Disability Support Pension Impairment Tables Questionnaire

Response: 248

National Legal Aid

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

Psychologists

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

Fatigue

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

We support the proposal in section 8 'Applying the Tables' to separate the rules for the diagnosed, reasonably treated and stabilised criteria. Specifically, we support the proposed change from 'fully treated' to 'reasonably treated'.

While the proposed changes provide greater clarity in relation to requirements to attain ratings, our experience is that many, if not most, of our clients do not gain access to the tables prior to an appeal before the General Division of the Administrative Appeals Tribunal.

Where clients (and more broadly applicants) or their clinicians have earlier access to the tables, clinicians often apply the relevant tables without review of the Rules for Applying the Tables.

Without easy and early access to the tables, applicants will continue to struggle to provide relevant evidence for correct assessment particularly where they cannot afford to commission reports.

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

Disagree

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.

Our concern in relation to the addition of examples and guidance is the tendency for decision makers to turn examples into de-facto requirements and to dismiss any facts particular to the applicant. We support the inclusion at section 13(2) of a statement that examples are provided as guidance only and evidence of comparable functional impacts may be used to illustrate the person's level of impairment.

Definition and use of "assistance"
In relation to the definition of "assistance" at (5), we would recommend "assistance" be amended to state "means that assistance from another person is either supported by compelling evidence, or is assessed by appropriately qualified health professional(s)..." This is because many of our clients in rural areas struggle to sustain an ongoing treating doctor or find appropriate referrals for specialists or allied health professionals. Specific reports addressing what assistance applicants need with day-to-day tasks are complex, intensive, and expensive. In our experience, doctors are usually only able to comment on the support a person might need across the day or week in general terms as they do not have capacity to assess the patient in the home. The requirement in the definition that the need for "assistance" be assessed by an appropriately qualified health professional will be a barrier to obtaining DSP for those who otherwise meet the eligibility requirements but are unable to afford or access relevant health professionals with capacity to address those issues. If compelling evidence can be provided from carers as to the day-to-day support needs, this should be sufficient for Centrelink to make an assessment of their need for assistance with particular tasks.

We also recommend consistent use of the word 'assistance' in the descriptors for each Table. For instance, descriptor 20 (1)(a)(iv) in Table 1 refers to "assistance from a carer." Descriptor 10(1)(c) in Table 3 concerning lower limb function requires that a person is "unable to stand independently with or without the use of aids." The use of "assistance'' and "independently" is likely to result in confusion. If the definition of "assistance" remains in section 5, we suggest consistent use of the word in all the tables.

Demonstration of capacity
Finally, section 9 sets out the information that must be taken into account when applying the Tables. Sub-section 2 states that a person may be asked to demonstrate abilities described in the Tables. We are concerned that decision-makers and job capacity assessors, who are not appropriately qualified, will ask claimants to demonstrate their abilities. To avoid injury and exacerbation to claimants, we recommend that such requests be made only by appropriate health professionals.

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

Disagree

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

In our experience many applicants reliant on drugs/alcohol may be self-medicating where they have underlying treatment resistant conditions such as mental health impairment or chronic pain and where they have acquired brain injuries.

We recommend improving clarity in relation to the Mental Health Function table by setting out in clearer terms that impairment of function arising from current and chronic misuse of drugs/alcohol (i.e. routine intoxication and recovery/come down) can be rated in addition to other impairment arising from a stabilised mental health impairment.

The introduction to the Brain Function table should clarify that this table is best suited to assessment of permanent neurological and cognitive impairment arising from brain injury precipitated by chronic drug or alcohol use.

We recommend improving clarity in relation to the Brain Function table by setting out in clearer terms that impairment of function arising from current and chronic misuse of drugs/alcohol (i.e. routine intoxication and recovery/come down) can be rated in addition to other impairment arising from a stabilised brain injury or other condition resulting in impairment of cognitive or neurological function.

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.

The guidance at Part 2 Section 12(3) on page 7 should be repeated in the guidance to Table 1, 5, 4, 10 and Table 14 to improve clarity for ease of reading.

