded role highlights the value of occupational therapy in addressing social determinants of health and demonstrates its relevance in a global context.

5. Collaborative Practice:

- Opportunity for OTs: Social prescribing encourages collaboration between OTs, healthcare providers, community organisations, and social services. This interdisciplinary approach ensures a more coordinated and comprehensive support system for clients.
- Impact: Effective collaboration enhances the quality of care and increases the likelihood of successful outcomes in social and occupational engagement.

6. Advocacy and Policy Influence:

- Opportunity for OTs: By engaging in social prescribing, OTs can advocate for the development and funding of community resources and programs that support social participation and well-being.
- Impact: Advocacy efforts can lead to systemic changes that improve access to social resources and promote greater social inclusion on a broader scale.

Conclusion

Integrating social prescribing into occupational therapy (and vice versa) offers a significant opportunity to impact individuals' lives positively. By focusing on meaningful occupations (including social occupations) and connecting clients with community resources, OTs can enhance social participation, well-being, inclusion, belonging, and quality of life. This integration not only aligns with the holistic and client-centered nature of occupational therapy but also underscores its relevance in addressing global health and social challenges.

Positive behaviour support for older children (9 years and above) and adults.

***EAC survey**:*

**This assessment is not limited to how positive behaviour support currently operates in the NDIS but considers the application of positive behaviour support in other sectors, across Australia and also overseas. We understand that some elements of the support as described may fall outside of the current legislated requirements as described in the NDIS Act and associated rules and in State and Territory legislation and policy. * This is a component of the survey information.*

The current application of Positive Behaviour Support (PBS) within the NDIS Quality and Safeguards Commission is largely derived from models originally developed for people with intellectual disability. While these models have value, they do not represent the full range of contemporary approaches available, particularly for individuals with psychosocial disability, autism, and complex trauma backgrounds. There is a need for the Evidence Advisory Committee to broaden its scope and consider additional evidence-informed frameworks that better reflect current practice across diverse populations.

It is recommended that the Committee review a wider body of work, including findings from the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, which provides critical analysis of restrictive practices and highlights the importance of systemic, environmental, and relational factors in understanding behaviours of concern. The Royal Commission emphasises that behaviours often described as “challenging” may instead represent distress, protest, or resistance within maladaptive “environments of concern.” This reframing has significant implications for how behaviour support is conceptualised and delivered, shifting the focus from behaviour reduction to environmental modification and support.

In addition, the Committee should consider models such as sensory modulation approaches, and the Six Core Strategies to Reduce Seclusion and Restraint Use.

Royal Disability Royal Commission's Final Report (2023) Volume 6: Enabling autonomy and access:

Further research on the effectiveness of positive behaviour support practices

In preparing the Pathway to elimination report, the researchers considered whether positive behaviour support is effective in reducing and eliminating the use of restrictive practices. If so, they were asked to consider whether it is more effective for certain types of disability, restrictive practices, or settings.[i]

Based on a review of the national and international scholarly literature, the Pathway to elimination report found that the evidence base for positive behaviour support is limited. Further, studies considered in the Pathway to elimination report often provide mixed or inconclusive results.[ii] *The report said the two core limitations of the existing evidence base are small sample sizes (some studies are based on a single case study design), and 'a lack of strength, accuracy and integrity' of research findings.*[iii]

Several studies have reported positive outcomes from implementing positive behaviour supports. However, design limitations make it unclear whether and to what extent positive outcomes resulted from the positive behaviour supports.[iv] *The Pathway to elimination report concluded that positive outcomes appear to occur for people with disability when:*[v]

- *staff are nonconfrontational and consistent in their communication with the person with disability*
- *staff do not impinge on the autonomy of the person with disability*
- *people with disability are enabled to participate in meaningful activities of their own choosing*
- *the wishes of the person with disability are listened to and acted upon.*

The researchers noted that these findings are 'consistent with the understanding that perceived "behaviours of concern" are distress, protest and resistance made in a context of maladaptive "environments of concern"'.[vi]

Overall, the researchers concluded:

> *it is not possible from the research literature currently available to generalise if positive behaviour support is more or less effective in certain settings. Nor is it possible from current research to determine if positive behaviour support is more or less effective when used in relation to certain types of disabilities, or used in the context of certain restrictive practices.*[vii]

