30 July 2021

Disability Support Pension Projects Section  
Carer and Disability Payments Branch  
Department of Social Services

By email to: DisabilityandCarerPayments@dss.gov.au

Dear Disability Support Pension Projects Section

Re: Review of the Disability Support Pension Impairment Tables

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide feedback to the Review of the Disability Support Pension Impairment Tables (the Review). The RANZCP also thanks the Department of Social Services (DSS) for their stakeholder engagement with the opportunity to attend virtual meetings during the consultation period.

The RANZCP has over 6900 members, including more than 5100 qualified psychiatrists and around 1800 members who are training to qualify as psychiatrists. Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support a person in their journey of recovery.

The RANZCP recognises the Disability Support Pension (DSP) as an important safety net supporting people with disability in Australia. The RANZCP welcomes the Review, and any initiatives that further ensure social support systems are fair, accessible and have eligibility requirements that are clear.

In addition to the verbal feedback provided to the DSS, the RANZCP has developed a written submission to the Review. The Review has identified that 35.2% of people accessing the DSP have psychological/psychiatric disability, and the RANZCP emphasises that more needs to be done to ensure streamlined access for this cohort. The RANZCP also recommends updating the Tables to contain more accurate and contemporary language.

The RANZCP welcomes opportunities to support the DSS in developing best practice guidance relating to the DSP Tables. To discuss any of the issues raised in this submission, please contact Rosie Forster, Executive Manager, Practice, Policy and Partnerships Departments via rosie.forster@ranzcp.org or by phone on (03) 9601 4943.

Yours sincerely

Associate Professor Vinay Lakra  
President

Ref: 2404
About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is responsible for training, educating and representing psychiatrists in Australia and New Zealand. The RANZCP has more than 6900 members, including around 5100 qualified psychiatrists.

The feedback contained within this submission is based on extensive consultation with RANZCP Committees, including the Section of Psychiatry of Intellectual and Developmental Disability, Attention-Deficit/ Hyperactivity Disorder Network, Section of Rural Psychiatry, Section of Social, Cultural & Rehabilitation Psychiatry, Faculty of Addiction Psychiatry, Section of Neuropsychiatry, and Faculty of Psychiatry of Old Age. RANZCP Committees include psychiatrists with direct experience working in the mental health and disability sectors. As such, the RANZCP is well positioned to provide assistance and advice about this issue due to the breadth of academic, clinical and service delivery expertise it represents.

The expertise at the RANZCP is most suited to comment on the following three Impairment Tables:

- Table 5 – Mental Health Function.
- Table 6 – Functioning related to Alcohol, Drug and Other Substance Use.
- Table 9 – Intellectual Function.

Key messages

- The RANZCP recognises the Disability Support Pension (DSP) as an important safety net supporting people with disability in Australia.

- There is no health without mental health. For more information, please see the RANZCP page Physical health and mental illness.

- The RANZCP encourages long-term action in supporting people to access the DSP and other appropriate services within a system which recognises the episodic nature of mental health in a recovery-oriented framework.

- Any review of the social support system should further ensure that eligibility requirements are clear, and the system is fair and accessible. Eligibility for income support should be irrespective of a person’s visa status.

Introduction

The RANZCP welcomes the opportunity to provide input into the Review of the Disability Support Pension Impairment Tables. The RANZCP supports this review of the current system with the purpose of clarifying eligibility requirements and resolving barriers to access for people with mental health conditions.[1] This is of particular importance considering the data in the Impairment Tables Review Issues Paper; the largest percentage (35.2%) of people accessing the DSP have psychological/psychiatric disability.

