Task 2017-18 Disability assessment – country report[1]

Country: Spain

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[1] Available at: https://ec.europa.eu/employment_social/empl_portal/ede/file_5d247c3e226d7_ES_ANED%202017-18%20-%20Assessment%20method%20-%20country%20report%20Spain_final%20for%20web.docx

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Part 1 – Main forms of disability assessment

The following forms of disability assessment are currently in use in Spain for a variety of purposes.

Example 1: Assessment for admission to official disability status (general register)

Example 2: Assessment for Dependency assessment

Example 3: Assessment for Special Education Needs

Example 4: Assessment for determining incapacity for work

Example 5: Assessment for Workplace adaptations or equipment

Example 1: Assessment for admission to official disability status (general register).

Policy function: Recognition of official disability status (e.g. a general register).

Benefit: Benefits in cash (e.g. pension). Benefits in kind (e.g. services). Beneficial treatment (e.g. eligibility to apply for quota jobs). Discounts or concessions (e.g. tax allowances).

Specificity: The disability assessment is designed for this specific purpose.

Responsible: Department of Social Services.

How to apply: http://www.discapnet.es/Areas-tematicas/nuestros-derechos/preguntas-y-resPuestas/certificado-de-discapacidad-antiguamente-llamado-de-minusvalia#3.

Type of assessment: Holistic assessment (combination of impairment, functional and environmental approaches).

Qualifying criteria: level of impairment must be higher than 33%.

Method: Combination of documentary evidence and personal interaction.

Assessor: Medical doctor, Therapist (physical, occupational, etc.). Other rehabilitation specialist, Psychologist, Social worker.

Supporting evidence: Evidence from someone who knows the applicant's situation (e.g. a relative, friend, neighbour or colleague). Evidence from a non-medical professional who knows the applicant. A medical note or letter from a doctor who treats the applicant., Medical records automatically retrieved from health care system (e-health).

Decision maker: Interdisciplinary team.

Further details of the assessment:
https://www.boe.es/boe/dias/2000/01/26/pdfs/A03317-03410.pdf.

Notification of outcome: A certificate (e.g. proof of disability status).

Appeal possible:

Administrative claim prior to the claim by judicial means.

Example 2: Assessment for Dependency assessment

Policy function: Help with additional costs of living associated with disability.

Benefit: Benefits in cash (e.g. pension). Benefits in kind (e.g. services). Beneficial treatment (e.g. eligibility to apply for quota jobs). Discounts or concessions (e.g. tax allowances).

Specificity: The disability assessment is designed for this specific purpose.

Responsible: Department of Social Services.

How to apply: https://www.boe.es/boe/dias/2011/02/18/pdfs/BOE-A-2011-3174.pdf.

Type of assessment: Holistic assessment (combination of impairment, functional and environmental approaches).

Qualifying criteria: According to a Barema of Dependency level, the score must be equal or higher than 25 points.

Method: Combination of documentary evidence and personal interaction.

Assessor: Social worker.

Supporting evidence: Evidence from someone who knows the applicant's situation (e.g. a relative, friend, neighbour or colleague). Evidence from a non-medical professional who knows the applicant. A medical note or letter from a doctor who treats the applicant. Medical records automatically retrieved from health care system (e-health).

Decision maker: An interdisciplinary team (from public administration).

Further details of the assessment:
http://www.dependencia.imserso.es/dependencia_01/ciudadanos/trami_solicutud/ccaa_dt_imserso/index.htm.

Notification of outcome: A certificate (e.g. proof of disability status).

Appeal possible.

Administrative claim prior to the claim by judicial means.

Example 3: Assessment for Special Education Needs

Policy function: Additional support at school or college.

Benefit: Benefits in cash (e.g. pension). Benefits in kind (e.g. services). Beneficial future treatment (e.g. eligibility to apply for quota jobs if these special educational needs are associated to a disability). Discounts or concessions (e.g. tax allowances).

Specificity: Only persons with a previous disability assessment can apply (but this is a second stage of disability assessment designed for the specific purpose).

Responsible: Department of Education.

How to apply: https://www.boe.es/boe/dias/1996/02/23/pdfs/A06918-06922.pdf.

Type of assessment: Holistic assessment (combination of impairment, functional and environmental approaches).

Qualifying criteria: Different levels of special education needs are associated to different school modalities (special education, full mainstreaming, partial mainstreaming).

Method: Combination of documentary evidence and personal interaction.

Assessor: Other rehabilitation specialist, Psychologist.

Supporting evidence: Evidence from someone who knows the applicant's situation (e.g. a relative, friend, neighbour or colleague). Evidence from a non-medical professional who knows the applicant. A medical note or letter from a doctor who treats the applicant. Medical records automatically retrieved from health care system (e-health).

Decision maker: Vocational counsellor/Educational team.

Further details of the assessment:
http://www.aspergeralicante.com/pdfrecursos/nee.pdf.

Notification of outcome: Other. Psycho pedagogical report with suggestions of the most appropriate schooling modality for the student.

Appeal possible.
Administrative claim prior to the claim by judicial means.

Example 4: Assessment for determining incapacity for work

Policy function: Access to a disability pension (invalidity).

Benefit: Benefits in cash (e.g. pension). Benefits in kind (e.g. services). Beneficial treatment (e.g. eligibility to apply for quota jobs). Discounts or concessions (e.g. tax allowances).

Specificity: The disability assessment is designed for this specific purpose.

Responsible: Department of Employment and Social Security.

How to apply:
http://www.seg-social.es/prdi00/groups/public/documents/binario/143518.pdf.

Type of assessment: Functional capacity (test of ability to carry out specified tasks or activity).

Qualifying criteria: Temporary of permanent incapacity to work. In case of permanent incapacity, it can be classified as partial, total, absolute or as major incapacity.

Method: Combination of documentary evidence and personal interaction.

Assessor: Medical doctor, Therapist (physical, occupational, etc.) Other rehabilitation specialist.

Supporting evidence: Self-assessment (statement or structured questionnaire completed by the individual). Evidence from someone who knows the applicant's situation (e.g. a relative, friend, neighbour or colleague). Evidence from a non-medical professional who knows the applicant. A medical note or letter from a doctor who treats the applicant. Medical records automatically retrieved from health care system (e-health).

Decision maker: Medical doctor of primary care, and Medical doctor specialist in Work Medicine.

Further details of the assessment: http://www.boe.es/boe/dias/1997/01/31/pdfs/A03031-03045.pdf.

Notification of outcome: A letter explaining the outcome.

Appeal possible.
Administrative claim prior to the claim by judicial means.

Example 5: Assessment for Workplace adaptations or equipment

Policy function: Workplace adaptations or equipment.

Benefit: Benefits in kind (e.g. services). Beneficial treatment (e.g. eligibility to apply for quota jobs). Discounts or concessions (e.g. tax allowances for the business to make reasonable accommodations).

Specificity: Only persons with a previous disability assessment can apply (but this is a second stage of disability assessment designed for the specific purpose).

Responsible: Private companies and public administration.

How to apply:
http://www.madrid.org/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobheadername1=Content-Disposition&blobheadervalue1=filename%3DSolicitud+adaptaci%C3%B3n+puesto+de+trabajo.pdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1352857717088&ssbinary=true.

Type of assessment: Functional capacity (test of ability to carry out specified tasks or activity).

Qualifying criteria: Being classified as disabled (i.e. 33% or higher level of impairment) makes the individual eligible for these accommodations.

Method: Combination of documentary evidence and personal interaction.

Assessor: Medical doctor, Therapist (physical, occupational, etc.) Other rehabilitation specialist.

Supporting evidence: Self-assessment (statement or structured questionnaire completed by the individual). Evidence from someone who knows the applicant's situation (e.g. a relative, friend, neighbour or colleague). Evidence from a non-medical professional who knows the applicant. A medical note or letter from a doctor who treats the applicant. Medical records automatically retrieved from health care system (e-health).

Decision maker: The employer.

Further details of the assessment:
http://www.ceapat.org/InterPresent2/groups/imserso/documents/binario/adaptacionpuestra.pdf.

Notification of outcome: A letter explaining the outcome.

Appeal possible.
Administrative claim prior to the claim by judicial means.

Part 2 – Analysis and evaluation of specific assessments

This part of the report provides more in-depth analyses of three selected case studies of assessment procedure, their suitability and effectiveness.

