# Final Evaluation Report

## Independent Assessment Pilot 2

July 2021
Research and Evaluation Branch

**ndis.gov.au**

## This document

This report presents evaluation findings from the Second Independent Assessment Pilot. It covers the experiences of participants and how they find the independent assessment process; the perspectives of independent assessors on the tools and their support needs; and whether participants feel their IA accurately reflects both what they told their assessor and their functional capacity.

## Contributors

The NDIA’s Research and Evaluation Branch delivered the evaluation, which has been validated by the Centre for Disability Studies and Centre for Disability Research and Policy at the University of Sydney.

The NDIA’s Community Events and Engagement Branch and Participant Advocacy Branch helped undertake interviews with participants and their supporters.

Members of the Independent Advisory Council also helped undertake interviews.

## Disclaimer

Material in this report is available on the understanding that future decision-making or changes to NDIA process would be subject to changes in legislation, which at the time of writing have not been formally proposed. Views and recommendations of third parties, which may also be included in this report, do not necessarily reflect the views of the NDIA, or indicate a commitment to a particular course of action.

## Acknowledgements

We would like to acknowledge and thank all of the participants, their families and carers who gave up their time to participate in this evaluation to provide feedback, and members of the Independent Advisory Council for their role in the participant interviews.

The NDIA also acknowledges the Traditional Owners and Custodians throughout Australia and their continuing connection to the many lands, seas and communities. The NDIA pays respect to Elders past and present, and extends this acknowledgement and respect to any Aboriginal and Torres Strait Islander people who may be reading this report.

# Contents

# Abbreviations and acronyms

| | |
|---|---|
| ASQ-3 | Ages and Stages Questionnaires |
| ASQ-TRAK | Ages and Stages Questionnaires - Talking About Raising Aboriginal Kids |
| CANS | Care and Needs Scale |
| CEO | Chief Executive Officer |
| CHIEF | Craig Hospital Inventory of Environmental Factors |
| COVID-19 | Coronavirus Disease 2019 |
| CRM | Customer Relationship Management business system |
| ECEI | Early Childhood Early Intervention |
| IA | Independent Assessment |
| IAP | Independent Assessment Pilot |
| ICD-10 | International Classification of Diseases 10th version |
| ICF | International Classification of Functioning |
| LAC | Local Area Coordinator |
| LEFS | Lower Extremity Functional Scale assessment instrument |
| NDIA | National Disability Insurance Agency, the Agency |
| NDIS | National Disability Insurance Scheme |
| NHMRC | National Health and Medical Research Council |
| OSA | Office of the Scheme Actuary |
| PEDICAT (CAT) | Paediatric Evaluation of Disability Inventory (PEDI) computer adaptive test |
| PEM-CY | Participation and Environment Measure for Children and Youth |
| PWD | People With Disabilities |
| QA | Quality Assurance |
| SIL | Supported Independent Living |
| TAB | Technical Advisory Branch |
| TSP | Typical Support Package |
| Vineland 3 | Adaptive Behaviour Scales assessment instrument (3rd edition) |
| WHODAS instrument | World Health Organization Disability Assessment Schedule assessment |
| YC-PEM | Young Children’s Participation and Environment Measure |

# Key observations

- 70% of participants/supporters who responded to the evaluation survey (n=948) reported their IA experience as excellent, very good or good (46% excellent or very good, 24% good; average rating 3.2 out of 5). Respondents valued the opportunity to discuss their disability in detail, to have their concerns and opinions heard, the assessment being held at home, and the high level of assessor professionalism.
- 60% of participants/supporters felt assessment length was “about right”, and 35% felt it was too long. Ratings appear to be influenced by individual preference, rather than participant characteristics. The average difference between assessments considered “too long” or “too short” was two minutes. Participants and assessors identified opportunities to shorten IAs including reducing repetition and better alignment of questions to their individual situation.
- Assessments were offered face to face in the participant’s home or via telepresence. Participants rated their experience of face-to-face assessments marginally higher, although the mode of assessment was not significantly associated with a participant’s rating of their overall experience. This suggests that both modes are acceptable for most participants.
- Assessors knowing about the participant’s disability was found to be the most important driver of a positive experience. Suppliers actively attempted to allocate assessors based on their previous experience, although only 53% of participant survey respondents reported that their assessor seemed to know a lot about their disability.
- Just over 200 allied health professionals delivered assessments from a range of professions. They were generally positive about the training they received, but identified a need for more training on administering the tools, working with different disabilities and delivering the participant interaction component of an IA.
- Assessor feedback and analysis of IA quality also identified a need for a better IT platform that supports assessors to use of their clinical judgement to only ask those questions that are relevant for each participant’s disability, life stage and previous answers.
- Assessor feedback indicated that some tools were easier to administer (e.g. CANS, PEDICAT and ASQ), but some were more difficult (WHODAS, PEM-CY/YC-PEM and Vineland III). While each tool is not sufficient to provide a comprehensive measure of functional capacity, combined they represent the best approach currently available.
- 75% of participants/supporters considered their IA report an excellent or very good reflection of their assessment, and 65% considered it an excellent or very good reflection of their functional capacity. Participants/supporters felt reports should include more contextual information about the participant and have more information on goals and support needs. Interviews with participants reinforced the need to improve communications and awareness about the role of IAs in NDIS planning reforms.

# Key considerations

1. The NDIA should continue further testing of functional assessments with priority cohorts to ensure its approach works effectively and consistently amongst all participant cohorts and in all locations.
2. If a participant requires their IA to be conducted by telepresence, suppliers must first ensure the participant is suitable to have their functional capacity accurately assessed this way, the participant has access to suitable technology, and the participant or their supporter has the capability to use that technology.
3. Based on best available evidence, the length of an IA meeting should not exceed a maximum of three hours. Multiple assessment sessions should be encouraged if longer is required.
4. To shorten IAs, the NDIA should design assessment packages which allow completion of some participant information prior to the appointment. This would help improve the accuracy of this data where it requires recall, and also provide suppliers with information to assist in allocating the most suitable assessor for the participant.
5. The NDIA should use a well-validated approach to analyse assessment data to determine how the tools can be streamlined to reduce the length of IAs, while still delivering valid and reliable assessment of functional capacity.
6. The NDIA should set up standard operating procedures that encourage assessors to use their clinical judgement on the most appropriate way to conduct each IA. This will promote an effective interaction with the participant/supporter, and reduce a prolonged question-answer exchange, which is clearly not preferred by participants/supporters. It will also be important to implement a robust quality assurance process to ensure the integrity of IAs.
7. The NDIA should improve the detail of IA information materials for participants/supporters to explain what the IA is, the process undertaken and how the resulting data would be used. This information should be in a range of formats accessible to people with various communication impairments, be available in languages other than English and in easy read formats.
8. The NDIA should ensure the format, language and level of detail of IA reports are responsive to participant need. This should be complimented by comprehensive communication about the role of IAs in the end-to-end reforms to NDIS budgeting and planning.
9. The NDIA should monitor the impact of assessor qualifications and experience on participant/supporter experience with IAs. This data should be used to develop minimum qualification and experience criteria for suppliers to allocate assessors to referrals.

10. The NDIA should proactively monitor assessor performance and engage early if quality issues emerge. A revision of data review processes should also be undertaken to ensure consistency with any tool modifications undertaken. Sufficient checks should be built into any future assessment system, including the platform used by assessors.

11. Assessor training and materials should be developed in partnership with people with a lived experience of disability. Training should emphasise practical, experientially-based learning about working with different disability types and IA delivery. Information contained in assessment tool manuals should be curated to focus on the key aspects necessary for accurate administration.

12. Further assessor training, involving people with a lived experience of disability, on the participant interaction activity is required to ensure it is relevant to the participant's disability and reflective of their functional capacity. Observations should also be obtained and recorded during the entire assessment, which would help lift IAs to more of an interactive assessment rather than just questions and answers and task observation.

# Executive summary

## Introduction

Currently, participants use different sources of evidence in their application to enter the National Disability Insurance Scheme (NDIS) and for the assessment of reasonable and necessary supports. The extent and quality of information to make these assessments varies between participants, leading to inconsistent decisions and inequity across participants. The introduction of free independent assessments (IAs) is a key part of proposed reforms to improve the NDIS and help make it more equitable and sustainable. An IA is an evaluation of a person's functional capacity and their individual circumstances, such as living arrangements and the support provided by family and friends, rather than an evaluation of expected level of NDIS supports.

The first IA pilot (IAP1) concluded in April 2019 offered IAs on a voluntary opt-in basis to NDIS applicants and participants aged seven to 64 years with a primary disability of autism spectrum disorder, intellectual disability or psychosocial disability. This pilot provided evidence that using standardised assessments can support better decision-making by the NDIA[1].

To include a broader cross-section of participants and assessment instruments, the NDIA launched a second pilot (IAP2) on 25 November 2019. This second pilot extended the eligibility of IAs to NDIS participants across all States and Territories. The intent was to provide free and voluntary IAs to up to 4,000 participants to help achieve the following:

1. Understand more about the **experiences of participants** and how they find the independent assessment process, including whether the report accurately reflects both what they told their assessor and their functional capacity.
2. **Understand the assessor workforce** and their delivery of IAs, including hearing from them on the process and their support needs.
3. Get feedback on the **independent assessment tools** and whether participants and assessors feel they collect the right information.
4. Collect **more data** to help the NDIA develop the approach for using IAs to support access and budget decisions.

The evaluation of IAP2 has focused on objectives 1 to 3. Future decisions that result from IAs around NDIS eligibility and personalised budgets, including the impact of IAs on equity, are not in scope of this evaluation.

The NDIA’s Research and Evaluation Branch delivered the evaluation, which has been validated by the Centre for Disability Studies and Centre for Disability Research and Policy at the University of Sydney.

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[1] NDIA (2020) Independent Assessments: Pilot learnings and ongoing evaluation plan. Refer www.ndis.gov.au/media/2686/download.

## Pilot achievements

As of 31 May 2021, suppliers had completed 3,759 IAs as part of IAP2. This included participants in all States and Territories, and across 84 primary diagnosis classifications according to the International Classification of Diseases (ICD-10).

**Consideration 1**

The NDIA should continue further testing of functional assessments with priority cohorts to ensure its approach works effectively and consistently amongst all participant cohorts and in all locations.

While a broad range of participants undertook a functional assessment, some cohorts were under-represented in IAP2. In particular this included participants in the NT and some disability types such as psychosocial disability.

## Evaluation Findings

The findings from the evaluation can be divided into those related to the experience of participants, the assessor workforce, perspectives on the assessment packages, and the consistency of IAs with previous assessments of functional capacity. These are summarised below along with considerations for the NDIA.

### Participant experience

#### Overall participant experience

In a voluntary survey of participants and their supporters, 46% rated their overall experience having an IA as excellent or very good (24% good; average rating of 3.2 out of 5). These results were consistent with the ratings given for how IAs were conducted (Figure ES1). The elements of the IA process participants/supporters rated most highly were the professionalism of their assessor and the booking process (75% and 56% of respondents rated these aspects excellent or very good respectively; 17% and 24% good respectively; average = 4.1 and 3.6 respectively)[2].

The most positive experience reported for the way IAs were conducted was from participants who have a sensory disability (52% excellent or very good; 20% good; average = 3.4 out of 5). Survey respondents rated the way IAs were conducted with people with a physical disability or neurological disability the least positive (42% excellent or very good; 19% and 23% good respectively; average = 3.0 and 3.1 respectively).

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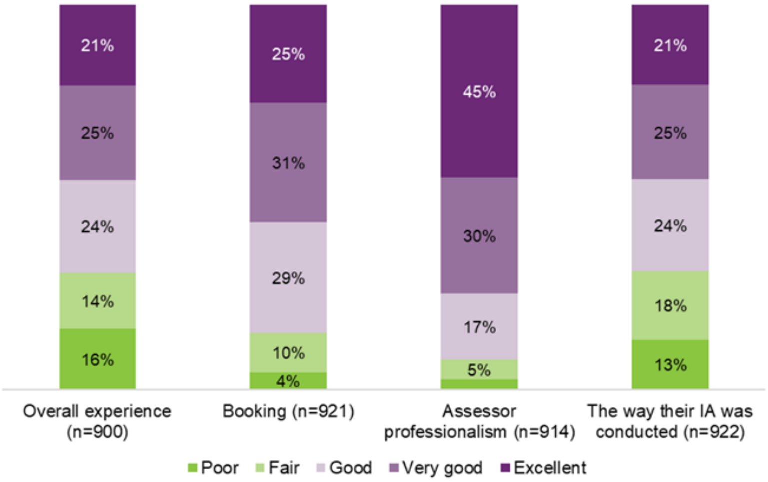
[2] Sample size varied dependent on response rates for each question and are as follows: Overall experience n= 900; the way IAs were conducted n=922; assessor professionalism n=914; booking process n=921

**Figure ES1: Participant/supporter experience with their IA**



**Data table for Figure ES1**

| Question | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| Overall experience (n=900) | 16% | 14% | 24% | 25% | 21% |
| Booking (n=921) | 4% | 10% | 29% | 31% | 25% |
| Assessor professionalism (n=914) | 3% | 5% | 17% | 30% | 45% |
| The way their IA was conducted (n=922) | 13% | 18% | 24% | 25% | 21% |

Source: Participant experience survey.

Participant/supporter overall experience with IAs was similar across all levels of functional capacity with 43% of participants with low functional capacity reporting an excellent or very good overall IA experience (average 3.1 out of 5) compared to participants with moderate (51%, average 3.3) or high (49%, average. 3.4) functional capacity. This difference was not significant after accounting for Aboriginal and Torres Strait Islander status, whether English was the primary language spoken at home, IA package and IA mode of delivery. Participant experience with the professionalism of their assessor and the booking process were also similar across all functional capacities.

Overall, 57% of participants with low functional capacity reported that given the choice, they would have an IA again, compared to 64% of participants with medium functional capacity and 70% of participants with high functional capacity. After accounting for Aboriginal and Torres Strait Islander status, whether English was the primary language spoken at home, IA package and IA setting, participants with a low functional capacity were 14% less likely than those with high functional capacity to indicate that given the choice, they would have an IA again; a statistically significant difference. The difference between participants with moderate functional capacity and high functional capacity was not statistically significant.

In the survey, 65% of participants/supporters who identified as being of Aboriginal and/or Torres Strait Islander descent, and 47% who mainly speak a language other than English at home rated their IA experience as very good to excellent (24% and 27% good respectively). Almost all of these participants/supporters reported that their IA was culturally appropriate.

### The assessment meeting

Survey and interview responses showed that a number of aspects of IAs worked well for participants/supporters. These included face to face contact, in-home visits and the professionalism and interpersonal skills of assessors. Participants reported face-to-face assessments slightly more positively than those delivered by telepresence. However, the mode of assessment was not found to be a significant factor predicting a participant's experience, confirming that both modes are acceptable for most participants.

The average length of IAs was 3:22 hours. While the majority of participants/supporters who responded to the survey thought the length of the assessment was about right (60%), 35% thought it was too long. IAs involving participants with autism, psychosocial or sensory disability were slightly more likely to be rated as too long. However, perceptions on the right length for an IA seem more likely to reflect personal expectation rather than any systematic characteristic(s) of participants.

Assessors also reported that the duration of IAs is too long and requires the participant and their support person/s to concentrate for an extended period of time. This led some to suggest that the assessment should be booked as two sessions for some cohorts, particularly for younger participants.

Participants/supporters and assessors suggested a range of ways to reduce the length of IAs, including scheduling assessments over two sessions when a longer assessment duration was likely, allowing some questions to be completed before the meeting, reducing the number of repeated topics between assessment tools, and customising the questions to the participant's disability and the way they answered earlier questions.

**Consideration 2**

If a participant requires their IA to be conducted by telepresence, suppliers must first ensure the participant is suitable to have their functional capacity accurately assessed this way, the participant has access to suitable technology, and the participant or their supporter has the capability to use that technology.

**Consideration 3**

Based on best available evidence, the length of an IA meeting should not exceed a maximum of three hours. Multiple assessment sessions should be encouraged if longer is required.

**Consideration 4**

To shorten IAs, the NDIA should design assessment packages which allow completion of some participant information prior to the appointment. This would help improve the accuracy of this data where it requires recall, and also provide suppliers with information to assist in allocating the most suitable assessor for the participant.

**Consideration 5**

The NDIA should use a well-validated approach to analyse assessment data to determine how the tools can be streamlined to reduce the length of IAs, while still delivering valid and reliable assessment of functional capacity.

Managers and assessors described several different approaches to conducting IAs, including semi-structured interviewing and face to face surveying, with data recorded during or after the assessment meeting. Sometimes assessors used notes or printed versions of assessment packages as an intermediate way of recording results prior to system entry.

**Consideration 6**

The NDIA should set up standard operating procedures that encourage assessors to use their clinical judgement on the most appropriate way to conduct each IA. This will promote an effective interaction with the participant/supporter, and reduce a prolonged question-answer exchange, which is clearly not preferred by participants/supporters. It will also be important to implement a robust quality assurance process to ensure the integrity of IAs.

The prevalence of each approach to conducting IAs is unknown as assessors were not required to record this information. Interviews with participants/supporters and assessors indicated a preference for entering participant responses after the meeting, as opposed to conducting an assessment that was more like a series of questions and answers in response to the tools. The impact of the approach adopted on the reliability and accuracy of IA data capture and entry is unknown, although the NDIA encouraged assessors to use their best clinical judgement on the most appropriate way to deliver each assessment.

### Bookings and information

**Consideration 7**

The NDIA should improve the detail of IA information materials for participants/supporters to explain what the IA is, the process undertaken and how the resulting data would be used. This information should be in a range of formats accessible to people with various communication impairments, be available in languages other than English and in easy read formats.

The IAP2 suppliers managed the booking process using NDIA provided communication materials and scripts. When surveyed after their IA, around a quarter of participants/supporters felt more information was needed upfront about the questions that would be asked, including any sensitive topics, and how their pilot IA data would be used. Interviews with participants/supporters indicated the latter was not clear to all participants, some of whom thought their IA would be utilised as part of their upcoming planning meeting.

### Assessment outputs

For 75% of participants/supporters who answered survey questions about their IA reports, it was felt that their IA results were an excellent to good reflection of their IA meeting (48% excellent or very good). However, 65% rated their results an excellent to good reflection of the functional capacity (42% excellent or very good). This means 35% of respondents rated their results as a poor or fair reflection of their functional capacity. This sentiment was confirmed in open ended feedback, where respondents commented about the low accuracy of their reports (21% of 238 comments received).

Participants/supporters indicated they wanted a report that was more tailored to them as individuals. Respondents noted that the contextual information they provided to elaborate on their responses during the assessment was missing. A theme elaborating this point was a desire for the report to have a greater focus on the participant's specific disability and support needs, include the impact of the participant's disability on their family and address future care needs.

Consistent with these opinions were comments that the report was too generic (12%) and was largely a list of answers to the questions their assessor asked them (12%). Some participants/supporters noted that the report should include recommendations and link back to their plan (12%). Interviews with participants/supporters suggested that negative sentiment might reflect limited understanding of the end-to-end IA process, the role of IAs, and expectations based on the content of previous allied health reports they had received.

In order to improve the layout of reports in the future, participants/supporters suggested the report needed to be easier to understand. Suggestions included limiting complex terminology or jargon, and including a description of the ranges used to describe abilities. It was noted that input from other sources, such as the participant's regular health professional team and/or specialist reports would improve the IA report.

**Consideration 8**

The NDIA should ensure the format, language and level of detail of IA reports are responsive to participant need. This should be complimented by comprehensive communication about the role of IAs in the end-to-end reforms to NDIS budgeting and planning.

### Participant experience drivers

A Shapley Value regression[3] of participant/supporter survey responses identified three key drivers (or must haves) of participant's having a positive experience with their IA. These are:

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[3] Shapley Value analysis is a regression technique which determines the relative importance of each of the predictor variables. For further details see: Conklin, M., Powaga, K., & Lipovetsky, S. (2004) Customer satisfaction analysis: Identification of key drivers *European Journal of Operational Research, 154/3,* 819-827

- Whether the participant felt the assessor knew a lot about their disability and understood how it affects their life.
- Whether the participant felt their assessment covered all areas important to them and gave an accurate picture of their skills and ability.
- Whether the participant got enough information during their booking to know what to expect from the assessment.

If these three key aspects were delivered, the participant was more likely to have a positive experience with their IA. Further drill-down analysis on individual cohorts was not feasible due to sample size limitations.

## Assessor workforce

### Assessor discipline and previous experience

Just over 200 allied health professionals delivered IAs as part of IAP2. Assessors were required to be registered allied health professionals, including Occupational Therapists, Physiotherapists, Psychologists, Speech Pathologists, Social Workers and Rehabilitation Counsellors, and be skilled in undertaking functional assessments. Of this group, Occupational Therapists delivered the most assessments (45%) followed by Physiotherapists (39%), Psychologists (8%) and Speech Pathologists (4%). Around half of all assessors delivered at least 10 IAs.

Assessors from each allied health profession assessed participants with a range of disability types. Participants referred to the pilot were allocated to the most suitably qualified and experienced assessor available. Managers from suppliers commonly held that administration of commercial assessment tools required generalist clinical skills acquired during professional training. They commented that while some triage was good practice, allied health professionals should be competent to work across a range of disability. The NDIA stipulated as a requirement that assessors have experience working with both people with disability and with the cohort of participant they were assessing, for example, children aged under six years.

When surveyed, assessors reported a range of prior clinical experience, including around working with people with disability and administering standardised assessment tools. When asked to identify up to five areas of disability where they had the most experience, assessors reported variable experience with some disability types. Specifically, the survey respondents reported the most clinical experience working with stroke (53%) and physical disabilities (51%). Only 31% of respondents reported working with autism, 28% with psychosocial disability and 26% with intellectual disability. Combined, these three cohorts represent around 63% of NDIS participants.

### The impact of assessor allocation on participant experience

Statistical analysis of survey responses showed that a participant’s perception that their assessor knows about their disability is important for their overall experience. In line with this, as part of best clinical practice, supplier managers reported they triaged participants to allocate appropriate assessors according to their previous experience. Almost half (48%) of surveyed assessors rated the alignment of referrals to their experience and skill set as excellent or very good (35% good).

Just over half (53%) of surveyed participants/supporters reported their assessor seemed to know a lot about their disability. This was highest for participants with autism (65%), especially when assessed by a Psychologist (83%). Participants with a sensory disability also rated this highly especially when assessed by a Psychologist (83%). This was lowest for participants with a sensory disability when assessed by a Physiotherapist (35%) or Occupational Therapist (46%), and participants with psychosocial disability or neurological disability when assessed by an Occupational Therapist (36% and 40% respectively).

It is unclear if participant experiences with their assessor explicitly relate to the assessor's professional discipline, or their assessor's previous clinical experience working with their disability type. The evaluation could not test this, as assessor survey responses were anonymous and suppliers were not required to provide details about the specific experience of assessors.

Theoretically, having a large pool of assessors, coupled with a planned future credentialing system should mean that participants can be allocated to participants according to their previous experience. However, the apparently narrow range of disability experience amongst the IAP2 assessor workforce could challenge this theory.

**Consideration 9**

The NDIA should monitor the impact of assessor qualifications and experience on participant/supporter experience with IAs. This data should be used to develop minimum qualification and experience criteria for suppliers to allocate assessors to referrals.

### The impact of assessor experience on IA data

For IAP2, the NDIA only made the assessment tools available in Excel format. In focus groups, assessors cited difficulties using these formats, noting both the lack of in-built logic to reduce the number of questions that are irrelevant to the participant and difficulties entering data. For a national rollout of IAs, the NDIA is building an online platform that supports assessors' use of clinical judgement and mirrors best clinical practice. This will support assessors to only ask questions relevant to the participant based on their disability, life stage and answers to previous questions.

An automated quality check on a sample of 895 IAs, identified incomplete information or inconsistencies in 509. A second expert review of a sub-sample of 781 IAs resulted in the NDIA returning 211 IAs to the supplier for remediation, with the most common issue being inconsistent responses (80%).

Statistical analysis showed the rate of an IA failing a check increases with every prior IA an assessor undertakes (+1.1%). This suggests that as assessors become more familiar with assessment packages, they may be using clinical judgement to streamline the assessments by not asking unnecessary questions. If this is occurring, then this aligns with how the NDIA encourages assessors to conduct IAs.

**Consideration 10**

The NDIA should proactively monitor assessor performance and engage early if quality issues emerge. A revision of data review processes should also be undertaken to ensure consistency with any tool modifications undertaken. Sufficient checks should be built into any future assessment system, including the platform used by assessors.

However, the likelihood of an IA requiring remediation does not appear to be associated with assessor experience with the IA process, suggesting that substantial errors in IAs are rooted in assessors' underlying approach to conducting IAs, and possibly standardised assessments in general. This also means it cannot be ruled out that at least some failed checks reflect quality issues. Moving IAs to an online platform with inbuilt logic that supports assessors effectively use their clinical judgement will make it easier for the NDIA to systemically identify data issues.

### Training and materials

IAP2 used a train-the-trainer approach whereby suppliers had responsibility for training their assessors using materials provided by the NDIA. Generally, suppliers were positive about the training they received, but wanted less emphasis on theory and tool development and a stronger focus on the practical implementation of the assessment packages including:

- How to check for internal consistency.
- Working effectively with people with different disabilities.
- How IA data is to be used.

Assessors also wanted more opportunities for experiential learning, particularly across different disability groups where they may have less experience.

**Consideration 11**

Assessor training and materials should be developed in partnership with people with a lived experience of disability. Training should emphasise practical, experientially-based learning about working with different disability types and IA delivery. Information contained in assessment tool manuals should be curated to focus on the key aspects necessary for accurate administration.

## Assessment tools and packages

### The assessment tools

Assessors provided feedback on the performance of each tool they had used during interviews and focus groups, and as part of a survey.

Generally, assessors viewed the ASQ-3/ASQ-TRAK, CANS, CHIEF, PEDICAT and LEFS as performing well. There was some criticism regarding the relevance of the LEFS for all participants, particularly those who did not have mobility issues or who had no lower limb function. This criticism reflects the use of this tool for all participants over 10 years rather than pre-screening participants for mobility issues.

Conversely, assessors rated the WHODAS, Vineland and PEM-CY/YC-PEM less favourably. While assessors felt the PEM-CY/YC-PEM had some relevance and covered important areas of functional capacity, they reported it was not easily understood by participants. Some questions in the WHODAS were seen as ambiguous and others too sensitive in terms of topic. Some assessors also felt the WHODAS did not identify functional capacity accurately for people with sensory disability. The WHODAS was also singled out for these issues by some participants/supporters.

The Vineland received the most feedback from participants, their supporters and assessors. The Vineland instructions require its completion separate to the participant by someone who knows them well. Some concerns related to the participant not being present during this part of the assessment, particularly when the participant did not have a cognitive impairment and could self-report. There was also concern that some participants did not have someone in their life who knew them well enough to complete the tool while others used NDIS funded staff (causing a potential conflict of interest). Assessors reported limited training in the use of the Vineland and how to exercise clinical judgement when administering it. This may have contributed to some participant/supporter concerns that the questions were inappropriate.

### The assessment packages

There were four assessment packages used in the pilot with three screened on age (0-6 years, 7 to 17 years and over 18 years) and one screened by accommodation type (SIL). Each package included four or five tools, drawn from a pool of eight tools, to ensure coverage across the functional domains of the NDIS Act and the International Classification of Functioning (ICF).

Assessors gave feedback about perceived challenges with each assessment package. For the 0-6 package, assessors perceived the PEM-CY/YC-PEM as the main concern. Assessors commented it was difficult for parents/guardians to benchmark their child against expected development when they may have no experience to make this assessment. There was also concern that some tools in the 0-6 package asked questions that were above the expected developmental stage for a child’s age and could give parents/guardians the impression their child was further developmentally delayed than was the case.

For the 7 to 17 package, assessors commented on the breadth of the age range, suggesting participants who had left school might be more suited to the 18+ package. It was also commonly mentioned that adolescents have very different needs to young children, and these were not addressed in the current 7 to 17 package.

For the adult packages, assessors commented they were not suitable for participants with sensory impairments or who relied on assistive technology. Assessors also identified that the adult packages were insensitive to conditions like multiple sclerosis that involve fatigue and/or can have fluctuating symptoms. The need for additional tools on psychosocial disability was also a common theme.

### Other components of the assessment packages

The information section included in each IA collected additional data about support needs, such as the number of support hours required and how proportions of time were allocated. In 20% of participant/supporter interviews it was noted that prior notice would have been preferred regarding such calculations. Without a common, systematic approach to collating this information, inconsistencies may occur, leading to inaccurate data.

Concerns were raised by participants/supporters regarding the interaction activity, including its introduction, nature, and representativeness in terms of functional capacity. It was suggested the interaction session could be used in a more natural way by observing the participant during a coffee break and/or occur later in the session to break up question/answer sessions. Assessors commented that the interaction activity is an area impacted by the assessor's clinical experience and profession, demonstrated in the choice of activity and the depth of the report made against the six NDIS activity domains.

**Consideration 12**

Further assessor training, involving people with a lived experience of disability, on the participant interaction activity is required to ensure it is relevant to the participant's disability and reflective of their functional capacity. Observations should also be obtained and recorded during the entire assessment, which would help lift IAs to more of an interactive assessment rather than just questions and answers and task observation.

# 1. Introduction

This report presents findings from the National Disability Insurance Agency's (NDIA) evaluation of the second Independent Assessment Pilot (IAP2).

## 1.1 Background to Independent Assessments

An Independent Assessment (IA) is an evaluation of a person's ability to manage the tasks and activities of everyday life. It helps identify a person's functional capacity and their individual circumstances, such as living arrangements and the support provided by family and friends.

IAs were first recommended by the Productivity Commission in 2011[4], and again more recently in the 2019 Independent Review of the NDIA Act by Mr David Tune AO PSM (also known as the Tune review)[5]. Specifically, it was recommended that the NDIA engage independent health professionals to conduct functional assessments of people seeking access to the National Disability Insurance Scheme (NDIS). These assessments would work within the framework of the World Health Organisation's International Classification of Functioning, Disability and Health (ICF)[6] as outlined in the Independent Assessment Framework[7].

Historically, there has been no consistency in the way participants have entered the Scheme and been assessed for reasonable and necessary supports. This has led to inequities in annual plan budgets, which are on average higher for NDIS participants who live in areas associated with higher socioeconomic status.

