[2015] AATA 402

|  |  |
| --- | --- |
| Division | **GENERAL ADMINISTRATIVE DIVISION** |
| File Number | 2012/5540 |
| Re | Duncan Sidwell |
|  | APPLICANT |
| And | Secretary, Department of Social Services |
|  | RESPONDENT |
| File Number | 2014/1155 |
| Re | Secretary, Department of Social Services |
|  | APPLICANT |
| And | Duncan Sidwell |
|  | RESPONDENT |

# **Decision**

|  |  |
| --- | --- |
| Tribunal | **Deputy President K Bean**  **Mr I Thompson, Member** |
| Date | **5 June 2015** |
| Place | **Adelaide** |

1. In application 2012/5540, the Tribunal affirms the decision under review; and

2. In application 2014/1155, the Tribunal sets aside the decision under review and in substitution for that decision decides that, during the relevant assessment period, Mr Sidwell was not qualified for disability support pension.

............[Sgd]............................................

**Deputy President K Bean**

# **Catchwords**

SOCIAL SECURITY - Disability Support Pension - Two DSP claims in respect of same conditions - Whether conditions fully diagnosed, treated and stabilised - Whether conditions attract an impairment rating of 20 points or more under the Impairment Tables - Applicant not qualified for DSP during relevant assessment periods.

# **Legislation**

Social Security Act 1991, s 94

Social Security (Administration) Act 1999, ss 41, 42; Sch 2 cls 3 and 4

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

**CASES**

Re Bobera and Secretary, Department of Families, Housing, Community Services and Indigenous Affairs [2012] AATA 922

Re Fanning and Secretary, Department of Social Services (2014) 144 ALD 133

Re Yazdari and Secretary, Department of Social Services [2014] AATA 34

# **REASONS FOR DECISION**

**Deputy President K Bean**

**Mr I Thompson, Member**

**5 June 2015**

# **INTRODUCTION**

1. The applicant, Mr Sidwell, who is 55 years old, lodged a claim for a disability support pension (DSP) on 1 March 2012. The basis of his claim was that he suffers from depression, osteoarthritis in the lower spine and chronic testicular pain (the first DSP claim).
2. Centrelink rejected the first DSP claim and on review the Social Security Appeals Tribunal (SSAT) affirmed Centrelink’s decision. Mr Sidwell then applied to this Tribunal for review of the decision of the SSAT, the hearing took place on 29 and 30 January 2014 (the first hearing), and the decision was reserved.
3. It subsequently came to our attention that, on 5 March 2013, Mr Sidwell had lodged another claim for DSP (the second DSP claim), although the parties had not referred us to the second DSP claim during the first hearing. The second DSP claim related to the same conditions as the first DSP claim, namely a back condition, depression and testicular pain.
4. Centrelink also rejected the second DSP claim. However, on review, the SSAT determined that Mr Sidwell satisfied the qualification requirements for DSP and that he had done so since 5 March 2013. The SSAT made its decision on 31 January 2014, being the day after the Tribunal had reserved its decision on the first DSP claim.
5. With respect to the second DSP claim, the SSAT assigned 10 points for Mr Sidwell’s back condition, 10 points for moderate functional impact arising out of depression, and 0 points for testicular pain on the basis that the condition was not fully diagnosed, fully treated and fully stabilised. Accordingly, the SSAT found that Mr Sidwell’s total impairment rating was 20 points and, as he also met the other relevant requirements, he therefore qualified for DSP. However on 5 March 2014, the Secretary applied to this Tribunal for review of the SSAT’s decision on the second DSP claim.
6. Accordingly, there are currently two applications before this Tribunal relating to Mr Sidwell’s entitlement to DSP, one brought by Mr Sidwell and one by the Secretary. After the Secretary’s application for review of the second SSAT decision had been lodged, it was determined at a Directions Hearing on 14 March 2014 that the two matters should be heard and determined together, and ultimately a further hearing was held on 16 and 17 March 2015.

# **legislation and issues**

1. It follows that the issue for us is whether Mr Sidwell satisfied the qualification criteria for DSP, which are set out in s 94 of the *Social Security Act 1991* (the Act). Under ss 41 and 42, and cls 3 and 4 of Schedule 2 to the *Social Security (Administration) Act 1999* (the Administration Act), an applicant must qualify for a social security payment on the day on which the claim was made or within 13 weeks of that date (the assessment period). Therefore for Mr Sidwell’s first DSP claim, the assessment period is from 1 March 2012 to 31 May 2012 (the first assessment period). For Mr Sidwell’s second DSP claim, the assessment period is 5 March 2013 to 4 June 2013 (the second assessment period).
2. In order to qualify for DSP, s 94 of the Act provides that an applicant must have:

* a physical, intellectual or psychiatric impairment;
* an impairment of 20 points or more under the *Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011* (the Impairment Tables); and
* a continuing inability to work.

1. For the purposes of s 94, a person is regarded as having a continuing inability to work if:

* they have an inability to work due to their accepted impairments for 15 hours or more a week, and
* they have actively participated in a program of support.

The second requirement does not apply, however, if a person has a severe impairment of 20 points or more under a single Impairment Table.

## CONSIDERATION

1. We will first consider whether Mr Sidwell’s conditions resulted in the required level of impairment during either of the assessment periods, noting that there is no dispute that at all relevant times he has suffered from physical and psychiatric impairments, satisfying subs 94(1)(a).

