CONSULTATION RESPONSE

Allied Health Professions Australia

Joint Standing Committee on the National Disability Insurance Scheme

Inquiry into Independent Assessments

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Introduction

Allied Health Professions Australia (AHPA) thanks the Joint Standing Committee on the National Disability Insurance Scheme (NDIS) for the opportunity to provide input into its Inquiry into Independent Assessments. AHPA is the recognised national peak association for Australia's allied health professions, collectively representing some 130,000 allied health professions. Allied health professionals are a critical part of the NDIS, providing a wide range of supports and services to help participants maintain and improve function, build their capacity to participate in community life, education and employment, and to access vital assistive technology (AT).

AHPA is well-placed to provide expert feedback on the independent assessment proposals. Allied health professions are well-recognised for their role in providing functional assessments for people with disability, and allied health professions from six key professions will comprise the independent assessment workforce under current proposals. This recognition of the important role and clinical expertise of allied health professionals has been welcomed by the sector. While the sector has significant questions about the current design of the independent assessment process, we are strongly supportive of the valuable role of allied health professionals in supporting access and eligibility decisions, and in informing the development of plan budgets. We note in this context that any introduction of independent assessments for early childhood intervention should also require assessments to be conducted by allied health professionals.

In addition to its role and expertise as the key voice representing the sector, AHPA has significant insight into the independent assessment proposals, and in particular the assessor workforce, through previous work undertaken with the six allied health professions identified as potential independent assessors and the National Disability Insurance Agency (NDIA). This Agency-funded project focused not on the assessment process itself, but rather on the skills, expertise and required credentials of potential assessors, the training of that workforce, and guidance about potential quality assurance processes. Important questions about the assessor workforce, and the processes for ensuring the quality of assessments, remain unanswered. AHPA sees clear opportunities to build on the recommendations of that project, in conjunction with evaluation data from current pilot activities, to begin addressing key questions such as the impact of pre-access requirements, the efficacy of the current assessment toolkit, the appropriateness of the proposed assessment process and its adequacy in relation to other factors that impact participant needs, the impact of assessments being undertaken by a profession without specific expertise in the participant's area of disability, the use of independent rather than known allied health professionals, the impact of standardised budget setting with minimal capacity for variation, and how the changed planning process impacts participant choice and control.

In responding to this inquiry, AHPA has sought to focus on potential issues and opportunities to address these. Our key focus is ensuring the safety of participants and the integrity of the Scheme. We stand by the participant sector and other stakeholders in calling for a delay in the rollout plan for independent assessments. Our belief is that extra time is required to support an evaluation of current trials, and to allow additional trials to be undertaken, in order to ensure that the goals of the independent assessment proposals are achieved without adversely impacting participants.

As a final note, AHPA argues in the strongest possible terms for the need to build ongoing mechanisms to provide clinical oversight and input from the allied health sector in any assessment reforms. We call on the government to recognise that it is seeking to put in place a process that is largely new and untested—any proposals will need to evolve on the basis of evaluation and clinical input and the processes for allowing that input and oversight must be prioritised.

Recommendations

While AHPA has provided detailed responses to the individual terms of reference below, we have summarised below our key recommendations for consideration by the Joint Standing Committee.

Our recommendations are that the Australian government and the NDIA:

1. *Delay the roll-out of independent assessments to allow additional testing and refining of the independent assessment trials as well as other complementary assessment models, such as those outlined below, to be undertaken.*
2. *Publish pilot results to show outcomes of current expanded independent assessment trials and identify areas where additional testing is required, such as for particular participant cohorts.*
3. *Separate the use of independent assessments for Access and Eligibility purposes and Planning Policy to allow time to fully test the impact on scheme entry before planning processes are changed.*
4. *Formally retract claims that allied health professionals are unduly impacted by sympathy bias and acknowledge the value of ongoing relationships between participants and health professionals as a foundation for quality care and appropriate assessments.*
5. *Establish an expert advisory group (EAG) comprising allied health professionals with appropriate disability expertise, and participant representatives, to support and oversee evaluation of current and future pilots. Allied health representation should cover key clinical areas of focus including physical disability, communication and auditory disability, mental ill-health, developmental delay, Autism Spectrum Disorder (ASD), assistive technology (AT) and behaviour support.*
6. *Use the EAG to act as an independent (of the NDIA) clinical advisory body on the assessment toolkit, noting the importance of independent clinical input and oversight to address potential bias from the NDIA, as the funder of services, in relation to ensuring the assessment process can fully capture participant needs.*
7. *Establish in parallel to the EAG an updated program of work in conjunction with the allied health sector to continue refining processes and requirements for assessor organisations in relation to the training, credentialing and quality assurance requirements for the assessor workforce, including the early childhood assessors. This group should also consider how training, credentialing and quality assurance would apply under the proposal to draw assessors from a participant's current team of supports.*

