Australian Parliament
Joint Standing Committee on the National Disability Insurance Scheme

Inquiry into independent assessments under the NDIS

Occupational Therapy Australia submission

April 2021

Occupational Therapy Australia Limited

Introduction

Occupational Therapy Australia (OTA) welcomes the opportunity to make a submission to the Joint Standing Committee's *Inquiry into independent assessments under the National Disability Insurance Scheme (NDIS)*.

OTA is the professional association and peak representative body for occupational therapists in Australia. As of December 2020, there were more than 24,000 registered occupational therapists working across the government, non-government, private and community sectors in Australia. Occupational therapists are allied health professionals whose role is to enable their clients to participate in meaningful and productive activities.

Recommendations

1. *The Australian Parliament should reject any legislative reform which will have the effect of:*
   - *eroding the rights of Australians with disability;*
   - *obstructing passage to the NDIS;*
   - *redefining reasonable and necessary supports; or*
   - *denying an unsuccessful applicant the right to an independent appeals process.*

2. *The use of Independent Assessments (IAs) – as currently proposed – as a proxy for functional assessments is clinically unsound, and they should therefore not be used as a gateway to the NDIS.*

3. *The IA pilot process should be halted until clinical authorities can better understand its relevance and impact on clients.*

4. *There should be rigorous and independent research into IAs, using consumer co-design methods in line with international standards. OTA believes this is the only way to ensure redesign and policy reform is appropriate, viable and sustainable.*

5. *The Federal Government should require the National Disability Insurance Agency (NDIA) to scrap its discriminatory panel of just eight approved Independent Assessments providers forthwith.*

6. *The NDIS Quality and Safeguards Commission should oversee the registration and conduct of all organisations undertaking eligibility assessments.*

7. *There should be distinctly separate mechanisms for determining eligibility and for the purposes of planning and budgets.*

8. *An NDIS participant's plan and budget should be determined by a process which includes a comprehensive functional assessment carried out by an allied health professional working strictly within their scope of practice and bringing their professional expertise and powers of clinical reasoning to bear.*

9. *OTA strongly recommends referral to an occupational therapist to determine what is required to optimise participants' function and what interventions, modifications and/or assistive technology is needed, in order to provide accurate estimates for personalised budgets.*

10. *There should be a robust and independent appeals process in place for unsuccessful applicants to the NDIS.*

11. *If reassessment is required to determine eligibility for the NDIS, the participant should be offered a comprehensive needs assessment with an experienced clinician who can use their clinical reasoning and problem-solving skills to understand the discrepancy between the assessed need and actual need.*

12. *The NDIA should consider the National Endorsed Assessor Team (NEAT) as an alternative model for assessing eligibility for the NDIS.*

The role of occupational therapists in the NDIS

Occupational therapy is a person-centred health profession concerned with promoting health and wellbeing through participation in occupation. Occupational therapists achieve this by working with participants to enhance their ability to engage in the occupations they want, need, or are expected to do; or by modifying the occupation or the environment to better support their occupational engagement. Occupational therapists provide services across the lifespan and have a valuable role in supporting participants affected by developmental disorders; physical, intellectual, chronic and/or progressive disability; and mental health issues.

Given their expertise and area of practice, many occupational therapists deliver services funded by the NDIS. Services focus on promoting independence in activities of daily living and enablement of social and economic participation. These services may include functional capacity assessment and intervention; disability-related chronic disease management; prescription and implementation of assistive technology and/or environmental modifications; mental health interventions; positive behaviour support; driving assessments (when specifically trained to do so); and targeted, goal-focussed rehabilitation.

Significantly, occupational therapists are highly skilled in assessing the degree to which a person's disability affects their level of function in daily tasks. Based on these assessments, occupational therapists make recommendations for, and then deliver, interventions that enhance and maintain an individual's functional capacity.

The current threat to the NDIS

OTA is concerned that IAs as currently proposed, and upcoming changes to the legislation which underpin the scheme, are quite deliberately aimed at reducing the scope of the NDIS and the range of its supports and, in so doing, undermine the rights of Australians with disability.

Proposed reforms also threaten the definition, and the centrality, of the “reasonable and necessary” supports which were supposed to be at the very heart of the scheme, and are fundamental to enabling Australians with disability to lead richer lives.

It appears that those driving these changes are aware that they run counter to the original vision for the NDIS; why else are they also proposing there be no independent appeals process for those found to be ineligible for the scheme?

Despite earlier assurances to the contrary, it has now been confirmed that IAs will be used to inform plans and determine budgets. And they will also be regularly required of existing NDIS participants, again in violation of earlier assurances. IAs have in effect become a means to cheapen the entire scheme and, in so doing, cheapen the participant’s experience by reducing the likelihood of meaningful engagement in activity.

While this submission focuses on the proposed model for IAs, it is imperative that Committee members be mindful of the legislative reforms that are being progressed in tandem with the assessments and which threaten the very purpose of the scheme.

OTA implores the Australian Parliament to reject any legislative reform which will have the effect of:

- eroding the rights of Australians with disability;
- obstructing passage to the NDIS;
- redefining reasonable and necessary supports; or
- denying an unsuccessful applicant the right to an independent appeals process.

NDIS Independent Assessments – the background

On Friday, 28 August 2020, the then Minister for the NDIS, the Hon. Stuart Robert MP, announced several changes to the scheme’s existing arrangements.

These included the release of a new Participant Service Charter and Participant Service Improvement Plan, which set out how the NDIA will deliver on the Participant Service Guarantee. These reforms set new services standards and clearer timeframes for decision making by the NDIA.

While these reforms are welcome, and in line with the recommendations of the review of the scheme conducted by Mr David Tune AO PSM, one new reform is of considerable concern to OTA members and their clients.

This is the rollout of new IAs, which will help determine eligibility for the scheme. In his media release, the Minister said IAs will:

> *… deliver a simpler, faster and fairer approach for determining a person’s eligibility right through to developing more flexible and equitable support packages.*

Very significantly, this was not a recommendation of the Tune Review.

Also significantly, the rollout of the assessments was announced before training modules for the assessments had been finalised, and without the release of all relevant data pertaining to a pilot project which informed the development of the eligibility screening tool.

Since July of 2020, OTA has been a member of a working group, commissioned by the NDIA and led by Allied Health Professions Australia (AHPA), charged with developing the training modules to enable select allied health professionals to become Independent Assessors for the NDIA, thereby helping improve access to the scheme.

The work of that group had not been completed at the time of the Minister's media release.

Such were OTA's concerns about these proposed assessments, we were drafting a letter to the Chief Executive Officer (CEO) of the NDIA about them when the Minister issued his media release. Accordingly, the letter was instead addressed to the Minister, and was sent on 31 August 2020.

As a result of that correspondence, OTA's CEO, Samantha Hunter, met with a senior official at the NDIA on Tuesday, 8 September, to voice the considerable concerns of our membership.

On Monday, 7 September 2020, the NDIA released its *Assessment of Functional Capacity for NDIS – Development and Framework*, usually referred to as its Functional Capacity Assessment Framework. This clinical tool is intended to support the Independent Assessor Panel.

OTA met with representatives of the NDIA to discuss our concerns regarding the Functional Capacity Assessment Framework. This is because it is not a functional assessment tool. It is at best a screening tool. And if it were a functional assessment, it would fall strictly within an occupational therapist's scope of practice, not a generalist's. Having said that, it remains a clinically flawed tool, something OTA continues to draw to the attention of the NDIA.

As a result of representations by OTA, the NDIA agreed to rename the tool. OTA remains concerned, however, that the NDIA continues to use this tool as if it were a functional assessment, and intends to use it as the basis for determining eligibility for the scheme.

OTA was also represented at a meeting of AHPA member associations and representatives of the NDIA on Thursday, 10 September, at which some of these concerns were addressed.

On Monday, 28 September, OTA conducted an online forum to hear the concerns of members around the proposed assessments. Feedback from that forum informed parts of OTA's submission to the Joint Standing Committee's inquiry into *General issues around the implementation and performance of the NDIS*.

OTA was one of scores of entities to raise significant concerns about the proposed IAs, and this was clearly a factor in the Committee's decision to conduct a standalone inquiry into the issue.

As a result of widespread concern about the proposed assessments, the NDIA in late 2020 postponed the launch of IAs until mid-2021, and announced that a consultation process about the proposed assessment model would be conducted in the interim. While the NDIA is to be commended for this, OTA is concerned that the agency continued to progress the implementation of IAs – and apparently in line with its pre-existing vision of the model – while undertaking this consultation.

This was effectively confirmed on 26 February, just three days after the deadline for submissions to the NDIA's own inquiries into independent assessment and planning arrangements, when the NDIA announced the successful tenders to perform IAs.

So, before the agency could possibly have absorbed and weighed the content of hundreds of submissions from concerned stakeholders, and fashion the IAs in line with this content, the NDIA had determined which providers were best able to deliver them.

It follows, therefore, that the views of interested stakeholders, some of them terribly vulnerable people, had no bearing whatsoever on the NDIA's decision making process around which providers are best able to assess, and in so doing, support these people.

