Pain and access – Lessons from the AAT

A recent case before the AAT case centred on whether access should be granted to Mrs Schwartz, a potential participant suffering from a number of conditions.

Mrs Schwartz specified her primary impairments as complex regional pain syndrome in her left arm, and bronchiectasis. Among her other conditions was long-standing moderate depression.

The tribunal ultimately decided in favour of Mrs Schwartz, and the case is an interesting insight into how the AAT separates out multiple conditions and sifts significant volumes of evidence.

You can read the full description of the case (running to 100 pages) – Schwartz and the NDIA – online; we have provided a summary of the case below.

The case

Mrs Schwartz's complex regional pain syndrome (CRPS) has resulted in a loss of functional use of her left arm – she has frozen shoulder, restricted movement, a permanently clawed left hand, and significant sensitivity to the touch. Her bronchiectasis results in shortness of breath.

Both conditions have been treated for over 20 years by a small number of highly-qualified medical specialists, who provided detailed evidence. Both conditions were found to be stable and unlikely to be remedied in future.

In particular, a consultant psychiatrist pain specialist, who had treated Mrs Schwartz over many years, noted that 'CRPS can have a devastating impact on those afflicted, both in terms of the individual's ability to function, as well as their psychological well-being. The pain and disability can create a vicious cycle of pain, isolation and depression'.

Hospital records were provided which showed 15 years of comprehensive treatment for moderate depression. The depression was (at least partly) shown to be a consequence of living with pain.

Evidence about a number of other conditions was provided, including cataracts, dizzy spells, bowel obstructions and pain, bladder problems and more. However, these were not considered, as they were considered medical conditions, rather than disabilities.

An interesting aspect of this case was the evidence from two occupational therapists, who provided opposing (but both thorough and robust) conclusions about Mrs Schwartz's level of function.

Her long-time specialists noted that 'Mrs Schwartz has always complied with recommendations together with investigations and treatments' and also that Mrs Schwartz 'was an honest and accurate historian and that she did not exaggerate her symptoms or the effects of her condition' – particularly important as pain is subjective and relies on patient reporting.

The tribunal, in great detail, assessed all of the relevant evidence provided by the medical practitioners and occupational therapists, in conjunction with the lived experience evidence of Mrs and Mr Schwartz.

The AAT concluded that Mrs Schwartz did experience substantially reduced functional capacity in mobility and self-care, two of the domains required to gain access to the NDIS.

In the context of mobility it accepted that Mrs Schwartz has trouble transferring from sitting to standing, limited endurance, and limited capacity to leave the home and move about in the community. This was largely based on a number of falls she had had in the past, and on Mr Schwartz's evidence about the physical support he provides, in particular when out and about or at the supermarket, to reduce the likelihood of her falling.

In the context of self-care, the AAT accepted that Mrs Schwartz has difficulties with hygiene, feeding and eating, showering, dressing and toileting. For example, Mr Schwartz assists by putting on her socks and shoes, putting toothpaste on her toothbrush, helping with showering, opening containers, preparing all meals (which can be eaten one-handed), and providing occasional helping with toileting.

As the sticking point for access was Mrs Schwartz's functional capacity, the fact that the tribunal considered her to have substantially reduced functional capacity in at least one domain meant that she was granted access to the scheme.

What can we learn from this case

This case had a couple of interesting features that may be useful to understand when developing an access request.

Firstly, although the AAT accepted that Mrs Schwartz suffers from depression, and that this depression (at least partly) stems from her CRPS, they did not assess the functional impacts of the depression, as the direct functional impacts from the underlying condition (CRPS) was enough to gain her access to the scheme.

Secondly, the AAT accepted the evidence given by Mr and Mrs Schwartz over that of one of the occupational therapists. This is likely for two reasons: their evidence was judged consistent and honest, and it lined up with detailed evidence from medical specialists over a number of years and that of the second occupational therapist.

The case shows that lived experience evidence can be very valuable when reliable, and that, in the case of multiple conditions, it is key to consider not only the overall functional impact, but to connect the impact to the disability from which it stems.