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.

We are concerned by increases in red tape in relation to the assessment of chronic pain (see the Rules for applying the tables at p 6).

We hold concerns that before being rated for any physical impairment which includes an experience of pain the applicant will need to:
a. Establish that the underlying condition is reasonably treated and stabilised, AND
b. Establish that an associated experience of chronic pain is diagnosed, reasonably treated and stabilised.

This is a consequence of clarification at Part 2 section 8(8) that these preconditions are required for a rating to be allocated in respect of experiences of pain.

We also recommend clarification of drafting in respect of ratings which require the meeting of multiple descriptors/criteria or allow for the meeting of alternate descriptors/criteria.

In cases where multiple descriptors must be met, each descriptor should end with “and”.

In cases where only one descriptor out of a number of options must be met, each descriptor should end with “or”.

This is to assist busy medical practitioners, advocates, applicants, and decision makers to quickly comprehend what evidence is required to meet any particular rating.

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.

We support the inclusion at 12(3) of the consideration in identifying loss of function of the ongoing side effects of prescribed medication and treatment.

Additional evidentiary burdens if not higher impairment required for ratings on the Brain Function table
The proposed Brain Function table increases the evidentiary burden on applicants by requiring evidence of difficulty in relation to at least 2 out of 10 functional domains set out in the table to obtain a rating.

The current Brain Function table sets out only 9 functional domains but requires a person demonstrate difficulty in relation to only one of those domains. We recommend that only one of the function domains should need to be engaged.

Changes to subjective test in relation to Functions of Consciousness
The 20 point rating on the current Functions of Consciousness table requires (amongst other descriptors) that a person is:
unable to perform many activities of daily living between episodes…

The equivalent descriptor set out in 20 point rating of the proposed tables requires that a person is:
unable to perform many of their usual activities of daily living between episodes…

The test in the current table is objective. The proposed new test is subjective and is harder to meet as the “usual” activities of daily living of claimants living with significant seizure activity will have already been already tailored and confined to ensure their safety and/or as a consequence of their medical condition (e.g. epilepsy).

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.

We note that the personal care needs of applicants on dialysis are not adequately captured by the criteria on Table 1 and should be recognised and rated. (i.e. need for attendance at frequent appointments, connection to dialysis machine, drugs necessary).

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.

We recommend clarification of drafting in respect of ratings which require the meeting of multiple descriptors/criteria or allow for the meeting of alternate descriptors/criteria.

In cases where multiple descriptors must be met, each descriptor should end with “and”.

In cases where only one descriptor out of a number of options must be met, each descriptor should end with “or”.

This is to assist busy medical practitioners, advocates, applicants, and decision makers to quickly comprehend what evidence is required to meet any particular rating.

Table 1 - Functions requiring Physical Exertion and Stamina
Noting the above point, we consider that in relation to Table 1 - Functions requiring Physical Exertion and Stamina, the descriptors across all of these levels of Impairment should include "or" where there is otherwise no connecting word. This would make it consistent with the previous Tables, and better reflect the range of different impacts that might be experienced by persons experiencing fatigue, or who struggle with physical exertion or stamina. Any one of the descriptors would impede the person's functional capacity. Using "or" would increase clarity and as noted above, would assist people to understand if they meet the criteria, and for their medical professionals to properly address the criteria.

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

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

We acknowledge the proposed specific references to cancer within the impairment tables, such as within Tables 1 and 9, provide certainty of a claimant’s ability to obtain impairment points for the functional impacts of cancer. There is inherent risk that specific reference to cancer in limited tables may lead decisions makers to discount the varied functional impacts of cancer under other tables where a diagnosis has not been specified. We support the inclusion at Part 1 of a statement that references to specific diagnoses in individual impairment tables are a guide and are not exhaustive.

The proposed tables purport to provide better representation of cancer and subsequent conditions (as described in Summary).

The changes refer only to the ratings set out in the tables themselves rather than to the requirements an applicant must meet in order to be rated.

