Planning a dance movement therapy program for clients with intellectual disability: considering National Disability Insurance Scheme, host agency and dance movement therapy priorities.

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Abstract

The National Disability Insurance Scheme (NDIS) in Australia offers new opportunities for funding of dance movement therapy (DMT) programs for people with disability. The NDIS' emphasis on participant choice and focus on outcomes propels new directions in service provision, with agencies impelled to consider individuals' preferences and report on progress with more rigour than they may have brought before. This change provides a challenge for dance movement therapists, as many practitioners have limited experience of working in a specifically outcomes-focussed way. This article addresses these issues by documenting the process of planning, goal setting, assessment and reporting in a DMT program for clients with intellectual disability. This process considers three different sets of outcome considerations: NDIS funding requirements; outcomes currently identified in participants' individualised program planning; and objectives of a DMT program. In so doing, the article articulates the relationship between NDIS funding requirements and the potential offering of DMT. It also provides DM therapists a model for how they might clarify the objectives of their own programs to make them NDIS-compatible and enable reporting of relevant outcomes to stakeholders.

Key words: dance movement therapy, intellectual disability, National Disability Insurance Scheme, planning, outcomes.

Introduction

The National Disability Insurance Scheme
The National Disability Insurance Scheme in Australia began as a pilot in a number of trial sites in March 2013, before full national roll out. The Australian Federal Government developed the NDIS model to address nation-wide shortcomings in disability funding and service provision highlighted by a 2010 Productivity Commission Inquiry (NDIS, 2018). The scheme echoes the ethos of the United Nations Convention of the Rights of Persons with Disabilities (United Nations Division for Social Policy and Development, 2008) by placing people living with disability at the centre of their decision making processes as they relate to life goals and the use of services (Ottman & Crosbie, 2013). It also aligns with international trends in the personalisation of funding packages and disability policy, such as the UK's National Health Service and Norway's Brukerstyrt Personaling Assistance (Carey et al, 2017).

The new NDIS system has replaced block-funding allocation to disability service providers with funding packages controlled by individual service users and their advocates. Agencies are now funded by NDIS to increase individuals' realisation of their personal aspirations. This work focusses on supporting independence in daily living, access to meaningful educational and work opportunities and active social/community participation (NDIS, 2018). Much greater onus is now placed upon the participant and their advocate/s to choose how and where they place their own funds to suit their personal circumstances, goals and preferences (Thill, 2015).

The resulting shift towards a more 'market based' environment impels service providers to utilise evidence-based and outcomes-focussed methods to demonstrate the quality and utility of their services (Carey et al, 2017). Rigorous assessment and reporting methods that meaningfully incorporate the experiences and perspectives of service users are central to this (Thill, 2015). Assessment and reporting for programs funded by NDIS require a clear alignment between participant's NDIS life goals and program or intervention outcomes (NDIS, 2018).

The NDIS has three funding streams, of Core Supports, Capital and Capacity Building. These apply to children and adults with disability under the age of sixty-five (NDIS, 2018). Capacity Building funding streams are very relevant to dance movement therapists, especially sub-streams of Social and Community Participation, Relationships, Health and Wellbeing and Daily Living, (NDIS, 2018). Whether funded through Capacity or Core Support streams, agencies are expected to facilitate assessment of participants' progress towards life goals and aspirations including: daily living; home, health and wellbeing; lifelong learning; work, social and community participation; and relationships and choice and control (NDIS, 2018).

Dance movement therapy and the NDIS
However, dance movement therapy (DMT) is not currently a modality recognised by the NDIS for direct funding support. The Dance Movement Therapy Association of Australasia (DTAA) is working towards DMT being recognised and registered as a fundable modality under the NDIS. This has required the development of material for the NDIS about the evidence-base and application of DMT and improvement of various DTAA membership-related processes, particularly related to quality control of services and the use of evidence to inform practice.

In addition to these systemic challenges, dance movement (DM) therapists face the difficulty of needing to report outcomes of their programs that are supported by evidence, without well-developed tools or practice in doing so (Dunphy, Mullane & Allen, 2016). Few DM therapists in Australia are yet skilled in conceptualising appropriate measures and reporting outcomes against them in a way that is compatible with NDIS demands. Some progress in this respect is reported, with current authors Hens & Dunphy (2018) for example, documenting the use of iPad app MARA to enhance outcome-focussed dance movement therapy assessment.

This article considers how dance movement (DM) therapists in Australia can plan their

programs to meet the requirements of the National Disability Insurance Scheme (NDIS), to enhance outcomes for participants and their own possibilities for funded work. This includes taking an evidence-informed approach to the needs of participants experiencing disability and the potential contribution of dance movement therapy (DMT) to those needs. The topic is explored through documentation of a DMT program for people with cognitive disability through a Melbourne-based service provider.