## What impairment ratings should be given?

1. The Impairment Tables provide the mechanism to assign ratings for the level of functional impact arising out of an impairment. The Impairment Tables are based on function rather than diagnosis and they describe functional activities, abilities, symptoms and limitations. Section 6 of the Impairment Tables provides that an impairment rating can only be assigned if the condition causing the impairment is permanent and is more likely than not to persist for more than two years. The Impairment Tables also provide that a condition is permanent only if it is fully diagnosed, fully treated and fully stabilised.
2. We propose to consider the applicable impairment rating for each of Mr Sidwell’s conditions, by reference to the Impairment Tables. As we have indicated, it is necessary to consider whether each condition was fully diagnosed, treated and stabilised during the relevant assessment period before determining an impairment rating, because the Impairment Tables make this a prerequisite for the allocation of an impairment rating.

### The back condition

Was the condition fully diagnosed, treated and stabilised?

1. Mr Sidwell gave evidence that he had suffered from back pain since 2011 and it had gradually worsened. The pain also affected his left leg. He regularly exercised in accordance with guidance from a physiotherapist and took medication to reduce the effects of the back pain. He said physiotherapy treatment continued for two years and he came under the continuing care of a physiotherapist at the Royal Adelaide Hospital Pain Management Unit. He described the adverse effects of the back pain on his daily activities, including long-term and consistent difficulties with housework, walking, lifting and driving. He said the back pain also interfered with his sleep.
2. Mr Sidwell’s general medical practitioner, Dr Afari, gave oral evidence to the Tribunal. Mr Sidwell had consulted Dr Afari for treatment for chronic back pain since 29 March 2010. Dr Afari said he had referred Mr Sidwell to a neurosurgeon, Associate Professor Zacest, who reported that an x-ray of Mr Sidwell’s lumbar spine revealed L4/5 and L5/S1 degenerative change. Associate Professor Zacest concluded in a report dated 5 November 2012 that surgical intervention was not likely to assist in the management of Mr Sidwell’s lower back and *“he needs to work on a pain management approach.”*[[1]](#footnote-1)Dr Afari’s opinion was that the back condition was fully diagnosed, treated and stabilised during the first assessment period, when he was Mr Sidwell’s treating general practitioner, although he acknowledged that specialist pain management had not been trialled at that stage.[[2]](#footnote-2)
3. A physiotherapist, Ms Baines, also gave oral evidence to the Tribunal. She has extensive experience in musculoskeletal physiotherapy. She conducted an assessment with Mr Sidwell on 4 April 2012 for the purposes of a Job Capacity Assessment report (JCA report). It was an assessment only, not an examination.
4. In the JCA report, Ms Baines stated that Mr Sidwell thought the onset of back pain was possibly linked to his duties in the armed forces overseas between 1979 and 1984 and that it had been aggravated further by repeated bending and lifting, several years later, when he was employed in a laboratory to analyse core samples for a geological exploration company. Ms Baines took into account an x-ray report which referred to mild disc degeneration at L5/S1 and mild, multi-level facet joint osteoarthritis. She concluded that the back condition was permanent but not fully diagnosed, treated and stabilised. She considered that Mr Sidwell would benefit from physiotherapy treatment and a specific spinal exercise program.[[3]](#footnote-3)
5. Nevertheless, on the evidence of Mr Sidwell and Dr Afari, together with the report of Associate Professor Zacest, we are satisfied that Mr Sidwell’s back condition was fully diagnosed during the first assessment period. We are also satisfied that the back condition was fully treated and stabilised, noting the treatment given under the direction of Dr Afari, being physiotherapy and medication. We acknowledge that Associate Professor Zacest recommended referral to a pain unit, which subsequently occurred. Therefore, at the time of the first assessment period, it was likely that some treatment would continue in the next two years, given the need for a holistic approach to pain management because of the multiple health problems affecting Mr Sidwell. However we consider that at the time of the first assessment period Mr Sidwell had undergone reasonable medical and physiotherapy treatment for his back pain, and further treatment was unlikely to result in significant functional improvement within two years. We note that s 6(6)(a) of the Impairment Tables provides that a condition is fully stabilised if:

(a) … the person has undertaken reasonable treatment for the condition and any further reasonable treatment is unlikely to result in significant functional improvement to a level enabling the person to undertake work in the next 2 years…

1. Accordingly, having regard to all of the evidence, we consider that as at 1 March 2012 or within 13 weeks of that date, Mr Sidwell’s lower back condition was permanent and was likely to persist for more than two years.[[4]](#footnote-4) Therefore we are satisfied that an impairment rating can be given for this condition.

What is the applicable impairment rating?

1. Table 4 provides the descriptors of impairment relating to spinal function. For a moderate functional impact Table 4 states:

***Table 4 – Spinal Function***

|  |  |
| --- | --- |
| ***Points*** | ***Descriptors*** |
| *10* | There is a **moderate** functional impact on activities involving spinal function*.*  *1) The person is able to sit in or drive a car for at least 30 minutes, and at least one of the following applies:*  *(a) the person is unable to sustain overhead activities (e.g. accessing items over head height); or* |
|  | *(b) the person has difficulty moving their head to look in all directions (e.g. turning their head to look over their shoulder); or*  *(c) the person is unable to bend forward to pick up a light object placed at knee height; or*  *(d) the person needs assistance to get up out of a chair (if not independently mobile in a wheelchair).* |

1. Having regard to these descriptors, we find that Mr Sidwell’s condition of low back pain attracted a rating of 10 points during the first assessment period. There is sufficient evidence before us to conclude that since that period Mr Sidwell has had difficulty sustaining overhead activities and been unable to bend forward, meeting the descriptors at (1)(a) and (c) in the Table, or at the very least certainly meeting the requirements of (1)(c). We therefore consider that he has borne a moderate functional impact on activities involving spinal function.
2. We note that Mr Sidwell’s evidence at the first hearing covered a timeframe which also included the assessment period for the second DSP claim, and is clear that the moderate functional impact from the lower back condition was present during both assessment periods. Accordingly, we find that Mr Sidwell’s back condition also rated 10 impairment points on the second DSP claim.

