Disability Support Pension Impairment Tables Questionnaire

Response: 233

Good Shepherd Australia New Zealand

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

Chronic Illness

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

Operational improvements

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

Agree

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

Agree

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

Strongly support the removal of the qualifier "fully" from "diagnosed, treated, and stabilised".

The clarification of "treated", in that it refers to treatment that is appropriate, available, and affordable, is not understood well, and needs to be communicated more clearly to both DSP applicants and people assessing applications.

However, it is inappropriate for many that "diagnosis" is a requirement, when diagnosis is unavailable to many: it may be expensive (especially for people receiving Centrelink as a primary income), have long wait times (reports of up to two years for cognitive conditions such as ADHD and Autism, or over 10 years for conditions such as Endometriosis), or be inaccessible due to factors such as rurality. These issues particularly impact women: there is strong evidence that women have pain and symptoms dismissed in the medical system, prolonging diagnosis and treatment. Therefore, the requirement for conditions to be diagnosed is likely to disproportionately impact women. As the rest of the assessment is about functional capacity, why is a diagnosis important? If someone has enough functional incapacity to meet the 20 point criteria, what difference does it practically make to know why they are incapacitated?

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

Agree

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

Agree

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

Unsure

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.

The inclusion of examples within the tables that articulate chronic illness and episodic conditions is important, as is the clarification that a person's capacity should be assessed as how often they are likely to need to do a task, not their ability to do the task at all (i.e. they might need to do a task several times a day, and then carry on with other work/living tasks). The clarification that the impact of the task on the person's ability to carry out other tasks is critical for reflecting the lived reality of 'pacing' disabled and chronically ill people: for many people who are impacted by pain and fatigue, it is inappropriate to consider whether they can carry out one task in isolation from their day to day living/working: an activity such as walking or showering might result in needing many hours of rest, or an incapacity to undertake other activities on the same day.

The application of these clarifications by DSP assessors will be just as important as what is written in the document: it is crucial that assessors have an advanced understanding of disability, chronic illness, psychosocial conditions, and episodic conditions, and that the appropriate tables are used as a primary assessment table. Note there is some inconsistency between tables currently, and this needs to be addressed (e.g. the same impairment affecting use of arms over head height may result in a different amount of points in the upper limb and spinal tables)

A plain language document including examples should be provided to DSP applicants.

There is still some room to improve the tables reflection of someone's inner experience rather than solely their ability to interact in the outside world. E.g. for psychosocial disability, activities may result in significant distress

The mental health table still jumps from "needs help 2 days per week" to "requiring continual support" which is a big jump: there could be an intermediary step

If the tables are primarily around assessing someone's capacity to work (to avoid being placed on the Program of Support), then the examples could better reflect a working environment, as they are currently based around general daily activities.

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

Agree

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

Agree

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

The impact of treatment on a person's capacity to undertake tasks - whether because of pain, fatigue, nausea, or something else - must be a key consideration in allocating 'points' of impairment

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.

An assessment of the way in which pain and function interact (i.e. pain limits functionality, or an activity causes pain) is critical to a functional assessment

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

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

Unsure

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

Strongly disagree

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

The addition of examples around the potential impact of undertaking activities on fatigue is helpful, as it better reflects the pacing undertaken by chronically ill and disabled people to manage their days. Strongly support the inclusion of post-exertional malaise, pain, fatigue, and shortness of breath in these descriptions

Better articulation of the impact of fatigue on the ability to work (not just day to day activities) would better enable the assessment to answer the question of whether it's appropriate for someone to work 15h/week.

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

Unsure

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 expansion of clinical psychologists to psychologists is welcomed: there is a significant shortage of mental health services at the moment, long wait times, high cost, and additional barriers for rural and regional people. Any extension of the practitioners able to provide evidence is welcomed.

It is recommended that the scope of practitioners able to provide evidence is widened further: any allied health or medical professional who someone sees to manage their condition/s should be able to provide evidence. The current limits around who can provide evidence create an unhelpful situation where people may not be able to rely on their regular treating professionals, who know them and their condition/s well, and instead need to find a new practitioner, who doesn't know them, to undertake fresh assessments and provide evidence. This is costly, time consuming, delays support for people (thus increasing financial insecurity), and does not reflect the reality of who is best placed to comment on someone's capacity.

Again, diagnosis is not available to many for practical reasons: cost, delays/waiting times, geographical location, medical gaslighting and sexism, and dismissal. These issues disproportionately impact women, who are more likely to rely on welfare payments (which are too low for day to day costs, let alone expensive medical investigations), earn less over a lifetime, are more likely to have chronic conditions that are difficult to diagnose (e.g. endometriosis, chronic fatigue/ME), are more likely to have pain and symptoms dismissed, and are more likely to face transport difficulties especially in rural areas, as they are more reliant on public transport. The requirement for diagnosis is a gender equity issue.

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

Unsure

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

Unsure

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

The upper limb function table and spinal function tables should be brought into better alignment so that the same impairment results in the same points across both tables. All tables should be assessed to ensure they are in alignment in this way

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

Unsure

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

Agree

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

As clinical psychologists make up such a small proportion of total psychologists in Australia, the expansion of professionals able to provide diagnosis to all psychologists is welcome.

Due to the significant wait time, cost, and inaccessibility of mental health diagnosis, it would me more appropriate if any treating mental health professional could provide a functional assessment, and diagnosis was not required. This would enable mental health social workers, for example, to provide evidence.

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)

Unsure

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.

It would be ideal if the new social skills descriptor was added and people needed to meet only one descriptor

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

Unsure

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

It's positive that cultural appropriateness has been addressed, however it's difficult to understand how this will be applied practically to the assessment of DSP applications. A lot of the diagnosis and assessment evidence requirements (e.g. specific tests or assessments suggested) are not necessarily culturally appropriate, and it is unclear how this criteria will be applied

28 In accordance with the Privacy Collection Notice, please select one of the following.

I would like my submission to be published with identifying information (including name or name of organisation as provided in the questionnaire)