The article documents the DM therapist's stepped planning process. It describes her interactions with her participants, their families and support networks and her host service provider; literature reviews on disability and DMT that she undertook; and the assessment tool and framework she utilised to support DMT specific outcomes setting, assessment and reporting. To illustrate the way these planning and assessment steps supported the therapist's DMT practice, the article provides three case studies of clients in the program. These detail information gathered through initial assessment and links between goals for each participant that address NDIS, PCP and DMT objectives.

It also provides a description of DMT activities to support progress towards these objectives, including a 'theory of change' which documents how participants' goals can be addressed by DMT processes and activities. Implications for the therapist's own practice of this stepped process are discussed along with recommendations for future DMT practice.

Methodology

This article is the result of an iterative reflective process undertaken by authors Hens and Dunphy. The two sought to articulate and then document in detail all the steps Hens took in establishing a new DMT program in an agency that was engaging with NDIS processes for the first time.
This project was one part of a larger research initiative on assessment in dance movement therapy, led by second author Dunphy. It was approved by University of Melbourne Human Research Ethics approval number 1647380.3. Written permission to contribute to this project was obtained from all clients involved in the program, supported by their advocates. Pseudonyms are used for each participant.

Establishing, planning, assessing and reporting on the dance movement therapy program: a seven-phase process

This section reports the therapist's processes of establishing and planning for the DMT program, assessment of clients and reporting on their progress involving a seven-phase process.

1. **Understanding workplace context and establishing the DMT program**
   The first phase of this process involved DM therapist Hens learning about the host organisation, its values and how these align with NDIS requirements, and how DMT might address them. In this process, she successfully gained the organisation's authorisation to begin planning a DMT program.

The DMT program discussed in this article was hosted by Bayley House (BH), a disability services provider in south-east Melbourne. The service was established in 1951 by a group of parents seeking to provide educational opportunities for their children with cognitive disabilities. It has since evolved to providing supported accommodation and other services to adults with cognitive disabilities seeking to increase their community participation, work skills and independent living skills through programs that link in with local community partners. Its values are strongly linked to creating strong community ties between its participants, their families and support networks and the local community.

Bayley House is significantly informed by person-centred approaches, through pro-active recognition of individuals' emotional narratives, interests and strengths (Clark & Smith, 2017). Participants are not viewed as fixed entities defined by their 'disability': rather, they are appreciated as individuals who are capable of personal development, peer support and creative expression if provided with enabling opportunities and support

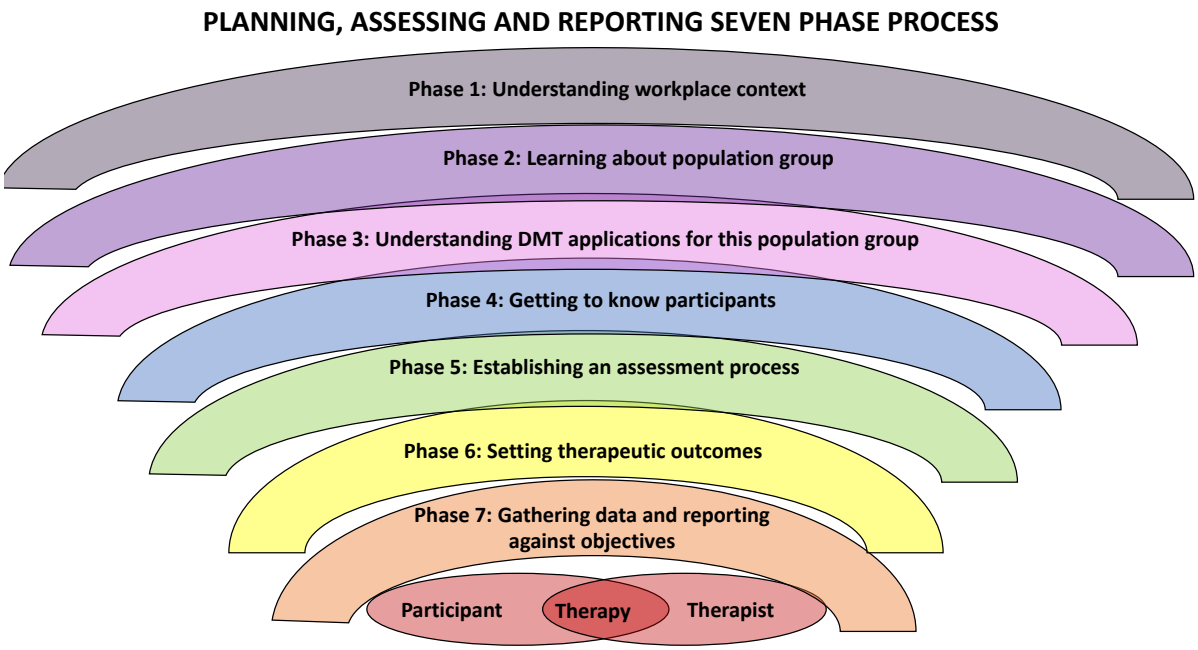

Figure 1: Seven planning, assessment and reporting phases for a DMT program

(Clark & Smith, 2017). This approach is taken to consciously counter limiting societal expectations that people with cognitive disability often experience (Clark & Smith, 2017; Thill, 2015).

