

# Initial Medical Assessment and Vocational Independence Assessment

## Guidelines for Providers

July 2013

This is a living document and will be updated as required



<b>1.</b>	<b>Introduction</b> .....	<b>2</b>
<b>2</b>	<b>Purpose</b> .....	<b>2</b>
	<b>2.1 ACC’s requirements in regard to rehabilitation and legislation</b> .....	<b>2</b>
	<b>2.2 Preparing for the assessment</b> .....	<b>4</b>
	Undertaking assessments as a non-treating practitioner. ....	4
	Your responsibilities: Privacy and storage of client health information. ....	4
	Check you have been sent the information required for the assessment.....	5
	Interpreting needs .....	5
	Clients who may pose a security or safety risk. ....	5
	<b>2.3 Conducting the assessment</b> .....	<b>6</b>
	The importance of establishing a client-centred approach to maximise participation and satisfaction.....	6
	Explaining the nature of and the purpose of the assessments.....	7
	Chaperones .....	7
	Multiple support people.....	7
	Recording assessments .....	8
	Stopping the Assessment. ....	8
	<b>2.4 Considerations during the assessment</b> .....	<b>8</b>
	Fitness for Work for safety-critical job types. ....	8
	Assessing conditions such as pain, mood problems and fatigue. ....	9
	Ongoing or Future treatment and vocational independence .....	9
	Completeness of rehabilitation - specific to VIMA .....	9
	Identifying urgent conditions during the assessment as a non-treating practitioner.....	10
	<b>2.5 Writing the reports</b> .....	<b>10</b>
	The standard of the required documentation for IMA and VIMA reports .....	10
	What key elements should the IMA or VIMA report contain?.....	10
	Diagnosis .....	11
	Non-injury related factors.....	11
	Restrictions and Limitations .....	11
	Incapacity and Capacity .....	12
	Medical sustainability. ....	12
	Snapshot in time.....	13
	Availability of employment is not relevant to ‘medical sustainability’.....	13
	Work Trials.....	13
	Assessing function using collateral information. ....	13
	<b>2.6 Reassessments</b> .....	<b>14</b>
<b>3.</b>	<b>IMA Report Headings and Content guidelines</b> .....	<b>15</b>
<b>4.</b>	<b>VIMA Report Headings and Content guidelines</b> .....	<b>19</b>
<b>5.</b>	<b>Assessing Fitness for Work in regard to function &amp; activity levels</b> .....	<b>23</b>
<b>6.</b>	<b>Types of work and work type detail sheets</b> .....	<b>24</b>
<b>7.</b>	<b>Quality Reviews of IMA/ VIMA assessments</b> .....	<b>25</b>
<b>8.</b>	<b>Relevant extracts from the Accident Compensation Act 2001</b> .....	<b>26</b>
<b>9.</b>	<b>Employment and Work Ability</b> .....	<b>28</b>
<b>10.</b>	<b>Rehabilitation and the IMA</b> .....	<b>30</b>
<b>11.</b>	<b>Pain, pain disorders and workability</b> .....	<b>32</b>
<b>12.</b>	<b>Fatigue and fatigability</b> .....	<b>35</b>
<b>13.</b>	<b>Depression, anxiety and workability</b> .....	<b>39</b>

## 1. Introduction

### Introduction

#### Welcome to the Vocational Medical Assessors' Operational Guidelines.

When undertaking the Initial Medical Assessment (IMA) and/or the Vocational Independence Medical Assessment (VIMA) on behalf of ACC, you are performing a very valuable and important advisory and legislative role in identifying appropriate treatment and rehabilitation which will guide ACC to support the client in achieving maximum independence in their injury recovery.



This document has been written to assist you

- understand the standards and requirements for undertaking and completing these assessments and reports
- ensure that there is consistency in the assessments and report writing and
- provide further information on the context of the assessments.

These Operational Guidelines provide further background to and need to be read in conjunction with the IMA and VIMA service specifications. Where there are any inconsistencies between the Operational Guidelines and the Service Specifications (Agreement), the Service Specifications will take precedence.

### Purpose

## 2. Purpose

The purpose of the guidelines is to provide some direction and provide further information on what you may need to know in regard to :



- 2.1 What you need to know about ACC's requirements in regard to legislation and vocational rehabilitation
- 2.2 Preparing for the assessment
- 2.3 Conducting the assessment
- 2.4 Considerations during the assessment
- 2.5 The standards for IMA and VIMA reports.
- 2.6 Reassessments

There is also guidance on

- IMA and VIMA headings and contents guidelines
- Assessing fitness for work in regard to function and activity levels
- Types of work and work detail sheets
- Relevant extracts from the Accident Compensation Act 2001

There are also sections on

- Employment and Work Ability
- Rehabilitation and the IMA
- Pain, pain disorders and workability
- Fatigue and fatigability
- Depression, anxiety and workability.

### 2.1 ACC's requirements in regard to rehabilitation and legislation

What you need to know about ACC's obligations in regard to vocational rehabilitation and IMA and VIMA assessments under the Accident Compensation Act 2001 (AC Act).

Vocational rehabilitation aims to return the client

- in the first instance to their previous employment – maintain employment
- or the closest possible equivalent – obtain employment
- Or prepare the client for employment that matches their experience and training before injury as closely as possible – regain employment or acquire Vocational Independence.



Vocational rehabilitation will include appropriately targeted assessments and services.

### **What is the Individual Rehabilitation Plan (IRP)?**

**The IRP** is a legal document that is used to document the agreed and planned activities that have been negotiated in partnership between the client and ACC is signed by the client and ACC and is binding on both parties.

It is an integral part of the client's vocational rehabilitation and vocational independence process as it is the record of the vocational rehabilitation agreed and completed and is one of the documents required to be provided and considered when an IMA and a VIMA is done.

In regard to the vocational independence process, the IRP should document

- a clear rehabilitation outcome
- the work types identified as medically sustainable or likely to be sustainable
- all medical rehabilitation recommendations from the IMA, or other medical reports
- all vocational rehabilitation recommended from the IOA or other vocational assessments to overcome barriers to a/some work type(s)
- The rehabilitation activities that have completed - or there is a clear statement why these have not been completed.

If during the course of vocational rehabilitation it appears that the client will be unable to return to their previous employment then ACC is required to provide appropriate assessments to determine the client's vocational rehabilitation needs - *Section 89 - Assessment of a claimant's vocational needs.*

This is done by providing

**(a) Initial Occupational Assessment (IOA)**

**(b) Initial Medical Assessment (IMA)**

These assessments identify the types of work that are, or are likely to be, medically sustainable for the claimant. If work types are not currently sustainable then you should provide reasoned rehabilitation suggestions that would lead to these work types becoming medically sustainable. If the work types are currently medically sustainable without the need for rehabilitation, then you should indicate this.

Following these two initial assessments, the recommended and agreed rehabilitation for the identified types of work are agreed and documented in the client's IRP and then provided to the client by ACC.

On completion of that rehabilitation, ACC is then required to make a determination of a client's vocational independence and ensure that comprehensive vocational rehabilitation has been achieved. - *Section 108 - Assessment of a Claimant's vocational*

*independence.*

This is done by providing

- (a) Vocational Independence Occupational Assessment (VIOA)**
- (b) Medical Independence Occupational Assessment. (VIMA)**

The purpose of the VIOA is to consider the progress and outcomes of the vocational rehabilitation under the individual rehabilitation plan and consider whether the types of work identified in the initial assessment or any new jobs are suitable for the client.

The purpose of the VIMA is to obtain an opinion on whether the client has the capacity to undertake any type of work identified in the occupational assessment and reflected in the rehabilitation plan.

The object of the legislation is to ensure that comprehensive vocational rehabilitation has been achieved.

## 2.2 Preparing for the assessment

### Undertaking assessments as a non-treating practitioner.

When you undertake assessments for ACC clients, you are required to follow a professional standard of care. Non-treating doctors do need to adhere to the principles in the Code of Health and Disability Services Consumers' Rights and the guidance in Medical Council of NZ statement which is available on the MCNZ website - [www.mcnz.org.nz](http://www.mcnz.org.nz) - *Non-treating doctors performing medical assessment of patients for third parties.*



These principles include

- treating the client in an environment of respect and dignity
- communicating with the client in a way that enables them to understand the information provided and your role in the assessment
- confirming you have their informed consent to undertake the assessment
- confirming the client understands the purpose and nature of the assessment and possible outcome of the assessment
- explaining the client has the right to withdraw from the assessment and the possible consequences

### Your responsibilities: Privacy and storage of client health information.

You are bound by the Health Information Privacy Code 2004 in regard to collecting and storing health information.

This means that

- health information may only be gathered for the purpose for which it is required and must be as accurate as possible
- the client must be informed why the information is being required and give their consent for this information to be gathered
- the client has the right to see their information and correct any information which is incorrect
- care should be taken with the storage of this information
- there are limits on the disclosure of this information
- the client's permission must be obtained for any disclosure of the information gathered.

### **Check you have been sent the information required for the assessment**

Following the receipt of a referral from ACC and when preparing for the assessment, you should ensure that you have been provided with sufficient relevant information to provide an informed background to the client and their current injury or injuries. You should allow sufficient time to review the information prior to the appointment to allow familiarity with the information and the client's condition and to determine if further information is required.

A necessary part of the process is to ensure that all background information is considered. It is necessary to ensure that where factors that may be considered relevant are able to be positively asserted or discounted and this should leave no doubt that all necessary information has been considered.

If you consider more information is required for you to complete the assessment, please ask the case owner before undertaking the assessment.

If, however, it is noted during the assessment, that there is information is clearly missing, you should request this information and fully complete your report once you have all material at hand. If required, you must discuss any new or changed recommendations with the client.

The case owner's referral should also outline if an interpreter is required and is to be provided for the client or if there are any security concerns or needs for the client. (For further information – See *Interpreting Needs and Clients who may pose a security or safety risk.*)

Cultural aspects may also need to be considered as part of the assessment. Disability is, in large part, defined by culture. The values, traditions, and behaviours of the patient need to be understood and in order to acquire such knowledge, you should acquire an appreciation of relevant cultural aspects that interact with impairment and disability; ideally such knowledge would be attained prior to the clinical assessment.

### **Interpreting needs**

ACC has a responsibility to ensure that any interpreting needs of the client have been identified prior to the assessment and been conveyed to you at the time of the referral.

For both IMA and VIMA, if interpreting needs have been identified, a professional interpreter is required to ensure that the assessment is conducted in a way that is confidential and effective and to ensure that clients are fully aware of what is being asked of and explained to them. Family members acting as interpreters are not appropriate in this setting.

