ME/CFS Legal Resources (Australia)

Guide to Disability Support Pension

(Version 2018:1.0 — Effective 13 June 2018)

Purpose

The purpose of this guide is to assist persons with ME/CFS to obtain access to Centrelink's Disability Support Pension. This is not a substitute for legal advice, nor is it intended to be a comprehensive account ofall potential claims. The information is general in nature and would be best accompanied by legal, medical and Centrelink advice so that your specific circumstances are taken into account.

Preparation

Before making your application to Centrelink, it is advisable that you gather together the document, including applicable reports, tests, investigations and scans. It is also appropriate to put together the following summaries:

- Dot point history of the condition(s);
- Dot point details for each condition, detailing the diagnosing doctor, treating doctor or allied health person, tests/investigations/scans conducted (and outcome), treatment undertaken, treatment outcome, medications used, impact of medications, why treatment or medications were stopped (if stopped) and which doctor authorised it;
- Dot point account of the symptoms of each of the condition(s);
- Dot point account of your daily activities (with frequency and duration), the impact of each symptom upon the activities, any post-exertional impact of activities and any limits or restrictions upon those activities, any activities you have had to cease.;
- Dot point account of current status of investigations of condition(s) that are not yet fully diagnosed including the investigating specialist, investigations to date, suspected diagnosis, foreshadowed investigations/tests/scans and proposed treatments;
- Dot point account of current status of condition(s) not fully treated at present, what treatments have been attempted to date (if any), what the outcomes of this treatment was and what the future treatment is likely to be;
- Dot point account of treatments you have not undertaken, including reasons for not engaging in the treatment (eg too expensive, not available in your area, adverse reaction to medication, not likely to significantly improve the function, etc).

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Eligibility for Assessment

The assessment of impairment is by way of the various tables in the *Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011* (see: https://www.dss.gov.au/sites/default/files/documents/05_2012/dsp_impairment_final_tables.pdf).

In order to be eligible for rating under tables, the

- condition causing impairment must be permanent; and
- the impairment is more than like to persist for more than two years.

Is ME/CFS an eligible condition?

ME/CFS, CFS and ME are all eligible conditions that can cause permanent impairment.

Permanent Impairment

The permanency of ME/CFS or an other condition is established by demonstrating:

(a) that the condition has been **fully diagnosed** by an appropriately qualified medical practitioner; and

(b) the condition has been **fully treated**; and

(c) the condition has been **fully stabilised**; and

(d) The condition is more likely than not, in light of the available evidence, to **persist more than two years**.

Claimants with ME/CFS and other conditions will more often than not, fail to demonstrate these requirements, hence their claim will fail. Often this is because the doctor providing the report does not comprehend what he/she has to demonstrate in their report.

(a) Fully Diagnosed

A condition is fully diagnosed when the claimant's condition has been diagnosed by an appropriately qualified medical practitioner and there is corroborating evidence of the condition.

An appropriately qualified medical practitioner means a **medical practitioner** whose qualifications and practice are **relevant to diagnosing a particular condition**. In ME/CFS that may well be a GP with a special interest in the condition. It might also be a specialist such as a neurologist, an immunologist, a rheumatologist or a general physician. It does not mean a psychologist, or a herbalist, a chiropractor or naturopath. This is important to understand in all conditions- it is one of the reasons why people fail in their claims.

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A claim will fail to demonstrate that a condition is fully diagnosed if, for example:

- the medical practitioner is still conducting investigations to rule out alternative causes for the condition (eg incomplete sleep apnoea testing; pending referral for anemia investigations; no evidence of having excluded any other condition; or statement that the condition is a 'provisional diagnosis' only);
- there are multiple reports with conflicting diagnoses for the same set of symptoms (eg one report says ME/CFS, another says possible MS, another says 'conversion disorder' and another says Functional Somatic Symptoms);
- there are investigations/tests/scans that suggest another diagnosis, but it has not been ruled out. Stating 'possible ME/CFS' would not be a diagnosis;
- there is no actual diagnosis by a medical practitioner (and it is an assertion by the claimant only);
- there is a diagnosis by the treating medical practitioner, but not a diagnosis by an a persons set out in the tables (eg. a psychiatrist; a specialist in the condition)