The introduction of free IAs is a key part of the proposed reforms to the NDIS. These reforms are focused on making the NDIS simpler, faster and more flexible for new and existing participants. Importantly, IAs intend to make the NDIS more equitable and sustainable for current and future participants.

IAs involve the use of evidence-based, validated tools that map to the domains of the ICF[8] and the six activity areas of functional capacity in the NDIS Act (Section 4(1)(c))[9]. The NDIA selected the tools guided by the COnsensus-based Standards for the Selection of health

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[4] Productivity Commission. (2011). Disability Care and Support, Report no. 54, Canberra, Recommendations 7.4 and 7.8, p340-41.

[5] Tune, D (2019) 'Review of the National Disability Insurance Scheme Act 2013: Removing red tape and implementing the NDIS participant service guarantee', *Report submitted to Hon Stuart Robert MP Minister for NDIS, Minister for Government Services,* Recommendation 7.

[6] World Health Organization (2016) *'International Classification of Functioning, Disability and Health (ICF)',* World Health Organization, Geneva.

[7] NDIA (2020) 'Independent Assessment Framework'. Refer: www.ndis.gov.au/participants/independent-assessments/independent-assessment-framework.

[8] The ICF focuses on three components: body, activities, participation (at individual and societal levels) and contextual (personal and environmental). These three components underscore the importance of the interplay and influence of both internal and external factors to each individual's health status. Refer: www.who.int/classifications/icf/en/#:~:text=The%20International%20Classification%20of%20Functioning,a%20list%20of%20environmental%20factors.

[9] A person's impairment or impairments must result in substantially reduced functional capacity to undertake, or psychosocial functioning in undertaking, one or more of the following activities: communication; social interaction; learning; mobility; self-care; and, self-management.

Measurement INstruments (COSMIN). Tools were selected based on evidence for reliability and validity, practicality to administer, and their ability to work together to describe the person's functioning including capacity, performance and environmental factors in a holistic way[10]. Table 1 outlines the recommended assessment tools for IAs for different ages. IAs also include a participant information form and a participant interaction session.

NDIA-approved suppliers employing registered allied health professionals delivered the IAs.

**Table 1: Assessment tools available by package**

| **Assessment tools** | Assessment package **Under 7 years** | Assessment package **7 to 17 years** | Assessment package **18 years+ and SIL** |
|---|---|---|---|
| Participant Interaction | Yes | Yes | Yes |
| Participant Information | Yes | Yes | Yes |
| Vineland 3 (Domain and Comprehensive) | Yes[11] | Yes [12] | Yes [13] |
| Lower Extremity Function Scale (LEFS) (all over 10 years to complete) | No | Yes | Yes |
| Ages and Stages 3 (ASQ-3) or ASQ TRAK (only for children with DD and up to the age of 5 years) | Yes | No | No |
| PEDICAT (Speedy) or PEDICAT ASD (Speedy) | Yes [14] | Yes | No |
| Young Children's Participation and Environment Measure (YC-PEM) (children 1-5 years 11 months who don't attend school) or PEM CY for children 4 to 6 years 11 months who do attend school) | Yes | Yes | No |
| WHODAS 2.0 36 | No | No | Yes |
| Care and Needs Scale (CANS) | No | No | Yes |
| Craig Hospital Inventory of Environmental Factors | No | No | Yes |

Appendix A gives a brief description of each assessment tool.

## 1.2 About the Pilot

### 1.2.1 Previous Pilots

A previous IA pilot (IAP1) concluded in April 2019, offered IAs on a voluntary opt-in basis to NDIS applicants and participants aged seven to 64 years with a primary disability of Autism Spectrum Disorder, Intellectual Disability or Psychosocial Disability. The Agency chose

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[10] NDIS (2020) 'Independent Assessment: Selection of Assessment Tools'. Refer : www.ndis.gov.au/participants/independent-assessments/independent-assessment-toolkit
[11] Comprehensive version (maladaptive behaviours domain is not completed for children under 3 years).
[12] Domain version (motor skills domain is not completed for children over 9 years 11 months).
[13] Ibid.
[14] Responsibility domain not completed for children under 3 years.

these groups as they represent 63% of all NDIS participants. IAP1 completed 513 opt-in IAs in nine metropolitan service delivery areas in NSW[15].

### 1.2.2 The purpose and scope of the current Pilot

To include a broader cross-section of participants and assessment instruments, the NDIA launched a second pilot (IAP2) on 25 November 2019. This second pilot extended the eligibility of IAs to NDIS participants across all States and Territories. The intent was to provide free and voluntary IAs to up to 4,000 participants to help the NDIA achieve the following:

1. Understand more about the experiences of different types of participants and how they find the IA process, including whether the report accurately reflects both what they told their assessor and their functional capacity.
2. Understand the assessor workforce and their delivery of IAs, including hearing from them on the process and their support needs.
3. Get feedback on the independent assessment tools and whether participants and assessors feel they collect the right information.
4. Collect more data to help the NDIA develop the approach for using IAs to support access and budget decisions.

The IAs included a standardised environmental assessment as well as additional environment specific questions in the participant information form. This captured further information around the availability of informal supports and barriers to participation in the home, school/work and community environments, aligning the IA framework to all domains of the ICF[16].

The impact of Coronavirus Disease 2019 (COVID-19) reduced the number of IAs completed in the IAP2 to just 99. Based on the Australian Government’s advice, as set out in the COVID-19 Emergency Response Plan, the NDIA suspended the second pilot on 19 March 2020. In October 2020, the NDIA resumed IAP2 with a target of 4,000 participants, randomly selected on the basis of age, disability and level of function. Other factors were monitored to ensure they were reflected in the sample, including gender, location (including State and Territory, underlying socioeconomic status, and remoteness), Aboriginal and Torres Strait Islander status, and cultural and linguistic diversity.

The pilot formally ended on 31 May 2021, although additional IAs were delivered until 9 July 2021.

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[15] Sydney, Western Sydney, North Sydney, South East Sydney, Nepean Blue Mountains, South Western Sydney, Central Coast, Illawarra-Shoalhaven, Hunter New England.

[16] The ICF focuses on three components: body, activities, participation (at individual and societal levels) and contextual (personal and environmental). These three components underscore the importance of the interplay and influence of both internal and external factors to each individual's health status. (https://www.who.int/classifications/icf/en/#:~:text=The%20International%20Classification%20of%20Functioning,a%20list%20of%20environmental%20factors.)

### 1.2.3 Pilot delivery

The NDIA initially contracted APM Australia, HealthStrong and Allied Care Group to deliver IAs as part of IAP2. This list has since expanded for 0-6 year olds to include BushKids, Wanslea, Northcott and Early Childhood Australia NT, and any approved sub-contractors.

Assessors employed by these suppliers were required to be registered allied health professionals, including Occupational Therapists, Physiotherapists, Psychologists, Speech Pathologists, Social Workers and Rehabilitation Counsellors, and be skilled in undertaking functional assessments.

The NDIA provided training to key supplier staff who were then responsible for training assessors before they commenced work with participants. This train-the-trainer model included content on the purpose of the IA, use of the tools, the administrative processes involved in conducting and reporting assessments and cultural sensitivity training.

Each IA pack was built in Microsoft Excel according to Table 1 above. Assessors were given a recommended order for administering the assessment tools. Following the completion of the IA, the assessor sent the completed Microsoft Excel pack back to their supplier's internal quality team for review prior to submitting to the NDIA. The NDIA then did a quality review of a sample of the materials, checking for consistency issues, and in certain circumstances, requesting the assessor clarify the assessment based on any flagged issue.

The NDIA contacted participants/supporters via email, post and SMS, inviting them to take part in IAP2. The invitation letter included details about IAs and the pilot, a consent form and details about contacting the NDIA to ask any questions before consenting. Once a participant or their nominee returned signed consent, the NDIA referred them to one of the suppliers. Participants or nominees who chose to opt out from the pilot were not contacted further about the pilot. Appendix B presents the end-to-end IAP2 service delivery model.

## 1.3 Pilot achievements

### 1.3.1 IAs completed

Table 2 shows that as of 31 May 2021, suppliers had completed 3,759 IAs as part of IAP2.

**Table 2: Assessments completed by package**

| Assessment package | Face-to-face | Telehealth | Mode not recorded | Total | % of total |
|---|---|---|---|---|---|
| **18+** | 1,286 | 664 | 0 | 1,950 | 52% |
| **7-17** | 537 | 421 | 0 | 958 | 25% |
| **0-6** | 339 | 117 | 9 | 465 | 12% |
| **SIL** | 251 | 135 | 0 | 386 | 10% |
| **Total** | **2,413** | **1,337** | **9** | **3,759** | **100%** |

Source: Supplier governance reports as of 31 May 2021.

In total, IAP2 encompassed 84 primary diagnosis classifications according to the International Classification of Diseases (ICD-10). Table 3 groups these, showing that as of

31 May 2021, participants with autism comprised the largest cohort of IAP2 participants (15.9%), followed by intellectual disability (14.8%) and cerebral palsy (9.9%).

**Table 3: Assessments completed by primary disability grouping**

| Primary disability grouping | Number of assessments |
|---|---|
| **Autism** | 596 (15.9%) |
| **Intellectual Disability** | 557 (14.8%) |
| **Cerebral Palsy** | 372 (9.9%) |
| **Other Neurological** | 300 (8.0%) |
| **Psychosocial Disability** | 228 (6.1%) |
| **Physical Disability** | 210 (5.6%) |
| **Developmental delay** | 203 (5.4%) |
| **Hearing Impairment** | 201 (5.3%) |
| **Acquired Brain Injury** | 197 (5.2%) |
| **Multiple Sclerosis** | 193 (5.1%) |
| **Visual Impairment** | 181 (4.8%) |
| **Spinal Cord Injury** | 132 (3.5%) |
| **Down Syndrome** | 121 (3.2%) |
| **Stroke** | 95 (2.5%) |
| **Global developmental delay** | 75 (2.0%) |
| **Other** | 61 (1.6%) |
| **Other Sensory/Speech** | 37 (1.0%) |
| **Total** | **3,759** |

Source: Supplier governance reports as of 31 May 2021.

Table 4 shows suppliers delivered the most assessments in NSW (1,366 or 36%). The lower than expected number of assessments in Victoria reflects COVID-19 restrictions.

**Table 4: Assessments completed by state and territory**

| State/Territory | 18+ | 7-17 | 0-6 | SIL | Total | % of total |
|---|---|---|---|---|---|---|
| **NSW** | 785 | 345 | 86 | 150 | 1,366 | 36% |
| **QLD** | 467 | 225 | 214 | 66 | 972 | 26% |
| **VIC** | 299 | 192 | 68 | 74 | 633 | 17% |
| **SA** | 141 | 96 | 20 | 25 | 282 | 8% |
| **WA** | 129 | 56 | 46 | 29 | 260 | 7% |
| **ACT** | 102 | 33 | 0 | 20 | 155 | 4% |
| **TAS** | 26 | 10 | 18 | 22 | 76 | 2% |
| **NT** | 1 | 1 | 13 | 0 | 15 | 0% |
| **Total** | **1,950** | **958** | **465** | **386** | **3,759** | **100%** |

Source: Supplier governance reports as of 31 May 2021.

Together, the above data shows that some cohorts were under-represented in IAP2, including participants in the NT and some disability types such as psychosocial disability.

**Consideration 1**

The NDIA should continue further testing of functional assessments with priority cohorts to ensure its approach works effectively and consistently amongst all participant cohorts and in all locations.

## 1.4 The evaluation

### 1.4.1 Evaluation objectives

The evaluation of IAP2 primarily focused on the experiences of participants and assessors with IAs in order to improve operational processes for a national IA rollout. Specifically, the evaluation aimed to inform the first three objectives of the pilot (refer Section 1.2.2.).

Future decisions that result from IAs around NDIS eligibility and personalised budgets including the impact on equity, are not in the scope of this evaluation. Also out of scope for this evaluation is whether the NDIA should implement IAs.

The Agency’s Research and Evaluation Branch have led the design and delivery of the evaluation. The Agency’s Independent Advisory Council, the sector Chief Executive Officer (CEO) Forum and Participant Advocates provided input at various stages.

### 1.4.2 Independent validation

The Centre for Disability Studies and Centre for Disability Research and Policy at the University of Sydney have independently validated the NDIA’s collection, analysis and reporting of data in this report.

Appendix C presents the University of Sydney’s summary of their validation.

### 1.4.3 This report

The structure of this report beyond this chapter is as follows:

- Chapter 2 – A brief overview of the methods used to collect and analyse data.
- Chapter 3 – A detailed review of participants’ experience with IAs.
- Chapter 4 – Assessor workforce characteristics and the impact on IAs, and assessor experience with training.
- Chapter 5 – Perceptions of the assessment packages and tools.
- Chapter 6 – Conclusions.
- Appendices A-I.

# 2. Summary of data and methods

This chapter describes the data and methods used for this report.

## 2.1 Online surveys

The evaluation administered online surveys to participants and/or their support person/s, and independent assessors. Appendix D presents the surveys.

### 2.1.1 Participant experience survey[17]

The IAP2 delivery team circulated the survey link to participants/supporters by email as part of a letter thanking them for their participation. Appendix D shows the assurances given to respondents about their anonymity.

Each recipient received a single reminder between one and two months after the initial invitation. A total of 948 responses were received by 31 May 2021 (43.2% response rate from those who received the survey).

Appendix E shows the characteristics of participant experience survey respondents are similar to the population of IAP2 participants (as of 31 May 2021) by primary disability grouping and age band/assessment package.

A second survey was sent to the same sample of participants/supporters in June 2021 to capture their feedback on their IA report accuracy and level of detail. This was necessary because, at the time of administering the first participant/supporter survey, many had not yet received their IA results. As of 18 June 2021, 265 responses were received (12.8% response rate from those who received the survey). At least 110 of these respondents (41.5%) had completed the initial participant experience survey, based on the ability to match responses by the participant’s NDIS number or name.

Closed ended questions from the survey were descriptively analysed used Microsoft Excel. Open-ended questions were thematically coded using Microsoft Excel (see Appendix F for the code frame).

Non-responses to closed questions were treated as missing and not imputed. Therefore, sample sizes (i.e. n=) in charts and tables reflect the number of responses to the relevant question(s) rather than the total number of responses.

#### A note on the scales used to evaluate participant/supporter experience

The response scales measuring participant/supporter experience are unbalanced (Excellent, Very Good, Good, Fair, Poor) which is a common feature of patient-based instruments evaluating health care services. These scales help overcome a tendency for positively skewed evaluations of health service experience inherent with balanced scales (i.e. people

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[17] Where required, the participant was either supported to complete the survey or a person who represented the participant’s views completed the survey

tend to report overly positively about services)[18,19]. Positive skew casts doubt over the validity of client evaluations as an indicator of quality, and reduces sensitivity to measure differences over time or between providers[20]. The data about participant experiences this evaluation collected will be used to measure the impact of enhancements the NDIA makes to IAs, making an unbalanced scale the best option.

The scale used is drawn from the Your Experience of Service (YES) survey and Australian National Health survey. The Australian Department of Health funded the YES survey's development under the National Consumer Experiences of Care project to measure and report on consumer experiences of public mental health services. Participant responses about their experience are reported in a manner consistent with Australian Government Department of Health guidelines for reporting data from the YES survey.[21]

### 2.1.2 Shapley Value Regression

Closed questions were also analysed using Shapley Value Regression to identify the key parts of IAs essential for participants to have a positive experience. Participants' experience with their IA was first regressed against their experience with booking, professionalism of their assessor and the way their assessment was conducted. Shapley Values from the regression results were then calculated.

Shapley Value regression was selected because the relationship between 'must-have' attributes and overall client experience is non-linear. Highly correlated attributes tend to have similar Shapley values. This is important because due to their high correlation, it is not known variable is the true cause of a positive experience. Linear statistical models tend to select one of the highly correlated variables at the expense of the others. Given specific recommendations are required, when there is doubt about the cause of a negative experience, both attributes should be improved instead of selecting one.

Appendix G shows the detailed method, but it is important to note that findings represent the average survey respondent. There was no control or stratification for characteristics such as disability type.

### 2.1.3 Assessor survey

The link to the assessor survey was circulated to assessors from APM Australia, HealthStrong and Allied Care Group, via the pilot engagement manager for each supplier. Appendix D shows the assurances given to respondents about their anonymity. In total, 72 responses were received (estimated response rate of 36%):

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[18] Bjertnaes, O., Iversen, H.H. and Garratt, A.M., 2016. The universal patient centeredness questionnaire: scaling approaches to reduce positive skew. Patient preference and adherence, 10, p.2255.

[19] Bjertnaes, O., Iversen, H.H., Holmboe, O., Danielsen, K. and Garratt, A., 2016. The Universal Patient Centeredness Questionnaire: reliability and validity of a one-page questionnaire following surveys in three patient populations. Patient related outcome measures, 7, p.55.

[20] Streiner, D.L., Norman, G.R. and Cairney, J., 2015. Health measurement scales: a practical guide to their development and use. Oxford University Press, USA.

[21] Australian Government Department of Health (2018). Your Experience of Service: Australia's National Mental Health Consumer Experience of Care Survey – Community Managed Organisation version: Guide for licenced organisations and organisations seeking a licence to use the instrument. Refer: www.amhocn.org/publications/your-experience-service-community-manged-organisation-yes-cmo-survey-guidance.

- 38 responses from APM Australia.
- 8 responses from HealthStrong.
- 24 responses from Allied Care Group.

Closed ended questions were analysed used Microsoft Excel. Content was directly extracted from open ended questions.

## 2.2 Participant/support person interviews

Participants/supporters were invited to volunteer to participate in a telephone interview as part of the Participant experience survey. The NDIA's evaluation team conducted 116 interviews (53 with participants and 63 with support person/s). Members of the NDIA's Independent Advisory Council participated in a sample of the interviews. Appendix E presents the characteristics of those interviewed, and Appendix H presents the interview guide and participant information sheet.

Interviewees were asked to provide written or verbal consent before their interview, and were provided with a copy of the interview questions in advance. Interviewers took notes during interviews which were thematically coded using Microsoft Excel (see Appendix F for the code frame).

## 2.3 Supplier manager and assessor consultations

Through the pilot contract manager, suppliers were invited to an online consultation. Separate consultations were held with managers from each supplier including managers involved in training, quality, clinical supervision and operations. Each supplier then facilitated the invitation of independent assessors to a consultation. Five consultations were held with small groups of assessors. In total, consultations included 10 managers and 26 independent assessors. The results were analysed thematically and included throughout the report.

## 2.4 Supplier governance and quality data

### 2.4.1 Supplier governance data

As part of contractual obligations, IA suppliers provided the NDIA with regular data about the IAs they had conducted, including the date and assessor who delivered the assessment. For various analyses, the Evaluation Team linked this data to Participant experience survey and IA quality data (see below). The evaluation used governance data up to 31 May 2021.

### 2.4.2 IA Quality data

The NDIA's Office of the Scheme Actuary and Technical Advisory Branches undertook a quality review of a random sample of 895 IAs. The data included the number and nature of quality checks failed and whether the suppliers/assessors were required to remediate the assessment and why. The Evaluation Team linked this data to participant experience survey data and supplier governance data for various analyses.

## 2.5 Consent and privacy

As defined in the NDIA Research and Evaluation Governance Policy, the IA pilot evaluation was classified as a Quality Assurance (QA) activity. This is in accordance with the guideline "Ethical Considerations in Quality Assurance and Evaluation Activities (National Health and Medical Research Council (NHMRC) 2014)[22]" as it involved the collection of health information. Information regarding a person's disability is considered to be health information in Australian privacy legislation. The evaluation was therefore considered to be a QA activity based on the following abridged definition contained in the NHMRC's Guideline:

> "An activity where the primary purpose is to monitor or improve the quality of service delivered by an individual or an organisation is a QA activity. Likewise an evaluation generally encompasses the systematic collection and analysis of information to make judgements, usually about the effectiveness, efficiency and/or appropriateness of an activity. QA, evaluation and research exist on a continuum of activity, and work that begins as one form of activity can evolve into another over time. Importantly, QA and evaluation commonly involve minimal risk, burden or inconvenience to participants, and, while some level of oversight is necessary, Human Research Ethics Committee (HREC) review processes are often not the optimal pathway for review of these activities."

In accordance with the NHMRC guideline, the evaluation was considered to be a QA activity and appropriate processes were implemented by the evaluators. The IA Pilot evaluation was designed and conducted to ensure participants were afforded appropriate protections and respect. This involved taking into account a range of issues including consent, privacy, relevant legislation, and national/professional standards.

In alignment with the NDIA Consent for Research and Evaluation Policy and the NHMRC's guideline, the evaluation was designed and conducted to ensure informed consent was obtained from all participants. All participants, their supporters, assessors and supplier managers voluntarily consented to participate in surveys, interviews and focus groups as per the information sheets included as part of Appendices D and H. The NDIA provided no financial reimbursement to participate in the evaluation, although participants were reimbursed for undertaking an IA.

Given the collection of personal, health and sensitive information as part of the evaluation, adherence to the highest standards of privacy were maintained in accordance with applicable NHMRC guidelines and privacy legislation. The regulatory and data security requirements are higher for this evaluation than in other contexts as the information collected is from vulnerable groups. This is consistent with legal requirements and applicable NHMRC guidelines pertaining to data security and management standards. All evaluation participants have remained anonymous in this report in line with the guarantees made to them. All responses have been securely stored such that the IAP2 delivery team and policy makers do not have access to raw data.

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[22] National Health and Medical Research Council (2014) Ethical Considerations in Quality Assurance and Evaluation Activities. Australian Government. Refer: ethical-considerations-in-quality-assurance-and-evaluation-activites.pdf (nhmrc.gov.au)

## 2.6 Limitations

The main limitation of data informing this report is the high-risk of self-selection bias due to the way participants were able to be recruited to the evaluation. Participants/supporters and assessors voluntarily completed the online survey and volunteered for interviews. While the samples are similar to the overall population of IAP2 participants (see Appendix E), people generally opt-in for evaluation research if they have positive or negative views.

A further limitation is that many participants/supporters were asked to provide survey and interview feedback on their experience having an IA before receiving their IA report. Their perspectives could have changed once they received their IA results. A follow-up survey asking participants/supporters about the accuracy of their IA results addresses this issue.

There is a risk that the perspectives of participants and their supporters about their IA could have been influenced by the intense public commentary and media coverage about IAs. It is also possible that some participants and supporters might have had difficulty separating out elements of their IA from other experiences with the NDIS.

In the case of assessors, the representativeness of the sample of survey respondents and/or focus group participants is unclear. While all assessors were invited to complete the survey, it is possible that management at the suppliers preselected assessors to participate in the consultations.

# 3. Participant experience

This chapter presents the evaluation findings related to participant/support person experiences having an IA. Findings are presented on the following aspects:

- Overall participant/supporter experience
- The assessment meeting
- Independent assessment results with their IA
- Bookings and communication
- The key drivers of participant experience

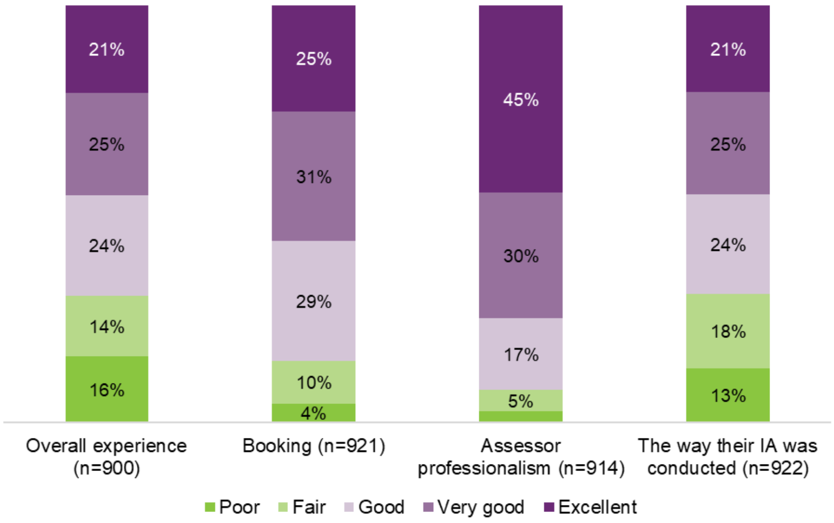
## 3.1 Overall participant experience

This section presents participant/support person ratings about their overall experience of their IA and the steps along the pathway. This is informed by the participant experience survey and interview data.

### 3.1.1 Participant/supporter ratings of their experience

Figure 1 shows 46% of survey respondents rated their overall experience having an IA as very good or excellent (70% good, very good or excellent; average rating of 3.2 out of 5[23]). The remainder rated their overall experience as fair or poor. The same ratings were achieved for the question regarding how the IA was conducted. Participants/supporters reported the most positive aspect of their IA experience was the professionalism of their assessor (75% excellent or very good; 17% good; average = 4.1) and their booking process (56% excellent or very good; 24% good; average = 3.6). Few respondents rated these aspects as poor or fair.

**Figure 1: Participant/supporter experience with their IA**



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[23] Calculated by assigning the following scores: Excellent = 5; Very good = 4; Good = 3; Fair = 2; Poor = 1.

**Data table for Figure 1**

| Question | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| Overall experience (n=900) | 16% | 14% | 24% | 25% | 21% |
| Booking (n=921) | 4% | 10% | 29% | 31% | 25% |
| Assessor professionalism (n=914) | 3% | 5% | 17% | 30% | 45% |
| The way their IA was conducted (n=922) | 13% | 18% | 24% | 25% | 21% |

Source: Participant experience survey.

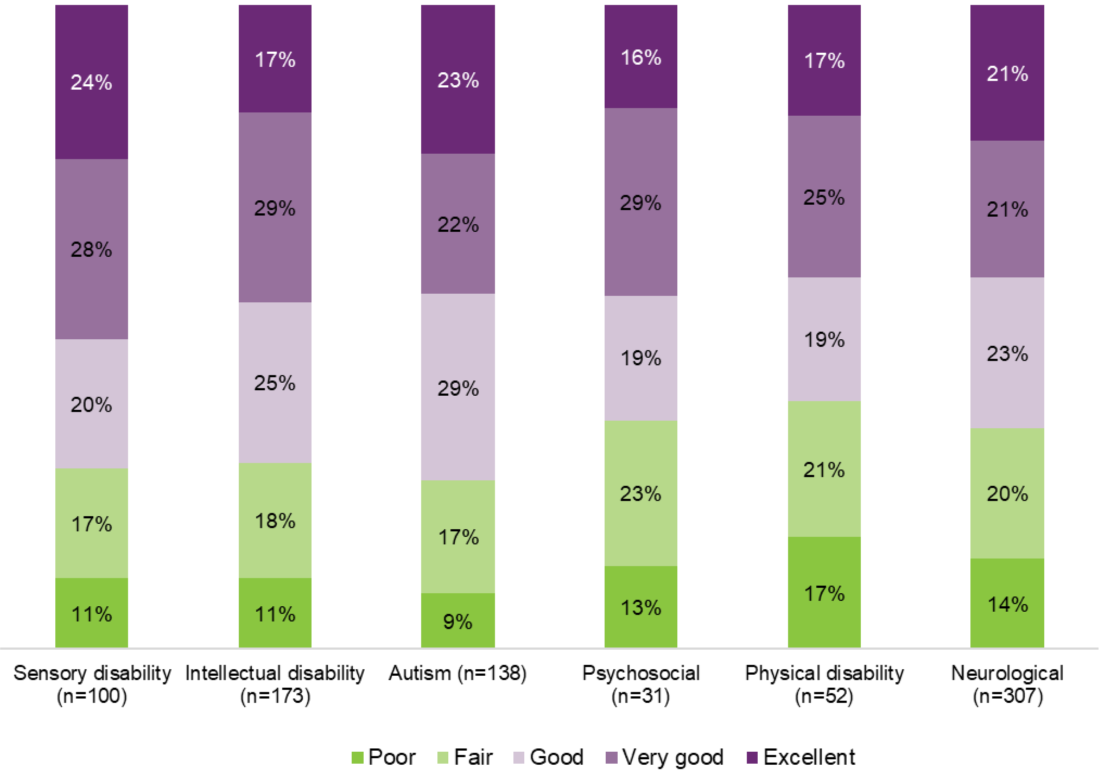
Note: Percentages may not add up to 100% due to rounding.

Of those interviewed, 31% of respondents rated both their overall experience and the way their IA was conducted as poor or fair. With positively weighted scales such as that used in the participant experience survey, ratings of poor or fair constitutes a negative experience.

Figure 2 shows the most positive experiences reported for the way IAs were conducted came from participants with a sensory disability (52% excellent or very good; 20% good; average = 3.4 out of 5). The way IAs were conducted with people with a physical or neurological disability were rated the least positive (42% excellent or very good; 19% and 23% good respectively; average = 3.0 and 3.1 respectively).

The way IAs with participants with autism were conducted had the least rated as poor or fair (26%), with 45% rated as excellent or very good (29% good).

