# Purple backgroundIndependent Assessment Framework

# August 2020

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## Background

### The Start of the Scheme

The National Disability Insurance Scheme (NDIS or “the Scheme”) and the National Disability Insurance Agency (NDIA) are relatively new and unique to Australian society. The NDIS has been established with the guiding principles that people with a disability have the same right as other members of Australian society to realise their potential for physical, social, emotional and intellectual development. That is, they be supported to participate in and contribute to social and economic life to the extent of their ability (National Disability Insurance Scheme Act -2013). The NDIA is an independent statutory agency responsible for implementing the NDIS.

In order to be part of the Scheme, a person must satisfy the criteria that have been legislated by the National Disability Insurance Scheme Act 2013 (“the Act”). These criteria include age and residence status, as well as either the disability or early intervention requirements that are specified. Part of the disability requirements state that an impairment or impairments result in substantially reduced functional capacity in one or more activities of communication, social interaction, learning, mobility, self-care and/or self-management, and affect the individual’s capacity for social or economic participation. Early intervention entry to the Scheme is also available under separate criteria. It is the intention of the NDIA that all the decisions that are made as part of the Scheme are equitable and consistent for all.

The NDIA commenced the NDIS in July 2013 at various trial sites across Australia. At that time, there were a variety of pre-existing specialist programs for people with disabilities, often with their own specific eligibility criteria spanning different age groups. As such, there were many people that were taken to meet the disability requirements without further assessment based on their involvement in an existing program. The NDIS could therefore be trialed and commenced without a particular assessment of a person’s functional capacity in place. In late 2013, the Support Needs Assessment Tool (SNAT) was adopted, but after the first year of trial, it was found that it was not fit for the purposes of NDIA (NDIS Costs Productivity Commission Study Report, Oct 2017, p 192).

In late 2014, work began on identifying appropriate assessment tools as the Scheme expanded. By the middle of 2015, a number of assessments that might be suitable were selected and testing began to determine whether these tools might meet the needs of the Scheme. A single multi-purpose assessment tool that was disability-neutral had not been found. Several tools across eleven key disability types were eventually agreed upon. Some of these assessments were administered in-house (by NDIS Planners, Local Area Coordinators and Early Childhood Partners), while others were completed externally by other agencies.

### Current State

Integral to the NDIS has always been a commitment to positive outcomes for all concerned. Ongoing NDIA review processes are an important part of this solid commitment to achieving positive outcomes. As the Scheme has rolled out across Australia, procedural reviews and quality assurance processes have increased the NDIA knowledge base and contributed to continuing improvements.

Recent procedural reviews indicate there is a level of inconsistency and subjectivity in assessment information for NDIS that may pose a risk to the future of the Scheme, both at an individual level and at a broader level across Australian society. In response, the NDIA commenced an in-depth review of the assessment tools and the overarching approach to the assessment of functional capacity in late 2019.

This paper details the reasons for this work and explains the foundations of a new framework for assessment of functional capacity suited to the NDIS context that takes into consideration the unique requirements of the Scheme. It discusses the rationales, principles and origins of the assessment framework and provides a way forward to a more robust and constructive NDIS experience.

## Rationale for Reviewing NDIS Assessment of Functional Capacity

### Information Currently Obtained

In order to satisfy the disability or early intervention requirements for sections 24 and 25 of the Act, information on an individual’s level of function needs to be obtained. Currently, the information provided to NDIA regarding a person’s functional capacity varies greatly between individuals.

There are many reasons for this variability including:

The Role and Experience of the Person Providing Information

Mainstream or specialist health professionals, who may or may not know the person well, may provide information. NDIS staff who have completed an in-house assessment, either in person or over the phone, may also provide information. Qualifications, skill level, experience, and understanding of functional capacity can also differ greatly between assessors, which in turn impacts the quality and quantity of information provided to NDIA.

The Assessment Measures Used

A multitude of assessment tools and measurement scales are available for use. Professionals may opt for a particular assessment tool for many different reasons. For instance, professionals may have a limited choice of assessments at hand and available to them, a limited amount of time in which to complete an assessment, training only in a certain assessment tool, or preference for a particular instrument. Factors such as these clearly influence the choice of assessment a professional may use, which in turn impacts on the reporting and information obtained and provided to NDIA, thus contributing to variability.

The Design and Purpose of the Assessment

Assessment tools are frequently designed and developed for specific applications, serving a range of populations and needs. Some assessments are highly specialised for a particular age or disability group or discipline. Design and purpose of assessment is another significant source of variability.

Level of Detail and Comprehensiveness

Assessments differ in terms of the information obtained and/or how comprehensive they are. Assessment measures may be limited to one or two functional domains rather than assessing functioning more widely. Some assessments are conducted as screeners, and others are used to obtain extensive and in-depth level of detail to inform treatment and therapy programs. Some are also designed to enable reassessment at specified intervals. The level of detail given by different assessments can therefore vary significantly.

Standardisation and Psychometric Properties

Assessment measures are not all developed with the same standardisation and psychometric properties. For example, assessments may or may not be norm-referenced, may have extensive research behind them, or may be more of a practical approach developed from grassroots experience. Consequently, some people will have assessment information drawn from a standardised assessment or approach. For others, there are no standardised assessments of functional capacity undertaken at any stage. This is another reason for the wide variability in the type of information given to NDIA.

How Recently Details Were Obtained

Information provided to NDIA can be highly variable with respect to when it was obtained or how recently an assessment was conducted. This is reasonable for some participants as their functional capacity has not changed. However, for others this may be problematic if the information is out of date and inaccurate.

Method of Assessment and Interpretation of Results

Assessments may be conducted in different ways (e.g. face-to-face, telephone discussion or interview), in a variety of contexts (e.g. familiar or unfamiliar environment, clinical setting, real life situation). Assessments may also be approached in different ways (e.g. hands-on task assessment, with or without supports in place). There are many different options for assessment, which are chosen to suit different requirements, then interpreted accordingly. This amount of variability inevitably impacts the type of information provided to NDIA.

This variability makes it difficult for the NDIA to collate, use, and evaluate assessment information in a consistent way. The result of inconsistencies is that decisions may appear erratic and possibly give rise to a situation in which two people with similar profiles and functional capacity, end up with different Access eligibility decisions. It is incumbent upon NDIA to minimise the possibility of this occurring, and to mitigate risks associated with incorrect Access decisions resulting from inadequate and inconsistent assessment procedures.

After a person is found to be eligible for the Scheme, the problems of variability and inconsistency do not go away. Issues may still arise due to variability in the information collected and how it is considered and applied to determine reasonable and necessary supports.

At a broader level, there are further negative impacts of variability in the amount and type of information provided to NDIA. It becomes especially challenging for NDIA to fully understand support needs and to make reasonable future projections for the Scheme as a whole. It also means that it is extremely challenging for the NDIA to draw any comparisons regarding functional capacity between individuals.

### Individual Difference is Compatible with Consistency of Assessment

NDIS participants are always treated as individuals, with each person’s particular circumstances and goals central to NDIS systems. Clearly, no two people are the same. Variability across people is a given and resolutely supported by NDIA. However, individual difference is not the same as the variability found in the quality, amount, and type of information obtained for each person. Variability in assessment information available and the processes to obtain this for NDIS is counter-productive and should be avoided wherever possible. Controls on the assessment process can diminish unnecessary and misleading variability among individuals’ information and improve the integrity of the Scheme. It is possible to accommodate individual difference while implementing consistent information gathering protocols and requirements.