The case law is of assistance:

- In *Dunne and Secretary, Department of Social Services* [2014] AATA 899 the decision maker noted that the diagnosis of Fibromyalgia required to the medical practitioner to 'analyse the condition and exclude other conditions';
- In *Foote and Secretary, Department of Social Services (Social services second review)* [2016] AATA 131 the claimant failed to establish depression because there was no evidence of a diagnosis being made by a clinical psychologist or psychiatrist as prescribed in Table 5;
- In *Provencal and Secretary, Department of Social Services (Social services second review)* [2016] AATA 494 the claimant failed to demonstrate PTSD because she used a registered psychologist but not a claincal psychologist as require by Table 5;

The testing used to make the diagnosis must also be appropriate. This is born out by case law:

- In *Whitham and Secretary, Department of Social Services* [2015] AATA 9 the claimant did underwent a lung function test at a general practice. The tribunal found this did not compare to the investigations performed in a respiratory function laboratory, hence tests were unreliable for diagnosis;
- In *WHTW and Secretary, Department of Families, Housing, Community Services and Indigenous Affiairs* [2008] AATA 399 the claimant's clinical psychologist report was not accepted because of the strong presentation of the claimant before the tribunal.

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If you omit evidence from the tribunal, even if you have an appropriate diagnosis, it can be rejected (even if referred to in the treating doctor's report):

- In *Foote and Secretary, Department of Social Services (Social services second review)* [2016] AATA 131, there was a claim made for sleep apnoea, however the tribunal found there to be limited evidence to satisfy the tribunal of the diagnosis;
- In *Whitham and Secretary, Department of Social Services* [2015] AATA 9 the claimant utilised a registered psychologist, a qualified social workers and a registered nurse to assess claimants conditions. These were insufficient to found the various diagnoses without a corroborating qualified medical practitioner report.

Both claimants and their medical practitioners must be aware of these pitfalls— particularly with respect to diagnosing depression/anxiety or neurocognitive symptoms of the condition. A medical practitioner needs to be strong in their statement that a diagnoses has been made. He/she should show how the diagnosis was made, and if conflicting diagnoses exist—demonstrate how and when they were ruled out. In *Gasteen v Secretary, Department of Family and Community Services* [2001] AATA 147 the claimant showed that her depression was fully treated and stabilised—hence the fatigue within he CFS symptoms was not coming from her depression.

(b) Fully Treated

A condition is fully treated when the claimant demonstrates:

(a) what treatment or rehabilitation has occurred with respect to the condition (if applicable); and

(b) whether the treatment is continuing or planned in the next two years.

This is the area where most claimants fall down—particularly where medications occur:

- In *Bugno v Secretary, Department of Employment and Workplace Relations* [2005] AATA 788 the claimant asserted an allergic reaction to various medications but provided no corroborating evidence of this reaction to confirm why it was stopped;

Where treatment has been attempted, the treating practitioner needs to outline the treatment used, the effect of the treatment, and if stopped, the reasons for stopping. If a medication is tried, but fails, and no other medications available are tried, there needs to be an explanation of why. In *Bungo*, the allergic reaction would be sufficient if detailed in a report.

This area is where the issue of Graded Exercise Therapy and Cognitive Behavioural Therapy are often raised by the decision makers as treatment for ME/CFS.

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The qualified medical practitioner must set out:

- treatments utilised throughout the comndition(s);
- treatments proposed for the condition(s);
- effect of treatments;
- if treatment is stopped or not attempted—provide a justified reason as to why the treatment was not reasonable (see below).

If a treatment is proposed and no outcome is known, then it is likely that the claim will fail because the condition is not fully stabilised (see below). If a treatment is stopped without permission from a medical practitioner, it will likely cause the claim to fail.

It is imperative that the medical practitioner's report cover these issues and make clear that all reasonable treatments (see below) have been attempted and no further improvement is possible in the next two years and is not likely to improve beyond two years.

