



Likely permanence and access to the NDIS – lessons from AAT rulings

As each NDIS access request is assessed on its own merits against the disability requirements, sometimes it is difficult to know what standard of evidence is required when demonstrating that an impairment is likely to be permanent.

In the recent case [KDYG and the National Disability Insurance Agency](#), the Administrative Appeals Tribunal overturned an access not met decision made by the NDIA, giving us further insight into how decisions are made for psychosocial disability.

The case

KDYG made an access request based on her psychosocial and mental health disabilities, which included complex post-traumatic stress disorder (PTSD) with dissociative identity disorder (DID), severe anxiety, severe depression, chronic suicidal ideation and disorientation.

The NDIA made an access not met decision, arguing that KDYG did not meet the disability requirements as she had not demonstrated that:

- her impairments were likely to be permanent
- the impairments resulted in substantially reduced functional capacity
- she was likely to require lifetime support from the NDIS ([section 24\(1\)\(b, c and e\) of the NDIS Act](#)).

The NDIS argued that she had not provided evidence 'detailing the specific treatments undertaken, nor the period of time, nor the frequency of such treatment'. It is not clear how much of the evidence considered by the AAT had been provided to the NDIS in the initial application.

Likely permanence

KDYG had seen a number of GPs and psychologists over the years, and notably had seen a psychiatrist in 2016 who had written a comprehensive report. Their diagnoses varied somewhat, but consistently recognised significant mental health issues with a variety of symptoms. KDYG's social worker's evidence was also taken into account.

The AAT noted that the evidence did show that KDYG has suffered from the impairments for over 20 years, and that she has regularly worked with counsellors and psychologists.

Although she had not tried every possible treatment, the lengthy history of therapy suggests that other treatments are unlikely to change the permanence of her impairments. A statement to this effect was made by



a GP, who stated that the range of therapies she had tried 'helped her to manage her symptoms a little better but the illnesses remain chronic and likely to be lifelong. The symptoms interfere with every aspect of her life'.

On this basis, the AAT concluded that KDYG's impairments were likely to be permanent.

Substantially reduced functional capacity

The AAT heard evidence from a range of people, including the applicant herself, and her partner, P.

This included evidence that P manages all of KDYG's finances as well as her medications, and does '99% of the day to day tasks for the family'. KDYG herself tends to get lost when driving, knows how to cook but sometimes burns herself, and needs prompting while making a cup of tea.

She needs 'constant reminders and personal care, taking medication, knowing where food and clothes are kept, is unable to go to a public toilet alone, hurts herself while grooming because of lack of concentration...and is unable to hang wash outside because of fear'.

The AAT accepted this evidence and noted that the assistance KDYG requires 'is not consistent with normal expectations of a person of a similar age'. Therefore, she has a substantially reduced functional capacity to undertake self care.

As *one* of the domains of impairment was satisfied (i.e. self care), the AAT did not continue to consider whether she also demonstrated reduced functional capacity in other domains.

Likely to require lifetime support from the NDIS

Having found that the KDYG's impairments are likely to be permanent and result in substantially reduced functional capacity, the AAT found that she is likely to require lifetime support from the NDIS.

What can we learn from this case when developing access requests?

This case focuses on an applicant with psychosocial disability, illustrating the challenges that many people face gathering evidence for mental health, and provides some valuable lessons for access requests.

Not every possible treatment must be explored

Ideally, when putting in an access request, an applicant would demonstrate that all appropriate treatments have been tried to prove that a disability is permanent.

However, in some cases, it may be enough to show a long history of illness and that a number of appropriate treatments have been tried. A statement from a relevant clinician stating that in their opinion the impairments are likely to be permanent regardless of treatment is also necessary.

Only one domain needs to be demonstrated

There are six impairment domains: communication, social interaction, learning, mobility, self-care and self management. An applicant only has to demonstrate substantially reduced capacity to undertake activities in *one* of these areas to meet the access criteria. If an applicant has substantially reduced capacity in more than one area, of course you should provide evidence for this, but one is enough.



Include a range of evidence where possible

In this case, the AAT was presented with medical reports and clinical notes from various GPs and specialists, a letter from the applicant's social worker, evidence from the applicant herself, and evidence from her partner – all of which helped them to come to a decision.

When developing an access request, provide all *relevant and consistent* evidence that you can. A letter from you describing the person's life will help the access assessor get a good picture of the applicant's situation and can bring all the evidence together.

However, it's not necessary to include every piece of information available – you shouldn't include things that aren't relevant, and if evidence is inconsistent, you can use a supporting letter to explain why.

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