



Australian Government
Department of Social Services

Explanation of proposed changes to the Disability Support Pension Impairment Tables

DSS 2786.09.22



Introduction

There are currently more than 750,000 people in receipt of DSP. To be eligible for DSP, applicants must have an impairment, which attracts at least 20 points under the Impairment Tables. When applying for DSP, the person must also be assessed as being unable to work for 15 or more hours per week, for at least the next two years, because of a physical, intellectual or psychiatric impairment.

The legislative instrument '*Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011*' (the Impairment Tables) contains 15 individual Impairment Tables used to assess a person's functional impairment and its effect on their capacity to work.

The Department of Social Services (the department) has been undertaking a review of the DSP Impairment Tables legislative instrument ahead of the instrument lapsing on 1 April 2023. As part of this review, the department consulted with key stakeholders, including disability peak bodies and advocacy groups, medical professionals, Services Australia and individuals with a lived experience of the DSP process. Feedback received during this process was used to inform proposed changes to the new draft legislative instrument.

Changes resulting from the Review

Following the first round of public consultations, the department collated issues raised to determine those that fell within the scope of the Impairment Tables legislative instrument. Consideration was given to how concerns could be appropriately addressed, for example, either as changes to the legislative instrument or to the Social Security Guide (the Guide) as specific guidance for assessors.

Any issues raised during the review not contained in the legislative instrument were considered out of scope. These issues have been noted and may be considered as part of future DSP policy development.

This paper provides a summary of the proposed changes to the legislative instrument and the Guide.

Next Steps for the Review

The department is now seeking feedback on the proposed changes to the Impairment Tables. To provide feedback on the changes, follow the instructions on the department's Engage consultation portal at www.engage.dss.gov.au.

Proposed amendments resulting from the Impairment Tables Review

New Impairment Tables numbering

The current Table 6 – ‘Functioning related to Alcohol, Drug and Other Substance Use’ has been removed (as unlike the other Tables, it is diagnosis based, not functional based) and the functional impacts resulting from substance misuse conditions have been captured in other Tables where appropriate. As a result, the new Impairment Tables have been renumbered as below and will be referred to as such throughout this paper:

Table 1 – Functions requiring Physical Exertion and Stamina

Table 2 – Upper Limb Function

Table 3 – Lower Limb Function

Table 4 – Spinal Function

Table 5 – Mental Health Function

Table 6 – Brain Function

Table 7 – Communication Function

Table 8 – Intellectual Function

Table 9 – Digestive and Reproductive Function

Table 10 – Hearing and other Functions of the Ear

Table 11 – Visual Function

Table 12 – Continence Function

Table 13 – Functions of the Skin

Table 14 – Functions of Consciousness

Summary table of changes to the legislative instrument

The table below summarises the proposed changes to the DSP Impairment Tables legislative instrument.

Category of change	Section	Proposed change	Impact for DSP claimants
Fully diagnosed, treated and stabilised (FDTs) and permanency			
Change to the 'fully diagnosed, treated and stabilised terminology'	Part 2, Section 8 - Applying the Tables	<ul style="list-style-type: none"> Removal of the term 'fully diagnosed, treated and stabilised' and replaced with 'diagnosed, reasonably treated and stabilised'. The term 'permanent condition' has also been removed and instead clarifies that for an impairment rating to be assigned, a condition must meet the criteria of 'diagnosed, reasonably treated and stabilised', and the resulting impairment is more likely than not, in light of available evidence, to persist for more than 2 years. 	The changes to this terminology is aimed to improve clarity around the diagnosis, treatment and stabilising of a condition to determine qualification for DSP.
Operational improvements			
Additions to definitions specific to the instrument	Part 1, Section 5 - Definitions	<ul style="list-style-type: none"> Inclusion of a definition of 'assistance' to clarify assistance means assistance from another person, and expansion of the definition of 'condition' to mean a diagnosed medical condition, disability or disorder. 	These changes will provide greater clarity around defined terms within the Impairment Tables.
Format and clarification improvements to the rules for applying the Tables	Part 2 – Rules for applying the Tables	<ul style="list-style-type: none"> Simplifications have been made to Part 2 to improve the guidance and readability of the section. For example the merging of 2 sections in Part 2 of the instrument which explained the assessment of impairments with no functional impacts. 	These improvements reduce repetitiveness and simplify text for ease of use.
Improvements to consistency, simplification and removal of outdated assessment tools throughout the instrument	Entire instrument	<ul style="list-style-type: none"> Table descriptions have been simplified. Consistent formatting of examples throughout the instrument. 0-point descriptors now recognise a person may experience no or minimal impacts as a result of their impairment. Where appropriate, descriptors have been simplified or merged to better represent impairment. For example in Table 5 – Mental Health Function, it is to align with the functional domains of the World Health Organization Disability Assessment Schedule (WHODAS). More medically appropriate terms have been included throughout Tables. Amendments to include specific mental health diagnostic tools. Consistency of descriptors within a Table. For example in Table 14 – Functions of Consciousness, the timeframe of a person's altered state of consciousness has been removed from the 10 point impairment rating, to be consistent with the other impairment ratings in the Table. 	<p>These amendments are aimed at improving the readability of the instrument and use more appropriate medical terminology throughout.</p> <p>Amendments to include mental health diagnostic tools will provide greater clarity in determining if a mental health condition has been appropriately diagnosed.</p>
Additional guidance in all appropriate Tables	Part 3 – The Tables	<ul style="list-style-type: none"> Additional guidance around assessing performance of activities. Additional guidance for assessing episodic or fluctuating conditions. Additional guidance indicating examples are not exhaustive and to be used as a guide. Additional guidance in relevant Tables for the assessment of impairments that may be considered on a number of Tables. 	Additional guidance across all Tables provides clear and consistent information.