(c) Fully Stabilised

A condition is fully stablised when the claimant demonstrates:

(a) that they have 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 two years; or

(b) the claimant has not undertaken reasonable treatment for the condition and:

  i) significant functional improvement to a level enabling the person to undertake work in the next two years is **not expected to result**, even if the person undertakes reasonable treatment; or

  ii) there is a **medical or other compelling** reason for the person not to undertake reasonable treatment.

Expereince, anecdotal evidence and AAT decisions up to 2018 under this current legislation, show that this is where the majority of claimants with ME/CFS come unstuck in their applications.

It is often not that claimants cannot demonstrate 20 points (on a single or multiple tables) —its that they have not shown the potential treatments offered are not 'reasonable treatment'. Two of these treatments—Cognitive Behavioural Therapy and Graded Exercise Therapy are the 'go to' treatments for ME/CFS because they believe them to be the appropriate treatments. There are compelling reasons that they are not.

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The next section deals with the definition of ’reasonable treatment’.   It bears upon the requirement that a condition be fully stabilised.

A condition will not be considered fully stabilised if:

- the medical practitioner is still trying treatments, such as different anti-depressants to stabilise depression;
- the treatment is incomplete, such as being past way through a 13 week graded exercise program that is not causing deterioration or having been diagnosed with sleep apnoea but not having yet utilised the CPAP machine to see if it eliminates fatigue symptoms;
- the claimant, and not the medical practitioner, discontinues treatment for a condition—even if that treatment is casuing a reaction;
- the claimant is diagnosed with a condition, but not prescribed treatment, or when prescribed treatment, never commences it.

The case law supports this view:

- In *Gasteen v Secretary, Department of Family and Community Services* [2001] AATA 147 the claimant suffered from CFS and depression.   The claimant demonstrated that the depression was fully diagnosed and treated, hence that the depression was stabilised and therefoe the fatiigue remaining was part of the CFS and not the depression;
- In *HYCJ and Secretary, Department of Social Services (Social services second review)* [2016] AATA 171 the claimant’s CFS was found to not have been fully treated hence it was found not to have been stabilised;
- In *KPZL and Secretary, Department of Social Services (Social services second review)* [2018] AATA 938 , the tribunal found the condition was not fully treated hence not fully stabilised. Specifically the claimant had not, due to cost, been able to attend a doctor in Sydney for follow up, and another doctor did not indicate what treatment would be appropriate.   A third doctor recommended a “physical deconditioning programme” and there was no evidence the claimant had participated;
- In *Lyddieth and Secretary, Department of Social Services (Social services second review)* [2017] AATA 1136, the tribunal accepted the diagnosis of chronic pain, but found there was no evidence of treatment hence was not fully treated and therefore not full stabilised;
- In *McAuley and Secretary, Department of Social Services (Social services second review)* [2017] AATA 1064 the absence of a diagnosis of CFS, it could be said to have been fully treated and stabliised.

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Reasonable Treatment

The definition of 'reasonable treatment' is the key area for claimants to ensure that their medical practitioner (or other appropriate report writer) makes their position very clear. Reasonable treatment is defined as treatment that:

(a) is available at a **location reasonably accessible** to the person; and

(b) is at a **reasonable cost**; and

(c) can **reliably be expected to result in a substantial improvement in functional capacity**; and

(d) is **regularly undertaken or performed**; and

(e) has a **high success rate**; and

(f) carries a **low risk** to the person.

This is where a claimant can direct their medical practitioner to demonstrate that GET/CBT is not 'reasonable treatment'. For example:

(a) Location—the location of the offices for CBT or GET may well be in another town, or a suburb that is a significant distance away. For a person with ME/CFS, this can be deemed arguing that (i) you cannot take the journey to illness, inability to drive or take public transport; (ii) the length of the journey would exacerbate symptoms on the way, therefore precluding the ability to participate; the length of the journey would cause post-exertional malaise/crash; (iii) you cannot get back due to PEM.