**Figure 1: Participant/supporter experience with how IA was conducted by primary disability grouping**



**Data table for Figure 2**

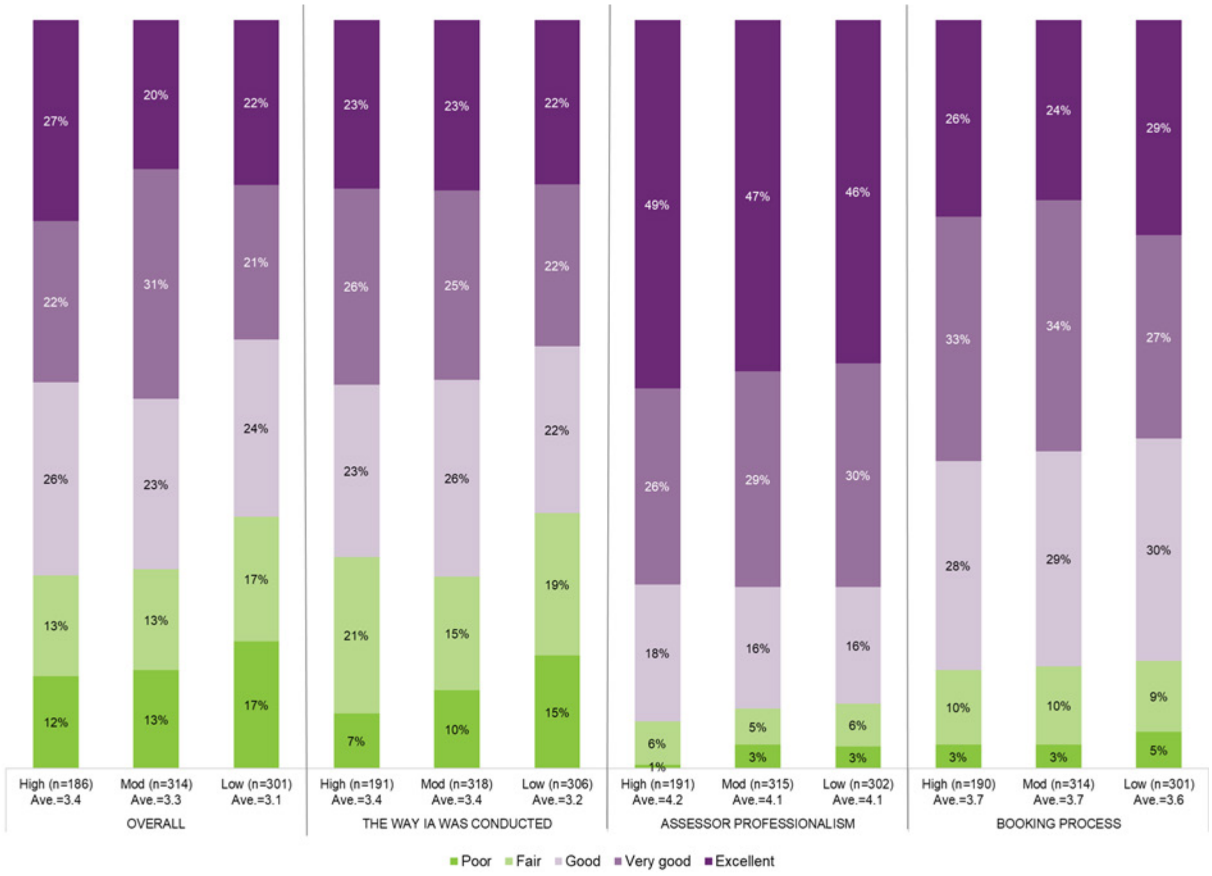
| Question | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| Sensory disability (n=100) | 11% | 17% | 20% | 28% | 24% |
| Intellectual disability (n=173) | 11% | 18% | 25% | 19% | 17% |
| Autism (n=138) | 9% | 17% | 29% | 22% | 23% |
| Psychosocial (n=31) | 13% | 23% | 19% | 29% | 16% |
| Physical disability (n=52) | 17% | 21% | 19% | 25% | 17% |
| Neurological (n=307) | 14% | 20% | 23% | 21% | 21% |

Source: Participant experience survey.

Note: Percentages may not add up to 100% due to rounding.

Figure 3 shows 43% of participants with low functional capacity reported an excellent or very good overall experience with their IA (average 3.1 out of 5) compared to participants with moderate (51%, average 3.3) or high (49%, average. 3.4) functional capacity. This difference was not significant after accounting for Aboriginal and Torres Strait Islander status, whether English was the primary language spoken at home, IA package and IA setting, suggesting that IAs provided a similar experience for participants of all functional abilities. Participant experience with the professionalism of their assessor and the booking process were also similar across all functional capacities.

**Figure 3: Participant/supporter experience with how IA was conducted by level of functional capacity**



**Data tables for Figure 3**

**Overall**

| IA group | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| High (n=186)<br>Average = 3.4 | 12% | 13% | 26% | 22% | 27% |
| Moderate (n=314)<br>Average = 3.3 | 13% | 13% | 23% | 31% | 20% |
| Low (n=301)<br>Average = 3.1 | 17% | 17% | 24% | 21% | 22% |

**The way IA was conducted**

| IA group | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| High (n=191)<br>Average = 3.4 | 7% | 21% | 23% | 26% | 23% |
| Moderate (n=318)<br>Average = 3.4 | 10% | 15% | 26% | 25% | 23% |
| Low (n=306)<br>Average = 3.2 | 15% | 19% | 22% | 22% | 22% |

**Assessor professionalism**

| IA group | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| High (n=191)<br>Average = 4.2 | 1% | 6% | 18% | 26% | 49% |
| Moderate (n=315)<br>Average = 4.1 | 3% | 5% | 16% | 29% | 47% |
| Low (n=302)<br>Average = 4.1 | 3% | 6% | 16% | 30% | 46% |

**Booking process**

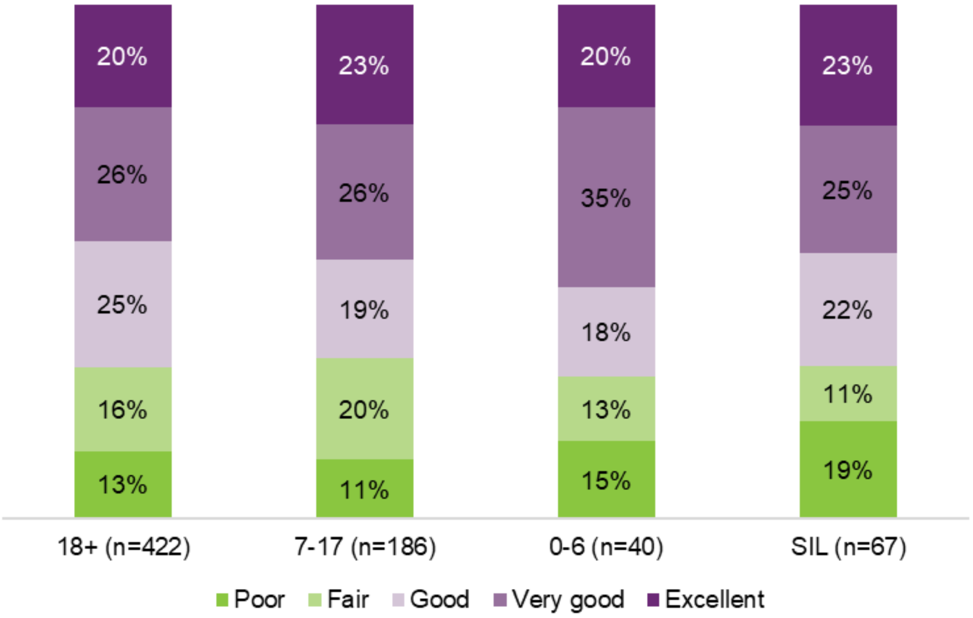
| IA group | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| High (n=190)<br>Average = 3.7 | 3% | 10% | 28% | 33% | 26% |
| Moderate (n=314)<br>Average = 3.7 | 3% | 10% | 29% | 34% | 24% |
| Low (n=301)<br>Average = 3.6 | 5% | 9% | 30% | 27% | 29% |

Source: Participant experience survey.

Overall, 57% of participants with low functional capacity reported that given the choice, they would have an IA again, compared to 64% of participants with medium functional capacity and 70% of participants with high functional capacity. After accounting for Aboriginal and Torres Strait Islander status, whether English was the primary language spoken at home, IA package and IA setting, participants with a low functional capacity were 14% less likely than those with high functional capacity to indicate that given the choice, they would have an IA again; a statistically significant difference. The difference between participants with moderate functional capacity and high functional capacity was not statistically significant.

Figure 4 shows IAs with children aged 0-6 were rated the most positively (55% excellent or very good, 18% good; average = 3.4) although the sample is small (n=40). The two adult groups (18+ and SIL) had the least positive sentiment towards the way IAs were conducted (46% and 48% excellent or very good respectively; 25% and 22% good respectively; average = 3.2 for each package).

**Figure 4: Participant/supporter experience with how their IA was conducted, by IA group**



**Data table for Figure 4**

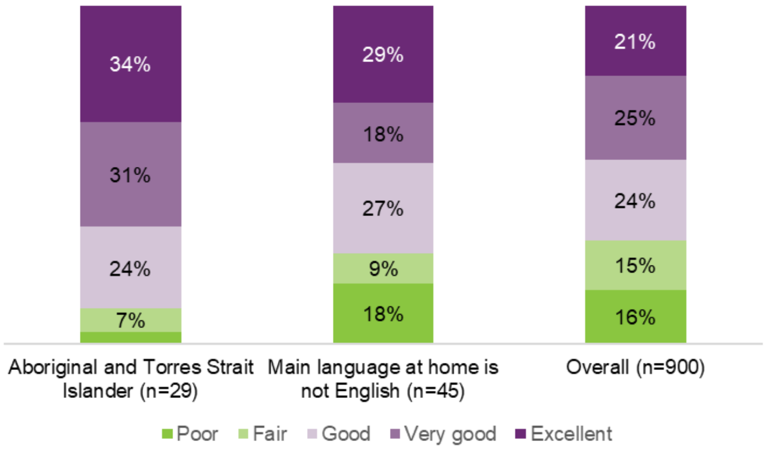
| IA group | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| 18+ (n=422) | 13% | 16% | 25% | 26% | 20% |
| 7-17 (n=186) | 11% | 20% | 19% | 26% | 23% |
| 0-6 (n=40) | 15% | 13% | 18% | 35% | 20% |
| SIL (n=67) | 19% | 11% | 22% | 25% | 23% |

Source: Participant experience survey.

Note: Package assignment for adult (18+) and SIL relied on survey respondents providing their participant ID or full name so their responses could be matched back to supplier governance data. 695 of the 948 survey respondents could be matched. Without matching it is impossible to distinguish between respondents for the adult (18+) and SIL packages, so unmatched responses are excluded.

Figure 5 shows that the small sample of Aboriginal and Torres Strait Islander IAP2 participants reported a more positive overall experience with their IA than across all IAP2 participants (65% excellent or very good vs 46%; 25% good). The experience of IAP2 participants whose main language at home was not English was similar to all IAP2 participants, although a higher percentage reported an excellent experience (29% vs 21%).

**Figure 5: The overall experience of Aboriginal and Torres Strait Islander and culturally and linguistically diverse participants/supporters with their IA**



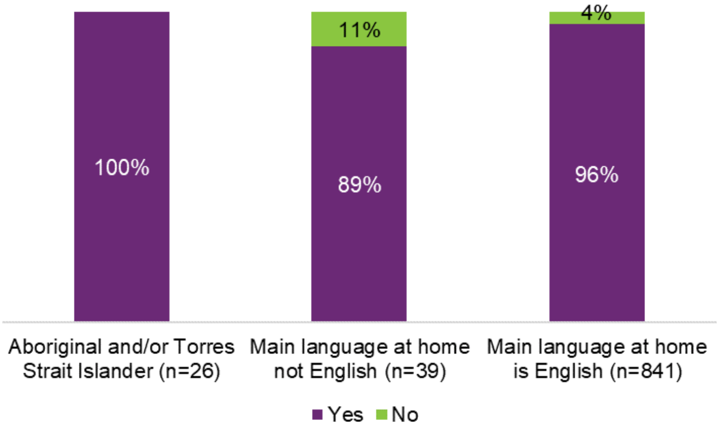
**Data table for Figure 5**

| Group | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| Aboriginal and Torres Strait Islander (n=29) | 4% | 7% | 24% | 31% | 34% |
| Main language at home is not English (n=45) | 18% | 9% | 27% | 18% | 29% |
| Overall (n=900) | 16% | 15% | 24% | 25% | 21% |

Source: Participant experience survey.

Importantly, 100% of participant experience survey respondents who identified as being of Aboriginal and/or Torres Strait Islander descent reported the assessment questions were culturally appropriate. Most respondents whose main language at home was not English also reported the assessment questions were culturally appropriate (89%),although this is seven percentage points less than those who mainly speak English at home (Figure 6).

**Figure 6: Percentage of participants reporting IA questions and activities were culturally appropriate**



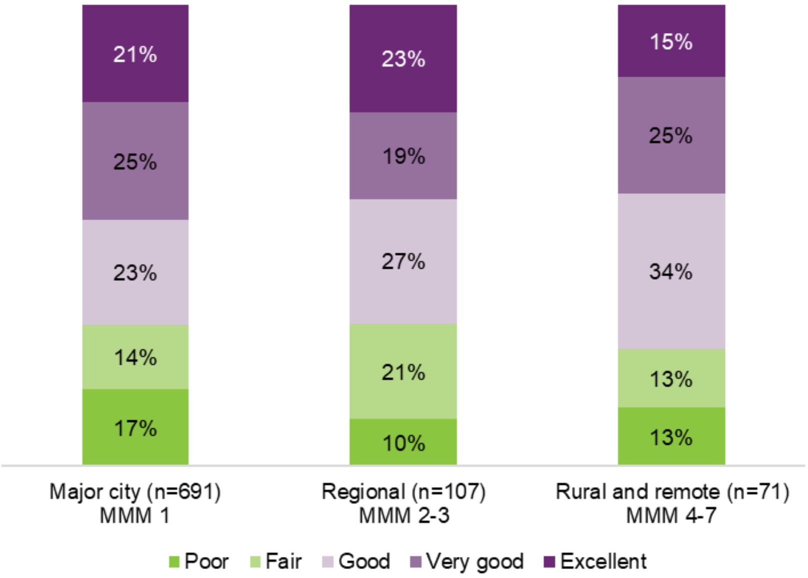
**Data table for Figure 6**

| Group | Yes | No |
|---|---|---|
| Aboriginal and Torres Strait Islander (n=26) | 100% | 0% |
| Main language at home is not English (n=39) | 89% | 11% |
| Main language at home is English (n=841) | 96% | 4% |

Source: Participant experience survey.

Figure 7 shows that most participant experience survey respondents live in major cities. These respondents reported a better overall experience with their IA compared to respondents in regional centres or rural and remote locations (47% excellent or very good vs 42% and 41% respectively).

**Figure 7: the overall experience of participants/supporters with their IA by remoteness**



**Data table for Figure 7**

| Remoteness | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| Major city (n=691) MMM 1 | 17% | 14% | 23% | 25% | 21% |
| Regional (n=107) MMM 2-3 | 10% | 21% | 27% | 19% | 23% |
| Rural and remote (n=71) MMM 4-7 | 13% | 13% | 34% | 25% | 15% |

Source: Participant experience survey.

For rural and remote respondents, this difference appears to relate to their booking experience (53% very good or excellent vs 87% in major cities). The reason for the difference for regional respondents is unclear. They reported similar experiences with their bookings, the professionalism of their assessor and the way their IA was conducted to that of respondents in other locations.

### 3.1.2 Participant Experience Drivers

Participant/support person ratings of their experience indicated the least positive sentiment towards the way IAs were conducted (i.e. the assessment meeting), and the most positive sentiment towards the professionalism of assessors.

To confirm the importance of the way IAs were conducted to overall participant experience, a Shapley Value Regression was performed. Overall IA experience on the participant experience survey was first regressed against experience with booking, professionalism of their assessor and the way their assessment was conducted. Shapley Values from the regression results were then calculated. The same analyses was then undertaken using responses to the question “Given a choice, would you have an IA again?” as the dependent variable (see Appendix G for a detailed method and results).

Figure 8 shows the strongest predictor of overall IA experience was the way a participant’s IA was conducted (the actual meeting). This accounts for 65% of variance in the overall respondent’s experience when all three measured aspects of the IA were included in the model. How the IA was conducted was 4 times more important than the booking process and 3.4 times more important than the professionalism of assessors. The results were similar using the alternative dependent variable (responses to the question “Given a choice, would you have an IA again?” (see Appendix G).

**Figure 8: Relative contribution of the key aspects of the participant pathway driving overall IA experience**

Source: Shapley Value regression of participant experience survey.

Although the participant experience survey sample is too small to undertake Shapley Value Regression for specific cohorts, the findings confirm that the most important part of a participant/support person’s IA experience was the way the assessment itself was conducted.

### 3.1.3 Best and worst things about the assessment

A section of the participant experience survey asked participants/supporters what were the best and worst things about the IA in an open-ended ended format. This allowed respondents to express their perceptions on any aspect of the IA they chose. **A total of 813 respondents provided feedback (32%).**

The results were consistent with the conclusions drawn from the Shapley Value Regression presented in Figure 8 above. Thematically, the best aspects of the IA reported by participants/supporters related to the way the assessment was conducted. Specifically, participants/supporters valued:

1. The opportunity to discuss their disability, raise concerns and be heard by the assessor (12%)
2. The assessment took place in the participant/supporter's (10%)
3. The assessor's interpersonal skills (9%)

> "The assessor was very professional and you could tell he was highly trained and experienced person in his field. You could see that he had considerable experience dealing with people like my son. As long as the NDIA strive to employ experienced professionals to carry out these assessments, I think they could work fine." Parent of participant, *Participant experience survey*

> "The actual appointment. I found it therapeutic to discuss my situation with a professional. From the outside I don't look like I have a disability and I rarely share that information. I look forward to the final report and any recommendations that are offered." *Participant, Participant experience survey*

In interviews, participants/supporters often described their assessor as 'courteous', 'listening', 'patient', 'understanding', 'helping me relax', and 'caring'. The assessors felt their overall approach was important in ensuring participants were engaged and had a positive experience with the assessment.

> "She came in when my daughter was in a meltdown. She spent a good 10-15 minutes with her in her room after and talked about her toys. My daughter came out of her room for part of the assessment…the assessor gave her the option to stay or leave. The assessor was really inclusive, really good. She wasn't prescriptive with [my daughter] or talked down to her, she was very engaging with her and very professional." Parent of participant, interview.

The themes provided for the worst aspects of the IA by participants/supporters were more diverse. Consistent with the Shapley Value Regression, the most frequently reported theme related to how the IA was conducted, specifically the length of the assessment. Other frequently reported themes focussed on assessment content (the questions) rather than conduct. The most frequently reported negative aspects of the IA were:

1. The length of the IA as too long, exhausting and making it hard to concentrate (14%).
2. Insufficient detail in the questions where the assessment was not comprehensive (11%).

3. The assessment questions did not cover issues related to my disability (10%).

> "It was really long & the assessor didn't know me so I had to repeat my whole medical history to them again which is annoying." *Participant, Participant experience survey*

> "There is no full context for the answers to questions to be recorded so it cannot give true assessment. It also felt like a Human Resources psych test where the same questions is asked in slightly different ways I assume to check on consistency of answers which not only is annoying but is very difficult for participants to answer themselves in many cases consistently so will skew the picture." *Sibling of participant, Participant experience survey*

## 3.2 The assessment meeting

This section presents findings related to the actual IA meeting itself. This includes the mode of assessment, the duration of assessments and the approach each supplier used to administer the assessment tools.

### 3.2.1 Mode of assessment

As part of the referral process, the NDIA nominated a preference for whether an IA would be conducted face-to-face or through telepresence using a smart phone, tablet or computer. The allocation was based largely on the local availability of independent assessors.

As shown in Table 2 above (see section 1.3.1), close to two-thirds of assessments were conducted face to face, with face-to-face assessments most likely for participants aged 0-6 years (78%). This is consistent with assessors' views during focus groups that face to face assessment is very important with younger children. Assessors consistently commented they were more likely to be 'hands on' with younger children, and the families were more likely to need reassurance about the development of their child.

> "I have become much more flexible in the way I do assessments, particularly with kids. You might start the assessment with the interaction with them and then with other kids you talk to Mum for an hour until they are ready to come over, you observe them a little, they run away, then they come back and you do a little more. It really isn't linear if you are trying to get everything done." *Independent assessor, focus group*

Around 10% of participants/support persons who responded to the participant experience survey, commented that having an assessor visit them at home was one of the best things about their IA. Some participants commented it was the first time an allied health professional had visited their home. There was generally a positive feeling that the home visit would give the assessor greater insight into the experience of the participant and the impact of disability on their life.

> "I liked the assessment. Less stressful than going in to an office, or having a planning meeting. It showed nuances of daily living. Shows how the disability affects me in my daily life." *Participant, interview*

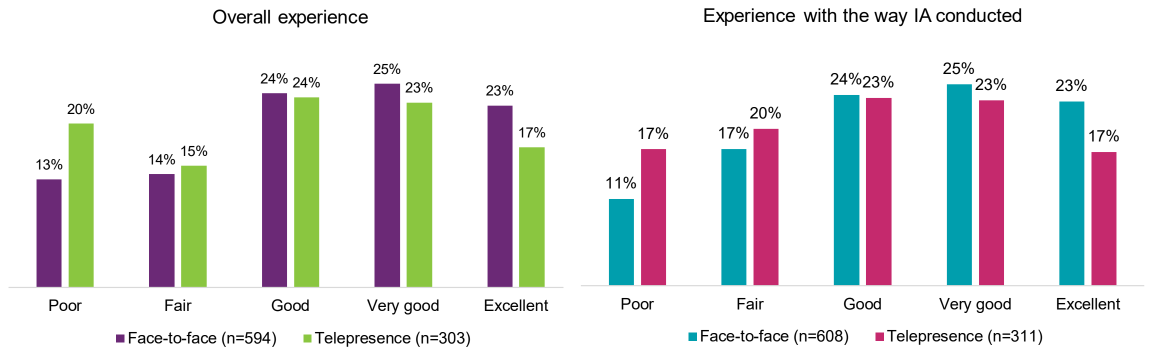
> “Doing the appointments in people’s homes was really important. COVID aside, people were just a little bit more comfortable.” *Independent assessor, focus group*

However, a small number of participants/supporters expressed concern that assessing a person in their home, in an environment modified for their needs and where they were most comfortable, may not give a realistic view of their functional capacity. Some participants felt the assessment should include the opportunity to assess functional capacity in the community when the social impact of disability may be more apparent.

> “I offered to have a coffee and go to the shops with the assessor but she said ‘No’. Not sure whether the assessor is qualified or insured to do that – would be a better way of validating the capacity.” *Participant, interview*

The positive sentiment towards face-to-face assessments was reflected in participant/supporter ratings of both their overall experience having an IA, and the way their assessment was conducted. There was a tendency for participants/supporters to rate their overall experience with their IA and the way their assessment was conducted more positively if it was face to face compared to telepresence (Figure 9).

**Figure 9: Participant experience with IAs by administration mode (% of respondents)**



**Data table for Figure 9: Overall experience**

| Administration mode | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| Face-to-face (n=594) | 13% | 14% | 24% | 25% | 23% |
| Telepresence (n=303) | 20% | 15% | 24% | 23% | 17% |

**Data table for Figure 9: Experience with the way IA conducted**

| Administration mode | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| Face-to-face (n=608) | 11% | 17% | 24% | 25% | 23% |
| Telepresence (n=311) | 17% | 20% | 23% | 23% | 17% |

Source: Participant experience survey.

Managers and assessors found some participants had difficulty with the telehealth assessment due to a lack of experience with the technology, internet connectivity and computer hardware issues. There were also more challenges managing the assessment and observing the interaction activity through telehealth.

> “We had a few challenges with telehealth initially. It can be a bit difficult with the interaction. Positioning the camera so we can see. There is also the troubleshooting issue with the IT. Even getting people to log on with telehealth can be a problem. I guess we get no shows with face to face but seems more with telehealth.” *Supplier manager, interview*
>
> “Very difficult to complete these assessments over the phone or zoom. My wife can’t speak so if the assessor if not able to see her in person there is no way you can have a real picture of her functional capacity. Zoom is not the best way to complete these assessments.” *Participant supporter, interview*

**Consideration 2**

If a participant requires their IA to be conducted by telepresence, suppliers must first ensure the participant is suitable to have their functional capacity accurately assessed this way, the participant has access to suitable technology, and the participant or their supporter has the capability to use that technology.

### 3.2.2 Assessment duration

The length of assessments was a common complaint from participants/supporters, assessors and their managers. According to supplier billing data, IAs during IAP2 averaged 3:22 hours (shortest was 1:40 hours and the longest was 7:00 hours as recorded by assessors). The average reported duration is similar for all assessment packages (Table 5), but varied depending on the participant’s primary disability (Table 6). The longest reported average duration was for participants with autism (3:32 hours) while the shortest was for participants with a sensory disability (3:08 hours). There was no difference between the reported average duration of face-to-face and telepresence assessments.

In the participant experience survey, 60% of participants/supporters considered the length of the assessment to be “about right,” while 35% reported the assessment was too long. Around 40% of respondents assessed with the 0-6, 7-17, and SIL packages felt their IA was too long, compared to 28% of respondents assessed with the 18+ package.

IAs with participants with a psychosocial disability (41%), a sensory disability (41%) or autism (40%) were most commonly reported as too long. This is despite participants with a sensory disability or psychosocial disability having the shortest assessment durations on average. The higher level of concern regarding the length of IAs with participants with autism aligns with the fact that these were on average the longest assessments. People with a physical disability were the least concerned about the assessment length with only 25% reporting their IA was too long (Table 6).

**Table 5: Duration of assessment by assessment package type**

| Age | % who reported their IA was too long | Average duration of assessment (Hrs:Mins) | IA length about right - Average duration of assessment (Hrs:Mins) | IA length too long - Duration of assessment (Hrs:Mins) |
|---|---|---|---|---|
| **18+** | 28% | 3:21 | 3:19 | 3:22 |
| **7-17** | 40% | 3:23 | 3:24 | 3:23 |
| **0-6** | 38% | 3:25 | 3:35 | 2:45 |
| **SIL** | 41% | 3:19 | 3:27 | 3:10 |
| **Average** | **35%** | **3:22** | **3:20** | **3:22** |

Source: Participant experience survey and supplier billing data as of 31 May 2021.

**Table 6: Duration of assessment by primary disability grouping**

| Disability Grouping | % who reported their IA was too long | Average duration of assessment (Hrs:Mins) | IA length about right - Average duration of assessment (Hrs:Mins) | IA length too long - Duration of assessment (Hrs:Mins) |
|---|---|---|---|---|
| **Psychosocial** | 41% | 3:10 | 2:56 | 3:14 |
| **Sensory** | 41% | 3:08 | 3:12 | 3:06 |
| **Autism** | 40% | 3:32 | 3:31 | 3:34 |
| **Intellectual disability** | 36% | 3:28 | 3:21 | 3:32 |
| **Neurological** | 31% | 3:21 | 3:21 | 3:22 |
| **Physical** | 25% | 3:19 | 3:23 | 3:18 |
| **Average** | **35%** | 3.22 | 3:20 | 3:22 |

Source: Participant experience survey and supplier billing data as of 31 May 2021.

Note: Package assignment for the adult (18+) and SIL relied on survey respondents providing their participant ID or full name so their responses could be matched back to supplier governance data. 695 of the 948 survey respondents could be matched. Without matching it is impossible to distinguish between respondents for the adult (18+) and SIL packages. Unmatched responses were excluded.

Table 6 also shows there was little difference in the average IA duration between participants reporting their IA was 'too long' compared to 'about right,' for most of the primary disability groupings (Too long - average = 3:22 hours, median = 3:20 hours; versus about right - average = 3:20 hours, median = 3:15 hours). The exceptions are for participants with a psychosocial disability, where the average duration for IA length rated as 'about right' was 2:56 hours versus 3:18 hours (+17 minutes) for those who reported it was 'too long.' There was also a +11 minute difference for participants with intellectual disability.

However, in the case of participants with a physical or sensory disability, survey respondents who felt the IA length was 'too long' had shorter IAs on average than those who thought the duration was 'about right.'

The above findings suggest that, while cohort specific preferences exist, the optimal length of IAs is influenced by a participant's preference and/or expectation. As part of the booking process, participants/supporters were supposed to be told how long to expect their IA would take. While 93% of participants/supporters who responded to the participant experience survey confirmed this occurred, responses indicate that ideally IAs would be shorter. It was indicated that 95% of respondents completed their IA in one session, when technically it could be split over multiple sessions.

Interviewed assessors also agreed that the duration of IAs was too long and required the participant/supporter to concentrate for an extended period of time. This led some to suggest that the assessment should be booked as two sessions for some, particularly younger cohorts.

> "For the under 18 years, it should always be two assessments. There is too much to get through." *Independent assessor, focus group*

> "People are just exhausted doing the assessments. You really have to work hard to keep them on track for the second half. They are so long. There is so much information." *Independent assessor, focus group*

Participant interview reports were consistent with the finding that the assessment duration was too long, with this being noted as a factor in 14% of interviews.

> "Definitely was too long for him to sit through. Four assessments, but by the last one he was truly done and not a true reflection, he just wanted to get it over and done with. Fine with the first two, the last two were beyond him… Would have been better to do it over two days and not one setting" *Parent of participant, interview*

**Consideration 3**

Based on best available evidence, the length of an IA meeting should be capped to a maximum of three hours. Multiple assessment sessions should be encouraged if longer is required.

**Consideration 4**

To shorten IAs, the NDIA should design assessment packages which allow completion of some participant information prior to the appointment. This would help improve the accuracy of this data where it requires recall, and also provide suppliers with information to assist in allocating the most suitable assessor for the participant.

**Consideration 5**

The NDIA should use a well-validated approach to analyse assessment data to determine how the tools can be streamlined to reduce the length of IAs, while still delivering valid and reliable assessment of functional capacity.

### 3.2.3 Approach to conducting assessments

A cornerstone of IAs is the use of a set of standardised tools delivered in a consistent way by different assessors to provide reliable and valid results. For a combination of reasons, including assessors being new to the role and from different professional groups, managers and assessors described several different approaches to conducting IAs. The impact of these different approaches, if any, on the reliability or accuracy of data is not known. The presence of different assessment administration approaches calls for further work to improve assessor consistency and to test the reliability of the assessment packages.

Some assessor approaches to assessment administration included using printed versions of the Microsoft Excel packs. This had the benefit of not needing a computer, which was seen as a barrier to engaging with participants. Generally, assessors who used printed forms said their usual practice was to use a tablet for assessments, but the IA packs were not available in a tablet accessible format. The packs also included online forms (such as the PEDICAT and Vineland). Some assessors printed and used these tools in hardcopy if they had their own licences.

> "A lot of our assessors found it not appropriate to be filling out the assessment tool while they were doing the questionnaires with the individuals. They felt that had challenges with building rapport. There was a bit of double handling in that sense as didn't want the laptop open while they were asking questions and gathering that data. They would have to then go after the assessment and fill out the assessment packs which took a little time. You need to think practically about how those packs are completed." *Supplier manager, interview*

Some assessors did not ask the assessment questions directly, preferring to have a general conversation and then complete the assessment package either over breaks or after the assessment. These were generally very experienced clinicians who knew the assessment questions well.