Category of change	Section	Proposed change	Impact for DSP claimants
		<ul style="list-style-type: none"> Clarification of evidentiary requirements for mental health conditions under Table 5. Additional guidance on alternative communication systems when assessing communication function on Table 7. 	
Clarification of assistive technology, and removal of outdated devices	Part 3, Table 1 – Functions requiring Physical Exertion and Stamina, Table 3 – Lower Limb Function, Table 10 – Hearing and Other Functions of the Ear	<ul style="list-style-type: none"> Assistive technology a person may use to mobilise has been expanded to mean a wheelchair or other equivalent assistive device. Addition of more appropriate wording around mobility aids in Table 3 descriptors. Removal of the 5 point descriptor point in Table 10 where a person may use a hearing aid, cochlear implant or other device, as a person must be assessed using assistive devices they would normally use. Removal of outdated technology – T switch and captioned telephone from Table 10 descriptors. 	Further clarification of assistive devices and the removal of outdated technology reduces confusion and modernises the Tables.
Broader range of examples of tasks in Tables, including more work related tasks	Part 3 – The Tables	<ul style="list-style-type: none"> Additional examples have been included in all Tables to show the level of impairment a person may demonstrate throughout the Tables. Expansion of local facilities to include local shops, and workplaces. Inclusion of modernised examples and work related tasks. Removal of outdated examples or those medical experts have indicated are inappropriate. 	Additional examples provide better indications of the level of impairment a person should be assessed as reaching. By expanding examples to include more work related tasks, the Tables further take into account how a person's impairment impacts their ability to work.
Impacts from alcohol, drugs and other substance misuse			
Amendments to capture impacts from alcohol, drugs and other substance misuse	Part 2, Section 8 - Applying the Tables Part 3, Table 5 – Mental Health Function, Table 6 – Brain Function	<ul style="list-style-type: none"> Removal of the current Table 6 – Functioning related to Alcohol, Drug and Other Substance Use. Addition of guidance around consideration of the ongoing impacts of alcohol, drugs and other substance misuse have been added to Table 5 and 6. 	The current Table used to assess these impacts is out of line with the intent of the Tables, which is to assess a functional impairment. The current Table 6 - Functioning related to Alcohol, Drug and Other Substance Use has been removed, with the impacts now reflected in appropriate Tables and additional guidance.
Ongoing side effects of treatment			
Recognition of the impacts of side effects of treatment, such as chemotherapy and dialysis	Part 2, Section 12 – Selecting the applicable Table and assessing impairments Part 3, Table 10 – Hearing and Other Functions of the Ear	<ul style="list-style-type: none"> Addition of a point to consider the ongoing impacts of side effects experienced due to treatment. Addition of side effects of medication such as chemotherapy, included as examples of functional impairments a person may experience in relation to Table 10. This has been highlighted in Table 10 as advice from stakeholders indicated this is an impact often missed when considering the side effects of chemotherapy. 	The impact of ongoing side effects from prescribed medication and treatment, such as chemotherapy and dialysis, is not reflected throughout the Tables. These additions will provide clarity when considering these effects.
Pain			
Better representation of pain related conditions and the impacts of pain	Part 3, Table 1 – Functions requiring Physical Exertion and Stamina, Table 2 –	<ul style="list-style-type: none"> Chronic pain has been removed as an example of a condition associated with cardiac or respiratory impairment as it is better reflected elsewhere in Table 1. 'Cardiac pain' has been amended in all descriptors to be broadened to 'pain' as examples of symptoms a person may experience in Table 1. 	These amendments provide more appropriate wording around the type of pain a person may experience and also provides clarity in Tables chronic pain and pain related conditions are likely to be assessed under.