Please use the EU MISSOC tables (similar to DOTCOM) providing country specific information on specific types of benefits as a starting point, http://www.missoc.org/INFORMATIONBASE/COMPARATIVETABLES/MISSOCDATABASE/comparativeTableSearch.jsp.

The cases are selected to enable systematic comparison between countries and to focus on areas of policy priority and development.

Case study 1: Assessment for admission to official disability status (general register)

(admission to a general register or status of disabled person(s) or comprehensive assessment for multiple purposes)

An outline of the key features of this assessment process is provided in Part 1 of this report (see **Example 1**). As stated previously, it is aimed at recognizing an official disability status, by an interdisciplinary team from the Social Services Department. A level of impairment higher than 33% make the individual eligible for different benefits in cash and in kind.

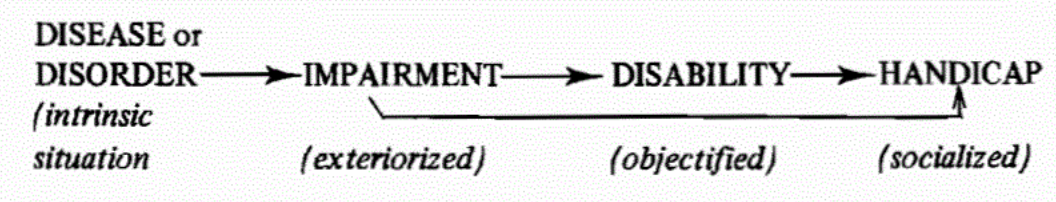
Detailed description of the assessment process

The main stages of the process, from application to decision, and appeal against decision, detailing the types of professionals involved and their responsibilities. Please also describe the administrative arrangements and the roles of the different institutions involved in the process. Please indicate what role the person being assessed plays in the procedure.

- The request must be made to the social security office/centre of each autonomous community.
- The assessment and guidance teams (EVO team) of these offices/centre, which are called base centre, are responsible for diagnosis and qualification. This is a holistic assessment, as the EVO team includes a medical doctor, a social worker, and psychologist.
- It can be requested throughout the year.
- There are official application forms to process this request (e.g. http://www.alhaurindelatorre.es/images/TRAMITES/0_317_1.pdf) although it is increasingly possible to make the request via the Internet. (see example in: http://politicasocial.xunta.gal/export/sites/default/Benestar/Biblioteca/Documentos/Contidos_Estandar/BS611A_cas.pdf).
- A copy of any previous medical, educational, psychological, and so on, reports can be included along with the application, as well as any other information deemed

appropriate according to the regulations[2] to provide proof of the alleged disability (e.g. https://sede.asturias.es/Asturias/SERVICIOS/2002547_informesmedicos.pdf).

- The EVO Team must issue a decision on the recognition of the degree of handicap, as well as the score obtained in the scales, which will specify the percentage of disability. So, according to the International Classification of Impairments, Disabilities, and Handicaps (WHO) (see Figure 1), the scales assess the degree of the impairments and gives a score for each organ and system that is impaired. Then, additional scores for disabilities to perform daily living activities are added. Then if the resulting score is 25% or higher, the level of handicap (i.e. social disadvantaged) is added, and depending on the disadvantaged economic, family, social, and cultural situations, a total of 15 points can be added. The total degree is the resulting of adding scores from impairment, disability, and handicapped situations.[3]



- Figure 1. Graphic representation of the association among concepts (source: WHO, 1980).
- Depending on the recognized percentage, the person is eligible for services and financial aid.
- The recognition of the degree of disability takes effect from the date on which the request was processed.
- The decision must include the date when the recognized degree of disability must be reviewed. In general terms, at least two years must have passed from the date of recognition of the degree, for that degree to be reviewed.
- The national regulation [Royal Decree 1971/1999, of December 23, on the procedure for the recognition, declaration and qualification of disability (BOE 26-01-2000),[4] as well as Royal Decree 1169/2003, of September 12 (BOE 26-01-2000)][5] is specified in the different regional regulations [for example, in Castilla y León there is the Order of June 15, 2000, establishing the Procedure for the Recognition, Declaration and Qualification of the Degree of Disability (BOCyL 06-07-2000).[6]

2 http://sid.usal.es/leyes/discapacidad/3119/3-1-5/real-decreto-1971-1999-de-23-de-diciembre-de-procedimiento-para-el-reconocimiento-declaracion-y-calificacion-del-grado-de-minusvalia.aspx.

3 See the complete document of the procedure, scores, etc., at: http://www.juntadeandalucia.es/export/drupaljda/valoracion_discapacidades.pdf.

4 https://www.boe.es/boe/dias/2000/01/26/pdfs/A03317-03410.pdf.

5 https://www.boe.es/boe/dias/2003/10/04/pdfs/A36136-36138.pdf.

6 http://www.jcyl.es/web/jcyl/binarios/778/186/CAP.%20VII%20-%20PARAGRAFO%2004.pdf?blobheader=application%2Fpdf%3Bcharset%3DUTF-8&blobheadername1=Cache-Control&blobheadername2=Expires&blobheadername3=Site&blobheadervalue1=no-store%2Cno-cache%2Cmust-revalidate&blobheadervalue2=0&blobheadervalue3=JCYL_ServiciosSociales&blobnocache=true.

Sources of official guidance and assessment protocols

Details of the guidance provided to assessors, methodology used, questionnaires, assessment scales, pro-forma used in the process, etc, with links to sources where available.

The impairments are classified according to the WHO (1980) classification in: Intellectual impairments; Other psychological impairments.; Language impairments; Aural impairments; Ocular impairments; Visceral impairments; Skeletal impairments; Disfiguring impairments; Generalized, sensory, and other impairments. There are published Tables to give a specific score for each impairment, depending on the degree of such limitation. For example, concerning language impairments, a degree of I means that there is a slight limitation in comprehension or expression (0-14% degree), whereas a degree of V means that the individual has total limitation in comprehension and expression (85-100% degree). The percentages of limitation for each system, organ, etc., are then transformed into a global level of disability for the individual. There is a Table to transform the different impairment into a combined percentage (see Figure 2).

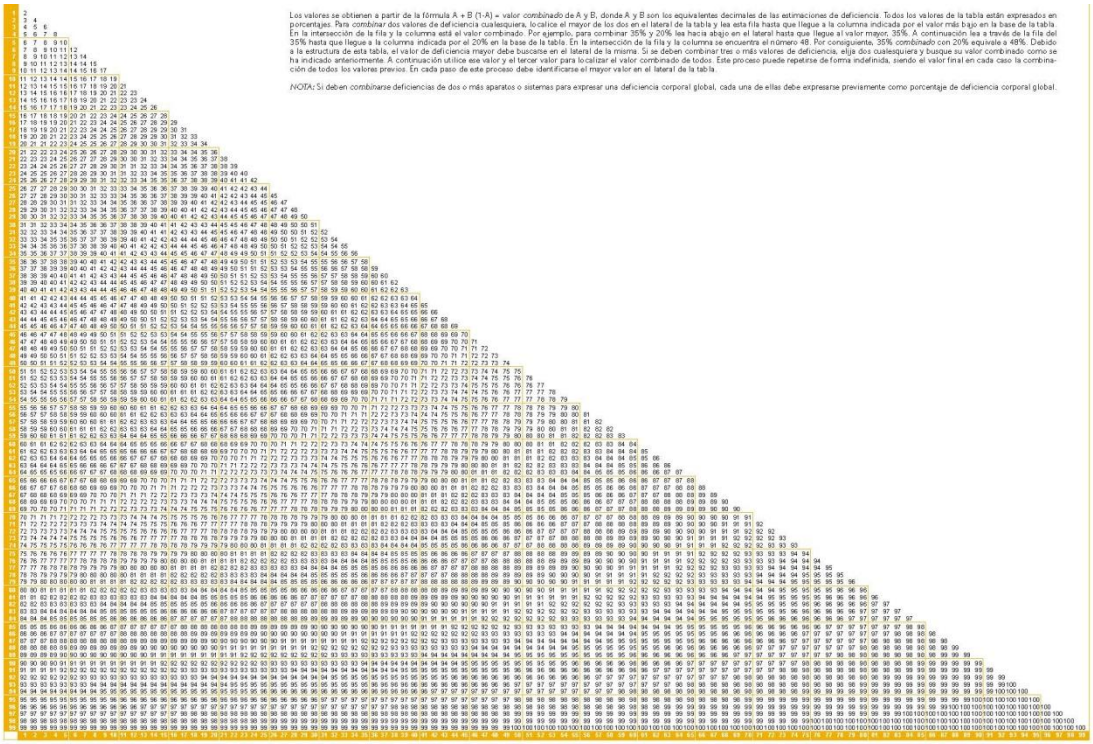


Figure 2. Table to estimate combined impairments (source: IMSERSO, page 249).[7]

[7] http://www.juntadeandalucia.es/export/drupaljda/valoracion_discapacidades.pdf.