The cost of the interpreter service is met by ACC. However payment is conditional on ACC's prior approval being given that an interpreter is needed, cost-effective and appropriate.

### **Clients who may pose a security or safety risk.**

There are specific internal ACC criteria and processes for identifying and managing clients whose behaviour is considered a risk. If a client has been identified as posing these risks, the case owner should have provided, in writing, any information in regard to

- any threatening or aggressive behaviour that ACC has observed that client exhibit; and/or
- Any diagnosed mental condition the client has which is likely to leave the client susceptible to becoming aggressive or violent.

If the client who has been referred for an assessment is considered by ACC to be a security or safety risk and who requires security guard presence to mitigate any risk, this should have been discussed and arranged by ACC prior to the assessment.

If the client is not considered by ACC to be a risk that requires a security presence, but you consider they may require this, you should discuss this with the case owner, prior to the assessment.

If ACC agrees a security guard is required at the requested assessment, ACC pays for this service.

It may be also appropriate for an advocate or support person to be present as this may lessen the incidence of aggression. If these matters have been discussed and the referral accepted, you should also take whatever steps necessary to ensure that their safety and yours is assured.

Your safety is the priority and any assessment should be terminated if the client or their advocate or support persons cause you to feel threatened or unsafe and the client's case owner contacted.

Please report any threatening behaviour:

- To the case owner and
- To the police, if you feel that is warranted in the circumstances.

### 2.3 Conducting the assessment



#### **The importance of establishing a client-centred approach to maximise participation and satisfaction.**

Due to the non-therapeutic nature and possible outcome of the assessment, many clients may feel some distress or apprehension at the prospect of an IMA or VIMA. These feelings may have an influence on their responses and frankness in discussing some of their concerns or opinions and may negatively impact upon their perception of the assessment process. Therefore it will be mutually beneficial to ensure that a client-centred environment of trust and empathy is established that fosters an open style of communication and rapport to encourage maximum participation and satisfaction.

Part of the client-centred approach is the assurance that the principles of natural justice are being followed.

One of these principles applied to the assessment is the client's right to express their opinion; be heard and be part of the discussion of the findings and recommendations. It is important that the client is invited to comment on and discuss any issues they have concerning their injury and the occupations and understand any recommendations made and that any decisions made as a result of the assessment are made by ACC.

However, a client also has responsibilities to participate and co-operate in their own rehabilitation. They have responsibilities to notify their case owner or yourself if they are unable to keep their appointment or there are unexpected changes in their

circumstances and they are obliged to participate appropriately in the assessment.

An unwillingness to participate in the assessment or an unwillingness to consider vocational rehabilitation during an IMA is in fact a flag that should be considered in the rehabilitation recommendations.

### Explaining the nature of and the purpose of the assessments

While the client should have been fully informed by ACC of the reasons for and what will happen following the assessment, it is still important to fully inform the client in regard to your role as the assessor and the nature of the assessment so they are aware of what to expect during the assessment process and what the report is likely to contain in regard to findings so they can be fully discussed with the client.

**However, the client also needs to understand that any decisions made as a result of the assessment are made by ACC.**

**For an IMA** the outcome may be recommendations for rehabilitation and likely medical sustainability for identified work types.

**For a VIMA** where the outcome may be a determination that the client has the capacity to undertake specific work types, that this determination informs ACC's further claims management.

It is likely to result in a decision by ACC that the client is vocationally independent and their entitlement to weekly compensation is likely to cease 3 months following that decision.

It is therefore important that the assessment is carried out correctly in all respects and by considering the supporting information and evidence and providing clear reasons and rationale for reaching the conclusions provided in the assessment.

### Chaperones

There is no policy for ACC for assessors to use chaperones, but this should fall within your normal practice consideration and professional behaviours. You should be familiar with the usual indications for chaperones and how this interacts with your professional style. If you consider a chaperone is necessary, it is not advisable for a family member to fill this role to avoid any misinterpretation of specific examinations.

### Multiple support people

To complete a good assessment, the client should feel comfortable and relaxed. This may be enhanced with the support of a friend or relative.

The client has the right to bring a support person(s) (friends, family members, whanau, or other representatives) with them, for support provided that the safety of all involved can be assured and the efficacy of the assessment is preserved. Clients do not have to explain or justify why they want to do so and it may involve more than one person.

However, if you are not comfortable with the situation and consider that you cannot undertake the assessment (e.g. a support person/s becomes disruptive and/or obstructs the assessment process or becomes threatening or there are too many support people in the room to appropriately undertake the assessment) this should be discussed with the client. If you cannot resolve the issues you may need terminate the assessment and contact the client's case owner.



The Medical Council of New Zealand has information regarding chaperones and support people this and can be found on the MCNZ website – [www.mcnz.org.nz](http://www.mcnz.org.nz) - When *another person is present during a consultation*.

#### Recording assessments

Clients also occasionally request to tape or video record the assessment. ACC considers recording is not necessary for the completion of a good quality assessment and while, with your agreement, taping could take place, you are under no obligation to agree. Taping cannot take place without your (written) permission.

Consider requests carefully. Consider how this might be undertaken, how it might affect the assessment, what benefits there might be, what risks there are of misuse, risks (in terms of Health and Safety) to yourself or clinical colleagues or invasion of privacy. Come to a conclusion about whether you would support any recording. Document the result of your discussion with the client.

ACC needs to see that there were attempts to negotiate agreement about the taping request, or to otherwise meet the client's wish for a record of what was said at the interview or assessment.

#### Stopping the Assessment.

If for some reason, such your safety or an inability to obtain a history or undertake a physical assessment, you consider that the assessment may not be able to continue, should discuss the situation with the client and try and resolve the situation.

If despite discussion you are unable to reach a resolution and feel that the assessment should not or cannot continue, you should explain this to the client and terminate the assessment.

You should notify the client's case manager as soon as possible and fully document the reasons for the termination of the assessment in your report.

## 2.4 Considerations during the assessment

#### Fitness for Work for safety-critical job types.

As a medical assessor, you will often have to determine the client's fitness for work in occupations with discrete fitness requirements. When assessing clients who have work types identified in safety-sensitive occupations e.g. passenger or commercial driving, it is important to consider the principles of risk management of those jobs and the specific regulatory standards required in the same way as any employer of those people might do when considering their safety to undertake the work. Assessors particularly need to be familiar with the [NZTA Medical Aspects of Fitness to Drive](#).



This does not mean you have to perform all the tests and investigations yourself but you should clearly indicate which ones are required before clearance to undertake this work.

For example, if undertaking an IMA for a client who is a heavy truck driver and you were unsure in regard to their safety to drive and wish to confirm that they would fit within criteria, you may request the results of completed investigations or recommend additional investigations to be completed as part of their rehabilitation.

If undertaking a VIMA, where heavy truck driving has been identified as all or part of a potential job option, you need to be assured that you have all the information required to make a determination of the client's fitness to drive heavy vehicles. This may mean awaiting the results of some investigations prior to finalising the report.

#### **Assessing conditions such as pain, mood problems and fatigue.**

The nature and degree of any significant pain condition, mood disorder or fatigue must be addressed in the medical assessment of the client's ability to work in the job or jobs suggested in the occupational assessment

When forming an opinion on fitness for work, you need to integrate the information on file with your own clinical findings and focus opinion on the client's likely tolerance for work. Where self-management strategies are being used, you must form an opinion on the likely success/failure of such strategies with respect to the various work types in the context of adaptation and the positive social and stamina effects of work participation.

**Note:** Pain, fatigue and mood disorders are covered in more detail in sections 11-13.

#### **Ongoing or Future treatment and vocational independence**

A client may require ongoing medical treatment for an injury from time to time but this should not affect the status of the client from reaching a stage where they can be assessed for vocational independence, provided that any rehabilitation that has been required has been agreed and provided is complete. For example, a client may require some intermittent pain psychological treatment to help them maintain and reinforce any management strategies.

You should be provided with information in regard to the client's ongoing need for any treatment and take those matters into account when determining if there is still an injury-related barrier to employment.

Any prospect for possible treatment some time in the future should also not be a bar to assessing for vocational independence. For example, metal ware may need to be removed some time in the future or a client may require a knee replacement some time in the future, but those procedures are not intended at the time of the assessment.

However, any specific treatment that has been recommended, agreed upon and documented on the Individual Rehabilitation Plan (IRP) as part of the vocational rehabilitation and independence process must have been completed prior to the vocational independence assessments.

#### **Completeness of rehabilitation - specific to VIMA**

ACC has a responsibility to ensure that all identified and required treatment and rehabilitation is complete before requiring the client to undergo vocational independence assessments – VIOA and VIMA.

It may be evident from the information provided that a client has not been compliant or participated fully in their rehabilitation or that the outcome of rehabilitation has not been totally successful.

However, the VIMA assessor needs to determine if the rehabilitation has been undertaken as much as possible and the client has been given every opportunity to participate in the process and the treatment or rehabilitation provided has made identified work types medically sustainable. If it is noted that the client participation has been less than ideal with recommended rehabilitation, the assessor should enquire as to the reason/reasons for that from the client.

If during an assessment, it is found that previously recommended treatments or rehabilitation have not been provided, the assessor must note these omissions and also note whether this interferes with a determination of the work capacity in respect of any of the job types.

### Identifying urgent conditions during the assessment as a non-treating practitioner.

If during the assessment you are made aware of a condition that requires either urgent medical attention or contact with the client's normal treating practitioner, you should act according to the urgency of the situation.

This may include arranging for immediate hospital assessment or treatment or arranging an urgent consultation with the client's normal practitioner and ensuring or arranging for the client to be transported safely for that assessment or treatment

The client should be fully informed of any urgent findings and your proposed response to these and get their consent to this.

The Medical Council of New Zealand has information regarding this and can be found on the MCNZ website – [www.mcnz.org.nz](http://www.mcnz.org.nz) - *A doctor's duty to help in a medical emergency*

### What key elements should the IMA or VIMA report contain?

## 2.5 Writing the reports

### The standard of the required documentation for IMA and VIMA reports



1. The IMA and VIMA reports report must be completed using the headings as detailed in the service specifications and further outlined below. See 3 *IMA Report Headings and Content Guidelines* and 4 *VIMA Report Headings and Content Guidelines*.
2. Each assessment must contain a detailed medical and occupational history of the client and details of the physical examination.
3. Each assessment should comment, where these symptoms are noted or reported, on the client's pain, mood and fatigue and how these affects their ability to engage in each of the work types in the Occupational Assessment. This issue should be addressed generally, in the body of the report, and in regard to each work type
4. In the case of an IMA, there should be clear recommendations to ACC on further medical treatment, rehabilitation or other options that will assist the client with their vocational rehabilitation programme in order to obtain employment or achieve Vocational Independence
5. In the case of the VIMA it should be noted whether there are any barriers to Vocational Independence and whether all agreed rehabilitation recommendations have been completed.
6. For VIMA there should be an assessment as to whether or not the client can sustain work for 30hrs or more in each of the work types identified in the VIOA; and the assessor should also identify any conditions that are not related to the client's injury but that prevent the client from having vocational independence. *[Clause 29 (2) Schedule 1 of the Act]*.
7. For IMA and VIMA, the client's comments in regard to each work type and general comments. (See clause 2.6)

Note: It is not the responsibility of the Initial Medical Assessor to determine work types in addition to those already determined by the Initial Occupational Assessor. The Initial Medical Assessor considers whether the types of work identified in the Initial Occupational Assessment are or are likely to be medically sustainable for the client. If you have concerns about the work types please contact the client's case owner.