> "As you become more familiar with the questions you are able to use your own words and adjust your body language and give the participant the attention they actually need. You can see how they react to the questions and change the way you ask things or see if they need a break." *Independent assessor, focus group*

Despite assessor awareness that computer use could negatively impact rapport, it was identified that hard copy data posed a security risk and that it took additional time to enter the data after the meeting. Furthermore, the IA tools were not designed to be printed. As a result, dropdown response lists and prompts did not appear in hardcopy, limiting their usefulness. Therefore, some assessors completed the assessment through a more structured question and answer approach, completing responses on their computer in Microsoft Excel pack during the assessment.

> "We try to fill in as we go but that is not always possible…Some assessors are as good at multitasking and it can be hard to type and talk at the same time or the participant may need more support." *Supplier manager, interview*

It is not possible to determine from the current data the impacts of different IA administration approaches to the experience of participants. However, feedback from participants/supporters through the interviews and survey strongly suggest that less use of 'robotic', 'repetitive' 'tick and flick' assessment tools was preferred.

> "The assessor was face down in the lap top clicking away and I thought "God almighty". It was quite sterile in that regard. I appreciate the need for some of that to keep arm's length, but it also forces clients to make a more aggressive approach. *Parent of participant, interview*
>
> The lady was doing it on a laptop. I've never seen an assessment carried out that way in my life. How you could tick and flick something for 3 hours. I couldn't see at the end of it how it was going to help my son." *Parent of participant, interview*

**Consideration 6**

The NDIA should set up standard operating procedures that encourage assessors to use their clinical judgement on the most appropriate way to conduct each IA. This will promote an effective interaction with the participant/supporter, and reduce a prolonged question-answer exchange, which is clearly not preferred by participants/supporters. It will also be important to implement a robust quality assurance process to ensure the integrity of IAs.

## 3.3 Bookings and communication

The booking process was a key source of information and communication with participants and their support person/s about the pilot. Pilot suppliers managed the booking process, using NDIA provided communication materials and scripts.

Figure 1 above (see section 3.1.1) shows that 56% of IAP2 participants reported an excellent or very good experience with their booking process, and only 14% reported a poor or fair experience. This shows the booking process was a success.

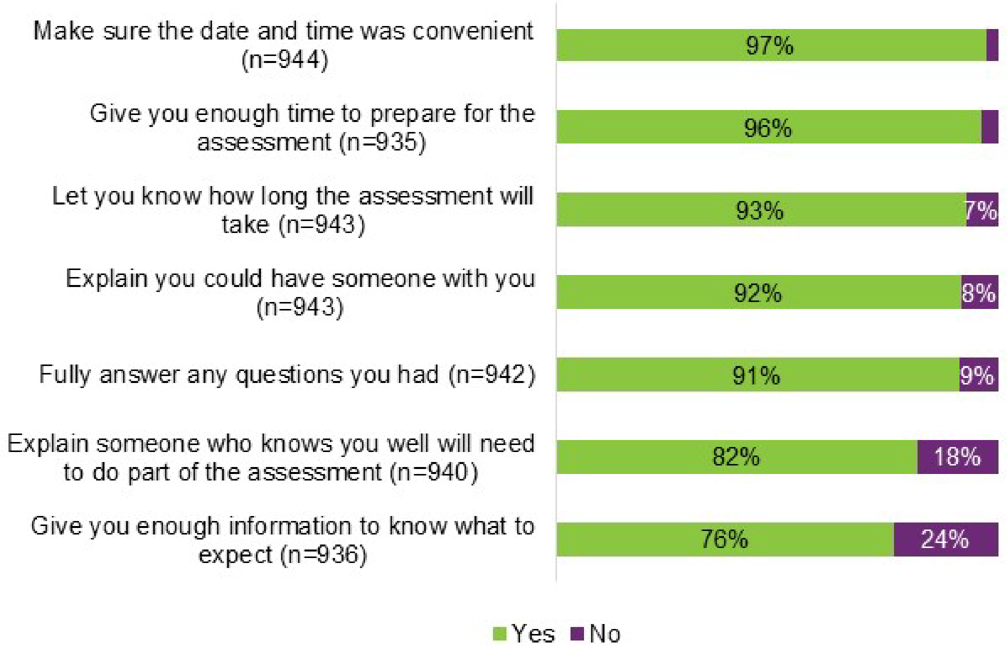
Figure 10 confirms this conclusion, with most participants/supporters reporting suppliers delivered the majority of features the NDIA associated with an effective booking process. This included making sure the time and date were convenient for the participant and their support person (97% reported yes) and communicating a range of information about the upcoming IA.

The effectiveness of this process was reflected during interviews, with most participants/supporters reporting the booking process ran smoothly and had no complaints. A very small number of interviewees noted issues where bookings were changed at the last minute due to unforeseen circumstances, such as an assessor falling ill. However, most were understanding of this and in general, suppliers organised a replacement assessor on short notice to minimise disruption to the participant.

However, while the booking process was successful, participant experience survey responses identified two areas to improve:

- Nearly one in five respondents (18%) reported it was not explained that someone who knew the participant well needed to be present at their IA. This was required to complete the Vineland assessment for all participants. In addition, for people with cognitive impairment, a person who knew them well may be required to support the participant to answer the questions.
- Nearly one quarter of respondents (24%) did not have enough information to know what to expect from the IA. This theme was reflected in the comments participants made about the booking process.

**Figure 10: Delivery of steps involved in booking IAs**



**Data table for Figure 10**

| Step | Yes | No |
|---|---|---|
| Make sure the date and time was convenient (n=944) | 97% | 3% |
| Give you enough time to prepare for the assessment (n=935) | 96% | 4% |
| Let you know how long the assessment will take (n=943) | 93% | 7% |
| Explain how you could have someone with you (n=943) | 92% | 8% |
| Fully answer any questions you had (n=942) | 91% | 9% |
| Explain someone who knows you well will need to do part of the assessment (n=940) | 82% | 18% |
| Give you enough information to know what to expect (n=936) | 76% | 24% |

Source: Participant experience survey.

In the participant experience survey, respondents were asked for the additional information they would have liked to have received when booking. Comments were provided by 32% of the 948 respondents, who noted they would have liked the following additional information:

- Detail on the assessment process (14%) such as that it was likely to be tiring, it needed to be partially completed by a representative without the participant present and requirements for the participant interaction activity.
- Information regarding the nature of the questions, including sensitive topics (13%).
- Information about their assessor, such as their qualifications, experience and the amount of information they knew about the participant (13%).
- An accurate indication of the assessment length (7%).
- Contact details so they could alter appointments, have correct time zone adjustments and check online link functionality (9%).
- Appointment options, such as choices of time, place, mode of administration and the number of sessions (8%). In closed survey questions 95% of respondents (or 898 out of 948 responses) indicated they were only given one choice of time. It was noted by 72% that they were given a choice of where they had their assessment.

### Participant/supporter feedback on the communications

In the participant experience survey, some participants/supporters expressed concern about how the assessment results would be used, the possible impact on funding and planning and the potential need to appeal a decision (22%).

> "I would like to have known [if] how the assessment may impact my funding. I would also have liked to have known that once the assessment had been completed that there was no way to query what had been submitted. This means if human error occurred there would be no way to know this and my funding may be impacted through no fault of my own." *Participant, Participant experience survey*

Assessors confirmed this sentiment during consultations, citing further information was needed for participants to fully understand the IA process.

> "A lot of the participants were quite confused as to what my role was…I don't know if they didn't get the information from the NDIA or if they didn't understand it? A lot of people had no idea why there were doing the assessment." *Independent assessor consultation*

> "I had quite a few times where people would start telling me I need more this in my plan. And you have to explain this is not a plan review." *Independent assessor consultation*

**Consideration 7**

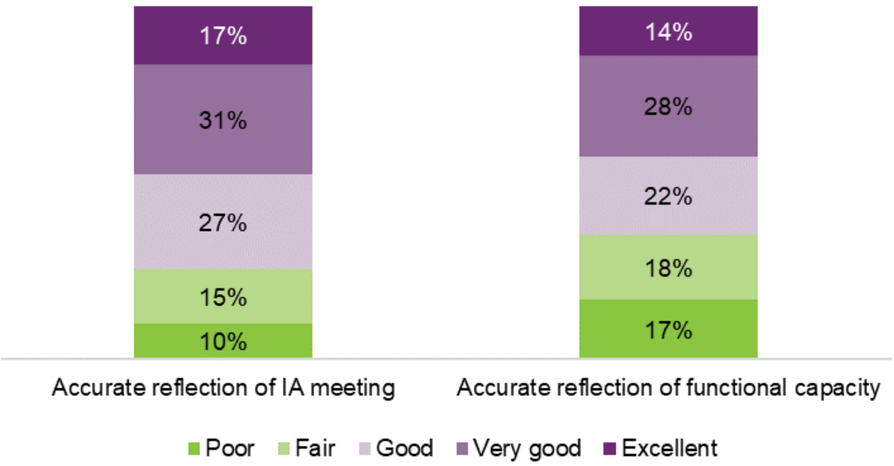
The NDIA should improve the detail of IA information materials for participants/supporters to explain what the IA is, the process undertaken and how the resulting data would be used. This information should be in a range of formats accessible to people with various communication impairments, be available in languages other than English and in easy read formats.

## 3.4 Assessment output

A key indicator of how effective IAs are is the accuracy of results. Participants and their supporters were invited to answer a second survey about their IA results, once they had received their reports.

Figure 11 shows 48% of respondents felt their IA results were an excellent or very good reflection of their IA meeting (24% good), while 42% felt the results were an excellent or very good reflection of functional capacity (22% good). This means 35% of respondents rated their results as a poor or fair reflection of functional capacity. This sentiment was confirmed in open ended feedback, where some respondents commented about the low accuracy of their reports (21% of 238 comments received).

**Figure 11: Participant/supporter experience with the accuracy of IA reports**



**Data table for Figure 11**

| Experience | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| Accurate reflection of IA meeting | 10% | 15% | 27% | 31% | 17% |
| Accurate reflection of functional capacity | 17% | 18% | 22% | 28% | 14% |

Source: Participant experience survey (n=265).

Survey responses showed 55% of respondents felt the amount of information contained in the report was 'about right', while 36% felt there was not enough information. Only 9% felt there was too much information.

To understand participant/supporter report preferences further, the survey asked participants/supporters to indicate what they think was missing from their IA results report, and how the NDIA can improve the presentation of results in future. Interviews with participants/supporters also explored these themes, although the majority had not received their IA results when they were interviewed.

Overall, participants/supporters indicated they wanted a report that was more tailored to them as individuals. In 25% of open-ended survey responses,[24] respondents noted that contextual information they provided to elaborate on their responses during the assessment was missing. A theme from these responses was a desire for the report to have a greater focus on the participant's specific disability and support needs. A further 22% of responses indicated a preference for a more holistic report that included information on the impact of the participant's disability on their family, and planning for future care needs.

Consistent with these opinions were comments that the report was too generic (12%) and was largely a list of answers to the questions their assessor asked (12%). Participants/supporters noted that the report should include recommendations and link back to their plan (12%).

> "This is not a report. It is scraps of information, not all of which are accurate. There is no cohesive summary of my child's situation and goals for the future. It's like a jigsaw puzzle that is missing many pieces. What I need to know is how this type of 'report' will impact upon my child's future funding. How can a funder accurately gauge her needs when this 'report' barely acknowledges the fact that she is a teenage above knee amputee and this is why she has difficulty performing certain tasks and why she needs particular supports?" *Parent of participant, Report survey*

> "There is nothing in the report about my daughter wanting to re-enter a day program or what she is aiming for in the future. There isn't mention about how much her anxiety and obsessive behaviours affects her functioning." *Parent of participant, Report survey*

These comments are important as they reflect the preferences of some participants/supporters for the content of IA reports. However, negative sentiment might also stem from expectations based on the content and/or format of previous allied health reports received, and limited end-to-end understanding of future Scheme reforms and the role of IAs. Many of those interviewed did not understand that IAs are intended to describe functional capacity and not support needs, and are intended to complement and not duplicate goal setting and planning.

In order to improve IA reports, participants/supporters indicated the report needed to be easier to understand. Suggestions included limiting complex terminology or jargon, and including a description of the ranges used to describe abilities. It was noted that input from other sources, such as the participant's regular health professional team and/or specialist reports would improve the IA report.

> "I believe it is necessary to have the client's history, and have reports from the medical staff and therapist who spend hours, sometimes years, working with the client, and therefore have a full understanding of the person's needs, and the complexities of the persons condition." *Participant, Report survey*

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[24] Multiple response questions, percentages do not total to 100%.

**Consideration 8**

The NDIA should ensure the format, language and level of detail of IA reports are responsive to participant need. This should be complimented by comprehensive communication about the role of IAs in the end-to-end reforms to NDIS budgeting and planning.

## 3.5 Participant experience drivers

The previous chapters suggest a number of opportunities to refine IAs to ensure participants/supporters have a positive experience. To do this, a two-stage Shapley Value Regression process was employed using data from the participant experience survey:

- **Step 1**: Key drivers of a positive participant/supporter experience were identified from the way their IA was conducted, their booking process and the professionalism of their assessor.
- **Step 2:** An assessment of which factors from step 1were the key drivers to having a positive overall IA experience was undertaken. The key drivers from this stage were ‘must haves’ for a participant to have a positive overall IA experience, and should be prioritised for improvement.

To identify key drivers, an additional variable, success, was calculated.[25] This calculation identified the point where adding any further aspects of the IA experience resulted in no further prediction of the quality of the participant/supporter experience. As such, it is the cut-off for identifying the key drivers of overall IA participant/supporter experience.

Appendix G presents the detailed results and methodology.

### 3.5.1 Findings from step 1

Figure 12 summarises the results from step 1 of the analysis. In summary:

- The key drivers of a participant/supporter’s experience with the **way their assessment was conducted**, in order of importance, were:
    - Their perception that the assessment covered all areas important to the participant and gave an accurate picture of their skills and ability
    - The assessment was not too long
    - The participant was comfortable with the activities they were asked to do.

  The mode of assessment (i.e. face-to-face versus telepresence) was not associated with participant experience, confirming that both modes are acceptable for participants/supporters. Differences between participant cohorts were not explored

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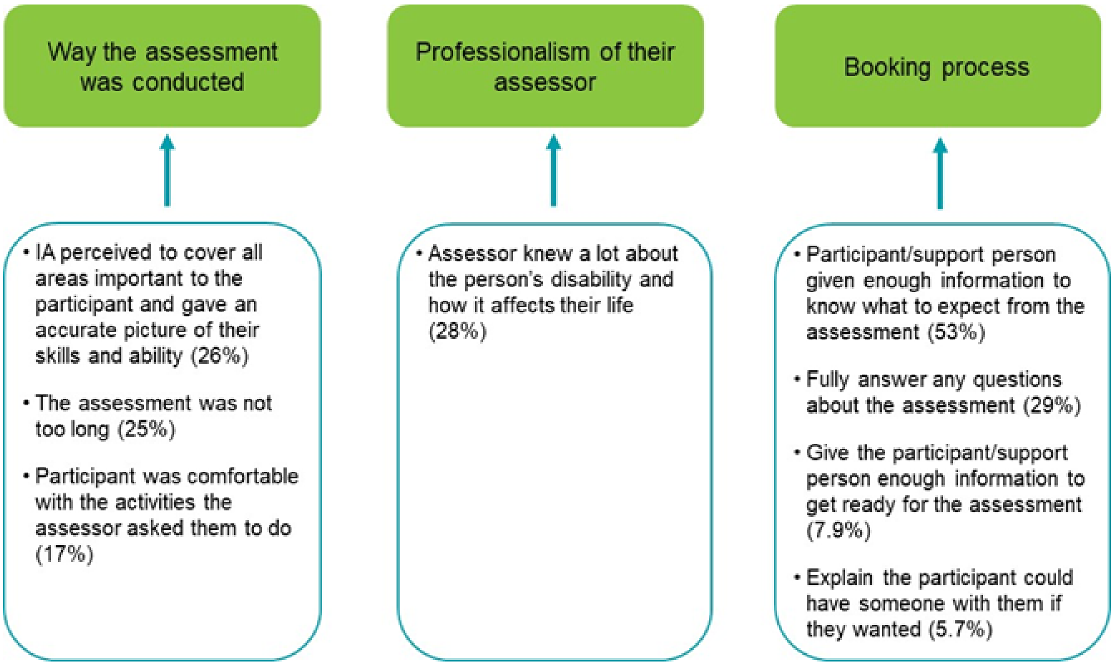
[25] Success = Cumulative reach – Cumulative noise
= [cumulative probability of IA attributes being reported as not delivered, amongst those who do not report a very good or excellent experience] – [cumulative probability of IA attributes being reported as not delivered, amongst those who report a very good or excellent experience].

due to data limitations, however this will be an important area to address as more data becomes available.

- The only key driver of a participant/supporter's experience with **the professionalism of their assessor** is whether the assessor appeared knowledgeable about the participant's disability and understood how it affects their life.
- The key drivers of a participant/supporter's experience with their **booking**, in order of importance, were:
    - They were given enough information to know what to expect at their IA
    - The person(s) making the booking fully answered any questions about the assessment
    - The participant/supporter had enough time to prepare for the assessment
    - It was explained they could have someone with them if they wanted.

**Figure 12: Key drivers of experience with steps along a participant's IA pathway**



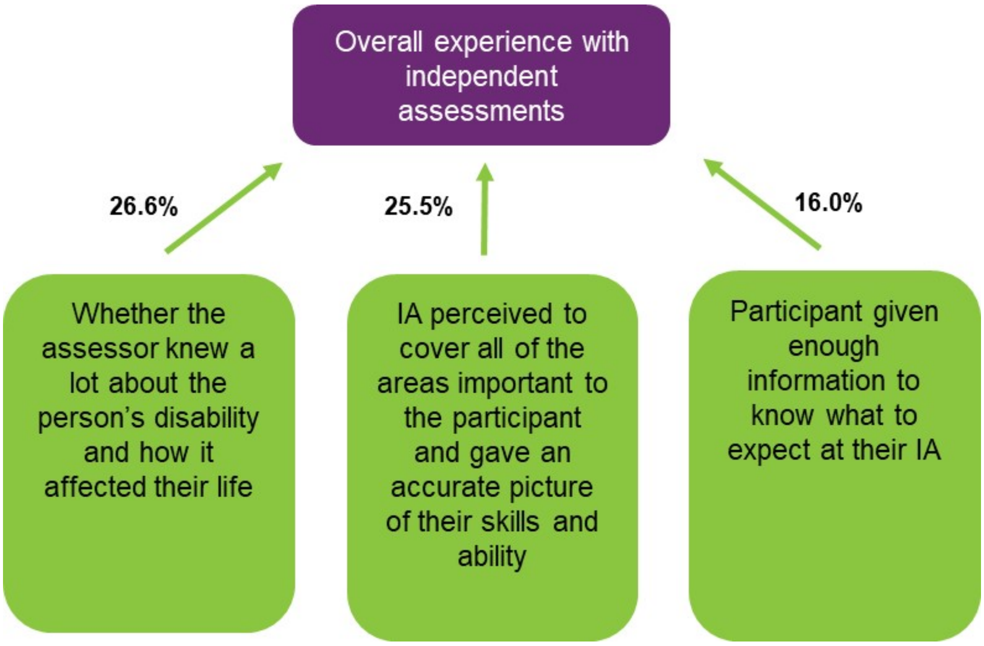
Source: Shapley Value Regression using participant experience survey data.

### 3.5.2 Findings from step 2

To understand the key components of IAs affecting a participant/supporter's overall experience with their IA, we undertook a Shapley Value Regression of the IA components identified in step 1, against overall participant satisfaction. Figure 13 shows that the following three components were identified as key drivers of participant overall IA experience IA:

- Whether the participant felt the assessor knew a lot about their disability and understood how it affects their life.
- Whether the participant felt their assessment covered all of the areas important to them and gave an accurate picture of their skills and ability.
- Whether the participant got enough information during their booking to know what to expect from the assessment.

**Figure 13: Key drivers of a participant's overall experience with their IA**



Source: Shapley Value regression of participant experience survey.

If a participant/supporter believed the above three aspects of their IA were delivered, this analysis demonstrated that a participant was likely to have had a positive overall IA experience. In simple terms, the aspects of the IA outlined above are the '**must have**' features of IAs.

# 4. Assessor workforce

This chapter presents the evaluation findings related to the independent assessor workforce. Specifically, it focusses on:

- Assessors’ professional discipline and experience
- The impact of assessor professional discipline and experience on participant experience and IA quality
- Assessors’ interpersonal skills
- The NDIA’s assessor training materials.

## 4.1 Assessor discipline and previous experience

This section presents the findings related to assessors’ clinical discipline and experience, in consideration of the population characteristics of NDIA participants.

### 4.1.1 IAs completed by assessors

As of 31 May 2021, 202 allied health professionals delivered IAs for either APM Australia, HealthStrong or Allied Care Group. Data for other suppliers was not available for this report. Table 7 shows 84% of IAs were completed by an Occupational Therapist (45%) or Physiotherapist (39%). Psychologists and Speech Pathologists delivered most of the remainder. The fact that Occupational Therapists and Physiotherapists delivered most IAs is not surprising given these professions focus on function to undertake daily activities.

**Table 7: IAs completed by assessor discipline**

| Assessor discipline | Number of IAs delivered | Number of assessors who delivered an IA[a] | Average number of IAs per assessor[b] | Maximum | Minimum |
|---|---|---|---|---|---|
| **Occupational Therapist** | 1,629 (45.0%) | 92 | 17 | 72 | 1 |
| **Physiotherapist** | 1,415 (39.1%) | 79 | 17 | 94 | 1 |
| **Psychologist** | 278 (7.7%) | 16 | 16 | 57 | 1 |
| **Speech Pathologist** | 158 (4.4%) | 15 | 10 | 25 | 3 |
| **Not recorded** | 143 (3.9%) | - | - | - | - |
| **Total** | **3,623** | **202** | **16** | **94** | **1** |

Source: Supplier governance reports as of 31 May 2021.

[a] Names of assessors were only available for APM, HealthStrong and ACG, while the number of IAs includes all suppliers. Therefore, the number of assessors for each discipline is under-represented.

[b] Average assessments are based on figures where assessors could be identified by name.

According to supplier governance reports, around half of assessors delivered 10 IAs or more, with a maximum of 95 IAs completed by one assessor. Around 75% of assessors delivered five or more IAs (148), and only 12% delivered just one IA.

Figure 14 shows IAs completed by various assessor disciplines for primary disability groups. The data shows Occupational Therapists delivered most IAs for all primary disability groups with the exception of physical disability, where Physiotherapists delivered the most IAs. Speech Pathologists and Psychologists delivered the least IAs amongst all disability groups. Psychologists delivered few IA s with participants with a developmental delay, and Speech Pathologists delivered few IAs with participants with a psychosocial or physical disability.

**Figure 14: IAs completed by assessor discipline and primary disability grouping**

| Primary disability grouping | Occupational Therapist (n=1,598) | Physiotherapist (n=1,391) | Psychologist (n=275) | Speech Pathologist (n=156) |
|---|---|---|---|---|
| **Neurological disability (n=1,230)** | 43% | 42% | 10% | 5% |
| **Intellectual disability (n=646)** | 43% | 40% | 11% | 6% |
| **Autism (n=534)** | 53% | 36% | 7% | 5% |
| **Sensory disability (n=391)** | 47% | 36% | 11% | 5% |
| **Developmental delay (n=207)** | 76% | 17% | 1% | 6% |
| **Psychosocial disability (n=216)** | 55% | 33% | 9% | 3% |
| **Physical disability (n=196)** | 40% | 48% | 10% | 2% |

Source: Supplier governance reports as of 31 May 2021.

Note: Reading across rows (i.e. by disability group), green represents the largest proportion of IAs completed for that professional discipline group, and red represents the smallest proportion.

### 4.1.2 Assessor clinical experience

A limitation of the available data is the lack of information about each assessor’s prior experience working with people with disability, and specific disability types.

Responses from the assessor survey indicated that, of the 68 respondents who answered a question about their highest level of allied health qualification:

- 41 (60%) reported they have an undergraduate degree
- 21 (31%) have a postgraduate degree
- 6 (9%) have an additional clinical credential beyond their undergraduate degree

Assessors who responded to the assessor survey reported their level of professional experience. In summary, responses show on average:

- Occupational Therapists reported **less** clinical practice experience than assessors from other professional disciplines. Assessors with a Psychology or Physiotherapy registration were the most experienced (Table 8).
- Psychologists reported the **most experience** administering standardised tools, with Speech Pathologists and Occupational Therapists reporting the least (Table 9).
- Psychologists and Speech Pathologists reported the **most experience** working with people with disability. Occupational Therapists and Physiotherapists reported the least experience working with people with disability (Table 10).

It is unclear how representative the survey sample is of all assessors[26] but the responses suggest that a substantial number of assessors will require training to build experience to undertake IAs.

**Table 8: Professional experience of assessors- Clinical practice**

| Age | Occupational Therapist (n=28) | Physiotherapist (n=27) | Psychologist (n=7) | Speech Pathologist (n=6) |
|---|---|---|---|---|
| 5 years + | 46% | 70% | 86% | 67% |
| 1-4 years | 43% | 26% |  | 33% |
| Less than 1 year | 11% | 4% | 14% | -% |

Source: Assessor survey.

Note: Percentages might not add up to 100% due to rounding.

**Table 9: Professional experience of assessors- Administering standardised tools**

| Age | Occupational Therapist (n=28) | Physiotherapist (n=27) | Psychologist (n=7) | Speech Pathologist (n=6) |
|---|---|---|---|---|
| 5 years + | 25% | 44% | 71% | 17% |
| 1-4 years | 46% | 33% | 14% | 67% |
| Less than 1 year | 29% | 22% | 14% | 17% |

Source: Assessor survey.

Note: Percentages might not add up to 100% due to rounding.

**Table 10: Professional experience of assessors- Clinical work with people with disability**

| Age | Occupational Therapist (n=28) | Physiotherapist (n=27) | Psychologist (n=7) | Speech Pathologist (n=6) |
|---|---|---|---|---|
| 5 years + | 36% | 41% | 86% | 67% |
| 1-4 years | 50% | 48% | - | 33% |
| Less than 1 year | 46% | 44% | 14% | - |

Source: Assessor survey.

Note: Percentages might not add up to 100% due to rounding.

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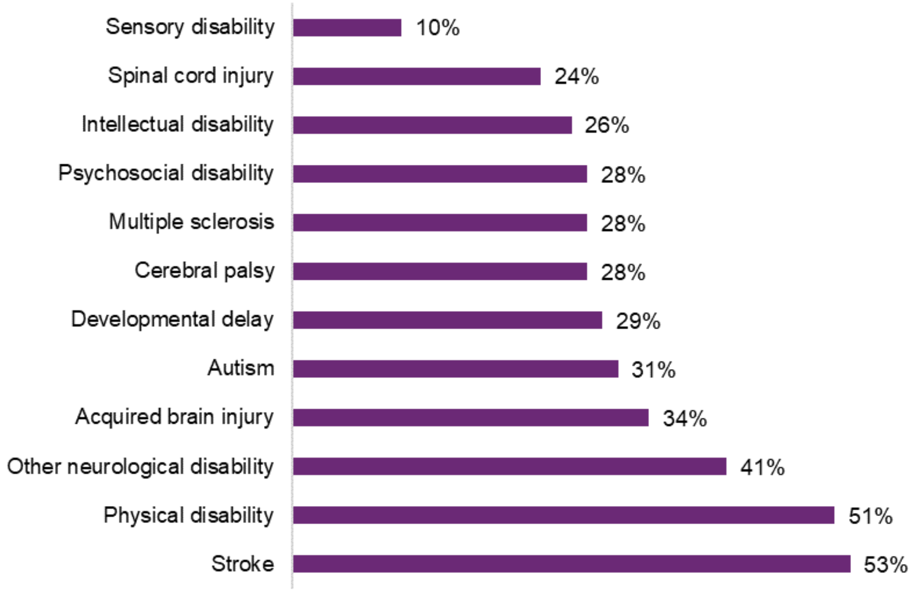
[26] The response rate was 35% based on the identifiable assessors who had completed at least one IA by 31 May 2021.

The survey asked assessors to identify up to five areas of disability where they have the most experience. Figure 15 suggests that the pool of assessors have limited experience with some disability types. This is particularly the case for sensory disability, with only 10% of respondents reporting this group as one of their top 5 disability types where they have experience. The responding assessors reported the most clinical experience working with stroke (53%) and physical disabilities (51%).

Only 31% of respondents reported working with autism, 28% with psychosocial disability and 26% with intellectual disability, as disability types in the top 5 areas where they have most experience. Combined, these cohorts represent around 63% of NDIS participants.

It is unclear how representative survey respondents are compared to the overall pool of assessors, but it is noted that suppliers typically have a large pool of assessors to allocate to participants. Despite this, the findings suggest the cohort of assessors requires training to work with the breadth of disability across the population of NDIS participants.

**Figure 15: Independent assessor reports on the disability types they have the most experience working with**



**Data table for Figure 15**

| Disability type | % of respondents with experience |
|---|---|
| Sensory disability | 10% |
| Spinal cord injury | 24% |
| Intellectual disability | 26% |
| Psychosocial disability | 28% |
| Multiple sclerosis | 28% |
| Cerebral palsy | 28% |
| Developmental delay | 29% |
| Autism | 31% |
| Acquired brain injury | 34% |
| Other neurological disability | 41% |
| Physical disability | 51% |
| Stroke | 53% |

Source: Assessor survey (n=68).

The survey showed only 15% of assessors who responded have specialised experience working with 0-6 year olds, and only 13% with 7-17 year olds. It is important to note though that due to timing, the assessor survey was only administered to assessors at APM Australia, HealthStrong and Allied Care Group. The NDIA has engaged specialist early childhood service providers to further test the approach to IAs with children.

## 4.2 The impact of assessor allocation on participant experience

### 4.2.1 Assessor professional discipline

Responses to the participant experience survey indicated it was important that participants perceive their assessor understood their disability and how it affects their life.