Some degree of comparison between participants is necessary to ensure that NDIS decisions are well-balanced, impartial, and consider a range of possible issues that may impact participants and the Scheme as a whole. A significant point of comparison for NDIS participants is their functional capacity. Information on a person’s functional capacity is required by the Act and is a major part of the decision-making process in NDIS, so the type of information obtained in this regard needs to be as consistent and reliable as possible.

### NDIS Processes

Inconsistency and bias, whether real or perceived, can contribute to frustration and reduced trust in the Scheme from the perspective of participants, prospective participants, support teams and the wider community. The need for consistency in decision-making by the NDIS has been a driving factor for undertaking this review of the NDIS assessment of functional capacity. There have been a number of indicators pointing to the need for closer examination of the decision-making process. These include the high number of requests for review of access decisions, subsequent overturned decisions, and participants applying multiple times to gain access, and high levels of complaints.

As well as the inconsistencies above which do not necessarily cause biased assessment, there are two key causes of potential bias:

1. An assessment approach which is perceived to be deficits-based, whereby people feel the need to present themselves at their worst in order to be funded for the supports that they need.
2. Real or perceived inconsistency and uncertainty around the process of decision making by the NDIS, which may lead to assessors overstating, whether intentionally or not, the need for funding for supports for the people with whom they have developed a professional relationship. Clinicians advocating for their clients is fundamental to any therapist-client partnership.

As a result, in 2011, the Productivity Commission recommended that those assessing functional capacity be drawn from an approved pool of allied health professionals who are independent of the person being assessed, to reduce the potential for “sympathy bias” (Productivity Commission-Disability Care and Support Inquiry Report 2011, page 327). The change in approach outlined in this framework is aligned with this original intent, in order to mitigate the potential for bias. The synthesis of independent assessment with the information provided by the person, as well as their circle of support (including health professionals), is vital in providing the equality and consistency that a National Disability Insurance Scheme requires.

It is important to note that functional capacity is a pivotal concept of the Scheme, yet obtaining consistent and meaningful assessment of functional capacity has been complicated by the absence of an explicit and measureable definition of ‘Functional Capacity’ for NDIS purposes. Confusion between the terms ‘diagnosis’, ‘impairment’ and ‘functional capacity’ has seen these used interchangeably at times. In some circumstances, this has led to severity of impairment or diagnosis being used as a measure of functional capacity.

However, ‘Classification based solely on diagnosis does not provide sufficient information regarding the need for supports’ (Klein and Kraus de Camargo, 2018). Importantly, Klein et al (2018) report that diagnosis alone has been found to be a poor predictor of participation for individuals with developmental disorders affecting learning and behaviour. An explicit definition of functional capacity is required for NDIS purposes that allows for evidence based assessment.

Current NDIS operational procedures require a person to specify their ‘primary disability’. This has encouraged the use of disability-specific assessment tools to describe a person’s functional capacity. Tools of this type serve a specific purpose and tend to assess a person’s functional capacity in assumed areas of functional concern, prioritising, weighting, or even neglecting some areas rather than taking a ‘whole person’ approach. This is not well aligned with the NDIS Act, which requires a broader assessment of functional capacity. Such tools also give rise to potential risks if certain areas of a person’s functional capacity are understated or even overlooked.

There is a need to recognise that a person’s functional capacity is influenced by a dynamic and complex relationship between one, or often multiple known conditions, as well as other conditions yet to be diagnosed, environmental and personal factors. A shift in assessment process is required to acknowledge that the existence of a particular condition or disability does not necessarily have the same impact on everyone, and differences in functional capacity are evident even when people have the same diagnosis. This understanding and appreciation of the relationship between functioning and the unpredictable impact of a particular condition, requires a shift towards a whole of person, diagnosis-neutral assessment process.

Another challenge for the NDIA is to ensure that the Scheme is equally accessible to all individuals that may need it. At present, an individual is required to gather evidence of their functional capacity, prior to Scheme access, either through publically funded services or through the private health sector. For many, obtaining this information through the private health sector is financially prohibitive and waiting lists in the public sector can be extensive. There may also be gap fees even with Medicare funded services which are prohibitive for some people. In addition, other cultural and social barriers may make access to the Scheme problematic for some. Changes to the assessment process should seek to level the playing field so that financial, cultural, social, education and literacy factors do not contribute to delays or barriers to accessing the Scheme.

Finally, it is important to establish a governance framework around assessment processes. There is a need to ensure that reliable, high quality, valid assessment tools are used in the NDIS assessment environment and that they are reviewed and tested regularly. Guidelines that set out requirements such as the qualifications, training and clinical experience of assessors also need to be established to ensure that those with an understanding of the complexities of disability are administering the assessment tools appropriately and consistently. The revised approach to the assessment of functional capacity set out in this framework will provide the structure needed to develop this governance process so that the NDIA can be confident the information gathered during an assessment is an accurate reflection of a person’s functional capacity.

The NDIA conducts ongoing evaluation to ensure standards are being maintained, and as part of this process has undertaken an evidence based review of the approach to how functional capacity is assessed. Assessment of functional capacity in the NDIS context is complex. The unique NDIS context has been closely examined and understood in order to ensure a robust framework for assessment. In submission 493 to the Productivity Commission on Disability Care and Support Inquiry Report, Madden, Bundy, Clemson, Glozier, Kayess, Llewellyn, Madden, Manga, Mpofu and Stancliffe (2011) observed:

*“The cost of developing disability assessment tools can be considerable, but applying ‘ready-made’ tools to the wrong measurement question is likely to be more costly.”*

The critical requirements and foundations for the assessment of functional capacity in the NDIS context must be identified so that the ‘right question’ can be determined, and methods found to provide the best possible answer.

*“Far better an approximate answer to the right question, which is often vague, than an exact answer to the wrong question, which can always be made precise”. Tukey 1962.p13-14.*

## Foundations of the Assessment Framework

### Underpinned by the NDIS Act 2013

The *National Disability Insurance Scheme Act 2013*, is the legislation which establishes the NDIS and the NDIA. The legislation sets out, amongst other things, the objectives and principles under which the NDIS operates, how a person can become a participant in the NDIS and how a person’s support needs may be identified and funded. The Disability Care and Support-Productivity Commission Inquiry Report 2011 preceded the Act and was completed as a result of a public inquiry into a long-term disability care and support scheme. The Inquiry Report produced a set of recommendations which provided the foundations upon which the NDIS legislation was built. These recommendations continue to be relevant as the Scheme continues to mature.

According to Section 24(1) of the Act, in order to become a participant in the NDIS, the NDIA must be satisfied that:

1. *the person has a disability that is attributable to one or more intellectual, cognitive, neurological, sensory or physical impairments or to one or more impairments attributable to a psychiatric condition; and*
2. *the impairment or impairments are, or are likely to be, permanent; and*
3. *the impairment or impairments result in substantially reduced functional capacity to undertake, or psychosocial functioning in undertaking, one or more of the following Activities:*
4. *communication*
5. *social interaction*
6. *learning*
7. *mobility*
8. *self care*
9. *self management; and*
10. *the impairment or impairments affect the person’s capacity for social or economic participation; and*
11. *the person is likely to require support under the National Disability Insurance Scheme for the person’s lifetime.*

Participants may also enter the Scheme through the early intervention requirements under separate criteria (Section 25). In order to meet the early intervention requirements:

25 Early intervention requirements

(1)  A person***meets the early intervention requirements*** if:

(a)  the person:

(i)  has one or more identified intellectual, cognitive, neurological, sensory or

physical impairments that are, or are likely to be, permanent; or

(ii)  has one or more identified impairments that are attributable to a psychiatric condition and are, or are likely to be, permanent; or

(iii)  is a child who has developmental delay; and

(b)  the CEO is satisfied that provision of early intervention supports for the person is likely to benefit the person by reducing the person’s future needs for supports in relation to disability; and

(c)  the CEO is satisfied that provision of early intervention supports for the person is likely to benefit the person by:

(i)  mitigating or alleviating the impact of the person’s impairment upon the functional capacity of the person to undertake communication, social interaction, learning, mobility, self‑care or self‑management; or

(ii)  preventing the deterioration of such functional capacity; or

(iii)  improving such functional capacity; or

 (iv)  strengthening the sustainability of informal supports available to the person, including through building the capacity of the person’s carer.

