[2015] AATA 146

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| Division | **GENERAL ADMINISTRATIVE DIVISION** |
| File Number(s) | 2014/0501 |
| Re | Sonia Armao |
|  | APPLICANT |
| And |  |
|  | RESPONDENT |

# Decision

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| Tribunal | **Dr T Nicoletti, Senior Member** |
| Date | **13 March 2015** |
| Place | **Sydney** |

The decision under review is affirmed.

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**Dr T Nicoletti, Senior Member**

# Catchwords

SOCIAL SECURITY – pensions – disability support pension – cancellation – qualification for pension – whether the applicant’s impairment rating was 20 points or more – decision affirmed

# Legislation

Social Security Act 1991 ss 26, 27, 94

Social Security (Administration) Act 1999 ss 63, 80

# Secondary Materials

Guide to Social Security Law

Social Security (Tables for Assessment of Work-related Impairment for Disability Support Pension) Determination 2011

# REASONS FOR DECISION

**Dr T Nicoletti, Senior Member**

# background

1. Mrs Armao has requested that this Tribunal review a decision of the Social Security Appeals Tribunal (SSAT) dated 17 December 2013, which affirmed a decision to cancel her disability support pension (DSP).
2. Mrs Armao was granted the DSP on 12 November 2004. On 23 September 2013, Mrs Armao was notified that her DSP had been cancelled because she was no longer considered eligible to receive the pension. This decision was affirmed by a Centrelink Authorised Review Officer (ARO) and, subsequently, the SSAT affirmed the ARO’s decision.

# Issue

1. The Tribunal is required to decide whether Mrs Armao qualified for the DSP on the date of cancellation. Specifically, this requires the Tribunal to determine whether, as at the date of cancellation, Mrs Armao:
	1. had a physical, intellectual or psychiatric impairment; and
	2. if she had such an impairment, the impairment was rated 20 points or more under the Impairment Tables; and
	3. she had a continuing inability to work.

# Legislation

1. Section 94 of the *Social Security Act 1991* (the Act) sets out the criteria for qualification for DSP. Relevantly, this section provides:

**94 Qualification for disability support pension**

(1) A person is qualified for disability support pension if:

(a) the person has a physical, intellectual or psychiatric impairment; and

(b) the person’s impairment is of 20 points or more under the Impairment Tables; and

(c) one of the following applies:

(i) the person has a continuing inability to work;

(ii) the Health Secretary has informed the Secretary that the person is participating in the supported wage system administered by the Health Department, stating the period for which the person is to participate in the system; and

…

Continuing inability to work

(2) A person has a **continuing inability to work** because of an impairment if the Secretary is satisfied that:

(aa) in a case where the person’s impairment is not a severe impairment within the meaning of subsection (3B)—the person has actively participated in a program of support within the meaning of subsection (3C); and

(a) in all cases—the impairment is of itself sufficient to prevent the person from doing any work independently of a program of support within the next 2 years; and

(b) in all cases—either:

(i) the impairment is of itself sufficient to prevent the person from undertaking a training activity during the next 2 years; or

(ii) if the impairment does not prevent the person from undertaking a training activity—such activity is unlikely (because of the impairment) to enable the person to do any work independently of a program of support within the next 2 years.

Note: For **work** see subsection (5).

(3) In deciding whether or not a person has a **continuing inability to work** because of an impairment, the Secretary is not to have regard to:

(a) the availability to the person of a training activity; or

(b) the availability to the person of work in the person’s locally accessible labour market.

…

Severe impairment

(3B) A person’s impairment is a **severe impairment** if the person’s impairment is of 20 points or more under the Impairment Tables, of which 20 points or more are under a single Impairment Table.

…

Active participation in a program of support

(3C) A person has **actively participated** in a program of support if the person has satisfied the requirements specified in a legislative instrument made by the Minister for the purposes of this subsection.

(3D) The Secretary must comply with any guidelines in force under subsection (3E) in deciding whether the Secretary is satisfied as mentioned in paragraph (2)(aa).

(3E) The Minister may, by legislative instrument, make guidelines for the purposes of subsection (3D).