8. *Work with EAG, allied health working group, and participant sector to identify gaps in current assessment proposals, based on pilot outcomes and consultation input, to find and test solutions through additional pilot programs. These should focus on:*
    a. *Reviewing the impact of pre-access requirements, particularly for cohorts that may have issues establishing eligibility, and options to increase access to funded allied health and medical assessments focused on establishing permanence and/or diagnosis as part of a more equitable and streamlined entry.*
    b. *Additional information needs, including environmental factors and the capacity of family or informal supports, that are needed as part of independent assessments if these are to support accurate budget setting process and the process by which allied health assessors gather this information.*
    c. *Identifying additional assessments, including communication assessments, that may be required and how these inform access and plan budget setting.*
    d. *Identifying the circumstances in which individual allied health professions or professionals with areas of specific clinical experience such as psychosocial disability or communication disorders may be more suited to carrying out assessments for particular cohorts of people with disability.*
    e. *Development of a complementary model that uses allied health professionals with existing relationships with participants or applicants to the scheme with existing health professional support to undertake independent assessments, using the standardised toolkit, and whether additional training, credentialing and quality requirements would be necessary.*
    f. *Identifying how goal-setting and differences in individual aims can be built into the budget setting process to support a more appropriate planning process.*
9. *Work with EAG to establish mechanisms to monitor, report on and advise on potential incremental changes to independent assessments during staged rollout including:*
    a. *Impact on scheme access, particularly for underrepresented cohorts such as people from Aboriginal and Torres Strait Islander communities and those with psychosocial disability.*
    b. *Effectiveness of using independent assessments for budget setting and overall impact on size of plan budgets and access to services using both scheme data and participant feedback mechanisms.*
    c. *Performance of independent assessor organisations through comparative benchmarking including benchmarking of independent assessors with assessments carried out by non-independent assessors.*
    d. *Effectiveness of current assessment toolkit and benchmarking with alternative tools identified by clinical experts during consultation.*
10. *Consider the role of the NDIS Commission in relation to the registration of independent assessor organisations and as a foundation for ensuring quality and regulatory oversight.*

Responses to the Terms of Reference

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

AHPA and its members have had extensive engagement with the NDIA and the independent assessment process over the last 12 months, providing advice on the assessor workforce, and participating in consultations on the proposals. Despite that engagement, AHPA and its members feel poorly placed to comment on the modelling and justifications for the introduction of independent assessments. The Australian government and the NDIA have provided limited data or justification for the changes, primarily focusing on Scheme sustainability as a result of projected future costs, and the varying size of plan budgets between postcodes supports arguments. It is not clear how well-substantiated these arguments are, given that the Scheme is still relatively immature and experiencing significant and ongoing change. Nor is it clear that the independent assessment proposals will significantly impact the advantage that inner city participants, with higher levels of education and capacity to self-advocate, may have.

The sector is well aware of issues with the consistency of access and planning decisions by the NDIA, with extensive anecdotal evidence from practitioners working in the field suggesting that significant issues remain in relation to planning, plan review, and the decision-making process. It appears clear that a key aim for the independent assessment process, and the introduction of flexible budgets, is to increase automation of the planning process to reduce the need for planners to make as many individual decisions about participant plans. We note the extensive work of this Committee in relation to planning issues and the relative lack of progress by government and the NDIA in addressing those specific planning recommendations.

Despite our uncertainty about the accuracy of modelling and the underlying justification for the planned introduction of independent assessments, AHPA is generally supportive of several key aspects of the proposals:

- **Equity** remains an issue in relation to Scheme access and it is clear that a range of cohorts are still underrepresented as participants. People with psychosocial disability, Aboriginal and Torres Strait people, those from a Culturally and Linguistically Diverse (CALD) background, those from lower socioeconomic strata and those living in rural and remote areas are all less able to access the Scheme as it currently operates. Given the impact of paying for the necessary assessments, and issues for some cohorts in accessing the necessary workforce to undertake assessments, the proposal to provide free access to appropriate allied health assessments must be seen as positive.
- **Ensuring the right practitioners are involved in assessments,** by placing allied health practitioners in a central role, is a further positive and there remains significant scope to utilise the clinical expertise and knowledge of allied health assessors to support Scheme access and planning processes.
- **Flexible budgets** provide increased flexibility for participants and reduce the dependence on experienced planners and self-advocacy to achieve good outcomes at the planning stage.

This is likely to significantly reduce the need for plan reviews or arguing for services that participants benefit from but planners don't understand.

Despite these positive aspects, the allied health sector considers the current proposals for independent assessments to have major flaws that, if unaddressed, are likely to undermine any potentially positive outcomes. These flaws include:

- **Pre-access eligibility requirements** will disproportionately impact a number of cohorts that are already underrepresented in the Scheme and will undermine any equity improvements. AHPA argues that additional pathways should be trialled for inclusion in the new access process that provide access to assessments without requiring a full diagnosis and demonstration of permanence for select cohorts.
- **Independent assessors** are more likely to inaccurately assess the individual participant's functional needs when compared with a practitioner who knows the participant well. This is likely to be exacerbated if the workforce is relatively inexperienced, and may not have specific professional training or experience in the area of disability experienced by the participant being assessed, as is likely under current proposals.
- **Sympathy bias**, as argued by government, and the resulting need for independence, is inaccurate and at odds with extensive research showing the importance of relationships between consumers and health professionals for good health outcomes.
- The **Assessment toolkit** has been developed without independent clinical input and it is not clear if, and how, the extensive feedback from the allied health sector about the need to expand the assessment process through the use of other tools and, where appropriate, additional assessments, will be addressed.
- Independent assessments, based on the current process and assessment toolkit, are untested in relation to their use for **setting plan budgets.** The tools have not been designed for this purpose and very significant questions remain about whether it will be safe and appropriate to generate standardised budgets, with limited ability to vary these during the planning process, on the basis of the participant profiles and/or assessment scores generated by the assessment process.
- Participants currently have no option of flagging issues with the assessment process and calling for a second assessment or **review.** Participants also appear not to have a process for calling for a formal review of the plan budget outcomes of their assessment. Current proposals only allow a participant to challenge reviewable decisions.
- The Australian government's decision to finalise tender arrangements before the completion of the consultation process, has undermined confidence in the proposals and the consultation process, and raised questions about potential conflicts of interest.

