



DEPARTMENT OF SOCIAL SERVICES EVALUATION OF THE REVISED DISABILITY SUPPORT PENSION ASSESSMENT PROCESS

STAGE 4 STAKEHOLDER CONSULTATION PAPER 6, 30 APRIL 2020 - RESEARCH DOMAIN KEY RESEARCH QUESTIONS OPPORTUNITIES FOR IMPROVEMENT

1. Have the changes introduced improved the consistency and quality of the DSP assessment process and in what way?

2. To what extent has the revised DSP contributed to the ability to achieve consistency and equity in DSP claims assessment across Australia?

1. Our members report that, in their experience advising and advocating for clients, the assessment of eligibility for DSP is not more consistently applied as a result of the changes. The complexity of DSP qualification criteria, and claim and appeal processes, place many DSP applicants at a significant disadvantage – including people who are prima facie eligible for DSP. As outlined below, certain cohorts of people with disability are particularly disadvantaged under current application and assessment processes.

Removal of the TDR has created systemic barriers

2. The removal of the Treating Doctor Reports (TDR) as part of the claim process has made it more difficult for claimants and doctors to understand what information should ideally be provided to support a DSP claim. The TDR was a source of guidance for both claimants and doctors about the information needed for decision-makers to determine DSP eligibility. While Services Australia provides online information regarding the types of medical evidence required to support a DSP claim, doctors do not necessarily access this information when approached by a patient seeking support for their claim.
3. Our January 2018 report, *Disability Support Pension (DSP): A snapshot of DSP client experiences of claims and assessments since the 2015 changes*,¹ examines data from our member centre, Basic Rights Queensland (BRQ). This report notes that the removal of the TDR has caused significant delays, and that in 77% of 22 DSP rejection cases for which BRQ provided assistance at the AAT, the appeal was successful due to provision of information that a TDR would likely have covered. The evidence required was only obtained by the claimant after seeking legal advice, with BRQ eliciting the evidence from the treating health

¹ Available on the EJA website at <https://ejaustralia.org.au/general/disability-support-pension-dsp-project-a-snapshot-of-dsp-client-experiences-of-claims-and-assessments-since-the-2015-changes/>

professional by requesting responses to a questionnaire tailored to the DSP eligibility requirements and impairment table guidelines (acting as a replacement TDR).

4. Providing clients with template treating doctor letters, and templates for doctors to complete in respect of relevant Impairment Tables, is in fact standard practice for our member services. These are useful tools for claimants and their doctors but such tools should be part of the claim process – not just for people who have had a claim refused and manage to access specialist legal advice.
5. The removal of the TDR has meant that worthy claimants can miss out on DSP simply because they are unaware of the specific information they need to obtain from their doctors. Treating doctors may have ample specialist reports on record that would establish their patient’s eligibility for DSP but they are only informed of the relevance of these reports once their patient has been refused DSP – and only if their patient understands this, and is able to pass the information on their doctor.
6. The TDR placed claimants on an equal playing field in terms of the information they could put forward to the decision-makers. Without the TDR, claimants and treating doctors are generally ill-informed regarding the evidence to provide at the time of claim. As one service’s senior solicitor puts it:

“Most of my clients’ difficulties over the years come down to removal of the TDR ... both treating doctor and claimant are flying blind for lack of knowing what information is required to show. Most clients have never heard of the concepts ‘fully diagnosed, treated and stabilised’, ‘continuing inability to work’, ‘impairment’, ‘Impairment Tables’, ‘program of support requirements’, etc., until contacting us and many times they’ve conveyed their treating doctor’s exasperation. A common problem is the misconception that having a long history of medical certificate exemptions (for Newstart) aids their case when often it becomes the obstacle”
7. The discontinuation of the TDR as part of the claim process has created a significant barrier for claimants/treating doctors with limited capacity/time/inclination to work out what evidence would support a DSP claim. It also places claimants at great disadvantage if their doctor either does not appreciate the need to provide supporting medical evidence/reports, or will not do so without payment for the report. The result is that the only way many applicants and their doctors can make their way through this process is with the guidance of a legal advocate. One of our solicitors with many years’ experience advocating for clients on DSP cases believes that:

“There should be a more holistic approach to assess people’s impairments and work capacity. Clearly, vulnerable people who do not have computer or literacy skills are disadvantaged and more likely to encounter greater barriers to accessing DSP. Typically, the homeless and itinerant are less likely to have access to a regular medical service and a support network. Consequently, at the time of lodging a claim for DSP they do not have all the medical evidence required and often have no resources to seek the required information. People in isolated areas, CALD and Aboriginal people are more likely to encounter barriers and difficulties in putting together the necessary medical evidence. Needless to say, anyone with serious or severe disabilities is more likely to find the whole claim process daunting and out of reach.”