Community sentiment supports the availability of Disability Support Pension to people undergoing traumatic and invasive cancer treatment without clear prognosis and who are unable to work in the foreseeable future.

Prior to September 2020 Sickness Allowance would have been available to persons undergoing treatment for cancer who did not at time of claim meet the requirements for Disability Support Pension.

Proposed changes will not assist claimants to obtain the pension in respect of cancer as they will still need to establish that their condition is unlikely to significantly improve within two years with treatment. Our experience is that persons with cancer struggle to obtain such evidence.

In particular, claimants struggle to establish that for degenerative disease, mental health conditions and some cancers that require ongoing therapy during remission or by way of palliative care can be taken to be “stabilised”.

This is in circumstances where claimants (like those with arthritis and chronic mental health impairment) expect and receive continual medication review and alteration without any expectation of cure or significant improvement.

In the words of Snr Member de Sosso in Cunningham and Secretary, Department of Social Services (Social services second review) [2019] AATA 5 (7 January 2019) from para 65;
65. It is usually the case that when a condition is diagnosed, the treating medical practitioner(s) is (or are) able to recommend a course of treatment that will deal with the condition and stabilise it, at least as much as is possible by extant medical science.
66. However, some people are afflicted by a degenerative disease which requires a plethora of medical interventions, none of which will cure the disease, but which may slow its progression, ease the pain suffered by the person or provide short to medium term relief. Arthritis (in each of its forms) is such a disease. In these situations, the condition is never actually stabilised; the treatment is palliative not curative. Importantly, viewed from the perspective of social security law, any further medical interventions will not result in any substantial improvement in functional capacity
67. It is tolerably clear in this matter that the Applicant’s arthritic condition was correctly diagnosed, and it is also tolerably clear that he has been given appropriate medications and had appropriate surgical interventions. There is no suggestion from the material before the Tribunal that any of the medications prescribed or surgeries undergone has or will cure the Applicant’s underlying condition and provide anything other than short to medium term relief.
68. The evidence suggests that the Applicant will be afflicted with arthritis until his death. Viewed from this perspective how does a tribunal of fact correctly apply the tests of fully treated and fully stabilised mandated by Cl 6(5) and 6(6) of the Determination? If it is contended that these tests can only be satisfied when all appropriate medical interventions have been exhausted, then

only death will satisfy that test. If that were the case, then people who are incapacitated by painful and long-term degenerative conditions would be deprived of receiving the DSP, despite the fact that due to no fault of their own, they are prevented from engaging in gainful employment.

In our experience applicants have difficulty establishing to the satisfaction of decision makers that they are “fully diagnosed” where they are undergoing therapy to prevent recurrence of cancer or maintain current (decreased) function following cancer.

There is little recognition within the current culture of decision making in respect of claims for Disability Support Pension that some conditions necessitate ongoing treatment without clear end, leaving applicants with ongoing intractable impairment and medical review.

Given the unique challenges with cancer and the difficulty satisfying the stabilisation requirement, we recommend a note 3 after section 8(6) should be included to recognise the challenges of cancer.

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

Disagree

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.

As applicants are not routinely provided with the tables or questions that would elicit relevant evidence when putting in a claim for the pension, they will be unaware and not obtain the benefit of the proposed changes.

Please refer to comments in response to question 20(b) above.

Applicants would be assisted at the point of claim by being provided with standard questions and a copy of the relevant tables and the Rules for Applying the Impairment Tables. This would assist applicants in marshalling relevant evidence to support their claim.

We also recommend clarification of drafting in respect of ratings which require the meeting of multiple descriptors/criteria or allow for the meeting of alternate descriptors/criteria.

In cases where multiple descriptors must be met, each descriptor should end with “and”.

In cases where only one descriptor out of a number of options must be met, each descriptor should end with “or”.

This is to assist busy medical practitioners, advocates, applicants, and decision makers to quickly comprehend what evidence is required to meet any particular rating.

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

Agree

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.

Higher impairment required for 20 points for Lower Limb impairment
The proposed tables set out a 20 point rating at Table 3 which may be harder to be allocated than the existing rating.