With the advent of the NDIS, significant changes in service provision and planning processes were being made at Bayley House, from Person-Centred Planning documentation to NDIS Framework planning processes. Although similar to Person-Centred Planning in some respects, NDIS requirements involved more rigorous incorporation of newly-set goals into program facilitation and monitoring processes. This was associated with changed invoicing systems that are directed by individuals' access to specific programs, in contrast to previous packaged funding that was directed by the agency more flexibly across its own services. This new model enabled participants to take a more directive role in planning which of the centre's services and programs they utilise, facilitating more frequent and flexible shifts between programs or services of their choice. It also impelled the trialling of new assessment methodologies at Bayley House.

Three years ago, first author Tessa Hens approached BH management with a proposition to trial a DMT program. She was aided in this task by an established working relationship with the organisation as an employee. Mindful of the changes prompted by NDIS, Hens first undertook a brief literature scan to ascertain what the evidence indicated were likely outcomes of DMT for this client group, and which of these were relevant considering the NDIS funding framework. Her findings, supported by her practice experience, indicated that DMT broadly has the capacity to support increased physical wellbeing, emotional intelligence and social connection. She shared findings of this review with Bayley House management and collaboratively they considered NDIS outcome areas that best aligned with potential for the DMT program.

The organisation then lent their support to trialling an out-of-hours DMT program. Information about the program was distributed to participants and families. Interested participants self-selected for the program, supported by pastoral, logistical and financial input from families and centre staff.

Bayley House funded the DMT program under the NDIS Core Supports price guide item of 'Group and Centre Based Activities, Provision of Support to enable a participant to engage in community, social and recreational activities' at a 1:4 group ratio. This funding stream did not belong to the Capacity Building strategy because DMT is not yet a recognised modality under NDIS. However, Hens chose to assess progress within her programs against the outcomes of the Capacity Building funding streams to foster the utilisation of DMT in this agency by illustrating its potential to meet NDIS-relevant assessment markers effectively.

This approach helped the therapist to prepare for a reporting process that would be helpful to NDIS planning for individuals. In reporting, she would need to document progress towards NDIS goals and funding streams in a format that could be shared meaningfully with participants, the agency, families and NDIS Local Area Co-ordinators. This would support participants and their advocates to reflect on their own program goals and also be useful to NDIS planning processes by justifying the incorporation of this program into participants' individual funding packages. BH participants could then claim the costs of the DMT program from the NDIS.

2. **Learning about the client group**

The next step was for the therapist to develop her knowledge of this client group, given that consideration of diagnostic factors and an understanding of the challenges that many with cognitive disability hold in common is important to ensuring safe and responsive DMT facilitation. This involved a literature review focussed on the needs of people with cognitive disability and reflection on these findings in the light of her existing professional expertise. Findings are presented below.

An estimated 588,700 people (3%) in Australia have a cognitive disability (AIHW, 2008). This is defined as a condition in which an individual has an IQ score of 70 or below, and arrested brain development or brain injury that can result in impairment of cognitive,

motor, language and social skills (AIHW, 2008). These conditions predominantly have a life-long impact (AIHW, 2008). Cognitive disability is also frequently accompanied by other conditions such as autism, epilepsy, physical disabilities, sensory impairments and psychiatric disabilities resulting in significant impacts on mental health and wellbeing (AIHW, 2008). Difficulties with sensory regulation, emotional and social functioning and managing major life transitions or change are also associated with cognitive disability (AIHW, 2008). Almost sixty percent of people with cognitive disability have severe communication difficulties, which directly impacts on their capacity for self-advocacy and social interaction (AIHW, 2008). People with cognitive disability also often experience limiting societal expectations around their capacity for self-care, communication, creative thinking and community participation (Clark & Smith, 2017; Thill, 2015). Whilst impairment related to disabilities can create health and wellbeing challenges, socially-derived disadvantage such as social and economic exclusion are indicated as causing at least as much negative impact (Carey et al, 2017).

An 'eco-systematic' approach to disability services proposed by Hoo (2017) acknowledges in therapeutic interventions, the significant influence of interactions between an individual and their immediate and wider social networks. This idea of individuals being impacted by a number of factors in their environment aligns with the NDIS' recognition of the role that families, advocates and social support networks play in the lives of those with disability (NDIS, 2018). The scheme's emphasis on facilitating support along the spectrum of life stages, exemplified in its Early Intervention programs and initiatives for school leavers, also takes eco-systematic factors into consideration by encouraging collaboration between multiple agencies and service providers. When applied to DMT practice, this 'eco-systematically' geared approach supports meaningful therapeutic goal setting and responsive assessment, by prompting the therapist to consider an individual's wider life circumstances (Hoo, 2017). Central to this approach is the concept of transferability: the idea that a therapeutic intervention has the capacity to impact the way an individual operates in other parts of her/his social systems and vice versa (Hoo, 2017).

