Impairment Tables Review – Senate Community Affairs Committee Inquiry Submission

Australian Federation of Disability Organisations (AFDO)
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About AFDO

The Australian Federation of Disability Organisations (AFDO) has been established as a primary national voice to Government that fully represents the interests of all people with disability across Australia.

The mission of AFDO is to champion the rights of people with disability in Australia and help them participate fully in Australian life.

Consultation with People with Disability and their Organisations

Although AFDO had one representative on the Impairment Tables Review Committee, it is our feeling that this does not amount to adequate consultation with what is a very diverse sector. One voice – especially when countered by medical expertise – cannot be said to represent all views of the lived experience of disability, especially when the committee's proceedings are strictly confidential. Without the ability to speak openly about proceedings, any representative is seriously curtailed in their ability to consult well.

In light of this, AFDO strongly believes that the Impairment Tables should not be made legally binding without further, broader consultation with the disability sector. People with disability and their families should have a right to openly debate the laws which affect them, and a Senate Committee looking at draft legislation gives only a limited time and scope for that to happen.

Recommendation: That the revised Impairment Tables not be brought into law until broad consultation with people with disability and their organizations has been undertaken by the Department of Families, Housing, Community Services and Indigenous Affairs.

Testing of the New Impairment Tables

AFDO is deeply concerned that the new Impairment Tables have not been thoroughly tested. As the report itself notes, the sample size of 215 people is relatively small. **When broken down over the fifteen tables, there are ten tables where the number of people tested under that table is six individuals or less.**

These tables are:

- Alcohol, drug and other abuse (6 people)
- Brain function (4 people)
- Communication function (2 people)
- Intellectual function (6 people)
- Gastrointestinal function (6 people)
- Hearing and other functions of the ear (2 people)
- Vision function (4 people)
- Continence function (4 people)
- Functions of the skin (2 people)
- Functions of consciousness (4 people)

The trial was conducted wholly within Victoria, which does not provide an adequate representation of rural and remote communities. There is no information about the number of people with disability involved in the trial from Non English Speaking Backgrounds or who have Aboriginal and Torres Strait Islander heritage.

What little testing has been undertaken provides an alarming picture, and not just because it shows a drop of between 35% and 40% in DSP eligibility when the new impairment tables are applied. It also indicates conflict between primary and secondary assessors, which brings into question the validity of assessments which cannot be applied consistently.

Recommendation: That further consultations include a broader trial of the new Impairment Tables, with a much larger and more diverse sample size, including people from rural and remote communities, people from Non English Speaking Backgrounds and people from Aboriginal and Torres Strait Islander backgrounds.

"Diagnosed, Treated and Stabilised"

Under the impairment tables, a person's condition must be diagnosed, treated and stabilized. AFDO considers these basic requirements to perpetuate the outdated medical model which the new system is trying to overcome. This is both impractical – for the reasons outlined below – and ideologically unsound. It would be far better to frame whether a person is a good candidate for assessment in a social context: does the person have stable, accessible housing, good formal and informal supports (paid and unpaid carers, interpreters or assistants) and any medical or non-medical aids and supports necessary to help them achieve their best outcomes?

It is worth noting that sometimes a disability is not even framed as a medical condition which requires the attention of doctors or allied health specialists. Intellectual disability is not a sickness or illness, and is measured by intelligence tests conducted by a psychologist. The Deaf community strongly opposes the idea that deafness is a medical condition to be cured; rather, people who are Deaf Auslan users see themselves as part of a rich culture with its own language.

Assessments based on medical precepts are also unable to take into account genuine choice. For example, Point 28 states that an assessor must consider what a person ‘can or could do’ not what they choose to do. People with disability often can or could do

things which they ‘choose’ not to for a variety of valid reasons. These may include the choice not to increase short term fatigue, the choice to save a significant amount of time, the choice to increase their personal safety, the choice not to risk longer-term medical damage, or the choice to maintain a certain level of dignity in front of others. To dismiss these choices as part of the assessment process for DSP is to dismiss the right of people with disability to live as social beings in a context which is not just about their ability to complete certain tasks.