(b) Cost—the cost factor can be argued in three phases being treatment, travel and employment costs. (i) the cost of treatments can be argued to be excessive when on a pension hence unaffordable or unable to be sustained on a regular basis, hence nullify the ability to participate effectively; (ii) the cost of travel to and from the office is excessive and therefore to much to be incurred for a person on a pension; (iii) the effect of PEM from treatment would result in a reduction in income (jf working part time whilst on DSP). In short—the argument is that the cost is prohibitively expensive;

(c) Substantial Improvement - This is the absolute key one with ME/CFS and the CBT/GET model. There is no study (not even the PACE study—which professed moderate and is not based on the criteria used in Australia) that demonstrates that CBT/GET results in 'substantial improvement in functional impairment'. Moreover the research demonstrates no long term sustaining of improvement. More substantially, your medical practitioner can argue that (i) if you have tried and failed or tried and deteriorated, the treatment is not effective; (ii) there is current literature that shows that CBT/GET is ineffective, or at best, mildly effective hence does not offer substantial im

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provement; (iii) there is evidence of potential for harms;

(d) Regularly Performed—In the case of CBT/GET, the argument may well go hand in hand with the travel and cost issue, or indeed, the risk issue below. (i) the cost of travel is so high that it cannot be carried out regularly; (ii) the cost of the treatment is prohibitive, hence can only be intermittently attempted, hence cannot be regularly performed; (iii) the side-effects of the treatment are unpredictable, hence recovery for the next session is not predictable and can restrict the ability to make appointments (with lead times to available appointments causing delays too);

(e) High Success Rate—In the case of CBT/GET there is no evidence in the literature of a high success rate. The literature in fact shows that the impact of CBT/GET is moderate at best and even less when the study was reviewed (mild to no effect at best);

(f) Low Risk—In the case of GET, the literature reveals that there is a risk of harm from GET and that this risk can result in significant PEM or even a significant to permanent crash, hence is not an appropriate treatment.

The rationale behind these examples can apply across a variety of treatments. In the case of medications, adverse side-effects are a common feature. Other treatments such as physiotherapy, chiropractic or even the Lightning Process can be ruled out via the above criteria. It is prudent to outline to the medical practitioner writing the report, what the key issues on each condition and/or treatment is to make their job easier.

Practical Expectations

Claimants need to have practical expectations about working with their medical practitioner (or other person if appropriate) to provide a report:

(a) Medical Practitioners have limited time to review files and write reports—especially for free;

(b) You need to have the correct paperwork and may need to spend money on tests (or if psychological or Cardiopulmonary Exercise Tests, need to approach a University to see if students can do the tests, supervised by an appropriate person who signs of the report). You may need to pay it off. Expecting reports for free leads to poor report quality, brevity, errors and a failure to address the mandatory elements;

(c) You need to coordinate the paperwork and provide summaries on each condition in accordance with the mandatory requirements. Its easier for the medical practitioner to cut, paste and edit. Moreover, you're more familiar and likely to be accurate;

(d) Get in early because these things take time. Allow for lag time.

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Tables and Diagnosed Conditions

The diagnosed condition is relevant to the applicable table utilised to assess impairments. Most claimants with ME/CFS will make a claim for one or several conditions such as Fibromyalgia, ME/CFS and sleep apnoea. All three conditions are assessed under Table 1 of the *Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011* (see: https://www.dss.gov.au/sites/default/files/documents/05_2012/dsp_impairment_final_tables.pdf). The points awarded within a single table cannot be added together. They can, however, be added between tables.

There are many symptoms and conditions that arise out of ME/CFS. For example, a person might well suffer the following:

- ME/CFS, CFS or ME;
- Fibromyalgia;
- Sleep Apnoea;
- Sleep disorders;
- Postural Orthostatic Tachycardia Syndrome;
- Neurally Mediated Hypotension;
- Migraines;
- Neurocognitive impairment;
- Depression and/or Anxiety;
- Dysarthia (slurred speech), Aphasia (comprehension/production of speech), Dysphasia (understand, speak, read write);
- Irritable Bowel Syndrome
- Severe Fat Malabsorption or other Gastroenterological Issues;
- Loss of Sexual Function;
- Severe endometriosis;
- Irlen Syndrome/Scotopic Sensitivity;
- Photophobia
- Fitting;
- Fainting or other loss of consciousness;
- Paralysis of limbs;

Again, despite this broad range, the claimant and/or the Doctor may well simply class these all as falling under the heading of ME/CFS. They can be separated and added together so that you can still achieve 20 points if the claimant fails to establish this under a single table (NB—It is acknowledged 20 points raised by adding tables leads to another pathway which doesn't necessarily raised the DSP immediately).