Hens reflected on these ideas from the literature in the light of her twelve years of experience in the disability sector as a support worker, specialist teacher and DM therapist. They aligned well with her observations that people with cognitive disability are capable of developing many skills for independence in communication and living skills, particularly when supported by open and collaborative connections between a participant/student, their advocates/families, allied health specialists and teachers or support workers, wherever possible and appropriate.

3. **Learning about DMT with this client group**
   The next phase was a literature review that explored DMT specifically for people with cognitive disability. This task enabled Hens to provide more detail to Bayley House about the possibilities of DMT to address challenge faced by program participants.

Outcomes of DMT for clients with cognitive disability substantiated in recent research include increased body awareness (Barnet-Lopez et al, 2015; Acolin, 2016); stimulation of creative thinking and expression (Dunphy, 2004; Uncovich et al, 2017); emotional literacy and positive self-concept (Barnet-Lopez et al, 2016; Meekums, 2008); increased capacity for self-reflection (Clark & Smith, 2017); expression of social and emotional aspects of being (Mullane & Dunphy, 2017); and social wellbeing including the ability to manage interpersonal relationships (Barnet-Lopez et al, 2016; Meekums, 2008). Relationships are observed between these outcomes as well, with increased body awareness, for example, seen to positively impact physical integration and functionality, cognitive control and emotional regulation (Acolin, 2016; Levy, 2005). In offering opportunities for creative expression, DMT is seen to activate the 'creative vitality' of participants (Acolin, 2016, p. 326) which is supported as valuable by emerging psychoneuroimmunology research because of its regulating influence on immune and

endocrine systems (Acolin, 2016). DMT is seen to enable transition between non-verbal, bodily expression of thought and feeling to cognitive processes (Mullane & Dunphy, 2017).

DMT is indicated as being particularly supportive of people who use non-verbal communication either solely or in conjunction with spoken language (Hoo, 2017) as do many of the participants in the BH group. Because DMT utilises embodied experiences as its main therapeutic medium, it has a much lower emphasis on verbal communication than other modalities, thus enabling authentic participation for people who have a wide range of communication preferences (Edwards, 2017; Hoo, 2017). Therefore, DMT enables such participants an inclusive and empowering means to express and explore their inner life and social experiences (Hoo, 2017; Clark & Smith, 2017).

4. **Getting to know participants: accessing client records and inviting input about DMT.**
   The next phase involved the therapist gathering information about individual participants, by accessing the host organisation's existing client information and planning documentation, and undertaking specific information gathering relevant to the DMT program. Face to face interaction with participants, their families and support workers at Bayley House also provided useful information to Hens to support her DMT planning. Information gathered from all of these methods is outlined below.

To develop goals for the program, the therapist first had to consider the planning and assessment processes that were already utilised by Bayley House. Though soon to be replaced by NDIS planning processes, Person Centred Planning (PCP) and Support Plan (SP) processes were still in use for many clients as the program commenced. The PCP documents, developed by individuals and their advocates, expressed individuals' long-term life goals, and strategies put in place at BH to support and promote these. These were generally monitored monthly by centre staff through collaborative discussion and case notes. They were then reviewed annually by participants, their advocates and Bayley House staff.

The DM therapist was permitted by participants and the organisation to access this documentation to enable her to understand each participant's broader life experiences and aspirations. Many participants utilised non-verbal communication methods, so these documents created an avenue for the sharing of important information with those who worked with them. This included information about whether an individual was living with their family or in supported accommodation, their independent living goals and social networks and whether they wanted to extend them in particular ways; vocational goals and special interests or strengths. SP documentation included specific information on physical, communication, behavioural and medical support needs. It also assisted the DM therapist to ensure safety during DMT facilitation, for example, by providing information on an individual's seizure management, and supported her to be sensitive to individuals' communication preferences, behavioural and emotional support needs. Examples of this include the knowledge that a group member may need extra rest points and reassurance due to increased anxiety from mental health challenges or life circumstances such as a family loss.

This access to existing data was complemented by Hens using a formal data gathering approach for the DMT program. She provided each participant and their family with a pamphlet describing DMT and outcome areas that might be expected from the program. Participants were invited to identify outcomes that were important to them and provide information about support and other preferences and favourite music. To enable accessibility for clients, the pamphlet had pictures accompanying written text that they could circle. There was also the option to complete this pamphlet with support from a chosen family member or advocate.

The twelve program participants in the group discussed here were aged 25-45 years, all with expressed interest in dance and music. Group members also shared many common life

challenges, in living with cognitive disability as a result of acquired brain injury or congenital conditions. Some were on the autism spectrum and some lived with mental health conditions. Members of this group experienced some of the challenges linked to the diagnosed conditions discussed above. These include limited movement range stemming from Acquired Brain Injury (AIWH, 2008); sensory processing difficulties often associated with diagnoses of autism (Autism Spectrum Australia [ASA], 2017); and challenges linked to conceptualising and managing emotional and social experiences (AIHW, 2008).