For some people with disability, one or more of the current requirements for a diagnosed, treated and stabilized condition may be difficult or impossible to achieve.

Diagnosed: Receiving a diagnosis may take a long time, either because there are no direct and conclusive tests for some conditions (such as neurological or psychosocial disabilities), or because a condition is rare or little understood - many doctors still do not have expertise in diagnosing chemical sensitivities or chronic fatigue syndrome, for instance, and individuals may be treated as though their condition is psychosomatic while they experience very real, very disabling outcomes.

While it is important not to rely completely on self-reporting of a condition, and it is important to have some objective measures of a person's condition, a diagnosis should not be the only gateway through which a person can gain an assessment for DSP. If a medical professional can prove that tests have shown that a person has ongoing physical, sensory, intellectual or psychological issues then that information should be used to determine eligibility even when a diagnosis is either not possible or remains unclear.

Treated: To say that a person has been treated is to assume that there is clearly defined, widely agreed upon level of medical and

allied health treatment which has a neat 'end point'. At this end point, everyone concerned agrees that the person is at their best possible level of functioning.

Although the guidance at the front of the Tables attempts to capture some of the complexities in this area, in reality, treatment for many conditions may depend upon the choices of a person and their health supports. These choices should be both acknowledged and respected. For example, a person who has refused surgery, rehabilitation or medication because they feel the physical, emotional or financial costs are too high should still be considered to have been treated so long as they have made an informed decision. This should be the case regardless of whether their treating medical experts agree with the decision, and regardless of whether the assessor agrees that the decision is reasonable – so long as it is informed. At the opposite end of the spectrum, a person who has decided to pursue new and experimental treatments should not be penalized for doing so by being denied the DSP while they wait for what may be highly uncertain results.

Depending on the view of the assessors and medical professionals, 'treatment' may also include the treatment of any 'flow on' conditions. That is, conditions caused by their primary condition (such as a person with HIV who develops pneumonia) or a condition caused by their initial treatment (such as a person on psychotropic medications who develops memory problems as a side effect of their medication). Again, treatment is relative, and causes ongoing issues for an assessment under the impairment tables.

It is also important to note that treatment can sometimes be carried out regardless of a diagnosis. It is possible to treat, and potentially stabilise, the condition of someone with a disability without fully understanding what has caused it. For example, a

person with back pain may get great benefit from physiotherapy even if the cause of the pain has not yet been discovered.

Stabilised: As with the concept of whether someone has been treated, a person's stability can be subjective. Stability does not necessarily mean certainty; for example, a person with Multiple Sclerosis may have stabilized after an episode, but their ongoing level of ability cannot be known – they may or may not have regular episodes which change their condition.

Assessment

Given all of the ambiguities outlined above, assessments need to be carried out with great care and sensitivity. Leaving appropriate judgment in the hands of an assessor is only useful if they are well versed in the condition that a person presents with. This is highlighted in the testing done with the new tables, where assessments undertaken with appropriately qualified occupational therapists and exercise physiologists for Tables 1 and 2 lead to less 'downward movement' or more people remaining eligible for DSP because they were appropriately assessed.

If an assessor wishes to see how a person functions, leeway needs to be provided so that a person can be assessed over a longer period of time if their condition fluctuates, and in different settings – at home or work – if their condition changes with the environment.

Furthermore, assessments should not be conducted by Job Capacity Assessors (JCAs) who are there to both assess a person's work capacity as part of their DSP eligibility, and/or to refer a person to appropriate Disability Employment Service providers (DES) as necessary. The role of JCAs has received ongoing criticism because their assessments are of the inflexible 'tick the box' variety and their skills and experience may not apply

to the specific disability type being assessed. AFDO is concerned that combining a job capacity assessment with an impairment table assessment will simply compound these already existing issues.