This appears to confirm the fears of thousands of Australians that the NDIA is merely going through the motions of consultation.

As one OTA member observed:

> *Offering companies 3yr contracts when the IA/reforms are not legal under the current NDIS Act; prior to considering sector feedback provided through a consultation that closed two days prior on Feb 23rd; and prior to a scheduled Parliamentary Inquiry, is undemocratic at best.*

Despite its undertakings to consult meaningfully, the NDIA has still not addressed concerns raised by OTA on numerous occasions and in numerous forums. This includes in the aforementioned correspondence to the former Minister for the NDIS, the Hon. Stuart Robert MP, our submission to the Joint Standing Committee's inquiry into *General issues around the implementation and performance of the NDIS*, and our two submissions to the NDIA in February of this year.

So, yet again, OTA raises three basic, unresolved issues around the proposed IAs.

First is the use and interpretation of IAs by professionals not trained to functionally assess clients carrying out occupational activities and tasks. The use of IAs as a proxy for functional assessments is clinically unsound, and they should therefore not be used as a gateway to the NDIS.

While we have been reassured that it is an eligibility screening process, the NDIA until recently used terminology pertaining to functional assessment, a practice that misled all stakeholders.

Functional assessments as occupational therapists know them, require a distinct skill set that is core to occupational therapy practice. They cease to be a reliable or valid means of assessment if used by other professional groups in the diminished way currently proposed by the NDIA.

Observation of a participant carrying out a task cannot be reliably interpreted as a valid method for determining functional capacity unless the Independent Assessor is a qualified occupational therapist using specific professional reasoning, detailed task analysis, risk management and assessment tools.

Second, how useful, reliable and valid are the proposed tools in determining eligibility?

And third, how effectively does the IA capture the needs of an individual?

Understanding the detail and nuances of a person's situational context has a substantial bearing on their functional capacity, and ultimately their eligibility for NDIS. This includes their health, additional disabilities, education, work and life experiences, physical or built environment, community environment, family and social supports and economic situation.

Generic measurement tools are limited in their capacity to detect and/or predict individual functional capacity and support needs because the characteristics and impact of disability are uniquely variable (WHO 2020; Madden et al., 2015). Occupational therapists are uniquely placed to carry out these assessments because they are trained in task analysis of cognitive, physical and psychosocial assessment components.

OTA believes there are two possible outcomes which give rise to concern.

The first is that the assessments will be perfunctory, with the focus on throughput rather than clinical decision making. The use of a checklist, and the expectation that the assessor will not bring their powers of clinical reasoning to bear on the exercise, suggest this will be the case.

By all means, facilitate the process of determining eligibility for the scheme, but not by means of a flawed tool.

As one OTA member remarked after the Minister's announcement:

> *How can a complex functional assessment be completed appropriately, and in enough depth, to inform plan funding, in 1 to 4 hours with only a minimum of 20 minutes of observation (as per tender documentation)?*

The other possibility of concern is that the proposed assessments will in fact prove a barrier to accessing the NDIS.

Improving access to the NDIS

OTA appreciates the need to improve access to the NDIS and hopes that this is indeed the ultimate driver for the development of the eligibility screening model. OTA is on the record as supporting more timely and equitable access to the scheme and is acutely aware that, too often, a potential participant's socio-economic status plays a big part in whether or not they make it onto the scheme. One of the commendable features of the proposed IAs is the fact that, for the first time, eligibility screening will be free of charge – something that will address one of the real injustices of existing arrangements.

OTA remains concerned, however, that the tools proposed, and the workforce proposed, are unsuited to the task of measuring the functional impact of disability.

OTA is concerned that systemic safeguards protecting access to reasonable and necessary support for people with disabilities are not clearly articulated under the proposed NDIS reforms (Cummins 2021). OTA is concerned that the solutions outlined in the NDIA's Consultation Paper will further entrench inequity and lead to more harm than good (NDIS 2020a & 2020b; Barr et al., 2015; Cummins 2021). Equally, if the foundations and/or legislation of the NDIS are changed, there is a serious risk that the economic gains the Productivity Commission anticipated may not eventuate (Australian Government Productivity Commission n.d).

The impact of disability on activity, participation and quality of life is so uniquely experienced, and these interrelated and multifaced factors are rarely detected in brief screening assessments or generic measurement tools (Madden et al., 2015; WHO, 2020). These factors are important considerations for determining eligibility and are core to the spirit, purpose and scope of the NDIS (Australian Government, 2013a, 2013b & 2013c). We do not see any evidence that these factors have been considered in the recent pilot and we have serious concerns about the ethics, validity and implementation of the pilot project that underpins this significant change in practice (NDIS, 2020a & 2020b).

It is unclear, therefore, how the eligibility screening process will improve access to the NDIS. Rather, it involves a layer of screening that will likely exclude many potential participants from the scheme before a proper assessment has been conducted.

In light of the potential for a conveyor belt approach to assessment, any IA should be followed by a proper functional assessment of the client by clinicians working strictly within their scope of practice. No potential participant should be excluded from the NDIS without this second, comprehensive and clinically credible functional assessment.

These concerns and others are elaborated on below, in line with the Joint Standing Committee's terms of reference.

A. The development, modelling, reasons and justifications for the introduction of independent assessments into the NDIS

OTA is gravely concerned that the IA model itself, as distinct from the training modules that will support it, was initially developed and put out to tender by the NDIA without a comprehensive process of consultation, as a fait accompli; certainly, OTA and AHPA were not consulted.

Given that functional assessment is a core skill of occupational therapists, this failure to engage with their professional association represents a remarkable oversight on the part of the NDIA. While the NDIA maintains that the IAs are not functional assessments, they are in effect an attempt to measure functional capacity and, as such, occupational therapists should have been intrinsically involved in their development.

Of further concern is the fact that this large scale reform of the NDIS has been justified on the basis of two pilots conducted by the NDIA, neither of which would meet Australian research standards.

Indeed, OTA was dismayed by the NDIA's conduct around the two pilots. The agency initially withheld data from the first pilot, until forced by public outcry to release it. Once released, the data proved to be patchy, calling into question the scientific rigour, and therefore the validity, of the exercise.

Half-way through the second pilot, the NDIA sought to attract participants by offering them payments of $150; this suggests the agency up to that point had been unable to attract sufficient participants to render the exercise credible.

OTA members have identified the following key concerns around the ethics, validity and implementation of the pilot studies.

Informed consent

It is unclear how well-informed participants were of:

- The intended purpose of the pilots;
- Their right to refuse participation without negative ramifications; or
- How their personal data would be stored and used, including whether or not it would inform their current or future NDIS plan.

For example, the IA pilot consent form indicates that participants' data will be disclosed to a third party, without specifying what information will be shared or why. It also states that the IA pilot data will be stored in a Canadian server, without explaining the implications on participant privacy. This implies participants were not in a position to give informed consent.

Potential for harm

Anecdotal evidence suggests that confusion around the IA pilots – including their intended purpose, implications on plan funding and repeated requests for participation – has been highly distressing for participants and their families.

The IA itself involves a lengthy interview of up to 3.5 hours; observation by an assessor who is unknown to the participant; and completion of a series of standardised assessments which explore the highly sensitive subject of functional capacity and, by default, involve participant disclosure of functional deficits due to their disability. This is not routine care or process for NDIS participants. It is reasonable to assume this could be stressful or traumatic, especially given the uncertainty around whether the NDIA obtained informed consent from participants.

There is no publicly available information on what external supports or complaint avenues, if any, were available to participants in the pilot studies.

Transparency

The current pilot examines participant satisfaction with the proposed IA process, rather than satisfaction with – or accuracy of – the findings of an IA. It is difficult to understand how a national policy for accurately assessing eligibility for the scheme, or ongoing support needs, is to be developed based on these findings.

More broadly, there is a lack of clarity around how data from either of the pilots will be used to inform NDIA policies around eligibility and planning. This has caused significant uncertainty and distress for participants, families, carers and providers.

Generalisability

If the outcomes of the IA pilots are to be used to inform large scale policy reform, they should be based on a representative sample of NDIS participants. Instead, both pilots have relied on individuals self-selecting to participate. This means the samples are likely to be biased towards participants with higher levels of functional capacity and self-advocacy skills.

OTA also notes that a very small percentage of participants in the first pilot study had a psychosocial disability. This, too, indicates that the pilot findings would not be generalisable to the wider NDIS population and should not be used in isolation to inform a national policy.

Conflict of interest

There is a potential conflict of interest if the organisation conducting the research has a vested interest, including financial interest, in the outcomes of the study. For this reason, OTA believes the IA pilot should have been overseen independently of the NDIA.

It would also be highly inappropriate for providers to have participated in the IA pilot whilst actively competing for the IA tender, as is confirmed to have been the case.

HREC

Above all, an independent Human Research Ethics Committee (HREC) should have been engaged to oversee the ethical conduct of the IA pilots, including: evaluation of risk to participants; informed consent; data record and management; publication of findings; potential conflicts of interests; and allegations of research misconduct.