Given these significant uncertainties, AHPA argues strongly for the need to delay rollout of the plan and for further testing and development work to be undertaken, based on a principle of co-design and independent clinical input, with people with disability and the allied health sector.

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

AHPA members have provided detailed feedback about their experience with other schemes with potentially similar features, their input primarily focusing on their experience of State and Territory accident and compensation schemes. This includes schemes such as the Victorian Transport Accident Commission (TAC). That feedback has suggested that these schemes differ significantly and cannot be directly compared to the NDIS or the independent assessment process as budget setting and access are not directly provided by an independent assessor. Instead these schemes tend to use one or both of two options—use of medical review panels and Independent Medical Examiners (IMEs)—to review whether supports recommended by non-independent health providers are appropriate and generally in relation to reviews to determine if further services are required. IMEs are most likely to be involved where there are disputes between the compensable scheme and the injured individual.

We note in this context that significant questions have been raised about the use of IMEs by compensable schemes. The Victorian Ombudsman found in several reports (2016, 2019) that the IMEs contracted by schemes like Workcover Victoria were potentially partisan and overly focused on the needs of the scheme in their decision-making.

Given the unique nature of the NDIS and the proposed assessment process, AHPA argues strongly for the need to ensure that there is ongoing clinical oversight and evaluation of the assessment process, in whatever final form it takes, as part of a process of continual review and refinement to address inevitable gaps. We note that the NDIA has already flagged the unique nature of its needs in relation to the toolkit and that it may become necessary to design a custom assessment process. We reiterate our argument that this should have a degree of independence from the NDIA, and comprise appropriate allied health clinicians and participant representatives. That group should be charged with providing regular reports to the public about its work and findings to support a sense of transparency.

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

The allied health sector takes the very strong view that an effective assessment requires an appropriately qualified and experienced practitioner, and sufficient time to undertake a full assessment. Given the high potential for variation in capacity over time, that is the likelihood that a participant may vary in their capacity at different times of day or on different days, assessments should take place across multiple sessions with the person. Practitioners also report the importance of observation in natural settings, to ensure that the practitioner can use their clinical judgement to verify what the participant or their family may report.

The sector continues to have significant concerns about the time constraints on assessors under current proposals, a concern we understand to be shared by organisations representing people with disability. Practitioners have repeatedly raised concerns about the adequacy of a three-hour block of time to complete a full assessment, particularly in light of the decision to use independent assessors with no prior knowledge of the participant that they can draw on. While the NDIA guidance for the

public flags potential flexibility for participants in relation to having the assessment undertaken over more than one day, it is not clear to what extent this will be mandated and how it aligns with the contractual requirements on the eight assessor organisations that the NDIA has signed contracts with.

The sector also continues to have concerns about how assessors and their professional qualifications and experience will be matched to the participant, noting for example that practitioners participating in work undertaken by AHPA with the NDIA in relation to the assessor workforce identified the need to ensure that a person with communication disability is assessed by a speech pathologist, and a person with psychosocial disability is assessed by a psychologist, mental health occupational therapist or mental health social worker (to use two simple examples). This is further complicated by the potential for participants to have functional needs across multiple distinct domains, for example having both physical disability and cognitive disability, and the resulting need for multidisciplinary assessment. Some aspects of assessment may require additional input from professionals not currently eligible to provide independent assessments—e.g. an audiologist in relation to hearing impairment or an orthotist/prosthetist in relation to the impact of assistive technology such as a prosthesis on functional capacity. While AHPA understands that the NDIA recognises the need to align clinical expertise and experience with the participant being assessed, it is not clear how this will be mandated for assessor organisations. We note in this context our concern that assessor organisations will not be able to attract the necessary workforce to meet this need, particularly in rural and remote areas.

The sector strongly argues for the need to have clear and mandated principles guiding assessor organisations in relation to the characteristics of the person undertaking assessments and how and when additional assessments or multidisciplinary involvement is triggered as a foundation for safe and effective assessments. These guidelines should be developed by the allied health sector, in conjunction with the NDIA, as a continuation of previous work already undertaken. We note that this guidance is appropriate regardless of whether the assessor is independent, or drawn from the health professionals currently providing services to a participant.

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

AHPA has flagged above its views in relation to the independence of potential assessors. We reiterate our strong rejection of the unsubstantiated government claim of sympathy bias and draw the Committee's attention to the health system where there is a contrasting view, based on extensive evidence, showing the benefit of an ongoing relationship with a health practitioner, such as a GP, and utilising that knowledge and expertise as the foundation for access to other care. Allied health practitioners working in the disability sector, and participants that AHPA has engaged with, have reported the importance of practitioners knowing the person, and their environment and supports, in order to properly understand their needs and individual capacity. For people with disability, there may a range of factors that amplify the need for a good understanding of the participant, including complex disability or behavioural factors, the need to establish trust, and the potential impact of environment and natural or informal supports. As such, AHPA rejects the need for independence, instead calling on the Australian government and the NDIA to acknowledge the value of clinical relationships as a foundation for effective assessments.