Under-weighting of the Tables

As the consultation report shows, a significant number of people who would currently receive DSP will not do so under the new impairment tables. While AFDO is obviously keen for people who can work to be encouraged to do so, the new impairment tables seem to move towards the assumption that:

(a) people with some fairly significant functional limitations still have at least a partial capacity to work and should be placed on NewStart where there are requirements for them to do so, and

(b) that someone with significant functional limitations who may or may not have a partial capacity to work would be able to adequately manage on significantly lower NewStart payments.

These assumptions are noticeable in the 5 and 10 point categories across all of the tables, where a person would not be eligible for DSP on the basis of limitations only in one category. Some striking examples include:

Table 6 (10 point criteria): "The person is **often** absent from work, education or training activities due to the effects of substance use."

Someone who met this criteria would find applying for jobs and filling out a job diary on a regular basis challenging. If their educational or employment opportunities are unstable because of their absenteeism, it is likely that their housing security would also be compromised. This could start a vicious cycle of searching for

new housing while looking for work. For both of these reasons, DSP would be a more appropriate payment.

Table 10 (10 point criteria): "...the person is unable to sustain work activity or other tasks for more than two hours without a break due to symptoms of the gastrointestinal condition; the person is **often** absent from work, education or training activities due to the gastrointestinal condition."

Not only would a person in this position be unlikely to be able to apply for or get work, they may have additional disability related expenses if they are unable to work on one task for more than two hours without a rest. For example, someone in this position may need to make shorter, more frequent trips to their local shopping centre to run errands, and may need to cut down on travel time by using their car. Because of their disability related needs, they would have a higher cost of living which requires a higher level of income.

Recommendation: That further consultation about the impairment tables include a discussion about the under-weighting of items worth 5 and 10 points.

<u>Gaps in the Tables</u>

There are some disability types which are poorly covered or not covered at all under the new Impairment Tables. Given the short timeframe for this inquiry, AFDO is unable to identify all possible disability types which fall into this category. However, there are two prominent examples.

People with HIV: Under the previous system, people with HIV would be assessed largely under Tables 20 – Miscellaneous and 21 – Intermittent Conditions. These Tables were important in ascertaining the true effects of what can be a cumulative set of

symptoms including overall frailty, heightened at times by the side effects of anti retroviral drugs.

Recommendation: that Tables to cover miscellaneous and intermittent conditions be reinstated.

People on the Autism Spectrum: Although some people on the autism spectrum have low IQs and are easily diagnosed with intellectual disability, there are many others – around 50% - who do not have a low IQ but instead experience a range of different issues not presently captured in the Tables. These include:

- Sensory processing issues which make seeing, hearing or smelling certain things overwhelming;
- Limited ability to understand and interpret social behavior and norms;
- Limited ability to remember to carry out daily self care tasks; and/or
- Sleep disorders meaning a lower amount of sleep each night.

The Australian Bureau of Statistics has found that people on the autism spectrum are rising in numbers – especially in younger age cohorts – as the diagnostic tools available become more appropriate. The same data finds that people on the autism spectrum have poorer outcomes than people without autism. Given this situation, autism needs to be addressed in the current iteration of the Impairment Tables.

Recommendation: that further consultation be undertaken with people on the autism spectrum and their representatives to ensure that they are appropriately represented within the Impairment Tables.

<u>The New Impairment Tables</u>

Table 1: Functioning Requiring Physical Exertion and Stamina

This chart is unclear as to:

- Whether ‘mobilising’ with a wheelchair includes the use of either an electric or a manual chair. The wording suggests that the table refers to the exertion from pushing a manual wheelchair, but it is not explicit. This is a significant detail because someone with major fatigue may still be able to mobilize a short distance outside the home in an electric wheelchair, which requires less energy.

- What constitutes participation in work, except at the 20 point assessment level, where a shift of at least 3 hours is specified.

Table 2: Upper Limb Function

The assessment for 20 points on the table seems contradictory, because it states that a person who has had a whole hand amputation is eligible under this criteria, but then states that a person must be assessed with the use of any prosthesis they possess.

Table 3: Lower Limb Function

AFDO is deeply concerned that this table does not accurately reflect many of the systemic social barriers facing people with physical disabilities.