The Job Capacity Assessment

8. In the experience of our member centres, the Job Capacity Assessment (JCA) is often an ineffective means of assessing eligibility for DSP, particularly for people with psychiatric and other cognitive disability. The JCA process is also generally unsuited to assessing the impact of multiple physical and/or psychiatric impairments on capacity to work. This means that claims from people with multiple impairments are likely to be refused at the original decision-maker level. Whether people in this situation can successfully navigate the review/appeal system and collect supporting evidence generally then depends on accessing advocacy and support services.
9. The criteria that a medical condition be stabilised and fully treated for an impairment rating to be assigned is often misapplied by decision makers. In our experience JCA assessors often re-interpret medical reports in ways that were unintended by the health professionals writing them, prompting unnecessary appeals and delays.

Case study - Fred: Fred claimed DSP providing medical reports which stated that his condition was permanent, stabilised and unlikely to improve with further treatment. However, one doctor noted that they had discussed the possibility of alternative treatment with client, or a referral to a pain clinic or for similar ameliorative treatment. The JCA determined that these comments indicated that the condition wasn't "fully treated". In this case the health professional had met their medical duty of care to fully inform the client of their treatment and referral options, and noted this in the report. The purpose of the report was not primarily for applying for DSP or any other benefit - it was part of the overall care of the patient. After DSP was rejected on this basis, the client then had to organise further medical reports to clarify that what was being recommended was only ameliorative, and that the health professional considered the condition to be stabilised and fully treated.

Program of support requirements

10. Many people with significant disability are excluded from DSP as a result of the requirements associated with Program of Support requirements. People who have left the labour market due to their disability often do not have a past history in employment services programs and therefore cannot qualify. This is despite the fact that on any reasonable assessment their level of disability is such that participation in an employment service program will not improve their prospects of re-entering the labour market.
11. The Program of Support requirement is often an unfair barrier to accessing DSP, particularly for older people, and people with numerous (often chronic) health conditions where it is often the effect of the conditions combined that prevents them from working, rather than any single condition assessed in isolation. People with multiple impairments are required to meet the Program of Support requirements to qualify for DSP irrespective of whether they score greater than 20 points on the impairment ratings. In contrast, a person with a single significant impairment assessed under one table as severe is excused from satisfying this requirement.

3. Are review/appeal outcome decisions communicated to applicants timely and clearly? Is there equity of access to these processes at present?

1. There can be extensive delays for cohorts of people who lack capacity to navigate the appeal system and gather evidence to support their appeal. Often, when an advocate queries progress with a DSP appeal, Centrelink's response is along the lines of "there is no timeframe for the review to be completed ... the customer is receiving Newstart so they're not in hardship".
2. ARO decisions vary in terms of the quality of information included in the written decision. While some ARO decision letters provide a detailed explanation of why a decision was made, with relevant legislation, facts and considerations explained; others merely cite a lack of evidence, with no information to assist the applicant and their doctors to understand the basis of the decision and work out what evidence may support a further appeal.
3. A fundamental issue is that many AROs tend not to consider DSP eligibility in its entirety; they stop as soon as one qualification criterion is not met. For example, if an applicant does not have 20 points on the Impairment Tables, the ARO will not consider or give information about inability to work, leaving the applicant with no understanding of how to proceed if they are able to provide evidence to support an increased impairment rating, and no idea what other evidence to provide to the AAT regarding work capacity. Our member centres have observed there tends to be a bias in favour of refusal, with evidence supporting this being given the greater weight in a matter.
4. As exemplified in some of the case studies below, ARO decision-making often lacks nuance. It is not uncommon for an ARO to regard any ongoing treatment as a reason a condition is not fully treated and stabilised, without considering what the treatment will achieve or whether ongoing treatment is required to manage a condition. This results in unnecessary and costly appeals to the AAT, with delays while medical evidence is obtained.

