Functional capacity and access – Lessons from the AAT

NDIS access is not based on disability alone, but rather, on the fact that the disability results in substantially reduced functional capacity undertake activities in one or more of six domains – communication, social interaction, learning, mobility, self-care and self-management.

This reduction in functional capacity must be demonstrated by evidence presented to the NDIA during the access process – often this is given via clinician reports, OT reports, and functional assessments.

A recent case before the AAT – HKJQ and the NDIS – shows the importance of consistent, objective evidence and clarifies how a judge may weigh conflicting evidence.

You can read the full description of the case online; we have provided a summary below.

The case

HKJQ is a 40-year-old man who has suffered from panic disorder and agoraphobia since he was a teenager, and was diagnosed with schizoaffective disorder in 2015.

He applied for access to the NDIS, giving evidence that he has not been able to maintain ongoing employment due to panic disorder.

He stated that due to his condition 'I rarely leave my house and hardly ever leave my neighborhood'.

Friends of his gave evidence that they had observed him becoming distressed while travelling in a vehicle, becoming increasingly estranged from his family, and not attending to personal grooming.

A psychiatrist's report from 2015 stated that 'the predominant issue impacting [HKJQ's] wellbeing and his ability to participate in the workforce, remains his untreated psychiatric condition'.

A psychologist's report from 2018 stated that HKJQ was on medication and being monitored by a psychiatrist; nonetheless, 'his panic disorder and underlying mood disorder is lifelong and permanent. He may occasionally function in society. However, the majority of time he requires a lot of support. His condition substantially affects his ability for social interaction and self-care.'

An OT report by Ms Battersby from 2019 (commissioned by HKJQ) stated that HKJQ demonstrates functional disability in self-care and self-management. She listed a number of factors, including avoidance of busy

locations, difficulty using escalators and lifts, poor sleep hygiene, and conflict with people in his family and the community.

Ms Battersby also stated 'the lack of insight into the nature of one's condition and need for treatment can be a symptom of psychiatric disorders. Failure to comply or adhere to recommended treatment can in such situations be understood as both a symptom of the condition as well as a factor limiting potential recovery or progress.'

Despite this evidence, the AAT upheld the NDIA's decision not to grant HKJQ access to the NDIS, as evidence from a second OT – Ms Welsche – was also made available, and the tribunal considered this more reliable.

The second OT report

Ms Welsche assessed HKJQ at the request of the NDIA, provided a report and gave evidence. Against the six domains of functioning she noted the following:

- Communication
  She observed HKJQ communicating with her in both spoken and written language, over nearly 3 hours, both on the phone and in person, and he was easily understood and socially appropriate.

- Social interaction
  HKJQ was able to maintain appropriate face-to-face contact during the assessment. He also described using a smartphone app for social interaction, and he volunteers for a political party. She referred to a medical record from 2017 showing that he attended a group on values where he contributed well. HKJQ also shared with Ms Welsche that he drove to and walked along quieter beaches most nights.

- Learning
  HKJQ explained how he had learned new tasks in his part-time employment managing his apartment building. Cognition screening didn't identify any barriers to learning.

- Mobility
  Ms Welsche observed HKJQ walking inside and outside his home, and estimated he could walk at least 1km over 10 minutes without a break. This was consistent with HKJQ's description that he's able to walk to access shops, services and the beach within 10 minutes of his house.

- Self-care
  HKJQ presented as well groomed, clean shaven and neatly dressed during Ms Welsche's assessment, and medical records didn't show evidence of problematic self-neglect. HKJQ explained that sometimes he neglects to shower and eat properly.

- Self-management
  HKJQ explained his weekly budget, and daily and weekly routine in detail, which covered essential tasks like shopping, paying bills, cleaning, laundry and attending appointments. During the assessment he demonstrated problem solving and decision making by rescheduling an appointment he'd forgotten.

Ms Welsche noted that an occupational therapist and/or dietician could provide HKJQ with strategies to address any issues with showering and diet via a Chronic Diseases Management Plan, and that this would likely be appropriate and sufficient support.

She also noted that HKJQ explained that while 'he previously has a history of making poor decisions, these issues were related to poor control of his psychiatric conditions'. Since commencing new medication in late 2017 he has been more able to engage in psychiatric intervention. He has good compliance with taking medications and medical advice.

On the basis of Ms Welsche's evidence, the AAT concluded that while HKJQ has a permanent disability and considerable impairment, he does not suffer from a *substantially* reduced functional capacity to undertake any of the activities listed above – one of the requirements for joining the NDIS.

The AAT stated that although HKJQ may 'appear not to meet the standards expected of him by others…he has demonstrated an ability to function appropriately when he considers it necessary'.

What can we learn from this case?

The AAT chose to rely on Ms Welsche's evidence rather than that of other health professionals for a number of reasons:

- She used objective functional assessment tools to support her findings
- She distinguished clearly between her observations and the information self-reported by HKJQ
- She provided detailed reasoning in support of her opinions
- Other health professionals did not have access to as full a picture of information and therefore their evidence was more limited
- Ms Welsche had the opportunity to observe HKJQ in his home environment, and therefore relied less on HKJQ's self-reporting.

This underscores the importance of providing *good quality*, *well-reasoned, up-to-date* evidence in an access request.

The case also shows why an NDIS applicant should be treated and stabilized (as far as possible) before making an NDIS access request – otherwise, it may be difficult to demonstrate that functional (in)capacity is unlikely to change.

Although not highlighted directly in this case, Ms Welsche's observation that the most appropriate support for HKJQ could be provided via a Chronic Diseases Management Plan (in the mainstream health system) also reminds us that a condition of NDIS support is that it must be *most appropriately* provided by the NDIS (not via another system or avenue).