QCQY and National Disability Insurance Agency [2024] AATA 153 (8 February 2024)

Division:	**NATIONAL DISABILITY INSURANCE SCHEME DIVISION**
File Number(s):	**2021/6729**
Re:	**QCQY**
	APPLICANT
And	**National Disability Insurance Agency**
	RESPONDENT

DECISION

Tribunal:	**Member W Frost**
Date:	**8 February 2024**
Place:	**Canberra**

The Tribunal affirms the decision under review pursuant to subsection 43(1)(a) of the *Administrative Appeals Tribunal Act 1975*.

..[SGD].....

Member W Frost

Catchwords

NATIONAL DISABILITY INSURANCE SCHEME – reasonable and necessary supports – definition of reasonable and necessary – sexual therapy – whether sexual therapy is a reasonable and necessary support – schizophrenia symptom management – medical evidence of benefits of sexual therapy for psychological conditions – inadequate pharmacological treatment – decision affirmed

Legislation

Administrative Appeals Tribunal Act 1975 (Cth) ss 37, 43.
National Disability Insurance Scheme Act 2013 (Cth) ss 3, 4, 9, 17A, 21, 24, 25, 28, 32, 33, 34, 100, 209.
National Disability Insurance Scheme (Supports for Participants) Rules 2013 rr 1.3, 2.5, 3.1, 3.2, 3.3, 5.1, 5.2, 7.6, 7.7.

Cases

Drake and Minister for Immigration and Ethnic Affairs (No 2) (1979) 2 ALD 634
McGarrigle v National Disability Insurance Agency [2017] FCA 308 NDIA
National Disability Insurance Agency v WRMF (2020) 276 FCR 415
WRMF and National Disability Insurance Agency [2019] AATA 1771

Secondary Materials

NDIS Operational Guidelines

REASONS FOR DECISION

Member W Frost

8 February 2024

INTRODUCTION

1. The Applicant, QCQY, is a 33 year old participant in the National Disability Insurance Scheme (**NDIS**), with a diagnosis of schizophrenia.[1] In 2021, the National Disability Insurance Agency (**NDIA**) approved a statement of participant supports for QCQY under the *National Disability Insurance Scheme Act 2013* (**NDIS Act**), with total funded support of $59,565.43 over a 12-month period.[2]

2. Later that year, following QCQY's requested review, a delegate of the Chief Executive Officer (**CEO**) of the NDIA made a decision under subsection 100(6) of the NDIS Act affirming its decision declining QCQY's request to fund access to the services of a sex worker. The NDIA found that, pursuant to rule 5.1(b) of the *NDIS (Supports for Participants) Rules 2013* (**Supports Rules**), the NDIS was unable to fund the requested support because it was not related to QCQY's disability.

3. QCQY subsequently applied to the Administrative Appeals Tribunal (**Tribunal**) for review of the NDIA's decision.[3] The Tribunal has considered all documents filed in this proceeding, including those provided pursuant to section 37 of the *Administrative Appeals Tribunal Act 1975* (**AAT Act**), and the hearing bundle, together with the parties' submissions. For the following reasons, the Tribunal affirms the decision under review to refuse to include funding to access the services of a sex worker in QCQY's statement of participant supports. This means that QCQY's application to the Tribunal is unsuccessful.

ISSUE

4. The issue for determination by the Tribunal in this proceeding was whether the support requested by QCQY to be funded by the NDIA, being funding to access the services of a

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[1] Exhibit 1, pages 67 and 84.
[2] Ibid., pages 79-90.
[3] Ibid., pages 48-52.

sex worker, is 'reasonable and necessary', pursuant to section 34 of the NDIS Act, and should be included in the statement of participant supports in his NDIS plan.

LEGISLATIVE INSTRUMENTS

The NDIS Act

5. The objects of the NDIS Act, set out in section 3, include to:

> *(a) in conjunction with other laws, give effect to Australia's obligations under the Convention on the Rights of Persons with Disabilities done at New York on 13 December 2006 ([2008] ATS 12); and*
>
> *(b) provide for the National Disability Insurance Scheme in Australia; and*
>
> *(c) support the independence and social and economic participation of people with disability; and*
>
> *(d) provide reasonable and necessary supports, including early intervention supports, for participants in the National Disability Insurance Scheme; and*
>
> *(e) enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports; and*
>
> *(f) facilitate the development of a nationally consistent approach to the access to, and the planning and funding of, supports for people with disability; and*
>
> *(g) promote the provision of high quality and innovative supports that enable people with disability to maximise independent lifestyles and full inclusion in the community; and*
>
> *(ga) protect and prevent people with disability from experiencing harm arising from poor quality or unsafe supports or services provided under the National Disability Insurance Scheme; and*
>
> *(h) raise community awareness of the issues that affect the social and economic participation of people with disability, and facilitate greater community inclusion of people with disability…*

6. Subsection 3(3) of the NDIS Act provides that, in giving effect to the objects of the NDIS Act, regard is to be had both to the need to ensure the financial sustainability of the NDIS, and to the provision of services by other agencies, departments or organisations, as well as the need for interaction between the provision of mainstream services and the provision of supports under the NDIS.

7. Section 4 of the NDIS Act sets out the general principles guiding actions under the legislation, including that:

> *(1) People with disability have the same right as other members of Australian society to realise their potential for physical, social, emotional and intellectual development.*
>
> *(2) People with disability should be supported to participate in and contribute to social and economic life.*
>
> *(3) People with disability and their families and carers should have certainty that people with disability will receive the care and support they need over their lifetime.*
>
> *(4) People with disability should be supported to exercise choice, including in relation to taking reasonable risks, in the pursuit of their goals and the planning and delivery of their supports.*
>
> *(5) People with disability should be supported to receive reasonable and necessary supports, including early intervention supports.*
>
> *…*
>
> *(8) People with disability have the same right as other members of Australian society to be able to determine their own best interests, including the right to exercise choice and control, and to engage as equal partners in decisions that will affect their lives.*
>
> *…*
>
> *(10) People with disability should have their privacy and dignity respected.*
>
> *(11) Reasonable and necessary supports for people with disability should:*
>
> > *(a) support people with disability to pursue their goals and maximise their independence; and*
> >
> > *(b) support people with disability to live independently and to be included in the community as fully participating citizens; and*
> >
> > *(c) develop and support the capacity of people with disability to undertake activities that enable them to participate in the community and in employment.*

8. Subsection 4(17) of the NDIS Act also provides that:

> *It is the intention of the Parliament that the Ministerial Council, the Minister, the Board, the CEO, the Commissioner and any other person or body is to perform functions and exercise powers under this Act in accordance with these principles, having regard to the need to ensure the financial sustainability of the National Disability Insurance Scheme.*

9. Section 17A of the NDIS Act sets out additional principles which must be had regard to in relation to the participation of people with disability.