Category of change	Section	Proposed change	Impact for DSP claimants
	Upper Limb Function, Table 3 – Lower Limb Function, Table 4 – Spinal Function, Table 9 – Digestive and Reproductive Function, Table 13 – Functions of the Skin	<ul style="list-style-type: none"> • Lead sentences of descriptors have been changed to better reflect that impairments under specific Tables (1, 2, 3, 4 and 13) could be due to chronic pain. • Clarification of pain to mean chronic pain in Table 9. • Nerve pain has been removed as an example of a condition associated with skin difficulties, and replaced with chronic pain in Table 13. • Fibromyalgia has been included as an example of a condition a person may provide evidence for to be assessed under Table 1. • Severe migraines have been included as an example of a condition a person may provide evidence for to be assessed under Table 1. • Chronic pain and peripheral neuropathy have been included as an example of conditions a person may provide evidence for to be assessed under Tables 2 and 3. • Chronic pain affecting the spine has been included as an example of conditions a person may provide evidence for to be assessed under Table 4. 	
Chronic illness			
Better representation of chronic illnesses	Part 3, Table 1 – Functions requiring Physical Exertion and Stamina, Table 14 – Functions of Consciousness	<ul style="list-style-type: none"> • Diabetes mellitus has been included as an example of a condition a person may provide evidence for to be assessed under Table 1. • Amended examples in Table 14 to more appropriately reflect conditions a person may provide evidence for to be assessed under the Table (inclusion of narcolepsy). • See also changes under pain, renal conditions, fatigue and cancer. 	Including references to specific conditions provides clearer examples of the types of conditions that may be assessed on a Table.
Renal conditions			
Better representation of renal conditions	Part 3, Table 1 – Functions requiring Physical Exertion and Stamina	<ul style="list-style-type: none"> • Renal failure has been included as an example of a condition a person may provide evidence for to be assessed under Table 1. 	Including references to specific conditions provides clearer examples of the types of conditions that may be assessed on a Table.
Fatigue			
Better representation of fatigue related conditions	Part 3, Table 1 – Functions requiring Physical Exertion and Stamina, Table 6 – Brain Function	<ul style="list-style-type: none"> • Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) has been included as an example of a condition a person may provide evidence for to be assessed under Table 1 and 6. 	Including references to specific conditions provides clearer examples of the types of conditions that may be assessed on a Table.
Better representation of the impact of fatigue on undertaking personal care activities	Part 3, Table 1 – Functions requiring Physical Exertion and Stamina	<ul style="list-style-type: none"> • A new 'personal care' descriptor has been added to all point descriptors within Table 1 to capture the impacts of fatigue on a person's ability to undertake personal care activities. 	This addition recognises that a person with a functional impairment being assessed under Table 1 may have limitations on their ability to undertake personal care activities due to the impacts of fatigue.

Category of change	Section	Proposed change	Impact for DSP claimants
Better representation of the impact of fatigue related symptoms	Part 3, Table 1 – Functions requiring Physical Exertion and Stamina	<ul style="list-style-type: none"> Post-exertional malaise has been added to examples of symptoms a person may experience for assessment under Table 1, along with being added to the examples of symptoms a person may experience when performing activities in the descriptors. Addition of the recognition some activities may require a recovery period after undertaking them. Amendment to Table 1 to recognise a person may be bed bound due to chronic fatigue. 	These amendments are aimed to better capture fatigue related symptoms in Table 1 and how they may be considered under the Table.
Cancer			
Better representation of cancer and subsequent conditions	Part 3, Table 1 – Functions requiring Physical Exertion and Stamina, Table 2 – Upper Limb Function, Table 3 – Lower Limb Function, Table 7 – Communication Function, Table 9 – Digestive and Reproductive Function, Table 10 – Hearing and Other Functions of the Ear, Table 11 – Visual Function, Table 12 – Contenance Function, Table 13 – Functions of the Skin, Table 14 – Functions of Consciousness	<ul style="list-style-type: none"> Lymphoedema has been included as an example of a condition a person may provide evidence for to be assessed under Table 1, 2 and 3. Addition of neck and throat cancer as an example of a condition a person may provide evidence for to be assessed under Table 7. Addition of cancers that may affect digestive and reproductive functioning as conditions a person may provide evidence for to be assessed under Table 9. Addition of head or neck cancer and side effects of medication such as chemotherapy, included as conditions a person may provide evidence for under Table 10. Addition of brain tumours as a condition a person may provide evidence for under Table 11 and Table 14. Addition of gastrointestinal malignancy as a condition a person may provide evidence for under Table 12. Addition of melanoma as a condition a person may provide evidence for under Table 13. 	Additions of specific types of cancers have been made to Tables where relevant.
Medical evidence and practitioners			
Acceptance of a broader range of medical evidence	Part 3, Table 1 – Functions requiring Physical Exertion and Stamina, Table 6 – Brain Function	<ul style="list-style-type: none"> Addition of actimetry linked blood pressure and heart rate monitoring results as evidence for Table 1. Addition of interviews with the person and those providing care as evidence for Table 6, but also recognising a person may not have sufficient self-awareness to describe the effects of their impairment. 	Where appropriate in the Tables, additional examples of specific pieces of evidence that may be used to support a claim have been added to broaden the types of evidence a claimant may provide. This has been further extended in the Guide (refer to the summary table of changes to the Guide below).
Recognition of additional professionals able to provide evidence	Part 3, Table 4 – Spinal Function, Table 10 – Hearing and Other Functions of the Ear, Table 11 – Visual Function, Table 13 – Functions of the Skin,	<ul style="list-style-type: none"> Addition of an Occupational Therapist as an example of an allied health professional that can provide evidence for Table 4 and Table 13. Addition of neurosurgeon and neurologist as examples of specialists that can provide corroborating evidence in support of a diagnosis from an appropriately qualified medical practitioner for Table 10. Addition of an audiometrist to the list of specialist that can provide audiological assessment results as evidence for Table 10. 	Where appropriate in the Tables, additional examples of practitioners broadens the range of appropriate practitioners that a person is likely to be receiving treatment from and supports their ability to provide evidence. This has been further extended in the Guide (refer to the summary table of changes to the Guide below).