Once the IMA/VIMA report has been submitted to ACC, the case owner may make further requests for clarification of the report before it is accepted. Once complete, copies of the report will then be distributed to the client and their General Practitioner.

### Diagnosis

The basis for good rehabilitation and treatment is a definitive and best possible diagnosis/diagnoses. You need to critically review the information provided and use your own examination and observations when confirming or determining the diagnosis to both avoid predetermining the diagnosis ('confirmation bias') and to be able to make recommendations based on your own diagnosis/es.

If you conclude that the diagnosis is incorrect or is not clear or there are additional diagnoses that have not been considered, you need to indicate this in the diagnosis section of your report.

Any change to the initial diagnosis needs to be clearly outlined as a difference in diagnosis, if not indicated, may affect the basic premise of the assessment.

### Non-injury related factors.

It is very important to note that ACC must consider non-injury related factors, and the effect this has on a client's work ability when making decisions as to whether a client has achieved vocational independence. Clearly non-injury factors will, from time to time, influence the client's ability to work, and must be taken into account

Injury and non-injury factors should be clearly differentiated in both the body of the report and for all identified work types – suitable and unsuitable – assessors should provide a clear opinion with rationale, in regard to the impact of injury and non-injury factors on the client's ability to undertake each work type.

Example - You are conducting an assessment on Mr Jones who injured his right anterior cruciate ligament and has undergone a repair. You are determining if he can perform one of the identified work types which is a truck driver. You note that he has good results from this repair, and although he still has some laxity he would be able to undertake truck driving. However, this work type would be unsuitable as Mr Jones has epilepsy, a non-injury related condition.

### Restrictions and Limitations

One of the most important components of the report is the identification of and summary of the client's Restrictions and Limitations.

**Restrictions** refer to prescribed measures relating to both the individual and/or others that serve to manage risks. They describe what the patient should not do, even if they are willing and able to do so.

Appropriate restrictions should be recommended in order to

- prevent injury recurrence;
- prevent injury aggravation and
- support healing.

Example - Mr Brown injured his shoulder and has undergone rotator cuff repair and has made an excellent recovery and is keen to get back to work but still has some loss of ROM and some pain on reaching above his head and you are undertaking an IMA. One of the identified tasks entails reaching above his head and you recommend that this activity be avoided for the next 2 months while he is completing his post operative physiotherapy programme.

For others, restrictions serve to protect co-workers or members of the public,

Example - Mr White sustained a mild traumatic brain injury and has made a good recovery but still has some fatigue issues, for which he is receiving rehabilitation. As one of the identified work types is as a truck driver, you recommend that this work type is not suitable currently due to the fatigue, but could be assessed in the future, following further progress and completion of the appropriate rehabilitation.

**Limitations** refer to what the client is simply unable to do i.e. existing constraints upon their physical or mental capacity to perform required tasks.

The assessment of limitations needs to be based on objective findings, where possible and considering physical, cognitive, social interaction and endurance /tolerance factors where relevant.

Example - Miss Smith had an MVA and sustained a spinal cord injury resulting in paraplegia at T12 level. One of the identified work types is a role which has the components of kneeling and bending and lifting objects above shoulder height. Due to her injury, Miss Smith would be unable to complete these specific work tasks.

### **Incapacity and Capacity**

The term incapacity is specific to the client's pre-injury occupation and their inability to perform their pre-injury employment and hours. It therefore follows that if a client is found to have capacity, they are no longer incapacitated for their preinjury employment.

It should be noted that IMA assessments cannot be used for determining incapacity for current employment or for determining Vocational Independence.

### **Medical sustainability.**

When determining whether job types are sustainable, you will need to appreciate the concept of medical sustainability. **"Medically sustainable"** is the term used in the IMA (Section 89.). This concept does not have hours attached to it but it is envisaged by the Act (and in practice) that it means 30 hours per week within a reasonable period of the assessment.

### **"Capacity to undertake work "**

This is the term used in regard to the VIMA (section 108). "Capacity to undertake" means work must be physically and mentally sustainable for at least 30 hours per week in a work type for which the person has been assessed as having the necessary education, training and experience. You should make express reference to 30 hours for each identified job type in the assessment of vocational independence (VIMA)

### **Snapshot in time**

Whether the client has a capacity for work can only be considered at the time the assessment is undertaken to determine the medical sustainability. That determination is made in a 'snapshot of time' meaning that when the assessment is carried out, the client was assessed as having the vocational and physical ability to perform the work types in question.

If events subsequent to the 'snapshot' indicate that the client is no longer capable, the process for determining this is for a client to apply for a subsequent assessment to be undertaken to determine if there has been deterioration. If it is found that the client no longer has a capacity for work at that time that does not imply that the original assessment was incorrect.

### **Availability of employment is not relevant to 'medical sustainability'.**

Whether or not the client could gain employment is not to be taken into account when determining or not whether work types are medically sustainable. This is part of the underlying principle that the assessment of medical sustainability relates to a generic work type, rather than an employer or job specific work type.

### **Work Trials**

While work trials are a desirable method of testing a client's capacity to sustain work for 30 hours a week or more, they are not compulsory and the availability of work trials may be limited in many areas or circumstances.

Should a work trial not be completed, you will be required to determine from reading collateral information, including reports on the rehabilitation provided and discussing the day to day activities of the client in regard to hobbies, activities and volunteer work etc, to draw an inference as to whether the client has an ability to sustain work for 30 hours a week or more and can make this determination, providing appropriate rationale.

### **Assessing function using collateral information.**

There are a number of assessments or interventions that the client may have had that will be of assistance when assessing the client's pain, mood, fatigue and their participation in everyday activities of daily living and help build a bigger picture of their abilities, particularly in regard to their potential for return to work.

These may include reports from rehabilitation services provided to the client including pain management and vocational reports. A Functional Capacity Evaluation is often used to assist in the assessment of fitness for work. However, generally FCE is not a test that can be regarded as a purely objective measure of physical function. The results are impacted by behavioural factors including pain factors and so a FCE must be seen as another assessment of physical function, and another source of functional information, but not one that can stand alone, nor provides validity within the context of chronic pain.

When eliciting information on function you may sometimes be required to use other collateral information, to make an assessment of the client's functional abilities.

You can use a number of methods such as using structured questionnaires to support the validity of your opinions or targeted questions about the non-occupational activities or history such as

- how the client occupies their typical day and the activities they undertake during their waking hours and
- key areas of interest : what motivates and grabs their attention
- how the client looks after their own needs ( preparing meals, hygiene etc )
- how the client sustains or tolerates a specific functions e.g. sitting, standing, walking driving, lifting and how often they undertake those activities.
- The effect of medication on these activities
- How the client copes with important events ( funeral/tangi; social occasions; travelling to meet case manager etc )

You should ask the client about contextual detail from their day to day lives including how they interact with interests, hobbies, pets, sport, activities of daily living shopping, who is at home, responsibilities for children and other dependents, time with friends/family, social clubs, volunteer work, domestic chores – cleaning, cooking, and gardening.

Both abilities and limitations should be explored, as well as attitudes and any inconsistencies. The degree of consistency of reported functioning should also be explored by referring to other sources and cross-referencing with the client.

If clients are not forthcoming on functional matters then you should make specific note of that in that particular section of the report.

### 2.6 Reassessments

#### IMA and VIMA Reassessments

A reassessment is a follow-up medical assessment to provide information on a client's progress subsequent to a completed IMA or VIMA.

The reassessment is done in accordance with the referral from ACC.



If the client had no medically sustainable job types in the medical assessment and further job types are added to the occupational assessment (as an addendum to the initial report or a new complex occupational assessment), an addendum may be sufficient if the time between the first assessment and the reassessment does not exceed 3 months, assuming there has been no significant change in the client's condition.

Alternatively, a reassessment would be necessary in situations where the assessor needs to provide a repeat clinical assessment. This might apply where there has been a significant change in the client's condition or if more than 3 months have passed between the first assessment and the reassessment.

## IMA Report Headings and Content Guidelines.

### 3. IMA Report Headings and Content guidelines.

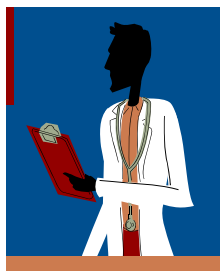
The IMA report is to be completed with the headings outlined below. Additional information has been added beneath the headings to guide and encourage quality, completeness, and consistency of reports. All sections should be completed.

It is not intended to limit the provider from recording any relevant information which should still be included in the report in the most relevant section. If additional information does not appear appropriate in the sections outlined, please record in the Additional Comments section.

#### 3.1 Identification/Assessment Information

Appropriate identification of information including

- assessor details
- referrer details, and date
- assessment date and duration and location.
- report date
- client details – name, date of accident, date of birth ACC Claim number, occupation at date of injury
- any support person present and
- any other relevant information.



#### 3.2 Documents Reviewed

List the documents provided by ACC. Comment on whether any information is missing/required.

#### 3.3 Introduction and Consent Statement

Indicate that there has been a discussion with the client and they are aware of the requirements of the assessment. The Introduction and Consent Statement is required to be in accordance with the guidance contained in the Medical Council of New Zealand statement - *Non-treating Doctors Performing Medical Assessments of Patients for Third Parties*.

#### 3.4 History of the Injury and its Management

A clear background history must be documented with

- presenting problem and contributing factors
- symptom onset and time course.
- chronological record of events
- relevant dates specified

Include details about the injury and management

- how the injury was sustained
- the consequences of the injury
- previous assessments and investigations
- any medical or surgical treatment undertaken and response to treatment
- any self management techniques.

Information about current medical certification and any attempts at returning to work should be described.