### Left testicular pain

Was the condition fully diagnosed, treated and stabilised?

1. The material before us includes reports dated 21 January 2012 and 1 May 2012 of Dr Harris, Urology Registrar at the Modbury Hospital.
2. In his initial report of 21 January 2012, Dr Harris stated:

His past history is significant for a bilateral vasectomy 14 years ago and he reports after that the procedure that he had chronic pain on the right side which is similar to his symptoms now. These symptoms were severe enough at the time to warrant right orchidectomy. He states he has delayed presenting on this occasion for fear of losing his left testis.[[5]](#footnote-5)

Dr Harris noted that the condition had not responded well to pain medication or antibiotic treatment. As to the cause of Mr Sidwell’s pain, Dr Harris indicated: *“It is likely that he has some post vasectomy chronic scrotal pain.”* In terms of treatment, Dr Harris stated:

At this point in time we will try to manage him with conservative treatment and we have referred him to the Chronic Pain Unit. I have ordered a renal ultrasound scan just to rule out any renal calculi that may be referring to his scrotum. We will review him in two months time following this. If we are unable to treat his problems conservatively then he may warrant a steroid injection into his scrotum. At the very least this may be a helpful diagnostic exercise. The only other options which may be available would be reversal of his vasectomy which would no [sic] guarantee resolution of his symptoms. The patient himself is not happy for a left orchidectomy.

1. In his subsequent report of 1 May 2012, Dr Harris indicated that the ultrasound of the renal tract he had ordered was normal, and noted that Mr Sidwell had an appointment with the Chronic Pain Unit at the Royal Adelaide Hospital. Dr Harris discharged Mr Sidwell from the Urology Clinic with the proviso that he could be seen again if he did not respond to chronic pain management and if he was interested in surgery.
2. However, the Tribunal notes the difficulties regarding surgical options which Dr Harris describes, namely, that they:

… would include in the extreme case an orchidectomy of the remaining testis, or alternatively reversal of the vasectomy … In addition both of these options do not necessarily have a high chance of solving his symptoms and may in fact make his problem worse.[[6]](#footnote-6)

1. We note that Mr Sidwell was subsequently seen by the Pain Unit and the material before us includes a record of a meeting of the Pain Unit Panel on 26 November 2013.[[7]](#footnote-7) This record refers to Mr Sidwell’s testicular pain and contains general recommendations for pain management, but no recommendations specific to Mr Sidwell’s testicular pain. In a subsequent report of 29 May 2014,[[8]](#footnote-8) Ms Robyn Campbell, Senior Consultant at the Pain Management Unit also referred to Mr Sidwell’s testicular pain, noted the results of the implementation of the PMU’s recommendations of November 2013 and made some further recommendations, none of them being specific to Mr Sidwell’s testicular pain.
2. In his evidence, Mr Sidwell stated that he was afraid to have surgical treatment. This is not surprising. Unfortunately, the symptoms which he reports are regular and painful. He reported a very sharp pain several times per day and sometimes also at night. He said the pain is quite constant and the aggravations are intense. At times, he took Panadeine Forte but it had reached the stage where the medication was not helping. He said the pain has been present since the vasectomy and in cold weather the level of pain increases and stays longer. For completeness, we should also note that in his evidence at the first hearing, Mr Sidwell referred to the fact that he had a further appointment booked with a Urologist, and he was hoping to have an MRI or CT scan done in an effort to determine more precisely what the problem was.
3. In the JCA report dated 4 April 2012, Ms Baines also referred to Mr Sidwell’s left testicular pain and indicated that she did not consider that this was fully diagnosed, treated and stabilised.
4. Nevertheless, on consideration of all the evidence before us concerning the left testicular pain, we conclude that there is an appropriate diagnosis by Dr Harris, of chronic pain secondary to a bilateral vasectomy. The condition has also been treated with medication. The Tribunal considers that Mr Sidwell has undertaken reasonable treatment. Unfortunately, the condition persists, however, it is stable.
5. As we have acknowledged in the context of Mr Sidwell’s back condition, we accept that at the time of the first assessment period, Mr Sidwell was yet to see the Pain Management Unit and participate in a pain management program. However, on the evidence before us, we do not consider that at the time of the first assessment period, this was likely to result in a significant functional improvement within a two year period. We also consider that Mr Sidwell is entitled to be apprehensive about surgical intervention and it is not reasonable to expect him to submit to surgery in view of the possible complications. The reports of Dr Harris support a conclusion that this condition is permanent. Accordingly, we are also satisfied that a rating can be assigned for this condition.

What is the applicable impairment rating?