> "I worry about whether the assessor had knowledge of my condition and how it impacts my life" *Participant, participant experience survey*

> "It gets back to his understanding, and his background. He explained to me where he had come from, his background and experience - I thought that for him to give that feedback to me, made me feel confident that the person I was dealing with knew what they doing. That's the crux of the matter, if you have that confidence and rapport, it makes it go easier and it seemed to flow fairly well." *Participant, interview*

Suppliers reported in consultations that, in line with best clinical practice, they triaged assigning assessors to a participant, where the assessor qualifications/knowledge was matched to the participant's disability. This process was undertaken to promote a situation where the assessor had maximal insight into the participant's disability, understood what the likely issues were and could accurately identify relevant signs and symptoms efficiently.

> "On multiple occasions I have had participants with physical disabilities, spinal cord injuries or MS or that sort of thing, where I have had positive feedback that 'my local area coordinator doesn't seem to get my issues'. But the fact that I am a physio with a background in this area is a positive affirmation that someone knows the clinical background." *Independent assessor consultation*

However, while suppliers did their best to match, and offered telepresence assessments, it is important to recognise that IAP2 was delivered nationally and some areas had a limited available workforce for some allied health disciplines.

Even with suppliers' best intentions, just over half (53%) of respondents to the participant experience survey commented that their assessor seemed to know a lot about their disability. This means 47% felt otherwise. To explore this further, supplier governance data was linked with the participant experience survey data where respondents provided their NDIS participant number, and gave permission to access other data about them. Links were made in 658 out of 948 participant experience survey responses.

Figure 16 shows the average experience reported by participants/supporters with the way the IA was conducted, according to their primary disability and assessor's professional discipline. The responses suggest that on average, participants had the best experience with Psychologists (3.8 out of 5).

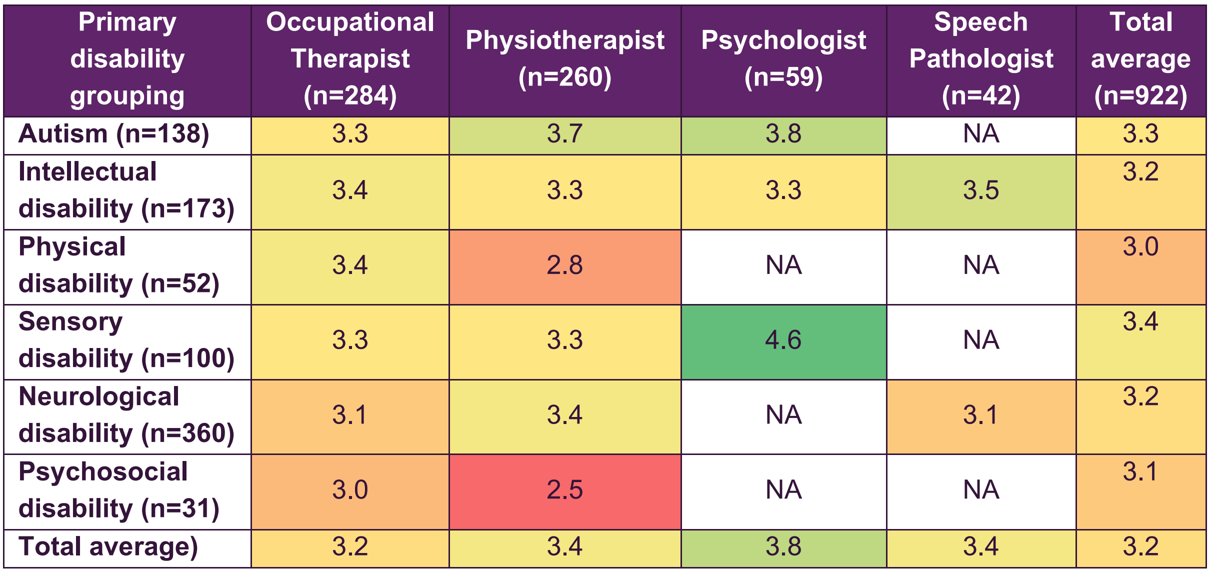
The pairings where participants reported the best experience were (out of 5):

- Sensory disability – assessed by a Psychologist (4.6)
- Neurological disability – assessed by a Psychologist (3.9).
- Autism – assessed by a Psychologist (3.8) or Physiotherapist (3.7)

The poorest experiences (out of 5) were reported for participants with:

- Psychosocial disability - assessed by a Physiotherapist (2.5) or Occupational Therapist (3.0)
- Physical disability - assessed by a Physiotherapist (2.8)
- Neurological disability - assessed by an Occupational Therapist (3.1) or Speech Pathologist (3.1).

**Figure 16: Average participant experience with the way their IA was conducted, by primary disability - assessor discipline matches**



| Primary disability grouping | Occupational Therapist (n=284) | Physiotherapist (n=260) | Psychologist (n=59) | Speech Pathologist (n=42) | Total average (n=922) |
|---|---|---|---|---|---|
| **Autism (n=138)** | 3.3 | 3.7 | 3.8 | NA | 3.3 |
| **Intellectual disability (n=173)** | 3.4 | 3.3 | 3.3 | 3.5 | 3.2 |
| **Physical disability (n=52)** | 3.4 | 2.8 | NA | NA | 3.0 |
| **Sensory disability (n=100)** | 3.3 | 3.3 | 4.6 | NA | 3.4 |
| **Neurological disability (n=360)** | 3.1 | 3.4 | NA | 3.1 | 3.2 |
| **Psychosocial disability (n=31)** | 3.0 | 2.5 | NA | NA | 3.1 |
| **Total average)** | 3.2 | 3.4 | 3.8 | 3.4 | 3.2 |

5 = Excellent; 4 = Very good, 3= Good, 2 = Fair; 1 = Poor.

Note: Green represents a high score (i.e. a positive experience and red indicates a low score (i.e. a negative experience). Combinations where less than five IAs could be matched are shown NA.

The total n includes participant/supporter survey responses that could not be linked to supplier governance data but where the respondent identified the participant's primary disability

Source: Participant experience survey linked to supplier governance data.

Figure 17 shows the percentage of respondents with different primary disabilities who reported their assessor seemed to know a lot about their disability, according to their primary disability and assessor's professional discipline. The participant experience survey responses show Psychologists (61%) and Physiotherapists (58%) performed best on this indicator. The most positive participant-assessor pairings were where a Psychologist assessed a participant with autism (83%) or a sensory disability (83%), or where an

Occupational Therapist assessed a participant with autism (73%). In contrast, the least favourable pairings where:

- Physiotherapists who assessed participants with a sensory disability (35%).
- Occupational Therapists who assessed participants with a psychosocial disability (36%), neurological disability (40%) or sensory disability (46%).

**Figure 17: Percentage of participants/supporters reporting their assessor seemed to know a lot about their disability, by primary disability - assessor discipline matches**

| Primary disability grouping | Occupational Therapist (n=263) | Physiotherapist (n=245) | Psychologist (n=57) | Speech Pathologist (n=37) | Total average (n=852) |
|---|---|---|---|---|---|
| **Autism (n=124)** | 73% | 67% | 83% | NA | 65% |
| **Intellectual disability (n=159)** | 63% | 55% | 50% | 63% | 55% |
| **Physical disability (n=49)** | 62% | 53% | NA | NA | 47% |
| **Sensory disability (n=92)** | 46% | 35% | 83% | NA | 51% |
| **Neurological disability (n=337)** | 40% | 63% | 63% | 50% | 51% |
| **Psychosocial disability (n=29)** | 36% | NA | NA | NA | 45% |
| **Total average)** | 49% | 58% | 61% | 49% | 53% |

Note: Green represents a high percentage of respondents reporting their assessor seemed to know a lot about their disability. Combinations where less than five IAs could be matched are shown NA.

The total n includes participant/supporter survey responses that could not be linked to supplier governance data but where the respondent identified the participant's primary disability

Source: Participant experience survey linked to supplier governance data.

Participant experience survey responses suggest some disability-assessor allocations result in better or worse participant experiences than others. However, based on responses to the assessor survey, this may not be related to the actual professional discipline of assessors, but rather their experience working with people with those disabilities, or their approach to undertaking IAs. This could not be tested in this evaluation because assessor survey responses were anonymous, and therefore could not be linked to participant experience survey data, and the NDIA did not require suppliers to report the experience of their assessors.

However, the findings above highlight that it is important the NDIA and suppliers ensure the pool of assessors have the necessary experience working with a range of disability types, and they use a consistent participant-centric approach to IAs.

**Consideration 9**

The NDIA should monitor the impact of assessor qualifications and experience on participant/supporter experience with IAs. This data should be used to develop minimum qualification and experience criteria for suppliers to allocate assessors to a referral.

### 4.2.2 Assessor experience undertaking IAs

In addition to the professional discipline and clinical experience, assessor experience undertaking IAs could also impact the participant/supporter's IA experience.

To assess this, responses from the participant experience survey were linked to individual assessors (where recorded, n=658). The number of IAs an assessor had previously completed before undertaking the IA of the survey respondent was then calculated. Univariate linear regression was used to assess whether participant experience with the way their IA was conducted was impacted by the number of IAs their assessor had previously completed.

The analysis shows that previous assessor experience had no significant association with a participant/supporter's IA experience. To exclude the possibility that any impact was confounded by APM using the same workforce they used in IAP1, the data for HealthStrong's and ACG's assessors was analysed alone. Again, no significant association was found. Appendix I presents the detailed results.

Together, these results suggest an assessor's prior experience undertaking IAs does not influence a participant/supporter's experience. Rather, the assessor's clinical experience working with the participant's disability and/or their approach to undertaking IAs is likely to be more important to the quality and experience of an assessment.

## 4.3 The impact of assessor experience on IA data

It is essential that the NDIS both ensures it is responsive to participant preferences and gives participants a positive experience with their IA. However, it is also important that assessors deliver high quality IAs that are reliable and valid assessments of each participant's functional capacity. An important precursor to this is that IAs are free of errors and inconsistencies.

For IAP2, the NDIA only made the tools available in Excel and printed format. In focus groups, assessors cited difficulties using these formats, noting there was a lack of data validation checks, no in-built logic to reduce the number of questions that are irrelevant to the participant and difficulties entering data. This is likely to have contributed to failed quality checks.

For a national rollout of IAs, the NDIA is building an online platform for assessors to complete assessments. This platform will include in-built logic to support assessors' use of clinical judgement and mirror best clinical practice. This will support assessors to ask only those questions relevant to the participant based on their disability, life stage and answers to previous questions.

In the first phase of IAP2, the NDIA's Office of the Scheme Actuary checked a sample of 895 IA results for their completeness and consistency. The sample was linked to supplier governance data to identify the assessor who delivered the IA.

In total, 1,198 checks failed across 48 categories in 509 IAs (average 2.35, range 1-10). The most common reason for a check to fail was an incomplete assessment tool, followed by various inconsistencies in the assessment data (Table 11).

**Table 11: Quality checks failed**

| Check fail | Frequency (%) |
|---|---|
| **Assessment tool Incomplete** | 609 (51%) |
| **Participant information inconsistent with assessment tool** | 381 (32%) |
| **Inconsistency across tools** | 182 (15%) |
| **Inconsistent within tool** | 14 (1%) |
| **Basic information - Mandatory fields missing** | 12 (1%) |
| **Total** | **1,198** |

Source: NDIA Office of the Scheme Actuary Quality data extract (May 2021).

The NDIA's Technical Advisory Branch undertook a second review of the sample to assess whether results were acceptable with respect to:

- The accuracy and completeness of language the assessor recorded
- Whether there were minimal blank fields
- Whether responses were consistent within and between assessment tools with no obvious errors
- Whether the Vineland was copied correctly.

If an IA failed any of these aspects, the NDIA returned the assessment to the supplier for remediation. **The NDIA returned 211 of 781 IAs reviewed (27%) of the sampled IAs for remediation,** with the most common issue being inconsistent responses (168 or 80% or returned IAs).

To assess whether the number of IAs an assessor had completed impacted IA quality, the quality data was matched with supplier governance data. The number of quality checks failed or whether an IA required remediation was then regressed against the number of IAs the assessor had previously undertaken.

Poisson regression showed that for each additional IA an assessor delivered, the rate of failing any quality check on their next IA increased by 1.1%. Furthermore, as an assessor increased the number of assessments they had completed, the number of checks failed in their next assessment also significantly increased. By the time an assessor had completed 75 IAs, their 76th IA was likely to fail on average 2.64 quality checks. In contrast, once an assessor had completed 5 IAs, their 6th IA was likely to fail 1.21 quality checks (Table 12). Appendix I presents the detailed regression results.

**Table 12: Impact of assessor experience conducting IAs on failed IA quality checks**

| Number of previous assessments | Estimated number of quality checks failed in next assessment |
|---|---|
| 5 | 1.21 |
| 15 | 1.35 |
| 25 | 1.51 |
| 35 | 1.69 |
| 45 | 1.88 |
| 55 | 2.11 |
| 65 | 2.36 |
| 75 | 2.64 |

p<.001 for each level of prior IAs.

Logistic regression was used to show that on average, the number of IAs an assessor had completed did not significantly increase, or decrease, the likelihood that their next IA would require remediation at a 95% level of confidence (see Appendix I for regression results).

Together, these results suggest that as assessors gained more experience undertaking IAs, they may be using clinical judgement to streamline assessments, possibly to shortening the duration of assessment by not asking unnecessary questions. If this is occurring, then this aligns with how the NDIA encourages assessors to conduct IAs.

However, as the likelihood of an IA requiring remediation does not appear to be associated with assessor experience substantial errors in IAs could be rooted in assessors' underlying approach to conducting IAs, and possibly standardised assessments in general. This also means it cannot be ruled out that at least some failed checks reflect quality issues. Moving IAs to an online platform with inbuilt logic that supports assessors effectively use their clinical judgement will make it easier for the NDIA to systemically identify data issues.

**Consideration 10**

The NDIA should proactively monitor assessor performance and engage early if quality issues emerge. A revision of data review processes should also be undertaken to ensure consistency with any tool modifications undertaken. Sufficient checks should be built into any future assessment system, including the platform used by assessors.

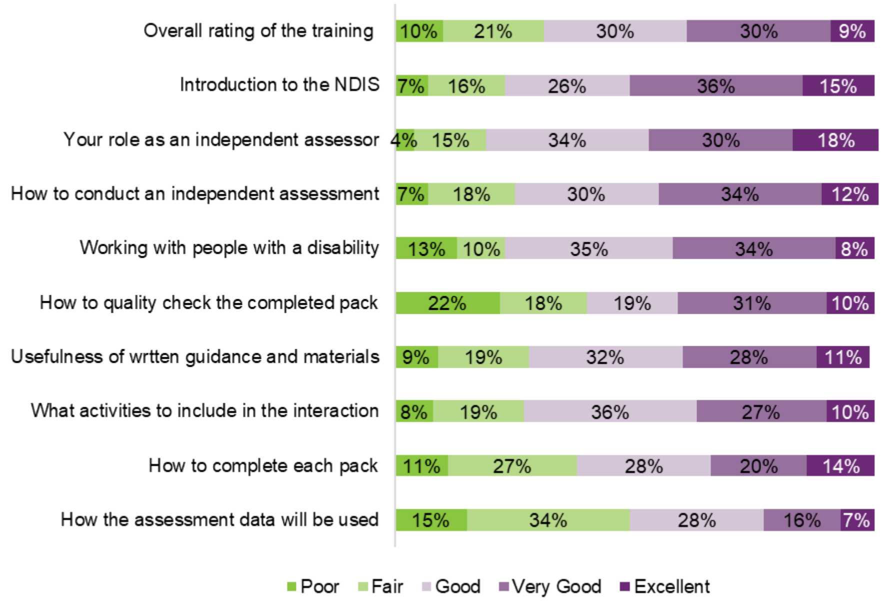
## 4.4 Training and materials

The model for training assessors was predominantly a train-the-trainer model, where suppliers were responsible for training their assessors using materials provided by the NDIA. In the assessor survey, assessors were asked to rate their training experience.

Figure 18 shows 39% of assessors surveyed rated their overall experience with the training as excellent or very good (30% good). The remaining 31% rated the training as fair or poor. The areas where training received the most positive feedback were around the introduction to the NDIS, their role as an independent assessor, how to conduct an IA and working with people with disability. Similarly, consultations with assessors noted positive responses to training, including the opportunity to develop skills and access resources.

> “The pilot has provided learning and upskilling opportunity for assessors, many were not previously aware of the outcome measures that are being used in the assessments so they have been able to enhance their skills in that capacity. There have also been some really valuable resources provided by the NDIA...” *Supplier manager consultations*

**Figure 2: Assessor rating of IA training**



**Data table for Figure 18**

| Part of training | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| Overall rating of the training | 10% | 21% | 30% | 30% | 9% |
| Introduction to the NDIS | 7% | 16% | 26% | 36% | 15% |
| Your role as an independent assessor | 4% | 15% | 34% | 30% | 18% |
| How to conduct an independent assessment | 7% | 18% | 30% | 34% | 12% |
| Working with people with a disability | 13% | 10% | 35% | 34% | 8% |
| How to quality check the completed pack | 22% | 18% | 19% | 31% | 10% |
| Usefulness of written guidance and materials | 9% | 19% | 32% | 28% | 11% |
| What activities to include in the interaction | 8% | 19% | 36% | 27% | 10% |
| How to complete each pack | 11% | 27% | 28% | 20% | 14% |
| How the assessment data will be used | 15% | 34% | 28% | 16% | 7% |

Source: Assessor survey (n=68).

Supporting findings from the IA quality checks (see section 4.4.2 above) and the challenges identified, assessors identified the least positive training experience around how to complete each IA package (38% poor or fair) and how the assessment data would be used (49% poor or fair). Knowledge and competence in these areas are prerequisites for completing high quality IAs.

In the consultations, assessors recommended a stronger practical focus to support consistent implementation of the assessment packages and tools. They suggested the use of more diverse examples and model packages. Some suppliers filled this gap through the production of videos and the use of mock assessments, role plays, training videos, scripts to introduce the assessments and talking points.

> "What is lacking is the application of the tools. And where our practitioners work best is in application. The team tells me that it is too theoretical. But the sessions we ran internally using scenario based learning or mock application of the tools were really useful and combined with the post go live quality sessions, where they are walked through ideal or quality packs has been a more useful way to learn. Maybe reduce the theoretical components and focus on the practical application." *Manager consultations*

**Consideration 11**

Assessor training and materials should be developed in partnership with people with a lived experience of disability. Training should emphasise practical, experientially-based learning about working with different disability types and IA delivery. Information contained in assessment tool manuals should be curated to focus on the key aspects necessary for accurate administration.

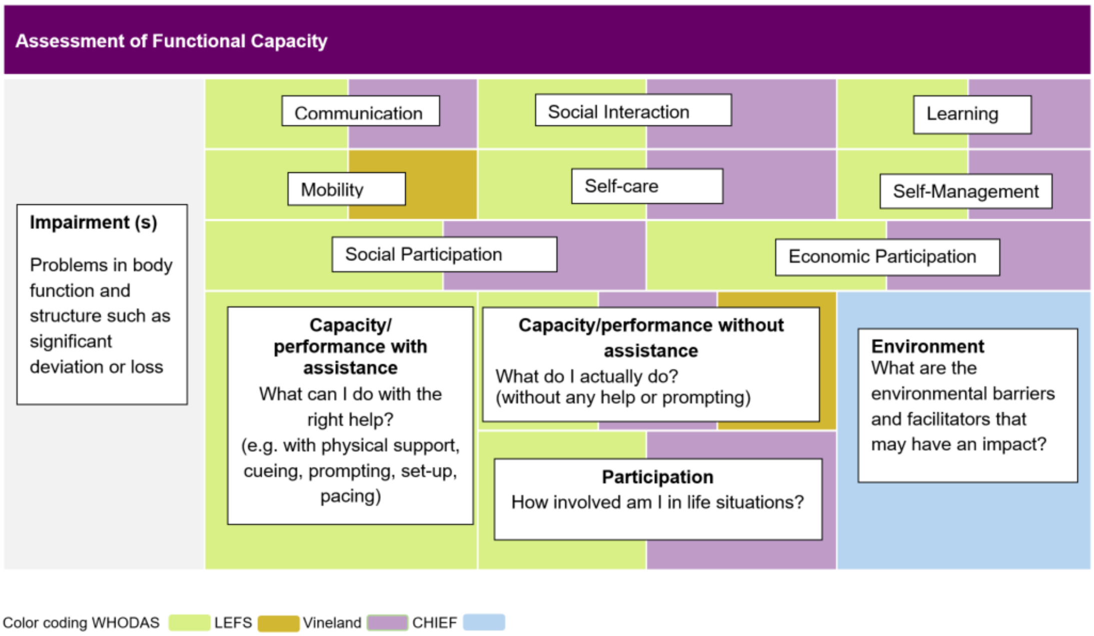
# 5. Assessment tools and packages

In 2011, the Productivity Commission provided recommendations regarding the design of the NDIS, including how it could meet the long-term needs of people with disabilities (PWD) and their families and caregivers. The report specifically recommended assessment tools which would "determine the level of needs and funding for a person covered by the scheme" and that these should be valid, reliable, rigorous, and effective. Further, the tools would need to be congruous with the WHO's ICF. The report also stated there was no 'ideal' tool identified so far and proposed a coherent package of tools or a toolbox to be used across Australia.[27]

The NDIS Act is the legislation which established the NDIS. The legislation outlines 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 Act references the impact on functional capacity in one or more of the following areas: communication; social interaction; learning; mobility; self-care; self-management; and social and economic participation. Figures 19 and 20 show how, when combined, the IA assessment tools map to these six functional domains of the NDIS Act.

**Figure 19: Coverage of assessment domains by IA tools for ages 18+ years**

View an accessible version of this image



Source: NDIS (2020) 'Independent Assessment: Selection of Assessment Tools'. Refer to the Independent Assessments area of the NDIS website:

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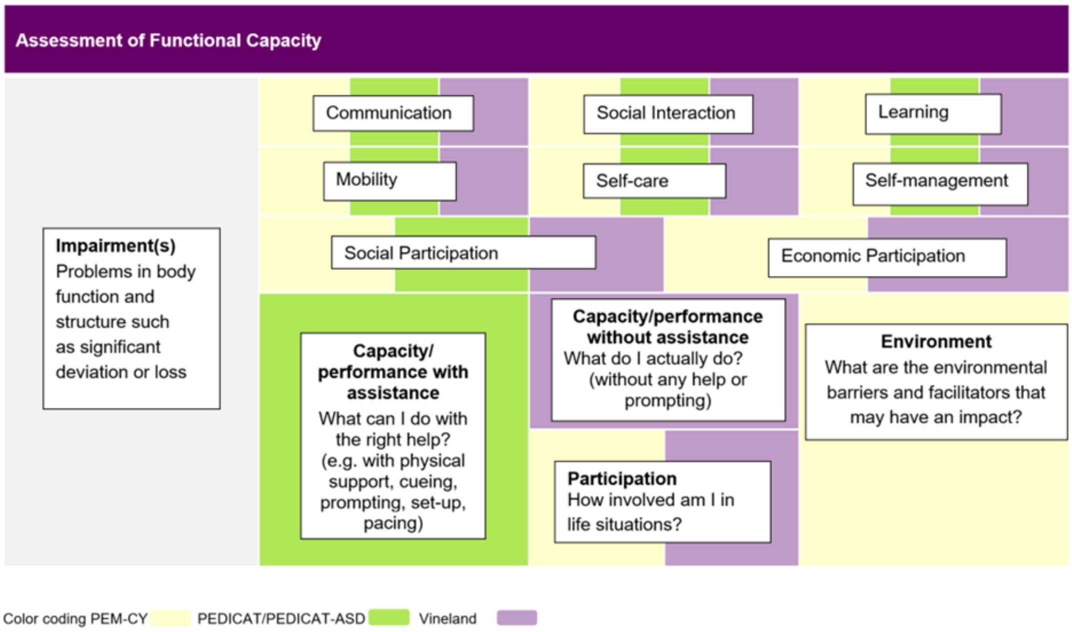
[27] Productivity Commission. (2011). Disability Care and Support, Report no. 54, Canberra.

**Figure 20: Coverage of assessment domains by IA tools for ages 7-17 years**

View an accessible version of this image



Source: NDIS (2020) 'Independent Assessment: Selection of Assessment Tools'. Refer to the Independent Assessments area of the NDIS website:

The tools selected for IAs have proven reliability and validity when used stand-alone. However, use of multiple assessment tools side by side to build an understanding of a person's function is unique. The NDIS Act requires the Agency to understand an individual's functional capacity against all six functional domains when making an access or planning decision. The Agency also endeavours to understand the environmental factors and context of the participant's daily life when making a determination of functional capacity.

The alternative of ignoring certain elements of a person's functioning for NDIS decision-making purposes carries great risk. Therefore, the solution lies in the NDIA progressively evaluating the tools, and developing a customised set of questions. This approach aligns with the advice of the Productivity Commission, which noted not to delay implementation of NDIS in the absence of the perfect tools and to use a suite of tools for this purpose[28].

This chapter **starts** the evaluation of the suite of IA tools from the perspective of assessors using the tools. The evaluation **did not** ask assessors to compare or recommend alternative tools or assessment processes. Similarly, the evaluation has not psychometrically assessed the performance of the tools in combination.

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[28] Ibid.

## 5.1 Perspectives on the assessment tools

During focus groups and interviews, assessors were asked to provide feedback on the performance of each of the assessment tools they had used. The sections below summarise the key aspects of their feedback.

### ASQ-3 or ASQ TRAK

While the sample size is low for the ASQ-3 or ASQ TRAK, assessors viewed it positively for its importance (89% always or usually) and ease of understanding and accuracy (both 78% always or usually). Confidence in answering was lower (56% always or usually) with assessors reporting parents or caregivers were often unsure if their child could do a task.

> "Difficult to complete via video as parents may not be certain if their child can complete the task, and the assessor would need to describe the task, or try to show the image on the camera to see if the participant could read, or identify shapes." *Assessor survey*

### CANS

The CANS stands out with assessors consistently rating its performance highly.

> "This tool is simple to administer and allows for clarification and explanation. I like having a degree of influence over the final rating where you can combine all of the knowledge you have gathered through the assessment." *Assessor survey*

### CHIEF

Assessors also rated the CHIEF highly for its relevance to all participants and importance. They rated it less highly for accuracy and respondent confidence in answering the questions. Specifically, assessors indicated that some participants/supporters found it difficult to decide the level of impact of environmental barriers.

> "In the CHIEF, there are a lot of questions about how much does the environment impact on what you do. But the reality is that you don't go to places that you can't access. So it doesn't pick up on how much the person has modified their life. The tools don't pick up on how you have modified your life and the things you want to do but you accept that you can't." *Independent assessor consultation*

> "I do the same [prompt and guide] a little in the CHIEF. They will talk about something and say 'Oh, I think that a little problem.' Then I will say 'It doesn't sound like a little problem. It sounds like a big problem'." *Independent assessor consultation*

### LEFS

Assessors reflected positively about the LEFS, stating respondents were generally confident with their answers. However, assessors rated the LEFS less positively on it being relevant to all participants. This is likely to reflect the use of this tool for all participants over 10 years, rather than pre-screening participants for mobility issues before administering the tool.

Assessors commented on concerns with the scoring system, the use of the tool with people who did not have mobility issues (or who have no lower limb function) and tasks that could not be completed due to a sensory or cognitive impairment rather than a mobility issue.

> "There needs to be more indication if the mobility issues are due to a motor disability. For example, lower limb as the tool is designed, or if the issues relate to other disabilities such as visual impairment. If it is going to be used as a general assessment tool, might not always collect the right information." *Assessor survey*

### PEDICAT

Assessors generally rated the PEDICAT quite highly, although noted some of the activities were not relevant for current times, such as doing up a belt buckle, tucking in a shirt or putting on gloves.

> "Out of the whole assessment suite, this was the only assessment which I felt provided a slightly more accurate picture due to a greater focus on actual function." *Assessor survey*

### PEM-CY and YC-PEM

Assessors rated the PEM-CY and YC-PEM least favourably of all the tools, specifically for children. While assessors noted the tool had some relevance and covered important areas of functional capacity, they reported it was not easily understood by participants.

> "Some parts of the assessments are difficult for the informants to understand. Some informants also reported the answers were rather vague e.g. 'sometimes yes, sometimes no'." *Assessor survey*
>
> "…I am not a fan of the PEMCY. I'm not sure how much information it give us about their disability. It tells us what they like and how they spend their time. People modify their behaviour to match what they can do and avoid everything else and I don't think the PEMCY covers that impact very well." *Independent assessor consultation*

### WHODAS

The WHODAS was among the lowest performing of the tools according to assessors. Assessors most commonly commented on the NDIA's restructuring of this tool to include answering questions with and without supports. The sexual activity question was also criticised for being blunt, not appropriate to ask in front of supporters without warning, and not appropriate for all participants based on their disability, in particular sensory disability, or their cultural situation.

### Vineland

Assessors commonly viewed the Vineland's performance particularly poorly in terms of relevance to all participants. This reflects that the NDIA required assessors to ask all domains of the Vineland, rather than just those applicable to the participant's disability.

The Vineland also received the most feedback from participants/supporters and assessors. A very small number of participants highlighted the value of a third person report.

> "At first I was not 100% comfortable with having a compulsory third party to sit in and then privately discuss my condition and I guess lifestyle; but after realised how much different and honest it is coming from someone on the outside looking in. I know I'm stubborn but for someone else to tell other people makes it much more real than I understood. I guess this is part of the transition of learning to deal with the changes in my life." *Participant, interview*

However, concerns were much more common. These related to the participant not being present when the questions are asked, the appropriateness of the questions and its use with participants who do not have a cognitive impairment and who could self-report.

> "If the person had severe intellectual disability it was usually appropriate. Otherwise, it was patronising and felt highly inappropriate. It also is very difficult to apply questions to an adult and can be quite humiliating." *Assessor, survey*
>
> "When it's supposed to be person centred, I felt very uncomfortable telling someone with a disability that they couldn't be present and we were going to talk about them. I felt it broke down the trust." *Independent assessor, focus group*

It is important to note that the Vineland is designed to be completed by someone who knows the subject of assessment well in order to provide an independent and unbiased perspective about the person's functional capacity. The NDIA used this tool according to its design.

## 5.2 The assessment packages

There were four assessment packages used in the pilot with three screened on age (under 7 years, 7 to 17 years and over 18 years) and one screened on accommodation type (SIL). Each package included four or five tools, drawn from a pool of eight tools, to ensure coverage across the functional domains of the NDIS Act and the ICF. Assessors gave feedback on the areas where they perceived challenges with each assessment package.