There is a scale for the assessment of the degree of disability, included in the current regulations.[8]

The degree of disability is determined by adding the disability percentage (resulting from applying the specific scale for each device or system) to the result from applying the social factors scale. The minimum assessment of disability on which the social factors scale can be applied cannot be less than 25%. Table 3 summarizes the Social (family, economic, labour, cultural, and environmental) factors.

1. SOCIAL FACTORS

1.1. FAMILY FACTOR

1.1.1.Serious problems in family members (up to 3 points):
- 1.1.1.1. Disability or serious illness in parents or guardians.
- 1.1.1.2. Disability or serious illness in children.
- 1.1.1.3. Disability in siblings or other family members.
- 1.1.1.4. Others (specify).

1.1.2.Absence of responsible members of the family unit (up to 3 points):
- 1.1.2.1. For death.
- 1.1.2.2. By default.
- 1.1.2.3. Others (specify)

1.1.3.intrafamilial relationships that hinder integration (up to 3 points):
- 1.1.3.1. Overprotection.
- 1.1.3.2. Covert abandonment.
- 1.1.3.3. Exploitation.
- 1.1.3.4. Others (specify)

1.1.4.Other situations not covered (up to 3 points):
- 1.1.4.1. Marginal general situations.
- 1.1.4.2. Low cultural level.
- 1.1.4.3. Social inability
- 1.1.4.4. Others (specify)

MAXIMUM SCORE: 1.1.1 to 1.1.4 = 5 POINTS

1.2. ECONOMIC FACTOR

It will be valued with reference to the minimum interprofessional salary, according to the following guidelines:

Sum of the total family income. This whole will be subtracted (1.2.1 + 1.2.2):

1.2.1.Housing expenses:
- 1.2.1.1. Rental.
- 1.2.1.2. First housing amortization.
- 1.2.1.3. Eviction.
- 1.2.1.4. Elimination of architectural barriers.

1.2.2.Extraordinary expenses of a prolonged nature:
- 1.2.2.1. Educational (support measures, expenses derived from the lack of educational resources
- 1.2.2.2. in the area, others: specify).
- 1.2.2.3. Sanitary (derived from rehabilitative and recovery measures, pharmacological treatments,
- 1.2.2.4. Others (specify.

The result will be divided by the number of members that make up the family unit.

Finally, a factor that takes into account the per capita income of the family unit (up to 4 points) is applied

1.3. LABOUR FACTOR

[8] http://sid.usal.es/leyes/discapacidad/3119/3-1-5/real-decreto-1971-1999-de-23-de-diciembre-de-procedimiento-para-el-reconocimiento-declaracion-y-calificacion-del-grado-de-minusvalia.aspx.

It will be valued (up to 3 points, the worse the situation is):
1.3.1. Unemployment situation
1.3.2. Underemployment situation
1.4. CULTURAL FACTOR
It will be valued (up to 4 points the smaller it is)
1.4.1. Cultural situation DEPRESSED
1.4.2. LOWER cultural situation
1.4.3. PRIMARY cultural situation, without compensating in post-school
1.4.4. ORDINARY cultural situation
1.5. ENVIRONMENT FACTOR
1.5.1. Lack or difficulty of access to health, rehabilitation, educational, cultural, professional, assistance, occupational, media resources, other -specify-, as long as they are considered necessary in the integrating process.
1.5.2. Difficulties in housing and / or architectural barriers and / or communication.
1.5.2.1. Housing: lack or inadequacy.
1.5.2.2. Barriers in the environment.
1.5.2.3. Lack of adapted transport.
1.5.3. Problems of social rejection.
MAXIMUM SCORE: 1.5.1 to 1.5.3 = 4 POINTS.
THE MAXIMUM SCORE TO BE GIVEN IN THE SUM OF ALL THE SOCIAL FACTORS WILL BE 15 POINTS.

Table 3. Summary of social Factors (source. IMSERSO, pp.251-256).[9]

In a complementary way, in the case of physical disability, another scale allows determining the need for third-party assistance, provided that a minimum of 15 points is obtained in the scale. In addition, another scale allows analysing the severity of the difficulties to use public transport (see IMSERSO, pp. 258-264).[10]

The complete scale can be downloaded from: http://www.juntadeandalucia.es/export/drupaljda/valoracion_discapacidades.pdf. This publication makes it easier for technical assessment teams to determine the degree of disability of a person.

The scale establishes norms for the evaluation of the consequences of the disease, in accordance with the model proposed by the WHO International Classification of Impairments, Disabilities, and Handicaps.[11]

Implementation and outcomes

Evidence of the practical implementation, including, where possible, the number of persons assessed, average waiting times, and the assessment outcomes.

The implementation of the process is 100% since it is mandatory, and the same process is followed throughout the country.

9 http://www.juntadeandalucia.es/export/drupaljda/valoracion_discapacidades.pdf.
10 http://www.juntadeandalucia.es/export/drupaljda/valoracion_discapacidades.pdf.
11 http://apps.who.int/iris/bitstream/10665/41003/1/9241541261_eng.pdf.

The maximum time between request and decision is also established by law and is a maximum of six months. In some Autonomous Communities the term is three months (e.g.: see the procedure in the region of Castilla y León: https://www.tramitacastillayleon.jcyl.es/web/jcyl/AdministracionElectronica/es/Plantilla100Detalle/1251181054765/281/1211891517654/Tramite).

Decisions can be appealed. Administrative silence (i.e. if the administration does not respond to the appeal) means that the appeal has been dismissed.[12]

There is a state database of assessment data for people with a degree of disability. The latest report is from 2015 and can be downloaded from: (http://www.imserso.es/InterPresent1/groups/imserso/documents/binario/bdepcd_2015.pdf). It includes figures of population and persons evaluated. It specifies the number of people with recognition of disability. It also includes figures of population with recognized degree of disability equal to or greater than 33% disaggregated by sex, autonomous community, province, age, etc.

This database, updated as of December 31, 2015, includes the data provided by all the Autonomous Communities and contains a total of 2,998,639 records related to persons who, after assessing their disability, have received a decision of having a disability. Of these, 1,505,645 (50.21%) are women, 1,492,946 (49.79%) men with 48 records of the total where gender data is unknown.

The data are collected grouped in intervals of severity of the disability and taking into consideration the variables of sex, age, type of disability and geographic scope.

Evaluation – fitness for purpose

Analysis of the strengths and weaknesses of the assessment method, including where possible evidence from official or independent evaluations, studies etc. For example, the balance of medical and non-medical input, cost-effectiveness, administrative burden, claimant experience, compatibility with the CRPD. Please indicate if there is a regular evaluation of the assessment method and, if so, who carries that out. Please include references to evaluations which have been carried out.

Studies have been carried out to evaluate and improve the evaluation process. An example is the following document: http://www.juntadeandalucia.es/export/drupaljda/proceso_de_valoracion_marzo_2016.pdf. This document suggests some improvement actions regarding to: (a) Create a document to inform about how the attention process is carried out during the face-to-face assessment. (b) Establish verification criteria: checklist with the essential elements that each medical, psychological and social opinion must contain. (c) Establish a system for calling users in the waiting room by number, instead of using their name and surnames in public (to protect confidentiality). (d) Establish how to track and locate records. (e)

[12] According to the Law 39/2015, of October 1, on the Common Administrative Procedure of Public Administrations.

Establish technical criteria to determine in which cases the assessment at home is necessary. (f) Establish technical criteria to determine in which cases to perform non-face-to-face assessments.

There are differences among Autonomous Communities. The years of the economic crisis have also had a negative impact on this process. In some communities there are waiting lists to receive a disability assessment that have exceed the six months established by law.

