AAT Ruling – Access to the NDIS with depression and chronic bilateral foot and lower back pain

Access to the National Disability Insurance Scheme (the NDIS) is not determined only by the presence of a disability but rather by the extent to which it impairs an individual's ability to engage in activities across one or more of six domains, namely communication, social interaction, learning, mobility, self-care and self-management. The substantial reduction in functional capacity should be demonstrated during the access process by the provision of evidence, typically through reports from clinicians, occupational therapists and functional assessments.
A recent case before the AAT, involving Ms Larkings and the NDIS, highlights the importance of presenting consistent evidence that would establish the permanency of the disability.
You can read the full description of the case online. This is a summary of the case.

The Case

Ms Larkings is a 68-year-old woman. When she applied to join the NDIS as a participant in June 2019, she was 64 years old. She stated in her application that her main disability was bilateral plantar fasciitis (chronic bilateral foot pain) that has negatively impacted her standing and walking abilities, necessitating the use of physiotherapy and orthotic support to aid her feet. She highlighted lower back problems, osteoarthritis of the feet and knees and depression as further conditions that have impacted her functional abilities. Her most recent (May 2022) psychiatric diagnosis included hoarding disorder, obsessive-compulsive disorder, generalized anxiety disorder, post-traumatic stress disorder and adjustment disorder with depressed mood.

The Evidence

A) Physical Impairments

Ms Larkings' Evidence: According to the evidence that Ms Larkings provided, she has been experiencing chronic foot pain for more than three decades. To alleviate the pain, she has undergone various treatments such as physiotherapy, orthotics and exercises and

frequently takes Panadol and Nurofen. She has also attended the ADAPT program at the Royal North Shore Hospital, which is a pain management program. Ms Larkings was informed that surgery was not an option for her. Although she requested a referral to hydrotherapy, she did not commence the course due to transportation difficulties to the facility to which she was referred. She has not explored other options.

Clinical Evidence: Two podiatrists, a doctor from the ADAPT program, a rheumatologist and a sports medicine physician who examined Ms Larkings unanimously confirmed her physical conditions.

One of the podiatrists noted that Ms Larkings' chronic bilateral foot pain could potentially improve with appropriate treatment such as shockwave therapy that shows lasting effects in 88% of patients. However, he noted that such treatments are costly. During his interaction with Ms Larkings, he had the impression that she might have a co-occurring mental health condition. The other podiatrist prescribed orthotics and supportive footwear and strengthening exercises with a physiotherapist as a remedy of Ms Larkings' condition.

According to a discharge summary report authorised by a doctor in the ADAPT program, Ms Larkings' attendance in the program was inconsistent, and she was not compliant with the program's aims and requirements. He noted that Ms Larkings had reported low levels of pain-related disability both before and after the program but a considerable level of depressive symptomatology. He concluded Ms Larkings' ongoing distress may be attributed more to her challenges in managing personal stressors and interpersonal relationships rather than her physical pain. As a potential course of action, he recommended that Ms Larkings be referred to a clinical psychologist or psychiatrist.

The rheumatologist who had examined Ms Larkings stated in his report that she maintained reasonable physical activity levels but experienced bilateral pain due to her flat feet. He refrained from assessing her chronic bilateral foot pain as permanent as it had immensely improved with a change of footwear and simple lacing techniques. In a later report, he noted that Ms Larkings' pain was interconnected with her mental health condition, and that she had difficulty in complying with physiotherapy.

The sports medicine physician who saw Ms Larkings twice temporarily made some supports for her to elevate her heels and arches, which she found extremely soothing.

B) Psychological Impairments

Ms Larkings' Evidence: Ms Larkings stated that her GP had recommended psychological treatment for her for at least the last decade, and as the result, she had seen several psychologists. Although Ms Larkings expressed her desire to continue receiving psychological treatment, she is currently not undergoing any such therapy, and she does not take any medication for her mental health condition. She was referred to a private hospital to get some advice about sleep hygiene and her anxiety. She first did a hoarding program in 2009, and she attends a hoarding support program in the private hospital without taking part in the action

requirement of the program (bringing in one thing each week to throw it away). She highlighted that she suffers from unhappiness and the inability of prioritising her tasks.

Clinical Evidence: The evidence presented to the Tribunal by two psychologists, Ms Larkings' GP, a psychiatrist and a counsellor and hoarding specialist establishes that Ms Larkings has been diagnosed with multiple mental health conditions during a significant period of time. They noted Ms Larkings' challenges in actively participating in and adhering to the prescribed treatment process.

While one of the psychologists who had seen Ms Larkings for six sessions reported that she is obsessed with cleanliness and hoarding, and that her mental health had declined in comparison to the time she first started to see her, another psychologist said that Ms Larkings has constant low mood and severe depression and needs psychological therapy.

The psychiatrist who had treated Ms Larkings during her inpatient admission at a private hospital noted that she had a strong trauma history, and her psychological conditions, namely hoarding disorder, obsessive-compulsive disorder, generalised anxiety disorder, post-traumatic stress disorder, adjustment disorder with depressed mood and cluster C1 personality traits are permanent and severe. The psychiatrist believed that psychotherapy would be beneficial for Ms Larkings' hoarding behaviour, and it is also more effective in treating obsessive-compulsive disorder than medication.

The hoarding counsellor noted that she had only one face-to-face meeting with Ms Larkings. However, based on their many telephone conversations and the photos of Ms Larkings' house that the counsellor saw about one month after their meeting, she highlighted Ms Larkings' worsening hoarding behaviour. The counsellor attributed this deterioration to the fact that hoarding disorder exacerbates by the passage of time and without intervention, a fact that negatively affects social interactions of patients, Ms Larkings included, because of the shame associated with it. While the counsellor noted that she could not get into details about the consequences of Ms Larkings' hoarding disorder due to the lack of funding for such a service, she emphasised that the hoarding program Ms Larkings was attending is not enough, and so is of limited success. However, the counsellor mentioned that Ms Larkings' hoarding behaviour could be improved with psychological treatment.

The Findings

A) **Ms Larkings' physical impairments:** The Tribunal reviewed the evidence Ms Larkings and her healthcare providers presented for her physical impairments and decided that her plantar fasciitis does not satisfy section 24(1)(b) of the NDIS Act. Even if Ms Larkings' physical impairments had been considered permanent, the evidence did not show that there was a significantly reduced functional capacity that would severely affect her daily functions. So, she would not have satisfied section 24(1)(c) of the NDIS act either.

B) **Ms Larkings' psychological impairments:** The Tribunal reviewed the evidence on Ms Larkings' psychological impairments and acknowledged their negative effects on her daily functions. However, it concluded that because she had failed to complete all the requirements of her treatments, her psychological impairments had not been optimally treated. Therefore, the Tribunal was not satisfied that Ms Larkings' psychological conditions were permanent and met the requirements of section 24(1)(b) of the NDIS Act.

What can we learn from this case?

This case demonstrates that to show likely permanence of an impairment, evidence on the unavailability of further treatments for the listed impairments should be provided. In other words, NDIS applicants need to undergo treatments and achieve a stable condition (to the extent possible) prior to submitting an NDIS access request. Failure to do so may make it difficult to demonstrate that a person's impairments and their associated impacts on their functional capacity are likely to persist for their lifetime.