The RANZCP commends the Department of Social Services (DSS) for the inclusion of stakeholders with a lived experience in the review process. Collaboration with lived experience and clinical expertise is critical in guiding system improvements and reform.
Table 5 – Mental Health Function

Complexity of the claim process

It is well known that people with mental illness can face significant barriers to accessing support services like the DSP. The RANZCP believes that more needs to be done to make disability income support more accessible for people with psychosocial disability, and we encourage further review of the DSP to ensure it is fit for purpose.[4]

The criteria for DSP can make it challenging for vulnerable Australians to qualify, and the claim process is both demanding and complex.[5] As recovery in mental health is often episodic, it is important to develop appropriate pathways and processes to support people in all phases of their journey, particularly when periods of illness approach rapidly, without warning. Additionally, the costs of gathering the required medical information for assessment, as well as waiting periods within the public system leaves the onus with individuals with disability.

Many people with mental illnesses are not able to fulfil the administrative requirements to access subsidies for people on low incomes (this may be due to cognitive impairment or other lifestyle issues) and therefore face higher costs when accessing services.[6] This is one example of the fragmented nature of our current system – there is no clear, supported pathway to access what is needed for the claim process. As such, it is important that timeliness is prioritised, to ensure that people can access the supports they need when they require them. The RANZCP highlights a need to reduce delays in the system and minimise the potential of conditions worsening in the interim.

The process is complex for clinicians as well as applicants. The RANZCP supports methods of attaining greater clinician awareness of DSP application processes and connection with the requirements. Clinicians have reported confusion regarding what evidence is required. Distribution of the updated Impairment Tables should be accompanied by an educational campaign or informational support package for clinicians, and a request for professional associations to provide a link to this on their websites.

Accessibility issues

The RANZCP highlights the importance of supporting people with psychosocial disability in the application process. In 2008, the Australian government signed the Convention on the Rights of Persons with Disabilities, which explicitly applies to people with serious mental illness.[7] This commits governments to enabling access to adequate social protection for people with a disability, including mental illness.[8] Specifically, there is a requirement to ensure access to poverty reduction and social protection programs, and government support in accessing disability-related services such as counselling and financial assistance.[8]

People with mental illnesses are at a significant financial disadvantage compared with the general population.[6] People with mental illnesses have lower than average incomes, largely due to the difficulties of obtaining and keeping a job while managing the symptoms of a mental illness.[6] The overall impact of this financial disadvantage is that people with mental illnesses face a number of cost barriers to establishing and maintaining healthy lifestyles, including the challenges of being able to afford adequate housing, food, health care and medical services.[6] Therefore, it is important that costs associated with application processes and delays in receiving application outcomes are considered.

The DSS has previously received stakeholder feedback regarding the challenge for people living in remote and regional areas to gather the required medical evidence due to availability of required services and barriers to accessing them. The RANZCP echoes this sentiment, and add that general practitioners are vital partners in providing support to individuals in these areas. To best provide support for applicants in remote and regional areas, general practitioners could be better included in the DSP application process and provided with the information support package previously suggested. The RANZCP adds that some
reports have shown that the challenge can be worsened by compounding disadvantage: for example, for Indigenous Australians living in rural and remote areas.[5]

Use of Government-contracted Doctors (GCDs)

The RANZCP understands that the DSS have previously received stakeholder feedback regarding the use of Government-contracted Doctors (GCDs). The RANZCP is supportive of systems, policy and practice based on evidence, and highlight the value of the longitudinal assessments that treating doctors can provide. 2018 data from the National Social Security Rights Network has found that the introduction of the requirement that Disability Medical Assessments (DMAs) be performed by GCDs is inefficient, delaying the claim process and increasing number of outcome appeals.[13] This report found that the removal of the TDR created further barriers to access for applicants, including eligible applicants.[13]

The RANZCP highlights the importance of supporting individuals with mental health issues through the assessment process in any form it may take, particularly if an ‘interview’ process undertaken by someone unknown to the applicant is required. There is potential for this to be experienced as an overwhelming or invalidating process.