Doing work independently of a program of support

(4) A person is treated as doing work **independently of a program of support** if the Secretary is satisfied that to do the work the person:

(a) is unlikely to need a program of support; or

(b) is likely to need a program of support provided occasionally; or

(c) is likely to need a program of support that is not ongoing.

Other definitions

(5) In this section:

**program of support** means a program that:

(a) is designed to assist persons to prepare for, find or maintain work; and

(b) either:

(i) is funded (wholly or partly) by the Commonwealth; or

(ii) is of a type that the Secretary considers is similar to a program that is designed to assist persons to prepare for, find or maintain work and that is funded (wholly or partly) by the Commonwealth.

**training activity** means one or more of the following activities, whether or not the activity is designed specifically for people with physical, intellectual or psychiatric impairments:

(a) education;

(b) pre-vocational training;

(c) vocational training;

(d) vocational rehabilitation;

(e) work-related training (including on-the-job training).

**work** means work:

(a) that is for at least 15 hours per week on wages that are at or above the relevant minimum wage; and

(b) that exists in Australia, even if not within the person’s locally accessible labour market.

…

1. When Mrs Armao was granted the DSP, the Impairment Tables which were to be used to assign an impairment rating were located in Schedule 1B of the Act.
2. On 1 January 2012, the *Social Security (Tables for Assessment of Work-related Impairment for Disability Support Pension) Determination 2011* (the Determination), which was made pursuant to s 26 of the Act, commenced. Pursuant to s 27 of the Act, this is the Determination that must be used to assess Mrs Armao’s qualification for DSP where an assessment notice under ss 63(2) or 63(4) of the *Social Security (Administration) Act 1991* (the Administration Act) is given by the Secretary, and where the Tribunal is reviewing a determination by the Secretary made under s 80 of the Administration Act.
3. The Determination contains rules for applying the Impairment Tables. The Determination states that for an impairment rating to be assigned, the person’s condition causing the impairment must be permanent. A condition shall be permanent if it has been fully diagnosed, treated and stabilised and the condition is more likely than not, in light of available evidence, to persist for more than two years.
4. Section 80 of the Administration Act provides:

(1) If the Secretary is satisfied that a social security payment is being, or has been, paid to a person:

(a) who is not, or was not, qualified for the payment; or

(b) to whom the payment is not, or was not, payable;

the Secretary is to determine that the payment is to be cancelled or suspended.

1. The Guide to Social Security Law (the Guide) contains a table at 3.6.1.100 outlining the circumstances in which DSP payments should be cancelled or suspended. The table states that the DSP must be cancelled if the recipient *“as a result of the medical qualification update, no longer meets the impairment and/or CITW qualification criteria (6.2.5.15). However, payment of DSP will continue for 42 days after the recipient has been notified of the cancellation decision”*.