Category of change	Section	Proposed change	Impact for DSP claimants
	Table 14 – Functions of Consciousness	<ul style="list-style-type: none"> • Addition of optometrist, neurosurgeon or neurologist as examples of medical practitioners that can provide evidence for Table 11. • Addition of oncologist as an example of medical practitioners that can provide evidence for Table 13. • Expansion of clinical nurse consultants or nurse practitioners to registered nurses as an example of practitioners that can provide evidence for Table 13 and 14. • Addition of physiotherapist and pain management specialist as examples of practitioners that can provide evidence for Table 13. 	
Musculoskeletal and skin functions			
Better representation of shoulder function	Part 3, Table 2 – Upper Limb Function	<ul style="list-style-type: none"> • Descriptors added to capture shoulder function in Table 2. 	This addition will better capture shoulder function for assessment under Table 2.
Recognition of loss of function of a dominant upper limb	Part 3, Table 2 – Upper Limb Function	<ul style="list-style-type: none"> • Addition of descriptor to capture the impact of the loss of function of a person's dominant upper limb. • Addition of nerve damage as an impact which may render an upper limb non-functional on upper limbs in Table 2. 	This addition recognises impacts of losing a dominant upper limb, which was not represented in the Tables previously.
Better guidance for the assessment of impacts resulting from lumbar spine conditions	Part 3, Table 3 – Lower Limb Function, Table 4 – Spinal Function	<ul style="list-style-type: none"> • Additional guidance in Table 3 and 4 for assessing functional impacts from lumbar spine conditions, including nerve pain or weakness in the lower limbs. 	Additional guidance will provide clear and consistent information.
Better recognition of skin conditions	Part 3, Table 13 – Functions of the Skin	<ul style="list-style-type: none"> • Addition of graft versus host disease and skin ulcerations as examples of conditions a person may provide evidence for under Table 13. 	Additions of these conditions have been made to Table 13 to better represent conditions that may be assessed under this Table.
Balance			
Better representation of ability to stand and balance	Part 3, Table 3 – Lower Limb Function, Table 10 – Hearing and Other Functions of the Ear	<ul style="list-style-type: none"> • Clarification of a person's ability to stand in descriptors of Table 3. • Addition of balance to Table 3 descriptors. • Addition of dizziness as something that impacts a person's balance in Table 10. • Acknowledgement of balance difficulties in the 30 point descriptor in Table 10. 	This addition will better capture the functional impacts on a person's ability to stand and balance in the Tables.
Psychologists			
Registered psychologists can provide evidence of a mental health condition	Part 3, Table 5 – Mental Health Function	<ul style="list-style-type: none"> • Addition of registered psychologists as a practitioner able to provide evidence in support of the diagnosis of a mental health condition. 	This change will allow people with a mental health condition to provide corroborating evidence of their condition. The current requirement for a clinical psychologist to provide corroborating evidence in support of a diagnosis has been extended to include all registered psychologists as part of the proposed changes.
Mental Health			

Category of change	Section	Proposed change	Impact for DSP claimants
Aligning descriptors related to mental health to standardised assessment tools	Part 3, Table 5 – Mental Health Function	<ul style="list-style-type: none"> Better alignment of the descriptors in Table 5 – Mental Health Function with the World Health Organization Disability Assessment Schedule (WHODAS). Amendments to the introduction of Table 5 – Mental Health Function to mention the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the World Health Organization International Classification of Diseases (ICD) as acceptable diagnostic tools. 	These changes will improve alignments with other recognised mental health assessment tools.
Neurodiversity			
Better representation of neurodiversity	Part 3, Table 5 – Mental Health Function, Table 6 – Brain Function	<ul style="list-style-type: none"> Addition of a guidance point in the introduction to Table 5 stating attention deficit hyperactivity disorder and autism spectrum disorder may be assessed under Table 5. Autism spectrum disorder has been added as an example of a condition a person may provide evidence for under Table 6. Addition of a guidance point in the introduction to Table 6 stating fetal alcohol syndrome and fetal alcohol spectrum disorder may be assessed under Table 6. Examples of difficulty in situations where a person is sensitive to noise, light or crowds have been added to Table 6. 	These additions are aimed to capture the impacts of neurodiverse conditions such as autism spectrum disorder.
Better recognition of social skills difficulties	Part 3, Table 6 – Brain Function	<ul style="list-style-type: none"> New social skills descriptors have been added to all impairment levels of Table 6. 	<p>The addition of new social skills descriptors recognises difficulties a person may experience in social situations.</p> <p>This addition across impairment levels in Table 6 has increased the number of descriptors contained in each level to 10. Due to the increase in number of descriptors, the qualification requirement for Table 6 has increased from having to meet one descriptor to two.</p>
Cultural appropriateness			
Better recognition of the need for culturally appropriate assessments	Part 3, Table 8 – Intellectual Function	<ul style="list-style-type: none"> Clarification that culturally appropriate assessments of intellectual and adaptive function can be used for Table 8. 	This addition recognises the need for culturally appropriate assessment tools to be considered as evidence under Table 8 and removes a barrier that may be in place for people from various backgrounds due to an inherent bias in standardised assessment tools. This has been further extended in the Guide to the summary table of changes to the Guide below.

Summary table of changes to the Guide

The table below highlights the proposed changes to the Social Security Guide. These changes are designed to provide clarity around terminology and guidance for users of the Tables.

Category of change	Proposed change
Fully diagnosed, treated and stabilised (FDTs) and permanency	
Change to the 'fully diagnosed, treated and stabilised terminology'	<ul style="list-style-type: none"> As a result of the changes in the Tables, this will be further explained in the Guide.