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Relevant Tables

There are many symptoms and conditions that arise out of ME/CFS. For example, a person might well suffer the following:

Symptom/Condition	**Applicable Table**
ME/CFS, PVFS, CFS or ME	1. Functions Requiring Physical Exertion and Stamina
Fibromyalgia	
Lyme Disease	
Sleep Apnoea	
Sleep disorders	
Paralysis of arms	2. Upper Limb Function
Paralysis of legs	3. Lower Limb Function
Depression	5. Mental Health Function
Anxiety	
Drug Abuse (Pharmaceutical and Non-Pharmaceutical)	6. Functioning related to Alcohol, Drug and Other Substance Use
Alcohol Abuse	
Neurocognitive Impairment	7. Brain Function
Acquired Brain Injury	
Dysarthia (slurred speech)	8. Communication Function
Aphasia (comprehension/production of speech)	
Dysphasia (understand, speak, read write)	
Irritable Bowel Syndrome	10. Digestive and Reproductive Function
Severe Fat Malabsorption or other Gastroenterological Issues	
Loss of Sexual Function	
Severe endometriosis	
Tinnitus	11. Hearing and Functions of the Ear
Cocktail Party Phenomenon	
Photophobia	12. Visual Function
Irlen Syndrome/Scotopic Sensity	
Frequent and uncontrolled urination	13. Continence Function
Fitting	15. Functions of Consciousness
Migraines	
Postural Orthostatic Tachycardia Syndrome	
Neurally Mediated Hypotension	
Fainting or other loss of consciousness	

Again, despite this broad range, the claimant and/or the Doctor may well simply class these all as falling under the heading of ME/CFS. They can be separated and added. Not everything needs to be included. A total of 20 points can be achieved by way of addition, particularly if 20 points cannot be achieved under a single table.

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Complying with the Tables

The medical evidence provided by the treating doctor is key to establishing a condition. However, in applying the Tables to the condition, the information provided must include:

(a) the information provided by the **<u>health professionals specified</u>** in the relevant Table; and

(b) any **<u>additional medical or work capacity information</u>** that may be available; and

(c) any **<u>information that is required</u>** to be taken into account under the Tables, including as specified in the introduction to each Table.

It must be noted at this point that there is a references to 'health professionals' in these requirements. These are defined as including "an appropriately qualified medical practitioner and an allied health practitioner." An allied 'health practitioner' includes "but is not limited to, a person who practises chiropractic, exercise physiology, physiotherapy, psychology, occupational therapy, osteopathy, pharmacy, podiatry or rehabilitation counselling." Each table sets out the type of health professional required.

It must also be noted that self-reported symptoms cannot be taken into account when applying the tables unless there is corroborating evidence. The type of corroborating evidence required will depend upon the table. For example:

Table	Corroborating Evidence of Symptoms
1. Functions Requiring Physical Exertion and Stamina	treating doctor report; or medical specialist report confirming diagnosis of conditions associated with cardiac or respiratory impairment; medical specialist report confirming diagnosis of conditions associated with extreme fatigue or exhaustions or other condition affects physical exertion or stamins; results of exercise, cardiac stress or treadmill testing; CPET
2. Upper Limb Function	treating doctor report; or medical specialist report confirming diagnosis of conditions associated with upper limb impairment (eg numbness, tingling, paralysis, etc); or allied health practitioner report confirming functional impact (eg physiotherapist, occupational therapist or exercise physiologist; or results of diagnostic tests (eg x-rays or imagery); or results of physical tests or assessments
3. Lower Limb Function	treating doctor report; or medical specialist report confirming diagnosis of conditions associated with lower limb impairment (eg numbness, tingling, paralysis, etc); or allied health practitioner report confirming functional impact (eg physiotherapist, occupational therapist or exercise physiologist; or results of diagnostic tests (eg x-rays or imagery); or results of physical tests or assessments
5. Mental Health Function	treating doctor report; or supporting letters, reports or assessments relating to the person's mental health or psychiatric illness; or interviews with the person and those providing care or support to the person (a range of sources is suitable)