For example, in this 2012 press article, (https://elpais.com/ccaa/2012/08/21/valencia/1345577377_327530.html) it is indicated that in 2012 in the Valencian Community there were more than 3,000 records pending consideration. The document indicates that the monthly average of applications was of 397 and the monthly average of decisions was of 486.

Another example is from a 2011 press article: https://www.lavozdegalicia.es/noticia/sociedad/2011/03/08/10000-gallegos-esperan-citacion-valorar-grado-minusvalia/0003_201103G8P34993.htm, relating to the situation of the region of Galicia indicated that at that time there was a waiting list of more than 10,000 people waiting for official recognition. In turn, there were significant disparities within the same autonomous community, since the time between application and decision could be up to 20 months in Ferrol, 19 months in Pontevedra, 13 months in Ourense, 12 months in Vigo and 8 months in A Coruña.

The document: "Analysis and evaluation of the centre and teams of the public administrations that intervene in the assessment of the different situations of disability" (IMSERSO, 2006) (http://www.imserso.es/interpresent3/groups/imserso/documents/binario/informecvo.pdf) includes many statistics in this regard, and it would be interesting to have an updated version of it.

Promising practice

If the case study includes examples of good practice, of interest to the EU and other countries, then identify and explain the most promising elements. Please indicate if disabled peoples' organisations have been involved in developing or evaluating the assessment method.

The implementation of quality processes in management, in relation to the evaluation and improvement of the evaluation process, constitute an example of good practice, as it offers the opportunity to exchange best practices, protocols, and flowcharts among regions, and Autonomous Communities: http://www.juntadeandalucia.es/export/drupaljda/proceso_de_valoracion_marzo_2016.pdf.

The assessment of disability is made in accordance with WHO, rather than being subject to the discretion of local organizations (for example the scale used or the definition of the degrees of disability).

The Spanish Committee of Representatives of Persons with Disabilities (CERMI), which brings together all the organizations for this group, has been requesting the approval of a new disability assessment scale that replaces the current 1999 one, considering it to be out of date. CERMI requires a new assessment instrument in accordance with the International Classification of the Functioning of Disability and Health (ICF) and with the social model of understanding disability that is enshrined in the UN Convention.[13] The CERMI proposes to unify criteria in everything related to evaluation, so that there are no inequalities, differentiated treatment or grievances for the place where a person resides, given that the place of residence impacts on the evaluation, time limits, etc. CERMI also insists on the need to "broaden the concept of the declaration of reduced mobility according to the new paradigms of personal autonomy and universal accessibility, as well as its extension to other groups of people with disabilities with support needs for their mobility, communication or understanding of the environment, which, traditionally, have been excluded from this declaration. In sum, the stress the need for adopting a social model, rather than a medical model of disability, which is more congruent with the UNC Convention. Since 2015, CERMI is part of the working group created by the government to consider possible changes in the scale of evaluation of dependency.

There is an active demand from early care professionals regarding greater observation and evaluation of the child in their environment (García-Sánchez, 2014; http://webs.um.es/fags/docs/2014cl_at_scf_aelfa.pdf) and increase of family involvement in all evaluation processes to develop a family-centred approach.[14]

Though WHODAS 2.0 is not used the effective application of the International Classification of Functioning, Disability and Health (ICF) proposed by the World Health Organization (WHO) in Spain is limited, although rapidly growing, of a scientific nature, and referring above all to the conceptual and diagnostic framework in different clinical, rehabilitation and population contexts, but with little application in services (Comin et al., 2011; https://doi.org/10.1016/j.gaceta.2011.09.004).[15]

[13] See: https://www.cermi.es/es/actualidad/noticias/el-cermi-demanda-al-imserso-un-baremo-de-discapacidad-ajustado-al-modelo-social.

[14] García-Sánchez, F. A. (2014). Atención Temprana: enfoque centrado en la familia. En AELFA (Ed.) XXIX Congreso AELFA. Logopedia: evolución, transformación y futuro (p. 286-302). Madrid: AELFA.

[15] Comín, M., Ruiz, C., Franco, E., Damian, J., Ruiz, M., & de Pedro-Cuesta, J. (2011). Producción científico-profesional española sobre discapacidad según el modelo CIF. Revisión de la literatura, 2001-2011. *Gaceta Sanitaria*, *25*(Suppl. 2), 39–46. https://doi.org/10.1016/j.gaceta.2011.09.004.

Case study 2: Assessment for determining incapacity for Work

(eligibility for invalidity pension, as defined by MISSOC)

An outline of the key features of this assessment process is provided in Part 1 of this report (see **Example 4**). As stated previously, it is aimed at recognizing an official incapacity for work status, by a medical doctor team from the Department of Employment and Social Security. In case of permanent incapacity, different degrees make the individual eligible for different benefits.

Detailed description of the assessment process

The main stages of the process, from application to decision, and appeal against decision, detailing the types of professionals involved and their responsibilities. Please also describe the administrative arrangements and the roles of the different institutions involved in the process. Please indicate what role the person being assessed plays in the procedure.

First, given the complexity of the Spanish system, we are including information on the definition, conditions, benefits, etc. All this information has been retrieved from MISSOC database.

Permanent incapacity (incapacidad permanente):[16] Situation of a worker who, after having undergone prescribed treatment, suffers from physical or functional disabilities, capable of objective assessment and probably definitive in character, which render him/her partially or totally incapable of work.

Conditions: (1) Minimum level of incapacity for work (33% reduction in capacity); (2) Possibility of review: Review possible at any time up to the minimum retirement age. (3) Period for which cover is given: From the date on which the Disability Evaluation Board (Equipo de Valoración de Incapacidades, EVI) declares claimant to be permanently incapable. At the retirement age, the name changes to retirement pension but this change does not imply any alteration concerning the conditions of the payment.

Second, concerning the stages of the process:

The claim for the assessment of Permanent Disability can be initiated by:

1. The interested party (claimant), at any time.
2. At the request of the Public Health Service (Physician or Inspector) or by a Mutua, a private insurance fund affiliated with the social security system.
3. Ex officio:
    - At the request of the National Institute of Social Security (INSS).

[16] All this information has been downloaded from: http://www.missoc.org/MISSOC/INFORMATIONBASE/COMPARATIVETABLES/MISSOCDATABASE/comparativeTableSearch.jsp.

- At the request of the Labour Inspectorate.[17]

4. Exhaustion of term: After 545 days of Temporary Incapacity.
5. In insured persons of a private insurance fund affiliated with the social security system (e.g. MUFACE or MUGEJU), the corresponding personnel body.

Once the process has begun, the decision determines the type, severity and level of the incapacity. As mentioned in the first section, the incapacity can be classified as Temporary or permanent incapacity to work. In case of permanent incapacity, it can be classified as partial, total, absolute or as major incapacity.

The assessment is carried out by the Disability Assessment Team: EVI Medical Tribunal, which is a social-medical team, framed in the National Institute of Social Security. It is a technical team from the Social Security, that is entrusted with Inspection and evaluation of pathologies that may or may not determine a temporary or permanent incapacity.

When a worker exhausts the maximum time of legally established temporary incapacity (365 + 180 = 545 days), the worker or official is summoned by the Disability Assessment Team (EVI) belonging to the INSS, where, after a routine review, and examination of the medical reports available on the worker, the INSS issues a proposed report that will be submitted to the competent body to issue the decision rejecting or granting Permanent Incapacity.

Private workers who do not agree with the decision issued by the INSS have a period of 30 days to file a claim to the labour court. In the case of public servants, there is only the possibility of a review of their incapacity situation by MUFACE or the corresponding personnel body or to appeal the denial of sick leave.

The report by a physician-appraiser assessor (from the public health administration), must assess the psychophysical capabilities of the patient and the requirements of the occupation. By virtue of this relationship they determine whether the worker is or is not able to perform their work activity. If they are not able to work, even with adaptations and or training the appraiser should determine the extent of incapacity and if it is temporary or permanent. The consequences of the injury or pathologies for work are what is really assessed. It is the functional limitations (i.e. the limitations to perform a job), not the diagnoses, which lead to the situation of incapacity.

Sources of official guidance and assessment protocols

Details of the guidance provided to assessors, methodology used, questionnaires, assessment scales, pro-forma used in the process, etc, with links to sources where available.