4. Are there any risks as a result of implementation of the revised DSP assessment process?

5. What are the known outcomes of those who are not considered eligible for the DSP? Do they seek alternative support?

1. The current system imposes fundamental systemic barriers to accessing DSP for particular cohorts of people with disability. As a result, many people in these cohorts who should be on DSP live in poverty on Newstart/JobSeeker, with periods of non-payment due to problems complying with mutual obligations. Ongoing requirements to negotiate and satisfy with mutual obligations with officers who may have no real understanding of the impact of particular impairments on work capacity creates considerable hardship, exacerbating mental health issues and causing some people with severe psychiatric conditions such as bipolar disorder or schizophrenia to disengage from maintaining income support.
2. At a systems level, rejected applicants are more likely to end up in hospital, more likely to rely on charities, and more likely to require other supports. This puts pressure on these systems, including from an economic perspective.

People with intellectual disability

3. People with intellectual disability can face challenges understanding DSP claim requirements and completing the tasks needed to get medical evidence – even with support. Given that intellectual disability is not a medical condition, it can be difficult for applicants and treating doctors to provide evidence to support a claim for DSP. Many people with intellectual disability rarely see a GP and may have had no tests to assess intellectual capacity since childhood. Others may see doctors and/or a psychologist regularly but for conditions unrelated to their intellectual disability. Processes need to be simplified and streamlined to ensure that DSP is accessible for people with intellectual disability.

***Case study - Paul:** Paul has an intellectual disability and cannot read or write. He received DSP before the 2015 changes but his DSP was cancelled, and when he contacted the legal service he was unable to explain why - he had been on Newstart for the past two years. Paul wasn't able to understand letters he was being sent by Centrelink, or the form he was given to make a new DSP claim. Our member assisted Paul to claim DSP, wrote to Centrelink asking for the records for previous claims, and arranged for Paul to see specialists in clinical psychology and cognitive impairment. Paul had great difficulty attending appointments and the service's social worker supported him to do this. After five months, Paul faced a final obstacle: he couldn't afford to see the specialist. Three weeks later Centrelink decided to schedule an appointment with their own doctor, for an assessment. Our member then wrote to Centrelink summarising all the medical evidence in relation to Paul, and submitted that he was eligible for DSP. After eight months, Paul was finally re-granted DSP.*

People with acquired brain injury

4. People with acquired brain injury are often unable to complete the tasks required to obtain medical evidence to support their claim for DSP. JCA's need to be open to seeking expert guidance regarding the impact of cognitive impairment on a claimant's capacity to work.

***Case study - Barry:** Barry has a cognitive impairment due to a brain injury and was unable to afford the specialist fees to get the assessment reports he needed for claiming DSP. He was struggling on Newstart Allowance. After over 10 months of assistance and advocacy provided by the legal service, Barry was referred to a specialist directly by the JCA, who was then paid by Centrelink. Barry was granted DSP based on his severe cognitive impairment. The referral by JCAs to specialists, or use of specialists in JCA assessments, are a method to overcome the barrier faced by this cohort.*

***Case Study - Mario:** Mario was 48 when he approached our member for assistance. He had suffered horrific injuries when he was run over by a car at high speed, suffering brain injury. Despite six months in hospital followed by intensive rehabilitative treatment, Mario was left with significant disability due to brain function deficit, with memory loss and inability to concentrate, and needing the ongoing support of his family and support worker. Mario claimed DSP but was rejected on the grounds of insufficient recent specialist opinion.*

Mario sought our member's assistance, and the advocate devised questions based on the Impairment Tables for his neurologist to provide an updated opinion in support of his appeal. The neurologist was "too busy" and unable to provide any written information or a report. With the help of Mario's support worker, the welfare rights advocate was able to identify older reports, already provided to Centrelink which detailed the extent of Mario's impairment. This was brought to the attention of Centrelink and nine months after Mario had claimed DSP the ARO decided that Mario was qualified.

People with psychiatric disability

5. Removal of the TDR as part of the claim process has placed people with psychiatric disability at a significant disadvantage. Clinical depression, anxiety, bipolar disorder and/or schizophrenia can severely affect capacity to plan and organize. The task of seeking out reports from treating doctors can be beyond the capacity of some claimants with psychosocial disabilities, with many potential claimants unable to pursue claims or appeals. For others, lack of insight into the seriousness and extent of psychiatric impairment can undermine proper assessment of impairment and work capacity – especially where they are unable to secure the support of treating doctors.
6. Assessment of people with severe but fluctuating psychiatric impairments needs to include consideration of functionality across a long time period, potentially years, to assess the impairment rating.