### 0-6 package

For the 0-6 package, assessors perceived the PEM-CY/YC-PEM as performing poorly. In interviews and focus groups, assessors raised concerns about parents/guardians having to benchmark their child against expected development when they may have insufficient experience to make this assessment. There was also concern that some tools asked questions that were above the expected developmental stage for a child's age, which could give parents/guardians the impression their child was further developmentally delayed than was the case.

> "[For young children] a lot of the questions aren't developmentally appropriate. You either have a laugh with the parents or sometimes it just tough on the parent. Just more things to pile on that the child can't do let alone that it's not developmentally appropriate yet." *Independent assessor consultation*

**7-17 package**

For the 7 to 17 package, assessors commented on the breadth of the age range, suggesting participants who have left school might be more suited to the 18+ package. It was also commonly mentioned that adolescents have very different needs to young children, and these were not addressed in the current 7 to 17 package.

> "The 7 to 17 package is like a little too broad. What a 7 year old is doing is very different to a 17 year old. Parents of teenagers wanted to talk more about their children's socialisation, accessing the community, puberty, and starting to navigate personal and sexual relationships as well. Perhaps there could be a teenage pack to address that." *Independent assessor consultation*

**Adult package**

For the adult packages, assessors commented they were not suitable for participants with sensory impairments or who relied on assistive technology. Assessors also identified that the adult packages were insensitive to conditions like multiple sclerosis that involve fatigue and/or can have fluctuating symptoms. The need for additional tools on psychosocial disability was also a common theme.

> "The packs did not fully help identify psychosocial impacts of disability, or sensory impairments such as hearing loss. I used the comments a lot for these participants, but not sure how the comments are used or assist with rating the needs." *Independent assessor, survey*

Assessor survey and interview responses indicated greater specificity was required for different cohorts than was possible with the current IA packages. It is important to note that this only reflects assessors' views, some of whom reported limited clinical experience working with people with disability and administering standardised tools. However, participants/supporters also commented that some questions were repeated between tools and some questions appeared irrelevant to participants and their support needs.

Revision of the tools into a format that asks participants/supporters only those questions that are required for decision making is likely to shorten the length of the assessment, improve participant/supporter experience, and improve the perceived performance of IAs.

## 5.3 Other components of the assessment packages

Participants, their supporters and assessors, also commented on two other components of the assessment packages; the participant information form and the interaction activity. This section summarises those comments.

### 5.3.1 Participant information form

Each assessment package included an information section developed by the NDIA to collect additional data about the participant and their support needs. One group of questions asks the participant's support needs in hours across an average week for a broad range of activities (including planning and making decisions, personal care, domestic tasks, travel, and community participation). The participant is then asked the proportion of care provided by informal carers and their willingness to continue. In the participant and supporter interviews, 20% of informants said they would have liked prior notice about the calculation of these hours and percentages.

> "I still panic sometimes that it will and the assessment was quite inaccurate. I remembered a lot more things afterwards that I should have said, particularly around the hours of support. The questions are just thrown at you without notice. Like how much support does my wife give me? You have to think about that. What is part of the relationship and what is because of the disability?" *Participant interview*

Assessors developed their approaches to assist participants and their supporters complete this section. This commonly included lists and examples. Without a common, systematic approach, it is likely that different approaches (and lists) will generate different results.

> "It would be best to have the components that go into the hours broken down. I usually make my own list so I can say what about sitting in the car, shopping and stuff. So I sort of break it into categories for them." *Independent assessor consultation*

### 5.3.2 The participant interaction activity

The NDIA designed the interaction activity to be conducted at the start of the IA meeting, to allow the assessor to observe the participant and learn a little about them. The guidelines suggest the interaction should take about 20 minutes, with no specific minimum or maximum, and include something 'as active as possible such as a leisure activity or hobby, like scrap booking, or kitchen task such as making a cup of tea or a snack.'

In the interviews, some participants/supporters (22%) raised concerns about the interaction activity, the 'silly' nature of some tasks they were asked to do and that they generally felt the interaction needed to be better introduced. It was also noted by some that the interaction activity was not reflective of their functional capacity in their day-to-day routines such as school, work or in the community.

Some assessors suggested the interaction session could be used later in the assessment to provide participants and their supporters with a break from the more structured question and answer components of the assessment. They also noted the interaction could be used in a more natural way by observing the participant during a coffee break. Similarly, if used later, the interaction could explore or expand on areas of capacity the assessor had observed incidentally during the assessment.

> "It is important to realise you are gathering information the whole time you are there. You need to keep your head up and be observant. There is lots going on that you can pick up on and it's obviously a lot more natural that if you ask them to do something"
> *Independent assessor*

Assessors commented that the interaction activity is an area impacted by the assessor's clinical experience and profession, demonstrated in the choice of activity and the depth of the report made against the six NDIS activity areas.

> "The participant observation is an area that is really different between assessors. You focus on those areas that are most allied to your profession." Independent assessor consultation

**Consideration 12**

Further assessor training, involving people with a lived experience of disability, on the participant interaction activity is required to ensure it is relevant to the participant's disability and reflective of their functional capacity. Observations should also be obtained and recorded during the entire assessment, which would help lift IAs to more of an interactive assessment rather than just questions and answers and task observation.

# 6. Conclusions

This chapter presents the conclusions from the NDIA's evaluation of IAP2 and considerations for either continued testing or broader rollout of IAs.

## 6.1 Participant experience

### 6.1.1 Overall participant experience

Participants/supporters generally reported a reasonably positive rating of their overall experience with the IA (46% excellent/very good). There were a number of areas where IAs worked well for participants, including the face to face contact, in-home visits and the use of allied health professionals as assessors. However, there are a number of areas where IAs may be refined to improve the experience of participants and their supporters. These are discussed below.

### 6.1.2 Length of the assessment

While 60% of participants/supporters thought the length of the assessment was 'about right,' with an average assessment length of around 3:20 hours, 35% of participants thought it was too long. IAs with participants who have autism, psychosocial or sensory disability were slightly more likely to have reported the IA as being too long.

Some participants or supporters commented in interviews that they found at least some of the questions asked irrelevant to their disability or life stage, which probably contributed to the feeling that the IA was too long. Revision of the tools into a format that supports assessors using their clinical judgement to ask participants/supporters only those questions relevant for the participant would have a substantial impact on the length of the assessment and the participant/ supporter experience. The minimum set of questions (or topics) could be identified through a psychometric analysis of the IA results. This analysis may also be able to identify any potential gaps in the assessment packages.

Aside from developing shorter assessment packages, one option to shorten IAs is to offer participants the option to have their IA over two sessions. While this is allowed, suppliers very rarely offered IAP2 participants this option. Furthermore, once an assessment had started, participants/supporters were reluctant to schedule a second visit. Assessors themselves suggested that two visits should be scheduled from the start for assessments where it can be predicted that the assessments will take longer, for example with children under 7 years, where the assessments are designed to take four hours.

Another option some participants/ supporters suggested in interviews was to allow some aspects of IAs to be done in advance, and only checked by the assessor during the meeting. In particular this could apply to time-based questions about informal supports, and possibly the Vineland.

This pre-assessment activity could also be used to give participants/supporters notice of questions that might take some time to think about (such as the hours of support for different activities, or whether a change is desired or likely in informal support arrangements). This would also provide suppliers with data to allocate assessors (particularly at initial access, where little information may be known about the participant).

### 6.1.3 The approach to conducting IAs

A cornerstone of the current approach to IAs is the use of a set of standardised tools delivered in a consistent way by different assessors to provide reliable and valid results. For a combination of reasons, including a lack of clinical training in pilot administration, entrenched clinical practice, and a desire to provide participants/supporters with an improved experience, managers and assessors described several different approaches to conducting the assessments.

The impact of these different approaches, if any, on the reliability or accuracy of data is not measureable unless the NDIA identifies the approach each assessor uses for each IA, which is not practical. The presence of different approaches to administering the assessment packs calls for further work to improve assessor consistency and reliability through more formal training. Improving the platform and design of the assessment packs will also help to promote consistency.

### 6.1.4 Bookings and information

The booking process was a key source of information and communication for participants and their support person/s about the pilot. Participants/supporters having sufficient information about what to expect from their IA was found to be important to having a positive experience.

IAP2 suppliers managed the booking process, using NDIA provided communication materials and scripts. While the booking process was successful, when surveyed after the assessment, around a quarter of participants/supporters felt more information was needed upfront so they knew what to expect from an IA. Participants/supporters were also interested in information about the questions and being warned about sensitive topics. This could affect the participant’s choice of support person invited to the assessment and/or what they prepared for the assessment (such as calculations of support hours).

A further issue identified during participant/supporter interviews was some uncertainty about the purpose of IAP2 and how their pilot IA data would be used. Some participants were under the impression their IAs would be used as part of their next plan review, which is not the case.

### 6.1.5 Independent assessment results

Three-quarters of participants/supporters who answered survey questions about their IA reports felt their IA results were an excellent to good reflection of their IA meeting. However, 35% of respondents rated their results as a poor or fair reflection of their functional capacity, a sentiment noted in qualitative feedback. It is unclear if this reflects the way the NDIA presented IA results back to participants, or if it reflects concerns with the way IAs are conducted and/or the assessment tools themselves. In either case, it is an area of concern.

Not surprisingly, participant experience survey and interview responses identified that limiting complex terminology or jargon, and including a description of the ranges used to describe abilities would be an improvement. However, participant/supporter sentiment also suggested a desire for more tailored and holistic reports. These reports would include aspects such as current and likely future support needs (linking back to their NDIS plan), and the impact of the participant's disability on their families.

While these comments highlight participant/supporter preferences, they also indicate a limited end-to-end understanding of the future Scheme reforms and the role of IAs. This, coupled with expectations based on reports from previous functional capacity assessments, is likely to be responsible for some of the negative sentiment towards IA reports, and perhaps IAs in general.

### 6.1.6 Allocating assessors to participants with certain disabilities

Analysis of responses to the participant experience survey and participant/supporter interviews highlighted it was important that participants perceived their assessor knew their disability and how it affected their life. If a participant/supporter did not believe this was the case, they were unlikely to have a positive experience with their IA. Participant experience survey responses indicated only 53% of respondents felt their assessor knew a lot about their disability.

The evaluation cannot conclude that certain professional disciplines are better suited to assessing participants with certain disabilities. This will require a greater volume of relevant data to confidently make conclusions. In some cases though, pairings are intuitive, such as using Psychologists to assess people with psychosocial disability.

The NDIA did not stipulate the extent of prior experience working with people with disability assessors required. However, managers from suppliers commented that allied health professionals are competent to work across a range of disability, rather than a more narrow scope of practice that might be inferred from their qualifications. As part of IAP2, just over 200 allied health professionals delivered IAs, with assessors from each professional discipline completing IAs with participants with a range of disabilities. Where the workforce was available, suppliers noted they triaged participants to the most appropriate assessor based on both the occupation and experience of the assessor.

However, it was clear from the assessor survey that the pool of IAP2 assessors who responded to the assessor survey had variable clinical experience working with people with various types of disability. This was especially evident for sensory disability, and some of the larger cohorts of NDIS participants, such as those with intellectual disability, a psychosocial disability or autism.

This limited experience appeared to be an issue for some participants, especially those with a sensory or psychosocial disability who reported the least positive experiences of any disability group. These cohorts were also the least likely to report that their assessor seemed to know about their disability, although this was not high for any cohort.

Generally, the assessors consulted commented that some participant cohorts would benefit from an assessor experienced or qualified with their disability. This includes psychosocial disability, young children and participants with complex conditions. This suggests that in some instances, assessors lack the confidence to accurately assess some cohorts.

Having a large pool of assessors, coupled with a planned future assessor credentialing system, should mean that suitably experienced assessors are available to conduct IAs with most participants. However, the apparently narrow range of disability experience amongst the IAP2 assessor workforce could challenge this theory, especially when IAs are rolled out nationally.

## 6.2 Assessor training and quality assurance

The NDIA developed IAs with the intent that any experienced allied health professional with relevant IA training could administer the suite of assessment tools to the majority of individuals, irrespective of the nature of their disability. However, assessor survey responses indicated assessors from some professional disciplines had limited experience administering standardised tools and working with some disability types.

Generally, suppliers were positive about the training provided by the NDIA, but wanted a stronger focus on the practical administration including:

- How to check for internal consistency
- Working effectively with people with different disabilities
- How IA data is to be used

Assessors also wanted more opportunities for experiential learning, particularly across different disability groups where they may have less experience. The common sentiment from participants that their assessor did not seem to know much about their disability reinforces this need, in the absence of better assessor allocation. Suppliers should ensure assessors are trained in using contemporary disability and strengths based language, and culturally safe practices relevant to the participants they assess. This would help to ensure IAs are delivered by assessors with the necessary competence, using a contemporary approach. This should help maximise the experience of participants having an IA.

Automated checks on a sample of around 800 IAs identified potential challenges for assessors to deliver quality IAs. Around three quarters of the sample failed between 1 and 10 quality checks, most commonly because assessment tools were incomplete or due to some form of internal inconsistency. For almost one quarter of the sampled IAs, issues were serious enough for the assessment pack to be returned to the supplier/assessor for remediation.

Surprisingly, the likelihood of failing a quality check increased as assessors delivered more IAs. This suggests that as assessors became familiar with the tools, they used their clinical judgement to streamline assessments and skip questions that were irrelevant for the participants. However, it cannot be ruled out that the Microsoft Excel based platform the NDIA provided assessors contributed to failed checks, with assessors commenting that they found the tools difficult to administer in the format provided.

The NDIA is building an online assessment platform to support assessors’ use of clinical judgement and to only ask those questions relevant to the participant based on their disability, life stage and answers to previous questions. This will improve participant experience, should ensure assessors enter data accurately, and make it easier for the NDIA to identify quality issues. However, the NDIA also needs to strengthen training around using the tools as the high percentage of sampled IAs requiring mediation cannot be solely attributed to the delivery platform used in IAP2.

## 6.3 IA assessment tools and packages

In this report, the main source of evidence for reviewing assessment packages and tools was drawn from suppliers (managers and assessors) with some qualitative data from participants/supporters and quality review data.

Feedback from assessors indicated the CANS, PEDICAT and ASQ were well regarded. Conversely, assessors rated the WHODAS, Vineland, and especially the PEM-CY/YC-PEM less positively. While assessors felt the PEM-CY/YC-PEM had some relevance and covered important areas of functional capacity, they reported it was not easily understood by participants, and parents/carers had difficulty benchmarking their children against age-specific norms.

The WHODAS was also singled out for comment by participants/supporters. Some questions were seen as ambiguous, others too sensitive (especially those about sexual activity), and the tool did not identify functional capacity accurately for people with sensory disability.

The Vineland received the most feedback from participants, their supporters and assessors. Concerns related to the participant not being present when the questions were asked, the age appropriateness of the questions and its use with participants who did not have a cognitive impairment and who could self-report were all noted. Notwithstanding that this mode of assessment reflects the tools design, participant concerns highlight that this tool might not be acceptable for all participants.

Consultation with assessors suggested a number of challenges with the assessment packs, most notably that the tools within each package were not designed to be administered together, resulting in a large amount of duplication and inconsistency in language, time references, scales and appropriateness for different disability groups and ages. This is reflective of the need for IAs to assess functional capacity against all six functional domains of the NDIS Act. At present, achieving this requires using a suite of commercial tools, some of which are copyright protected. However, this approach clearly introduces repetition, increases the duration of IAs and places an increased cognitive burden on participants/supporters.

This highlights the need for ongoing evaluation and development of IA packages, as anticipated by the Productivity Commission[29].

The participant interaction activity received mixed feedback from both participants/supporters and assessors. Participants raised concerns that the tasks they were asked to do were not reflective of their functional capacity in their daily routines, and assessors asked for more training and guidance. As part of improving IA packages, the

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[29] Productivity Commission. (2011). Disability Care and Support, Report no. 54, Canberra.

NDIA should ensure that participants have the option of choosing an activity that is reflective of their functioning in a range of contexts. Assessors should also observe and interact throughout the entire assessment, which would help lift IAs to more of a clinical assessment rather than just questions and answers and task observation. This could also help alleviate some of the criticism from participants about the relevance of IAs in their current format.

# Appendix A Assessment tools

### Ages and Stages Questionnaire (ASQ 3) (Under 7 and only with developmental delay diagnosis)

The Ages and Stages Questionnaire is a developmental screening tool where the assessor asks questions about whether a child is regularly, sometimes or not yet completing different activities. The activities in the questionnaire are about different areas of a child's development, including gross motor skills, fine motor skills, problem solving sills and personal social skills.

The Ages and Stages Questionnaire highlights a child's strengths as well as any concerns care givers may have and relies on care givers being the expert in knowing the child.

### CANS – Care and Needs Scale (18+)

The CANS is an assessment where the assessor asks 28 questions about the type of care and support the participant needs for different activities and areas of their life. The assessment looks at many areas, including support needs for personal care, meal preparation, shopping, and leisure and recreation among others.

### CHIEF - Craig Hospital Inventory of Environmental Factors (18+)

The CHIEF asks the participant questions about their environment and possible barriers the participant may face at home, work or in the community.

It considers the following environmental areas:

- Attitude and support
- Service and assistance
- Physical and structural
- Policy
- Work and school

The participant is asked how often they have faced these barriers over the last 12 months and if they caused little or big problems. The preference is to ask the questions of the participant, and if this is not possible, a person who knows the participant well.

### LEFS

LEFS is a questionnaire containing 20 questions about a person's difficulty with performing everyday tasks. If there are concerns about mobility, the assessor asks how much difficulty is associated with completing different activities. The preference is to ask the questions of the participant, and if this is not possible, with a person who knows the participant well.

**PEDI-CAT or PEDI-CAT ASD (7+)**

The Paediatric Evaluation of Disability Inventory- Computer Adaptive Test is an assessment that asks questions about what activities a child can do and whether they need extra time and support. The assessor asks questions about the child's physical skills, how they interact with others, problem solving (except for children under 3 years of age) and completing self-care activities. If the child has a confirmed diagnosis of Autism Spectrum Disorder, then the PEDI-CAT ASD version is used, which asks some additional questions.

**PEM-CY and YC-PEM**

The Participant and Environment Measure for Children and Youth is an assessment that asks questions about a child's participation in everyday activities at home, school and in community settings. It aims to identify aspects of the environment which impact participation across these areas.

The Young Children-Participant and Environment Measure is a tool that asks questions about a child's participation and involvement in everyday activities at home, preschool/day-care and in community settings. It aims to identify aspects of the environment which impact participation across these areas.

**Vineland 3 (Domain and Comprehensive)**

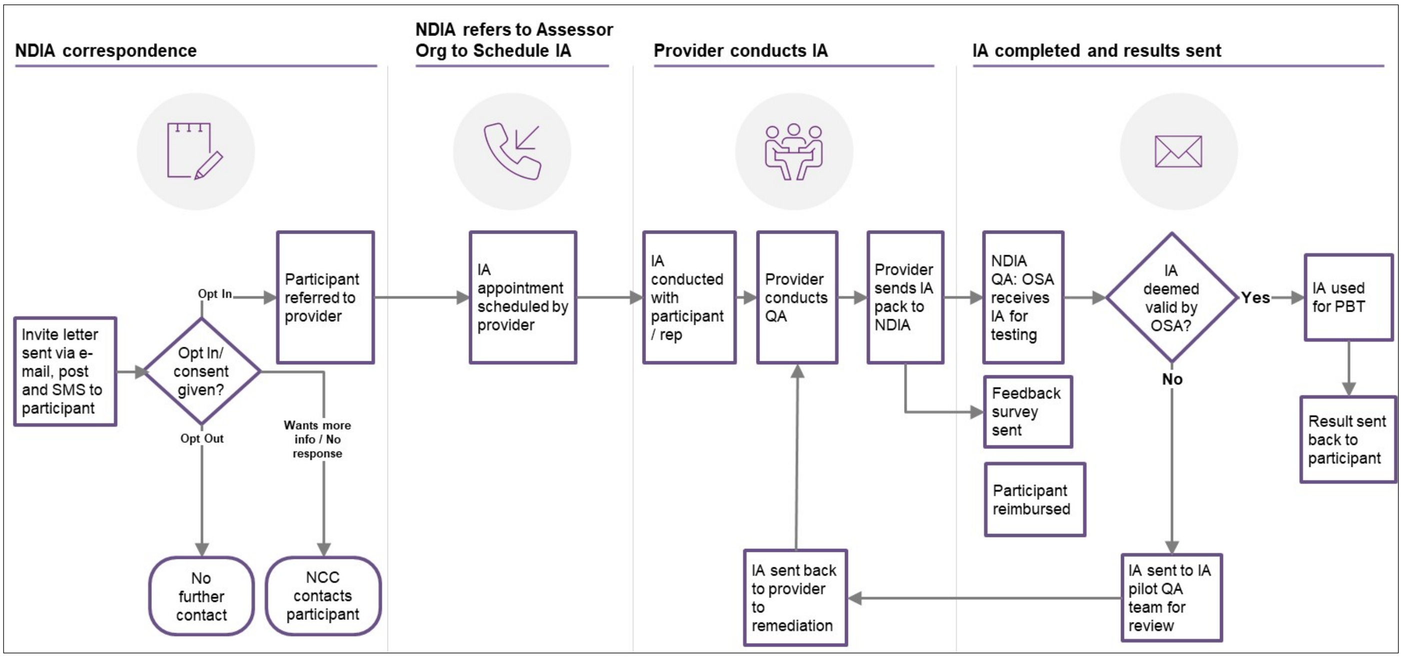
The Vineland 3 comprehensive is an assessment where the assessor asks questions about how a child is able to communicate with others, complete daily living skills, socialise with others and do motor skills without help or prompting. The assessment also asks questions about complex behaviours for children over 3 years and maladaptive behaviour. This assessment is designed to be completed without the child present (due to the nature of some questions). The Vineland 3 Domain-level is the abbreviated version of this tool.

**WHODAS 2.0 36 Question (18+, SIL)**

The WHODAS 2.0 (World Health Organisation Disability Assessment Schedule 2.0) is an assessment where the assessor asks participants questions about how well they have been able to do things with and without the support of another person over the past 30 days. The questions focus on:

- Cognition - understanding and communicating
- Mobility – moving and getting around
- Self-Care – bathing, dressing, eating and staying alone
- Getting along with people who are close to the participant
- Life Activities – domestic responsibilities, leisure, work and school
- Participation – Joining in community activities

# Appendix B End to end IA service model



Source: NDIA Service Design and Outcomes Branch

# Appendix C Validation summary

The following presents a summary of the validation of this evaluation by the Centre for Disability Studies and the Centre for Disability Research and Policy at the University of Sydney.

## Overall assessment of the NDIA report

The evaluation design and process meets the objectives set out within scope by the NDIA.

The independent qualitative analysis conducted by the University of Sydney team confirms the findings from the NDIA as presented in the report. This confirmation should be read in the context of the project aims and limitations, as discussed in the full validation report.

From the quantitative perspective, overall a sound survey design was used, with some minor points of improvement noted. Further measures to ensure accessibility for people with intellectual disability is advised.

The NDIA evaluation team were open and responsive to all questions and queries. They freely shared all data with the University of Sydney team. The final report represents an iterative process of engagement with the data, feedback and queries, responses and clarifications, between both parties and refinement of final assessment of process and findings.

## General statement on project limitations

All research and evaluation is limited by the circumstances in which data is collected and analysed. It is never an objective replication of what has occurred. It is an important and standard, part of validation of results that any possible limitations of a study are recognised and reported alongside outcomes data. This is a normal part of reporting research results – results must be read in the context in which they were collected and analysed. The limitations that we have recognised in relation to the data presented here are therefore offered as part of our data validation.

## Assessment of evaluation acceptability

Akkerman et al (2008)[30] describe a framework for understanding the credibility of an evaluation process based on three criteria:

- Visibility – i.e. the evaluators make linkages between methods, data and findings visible.
- Comprehensibility – i.e. evaluation findings can be substantiated by the data gathered and the analysis of that data.
- Acceptability – the methods used to gather and analyse data are logical and scientifically sound.

The tables below use this framework to present an overview of findings from the combined qualitative and quantitative validation exercise. It should be read in tandem with the full validation report for completeness.

### Data gathering and storage

| Criteria | Visibility | Comprehensibility | Acceptability |
|---|---|---|---|
| Quantitative planned | Data collection aims and processes were clear and structured. | Sound survey design used. Further detail on sampling frame and consent would be of benefit to the reader.<br>The second Pilot attempted to include broader range of disability types and have more diverse sampling composition than the previous Independent Assessment Pilot. | Sampling limitations and response bias in survey respondents noted and acknowledged in the report.<br>Underrepresentation of some cohorts can be addressed with future data collection which the NDIA are planning. The NDIA interpreted data in the context of sample achieved and not as representative sample of all NDIS participants. Therefore the findings as presented in the report are acceptable. |
| Quantitative realised | Evaluation aims and questions asked were explained to participants. | Survey design was uncomplicated and in general user friendly. However, not in easy read format for people with intellectual disability or other cognitive challenges. | The design of quantitative evaluation design and process adequately meets the objectives as set out by the NDIA. |
| Qualitative planned | Data collection aims and processes were clear and structured. | The data gathering processes were comprehensible from a standard research design process. | Acceptable but note: 1) interview participants were identifiable to the NDIA Evaluation Team from their responses, however survey respondents were only visible if they voluntarily offered their NDIS number and/or name; 2) data collection was conducted by NDIA employees. |

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[30] Akkerman, S., Admiraal, W., Brekelmans, M., & Oost, H. (2008). Auditing quality of research in social sciences. *Quality & Quantity*, *42*(2), 257-274.

| Criteria | Visibility | Comprehensibility | Acceptability |
|---|---|---|---|
| Qualitative realised | Evaluation aims and questions asked were explained to participants. | The data gathering was accessible and comprehensible. However, the responses of some participants shows that they may not have fully understood the questions asked (e.g. large number of off-topic responses in Survey 2). The data as presented in the report is a good reflection of participant responses. | Overall the research data collection was acceptable. Further details are outlined in the full validation report. |

### Data analysis and reporting

| Criteria | Visibility | Comprehensibility | Acceptability |
|---|---|---|---|
| Quantitative planned | Data files in excel, syntax for regression and other graphs and table output provided for review. Standard formatting and coding of quantitative data.<br>Additional information and points of clarity provided where requested. | Analysis conducted fits with the design of survey and nature of the data collected. Shapley is not common in health and social sciences, more prominent in market research and consumer satisfaction. Justification for this choice provided. | Data analysis was acceptable. Further mining of the dataset possible with more time.<br>Limitations of sample size and sample composition are acknowledged and inform the interpretation of findings. |
| Quantitative realised | Some quality issues with format and content upon export. These were addressed in the data cleaning process.<br>University of Sydney reported results based on self-report data alone while NDIA reported on self-report linked governance data. This was not clear from the outset. | Analysis ran as planned. Noted limitations in within group comparisons identified and addressed with point prevalence data presented and Shapley presented as average of participants. Provides some insights but limited by no disaggregation by cohort, which was impacted by sample size.<br>Additional analysis could be performed using alternative regressions to show most significant factors in a satisfactory independent assessment experience. This was not set out a goal of the current review but would provide NDIA additional useful insights in future. | Overall data presented clearly. Sample size included within the data chapters shows extent of missing values (low) and allows interpretation of results of realised sample. This could be extended to other sections of report such as executive summary. Inconsistencies in point prevalence are minimal and likely relate to differences in handling of missing data, and the use of linked governance data set by NDIA and self-report only data by the University of Sydney. |

| Criteria | Visibility | Comprehensibility | Acceptability |
|---|---|---|---|
| | | More disability groupings were included in this sample composition than previous pilot with varying levels of success (see participant profile in Appendix E) | |
| Qualitative planned | The coding frame developed by the NDIA made coding decisions visible to coders. | Coding frames made sense in relation to the aims of the second Independent Assessment Pilot evaluation. | Both the NDIA's approach to qualitative data analysis and approach to report findings was acceptable given the nature of the data gathered and the assurances given to participants. The full validation report identifies limitations overall. |
| Qualitative realised | Coding took place according to the coding scheme developed. | There was high level of agreement (97%) between NDIA and University of Sydney coders across all qualitative data. Discrepancies related to different interpretations of the coding frame that led to a small variation in the final sets of codes. Further details are provided in the full validation report.<br>The NDIA's reporting of qualitative data reflected participant responses. | Coding took place according to the coding scheme developed. |

# Appendix D  Online surveys

## Participant experience survey

This survey asks questions about your recent experience with the free independent assessment organised by the National Disability Insurance Agency (NDIA). The survey will take you about 10 to 15 minutes to fill in.

By filling in this survey you will be helping the NDIA to make the independent assessment process better for people in the future.

You don't have to do the survey if you don’t want to. If you choose to do the survey, your feedback is private and confidential.

You don’t have to give us your name if you don’t want to. If you do give us your name, we won’t tell anyone what you said.

Your decision to do the survey or not won’t affect any of the support or funding you receive.

If you have any questions or comments about the survey you can email the NDIA at: research@ndis.gov.au and give this number: 20020 REB.

Information about how we handle your responses can be found in the NDIS Privacy Policy (www.ndis.gov.au/about-us/policies/privacy).

By answering the question below, you agree that you understand this information, you are over 18 years old and you are willing to continue to the survey.