[17] When the institutions referred to in points 2 and 3 consider that the health status of a worker is not changing and it is not going to improve, they may request this type of assessment, so the government takes care of the pension and related benefits.

There are guides for primary care physicians to assess incapacity, given that temporary incapacity (medical leave due to an accident, a professional illness, a disease) is decided by these professionals. Thus, Primary care physicians, specialists in family and community medicine, are usually competent to issue the parts of discharge, confirmation and discharge, initiating, maintaining and ending this way, the vast majority of situations that after the part of discharge can reach be recognized with the right to temporary disability subsidy by the National Institute of Social Security (page 13 of the guide downloadable from: http://www.seg-social.es/prdi00/groups/public/documents/binario/143518.pdf).

There are regulations governing this process:

- Royal Legislative Decree 8/2015, of October 30, approving the revised text of the General Social Security Law (BOE num. 261, de October 31, 2015).[18]
- Law 40/2007, of December 4, on Social Security measures. (BOE num. 291, December 5, 2007).[19]
- Royal Decree 1430/2009, of September 11, which regulates the Law 40/2007, of December 4, on measures in matters of social security, in relation to the provision of temporary incapacity. (BOE num. 235, September 29, 2009).[20]
- Royal Decree 1300/1995, of July 21, by which develops, in matters of work incapacities of the Social Security system, the law 42/1994, of December 30, of fiscal, administrative and social measures. (BOE num. 198, August 19, 1995).[21]
- Royal Decree 625/2014, of July 18, which regulates certain aspects of the management and control of the processes for temporary incapacity in the first 365 days of its social duration (BOE num. 175, July 21, 2014).[22]
- Order ESS / 1187/2015, of June 15, which develops the Royal Decree 625/2014, of July 18, which regulates certain aspects of management and control of the processes of temporary incapacity in the first 365 days (BOE num. 147, June 20, 2015).[23]

Implementation and outcomes

Evidence of the practical implementation, including where possible the number of persons assessed, average waiting times and the assessment outcomes.

There are annual statistics of temporary incapacities.[24] For example, the executive summary of the Report on occupational diseases indicates that in 2016 there have been a total of 26,277 diseases caused by work, of which 20,600 were occupational diseases

18 https://www.boe.es/boe/dias/2015/10/31/pdfs/BOE-A-2015-11724.pdf.
19 https://www.boe.es/boe/dias/2007/12/05/pdfs/A50186-50200.pdf.
20 https://www.boe.es/boe/dias/2009/09/29/pdfs/BOE-A-2009-15442.pdf.
21 https://www.boe.es/boe/dias/1995/08/19/pdfs/A25856-25860.pdf.
22 https://www.boe.es/boe/dias/2014/07/21/pdfs/BOE-A-2014-7684.pdf.
23 https://www.boe.es/boe/dias/2015/06/20/pdfs/BOE-A-2015-6839.pdf.
24 http://www.seg-social.es/Internet_1/Estadistica/Est/Otras_Prestaciones_de_la_Seguridad_Social/Incapacidad_Temporal/index.htm.

and 5,677 were non-traumatic pathologies caused or aggravated by work. The report indicates that comparing with Europe, France and Spain are the countries with the highest number of diseases caused by work.[25] Of all reports of professional diseases, 47.99%, namely 9,886, were off work (i.e. temporary disability) and 10,714 had no sick leave. With respect to 2015, the files with sick leave increased by 8.96% (page 6). The reports of occupational diseases reported in 2016 represent an incidence of 124,24 cases per each 100,000 workers, a higher rate than in previous years (page 8).

Permanent incapacity statistics are also available, as of 2017.[26] By February 2018, there were a total of 948,393 individuals with permanent incapacity of whom, 33,449 had Severe incapacity (Gran invalidez), whereas 347,168 had absolute permanent incapacity, for example.[27]

Benavides et al. (2010),[28] in a study of the incidence of permanent, common and occupational incapacities, according to socio-labour and territorial variables, found significant demographic, social and territorial differences among the Spanish autonomous communities, which requires a detailed study. The authors state that the incidence of non-work-related permanent incapacity was 10 times greater than that of work-related incapacity (36.3 versus 3.7 per 10,000 workers-years). The incidences for both non-work-related and work-related incapacity were higher in men and increased with age and lower education level. For non-work-related permanent incapacity, the region with the highest incidence was Asturias and that with the lowest was Madrid (56.7 vs. 23.3). For work-related permanent incapacity, the highest incidence was found in Asturias and the lowest in Navarre (7.8 vs. 1.4). This differential was maintained for work-related and non-work-related permanent incapacity for Asturias, after adjustment was made by sex, age, educational level, company size and economic activity.

Evaluation – fitness for purpose

Analysis of the strengths and weaknesses of the assessment method, including where possible evidence from official or independent evaluations, studies etc. For example, the balance of medical and non-medical input, cost-effectiveness, administrative burden, claimant experience, compatibility with the CRPD. Please indicate if there is a regular evaluation of the assessment method and, if so, who carries that out. Please include references to evaluations which have been carried out.

[25] Downloadable at: http://www.seg-social.es/Internet_1/Estadistica/Est/Observatorio_de_las_Enfermedades_Profesionales/Informes%20anuales/index.htm#documentoPDF.

[26] http://www.seg-social.es/Internet_1/Estadistica/Est/Pensiones_y_pensionistas/Pensiones_contributivas_en_vigor/Incapacidad_permanente/index.htm.

[27] See data at: http://www.seg-social.es/Internet_1/Estadistica/Est/Pensiones_y_pensionistas/Pensiones_contributivas_en_vigor/Incapacidad_permanente/ESTC_005394.

[28] Benavides, F. G., Durán, X., Martínez, J. M., Jódar, P., Boix, P., & Amable, M. (2010). Incidencia de incapacidad permanente en una cohorte de trabajadores afiliados a la Seguridad Social, 2004-2007. Gaceta Sanitaria, 24(5), 385–390. https://doi.org/10.1016/j.gaceta.2010.06.003.

The assessment is carried out by the by the Disability Assessment Team (EVI) belonging to the INSS. There is a lack of independent evaluations. The information is mostly medical, as what is assessed is the functional limitation to perform a job (or any kind of job). The CERMI demands that the pension for severe incapacity, as well as the dependency pension, be declared unattachable, which requires amending several Spanish laws.

Promising practice

If the case study includes examples of good practice, of interest to the EU and other countries, then identify and explain the most promising elements. Please indicate if disabled peoples' organisations have been involved in developing or evaluating the assessment method.

The guide for primary care physicians for the assessment of disability is a good practice since it includes not only information to make an adequate assessment of disability but also to evaluate a job position and the necessary adjustments: http://www.seg-social.es/prdi00/groups/public/documents/binario/143518.pdf. The disability assessment is mostly focused on the individual capabilities; thus, it is a medical-focused assessment. This promising practice tries to stress the relevance of assessing the environment when performing the evaluation process.

Reneman & Chaler (2017)[29] propose the use of an evaluation of functional capacity to assess the ability to work for people with disabilities in Spain, and collect the current problems for their implementation. Such functional capacity evaluation (FCE) is an evaluation of capacity of activities that is used to make recommendations for participation in work, while considering the person's body functions and structures, environmental factors, personal factors and health status.It consists of a battery of standardized tests. In recent years, in order to improve disability evaluation, a growing interest has developed among researchers and clinicians about this specific area. The aim of this editorial is to introduce FCE, which has potential to enhance the quality of disability evaluation in Spain. Thus, disability evaluation will be considered as an assessment of work (dis-)ability, which typically focuses on the activity level of functioning, defined within the Inter-national Classification of Functioning, Disability and Health(ICF) as 'the execution of a task or action by an individual'. It includes complex interactions between the ICF components body functions, body structures and activities and participation. Related terms include activity (limitations), disability, functional capacity, and performance potential. According to the authors, at present, no clinic or institution that can offer FCE in Spain. This seriously hinders implementation. A few innovative institutions take up a frontrunner position, start offering FCE, learn and apply it to the Spanish environment, before widespread rollout of FCE in Spain. There are no FCE research papers published by Spanish research groups in the peer reviewed international literature. Although a relatively small field, an informal international FCE research community has been established and is still developing. An

[29] Reneman, M. F., & Chaler, J. (2017). Disability evaluation and functional capacity evaluation (FCE): Is Spain ready for FCE? Is FCE ready for Spain? Rehabilitación, 51(3), 139–142. https://doi.org/10.1016/j.rh.2017.04.003.

open Linked-in FCE Research Forum has recently been installed, to stimulate communications between and among researchers and clinicians (https://www.linkedin.com/groups/13523105).