This assertion is based on strong evidence that the IA pilots do not reflect routine quality assurance undertakings but, rather, a piece of human research.

According to the National Statement on Ethical Conduct in Human Research (2007), human research is that which is conducted with or about people, including: taking part in surveys or interviews; undergoing psychological or other forms of assessment; and being observed by researchers. This aligns closely with the activities undertaken as part of the IA pilots.

OTA would also argue that the pilots were not necessarily low-risk for participants; that they did not reflect routine processes or data gathering; and that there was an intention to publish some or all of the results – all of which denotes research requiring ethical considerations.

OTA believes the pilot process should be halted until clinical authorities can better understand its impact on clients. There should be:

- Proper, clinically driven evaluation of data;
- A broader cohort; and
- More rigorous design, including consumer input into methodology.

B. The impact of similar policies in other jurisdictions and in the provision of other government services

There is a notable precedent for harm associated with large-scale eligibility assessment delivered through checklist-based assessment.

In England between 2010 and 2013, just over one million recipients of disability benefit had their eligibility reassessed using a new functional checklist: The Work Capability Assessment. Soon after, researchers at the University of Liverpool undertook a population level study to investigate concerns that the program had had an adverse effect on the mental health of claimants.

Following the study, researchers concluded that the Work Capability Assessment program was independently associated with an increase in suicides, self-reported mental health problems and antidepressant prescribing (Barr et al., 2015). Furthermore, the greatest increases in adverse mental health outcomes occurred in the most deprived areas of the country, thereby widening existing health inequalities (Barr et al., 2015). Significantly, the researchers noted that these adverse mental health outcomes could outweigh any benefits that arise from moving people off disability supports.

OTA notes that there are clear parallels between the Work Capability Assessment programme and the NDIA’s proposed use of IAs to assess people’s eligibility for the scheme, and then to periodically reassess their eligibility for supports on an ongoing basis.

In light of the English experience, it beggars belief that the NDIA would move to implement these reforms without due consideration of the potential risks involved. These include, but are not limited to:

- Higher incidence of mental health problems and suicides;
- Widening of existing inequities in health outcomes; and
- Undermining of the gains predicted by the Productivity Commission when it recommended the introduction of the NDIS.

C. The human and financial resources needed to effectively implement independent assessments

OTA is concerned that the implementation of the IA toolkit for determining eligibility, planning and budgets in lieu of comprehensive functional assessments will create delays and cost more to the client and NDIS in the long run. At some point comprehensive allied health assessments are required to determine an individual participant’s needs, goals, aspirations, reasonable and necessary supports, interventions based on their potential to improve functional capacity and/or adapt to their circumstances and/or adapt to the physical, psychosocial environment in which they live.

IAs are simply not fit for this purpose, so at some point a comprehensive assessment will need to be factored into the process.

It would be a personal tragedy for participants, and a stunning example of incompetent public policy, if IAs prove ultimately to be a false economy while throwing clinical considerations out the window and subjecting some of Australia's most vulnerable people to great distress.

D. The independence, qualifications, training, expertise and quality assurance of assessors

OTA is acutely aware of workforce shortages across the sector and the impact this has on a person's capacity to access the scheme. OTA supports a model of engaging allied health providers with the relevant background, experience and training to improve timeliness of eligibility screening.

However, OTA must emphasise that the model as currently proposed is clinically unsound. Even if only used to test eligibility for the scheme, IAs should be carried out by allied health practitioners acting strictly within scope of practice. A physiotherapist should not be assessing a person with Autism Spectrum Disorder, as has happened during the IA pilots.

It is of great concern that in its response to the public consultation process, at page 15 of its report on Access, the NDIA clearly states that any assessor will be able to perform any assessment, regardless of the disability being assessed and the assessor's professional background. This is clinically unsound and, OTA understands, represents a departure from the agency's position in earlier discussions between the agency and AHPA.

OTA also rejects categorically claims that a stranger assessing an applicant is preferable to an allied health professional known to and trusted by the applicant, owing to considerations of "sympathy bias". OTA strongly endorses AHPA's recommendation in its submission to the Joint Standing Committee that the Australian Government and the NDIA:

> *Formally retract claims that allied health professionals are unduly impacted by sympathy bias and acknowledge the value of ongoing relationships between participants and health professionals as a foundation for quality care and appropriate assessments.*

When assessment of a person's occupational performance is deemed necessary, OTA would strongly recommend referral specifically to a registered occupational therapist. This is because occupational therapists are uniquely qualified to assess a client's ability to engage in the activities and tasks they want and need to do, including both productive occupations and social and community activities.

As of February 2020, the NDIA has contracted eight organisations to provide IAs, thereby limiting the pool of assessors available and ultimately limiting participant choice – supposedly a key tenet of the scheme. These assessors may or may not have the relevant background or experience to effectively assess all cohorts, particularly those who are vulnerable and/or those with complex needs from an area of practice in which the assessor is not experienced.

OTA asks, who is overseeing the IA workforce? There appear to be no NDIS Quality and Safeguards Commission standards in place to ensure oversight and accountability around the implementation of IAs or their interpretation in informing eligibility or budget decisions. This is particularly galling, given the onerous credentialling demands placed on NDIS service providers by the Commission and multiple layers of government.

Accordingly, OTA recommends that the NDIS Quality and Safeguards Commission oversee the registration and conduct of all organisations undertaking IAs.

An alternative model

OTA believes that Australians with disability have a right to best-practice assessment of their individual needs. Any eligibility assessment model must uphold principles of choice and control, trauma-informed care, inclusion of existing support providers, and participant co-design.

Practically, it must also:

- Create access to experienced professionals;
- Be cost effective; and
- Have demonstrable ‘reach’ to Australia’s most vulnerable people with disabilities, and to our most remote communities.

It is clear that the IA model put forward by the NDIA fails to meet these criteria.

In its recent submissions to the NDIA, OTA provided the agency with an alternative model for IAs. The model would involve a preliminary interview to identify clients’ concerns, needs and goals. An Independent Assessor with appropriate training would carry out these preliminary interviews, gathering information and, where required, referring the client on for appropriate assessment by clinicians working within their scope of practice.

In the same submission, OTA expressed its willingness to assist the NDIA to develop a model for training or endorsing assessors to carry out eligibility screens. Given that the successful tender applicants were announced just three days later, it is doubtful that this alternative model or offer of assistance was seriously considered by the NDIA.

A summary of OTA’s proposed National Endorsement Assessor Team (NEAT) model is outlined below for consideration by the Joint Standing Committee.

To uphold the integrity of the original intent of the NDIS, the model must include participant support-need identification. The Productivity Commission (2011), strongly recommended support needs identification as an essential step in budget determination. Without this, plans and budgets cannot meet the individual needs of participants. The Disability Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Interim Report 2020), highlighted that access to suitably tailored supports and access to adequate funds, are preventative of harm to people with disability. Removing support-needs assessment places NDIS participants at risk of preventable harm.

Once a new program is rolled out universally across the country, the opportunity to carry out methodologically rigorous research with appropriate controls is lost. Previous changes to the NDIS, have been substantially trialled within distinct geographical areas, enabling sound test-and-refine model development. This has not occurred with IA, which has undergone limited piloting. Ethical concerns have been extensively documented regarding the pilot program, which has trialled the assessment process only, not the substantial changes to participant plan budgets (refer to OTA response to Term of Reference A above).

There is merit in further exploring alternative allied health models which are consistent with the principles identified above, and that may hold practical advantage, such as cost-effectiveness, and importantly, superior ‘reach’ to our most vulnerable people and communities. Examining Medicare models of allied health service provision that strive for universal access, demonstrates the value of skill endorsement programs enabling access to skilled and experience allied health professionals, while retaining choice of provider.

Access to skilled mental health professionals for people with psychosocial disability is a case in point. The *Better Access to Mental Health (BAMH)* initiative is an example of a program with proven capacity to deliver equitable access to mental health professionals in rural and socioeconomically disadvantaged areas. A 2011 study found very similar rates of service use for capital cities, other metropolitan areas and rural centres. When socioeconomic disadvantage was examined, rates were around 10 percent lower in the most disadvantaged areas when compared with the least disadvantaged.

Despite these remaining inequalities, it is notable that the scheme has greatly increased access to services across all sections of the population, including people living in rural, remote and socioeconomically disadvantaged areas. The ‘reach’ of this type of model exceeds what can possibly be delivered by a small number of government contracted providers drawing on an inexperienced workforce.

Considering a National Endorsed Assessor Team (NEAT) to deliver functional assessment

OTA asks that the NDIA consider the National Endorsed Assessor Team (NEAT) as an alternative model for assessing eligibility for the NDIS. The NDIA, in consultation with stakeholders, could develop a functional assessor endorsement program, which appropriately skilled and experienced allied health professionals could choose to undertake in order to qualify to assess eligibility for the NDIS. The model would not require costly establishment of a new national service infrastructure, as it would use the existing provider base. This would ensure functional assessments are completed by experienced allied health professionals, including mental health professionals for people with psychosocial disability.