Are you ready to enter the survey?*

**Yes**

**No, I need more information - Go to PIF**

**No, I might do it later – Go to end**

**Q1. Who are you?**

I am the participant

I am the spouse or partner of the participant

I am the mother or father of the participant

I am the brother or sister of the participant

I am a child of the participant

I am another family member of the participant

I am a friend

I am a support worker

I am someone else

**If the person completing the survey is not the participant ask Q2 and show text box**

**Q2. Are you the nominee or guardian of the participant?**

No

Yes - I am the nominee

Yes - I am the guardian

**If you are supporting an NDIS participant, you may want to talk to them about their experience before answering the survey on their behalf.**

**Q3. Who employed the assessor that did your independent assessment?**

APM Australia

HealthStrong

Plena Healthcare/ Allied Care Group

Not sure

**Q4. When you were invited to have an independent assessment, do you think you got all the information and help you needed from the NDIA to decide what to do?**

Yes/No

**Q5. What other information or help would you have liked from the NDIA?**
<Open text>

**Q6. How did you have your independent assessment?**
At a face to face meeting

Online/videoconference (through a smart phone or computer)

By telephone (voice only)

**Q7. Where were you when you had the independent assessment?**

At home

At work

At school

At the assessor's office

Somewhere else

**Q8. Did you have a choice about where you had the assessment?**

Yes/No

**Q9. How many times did you meet with the assessor to do the independent assessment?**

One time

Two times

Three times

Four times or more

**Booking your appointment**

**Q10. Did the person booking your independent assessment do the following?**

a. Make sure the assessment was on a date and time that was good for you

b. Explain you could have someone with you if you wished

c. Explain that one of the assessments might need to be done by someone who knows you well

d. Tell you how long the assessment will take

e. Give you enough information to know what to expect from the assessment

f. Give you enough time to get ready for the assessment (for example, to get someone to support you, make any child care, school or work plans you needed)

g. Fully answer any questions you had about the assessment

**Q11. What other information would you have liked when booking your independent assessment?**

<Open text>

**About the assessor**

**Q12. What was your experience of the independent assessor in the following areas?**

a. The assessor seemed prepared for your meeting

b. The assessor seemed to know a lot about your disability

c. The assessor understood how your disability affects your life

d. The assessor was sensitive to your values and beliefs

**Q13. During your assessment, did the independent assessor do the following?**

a. Arrive on time for your meeting

b. Tell you clearly what would happen during the assessment

c. Treat you with respect

d. Listen to what you had to say

e. Ask if you needed a break

f. Answer any questions you had

g. Talk to you (even if someone else was present)

h. Give you the chance to talk about all the areas where you needed support or help

**Q14. Was there anything you wanted to talk about with the independent assessor that was not covered in the assessment?**

<Open text>

### The independent assessment

**Q15. These questions ask how you felt about the independent assessment**

a. Were you comfortable with the questions the assessor asked?

b. Were the questions easy to answer?

c. Did the assessment cover all of the areas important to you where you need help or support?

d. Were you ok with the activities the assessor asked you to do?

e. Were the questions culturally appropriate?

f. Do you think your independent assessment gave an accurate picture of your skills and ability?

**Q16. How long did the assessment take (across all sessions)?**

_____ hours _____minutes

**Q17. How did you feel about the length of the assessment?**

It was too long

It was about right

It was too short

**Q18. Is there anything else you would like to tell us about the assessment?**

<open text>

### SATISFACTION WITH THE INDEPENDENT ASSESSMENT

**Q19. How would you rate your experience of the independent assessment in the following areas? Rating options: Poor, Fair, Good, Very good, Excellent**

a. The process of booking the assessment

b. The way the assessment was done (including the assessments used, time taken, etc.)

c. The professionalism of the assessor

d. The independent assessment overall

**Q20. What were the worst things about having an independent assessment?**

<open text>

**Q21. What were the best things about having an independent assessment?**

<open text>

**Q22. Would you recommend independent assessments to other participants?**

Yes/No

**Q23. Why do you say that?**

<open text>

### About you

It would help us to understand your experiences better if you would answer some questions about yourself. (If you are completing this survey for the participant, please fill out the **participant's details**). Remember, this information will be treated as confidential.

**Q24. What is the participant's gender?**

Male

Female

Other

Prefer not to answer

**Q25. How old is the participant?**

**Q26. What is your postcode?**

**Q27. What is the main language you speak at home?**

English

Other <please specify>

Prefer not to answer

**Q28. Are you of Aboriginal and/or Torres Strait Islander descent?**

No

Aboriginal

Torres Strait Islander

Aboriginal and Torres Strait Islander

**Q29. What do you feel is your primary disability at the moment? (select one)**

**Q30. What other disabilities do you have? (select all that apply)**

None

Acquired brain injury

Autism

Cerebral palsy

Developmental delay

Down syndrome

Global developmental delay

Hearing impairment or deaf

Intellectual disability

Multiple sclerosis

Psychosocial disability

Spinal cord injury

Stroke

Visual impairment

Other neurological

Other physical

Other sensory/speech

Other

**More information**

You can choose to provide your feedback anonymously if you wish. However, it would help us to understand your experience if we could access some information from your NDIS records about you and your plan.

**Q31. If we need to, can we use your data on our files? We will not use your name in our reporting or show your personal records to anyone.**

Yes/No

**Q32. Please type in your full name and NDIS participant identification number (if you know it).**

Participant's name:

NDIS ID (OPTIONAL):

**We will also be conducting interviews with some participants (or their representatives) so that we can understand their experience with independent**

**assessments in more depth. The interviews will be on the phone or online and take about 15 minutes.**

**Q33. If we need to, can we talk with you more about your experience with the independent assessment?**

Yes/No

**If yes at Q33 go to Q34 else skip to end**

**Q34. What is your preferred name?**

**Q35. How would you prefer we contact you if we need to?**

I would prefer an online or video call. My email address is

I would prefer a telephone call. My phone number is

I would prefer a different way of being contacted. My preferred way is

**End**. Thank you for your time. Your responses will help the NDIA improve independent assessments for everyone.

## Additional questions for participants about their IA results

**Q1. Have you received the results from your independent assessment?**

No

Yes

Not sure

If the person completing the survey responds no or not sure, exit the survey with the message: “Thank you, we want to get your feedback on your results from your independent assessment. Please do come back and complete the survey once you’ve received your independent assessment report.”

**Q2. How would you rate your independent assessment report in the following areas? Rating options: Poor, Fair, Good, Very good, Excellent**

a. Accurately reflecting what you told your assessor during your meeting

b. Accurately reflecting your functional capacity

**Q3. How did you feel about the amount of information in your report?**

There was too much information

It was about right

There was not enough information

**Q4. Is there anything that you think is missing from your independent assessment report?**

No

Yes <please specify>

**Q5.** What changes do you think would improve independent assessment reports for participants in the future?

<open text>

Note… the survey introduction and demographic questions were the same as the participant experience survey above.

# Short title: Independent Assessment Survey

# Participant Information

**Survey information for:**

- NDIS participants who have had an Independent Assessment during the Pilot

This document explains the survey so you can decide if you would like to take part.

You can read this information with someone else if you like.

## 1. Who is doing this survey?

This survey is being conducted by the NDIA Research and Evaluation Branch.

## 2. What is this survey about?

You recently had an independent assessment. Now we are asking you to complete a 10 to 15 minute survey about your experience with the assessment. You don't have to complete the survey if you don't want to, but if you do it will help us to improve the assessment process for other participants in the future.

The survey asks questions about different parts of the independent assessment process, including:

- The information and appointment making process
- The type of questions you were asked
- The communication and skills of the assessor
- The usefulness of the report you received.

## 3. Who can take part in this survey?

Only people who have had an independent assessment, or supported someone to have an independent assessment during the Pilot can take part in this survey.

You may wish to talk your involvement in the survey with a family member or support person. If you are someone who supports a NDIS participant, you may want to talk with them before agreeing to do the survey and see what they want to do.

## 4. Can I choose how I do the survey?

The survey is online. You can ask someone to help you complete the survey if you like.  We can also help you to complete the survey over the phone. If you would like to make an appointment to do the survey on the phone, please email research@ndis.gov.au and quote this number 20020 REB. Don't forget to give your telephone number and we will call you back.

## 5. Are there supports for me?

Yes. Please let us know if there is anything we can do to help you feel more comfortable doing the survey.

## 6. Will the evaluators have access to information about me and my NDIS plan?

This is your choice. The evaluators will only have access to the information you choose to provide.  If you wish, you can complete the survey anonymously.

The survey includes information about your disability and personal characteristics such as age and gender.  You don't have to do these questions if you don't want to. If you do choose to answer, this information will be included in a data set to help us understand the experience of different groups of people.

The survey includes an option to provide your name and NDIA number so that we can use your NDIS records to get statistical data to help us in analysing the results of the survey. This might include information about other assessments you have had, your plan management or budget. This information will help us understand how well the independent assessments work for different types of participants. You don't have to provide this information if you don't want to.

## 7. Do I have to complete the survey?

No. You do not have to complete the survey if you don't want to. If you agree then change your mind, you can close your internet browser before you select 'submit' on the final page and your information will not be saved.

## 8. Are there any risks to me if I complete the survey?

If you had a poor experience with the independent assessment, there is a small risk that you might feel upset doing the survey. If you do find that any of the questions in the survey are upsetting, you don't have to answer them. You can stop the survey at any time.

## 9. What will you do with the information I give you?

We will remove any contact details from your survey and keep the data in a separate folder to your answers. All information will be kept on a password protected computer. Only the evaluators will be able to see this information.

We will write a report about the experiences of all of the people who completed a survey. This report will not identify you. The report will be used by the NDIA to improve the independent assessment process and how the information from assessments is used in the future.

The survey will be conducted in accordance with Australian privacy laws. This survey has approval as a Quality Improvement project from the NDIA Research and Evaluation Office.

A report about the evaluation of the independent assessments will be published on the NDIS website.

## 10. Will the NDIS, my planner, or Local Area Coordinator know that I completed a survey?

No. The NDIS will not know that you did the survey or what you told us about the independent assessment.

## 11. Can I speak to someone about this survey?

If you have questions about this survey you can contact the survey coordinator.

To verify this survey you can call the NDIS on 1800 800 110.

## 12. Can I complain to someone about this survey?

If you have any complaints about this survey, you can email the NDIA at: research@ndis.gov.au and quote this number 20020 REB.

Thank you for your time.

## Assessor survey

Welcome to the Assessor Survey for the Independent Assessment Pilot. We are seeking your expert views and opinions to help improve the efficiency and effectiveness of the independent assessment process for participants, the people who support them in this process, and assessors.

Depending on the range of assessments you have conducted, the survey should take to 20 minutes to complete.

Please be assured that we are not evaluating your performance, or that of your employer, but the processes established by the NDIA to pilot independent assessments.

If you have any questions or comments about the survey you can email the NDIA.

If you have any concerns about this project or its bona fides, you can contact the NDIA research office.

Further information about how we handle your data can be found in the NDIS Privacy Policy**.**

Are you ready to enter the survey?

Yes

No, I need more information - **go to further information**

No (close the browser to leave now) – **go to end**

Please note that you must select 'submit' at the end of the survey for your responses to be recorded.

# Further Information

This page explains more about the assessor survey so you can decide if you would like to take part.

## 1. Who is doing this survey?

This survey is being conducted by the NDIA Research and Evaluation Branch.

## 2. What is this survey about?

The NDIA is evaluating the second Independent Assessment Pilot ahead of the national roll out of independent assessments later this year. As an independent assessor, you are in a unique position to provide your experience and professional insights on the pilot. This information will be used to improve the independent assessment process for assessors, participants and their family, friends and workers who support them through the process. It will also help us to understand the validity and reliability of the independent assessment reports.

The evaluation is not reviewing your individual performance or that of your employer. The focus of the evaluation is on the processes and materials used by the NDIA in delivering the pilot.

To help us in this evaluation, we are asking all assessors to complete a 15 – 20 minute online survey about their experience as an independent assessor. You don’t have to complete the survey if you don’t want to, but if you do it will help us to understand your experience and improve the independent assessment process for the future. Most questions can be left blank if you choose not to provide a response.

The survey asks questions about different parts of the independent assessment process, including:

- Your training to conduct the independent assessments
- Your experience and opinions on the assessment packs and tools
- Questions about your qualification and experience to help us understand your perspective

There are also opportunities for you to tell us about your experience in your own words.

## 3. Will my employer know what I said

No. We will not tell your employer anything you tell us. We will not tell your employer whether or not you completed a survey.

The NDIA will only use the information from the survey to evaluate the Independent Assessment Pilot.

## 4. Do I have to complete the survey?

No. You do not have to complete the survey if you don't want to. If start the survey and then change your mind, you can close your internet browser before you select 'submit' on the final page and your information will not be saved.

What you have to say is important and we really hope you do choose to participate.

## 5. Are there any risks to me if I complete the survey?

There are no risks to you.

## 6. What will you do with the information I give you?

The feedback from assessors will be included in the evaluation of the independent assessment pilot and help inform the learning and future directions of the program. This report will not identify you, either directly or indirectly. What you tell us will be treated as private and confidential. Your identity will not be shared internally or externally.

The survey will be conducted in accordance with Australian privacy laws. This survey has approval as a Quality Improvement project from the NDIA Research and Evaluation Office. Further information about how we handle your data can be found in the ***NDIS Privacy Policy***.

A report about the evaluation of the independent assessment pilot will be published on the NDIS website.

## 7. Is this survey anonymous?

If you wish, you can complete the survey anonymously.

At the end of the survey we ask for your name. Like most questions, this is optional. The reason that we ask for your name is so that we can link your survey responses to the assessments you conducted. This will help us understand more about your experience as an independent assessor.

You should also be aware that answering questions about your employer and background could also identify you. We will not report this data in a way that could identify you. If this is still a concern to you, we recommend you leave these questions blank.

## 8. Can I speak to someone about this survey?

If you have questions about this survey you can contact the survey coordinator.

To verify this survey you can call the NDIS on 1800 800 110.

## 9. Can I complain to someone about this survey?

If you have any complaints about this survey, you can email the NDIA at: research@ndis.gov.au and quote this number 20020 REB.

If you would like to continue to the survey, please select 'next'. Otherwise, close your browser to leave the survey now.

**Your professional experience**

**Q1. Which health professional registrations do you currently hold? (Select all that apply)**

Occupational Therapist

Physiotherapist

Psychologist

Rehabilitation Counsellor

Social Worker

Speech Pathologist

Other (Specify)

**Q2. Which best describes your allied health qualifications? (Select all that apply)**

Undergraduate degree

Additional clinical credentials, registrations or certifications (e.g. Lymphoedema Therapist, Driver Assessment, TAC CAPE, etc.)

Clinical postgraduate degree

Other postgraduate degree

**Q3. Please estimate your level of experience in the following areas**

| Area | Low (less than 1 year) | Medium (1 to 4 years) | High (over 5 years) |
|---|---|---|---|
| Clinical practice | | | |
| Administering standardised tests of functional capacity | | | |
| Clinical work with people with disability | | | |

**Q4. In which areas of disability do you have the most clinical experience? (Select up to five areas)**

None – no disability experience

Acquired Brain Injury

Autism

Cerebral Palsy

Developmental delay

Intellectual Disability

Multiple Sclerosis

Psychosocial Disability

Sensory/ speech

Spinal Cord Injury

Stroke

Other Neurological

Other Physical

Other

**Q5. In your clinical work with people who have disability, have you specialised in any particular age groups?**

No - all ages

0 to 6 years old

7 to 17 years old

18 to 64 years old

65 years and over

**Q6. Who is your employer for the independent assessment pilot?**

APM Australia

HealthStrong

Plena / Allied Care Group

### Training and guidance materials

This section asks about the training you received to conduct independent assessments.

**Q7. How would you rate your training to conduct independent assessments in the following areas? Rating options: Poor, Fair, Good, Very Good, Excellent**

Please note, we have used the term 'informant' to refer to the person who completed the assessment. This could be the participant, their nominee or other representative.

a. Introduction to the NDIS
b. How the independent assessment data will be used by the NDIS
c. Your role as an independent assessor
d. How to conduct an independent assessment
e. What activities to include in the participant interaction
f. How to complete each of the tabs in the pack (including selecting responses, making comments)
g. Working with people with disability

**Q8. How would you rate the usefulness of written guidelines and support materials? Rating: Poor, Fair, Good, Very Good, Excellent**

**Q9. Can you suggest any improvements to the training or written support materials?**

### Independent assessments

**Q10. How many times have you used the assessment pack for children and infants (under 7)?**

None

1 to 10

Over 10

**For assessors who have used the pack over 10 times**

**Q11. Thinking of the assessment pack for children and infants aged under 7 years (including the tools, NDIS form and interaction) please rate the following statements. Rating options: Never, Rarely, Sometimes, Usually, Always**

Please note, we have used the term 'informant' to refer to the person who completed the assessment. This could be the participant, their nominee or other representative.

a. The pack was suitable to use across participants with a range of disability
b. The results for each domain made sense across the different tools within the pack
c. The pack was appropriate for children / infants at different life stages
d. The results for each domain made sense across the different tools within the pack
e. The assessment provided an accurate reflection of the participant's functional capacity and support needs

**Q12. Do you have any suggestions on how to improve the assessment pack for children and infants?**

<Open text>

**Q13. How many times have you used the assessment pack for young people (7 to 17)?**

None
1 to 10
Over 10

**For assessors who have used the pack over 10 times**

**Q14. Thinking of the assessment pack for young people aged 7 to 17 years (including the tools, NDIS form and interaction) please rate the following statements. Rating options: Never, Rarely, Sometimes, Usually, Always**

Please note, we have used the term 'informant' to refer to the person who completed the assessment. This could be the participant, their nominee or other representative.

a. The pack was suitable to use across participants with a range of disability
b. The results for each domain made sense across the different tools within the pack
c. The pack was appropriate for young people at different life stages
d. The assessment provided an accurate reflection of the participant's functional capacity and support needs

**Q15. How could the assessment pack for young people be improved?**

**Q16. How many times have you used the assessment pack for adults (18+)?**

None
1 to 10
Over 10

**For assessors who have used the pack over 10 times**

**Q17. Thinking of the assessment pack for adults aged 18 years and over (including the tools, NDIS form and interaction) please rate the following statements. Rating options: Never, Rarely, Sometimes, Usually, Always**

Please note, we have used the term ‘informant’ to refer to the person who completed the assessment. This could be the participant, their nominee or other representative.

a. The pack was suitable to use across participants with a range of disability
b. The results for each domain made sense across the different tools within the pack
c. The pack was appropriate for participants at different life stages (e.g. choosing a course of study, finding work, moving out of home, developing relationships, having a family, etc.)
d. The assessment provided an accurate reflection of the participant’s functional capacity and support needs

**Q18. Do you have any suggestions on how to improve the assessment pack for adults?**

**Q19. How many times have you used the assessment pack for SIL?**

None
1 to 10
Over 10

**For assessors who have used the pack over 10 times**

**Q20. Thinking of the assessment pack for SIL (including the tools, NDIS form and interaction) please rate the following statements. Rating options: Never, Rarely, Sometimes, Usually, Always**

Please note, we have used the term ‘informant’ to refer to the person who completed the assessment.  This could be the participant, their nominee or other representative.

a. The pack was suitable to use across participants with a range of disability
b. The results for each domain made sense across the different tools within the pack
c. The pack was appropriate for participants at different life stages (e.g. choosing a course of study, finding work, moving out of home, developing relationships, having a family, etc.)
d. The assessment provided an accurate reflection of the participant’s functional capacity and support needs

**Q21. Do you have any suggestions on how to improve the assessment pack for SIL?**

**Using the independent assessment tools**

**Now we would like to ask you some questions about the individual tools.**

Reviewers note: tools will be selected based on the assessor's level of experience with each pack.

**Q22. Thinking of the <insert tool name> please rate the following statements from your experience with the current Independent Assessment Pilot.**
**Rating options: Never, Rarely, Sometimes, Usually, Always**

a. This tool covered areas of functional capacity important to the participant
b. The questions were relevant to participant's lifestyle and circumstance
c. Informants easily understood the questions (e.g. did not ask for explanations or clarifications, etc.)
d. Informants were confident of their answers (e.g. did not hesitate or waiver in their answers, etc.)
e. The responses seemed to be an accurate reflection of the participant's functional capacity in the areas covered

**Q23. Do you have any other feedback on the <insert tool name>?**

Prompt with areas of low performance from above question

**Overall satisfaction**

Note for reviewers: These questions are dependent variables. They help us in analysing the earlier responses and identifying the strengths and weakness of the independent assessment approach from assessors' experience.

**Q24. Please rate your satisfaction in each of the following areas.**
**Rating options: Poor, Fair, Good, Very good, Excellent**

a. The training you received to conduct independent assessments
b. Alignment of referrals to your experience and skill set
c. Working with participants and their support person/carer/family member
d. Accuracy of the independent assessments you conducted
e. Your overall experience with the independent assessment pilot

It would help the NDIA evaluation team to analyse your feedback if we can identify the participants you assessed. To do this, we need your name. We will not use your name for any other purpose nor will we identify you in any of our reporting. We will not share any information with your employer, including whether or not you chose to provide your name. Your decision on whether or not to provide your name will not affect your relationship with the NDIA.

Further information about how we handle your data can be found in the NDIS Privacy Policy.

**Q25. What is your name?**

## Other feedback

**Do you have any other comments you would like to make about your experience with the independent assessment pilot?**

Thank you for your time, your responses will help the National Disability Insurance Agency improve independent assessments for everyone.

Don’t forget to select ‘submit’ so that your responses will be recorded.

# Appendix E Participant respondent characteristics

## Participant survey respondent characteristics

**Respondent type**

| Respondent characteristics | No of responses | % of total | Expected % |
|---|---|---|---|
| Participant | 378 | 39.9% | NA |
| Parent | 451 | 47.6% | NA |
| Support worker | 3 | 0.3% | NA |
| Other | 116 | 12.2% | NA |

**Primary disability**

| Respondent characteristics | No of responses | % of total | Expected % |
|---|---|---|---|
| Intellectual disability/developmental delay/Down syndrome | 174 | 18.7% | 20.9% |
| Autism | 141 | 15.1% | 15.2% |
| Physical disability | 54 | 5.8% | 5.8% |
| Sensory disability (e.g. visual impairment, hearing impairment or deaf) | 102 | 10.9% | 11.4% |
| Neurological (e.g. stroke, MND, MS, ABI, cerebral palsy, spinal cord injury) | 374 | 40.1% | 37.1% |
| Psychosocial | 32 | 3.4% | 6.1% |
| Other | 55 | 5.9% | 3.5% |

**Age of participant**

| Respondent characteristics | No of responses | % of total | Expected % |
|---|---|---|---|
| 0-6 | 40 | 4.3% | 7.9% |
| 7-17 | 197 | 21.0% | 27.1% |
| 18+ | 699 | 74.7% | 65.0% |

**Location**

| Respondent characteristics | No of responses | % of total | Expected % |
|---|---|---|---|
| Major city (MM 1) | 724 | 79.5% | NA |
| Regional (MM 2-3) | 112 | 12.3% | NA |
| Rural and remote (MM 4-7) | 75 | 8.2% | NA |

### Cultural background

| Respondent characteristics | No of responses | % of total | Expected % |
|---|---|---|---|
| Aboriginal and/or Torres Strait Islander descent | 29 | 3.0% | NA |
| Mainly language spoken at home is not English | 46 | 4.8% | NA |
| Main language spoken at home is English | 892 | 92.2% | NA |

Source: IAP2 Participant experience survey as of 31 May 2021.

Notes:

- The total responses is 948. Not all values add up to the total due to unanswered questions.
- The expected percentage is based on the distribution of IAP2 participants as of 31 May 2021.
- Where an expected percentage is marked NA, the figure cannot be calculated from supplier governance reports.

Chi-squared goodness of fit tests show that the characteristics of participant/carer survey respondents is similar (but not statistically identical) to the population of IAP2 participants (as of 31 May 2021) by primary disability grouping ($\chi^2(6) = 30.0$; $p<.0001$) and age band/assessment pack ($\chi^2(2) = 42.0$; $p<.0001$).

## Participant interviewee characteristics

### Respondent type

| Respondent characteristics | No of responses | % of total |
|---|---|---|
| Participant | 48 | 43.2% |
| Parent | 50 | 45.0% |
| Other | 13 | 11.7% |

### Primary disability

| Respondent characteristics | No of responses | % of total |
|---|---|---|
| Intellectual disability/developmental delay/Down syndrome | 29 | 26.1% |
| Autism | 9 | 8.1% |
| Physical disability | 7 | 6.3% |
| Sensory disability (e.g. visual impairment, hearing impairment or deaf) | 8 | 7.2% |
| Neurological (e.g. stroke, MND, MS, ABI, cerebral palsy, spinal cord injury) | 49 | 44.1% |
| Psychosocial | 2 | 1.8% |
| Other | 7 | 6.3% |

### Age of participant

| Respondent characteristics | No of responses | % of total |
|---|---|---|
| 0-6 | 3 | 2.9% |
| 7-17 | 22 | 21.0% |
| 18+ | 80 | 76.2% |

### Location

| Respondent characteristics | No of responses | % of total |
|---|---|---|
| Major city (MM 1) | 61 | 78.2% |
| Regional (MM 2-3) | 9 | 15.5% |
| Rural and remote (MM 4-7) | 8 | 10.3% |

### Cultural background

| Respondent characteristics | No of responses | % of total |
|---|---|---|
| Aboriginal and/or Torres Strait Islander descent | 2 | 1.9% |
| Mainly language spoken at home is not English | 2 | 1.9% |

# Appendix F Code frame for analysing qualitative data from participants/supporters

**Booking and Information**

More information about the assessment: Purpose, assessment process, questions, assessor

I had sufficient information/positive about the information.

**Appointment process**

Appointment organisation problems: inconvenient time, not informed about changes, appointment maker lacked interpersonal skills

Easy to make appointment/got a convenient time/good help for online interview setup

**Motivation for participation**

Liked having the opportunity to participate in an NDIS initiative/give an opinion and better inform future NDIS plans, improved care; give feedback; get information about NDIS

Hope that by participating it helps improve the system; Standardised/unbiased approach to funding decisions; Help planners/ LACS/participants.

Want an assessment, a review, a detailed assessment, help with future NDIS reviews

**Assessment**

Dislike online/video assessment:  on screen not face-to-face, technology problems, assessor unable to observe

Assessment too long: too many questions, exhausting, hard to concentrate

Liked that the assessment was done face-to-face

Liked that the assessment was done in-home, could see problems first-hand

Liked convenience: single assessor, done in one session, quick

Insufficient focus on functioning in the community; assessment in home environment may not reflect abilities

Waste of time and money: takes a lot of time out of day, time off work/driving/organizing, disrupt routine, additional costs (e.g. parking)

Liked online/video assessment

**Questions**

Dislike answering the same questions again, telling my story again.

The questions did not cover issues related to my specific disability/ were irrelevant/generic

The questions were too scripted, impersonal, standardised; was a Q&A/questionnaire; wrong format, limited response options (e.g., tick a box); response scales change

Some questions viewed negatively (inappropriate, demeaning, condescending, too personal/ offensive/ confronting, asking children about sexual activity/adults about play).

Provide the questions in alternative formats (e.g., braille/visual cue/prompt cards) to facilitate responses/communication and avoid exclusion due to disability

Some questions felt repetitive/overlapped/ambiguous. Some questions need logical skips (e.g., asking retirees about school/work; asking people in wheelchairs how far they can walk)

Some questions difficult; hard to interpret/answer; confusing; need time to prepare (e.g. percentages/require guessing/remembering/scales mixed up/grey areas).

Appreciated that the questions were easy to answer/understand; consistent; interesting; well-established

Too negative/ deficit focused

No questions on how supports help/negate disability

**The process**

Issues conveying information during assessment: speaking in front of participant/when participant not present; not speaking directly to participant; speaking to the wrong person

Issues related to the assessment tasks/activities: The observation task needs more/time/explanation/clarification.

Disliked being assessed by person only just met/ telling stranger personal info/ trusting a stranger

Assessment should have input from participants' treatment team (OT/Physio)/ others

Positive comparison to other assessments (e.g. first NDIS assessment, meeting with LAC)

Assessment was about proving disability/verification/checking for NDIS/ not independent

Specialist reports: Not required to get/pay for specialist reports; Free assessment

It was positive to see the client participating in the process (responding/ videoing etc.)

Hard to find someone to speak on behalf of participant

Assessor not well enough prepared with knowledge of the participant.

Need to know next steps after the assessment

Prefer to do questions online/in advance/see questions beforehand/see questions during assessment

**Report and post assessment**

Concerns about the report not being received/ timelines for reporting

Hopeful of getting a report that is accurate/comprehensive/ individualised; help with improved supports/ having needs met/ future meetings; confirm other documentation; give NDIS information

Report was hard to read: complex terminology, jargon

Report did not have a summary, conclusions

Report did not have recommendations, did not link to my plan

Report was not accurate

Report did not address my disability, support needs

Report does not include contextual information, elaboration, clarification given to the assessor during the assessment

Had/would ask someone (LAC/health professional etc.) assist with reading/understanding the report

Report: other negative

Report: content positive

**Assessor**

Lacked interpersonal skills (no rapport, only looked at screen, made me feel rushed)

Lacking in professionalism inappropriately dressed/ late; not use language appropriate to ability

Assessor’s profession not suitable for assessment.

Inexperienced in conducting assessments; not consider privacy, not answer questions, rushed, problems observing over Zoom

Insufficient knowledge of disability

Lacking professional skill/knowledge

Strong interpersonal skills- courteous, listened, patient, understanding, helped me relax, caring

Good professionalism- on time, appropriately dressed, organised

Profession suitable for assessment

Assessment process well-conducted, answered questions

Knowledgeable about disability

Good professional skill/knowledge

**Needs/ coverage**

Assessment not comprehensive/ not long enough/ not cover all the individual's needs; No personalization; Only gives a snapshot (disability can vary); Family impact not covered; Tools inappropriate (e.g. blunt); Limited physical testing; no context

The assessment did not address future needs/ goals; Assessment may not benefit participants

It was very detailed, comprehensive, accurate, liked it, well done, thorough, not rushed. Got a good idea of situation/needs

Can show extent of disability and everyday difficulties; Helps identify strengths and weaknesses/ milestones; Opportunity to discuss/explain/express needs and have concerns heard/ be listened to

Received useful information/feedback

**NDIS related - big picture**

Concerns regarding accuracy/reliability of data; content/comprehensiveness of assessor notes, not transparent

Appreciated the independent assessment (new insights, fair, fresh eyes) Unbiased; no preconceptions/ different approach/ different perspective, consistency

**Thoughts and feelings**

Worried about how the report/data will be used; risk/impact to funding; whether assessment will make a difference; impact on outcome/annual review; having to appeal results

Visit negatively impacted mental well-being; Distressing/ disempowering/ frustrating/ stressed before-hand/ emotional; Discussing disability and limitations brings sadness, grief, pain

Concern about adequately expressing/conveying the participant situation and needs/ covering all areas/ not forgetting anything; that the assessor may not understand needs, participant giving inaccurate information

**Other**

Other (response relevant to the question)
N/A, nothing or off spec.
Other positive, e.g. Choice of assessment location; payment for participation
Other negative

# Appendix G  Shapley Value regression methodology and detailed results

Shapley Value Regression on responses to the Participant experience survey (see Appendix C) was undertaken using Stata version 15 statistical software using a two-step process:

1. Logit regression using the code: logit [independent variable] [dependent variables]
2. Post estimation Shapley Value analysis using the shapley2 package and the following code: shapley2, stat(r2_p)

The following sections describe the various regressions undertaken and the full set of results.