Case study 3: Assessment for dependency assessment

(eligibility for long-term care benefits as defined in MISSOC)

An outline of the key features of this assessment process is provided in Part 1 of this report (see **Example 2**). As stated previously, it is aimed at recognizing an official dependency status, by an interdisciplinary team from the Social Services Department. A level of dependency equal or higher than 25 points make the individual eligible for different benefits in cash and in kind. In most of the instances, dependency is associated to aging and related cognitive decline.

Detailed description of the assessment process

The main stages of the process, from application to decision, and appeal against decision, detailing the types of professionals involved and their responsibilities. Please also describe the administrative arrangements and the roles of the different institutions involved in the process. Please indicate what role the person being assessed plays in the procedure.

First, given de complexity of the Spanish system, we are including information on the definition, conditions, benefits, etc. All this information has been retrieved from MISSOC database.[30]

- Long-term care (dependencia), legal definition: Situation of a person who, on account of age, disease or incapacity, and linked to lack or loss of physical, mental, intellectual or sensorial autonomy, requires assistance from (an)other person(s) or considerable help to carry out essential daily activities or, in the case of persons with a mental disability or illness, other forms of support for their personal autonomy. In Spain,[31] the definition of dependency is included in article 2 of Act 39/2006, of 14th December, on the Promotion, Personal Autonomy and care for Dependent persons. It is defined as a "permanent state in which persons that for reasons derived from age, illness or disability and linked to the lack or loss of physical, mental, intellectual or sensorial autonomy require the care of another person/other people or significant help in order to perform basic activities of daily living or, in the case of people with mental disabilities or illness, other support for personal autonomy. Not all dependants are suffering this contingency with the same intensity. So, one of the main issues is the measurement of dependency. Usually, a scale is used to do it. The most common item measured is the time another person dedicates to helping a dependant to do certain activities such as dressing or feeding themselves. This is the assessment used by the Spanish systems. For instance, the Spanish scale is ruled by the Royal Decree 504/2007, of 20th April, that passes the scale for

30 http://www.missoc.org/MISSOC/INFORMATIONBASE/COMPARATIVETABLES/MISSOCDATABASE/comparativeTableSearch.jsp.

31 https://e-archivo.uc3m.es/bitstream/handle/10016/16239/ws130403.pdf;jsessionid=87A33CD78A32ED77B1861A042E820C68?sequence=1.

assessment of the situations of dependency set by Act 39/2006. According to it, the scale goes from 0 to 100 points and at least 25 points are needed to acknowledge entitlement to the benefits of the system.

- The coverage of this situation supplements the protection provided by the Social Security Public System as a benefit of the Social Assistance System. Benefits (in kind and cash benefits) are public and provided by the State and the Autonomous Communities with the collaboration of local institutions.

- Conditions: ((2) Minimum level of dependency: Long-term care: Situation of a person who, at least once a day, requires help to carry out the most essential daily activities. (3) Age: Long-term care: No age conditions. Special provisions for children under three years of age.

- Organisation: (1) Evaluation of dependency: Evaluation board of the Autonomous Communities. The board is composed of health and social professionals, including medical doctors and typically has 3-5 members. Concerning indicators and categories of need: The decision about the degree of dependency is taken by the Evaluation board of the Autonomous Communities, on the basis of a scale according to the International Classification of Functioning, Disability and Health (ICF) of the World Health Organisation. There are three different degrees of dependency: (a) Degree I, moderate dependency, the person needs help at least once a day; (b) Degree II, great dependency, the person needs help more than twice a day; (c) Degree III, severe dependency, the person needs help continuously.

- If an applicant disagrees with any decision, they have some time to appeal it. The review of the level of dependency is undertaken in case of change of the level of need or mistake in the application of the scale. The review can be requested by the recipient or promoted by the Autonomous Community. There is no legal regular periodic review. (2) Professional providers: institutions and home care providers, of a public, private or semi-public nature. These institutions are certified by the Autonomous Communities according to certain quality standards relating to human and material resources and provide the care if an individual is assessed as eligible.

- Benefits: (1) Benefits in kind: (1a) home care: Different forms of assistance in the home of the person in situation of dependency (household help and personal care). Tele-assistance and prevention are provided for. No duration limits. (1b) semi-residential care: Attendance at day and night-care centres. They provide counselling, prevention, rehabilitation, guidance for the promotion of autonomy, empowerment and personal attention or assistance services. The duration and the type of care depend on the individual need of the dependent person. (1c) residential care: Long-term care provided in institutions, mainly old-age homes and centres for the disabled. The competent Autonomous Community determines the services and programmes of these centres according to the level of dependency. No limits to the duration of residential care.
(2) Cost sharing for benefits in kind: Participation according to the type and cost of

the service and to the individual economic situation of the beneficiary. The economic criteria are set in Agreements with the Autonomous Communities. (3) Cash benefits: Cash benefit linked to the purchase of services; Cash benefit for personal assistance to access education and employment; Cash benefit for informal care at home. The maximum amounts are fixed by law and vary according to the degree of dependency and the type of benefit, in a range between EUR 153 and EUR 833.96. The economic resources of the beneficiary are taken into account to determine the amount of the benefit. (a) Means test of cash benefits: Benefits are conditional upon income and personal assets not exceeding a certain level. Competence of the Autonomous Communities. (b) User choice: No discretionary use. Benefits in kind: no free choice between professional providers. Cash benefits for personal assistance to access education and employment: free choice between professional providers. Cash benefit for informal care at home: free choice between informal carers as long as they meet the requirements. No free choice between cash benefits and benefits in kind. Cash benefits are paid only when benefits in kind cannot be provided (e.g. due to lack of capacity). Combing cash benefits with benefits in kind is not possible, except with services to prevent situations of dependency, promotion of personal autonomy and tele assistance. Combining benefits in kind is not possible, with the exception of tele assistance. Nevertheless, the Autonomous Communities can set their own compatibility system.

- Taxation: Benefits are not subject to income tax.

Second, concerning the stages of the process:

The procedure begins in the corresponding managing body of the Autonomous Community where the applicant of resides. It can be done at any time.

It is requested by the person who may be affected by some degree of dependency or by the person who is his/her legal representative.

Once the assessment has been carried out, the Autonomous Administration issues a decision in which the services and benefits corresponding to the applicant are determined according to their degree of dependency; This decision is valid throughout the State's territory.

The maximum period between the date of entry of the application and the decision to recognize benefit is six months. The decision of recognition of the situation of dependency of children under three years must be issued within a maximum period of thirty calendar days.
In case of disagreement with the decision, an appeal may be filed. Specifically, against decisions that put an end to the administrative procedure, interested parties may file a discretionary appeal for reconsideration before the same body that issued it, within one month of the day following its notification, or be challenged. directly before the contentious-administrative jurisdictional order in the manner and term provided for it in the Law Regulating the Contentious-Administrative Jurisdiction. Against decisions that do

not put an end to the administrative procedure, interested parties may file an appeal to the higher hierarchical body of the person who issued it, within one month of the day following the notification.

The effectiveness of the right to dependency benefits has been implemented gradually, and has been carried out according to the following schedule (First final provision of Law 39/2006, of December 14,[32] amended by Royal Decree-Law 20/2012, of July 13,[33] of measures to guarantee budgetary stability and promote competitiveness):

- 2007, people valued in Grade III of Great Dependency, levels 1 and 2.
- 2008-2009, people valued in Grade II Severe Dependency, level 2.
- 2009-2010, people rated in Grade II Severe Dependency, level 1.
- From January 1 to December 31, 2011, persons valued in the Grade I of Moderate Dependency, level 2, who have been recognized the specific benefit.
- As of July 1, 2015, the rest of the people assessed in Grade I of Moderate Dependency, level 2.
- As of July 1, 2015, people who have been assessed in Grade I Moderate Dependency, level 1 or are assessed in Grade I Moderate dependency.

Sources of official guidance and assessment protocols

Details of the guidance provided to assessors, methodology used, questionnaires, assessment scales, pro-forma used in the process, etc, with links to sources where available.

Every step of the process is regulated by law. There are protocols to be used throughout the process.