Category of change	Proposed change
Co-morbidities	
Clearer guidance for the assessment of co-morbidities	<ul style="list-style-type: none"> Further guidance for the assessment of co-morbidities will be included in the Guide.
Medical evidence and practitioners	
Acceptance of a broader range of medical evidence	<ul style="list-style-type: none"> As the examples in the Tables and the Guide are not exhaustive, further examples of evidence that will be accepted across all Tables will be listed in the Social Security Guide.
Recognition of additional professionals able to provide evidence	<ul style="list-style-type: none"> As the examples in the Tables and the Guide are not exhaustive, further examples of practitioners that may provide evidence for each Table will be added to the guidance page relevant to that Table.
Chronic conditions	
Better representation of chronic conditions	<ul style="list-style-type: none"> Additional guidance will be included in the Guide along with a more extensive list of chronic illnesses for reference.
Cultural appropriateness	
Better recognition of the need for culturally appropriate assessments	<ul style="list-style-type: none"> Additional information about assessment tools appropriate for the assessment of First Nations, and culturally and linguistically diverse claimants will be included in the Guide.

Frequently Asked Questions

Why are you changing the Impairment Tables?

The legislative instrument '*Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011*' (the Impairment Tables) contains 15 individual Impairment Tables used to assess a person's functional impairment and its effect on their capacity to work when a person applies for the Disability Support Pension (DSP).

This legislative instrument is due to lapse (sunset) on 1 April 2023. Sunsetting is the automatic repeal of legislative instruments after a fixed period. Without an instrument in place, there is no legal basis to assess and grant DSP to new applicants.

What is a legislative instrument? Why are the Tables not included in the *Social Security Act 1991*?

The Impairment Tables is a legislative instrument rather than being in primary legislation (i.e. the *Social Security Act*) because this allows policy makers to more easily update the Tables in response to new developments, such as medical and rehabilitation practice, and diagnostic tools.

Who will this impact?

From its commencement, the new instrument will be used to assess claims for DSP going forward.

Is this the final instrument?

The draft instrument results from extensive consultation and is being released for public feedback. However, further changes may be considered as part of this consultation process to finalise the instrument for introduction to Parliament prior to 1 April 2023.

Who has been consulted so far?

The department has consulted with a range of stakeholders, including welfare and disability rights organisations, medical specialists and internal stakeholders. The department has also consulted with people with lived experience of the DSP process. The proposed changes to the Impairment Tables are now available for public consultation prior to the instrument lapsing.

How can I provide feedback?

Feedback can be provided by following the instructions on the Department of Social Services' Engage website at www.engage.dss.gov.au.

How long is the consultation period?

The consultation period is expected to open mid-October and will close mid-November 2022.

Will anyone be worse off under the new Instrument?

The changes to the instrument are predominantly to improve consistency, address advancements in medical technology and terminology, and provide clearer guidance. Individuals will still have to be determined as eligible under the Tables in order to qualify for DSP.

Will current DSP recipients be reassessed under the new Tables?

There are no changes being made to the policy of reviewing recipients of income support payments, including DSP. The random selection of current recipients for review is an existing arrangement. The new Impairment Tables will apply to new claimants and all DSP medical reviews, where the notice to participate in the review is issued on or after 1 April 2023.

Why didn't the department use an Advisory Committee for the Review?

The Tables were last reviewed in 2011, when the focus was changed from being a condition-based assessment to a function-based assessment of a person's ability to work. Due to the significant changes being introduced in the 2011 instrument, an Advisory Group of relevant medical professionals was convened to review and re-draft each of the Tables, including reducing the number of Tables from 22 to 15. To ensure a broad coverage, membership included representatives from a comprehensive range of established medical bodies and advocacy groups, as well as representatives from the then Department of Families, Housing, Community Services and Indigenous Affairs, Centrelink, Department of Veterans' Affairs and the Department of Education, Employment and Workplace Relations.

Given there is no evidence to suggest the current Impairment Tables are not working as intended, the department considered an equivalent process for the remaking of the instrument as part of this review was not required and that a broad public consultation was appropriate. As a result, the main channel of stakeholder consultation for the review has been via the Engage website with the focus being to ensure the Impairment Tables remain fit for purpose and reflect advances that have been made in medical treatments and assistive technology.

In addition, to ensure the correct use of medical terminology and inclusion of appropriate examples in the instrument, the department has consulted medical professionals in the drafting process.

How do the changes to the instrument relate to the Senate Inquiry into the Purpose, Intent and Adequacy of the Disability Support Pension?

Recommendations relevant to the Impairment Tables made in the Senate Inquiry into the Purpose, Intent and Adequacy of the Disability Support Pension final report have been considered when drafting the new legislative instrument.

Why did you remove the ‘Functioning related to Alcohol, Drug and Other Substance Use’ Table? Does this mean a person who has a substance misuse condition is no longer eligible for the DSP?

The current Table 6 – Functioning related to Alcohol, Drug and Other Substance Use is inconsistent with the function-based approach to assessment used under all other Impairment Tables. Functional impacts associated with substance misuse are covered in the amendments made to Table 5 – Mental Health Function and Table 6 - Brain Function. This will ensure individuals with severe functional impairment resulting from substance abuse or misuse can be assessed for the DSP.

Have you made any changes to the medical evidence requirements?

The new draft instrument broadens to include the ability of all registered psychologist to provide corroborating evidence in support of a mental health condition for assessment under Table 5, if the diagnosis is made by a medical practitioner that is not a psychiatrist, such as a General Practitioner. In other instances, further examples of types of evidence a person may provide in support of their claim has been expanded in the introduction to a Table. There will be further amendments to the Social Security Guide to expand on the types of items that may be used for medical evidence.

Why does a diagnosis have to be made by a medical practitioner for the purposes of DSP?