AHPA and the six professions identified as potential independent assessors—occupational therapy, physiotherapy, psychology, rehabilitation counselling, social work, and speech pathology—undertook extensive work in 2020 to identify the experience and credentialling requirements for allied health professionals working as independent assessors. This also included mapping out the support and supervision needs of that workforce, as a means of ensuring quality and appropriate clinical oversight. A detailed report was submitted in October 2020, outlining a range of recommendations and proposing that additional work to refine and enhance the advice, based on the findings of current pilot programs and changes to the independent assessment proposals was still required. That work has not yet occurred, however AHPA and its members welcome any opportunity to provide that clinical input as a means of ensuring the highest quality workforce is available to support participants during the assessment process.

The key findings of that work were:

- assessors should have a minimum of twelve months full-time clinical experience working as a clinician to be eligible to undertake the training to become an independent assessor
- newer graduates with less than 2 years full-time clinical experience should receive regular clinical supervision from a clinical supervisor, who has a minimum of three years of experience working in the area of disability and the same professional qualification
- training for all assessors should cover a wide range of areas of functional impairment to ensure that those assessors are able to identify potential functional needs and how best to undertake assessments for different types of disability
- all assessors should be subject to a competency assessment after successful completion of assessor training
- a consistent supervision template should be in place across all assessor organisations with a focus on ensuring that new assessors undertake case reviews and discussions with their supervisor when finalising reports
- formal supervision arrangements should remain in place even after assessors become more experienced as a component of quality assurance, noting that there are potential benefits from supervisors being from a different profession as a foundation for enabling multidisciplinary understanding and collaboration
- assessor organisations must have internal audit processes in place to monitor the consistency and quality of assessments conducted by their assessors
- the NDIA must have an overarching quality assurance process that involves auditing and benchmarking of performance across assessor organisations, with public reporting of outcomes.

AHPA also argues that the following additional quality assurance mechanisms are required to ensure consistency, quality and transparency:

- a proportion of audits should involve participant feedback to ensure that there is consistent input from participants into evaluation of overall quality
- monitoring and reporting on scheme data is required, particularly in relation to scheme access for key cohorts currently experiencing additional access barriers

- monitoring and reporting on scheme data in relation to overall plan values, plan utilisation and rates of plan reviews or complaints are required to establish quantitative measures to report on the impact of plan budget measures
- establish dedicated feedback mechanisms to allow participants to contribute feedback or seek additional reviews of their assessments where they feel these have not accurately represented their experiences.
- establishment an independent assessment expert advisory group consisting of participants, allied health practitioners to oversee evaluation and quality assurance at a national level.

We note that the project work undertaken by AHPA did not include in its scope the qualifications and experience of assessors undertaking early childhood assessments. We argue strongly that additional work is required by the allied health professions to identify those requirements in more detail, but that that a minimum qualification as an allied health professional, with 12 months of experience, is essential.

AHPA also notes that other allied health professions are likely to be appropriate as providers of independent assessments, noting that the key requirement for participation appears to be a combination of allied health qualification and meeting the Level B assessor requirements of Pearson Clinical, the developer of the Vineland 3 assessment tool. We very much support additional work to identify other professions that may be relevant as potential assessors, either in an independent capacity or as existing supports for participants that could provide assessment services. Engagement with Pearson suggests that other professions may well meet these requirements and we encourage a process that allows other professions to be included in the pool of potential assessors.

In some cases, assessors will require specific expertise that will supplement the standardised independent assessment process. Our previous work with the Agency in relation to independent assessments suggests that there are areas of additional input likely to be required for some participant cohorts and that additional assessments by appropriate allied health professionals will be required in areas such as communication disability. Further work will be required to identify these and to monitor the overall effectiveness of the assessment process both during current pilots and during a staged rollout. We note that there are already provisions for the use of additional assessments in the proposed process in relation to assistive technology and specialist disability accommodation.

We note that additional detail about these recommendations is provided in submissions by individual allied health professions to the Joint Standing Committee and in the report submitted to the NDIA by AHPA.

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

AHPA and its members have argued strongly that the use of independent assessments for the purpose of determining plan budgets is untested and that this use represents a far more significant deviation from the original purpose of the tools than access and eligibility. While we understand that the current pilot is seeking to test plan budgets, the allied health sector has not seen evaluation data

or been provided information about how effectively this is working. Instead, there has been extensive feedback from experienced allied health practitioners identifying a wide range of scenarios where a participant's needs would not be captured with sufficient granularity about environment, natural supports, and accessibility of local services and the costs associated with that access, to support the development of accurate plan budgets. We note the following examples that do not appear to be addressed by the current assessment tools:

- a participant who lives with his parents and who provide the majority of supports, but who experience physical or mental ill-health that may impact on their ability to provide care and which may require additional carer services
- a participant who uses a wheelchair and lives in a metropolitan area serviced by buses versus another participant based in an area with accessible train and tram services
- a participant who lives in an MM6 rural area with fly-in allied health services such as orthotic/prosthetic services, versus a participant in an MM6 area where local services are available but with significant travel time involved.