Other shared life challenges were complex, deriving from a combinations of societal and diagnostic factors. As discussed above, research demonstrates that those with cognitive disability require significant support at times of major life transitions (AIWH, 2008). Many members were working towards moving out of family homes, entering the workforce and navigating new social and community settings. These life circumstances required an increasing ability for participants to manage emotions and relationships in their daily lives and the practicalities of daily living with greater independence. Participants and their families were also adapting to increased expectations around self-advocacy and logistical changes instigated by introduction of the NDIS. Several members of this group used non-verbal communication methods solely or predominantly. They also often experienced being in settings where individualised communication supports or familiarity with their preferred communication methods were not available to them. This could at times, contribute to a sense of social isolation that could be overcome through development of social skills and creation of environments that validate their communication preferences.

5. **Establishing an assessment process**
   Then Hens made the decision to use the iPad app MARA (Dunphy, 2019) to assess participants, both in the initial intake process and throughout the program. She had become aware of MARA through professional colleagues and decided that it seemed appropriate for her client group and context. This was particularly because the framework seemed aligned with her and the host organisation's shared philosophical stance of person-centred and strength-based paradigms.

Hens familiarised herself with the explanatory material provided with MARA, including how the app's assessment process is underpinned by the *Outcomes Framework for Dance Movement Therapy* (Dunphy & Mullane, 2019). This tool is posited as offering a comprehensive assessment process suitable for all DMT programs, given its breadth of outcomes areas. It structured across five domains; Physical; Cultural; Cognitive; Emotional; and Social, with each domain having several sub-domains that include more specific objectives. The Framework is informed by person-centred and strength-based paradigms rather than diagnostic or deficit-focussed approaches. It elicits therapeutic judgements that are cognisant of individuals' lived experiences and current capacity and seeks to maximise that capacity rather than comparing them to a norm.

During the initial assessment and planning phase of her program, Hens utilised the app to structure her thinking about possible outcome areas that could be beneficial to participants. In their first few weeks in the program, participants were observed and assessed against a broad range of objectives from the *Framework*. This occurred within sessions, utilising Laban Movement Analysis-informed observations (Hoo, 2017), and verbal and non-verbal interaction between the DM therapist and the group (Hoo, 2017; Clark & Smith, 2017). Participants used their preferred communication methods to express what was important to them, including movement/ danced responses to DMT activities. This provided rich assessment information to support Hens to plan the types of interventions and experientials she would use in future. Three weeks of in-session observation also allowed time for the DM therapist to develop rapport with participants, and for them to develop a sense of safety and trust. This enabled them to invest more fully in the DMT therapeutic processes, which in turn enabled more sensitive observation and assessment from the therapist. With permission from participants, further consultation with centre

staff and/or families also augmented data collection during this assessment phase where the DM therapist felt she needed further information or clarification.

6. **Setting therapeutic outcomes**
   The next phase was the selection and refinement of outcomes for the program and formulating theories of change based on outcomes and linked DMT experiences.

Therapist Hens had initially trialled assessing one or more specific objectives for each group member in order to best address their individual goals. However, she very quickly found that she was unable to assess different objectives for each client within the limitations of weekly one-hour sessions for the large group of twelve members. Therefore, she made the decision to set two objectives from the *Outcomes Framework* for the whole group but ensured that these meaningfully linked to each participant's individual Person Centred goals, and more broadly to NDIS outcome areas.

For the block of eight sessions this article is focussed on, the following objectives were selected:

1. Physical domain: integration of body parts, body parts connectivity
2. Social domain: appropriate initiation, sustainment and release of engagement; give and take in relationships

Three case examples offered in the section below provide information about each participant that illustrate the links between NDIS Outcome Areas, participants' PCP goals and DMT program objectives. A set of DMT experientials that were considered to potentially address these objectives are outlined for each case. A theory of change explaining the anticipated relationship between all of the goals, the DMT program and its activities are also offered.

7. **Gathering data and reporting against objectives**
   The final phase involved Hens tracking progress against program objectives and reporting this to participants and their families.

Hens used the MARA app to gather and report data about outcomes of the DMT program over two eight-week blocks. *MARA* allowed Hens to assess against selected outcomes using data gathering options of numerical scoring, case notes, photos, videos and drawings. This data was stored in the app within each client's profile against the date they were gathered. Quantitative scores were turned into graphs by MARA, which enabled tracking of patterns in clients' responses and progress over time.

Hens developed a reporting format that particularly focused on links between NDIS funding areas, individual PCP goals and the DMT program's two chosen goals. Each report included two short written summaries of each participant's progress against these goals accompanied by relevant photos and short video clips. The reports also included verbal and non-verbal feedback from participants after they had each reviewed their goals and viewed video clips of themselves in one on one reflective interviews. Reflective discussion and supervisory input between Hens and co-researcher Dunphy, another external DMT supervisor and informal and formal discussion with the Bayley House management team contributed to this formative assessment process.