An assessor endorsement program would meet the NDIS requirements of a more consistent approach to assessment, while enabling participants and applicants to retain choice and control of provider. Assessors would be empowered to utilise their professional judgement and clinical reasoning skills.

This model would prevent costly duplication of assessment process, as the functional assessment would include tailored, needs-specific recommendations for supports. This is particularly important if the NDIA expects data obtained from IAs to inform plan funding. (Refer to OTA's submission to the Planning Consultation Paper for further discussion around plan funding). Conflict of interest concerns could be mitigated by the assessor being prohibited from providing therapeutic support or services in the proceeding term of the NDIS-participant support plan.

The NEAT model would not require costly establishment of a new national service infrastructure, as it would use the existing provider base. This would ensure functional assessments are completed by experienced allied health professionals, including mental health professionals for people with psychosocial disability.

Independent Assessment Panel (IAP) Model	**National Endorsed Assessor Team (NEAT) Model**
Establishes a limited panel of government-contracted private organisations to provide a function/eligibility screen.	Establishes a standardised, regulated endorsement program to qualify suitably skilled and experienced existing providers to provide comprehensive functional assessment, including identification of support needs.
Creates a compliance/eligibility-focused institution with an emphasis on being 'disabled enough,' which may be stigmatising for participants.	Delivers an integrated community model with a focus on quality assessment and expert needs identification.
Generic, disability 'neutral', approach to function/eligibility screen.	People with disability can access assessors with disability-specific expertise and ability to accurately determine support needs.
Functional screen only – no support need identification, meaning support needs will require an additional assessment. This results in duplication and is less person-centred.	One functional capacity assessment, including support needs identification. To offset conflict-of-interest, assessors cannot provide further service to the participant for the term of future NDIS plan.
Limited choice of panel providers.	Choice and control of provider preserved.
Generic workforce, no minimum experience or disability specific experience required.	Skilled workforce, with defined standards of skills and experience required e.g. minimum 3 years disability-specific experience.
Disrupts and erodes emerging allied health provider base.	Builds the emerging allied health NDIS workforce, which is especially important in areas with thin markets.

E. The appropriateness of the assessment tools selected for use in independent assessments to determine plan funding

OTA is fundamentally opposed to the use of the proposed toolkit for determining personalised budgets and plan flexibility. The toolkit is based on standardised self-report items linked to broad conceptual domains, not the client's individual circumstances, needs and goals which are purported to be core to the intent of the scheme (NDIS 2020a, 2020b & 2020d). This disparity is extremely concerning when there seems to be such heavy weighting towards the IA in informing personalised budgets and plan flexibility.

Moreover, it is entirely inappropriate to determine a person's eligibility for NDIS supports – or their ongoing level of support needs – using a set of tools which were neither designed nor validated for this purpose.

OTA has the following overarching concerns with the proposed toolkit:

1. **Construct validity:** There is a lack of evidence, in Australia or internationally, that the chosen toolkit can accurately measure a person's functional capacity and thereby determine their support needs.
2. **Disability-neutral approach:** There is a lack of evidence, in Australia or internationally, to support the assumption that functional capacity can be measured with a disability-neutral approach. It is important to note that the WHO themselves endorse the use of disability-specific assessments that are contextualised to the nuances of the individual circumstances of people with disability (WHO, 2020).
3. **The full picture:** Even used cumulatively, the proposed tools will fail to capture a significant amount of information about an applicant's current and ongoing support needs. In particular, the tools do not effectively account for:
   - Upper limb impairment, fatigue, chronic pain or the need for assistive technology;
   - The functional impact of psychosocial disability, such as interpersonal and role functioning (e.g. parenting);
   - The fluctuating nature of some disabilities, including how this interacts with environmental factors;
   - Most situational variables (e.g. homelessness, unemployment and dual physical disability); or
   - The interface of diverse cultural perspectives and environmental factors that impact on activity, participation and community integration.

These limitations are demonstrated in **Case Study 1**.

Case Study 1: Limitations of IA Toolkit

If I were to assess adult client X using the assessment tools only, the NDIA would not know that:

- *She can drive some of the time (i.e. in the mornings but not the afternoons or evenings);*
- *If she drives too far or for too long, her husband has to come and get her out of the car and carry her into the house;*
- *She needs help with dressing about fifty percent of the time. This is currently done by her husband who works full time and helps care for their two children, who are also NDIS participants.*
- *She has difficulties swallowing and sometimes aspirates;*
- *She has a lot of difficulty chewing; all of her food must be pureed, which she cannot do herself;*
- *She loses her voice when she is tired, emotional or has run out of energy;*
- *She has to have maintenance treatment (infusions) once every four weeks to give her body enough fuel to fight her autoimmune disorder;*
- *She uses her daughter's shower chair and other toilet aids on her really bad days which, depending on the point during her four-week treatment cycle, could be one per week or every day;*
- *Some days she struggles to wipe her own bottom after a bowel movement;*
- *She used to work full time but now struggles to do one hour every second day;*
- *She is responsible for her two children five days a week while they do distance education from home;*
- *She lives regionally and out of town, away from community supports;*
- *Her friends live too far away to provide "at the drop of a hat" support;*
- *She needs to hold her husband's hand when walking in town because she is unsteady on her feet and her legs sometimes give way;*
- *She has had multiple falls in the last twelve months;*
- *She doesn't have a wheelchair yet, though she desperately needs one;*
- *She cannot cook for herself or her children six out of seven days per week, relying on the freezer being stocked with meals prepared by her family who live 300 kilometres away; and*
- *She can sometimes put on a load of laundry but will struggle to get it out of the machine and could not hang it on the line.*

Without this information, the NDIA could not accurately estimate the support needs of adult client X to determine plan funding.

OTA has also identified the following limitations associated with each specific tool.

CHIEF

- Intended to measure environmental factors, not functional capacity.

Vineland-3

- Intended to measure adaptive behaviour, not functional capacity.
- Inappropriate for people without cognitive or intellectual impairment and invalid for psychosocial disability where the impairment is due to mental health issues.

- Typically administered through a proxy, which some applicants may be uncomfortable with and/or unable to provide.

WHODAS-2

- Does not comprehensively assess functional capacity to engage in self-care activities (e.g. to wash; get dressed; or plan, organise and prepare a meal).
- Does not address a person's capacity for economic participation, including work and study, if the person is not already engaged in these activities.
- Insufficiently addresses fluctuating nature of many disabilities, as it only considers experiences within the past thirty days.
- Questions are vague and can be hard for some applicants to understand.

LEFS

- Only useful for applicants with lower limb physical disability.

To date, OTA has not been able to determine how the raw assessment scores from these tools will be collated and/or interpreted in a meaningful way to inform a realistic personalised budget estimate.

OTA also notes that many of the proposed tools do not record what supports were in place when the participant achieved the recorded level. For example, an individual might score highly on WHODAS only because they have an existing support in place which enables them to complete a certain task. Based on the WHODAS score, NDIA would not be aware of this caveat and, by extension, a participant's actual support needs.

The proposed assessments also do not document in any real way a description of the disability, related comorbidities or risks for disability-related health needs. It is difficult to understand how this information could be used in isolation to inform a participant's budget.

OTA is deeply concerned that budget estimates will rely on the use of arbitrary criteria aligned to 'scores' generated from the IA tools and matched to predetermined budgets, rather than being determined by the participant's support needs and goals.

As noted by an OTA member:

> *If a person on the autism spectrum received a particular 'score' because they needed a carer for ADLs [activities of daily living], and a person with tetraplegia received a particular 'score' because they needed a carer for ADLs, this actually tells you nothing about the budget for care supports for either of them. Certainly, they are unlikely to require the same budget.*
>
> *The person on the spectrum may just require someone for one hour for prompting and timekeeping or, if they have challenging behaviour, may require two people for two hours. Conversely, the person with tetraplegia may have specific continence and skin care requirements; they may need two-person manual handling. This could take between two and three hours. Or they may just need assistance of one with set up in the environment and bowel care but be independent in transfers and other tasks.*

> *None of that is recorded anywhere, so I cannot begin to imagine how you could generate a budget.*

It seems that the assessment tools, rather than participants, are driving the agenda. Too much weight has been placed on the tools and not enough on the participants' needs, goals and/or aspirations.

Instead, a participant's plan and budget should be determined by a process which includes a comprehensive functional assessment carried out by an allied health professional working strictly within their scope of practice and bringing their professional expertise and powers of clinical reasoning to bear.

OTA strongly recommends referral to an occupational therapist to determine what is required to optimise participants' function and what interventions, modifications and/or assistive technology is needed, in order to provide accurate estimates for personalised budgets.

F. The implications of independent assessments for access to and eligibility for the NDIS

It is unclear how the proposed IA model will improve access to the NDIS. Rather, it involves a new layer of screening that risks excluding many potential participants from the scheme before a comprehensive assessment has been conducted.

OTA is particularly concerned that the applicant's first experience of the NDIS will be based on the objective collection of a substantial amount of data that by nature is impersonal. This is particularly so because, as noted above, the proposed assessment tools are primarily based on standardised self-report items linked to conceptual domains, as opposed to the nuances around the client's individual circumstances, needs and/or goals.