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6. Functioning related to Alcohol, Drug and Other Substance Use	treating doctor report; or report of medical specialist (eg addiction specialist, psychiatrist with experience in disorder) that confirms diagnosis and resulting impairment of other body systems or functions; or results of investigations (eg liver function tests, alcohol and substance use assessment scales); or reports or other records of participation in treatment and rehabilitation programs; or work or training attendance records
7. Brain Function	treating doctor report; or report from specialist health practitioner (eg neurologist, rehabilitation physician, psychiatrist or neuropsychiatrist) supporting diagnosis or conditions associated with neurological or cognitive impairment; or results of diagnostic tests (eg MRI, CT scans, SPECT, EEG or qEEG); or results of cognitive function assessments (by clinical psychologist)
8. Communication Function	treating doctor report; or specialist assessment by speech pathologist, neurologist or psychologist; or report from specialist health practitioner confirming diagnosis associated with communication impairment (eg stroke, other acquired brain injury, cerebral palsy, neurodegenerative conditions, damage to speech related structures of the mouth, vocal cords or larynx); or results of diagnostic tests (eg X-Rays, MRI, SPECT, etc); or results of functional assessments.
10. Digestive and Reproductive Function	treating doctor report; or report from a medical specialist (such as a gastroenterologist, a gynaecologist, an urologist or an oncologist) confirming diagnosis of a digestive or reproductive system condition; or results of investigations (such as X-Rays or other imagery, endoscopy or colonoscopy).
11. Hearing and Functions of the Ear	treating doctor report; or a report from a medical specialist (e.g.an ENT specialist or neurologist) confirming diagnosis of conditions associated with hearing impairment or other impaired function of the ear (e.g. congenital deafness, presbyacusis, acoustic neuroma, side-effects of medication, Meniere's disease or neurological conditions including Multiple Sclerosis); or results of audiological assessment undertaken by a fully qualified audiologist or ENT specialist.
12. Visual Function	treating doctor report; or a report from a medical specialist (e.g. ophthalmologist, ophthalmic surgeon) confirming diagnosis of conditions associated with vision impairment (e.g. diabetic retinopathy, glaucoma, retinitis pigmentosa, macular degeneration, cataracts, congenital blindness); or results of vision assessments (e.g. from an optometrist).
13. Continence Function	treating doctor report; or a report from a medical specialist, particularly in cases of moderate or severe incontinence, (e.g. urogynaecologist, gynaecologist, urologist, gastroenterologist) confirming diagnosis of conditions associated with incontinence (e.g. some gynaecological conditions, prostate enlargement or malignancy, gastrointestinal conditions, incontinence resulting from paraplegia, spina bifida, neurodegenerative conditions or severe intellectual disability); or assessments and reports from practitioners specialising in the treatment and management of incontinence (e.g. urologists, urogynaecologists, continence nurse advisors, continence physiotherapists).
15. Functions of Consciousness	treating doctor report; or a report from a medical specialist (e.g. neurologist, endocrinologist or physician) confirming diagnosis of conditions associated with episodes of loss of or altered state of consciousness (e.g. epilepsy, POTS, NMH, diabetes mellitus, transient ischaemic attacks, some forms of migraine); or assessments or reports from practitioners specialising in the treatment and management of these conditions, including neurologists, endocrinologists, clinical nurse consultants or nurse practitioners specialising in diabetes management.

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Achieving 20 Points

The final hurdle for the ME/CFS claimant to overcome is the impairment rating itself.

Experience, anecdotal evidence and AAT case law shows that when the claimant gets to the impairment point, the claimant often fails to meet the 20 points required under one table (for direct entry to the DSP) or 20 points in total between tables (which moves the claimant down the alternative pathway, being a ‘Program of Support’ requirement).