The diagnosis of a condition is an important eligibility requirement. Medical practitioners are most appropriately qualified to diagnose medical conditions.

Why can't a psychologist diagnose a mental health condition for the purposes of DSP?

The diagnosis requirements are set to a medical practitioner for all Tables. The proposed changes to the instrument still requires the diagnosis of a mental health condition is made by an appropriately qualified medical practitioner, such as a psychiatrist or General Practitioner, but with evidence now allowed from a registered psychologist (where the diagnosis has not been made by a psychiatrist).

The Advisory Committee for the review of the current version of the Impairment Tables considered the question of diagnosis very carefully. The Advisory Committee was of the view a high level of diagnostic expertise is required given the diagnosis of a mental health condition can be challenging. The department is retaining the requirement for a medical practitioner to provide diagnosis.

Have you made any changes to the requirement for a condition to be fully diagnosed, treated and stabilised?

Feedback received during consultations indicated the terms “fully diagnosed, treated and stabilised” and “permanent” are inconsistent with their plain English meanings, and this causes confusion. The proposed terminology amendments (diagnosed, reasonably treated and stabilised) incorporate language which is easier

to understand and will provide greater clarity around these requirements without changing the eligibility criteria, integrity or intent of the policy.

Have you made any changes to the Program of Support (POS) requirements?

The scope of the review was limited to the Impairment Tables legislative instrument. As POS rules are contained in legislation separate to the Impairment Tables legislative instrument this issue is out of scope of the review.

How have you addressed the functional impacts of co-morbidities?

The impacts of co-morbidities are sufficiently covered in the legislative instrument. For clarity, clearer guidance for how co-morbidities can be assessed is being added to the Guide to Social Policy Law – Social Security Guide (<https://guides.dss.gov.au/social-security-guide>).

What is the Social Security Guide?

The Social Security Guide provides provides clarification of complex legislation details which underpin the law, and details of policy. The Social Security Guide can be found at <https://guides.dss.gov.au/social-security-guide>.

Have you made any changes to the Instrument to acknowledge the impacts of cancer?

Eligibility for DSP is based on functional impairment resulting from a person's medical condition on their ability to work. In addition, the person's condition must be fully diagnosed, treated and stabilised and permanent, meaning the resulting impairment is more likely than not, in light of available evidence, to persist for more than 2 years. These requirements apply to a person with cancer. Changes have been made to acknowledge the ongoing impacts of treatments such as chemotherapy, and also references to specific types of cancer have been included in appropriate Tables to provide examples of conditions that may cause a functional impact within the Table.

Have you made any changes to support the assessment of “long COVID”?

Eligibility for DSP is based on functional impairment resulting from a person's medical condition on their ability to work. In addition, the person's condition must be fully diagnosed, treated and stabilised and permanent, meaning the resulting impairment is more likely than not, in light of available evidence, to persist for more than 2 years. These requirements apply to a person with long COVID.

Certain conditions aren't mentioned in the Impairment Tables, does this mean people with these conditions cannot be granted DSP?

The Impairment Tables are designed to assess a person's loss of functional capacity that affects their ability to work. The Impairment Tables are specifically designed to assess work-related impairment rather than whole person impairment. The Tables are therefore function-based rather than diagnosis-based and describe functional activities, abilities, symptoms and limitations. The inclusion of some medical

conditions to the Impairment Tables are to provide examples in the Tables of where certain conditions should be assessed. It is not necessary to include all medical conditions.

Are the new Tables better aligned with the National Disability Insurance Scheme (NDIS)? If so, how?

The NDIS and DSP have different purposes and the eligibility requirements are different to reflect the purpose of each. DSP provides income support for those who cannot work due to their disability and the NDIS provides disability supports.

When will be the next opportunity to change the Impairment Tables?

As per the sunseting rules, the Instrument will next be reviewed prior to 1 April 2033. However, the Minister for Social Services can make changes prior to this date if needed.

Consultation Questionnaire

The Department of Social Services' Engage consultation portal will be used for this phase of consultation. A questionnaire has been developed to capture feedback on the proposed changes to the new draft Impairment Tables. The questionnaire is provided below.

Part 1 – Demographics

Q1 Respondents name

Anne Wilson

Q2 Respondents contact email

ceo@emerge.org.au

Q3 Respondents age range

N/A

Q4 Capacity in which a person is responding, such as a person with disability or an advocacy group representative

Q5 Respondents state or territory

Vic

Q6 Respondents geographical area, such as rural area, remote area

Metro

Q7 Name of respondent's organisation, if applicable

EA

Q8 State or territory the respondent's organisation provides services to, if applicable

All

Q9 Geographical area the respondent's organisation provides services to, if applicable

All

Q10 Did the respondent participate in the first phase of the review?

No

Part 2 – Issues

Q11 Indicate the three most important issues to you, such as fully diagnosed, treated and stabilised (FDTS) requirement, medical evidence requirements or other.

2. Fully diagnosed, treated and stabilised (FDTS) component

Operational improvements

Functional impairments related to drug, alcohol or other substance misuse

Ongoing side effects of treatment

Pain

Chronic illness

Renal conditions

1. Fatigue

Cancer

3. Medical evidence requirements

Musculoskeletal and skin functions

Balance

Psychologists

Mental health

Neurodiversity

Cultural appropriateness

Other

If a person selects 'other' from the possibilities, they will be asked to identify what key theme to the Impairment Tables is important to them.