Each autonomous community has online information about the process. As an example, the autonomous community of Castilla y Leon includes a comprehensive webpage,[34] where it is possible to:

- Make the application in person or online;[35]
- Check the status of processing of the application.[36]

[32] https://www.boe.es/boe/dias/2006/12/15/pdfs/A44142-44156.pdf.
[33] https://www.boe.es/boe/dias/2012/07/14/pdfs/BOE-A-2012-9364.pdf.
[34] http://serviciossociales.jcyl.es/web/jcyl/ServiciosSociales/es/Plantilla100/1168278410141/_/_/_.
[35] https://www.tramitacastillayleon.jcyl.es/web/jcyl/AdministracionElectronica/es/Plantilla100DetalleFeed/1251181050732/Tramite/1259395711876/Tramite.
[36] https://www3.ae.jcyl.es/veci/.

Implementation and outcomes

Evidence of the practical implementation, including where possible the number of persons assessed, average waiting times and the assessment outcomes.

The Spanish government (the office on Social Services) has developed a Webpage specially design for dependency issues: http://www.dependencia.imserso.es/dependencia_01/index.htm.

That Webpage includes updated information on practical implementation of the law among the autonomous communities and the whole country. Every year there is an evaluation report. An example can be found here, for the 2015 data.[37]

There are significant inequalities between Autonomous Communities in terms of the number of applications processed, resolved, and granted. For example, in Castilla y León (the region that is in the first position in this regard) 98.68% of people entitled to benefit are receiving them in November 2017, while the national average is at 75.08%.[38]

Evaluation – fitness for purpose

Analysis of the strengths and weaknesses of the assessment method, including where possible evidence from official or independent evaluations, studies etc. For example, the balance of medical and non-medical input, cost-effectiveness, administrative burden, claimant experience, compatibility with the CRPD. Please indicate if there is a regular evaluation of the assessment method and, if so, who carries that out. Please include references to evaluations which have been carried out.

The previously mentioned national Webpage includes comprehensive information and performance indicators. The yearly reports include global and disaggregated data for autonomous communities.

The webpages on dependency for each autonomous community include data and annual reports. For example, the autonomous community of Castilla y Leon has published annual reports since 2009.[39] The last reports have been updated on December 31, 2017, and there are separated reports for each of the nine regions that compose the autonomous

[37] http://www.dependencia.imserso.es/InterPresent2/groups/imserso/documents/binario/im_102607.pdf.

[38] https://serviciossociales.jcyl.es/web/jcyl/binarios/360/620/1%20Datos%20regionales%20sobre%20personas%20en%20situaci%C3%B3n%20de%20dependencia%2030-11-17%20(p%C3%A1gina%20web).pdf?blobheader=application%2Fpdf%3Bcharset%3DUTF-8&blobheadername1=Cache-Control&blobheadername2=Expires&blobheadername3=Site&blobheadervalue1=no-store%2Cno-cache%2Cmust-revalidate&blobheadervalue2=0&blobheadervalue3=JCYL_ServiciosSociales&blobnocache=true.

[39] See: https://serviciossociales.jcyl.es/web/jcyl/ServiciosSociales/es/Plantilla100/1284767745996/_/_/_.

community of Castilla y Leon (e.g. Salamanca).[40] as well as a summary report for the whole region.[41]

The main problem is regional inequalities and waiting lists, as several reports suggest.[42]

Dependency assessment is done through a rating scale of the dependency, which is officially recognized and is mandatory. The scale (Barema) includes up to 52 tasks (e.g. "Open bottles and cans") grouped into 11 activities that have their own weight (e.g. "eat and drink" = 17.80 for people without intellectual disabilities or mental illness, and = 10, for people with intellectual disabilities or mental illness). Depending on the age of the person, some tasks are applicable or not. Each task has a specific weight (e.g. "Open bottles and cans" = 0,10). A person may experience performance issues on each task that may require different levels of support. Those levels can range from Supervision to Special Assistance. The final score is obtained from the sum of the weights of the tasks (e.g. 0,10) in which the person valued has performance problems weighted by the coefficient of the degree of support needed in each task (e.g. Supervision = 0,90) and the weight of the corresponding activity (e.g. 17.80). Next we are including the scale with the weights for people 18+, with or without intellectual disabilities/mental illness.

	18 +		Performance Issue*	Level of Support**
TASKS	Without ID/MI	With ID/MI		
EAT AND DRINK	**17.80**	**10,00**		
Open bottles and cans	0.10	0,10		
Cut or split the meat into pieces	0.25	0,25		
Use cutlery to bring food to your mouth	0.25	0,25		
Holding the drink container	0.15	0,15		
Approaching the drink container to the mouth	0.15	0,15		
Sip the drinks	0.10	0,10		

[40] See: https://serviciossociales.jcyl.es/web/jcyl/binarios/125/517/Salamanca.pdf?blobheader=application%2Fpdf%3Bcharset%3DUTF-8&blobheadername1=Cache-Control&blobheadername2=Expires&blobheadername3=Site&blobheadervalue1=no-store%2Cno-cache%2Cmust-revalidate&blobheadervalue2=0&blobheadervalue3=JCYL_ServiciosSociales&blobnocache=true.

[41] See: https://serviciossociales.jcyl.es/web/jcyl/binarios/360/620/1%20Datos%20regionales%20sobre%20personas%20en%20situaci%C3%B3n%20de%20dependencia%2030-11-17%20(p%C3%A1gina%20web).pdf?blobheader=application%2Fpdf%3Bcharset%3DUTF-8&blobheadername1=Cache-Control&blobheadername2=Expires&blobheadername3=Site&blobheadervalue1=no-store%2Cno-cache%2Cmust-revalidate&blobheadervalue2=0&blobheadervalue3=JCYL_ServiciosSociales&blobnocache=true.

[42] See: https://www.consaludmental.org/publicaciones/XVIII-Dictamen-Observatorio-Discapacidad.pdf and http://documentos.fedea.net/pubs/eee/eee2017-22.pdf.

REGULATION OF THE MICTION / DEFECATION	**14.80**	**7,00**		
Go to an appropriate place	0.20	0,20		
Manipulate clothes	0.15	0,15		
Adopt and abandon the proper posture	0.20	0,20		
Clean	0.20	0,20		
Urination continence	0.10	0,10		
Defecation continence	0.15	0,15		
WASH UP	**8.80**	**8,00**		
Handwashing	0.15	0,15		
Wash your face	0.15	0,15		
Wash the lower part of the body	0.35	0,35		
Washing the upper part of the body	0.35	0,35		
OTHER BODY CARE	**2.90**	**2,00**		
Combing	0.30	0,30		
Cutting the nails	0.15	0,15		
Wash your hair	0.25	0,25		
Brush your teeth	0.30	0,30		
DRESS	**11.90**	**11,60**		
Put on	0.15	0,15		
Button buttons	0.15	0,15		
Wear garments of the lower body	0.35	0,35		
Dressing upper body garments	0.35	0,35		
MAINTENANCE OF HEALTH	**2.90**	**11,00**		
Apply recommended therapeutic measures	0.25	0,25		
Avoid risks within the home	0.25	0,25		
Avoid risks outside the home	0.25	0,25		
Ask for help in an emergency	0.25	0,25		
BODY TRANSFERS	**7.40**	**2,00**		
Sit down	0.10	0,15		
Lie down	0.15	0,10		
Stand	0.10	0,20		
Transfer while sitting	0.10	0,25		
Transfer while lying down	0.10	0,30		
DISPLACING WITHIN THE HOME	**12.30**	**12,10**		
Displacements linked to self-care	0.50	0,50		
Displacements not linked to self-care	0.25	0,25		
Access to all the common elements of the rooms	0.10	0,10		
Access to all common rooms of the home in which reside	0.15	0,15		
MOVING OUT OF THE HOME	**13.20**	**12,90**		
Access to the exterior of the building	0.25	0,25		
Displacement around the building	0.25	0,25		
Close displacement	0.20	0,10		

Far displacement	0.15	0,15		
Utilization of transport means	0.10	0,25		
PERFORM DOMESTIC TASKS	**8.00**	**8,00**		
Prepare meals	0.45	0,45		
Go shopping	0.25	0,25		
Clean and take care of the house	0.20	0,20		
Wash and take care of clothes	0.10	0,10		
MAKE DECISIONS		**15,40**		
Self-care activities	NA	0,30		
Mobility activities	NA	0,20		
Domestic tasks	NA	0,10		
Interpersonal interactions	NA	0,20		
Use and manage money	NA	0,10		
Use of services available to the public	NA	0,10		
TOTAL	100.00	100,00		

*F = Does not physically execute the task; C = (only applicable in ID / MI). Does not understand the task and / or executes it without coherence and / or with disorientation; I = (only applicable in ID / MI). Does not show initiative for the completion of the task.