Additional considerations

The RANZCP commends the DSS awareness of issues with ‘permanency’. The criteria for a ‘severe impairment’ can be difficult for people with episodic and fluctuating conditions. It can also be difficult to clinicians to make assessments in cases where client functions change rapidly; in these cases, it can also be difficult for clinicians to provide the diagnoses required for application. The RANZCP encourages long-term action in supporting people to access the DSP and other appropriate services within a system which recognises the episodic nature of mental health in a recovery-oriented framework.[3]

Table 6 – Functioning related to Alcohol, Drug and Other Substance Use

Considerations

The RANZCP notes that in comparison to Table 6, the other tables appear to be more specific, including criteria with examples. For example, Table 5 provides specific criteria to assess, citing examples for each (a through to f) in every category. Table 6 instead has fewer criteria, and fewer examples. Table 6 may be improved by more closely emulating the functionality criteria descriptions of Table 5 to create a more standardized process.

Table 9 – Intellectual Function

The RANZCP recommends the consideration and/or re-wording of Table 9 in the following ways:

Table 9 states:

- A person with Autism Spectrum Disorder, Fragile X Syndrome or Foetal Alcohol Spectrum Disorder who also has a low IQ should be assessed under this Table.

Table 9 could instead read:

“A person with Autism Spectrum Disorder, Fragile X Syndrome or Foetal Alcohol Spectrum Disorder who also has an IQ score of 70-85 should be assessed under this Table.”
Table 9 states:
- Diagnosis of a learning disorder such as dyslexia does not equate to a diagnosis of intellectual disability.

The review should consider:
The RANZCP recommends the removal of this statement, as Table 9 is not specific to Intellectual Disability (ID). Table 9 is not about ID, it is about Borderline Intellectual Ability, and requires improvements for clarity. The idea represented in Table 9 is that the DSP should be accessible to people who fall outside the category of ID, but who nevertheless have problems with intellectual functioning (within the borderline IQ range of 70-85) and who also have functional impairment.

Table 9 states:
- Table 9 is to be used where the person has a permanent condition resulting in low intellectual function (IQ score of 70 to 85) resulting in functional impairment, which originated before the person turned 18 years of age.
- An assessment of the condition must be made by an appropriately qualified psychologist.
- An assessment of intellectual function is to be undertaken in the form of a Wechsler Adult Intelligence Scale IV (WAIS IV) or equivalent contemporary assessment. This assessment should be conducted after the person turns 16 years of age. A Wechsler Intelligence Scale for Children (WISC) assessment completed between the ages of 12 and 16 years is also acceptable for people aged 18 years or under at the time of assessment.

The review should consider:
The RANZCP notes that this wording implies that an IQ test has to be completed between ages 16 and 18. If the intended meaning is that IQ testing should use WAIS if the individual being assessed is older than 16, and WISC if younger than 16, this should be made clear.

Table 9 states:
- Consideration of the adaptation of recognised assessments of intellectual function for use with Aboriginal and Torres Strait Islander peoples is required.

The review should consider:
The RANZCP highlights that this statement follows passages requiring the application standardised and culturally insensitive instruments of intelligence testing and functional impairment.
Table 9 states:

- An assessment of intellectual function is to be undertaken in the form of a Wechsler Adult Intelligence Scale IV (WAIS IV) or equivalent contemporary assessment. This assessment should be conducted after the person turns 16 years of age. A Wechsler Intelligence Scale for Children (WISC) assessment completed between the ages of 12 and 16 years is also acceptable for people aged 18 years or under at the time of assessment.

- An assessment of adaptive behaviour is to be undertaken in the form of either the Adaptive Behaviour Assessment System (ABAS-II), the Scales for Independent Behaviour – Revised (SIB-R), the Vineland Adaptive Behaviour Scales (Vineland-II) or any other standardised assessment of adaptive behaviour that:
  - provides robust standardised scores across the three domains of adaptive behaviour (conceptual, social and practical adaptive skills);
  - has current norms developed on a representative sample of the general population;
  - demonstrates test validity and reliability; and
  - provides a percentile ranking.