Part 3 – Proposed Changes

Questions in this section require a respondent to indicate their level of agreement to the proposed changes addressing issues around:

Q12 The fully diagnosed, treated and stabilised (FDTs) requirement

- a) The removal of the term 'permanent condition' provides greater clarity that a condition must persist for two years as part of the DSP eligibility criteria
Agree
- b) The proposed changes more clearly describe the requirements of diagnosis, treatment and stabilisation of conditions for DSP assessment
Strongly agree
- c) Please provide any additional comments regarding changes to the FDTs requirement (free text)

Emerge Australia strongly supports the change to this definition. While most patients with ME/CFS are severely disabled by this disease for their entire lives, a lack of research funding means supporting data is minimal. This change acknowledges fluctuating conditions and sets expectation of assessors that individual does not need to have undertaken every single treatment.

We would like to raise one concern: will people need to prove they're still eligible every two years?

The ongoing issue people with ME/CFS face is getting diagnosed in the first place. It is common for it to take 2-5 years for a diagnosis, and for many people it takes a lot longer. For these people, how do they get support?

Encephalomyelitis

Q13 The operation of the Tables

- a) The inclusion of additional defined terms provides greater clarity around terminology used in the Instrument
Agree
- b) Simplification in Part 2 of the Instrument improves the guidance and readability of the section
Agree
- c) The proposed changes to Table introductions and descriptors has made it easier to understand the requirements of Tables
Strongly Agree
- d) The additional guidance in appropriate Tables provides greater clarity when considering functional impairment. For example an additional guidance point to all Tables on fluctuating and episodic conditions
Strongly Agree

- e) The updating of references to relevant assistive technology provides clearer guidance and modernises the Tables

Agree

The broader range of examples in the Tables illustrates how a person's functional impairment may impact their ability to work

Strongly Agree

- f) Please provide any additional comments on the proposed operational improvements (free text)

Nil

Q14 Alcohol, drug and other substance misuse

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

Strongly agree

- b) Please provide any additional comments regarding changes about the impacts from alcohol, drug and other substance misuse (free text).

Nil

Q15 Prescribed medication and treatment

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

Strongly agree

- b) Please provide any additional comments regarding changes about the ongoing side effects of treatment (free text).

Nil

Q16 Pain

- a) Proposed changes better represent the functional impact of pain

Agree

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

Strongly Agree

- c) Please provide any additional comments regarding changes about pain (free text).

Chronic pain and fibromyalgia are common comorbidities for people with ME/CFS and Long COVID. We are pleased to see it included as an example of a condition a person may provide evidence for to be assessed under Table 1.

Q17 Chronic illness

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

Agree – check for ME/CFS as a chronic illness

- b) Please provide any additional comments regarding changes about chronic illness (free text).

Emerge Australia is pleased to see ME/CFS recognised as an illness in tables 1 and 6. We urge the department to implement training in using the new impairment tables for conditions like ME/CFS, related to physical stamina. This extends to the new patient cohort, those with Long COVID, who also experience PEM.

We raise this concern, because our patient community have told us about the ongoing misunderstanding or disbelief some DSP assessors have about ME/CFS. There are two areas we specifically highlight:

“Assigning an impairment rating”: This rating should focus on whether the individual can perform the activity repetitively, not just once. PEM means a person who can perform an activity one day, may not be able to repeat this the next day, or the day after that. However, many people with ME/CFS have their DSP applications rejected because the impact of PEM on their capacity to undertake activities regularly is not fairly considered. Additionally, it is critical that an assessment of ability includes meeting basic daily needs. Such as, a person may be able to sustain clerical work for 3 hours a day, 5 days per week but lacks the capacity to also shower, or cook a meal.

“Assessing episodic and fluctuating conditions”: Impairment rating should assess overall impact of the condition. Currently, people with ME/CFS are often unfairly assessed based on their best days, not their overall functioning and impact of PEM over the week.

Q18 Renal conditions

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

Strongly agree

- b) Please provide any additional comments regarding changes about renal conditions (free text).

Nil

Q19 Fatigue

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

Strongly agree

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

Strongly agree

- c) Proposed changes better represent the functional impact of fatigue related conditions

Disagree

- d) Please provide any additional comments regarding changes about fatigue (free text).

As the national patient organisation for people with ME/CFS and Long COVID, we are extremely pleased with all of the changes to this 'Fatigue' section. Recognition of post-exertional malaise (PEM) is an important step to obtaining support for more people from our community. This change will help assessors recognise that ME/CFS is a legitimate condition and PEM is a disabling symptom. It will also help the Long COVID patients who are starting to become eligible for DSP, some having been sick for two years already.

We responded "disagree" to question c for two reasons. These reasons also closely relate to the comments we made in response to Q17, about training to fairly and accurately assess fluctuating conditions like ME/CFS.

First, the examples provided for 'mild' functional impact may not reflect the capacity of some 'mild' people with ME/CFS. This is because, for people with ME/CFS, the accepted definition of 'mild' is **up to 50% of pre-illness functioning**. Even a 'mild' patient can be significantly impacted by this disease. Further, due to the fluctuating nature of the disease, some people may move between categories from day to day, or week to week. Further clarification should be provided about activity expectation, consistency of activity and safety when performing the activity.