This is of particular concern when the client does not already know the assessor, when they are unable to effectively engage in the process and/or when they have limited capacity to complete self-report measures.

For example, OTA holds serious concerns for those clients who are particularly vulnerable because of the extent of their:

- Communication and comprehension difficulties;
- Psychosocial disability;
- Social disconnection, e.g. homelessness; and/or
- Aboriginal and Torres Strait Islander (ATSI) or Culturally and Linguistically Diverse (CALD) background.

Mandating that people with disability engage in an IA process which they do not have the functional capacity to complete creates a procedural and systemic barrier to access and participation in the NDIS. It is essential that people who cannot engage in an IA are offered an alternative pathway to access the NDIS.

In fact, it is highly likely that the proposed IA model will exacerbate rather than alleviate inequitable access to the scheme. This is because people of higher socioeconomic status typically have greater self-advocacy and negotiation skills to navigate complex systems.

This assertion is supported by Executive Director of the Melbourne Disability Institute and former NDIA Chairman, Professor Bruce Bonyhady AM (2021, p. 10-11), who writes:

> *It [the proposed IA Model] is also likely to generate inequity, as those who are better educated or more knowledgeable about the underlying assumptions of the questions will be more successful in detailing their impairments in a particular way...*
>
> *…questions which are being piloted, such as "Can you dress yourself independently?", frequently cannot be answered with a simple "yes" or "no". Without further information and context, simplistic responses risk misleading or inaccurate scores.*
>
> *This jeopardises the validity of the entire assessment – and the resource allocation which will follow it. Consequently, the current piloting of IA leads to major questions about whether it will in fact result in improved equity and fairness.*

OTA strongly encourages the Joint Standing Committee to review the response to the NDIA's Consultation Papers by the Melbourne Disability Institute in full.

OTA also strongly objects to participant observations being used in the IA as a proxy for a functional assessment. The NDIA IA document, which outlines the evaluation of all tools, specifically states that assessments that require a person to "perform" or to be observed performing a task will not be included in the toolkit. Despite this, the NDIA is requesting that the assessor does just this.

This type of observation is likely to have only limited usefulness in determining eligibility when it is based on a component activity that may or may not relate to the client's typical daily routines. Moreover, if the assessor is not trained or qualified to functionally assess task performance, there is also the potential for harm due to inappropriate activity choice and/or failure to draw appropriate conclusions from the observation.

G. The implications of independent assessments for NDIS planning, including decisions related to funding reasonable and necessary supports

OTA recognises the importance of having clear criteria across the sector to ensure there is consistency and transparency in the way personal budgets are set. However, OTA is deeply concerned that with the introduction of IAs, the criteria for determining this has moved from what is a 'reasonable and necessary support' to what is 'reasonable and necessary funding'.

While this may appear to be a subtle shift in language, it reflects a profound change in NDIA policy; from a personal budget being determined by a participant's individual needs to its being predetermined by a standardised funding model. OTA has serious misgivings about this shift of focus.

This is particularly concerning if the personal budget is informed by the proposed IA tools in the absence of a comprehensive needs assessment; if a draft budget is likely to be determined before there has been any real engagement with the participant; and if there are limited options for the draft budget to be changed once it has been determined.

It should be a matter of grave concern to JSC members that recent media coverage of draft legislation to reform the NDIS indicates that the Federal Government is considering the abolition of the reasonable and necessary test (*Sydney Morning Herald*, March 26). This would strike at the very purpose of the scheme, doing away with the tailored nature of supports and reducing people with disability to a type rather than an individual. (It should be noted that the same article mooted the possibility that references to “co-design” would be removed from the legislation, thereby potentially marginalising stakeholders.)

It would appear that, regrettably, IAs are just one aspect of a broader assault on the individualised nature of NDIS supports.

There appears to be a de-emphasis by the NDIA of participants' goals and aspirations, as well as their social and economic participation. This is because the tools selected by the NDIA are inherently deficit-centric, focussing on what participants cannot do, as opposed to what they have the potential to do with the necessary supports.

As a result, budgets will be inadvertently aligned with a deficit-focussed model of disability, which emphasises disablement rather than individualised supports to enable social and economic participation. This would be a clear departure from a fundamental purpose of the NDIS and from the principles of the United Nations Convention on the Rights of People with Disability, to which Australia is a signatory (NDIA, 2021; Mannan, 2012; UN, 2007).

Moreover, OTA is deeply concerned that these changes will result in people with disability receiving inadequate funding. When funding is inadequate, participants will be forced to use available funds to sustain basic, daily core supports, to cope and survive. There may no longer be sufficient funds to support capacity building; to reduce the need for core support; or to transition from simply coping to engaging in active social participation. This is not consistent with the original purpose or spirit of the scheme.

In essence, OTA believes that the rollout of IAs will mean many participants no longer receive the reasonable and necessary supports promised by the NDIS. This is due in part to the shortcomings of the proposed toolkit and model; in part to a deliberate shift in policy by the NDIA, presumably aimed at lowering the ongoing cost of the scheme.

Once again, OTA notes that the proposed reforms are likely to disproportionately affect those with less capacity to engage in the IA process, exacerbating the very inequities which the IA was intended to resolve.

Moreover, the apparent prioritisation of core supports over capacity building supports – those which build independence and skills to help participants to participate socially and economically – is likely to cost the scheme more in the long-term. For example, the NDIA may end up funding a support worker to assist with a particular task for the lifetime of the participant, rather than a limited number of occupational therapy sessions which could enable the participant to complete that task independently.

H. The circumstances in which a person may not be required to complete an independent assessment

OTA is extremely concerned that the IA tools have limited capacity to capture and/or accommodate for:

- The unique issues and needs of vulnerable client cohorts;
- The complex interplay of multiple disabilities and/or illnesses;
- Fluctuating capacity, and how this interacts with environmental factors;
- The needs of people with histories of homelessness;
- The experiences of disadvantage, abuse and trauma that many people with psychosocial disability have experienced;
- The unique needs of people affected by psychosocial disability (Cummins, 2021);
- The unique needs of people of CALD and ATSI descent.

OTA is also acutely aware that participants who have substantially reduced capacity in the domains of communication, social interaction and cognition (self-management) would not be able to participate in the proposed IA.

In each of these instances, OTA does not believe it is appropriate for the NDIA to mandate participation in an IA, either to assess eligibility for the scheme or to determine plan funding.

I. Opportunities to review or challenge the outcomes of independent assessments

While the legislation governing the NDIS requires the ultimate decision regarding a person's eligibility for the scheme to be made by an NDIA delegate, OTA is concerned that these delegates will not have even the training of the Independent Assessor.

So, as the process is currently envisaged, an allied health professional will be expected to conduct an assessment using the generalist tools developed, but not drawing on their years of clinical experience or their powers of clinical reasoning – in effect ticking boxes. That person will then forward the raw data to an NDIA delegate who may or may not be a clinician – the NDIA does not intend sharing that detail, nor even the percentage of NDIA delegates who are clinicians. The NDIA delegate, who may have no clinical background and who has had no particular training, will then decide whether the client is eligible for the scheme, basing their decision on data collected from tools not designed for this use and without knowing or seeing the client.

OTA is further concerned that the delegate will be making the final decision around an applicant's eligibility for the scheme using criteria that have not been made public. If the NDIA is so confident of the proposed IA process, why the constant secrecy?

Is this in the spirit of a scheme which is supposed to represent world's best practice in disability support and which the Productivity Commission estimates will ultimately cost about $22 billion a year?

Given this flawed decision-making process, it is unsurprising that concern has been raised about the fate of those people excluded from the NDIS as a result of an adverse IA outcome.

It is imperative there be a robust and independent appeals process in place.

In late 2020, postings on the NDIA website stated that decisions arising from IAs would be able to be appealed, but the site's FAQs page, designed to inform consumers in an easy-to-read fashion, lacked detail around any appeals process.

More recently, the NDIA has taken the position that the initial assessments will not be directly reviewable by the Administrative Appeals Tribunal (AAT). As currently envisaged by the NDIA, it seems the only route of appeal will be via another IA.

While the Commonwealth Government might seek to limit an unsuccessful applicant's access to the AAT, it cannot obstruct their access to higher courts. This gives rise to the possibility that, once again, those with sufficient means will be able to challenge adverse outcomes in the federal justice system. This creates issues of equity, the very problem IAs are supposed to address. Moreover, it gives rise to the possibility that legal precedent will be set around the fairness of the IA process itself.

OTA supports the retention of the AAT, or some other genuinely independent appeals process, and asks two questions.

First, who is the NDIA to make this call? Surely natural justice dictates there be an appeals process and that the body which has made a questionable judgement not be the entity which then decides whether and how this judgement is appealed.

Second, if the NDIA is confident of the fairness and efficacy of its proposed arrangements, why does it fear being held accountable for them?

Moreover, unless there is some sort of financial support for those wishing to appeal a decision, either through the AAT or some other independent body, we will end up where we currently are – in a situation where those with adequate means, and the capacity to engage advocates and lawyers, will likely fare much better than those without independent means. That, of course, is fundamentally unfair.