Case study - Harriet: *Harriet was a trained registered nurse with intermittent work history due to crippling and increasingly frequent bouts of depression. When she was referred to the member service by her support worker, Harriet clearly satisfied the 'severe impairment' rating for Impairment Table 5 as she was unable to complete daily tasks such as meal preparation, washing and cleaning without support from mental health workers, but Harriet's condition would fluctuate and there are periods where she could undertake the kinds of activities that would give her an assessment of 10 points under the same table. Despite these fluctuations, throughout the prior 10 years Harriet was unable to sustain employment due to regular, severe episodes of depression. Harriet's applications for DSP had been rejected based on assessments of short time periods when she was well, as being more important in assessing functionality than those times when she was unwell.*

Case study - Chris: *Chris is in his late 40s. He was diagnosed with Dissociative Identity Disorder and PTSD many years ago, and has a long treatment and management history, ongoing support from psychiatrist and regular GP. He has also had recent serious cardiac and circulatory issues. He is not on any Centrelink payments as he was employed for a couple of months before making contact the legal service, seeking information about what payments he may be eligible for. During the course of the advice Chris advised that he has not applied for DSP up until this point; his psychiatrist advised him to apply and offered to write a report but his GP told him not to bother as 'no one gets DSP any more'. The service advised him to claim DSP and let them know of the outcome. When the service checked in with Chris a couple of months later, he stated that he had not yet managed to finish his application as he disassociates every time he is reminded that he has not yet completed the DSP application. His GP was still discouraging him from applying as 'no one gets on*

payment anymore'. He also had not applied for any other social security payment as he was concerned of further disassociating if he has any contact with Centrelink.

7. In most cases, where a person is applying for DSP due to a mental health condition, the long process of applying for a DSP is harrowing and, in our member centres' experience, for many people the process exacerbates their condition.
8. People with severe psychiatric conditions can face challenges accessing and pursuing on-line information and claim processes, and often require a great deal of support and assistance to make a successful claim. People in these situations present to our member services in obviously great need, and have been relying on ad-hoc assistance from third parties to obtain and remain on Newstart Allowance/JobSeeker Payment, and even then frequently fail to meet requirements and lose payments. We see many clients who have been hospitalised because of severe illness and unable to meet requirements, only to have their Newstart/JobSeeker cancelled - and they may be eventually discharged without any income support. These are the people that our system should most be helping.
9. For many mental health conditions, it is impossible to obtain a diagnosis or report based on one appointment with a psychiatrist or psychologist. Often multiple sessions are needed for a medical professional to be able to provide a report required for a DSP application. This can result in great difficulties. In some cases, a person may have been engaged with a particular professional for some time, but the practitioner has a 'policy' that they do not provide DSP reports. The person's only option is to try to engage with an entirely new practitioner, and form a relationship, in order to be able to obtain a report. This can take a considerable amount of time and the fact that a person with a long-standing psychiatric condition has engaged with a new psychiatrist or doctor can complicate Centrelink's assessment of whether the person's condition has been fully treated and stabilised.
10. There are some cases where claimants for DSP are obviously seriously traumatised and have had long term treatment but find it difficult or impossible to find an affordable Clinical Psychologist or Psychiatrist to confirm their past PTSD and status. These vulnerable clients should be recommended by Centrelink for either a Specialist JCA or a Government Contracted Doctor who could fill any gaps on missing evidence. As the system now stands, people with psychiatric disability face hurdles that can bar their access to DSP, placing extremely vulnerable people at great risk.

Case Study - Anil: *Anil is a 52 years old woman who was a victim of child abuse followed by horrific domestic violence over a long period. She has PTSD. In recent times she had been homeless and itinerant and had difficulties maintaining her Newstart due to inability to comply with mutual obligation requirements, spending periods of time without income support. On contacting the service Anil's DSP claim had been rejected on the basis that she had not provided a recent psychiatric report. Anil explained that most of her medical records are in other states, where she received psychiatric treatment during the time when she was experiencing domestic violence. The welfare rights advocate suggested that she ask her current psychiatrist for a report, explaining this history. She lodged the new report with her appeal and was told by Centrelink that she needed to reclaim DSP. Anil did so, and DSP was granted.*

People with hearing impairment

11. "Table 11: Hearing and other functions of the Ear" is outdated and needs to be revised in the light of modern technology. The criteria to obtain 20 points under Table 11 are strict criteria and all must be met before 20 points can be reached. One of the criteria that must be met is that the person must use a captioned telephone. Captioned phones are generally no longer in use as they have been superseded by the use of text message SMS, but unless a captioned telephone is used, the 20 point criteria cannot be met.
12. Table 11 criteria should be revised and worded so that not all, but a majority of the criteria need to be met to obtain 20 points.