10. Under section 9 of the NDIS Act, 'participant' means 'a person who is a participant in the National Disability Insurance Scheme (see sections 28, 29, and 30)'. Relevantly for these proceedings, subsection 28(1) provides that a person becomes a participant in the NDIS 'on the day the CEO [of the NDIA] decides that the person meets the access criteria'. Section 21 of the NDIS Act provides that a person meets the access criteria when, relevantly, they meet either the requirements of section 24, being the disability requirements, or the requirements of section 25, being the early intervention requirements.

11. Section 32 of the NDIS Act provides that if a person becomes a participant in the NDIS, the CEO of the NDIA must facilitate the preparation of the participant's plan, and this is to occur within 21 days of the person becoming an NDIS participant. Subsection 33(2)(b) of the NDIS Act requires a participant's plan to include a statement, being the 'statement of participant supports', prepared with the participant and approved by the CEO of the NDIA, that specifies (amongst other things) 'the reasonable and necessary supports (if any) that will be funded' under the NDIS.

12. Subsection 33(5) of the NDIS Act stipulates that in deciding whether or not to approve a statement of participant supports under subsection (2), the CEO of the NDIA or, in this proceeding, the Tribunal, must:

> *(a) have regard to the participant's statement of goals and aspirations; and*
>
> *(b) have regard to relevant assessments conducted in relation to the participant; and*
>
> *(c) be satisfied as mentioned in section 34 in relation to the reasonable and necessary supports that will be funded and the general supports that will be provided; and*
>
> *(d) apply the National Disability Insurance Scheme rules (if any) made for the purposes of section 35; and*
>
> *(e) have regard to the principle that a participant should manage his or her plan to the extent that he or she wishes to do so; and*
>
> *(f) have regard to the operation and effectiveness of any previous plans of the participant.*

13. The criteria in section 34 of the NDIS Act set out what supports will be provided to an NDIS participant, as follows:

> *(1) For the purposes of specifying, in a statement of participant supports, the general supports that will be provided, and the reasonable and necessary supports that will be funded, the CEO must be satisfied of all of the following in relation to the funding or provision of each such support:*
>
> *(a) the support will assist the participant to pursue the goals, objectives and aspirations included in the participant's statement of goals and aspirations;*
>
> *(b) the support will assist the participant to undertake activities, so as to facilitate the participant's social and economic participation;*
>
> *(c) the support represents value for money in that the costs of the support are reasonable, relative to both the benefits achieved and the cost of alternative support;*
>
> *(d) the support will be, or is likely to be, effective and beneficial for the participant, having regard to current good practice;*
>
> *(e) the funding or provision of the support takes account of what it is reasonable to expect families, carers, informal networks and the community to provide;*
>
> *(f) the support is most appropriately funded or provided through the National Disability Insurance Scheme, and is not more appropriately funded or provided through other general systems of service delivery or support services offered by a person, agency or body, or systems of service delivery or support services offered:*
>
> *(i) as part of a universal service obligation; or*
>
> *(ii) in accordance with reasonable adjustments required under a law dealing with discrimination on the basis of disability.*

14. In *McGarrigle v National Disability Insurance Agency* [2017] FCA 308 (***McGarrigle***), Mortimer J (as her Honour then was) observed that:[4]

> *Although the phrase "reasonable and necessary supports" is used throughout the legislative scheme, including in the objects and principles provisions, it is not defined. Its meaning can be derived from the context in which it is used, especially in my opinion s 4(11), which sets out what reasonable and necessary supports should enable and empower people with a disability to do, read with s 14 which sets out the purposes for which funding for reasonable and necessary supports is provided.*
>
> *...*

[4] At [41]-43] and [93].

> *The rules are legislative instruments to be made by the Minister: see s 209. Section 209, sub-paras (4) to (7) constrain the rule-making power to preserve the federal characteristics of the NDIS. The National Disability Insurance Scheme (Supports for Participants) Rules 2013 (Cth) (the Rules) are an important element of the legislative scheme, introducing the ability to modify the operation of ss 33 and 34 by, for example, excluding certain kinds of supports from inclusion in participant plans. It is through the Rules that the executive is able to implement, within the federalism constraints imposed in s 209, some policy decision-making about the nature and extent of supports to be provided or funded under the NDIS.*
>
> *…*
>
> *In my opinion, the text and context of s 33(5)(c), read with s 34(1) indicates that the CEO (or the delegate or Tribunal) must either be satisfied that a support has the character of being a reasonable and necessary support, or that it does not. Once a support is identified and described (to take an example away from this case, speech therapy lessons three times a week), then the question for the CEO (or the delegate or Tribunal) is whether she or he is satisfied that support, as identified, is reasonable and necessary for that particular participant. It may be open to the CEO to be satisfied that a differently identified support is reasonable and necessary: in this example, speech therapy lessons once a week. That determination can only be made on the basis of probative evidence.*

15. As the Full Federal Court of Australia explained in *National Disability Insurance Agency v WRMF* (2020) 276 FCR 415 (***NDIA v WRMF***) at [201]:

> *The matters set out in s 34(1) are more than mandatory considerations, because in terms s 34 requires that a decision-maker be positively satisfied about each matter. They are more in the nature of criteria of which the decisions-maker (CEO, delegate or Tribunal) must be satisfied on the material. That satisfaction must be reasonably and rationally formed, not taking into account irrelevant considerations, and taking into account any relevant considerations, but otherwise it is for the decision-maker to form the requisite state of satisfaction on the given material.*

The Supports Rules

16. Pursuant to subsection 209(1) of the NDIS Act, the Minister may, by legislative instrument, make rules regarding the NDIS. Subsection 34(2) of the NDIS Act authorises NDIS rules to prescribe 'methods or criteria to be applied, or matters to which the CEO is to have regard, in deciding whether or not he or she is satisfied as mentioned in any of paragraphs (1)(a) to (f)' in section 34. Such rules include the Supports Rules, which relate to the assessment and determination of the reasonable and necessary supports that will be funded for participants under the NDIS. The CEO of the NDIA, or here the Tribunal, is bound to apply any NDIS rules, pursuant to subsection 33(5)(d) of the NDIS Act.

17. Rule 1.3 of the Supports Rules, in line with subsection 3(3) of the NDIS Act, provides that in giving effect to the objects set out in the Supports Rules, 'regard is to be had to the

need to ensure the financial sustainability of the NDIS'. Additionally, rule 2.5 of the Supports Rules states that in administering the NDIS and in approving each plan, 'the CEO must have regard to [the] objects and principles of the Act including the need to ensure the financial sustainability of the NDIS and the principles relating to plans'.

18. Part 3 of the Supports Rules provides guidance for assessing whether supports meet the criteria in subsection 34(1) of the NDIS Act to be found to be 'reasonable and necessary supports' that will be funded by the NDIA.