Note:  In certain circumstances, a person with a degenerative condition could meet the early intervention requirements and therefore become a participant.

(2)  The CEO is taken to be satisfied as mentioned in paragraphs (1)(b) and (c) if one or more of the person’s impairments are prescribed by the National Disability Insurance Scheme rules for the purposes of this subsection.

(3)  Despite subsections (1) and (2), the person does not***meet the early intervention requirements*** if the CEO is satisfied that early intervention support for the person is not most appropriately funded or provided through the National Disability Insurance Scheme, and is more appropriately funded or provided through other general systems of service delivery or support services offered by a person, agency or body, or through systems of service delivery or support services offered:

(a)  as part of a universal service obligation; or

(b)  in accordance with reasonable adjustments required under a law dealing with discrimination on the basis of disability.

Further criteria for developmental delay are included in Section 9 of the the Act:

*Developmental delay means a delay in the development of a child under 6 years of age that:*

1. *is attributable to a mental or physical impairment or a combination of mental and physical impairments; and*
2. *results in substantial reduction in functional capacity in one or more of the following areas of major life Activity:*
3. *self care;*
4. *receptive and expressive language;*
5. *cognitive development;*
6. *motor development; and*
7. *results in the need for a combination and sequence of special interdisciplinary or generic care, treatment or other services that are of extended duration and are individually planned and coordinated.*

The *NDIS (Becoming a Participant) Rules 2016* were made by the Minister to assist the Chief Executive Officer (CEO) with determining who becomes a participant. The *NDIS (Supports for Participants) Rules 2013*, were made by the Minister to assist with the determination of the reasonable and necessary and general supports that would be funded for participants under the Scheme. Both these documents refer to the use of assessment tools (Part 7 and Part 4 respectively), and acknowledge that the assessment tools may be the same for decisions across both Access and approval of the statement of participant supports. The assessments may be different for children and adults and/or tailored specifically to particular impairments. Both legislative instruments state that a tool must be designed to ensure fair and transparent assessment and have reference to areas of Activity and social and economic participation identified in the World Health Organization International Classification of Functioning, Disability and Health (WHO ICF).

Information Currently Provided to NDIA

Since the inception of the Scheme, there has not been a single, generic multi-purpose assessment tool available that is fit for purpose. Individuals have provided a variety of assessment information to NDIA based on the preferred tools that their service teams have administered, which frequently have their origins in a specific area of focus or expertise, and are designed for a particular application. While comprehensive in some areas, these assessments do not usually cover all areas of function. This ‘diagnosis-specific’ approach to assessment has inadvertently resulted in some divergence from the Act.

Diagnosis-specific assessment tools have their place in certain situations and for particular outcomes; however it is a challenge to make them fit the NDIS context. To meet the disability requirements, amongst other matters, the prospective participant’s permanent impairment, or impairments, must result in a substantially reduced functional capacity to undertake one or more of the activities listed in section 24(1)(c)(i)-(vi). While access to the NDIS may be granted if functional capacity is substantially reduced in only one of the six NDIS activity areas, assessments that do not assess functioning across all the activities listed in section 24, carry a significant risk of neglecting a critical activity area for access and under-stating the person’s overall need for supports e.g. by overlooking an unexpected area of reduced function. The risk of this occurring is heightened when assessment is restricted to a disability-specific assessment tool that does not consider the person holistically, and areas of support and need are not identified.

Currently, in some cases, Access to the Scheme is decided by measuring the level of impairment rather than determining how the impairment influences a particular person’s functioning. The assumption that a person’s functioning is determined solely by a specific condition or impairment is not supported by the evidence and fails to acknowledge that function is the result of dynamic and complex interactions between one or more conditions, impairments and other personal and contextual factors. It assumes, incorrectly, that a particular health condition will affect the function of every person in the same way.

Klein et al (2018) note “There is an increasing realization that service delivery based on functioning and participation considerations (rather than diagnostic labels) is more appropriate in a system supporting individuals with disabilities”.

The Disability Care and Support-Productivity Commission Inquiry Report, 2011 noted:

*In addition to encompassing elements of self-care, communication and mobility, the assessment process should include aspects of learning and applying knowledge, and community and social participation. To do otherwise, might mean the support needs of some individuals were systematically overlooked (p 311).*

This is not to say that assessments provided to date have been done incorrectly or are a reflection of poor practice. Instead, the current assessment process and any perceived inadequacies are a reflection of the fact that the NDIS system is unique and relatively new. It follows that the specific assessment requirements of NDIS are also unique and often unfamiliar to the many stakeholders involved, and meeting such requirements is therefore new territory for many professionals. A comprehensive assessment of function across all the domains referenced in the disability requirements may place unrealistic and unmanageable demands on professionals in terms of time, costs incurred, training and resources available to explore multiple domains.

There is a reasonable solution that will support individuals to obtain the type of information that is needed by NDIA. This solution involves building an assessment framework on the internationally recognised WHO ICF. In doing so, it is important to state an evidence based, clear, concise and measurable definition of ‘assessment of functional capacity’ for the NDIS context that can be used to inform NDIS decisions.

**An assessment of functional capacity, arising from a disability that is attributable to one or more intellectual, cognitive, neurological, sensory or physical impairments or to one or more impairments attributable to a psychiatric condition, will need to assess a person’s functional capacity across all six activity areas in the Act to determine if there is substantial reduction in functional capacity. It will also need to consider whether the impairment or impairments affect the person’s capacity for social or economic participation. The assessment will need to be consistent and equitable and have reference to areas of activity and social and economic participation identified in the World Health Organization International Classification of Functioning, Disability and Health.**

### Aligned with the International Classification of Functioning

In order to determine if a person has substantially reduced functional capacity, it is vital that functional capacity is defined in a clear, concise and measurable way. Both the NDIS Act 2013 and the Inquiry Report 2011, recommend that the assessment of function process takes place within the framework of the World Health Organization International Classification of Functioning, Health and Disability (ICF).

Outline of the ICF

The ICF is a common framework developed to help understand and describe functioning and disability. The ICF was developed as a move away from classifying disability according to the “consequences of disease” towards a “components of health” classification, thus taking a neutral stand with regard to disease, diagnosis and aetiology and their relationship to functioning and disability (ICF p4). The ICF organises information into 2 parts:

* 1. Functioning and Disability:
	Body Functions and Body Structures
	Activities and Participation
1. Contextual factors:
Environmental Factors

Personal factors.

This organisational framework recognises the dynamic and complex interactions between these components of disability.