# EVIDENCE

1. In 2004, when Mrs Armao originally claimed the DSP, a health assessor’s report from Health Services Australia described two diagnoses: depression/panic attacks and chronic pain syndrome, both with onset in 2000. A Treating Doctor’s Report completed by her general practitioner, Dr Jamal Rifi, also identified the same two conditions. Both reports indicated that Mrs Armao was taking medication for the conditions – Lexapro for the psychiatric condition (previously, Lovan had been prescribed but had been discontinued because it was not effective) and various pain medications. The health assessor’s report noted that Mrs Armao *“has been advised to see psych by GP – refused as – didn’t want anyone to know – not even family”*. It also noted that Mrs Armao had not been to a pain clinic or seen a specialist in relation to her chronic pain syndrome.
2. In July 2013, as part of a random review Mrs Armao was sent a Medical Report Disability Support Pension Review form which was to be completed by herself and her doctor and returned to Centrelink. In the section completed by Mrs Armao, she wrote that she had the following disabilities, illnesses or injuries: *“depression, chronic pain, headach[e]s, backpain, done throat surgery”.* She said that the treatment she had been receiving was “medicines” including Voltaren, Lexapro, Nurofen and Panadeine Forte. Dr Rifi completed section B of the report.
3. Dr Rifi identified depression-major as the condition which most impacted Mrs Armao. He indicated that the diagnosis made on 22 February 2005 was not supported by further specialist opinion. Treatment at the time was identified as counselling, which had commenced on 22 February 2005. He stated that Lexapro, which was commenced on 22 February 2005, had been used for past treatment and that the duration of treatment was five years. Future/planned treatment was identified as *“possible psychologist intervention”*. Mrs Armao’s symptoms were described as *“depressed mood, socially withdrawn, difficulty concentrating, unable to be around other people, feelings of inability to cope”*. The functional impact of the condition was described by Dr Rifi as *“difficulty concentrating, poor decision making skills, poor memory, unable to complete set tasks, poor people skills, unable to relate or be around others”*. Dr Rifi expected that the effect of the condition on Mrs Armao’s ability to function would *“deteriorate”* and *“fluctuate”* in the two years that followed.
4. Dr Rifi identified Reinke’s oedema-recurrent bronchitis as a second condition that had a significant impact on Mrs Armao’s ability to function. The onset of this condition was 28 February 2011. The diagnosis had been confirmed by an ear, nose and throat specialist on 21 November 2011. The treatment at the time and intended future treatment for this condition was the use of a mouthwash. Prior to that, Mrs Armao had been treated with antibiotics and lozenges and she had had a microlaryngoscopy and vocal cord biopsy. The described symptoms were *“husky voice, recurrent chest infections [and] shortness of breath”*. The effect of the condition on Mrs Armao’s ability to function was *“unable to communicate effectively with other people”*. The condition was expected to impact on Mrs Armao’s ability to function for more than two years. The condition’s impact was expected to “deteriorate” and “fluctuate”.
5. Dr Rifi did not identify any other conditions in the report.
6. At the request of Centrelink, a face-to-face Job Capacity Assessment was conducted on 27 August 2013 by a registered nurse, with a registered psychologist contributing to the assessment. The JCA report addressed the conditions of depression, Reinke’s oedema, recurrent bronchitis and chronic pain. The condition of depression was considered not fully diagnosed, treated and stabilised due to the absence of specialist assessment and intervention, limited treatment and the possibility that Mrs Armao might benefit from psychiatric review of her condition and treatment. The condition of Reinke’s oedema was considered fully diagnosed, treated and stabilised and was given an impairment rating of 0 because it was considered the condition had no functional impact. The condition of recurrent bronchitis was considered fully diagnosed but not fully treated and stabilised as there was potential for improvement of her symptoms with lifestyle changes, reducing or ceasing smoking and active health treatments that had not been pursued. The condition of chronic pain syndrome was not considered verified as there had been no medical corroboration of the condition at the time. Mrs Armao was assessed as having a baseline work capacity of 8-14 hours and a capacity to work 15-22 hours within two years with mainstream intervention.
7. Dr Rifi provided a further medical report dated 8 October 2013, prior to the reconsideration of Centrelink’s decision to cancel Mrs Armao’s pension by an ARO. The information he provided about Mrs Armao’s depressive condition was consistent with the information in the earlier report. He identified chronic pain syndrome, having a date of onset of sometime in 2002, as a condition having a significant impact on the ability of Mrs Armao to function. The report indicated that the diagnosis was not supported by further specialist opinion. The treatment at the time was Voltaren, Panadeine Forte, Nurofen Plus, Panadol and Lexapro. Dr Rifi indicated that Mrs Armao had received physiotherapy in the past. Future/planned treatment was described as *“possible specialist intervention”*. The symptoms were described as *“constant complaints, generalised aches and pains and weakness in arms and legs, generalised tiredness, all over body pain”*. The impact on Mrs Armao’s ability to function was *“unable to stand, sit for too long, cannot walk for long distances, cannot push or pull anything heavy”*. The impact on her ability to function was expected to persist for more than 24 months and in the following two years the effect of the condition on Mrs Armao’s ability to function was expected to deteriorate and fluctuate. Other conditions Mrs Armao had that were generally well managed and caused minimal or limited impact on her ability to function were Reinke’s oedema and migraines.
8. The ARO affirmed the original decision to cancel Mrs Armao’s DSP. In summary, the ARO’s decision was that:
	1. the Reinke’s oedema was accepted as being permanent;
	2. the conditions of depression and recurrent bronchitis were not accepted as being permanent, because they had not been fully treated and stabilised;
	3. Mrs Armao’s total impairment rating was zero; and
	4. Mrs Armao no longer qualified for DSP.
9. The ARO stated:

One of the changes to qualification for Disability Support Pension from January 2012 is that a diagnosis of a mental health condition – such as depression – must be confirmed by either a psychiatrist or a clinical psychologist. Both you and your GP, Dr Rifi, have advised the Department that you have not had any consultation with either a psychiatrist or a clinical psychologist. As such, I am not able to consider your depression condition when deciding your eligibility for Disability Support Pension.