AHPA also notes that a number of allied health professions, including physiotherapy, psychology and speech pathology, have raised concerns about the appropriateness of the current toolkit and argued for changes or expansions to the assessment tools. Rather than re-stating those recommendations, we direct the Commission to those individual submissions. If the concerns highlighted by those professions are not addressed, and appropriate changes to the tools made, AHPA is of the view that there are significant risks that plan budgets will not match the requirements of participants.

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

The introduction of independent assessments, under current proposals, will have a range of potentially significant implications for access and eligibility to the NDIS. An immediate change will be the removal of access lists. AHPA recognises that the use of access lists has been imperfect and that particularly those that fall into category 2 or List B[i] have had unnecessary challenges demonstrating the impact of their disability on their daily life at the point of seeking access. Participants and providers report that this process can be both expensive and traumatic for people with disability. It can also have the effect of turning away people who should be accessing the scheme, particularly if they are still at a stage where they require only minimal supports. For example, those with degenerative conditions such as Parkinson's disease or multiple sclerosis will in almost all cases become participants and receive NDIS-funded services.

Many people with degenerative illnesses report being rejected on the basis of their functional capacity. The proposed shift to requiring only demonstration of diagnosis and permanence will ease some of the evidentiary burden and cost for this cohort. Despite this potential improvement, it will remain to be seen if the independent assessment process continues to reject participant at an earlier stage of progression of illness or if there will be increased capacity to be enrolled as participants with limited plan supports. It is also not clear how a person would access a new independent assessment if they have been rejected on the basis of limited functional need at the time of initial assessment. We note in this context our strong view that the scheme would be significantly improved by greater capacity to enrol people with disability as participants even if they

do not have extensive support needs, where it is clear that they will need more extensive supports at a future date.

In relation to cohorts that are currently underrepresented in the scheme, including people on the autism spectrum, people with psychosocial illness, people with single-domain disabilities such as auditory or speech conditions, and those with mild cognitive disability, it is less clear what the implications of the new assessment proposals will be. Pre-access requirements and the ability to demonstrate permanence will challenge some cohorts, potentially providing an ongoing barrier to access. Other cohorts will be able to demonstrate diagnoses and permanence and may benefit from improved access to functional assessments under these proposals which may increase their likelihood of being able to access the Scheme. In the absence of clear evaluation data from the pilot programs, it is difficult to make any real determinations about the implications for access and we argue strongly for formal and detailed reporting on current trials and work with participants and the allied health sector to identify gaps in the trial data that will need to be addressed by further testing.

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

The impact of independent assessments on plan budgets is one of the greatest sources of anxiety for both participants and providers, particularly in light of the proposals by the Agency to lock in the draft budget prior to planning meetings and to limit opportunities to adjust budgets based on the planning process. It appears clear that the new process will significantly impact the ability for participants to have budgets that meet their individual needs rather than a standardised profile, based on functional assessment results determined by the NDIA. While NDIA consultation documents (section 3.2 and 3.3) state that "a personalised budget will be informed by the participant's individual circumstances, such as their age and where they live, and their functional capacity, including any relevant environmental factors, such as available informal supports", a careful review of the current assessment tools by allied health professionals suggests that this is not currently possible with the proposed toolkit. Instead, the current process will provide a potentially incomplete picture of a person's functional capacity, with no real measure of need in relation to informal supports, including potential variation in capacity for informal carers, and limited ability to determine how local environmental factors may need to be considered.

In addition to concern about the capacity of the proposed assessment toolkit to capture sufficient information about a participant's circumstances to support a largely automated and standardised plan budget, AHPA also argues against the notion of standard budgets for participants that do not account for differing goals and aims. While AHPA recognises that this is a current position of the Australian government and NDIA, and one which recent media reports suggest was added by government to the final Tune Review[ii] report, we hold the strong view that it is incorrect, inefficient and contrary to the aims of the Scheme. The Tune review states that for "two participants with the same or very similar, functional capacity, of the same age and living in the same region, the NDIS is not designed to provide more funding for one participant over the other on the basis that their goals and aspirations are more expensive." While this approach clearly challenges the notion of genuine choice and control, AHPA also argues also that this type of standardisation is likely to result in inefficiency, and potential additional costs to the Scheme.

Participants may vary enormously in their individual circumstances and goals, despite otherwise fitting an Agency-generated functional capacity profile, with potentially significant differences in the level of funding that they may require. For example, several participants may all have similar levels of visual impairment, similar family and community supports, and also live in similar metropolitan environments. Yet one may be seeking to enter the workforce for the first time, another may want to learn how to use a guide dog, and another may wish to improve their physical capacity to ambulate safely in the community after a fall. Each of these is likely to require a significantly different range of supports and services with different costs associated with each. It is not at all clear how the proposed process will in any way engage with the individual goals of the participant, or how standardised budgets will accommodate this variation. Instead, any move to create average funding packages will mean that some participants are underfunded and likely to seek formal plan reviews and otherwise challenge the outcomes of the planning process. Other participants will be funded beyond what they may need, with the likely outcome that they are encouraged to spend more than they may have under current arrangements.

It is also not clear at all how individual assessments will reflect changes in circumstances such as a child starting school or an adult moving from supported into open employment. This lack of clarity around how independent assessments will account for critical factors in a participant's life and circumstances must be addressed to help the sector understand and have confidence in the proposed process.