19. Rule 3.1 of the Supports Rules relates to the 'value for money' criterion in subsection 34(1)(c) of the NDIS Act, and provides that:

> *In deciding whether the support represents value for money in that the costs of the support are reasonable, relative to both the benefits achieved and the cost of alternative support, the CEO is to consider the following matters:*
>
> *(a) whether there are comparable supports which would achieve the same outcome at a substantially lower cost;*
>
> *(b) whether there is evidence that the support will substantially improve the life stage outcomes for, and be of long-term benefit to, the participant;*
>
> *(c) whether funding or provision of the support is likely to reduce the cost of the funding of supports for the participant in the long term (for example, some early intervention supports may be value for money given their potential to avoid or delay reliance on more costly supports);*
>
> *(d) for supports that involve the provision of equipment or modifications:*
>
> *(i) the comparative cost of purchasing or leasing the equipment or modifications; and*
>
> *(ii) whether there are any expected changes in technology or the participant's circumstances in the short term that would make it inappropriate to fund the equipment or modifications;*
>
> *(e) whether the cost of the support is comparable to the cost of supports of the same kind that are provided in the area in which the participant resides;*
>
> *(f) whether the support will increase the participant's independence and reduce the participant's need for other kinds of supports (for example, some home modifications may reduce a participant's need for home care).*

20. Rules 3.2 and 3.3 of the Supports Rules relate to the 'effective and beneficial' criterion in subsection 34(1)(d) of the NDIS Act, and provide that:

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

(a) published and refereed literature and any consensus of expert opinion;

(b) the lived experience of the participant or their carers; or

(c) anything the Agency has learnt through delivery of the NDIS.

In deciding whether the support will be, or is likely to be, effective and beneficial for a participant, having regard to current good practice, the CEO is to take into account, and if necessary seek, expert opinion.

21. Rules 5.1 and 5.2 of the Supports Rules set out general criteria for whether supports are reasonable and necessary, as follows:

A support will not be provided or funded under the NDIS if:

(a) it is likely to cause harm to the participant or pose a risk to others; or

(b) it is not related to the participant's disability; or

(c) it duplicates other supports delivered under alternative funding through the NDIS; or

(d) it relates to day-to-day living costs (for example, rent, groceries and utility fees) that are not attributable to a participant's disability support needs.

The day-to-day living costs referred to in paragraph 5.1(d) do not include the following (which may be funded under the NDIS if they relate to reasonable and necessary supports):

(a) additional living costs that are incurred by a participant solely and directly as a result of their disability support needs;

(b) costs that are ancillary to another support that is funded or provided under the participant's plan, and which the participant would not otherwise incur.

EVIDENCE

QCQY

22. The Tribunal has considered QCQY's two Statements of Lived Experience dated 11 July 2023 and 28 September 2023, which were identical except for one sentence.[5] The former version, containing that additional sentence, is reproduced below for completeness:[6]

1. *I am 32 years old; I live in a self-contained granny flat at the back of my mum's house.*
2. *I have Schizophrenia.*
3. *I eat prepared meals. I get overwhelmed easily with daily tasks.*
4. *Sometimes I feel like I don't have a floor to walk on. I do a lot of sitting and thinking. I think about an enormous number of thinks.*
5. *My moods are unpredictable and change like Melbourne weather.*
6. *I only have few people I can communicate with. These are my mum, uncle and brother. I don't have any friends. This is separate to my disability supports.*
7. *I can't spend more than an hour with someone because I get very bad feelings and I lose the ability to think and speak properly. I feel like I am the only person on the earth and become frightened.*
8. *People have been too much for me to handle my entire life.*
9. *I have never had people I can get close enough too [sic], to have sex.*
10. *When I see a sex worker, I am happy, confident, I think clearer, and I'm able to handle life challenges.*
11. *If I don't see a sex worker, I get very depressed, angry and upset and my life becomes too much for me.*
12. *Seeing a sex worker is perfect for me because I only need to spend a short amount of time with them. They do not expect a relationship from me. Having a girlfriend is off the table, I cannot cope with spending that amount of time with them.*
13. *My alone time is as important to me as my air.*
14. *Social interaction with someone, even for a short time, is like running a marathon for me. I can't stand people for more than a short amount of time.*

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[5] Exhibit 1, pages 187-190.
[6] Ibid., pages 187-188.

15. *A Psychologist would not be able to provide the desired results. I am already seeing Dr O'Brian [sic] every couple of months. I don't believe that talking to a psychologist is going to help me due to my challenges with social interaction. A sex worker only provides a physical interaction and I do not seek any social connection from them.*

16. *I am not seeking to learn the skills to have relationships with other people. This is why a sex worker is the most appropriate support as it addresses the specific need I have that results in better self-regulation of emotions.*

17. *When I have gone without a sex worker for a long period of time, my negative feelings have escalated. I begin to hate life and it feels too challenging.*

23. At the Tribunal hearing, the NDIA initially indicated that it required QCQY for cross-examination, however it withdrew this request following discussion with the Tribunal about the utility of such oral evidence in the following circumstances:

(a) QCQY had provided two sets of written responses to the NDIA's questions (which course was undertaken to potentially obviate the need for QCQY to be cross-examined, although the NDIA had reserved its right to do so following receipt of the written responses);

(b) QCQY was reluctant to being cross-examined at the Tribunal hearing; and

(c) QCQY's diagnosed schizophrenia, having regard to his verbal responses when assessed by Dr Jacqueline Rakov, Psychiatrist, (referred to below in the Tribunal's reasons) which gave rise to the Tribunal's concern about QCQY's ability to give oral evidence at the hearing.

24. The Tribunal also notes for completeness that QCQY did not wish to give any oral evidence at the Tribunal hearing and relied on his written submissions in this proceeding.

Dr Jacqueline Rakov – Psychiatrist

25. The Tribunal has considered the report of Dr Rakov dated 25 November 2022, which was prepared at the request of the NDIA following her assessment of QCQY by video on 9 September 2022.[7] The report relevantly stated that:[8]

[7] Ibid., pages 195-202.
[8] Ibid.

Over Videolink, [QCQY] presented as a young man with neat short hair. He was markedly distracted throughout the assessment.

It was very difficult to obtain answers from [QCQY], who presented with marked latency in both thoughts and speech. I had to repeat questions multiple times.

When I asked him about his mood, "if I don't listen to the bible today, I'll have a scary night tonight."

[QCQY] appeared to be distracted by non-apparent stimuli. He told me the night before he had heard a loud bang and was quite scared. He thinks he hears these bangs often. He thinks the bible "helps with noise but can also make it worse… it's helping at the moment." He told me that he speaks to God and God speaks to him.