Any relevant inconsistencies should be highlighted



### 3.5 Current Situation/ Functional Enquiry

The client's current situation in regard to their function needs to be explored and discussed, including:

- functional or cognitive limitations
- pain, site and radiation, character, severity, aggravating or relieving factors and associated symptoms
- focused general medical functional enquiry
- general symptoms (sleep, energy, mood) should be stated including their perception of what is wrong and their concerns
- their current abilities and participation in activities of daily living, household chores, family responsibilities, volunteer work, exercise, hobbies and sporting and social activities, including driving
- specifics in regard to what exactly the client does throughout a typical day.
- The client's goals for work and non-work activities should be discussed and noted.

**Note:** Where symptoms such as pain, fatigue or mood disorder are identified, these need to be specifically noted and explored in terms of their nature and significance

### 3.8 Past Medical/Surgical History

The client's past medical history must be outlined.

The impact of any illness or injury should be outlined including

- ongoing symptoms
- any disability and
- any adverse consequences of treatment.

### 3.9 Medications

List current medications including any noted side effects.

Allergies should be noted.

### 3.6 Most recent employment

In regard to the most recent employment, information is required about

- the job title, name of employer, period of employment and hours of work, tasks undertaken, additional responsibilities, travel requirements, work environment.
- Where appropriate, exposure and duration to potentially hazardous substances or situations.
- comment on job satisfaction, work security, work performance, and relationship with manager and co-workers and any conflicts
- comment on presence/ absence of ongoing communications with employer
- comment on whether or not the job is still available for the injured worker in any form.

### 3.7 Past Occupational History

A brief outline needs to be noted of the client's past occupational history including

- work types and periods of employment.
- Where appropriate, any exposure and duration to potentially hazardous substances or situations.

### 3.10 Personal and Social History

The client's personal and social history must be noted including

- smoking alcohol & drug habits and history

- past participation in volunteer work, sports or hobbies
- areas of interest and motivation
- significant relationships, responsibilities and living arrangements
- any financial, social or domestic issues or concerns.

### 3.11 Examination

A focussed assessment should be undertaken in respect to the injury and any other medical conditions. This assessment should address

General observations such as

- your overall impressions
- the person's attitude, thought process, communication and participation in the assessment
- any normal or abnormal behaviours or postures
- any consistencies and inconsistencies.

Specific observations such as

- height, weight, hearing, vision and mobility, BMI, blood pressure and heart rate etc
- specific observations e.g. swelling, scars muscle wasting

Specific relevant injury examination should be included

- regional examination e.g. back condition with lower limb neurology
- organ system examination e.g. neurological

More specific examinations should be undertaken, where relevant. These should take into consideration the injury and the demands of the various work types and the fitness to undertake that work including

- functional tests - range of movement, strength, nerve function, cognitive function etc.
- general capabilities and any restrictions or limitations should be noted or discussed, as relevant, such as walking, standing, sitting, kneeling, squatting, lifting & carrying, reaching, climbing stairs, rising from sitting, dexterity.

### 3.12 Diagnosis and any conditions /barriers to rehabilitation

Diagnosis -

Provide a diagnosis/ diagnoses for the injury/ injuries (or failing that a differential diagnosis) and recommendations for investigations if necessary. .

List other medical and surgical conditions

Barriers to rehabilitation -

Explore and list any other barriers to participation in rehabilitation such as

- diagnostic difficulties
- access to work
- attitudes, beliefs and goals
- any noted cognitive and behavioural issues.
- Any work, social, cultural , family or other issues raised by the client

### 3.13 Recommendations for management and rehabilitation

Clarification of diagnosis: If the diagnosis is in doubt, specify what steps need to be undertaken to clarify the diagnosis: appropriate investigations, specialist referral or opinion.

Clinical management /rehabilitation: provide recommendations with rationale and likely/expected outcomes including:

- the recommended modality/ modalities
- frequency and
- duration
- type of therapy/therapist

Use a biopsychosocial and vocational framework and consider all the barriers identified and the pre-injury job and whether there are any options for accommodations or modifications in the workplace.

Include any client comment regarding recommendations.

### **3.14 Current restrictions and limitations, if any.**

List any current restrictions and limitations.

What can/can't the client do? what activities can / can't they safely perform? What activities need to be avoided for the safety in the workplace for the client and others? What activities need a shortened exposure time to account for specific symptoms?

Describe any work schedule modifications, equipment or other accommodations which would make a difference to the client's ability to engage with work activities.

**Note:** Restrictions and limitations need to be listed and clearly defined as they will be used to inform employers and others involved in any future vocational rehabilitation. This ensures that any proposed return to work or work trial is provided in a safe environment for the client.

### **3.15 Determination of likely sustainability of work types, including client comments**

The assessor needs to make a determination of the likely medical sustainability of the work types by

- having regard to the present consequences of the client's personal injury
- having regard to any medical/surgical conditions not related to the injury and
- disregarding any non-medical issues such as lack of job opportunities, child care etc.

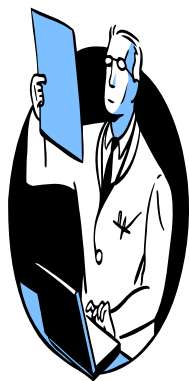
Each work type should be listed separately noting

- Work types medically sustainable now with rationale.
- Work types likely to be medically sustainable with rationale, including timeframes.
- Work types medically unsustainable indefinitely with rationale.
- Special attention should be placed on the pre-injury work type, abilities, restrictions, limitations and timeframes.
- Consistent and reasoned recommendations should be provided for all work types.
- Adhere to the work types as specified in the work detail sheets.
- Where present, the impact of pain, fatigue and mood needs to be specifically addressed for each work type.
- Tolerance for each work type must be discussed, including the viability for self-management practices in the workplace.
- Record client's comments with respect to the work ability assessment for each work type and the assessor's findings and proposed rehabilitation recommendations.

### **3.16 Additional Comments**

Assessor to add any additional comments or relevant information

## VIMA Report Headings and Content Guidelines



### 4. VIMA Report Headings and Content guidelines

The VIMA report is to be completed with the headings outlined below. Additional information has been added beneath the headings to guide and encourage quality, completeness, and consistency of reports. All sections should be completed.

It is not intended to limit the provider from recording any relevant information which should still be included in the report in the most relevant section. If additional information does not appear appropriate in the sections outlined, please record in the Additional Comments section

#### 4.1 Identification / Assessment Information

Appropriate identification of information including

- assessor details
- referrer details, and date
- assessment date and duration and location
- report date
- client details – name, date of accident, date of birth ACC Claim number, occupation at date of injury
- any support person present and
- any other relevant information.

#### 4.2 Documents Reviewed

List documents provided by ACC. Comment on whether any information is missing/required.

#### 4.3 Introduction and Consent Statement

Indicate that there has been a discussion with the client and they are aware of the requirements of the assessment. The Introduction and Consent Statement is required to be in accordance with the guidance contained in the Medical Council of New Zealand statement; *Non-treating Doctors Performing Medical Assessments of Patients for Third Parties*.

#### 4.4 History of the Injury and its Management

A clear background history must be documented with

- an account of the presenting problem and contributing factors
- symptom onset and time course.
- chronological record of events relevant dates

Include details about the injury and management

- how the injury was sustained
- the consequences of the injury
- previous assessments and investigations
- any medical or surgical treatment undertaken and response to treatment
- any self management techniques.

Information about current medical certification and any attempts at returning to work should be described.

Any relevant inconsistencies should be highlighted

#### 4.5 Current Situation/ Functional Enquiry

The client's current situation in regard to their function needs to be explored and discussed, including:

- functional or cognitive limitations
- pain, site and radiation, character, severity, aggravating or relieving factors

and associated symptoms

- focused general medical functional enquiry
- general symptoms (sleep, energy, mood) should be stated including their perception of what is wrong and their concerns
- current abilities and participation in activities of daily living, household chores, family responsibilities, volunteer work, exercise, hobbies and sporting and social activities, including driving
- specifics in regard to what exactly the client does throughout a typical day.
- The client's goals for work and non-work activities should be discussed and noted.

**Note:** Where symptoms such as pain, fatigue or mood disorder are identified, these need to be specifically noted and explored in terms of their nature and significance

#### 4.7 Past Medical/ Surgical History

The client's past medical history must be outlined

The impact of any illness or injury should also be outlined including

- ongoing symptoms
- any disability and
- any adverse consequences of treatment.

#### 4.8 Medications

List current medications including any noted side effects

Reference to significant trials of other medications: outcome; reasons for discontinuation etc.

Allergies should be noted.

#### 4.6 Past occupational history

A brief outline needs to be noted of the client's past occupational history including

- work types and periods of employment.
- Where appropriate, any exposure and duration to potentially hazardous substances or situations.

#### 4.9 Personal and Social History

The client's personal and social history must be noted including

- smoking history, alcohol & drug habits and history
- past participation in volunteer work, sports or hobbies
- areas of interest and motivation
- significant relationships, responsibilities and living arrangements
- any financial, social or domestic issues or concerns

#### 4.10 Examination

A focussed assessment/examination should be undertaken in respect to the injury and any other medical conditions. This assessment should address

General observations such as

- your overall impressions
- the person's attitude, thought process, communication and participation in the assessment
- any normal or abnormal behaviours or postures
- any consistencies and inconsistencies.

Specific observations such as

- height, weight, hearing, vision and mobility, BMI, blood pressure and heart

rate etc

- any mental or psychological issues
- where appropriate, specific observations e.g. swelling, scars muscle wasting

Specific relevant injury examination should be included

- regional examination e.g. back condition with lower limb neurology
- organ system examination e.g. neurological

More specific examinations should be undertaken, where relevant.

These should take into consideration the injury and the demands of the various work types and the fitness to undertake that work including

- functional tests - range of movement, strength, nerve function, cognitive function etc.
- general capabilities and any restrictions or limitations should be noted or discussed, as relevant, such as walking, standing, sitting, kneeling, squatting, lifting & carrying, reaching, climbing stairs, rising from sitting, dexterity.

#### **4.11 Diagnosis and any conditions /barriers to vocational independence.**

Diagnosis -

Provide a diagnosis/ diagnoses for the injury/ injuries

List other medical and surgical conditions

Barriers to rehabilitation -

Explore and list any other barriers to participation in rehabilitation such as

- diagnostic difficulties
- access to work
- attitudes, beliefs and goals
- any noted cognitive and behavioural issues.
- Any work, social, cultural , family or other issues raised by the client

#### **4.12 Current restrictions and limitations, if any.**

List any current restrictions and limitations.

What can/can't the client do? what activities can / can't they safely perform?  
What activities need to be avoided for the safety in the workplace for the client and others? What activities need a shortened exposure time to account for specific symptoms?