Significantly, OTA is advised that in the state of Victoria, the Transport Accident Commission and WorkSafe Victoria do provide financial support to prospective clients seeking to appeal adverse eligibility findings.

OTA strongly recommends that an independent appeals process be established and that all participants seeking an appeal are offered a comprehensive functional assessment by a suitably qualified occupational therapist and/or other allied health professional to provide a thorough profile of the participants' capacity and needs (WHO n.d; UN 2007).

No applicant should be excluded from the NDIS on the basis of an IA alone.

K. The appropriateness of independent assessments for people with particular disability types, including psychosocial disability

Many OTA members have questioned the appropriateness of IAs for those clients with rare or complex disabilities, and those with psychosocial disability.

Cognitive and psychosocial issues are poorly addressed in the battery of tools being proposed by the NDIA as part of the IA process. This is of considerable concern, given the great difficulty clients with mental health issues have had accessing the scheme to date.

Significantly, Mental Health Australia, of which OTA is a member association, has expressed concern that the measurement tools proposed are not appropriate for psychosocial assessment.

Consumer groups in the mental health space have also been advocating on this issue. They are concerned about the mandatory nature of the proposed assessments, and the fact that highly vulnerable people will be assessed by complete strangers rather than the health professional they have come to know and trust. And, of course, how can the often episodic and fluctuating nature of mental illness be assessed in the context of a one-off engagement, lasting one to four hours, and with as little as 20 minutes of clinical observation?

It appears that people with disability, particularly those with psychosocial disability and/or complex, fluctuating needs, are the most likely to be disadvantaged by this process. This will exacerbate existing inequities, as these cohorts are also less likely to be able to engage in the IA process or advocate for themselves (Barr et al., 2015; Carey, 2017; Cummins, 2021).

OTA refers the Committee to Appendix 1, *The Impact of Proposed IAs on People With Psychosocial Disability,* a comprehensive response developed by OTA member and mental health clinician, , in collaboration with a team of occupational therapists working with clients with psychosocial disability.

L. Any other related matters

The Panel of Approved Providers

As stated in our submission to the Joint Standing Committee's inquiry into *General issues around the implementation and performance of the NDIS,* OTA holds grave concerns about the future of those smaller occupational therapy practices which have been involved in assessment processes to date and might lose that work as a result of the NDIA's proposed reforms.

What we did <u>not</u> want, but what has already been summarily implemented by the NDIA, is a small panel of approved providers because, as OTA correctly predicted in this case, these comprise a few large, impersonal, multidisciplinary companies. And all too often, such arrangements – while bureaucratically convenient – result in the termination of longstanding and hugely beneficial clinical relationships between highly experienced clinicians working in small practices with often very complex clients.

The victims of this discernible trend in public policy are twofold. First there are people with disability who, while being promised unprecedented choice in an age of consumer driven care, are actually seeing their choice limited by public policy that is quite deliberately anti-competitive. Excluding qualified practitioners from whole fields of practice makes a mockery of all the rhetoric around consumer choice. Second, there are those service providers who, while perfectly competent and conscientious, don't make the cut and, as a result, are denied access to a reliable source of work.

As has happened in this case, none of the successful tenderers works in a small practice and none is a sole provider. So, the NDIA's policy with regard to its panel of approved IA providers is deliberately anti-small business.

Moreover, in the case of occupational therapists, more than 90 per cent of whom are women and many of whom work in small practices, the NDIA's policy is also anti-women.

The Federal Government should require the NDIA to scrap this discriminatory panel forthwith.

As revealed by ABC News on 25 March, successful tenderers for the delivery of IAs are, in some instances, subsidiaries of companies which provide services under the NDIS. So, the NDIA's arrangements to prevent conflicts-of-interest are being deliberately circumvented by large conglomerates. Moreover, the IA providers are advertising for employees on their parent companies' websites.

The Joint Standing Committee would also be aware that one of the successful tenderers is Allied Care Group, which is owned by Zenitas, whose CEO is Mr Rob De Luca. Mr De Luca was formerly the CEO of the NDIA.

Committee members should also be aware that a company called Plena Healthcare, which is another subsidiary of Zenitas, was called in to assist with the NDIA's second pilot project, without a tender process.

OTA believes such an arrangement is highly questionable. While we are not suggesting it is illegal, OTA asks what kind of message it sends to people with disability.

The newly appointed Minister for the NDIS should intervene immediately to restore the credibility of the NDIA in the eyes of Australians with disability, their carers and service providers.

Clinicians' professional responsibilities under relevant codes of ethics and conduct
Concerns have been raised by OTA members around the professional responsibilities of those allied health clinicians conducting the proposed IAs.

Given the deliberately un-clinical nature of checklists requiring nothing more than yes/no answers, and the inability of assessors to apply their powers of clinical reasoning to the often nuanced nature of a person's disability, OTA asks whether those performing the assessments will be in breach of their respective profession's code of conduct and/or code of ethics.

OTA members have rightly raised concerns about an arrangement which requires allied health professionals to administer a form of assessment which:

- does not align with their professional values;
- does not ensure decisions about access to care are free from bias and discrimination;
- is not founded on the best available evidence; and
- requires the allied health professional to work outside the limits of their competence and scope of practice.

This last point is of particular concern:

- when the work required of the allied health professional is not ordinarily in their scope of practice and no additional training or competency assessment has occurred;
- when there are significant limitations to the relevance, utility and appropriateness of the tools;
- when there is the potential to exacerbate inequity by creating additional barriers to accessing the scheme; and
- when, for all of the above reasons, there is the potential to cause substantial harm.

In the case of professions registered with the Australian Health Practitioner Regulation Agency (AHPRA), such as occupational therapy, OTA asks if Independent Assessors could be in breach of the relevant AHPRA National Board's Code of Conduct. Indeed, there have already been instances of complaints against Independent Assessors being made to AHPRA as a result of assessments being conducted as part of the pilots.

Irrespective of the answers to the above questions, it should be a matter of grave national concern that, as a result of deliberate Commonwealth Government policy, young health professionals will be required to ignore the fundamentals of their recent education, and the ethical basis of their profession, by processing highly vulnerable people in a manner which is at best cursory.

Use of IAs to reassess eligibility for NDIS supports
OTA understands the importance of reviewing the needs of participants and their NDIS plans to accommodate for superimposing fluctuation and/or deterioration of their condition.

However, OTA does not understand why participants' eligibility for the scheme is now to be reassessed routinely if the initial assessor has already deemed them to have a permanent, ongoing disability. OTA considers this an unnecessary impost on participants and is concerned that this will cause participants a high degree of uncertainty about the viability of their future. This is most alarming when the reassessment is based on generic tools that have limited capacity to discern individual needs or circumstances.

OTA also questions the circumstances and criteria for changing a participant's permanent disability status. If this does result in a participant being withdrawn from the scheme, we ask what mechanisms will be put in place to enable participants to re-enter the scheme as their needs change (UN, 2007).

If reassessment is required to determine eligibility, OTA strongly recommends the participant be offered a comprehensive needs assessment with an experienced clinician who can use their clinical reasoning and problem-solving skills to understand the discrepancy between the assessed need and actual need.

Submission to the JSC by the NDIA and DSS

OTA refers JSC members to the NDIA and Department of Social Services (DSS) submission to this inquiry.

OTA is concerned that a number of the positions put forward in the submission were misleading.

For example, on page 6, the NDIA and DSS make the following comment:

> *Importantly, the idea of independent assessments is not new. Evidence of a person's functional capacity has always been part of the NDIS and is embedded in the NDIS act as being a key input to decision making.*

This statement strongly implies that IAs have been validated as definitive "evidence of a person's functional capacity". This is simply not the case. Moreover, the fact that functional capacity is written into the legislation has no bearing on whether IAs can accurately capture a person's function, much less determine their eligibility for the scheme or ongoing support needs.

The NDIA and DSS also make frequent reference to the Productivity Commission (PC), claiming that the rollout of IAs will better align the scheme to its recommendations. In fact, there are significant discrepancies between what was recommended by the PC and what has been proposed by the NDIA.

In chapter 7 of the 2011 Disability Care and Support Inquiry Report, the PC very clearly recommends a needs assessment, not an assessment of functional capacity. They also place strong emphasis on assisting participants to meet their goals and aspirations.