- Consideration of the adaptation of recognised assessments of intellectual function for use with Aboriginal and Torres Strait Islander peoples is required.

Table 9 could instead read:

“An assessment of intellectual function is to be undertaken in the form of a Wechsler Adult Intelligence Scale IV (WAIS IV) or equivalent contemporary, culturally appropriate assessment. This assessment should be conducted after the person turns 16 years of age.

An assessment of adaptive behaviour is to be undertaken in the form of a standardised assessment of adaptive behaviour that is culturally appropriate in nature.’

Table 9 states:

5  There is mild impact on intellectual function.

This review should consider:

Within the criteria section of Table 9 there are a series of assessments such as the example above. The RANZCP notes that “There is mild impact on intellectual function” is more accurately referred to as “Borderline intellectual functioning”. The following labels also should be changed to better reflect a contemporary understanding within health and psychology fields.
Additional considerations

The RANZCP highlights that within Table 9, the terms ‘intellectual function’ and ‘adaptive function’ are used incorrectly. Table 9 should indicate the impact of impaired intellectual function on adaptive function. It currently it reads as though the adaptive behaviour score has an impact on intellectual function.

This is further complicated by the following issues:

- The table identifies people with Borderline Intellectual Function, which is not a specific mental disorder, and not usually associated with functional impairment.
- The correlation between IQ and adaptive function is not strong; some people with low IQ can function very well, whereas others with a higher IQ may have impairments in function.

The review may also consider replacing ‘Intellectual’ with ‘Executive’ Impairment.

Additional comments

The RANZCP re-emphasises our support for further increases to DSP and Carer’s Payment. People with mental illnesses have higher than average needs for medication and treatment for both mental and physical health issues, which can result in higher health care expenses.[6] Discrimination against people with mental illnesses can also make it more difficult for them to find housing, resulting in higher housing costs.[6]

2018 data from the National Social Security Rights Network has found that there is significant confusion regarding the Program of Support (POS) requirement regarding when this is and is not a requirement, and in some cases has caused delays in processing claims.[13] Improved supports in place for applicants navigating the claim process are needed, in addition to provision of support following a rejected claim.

The RANZCP recommends that the Government ensures income support and social services are effectively integrated into an individual’s mental health care pathway.[1] This applies to the variety of government-funded payments and supports available, including the DSP.

It is also the position of the RANZCP that income support payments should be extended to all people, irrespective of their visa status.[1]

Assessment of co-morbidities

People living with a serious mental illness have significantly higher rates of major physical illness than the general population.[7,10] A bidirectional relationship exists between mental and physical health, with those with a serious mental illness experiencing physical illness and those experiencing chronic illnesses also likely to develop a mental illness. The gap in life expectancy between those who live with a mental illness and the general population is stark and needs to be addressed. Reasons for the burden of disease being high amongst people with a serious mental illness include unemployment and poverty.[7] People reporting poor mental health are likely to also report themselves as having three or more chronic diseases, suggesting that for these individuals and groups, all of the negative effects of chronic disease are compounded.[7]

Psychiatrists treat both physical and emotional effects of mental disorders.[11] The side effects of some medications for mental illness can also affect consumers’ physical health, meaning a delicate balance must be achieved between managing the mental and physical illness. For further information, please see the RANZCP resource on Physical health and mental illness.

As such, the RANZCP recommends that the Review consider providing clear information around assessment of co-morbidities. This is particularly important in the consideration of Table 6. Members of the RANZCP note cases where functionality assessments under Tables 5 and 6 independently may not reach the required points, but the dysfunction that occurs when considering both Tables combined is more...
significant. The review might consider including a clause in the introduction section of both tables, considering how impairments within Tables 5 and 6 may interrelate. It would be useful for clinicians to be supported by a clear process in the assessment of co-morbidities.
References