In the first instance, a person who uses a lower limb prosthesis appears to be only eligible for a 5 point assessment under this table, regardless of whether they have problems with squatting and kneeling, or whether they are unable to effectively balance on their prosthesis for a long period of time. Many prosthetic devices

fitted in the Australian public health system are of a poor quality and fit, and cause not just bad balance issues but bleeding and pain. The impact of using a prosthesis needs to be taken into account in its entirety; where a prosthesis causes significant difficulties a person should be assessed for a higher points value, including for any side effects which are represented under other tables.

People who use wheelchairs independently – with independent transfer and use of public transport and toilet facilities – would not be eligible for DSP based on their mobility limitation alone under the current impairment tables, because they would only be entitled to a 10 point assessment.

This situation blatantly ignores the many social disadvantages in achieving real-world functionality in these areas: using public transport independently requires that local transport is appropriately accessible, which is an ongoing issue for many people with disability especially in rural, regional and outer urban areas. Likewise, the provision of accessible toilets which allow for appropriate transfers is limited, especially for people who can only transfer safely and independently on one side. Accessible toilets are often placed towards a corner of the room, blocking choice of transfer from either the left or the right. Furthermore, people who use wheelchairs may only be able to achieve independent activity in their own, specifically scripted wheelchair; the lack of a personalized wheelchair can diminish a person's independence greatly.

All of the above factors can have a severe impact on a person's ability to participate in everyday activities, and in especially in employment. It is AFDO's belief that this table is underweighted, and should be appropriately adjusted to take account of the fact that in the 'real world' use of a prosthesis or wheelchair does not often equate to independent function.

Table 4: Spinal Function

AFDO was unable to receive sufficient expertise in this area in time for this submission.

Table 5: Mental Health Function

AFDO is concerned that this table may be under-weighted. This is particularly evident for people in the ‘moderate’ category which excludes them from DSP eligibility: a person who has limited social contact and frequent problems at work because of their psychosocial disability would be quite likely to be under serious stress, and may have a limited ability to seek and accept assistance.

Gauging where a person fits in this table may be made more difficult because the kinds of supports needed by a person might not be available (for example, someone living alone who experiences severe anxiety late at night may not have access to any paid or unpaid support even though they need it), or because supports are constantly available in the form of live-in family or friends who capture many of a person’s support needs so that they appear more functional than they are.

Furthermore, this table requires a great deal of flexibility in interpretation. While there are some good examples available, further guidance for assessors needs to take into account that psychosocial disabilities manifest in many different ways. For example, difficulties with sleep are not mentioned as part of the Table, but may cause chronic problems with making and keeping appointments and social activities for someone with a psychosocial disability.

Table 6: Functioning Related to Alcohol, Drug and Other Substance Use

AFDO was unable to receive sufficient expertise in this area in time for this submission.

Table 7: Brain Function

AFDO is concerned that this Table does not accurately reflect the needs of people who have early onset dementia. This is a relatively common issue for certain disability groups, including people with HIV and those with certain types of intellectual disability, such as Downs Syndrome.

As with many of the other tables, AFDO is concerned that this Table is under-weighted, meaning that people with very little or no work capacity are not accurately captured.

Table 8: Communication Function

In the mild and moderate categories, this table relies heavily on a person using a ‘recognised language or sign language’. For many people with communication disabilities, self-adapted communication becomes particularly important. Someone who uses home sign – not a recognized sign language, but a common substitute in rural and remote communities where English, let alone teachers of sign language are rare – may not be covered very well or at all under the current table. Likewise, someone who uses more complex facial expressions, noises and gestures to communicate effectively may not be appropriately assessed.

Table 9: Intellectual Function

AFDO is deeply concerned that this table is under-weighted. The National Council on Intellectual Disability (NCID) has found

through its own trial that no person with intellectual disability with an IQ between 70 and 79 would be eligible for DSP under this table. This is in spite of the fact that many of these people would have significant difficulty with comprehending complex ideas, learning quickly and learning from experience. NCID also notes that people with intellectual disability are more likely to be over represented in prisons, boarding houses and among homeless populations; a situation far less likely to be resolved without a stable source of income support.