The ICF is about all people, of all ages, and can be applied universally irrespective of health conditions/diagnoses present. It uses a ‘biopsychosocial model’ integrating both the medical and social models to explain disability and functioning. The medical model views disability as a problem of the person directly caused by disease, trauma or other health condition, and requiring medical care and individual treatment aimed at a cure, or an individual’s adjustment or behaviour change. The social model views disability not as an attribute of an individual, but rather a “complex collection of conditions, many of which are created by the social environment” (ICF p20). According to the social model, disability management requires social change, and is the responsibility of society collectively rather than the individual. The ICF combines these two views to provide a “coherent view of different perspectives of health from a biological, individual and social perspective” (ICF p20).



Impairment

Impairments, as defined by the ICF, are problems in body function and structure such as significant deviation or loss. The presence of one or more impairments forms part of the disability and early intervention requirements of the Act (section 24 and section 25 with the exception of developmental delay for children 0-6 years). The evidence for impairment, in most circumstances, will be provided by health professionals external to the NDIS who have the appropriate knowledge, skill and expertise. The ICF notes that impairments are not the same as the underlying pathology but are manifestations of that pathology (ICF p12). In some cases, it may be difficult to distinguish impairment from activity limitation however, the impairment evidence will still need to be provided by experts external to NDIS.

**An assessment of functional capacity will need to include information regarding a person’s health conditions and impairments, which will be provided by health professionals external to the NDIS (with the exception of children 0-6 years entering the Scheme under the developmental delay criteria).**

Activities and Participation

The ICF divides the activities and participation domains into nine chapters:

* + 1. Learning and applying knowledge: about learning, applying the knowledge that is learned, thinking, solving problems, and making decisions (p125).
		2. General tasks and demands: about general aspects of carrying out single or multiple tasks, organizing routines and handling stress (p129).
		3. Communication: about general and specific features of communicating by language, signs and symbols, including receiving and producing messages, carrying on conversations, and using communication devices and techniques (p133).
		4. Mobility: about moving by changing body position or location or by transferring from one place to another, by carrying, moving or manipulating objects, by walking, running or climbing, and by using various forms of transportation (p138).
		5. Self-care: about caring for oneself, washing and drying oneself, caring for one's body and body parts, dressing, eating and drinking, and looking after one’s health (p149).
		6. Domestic life: about carrying out domestic and everyday actions and tasks. Areas of domestic life include acquiring a place to live, food, clothing and other necessities, household cleaning and repairing, caring for personal and other household objects, and assisting others (p153).
		7. Interpersonal interactions and relationships: about carrying out the actions and tasks required for basic and complex interactions with people (strangers, friends, relatives, family members and lovers) in a contextually and socially appropriate manner (p159).
		8. Major life areas: about carrying out the tasks and actions required to engage in education, work and employment and to conduct economic transactions (p164).
		9. Community, social and civic life: about the actions and tasks required to engage in organized social life outside the family, in community, social and civic areas of life (p168).

The ICF defines activity as ‘the execution of a task or action by an individual’, with activity limitations being “the difficulties an individual may have in executing activities” (ICF p10).

Participation is defined as ‘involvement in a life situation’ with participation restrictions being ‘problems an individual may experience in involvement in life situations’ (ICF p10).

Activities focus on a person’s individual functioning and are more likely to be performed alone while participation is more likely to be performed with others (Resnik and Plow, 2009).

The ICF provides additional constructs around activities and participation which may be used to describe function:

* Capacity describes a person’s ability to execute a task or action. It aims to indicate the highest probable level of functioning that a person may reach in a given domain at a given time; it requires a ‘standardized’ environment in which to carry out the assessment (ICF p15).
* Performance describes what a person does in their current environment. It can be understood as the ‘lived experience’ of a person in the actual context in which they live (the environmental context).

The gap between capacity and performance is important in order to identify the impacts of varying environments and “is a useful guide as to what can be done to the environment of the individual to improve performance” (ICF p15).

Additional qualifiers can also be applied to capacity and performance. Assessment with and without assistive devices or personal assistance may be used. Assistive devices and personal assistance do not remove the person’s impairments but they may remove or reduce limitations on function (ICF p15).

| ICF Component | ICF Constructs | ICF Qualifier |
| --- | --- | --- |
| Activities and Participation | Capacity | With assistive devices or personal assistance |
| Without assistive devices or personal assistance |
| Performance | With assistive devices or personal assistance |
| Without assistive devices or personal assistance |

Environmental Context

The ICF specifies that the environmental context include all aspects of the physical, social and attitudinal world in which people live and conduct their lives. These aspects are external to a person and can have positive influences (facilitators) or negative influences (barriers) on a person’s functioning. The presence of an environmental factor may be a barrier (e.g. negative attitudes towards people with disabilities), just as the absence of an environmental factor may be a barrier (e.g. suitable transport not available).

The identification of environmental factors and their impact on functioning is critical when assessing the functional capacity of an individual for the purposes of the Scheme. An individual may function well in one environmental context (e.g. at home where the environment has been set up with supports in place), but have significant functional difficulties in another environmental context (e.g. due to multiple barriers in the workplace or community where there are inadequate adaptations and supports).

The Environmental Factors component of the ICF is divided into five chapters:

* + 1. Products and technology: about natural or human-made products or systems of products, equipment and technology in an individual's immediate environment that are gathered, created, produced or manufactured (p173). Includes factors such as computers, communication devices, building design and construction.
		2. Natural environment and human-made changes to environment: about animate and inanimate elements of the natural or physical environment, and components of that environment that have been modified by people, as well as characteristics of human populations within that environment (p182). Includes climate, air, water, light, sound, vibration.
		3. Support and relationships: about people or animals that provide practical physical or emotional support, nurturing, protection, assistance and relationships to other persons, in their home, place of work, school or at play or in other aspects of their daily Activities (p187). Includes family, friends, and care providers.
		4. Attitudes: about attitudes that are the observable consequences of customs, practices, ideologies, values, norms, factual beliefs and religious beliefs. These attitudes influence individual behaviour and social life at all levels, from interpersonal relationships and community associations to political, economic and legal structures. The attitudes classified are those of people external to the person whose situation is being described (p190). Includes the attitudes of family, friends, care providers, health professionals, work colleagues, strangers and society.
		5. Services, systems and policies:

(i) Services that provide benefits, structured programs and operations, in various sectors of society, designed to meet the needs of individuals (p192). Included in services are the people who provide them.

(ii) Systems that are administrative control and organizational mechanisms, and are established by governments at the local, regional, national, and international levels, or by other recognized authorities (p192).

(iii) Policies constituted by rules, regulations, conventions and standards established by governments at the local, regional, national, and international levels, or by other recognized authorities (p192).

Personal Factors

The ICF defines personal factors as the particular background of an individual’s life and living. They comprise features of the individual that are not part of a health condition or health state. The ICF does not include a classification of personal factors but provides examples including gender, race, age, social background, education, profession, past and current experience.

Assessment of Functional Capacity and the ICF

The ICF poses the following broad questions in relation to activities, participation and environmental factors:

* + 1. What is the best a person can do at a given time in a given place with and without assistance?
		2. What does a person do in their actual environment with and without assistance?
		3. What is the person’s involvement in the different areas of life?
		4. Which environmental factors act as barriers or facilitators of function for the person?

When assessing functional capacity for NDIS purposes, it is important that all of the above questions be answered to satisfy requirements of sections 24 and 25 of the Act. The first question allows for a participant’s strengths to be acknowledged. The second, third and fourth questions provide an understanding of impact of the ‘real world’ on a person’s function, and assist with the identification of support needs. Failure to answer all of these questions could result in either an over or under-estimation of functioning for that person.

