LEGAL AID NSW

Comments on the review of Impairment Tables for
Disability Support Pension

Submission on behalf of

Legal Aid NSW

to the

DEPARTMENT OF FAMILIES, HOUSING, COMMUNITY SERVICES
& INDIGENOUS AFFAIRS

14 October 2010

1. The Legal Aid Commission of New South Wales (Legal Aid NSW) is an independent statutory body established under the Legal Aid Commission Act 1979 (NSW) to provide legal assistance, with a particular focus on the needs of people who are economically or socially disadvantaged. Legal Aid NSW provides information, community legal education, advice, minor assistance and representation, through a large in-house legal practice and through grants of aid to private practitioners. Legal Aid NSW also funds a number of services provided by non-government organisations, including 35 community legal centres and 28 Women's Domestic Violence Court Advocacy Services.

2. In general, recipients and claimants for the Disability Support Pension (DSP) are a disadvantaged group by virtue of their physical, psychiatric or intellectual impairment. These disadvantages are usually compounded by economic, educational, skill and language difficulties, as well as cultural differences and remote location.

3. Legal Aid NSW’s lawyers provide advice, minor assistance and representation to people who are adversely affected by Centrelink decisions. Services are provided through appointments at Legal Aid offices with civil law solicitors, as well as through the duty advice scheme at the Administrative Appeals Tribunal (AAT).
4. In the context of this submission, Legal Aid NSW lawyers act for clients whose claims for Disability Support Pension (DSP) have been refused or whose pension has been cancelled, at all levels of the review process and before the Federal Court.

5. Legal Aid NSW represents many people before the AAT, and the comments provided in this submission draw substantially on the practical experience of the Commission’s lawyers in advocating on behalf of clients with DSP cases in the AAT.

6. This submission will not address all the terms of reference, as some of them require medical expertise and knowledge.

Overview

7. It is the view of Legal Aid NSW that whatever changes to the Impairment Tables the current review recommends, considerable attention also needs to given to the implementation of those changes. It is our experience that there are currently significant problems in the assessment of entitlement to DSP which arises not out of the legislation, but rather from the assessment process which is undertaken.

8. Some of those difficulties were detailed in the submission of Legal Aid NSW to the review of Job Capacity Assessments (JC Assessments) undertaken by Minister for Human Services in 2008 (Legal Aid NSW submission dated 28 February 2008). Many of the concerns raised in that submission were systemic issues that, in our experience, have not been adequately addressed, or addressed at all, in the ensuing period. (NOTE: A link to a copy of the Legal Aid NSW submission on JC Assessments can be found on the GovDex site for the current review, posted by Linda Forbes on 8 September 2010).

9. The relevance of those submissions to the current review arises from a concern that changes to the impairment tables that are not accompanied by changes to the system of assessing DSP entitlement will fail to make the system fairer and more efficient.

10. Our comments and observations regarding the issues raised by the Terms of Reference are set out in detail below. In summary:

(i) Wherever possible, Centrelink should consider adjusting its allocation processes to align a customer’s primary medical condition with the JCA assessor’s area of specialisation. (adoption of Recommendation 2, Implementation of job capacity assessments for the purposes of Welfare to Work initiatives, June 2008)

(ii) The definition of “permanent” in the Introduction to the Impairment Tables should be more succinctly stated so that the various elements of the definition are able to readily identified and understood.

(iii) Assessments of impairment should properly consider all elements of the definition of “permanent”. The experience of Legal Aid NSW shows that the following parts of the definition are often overlooked or misinterpreted by JCAs in practice are:

i. Whether any treatment suggested for the condition would lead to a significant functional improvement within the next 2 years.
ii. Whether any treatment which is suggested is “feasible and accessible”

iii. The significance of other treatments which have not been tried.

(iv) The Department’s guidelines *A Guide to the Tables for the Assessment of work-related impairment for Disability Support Pension* should be amended to omit the terms “optimal” or “optimally treated” as these do not reflect the words of the legislation and binding case law on the subject.

(v) JCAs should not assess the permanence of a condition on the basis of whether it has been “optimally treated”.

(vi) Any amendment to the definition of “permanent” should not replace the current definition with a requirement that a condition be “optimally treated”.

(vii) The process of assessment of an impairment rating for intermittent psychiatric conditions should not be different to any other intermittent condition.

(viii) The current tables already impose a rigorous level at which points can be assessed for conditions. The amended tables should not impose more onerous criteria in order for a claimant to achieve impairment points.