We are also concerned that the Table – particularly taken in the context of the other tables – does not accurately capture people with Autism Spectrum Disorder (ASD). While people with ASD may have both a low IQ and difficulty with adaptive behaviours, the two are not necessarily linked.

Furthermore, AFDO supports NCID's concerns that this table:

- lacks coherence with international definitions and assessments of intellectual function. Intelligence is a general mental ability. It includes reasoning, planning, solving problems, thinking abstractly, comprehending complex ideas, learning quickly, and learning from experience. Intellectual functioning is currently best conceptualised and captured by a general factor of intelligence. The revised Table has incorrectly used an adaptive behaviour scale instead of assessment or scale for intellectual functioning.

- lacks consistency with the World Health Organisations' International Classification of Functioning, Disability and Health (ICF),
* The ICF uses the term "impairment" to relate only to body functions and structures. Yet the revised Tables use the term to mean a mix of health conditions, body functions and structures, activity limitations and participation restrictions. This is a

confusion of concepts and makes the revised Tables incoherent and inconsistent with the ICF framework.

* The revised Table for intellectual function appears to have created an additional adaptive behaviour test. This scale has no evidence of a history of testing against a normative population to provide standardisation, or demonstrate correlation with intellectual function and adaptive behaviour assessments.

* There is no explanation as to how the items in the Table for link to a notion of work capacity that is related to intellectual function. For example, NCID are aware of research showing that intellectual disability has a significant impact on the capacity of an individual to find and compete for work, to gain job skills, and maintain employment. Research also shows that there is a societal impact, where people with intellectual disability are given low expectations of working in the open labour market. We know from the research that open employment outcomes for this population are heavily dependent on receiving the right support and evidence based assistance. Yet the Table is unclear on the relationship between the Tables and an assessment of work capacity.

* The rating and scaling of ‘intellectual function’ (Table 10) is problematic: The categories are not exhaustive: for instance, while the Table 9 (communications) goes from ‘0 – no functional impact’, to ‘5 – mild impact in at least one area’, Table 10 goes from ‘0 – not functional impact’ to ‘5 – mild impact in at least 2 areas’. This ‘skipping’ continues up the categories.

Recommendation: That the revised Table be rejected as insufficient in terms of coherence with the international definition of intellectual disability and does not demonstrate validity in terms of its correlation and coherency with intellectual functioning and adaptive behaviour assessments.

A new Table should be designed to be coherent with the latest definition and research of intellectual disability, its definition and assessment, and the current DSP manifest qualification guidelines.

We propose a table with two parts; 9A and 9B.

9.A Intellectual Function

9.A.1 Intellectual function measured as an IQ of less than 70, (where the mean is 100 and the standard deviation is 15), or two standard deviations below the mean of an individually administered, standardised instrument that measures general intellectual function, is deemed to have met the 20 point requirement for qualification of the DSP.

Note: This is similar to the current manifest definition of intellectual disability currently in the Social Security Guidelines - and the Commonwealth will be keeping this guideline.

9.A.2. Intellectual function measured as an IQ from 70 to 85, (where the mean is 100 and the standard deviation is 15), or is one standard deviation below the mean of an individually administered, standardised instrument that measures general intellectual function, receive a score of 10 points.

Notes:
This recognises a population which has a lower than average intellectual function. That this is not sufficient to meet the international definition of intellectual disability.
Research indicates that some members of this group have major difficulties adaptively functioning in the community, including finding and keeping employment.

This level of intellectual functioning is not alone sufficient to qualify for the DSP, and should be subject to further assessment inquiry in terms of adaptive behaviour.

9.B Adaptive Behaviour

9.B.1 One standard deviation below the mean of either: (a) one of the following three types of adaptive behaviour: conceptual, social, and practical skills or (b) an overall score on a standardised measure of conceptual, social, and practical skills, receives a score of 10 points.

9.B.2 Two standard deviations below the mean of either: (a) one of the following three types of adaptive behaviour: conceptual, social, and practical skills or (b) an overall score on a standardised measure of conceptual, social, and practical skills, receives a score of 20 points.