AHPA argues strongly that allied health professionals, and the clinical assessment and planning that they undertake with participants, are an important source of input into the planning and budget-setting process. That expertise should be drawn in both through initial input as part of the independent assessment that provides context about a person's individual circumstances and the capacity of their family or informal supports, as well as their overall environment. There should also be capacity for participants to begin identifying goals, and to seek additional input from allied health professionals and other service providers, in order to provide input about potential plan needs before draft budgets are set.

Given the enormity of the change represented by the shift to basing plan budgets on standardised assessments and participant profiles, AHPA argues in the strongest possible terms for clear and transparent discussion about the outcomes of current trials with participants and allied health professionals. We argue for a delay in the rollout of this process and for additional testing, should an evaluation of current trials show that there is insufficient representation of different participant cohorts to validify the NDIA's budget planning assumptions. We reiterate our argument about the need to establish a dedicated expert advisory group to review trial data and to provide an ongoing monitoring function. This group should have very strong participant representation and interaction with the Independent Advisory Council. It should also consist of a broad range of relevant allied health professionals with appropriate expertise and experience. These allied health professionals will not directly represent their professions, but rather provide an independent, clinical input and oversight role, covering an appropriate range of clinical areas of operation including mental health and behavioural supports, intellectual disability, communication, auditory and hearing disability, and physical disability.

We also argue that it will be important for the Agency to collect and share both quantitative and qualitative data about plan budgets. This should include data on average plan budgets before and after the introduction of independent assessments, utilisation of plans, applications for plan review, and reporting on issues relating to expenditure of plan funds such as participants expending all plan funds significantly before the end of that payment period. In addition, we have argued strongly for the need to build in a review and feedback process that allows participants to provide input on independent assessments. This information should be formally reviewed and responded to by the expert advisory group with reports to be published by the Agency on their website.

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

While AHPA has flagged significant concerns about the need for further testing and refinement of the proposals for independent assessments, we also recognise the value of introducing a consistent assessment process for most, if not all, participants. Our view is that it will be essential to make sure that the assessment process works for all cohorts, including underrepresented cohorts, people with communication disability, cognitive disability, or who may be non-literate. It will also need to support people with disability who have no natural supports and instead are supported by formal paid supports. AHPA takes the view that it is appropriate and possible to design a process that has sufficient flexibility to support all Australians with disability, rather than sticking with the current imperfect process and identifying a range of circumstances where a person may not be required to undergo an assessment. AHPA argues strongly that relatively minimal changes—including allowing known allied health professionals chosen by the participant to provide an assessment using a standardised set of assessment tools—could address many of the major issues currently being flagged. AHPA also argues for the development of alternate and less formal assessment processes, based on the standard assessment tools, most likely comprising a flexible degree of interaction between the potential or current participant, their existing health professionals and other supports.

The intention of this less formal process will be to gather the information required for an assessment through other means that may be less intrusive for the person and may be based on the knowledge and expertise of others. We note examples provided by allied health professionals of people that have experienced trauma or have complex psychosocial or other disabilities that mean the person is unlikely to be able to participate in an assessment, particularly if they do not know that assessor. We note that Section 3.5.2 of the NDIA consultation documents released as part of the recent consultation on independent assessments refers to the possibility of significant aspects of the assessment being completed by ‘a person who knows them well’. We argue that with appropriate safeguards in place, this should be expanded to also include formal and informal supports involved in their life, potentially without their direct involvement.

AHPA notes that if a person has existing assessment information sufficient to demonstrate their functional needs, and is able to meet the information requirements of the assessment with information already gathered by health professionals, they should not need to undertake an additional independent assessment. It may be viable in such a case to have an assessor review evidence that has been provided and to complete a ‘desktop independent assessment’.

AHPA notes that these proposals will require additional work to refine and that it will be essential to co-design these with the participant sector, allied health professionals, and representatives from areas such as mental health. It will also be essential to undertake specific trials of these proposed assessment process with a range of cohorts such as those outlined above.

I. opportunities to review or challenge the outcomes of independent assessments;

AHPA strongly argues that there is a need to ensure that the independent assessment process can be challenged by participants, despite the lack of a formal reviewable decision in Administrative Law terms. In making this argument, we note that there are two different aspects of the assessment process that a participant may need to challenge, and a need for separate processes that allow each to be addressed. The first of these is challenging the assessment process undertaken by an independent assessor. A participant or their family may feel that the assessment itself did not proceed satisfactorily—e.g. they may feel the assessor lacked the necessary understanding or expertise to understand their disability and needs (such as feeling the wrong allied health professional is undertaking the assessment), they may feel they were unable to communicate their needs effectively (such as in situations where communication is difficult due to communication disability or the person's Culturally and Linguistically Diverse background), or they may feel that the assessor made incorrect assumptions. In this case there is a need to develop a process that ensures that a participant can flag concerns about the assessment process and can request a second independent assessment. We note that in this scenario, the participant may not have received either an access decision or a draft budget (i.e. the outcome of the assessment) and would only be raising legitimate concerns about the process of being assessed. AHPA argues strongly that the ability to raise issues about the review process is an essential aspect of overall quality assurance and must be embedded in the independent assessment process, particularly while the program is still in its infancy. We also argue that it will be necessary to provide protections for participants that ensure that they feel secure in their ability to raise issues without endangering their access to supports.

