Disability Support Pension Impairment Tables Questionnaire

Response: 196

Anonymous

11a Select the key theme of the proposed changes to the Impairment Tables that is the most important to you

Fully diagnosed, treated and stabilised (FDTS) requirement

11b Select the theme of the proposed changes to the Impairment Tables that is the second most important to you

Medical evidence requirements

11c Select the theme of the proposed changes to the Impairment Tables that is the third most important to you

Mental health

12a (i) The removal of the term 'permanent condition' provides greater clarity that a condition must persist for two years as part of the DSP eligibility criteria

Strongly disagree

12a (ii) The proposed changes more clearly describe the requirements of diagnosis, treatment and stabilisation of conditions for DSP assessment

Strongly disagree

12b Please provide any additional comments regarding changes to the FDTS requirement

An individual applying for the DSP relies heavily on the ability of their treating medical practitioner in applying the Tables. However, medical practitioners and allied health professionals are not trained in writing letters or reports to provide medical evidence on a person's medical history that is relevant for the DSP criteria. I am concerned that there is a gap between how the Impairment Tables are formulated and how the Federal Government consults with medical practitioners in their development. There does not appear to be widespread knowledge from medical practitioners and allied health professionals in how the Impairment Tables work, what evidence Centrelink requires for DSP assessment, and what the definitions for permanency or fully diagnosed, treated and stabilised mean in practice. For example, we have seen multiple letters from well-meaning and supportive General Practitioners stating that their patients' medical conditions are 'fully diagnosed, treated and stabilised' without providing the necessary context and history of treatment required. Therefore, it often falls on legal aid representatives and disability advocates to explain how the Impairment Table rules work to medical professionals. This includes sending letters to medical professionals about what the DSP legislation means and what questions Centrelink requires they answer. Applicants for the DSP should not and cannot be expected to translate complex legal terminology to their treating doctors and specialists in the course of claiming the payment. It may assist advocates and legal representatives to explain to applicants what the rules mean more clearly.

I think the amendments will provide minimal changes to this current situation if the wording of the legislation is amended to read 'diagnosed, reasonably treated and stabilised'. In application, the legal definition of these terms remains the same as the definition of 'fully diagnosed, treated and stabilised'. For example, the current definitions for the Impairment Tables under s6(5) read that fully diagnosed and fully treated means whether there is corroboarting evidence of the condition, what treatment or rehabilitation has occurred in relation to the condition, and whether treatment is continuing or is planned in the next 2 years. The proposed changes to the Impairment Tables under s 8(4) and (5) read that a condition is diagnosed if there is corroborating evidence of the condition, and a condition is reasonably treated by considering what treatment or rehabilitation has occurred in relation to the condition and whether treatment is continuing or is planned in the next 2 years and is likely to result in significant functional improvement. The only difference here is that s8(5)(b) adds 'likely to result in significant functional improvement'. However, decision-makers already understand this to be part of the current suite of rules, so this does not add any further clarification and does not change the legislation to as to make accessing the DSP any simpler for applicants.

Furthermore, the definitions related to whether a condition is 'stabilised' have not changed and they read exactly the same under the current Impairment Tables (s 6(6)) and the proposed Impairment Tables (s 8(6)). The only difference is that under

the proposed Impairment Tables there is an added Note 2 relating to degenerative conditions, which reiterates the meaning of what fully stabilised means.

The Part also defines what 'reasonable treatment' means, Again, there is not much difference between the existing definition under s6(7) of the current Impairment Tables, with comparison to the proposed Impairment Tables at s8(7). The only difference is that s6(7)(c) changes from 'reasonable treatment is treatment that can reliably be expected to result in a substantial improvement in functional capacity' to 'reasonable treatment is treatment that can reliably be expected to result in a significant functional improvement'. It is unclear whether the application of 'significant' rather than 'substantial' will have any impact on how a person is assessed as having reasonable treatment. There often seem to be disagreements between Centrelink and a person's treating doctor or specialist about how to assess whether a person's treatment can be expected to result in a functional improvement.