In the current tables the requirements for a rating of 20 points on Table 3 – Lower Limb Function require that a person is unable to:
a. walk around a shopping centre or supermarket without assistance from another person, AND
b. walk from the carpark into a shopping centre or supermarket without assistance from another person, AND
c. stand up from a sitting position without assistance from another person, AND
d. use public transport without assistance from another person.

Our experience is that persons who require assistance from another person to stand up from a sitting position are likely to be found to be manifestly eligible for disability support pension on the basis that they require nursing home level care.

Consequently, we have very few clients who are rated or who seek to be rated 20 points on Table 3 – Lower Limb Function.

The 20 point rating on Table 3 of the proposed tables requires that a person:
a. is unable to walk around their home and in the community, AND
b. is unable to stand independently, AND
c. has significant difficulty standing up from a sitting position in a standard chair without assistance from another person, AND
d. requires assistance from another person to use public transport.

This rating introduces requirements that the person is:
a. unable to walk around their home, and
b. unable to stand independently.

The requirement that a person is unable to stand independently is set out in insufficiently certain terms, having regard to a similar descriptor set out at the 10 points rating which requires that a person is unable to stand independently with or without the use of a medically recommended walking aid such as a walking stick.

Across the table as a whole, there is uncertainty as to the application of the term 'assistance'. Within the criteria for 20 points there are six separate references to 'assistance', in addition to the definition of what assistance means in the Introduction to Table 3. Criteria 1(a)(i) specifies a person must illustrate they are unable to walk around their home and in the community, yet the example provided for this criteria retains the concept of 'without assistance'. The descriptor for 20 points under Table 3, especially when compared with the level of functional impact described in other musculoskeletal tables (for example Tables 2 and 4), appears to reflect an extreme functional impact rather than a severe functional impact.

We note, with concern, the lack of parity between the level of impairment that could attract 20 points on Table 4 – Spinal Function compared to Table 2 – Upper Limb Function.

Table 4 allows 20 points if the person is unable to perform any overhead activities as a result of spinal impairment whereas Table 2 allows for a rating of 20 points for being unable to undertake any activity that involves reaching overhead but only where the person also meets three other descriptors in the 20 point rating.

The introduction of the current tables in 2011 marked a change to function based assessment for Disability Support Pension rather than condition based assessment. The current tables and the proposed tables do not reflect function based assessment in respect of the differences in assessment of restriction of capacity to engage in overhead activities based on whether that impairment arises as a result of a spinal or an upper limb condition.

Purpose of Note in Table 4 unclear
We are also concerned that the note included in the 20-point rating in Table 4 of the proposed tables is likely to cause confusion among doctors and decision-makers. The note which appears in the 20-point rating under the current Table 3 concerning lower limb function states that "the impairment rating includes a person who requires assistance to a) move around in, or transfer to and from a wheelchair; or move around using medically recommended walking aids such as a quad stick, crutches or walking frame such as the person requires assistances from another person to walk on some surfaces..." The purpose of this note in Table 4 is unclear and likely to be interpreted as a de facto requirement by decision-makers.

Clarification where multiple descriptors must be met
We also recommend clarification of drafting in respect of ratings which require the meeting of multiple descriptors/criteria or allow for the meeting of alternate descriptors/criteria.

In cases where multiple descriptors must be met, each descriptor should end with "and".

In cases where only one descriptor out of a number of options must be met, each descriptor should end with "or".

This is to assist busy medical practitioners, advocates, applicants and decision makers to quickly comprehend what evidence is required to meet any particular rating.

Upper limb impairment – additional descriptors
Whilst the addition of two additional descriptors for the 20 point impairment is welcomed, the increase in the number of descriptors that need to be met has the effect of making it more difficult for a person to be assessed as meeting that particular level of impairment, unless they meet one of the two additional descriptors. From our experience applicants with significant disability who are unable to work were already struggling to meet the criteria under this Table. We recommend that a person should meet 20 points if they meet three of the descriptors, not four.

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

Disagree

23b Please provide any additional comments regarding changes about balance.