1. Table 10 of the Impairment Tables is appropriate for assessing the degree of impairment resulting from the condition of left testicular pain.[[9]](#footnote-9) For a mild or moderate functional impact Table 10 states:

***Table 10 – Digestive and Reproductive Function***

|  |  |
| --- | --- |
| **Points** | **Descriptors** |
| *5* | There is a **mild** functional impact on work-related or daily activities due to symptoms or personal care needs associated with a digestive or reproductive system condition.  *(1) At least one of the following applies:*  *(a) the person’s attention and concentration at a task are sometimes (on most days) interrupted or reduced by pain or other symptoms or personal care needs associated with the digestive or reproductive system condition; or*  *(b) the person is sometimes (less than once per month) absent from work, education or training activities due to the digestive or reproductive system condition.* |
| *10* | There is a **moderate** functional impact on work-related or daily activities due to symptoms of personal care needs associated with a digestive or reproductive system condition.  *(1) At least two of the following apply to the person:*  *(a) the person’s attention and concentration on a task are often (at least once a day but not every hour) interrupted or reduced by pain or other symptoms or personal care needs associated with the digestive or reproductive system condition;*  *(b) the person is unable to sustain work activity or other tasks for more than 2 hours without a break due to symptoms of the digestive or reproductive system condition;*  *(c) the person is often (once per month) absent from work, education or training activities due to the digestive or reproductive system condition.* |

1. The evidence about Mr Sidwell’s testicular pain was adduced at the first hearing, but covers both assessment periods, as Mr Sidwell said there had been very little change in the condition since shortly after his vasectomy in 1997. As to how many times a day he experienced sustained acute pain in the area he said:

Several. Between eight and 10 times average, I would say, but it can also happen at the night or – as well. It’s like the whole – through the whole 24 hours every day. So it could be at any time, so even if I’m asleep and it could come on and that’s it, I’m awake …[[10]](#footnote-10)

1. Although this evidence was challenged in cross-examination, we accept that Mr Sidwell experiences testicular pain of sufficient intensity and frequency so as to satisfy (1)(a) of the descriptors for a 10 point rating. However, having carefully reviewed the evidence, we do not believe there is any foundation for a conclusion that, due to his testicular pain, Mr Sidwell has been unable to sustain relevant activities for more than 2 hours without a break, or has been absent from education or training activities at least once per month. We note that with respect to the latter part of 2012, Mr Sidwell indicated that he was studying at TAFE at that time and was *“off a lot sick because of pain”*.[[11]](#footnote-11) However he was not specific about the source of the pain, and we do not consider it properly open to us to assume he was referring to testicular pain only.
2. Accordingly, we consider a rating of 5 points to be applicable for this condition during each assessment period, and we note that Ms Riley, who appeared as advocate for Mr Sidwell at the second hearing, acknowledged that a rating of 5 points was the appropriate rating for this condition.

### Depression

1. In the context of assessing this condition, it is relevant for us to note that the Introduction to Table 5 of the Impairment Tables (Mental Health Function) specifies that the diagnosis of a mental health condition must be made by a medical practitioner with evidence from a clinical psychologist if the diagnosis has not been made by a psychiatrist. In full, the Introduction to Table 5 states:

### Table 5 – Mental Health Function

|  |
| --- |
| **Introduction to Table 5** |
| *● Table 5 is to be used where the person has a permanent condition resulting in functional impairment due to a mental health condition (including recurring episodes of mental health impairment).*  *● The diagnosis of the condition must be made by an appropriately qualified medical practitioner (this includes a psychiatrist) with evidence from a clinical psychologist (if the diagnosis has not been made by a psychiatrist).*  *● Self-report of symptoms alone is insufficient.*  *● There must be corroborating evidence of the person’s impairment.*  *● Examples of corroborating evidence for the purposes of this Table include, but are not limited to, the following:*   * *a report from the person’s treating doctor;* * *supporting letters, reports or assessments relating to the person’s mental health or psychiatric illness;* * *interviews with the person and those providing care or support to the person.*   *● In using Table 5 evidence from a range of sources should be considered in determining which rating applies to the person being assessed.*  *● The person may not have good self-awareness of their mental health impairment or may not be able to accurately describe its effects. This is to be kept in mind when discussing issues with the person and reading supporting evidence.*  *● The signs and symptoms of mental health impairment may vary over time. The person’s presentation on the day of the assessment should not solely be relied upon.*  *● For mental health conditions that are episodic or fluctuate, the rating that best reflects the person’s overall functional ability must be applied, taking into account the severity, duration and frequency of the episodes or fluctuations as appropriate.* |

1. Therefore it is important for us to have regard to the qualifications of those treating and assessing Mr Sidwell.

Has the condition been fully diagnosed, treated and stabilised?

Evidence at first hearing

1. Mr Sidwell also gave oral evidence about his depression, which he has suffered intermittently since 2005. At that time, the depression was associated with matrimonial difficulties. His marriage broke down in 2009 and a dissolution of marriage followed. Since 2009, Mr Sidwell has suffered sporadic bouts of depression. In evidence he said that he feels down and depressed frequently. He tries to cope as best he can. He consulted a clinical psychologist, Mr De Blasio, on several occasions in 2011. His general medical practitioner, Dr Afari, monitored his psychological condition and treatment included prescription of sleeping tablets.
2. Mr Sidwell’s initial referral to the clinical psychologist Mr De Blasio occurred on 9 March 2011. The stated problems were chronic pain, which worsened during cold weather, difficulty with going to sleep and dealing with significant problems concerning his teenage daughter. In a report dated 5 June 2011, Mr De Blasio wrote that Mr Sidwell *“seems to get some benefit from supportive counseling* [sic] *but limited responses to cognitive behavioural therapy.”*[[12]](#footnote-12)Six consultations followed with Mr De Blasio, concluding on 21 February 2012. At that time Mr Sidwell told Mr De Blasio that he was feeling helpless and hopeless some of the time, his experience with pain was terrible and he was having physical difficulties, psychological problems and was under financial stress.
3. Mr Sidwell did not seek further treatment from Mr De Blasio. However, Dr Afari subsequently referred him to a registered psychologist, Mr Rankine. The referral which Dr Afari made to Mr Rankine described a condition of *“depression with anxiety”*.
4. In a report dated 6 June 2012, Mr Rankine stated that he had seen Mr Sidwell on two occasions. Mr Sidwell had completed the DASS Mood Questionnaire, the “K10”[[13]](#footnote-13) and the Beck Depression Inventory for Mr Rankine. Each of these measures indicated severe/extreme depression. In Mr Rankine’s opinion, Mr Sidwell suffered from major depression *“given his expressed history that this has existed for more than two years and is likely to continue to be a problem.”*[[14]](#footnote-14)
5. Mr Rankine provided another report dated 24 October 2012, by which time he had seen Mr Sidwell on eight occasions. In this report, Mr Rankine also stated that Mr Sidwell:

… additionally suffers posttraumatic stress which contributes to his current mood disorder. He continues to experience back pain which is additional to the depression.

His mood disorder has existed for more than two years and is quite intractable. He has completed a mood assessment though (sic) the “Black Dog Institute” and this has resulted in a symptom diagnosis of melancholic depression with moderate PTSD.

It is the opinion of myself and the back-up opinion of the national on-line specific diagnostic service to psychologists that the condition is stable and likely to persist.[[15]](#footnote-15)

1. In an undated reported received by the Tribunal on 23 April 2013, Mr Rankine stated that he had then seen Mr Sidwell on 13 occasions. At that time Mr Rankine stated that Mr Sidwell was suffering from severe pain, PTSD and melancholic depression. He wrote that the condition was adequately diagnosed and treated and it was reasonably stabilised. He recommended continued pharmacological treatment and continuing psychotherapy including pain treatment and cognitive behaviour therapy. He considered that Mr Sidwell presented with moderate functional impact on activities involving mental health function.
2. The material before us also includes a further JCA report dated 15 March 2013, contributed to by Ms Osman-Grela, a clinical psychologist, who also gave oral evidence to the Tribunal. She did not meet Mr Sidwell and her contribution to the JCA report was based on reports which she read and material that the author of the JCA report provided to her. On the basis of that material, Ms Osman-Grela considered that Mr Sidwell’s condition was not fully treated and stabilised during the first assessment period. In her opinion, a person with severe or extreme depression should be referred to a psychiatrist for further management.[[16]](#footnote-16) In evidence she stated that it would have been preferable for Mr Sidwell to be referred to a psychiatrist early in the first assessment period.
3. Given the contents of Table 5, which we have referred to above, it is important that we acknowledge that Ms Osman-Grela and Mr De Blasio are both clinical psychologists. By contrast, Mr Rankine is a registered psychologist, but he is not a clinical psychologist. Therefore Mr Rankine’s professional qualifications do not meet the criteria specified in Table 5 for provision of the diagnosis of a mental health condition.
4. As we have alluded to above, during the first hearing, other factors relevant to a possible diagnosis of depression arose from evidence about the possibility of Mr Sidwell suffering from PTSD. Mr Sidwell was cross-examined in a sensitive, detailed manner about unfortunate experiences that he endured while he was in military service overseas between 1979 and 1984. Memories, flashbacks and dreams about those incidents have subsequently affected Mr Sidwell from time to time. Mr Sidwell’s evidence, and also the oral evidence from Mr De Blasio, Dr Afari and Ms Osman‑Grela, raised the prospect that Mr Sidwell may have suffered from PTSD before, during and after the first assessment period. This issue would have been better addressed, according to Ms Osman-Grela, if a psychiatric assessment had taken place during the first assessment period.

Evidence at second hearing

1. In his evidence at the second hearing, Mr Sidwell confirmed that he continued to experience depression. He said that he still had some dreams and flashbacks about incidents when he was in the military. He said the dreams occur occasionally, probably less than one per month. He said he did not find them as disturbing as he used to. More troubling for him were dreams about problems he had with his wife. Those dreams were disturbing and caused him to wake up in a cold sweat, feeling very upset. He had difficulty going back to sleep. The dreams related to his hospitalisation in 2005 when he found out that his wife was having an affair.
2. He confirmed that he had recently recommenced psychotherapy with Mr De Blasio. However, that psychotherapy was focused on current events, including problems with his daughter. He had not received psychotherapy in relation to his military experiences. His general medical practitioner had prescribed Seraquol for about a month to help with sleeping, however he said he did not react well to that medication as it was too powerful.
3. Mr Sidwell said that his feelings about his marital breakdown were the main cause of his depression. He also thought that he may have PTSD arising out of the problems in his marriage. In contrast to the memories which he has about his military service, which do not cause significant distress anymore, the negative feelings that he has about the marriage breakdown are more significant. He thinks that he has never been asked the right questions about the breakdown of his marriage and the effects it has had on him emotionally. He takes medication, Cymbalta, which he thought was working as well as it could.
4. After the first hearing, during which the possibility of PTSD arose, Mr Sidwell was referred by the Secretary for an assessment and report by Dr Ewer, who has practised as a consultant psychiatrist since 1990 and has significant experience in treating war veterans and people with PTSD. He indicated in his evidence that over many years he has treated more than 1,000 war veterans.
5. Dr Ewer provided a written report dated 1 July 2014.[[17]](#footnote-17) In that report he outlined the history of events which Mr Sidwell related to him about some traumatic events which he experienced during military service in 1982. Problems which followed included difficulty with sleeping, troubling nightmares, tension, anxiety and irritability. Dr Ewer considered that Mr Sidwell’s mood was depressed and anxious, that his memory and concentration were impaired, but there were no psychotic symptoms. Dr Ewer stated:

… it is my clinical opinion, based upon a reasonable degree of medical probability that Mr Sidwell is suffering from a **chronic post-traumatic stress disorder** and a **major depressive disorder**.[[18]](#footnote-18) (emphasis in original)

Dr Ewer considered that Mr Sidwell was suffering those conditions during both of the assessment periods.