***Case Study - Jonica:** Jonica had to reapply for DSP - her previous DSP payment was cancelled when her husband had a temporary increase in income. She was unsuccessful with her application and subsequent appeals because she did not use a captioned phone, despite the fact that doctors and the AAT member all agreed she had profound hearing loss. Jonica used text message SMS rather than a captioned phone. She had previously tried a captioned phone but because of the lack of internet reception in her area it would not work. After the loss of her DSP, Jonica and her husband were forced to sell their home of many years and move to a cheaper area.*

People with degenerative conditions

***Case study - James:** James, a 58 year old man with chronic renal failure, back pain, osteoarthritis and anxiety and depression, first applied for DSP in March 2017, and was advised six months later that he was ineligible. He immediately applied for a review of the decision, as he had medical evidence that he was unable to work. While waiting for the review, James was required to participate in a Program of Support with a Job Network provider, which he commenced in October 2017. The Job Network Provider placed James in a part time job that required him to undertake manual labour, including moving relatively heavy objects and physical exertion. James attempted the job as asked. He collapsed while at work and was hospitalised for two weeks with chronic renal failure. In October 2018, more than 18 months after first applying, Centrelink contacted James and told him that his ARO review was unsuccessful, in part because his medical evidence was no longer current, and that he would need to reapply for DSP. James has thus been unable to meet the criteria for participating in a Program of Support due to his poor health, and is also unable to access DSP for this same reason. James is continuing to live on the Newstart Allowance. He has difficulty affording medication and has been forced take early release of his superannuation to meet medical expenses. He is also behind on his mortgage payments and has no employment prospects due to his medical conditions. Our member is supporting James with a new application for the DSP.*

People with multiple conditions/impairments

13. The burden on claimants who have multiple impairments and need to provide updated specialist reports on each of their conditions in the form required by the DSP assessment process can be overwhelming and difficult to satisfy.

Case study - Jack: Jack has a degenerative hip condition and was advised to have two total hip replacements. He also has a psychiatric disability. On contacting our member service, Jack had applied for DSP twice and been rejected each time, on the grounds that until both hip replacements were completed his medical condition wasn't "fully treated". After the first hip replacement was done, Jack's fear of further surgery and poor quality of life meant that his mental health quickly degenerated to the point he was unable to function. The member service assisted Jack to review the rejection of his DSP, on the grounds that his psychiatric condition should have been assessed at claim and that his poor mental health prevented him from having any further surgery. The member service assisted Jack to obtain reports from specialists who assessed his mental health condition as the highest severe category under the DSP rules. The service then advocated for Jack for a further 6 months before a decision to grant the DSP was finally made, more than 14 months after Jack originally applied.

Case study - Fatima: Fatima is a refugee who has suffered long term domestic violence and abuse. She is 56. She has been diagnosed with PTSD, associated with being held captive during the Iraq war and later experiences living in a refugee camp prior to migrating to Australia. Fatima received psychological counselling by a Specialised Trauma Counselling Service for Refugees which confirmed her attendance at more than 80 counselling sessions. In addition, Fatima has received ongoing support and counselling from refugees and women's health services. Fatima has never worked in Australia and is being put under a lot of pressure to attend Job Service Providers, with some suspensions or her payment as she struggles to cope day to day. She has applied for DSP twice. Her first claim was rejected as she was assessed as rating less than 20 points on Table 5 - Psychiatric Impairment. She applied again and appealed, without success. Fatima feels that the whole DSP assessment process ignores her plight and serious long-term PTSD along with other physical limitations.

People in regional, rural and remote communities

14. People living in regional, rural and remote communities face barriers accessing Centrelink services, as well as health and support services. Navigating DSP assessment processes and the appeals system is significantly more difficult for people outside metropolitan areas, and organising/obtaining medical reports can be impossible.
15. Overall, DSP claimants from regional and rural areas are disadvantaged by requirements to obtain up to date medical reports for each and every condition - as often specialists will only visit regional or rural areas infrequently. Specialists in rural and regional areas are limited in number, and often unable/unwilling to provide a report required for DSP purposes, especially if the applicant is not fee paying.
16. For Job Capacity Assessments, although Services Australia generally attempts to locate a specialist within a certain driving distance from the applicant's home, many applicants are still not able to attend these appointments due to transport issues or mobility restrictions associated with their disability. Services Australia will often be able to accommodate this by providing alternative phone and/or video appointments with the relevant assessor, but this is generally only if the claimant has raised the matter with them, and the person needs

to have access to the technology and skills to facilitate video conferencing as an alternative.