#### **4.13 Comments on completeness of rehabilitation and medical treatment**

Comment on whether recommended and agreed rehabilitation is "complete" or not and what outcomes have been achieved. Give sufficient detail. In cases where rehabilitation has been provided but is incomplete or the outcome is less than expected, discuss whether there has been adequate opportunity for the client to engage with the rehabilitation and what is the significance of the outcome?

If further medical treatment is required (for either injury or non-injury conditions), then provide recommendations for clinical management.

Include any client comment regarding recommendations.

#### **4.14 Specific determination of sustainability of work types including client comments.**

The assessor needs to make a determination of the medical sustainability of the work types by

- having regard to the present consequences of the client's personal injury
- having regard to any medical/surgical conditions not related to the injury
- disregarding any non-medical issues such as lack of job opportunities, child care etc.
- either "yes, the work type is sustainable " or " no"

Comment on each work type separately noting

- whether the work type is medically sustainable now for 30 hours or more per week
- Conversely whether the work type is medically unsustainable now for 30 hours or more per week
- For each type provide a short rationale
- Do not include any provisos when commenting on the work types, e.g. 'provided that' or 'as long as'.
- Consistent and reasoned recommendations should be provided for all work types.
- Adhere to the work types as specified in the work detail sheets.
- Where present, the impact of pain, fatigue, and mood needs to be specifically addressed for each work type i.e. describe why work is or is not sustainable with regard to these symptoms.
- Tolerance for each work type should be discussed including the viability for self-management practices in the workplace.
- Record client's comments with respect to the work ability assessment for each work type and the assessor's finding and any proposed rehabilitation recommendations.
- If your opinion differs from that of other doctors, then provide further comment and justification.

#### **4.15 Additional Comments**

Assessor to add any additional comments or relevant information

**Assessing  
fitness for  
work -  
Physical  
demands of  
work.**



## 5. Assessing Fitness for Work in regard to function & activity levels.

To classify the occupational requirements for physical exertion ACC use the 37.02 US Department of Labor Physical Demand Characteristics of Work chart.

### Physical demands of work

The physical demands of work include:

1. **Strength**
2. Climbing or balancing
3. Stooping, kneeling, crouching and/or crawling
4. Reaching handling, fingering and/or feeling
5. Talking and/or hearing
6. Seeing.

### The Parameters of Strength

The parameters of **Strength** are measured by the involvement of the worker with one or more of the following activities - Standing, walking or sitting and the amount of weight moved at work and the relative frequency that activity occurs during a workday.

**How work functions/activity levels e.g. light, moderate are defined**

**From the US Department of Labor Physical Demand Characteristics of Work**

Physical demand level	Occasional (0-33% of the workday)	Frequent (34-66% of the workday)	Constant (67-100% of the workday)	Typical energy required
1. Sedentary	10lbs (4.5 kilos)	negligible	negligible	1.5-2.1 METS
2. Light	20lbs (9 kilos)	10lbs (4.5 kilos) and/or walk and/or stand with operation of controls	negligible and/or operate controls while seated	2.2-3.5 METS
3. Medium	20-50lbs (9-22.7 kilos)	10-25lbs (4.5-11.4 kilos)	10lbs (4.5 kilos)	3.6-6.3 METS
4. Heavy	50-100lbs (22.7-45.4 kilos)	25-50lbs (11.4-22.7 kilos)	10-20lbs (4.5-9 kilos)	6.4-7.5 METS
5. Very heavy	> 100lbs (45.4 kilos)	> 50lbs (> 22.7 kilos)	20lbs (> 9 kilos)	> 7.5 METS

Reference *K Palmer & R Cox – a general framework for assessing fitness for work Chapter 1, pages 14-125. K Palmer, R Cox, I Brown Fitness for Work – the medical aspects. 4<sup>th</sup> edition. 2007 Faculty of Occupational Medicine of the Royal College of Physicians*



**Types of Work  
Work and Work  
type details  
sheets**

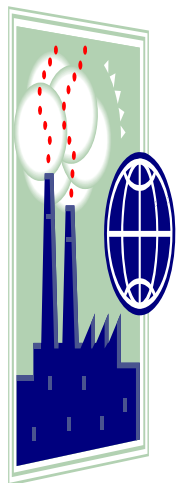
## 6. Types of work and work type detail sheets

### 6.1 Types of work

**“Types of work”** means occupational categories of work that include a set of job functions requiring the performance of a common set of tasks and can include several jobs.

(“Types of work” refers to a broad group of jobs and roles that have a common set of work tasks and functions.

These work types are detailed the Occupational Assessor in the IOA and VIOA report and the details of the work types are outlined in Work Detail Sheets. The IOA and/or VIOA report must be provided to the IMA and VIMA assessors by the client’s Case Owner with the IMA/VIMA referral.)



### 6.2 Work Type Detail Sheets

ACC has a link on its <http://www.acc.co.nz/for-providers/work-type-detail-sheets/index.htm> site for details and examples of work type detail sheets.

The sheets were developed by occupational assessors and are based on the occupational classification system Australian and New Zealand Standard Classification of Occupations, 2006.

The sheets refer to types of work available in the current New Zealand labour market and detail:

- tasks
- work environment
- functions
- activities involved

Assessors may choose to use these sheets or to develop their own for types of work they consider

The work type detail sheets can be accessed through the following major occupational groups:

- [Managers](#)
- [Professionals](#)
- [Technicians and Trades Workers](#)
- [Community and Personal Service Workers](#)
- [Clerical and Administrative Workers](#)
- [Sales Workers](#)
- [Machinery Operators and Drivers](#)
- [Labourers](#)

## 7. Quality Reviews of IMA/ VIMA assessments

### Quality review of assessments



<b>Name of Reviewer:</b>		<b>Date of review:</b>	
<b>Name of Assessor:</b>		<b>Assessment Type:</b> IMA / VIMA	
	<b>Item</b>	<b>Additional Description</b>	<b>Score</b>
<b>1</b>	Meets contractual timeframes		<b>Yes/No</b>
<b>2</b>	Reports on injury and its response to management, past medical, social and occupational history	If appropriate, cites relevant reports and information	
<b>3</b>	Describes current situation, including symptoms, function, daily activities, medications and any side effects	Comments on claimant's pain, mood, and energy	
<b>4</b>	Diagnosis/es given with clear rationale.  Relevant non-injury factors, conditions, and barriers to rehabilitation must be specified.	Diagnostic findings supported by rationale.	
<b>5</b>	Discusses functional abilities and any restrictions and limitations,	Fully outlines workability, taking both injury and non-injury factors into consideration.  Findings are supported by rationale	
<b>6</b>	<i>IMA</i> : Recommendations for rehabilitation <i>VIMA</i> : Comments on completeness of agreed rehabilitation	Ensures pain, mood and fatigue are considered if relevant. Comments/recommendations are supported by rationale	
<b>7</b>	Provides an analysis of the claimant's post injury work capability, and measures this against the identified work types with reasoning.	Includes claimant's comments and ensures symptoms, medication, and geographical area have been considered in context of each job type	
<b>8</b>	Additional comments		
<b>Total</b>			<b>/30</b>

### 7.2 Scoring the IMA/VIMA report evaluations

#### Scoring

<b>1</b>	Poor	Missing or not comprehensible
<b>2</b>	Fair	Information incomplete/confusing/conflicting
<b>3</b>	Good	Moderate detail and clarity
<b>4</b>	Very Good	Good detail and clarity
<b>5</b>	Excellent	Excellent detail and clarity with clear supporting rationale

## 8. Relevant extracts from the Accident Compensation Act 2001.

### 72 Responsibilities of claimant who receives entitlement

- (1) A claimant who receives any entitlement must, when reasonably required to do so by the Corporation,—
- (a) give the Corporation a certificate by a registered health professional or treatment provider that deals with the matters and contains the information that the Corporation requires;
  - (b) give the Corporation any other relevant information that the Corporation requires;
  - (c) authorise the Corporation to obtain medical and other records that are or may be relevant to the claim;
  - (d) undergo assessment by a registered health professional specified by the Corporation, at the Corporation's expense;
  - (e) undergo assessment, at the Corporation's expense;
  - (f) co-operate with the Corporation in the development and implementation of an individual rehabilitation plan;
  - (g) undergo assessment of present and likely capabilities for the purposes of rehabilitation, at the Corporation's expense;
  - (h) participate in rehabilitation.
- (2) Every such claimant must give the Corporation a statement in writing about any matters relating to the claimant's entitlement, or continuing entitlement, to an entitlement that the Corporation specifies, and must do so whenever the Corporation requires such a statement.
- (3) If the Corporation requires the claimant to do so, the claimant must make the statement referred to in subsection (2) as a statutory declaration or in a form

### Individual Rehabilitation Plan

#### 77 Assessment of needs and content of plan

- (1) In preparing an individual rehabilitation plan, the Corporation must assess the claimant's needs for rehabilitation having regard to the purposes in sections [79](#) and [80](#).
- (2) An individual rehabilitation plan must—
- (a) identify the claimant's needs for rehabilitation; and
  - (b) identify the assessments to be done; and
  - (c) identify services appropriate to those needs, whether or not the Corporation is liable to provide any or all of those services; and
  - (d) specify which of the services identified under paragraph (c) that the Corporation will provide, pay for, or contribute to.
- (3) For the purposes of subsection [\(2\)\(a\)](#), the Corporation must assess a claimant's needs for—
- (a) social rehabilitation under section [84](#) and clauses [13 to 23](#) of Schedule 1; and
  - (b) for vocational rehabilitation under sections [89 to 96](#).
- (4) However, the Corporation is not required to assess

### Vocational Rehabilitation

#### 89 Assessment of claimant's vocational rehabilitation needs

An assessment of a claimant's vocational rehabilitation needs must consist of—

- (a) an initial occupational assessment to identify the types of work that may be appropriate for the claimant; and
- (b) an initial medical assessment to determine whether the types of work identified under paragraph (a) are, or are likely to be, medically sustainable for the claimant.

#### 95 Conduct of initial medical assessment

- (1) A medical assessor undertaking an initial medical assessment must take into account—
- (a) information provided to the assessor by the Corporation; and
  - (b) any of the following reports, information, or comments provided to the assessor:
    - (i) medical reports requested by the Corporation before the individual rehabilitation plan was prepared;
    - (ii) any other relevant medical reports; and
  - (c) the report of the occupational assessor on the initial occupational assessment; and
  - (d) the medical assessor's clinical examination of the claimant; and
  - (e) any other information or comments that the claimant requests the medical assessor to take into account and that the medical assessor decides are relevant.
- (2) The medical assessor must also take into account any condition suffered by the claimant that is not related to the claimant's personal injury.
- (3) The Corporation must provide to a medical assessor all information the Corporation has that is relevant to an initial medical assessment.