(ix) A better and clearly construed *Medical report - Disability Support Pension* form should be designed which seeks evidence from the claimant’s treating doctors about matters that are directly relevant to the DSP qualification criteria, including impairment ratings and other clinical information that is specifically referred to in the Impairment Tables and Introduction to the Tables.

**Issues not directly raised by the Terms of Reference**

- **Lack of relevant experience of JCAs**

11. A serious flaw in the assessment process is the lack of relevant experience or qualifications held by a Job Capacity Assessor (JCA) who is assessing the medical condition with which a claimant presents.

12. In most cases, the health professional who undertakes the JC Assessment is not medically qualified. Most commonly, when JCAs identify their qualifications, they tend to be allied health professionals such as psychologists, social workers, registered nurses and physiotherapists.

13. As a result, the JCA is frequently asked to make findings outside their professional expertise. It is difficult to see how, for example, an “accredited exercise physiologist” is qualified to properly assess a psychiatric condition (example taken from a Legal Aid case before the AAT), or how a social worker can assess the level of impairment for a back or
14. Although it has been said that the JCA will use evidence from other sources, such as the claimant’s treating doctor’s report(s), it will be submitted below that these reports are of limited value because of inadequacies in the form the doctor is asked to complete (see comments in relation to Term of reference 6). In our view, the combined effects of a lack of relevant experience of the JCA and the inadequate information sought from treating doctors leads to problems for the proper assessment of a DSP claim.

15. This issue was also raised in the Legal Aid NSW submission on JC Assessments, and has been referred to in the following Commonwealth Ombudsman reports:


16. We support the Ombudsman’s recommendation that:

   Wherever possible, DHS should consider adjusting its allocation processes to align a customer’s primary medical condition with the JCA assessor’s area of specialisation.

   (Recommendation 2, Implementation of job capacity assessments for the purposes of Welfare to Work initiatives, June 2008)

17. Finally, it is noted that this recommendation was cited with apparent approval by the AAT in Re Anderson and Secretary, Department of Families, Housing, Community Services and Indigenous Affairs [2009] AATA 306 (7 April 2009), Member Shanahan

**Term of Reference 3 - reassess the appropriateness of definitions contained in the Introduction to the DSP Impairment Tables, with particular regard to the assessment of people with intermittent psychiatric conditions**

18. The definition in the Introduction to the Impairment Tables which receives most attention and is the subject of many AAT cases is the definition of “permanent”. Under the tables, a medical condition can only be given an impairment rating if it is found to be “permanent”. The definition of this term is contained in paragraphs 4-6 of the Introduction to the Impairment Tables.

19. It is the experience of Legal Aid NSW that the assessment of whether a condition is permanent causes great difficulties due to a number of factors. These include:

   (i) **A lack of clarity in the way the definition is set out in the Introduction.**

   It is our view that the definition should be more succinctly stated. The various elements of the definition should be readily identifiable and understood by a JCA or any treating doctor or other health professional who is asked to provide information about the claimant’s medical condition.
(ii) \textit{Lack of focus on all aspects of the definition}

It is our experience that due, at least in part, to this lack of a clearly stated definition, certain elements of the definition are often overlooked or are not properly considered. The areas of concern which arise frequently in practice are:

- Whether any treatment suggested for the condition would lead to a significant functional improvement within the next 2 years.

- Whether any treatment which is suggested is “feasible and accessible”.

\textit{Significant functional improvement}

20. We often find that JCAs in particular might suggest a treatment for a particular condition with little or no consideration given to whether that treatment would actually lead to a significant functional improvement within the next 2 years, as required by paras 5 and 6 of the Introduction to the Tables.