Notes:
A person with an IQ from 70 to 85 would receive a standardised adaptive behaviour test to determine if their low IQ was associated with limitations in adaptive behaviour.
9.B.1 is a slightly modified recommendation proposed by National Research Council (USA)
9.B.2 meets the international requirement for a classification of intellectual disability.

Recommendation: that the introduction to the Impairment Tables be modified thus:

Manifest DSP Qualification (insert in general introduction to the Tables)

DSP claimants are considered to be manifestly qualified, when they clearly and obviously meet all the qualification

criteria in SSAct section 94. Only in very clear cut cases outlined in the guidelines, can claims be granted without assessment via the DSP Impairment Tables and JCA. [See Guide to Social Security Law (Version 1.178 - Released 1 July 2011), 1.1.M.30 Manifest (DSP), & 3.6.2.20 Manifest Grants & Rejections for DSP].

Recommendation: that there be an amendment to Introduction to Impairment Table 9 to state:

Table 9 - Intellectual Function

Intelligence is a general mental ability. It includes reasoning, planning, solving problems, thinking abstractly, comprehending complex ideas, learning quickly, and learning from experience.
Intellectual functioning is currently best conceptualised and captured by a general factor of intelligence.

An assessment should be conducted by a psychologist who is qualified in terms of professional regulations, and who has met the assessment instrument publisher's guidelines for conducting a test.

The Wechsler Adult Intelligence Scale - Fourth Edition (WAIS-IV), and the Stanford Binet Intelligence Scales - Fifth Edition (SBIS-5), are widely used and accepted measures to assess intellectual function. The Wechsler Intelligence Scale for Children (6 years - 16 years 11months; WISC-IV Australian) is also acceptable for people aged 18 years or under at the time of a DSP claim.
There will be circumstances, however, in which the WAIS-IV, SIBS-5 or the WISC-IV will not be appropriate. This maybe because an individual has cognitive deficits below the floor of the test, has sensory or motor limitations that preclude

test presentation and response, or is influenced by a variety of cultural, social, ethnic and language based factors.
An equivalent contemporary assessment must be deemed acceptable by the Health Professional Advisory Unit. Test selection should employ an individually administered, standardised instrument, with relatively recent norms, that yields a measure of general intellectual functioning. Test selection should also be based on individual factors, including the individual's social, linguistic, and cultural background.

The full scale or composite score, and the standard error of measurement for the specific instrument, should be recorded.
A claimant with an assessed intellectual function of less than 70, or two standard deviations below the mean of an acceptable assessment, considering the standard error of measurement, meets the manifest qualification which would attract 20 or more points for the DSP without assessment via the Tables or a JCA. [See Guide to Social Security Law: (Version 1.178 - Released 1 July 2011), 3.6.2.50 Assessment of People with Intellectual Impairments for DSP.]
A claimant with an assessed intellectual function above 70 and below 85, or one standard deviation below the mean of acceptable assessment, considering the standard error of measurement, is subject to an assessment by the Tables. Assessors should consider evidence from a range of sources in determining which rating applies to the person being assessed. Examples of corroborating evidence may include (but are not limited to):

supporting letters, reports and/or assessments relating to the person's development, intellectual function, adaptive behaviour and/or programs of support.

interviews with the person and those providing care, support or treatment to the person.

Assessors should note that a diagnosis of a learning disorder such as dyslexia does not equate to a diagnosis of intellectual disability. [See draft Fifth version of the Diagnostic and Statistical Manual of Mental Disorders for the definition of "learning disorders" (American Psychiatric Association)].

Table 10: Gastrointestinal Function

AFDO was unable to receive sufficient expertise in this area in time for this submission.

Table 11: Hearing and Other Functions of the Ear

As with many other Tables, AFDO is deeply concerned that this Table is under-weighted.