1. In his report, Dr Ewer also indicated that Mr Sidwell’s PTSD was not fully diagnosed and not fully treated during either assessment period. In particular, Mr Sidwell had not had any trauma-focused therapy for his military experiences. Dr Ewer commented that a thorough assessment would be necessary and it should include a full evaluation of treatment options, which may include general treatment modalities, psychotherapy or antidepressants. Given that Mr Sidwell had not undertaken that kind of treatment, his PTSD could not be considered to be fully treated or fully stabilised.
2. The issue of depression occurring in the context of PTSD was noted by Dr Ewer and he reported that in his experience approximately 50% of people suffering from PTSD develop a clinically significant depressive disorder. He said the depression can often improve if the PTSD is also treated. However this had not happened in Mr Sidwell’s case during either of the assessment periods. Dr Ewer’s conclusion about Mr Sidwell’s condition was:

From a psychiatric perspective, he was not suffering from one or more fully diagnosed, fully treated and fully stabilised psychiatric conditions during either of the claim periods.[[19]](#footnote-19)

1. As we have alluded to above, Dr Ewer also gave oral evidence at the second hearing, which was consistent with his report.
2. We have also had the benefit of evidence from Dr Dhillon, a psychiatrist at the Cramond Clinic, Queen Elizabeth Hospital, to whom Mr Sidwell was referred by his general medical practitioner. Dr Dhillon wrote a report dated 31 March 2014, together with a supplementary report dated 20 May 2014, and he also gave evidence to the Tribunal by telephone. Dr Dhillon assessed Mr Sidwell on 21 March 2014. During that assessment Mr Sidwell reported that he had been chronically depressed over the last few years. The causes were problems in his marriage, his encounters with Centrelink and physical health problems with chronic pain. Mr Sidwell mentioned the possibility of having PTSD symptoms because of his experiences in the military.
3. In Dr Dhillon’s opinion, Mr Sidwell had a *“Dysthymic Disorder which has been chronic for many years.”*[[20]](#footnote-20) Dr Dhillon said that the causes were likely to be a combination of personality and psychological factors related to a series of stressful life events going back to the time when he was in the military. Dr Dhillon reported that Mr Sidwell also has:

… a Post-Traumatic Stress Disorder (PTSD) which was chronic and attenuated. These disorders have been evident for many years and are unlikely to change to a large extent in the future.

Dr Dhillon considered that Mr Sidwell’s *“main presentation now”* was *“an Adjustment Disorder with a depressed and anxious mood related to his battles with Centrelink”.*[[21]](#footnote-21)

1. In his oral evidence, Dr Dhillon stated that the PTSD Mr Sidwell may have suffered as a result of his military duties made him more vulnerable to stressful events later in his life. In relation to treatment, Dr Dhillon queried whether cognitive behavioural therapy would be effective because it would relate principally to events that were 30 years old. Rather, Dr Dhillon considered that the depression should be treated first. He did not see any reason to change the medication that Mr Sidwell was currently taking. He suggested that referral to a psychologist may assist Mr Sidwell to develop coping strategies to help him adjust better to his difficulties.
2. In cross-examination, Dr Dhillon confirmed that he does not treat war veterans in his clinical practice. He acknowledged that Dr Ewer’s examination and report were comprehensive and amounted to a “textbook” treatment of PTSD and depression. Nonetheless, Dr Dhillon did not change his view about a diagnosis of dysthymic disorder rather than a major depressive disorder. He did not think that symptom magnification was an issue and he thought that from a mental health perspective, Mr Sidwell *“was doing as well as can be expected based on the chronicity of his problems and his current life circumstances.”*[[22]](#footnote-22)
3. In contrast to Dr Dhillon’s assessment and recommendation, Dr Ewer indicated in his report that Mr Sidwell had not had any trauma-focused therapy to enable an improvement in his PTSD, nor had he had other treatment specific to PTSD. Specifically, Dr Ewer reported that an extensive management plan is best for the treatment of PTSD and it should incorporate a thorough assessment, consideration of general treatment modalities, psychotherapy that could include trauma-focused cognitive behaviour therapy or eye movement desensitisation, and medication. In relation to psychotherapy, Dr Ewer reported that cognitive behaviour therapy would usually involve 8 to 12 sessions. As Mr Sidwell had not had treatment of this kind through a comprehensive management plan, Dr Ewer reported that Mr Sidwell’s PTSD could not be considered to be fully treated or fully stabilised. Furthermore, as we have already noted, Dr Ewer considered:

Depression in the setting of PTSD often improves considerably once the PTSD is treated.[[23]](#footnote-23)