1. At the SSAT hearing, Mrs Armao supplied a letter dated 10 December 2013 from Ms Shayma Almoty, a consultant psychologist. The letter stated that Mrs Armao had been attending the Centre for Wellbeing since 11 November 2013 for treatment of major depressive disorder, severe anxiety and post-traumatic stress disorder. Ms Almoty stated that *“Mrs Armao has disclosed significant life events which have caused her to experience marked mental health issues for the past 26 years... These issues have gone untreated until such time that Mrs Armao attended her first session.”* The report referred to Mrs Armao’s reported chronic pain and observed that *“it appears that Mrs Armao’s physical health issues also impact on her ability to gain and maintain employment as the pain lowers her tolerance levels and impacts on her ability to cope with others and stressful situations.”* Ms Almoty also stated:

… Mrs Armao’s mental health issues impact on her ability to concentrate and remember things, learn new skills, follow instructions, remain diligent and alert. Further to these, Mrs Armao’s ability to communicate effectively and work in a team with others is compromised. For these reasons it is my opinion that Mrs Armao remains currently unfit for work. Mrs Armao requires extensive psychological treatment sessions to address the trauma that she has suffered and deal with the lasting depression, anxiety and PTSD.

1. Ms Almoty also wrote reports dated 27 February 2014 and 5 June 2014. The report dated 27 February 2014 repeated the contents of the previous letter dated 10 December 2013. The report dated 5 June 2014 provided more information regarding the symptoms and functional impact of the mental health conditions on Mrs Armao. Mrs Armao’s symptoms were reported at the time as insomnia, chronic pain, difficulty concentrating, poor memory, and difficulty following instructions and absorbing or processing new information. Ms Almoty stated that Mrs Armao told her that she was unable to complete many activities of daily living independently and relied on her husband and adult children to provide her assistance several times per week. Ms Almoty then stated:

Mrs Armao also appears to have a low tolerance for novel situations, meeting new people, socialising in an effective manner or dealing with new acquaintances. Mrs Armao struggles with being in a crowd of people for fear of losing control in challenging situations. As a result of her anxiety, Mrs Armao has become isolated and her social interaction has progressively reduced over the years. Mrs Armao has explained that she may only leave home alone if necessary for groceries or appointments and confines herself to local venues. In addition, Mrs Armao has also admitted to having isolated her old friends and relatives and feels that many people have given up on her as she takes no initiative to keep in contact with others outside of her immediate family.

As Mrs Armao has been suffering from the above-stated mental illnesses and challenges for a significant amount of time, they have worsened and become more severe over time. This in turn makes treatment and recovery more complicated and lengthy with several aspects of Mrs Armao’s function being permanently impaired including her ability to gain and maintain employment, study or training activities. Mrs Armao’s ability to remain engaged in a conversation or sustain her concentration for extended periods of time appears to be impaired.

It is my professional opinion that should Mrs Armao be placed in paid employment it is highly likely to exacerbate her current symptoms and may lead to an increase in panic attacks. Overall, it appears that Mrs Armao is Severely Functionally Impaired according to the Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011.

1. Mrs Armao was referred by her GP to Dr Ishrat Ali, a consultant psychiatrist. Dr Ali saw Mrs Armao on 13 January 2014. Dr Ali diagnosed Mrs Armao as having recurring major depression with dysthymia. Dr Ali referred to Mrs Armao’s ten year history of depressive symptoms including depressed mood, insomnia, irritability, poor concentration, social withdrawal and chronic pain. Dr Ali stated that there was no history of weight loss or active suicidal thoughts, and no evidence of panic attacks or any anxiety symptoms. In relation to treatment, Dr Ali noted that Mrs Armao had tried various antidepressant medications but wasn’t taking anything at that time and that she was receiving counselling with a psychologist. Dr Ali prescribed Pristiq and an appointment was made for Mrs Armao to see him again.
2. Dr Rifi provided a letter dated 20 May 2014 which stated that Mrs Armao had been in his care for 15 years and that she had suffered from major depression from 2005. He described her symptoms as depressed mood, anxiety symptoms associated with panic attacks, socially withdrawn, reduced memory and limited concentration. Dr Rifi states that “she has great difficulty being around a crowd of people and loses control in challenging situations therefore causing significant interference in her ability to work.” He expresses a view that “we have exhausted all treatments options for Sonia for her Depression with Dysthymia”.