The bigger issue here is that the markers on what 'reasonable treatment' is do not reflect the reality of the situation for many people attempting to access the healthcare system. For example, theoretically a person can access treatment 'at a reasonable cost' but in reality they may have to wait for that treatment for several months of years. While there is a caveat under the Social Security Guide that if a person has been on an excessively long public wait-list for a period of 2 years, this person can be assessed as accessing reasonable treatment. However, decision-makers will often not apply this, or will be strict in applying this exception only if a person has been waiting for up to 2 years (rather than 1 year for example). People in rural areas cannot always access treatment but this is not always considered by decision-makers, particularly if they are in a regional area and may be able to access telehealth, although this is not always accessible for people without stable internet connections.

It can be difficult to get a history of detailed diagnosis and treatment for vulnerable people, particularly with mental health conditions, because of their transience and inability to follow up on appointments, they are at a disadvantage because they cannot access the healthcare system reasonably.

Without professional development for medical practitioners and allied health professionals on how the legislation works, these amendments will be unhelpful.

13a (i) The inclusion of additional defined terms provides greater clarity around terminology used in the Instrument

Agree

13a (ii) Simplification in Part 2 of the Instrument improves the guidance and readability of the section

Disagree

13a (iii) The proposed changes to Table introductions and descriptors has made it easier to understand the requirements of Tables

Disagree

13a (iv) The additional guidance in appropriate Tables provides greater clarity when considering functional impairment. For example an additional guidance point to all Tables on fluctuating and episodic conditions

Agree

13a (v) The updating of references to relevant assistive technology provides clearer guidance and modernises the Tables

Agree

13a (vi) The broader range of examples in the Tables illustrates how a person’s functional impairment may impact their ability to work

Agree

13b Please provide any additional comments on the proposed operational improvements.

I think that the proposed changes may provide more guidance to decision-makers within Services Australia or the Administrative Appeals Tribunal. Changes to clarify and embed fluctuating and episodic conditions are welcome. Examples included in the Tables will assist decision-makers. However, there will be no or limited impact on the ability for applicants to the DSP or their medical professionals to understand and apply the Tables. Terms included are still in legalistic or medical language. In my experience medical practitioners or allied health professionals simply do not read the Impairment Tables or

have the training to apply them adequately. There needs to be professional development for medical practitioners and allied health professionals to assist them in understanding and applying the Impairment Tables because otherwise the changes to the Introduction of Tables and examples included throughout will be of little utility.

14a The proposed changes recognise and capture the functional impacts relating to alcohol, drug and other substance misuse in appropriate Tables

Agree

14b Please provide any additional comments regarding changes about the impacts from alcohol, drug and other substance misuse.

Alcohol, drug and other substance misuse seems to be incorporated well into Mental Health / Brain Function. Although this is more of an aesthetic change than a functional change and will not assist applicants overall in accessing the DSP.

15a The addition of guidance recognises the impacts of ongoing side effects from prescribed medication and treatment

Disagree

15b Please provide any additional comments regarding changes about the ongoing side effects of treatment.

Important that this is being recognised, however, 'chemotherapy' is only included once in the proposed Impairment Tables under the Introduction to Table 10. There are other impacts that chemotherapy has i.e. fatigue. The side effects of medication and treatment is also only mentioned once under s 12(3). It should be embedded more throughout the legislation.

16a (i) Proposed changes better represent the functional impact of pain

Agree

16a (ii) Additional examples of pain related conditions that result in functional impairment provide more clarity around the types of conditions that may be assessed against a Table

Agree

16b Please provide any additional comments regarding changes about pain.

It is important to include fibromyalgia because this condition is generally not taken seriously by decision-makers. It is important to embed chronic pain throughout the Tables as this is not generally recognised by decision-makers as being relevant.

17a Additional examples of chronic illnesses that result in functional impairment provide greater clarity around the types of conditions that may be assessed against a Table

Agree

17b Please provide any additional comments regarding changes about chronic illness.