### **96 Report on initial medical assessment**

- (1) The medical assessor must prepare and provide to the Corporation a report on the initial medical assessment.
- (2) The report must—
  - (a) contain the determination required by section 89(b); and
  - (b) take into account the matters referred to in section 95.
- (3) The Corporation must provide a copy of the report to the claimant.

### **Vocational Independence**

#### **108 Assessment of claimant's vocational independence**

- (1) An assessment of a claimant's vocational independence must consist of—
  - (a) an occupational assessment under clause 25 of Schedule 1; and
  - (b) a medical assessment under clause 28 of Schedule 1.
- (2) The purpose of an occupational assessment is to—
  - (a) consider the progress and outcomes of vocational rehabilitation carried out under the claimant's individual rehabilitation plan; and
  - (b) consider whether the types of work (whether available or not) identified in the claimant's individual rehabilitation plan are still suitable for the claimant because they match the skills that the claimant has gained through education, training, or experience.
- (3) The purpose of a medical assessment is to provide an opinion for the Corporation as to whether, having regard to the claimant's personal injury, the claimant has the capacity to undertake any type of work identified in the occupational assessment and reflected in the claimant's individual rehabilitation plan.

#### **Schedule 1 Clause 28 Conduct of medical assessment**

- (1) A medical assessor undertaking a medical assessment as part of an assessment of a claimant's vocational independence under section 108 must take into account—
  - (a) information provided to the assessor by the Corporation; and
  - (b) any individual rehabilitation plan for the claimant; and
  - (c) any of the following medical reports provided to the assessor:
    - (i) medical reports requested by the Corporation before the individual rehabilitation plan was prepared;
    - (ii) medical reports received during the claimant's rehabilitation; and
  - (d) the report of the occupational assessor under clause 26; and
  - (e) the medical assessor's clinical examination of the claimant; and
  - (f) any other information or comments that the claimant requests the medical assessor to take into account and that the medical assessor decides are relevant.
- (2) The Corporation must provide to a medical assessor all information the Corporation has that is relevant to a medical assessment.

#### **Schedule 1 Clause 29 Report on medical assessment**

- (1) The medical assessor must prepare and provide to the Corporation a report on the medical assessment specifying—
  - (a) relevant details about the claimant, including details of the claimant's injury; and
  - (b) relevant details about the clinical examination of the claimant undertaken by the assessor, including the methods used and the assessor's findings from the examination; and
  - (c) the results of any additional assessments of the claimant's condition; and
  - (d) the assessor's opinion of the claimant's vocational independence in relation to each of the types of work identified in the occupational assessor's report; and
  - (e) any comments made by the claimant to the assessor relating to the claimant's injury and vocational independence in relation to each of the types of work identified in the occupational assessor's report.
- (2) The report must also identify any conditions that—
  - (a) prevent the claimant from having vocational independence; and
  - (b) are not related to the claimant's injury.
- (3) The Corporation must provide a copy of the report to the claimant.

## 9 Employment and Work Ability

### Employment and Health

There have been numerous studies on the effects of employment on a person's physical and mental well being.

In 2006 Waddell and Burton published "Is Work Good for Your Health and Well Being?"<sup>1</sup> in which they examined the role of employment in the wellbeing of individuals, their families and their communities and also looked at the association between worklessness and poor health. They found a strong evidence base that work is generally good for physical and mental health and well-being and that worklessness was associated with poorer physical and mental health.

They also found that work could be therapeutic and could reverse the adverse effects of unemployment in the majority of healthy people of working age as well as for sick and disabled individuals and they should be supported and encouraged to remain in or to re-enter the work force as soon as possible because of the benefits.

We do need to remember this evidence in assessing the fitness for work and the relative enhancement of health.

### Current Models of Work Ability

There are many models relevant to the concept of work ability, and the associated concepts of work disability and return-to-work (RTW). Many of them have been growing increasingly similar and are addressing the multifactorial nature of both work ability and RTW.

The most empirically based and accepted are those that conceptualise disability as a consequence of the interaction between biological, physical, behavioural/psychological, and social phenomena, loosely termed the "biopsychosocial model" and how these factors interact with the dynamic relationship between an individual, the workplace, and the wider social environment.

It is important to note here the importance of the WHO International Classification of Functioning (ICF) model, Fadyl's excellent synthesis of the factors contributing to workability for injured workers. Figure 1 below identifies the factors that are important to work-ability from the Fadyl literature review presented in terms of the ICF framework.

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<sup>1</sup> Gordon Waddell & Burton K "Is work good for your health and wellbeing" Pub - TSO 2006 - [www.tsoshop.co.uk](http://www.tsoshop.co.uk).

<sup>2</sup> Fadyl, J. K., McPherson, K. M., Schlüter, P. J., & Turner-Stokes, L. (2010). Factors contributing to work-ability for injured workers: Literature review and comparison with available measures. *Disability and Rehabilitation*, 32, 1173-1183.

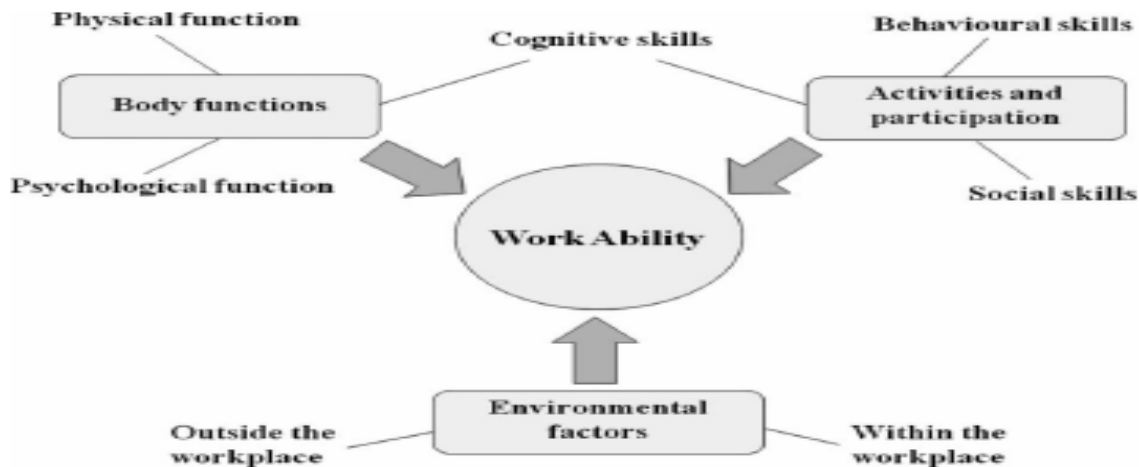


Figure 1. Factors contributing to work-ability.

Fadyl described Work-ability as the match between the physical, mental, social, environmental and organisational demands of a person's work and his or her capacity to meet those demands and that all the factors needs to be considered in order to maximise the likelihood of a sustainable return to work.

It therefore follows that there are a number of factors that an assessor needs to consider when undertaking an Initial Medical Assessment (IMA). These factors can be broadly considered as "biopsychosocial" and pertain to both work and non-work environments.

These factors must be sufficiently evaluated so that any barriers can be identified and targeted for personalised intervention as per your treatment and rehabilitation recommendations for the client. Such barriers must be managed in order to maximise the potential of a client to return to work or the state of optimal Work-Ability. Where more subjective conditions such as pain, mood disorder and fatigue are noted, these need to be explored and noted and appropriate management strategies recommended.

When undertaking a Vocational Independence Medical Assessment (VIMA) the factors also need to be explored. The assessor must ask probing questions, and note relevant report outcomes, in order to determine whether or not the client's barriers have been adequately identified, assessed and managed. Clients must have been given fair and reasonable opportunities to participate in recommended treatment and or rehabilitation. Reasons for any non-participation must be noted and evaluated. Conclusions must be drawn on the completeness of treatment and or rehabilitation. Finally, Work-Ability must be considered as a broad concept as per Fadyl, in order to support valid and sustainable opinions on vocational independence. Other examples of this type of model include the *Readiness for RTW Model*<sup>3</sup> which incorporates the *State of Change Model*, the *Institute of Medicine Model*<sup>4</sup>, and the *Dynamic Work Disability Model*.<sup>5</sup>

<sup>3</sup> Franche RL, Krause N. Readiness for return to work following injury or illness: conceptualizing the interpersonal impact of health care, workplace and insurance factors. *J Occup Rehabil* 2002; 12 (4): 233-56

<sup>4</sup> Edward N. Brandt, Jr., and Andrew M. Pope, Editors; Committee on Assessing Rehabilitation Science and Engineering, Institute of Medicine Enabling America: Assessing the Role of Rehabilitation Science and Engineering ISBN: 978-0-309-06374-6, 424 pages, 6 x 9, hardback (1997)

<sup>5</sup> Institute of Medicine of the National Academies The Dynamics of Disability: Measuring and Monitoring Disability for Social Security Programs Released: July 2, 2002 Consensus Report

## 10 Rehabilitation and the IMA

The initial medical assessment (IMA) is usually requested when the client has little chance of returning to his or her pre injury job (tasks and hours). In many cases, treatment for the injury will have been largely completed but the client's function will still be below optimal and many rehabilitation options may still be indicated. The IMA offers an opportunity to guide the client and case manager on reasonable and practical measures to improve the client's function.

The goal of rehabilitation is an improved functional status. This includes physical & cognitive function, emotional and behavioural function, self care, social and vocational participation and sleep. Rehabilitation takes a holistic view of the client and recognises that the client's personal goals and the degree to which they have accepted the changes wrought by their injury are the starting point for building improved function and maximal independence.

The client, in receiving weekly compensation, is in fact also committing themselves to a journey of vocational rehabilitation<sup>6</sup> but for many clients this goal can seem a long way off.

### **What is important to the client?      Describing a pathway forward**

At the midpoint of the IMA, you will have identified the current diagnosis and limitations and restrictions for work based activity. It is helpful to reflect this back to the client and ask what level of function they envisage themselves attaining with support. While this should not limit rehabilitation provided, it does give very important clues to injury and disability belief and hence the degree of input likely to be required. Useful ways to ask this include:

- *"My advice to ACC is going to be that at this stage you are really only fit for activities where you can sit and stand as you need to but don't need to walk much : does that sound right? Can I ask you, then, when you think about your function in 6 months time, what would you like to be able to do? How do you see yourself functioning then?"*
- *"We've talked about safe level of activity for you currently. When you think about managing with your injury from now on, where would you like to get to in 6 months? What would you like to be able to do in a given day?"*

### **You don't have to be an expert at everything but you do have to know about the usual rehabilitation for common conditions**

- You will need to keep up to date with modalities for treatment and rehabilitation of common conditions
- Interventions and recommendations should be the "normal" and "accepted" evidence based management of the condition.
- An awareness of ACC rehabilitation services and programmes will help you present your recommendations but you do not need to specifically name programmes or services

### **Stepped rehabilitation to match psychosocial risk factors**

Rehabilitation will often require multiple modalities: self managed change, medication, physical therapies for stamina and muscle balancing, coaching & CBT/mindfulness training, vocational exposure and work

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<sup>6</sup> See AC Act Section 72 Responsibilities of claimant who receives entitlement

task build up, psychological interventions (e.g. TBI/anxiety).