# CONSIDERATION

1. It is conceded by the Respondent that Mrs Armao has physical, intellectual or psychiatric impairment.
2. The Respondent contended that Mrs Armao did not qualify for DSP because her conditions did not attract an impairment rating of 20 or more points.
3. In support of her appeal to the SSAT, the applicant provided medical evidence which she submitted qualified her to receive the DSP.
4. However, the SSAT determined that the medical evidence submitted by the applicant could not be relied upon to establish her impairment rating because it had not been obtained from an “*appropriately qualified medical practitioner*”, as that term is defined in section 6(4)(a) of the Determination.
5. This finding was particularly based on the SSAT’s determination, at paragraph 20, that *“there was no collaborating evidence at that time from a psychiatrist or a clinical psychologist”* which established the impairment rating applying to her psychiatric conditions*.*
6. However, before I consider the evidence relating to Mrs Armao’s psychiatric condition, I note that it has been reported at various times during the past ten years that aside from the psychiatric condition, Mrs Armao has also suffered from Reinke’s oedema, recurrent bronchitis and chronic pain.
7. I am satisfied from the evidence that the Reinke’s oedema was fully diagnosed, treated and stabilised and that an impairment rating of zero is appropriate, on the basis that the condition does not have any functional impact.
8. I am also satisfied that whilst Mrs Armao’s recurrent bronchitis was considered fully diagnosed, it was not fully treated and stabilised on the basis that treatment which would have improved Mrs Armao’s symptoms, such as reducing or ceasing smoking and active health treatment, had not been pursued.
9. In relation to Mrs Armao’s episodes of chronic pain, it is important to emphasise that pain is a symptom of an underlying condition, rather than a condition itself, and I could find no reliable evidence of a diagnosis which explained Mrs Armao’s chronic pain. There is therefore no identifiable condition upon which the chronic pain can be based, and which I can assess as the condition that has been properly diagnosed, treated and stabilised.
10. In consideration of paragraphs 30 and 31 above, I am satisfied that an impairment rating either cannot be assigned in respect of Mrs Armao’s recurrent bronchitis and chronic pain.
11. Turning to the SSAT’s determination that there was no collaborating evidence at that time from a psychiatrist or a clinical psychologistwhich established the impairment rating applying to Mrs Armao’s psychiatric condition, after the hearing in this Tribunal, the applicant engaged a representative, Mr Wardle, from the Welfare Rights Centre, who submitted a Statement of Facts and Contentions on Mrs Armao’s behalf. By those submissions, the applicant contended that:
	1. she was unaware until receiving the SSAT’s decision that she was required to substantiate her claim with evidence from a psychiatrist or clinical psychologist; and
	2. upon becoming aware of the requirement, she consulted a psychiatrist, Dr Ishrat Ali, on 23 January 2014.
12. The applicant contended that notwithstanding the consultation, the joint diagnosis made by Dr Rifi and Ms Almoty, which was considered by the SSAT in its decision, sufficiently met the requirement that the diagnosis be made by an *“appropriately qualified medical practitioner”.* In the alternative, the Applicant submitted that the Tribunal *“is permitted to consider the medical evidence of Dr Ali in determining whether the applicant’s condition was fully diagnosed under the Determination”.*
13. Section 3 of the Determination provides that an *“appropriately qualified medical practitioner means a medical practitioner whose qualifications and practice are relevant to diagnosing a particular condition”*. However, section 3.6.3.50 of the Guide provides that:

*The diagnosis of the condition must be made by an appropriately qualified medical practitioner. This includes a general practitioner or a psychiatrist. Where the appropriately qualified medical practitioner is not a psychiatrist, the diagnosis must be made by a medical practitioner with evidence from a clinical psychologist.*