The mere fact that a claimant achieves 20 points doesn't mean the claimant is incapable of working. It means it will potentially cause difficulties. The claimant must demonstrate a continuing inability to work—ie inability to work at least 15 hours per week in the next two years. A claimant will attend a ‘Job Capacity Assessment’ in which they attend a qualified health or allied professional to complete an assessment. This person will considet the medical evidence provided and may contact the claimant’s medical practitioners. The claimant can take new evidence to this appointment. During the appointment the assessor will discuss the conditions and medical evidence, the barriers to attending work, the current assistance and rehabilitation you receive and the services required to find and keep a job (if required).

If the assessor deems it appropriate, the claimant may be referred for a ‘Disability Medical Assessment’ with a Government Contracted Doctor who will review the medical evidence and assess eligibility for the DSP.

Where the claimant extends across several tables in order to achieve 20 points, they will be required to undertake a ‘Program of Support’ that precedes the DSP. The program includes job preparation and job search, work experience and training and injury management. A claimant is required to demonstrate:

- participation in the program for 18 months (at least) in the 3 years before the claim; or
- completion of the program if the program was less than 12 months duration.

In very limited circumstances where the claimant’s ill-health prevents improvement of the ability to work by staying the program, the shorter period may, in such circumstances, count.

This is where the issues arise in ME/CFS. The default option for injury management is CBT/GET. This is where a strong argument needs to be mounted from the medical practitioners that the treatment is not reasonable (see above for the reasons and meaning of ‘reasonable treatment’.

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Meeting the Impairment Ratings

Each table within the the *Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011,* each rating (being 5, 10, 20 and 30 points) holds a set descriptors unique to each table. Where a claimant falls between two rating criteria descriptors, the lower will apply (ie you cannot have a rating of 15—it will revert back to 10).

Some descriptors involve activities that a claimant engages in. These descriptors apply where a claimant can do the activity normally and on a repetitive or habitual basis—not just once or on rare occasions. In ME/CFS this is important because the fact that a person can do an activity once doesn't mean it can be repeated generally.

Another important consideration in the assessment is the episodic or fluctuating nature of ME/CFS for some claimants. When assessing the rating for these type of symptoms, the rating will take account of the severity, duration and frequency of the episodes or fluctuations as appropriate.

Table	Descriptors Examined
1. Functions Requiring Physical Exertion and Stamina	experience of symptoms (eg shortness of breath, fatigue, cardiac pain) when performing activities requiring physical exertion or stamina (eg walk, mobilise in wheelchair around a shopping centre; walk from carpark to shopping centre; use public transport; perform light household activities) and if assistance is required or not; frequency of symptoms is relevant has or likely to have difficulty sustaining work-related tasks or clerical, sedentary or stationary nature for 3 hours continuously;
2. Upper Limb Function	functional impact on activities using hands or arms assessed by examining management of daily activities – such as the picking up of objects (like 2 litre liquid), handling of small objects, doing up buttons, reaching out to pick up objects; degree of functional impact is assessed by reference to more activities like picking up bulky objects, holding a pen or pencil, doing shoelaces, using a keyboard or unscrewing a lid.
3. Lower Limb Function	functional impact on activities using lower limbs assessed by examining difficulties in the ability to walk around a shopping centre, climb stairs, stand for 5 or 10 minutes, function without a walking stick; functional impact on ability to walk outside home, drive or use transport, use stairs, or stand, move around independently.
5. Mental Health Function	difficulties with self-care, independent living, social/recreational activities, travel, interpersonal relationships, concentrate and complete tasks, behaviour, planning and decision-making, work/training capacity
6. Functioning related to Alcohol, Drug and Other Substance Use	experiences difficulties performing physical or cognitive tasks, with such effects extending into work hours; experiences difficulties attending work, education, training or appointments, completing tasks or duties; experiences impact upon completing daily tasks and responsibilities, detrimental effects upon family and social relationships and activities, unreliability in attending appointment, completing duties or assigned tasks; experiences impact upon personal care, hygiene, nutrition, and general health, is impact by drugs or alcohol the majority of the time, has medical or psychological evidence of physical or cognitive impacts.