Aboriginal and Torres Strait Islander people

17. The current DSP application and assessment process often creates significant barriers for applicants who are Aboriginal or Torres Strait Islander, particularly those living in remote communities. Our member centres assisting these communities report seeing individuals with strong claims for DSP who have cycled through the assessment process and been rejected, sometimes multiple times, before seeking assistance.
18. A key barrier is often the need to obtain specific and targeted information from a treating medical professional for the application. Clients who speak English as a second, third, fourth or fifth language and lack strong skills in written and spoken English will most often not be in a position to self-advocate with clinicians to obtain a letter addressing the DSP criteria. Often, treating practitioners submit letters that simply list the individual's health conditions but do not address the criteria. Claims are subsequently rejected.

***Case study - Warren:** Warren is an Aboriginal man from a remote community with a cognitive impairment. He has limited English and literacy skills. He previously submitted a DSP claim and had inquired about DSP with Centrelink. Previous claim(s) appear to have been rejected due to lack of medical evidence. It was only when a legal service assisted the client with the claim process that the DSP was granted. The Department had arguably been aware the client's cognitive impairment, and the significant language and cultural barriers he faced in navigating the DSP process, for many years. However, Centrelink did not have medical evidence in their possession to support this and continuously placed the onus on the client to obtain and provide such evidence. Warren struggled to understand what was required of him and didn't provide the requisite evidence. The inability of our client to provide the requisite medical evidence and navigate the process appears to relate directly to his cognitive impairment, together with his status as an Aboriginal man living in a remote Aboriginal community whose first three languages are not English.*

***Case study - Elinor:** Elinor is an Aboriginal woman from a remote community. She has limited English and literacy skills, and a long history of substance abuse, which Centrelink has been aware of for many years, with medical records confirming this in its possession. On contacting the legal service Elinor had applied for DSP on numerous occasions but was rejected due to failure to provide either proof of identification and/or medical evidence. On one occasion, Centrelink referred Elinor to their contracted doctor for a medical assessment. The contractor made three attempts to contact Elinor and Centrelink, and then rejected the claim. Eventually, largely as a result of assistance from a legal service, the client was granted the DSP on the basis of her substance abuse.*

19. The consequences of not being placed on the DSP from an earlier date for both these clients included being subjected to onerous and inappropriate mutual obligation requirements and consequently being subjected to extensive compliance failures. This led to penalties being imposed and their Newstart Allowance being cancelled. As a result, both clients were not in receipt of any income for many weeks. Both clients were not aware of

and/or were unable to exercise their right to seek review of the compliance failures and therefore did not do so within the 13 week timeframe to obtain back pay.

20. Another barrier is often difficulty accessing “programs of work” in some remote communities or for individuals living remotely on outstations and homelands.

6. Has the revised assessment process impacted in any way on the way manifest claims are identified, assessed and processed?

1. The discontinuation of the TDR in respect of all new claims lodged from 1 July 2015 - requiring people to provide the raw data medical evidence even where their treating doctor managing their condition might be able to provide that information in a concise report - makes the process particularly onerous for claimants who are likely to have grounds to be regarded as manifestly eligible for DSP. Often the raw data does not include the information that Service Australia requires to consider the claim.
2. Even if a claimant’s life expectancy is clearly less than two years, there are still grounds for denial of DSP (for instance if the claimant has the capacity to work 15 hours or more per week). The introduction of the Disability Medical Assessment (DMA) appears to have increased delays in processing these claims, which are particularly time critical given uncertainty of the claimant’s life expectancy.

People with terminal conditions such as cancer

3. Clients with terminal conditions can be dismayed that despite submitting medical reports stating that their condition is “terminal”, they have been denied DSP because the condition has not been “fully treated” or “stabilised”.

Case study: Sandrine has a rare type of bone cancer. With the help of her husband she applied for DSP because she was too fragile and weak from intensive chemotherapy and other treatments to satisfy Newstart Allowance job-seeking requirements. Her payments had been stopped many times. The welfare rights advocate contacted Sandrine’s specialist, who after some time provided a report which stated that her condition would not improve with further treatment, and that the treatment was merely keeping her alive. Her claim for DSP was subsequently granted. Sandrine’s husband felt frustrated and distressed that it took so long for Centrelink to understand the severity of his wife’s condition, and that she wife was too ill to work.