The other area of need for participants reviews or challenges of Independent Access outcomes is in relation to the draft budget that is developed on the basis of the independent assessment outcomes. It is clear from discussions with providers involved in trials that the independent assessment process will result in a score-based profile of the participant and that this will be used to determine the budget available to the participant. It is also clear from participants and providers that there is significant and appropriate variation in the plan budgets that individual participants will require, variation that is not currently captured in the assessment and budget development process. It is not clear that this is an administrative decision and eligible for review under Section 99 'Reviewable decisions' of the NDIS Act, yet it is fundamental to the Scheme and outcomes for participants. As such, provisions to allow a review or challenge to this budget is essential.

While formal review processes exist within the NDIA and through the Administrative Appeals Tribunal for decisions by delegates in relation to Scheme access, we encourage the Committee to consider whether these are accessible and appropriate for all participant cohorts.

J. the appropriateness of independent assessments for particular cohorts of people with disability, including Aboriginal and Torres Strait Islander peoples, people from regional, rural and remote areas, and people from culturally and linguistically diverse backgrounds

AHPA has raised concerns about the impact of pre-access requirements for a range of cohorts above, noting our concern about the potential cost of collecting appropriate evidence and reports, as well as the potential inaccessibility of the health professionals that could do the necessary assessments. For example, a family in a regional area may need to travel to a metropolitan centre on multiple occasions to access the necessary reports to demonstrate a diagnosis of developmental delay, and to establish permanence, at significant time and financial cost. This is a significant barrier for many who should be accessing services under the NDIS currently and is not addressed by the proposals. We note in this context that the NDIA in its initial response to the recent consultations noted the additional cost of rural and remote independent access services, and provides higher levels of funding in rural areas, yet provided no response to the potential issues around pre-access for rural communities.

AHPA and its members argue strongly that the impact of these requirements should be carefully reviewed, and consideration given to the development of alternate entry pathways to NDIA-funded assessments. This may involve reduced pre-access requirements for those cohorts that have been identified as under-represented and at potential disadvantage in relation to Scheme access. It may also involve options for funded pre-access assessments. We argue that an equitable approach is not one that is standardised for all cohorts. Rather it is one that recognises the different support needs of different groups and seeks to address those needs by developing the necessary entry pathways and support mechanisms to actively support access. It does so not in in isolation but in genuine co-design with the communities it is seeking to support, and the clinicians with the expertise and knowledge that is required.

AHPA also argues for the need to ensure appropriate training for the assessor workforce to ensure that they have appropriate competency and understanding of the cohorts that they are assessing. We reiterate our argument for allowing assessors to be chosen by participants from the health professionals known to them. This is particularly relevant for people from culturally diverse or Aboriginal and Torres Strait Islander communities. The importance of cultural understanding cannot be understated in relation to gathering appropriate evidence to underpin an assessment. Similarly, we argue strongly for the importance of ensuring that there is a foundation of trust between the assessor and the person being assessed, particularly for communities that have experienced previous trauma in relation to their engagement with government services. We note strong evidence for the value of investing in building the Aboriginal and Torres Strait Islander allied health workforce with a view to increasing the availability of assessments undertaken by people from within indigenous communities rather than outside of them.

We also note the value of increasing cultural awareness within the Agency. We argue strongly that improved access to indigenous practitioners should be a key focus of the scheme and other government initiatives and call for increased coordination between all governments, in the form of a national allied health workforce strategy, with targeted initiatives focused on issues and opportunities to build the Aboriginal and Torres Strait Islander allied health workforce.

AHPA recognises that cultural safety and inclusion also impacts heavily on Australians with a CALD background and we recommend increased engagement with organisations representing CALD communities for further advice and input. AHPA is aware that a key factor for consideration is recognising potential stigma and cultural factors that may impact on how participants and their families or informal supports may report on their own capacity and needs.

AHPA welcomes the opportunity to consider with the Agency how to develop training of assessors and the broader allied health disability workforce in relation to cultural safety.

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

AHPA and its members continue to have significant concern about the appropriateness of independent assessments for people with disability types that have been shown to be poorly supported by current Scheme entry processes. We also have concerns about the appropriateness of independent assessors performing assessments for people whose disability or previous experience of trauma may make participating in an independent assessment more difficult. Allied health practitioners flagged several types of disability during AHPA consultation activities, highlighting people with psychosocial illness, people with cognitive disability and limited family support, and people with communications disabilities such as Developmental Language Disorder (DLD) as being at particularly at risk. There are a range of reasons why these cohorts are likely to be particularly impacted by the introduction of independent assessments. We have outlined these below and argue that they must be carefully considered and addressed by appropriate process changes to ensure that reforms don't further exacerbate problems in the current Scheme or create new areas of disadvantage.

- **Equitable access:** Achieving genuine equity in terms of access cannot be achieved simply by creating greater standardisation through Independent Assessment. Instead, it requires the NDIA to identify those cohorts currently at a disadvantage, to proactively monitor the implementation of reforms to identify any new cohorts that might experience access barriers under the new process, and to create additional supports and processes for these cohorts.
- **Pre-access requirements:** AHPA has argued previous that the pre-access requirements create significantly greater barriers for some cohorts, such as those with psychosocial disability, which doesn't neatly fit the NDIA definitions around permanence. The cost and other barriers for disadvantaged cohorts must be identified and addressed.
- **Eligibility under the Act:** Some disabilities, such as DLD, appear to exist in something of a policy vacuum and access to the Scheme is highly variable and typically dependent on significant advocacy by participants and their health professional supports. Independent assessments, under current proposals, are unlikely to improve this uncertainty though in the absence of pilot data, their impact on access for many cohorts remains unknown. Feedback from practitioners familiar with the proposed assessment toolkit suggests that in addition to potential challenges relating to pre-access requirements, some participant cohorts will not

be well-served by the proposed tools and, in combination with the potential use of assessors with no direct experience in a particular area of disability, may struggle to access the Scheme and to receive appropriate budgets.