[QCQY] could not tell me his diagnosis. He said he took medications, "half a tablet from one packet, a full tablet from the other." He said his medication "really does help," but would not articulate with what. On repeated questioning about his diagnosis [QCQY] replied, "I think a lot of people in the bible… Moses heard banging too… not my banging… his own banging."

I was unable to take a meaningful history of any risk posed to self or others due to [QCQY]'s presentation and (by way of either incapacity or choice to) unanswered questions. I did feel it pertinent to leave his psychiatrist a message given the presentation.

…

[QCQY] responded with a blanket "no" to questions about any substance use.

<u>From other sources</u>:

RCH records suggest (p166) that he historically used cannabis.

Dr. Fitzpatrick documented marijuana use 2-3g per night via bong in his records (2008)

…

[QCQY] could not convey an understanding of his diagnosis/es.

[QCQY] is under the care of psychiatrist, Dr. Gerald O'Brien. He is prescribed oral antipsychotic mediations…

Symptoms

[QCQY] experiences auditory hallucinations, and a preoccupation with religion at present. He conveyed some concern about his safety (paranoia) relating to a banging on the walls.

<u>From other sources</u>:

From the psychiatric materials of Dr. Gerald O'Brien:

Dr. O'Brien met with [QCQY] in early 2020. He found him to present with "longstanding paranoid delusions relating to him having antennae that means other people's thoughts get into his head and his thoughts into others." [QCQY] described other paranoia to Dr. O'Brien around poison and AIDS. Overall, the doctor found him to be "floridly psychotic." He commenced [QCQY] on antipsychotic medication, lurasidone 40mg.

On 28 February 2020 Dr. O'Brien noted [QCQY] continued to feel significantly overanxious and to hold delusions around antennae. He increased the lurasidone to 80mg.

On 25 May 2020 Dr. O'Brien found him to present with ongoing paranoid delusions and active ADHD. He reasoned to commence lisdexamfetamine (Vyvanse) for the ADHD.

By October 2020, [QCQY] was taking lurasidone 40mg, a second antipsychotic amisulpride 100mg, and methylphenidate (a stimulant medication used to treat ADHD).

On 4 March 2021, Dr. O'Brien had observed that the stimulant medication had exacerbated [QCQY]'s psychotic symptoms and changed him over to guanfacine 3mg (a non-stimulant treatment for ADHD).

On 13 July 2021, no changes were made and the plan was to review [QCQY] in three months.

From phone call with Dr. O'Brien in late October 2022:

Dr. O'Brien noted that [QCQY] is "not infrequently psychotic." He described [QCQY] as "fluctuating considerably" and said that [QCQY] was "never fully present." The doctor said he had seen him ten days prior and conceded that he was "probably psychotic."

Dr. O'Brien noted that [QCQY] had been "case managed quite a bit"…but that that had not been the case recently.

From the GP materials of Dr. Paul Fitzpatrick:

[QCQY] attracted a diagnosis of "schizophreniform disorder" in 2004.

…

Current Functioning & Supports

I attempted to enquire about his activities. [QCQY] responded, "I really love words of God, the bibles, I like all of them a lot." When asked about friends [QCQY] said that he on occasion saw his uncle. He also that that "other people can talk through the bible… like Moses and Abraham… I really like them."

I asked [QCQY] about the application for funding to attend a sex worker, and how it sought to build his capacity. He told me that "everything is a lot better for me after I leave the brothel."

He added, "the ladies there really understand me." He added that he has a "hard time most of the time and when I leave the brothel, I'm not having a hard time." He said that he did not achieve stress relief through solo sexual expression.

Given the assertion this intervention would assist him with "better ways of relating" and being "a lot more able to communicate with people," I asked him whether any of the interpersonal skills he learned at the brothel had been transferred to life outside and he said "no."

…

Medical History

I asked [QCQY] whether he had any medical conditions. He responded, "I don't think the bible will scare me, I think it'll actually help me."

…

Opinion & Recommendations – In response to your questions

1. What psychiatric conditions does the Applicant have? In answering this question, please described [sic], for each condition, the diagnostic criteria, and your reasons for concluding that [QCQY] satisfies that criterion.

[QCQY] meets criteria for schizophrenia. There is longitudinal clinical information available which supports this diagnosis. Symptomalogically, the diagnosis is evidenced by his disorganised thought, paranoid delusions, and perceptual disturbances (hallucinations).

Given the acuity of his psychosis, it was not possible to determine any clear presence of any additional anxiety, mood, or personality disorders, which have been referred to historically, but less consistently than schizophrenia.

2. Having regard to your answer to question 1, how and in what ways is the Applicant's capacity and opportunity to form and develop romantic, intimate, and sexual relationships reduced? In answering this question, you may wish to consider and address:

• What the barriers he confronts that relate directly or indirectly to his psychiatric conditions.
• The underlying cause/s of these barriers such as physical inability, lack of motivation, anxiety.

[QCQY] is labouring under an active psychotic illness. Simplistically, he is experiencing a detachment from objective reality some or most of the time. This limits his capacity for any meaningful interaction with others, let alone ones that require vulnerability and relational intelligence.

The limitations experienced by [QCQY] in forming such relationships range from the capacity to maintain a conversation – as he is quite thought disordered – to difficulties with the capacity to mentalise the needs and feelings of another.

Outside acute illness, it is not clear whether anxiety or any other barriers exist. Until the active schizophrenia is addressed, the more nuanced skills necessary to exercise within interpersonal relationships cannot be meaningfully addressed.

3. Having regard to your previous answers, what strategies and supports (including pharmacological, specialist or therapeutic treatments) would you recommend for the Applicant to enable the Applicant to build his capacity and opportunity to form and develop romantic, intimate, and sexual relationships? For each support identified, please outline:

• the likely benefit to the Applicant and the evidential basis for the treatment.
• the frequency and duration of each treatment and, where relevant, the qualification of the provider of the treatment.
• the outcomes that you would expect from these treatments.

In providing your opinion in respect of the above matters, please identify the factual premises upon which each of your stated opinions is based and explain the process of reasoning by which you have reached that opinion. Where, in expressing an opinion you rely upon an assumption, please also identify, and describe that assumption with specificity. Please also identify the documents you have had regard to (if any) in reaching your conclusions.

[QCQY] needs optimising of his treatment with antipsychotic medication. Lurasidone and amisulpride are both second-generation antipsychotics. Adherence is presumed but he is not supervised. Liaison with an assertive outreach team for medication monitoring could facilitate some certainty, or alternatively if [QCQY]'s mother felt their relationship means she was able to do so.

Consideration could also be given to a more potent first-generation anti-psychotic. Some medications are available in long-acting injectable form.

Continuation of avoiding stimulant would be pertinent. [QCQY] does not participate in any meaningful activities which ADHD could intervene and as Dr. O'Brien observed, stimulants can worsen psychotic symptoms.