Case study: Bob has terminal cancer and claimed DSP while receiving chemotherapy. When Centrelink rejected his claim for DSP, Bob could not comprehend why. On appeal he was successful but Bob’s view that it should not be so onerous for people with terminal cancer prognosis to qualify for DSP is valid. He told his welfare rights advocate that “it’s bad enough battling the disease ... coping with this whole new experience (i.e. claiming DSP) is overwhelming in itself.”

7. What has been the impact on the revised process on DSP claims lodged, assessment processes, referrals made, claims granted, and appeals lodged?

8. What have been the key issues, barriers and enablers to implementation of the revised DSP assessment process which may impact ability to achieve intended outcomes?

1. The Australian National Audit Office's graphs, copied below, show steady reductions in DSP claims and recipients (*Disability Support Pension - Follow-on Audit*. <https://www.anao.gov.au/work/performance-audit/disability-support-pension-follow-audit>)

Figure 1.1: DSP claims data – claims and rejections, 2010–11 to 2017–18

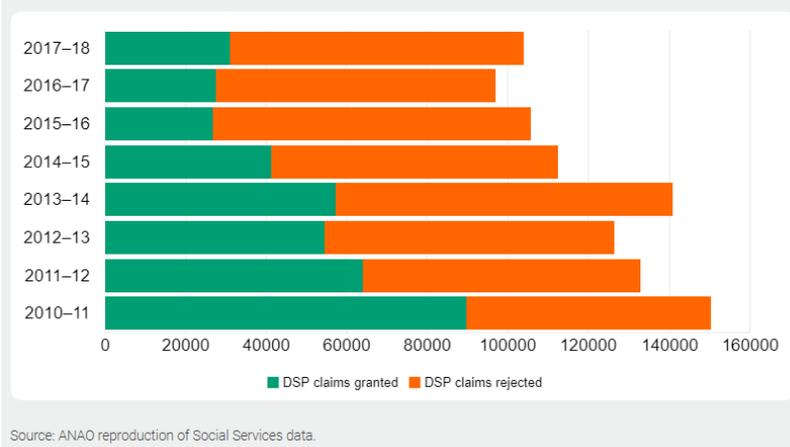
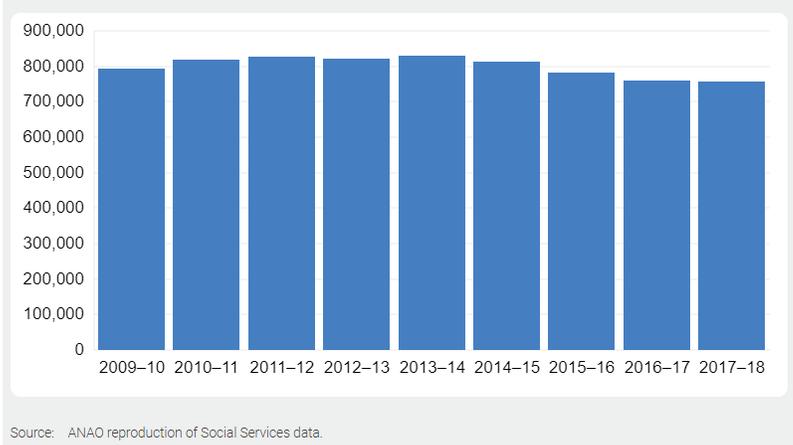


Figure 1.2: Number of DSP recipients, 2009–10 to 2017–18



2. As outlined above, the fact that the 2015 changes have led to a significant decline in the number of DSP claims, and in the size of the DSP cohort as a proportion of the working age population, should not be regarded as a measure of 'success'.

9. In reviewing the administration of the revised DSP assessment process, including the data collected and management systems, what if any changes are recommended to the administration of DSP in the future?