- **Assessment by an appropriate allied health professional:** AHPA and its members are concerned that the most recent updates from the NDIA[iii] indicate that the assessment may be undertaken by any of the eligible allied health professions rather than relying on appropriate skills-matching. This goes against the clinical advice provided by AHPA and its members to the NDIA, and is likely to disproportionately impact some cohorts of participants.
- **Input by relevant practitioners**: AHPA and its members have argued strongly that the independent assessment process must provide access to more complete assessments by relevant health professionals where the assessing clinician flags concerns or gaps in the assessment toolkit in relation to the participant being assessed. This was flagged on several occasions as part of project activities undertaken for the NDIA about the assessor workforce, however current proposals do not appear to include provisions for any assessments other than those needed to account for assistive technology and accommodation costs. Similarly, it is unclear how the assessment process might take into account input from reports and recommendations from health professional developed outside of the independent assessment process.
- **Telehealth-based assessments:** AHPA and its members are concerned about the potential impact of telehealth-based assessments, as proposed for participants in remote areas, and the potential disadvantage that this may create for some cohorts. There are a range of reasons why a video-based assessment may not be appropriate for some participants, or may provide barriers to appropriate assessment. We note in this context the important role of observation by assessors as a foundation for using clinical judgement and that observation is more difficult in the context of telehealth assessments. It is likely that additional time for the assessor to talk to the participant and their supports will be required to account for this difference.

In flagging these concerns, AHPA reiterates our strong call for a delay of the implementation of independent assessments until there has been transparent reporting on recent trials and additional testing of other approaches. We argue in the strongest possible terms against the national rollout of a process that has not been shown to be effective for all cohorts and for the establishment of a clinical and participant expert advisory committee to provide independent and unbiased oversight and input.

L. Any other related matters

AHPA continues to have concerns about the appropriateness of independent assessments, and the development of plan budgets on the basis of those assessments, for recipients of early childhood intervention services. We note the lack of detailed consultation with the sector about Early Childhood assessor training, credentialing and quality assurance. We also note that there is significant concern among experienced allied health professionals working in early childhood intervention about the proposed set of assessment tools for young children and their capacity to accurately measure need. Allied health practitioners working in the early childhood space have also

argued strongly that the assessment and budget setting process is likely to face challenges in being response to the needs of children with disability, who are subject to potentially rapid changes in their requirements due to the speed at which they may be developing. Those professionals argue that the planning process needs to be flexible and responsive enough to allow families to access different levels of funding at different times to align with periods of transition and change. It is not clear that the independent assessment planning process will provide that or that EC partners have the resourcing to support regular assessments and check-ins.

AHPA also notes concerns about plans for the release of funds under the proposals for independent assessment and flexible budgets. While we recognise the need to manage risks in relation to the release of funds, in order to ensure that participants have appropriate access to funds throughout the year, it is not clear that the current proposals will achieve that need. AHPA understands that participants will not be able to draw down on additional funds from their budgets if they require additional services early in the year, even where this does not change the overall annual plan budget. This contradicts the intention of greater flexibility and control for families as well as potentially impacting access to intensive therapy packages, a common intervention type utilised by allied health practitioners and supported by strong research for some intervention types.

AHPA notes that participants will need to be able to identify if funding levels need to be varied across the year, and to have the flexibility to vary timing where needed. For example, a family may receive quarterly payments for their child with disability. As part of the planning process, they have planned with one of their child's therapists to start a program of intensive therapy focused around capacity building so that the child can travel to their school independently. In this case it may be appropriate to draw down a larger proportion of the total plan budget in the first quarter with smaller amounts in following quarters to allow for more intensive use of supports during that period. However, we note that there may also be circumstances in which the timing for plans change and so there should be capacity to vary when funds are released with a minimum of administrative effort or time delay.

AHPA also notes that there are a range of circumstances in which it may be appropriate to draw down on a plan due to temporary changes in circumstances for the participant or their carer. For example, a family carer may experience illness and require additional support worker supports. Many of these situations may not require any change in the size of the total budget but rather just the ability to access some flexibility in the timing of funds being released. The NDIA should seek to develop processes that allow automatic releases or light-touch review processes for small amounts of funds where a participant or their family has not otherwise had to draw down on funds and where it is likely that this will not impact their overall annual budget. However, there should also be a rapid review process that allows participants to access funds beyond those in their budget.

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[i] https://www.ndis.gov.au/about-us/operational-guidelines/access-ndis-operational-guideline/list-b-permanent-conditions-which-functional-capacity-are-variable-and-further-assessment-functional-capacity-generally-required

[ii] Section 4.1. Available at https://www.dss.gov.au/disability-and-carers-programs-services-for-people-with-disability-national-disability-insurance-scheme/review-of-the-ndis-act-report

[iii] https://www.ndis.gov.au/community/we-listened/you-said-we-heard-post-consultation-reports