A trial of clozapine could be considered if it were felt [QCQY] could participate in the necessary pathological and metabolic monitoring.

[QCQY] has been case managed intermittently…Serious mental illness can be notoriously burdensome for a solo practitioner to manage with adequate support and care co-ordination. I am of the view that [QCQY] would benefit from a mental health case manager. The role of such a case manager exists within a multidisciplinary team of an area mental health service (AMHS), which has been available to him previously. The expertise of such a team lies in recovery-focused care, and they work in collaboration with psychiatric doctors, psychologists, and other allied health. It is not uncommon for such case managers to co-ordinate other requisite supports.

CBT for psychosis has reasonable evidence (NNT = 6) in order to alleviate any distress [QCQY] experiences with his residual symptoms such as paranoia and hallucinations. This can be provided by an appropriately trained psychologist... [emphasis in original]

26. The Tribunal has also considered the supplementary report of Dr Rakov dated 2 October 2023, which relevantly stated as follows:[9]

> ***…please confirm whether it is your clinical opinion that the Applicant should first seek treatment for his "active psychotic illness" prior to engaging* in physical encounters with a sex worker or any other partner. And/or work on building on capacity to form social/intimate partnerships skills. If not, please confirm your clinical recommendation for the Applicant to safely access capacity building supports and/or sexual activity supports.**
>
> *As highlighted in the original report, [QCQY]'s active psychotic illness significantly hampers his capacity for meaningful interaction, particularly those requiring a higher degree of vulnerability and relational intelligence such as intimate relationships.*
>
> *Even in his own statement of lived experience, [QCQY] concedes that "having a girlfriend is off the table" due to his inability to "spending that amount of time with them (p12)." He noted he is unable to spend more than an hour with someone because he experiences "very bad feelings" and loses "the ability to think and speak properly (p7)." He conveys that he experiences unpredictable mood changes (p5).*
>
> *Clearly, active symptomatology is a predominant limiting factor in the capacity to form social and intimate partnership skills. A young man does not need to experience the world as isolating and fearsome and concede that friendships and relationships are "off the table". It is therefore crucial to first address [QCQY]'s active symptoms. His statement suggests the presence of a mood component and potentially anxiety, too, which opens the window for further clinical exploration. Treatment of his psychiatric symptoms would ensure a safer and more understanding environment for both [QCQY] and any other parties involved.*
>
> *The interventions mentioned in my previous report are primarily targeted at treating [QCQY]'s schizophrenia and improving his social and relational skills, which I consider essential steps before exploring sexual activity supports. These interventions are grounded in evidence-based practice and – while primarily targeted at treating his schizophrenia – are in turn aimed at promoting [QCQY]'s overall well-being and autonomy, which might enrich his ability to form meaningful relationships eventually.*
>
> *While in his statement [QCQY] conveys no current intention to seek to learn the skills to have relationships with other people, it is important to consider that treatment and stabilisation of [QCQY]'s symptoms could potentially allow for a broader exploration of relationships, whether they are social, romantic, or sexual in nature. This aligns with a holistic approach towards addressing his mental health needs, and subsequently exploring supportive interventions that cater to his desire for intimacy and sexual expression in a safe and responsible manner.*
>
> ***Based on your assessment and clinical experience and/or relevant literature, could the Applicant build the capacity and skills required to have relationships with other people, if his active psychotic illness was addressed?***

[9] Ibid., pages 203-210.

…

Yes, addressing the active psychotic symptoms could potentially create a conducive environment for [QCQY] to build the capacity and skills required for forming relationships.

…

…in your clinical opinion, do you consider this support as related to the Applicant's disability? If so, please specify how.

No. The engagement with a sex worker may subjectively serve as a coping mechanism for [QCQY]'s current emotional regulation challenges, which could be exacerbated by his psychotic illness. It may provide temporary relief or fulfilment; however, it doesn't directly address the underlying issues associated with his schizophrenia. The desire for sexual contact may stem from a need for alleviation of distress, which might be tied to the challenges posed by his disability. [QCQY] himself suggests that the temporary reprieve results in him feeling "happy, confident," thinking "clearer" and with a sense of being "able to handle life challenges." The benefits, as stated, do not extend beyond the immediate interaction. According to a note from [QCQY]'s psychiatrist dated 26 October 2021, these encounters have "significantly boosted his confidence, thereby enhancing his communication skills and engagement within the community." However, [QCQY]'s personal testimony seems to contradict this assertion – there is no alleviation in his schizophrenia symptoms, let alone a lasting one, and he displays no inclination towards forming ongoing engagements or relationships. He continues to avoid people due to the distress they evoke.

[QCQY]'s desire for sexual interaction is a natural human inclination. However, the primary focus of disability support should be on addressing his ongoing symptoms of schizophrenia, which at the time of assessment was marked by his active psychosis. He has not identified any psychosocial goals relating to the alleviation of his schizophrenic symptoms that would be addressed by engaging with a sex worker. [emphasis in original]

27. Dr Rakov gave evidence at the Tribunal hearing and confirmed adherence to her written reports. Counsel for the NDIA asked Dr Rakov whether there was any clinical reason why the requested support would be necessary for treatment of QCQY's schizophrenia. She told the Tribunal that there was 'no clinical indication' that using a sex worker was an effective treatment for schizophrenia. Dr Rakov said that, generally, because schizophrenia was a 'serious or severe mental illness', to be 'symptom free' requires the use of anti-psychotic medication, as well as potentially mood stabilising or anti-depressant medication. The longer psychosis is left untreated the more difficult it is to effectively address active symptoms. Dr Rakov told the Tribunal that this illness first required pharmacological treatment, then the establishment of rehabilitative goals, such as activities of daily living and personal skills to enhance quality of life. In this regard, Dr Rakov opined, a person with schizophrenia should not receive medication alone, but also requires other occupational and social interventions.

28. Dr Rakov said that it was 'clinically indicated' that QCQY requires an alteration to his current medication regime for schizophrenia; he still had 'active psychotic symptoms' at the time of Dr Rakov's assessment, therefore she recommended his medications be reviewed because they were partially or wholly ineffective. Dr Rakov told the Tribunal there were 'more potent' anti-psychotic medications available, and that more regular support for QCQY was also required through community case management services. To this end, Dr Rakov opined that the goals of treating QCQY's schizophrenia and the use of a sex worker were at 'cross-purposes' in terms of 'any evidence-based or scientific indication'. While Dr Rakov acknowledged that people could benefit from the use of a sex worker, she said that in relation to schizophrenia the optimal treatment comprised a coordinated approach from a multidisciplinary team, including such professionals as a psychiatrist, occupational therapist, social worker, psychological and nursing staff. Support from these professionals can include ensuring adherence to medication, possibly via the delivery of a long acting injectable. Dr Rakov said that the foundations of a treatment regime are required to be built up from the bottom, beginning with 'optimal medication' overseen by health professionals.