Changes to clarify that diabetes mellitus, chronic pain and fatigue should be assessed under Table 1 and that narcolepsy should be assessed under Table 14 are welcome. Embedding chronic pain across the Tables is welcome. Clarifying that renal conditions should be assessed under Table 1 is welcome. Addition of cancers that can be assessed under the Impairment Table is welcome - however people with cancer often come up against the 'treated/stabilised' criteria and are rejected on this basis, as they have ongoing treatment due to the nature of their illness. It is unclear how the current iteration of the Impairment Tables seeks to address this.

18a Additional examples of renal conditions that result in functional impairment provide more clarity around the types of conditions that may be assessed against a Table

Agree

18b Please provide any additional comments regarding changes about renal conditions.

Including renal failure under Table 1 is welcome, however there is not much detail as to how this would be assessed under the specific markers of Table 1 i.e. fatigue/pain.

19a (i) Additional examples of fatigue related conditions that result in functional impairment provide greater clarity around the types of conditions that may be assessed against a Table

Agree

19a (ii) The inclusion of a personal care descriptor captures the functional impacts of fatigue on a person's ability to undertake personal care activities

Agree

19a (iii) Proposed changes better represent the functional impact of fatigue related conditions

Agree

19b Please provide any additional comments regarding changes about fatigue.

Including Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) under Tables 1 and 6 is welcome. Including a new 'personal care' descriptor to Table 1 to capture the impacts of fatigue on a person's ability to undertake personal care activities is welcome. Including post-exertional malaise under Table 1 is welcome. These additions will hopefully assist decision-makers to better assess the full experience of people's disabilities and how their conditions impact them in their everyday lives.

20a Additional examples of cancer and subsequent conditions that result in functional impairment provide more clarity around these types of conditions that may be assessed against a Table

Agree

20b Please provide any additional comments regarding changes about cancer.

We support the inclusion of lymphoaedema under Table 1, 2 and 3; neck and throat cancer under Table 7; cancers affecting digestive and reproduction functioning under Table 9; head and neck cancer any chemotherapy side effects under Table 10; brain tumours under Table 11 and 14; gastrointestinal malignancy under Table 12; and melanoma under Table 13. As noted, however, there is a concern that people with cancer will still not be able to overcome the hurdle of the 'treated/stabilised' requirements as the nature of cancer is that treatment is often ongoing so may not ever be able to be considered 'stabilised'.

21a (i) Additional examples of specific pieces of evidence that may be used to support a claim assists individuals to identify the accepted range of medical evidence that can be provided

Agree

21a (ii) Additional examples of professionals assists individuals identify the range of appropriate practitioners who are able to provide medical evidence in support of their claims

Agree

21b Please provide any additional comments regarding changes to medical evidentiary requirements.

The acceptance of a broader range of medical evidence is welcome i.e. acimetry linked blood pressure and heart rate monitoring results under Table 1; and interviews with the person and those providing care as evidence for Table 6. Although there is a question as to how seriously interviews with the person impacted and those providing care will be considered by Centrelink. This will still need to be balanced with the requirement that self-reporting of symptoms alone is insufficient. Under the current DSP, people are interviewed about their disabilities, but their views are often ignored unless there is corroborating medical evidence.

Additional examples of professionals able to provide evidence is welcome i.e. occupational therapists, neurosurgeons, neurologists, audiometrists, optometrists, oncologists, clinical nurse consultants/practitioners, physiotherapists or pain management specialists. However, it is hoped that Centrelink will not use any lack of people not being able to access these professionals as reasons for rejecting the DSP. For example, people on public waiting lists can wait for many months or years to see many of these allied health professionals or medical practitioners, and the cost of these professionals writing up a report is not covered by Medicare, leaving potentially vulnerable people thousands of dollars out of pocket simply for trying to get onto the DSP.