## Mid-level dependent variable models

Mid-level dependent variable models were run to understand the relative importance of the booking process, the way IAs are conducted and the professionalism of assessors, on overall participant experience.

The following logit model was run:

**Logit [overall participant experience] [booking experience] [experience with the way the assessment was conducted] [experience with the professionalism of the assessor]**

All variables are derived from survey questions that use an ordinal scale (Poor, Fair, Good, Very good, Excellent).

Very good and Excellent, and Poor to Good were grouped separately.

The Poor to Good grouping was designated ‘not satisfied’ and assigned a value of 1.

The Very Good to Excellent grouping was designated ‘satisfied’ and assigned a value of 0.

The reason for these assignments is that Shapley Value regression aims to identify the key drivers of non-satisfaction.

**We ran a second variant** where the dependent variable was derived from the binary survey question ‘Given the choice, would you have an IA again?’ No was designated 1 and Yes was designated 0.

## Results: Overall experience

### Logit model

| Independent assessment overall | Coefficient | Standard errors | z | P>\|z\| | Lower bound (95% Confidence interval) | Upper bound (95% Confidence interval) |
|---|---|---|---|---|---|---|
| The process of booking the assessment | 0.834 | 0.238 | 3.500 | 0.000 | 0.366 | 1.301 |
| The way the assessment was done | 3.324 | 0.230 | 14.460 | 0.000 | 2.873 | 3.774 |
| The professionalism of the assessor | 1.755 | 0.426 | 4.120 | 0.000 | 0.919 | 2.590 |
| _cons | -2.177 | 0.167 | -13.020 | 0.000 | -2.505 | -1.850 |

### Shapley Value analysis

| Independent assessment overall | Shapley Value | Relative contribution% |
|---|---|---|
| The way the assessment was done | 0.34 | 65.01 |
| The professionalism of the assessor | 0.10 | 19.34 |
| The process of booking the assessment | 0.08 | 15.65 |
| TOTAL | 0.52 | 100.00 |

## Results: Given the choice, would you have an IA again

### Logit model

| Would you have an IA again | Coefficient | Standard errors | z | P>\|z\| | Lower bound (95% Confidence interval) | Upper bound (95% Confidence interval) |
|---|---|---|---|---|---|---|
| The process of booking the assessment | 0.409 | 0.183 | 2.230 | 0.026 | 0.050 | 0.768 |
| The way the assessment was done | 2.100 | 0.213 | 9.840 | 0.000 | 1.682 | 2.518 |
| The professionalism of the assessor | 0.646 | 0.198 | 3.260 | 0.001 | 0.258 | 1.035 |
| _cons | -2.194 | 0.166 | -13.260 | 0.000 | -2.519 | -1.870 |

**Shapley Value analysis**

| Would you have an IA again | Shapley Value | Relative contribution % |
|---|---|---|
| The way the assessment was done | 0.15 | 62.72 |
| The professionalism of the assessor | 0.05 | 20.79 |
| The process of booking the assessment | 0.04 | 16.48 |
| TOTAL | 0.24 | 100.00 |

## Key driver selection models

### Model results for experience with the booking process

We ran the following logit model followed by Shapley Value analysis:

**Logit [participant booking experience] [assessment was on a date time that was good for you] [explained that you could have someone with you if you wanted] [explain that one of the assessments might need to be done by someone who knows you well] [tell you how long the assessment will take] [give enough information to know what to expect] [give enough time to get ready for the assessment] [fully answer any questions you had about the assessment]**

We derived all variables from survey questions.

Booking experience was measured that use an ordinal scale (Poor, Fair, Good, Very good, Excellent). Very good and Excellent, and Poor to Good were grouped separately.

The Poor to Good grouping was designated ‘not satisfied’ and assigned a value of 1.

The Very Good to Excellent grouping was designated ‘satisfied’ and assigned a value of 0.

All independent variables come from binary survey questions where ‘No’ is designated 1 and ‘Yes’ is designated 0.

### Logit model

| Booking experience | Coefficient | Standard errors | z | P>\|z\| | Lower bound (95% Confidence interval) | Upper bound (95% Confidence interval) |
|---|---|---|---|---|---|---|
| q10a: Make sure the assessment was on a date and time that was good for you | 0 | (omitted) | | | | |
| q10b: Explain that you could have someone with you if you wanted | 0.386 | 0.304 | 1.270 | 0.205 | -0.211 | 0.982 |
| q10c: Explain that one of the assessments might need to be done by someone who knows you well | 0.172 | 0.207 | 0.830 | 0.404 | -0.233 | 0.578 |
| q10d: Tell you how long the assessment will take | -0.390 | 0.315 | -1.240 | 0.215 | -1.007 | 0.227 |
| q10e: Give you enough information to know what to expect from the assessment | 1.081 | 0.197 | 5.480 | 0.000 | 0.695 | 1.468 |
| q10f: Give you enough time to get ready for the assessment | 0.915 | 0.553 | 1.650 | 0.098 | -0.169 | 1.998 |
| q10g: Fully answer any questions you had about the assessment | 1.075 | 0.339 | 3.170 | 0.002 | 0.410 | 1.740 |
| _cons | -0.722 | 0.088 | -8.160 | 0.000 | -0.895 | -0.548 |

**Shapley Value analysis**

| Booking experience | Shapley Value | Relative contribution% | Reach | Noise | Added reach | Added noise | Success |
|---|---|---|---|---|---|---|---|
| q10e: Give you enough information to know what to expect from the assessment | 0.04 | 52.8 | 38.67 | 12.35 | | | |
| q10g: Fully answer any questions you had about the assessment | 0.02 | 28.6 | 40.53 | 13.36 | 1.87 | 1.01 | 0.85 |
| q10f: Give you enough time to get ready for the assessment | 0.01 | 7.9 | 42.13 | 13.56 | 1.60 | 0.20 | 1.40 |
| q10b: Explain that you could have someone with you if you wanted | 0.00 | 5.7 | 45.87 | 16.80 | 3.73 | 3.24 | 0.49 |
| q10c: Explain that one of the assessments might need to be done by someone who knows you well | 0.00 | 3.8 | 53.33 | 25.30 | 7.47 | 8.50 | -1.04 |
| q10d Tell you how long the assessment will take | 0.00 | 1.3 | | | | | |
| TOTAL | 0.08 | 100.0 | | | | | |

## Model results for experience with assessor professionalism

We ran the following logit model followed by Shapley Value analysis:

**Logit [participant experience with assessor professionalism] [assessor seemed prepared] [assessor seemed to know a lot about your disability and understood how your disability affects your life] [assessor was sensitive to your values and beliefs] [assessor arrived on time] [assessor told you clearly what would happen during the assessment] [assessor treated you with respect] [assessor listened to what you had to say] [assessor asked if you needed a break] [assessor answered any questions you had] [assessor talked to you even if someone else was present] [assessor gave you the chance to talk about all the areas where you needed support or help]**

We derived all variables from survey questions.

Experience with assessor professionalism was measured that use an ordinal scale (Poor, Fair, Good, Very good, Excellent). Very good and Excellent, and Poor to Good were grouped separately.

The Poor to Good grouping was designated ‘not satisfied’ and assigned a value of 1.

The Very Good to Excellent grouping was designated ‘satisfied’ and assigned a value of 0.

All independent variables come from binary survey questions where ‘No’ is designated 1 and ‘Yes’ is designated 0.

We derived the independent variable ‘assessor seemed to know a lot about your disability and understood how your disability affects your life’ from two separate questions. These questions explored related topics and had a Spearman’s correlation <0.6. If the participant answered no to both questions, they were designated 1 for this variable and 0 otherwise.

## Logit model

| Experience with assessor professionalism | Coefficient | Standard errors | z | P>\|z\| | Lower bound (95% Confidence interval) | Upper bound (95% Confidence interval) |
|---|---|---|---|---|---|---|
| q12a: The assessor seemed prepared for your meeting | 1.198 | 0.459 | 2.610 | 0.009 | 0.299 | 2.097 |
| q12bc:The assessor seemed to know a lot about your disability and understood how your disability affects your life | 1.105 | 0.218 | 5.070 | 0.000 | 0.678 | 1.532 |
| q12d: The assessor was sensitive to your values and beliefs | 1.108 | 0.539 | 2.050 | 0.040 | 0.051 | 2.165 |
| q13a: Arrive on time for your meeting | 0.897 | 0.373 | 2.400 | 0.016 | 0.165 | 1.628 |
| q13b: Tell you clearly what would happen during the assessment | 1.204 | 0.429 | 2.810 | 0.005 | 0.364 | 2.045 |
| q13c: Treat you with respect | 0 | (omitted) | | | | |
| q13d: Listen to what you had to say | 0.518 | 0.651 | 0.800 | 0.427 | -0.758 | 1.794 |
| q13e: Ask if you needed a break | 0.546 | 0.241 | 2.270 | 0.023 | 0.074 | 1.017 |
| q13f: Answer any questions you had | -0.091 | 0.563 | -0.160 | 0.871 | -1.195 | 1.012 |
| q13g: Talk to you (even if someone else was present) | 1.403 | 0.561 | 2.500 | 0.012 | 0.303 | 2.503 |
| q13h: Give you the chance to talk about all the areas where you needed support or help | 0.504 | 0.290 | 1.740 | 0.082 | -0.064 | 1.071 |
| _cons | -2.121 | 0.141 | -15.070 | 0.000 | -2.396 | -1.845 |

### Shapley Value analysis

| Experience with assessor professionalism | Shapley Value | Relative contribution % | Reach | Noise | Added reach | Added noise | Success |
|---|---|---|---|---|---|---|---|
| q12bc:The assessor seemed to know a lot about your disability and understood how your disability affects your life | 0.06 | 28.3 | 61.93 | 20.65 | | | |
| q13h: Give you the chance to talk about all the areas where you needed support or help | 0.02 | 12.1 | 63.96 | 24.06 | 2.03 | 3.41 | -1.38 |
| q13b: Tell you clearly what would happen during the assessment | 0.02 | 12.1 | | | | | |
| q12a: The assessor seemed prepared for your meeting | 0.02 | 11.3 | | | | | |
| q12d: The assessor was sensitive to your values and beliefs | 0.02 | 9.5 | | | | | |
| q13e: Ask if you needed a break | 0.02 | 8.5 | | | | | |
| q13g: Talk to you (even if someone else present) | 0.01 | 5.9 | | | | | |
| q13a: Arrive on time for your meeting | 0.01 | 4.7 | | | | | |
| q13d: Listen to what you had to say | 0.01 | 4.0 | | | | | |
| q13f: Answer any questions you had | 0.01 | 3.7 | | | | | |
| TOTAL | 0.20 | 100.0 | | | | | |

**Questions**

Dislike answering the same questions again, telling my story again.

The questions did not cover issues related to my specific disability/ were irrelevant/generic

The questions were too scripted, impersonal, standardised; was a Q&A/questionnaire; wrong format, limited response options (e.g., tick a box); response scales change

Some questions viewed negatively (inappropriate, demeaning, condescending, too personal/ offensive/ confronting, asking children about sexual activity/adults about play).

Provide the questions in alternative formats (e.g., braille/visual cue/prompt cards) to facilitate responses/communication and avoid exclusion due to disability

Some questions felt repetitive/overlapped/ambiguous. Some questions need logical skips (e.g., asking retirees about school/work; asking people in wheelchairs how far they can walk)

Some questions difficult; hard to interpret/answer; confusing; need time to prepare (e.g. percentages/require guessing/remembering/scales mixed up/grey areas).

Appreciated that the questions were easy to answer/understand; consistent; interesting; well-established

Too negative/ deficit focused

No questions on how supports help/negate disability

**The process**

Issues conveying information during assessment: speaking in front of participant/when participant not present; not speaking directly to participant; speaking to the wrong person

Issues related to the assessment tasks/activities: The observation task needs more/time/explanation/clarification.

Disliked being assessed by person only just met/ telling stranger personal info/ trusting a stranger

Assessment should have input from participants' treatment team (OT/Physio)/ others

Positive comparison to other assessments (e.g. first NDIS assessment, meeting with LAC)

Assessment was about proving disability/verification/checking for NDIS/ not independent

Specialist reports: Not required to get/pay for specialist reports; Free assessment

It was positive to see the client participating in the process (responding/ videoing etc.)

Hard to find someone to speak on behalf of participant

Assessor not well enough prepared with knowledge of the participant.

Need to know next steps after the assessment

### Logit model

| Experience with the way the assessment done | Coefficient | Standard errors | z | P>\|z\| | Lower bound (95% Confidence interval) | Upper bound (95% Confidence interval) |
|---|---|---|---|---|---|---|
| q8: Did you have a choice about where you had the assessment | 0.278 | 0.201 | 1.38 | 0.166 | -0.116 | 0.672 |
| q15a: Were you comfortable with the questions the assessor asked | 1.460 | 0.494 | 2.95 | 0.003 | 0.491 | 2.439 |
| q15b: Were the questions easy to answer | 0.804 | 0.210 | 3.82 | 0.000 | 0.391 | 1.217 |
| q15c: Were the questions culturally appropriate | 0.188 | 0.852 | 0.22 | 0.825 | -1.484 | 1.860 |
| q15df: Did the assessment cover all of the areas important and gave an accurate picture of your skills and ability | 1.600 | 0.273 | 5.86 | 0.000 | 1.065 | 2.134 |
| q15e: Were you ok with the activities the assessor asked you to do | 2.633 | 0.748 | 3.52 | 0.000 | 1.166 | 4.099 |
| q17: How did you feel about the length of the assessment | 1.367 | 0.191 | 7.16 | 0.000 | 0.993 | 1.7415 |
| q6: How did you have your IA? (note face-to-face =1, telehealth = 0) | -0.115 | 0.186 | -0,62 | 0.536 | -0.480 | 0.249 |
| _cons | -0,993 | 0.182 | -5.45 | 0.000 | -1.350 | -0.635 |

## Shapley Value analysis

| Experience with the way the assessment done | Shapley Value | Relative contribution% | Reach | Noise | Added reach | Added noise | Success |
|---|---|---|---|---|---|---|---|
| q15df: Did the assessment cover all of the areas important and gave an accurate picture of your skills and ability | 0.07 | 26.3 | 41.11 | 5.56 | | | |
| q17: How did you feel about the length of the assessment | 0.07 | 24.9 | 69.33 | 20.11 | 28.22 | 14.55 | 13.67 |
| q15e: Were you ok with the activities the assessor asked you to do | 0.05 | 16.8 | 71.78 | 20.11 | 2.44 | 0.00 | 2.44 |
| q15b: Were the questions easy to answer | 0.04 | 15.0 | 78.00 | 28.04 | 6.22 | 7.94 | -1.71 |
| q15a: Were you comfortable with the questions the assessor asked | 0.03 | 12.4 | | | | | |
| q15c: Were the questions culturally appropriate | 0.01 | 2.5 | | | | | |
| q8: Did you have a choice about where you had the assessment | 0.01 | 2.1 | | | | | |
| q6: How did you have your IA? (note face-to-face =1, telehealth = 0) | 0.00 | 0.5% | | | | | |
| TOTAL | 0.28 | 100.0 | | | | | |

### Model results for overall experience having an IA

We ran the following logit model followed by Shapley Value analysis:

**Logit [overall experience having an IA] [give enough information to know what to expect from the assessment] [give enough time to get ready] [fully answer any questions] [assessor seemed prepared] [assessor sensitive to beliefs and values] [assessor told you clearly what would happen during the assessment] [assessment covered all of the areas where you need help or support and gave an accurate picture of your skills and ability] [assessor seemed to know a lot about your disability and understood how your disability affects your life] [were you ok with the activities the assessor asked you to do] [assessment length]**

We treated all variables as outlined for other models above.

We chose independent variables based on them being key drivers for individual aspects or steps involved in having an IA.

### Logit model

| Overall experience | Coefficient | Standard errors | z | P>\|z\| | Lower bound (95% Confidence interval) | Upper bound (95% Confidence interval) |
|---|---|---|---|---|---|---|
| q10b: Explain that you could have someone with you if you wanted | 0.756 | 0.405 | 1.870 | 0.062 | -0.037 | 1.550 |
| 10e: Give you enough information to know what to expect from the assessment | 1.066 | 0.293 | 3.630 | 0.000 | 0.491 | 1.641 |
| q10f: Give you enough time to get ready for the assessment | 0.811 | 0.825 | 0.980 | 0.326 | -0.806 | 2.427 |
| q10g: Fully answer any questions you had about the assessment | 1.089 | 0.673 | 1.620 | 0.106 | -0.231 | 2.409 |
| q12bc:The assessor seemed to know a lot about your disability and understood how your disability affects your life | 1.545 | 0.263 | 5.880 | 0.000 | 1.030 | 2.060 |
| q15df: Did the assessment cover all of the areas important and gave an accurate picture of your skills and ability | 1.732 | 0.344 | 5.030 | 0.000 | 1.057 | 2.406 |
| q15e: Were you ok with the activities the assessor asked you to do | 1.066 | 0.547 | 1.950 | 0.051 | -0.006 | 2.138 |
| q17: How did you feel about the length of the assessment | 0.933 | 0.195 | 4.790 | 0.000 | 0.551 | 1.314 |
| _cons | -1.108 | 0.116 | -9.530 | 0.000 | -1.336 | -0.880 |

### Shapley Value analysis

| Overall experience | Shapley Value | Relative contribution% | Reach | Noise | Added reach | Added noise | Success |
|---|---|---|---|---|---|---|---|
| q15df: Did the assessment cover all of the areas important and gave an accurate picture of your skills and ability | 0.08 | 26.6 | 42.59 | 3.23 | | | |
| q12bc:The assessor seemed to know a lot about your disability and understood how your disability affects your life | 0.08 | 25.5 | 58.10 | 8.63 | 15.51 | 5.39 | 10.12 |
| q10e: Give you enough information to know what to expect from the assessment | 0.05 | 16.0 | 67.59 | 12.40 | 9.49 | 3.77 | 5.72 |
| q17: How did you feel about the length of the assessment | 0.04 | 12.8 | 78.01 | 28.30 | 10.42 | 15.90 | -5.49 |
| q15e: Were you ok with the activities the assessor asked you to do | 0.02 | 8.0 | | | | | |
| q10g: Fully answer any questions you had about the assessment | 0.02 | 6.0 | | | | | |
| q10b: Explain that you could have someone with you if you wanted | 0.01 | 2.8 | | | | | |
| q10f: Give you enough time to get ready for the assessment | 0.01 | 2.3 | | | | | |
| TOTAL | 0.31 | 100.0 | | | | | |

# Appendix H Participant/supporter interview guide

## Interview guide

The purpose of these interviews is to enable participants and their supporters to provide feedback on their recent experience with an independent assessment. The topics should reflect the areas of interest to the interviewee. Some questions are provided to guide this process.

### Before you start the interview

Review the person's survey responses and identify their positive and negative experiences so that you can use this as a prompt in the interview.

Familiarise yourself with the person's accessibility requirements. Check the contact sheet to make sure any necessary supports (e.g. interpreters) have been organised by the appointment maker.

Contact the person at the agreed time and introduce yourself. Reconfirm consent, contact method, length of interview, voluntary participation and withdrawal.

Check for any questions before you start.

Remind nominees/ reps to consider the questions from the participant's perspective where appropriate.

### Start with these open questions

1. Why did you decide to have an independent assessment?

   **Prompt with** Did you get all of the information you needed before you made the decision? What else would you have liked to know?

2. Tell me a bit about your experience with the independent assessment? What happened?

   **Probe on expectations verses experience.**

3. What [else] could we have done to improve your experience with the independent assessment? **Probe. Prompt with survey responses if needed. Look for solutions**

4. Were there any [other] areas where you thought we did really well? **Probe. Prompt with survey responses if needed. Look for how this can be replicated.**

**These questions are more directive**

Reviewers note: questions on the tools have not been included as concern was raised over consulting with participants on topics where they cannot have an impact.

Participants can raise issues on the tools in the open questions. Questions on the tools are also covered in the survey.

5. Have you seen your independent assessment report? **[if no go to Q8]**

   What did you think of your report?

   **Probe on accuracy, holistic, usefulness in planning, consistency with other assessments, etc.**

6. Was the assessment report easy to understand? Were any sections particularly difficult?

   **Prompt on suggestions for improvement. Drill down to specific areas**

7. There is a lot of information in these reports, did you have someone you could talk to about your report?

   **If no, ask who they would have liked to talk to.**

   **If yes, prompt for the role of the other person/s. Separate friends and family from treating health professionals, assessors, planners, support coordinators, etc.**

8. How long did the assessment take? Was that time ok?

   **Prompt on how did this impact on your usual routine. Childcare, school pick-ups, work, support, etc.**

9. Did you find the assessment to be appropriate for your individual needs and circumstances? Did you get all of the support you needed to participate in the assessment?

   **Prompt on cultural appropriateness, participant centred, accessible, need to take breaks, etc.**

10. What did you think of the assessor? Prompt on rapport, knowledge, etc.

**Close**

11. Was there anything else you wanted to talk about with me? **Probe fully. Focus on what we can learn, solutions and embedding good experiences in our processes.**

**Thank and close.**

## Participant information sheet

This information is for people who did a survey about their experience with the NDIA independent assessment, and provided their contact details so that they could be invited to an interview.

This document gives you some information about the interview so you can decide if you would like to take part.

You can read this information with someone else if you like.

Anyone who completed a survey can take part in an interview. This includes participants, their nominees, family or other supporters.

### Who is doing these interviews?

These interviews are being conducted by the NDIA Research and Evaluation Branch.

### What are the interviews about?

You recently had an independent assessment and completed a survey. In that survey you gave us permission to invite you to have an interview so that we can get some more information about your experience with your independent assessment. The interview will take up to 30 minutes. You don't have to be interviewed if you don't want to, but if you do it will help us to improve the assessment process for participants and their supporters in the future.

The interview asks about different parts of the independent assessment process. It will include areas you identified where your experience could be improved as well as areas that worked well for you. We will ask you some questions about your experience in other areas, such as:

- Why you chose to have an independent assessment
- What we did well in the assessment process
- Where we need to improve
- Anything else you want to tell us about your experience with the assessment

### Will I be paid to have an interview?

No

### Who can take part the interviews?

Only people who completed an independent assessment survey can take part in these interviews. Of course, you can have a support person with you if you wish.

You may wish to talk about your involvement in the interview with a family member or support person. If you are someone who supports a NDIS participant, you may want to talk with them before agreeing to have an interview and see what they would like to say.

### Can I choose how I do the interview?

You can have the interview online, by telephone or by text. In the survey you told us your preferred contact method. We will use that contact method to make an appointment to talk to you. We will check if this is the best way to talk to you.

### Are there supports for me?

Yes. Please let us know if there is anything we can do to support you in the interview.

### Will the interviewers have access to information about me and my NDIS plan?

The interviewers will only have access to the information you provided in the survey. This is so that we can made sure we ask questions that are relevant to your experience and that you don't have to tell us the same information again.

The interviewer will not have access to your plan or to your NDIS file. What you tell us is private and confidential. They will not be included in your NDIS file.

### Do I have to agree to an interview because I provided my contact details in the survey?

No. You do not have to have an interview if you don't want to. If you agree then change your mind, you can stop any time. You can also ask for a shorter interview if you would prefer.

### Are there any risks to me if I have an interview?

If you had a poor experience with the independent assessment, there is a small risk that you might feel upset talking about it. If you do find that any of the questions in the interview are upsetting, you don't have to answer them. You can stop the interview at any time.

### What will you do with the information I give you?

With you permission, we will record the interview to help with our note taking. This recording will be destroyed once we have finalised our report.

We will remove any contact details from our notes of your interview and keep the data (and any recordings) on a password protected computer. Only the evaluators will be able to see this information.

We will write a report that will include the experiences of all of the people who had an interview. This report will not identify you. The report will be used by the NDIA to improve the independent assessment process and how the information from assessments is used in the future.

The interview will be conducted in accordance with Australian privacy laws. This interview has approval as a Quality Improvement project from the NDIA Research and Evaluation Office.

A report about the evaluation of the independent assessments will be published on the NDIS website.

### Will the NDIS, my planner, or Local Area Coordinator know that I had an interview or what I said?

No. The NDIS will not know that you did the survey or what you told us about the independent assessment.

### Can I speak to someone about this interview?

If you have questions about this interview you can contact the evaluation coordinator, you can send her an email. To verify this interview you can call the NDIS on 1800 800 110.

### Can I complain to someone about this interview?

If you have any complaints about this interview or the way it was conducted, you can email the NDIA and quote this number 20020 REB.

Thank you for your time.

# Appendix I Regression results for testing the influence of assessor experience on IA quality

## Association between the number of IAs an assessor has previously conducted and participant/supporter experience

Participant/supporter responses to a question in the participant experience survey asking them to rate their experience with the way their IA was undertaken were coded as follows: Excellent = 5; Very good = 4; Good = 3; Fair = 2; Poor = 1.

Univariate OLS regression was then used to test for an association between the number of IAs the participant's assessor had undertaken before theirs, based on matching to supplier governance data. The results are shown below.

**APM, HealthStrong and ACG assessors combined**

| | Coefficients | Standard errors | t-statistic | p-value | Lower 95% | Upper 95% |
|---|---|---|---|---|---|---|
| Intercept | 3.257 | 0.064 | 51.213 | 0.000 | 3.132 | 3.382 |
| Number of prior assessments | 0.002 | 0.003 | 0.509 | 0.611 | -0.005 | 0.008 |

Observations = 669.

**HealthStrong and ACG assessors only**

| | Coefficients | Standard errors | t-statistic | p-value | Lower 95% | Upper 95% |
|---|---|---|---|---|---|---|
| Intercept | 3.079 | 0.126 | 24.372 | 0.000 | 2.830 | 3.328 |
| Number of prior assessments | 0.006 | 0.011 | 0.601 | 0.548 | -0.015 | 0.027 |

Observations = 201

## Association between the number of IAs an assessor has previously conducted and IA quality

### IA checks failed

Poisson regression was used to test for an association between the number of IAs and assessor has undertaken, and the number of quality checks their next assessment fails. The data used came from matching IA quality data from the NDIA's Office of the Scheme Actuary and IA supplier governance data.

| | IRR | Standard errors | z-statistic | p-value | Lower 95% | Upper 95% |
|---|---|---|---|---|---|---|
| Intercept | 1.143 | 0.0698 | 2.18 | 0.029 | 1.013 | 1.288 |
| Number of prior assessments | 1.011 | 0.003 | 4.31 | 0.000 | 1.006 | 1.016 |

Observations = 841.

The margins command was then used to estimate the number of quality checks an IA will fail at different levels of assessor experience.

| Prior number of IAs undertaken | Margin (i.e. predicted number of quality checks failed for next assessment | Standard errors | z-statistic | p-value | Lower 95% | Upper 95% |
|---|---|---|---|---|---|---|
| 5 | 1.208 | 0.064 | 18.93 | 0.000 | 1.083 | 1.333 |
| 15 | 1.351 | 0.060 | 22.88 | 0.000 | 1.236 | 1.467 |
| 25 | 1.511 | 0.074 | 20.53 | 0.000 | 1.367 | 1.655 |
| 35 | 1.690 | 0.109 | 15.46 | 0.000 | 1.476 | 1.904 |
| 45 | 1.890 | 0.161 | 11.68 | 0.000 | 1.573 | 2.207 |
| 55 | 2.112 | 0.230 | 9.19 | 0.000 | 1.663 | 2.564 |
| 65 | 2.234 | 0.314 | 7.52 | 0.000 | 1.748 | 2.980 |
| 75 | 2.642 | 0.417 | 6.34 | 0.000 | 1.827 | 3.460 |

### IA returned to supplier/assessor for remediation

Logistic regression was used to test for an association between the number of IAs and assessor has undertaken, and the likelihood their next IA requires remediation. The data used came from matching IA quality data from the NDIA's Office of the Scheme Actuary and IA supplier governance data.

| | Odds ratio | Standard errors | z-statistic | p-value | Lower 95% | Upper 95% |
|---|---|---|---|---|---|---|
| Intercept | 0.988 | 0.007 | -1.74 | 0.082 | 0.974 | 1.002 |
| Number of prior assessments | 1.011 | 0.003 | -7.89 | 0.000 | 0.329 | 0.512 |

Observations = 708.

# Accessible versions of Figures 19 and 20

**Figure 19: Coverage of Assessment Domains By IA Tools For Ages 18+ Years**

| Domain | WHODAS | LEFS | Vineland | CHIEF |
|---|---|---|---|---|
| Communication | Yes | No | Yes | No |
| Social Interaction Self Care | Yes | No | Yes | No |
| Learning | Yes | No | Yes | No |
| Mobility | Yes | Yes | No | No |
| Self Care | Yes | No | Yes | No |
| Self Management | Yes | No | Yes | No |
| Social Participation | Yes | No | Yes | No |
| Economic Participation | Yes | No | Yes | No |
| Capacity / Performance with assistance | Yes | No | No | No |
| Capacity / Performance without assistance | Yes | Yes | Yes | No |
| Participation | Yes | No | Yes | No |
| Environment | No | No | No | Yes |

Return to figure 19

**Figure 20: Coverage of Assessment Domains By IA Tools For Ages 7-17 Years**

| Domain | PEM-CY | PEDICAT / PEDICAT-ASD | Vineland |
|---|---|---|---|
| Communication | Yes | Yes | Yes |
| Social Interaction Self Care | Yes | Yes | Yes |
| Learning | Yes | Yes | Yes |
| Mobility | Yes | Yes | Yes |
| Self Care | Yes | Yes | Yes |
| Self Management | Yes | Yes | Yes |
| Social Participation | Yes | Yes | Yes |
| Economic Participation | Yes | No | Yes |
| Capacity / Performance with assistance | No | Yes | No |
| Capacity / Performance without assistance | No | No | Yes |
| Participation | Yes | No | Yes |
| Environment | Yes | No | No |

Return to Figure 20