29. Counsel asked Dr Rakov whether an optimised treatment regime should occur before a serious attempt was made for QCQY to integrate into an emotional relationship. She told the Tribunal that the timing of entering an emotional relationship was beyond the scope of her expertise as a psychiatrist, but that psychiatrists can determine where people's 'interpersonal risk for psychological or physical harm can be made worse by untreated mental illness'. In this regard, Dr Rakov said that if a person's mental illness was optimally treated, they were 'more likely to flourish' in whatever their personal pursuits. Dr Rakov agreed with the proposition that, in terms of value for money, a person should 'start with the basics before any of the other things will pay dividends or be a reasonable expense', and that a large portion of the required treatment was funded and available through Medicare and public-health-sector-funded schemes. Dr Rakov noted that, if a person's schizophrenia is untreated or not properly medicated or supported, the risks include 'worsening cognitive capacity' because the brain 'physically deteriorates over time'. This in turn can 'impair judgment', including that involved in everyday interactions. Dr Rakov also noted that, while people with schizophrenia were more likely to be victims of violence than perpetrators, a higher proportion of those who do perpetrate violence have schizophrenia than the general public, and that this incidence increased with any illicit drug use.

30. Dr Rakov was asked whether the requested support provided a therapeutic benefit. She noted QCQY's view regarding the utility of the requested support, and the related benefits of physical exercise for schizophrenia which improves symptoms and mood, but Dr Rakov recommended exercise physiology, not the services of a sex worker, to achieve those benefits. Dr Rakov confirmed that there is 'nothing' in the medical evidence or literature that suggests the use of a sex worker is an 'accepted treatment of schizophrenia'.

Dr Gerald O'Brien – Psychiatrist

31. The Tribunal has considered the letter of Dr O'Brien dated 26 October 2021, which relevantly stated that:[10]

> *I have been [QCQY]'s treating Psychiatrist since January 2020. I understand he is registered with the NDIS and I am writing to support him receiving funding to attend a sex worker.*
>
> *I feel that this would benefit [QCQY] in a number of areas. This support is related to his disability in that he has considerable limitation in his ability to form relationships particularly intimate relationships. [QCQY] also reports that his experience attending a sex worker has greatly improved his confidence and he feels a lot more able to communicate with people and thereby engage with the community.*
>
> *It also provides him with an opportunity to learn better ways of relating that may mean that he no longer requires this support in the future. [QCQY] has had very limited opportunity to explore and learn about intimate relationships due to his disability, mental health issues and isolation. With experience it is likely he will get much better at functioning and engaging in this area.*

32. Dr O'Brien was not called by QCQY to give evidence at the Tribunal hearing and was not required for cross-examination by the NDIA.

Dr Susan Page Mitchell – Medical Practitioner and Strategic Advisor at the NDIA

33. The Tribunal has considered the report of Dr Page Mitchell dated 11 October 2023, which relevantly stated that:[11]

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[10] Ibid., page 186.
[11] Ibid., pages 211-428.

I have worked in a variety of medical positions over the course of a professional career spanning 35 years, both clinical and administrative.

…

I have knowledge of QCQY ('the participant') through documentation only. I have not met the participant in person.

…

I am aware the participant obtained access to the National Disability Scheme ('the Scheme') on 12 May 2014 for Schizophrenia.

…

The participant has been documented as having symptoms since childhood and his early treatments are not recorded in the documents that I have seen, meaning his clinical record appears incomplete. More recently he has been prescribed a number of medications including the Second Generation Antipsychotic (SGA) lurasidone. These medications accord with the Australian Clinical Practice Guidelines…but in lower doses than I would have expected given his symptom severity. This is an opinion I make as a general practitioner and in a clinical context I would routinely defer to specialist psychiatrists as holding greater expertise.

…

The ongoing, albeit fluctuating, nature of symptomatology that the participant's record describes is suggestive overall of inadequate medication and/or inadequate medication compliance, and/or treatment resistance. I note Dr Rakov has similar concerns and recommends treatment optimisation at point 3.1 of her report…

…

In the [participant's] SOLE, he seeks to see a sex worker for a "short amount of time" with the goal to feel "better able to handle life challenges". There are no outcome indicators including reference as to how much better the participant feels, nor at what frequency the time will be requested.

Although the participant has previously engaged with sex workers there is no documentation that his functioning has improved over time, that this has contributed to his social and economic participation, that he actually became better able to handle life challenges, nor that his reliance on other services has reduced.

…

There are alternatives to the requested support that are of lesser cost, including masturbation and the use of sex toys and mannequins; noting the intent precludes other activities to build skills in intimate relationships.

> *There is limited reference to sexual activity in the RANZP Clinical Guideline...However, the guidelines note: "The preferred community-based treatment model provides greater socialisation and hence greater opportunities for sexual relationships" for people with schizophrenia and recommend that clinicians provide screening and care relating to sexually transmitted infections, fertility, and planned pregnancy along with regular review of potential sexual dysfunction as a complication of antipsychotic medication. There is no recommendation to support sexual activity as treatment for the symptoms of schizophrenia having regard to current good practice.*
>
> *…*
>
> *Sexual activity supports provided by the NDIS are generally considered to be those delivered by a specialised sex worker who has disability-related training and experience to provide assistance to manage specific aspects of intimacy including physical positioning and assistive technology.*
>
> *In considering the above, it is my opinion that the provision of sex workers is not a reasonable nor necessary support for the participant.*
>
> *Rather, I would strongly recommend improved management of his schizophrenia through adherence to the clinical guideline including consideration of Clozapine should his symptoms prove otherwise resistant to treatment…*

34. The NDIA did not call Dr Page Mitchell to give evidence at the Tribunal hearing.

CONTENTIONS

QCQY

35. QCQY sought funding from the NDIA to engage a sex worker fortnightly over the period of his 12-month NDIS plan. He contended that this requested support was reasonable and necessary and met all of the criteria in section 34 of the NDIS Act.

36. QCQY submitted that the evidence demonstrated how the requested support was linked to his disability, and that regular visits to a sex worker result in significant symptom reduction, meaning he is calmer and better able to interact with people. In this regard, QCQY contended that the requested support was value for money because it reduced his symptoms and this would, over the long-term, reduce the supports he required and increase his independence.

37. QCQY also submitted that there are no alternative therapies that can offer him sexual relations, and that access to a sex worker is more effective at treating his illness than medication, which was evidenced by many years of trial and error of both. To this end,

QCQY contended that sex toys do not offer him access to human sexual intimacy. QCQY submitted that he needs intimacy in order to keep his mental health from deteriorating and that sexual intimacy addresses his schizophrenia better than anything else.

38. In summary, QCQY sought a decision setting aside the NDIA's decision and in substitution for the Tribunal to find that the disputed support should be included in his statement of participant supports and funded under the NDIS.