21. A Legal Aid case example is given below where this issue was squarely raised:

\begin{center}
\begin{tabular}{|p{0.9\textwidth}|}
\hline
\textbf{CASE STUDY} (see Appendix A for copies of treating doctor report and JC Assessment) \\
\\
Mr M claimed DSP in November 2009. In the \textit{Medical report - Disability Support Pension}, Mr M’s treating doctor stated that he had been diagnosed with rectal cancer in August 2008. He previously had surgery, radiotherapy and chemotherapy, and at the date of claim suffered from faecal incontinence and had a colostomy bag. There was further surgery planned in late November 2009 to close a temporary stoma. In response to Question 1 and 2, the doctor ticked boxes that indicated Mr M’s condition would affect his ability to function for the next 3-24 months and that his condition would “somewhat improve”. [Mr M also suffered from other conditions]
\\
On the basis of this report, a JCA (a rehabilitation counsellor) found that Mr M’s cancer was “temporary”. Although the JCA seems to have recognised the seriousness of the condition, she did not contact the treating doctor for further information. It appears from the JC Assessment that no proper assessment was made on whether the operation (or indeed other treatment) would lead to any significant functional improvement. The claim for DSP was refused.
\\
The case reached the AAT before a further report was obtained from the treating doctor. It showed that the “improvement” mentioned in his earlier report was the fact Mr M would not need a colostomy bag after closure of the stoma, but that after the operation he would continue to suffer from faecal incontinence. It was apparent that the JCA did not fully appreciate the rationale or prognosis for this type of operation.
\\
The \textit{Medical report - Disability Support Pension} did not make it clear to the treating doctor how his answers would be interpreted by the JCA. For example, the term “somewhat improve” is unclear.
\\
\end{tabular}
\end{center}

\textit{Treatment that is feasible and accessible}

22. It is our experience that often, little or no consideration is given to this part of the definition. An assessment will rarely consider whether a suggested treatment for a condition is available through the public health care system which fits the particular profile of the claimant, or whether claimants in regional parts of Australia with limited
access to services are able to access the suggested treatments. (It is noted that claimants rarely have the financial capacity to pay for ongoing privately funded treatment).

23. For example, cognitive behavioural treatment is often suggested by JCAs for psychiatric conditions, but rarely is any consideration given to whether that treatment is accessible to the claimant because of an inability to speak English and the fact that the person would require a trained clinical psychologist who speaks their language.

24. An example of how this aspect of the Introduction to the Impairment Tables failed to be considered until the AAT heard the case is found in the decision of Senior Member Toohey in Walker and Secretary, Department of Families, Housing, Community Services and Indigenous Affairs [2010] AATA 191 (22 March 2010), where after reviewing the evidence the Tribunal found:

27. Whether it is reasonable for Ms Walker to undergo further phototherapy has to be considered in context. Accessibility, including distance and how able a person is to travel, is relevant, as is cost.

28. I accept Ms Walker’s evidence that it would take her up to three hours to make each return trip to Georgetown for phototherapy. She would have to make the return trip three times a week, although less frequently after six to eight weeks. The weekly cost would be considerable. In the first six to eight weeks treatment would cost approximately $40 each week, allowing for the Medicare rebate. Transport to appointments, whether by public transport or private vehicle, would add to the cost. I am satisfied that, in Mrs Walker’s circumstances, cost affects the accessibility of treatment and makes it unreasonable to require her to continue to undergo treatment.

- **Significance of other possible treatments – “optimal” treatment**

25. Another area of difficulty we observe in many cases is that despite the fact a claimant may have received treatment for a condition, sometimes over a long period, a JCA will suggest that the condition is not permanent because a different type of treatment has not been tried. The treatment may not have been suggested by the claimant’s treating doctor.

26. This approach has been firmly rejected by the Federal Court – see decision of Harris v Secretary, Department of Employment and Workplace Relations (2007) 158 FCR 252, where Gyles J stated:

17. It is troubling that an applicant presenting with a long standing diagnosed condition being treated in a conventional fashion should be rejected for a benefit, not because of any identified defect in diagnosis or treatment but, rather, upon the basis that further examination by another medical practitioner or other practitioners might suggest some other diagnosis or some other treatment.

27. It is suggested this problem in assessment arises, at least in part, because some JCAs take the view that a condition must be “optimally treated” in order to be permanent. The term “optimally treated” is not used in the legislation, and is the wrong test to apply to assess whether a condition is permanent (see comments by Senior Member Toohey in Walker’s case, referred to above, at para 31).

28. Unfortunately the word “optimal” or term “optimally treated” is used extensively in the Department’s guidelines, A Guide to the Tables for the Assessment of work-related impairment for Disability Support Pension. It is submitted that the Department’s guidelines should be amended to reflect the words of the legislation and binding case law on the subject to avoid the use of tests that are clearly wrong.
29. Any amendment to the definition of “permanent” should not replace the current definition with a requirement that a condition be “optimally treated”. This would impose an uncertain and unnecessarily onerous burden on a pensioner or claimant for DSP.

**Intermittent psychiatric illnesses**

30. It is not understood why the situation of people with intermittent psychiatric illnesses has been singled out for particular attention in this Term of Reference.