### Definition of Functional Capacity for NDIS

The ICF provides the most suitable basis to formulate an explicit and measureable definition of functional capacity for the NDIS context. The definition below will enable a diagnosis-neutral approach that is applicable to all ages. This definition of functional capacity needs to be understood as a vital part of the NDIS process. It is at the core of the assessment approach and informs selection of the tools that are most appropriate in fulfilling NDIS requirements.

*Functional capacity refers to an individual’s ability to be involved in life situations and to execute tasks or actions, with and without assistance (assistive devices and/or personal assistance). Information regarding impairment(s) and environmental factors, and how they impact the individual’s function is included when assessing functional capacity.*

An assessment of functional capacity for the NDIS will need to capture information on the following:

1. A person’s ability to execute tasks or actions with and without assistive devices and personal assistance in a given domain at a given time
2. What a person does and their involvement in life experiences with and without assistive devices and personal assistance, in the context of the world in which they live including all aspects of the physical, social and attitudinal environment.
3. Whether the environmental factors in a person’s life are barriers or facilitators of their function.
4. Details of impairments and health conditions/diagnoses

### A Suite of Assessment tools

As noted by the Australian Institute of Health and Welfare (AIHW) in 2003, it is important to highlight that “The ICF is not an assessment or measurement tool, but rather a framework and set of classifications on which assessment and measurement tools may be based and to which they can be mapped” (ICF Australian User Guide. Version 1.0. Disability Series. AIHW Cat. No. DIS 33. Canberra: AIHW). There has been considerable work undertaken in relation to the application of the ICF, and in particular relating existing assessment tools to the ICF.

In 2005, Cieza, Sabariego, Bickenbach, Chatterji, Kostanjsek, Üstün and Stucki proposed “rules for linking health-status measures, technical and clinical measures, and interventions to the ICF will allow researchers systematically to link and compare meaningful concepts contained in them” (Cieza, Sabariego, Bickenbach, Chatterji, Kostanjsek, Üstün and Stucki , 2005, p217). This linking process enabled the identification of aspects of functioning that were well covered or missing from the measures (Madden and Bundy, 2018).

The NDIS activities and social and economic participation components listed in sections 24 and 25 of the Act can be mapped to the nine ICF activities and participation chapters. This relationship is important when a prospective assessment tool is examined in terms of coverage of the NDIS activities and participation areas. Many assessment tools have been mapped to the ICF but not surprisingly have not been mapped to the NDIS Act. Research undertaken by Chamberlain, D’Arcy, Hayden-Evans, Whitehouse, Girdler, Milbourn and Evans (2019) has completed this mapping and established the link required between the Act and the ICF.

**Table 1 – Mapping NDIS disability requirements against the ICF Activities and Participation chapters**

| **NDIS Act 2013 disability requirements under section 24(1)** | **ICF chapters and/or sub chapters** |
| --- | --- |
| c) (i) Communications\* | Chapter 3 Communication (All sub-chapters) |
| c) (ii) Social interactions\* | Chapter 7 Interpersonal interactions and relationships Communication (All sub-chapters) |
| c) (iii) Learning\* | Chapter 1 Learning and applying knowledge (All sub-chapters)Chapter 8 Major life areas* Education (d810-d839)
 |
| c) (iv) Mobility\* | Chapter 4 Mobility (All sub-chapters) |
| c) (v) Self-care\* | Chapter 5 Self-care (No sub chapters) |
| c) (vi) Self-management\* | Chapter 2 general tasks and demands (no sub-chapters)Chapter 6 Domestic life* Household tasks
* Caring for household objects and assisting others (d650-d669)
 |
| d) Social participation | Chapter 9 Community, social and civic life (No sub-chapters) |
| d) Economic participation | Chapter 6 Domestic life* Acquisition of necessities (d610-d629)

Chapter 8 Major life areas* Work and employment (d840 – d859)
* Economic life (d860 – d879)
 |

\*Also included in Section 25 (f) (a) (i)

At present no assessment tools have been identified that are suitable for the scope of the NDIS which map to the whole ICF. There are ICF ‘core sets’ that have been created with reference to specific conditions, which provide “a list of essential categories that are relevant for specific health conditions and health care contexts” (ICF based documentation tool. https://www.icf-core-sets.org/), however, there are difficulties with the core sets methodology. Madden and Bundy (2018) identified the following concerns from the literature:

* Core sets may look like the medical model
* They may not be feasible in low income countries
* They are hard to implement with people who have multiple conditions
* They may encourage clinicians to overlook more unusual functioning difficulties which can nevertheless be significant.

Madden, Glozier, Fortune, Dyson, Gilroy, Bundy, Llewellyn, Salavdor-Carulla, Lukersmith, Mpofu and Madden (2015) have recommended that all nine chapters of Activities and Participation in the ICF are important when describing functioning in diverse populations. They further caution that “a subset of these domains cannot predict the whole picture of a person’s activities and participations in diverse populations” (Madden et al, 2015, p5823)

In the absence of a single diagnosis-neutral assessment tool that maps directly and precisely to the whole ICF, an alternative for the NDIS context is to use a suite of assessment tools. This means that multiple assessment tools are used side by side, complementing each other in gathering information on a person’s functional capacity across the ICF domains. These tools are mapped collectively rather than separately to the whole ICF with the caveat that, for practical reasons, this is not a ‘perfect fit’ but is the ‘closest fit’.

Used this way, the suite of assessment tools can answer the four questions posed by the ICF and ensures that there is adequate coverage of all six NDIS Activities. This approach can be used until a single dedicated assessment tool becomes available. The suite of assessments provides a preferable option to the status quo, in light of the issues inherent in existing NDIS assessment procedures outlined earlier in this paper.

**In the absence of a single ideal assessment tool, an assessment of functional capacity may include a suite of assessment tools which can be collectively mapped closely to the whole ICF and the six NDIS Activities.**

### Supporting Access and Planning decisions

Currently, there are no assessment tools that have been developed specifically for the purposes of supporting access and planning decisions by the NDIS. The majority of assessment tools that are available for use have been designed for a particular application, a particular health condition, and frequently in a specific context for a certain population.

The primary properties of an assessment tool can be broadly divided into three types: discriminative, predictive and evaluative. Hsieh, Lin, Wang, Sheu, Hsueh and Hsieh (2007) describe these as follows.

*The* ***discriminative*** *property of a measure is important in determining whether it can differentiate between patient groups and identify differences in patients’ abilities. A* ***predictive*** *measure can be used to predict outcome or make a prognosis, help clinicians set treatment goals or discharge plans, and anticipate the need for home adjustments or community support. An* ***evaluative*** *measure is useful for detecting the magnitude of longitudinal change over time in an individual or group (p 454).*

It is difficult to find all three properties present in the one assessment tool to support Access and Planning decisions for NDIS. The suite of assessments concept, whereby a combination of assessment tools are used, allows for tools with different properties to be administered side by side.

It is worth highlighting that the choice of functional capacity assessment tools for NDIS decision making is likely to differ from the choice of tools used for other purposes in health services. Assessments utilised in health services external to the NDIS are often used as part of a diagnostic and/or intervention process. NDIS has requirements unlike health services, and also needs information to answer questions which are fundamentally different to any other service. The purpose of assessment in each of these contexts reflects the underlying obligations of each of these systems.