NDIA

39. The NDIA contended that QCQY's requested support was not reasonable and necessary and therefore did not satisfy the criteria prescribed by the NDIS Act, because it:

(a) is not related to QCQY's disability under rules 5.1(a) to (d), 7.6 and 7.7 of the Supports Rules;

(b) will not assist QCQY to pursue his goals and aspirations, included in the statement of goals and aspirations, as required by subsection 34(1)(a) of the NDIS Act;

(c) will not assist QCQY to undertake activities so as to facilitate his social and economic participation in accordance with subsection 34(1)(b) of the NDIS Act;

(d) is not value for money pursuant to subsection 34(1)(c) of the NDIS Act;

(e) is not a clinically supported method of treating QCQY's active psychotic illness; and

(f) is not effective and beneficial for QCQY having regard to current good practice, as required by subsection 34(1)(d) of the NDIS Act.

40. The NDIA submitted therefore that the requested support should not be included in QCQY's statement of participant supports and the decision under review should be affirmed by the Tribunal.

CONSIDERATION

Does funding to access the services of a sex worker represent value for money?

41. Subsection 34(1)(c) of the NDIS Act requires the Tribunal to be satisfied that the requested support represents value for money in that the costs of the support are reasonable, relative to both the benefits achieved and the cost of alternative support.

42. QCQY provided the Tribunal with three quotes for the services of a sex worker, which were between $220 and $230 per hour each fortnight, at a total cost of between $5,720 to $5,980 per annum.[12]

43. As set out above, rule 3.1 of the Supports Rules provides that in deciding whether a support represents value for money in that the costs of the support are reasonable, relative to both the benefits achieved and the cost of alternative support, consideration must be given to a number of matters.

44. Rule 3.1(a) of the Supports Rules requires consideration of whether there are comparable supports which would achieve the same outcome at a substantially lower cost. QCQY did not provide any corroborating evidence in support of his rejection of the NDIA's submission that sex toys or aides would be sufficient to assist him to achieve sexual release, rather than the more expensive support of a sex worker. This contrasted with the circumstances in *NDIA v WRMF*, where the Federal Court held that it was reasonably open to a differently constituted Tribunal to find, on the evidence, that the support the NDIS participant required in order to have sexual relations and obtain sexual release to assist her wellbeing realistically could only be achieved with a sex worker.[13] In this proceeding, there was no evidence before the Tribunal that QCQY has any physical or functional impediments to conducting sexual relations and obtaining sexual release; the impairment for which he is a participant in the NDIS, and therefore seeks support, is schizophrenia. Dr Rakov's unchallenged evidence highlighted that there are many efficacious alternative supports which could deliver long-term benefits and reduce QCQY's psychotic symptoms, as distinct from the requested support which lacks a credible clinical basis. These alternative supports include psychiatric treatment, psychotherapy, social skills training, occupational therapy, speech pathology, support

[12] Exhibit 2.
[13] At [123]-[125].

groups, and supported employment or education.[14] QCQY contended that the requested support was value for money because 'using a sex worker reduces my symptoms'.[15] However, unlike the use of a sex worker, the medical evidence points to these proposed alternative supports assisting in the alleviation of schizophrenic symptoms.[16] To this end, both Dr Rakov and Dr Page Mitchell emphasised the need for QCQY to seek and receive adequate medical attention, including by way of improved management of his schizophrenia through adherence to clinical guidelines, or new medication if the symptoms proved resistant.[17]

45. Rule 3.1(b) of the Supports Rules requires consideration of any evidence that the requested support will substantially improve the life stage outcomes for, and be of long-term benefit to, QCQY. There was no independent evidence to this effect before the Tribunal. The strongest elements in Dr O'Brien's one-page letter of support for QCQY's requested funding amounted to a statement that, 'I feel that this would benefit [QCQY] in a number of ways', including 'to learn better ways of relating that may mean that he no longer requires this support in the future'.[18] As previously noted in these reasons, Dr O'Brien was not called to give evidence at the Tribunal hearing. The evidence does not rise to an extent to allow a finding that the support will substantially improve the life stage outcomes for, and be of long-term benefit to, QCQY. The unchallenged evidence of Dr Rakov emphatically rejected such a proposition and the Tribunal gives substantial weight to that evidence.

46. For the same reasons, the Tribunal is not satisfied that provision of the requested support will likely reduce the cost of the funding of supports for QCQY in the long-term, being a requisite consideration under rule 3.1(c) of the Supports Rules. QCQY has used the services of sex workers approximately weekly since he was 18 years old.[19] He considers this to be the best method of controlling and managing his psychiatric illness.[20] However, this contention is not supported by the overwhelming medical evidence before the

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[14] Exhibit 1, page 208.
[15] Ibid., page 6.
[16] Ibid., page 209.
[17] Ibid., page 225. See also Exhibit 1, page 201.
[18] Ibid., page 186.
[19] Ibid., page 191.
[20] Ibid., page 193.

Tribunal. Accordingly, based on the available evidence regarding QCQY's use of sex workers, the Tribunal is not satisfied that the requested support would likely reduce the cost of funding supports for QCQY in the long term.

47. Aside from the potential improvement in QCQY identified in Dr O'Brien's letter of support, there was no independent evidence before the Tribunal that NDIS funding to access the services of a sex worker will increase QCQY's independence and reduce his need for other kinds of support, being a consideration set out at rule 3.1(f) of the Supports Rules. The Tribunal gives considerable weight to the opinion of Dr Rakov that, until QCQY's active schizophrenia is addressed, the more nuanced skills necessary within interpersonal relationships and, therefore, greater independence, cannot be meaningfully developed.[21]

48. For the foregoing reasons, and based on the available evidence, the Tribunal is not satisfied, as required by subsection 34(1)(c) of the NDIS Act, that the requested support represents value for money in that the costs of the support are reasonable, relative to both the benefits achieved and the cost of alternative support.

Will the services of a sex worker be, or likely to be, effective and beneficial for QCQY?

49. For completeness, and despite the Tribunal's above finding, which means QCQY's application is unsuccessful because each of the criteria in section 34 of the NDIS Act must be satisfied for a support to be found to be reasonable and necessary, the Tribunal also considers below whether the requested support will be, or is likely to be, effective and beneficial for QCQY.

50. As set out above in these reasons, subsection 34(1)(d) of the NDIS Act requires the Tribunal to be satisfied that the requested support will be, or is likely to be, effective and beneficial for QCQY, having regard to current good practice. Rules 3.2 and 3.3 of the Supports Rules detail matters to be considered in deciding whether a support meets this criterion.

[21] Ibid., page 200.