** SP. Supervision / Preparation= The person valued only needs that another person prepares the necessary elements to him to realize the activity and / or he makes him indications or stimuli, without physical contact, to realize the activity correctly and / or to avoid that it represents a danger (Coefficient=0,90); FP = Partial physical assistance. The valued person requires that another person physically collaborate in the realization of the activity (Coefficient=0,90); FM = Maximum physical assistance; The valued person requires that another person substitute him in the physical realization of the activity (Coefficient=0,95). ES = Special assistance; The person valued has disorders of behaviour and / or perceptive-cognitive problems that hinder the provision of support from another person in carrying out the activity (Coefficient=1,00).

It is regulated by Royal Decree 174/2011, of February 11,[43] which approves the scale of assessment of the dependency situation. Annually, agreements are published between autonomous communities to guarantee common minimum services, for example, in the area of centre and services[44] or regarding telecare.[45]

The scale and regulations that regulates it have been approved after consulting the autonomous communities and, in accordance with the law on dependency.[46] The Consultative Committee of the System for Autonomy and Care for Dependency, the State Council for the Elderly, the National Council for Disability and the State Council of Non-

43 https://www.boe.es/boe/dias/2011/02/18/pdfs/BOE-A-2011-3174.pdf.
44 https://www.boe.es/boe/dias/2017/12/30/pdfs/BOE-A-2017-15896.pdf.
45 http://www.dependencia.imserso.es/InterPresent2/groups/imserso/documents/binario/acuerctserteleasis.pdf.
46 https://www.boe.es/boe/dias/2006/12/15/pdfs/A44142-44156.pdf.

Governmental Social Action Organizations have also been consulted. In addition, Delphi groups have been made with different groups involved.[47] The assessment has as one of its points of references the International Classification of Functioning, Disability and Health (ICF, WHO, 2001).

There are manuals[48] on how to use the dependency rating scale, for the professionals responsible for carrying out such evaluations. The scale is applied in the habitual domicile of the person under evaluation, in order to identify barriers and facilitators.

On the other hand, the CERMI since 2014[49] has been raising the need to consider "persons with disabilities" as those who have been recognized as having a level of dependency in any of their degrees. In this regard, it is important to note that there are different assessment procedures, different assessment scales and different competent bodies for assessing the recognition of disability (example 1 of this report), access to recognition of dependency (example 3 of this report) and access to recognition of permanent incapacity (example 2). In addition, the State or central government has transferred to the different Autonomous Communities the competencies to make the relevant assessments, and there are different degrees of implementation, management, waiting lists, etc., between these Communities. CERMI makes this claim based on social justice, technical reasons, political opportunity and budget neutrality. However, this request has not been considered and it has, therefore, not been reflected, in the current regulations.[50]

Promising practice

If the case study includes examples of good practice, of interest to the EU and other countries, then identify and explain the most promising elements. Please indicate if disabled peoples' organisations have been involved in developing or evaluating the assessment method.

The scale itself,[51] and the use manuals of the scale.[52] constitute examples of good practices, since they offer very complete information to carry out the process.

47 http://femp.femp.es/files/566-29-archivo/manualusoBVD.pdf.
48 See for example: http://femp.femp.es/files/566-29-archivo/manualusoBVD.pdf.
49 http://www.cermi.es/sites/default/files/docs/novedades/Propuesta_asimilacion_dependencia_discapacidad.doc.
50 https://www.boe.es/buscar/pdf/2006/BOE-A-2006-22080-consolidado.pdf.
51 https://www.boe.es/boe/dias/2011/02/18/pdfs/BOE-A-2011-3174.pdf.
52 http://femp.femp.es/files/566-29-archivo/manualusoBVD.pdf.

Summary and conclusion

Taking an overview of national approaches to disability assessment and including any recommendations. Considering the range of examples identified in Part 1, and the analysis of selected cases in Part 2, please reflect on the extent to which these various assessment systems are integrated (or not). For instance, to what extent are similar application processes, similar assessment methodology, or similar administrative processes used to determine eligibility for different benefits? How could the system in your country become more integrated, cost-effective, or result in an easier applicant journey through the processes? Please also indicate any explicit references to the CRPD in the assessment procedure or whether the CRPD has been taken into account in determining the assessment procedure to be used.

The situation in Spain is one of clear duplication of procedures, managing bodies and responsible bodies. This supposes an increase and a slowness in the management to ask for and to be recognized as having one or another condition (disability, incapacity, dependency), as well as an increase in the cost of managing the aids and providing them.

Since the competences in these matters are transferred to the Autonomous Communities (with the exception of the autonomous cities of Ceuta and Melilla), and as each one has different budgets there are very significant territorial inequalities although there is national guidance indicating how assessments should take place across Spain, and in law, the eligibility criteria are the same across Spain. These are related to aspects, such as the management of applications, waiting lists for decisions and waiting lists to make effective the aids (in terms of services and economic) to which a person is entitled.

The evaluation systems of the different areas studied have little integration. Each department has been developing its assessment systems independently, progressively improving them, and progressing with some slowness towards the conceptual proposals of the WHO but are still far from incorporating the CRPD. And, without examining the global coherence of all systems. The mention of the CRPD regulations in different legal documents is more a declaration of intentions than a clear assumption of the repercussions of the convention on the assessments and decisions.

As an example, in other field, a recent study examined the normative regulation on evaluation and diagnosis of special educational needs in the 17 Spanish autonomous communities (Amor et al., 2018).[53] The study finds that the evaluation focuses excessively on organizational and curricular aspects and hardly values the rights and quality of life of the students. There is a patent lack of updating of the regulations. The CRPD is only mentioned by several Autonomous Communities, and there is talk about rights and family participation, but there are no protocols for evaluation procedures that guarantee the rights of students and their families to participate in all evaluation processes from the

[53] Amor, A. M., Verdugo, M. Á., Calvo, M. I., Navas, P. & Aguayo, V. (2018). Psychoeducational assessment of students with intellectual disability: Professional-action framework analysis. *Psicothema*, *30*(1), 39-45.

same diagnosis and school location. A relevant author (Echeita, 2014)[54] criticizes that evaluative practices in education have been linked in recent years to exclusionary options (such as forcing change in schooling modalities) closer to the medical model, than to the planning of inclusive proposals for all students, contradicting the national educational legislation and international (Convention on the Rights of Persons with Disabilities, UN, 2006). Echeita (2014) proposes that the debate rather than focusing on the bureaucracy should be on ethics.

The declaration of disability, dependency and permanent incapacity often comes into collision with the principles of the convention, given that the opinions assume a fundamentally medical approach while the Convention assumes a fundamentally social approach. Thus, in Spain, many people with intellectual disabilities have an incapacity report (i.e. are legally incapacitated). This decision can incapacitate them judicially for varied topics such as: voting in elections, accessing a mortgage, getting married. Although legal incapacity (total or partial) is a measure to protect people who need support, in many cases it becomes a tool for limiting rights. At their own request or from third parties, they can reinstate the capacity, or they can ask for a modification in the incapacitation sentence. If the application is made by the incapacitated person him/herself, he/she must obtain express judicial authorization to act in the process, if he/she has been deprived, in the incapacitation sentence, of capacity to appear in court, according to the 761.2º paragraph 2º Civil Prosecution Law (LEC, in Spanish).[55] It is, however, a long and arduous process, to which many people with intellectual disabilities renounce for this reason. Thus, there should be much more support (legal, social, etc.) to help start resources to reinstate the capacity or to modify the sentence of incapacitation

[54] Echeita, G. & Calderón, I. (2014). Obstáculos a la inclusión: cuestionando concepciones y prácticas sobre la evaluación psicopedagógica. *Àmbits de Psicopedagogia i Orientació*, vol. 41.

[55] https://www.boe.es/boe/dias/2000/01/08/pdfs/A00575-00728.pdf.