Rehabilitation will also require a stepped approach to build confidence and overcome doubt in tandem with other therapies. The specific modalities and the way they are combined should be dictated by the biopsychosocial presentation.

You do need to be familiar with the important contribution to disability of factors other than the physical injury i.e. the full range of psychosocial and behavioural flags. Your history will have identified many of these. A good rule of thumb is wherever there is distress, sleep disturbance, intrusive pain or fixed disability belief; behavioural or psychological approaches are going to be pivotal to a good rehabilitation outcome. Distress can manifest in a range of behaviours including anger. Often a psychological approach will be necessary to get underneath the behaviour and identify the cause of the distress.

You need to have a good working knowledge of:

- how CBT /mindfulness and motivational approaches work and which type of client can benefit
- when formal psychological and/or psychiatric interventions are required
- Common effective approaches to improve self care, social and vocational function and how these are implemented
- physical therapy approaches and how they can combine with other modalities
- where multiple professionals are recommended, the role of coordinating or case conferencing
- specific strategies to apply where the client has identified relationship difficulties with ACC and/or participation in rehabilitation.

### Medication

You may recommend medication approaches or reviews by appropriately qualified clinicians. You should not be prescribing these medications yourself. Where medications may cause drowsiness, you will need to discuss the benefit/risk of such regimens and recommend appropriate titration and review.

### Sleep

Disturbance of sleep will aggravate pain, mood disturbance and cognitive problems. Medications aimed at treating pain or depression will often further disrupt the sleep architecture. You need to be familiar with methods of sleep restoration and be able to recommend an approach to this problem.

### Non injury conditions requiring assessment, treatment or rehabilitation

There may be areas where the injury-related and non-injury related needs are so inter-related it is difficult to distinguish them when recommending appropriate assessments, treatment and rehabilitation.

However, where there are clearly identified non-injury needs, it is helpful to note them separately when making both recommendations and denoting responsibilities for the followup of the provision of this treatment

For example, you are aware that the client is on medication for his blood pressure but when undertaking the examination also note that his BP is raised and you discuss this with the client and advise him to consult his GP and also note this discussion and recommendations in your report.



## 11. Pain, pain disorders and workability

Research from the International Study of Pain (IASP) describes international prevalence of significant pain in keeping with that found in Australia and New Zealand: one in five in the general population experience intrusive or disabling pain.<sup>7</sup> So amongst ACC clients who may have persisting injury effects, pain could be expected to be an aspect of the injury they have to deal with daily, often years after the original accident event.

Yet despite experiencing pain, most people manage a range of activities and with optimal management, will also manage participation in the workplace. Many clients coming to the assessment will have a lot of anxiety about how they would cope with the more formal structure of the workplace. This anxiety can aggravate the experience of the symptoms and has been shown to affect self report of symptoms during assessment. Therefore your diligent assessment of workability in the context of pain as a discrete symptom, will reassure ACC and the client that your conclusions are robust and reliable.

Pain is important in the clinical assessment of fitness for work in several important ways.

1. The diagnosis may require clarification : pain may not have been well characterised
2. Pain management may not yet be optimised
3. Moderate - Severe pain limits an individual's tolerance of tasks
4. The impact of pain on concentration and mobility can make some work tasks more risky

### **Elicit the client's report of pain as a bio psychosocial phenomenon: incorporate evidence from examination and investigations to characterise pain.**

The way in which the client describes their experiences of pain is an important clue to the factors modifying the pain. The experience of pain is the end point of a complex neural interchange. Neural tissue is immensely plastic and responsive to a range of modifying factors including the influence of thoughts and emotions. Central and spinal cord changes dramatically affect the experience. This helps explain the limited effect of a purely nociceptive approach to pain management and the demonstrable aggravation of pain related disability with well studied psychological responses such as 'grief', 'fear avoidance' and 'catastrophising'.

As a medical assessor, you need an excellent understanding of pain modulation. This will help you characterise the client's pain recommend rehabilitation, restrictions, and limitations and ultimately work fitness. We recommend you familiarise yourself with the standard literature.

Considering pain as a phenomenon of neurological disturbance has helped us group pain experiences into "types". The International Association for the Study of Pain (IASP) has further developed criteria for pain conditions and this does help with applying medications, therapies and prognosis.<sup>8</sup> The Neuro Orthopaedic Institute (NOI) is another site which has on line resources and offers courses on pain management.<sup>9</sup>

Research from the International Association for the Study of Pain (IASP) describes international

### **Key points for Initial Medical Assessment (IMA)**

- Take a good pain history which includes a biopsychosocial approach
- Specifically identify the client's personal psychological/behavioural response to pain
- Describe the character of the pain and where possible the diagnosis
- For the IMA - Identify any important & necessary investigations or treatments

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<sup>7</sup> [World Health Organization supports global effort to relieve chronic pain Geneva 11 October 2004](#)

<sup>8</sup> [http://www.iasp-pain.org/IASP\\_taxonomy](http://www.iasp-pain.org/IASP_taxonomy)

<sup>9</sup> <http://www.noigroup.com/en/Home>

### Has pain been well managed?

Just as the characterisation of pain benefits from a holistic approach, so the management of pain requires attention to multiple modalities.

Modern pain management encompasses the following approaches:

- Calming the emotional reactivity & fear response to pain - mindfulness/ relaxation/Cognitive Behavioural Therapy (CBT)
- Sleep habit recovery
- Treating the nociceptive aggravation –
  - specific injection
  - regular pain medication
  - guarded use of opiates
- targeted approaches for neuropathic pain & complex regional pain syndrome (CRPS) - tricyclic antidepressants (TCAs) , neuroleptics, serotonin and norepinephrine reuptake inhibitors (SNRIs)
- increasing physical activity/balance.
- normalising, maintaining and enhancing social /participation activity

Because most people naturally respond to severe pain with freezing and retreating, it can take considerable coaching to get multimodal support accepted and in train. Risk factors for poor outcome of pain disorders include poor social supports, poor personal thought habits /emotional habits and low resilience. If pain has come to dominate the injury recovery, we can expect some negative emotional reactions, loss of fitness and subtle changes in mood to emerge and therapies need to be well coordinated and perseverant. However return to work participation is part of the multimodal approach although often accommodation or adaptation and lots of support are required.

As you take a history of pain experience and pain management, consider whether these aspects above have been addressed. If pain management has not been successful, consider the reasons and what this means for current fitness for work. At VIMA, a client with pain will usually have participated in a range of pain management, yet pain management may still need ongoing regular review in much the same way as Chronic Obstructive Pulmonary Disease or Rheumatoid Arthritis. Consider whether the client has had opportunities to use helpful modalities and how they have responded. Discuss the role of future pain management updates or medication reviews.

### Key points for IMA/VIMA

- Identify what modalities have been used for pain management
- For IMA, recommend appropriate modalities for further management
- For VIMA, comment on the client's response to and your assessment of the efficacy and appropriateness of the pain management.
- Keep up to date with multimodal approaches to pain management

### What limitations apply because of pain: what effect does pain have on the client's concentration, coordination stamina and tolerance?

Pain and pain medication can affect clients' concentration, memory, stamina, coordination and confidence to engage. Fear of further harm, aggravation of pain and common psychological responses to pain such as catastrophising may lead to self imposed limitations to activity and shortening of tolerance. Some of these consequences increase short term with a change in daily routine but resolve with adaptation to a new environment. In general structured daily routines are helpful for pain management and pacing.

In both the IMA and VIMA assessment, it is important to analyse the current effect of pain on the client's physical, social, cognitive activities. Your analysis will take into account the client's self report of limitations, current activity levels, evidence from work trials, physical activity programmes and medication but also your understanding of potential for specific activities to cause harm to this client, the likelihood of positive adaptation to a work environment and positive effects of routine, activity and socialisation of the work environment.

### Key Points

- Show your analysis
- Are any restrictions or limitations required because of the client's pain?
- How would you expect the client to adapt to the working environment?
- What information supports your conclusions?

### Are any work tasks likely to be more dangerous to the worker /other workers or public because of the client's pain?

Pain can cause the loss of coordination, concentration and cognitive sharpness. Lack of adequate sleep, sedating medications can aggravate these functional deficits. After your interview and examination, consider any discrete restrictions from a safety point of view. Neuropsychological testing may be required in rare cases where safety critical roles are identified and you consider function to be impaired.

### Key points

- What limitations or restrictions apply to ensure safety?
- What information supports this determination?
- Show your analysis

## 12. Fatigue and fatigability

We will all fatigue with effort but after an injury or illness, clients may be worried about how they will manage to resume participation when fatigue is part of their everyday experience. During the IMA and VIMA assessment, your attention to their fatigue will reassure ACC and the client that the conclusions of the report are reliable and robust.

Fatigue is an important symptom of many medical, surgical and psychological conditions. Fatigue is also commonly reported at an intrusive level in the absence of defined disease or illness and is frequently linked to emotional strain in the context of personal or environmental stress. Fatigue is a common presenting complaint to GPs where initial steps are taken to characterise the symptom and whittle down a differential diagnosis.

Once medical or surgical conditions are identified and medical management is optimized, most people manage fatigue well with simple strategies and planning however some clients will need support to reach this equilibrium. Work participation is not usually precluded.

Fatigue is important in the clinical assessment of fitness for work in several important ways.

1. The diagnosis may require clarification
2. Fatigue management may not yet be optimized
3. Fatigue limits an individual's tolerance of tasks
4. Fatigue can make some work tasks more risky

### Clients' report of fatigue

It is important to clarify what a client is talking about when you discuss fatigue. Is it sleepiness? Is it a feeling of languor or exhaustion? Is it shortness of breath; panicky feelings, palpitations, trouble thinking or remembering or weakness in the legs or arms? Is it provoked by exercise or pain or does it happen regardless? Is it something that has variation during the day or is it constant? Is it better after a good sleep or just the same no matter what? How is it affected by emotional strain (such as coming for the assessment or going to a work trial?)