1. Our members consistently report that their DSP clients are worn down by claim and appeal processes to the point that many give up on claiming or pursuing applications or reviews/appeals, and that it is people who struggle with Newstart/JobSeeker obligations who are most likely to find barriers to appealing insurmountable. This is especially so for people with cognitive/psychiatric disability.
2. In our view, whether or not the 2015 changes have produced greater consistency and rigor in decision-making, they have also created systemic barriers that would be contributing to a reduction in DSP claims, grants and appeals. This culling effect is iniquitous and as outlined below, excludes many people with disability from accessing DSP purely because they cannot meet the rigours of the processes. The result is that there is an expanding pool of people with disability on Newstart/JobSeeker who are unable to comply with mutual obligation requirements for the very same reasons they lack the wherewithal to pursue DSP claims and appeals.
3. We make the following recommendations to improve the operation of the claims and assessments process for DSP:
 - a) Develop targeted information resources on DSP eligibility criteria for people with disability, in accessible formats that take into account barriers experienced by people with disability.
 - b) Improve communications with DSP claimants surrounding eligibility criteria, medical assessments, information regarding what medical evidence is outstanding and required by Services Australia.
 - c) Ensure that communications with clients regarding DSP claims and decisions are accessible to people with disability, including people with sensory impairment, cognitive impairment, psycho-social disability.
 - d) Ensure that DSP resources and communications for Aboriginal and Torres Strait Islander people and people from CALD communities are accessible, and in Easy English as well as community languages.
 - e) Ideally **reintroduce the TDR process**; OR in the alternative, develop questionnaires for each impairment table (acting as a replacement TDR) for the claimant's treating health professionals, with the questionnaires requiring responses to specific matters considered by Services Australia in assessing claims for DSP.
 - f) Require JCAs to contact the claimant's treating health professional where:
 - g) the assessment is conducted via telephone or video link;
 - h) the claimant is a vulnerable person; or
 - i) the JCA is going to make a determination contrary to the treating health professional's opinion (to circumvent unnecessary delays for the meritorious claims, having regard to the case study referred to above).
 - j) Require JCAs to refer the matter to Centrelink's Health Professional Advisory Unit in circumstances where their determination is contrary to medical evidence from the treating healthcare professional (to circumvent unnecessary delays for the meritorious claims, having regard to the case study referred to above).

- k) Require JCAs to advise claimants of the gaps in their medical evidence if it is considered that the medical evidence submitted does not address some of the DSP eligibility requirements.
- l) Require that a copy of the JCA report be provided to the claimant.
- m) Require that the treating health professional be compensated for providing reports to support DSP claims, particularly when it is requested by an authorised representative or agent of Service Australia, to encourage and ensure reports are provided in a timely manner and address all the issues.
- n) GCDs who conduct Disability Medical Assessments must be provided with an assessment checklist, designed for the claimant, to ensure they assess each aspect of the claim.
- o) GCDs must contact the treating health professional if the Disability Medical Assessment is conducted via telephone or video conference.
- p) The Disability Medical Assessment process should focus on assisting vulnerable and disadvantaged claimants whose claims are denied following a JCA, rather than limiting the process to double checking favourable assessments.
- q) Amend the legislation and policy to allow for individuals who appeal the decision to reject their DSP claim to be deemed eligible for DSP on any date between the time of claim and a review determination. This will fast track claimants who: request an internal review of the decision to reject their DSP claim or pursue an appeal to the Administrative Appeals Tribunal; deteriorate in their condition while their review or appeal is on foot; are unsuccessful in their appeal because they were not medically eligible at the time of claim; submit medical evidence which proves that they became medically eligible for DSP after the time of claim but before the appeal is determined. This will also reduce the number of claims lodged as claimants are less likely to lodge multiple claims concurrently.
- r) Improvements to the Program of Support:
 - Ensure that clear communication and information is provided to all claimants regarding the POS, particularly to unemployment payment recipients who are likely to be potential DSP claimants (and at the very least, information should be targeted to reach those on unemployment payments who are regularly exempted from mutual obligation requirements due to ongoing medical issues);
 - Any claimant who is found ineligible for DSP on the basis that they have not commenced a POS should be assessed as to their capacity to participate in the program and, if medical evidence indicates that they cannot participate in the program, they should be found to be eligible for DSP.
 - A no-cost POS should be available to any claimant who satisfies the DSP income and assets test, is not currently in receipt of an income support payment, and who is required to complete a POS to become eligible for DSP.
 - Services Australia should be required to regularly publish comprehensive data about the DSP program, including: consistent data about claim processing timeframes, including data broken down by reference to the two current stages (JCA and DMA); consistent, data about the DMA process, including proportion of claims referred for a DMA, outcomes of the DMA process and proportion of DMA determinations which differ from the JCA process; and, information about the use of interpreters, face to face assessment versus assessment by phone, video link or on the papers, and other measures of service delivery relevant to assessing the

process' quality for particular groups such as residents of remote communities, non-English speaking claimants and so forth.

Contact for this submission

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