With permission from participants, these reports were emailed to families. They were also uploaded to BH's intranet data system so that management and support staff could access them also for goal monitoring purposes. Some families reported their intention to use the reports in future NDIS planning meetings to gain funding for further access to the program. The process of sharing of these reports also spurred further informal discussion between the DM therapist, participants, families and support staff. These discussions supported participants and their support networks to recognise the potential for DMT to support therapeutic goals that are meaningful to participants' life experience, beyond the first expected recreational function. These discussions in turn supported the DM therapist in her ongoing assessment and in the development of future goals that would link meaningfully to individuals' lives and extend on progress already attained.

Case studies

The following three case studies of program participants detail information gathered through initial assessment processes and links between goals for each participant that address NDIS, PCP and DMT objectives. They also provide a description of DMT activities that could support progress towards these objectives, including a 'theory of change' which articulates how participants' goals can be addressed by DMT processes and activities.

Case study 1: 'Jason'

Issues to be addressed derived from PCP goals and consultation

Jason is a very social and friendly man in his mid-twenties. A brain condition acquired at birth can make speech, remembering sequences and coordinating movements challenging for him. However, his receptive language is strong, and he uses gesture and vocalisation effectively to communicate. Jason is working towards becoming more independent in his daily living by improving his sequencing skills and ability to follow instructions.

Jason, with the support of his family and staff at Bayley House, wants to increase his independence when transitioning between different activities in day to day life, preparing food, and performing daily living tasks. He currently lives with his family but has aspirations to move into his own house with friends. Sometimes he appears to be overwhelmed by tasks and loses confidence. In these situations, he disengages from activities or seeks out another person to complete a task on his behalf.

Initial observation in DMT sessions

Jason responded well to one to one prompting, modelling and interaction when he was moving. Without this support he often disengaged from the session. Jason was able to recall single and occasionally two-step movement sequences after modelling and repetition. Jason enjoyed free flow movements in his hips and core indicated by smiles when dancing to music he enjoyed or when moving with a friend. He preferred not to make eye contact, but could connect with others, for example by attuning with the therapist's movement and rhythms when moving together for short periods. Jason also often vocalised in response to group interaction and novel or funny movement experiences. Jason usually used parts of his kinaesphere close to his body and preferred not to travel through space, staying fairly stationary when moving. With modelling and one- on-one movement support, he was open to trying to extend his limbs more, and to experimenting with both direct and indirect travel through space. After the first few sessions, Jason's mother communicated that she observed him to be more alert, energetic and social than usual in the evenings after the DMT program.

Figure 2. Jason stepping 'over and around' in the DMT session

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Table 1: Relationship between outcomes of PCP, NDIS and DMT - Jason

Outcome considerations	**Therapeutic outcomes set after initial assessment phase.**
PCP goal:	To maintain and improve cognitive skills such as sequencing and following instructions.
NDIS Outcome area this best relates to:	Independence
Relevant DMT program objectives	MARA Reference: *Physical domain: integration of body parts, body parts connectivity* Jason will develop his ability to integrate different body parts through movement experiences that support the development of coordination, sequencing and strength.

Theory of change:	DMT experiences provide Jason opportunities for learning and remembering movement and practicing ordering and sequencing, to support using body parts in a more integrated way. These experiences may transfer to greater physical mastery, memory and confidence when Jason undertakes daily living tasks that require these same skills, thus enhancing his capacity for independent activity.
DMT activities to address the goals:	• Movement and dance experiences which require Jason to practice sequencing skills, memory recall, co-ordination, and response to verbal and modelled instruction. • Development of short movement sequences (3-5 steps) using novel dance experiences – e.g dance obstacle course, movement story-telling to support body integration and sequencing skills. • Practice of physically integrating body parts to move fluidly, through emulation of daily movement in dance and specific movements that encourage whole body integration such as spinal rolls. • Clear cues and routines to support Jason to work on independently anticipating and managing transitions between routine session elements. • Group and partnered dance experiences in a supportive setting to increase Jason's ability to engage for longer periods and increase his confidence.

Case study 2: 'Kate'

Issues to be addressed derived from PCP goals and consultation

Kate is a softly spoken person who likes dance, music, the arts and going out socially. She enjoys a few close friendships, but often seems reticent about connecting with people outside of those friendships. She also sometimes finds it difficult to self-advocate or to connect with others in such a way that she can share her experiences or enjoy social interaction. Generally, she speaks only when spoken to and in single words, although her wide vocabulary and writing skills indicate strong language skills. Kate is slowly working towards moving out of her family home into a house with friends. To practice independent living, she sometimes stays at respite accommodation. She does not complain when she is there and reports that she enjoys it, but often appears more quiet and withdrawn in DMT sessions during these times.