**When considering the selection of assessment tool(s), the primary purpose needs to be considered. The primary purpose of an assessment of functional capacity for NDIS is to support Access and Planning decisions. This can be achieved by using a suite of assessment tools that collectively have different properties.**

### Support equitable, valid and consistent NDIS decision making

As discussed in Section 2 of this paper, details provided to NDIS regarding functional capacity vary greatly amongst participants and prospective participants. There exists a diverse array of information supplied in terms of quality, quantity and type. Details may be presented in a report, letter, summary statement or form, with content sourced from a range of assessment methodologies. This may include standardised assessments (with or without norm-referencing), criterion-based assessments (with evaluation against criteria rather than other people), questionnaires, scales, observational checklists, profiles, descriptive and subjective practices, or a combination of assessments from mixed sources. Many of the assessments utilised are also diagnosis and/or discipline specific. Significant issues resulting from variability of information are explained in Section 2, with particular reference to impact on Access and Planning decisions.

There are five main strategies that will assist NDIA to address concerns around equity and consistency.

Equity and consistency may be gained through a suite of assessment tools utilising standardised and criterion referenced assessments across all disabilities

The ICF recognises that “human functioning, and decrements of functioning or disability, lies on a continuum” from no disability to complete disability (Cieza, Sabariego, Bickenbach & Chatterji 2018 p2). Using this model, every person’s function in the entire population lies on this continuum. Cieza et al (2018) further explain that as disability is etiologically neutral, any decrement in functioning is not linked to or solely predicted by the presence of a specific health condition or conditions. Having difficulty leaving one’s home, whether it arises from a spinal cord injury or pathological fear of open spaces, has a comparable impact on a person’s life (Cieza, 2018). Describing disability in terms of impairments and/or level of impairment, or through use of a diagnosis-specific assessment tool, does not allow for the disability associated with different conditions to be quantified in a comparable manner. This means that there is no way of determining whether an individual with one condition has more or less functional ability than an individual with a different condition.

The ideal solution would be a single, easy to use, generic, standardised and norm-referenced assessment tool, with the same discriminative, predictive and evaluative properties for all conditions, ages and cultures, acceptable to all, and including all ICF chapters and NDIS activity areas. Standardised, norm-referenced assessments are formalised assessments that have clearly defined procedures for administration and scores that are interpreted with reference to a sample of the entire population. This ideal assessment would allow for the continuum of functioning to be partitioned by thresholds, permitting equitable and consistent Eligibility decisions to be made. It would allow for functional capacity to be compared across all individuals no matter which or how many conditions they may have. It would provide a means of quantifying an individual’s function and the assistance and environmental change needed, in order to appropriately and adequately fund their supports.

This ideal solution is, however, unattainable at present as the ideal assessment tool does not exist. In 2011, the Productivity Commission Inquiry Report recognised the relatively limited research into generic assessment tools and recommended that the Government should not delay the implementation of the NDIS in the absence of ‘perfect’ tools. Currently, the perfect tool remains elusive, compelling the NDIS to undertake the process of determining the ‘best fit’ suite of assessment tools instead. That is, an ‘approximate answer to the right question’ (Tukey, 1962 p13-14)

There are some issues to be aware of when using norm-referenced assessments:

* While these assessments are sensitive in providing thresholds across the entire population to support Eligibility access decisions, there may be issues with sensitivity when comparing functional capacity between people at the extreme ends of the bell curve
* Information on environmental factors and participation is also needed to understand the functioning of individuals and to support access and planning decisions, but assessment of these areas can be difficult when relying on norm-referenced tools alone. Criterion referenced assessment tools may be more appropriate when assessing environmental contexts of function and a person’s involvement in life situations, because these can only ever be measured according to an individual’s context, perspective and values. These assessments can detect the magnitude of longitudinal change over time for each person in relation to their own personal situation.

The individual-specific nature of environment and participation factors are evident across many different situations. For instance, one aspect of the environment may be a barrier for one person and a facilitator for another (e.g. an angled entrance ramp may be a facilitator for a person using a power wheelchair but a barrier for a person who is unable to walk up an incline). Similarly, participation factors need to be considered with regard to a person’s individual situation and preferences.

There are issues that relate to situations where the norm-referencing of an assessment tool has occurred outside of the Australian context. This is an issue that is challenging as many of the assessments commonly used across Australia have been developed in other countries. It may be argued that Australian society and culture are unique and comparisons with normative data from elsewhere may be brought into question. However, the difficulty is that assessments normed in Australia are few and often do not meet the needs of NDIS.

These issues mean that additional information will need to be gathered and considered carefully to acknowledge the complexity of disability and humanity. This information may include additional personal and environmental factors, individual goals, observations, and parent and caregiver perspectives. Further, more detailed assessments may be triggered when a specific major support need is identified, such as Supported Independent Living or Assistive Technology and Home Modifications.

This assessment approach will inform decision making and assist NDIS delegates by providing a holistic profile of each person’s function. Having gone through a consistent process and evaluation, participants, prospective participants, NDIA staff and the wider community will have greater confidence in a more reliable and robust system. Details gathered through a suite of assessments will readily inform decisions for many, which will add value and clarity to their NDIS journey.

**The suite of assessment tools should include generic, standardised norm-referenced assessment(s) in order to quantify the magnitude of an individual’s functional capacity in a comparable manner across the entire population.**

**The suite of assessment tools should also include standardised criterion based assessments to support Access and Planning decisions as they identify and evaluate the benefits of support needs for each person individually**.

Equity and consistency may be gained in multifaceted complex cases when NDIS delegates have consistent and comparable assessment findings available to them

A suite of assessments will enable equitable decision making for many people. This approach will provide NDIA with a holistic methodology to gather information across all the recommended ICF domains. Nonetheless, there are some complex circumstances where supplementary information will be needed for an NDIS delegate to examine before a final decision can be reached. In these circumstances, the suite of assessments will form the solid foundations upon which the decision will be made, with supplementary details providing the scaffolding and reinforcement to shore up any gaps that may appear.

The NDIA acknowledges that decision making cannot be automated because people are complicated multi-layered individuals and deserve to be treated as such. This is one of the reasons NDIS staff have been entrusted with connecting with people and supporting them through their individual NDIS journey. In keeping with this philosophy, it is also necessary to accept that for some people, even a suite of assessments will not provide all the details that are needed.

Some people present with a degree of complexity that requires more in-depth deliberation than assessment findings can provide on their own. The complexity, nuances and intertwining of factors may need to be examined more closely or may prompt more questions that need to be answered. Where a clear decision has not come to light after the suite of assessments has been completed, it would be a mistake to simply extend the assessment regime. Administering extra tools in an attempt to tally up factors to generate a final decision in this situation would be an ineffective attempt at a solution.

If a clear decision does not immediately follow from the suite of assessments, it is likely that supplementary consideration will be needed. It is important to understand that conditions and disabilities do not behave in a linear or predictable fashion. For many, it is the interplay of factors that has a profound impact on their function and manifests in a unique way. Sometimes the results will be evident in a person’s functional capacity across many situations. For others, there will be effects that are more erratic, situation-specific, or episodic. This means that, for some people, a suite of assessments may not be sufficient or sensitive enough to tease out all the issues, identify subtleties, and examine the impacts of the individual factors to lead to a clear decision.

There are times when it will be necessary for delegates to scrutinise specific assessment items, to ask more questions, to source extra information from parents, carers, significant others and health professionals as needed. However, the way this supplementary information is included in the assessment process will be different to the current state. At present, this information would be added to an already variable and inconsistent repository and run the risk of overcomplicating or confusing matters further rather than clarifying them.