Analysis

1. At the first hearing, the evidence raised the real possibility that Mr Sidwell may have been suffering from PTSD or depression, or both, without resolving the question of diagnosis. However at the second hearing, the evidence from the two psychiatrists, Dr Ewer and Dr Dhillon, drew together the threads of the evidence received in the first hearing and provided elaboration and context that was previously missing. The psychiatric evidence provided a more satisfactory basis for the Tribunal to weigh the evidentiary material about depression and PTSD in relation to both assessment periods.
2. In Mr Sidwell’s Statement of Facts and Contentions dated 3 September 2014, it was submitted that *“his depression and anxiety was fully documented, diagnosed, treated and stable”* at the time of his claims for DSP, in March 2012 and March 2013. At the second hearing, it was not disputed on his behalf that a diagnosis of PTSD was appropriate, however it was argued that the evidence of Dr Dhillon suggested that it was *“compartmentalised”* and the treatment for depression would not have been changed, or affected, in any event.
3. It is important to appreciate that the progression of a medical condition after the assessment period cannot be used as material to award DSP. The Tribunal notes the comments of Member Breen in *Re Bobera and Secretary, Department of Families, Housing, Community Services and Indigenous Affairs*:

In the Tribunal’s consideration as to whether a condition has been stabilised and is likely to persist for the foreseeable future, the Tribunal must look at the situation as it was, and the evidence that was available, at the time of the application for DSP (and the subsequent 13 weeks). Any subsequent evolution of a particular condition might be relevant to any weight the Tribunal places on competing prognostications or on an assessment of the quality of the medical reports provided (most notably where evidence indicates that the creator of a medical report may not have had access to all relevant information or may not have turned his or her mind to all the relevant issues). This point is important as it is quite frequently the case that appeals on DSP decisions arrive at this Tribunal twelve or more months after the initial DSP application was refused. In many instances, the natural course of illnesses or injuries has then become more obvious, thereby confounding the professional opinions honestly proffered by thorough and conscientious treating doctors. If a medical condition has progressed since the time of the original DSP application, then it is up to the applicant to make a new DSP application. It is not open in law for this Tribunal to use any evidence of such progression to directly award a DSP because of those changed circumstances.[[24]](#footnote-24)

1. In addition, the Tribunal notes the comments of Deputy President Handley in *Re* *Fanning and Secretary, Department of Social Services*:

31. In my view, in the case of DSP, it is implicit in cl 4 of Sch 2 of the Administration Act that an applicant must be qualified for DSP on the date of claim or with 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.

32. This is supported by the judgment of Gyles J in Harris v Secretary, Department of Employment and Workplace Relations (2007) 158 FCR 252; [2007] FCA 404. Gyles J stated at [1] that as an applicant’s entitlement to DSP must be considered at the date of claim and within the 13 week period, “Any subsequent change in her health is irrelevant to the questions which arise in this proceeding except in so far as it may cast light on the position at the relevant time”.

33. The language in cl 6(5) and (6) of the 2011 Determination is forward-looking. With respect to whether a condition was fully stabilised, for example, the question for the tribunal is whether “any further reasonable treatment is unlikely to result in significant functional improvement to a level enabling the person to undertake work in the next 2 years” (emphasis added). While hindsight may suggest that treatment did not result in improvement within 2 years, that is not the question for the Tribunal to determine. The legislation requires the tribunal to consider the treatment that has taken place, and was intended to take place, and the likely effect of that treatment, at the time of the claim and in the 13 weeks thereafter. For that reason, evidence of treatment, and the efficacy of that treatment, after the relevant period is not directly relevant to the tribunal’s decision.[[25]](#footnote-25)

1. In relation to mental health function, the Tribunal, constituted by Senior Member Dunne and Professor Reilly, in *Re Yazdari and Secretary, Department of Social Services*[[26]](#footnote-26), also provided helpful guidance as follows:

30. …

(a) the Impairment Tables are for assessing the degree of psychiatric impairment, not to assess the severity of psychiatric conditions;…

(b) an impairment rating can only be assigned to a psychiatric impairment if the condition causing that impairment is ‘permanent’;…

(c) a psychiatric condition is only ‘permanent’ if it has been fully diagnosed by an appropriately qualified medical practitioner such as a psychiatrist or, failing that, a general practitioner with input from a clinical psychologist; …

(d) while psychiatric conditions are diagnosed by reference to psychiatric symptoms, an appropriately qualified medical practitioner would usually differentiate between a diagnosed condition and the symptoms on which their diagnosis is based; and

(e) it is not possible to assess whether a psychiatric condition has been fully treated and stabilised without a proper diagnosis, which is essential for the development of a fully informed treatment plan.

1. Both Dr Ewer and Dr Dhillon agreed on the existence of a psychiatric condition. They differed about Mr Sidwell’s precise diagnosis and, consequently, the optimal course of treatment. Their opinions, coming well after the second assessment period, highlight the factors that were relevant to diagnoses during both assessment periods and provide assistance in assessing those factors. Their expertise in psychiatry assists in the interpretation of the evolution of Mr Sidwell’s psychological conditions and their treatment. This assists the Tribunal, in turn, in its task of determining the situation in each of the assessment periods and whether it could be concluded at those times that Mr Sidwell’s mental health issues were permanent because they were fully diagnosed, fully treated and fully stabilised.
2. On consideration of all of the evidence in both hearings, we prefer Dr Ewer’s analysis of Mr Sidwell’s mental health condition to that of Dr Dhillon. Dr Ewer has carefully analysed and provided consistent evidence about the relevant events, including the experiences which Mr Sidwell had in the military, the difficulties later on in his marriage, and the psychological impact which those difficulties had. In relation to Mr Sidwell’s PTSD, Dr Ewer reported:

… it would appear that his post-traumatic stress disorder was not fully diagnosed during the relevant periods. His post-traumatic stress disorder was not fully treated during the relevant periods. In particular, Mr Sidwell has had treatment for depression. People suffering from PTSD require more specific treatment and in particular evidence based, best practice treatment involves trauma focused therapy.[[27]](#footnote-27)