Figure 3: Kate socially connecting through shared movement in a DMT session

Initial observation in DMT sessions

Kate was often quiet in sessions, at times appearing engaged and present and at other times lowering her gaze or disengaging from participation. With prompting and encouragement, she re-engaged and managed to participate in a wide range of dance interactions. She did not appear to express emotion with facial expression often, but very occasionally smiled. Kate tended to stand close to one favoured friend and did not often dance or interact with others in the group unless encouraged by the therapist. Kate generally waited until after others have contributed before participating in a dance experience herself. She always responded to questions or interaction from the therapist but had not yet initiated an interaction during sessions. Kate used the same movement each week during warm up but attempted new movement experiences with prompting and support from the therapist or her close friend. Kate indicated preferences for 'small movements', that were close to her inner kinaesphere, in the near space, and 'light' and 'bound flow' in terms of effort quality.

Table 2: Relationship between outcomes of PCP, NDIS and DMT - Kate

Outcome considerations	Therapeutic outcomes set after initial assessment phase.
PCP goal:	To build confidence and the ability to 'speak out' (self-advocate and interact)
NDIS Outcome area this best relates to:	Social Inclusion, Health and Wellbeing
Relevant DMT program objectives	MARA Reference: Interpersonal domain: appropriate initiation, sustainment and release of engagement; give and take in relationships. Kate will develop and widen her social interactions and confidence through shared DMT experientials with her group and peers she is comfortable with.
Theory of change:	By experiencing social interaction in a safe and validating DMT space, that is not solely reliant on verbal communication, Kate may find ways to increase her confidence in social interaction. The skills and confidence developed from these experiences may transfer to widened social opportunities and greater capacity for self-advocacy in her daily social interactions.
DMT activities to address the goals:	Creative dance experiences that are socially geared and allow Kate to experience: • Positive interaction through movement and speech, that might include mirroring, partner /small group work, movement-based story sharing, shared movement with props, movement greetings, etc. • Creative expression experiences that are validating to build confidence in own voice and ideas (contributing own warm up movements to group warm up, workshopping movement or body shaping ideas in small groups, being witnessed and validated by group in short solos or small group dances etc) • Opportunities for practicing turn taking, listening, speaking out and leadership through creative dance experiences • Experimentation with a wider range of movement dynamics, particularly those utilising 'strong weight' and 'free flow' efforts to offer new avenues for social interaction through movement and to build confidence in risk taking.

Case study 3: 'Helen'

Issues to be addressed derived from PCP goals and consultation

Helen is a caring and friendly person who often looks out for others. She communicates verbally. She is very independent, living away from her family (though not far from home) undertaking two work placements and managing many daily living tasks on her own. Recently, she has had some counselling and is on medication to support her with a diagnosed mental health condition. When Helen is feeling anxious she sometimes struggles to assert her own needs over those of others. Helen has recently struggled with relationships with housemates at her supported accommodation and has been feeling anxious about these relationship dynamics. Helen's mother and key worker both expressed a desire to support her to find ways to develop skills in stress management and relaxation.

Initial observation in DMT sessions

Helen was very independent in sessions managing transitions, movement and participation with minimal guidance from the therapist. She was also caring towards others in the group, helping them with extra instruction or encouragement during sessions. She showed enjoyment of dancing with others in the group with smiles and verbal interaction. When placed in a leadership role such as leading the group with a warm up movement, she often hesitated and needed time and encouragement to share her ideas. The DM therapist noticed on two occasions that Helen struggled to transition into the session and seemed distracted and not at ease. She later discovered that Helen had not been able to complete an errand she had been given for her work placement before the dance session, which resulted in her feeling worried and not able to fully engage.

Helen's movement preferences were for 'bound', 'light' movements expressed mostly in her arms and core. The DM therapist has observed tension and holding in her core and some reticence when she was invited to experiment with strong and direct movement efforts. After she had experienced focussed breath work and cool down stretches over a few sessions, the DM therapist observed Helen sigh loudly, shake out her shoulders and breath more deeply during the end of session relaxation.

Figure 4. Helen and others using props, breath and movement to practice relaxation and self-regulation in DMT session.

Table 3: Relationship between outcomes of PCP, NDIS and DMT - Helen

Outcome considerations	**Therapeutic outcomes set after initial assessment phase.**
PCP goal:	To participate in programs to assist with relaxation and stress management.
NDIS Outcome area this best relates to:	Health and wellbeing
Relevant DMT program objectives	MARA References: Physical domain: integration of body parts, body parts connectivity Interpersonal domain: appropriate initiation, sustainment and release of engagement; give and take in relationships Helen will develop her ability to self-calm through increased body awareness and practicing integrating breath into movement. Helen will develop her ability to manage and navigate interactions with her peers through targeted DMT experientials with peers.