The Reducing restrictive practices report reached a similar conclusion on strategies to prevent challenging behaviour, reduce the need to use restrictive practices or adopt alternative approaches where challenging behaviour occurs. It found 'there are a number of evidence gaps; and no clear consensus as to what constitutes good practice or how to achieve change'.[viii]

Six Core Strategies to reduce seclusion and restraint use

The 6 core strategies were developed by the National Association of State Mental Health Program Directors in the United States. The Six Core Strategies provide a trauma-informed, systems-level framework aimed at reducing the use of restrictive practices. Importantly, this model is not prescriptive but is designed to be applied flexibly across service settings, allowing for context-specific and individualised responses. It incorporates organisational leadership, workforce development, data-informed practice, and the integration of tools such as sensory modulation and individualised safety planning.

These approaches highlight that effective behaviour support extends beyond individual-level intervention and requires significant organisational and environmental change. Evidence from services that have successfully reduced seclusion and restraint demonstrates that outcomes are achieved not solely through individual behaviour plans, but through broader shifts in culture, policy, staff training, and environmental design. The Peninsula Mental health Service in Australia has completely eliminated seclusion and restraint.

Sensory Modulation Approaches.

In mental health contexts, approaches such as sensory modulation and trauma-informed care have been widely implemented to support self-regulation and reduce distress. These approaches recognise the role of the environment and the nervous system in shaping behaviour and provide practical, individualised strategies to support regulation and participation. These approaches need to be combined with organisational change approaches and education for staff regarding the impact of sensory processing on psychosocial, neurological, intellectual and neurodevelopmental disabilities.

Occupational therapists brings expertise in analysing the interaction between the individual, their environment, and their occupations, including identifying sensory and environmental triggers, supporting trauma-informed practice, and implementing practical modifications. This may include environmental adaptations within the home, adjustments to daily routines, and changes to personal care practices, such as showering, to reduce distress and improve participation. Recognising and utilising this expertise is critical to strengthening the quality and effectiveness of behaviour support within the NDIS. Detailed sensory assessments are critical in identifying environmental triggers and unmet needs that may contribute to distress behaviours. Without this level of assessment, behaviour support risks being reactive and behaviour-focused, rather than preventative and needs-based.

The role of Sensory Modulation in reducing seclusion and restraint has been most researched within Mental Health Units and there are multiple studies to demonstrate its effectiveness. Studies include Andersen et al. 2017; Barton et al. 2009; Champagne & Stromberg 2004; Lloyd et al. 2014; Maguire et al. 2012; Sivak 2012; Yakov et al. 2017 cited in

Wright et al , (2021) and Seckman et al (2017) Bobier et al (2015). More recently, Zimmerman's 2020 study on the implementation of a serenity/comfort room for sensory modulation found a decrease in chemical restraint, seclusion and mechanical restraint. Azuela (2019) found that service users in a psychiatric unit reported that sensory modulation was preferred over in situ medication (PRN) as a calming strategy. In a study by Van den Boogert (2021) autistic adults with higher scores in sensory sensitivity had the highest risk of aggressive behaviour and thus applying detailed diagnostics on sensory processing difficulties when treating aggressive behaviour was recommended.

Sensory Modulation has also been used to decrease self harm. In one study (Matson et al (2021) participants found that they were able to use sensory input to experience a sense of release that they would normally achieve from self harming, but without any different. This depended on the usual method of self harm and was different for each individual

Im (2021) reviewed treatment of Aggression in Adults with Autism Spectrum Disorder and found that both multisensory interventions and behavioural interventions had similar levels of evidence.

In the area of dementia, there have been studies reporting a decrease in the number of behavioural and psychological symptoms with the use of multi sensory environments (cited in Unwin et al (2020).

Australian National Policies, Reports and Frameworks that contain references to Sensory Modulation, Sensory Items, Sensory Rooms or Sensory Approaches.

An OTSi member has contributed this list for this submission.

- NDIS QUALITY & SAFEGUARD COMMISSION (2020) Regulated Restrictive Practices Guide
- National Mental Health Commission
- National Principals to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services (Mental Health Commission)
- Australian National framework for recovery-oriented mental health services: Guide for practitioners and providers (2013)

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