The future state where a consistent assessment approach is offered to everyone, ensures that there is a solid, reliable structure to which supplementary information may be attached. This reduces inconsistencies while allowing for individual difference and consideration, minimising variability and inconsistency as much as possible. Equity and consistency may be gained in multifaceted complex cases when delegates have consistent and comparable assessment findings available to them.

**NDIS decisions may need to take into account supplementary information for some participants/prospective participants.**

Equity and validity can be improved by using a combination of assessment methods

Assessment information currently provided to NDIA is obtained from the participant in a variety of ways, including interviews, ‘hands on’ assessment, observation and self-report questionnaires. Some assessment tools are face-to-face, requiring direct observation of a set of skills, performed in response to standardised instructions and/or in a standardised setting. These assessments have the advantage of reducing the risk of subjectivity and bias that may occur with self-report questionnaires. Limitations arise, however, with this type of direct assessment. This requires a person to follow instructions and co-operate with the assessor, and also relies on the assessor having the skills and rapport to administer the assessment appropriately to obtain reliable results.

For some individuals, the presence of a ‘new’ person can impact their performance, and some people will behave differently in an unfamiliar or clinic setting, or even at home with an unfamiliar person. Further, this type of assessment only provides a snap shot of a person’s functional ability on a particular day, at a particular time and place, with certain people, which introduces the risk of capturing functional capacity on a ‘good’ or ‘bad’ day, or in a ‘good’ or ‘bad’ context. In addition, these type of assessments have been criticised for their “lack of functionality and lack of congruence” with early childhood practices (Bagnato, 2005).

Assessment tools that are interview and questionnaire based with standardised questions, allow the individual or their representative, parent or caregiver to provide the information on functional capacity without the need to ‘perform’. These assessments also allow for functional capacity to be considered over a longer period and in a variety of settings, providing insight into the real world experiences of an individual in a time and cost effective way. They also allow for the individual and/or their representative to be empowered during the assessment process by ensuring that they get to provide the input. The presence of the health professional as the interviewer can make the assessment more consistent across people and more robust than a self-administered questionnaire, especially if combined with an observational assessment or interaction.

**The combination of standardised interview/questionnaire assessments with informal observation allows for function to be considered across different settings and different times, rather than reflecting assessment performance in an unfamiliar or unnatural setting on a good or bad day.**

Equity and consistency can be improved by having independent assessors administer the assessments of functional capacity

The potential for “sympathy bias” during assessment was recognised as part of the Inquiry Report, 2011. Currently, health professionals who have been supporting an individual are often placed in a difficult position when asked to undertake an assessment that relates to a person’s eligibility for NDIS. The potential for the over-stating of an individual’s needs by a health professional who has known a person for a period of time even if it is unintentional, poses a risk for both equity and sustainability of resources.

An Australian study by Guscia, Harries, Kirby and Nettelbeck (2006) investigated whether assessment tools obtained different results for different purposes. They found that support measures “may significantly overestimate support needs when raters know they are being used for funding purposes” (Guscia et al 2006, p159). This risk may be amplified if the ‘rater’ or assessor has a professional relationship with the person being assessed.

The Inquiry Report of 2011 recommended that “in order to promote independent outcomes, assessors should be drawn from an approved pool of allied health professionals” (p327). This would require a health professional with no past and/or ongoing treatment or support responsibilities for a particular person to administer an assessment of functional capacity for Eligibility and Funding purposes in order to improve professional objectivity. It is important to note that while the health professional administering the assessment should be independent, the participant and a ‘circle of support’ should be involved in the assessment process whenever possible. It should also be noted that there are extenuating circumstances where there will be no option but to have an assessor who knows the person they are assessing, particularly in rural, remote and hard to reach populations. In these situations any risk of sympathy bias is outweighed by the need to complete the assessment process and to do so in a culturally-sensitive manner.

**As assessment of functional capacity should be administered by an independent assessor in order to minimise the risk of sympathy bias and to improve professional objectivity whenever possible (Independent Assessment).**

Equity and consistency can be improved by providing an uncomplicated Access pathway for an assessment of functional capacity which is free of cost to participants and prospective participants

Currently, the legislation allows the CEO to request evidence of functional capacity, or other information reasonably necessary for deciding whether the person meets the access criteria. This can be a significant barrier for many trying to access the Scheme. The gathering of evidence presently requires an assessment of functional capacity to be obtained through consultation with private health professionals or those in the publicly funded health system. The public health system frequently has extensive waiting lists for services, and accessing the private health system is a financial barrier for many. For others, the ability to ask the right questions, to locate the appropriate centre, to navigate the health system, to know which services are available and/or how to access them, is an additional barrier. Social, cultural and language barriers, as well as the individual’s functional ability, can magnify these concerns even further.

An independent assessment of functional capacity, as part of an uncomplicated and clear access pathway that is provided at no cost to the individual, will help to minimise the impact of barriers for people trying to access the Scheme. The NDIA estimates that average savings for people with disabilities of $130 million to $170 million per year will result from the NDIA removing this financial burden, calculated based on the cost of assessments and current need for prospective participants and participants to source their own assessments.

This is a necessary change to achieve equity, as well as consistency of assessment, irrespective of financial, social, cultural and language barriers.

*“I just think this pilot is a wonderful initiative. I first had my son assessed for ASD when he was 5 after it was suggested by his future principal at a kindergarten interview. He was not correctly diagnosed until we went through the testing process again at the age of 10. The assessments were very expensive and it was a huge financial strain on our family. I wish this service was available for us back then. I think this process will help a lot of struggling families allowing them to get access to early intervention for their children” (Feedback from a parent who participated in the NDIS Independent Assessment pilot, 2020).*

**An assessment of functional capacity should be provided free of cost as part of an uncomplicated and clear Access pathway in order to reduce the impact of any financial, social, cultural and functional barriers that may exist for an individual approaching the scheme at Access.**

### Practical considerations are necessary when selecting assessment tools.

When selecting assessment measures for use in the NDIS context, it is important that the practical elements of an assessment tool are also considered. Madden et al (2015) suggested that “measurement must not only be fit for purpose, but also fit for process” (Madden et al 2015 p 5816)

Several factors should be taken into consideration when choosing assessments for NDIS purposes.

Time taken to administer and interpret:

When selecting assessment tools, the time required to administer and interpret results is an important consideration. There is a need to carefully balance the duration of assessments with the practical needs of the individual. While it may be suggested that ideally, detailed assessments be conducted for each of the six NDIS functional activity areas, this could lead to an extensive assessment duration. This would create the risk of fatigue and difficulties with concentration for both the assessor and the individual and is likely to impact on the validity of results. There may also be additional meal breaks, personal care or other factors that impact a person’s ability to complete assessments of lengthy duration.

In addition, a suite of assessments that take a long time to administer could potentially create unacceptable and unmanageable waiting lists as fewer people can be seen by each assessor during the course of the working week. A reasonable compromise must be made between length of assessment process and practical considerations for individuals.

Training and Qualification requirements:

Some assessments have specific requirements regarding assessor qualifications e.g. only to be administered by certain allied health professionals. This is an important consideration especially in areas where there are already thin markets of health professionals operating. Assessment tools that require highly specialised qualifications (such as psychologist or medical specialist qualifications) will not be practical on a national scale especially in geographically isolated areas.

Cost of administration:

In order for the NDIS to be sustainable long term, the selection of assessment tools needs to consider the cost implications at a national scale. There will need to be consideration of the costs involved with licensing, training and time to administer and score each assessment.