### Key points

- Take a really good history: Fatigue means different things to different people
- Find out what makes it better and worse

### Clarify the cause of fatigue

In your assessment, where you gain a history of fatigue, ensure the history and review of medical notes explores the character of the fatigue and the contributing factors. In the context of injury related disability, clinicians will yet need to keep an open mind as to the cause of fatigue while simultaneously assessing the effect of the symptom on sustainability of work.

### Key points for IMA/VIMA

- Identify any important & necessary investigations
- Describe the character of the fatigue and likely diagnosis
- Give some context to the stability of fatigue symptoms

<b>Causes of Fatigue</b>	
<b>Medical /surgical</b>	E.g. rheumatological ; cancer; liver and renal conditions; thyroid disorders; respiratory disease; cardiovascular disease ; blood disorders ; diabetes & other endocrine disorders ; neurological disorders; neurological injury ; GI disorders via malabsorption or anorexia.

<b>Sleep disorders</b>	primary sleep disorder
	secondary sleep disorder 1. mechanical :obstructive sleep apnoea (OSA) 2. other : alcohol; caffeine; eating habits; medications; exercise habits ; obesity; pain, young wakeful children.
<b>Psychological</b>	Anxiety; grief; worry; depression
<b>Medications</b>	Pain medication; some blood pressure and antidepressant medication
<b>Fatigue states without progressive disease</b>	Sensitivity to fatigue: chronic fatigue syndrome; post viral fatigue syndrome
<b>Temporary fatigue states due to physiological change</b>	Pregnancy; lactation; post extreme exercise; post surgical/post anaesthetic intervention; post emotionally charged event

**Has fatigue been well managed?**

IMA and VIMA assessors will need to be familiar with the management of conditions manifesting with fatigue and be able to comment on the potential for further improvement and self management. To do this the history will need to encompass self management and habits.

**Key points**

- Comment on whether treatment of causal factors and management of fatigue have been implemented and with what success.
- Comment on the role of medications in fatigue and whether this is optimized.
- For the IMA describe appropriate rehabilitation/ treatment/therapies to manage fatigue including self management.

<b>Type of fatigue</b>	<b>Improved by</b>	<b>Aggravated by</b>
<b>Fatigue due to brain injury</b>	Maintaining good regular exercise; avoid having to attend to different sensory inputs at the same time ; avoid noise/complex visual input; plan cognitive tasks for morning ; “power naps”; structured and “contained” social interaction;	Multiple simultaneous stimuli; noise; complex visual input; concentrating on social interaction; tasks involving cognitive as well as verbal and social cue processing; untreated mood disorder; some medication
<b>Fatigue due to sleep disorders</b>	Going to sleep at the same time each night; exposure to natural light early in am; avoid alcohol & caffeine; light, cooked meal only in evening; exercise regularly before 5pm; use body relaxation through day or just at night; address OSA; no power naps ; “wind down ritual” starting 90 mins before regular bed time.	Shift work, night work, erratic hours of activity and sleep; consumption of heavy meal, alcohol within 4 hours of bed time; caffeine at any time in the day; day time dozing; some medication; anxiety /worry; use of TV/screens in late evening.
<b>Fatigue accompanying mood disorder</b>	Sleep hygiene as above; exercise as therapy ( three times a day light –mod 30 mins); cognitive behavioural therapy (CBT); mindfulness; some medication;	Erratic sleep/activity cycles; lack of routine; some medications; low physical activity; low social engagement; alcohol and stimulants;

Type of fatigue	Improved by	Aggravated by
<b>Fatigue accompanying chronic disease</b>	Structured routines; planning energy expenditure throughout day; avoiding “borrowing tomorrow’s energy today” i.e. pacing; maximize disease management; positive behavioural thought patterns ; CBT; Mindfulness; regular appropriate exercise; relaxation; visualization	Boom/bust cycle; poorly managed disease process; untreated mood disorder; low social and physical activity; sleep disturbance ; negative thought behavioural patterns ( anger/ non-acceptance )
<b>Fatigue accompanying chronic pain</b>	Structured routines; planning energy expenditure throughout day; avoiding “borrowing tomorrow’s energy today” i.e. pacing; maximise medical pain management; positive behavioural thought patterns ; CBT/ Mindfulness/ACT etc ; exercise as therapy ( low-moderate - 30 mins 3 times a day)	Boom/bust cycle; poorly managed medication; untreated mood disorder; low social and physical activity; sleep disturbance ; negative thought behavioural patterns

**What effect does fatigue have on the client’s stamina and tolerance?**

If the client’s fatigue is optimally managed, the next consideration is what limitations should be placed on his/her activity to maximize the sustainability of participation. Here, evidence of daily activity, tolerance for travel, social activities and home responsibilities are useful benchmarks for current state.

Work tasks require attention, focus and perseverance at variable levels depending on the work. When considering whether the client has any limitations, take into account the sustainability over a working week. Working days should not completely exhaust clients. Generally speaking, the output on a working day should not exceed 70% of the total daily capacity for activity and effort. .

Performance of some specific cognitive activities may drop off over a day or over the week. Investigations such as neuropsychological assessment in clients with neurological injury may further demonstrate appropriate accommodations or limitations.

Clients with stable conditions may still be regarded as unsuitable for shift work, extended hours or evening work in order to minimize the disruption to the management of fatigue.

Clients who have not been in the working environment will experience heightened fatigability starting a new role but once familiar with the surroundings, the increase in daily activity and engagement with others may actually reduce troublesome symptoms of fatigue. When conducting your assessment take into account all the information and show how you have reached conclusions about sustainability.

**Key points**

- Are any restrictions or accommodations required because of the fatigue?
- How would you expect the client to adapt to the working environment?
- What information supports your conclusions?

**Are any work tasks likely to be more dangerous to the worker /other workers or public because of the client's fatigue?**

Fatigue is a risk factor for accident events and injury in the work place; so many safety critical work roles require screening for fatigue as part of the pre employment or interval medical. Doctors practicing in the field of Occupational Medicine are very familiar with assessing fitness for work in jobs requiring concentration, coordination and stamina. You will need to consider how this client's limitations measure up against certain work types with regard to the responsibilities and what would happen if they were to lose concentration or attention due to fatigue.

**Key points**

- What limitations or restrictions apply to ensure safety?
- What information supports this determination?

## 8. Depression, anxiety and workability

The prevalence of mood and anxiety disorders in the general population is such that we would expect, with the added strain of injury, pain and challenging lifestyle changes associated with an accident, that many clients coming to you for an IMA or VIMA assessment would have some symptoms of mood dis-regulation if not mood disorder.

The New Zealand Mental Health Survey,<sup>10</sup> undertaken between 2003 and 2004 was a nationally representative face-to-face household survey of nearly 13,000 New Zealanders (aged 16 years and over) revealed that mental disorders are common in New Zealand, with 40% of respondents reporting that they had experienced a disorder at some time in their lives.<sup>11</sup>

Usually, significant psychological disorders will have been identified and treatment commenced. More rarely clients may have not disclosed their psychological distress to any therapist or medical practitioner prior to the assessment and it is important that the assessment remains an opportunity for enquiry into mood and analysis of work implications of psychological symptoms and signs.

Although many people with psychological disorders present with physical complaints, the majority will divulge psychological problems if asked directly. A nonjudgmental manner and assurance of confidentiality increase the likelihood of disclosure.<sup>12</sup>

In general, as part of self management, participation and structure of the workplace are highly protective against episodic deterioration in mood. Importantly mood and anxiety disorders do not preclude work, and once treatment or therapy is instigated, work forms part of a therapeutic structure. However excessive work hours or work strain, unpredictability and hostile work relationships can be detrimental for vulnerable mental health consumers.

It is important that you, as an assessor of work fitness have a good understanding of factors affecting mood /anxiety and also can show methodical consideration of how the condition affects or does not affect fitness for work.

### **Take a good history, enquiring about signs and symptoms of mood and anxiety disorders; explore protective and aggravating factors.**

Always check for psychological symptoms as part of a general functional enquiry. If there is low mood, anxiety/worry, panic attacks, disturbed sleep, intrusive distressing thoughts, physical agitation symptoms, ensure the interview history adequately probes the symptoms and functional problems. As an assessor, you need to be familiar with common psychiatric presentations, the significance of symptoms and likely prognosis.

### **Has the condition been well managed?**

Often therapy and/or medication will have been started. You will need to comment on the efficacy

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<sup>10</sup> Oakley Browne MA, Wells JE, Scott KM. (eds). Te Rau Hinengaro: The New Zealand Mental Health Survey. Wellington: Ministry of Health; 2006

<sup>11</sup> NZ Guidelines Group –Evidence-based guidelines - Identification of common mental disorders and management of depression in primary care. Pub -1 July 2008. P 4\

<sup>12</sup> NZ Guidelines Group –Evidence-based guidelines - Identification of common mental disorders and management of depression in primary care. Pub -1 July 2008 P 17.



and appropriateness of treatment. This means you do need to have a good knowledge of common treatment regimens. For further information on management of depression in adults see the New Zealand Guidelines Group publication - Identification of Common Mental Disorders and Management of Depression in Primary Care Chapter 6.

The IMA asks for recommendations for further rehabilitation. Sometimes the mood disorder/anxiety disorder will be a covered condition and treatment managed under the claim. Other times the GP will be managing therapy and medication. Your recommendations will support the integration of treatment with other strands of rehabilitation and approach to vocational rehabilitation.

In the VIMA you are asked whether treatment for the covered conditions has been addressed. If there is outstanding treatment required for a mood or anxiety disorder, comment on how this affects the ability to assess fitness for work.

**What limitations apply because of psychological disorder: what effect does the condition and associated medication have on the client's concentration, coordination stamina and tolerance?**

The purpose of both IMA and VIMA assessments is centred around fitness for work. The report must show a logical progression from symptoms, signs, corroborative medical material through to diagnosis, analysis of restrictions and then recommendations. Mood and anxiety disorders may affect memory, concentration, and a range of cognitive functions, social interaction and capacity for self management. Whilst therapeutic interventions usually result in improved function, the question at the time of assessment is what restrictions exist on that day due to the condition(s). Sometimes, neuropsychological testing may be appropriate and if recorded may give an insight into the cognitive impairment.

Where significant psychological dysfunction is evident, it is necessary to spell out the very specific restrictions which apply. This may range from excluding shift work to reducing exposure to high stress customer-facing roles.

**Are any work tasks likely to be more dangerous to the worker /other workers or public because of the client's pain?**

Safety critical roles involve mood and anxiety screening precisely because these disorders reduce efficacy in decision making, cognitive functions and response. Where these symptoms are identified and the client's role will be affected, it is important to comment on any restrictions which apply.