Higher impairment required for 20 points for Lower Limb impairment
The proposed tables set out a 20 point rating at Table 3 which may be harder to be allocated than the existing rating.

In the current tables the requirements for a rating of 20 points on Table 3 – Lower Limb Function require that a person is unable to:
a. walk around a shopping centre or supermarket without assistance from another person, AND
b. walk from the carpark into a shopping centre or supermarket without assistance from another person, AND
c. stand up from a sitting position without assistance from another person, AND
d. use public transport without assistance from another person.

Our experience is that persons who require assistance from another person to stand up from a sitting position are likely to be found to be manifestly eligible for disability support pension on the basis that they require nursing home level care.

Consequently, we have very few clients who are rated or who seek to be rated 20 points on Table 3 – Lower Limb Function.

The 20 point rating on the Table 3 of the proposed tables requires that a person:
a. is unable to walk around their home and in the community, AND
b. is unable to stand independently, AND
c. has significant difficulty standing up from a sitting position in a standard chair without assistance from another person, AND
d. requires assistance from another person to use public transport.

This rating introduces requirements that the person is:
a. Unable to walk around their home, and
b. Unable to stand independently.

The requirement that a person is unable to stand independently is set out in insufficiently certain terms, having regard to a similar descriptor set out at the 10 points rating which requires that a person is unable to stand independently with or without the use of a medically recommended walking aid such as a walking stick.

The descriptor for 20 points under Table 3, especially when compared with the level of functional impact described in other musculoskeletal tables (for example Tables 2 and 4), appears to reflect an extreme functional impact rather than a severe functional impact.

Changes to subjective test in relation to Functions of Consciousness
The 20 point rating on the current Functions of Consciousness table requires (amongst other descriptors) that a person is:
unable to perform many activities of daily living between episodes…

The equivalent descriptor set out in 20 point rating of the proposed tables requires that a person is:
unable to perform many of their usual activities of daily living between episodes…

The test in the current table is objective. The proposed new test is subjective and is harder to meet as the “usual” activities of daily living of claimants living with significant seizure activity will have already been already tailored and confined to ensure their safety and/or as a consequence of their medical condition (e.g. epilepsy).

Use of “or” and “and”
We recommend clarification of drafting in respect of ratings which require the meeting of multiple descriptors/criteria or allow for the meeting of alternate descriptors/criteria.

In cases where multiple descriptors must be met, each descriptor should end with “and”.

In cases where only one descriptor out of a number of options must be met, each descriptor should end with “or”. As noted above, we consider that Impairment Table 1 should have “or” inserted where there is currently no connecting word for ratings, 5, 10, and 20, consistent with the current Impairment Table 1.

This is to assist busy medical practitioners, advocates, applicants and decision makers to quickly comprehend what evidence is required to meet any particular rating.

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.

We strongly support the proposed change to enable a diagnosis to be made by an appropriately qualified medical practitioner with evidence from a registered psychologist (if the diagnosis has not been made by a psychiatrist).

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

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

Refer to answer concerning ongoing treatment at Q 20(b).

We support the proposed changes to the listed activities involving mental health function, specifically the separation of travel and accessing the community from social and recreational activities.

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

Agree

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

Strongly agree

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

keep the current list of descriptors and require a person to meet only one descriptor for the relevant impairment rating to be assigned

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

Additional evidentiary burdens if not higher impairment required for ratings on the Brain Function table
The proposed Brain Function table increases the evidentiary burden on applicants by requiring evidence of difficulty in relation to at least 2 out of 10 functional domains set out in the table to obtain a rating.

The current Brain Function table sets out only 9 functional domains but requires a person demonstrate difficulty in relation to only one of those domains.

On the current tables a correct rating requires evidence in relation to two matters. One being the extent of the person's need for assistance or supervision day to day and, the second, being the extent of the person's difficulties in relation to one of the functional domains.

Given the extent of vulnerability and barriers experienced by the cohort seeking a rating on this table we strongly recommend the reduction of evidentiary burden. This would be assisted by a greater range and choice of domains but no increase in the number of descriptors which must be met.