> *At the most general level, the assessment process will be about* ***identifying the supports*** *that would allow a person to fulfil a range of functions, such as participate in their community* ***in keeping with personal goals and aspirations*** *(page 306, emphasis added).*

The PC's specific recommendations relating to assessments are as follows:

> ***Recommendation 7.1***
> *Working within the framework of the International Classification of Functioning, Disability and Health* ***(ICF),*** *the assessment process undertaken by the NDIA should* ***identify the supports*** *required to address an individual's reasonable and necessary care and support needs across a broad range of life activities, and should* ***take account of an individual's aspirations*** *and the outcomes they want to achieve.*
>
> ***Recommendation 7.2***
> *The assessment process should be a valuable intervention in its own right, rather than just an entry point to supports. The process should:*
>
> - *draw on* ***multiple sources of information****, including:*
>   - *information provided by* ***the individual*** *with a disability, including their aspirations and requirements for supports*
>   - *information provided by an individual's* ***circle of support, including family members, carers and direct support professionals***
>   - ***information on the current support*** *provided both formally and informally*
>   - ***current medical information*** *on the person with a disability*
> - *assess the nature, frequency and intensity of an individual's* ***support needs****. The process should be person-centred and forward looking and consider the supports that would cost-effectively* ***promote people's social and economic participation, rather than only respond to what an individual cannot do***
> - *determine what supports outside the NDIS people should be referred to, including referrals to Job Services Australia providers*
> - *consider what reasonably and willingly could be provided by unpaid family carers and the community* ***('natural supports')***
> - *translate the reasonable needs determined by the assessment process into a person's* ***individualised support package*** *funded by the NDIS, after taking account of natural supports*
> - *provide efficiently collected data for program planning, high level reporting, monitoring and judging the efficacy of interventions (emphasis added).*

The NDIA is to be commended for its commitment to working within the framework of the ICF as recommended by the PC. However, at no point does the PC recommend that the NDIA primarily use an arbitrary and superficial screening tool to determine eligibility or plan funding.

The IA model also falls short of the PC's recommendations by:

- failing to draw on multiple sources of information and not drawing on relevant medical information;
- utilising a toolkit that restricts people with disability from explaining their goals, aspirations or support needs;
- responding primarily to what an individual cannot do rather than promoting social and economic participation;
- failing to take account of 'natural supports' which are or could be provided by unpaid family, carers or the community; and, above all,

- utilising an appropriate needs assessment to develop an individualised support package.

The need for independent clinical oversight

Given the Federal Government's determination to proceed with IAs, and quite possibly clinically flawed IAs, it is imperative there be independent clinical oversight of their implementation and their ongoing effect on Australians with disability.

Accordingly, OTA calls for the establishment of a permanent Committee of Clinical Oversight, genuinely independent of government and comprising representatives of the six allied health professions whose members are allowed to conduct IAs, and representatives of disability consumer groups. Consideration should be given to the Committee being chaired by the Commonwealth Chief Allied Health Officer.

OTA understands that AHPA has made a similar recommendation in its submission to the Joint Standing Committee, calling its proposed body an Expert Advisory Group and detailing its purpose and specific role.

Given the potential for IAs to do real harm, it is imperative the Federal Government commit to such a safety mechanism.

If the Federal Government opposes this recommended course of action, it will confirm the worst fears of the disability sector; that the purpose of IAs and proposed legislative reform is to cut costs at the expense of clinical excellence.

And, regrettably, revelations in the *Sydney Morning Herald* and *The Age* on 6 April of this year appear to confirm fears that IAs are simply a cost cutting exercise.

It was reported that significant additions were made by NDIA officials to the supposedly independent Tune Review. Most notably, it was reported that:

> *The tracked changes appear to show the entire chapter devoted to introducing independent assessments – which was initially recommended by the Productivity Commission in 2011 – was also inserted by a public servant.*

If accurate, this report calls into question the very trustworthiness of the agency charged with the care and support of arguably our most vulnerable citizens. It certainly calls into question the fundamental purpose of IAs.

Conclusion

OTA recognises the need to determine a person's eligibility for NDIS in a timely manner and to do this transparently and equitably.

Regrettably, IAs as currently envisaged will fail to achieve that objective. And such failure is inexcusable, given the fundamental power imbalance involved; applicants must subject themselves to assessment or be automatically excluded from the scheme.

And the disability sector was led to believe that IAs were intended only to determine eligibility for the NDIS and would in no way inform the plan of a successful applicant for the scheme, nor the budget supporting that plan. The sector was misled.

As we have made repeatedly clear, OTA has major concerns about the relevance and scope of the proposed IA toolkit; the process for determining eligibility; the effectiveness of the tools being used to determine eligibility; and, most importantly, what impact this will have on participants, their families and caregivers. Given these limitations, OTA has serious concerns about the IA being used as a proxy assessment for determining eligibility or funding, and has proposed an alternative model for the Committee's consideration. This alternative model has been shared with the NDIA.

The proposed IA model is in fact a screening device, and its suite of tools is unsuited to the task of determining eligibility. The toolkit lacks sensitivity, specificity and, in many cases, relevance to a broad range of people that live with substantial and permanent disability. As one OTA member has observed, it is little more than an exercise in data entry.

It is of concern that this will be used to determine a person's eligibility for the NDIS by people unable, or not allowed, to bring their clinical expertise to bear.

That is clinically unsound.

Moreover, recent advertisements by companies appointed to the panel of IA providers and now seeking assessors, note the need for only twelve months' experience; this points to a focus on throughput rather than clinical observation and analysis.

OTA strongly refutes the claim that the implementation of the IA tool for determining personalised budgets and plans will benefit participants.

There needs to be quite separate mechanisms for determining eligibility and for the purposes of planning and budgets.

A participant's plan and budget should be determined by a process which includes a comprehensive functional assessment carried out by an allied health professional working strictly within their scope of practice and bringing their professional expertise and powers of clinical reasoning to bear.

OTA is also concerned that, contrary to earlier undertakings, existing NDIS participants will be subjected to regular reassessment using the IA. This puts in jeopardy the certainty of funding and the attendant peace of mind that the scheme was supposed to offer Australians with permanent disability.

OTA notes that while a number of these issues were elevated to the NDIA during our involvement in AHPA Working Group developing the training modules for the model, not all of these matters have been addressed, let alone satisfactorily resolved by the NDIA. Moreover, it appears that the good work done by the Working Group has been largely ignored by the NDIA.

OTA recommends that no potential participant be excluded from the NDIS on the strength of an IA alone. In all circumstances, an IA should be followed up with a comprehensive and clinically credible functional assessment carried out by an allied health professional acting strictly within scope of practice. Unsuccessful applicants should have recourse to a genuinely independent appeals process.

And there should be financial support for those wishing to appeal an adverse decision arising from an IA, ideally through the Administrative Appeals Tribunal. This will help ensure that one's eligibility for the NDIS is determined by clinical considerations, not one's socio-economic status.

There needs to be rigorous and independent research carried out into IAs, using consumer co-design methods in line with international standards. OTA believes this is the only way to ensure redesign and policy reform is appropriate, viable and sustainable.

Finally, OTA calls for the establishment of a permanent Committee of Clinical Oversight, independent of government and comprising representatives of the six allied health professions whose members are allowed to conduct IAs, and representatives of disability consumer groups. Consideration should be given to the Committee being chaired by the Commonwealth Chief Allied Health Officer.

OTA thanks the Joint Standing Committee for this opportunity to comment on the NDIA's proposed course of action. Members of the Committee requiring a more clinically detailed presentation of OTA's objections to Independent Assessments should read our recent submissions to the NDIA, available at:

https://otaus.com.au/publicassets/701ad0dc-457a-eb11-943a-005056be13b5/OTA%20submission%20to%20NDIA%20-%20Access%20Policy.pdf

https://otaus.com.au/publicassets/fb9bced6-457a-eb11-943a-005056be13b5/OTA%20submission%20to%20NDIA%20-%20Planning%20Policy.pdf

Representatives of the association would be pleased to appear before the Committee to expand on any points raised in this submission.

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The impact of proposed independent assessments on people with psychosocial disability

Updated 24/11/2020

THE NATIONAL DISABILITY INSURANCE AGENCY'S FOCUS ON EQUITY WITH THE NDIS IS WELCOMED. HOWEVER, THE INTRODUCTION OF THE PROPOSED INDEPENDENT ASSESSMENTS FRAMEWORK RAISES CONCEPTUAL AND PRACTICAL ISSUES REQUIRING URGENT ATTENTION. THIS DOCUMENT IS A DIRECT RESPONSE TO THE NDIS 'INDEPENDENT ASSESSMENT FRAMEWORK' AND 'SELECTION OF TOOLS' DOCUMENTS PUBLISHED BY THE NDIS, SEPTEMBER 2020.

Conceptual issue	Analysis of independent assessment (IA) process	Impact on people with psychosocial disability, their families and carers
1. Australians with a disability, including psychosocial disability, have a right **to expect an evidence-based, robust and safe process for assessment of functional capacity** to determine access to, and reasonable and necessary supports from, the NDIS.	**Robust empirical research** is needed to ensure that independent assessment processes are fit for purpose; delivered by an independent party. There is a conflict of interest when organisations conducting the research and piloting the process have a vested interest, including financial interest, in the outcome of the pilot. Of the pilot scheme completed to date, only a small number **(7%, 35-40 people)** had a psychosocial disability [1]. Volunteers self-selected; therefore, this is not a representative sample of people with psychosocial disability, many of whom have reduced functional capacity that may have impacted on self-advocacy. These issues are likely to persist in second pilot as the selection methodology has not changed.	In the absence of an evidence base demonstrating the effectiveness and safety of IAs, there **is the potential for causing harm.** International studies evidence the potential for harmful outcomes when disability assessment is conducted via a point-in-time standardised checklist by a mandated assessor. These harmful outcomes include increased rates of suicide, increased mental health impacts and increased reliance on prescribed medication [2].