**When selecting assessment tools for the NDIS context, the practical considerations of time to administer, qualification requirements and cost of administration must be carefully considered.**

### Assessment tools should have adequate psychometric properties

The psychometric properties of any assessment tool considered for selection need to be evaluated. Examples of psychometric properties include reliability and validity.

Reliability is defined as the stability of the measure when it is repeated under identical conditions. (Rydz, Shevell, Majnemer and Oskoui, 2005). There are four subtypes of reliability:

* + 1. Inter-rater : the reliability when a test is repeated by different evaluators on the same subject
		2. Intra-rater: the reliability when a test is repeated by the same evaluator on the same subject
		3. Test-retest: the reliability (stability) of a test when repeated by the same evaluator on the same individual at different times.
		4. Internal consistency: the degree to which all test items measure the same trait (Rydz et al 2005 p8.).

Reliability scores range between 0 (no reliability) and 1 (perfect reliability). No test is expected to have perfect reliability. There does not appear to be consensus in the literature about exact correlation values to determine whether reliability is excellent or adequate as there are many factors that impact on these scores. According to Rosaroso (2015) “As a rule of thumb, reliability coefficients of 0.8 or above are within acceptable standards” (Rosaroso 2015 p371). The Can Child Outcome Measures guideline states “levels of the reliability coefficient indicate that it will be rated excellent if the coefficient is greater than .80, adequate if it is from .60 to .79, and poor if the coefficient is less than .60.”(Law, 2004 p4).

Validity evaluates the extent to which an assessment measures the quality it is claiming to measure. Validity can be split into the following:

1. Content validity: whether the assessment tool measures all aspects of the intended trait
2. Construct Validity: A construct is a hypothetical underlying characteristic of a trait. It can be measured by comparing it to another assessment which measures the same trait or by evaluating the tool’s ability to differentiate between two groups
3. Criterion Validity: looks at how well the test performs in relation to a gold standard established tool used to evaluate the same trait. Criterion validity can be concurrent (same time) or predictive (tests performed at different times) (Rydz, 2005, p8-9).

It is important to note that validity is not a property of an instrument (Cook and Beckman, 2006). Cook et al (2006) explain that validity must be established for each intended interpretation and is best viewed as a hypothesis as it can never be proven. Similarly, Cook et al (2006) note that reliability, like validity, is a property of the score and not the instrument itself - “the same instrument, used in a different setting or with different subjects can demonstrate wide variation in reliability” (Cook et al, 2006, p13).

These qualities are of importance when developing a framework around the assessment of functional capacity for NDIS purposes, especially when applying tools across the Australian population and all disabilities. Just because an assessment tool has demonstrated strong psychometric properties in the country of development does not mean that it will necessarily have strong psychometric properties in the Australian population, or in all settings in Australia. In addition, because an assessment tool has been proven to have strong validity and reliability under research conditions does not mean it will have strong reliability and validity in practice outside of the study constraints.

These limitations make it challenging to identify a suite of assessments that meets all the critical criteria and has strong psychometric properties in the Australian context and across all disabilities. In the absence of a generic assessment tool that has been developed and/or tested in the Australian population, the “most suitable” approach to the selection of assessment tools must therefore be taken.

**Assessment tools should demonstrate adequate reliability and validity within the context that they were developed.**

### Governance must be part of the assessment framework approach

Governance is vital for a number of reasons.

1. Governance to ensure that the established reliability and validity of assessment tools is replicated to the extent possible, in the NDIS assessment environment. This will include centralised and consistent training of the health professionals conducting the independent assessments as well as research into the reliability and validity of assessment tools and results in the NDIS context for Australians.
2. Governance over assessor competency is necessary to ensure adequate professional standards and maintenance of assessor skills in administering the assessment approach. It is essential that assessors develop and maintain an awareness of sensitivities when working with a variety of participants/prospective participants and support teams.
3. Governance over the assessment approach to ensure that the experience of the participant, prospective participant, and their support team remains acceptable. This would include the evaluation of feedback from the participant and/or representative.
4. Governance to ensure that each of the assessments included in the suite continues to be the most suitable. It is necessary that the assessment tools and approach are subject to ongoing monitoring as well as “a regular cycle of evaluation against best practices, including the ICF framework” (Productivity Commission, Disability Care and Support Inquiry Report 2011 p338). Anomalies of processes and results need to be analysed and addressed. The way must be left open for new assessment tools or existing tools with new evidence to be considered as more suitable additions or replacements in the suite of assessments.

**Governance is a necessary part of the assessment approach and vital to ensure that the suite of assessment tools being used to support NDIS decisions are reliable, valid, acceptable and most suitable.**

## Final Remarks

Guiding principles of the NDIS are firmly grounded in an approach that acknowledges people with a disability have the same right as other members of Australian society to realise their potential, and contribute to social and economic life to the extent of their ability (NDIS Act, 2013). It is incumbent upon the NDIA to deliver a Scheme that is both equitable for participants, and sustainable for society as a whole. Important steps towards this include implementation of robust procedures, continual evaluation, quality checks and adjustments when needed, in order to deliver the best decisions possible across Access and Planning.

Gathering more reliable information on functional capacity for each participant/prospective participant is a critical part of the procedural change that is required. Information on each person’s functional capacity within the proposed Independent Assessment framework will strengthen the capacity of NDIA staff to make sound decisions, and offer a point of comparison between individuals who are inherently different. When the suite of assessment tools are administered in a consistent way, to gather the information needed for NDIS, from all people of a certain age and irrespective of diagnosis, a solid base for achieving equity and consistency of Scheme decision making can be achieved.

## Functional Capacity Definition

“Functional capacity refers to an individual’s ability to be involved in life situations and to execute tasks or actions, with and without assistance (assistive devices and/or personal assistance). Information regarding impairment(s) and environmental factors, and how they impact the individual’s function is included when assessing functional capacity.”

## Key Terms

**Functioning** - is an umbrella term for body functions, body structures, Activities and participation. It denotes the positive aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors (environmental and personal factors).

**Disability** - is an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors (environmental and personal factors).

**Health Condition** - is an umbrella term for disease (acute or chronic), disorder, injury or trauma. A health condition may also include other circumstances such as pregnancy, ageing, stress, congenital anomaly, or genetic predisposition. Health Conditions are coded using the ICD-10.

**Body functions** – are the physiological functions of body systems (including psychological functions). “Body” refers to the human organism as a whole, and thus includes the brain. Hence, mental (or psychological) functions are subsumed under body functions. The standard for these functions is considered the statistical norm for humans.

**Body structures** – are anatomical parts of the body such as organs, limbs and their components.

**Impairments** - Problems in body function or structure such as significant deviation or loss.

**Activity** – is the execution of a task or action by an individual.

**Participation** – is involvement in a life situation.

**Activity limitations** – are difficulties an individual may have in executing Activities.

**Participation restrictions** – are problems an individual may experience in involvement in life situations.

**Environmental factors** – make up the physical, social and attitudinal environment in which people live and conduct their lives.

**Personal Factors** - are the particular background of an individual’s life and living and comprise features of the individual that are not part of a health condition or health states. These factors may include gender, race, age, other health conditions, fitness, lifestyle, habits, upbringing, coping styles, social background, education, profession, past and current experience, overall behaviour pattern and character style, individual psychological assets and other characteristics, all or any of which may play a role in disability at any level. Personal factors are not classified in the ICF.

**Delegate** – an officer of the Agency with specific powers and functions to make decisions, delegated under the Act by the CEO.

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