Changes to subjective test in relation to Functions of Consciousness
The 20 point rating on the current Functions of Consciousness table requires (amongst other descriptors) that a person is:
unable to perform many activities of daily living between episodes…

The equivalent descriptor set out in 20 point rating of the proposed tables requires that a person is:
unable to perform many of their usual activities of daily living between episodes…

The test in the current table is objective. The proposed new test is subjective and is harder to meet as the "usual" activities of daily living of claimants living with significant seizure activity will have already been already tailored and confined to ensure their safety and/or as a consequence of their medical condition (e.g. epilepsy).

We also recommend clarification of drafting in respect of ratings which require the meeting of multiple descriptors/criteria or allow for the meeting of alternate descriptors/criteria.

In cases where multiple descriptors must be met, each descriptor should end with "and".

In cases where only one descriptor out of a number of options must be met, each descriptor should end with "or".

This is to assist busy medical practitioners, advocates, clients and decision makers to quickly comprehend what evidence is required to meet any particular rating.

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

Strongly disagree

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

Dianne's story, in Victoria Legal Aid's 2021 submission, Building a fair disability support pension, to the Review of the Disability Support Pension Impairment Tables [online], illustrates this issue of the challenges faced by Aboriginal and Torres Strait Islander

people seeking to access the DSP, including the way in which evidence provided by Aboriginal health services is viewed by Centrelink.

We would encourage the Department to conduct a First Nations specific consultation, if this has not happened through this review, to define cultural safety and culturally appropriate assessments, and to consider whether the Tables provide adequate and culturally safe pathways for First Nations applicants to meet the evidentiary requirements. We also recommend the Department considers how evidentiary requirements can best be met, including how evidence provided by Aboriginal community controlled health services can be used to effectively support applications for DSP even where it may not include the particular specialists referred to under the particular Tables.

The Summary states that the proposed tables provide better recognition of the need for culturally appropriate assessments.

In particularising this, the Summary refers to “clarification that culturally appropriate assessments of intellectual and adaptive function can be used for Table 8 [Intellectual Function]”.

Cultural appropriateness is not stated to be improved for any other table.

A comparison of the current Intellectual Function table with the proposed table shows exactly the same wording in respect of the requirement for consideration of the adaptation of recognised assessments of intellectual function for use with Aboriginal or Torres Strait Islander persons.

The proposed table makes no reference at all to consideration of adaptation of recognised assessments of adaptive function in respect of use with Aboriginal or Torres Strait Islander persons nor with any other culturally or linguistically diverse population members.

Once it is established that a claimant meets the requirements to be rated on the Intellectual Function table (an IQ of 85 or less as a consequence of a permanent condition arising before the claimant turned 18 years old) the claimant’s rating on both the existing and proposed intellectual function tables hinge on the outcomes of assessments of adaptive function. These assessments rely on the capacity of claimants to speak meaningfully to difficulties they experience with day to day function at assessment. Persons with impairment of mental health or significant impairment of intellectual function nearing manifest eligibility for disability support pension (IQ under 70) and those with limited insight or other cultural barriers to accurately self-report difficulties with day to day function struggle to be rated accurately on the intellectual function table.

We consider the proposed tables provide no improvement in respect of increasing cultural appropriateness of the tables, as they still do not define cultural safety or culturally appropriate assessments, and also do not provide pathways for First Nations applicants to meet the evidentiary requirements.

We recommend that First Nations communities be further consulted about the Tables and that consideration be given to how evidence provided by Aboriginal community controlled organisations health services (ACCOs) can support Aboriginal and Torres Strait Islander people's DSP applications, without requiring Aboriginal and Torres Strait Islander people to seek medical treatment or reports from mainstream services.

We support the inclusion within other tables that refer to specific assessments (for example Table 5, which is proposed to include an evidentiary requirement of reference to diagnostic tools) of consideration of the adaptation of recognised diagnostic assessments for use with Aboriginal and Torres Strait Islander peoples and other culturally and linguistically diverse people.

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)