2. There is an absence of evidence supporting the assumption that functional capacity can be measured in a 'disability neutral' manner, in Australia or internationally. Research highlights the global absence of a single assessment tool or suite of tools, proven to have the ability to do this [3]. **WHO ICF research branch developed the ICF Core Sets in acknowledgement of functional variability between disability groups, including psychosocial disability, where the impairment is derived from mental health issues [4].** The subordinate rules under the NDIS Act 2013 Supports for Participants Rules (Australian Government, 2013a) acknowledge this by highlighting that assessment tools, should be **"specifically tailored to particular impairments**" (Part 4, point 4.5 b) [5]	**It appears the combination of tools were selected based on constraints imposed by the NDIA [6]. There are significant issues with assessing functional capacity using assessment tools not researched as reliable or validated for this purpose, for people with psychosocial disability.** These concerns are exacerbated when such tools are used in combination and in a novel context, such as the NDIS in Australia. Two of the three IA tools proposed for psychosocial disability, the CHIEF and the Vineland-3, have not been researched or validated for use with people with psychosocial disability, and were designed for other populations and purposes [7] [8]. Vineland-3 invalidity for psychosocial disability where the impairment is due to mental health issues is also confirmed by the NDIS Quality and Safeguard Commission's Compendium of Resources for Positive Behaviour Support (p182) [9]. Construct validity is the ability of the tool to actually measure what it is intended to measure. There are issues with construct validity in the Independent Assessment toolkit - the construct being measured with Vineland 3 and CHIEF are adaptive behaviour and environmental factors respectively, not functional capacity. Interestingly, the inclusion of the Lower Extremity Function Scale (LEFS) administered "where applicable" appears to contradict the disability neutral approach outlined by the NDIA.	The impact of an Independent Assessment not fit for purpose is **insufficient assessment of substantially reduced functional capacity,** forming a restrictive barrier to accessing the NDIS, or an inappropriately funded support package. Neither the Vineland-3 nor CHIEF is validated for psychosocial disability and the WHODAS-2 has limitations e.g. does not comprehensively assess functional capacity for self-care because it does not assess the **capacity or barriers to consistently wash; get dressed; plan, organise and prepare a meal; manage medication; implement daily routine.** The WHODAS-2 only considers the past 30 days, not sufficient to capture **the fluctuating capacity** experienced by many people with psychosocial disability [10]. The WHODAS-2 does not consider capacity for work and study, when the person is not currently engaged in these activities. The WHODAS-2 does not provide insight into **the person with psychosocial disability's capacity for economic participation.**

3. A fundamental principle of the NDIS Act (2013) is the identification of reasonable and necessary supports, that are individualised and goal-oriented. Assessment Tools that focus on 'norm-referencing' people with disabilities with the general population, is contrary to individualised, tailored, goal-oriented support identification. The subordinate rules under the *NDIS Act 2013* Supports for Participants Rules (Australian Government, 2013a) - state that the assessment tools **must ensure fair assessment of reasonable and necessary supports, and it should reference activity, social, and economic participation**, as identified in the WHO ICF (Part 4, point 4.6 a and b) (Australian Government 2013a) [11]. These rules were confirmed in the NDIS Becoming a Participant Rules (2016) under Part 7 (Australian Government, 2016)[12].	The proposed Independent assessment **does not include needs assessment, or a process to identify reasonable and necessary supports.** Aspects of the assessment tools are contrary to the NDIS Act 2013 **concept of enabling social participation**. E.g. The CHIEF explicitly states social supports cannot be addressed through funded supports. Direct quote - "Social barriers can only be remedied by attitude change in others. Extra funding is not likely to solve these particular problems." (See P3 CHIEF User Manual version 3.0)[13].	Funding and support packages that do not address the, often invisible, individual reasonable and necessary support needs, may lead to **negative outcomes and harm** for people with psychosocial disability. These include, but are not limited to, increased reliance on the acute mental health system through mental health decline; unnecessary, costly and distressing hospitalisations or crisis service engagement; further reduced capacity for social and economic participation; social isolation; difficulty completing personal care and daily living tasks.

4. 'Nothing About Us Without Us' **Choice and control for people with disabilities are cornerstone principles of the NDIS Act (2013)[14].** The United Nations Convention on the Rights of the Person with Disability (UNCRPD), which Australia signed in 2007, and the National Disability Strategy 2010-2020 (2010), emphasise the inclusion of people with disabilities in decision-making, **and active participation in designing systems that support them [15][16]**. There has been limited consultation with people with disabilities and other stakeholders, in the development of independent assessments.	Due to the inclusion of the Vineland 3, the IA toolkit for psychosocial disability **is weighted towards a carer or other support person** rating the person's functional capacity. This approach **undermines the person's place as the expert in their own disability.** **The Vineland-3 is fully rated by a carer or support person, not the NDIS applicant or participant. It includes an extensive interview with, and scoring by, the carer or support person [8].** It is unclear what the alternative process will be if person does not have a carer or support available to complete this assessment. The CHIEF User Manual version 3.0 (p8) describes a discrepancy in scoring between client scoring and carer/support person scoring, which they attribute to "the unique barriers faced by these groups"[13]. This highlights that this tool is not reliable when scored by anyone other than the applicant or participant. It is unclear what the alternative process to gather environmental information will be if person does not have the capacity to respond to the CHIEF.	The proposed IA approach **is contrary to current mental health standards of service which emphasise trauma-informed care and recovery-oriented practice [17]**. The expectation that a person with a disability meet with a mandated assessor, a stranger, to complete a series of standardised tools to assess the impact of disability, for the purpose of making decisions around access to essential supports, has the potential to be a highly stressful experience. Many people with psychosocial disability have histories of mandatory treatment and involuntary hospitalisation, or experiences with assessments delivered by unknown professionals that have resulted in loss of freedom or self-determination. NDIS Act 2013, Section 4 (3), states that people with disability and their families and carers **should have certainty that they will receive the care and support they need over their lifetime [14]**. IA at multiple points in the NDIS journey introduces uncertainty, loss of sense of control, and fear. Inclusion of Vineland 3 is likely to cause distress to people with psychosocial disability who may have complex relationships with their family and carers (e.g. family violence situations).

5. The Social model of disability aims to reduce systemic and procedural barriers to participation for people with disabilities. Mandating people with disabilities to engage in an IA process where they do not have the functional capacity to complete creates a **procedural and systemic barrier to access,** and participate in, the NDIS. It raises significant concerns regarding equity of access and equity of IA process. People without functional capacity to complete the IA will require an alternative process and pathway to assess eligibility for the NDIS.	The WHODAS-2 can be used to screen for substantially reduced capacity in the domains of communication, social interaction and cognition (self-management), **that indicate reduced functional capacity to engage in the IA process**. Specifically, those who rate 2 or higher (mild, moderate, severe or extreme difficulty) on the following items evidence reduced functional capacity to engage in the IA process: WHODAS item D1.1 - Concentrating on doing something for more than ten minutes; WHODAS item D1.5 - Generally understanding what people say; WHODAS item D1.6 - Starting and maintaining a conversation; WHODAS item D4.1 -Dealing with people you do not know. If the person rates 2 or higher on the items D1.1, D1.5, D1.6, then continuation with the assessment is inappropriate – as they do not have capacity to engage in its completion. It is unreasonable and unethical to proceed with administering IA in these circumstances.	**People with psychosocial disability currently represent approximately 12 per cent of participants accessing the NDIS [18]**. These numbers continue to be lower than expected, at this stage of the Scheme development. Great care needs to be taken to ensure access pathways are accessible to people with psychosocial disability. To minimise risk of the IA becoming a barrier, assessors are required to be mental health professionals who are very clear on the understanding of functional capacity as outlined in the NDIS Act 2013. Choice of provider to complete an IA must be preserved. Skilled, known providers, who are mental health professionals, minimise and offset the risk of non-standardised assessment tools through clinical reasoning and triangulation of information sources to build a clear picture of functioning for each individual.
6. The proposed IA process is wholly contradictory to recovery-oriented practice principles outlined in the national framework for recovery-oriented mental health services agreed by Australian government ministers, including recovery conceptualised as a unique, individual and personal journey (not 'norm-referenced'); a non-linear journey interspersed with achievement and setback; and personal autonomy [17].	The NDIA has committed to the development of an NDIS Recovery Framework for people with psychosocial disability [19]. However, this approach will be contradictory to the disability neutral approach proposed by the NDIA regarding IAs.	People with psychosocial disability will question the NDIA's stated commitment to develop an NDIS Recovery Framework, as it coincides with the introduction of an IA process that is not recovery-oriented and has potential to cause harm, as described above. **The conceptual contradiction between IA process and the NDIS Recovery Framework is substantial and requires addressing, with the reasonable and necessary support needs and the goals and aspirations of people with psychosocial disability central to this conversation.**

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