51. The following relevant sections from the NDIS Operational Guidelines regarding this consideration are also noteworthy, which form government policy and should be applied by a decision-maker where consistent with the primary legislation unless there are cogent grounds to the contrary:[22]

> *The term 'current good practice' means a practice which, even if not widely used, is recognised by sufficient numbers of practitioners as being based on sound evidence (see TKCW and NDIA [2014] AATA 501 at [70]) (external).*
>
> *When deciding whether a support will be, or is likely to be, effective and beneficial for the participant, having regard to current good practice, the NDIA must consider the available evidence of the effectiveness of the support for others in like circumstances.*
>
> *…*
>
> *Also, the participant's lived experience (i.e. their first-hand knowledge, experience and understanding of their conditions and various treatments) will inevitably be subjective, however, this does not mean that it is of limited probative value. How much weight 'lived experience' should be given will depend on all of the available evidence. Where lived experience is consistent with reliable, relevant, independent evidence, it will likely be given a good deal of weight. Where it is at odds with other evidence, it may be given less weight.*

52. On a plain reading of the available evidence, QCQY's testimony in relation to the purpose and effects of accessing a sex worker directly contradicted the letter provided by his treating psychiatrist, Dr O'Brien, who was not called to give evidence in the proceeding. In that correspondence dated 26 October 2021, set out above in these reasons, Dr O'Brien stated that the requested support would assist QCQY in accessing and engaging with the community through improved communication and 'better ways of relating' and building his ability to form intimate relationships.[23] However, as the NDIA submitted, all of the reasons Dr O'Brien considered the support would be beneficial were disclaimed by QCQY. Dr O'Brien emphasised the notion of sex work as capacity building therapy, whereas QCQY expressly disclaimed any notion of capacity building; in his words, a sex worker 'only provides a physical interaction and I do not seek any social connection from them'.[24] Dr Rakov concluded that any exploration of sexual activity supports can only occur once other steps have been taken to improve QCQY's social and relational skills.[25] In addition,

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[22] Exhibit 1, page 129. See *Drake and Minister for Immigration and Ethnic Affairs (No 2)* (1979) 2 ALD 634.
[23] Exhibit 1, page 186.
[24] Ibid., pages 5, 188 and 190.
[25] Ibid., page 205.

Dr Rakov's unchallenged evidence was that there is no clinical indication that using a sex worker is an effective treatment for schizophrenia.

53. QCQY has been using sex worker services approximately weekly since he was 18 years old.[26] QCQY stated, in response to questions posed by the NDIA, that his symptoms have 'fluctuated greatly' since the original diagnosis of psychosis in 2004, when he was 14 years old.[27] QCQY asserted that using a sex worker has 'always offered me great help when it comes to helping me manage my symptoms' and that it 'enables me the ability to control a very large percentage of my symptoms, most if not all the time'.[28] As a result, QCQY contended, when his 'symptoms don't get in the way, it is much easier for me to engage with my community on a deeper level'.[29] QCQY also submitted that nothing controls his symptoms and manages his mental illness better than seeing a sex worker.[30] He further stated that a sex worker 'offers the same help as my medication plus when seeing a sex worker, my schizophrenia receives the same effects to it as the effect soap has to bacteria on dirty hands'.[31]

54. Despite these submissions from QCQY regarding the benefits and efficacy of the use of sex workers, there was no corroborating medical evidence to sustain such propositions. To this end, and as previously stated in these reasons, Dr Rakov confirmed to the Tribunal that there was no medical evidence or literature to support the suggestion that the use of a sex worker can manage or alleviate the symptoms of schizophrenia. Most importantly for the Tribunal's consideration of this criterion, Dr Rakov's evidence was that there was 'no clinical indication' that using a sex worker was an effective treatment for schizophrenia. She told the Tribunal that it was critical to first address QCQY's active psychiatric symptoms, with the foundational treatment being pharmacological. This position was endorsed by Dr Page Mitchell from the NDIA.[32] The Tribunal gives significant weight to the overwhelming medical evidence in this proceeding that the use of a sex

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[26] Ibid., page 191.
[27] Ibid.
[28] Ibid.
[29] Ibid.
[30] Ibid., page 193.
[31] Ibid., page 194.
[32] Ibid., page 224.

worker would not be effective and beneficial for QCQY, having regard to current good practice.

55. By way of contrast, in *WRMF and National Disability Insurance Agency* [2019] AATA 1771 (***WRMF and NDIA***), a differently constituted Tribunal concluded that an applicant suffering from multiple sclerosis was entitled under the NDIS to support from a trained sex therapist as a reasonable and necessary support.[33] In *WRMF and NDIA*, the applicant's condition was so severe that she was unlikely to ever have a willing partner from within the community, because it was unlikely anyone would be willing to provide the requisite specialist services. The applicant in *WRMF and NDIA* needed to experience sexual release, and she was unable to sexually stimulate a potential partner.[34] The approved support was to achieve sexual release, it was not to build transferrable social skills, and was the only means by which the applicant could obtain sexual release.[35] In contrast, QCQY did not provide any independent evidence concerning alternative, cheaper sexual aides, nor did he provide any demonstrable reason why such aides would be ineffective at achieving the release sought. Further, the applicant in *WRMF and NDIA* was seeking the services of a sex therapist who had specialised training, not funding to access the services of a sex worker.[36] As the Federal Court confirmed in *NDIA v WRMF*, the support provider had acquired knowledge about the applicant's needs, understood how her symptoms impacted her and was able to tailor services to her needs.[37] In contrast, QCQY did not contend that any sex worker he was proposing to engage possessed any specific knowledge or expertise in relation to him and his psychological impairment.

56. Having regard to all of the available evidence, the Tribunal is not satisfied that the requested support of funding to access the services of a sex worker will be, or is likely to be, effective and beneficial for QCQY, having regard to current good practice. Accordingly, the Tribunal finds that the requested support does not meet subsection 34(1)(d) of the NDIS Act.

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[33] At [54].
[34] At [3].
[35] At [10].
[36] At [45].
[37] At [79].

CONCLUSION & DECISION

57. Having considered all of the evidence, the Tribunal is not satisfied that the requested support, being funding to access the services of a sex worker on a fortnightly basis, meets the requisite criteria to be approved as 'reasonable and necessary' under the NDIS Act and for inclusion in the statement of participant supports in QCQY's NDIS plan.

58. The Tribunal affirms the decision under review pursuant to subsection 43(1)(a) of the AAT Act.

I certify that the preceding 58 (fifty-eight) paragraphs are a true copy of the reasons for the decision herein of Member W Frost.

..[SGD].....
Associate

Dated: 8 February 2024

Date(s) of hearing:	**18 January 2024**
Date final submissions received:	**29 January 2024**
Representative for Applicant:	**Ms Susie Wilson, Rights, Information and Advocacy Centre**
Counsel for the Respondent:	**Mr Marshall Cooke**
Solicitor for Respondent:	**Mr Matthew Cuskelly, NDIA**