Second, although post exertional malaise is listed, the wording could be improved. We suggest "or mild post-exertional malaise, [during or after] performing physically demanding activities". We suggest this change because PEM, and its associated loss of capacity due to increased symptoms, can be delayed for up to 72 hours after activity.

We note that "treatment" is listed as one of the details required in a report from the medical specialist. There are no proven treatments for people with ME/CFS. Graded exercise therapy and cognitive behaviour therapy were recommended as treatments in the past, however these have since been proven ineffective and potentially harmful.

Further, calling ME/CFS a fatigue-related illness perpetuates misunderstanding of what this disease actually is. ME/CFS is a multi system disease, with the hallmark symptom of post-exertional malaise. PEM is not just fatigue, but an exacerbation of all symptoms including brain fog, pain, orthostatic intolerance, etc.

Q20 Cancer

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

Strongly Agree

- b) Please provide any additional comments regarding changes about cancer (free text).

Nil

Q21 Medical evidence requirements

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

Strongly agree

- b) Additional examples of professionals assists individuals identify the range of appropriate practitioners who are able to provide medical evidence in support of their claims

Strongly agree

- c) Please provide any additional comments regarding changes to medical evidentiary requirements (free text).

Emerge Australia broadly supports the changes to medical evidentiary requirements. In particular, actimetry linked blood pressure and heart rate monitoring will help provide evidence of PEM.

However, often patients are asked for a specialist report but ME/CFS does not belong to a specialty, and there are few specialists trained and knowledgeable enough to assess. By comparison, the proposed Impairment tables will allow reports from generalist psychologists (rather than only clinical psychologists) as accepted evidence for impairment under mental health table, recognising their skills and training. Similarly reports from GPs with skills and training in ME/CFS should be acceptable.

In addition, reports from Occupational Therapists are expensive and often out of reach of our patient community.

We would like to note that much work still needs to be done with the medical community – including all of those professions added to this list – to educate them about how to diagnose ME/CFS. Research suggests up to 90% of people with ME/CFS are undiagnosed. Even for those who do obtain a diagnosis, disbelief and stigma remains in the medical community about the existence of the disease, and the severity of symptoms and disability.

Q22 Musculoskeletal and skin functions

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

Unsure

- b) The addition of descriptors for the loss of function of a dominant limb under Table 2 – Upper Limb Function better recognises functional impacts of losing a dominant upper limb
Unsure
- c) Additional examples of specific skin conditions that result in functional impairment provide more clarity around the types of conditions that may be assessed against a Table
Unsure
- d) Please provide any additional comments regarding changes about musculoskeletal and skin functions (free text).

People who have ME/CFS and Long COVID should be included in this category. There is some evidence that this group of patient experience reduced cardiac output that worsens when standing for a period of time, thus impacting their capacity to safely use their lower limbs for mobility.

Emerge Australia would encourage that ME/CFS and Long COVID be included in this table. Below is a suggestion for examples to include in each section:

Mild - stand unsupported in a line at the shops for 15-25min

Moderate - noticeable increase in heart rate or decrease in blood pressure after 8minutes of standing

Severe – an increase in heart rate or decrease in blood pressure after 3-8min

Extreme – a significant increase in heart rate or decline in blood pressure within the first three minutes of standing.

Q23 Balance

- a) The proposed changes better capture the functional impacts of balance, dizziness and a person's ability to stand
Disagree
- b) Please provide any additional comments regarding changes about balance (free text).

There is inconsistency in the way different disabilities are treated in tables 1 & 3. We acknowledge other criteria need to be met for both tables, but the inclusion of wheelchair or other assistive technology (AT) in table 1 isn't included in table 3 in the same way.

Comparing 20 points on Tables 1 and 3, if a person with ME/CFS can't walk around the shops, but they can mobilise around the shops if they have a scooter or wheelchair, then they don't meet the definition of a 20-point impairment rating on Table 1. The AT is a necessary mobility aid due to their disability, and they can't manage without it. The same qualification isn't made for a person with a lower limb disability in Table 3. Including wheelchair/AT in Table 1 is indicating that, if the person's limitations are at least partially overcome with a wheelchair, then they're not impaired. This is inconsistent, and biased.

The impairment should be that the person can't walk around without needing rest, assistance or AT.

Q24 Psychologists

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

Strongly Agree

- b) Please provide any additional comments regarding changes about psychologists (free text).

Nil

Q25 Mental Health

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

Strongly Agree

- b) Please provide any additional comments regarding changes about mental health (free text).

Nil

Q26 Neurodiversity

- a) Proposed changes better reflect conditions on the spectrum of neurodiversity

Strongly Agree

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

Strongly Agree

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

- keep the current list of descriptors and require a person to meet only one descriptor for the relevant impairment rating to be assigned
- add a new social skills descriptor and require a person to meet at least two descriptors for the relevant impairment rating to be assigned

- d) Please provide any additional comments regarding changes about neurodiversity (free text)

Q27 Cultural appropriateness

- a) The proposed changes better recognise the need for culturally appropriate assessments
Strongly Agree
- b) Please provide any additional comments regarding changes to address cultural appropriateness (free text).

Part 4 – Privacy and Publishing

This section requires ALL respondents to acknowledge they have read the consultation Privacy Collection Notice, as well as:

Q28 Respondents must indicate if they authorise their feedback to be published, and if they choose to have their feedback remain anonymous.

- I would like my submission to be published with identifying information (including name or name of organisation as provided in the questionnaire)
- I would like my submission to be published anonymously
- Do not publish my submission