Theory of change:	By developing and practicing simple strategies using breath and body-based relaxation techniques, Helen may develop some transferable skills to support her to manage feelings of anxiety in daily life. The DMT group also offers to Helen a safe and validating space to practice expressing her feelings, self-advocating and managing different types of social interaction, providing her with skills and references for managing relationships in other parts of her life.
DMT activities to address the goals:	• release of muscular tension through integration of body parts in movement and supported breath work; • development of skills in relaxation and management of stress through embodied techniques; • increased integration of movement through experimentation with strong effort movement dynamics and more expansive use of kinaesphere and space; • strengthened awareness of the relationship between different body states and feelings, particularly contrasting anxious and relaxed states; • development of social skills through use of creative group and partner work such as experimentation with mirroring, cooperation, leading, following and managing interpersonal and teamwork dynamics; • experience in leadership roles through short periods of safe and validating group dance work.

Discussion

This article has presented the planning, assessment and reporting methods used by DM therapist Hens in establishing a DMT program for clients with cognitive disability that is supported by NDIS funds. She continues to refine these processes as her program develops and she receives feedback from stakeholders about them. Clear benefits perceived by the therapist of aligning DMT work with NDIS-derived outcomes include promotion of rigorous reflection on potential relationships between the DMT program and the broader lived experiences of group members. This may maximise the meaningfulness and usefulness of DMT for participants. The assessment and reporting processes also increased interaction between the program's stakeholders, allowing for more collaboration between the DM therapist, participants and their wider support networks, including centre staff supporting the 'eco-systematic' approaches in the therapy as discussed. This ensured that support and goal setting was consistent and therefore more likely to result in more meaningful progress for clients and to be applied across multiple contexts of participants' lives.

These assessment methods also compelled the DM therapist to assess more frequently and rigorously. This resulted in more clarity around objective setting and improved decision-making during program facilitation. Working in an evidence-based manner also supported the DM therapist to communicate more effectively about the benefits of DMT to a range of stakeholders. The subsequent expansion of the DMT program to two groups of nine, the introduction of a waiting list, the addition of holiday programs and the trialling of a wheel-chair-specific DMT program may be in part attributed to this.

Hens' decision to select only two objectives for assessment that were the same for all participants did not negate many of the more spontaneous therapeutic themes that occurred and were responded to within sessions. Nor did the assessment process uncover any philosophical or logistical conflicts between the DMT program and BH's organisational values and procedures and required reporting processes, or the new demands from NDIS. However, the therapist was mindful of ensuring that the integrity of the DMT modality was preserved. Inquiry and debate about the possibility of tension between DMT-specific goals and larger organisational requirements may be beneficial to the profession.

The time required to carry out this assessment and reporting was substantial. Whilst the DM therapist was paid for planning and assessment, including a small additional fee for report- writing, these processes require further streamlining to ensure they are commensurate with the financial and practical limitations of her role. Another area for future development revealed by this process was the need for development of more robust support mechanisms for self-assessment by participants.

Conclusion

The introduction of the NDIS creates a new socio-political influence on assessment, practice and funding of DMT in Australia. While the NDIS opens up opportunities for DM therapists to work in the disability sector, it also impels these professionals to consider more deeply the way they plan and assess in their practice and to articulate the ways in which their programs or interventions are meaningful to the lives of participants. These methods require balancing the ethical and organisational needs of the DMT program's stakeholders with maintaining the integrity of the modality itself.

This article offers an example of planning, assessing and reporting of a dance movement therapy program for clients with cognitive disability against outcomes that takes into consideration some of these eco-systematic factors. In doing so it provides some insight into the NDIS and its background and its impact on a small to medium size service provider operating within it. The article specifically articulates a seven phase process for planning, assessing and reporting of the DMT program. These phases include practice-based work of understanding the workplace context, as well as examination of the relevant research literature and integration of both practice and research knowledge. The final phases articulated are establishment of an

assessment process, setting of therapeutic objectives and gathering data and reporting against objectives.

The articulation of the phased approach to planning and assessment is illustrated by three case examples of participants from the program. The way the DMT program planning addressed their needs as identified in NDIS goals, Person Centred Planning in use at the centre at that time and DMT-specific objectives is elaborated. Each case study includes activities for a DMT program and a theory of change that explains why the activities might be expected to address the various objectives.

The work described in this article opened up a range of questions and future lines of inquiry for Australian DM therapists. It challenges DM therapists to create efficient and economically feasible methods for assessment, an area of ongoing development. It also highlights areas for discourse and debate that would benefit Australian DM therapists. For example, potential for friction between DMT-specific and wider expectations created by the NDIS; and how a DM therapist can articulate the benefits of their work to a range of stakeholders without losing the integrity of their practice. The need for stronger practice around participant self-assessment was also identified.

Future DMT work will continue to be influenced by the evolution of the NDIS scheme; understanding its influence on the lives of DMT clients, their support networks and on the practice of DMT will be central to good practice. It will warrant ongoing consideration, inquiry and discussion amongst DM therapists in Australia.

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