Furthermore, there are other concerns with the measures for hearing function listed:

- The table seems to assume an ongoing hearing loss, rather than a fluctuating loss due to glue ear, tinnitus, ongoing ear infections or other intermittent causes of hearing loss. Hearing loss can also be gradual and progressive; this is often the case during the natural ageing process. Less than one percent of people under 15 have a significant hearing loss, while 75% of those over 70 do. Explicit guidance needs to be provided to assessors in such cases;

  It is also assumed that hearing aids as a piece of adaptive technology will work on their own to provide the best possible outcome for a person with hearing impairment. For

many, a hearing aid needs to be used in conjunction with other expensive devices – such as a portable neckloop – or a number of communication methods, including lipreading, sign language and speech to speech. These in turn may require other kinds of technology such as Skype (for video conferencing to sign).

- The table uses the loudness of a television set to determine the milder levels of hearing loss when it is far more likely that even those with a mild or moderate hearing impairment will use captions than a louder television, especially in a house where they share space with others. This measure is also difficult to apply for people who live alone;

  Additionally, quiet environments – such as a home environment where one can have reasonable control over the level of noise – are not the best test of how difficult it is for a person to hear. Many people with hearing impairment find background noise such as traffic, other conversations or loud music drastically reduces their ability to hear. For those who rely heavily on lipreading to communicate, the simple act of a person turning away or dimming the lights can make following a conversation impossible.

- An inability to use Auslan is listed as an extreme functional limitation, but for someone who has chosen to rely on lipreading (maintaining English as their first language), a lack of ability to do so– and to rely instead on written notes or other translations – is an equally severe limitation, yet it is listed as less severe.

- Use of the telephone may also be an inappropriate measure for many younger people who are taking advantage of text messaging, captioned telephony and instant messaging programs online to communicate.

- People who are Deaf or hearing impaired will often use a combination of sign language and lip reading to follow a conversation, especially if they have not got access to an Auslan interpreter. This mode of communication is not adequately reflected in the Table.
- People who are Deafblind do not necessarily rely upon a recognized sign language, but may instead use tactile Auslan, tactile fingerspelling or touch cues to communicate. This is not accurately reflected in the Table.

Table 12: Visual Function

Much of this Table appears reasonable and makes it considerably easier for a lay person to interpret than the previous tables related to vision impairment. However, some issues remain.

The difference between statements at 10 and 20 points is confusing. For an assessment at 10 points, a person can independently navigate in and around familiar environments. An assessment of 20 points references that people would not be able to move around in unfamiliar environments. It may be better for the same term to be referenced in the criteria of both points- i.e. familiar or unfamiliar - for example, 20 points could refer to difficulties that people experience navigating familiar areas.

It is important that ‘needs assistance’ is defined more clearly for assessors in guidelines. A person who does not need assistance can learn and continue to use a route without a qualified orientation and mobility instructor or a family member or friend teaching them to use a route. A need for assistance may mean anything from constant help – unable to travel

independently on public transport which is not a taxi – or occasional help, such as a driver announcing bus stops, a friend offering specific directions, confirmation of location or help to hail a taxi or a bus. The qualifier of “the person needs assistance to travel independently… even when using a guide dog or cane” may also be confusing; many people who use a guide dog or cane do so to maximize their independence and travel well without other help.

It is also important that assessors are made aware that where a person lives can make a difference to their ability to travel independently. For example, this is true for people with a vision impairment who live in an area where buses are unlikely to stop unless hailed, traffic is especially busy or independent travel requires navigating poorly lit areas for a person with nightblindness.

Furthermore, it is important that someone with a visual acuity which means they would fail a driving test is eligible for the 20 points category alongside those who have been rejected for a licence outright. This can easily be determined, and should not require a person to undergo a driving test and to be rejected. Consideration should also be given to people with conditions not easily picked up during a driving test, such as those who have good central vision but only a very narrow field of sight. Someone in this position may pass a driving test, but would not be able to drive in real world conditions.

Table 13: Continence Function

AFDO was unable to receive sufficient expertise in this area in time for this submission.

Table 14: Functions of the Skin

AFDO was unable to receive sufficient expertise in this area in time for this submission.

Table 15: Functions of Consciousness

AFDO was unable to receive sufficient expertise in this area in time for this submission.