1. Accordingly, we are not satisfied that any PTSD condition suffered by Mr Sidwell can be said to have been fully diagnosed, treated and stabilised during the first or second assessment periods. Even if Mr Sidwell could be said to have suffered from a major depressive disorder during one or both assessment periods, on the evidence before the Tribunal, any such major depressive disorder was also not fully treated and stabilised during either assessment period, particularly given that treatment of Mr Sidwell’s subsequently diagnosed PTSD is likely to result in improvement in his depression. Therefore no points can be assigned to any resulting impairment under Table 5 of the Impairment Tables.
2. Mr Sidwell’s journey through two DSP claims resulting in two separate applications to the Tribunal has been lengthy and complex. However, it is necessary, though not always easy, for DSP claimants to interpret and follow the rules laid out in the legislative scheme. The Tribunal notes the Secretary’s comment:

If, after undertaking the further reasonable treatment recommended by Dr Ewer, Mr Sidwell’s psychiatric impairment still does not improve, the appropriate solution is for Mr Sidwell to lodge a further claim for DSP at that time.[[28]](#footnote-28)

# **CONCLUSION**

1. We are satisfied that the conditions from which Mr Sidwell suffers which give rise to impairment ratings under the Impairment Tables during the assessment periods are the lower back condition and the testicular pain. The applicable rating for the lower back condition is 10 points for each assessment period and the applicable rating for the testicular pain is 5 points for each assessment period, resulting in a total of 15 points for each period. It follows that Mr Sidwell did not have an impairment or a combination of impairments attracting a rating of at least 20 points under the Impairment Tables during either of the assessment periods, and therefore he did not satisfy subs 94(1)(b) of the Act with respect to either period.
2. Accordingly it is not necessary to consider whether or not, during the assessment periods, Mr Sidwell had a *“continuing inability to work”* within the meaning of subs 94(1)(c).
3. As Mr Sidwell was not qualified for DSP at the time he lodged his first DSP claim or within 13 weeks of that date, the Tribunal is obliged to affirm the decision under review in the first application.
4. As Mr Sidwell was not qualified for DSP at the time he lodged his second DSP claim or within 13 weeks of that date, in the second application the Tribunal is obliged to set aside the decision of the SSAT and substitute a decision that, during the relevant assessment period, Mr Sidwell was not qualified for DSP.

# **decision**

1. (a) In application 2012/5540, the Tribunal affirms the decision under review; and

(b) In application 2014/1155, the Tribunal sets aside the decision under review and in substitution for that decision decides that, during the relevant assessment period, Mr Sidwell was not qualified for disability support pension.

|  |
| --- |
| I certify that the preceding 72 (seventy-two) paragraphs are a true copy of the reasons for the decision herein of Deputy President K Bean and Mr I Thompson, Member |

..........[Sgd].......................................

Dated 5 June 2014

|  |  |
| --- | --- |
| Dates of hearing | **29 and 30 January 2014**  **16 and 17 March 2015** |
| Advocate for the Applicant | **Ms M Riley**  **Welfare Rights Centre (SA) Inc.** |
| Counsel for the Respondent  Solicitors for the Respondent | **Mr A Schatz**  **Australian Government Solicitor** |
|  |  |

1. Exhibit 2, Annexure 2. [↑](#footnote-ref-1)
2. Transcript 29/1/14, p. 111. [↑](#footnote-ref-2)
3. Exhibit 1, T13/105-106. [↑](#footnote-ref-3)
4. See also Secretary, Department of Employment and Workplace Relations v Harris (2007) 97 ALD 534. [↑](#footnote-ref-4)
5. Exhibit 4. [↑](#footnote-ref-5)
6. Exhibit 2, Annexure 1**.** [↑](#footnote-ref-6)
7. Exhibit 5. [↑](#footnote-ref-7)
8. Exhibit 15. [↑](#footnote-ref-8)
9. See subs 6(9) of the Determination. [↑](#footnote-ref-9)
10. Transcript 29/1/14, p. 28. [↑](#footnote-ref-10)
11. Transcript 29/1/14, p. 56, line 31. [↑](#footnote-ref-11)
12. Exhibit 6. [↑](#footnote-ref-12)
13. Kessler Psychological Distress Scale, which consists of 10 questions. [↑](#footnote-ref-13)
14. Exhibit 1, T15/113. [↑](#footnote-ref-14)
15. Exhibit 1, T7/62. [↑](#footnote-ref-15)
16. Exhibit 2, Annexure 4. [↑](#footnote-ref-16)
17. Exhibit 20. [↑](#footnote-ref-17)
18. Exhibit 20, p. 19. [↑](#footnote-ref-18)
19. Exhibit 20, p. 26. [↑](#footnote-ref-19)
20. Exhibit 16, p. 3. [↑](#footnote-ref-20)
21. Exhibit 16, p. 3. [↑](#footnote-ref-21)
22. Exhibit 16, p. 3. [↑](#footnote-ref-22)
23. Exhibit 20, p. 25. [↑](#footnote-ref-23)
24. [2012] AATA 922, at [34]. [↑](#footnote-ref-24)
25. (2014) 144 ALD 133. [↑](#footnote-ref-25)
26. [2014] AATA 34. [↑](#footnote-ref-26)
27. Exhibit 20, p. 21. [↑](#footnote-ref-27)
28. Secretary’s Further Statement of Issues, Facts and Contentions, dated 17 September 2014, [61] at p. 26. [↑](#footnote-ref-28)