22a (i) Addition of descriptors better capture shoulder function in Table 2 - Upper Limb Function

Unsure

22a (ii) The addition of descriptors for the loss of function of a dominant limb under Table 2 – Upper Limb Function better recognises functional impacts of losing a dominant upper limb

Agree

22a (iii) Additional examples of specific skin conditions that result in functional impairment provide more clarity around the types of conditions that may be assessed against a Table

Agree

22b Please provide any additional comments regarding changes about musculoskeletal and skin functions.

Examples under Table 1 have been expanded but it is unclear what impact they will have as they are still quite similar to the current DSP Impairment Tables but have been slightly reworded. The addition of descriptors for the loss of function of a dominant limb is welcome. Giving decision-makers the ability to assess lower limb impairments arising from lumbar spine conditions under Table 3 is welcome.

Addition of graft versus host disease and skin ulcerations as examples of conditions a person may provide evidence for under Table 13 is welcome.

23a The proposed changes better capture the functional impacts of balance, dizziness and a person's ability to stand

Agree

24a The proposed change will better support individuals by providing a broader range of medical professionals allowed to provide corroborating evidence in support of a diagnosis of a mental health condition for assessment under Table 5 – Mental Health Function

Strongly agree

24b Please provide any additional comments regarding changes about psychologists.

It is incredibly important that the current requirement for a clinical psychologist to provide corroborating evidence in support of a diagnosis has been extended to include all registered psychologists as part of the proposed changes. Many people with mental health conditions have in the past been unfairly rejected from the DSP, as even though they had a registered treating psychologist, they had not seen a clinical psychologist. This caused unnecessary complexity and confusion for applicants. Expanding the requirement to include all registered psychologists is welcome. It will be helpful for DSS to provide professional development to all mental health practitioners so they understand how to write up medical reports against the criteria for the DSP.

25a The proposed changes improve alignment with other recognised mental health assessment tools (including the World Health Organization Disability Assessment Schedule –WHODAS, Diagnostic and Statistical Manual of Mental Disorders – DSM, World Health Organization International Classification of Diseases - ICD)

Agree

25b Please provide any additional comments regarding changes about mental health.

Better alignment of descriptors to WHODAS, DSM and ICD will hopefully assist decision-makers and their treating professionals to assess medical evidence more accurately. It will be helpful for DSS to provide professional development for mental health practitioners so they can fully understand how to write reports against the criteria for the DSP.

26a (i) Proposed changes better reflect conditions on the spectrum of neurodiversity

Unsure

26a (ii) The addition of a new social skills descriptors in the table relating to brain function recognise difficulties a neurodivergent person may experience in social situations

Agree

26b Regarding the proposed change on Table 6 – Brain Function to better recognise social skills difficulties, would you prefer to:

add a new social skills descriptor and require a person to meet at least two descriptors for the relevant impairment rating to be assigned

26c Please provide any additional comments regarding changes about neurodiversity.

Specifically and more explicitly including ADHD and ASD under the Impairment Tables is welcome. However, it is unclear why ADHD and ASD are viewed as mental health conditions. They may be more appropriately captured under Table 6 Brain Function or Table 7 Communication. It is important for the Department of Social Services to consult with groups representing people with ADHD or ASD to clarify this matter.

27a The proposed changes better recognise the need for culturally appropriate assessments

Disagree

27b Please provide any additional comments regarding changes to address cultural appropriateness.

While the consideration of the adaptation of recognised assessments of intellectual function for use with Aboriginal and Torres Strait Islander peoples is required under Table 8 (Intellectual Function), cultural appropriateness is not required to be considered in any other Table or Part of the Impairment Tables. The only other section of the Impairment Tables that references culture is s 10(2) that mentions that unless required under the Tables, the impact of non-medical factors when assessing a person's impairment must not be taken into account, which under the example used includes religious or cultural factors. Following this, one can interpret that culturally appropriate assessments are only recognised under Table 8 and not under any other Table. Therefore, the proposed changes overall do not better recognise the need for culturally appropriate assessments. Furthermore, there is a concern that decision-makers could use the requirement under Table 8 to disqualify people by saying that under a culturally appropriate assessment, they do not meet the requirements for the DSP.

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