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7. Brain Function	functional impact upon ability to complete day to day activities and difficulties with memory, attention/concentration, problem solving, planning, comprehension, visuo-spatial function, behavioural regulation, self-awareness; degree and frequency of functional impact determinate
8. Communication Function	functional impact in claimant's main language that impacts abilities to understand words and sentences (degree of impact relevant), difficulty in speech production (eg slur, stutter, stammer), speech movements, damage to speech structures making speech an effort or difficult to understand, cant speak clearly, or uses argumentative communication.
10. Digestive and Reproductive Function	functional impact on work-related or daily activities due to symptoms or personal care needs associated with the condition; assessment of degree of interruption or reduced attention and concentration on a task due to pain symptoms, or personal care needs; degree of absence from work due to the condition; ability to sustain work activity or tasks, need for breaks.
11. Hearing and Functions of the Ear	functional impact on activities involving hearing (communication) or other functions of the ear (even with aids) assessment of difficulty with hearing conversation at average volume in room with no or some background noise (eg cocktail party phenomenon), problems with normal use of phone or use of telephone with T-switch and difficulty with words and partially reliant on lip-reading or signing; frequent difficulty with balance, ringing in the ears that interferes with communication ability or routine activities (eg tinnitus).
12. Visual Function	functional impact on visual function; impact on day to day activities involving vision, difficulties seeing at distance or close up when wearing glasses or contact lenses, difficulty seeing fine print in newspaper/magazine, or seeing road signs road signs, street signs, bus numbers, and ability to travel in the community; impact on field of vision, discomfort in performing day to day activities involving the eyes (eg watering of eyes, difficulty in opening eyes, difficulty moving eyes, <u>difficulty tolerating bright lights and sunlight</u>); use of visual aids or assistive devices on tasks; difficulty in seeing routine workplace, educational or training information, use of alternative formats, assistive devices or technology for vision; ability to operate in familiar environments and travel independently using public transport using assistive devices.
13. Continence Function	functional impact on maintaining continence of bladder or bowel; leakage of bladder of bowel and frequency. Soiling issues; urgency or occasional loss of control, and degree of interruption to tasks, work or training; difficulty passing urine (eg strain, flow restriction, difficulty emptying); use of stoma, catheter or other collection device to manage condition, level of interruption to tasks, work or training.
15. Functions of Consciousness	functional impact from loss of consciousness or altered state of consciousness during waking hours when occupied with task or activity; frequency of episodes of loss of consciousness requiring first aid, emergency medication or hospitalisations; frequency and duration of involuntary altered state of consciousness impacting functional abilities; ability to perform activities of daily living between episodes, impact on drivers license or safety-related activities; ability to attend work, education or training activities on a full-time or part-time basis, safety-related restrictions on work-related activities.

Other tables may have application for some claimants. The goal of the reporting doctor is to fit within these descriptors. Reference to the actual tables is essential. Preparation by the claimant to assist the doctor will limit the opportunity for omissions and errors. Good preparation makes for good quality reports.

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Other References

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3. Department of Human Services, *Guide to Social Security Law: 3.6.3.05 Guidelines to the Rules for Applying the Impairment Tables*, (1 July 2015), <http://guides.dss.gov.au/guide-social-security-law/3/6/3/05>
4. Department of Human Services, *Guide to Social Security Law: 3.6 Disability and Carer* (20 March 2015) <http://guides.dss.gov.au/guide-social-security-law/3/6>
5. Berrill Watson, *Social Security and Centrelink*, (2018) <https://www.berrillwatson.com.au/expertise/other-work/social-security-or-centrelink/>

Disclaimer

This guide is not a substitute for legal and/or medical advice. The information contained herein is the opinion of the author and therefore does not constitute advice. Before acting on any application for the Disability Support Pension, the claimant would be prudent to discuss the requirements with Centrelink, make use of their online guides and consult with their medical or other advocate.

The author will not be responsible for any errors or omissions in this paper, nor the success or failure of any applications for the DSP that a claimant undertakes.

The claimant is therefore obliged and should make their own enquries to ensure that they get the best advice suited to their specific needs and circumstances.

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