1. In order to provide evidence of her disability, the applicant submitted reports from her general practitioner, Dr Rifi, dated 8 October 2013 [T14] and a consultant psychologist, Ms Almoty, dated 10 December 2013. Both reports indicate that the applicant was diagnosed as suffering from major depression, a diagnosis which the respondent does not dispute. The applicant contends that these reports are sufficient to satisfy the requirement in the Determination that the diagnosis is made by an *“appropriately qualified medical practitioner”.*
2. In the alternative, the applicant submits that the report of Dr Ali, dated 23 January 2014 should be taken into account in determining whether the required impairment rating is reached. Although, in this regard, sub-clauses 4(1)(b) and (c) of Schedule 2 of the Administration Act provide that a person must be qualified for a particular social security payment on the date of the claim or within 13 weeks after the date on which the claim is made, the applicant relies on *Shi v Migration Agents Registration Authority* [2008] HCA 2001 (Shi) to contend that the Tribunal is permitted to consider evidence or additional information that may not have been available to the original decision-maker at the time the decision was made. Kirby J held in Shi, at [43], that *“the Tribunal is not ordinarily confined to material that was before the primary decision-maker, or to consideration of events that had occurred up to the time of its decision”.*
3. There have been a number of decisions of this Tribunal that consider the relevance of evidence provided after the assessment of the relevant claim. In *Fanning and Secretary, Department of Social Services* [2014] AAT 447, Deputy President Handley held, at [31], that:

*In my view, in the case of DSP, it is implicit in clause 4 of Schedule 2 of the Administration Act that an applicant must be qualified for DSP on the date of claim or [within] the period of 13 weeks following. Evidence, such as medical reports, that come into being after the relevant period may still be relevant, but only in so far as they are referrable to the applicant’s condition during the relevant period.*

1. In *Bektas and Secretary, Department of Families, Housing, Community Services and Indigenous Affairs* [2013] AATA 249 (Bektas), the Tribunal accepted, at [54], medical evidence obtained several years prior the relevant period:

*Ms Bektas describes very poor hearing in her left ear and is troubled also by tinnitus. The assessor who conducted the JCA in January 2012 reported that Ms Bektas had been provided with a hearing aid but had not used it as she found it uncomfortable. No reports were available to the Tribunal from an audiometrist or a medical specialist. The introduction to Table 11 (entitled* Hearing and other Functions of the Ear*) of the Impairment Tables states that:* The diagnosis of the condition must be made by an appropriately qualified medical practitioner with supporting evidence from an audiologist or Ear, Nose and Throat (ENT) specialist. *The document is silent in regard to what constitutes such* supporting evidence*. The Tribunal in this instance is prepared to accept as* supporting evidence *the evidence given on affirmation by Ms Bektas that several years ago she did consult an Ear, Nose and Throat specialist, that the diagnosis of a perforated ear drum was confirmed and that the perforation was not suitable for surgical repair. In the view of the Tribunal, it would be an inappropriate cost to the applicant and/or the health care system to insist on either obtaining a report from that specialist or from a new specialist. [emphasis added]*

1. In *Palmblad and Secretary, Department of Social Services* [2013] AATA 761 (Palmblad), although the relevant period was from 4 October 2012 to 3 January 2013, the Tribunal held that medical evidence obtained a year before this period was relevant to a determination of whether the condition was fully diagnosed.
2. In making my decision, I must consider whether I may take into account Dr Ali’s report as evidence of the applicant’s medical condition during the relevant period.
3. The applicant notes that Dr Ali’s report states that:

*Mrs Armao has given me a ten year history of depressive symptoms which have included depressed moods, insomnia, irritability, poor concentration, social withdrawal and chronic pain. She told me she often withdraws and does not want to go anywhere.*

*[…]*

*On further examination of her mental state there was no evidence of psychosis, brain damage or any other problem.*

*[…]*

*With regard to the main diagnosis this basically appears to be a case of recurring major depression with Dysthymia.*

1. The applicant contends that although the diagnosis was only corroborated by Dr Ali on 23 January 2014, it related to symptoms that the applicant had been suffering for an extended period of approximately ten years. However, whilst the Tribunal accepts that contention, I must nevertheless be satisfied that the applicant’s symptoms and diagnosis during the relevant period would have attracted an impairment rating of 20 and thereby qualified her for DSP.
2. The applicant’s proposition is that:

*“If this Tribunal is prepared to accept supporting medical evidence (as in Bektas) or diagnosing medical evidence (as in Palmblad) from years before the relevant period, then it must follow that subsequent medical evidence is equally as acceptable, especially where it supports a diagnosis already made by a medical practitioner in the relevant period. In fact, subsequent medical evidence, particularly in diagnoses of mental health conditions as explained in the preceding paragraph of these submissions, must be more acceptable. In the case of antecedent medical evidence leading to a diagnosis at a point in time well before the relevant period, there is a possibility, albeit remote, that the sufferer will be cured of his or her condition prior to the commencement of the relevant period. In the case of medical evidence subsequent to the relevant period there is no such possibility because the diagnosis relates to symptoms that were actually suffered in the relevant period.*

1. Whilst I agree that Dr Ali’s report establishes that the applicant had a ten-year history of depressive symptoms, I do not accept the applicant’s proposition that *“it must follow that the diagnosis of major depression also covers the period in which the applicant was suffering those symptoms”.* The spectrum of depressive symptoms can be very wide and fluctuating and, in that regard, the reference by Dr Ali to *“recurring”* major depression suggests to me that Dr Ali’s opinion was that the applicant’s symptoms were episodic and were not necessarily ongoing during the ten year history.
2. It is also noteworthy that Dr Ali’s report was based on the applicant’s account of her symptoms during the previous ten years. The report does not even indicate that Dr Ali’s diagnosis was definitive; that is, Dr Ali’s opinion was that *“this basically appears to be a case of recurring major depression with Dysthymia”*. The respondent submitted that the diagnosis appeared to be *“presumptive”* in that it *“identified the likely condition but it was too early for Dr Ali to provide confirmation without further consultation and trials of treatment”.*
3. Further complicating Dr Ali’s provisional diagnosis, the respondent referred to inconsistencies between Dr Ali’s report and the GP’s and Ms Almoty’s report. Specifically, the respondent noted that Dr Ali’s report did not corroborate the GP’s diagnosis of PTSD (as referred to in the GP’s medical certificate dated 17 March 2014) and, contradictory to Ms Almoty’s report dated 5 June 2014, Dr Ali stated that *“there was no evidence of any panic attacks or any other anxiety symptoms”.*
4. Even if I were to accept a diagnosis of major depression at the time the applicant consulted Dr Ali, because Dr Ali provisionally diagnosed the applicant as having *“recurring”* major depression, there is no basis upon which I can reliably conclude that the applicant was suffering from major depression during the relevant period, or establish that the symptoms she was experiencing would have been sufficient to attract an impairment rating of 20 or more.
5. On the available evidence, I am not satisfied that, as at the date of cancellation of the applicant’s DSP, a diagnosis of major depression was established, which diagnosis was confirmed by either a psychiatrist or a clinical psychologist, and was determined to attract an impairment rating of 20 or more The evidence only allows me to properly conclude that the applicant was *probably* suffering depressive symptoms and *may* have been suffering major depression during the relevant period and at the time her DSP was cancelled.
6. Given my determination in paragraph 49 above, it is not necessary for me to consider whether the condition was fully treated or stabilised at the date of cancellation. Nevertheless, it is helpful to note that Dr Ali’s report stated that future management of the applicant’s condition would include a trial of medication and further appointments with Dr Ali. The obvious inference to be drawn from Dr Ali’s reference to “a trial of medication” is that, as of the date of the applicant’s consultation with Dr Ali, her condition was not fully treated or stabilised.
7. It follows from paragraphs 49 and 50 above that at the time the applicant’s DSP was cancelled, she did not qualify for the DSP because her condition was not fully diagnosed, treated and stabilised.

# Decision

1. The decision under review is affirmed.

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| 1. I certify that the preceding 52 (fifty-two) paragraphs are a true copy of the reasons for the decision herein of Dr T Nicoletti, Senior Member.
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Dated 13 March 2015

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| Date(s) of hearing | **28 July 2014** |
| Representatives for the Applicant | **Self-represented** |
| Representatives for the Respondent | **Ms Biljana Salaji, Advocate** |