31. The current Impairment Tables are designed to take into account conditions which are ongoing but whose symptoms may wax and wane intermittently. It is the underlying condition which must be assessed. Impairment Table 21 demonstrates this approach. Paragraph 8 of the Introduction to the Tables refers to a consideration of the underlying condition in relation to assessing the impact of pain.

32. It is suggested that the tables adequately cater for the assessment of intermittent psychiatric conditions. The approach of Deputy President Hanley in *Re Secretary, Department of Family and Community Services and Mearns, [2003] AATA 274* (24 March 2003) forms a sensible basis on which to assess any intermittent condition, including a psychiatric condition.

33. In that case the person’s DSP had been cancelled because a review found that his Meniere’s disease had improved. The pensioner’s evidence was that his symptoms had improved because he took steps to minimise stress and tiredness in his life to avoid exacerbations of the symptoms. The Departmental advocate submitted to the AAT that if his condition deteriorated (as it had because of the stress of the appeal), he could lodge a new claim.

34. After considering all the evidence the Tribunal found:

> 30. In the Tribunal's opinion, it is the underlying condition which is to be assessed under the Impairment Tables. Mr Mearns' Meniere's Disease is an incurable condition that has remained unchanged in its effect since he contracted the condition in 1994. The Tribunal finds ..................... that stress and tiredness exacerbate Mr Mearns' symptoms and, in particular, increase the frequency of the Meniere's Disease attacks. Mr Mearns manages the condition by arranging his life to, as far as possible, avoid stress and tiredness.

35. This approach is in fact supported by current Departmental guidelines and should be maintained. Chapter 7 of *A Guide to the Tables for the Assessment of work-related impairment for Disability Support Pension* relates to the use of Table 6 for psychiatrist impairments. The guide states:

> Some established psychiatric conditions such as Bipolar Affective Disorder (“Manic Depression”) may be highly variable in their clinical presentation with a fluctuating course. They may still be considered stable and rated accordingly if they are being optimally managed and their current overall impact on work ability is unlikely to improve significantly within the next two years. In determining the work-related impairment for such fluctuating conditions, one should consider their impact on the person's ability to reliably sustain full-time work over two years without significant absences.

36. [NOTE: see the comments above in relation to the inappropriate use of the term “optimally”. The guidelines should be amended to avoid the use of the word in relation to treatment].
37. It is preferable for conditions to be treated under the Impairment Tables in a consistent fashion. There is, in our submission, nothing that would justify the different treatment of an intermittent psychiatric condition to any other intermittent condition.

**Terms of Reference 4 and 5 - re-examine the descriptors in the DSP Impairment Tables to ensure that a score of 20 points aligns with an inability to work 15 or more hours per week in the open-labour market at or above award wages without the need for on-going support; and redesign the DSP Impairment Tables to focus more on ability**

38. The current system of assessing eligibility for DSP considers:

i. The level of the person’s functioning in light of their impairment, leading to an impairment rating; and

ii. An assessment of what the person can do in terms of their ability to work or be re-trained (their “continuing inability to work”).

39. The suggestion that the descriptors in the Tables could be amended to align “....with an inability to work 15 or more hours per week in the open-labour market....” would appear to conflate the 2 concepts. We believe it would make the assessment of impairment more complex by introducing a further criterion into the assessment, namely the hours of work which an assessed impairment would allow a person to do. This exercise is undertaken in any event by the assessment of “continuing inability to work” (as defined in s94(2) Social Security Act 1991).

40. As such, we are unclear about the objective of these terms of reference. We are concerned that the terms are an attempt to steer the re-designed impairment tables towards more onerous criteria in order for a claimant to achieve any impairment points.

41. It is our view that the current tables already impose a rigorous level at which points can be assessed for conditions. For example, it is submitted that the criteria to achieve 20 points for a psychiatric impairment under Table 6 are currently quite onerous.

42. The Impairment Tables are function based rather than diagnosis based (see para 2, Introduction to the Tables). Many of the Tables therefore already focus on what a claimant is able to do, that is, they assess the person’s ability. For example tables assess a person’s ability to use their dominant limb (Table 3), ability to walk, sit or kneel (Table 4), move their back or neck (Tables 5.1 & 5.2), comprehend certain things (Table 8), hear (Table 12) and see (Table 13).

43. While we support the principle of highlighting the abilities of a person, we submit that this is better dealt with as part of any support programs that are made available to the person to try to get them back to work, whether or not they are found to qualify for a DSP.

**Term of Reference 6 - ensure that the DSP Impairment Tables can be used by both Allied Health Professionals and Medical Officers.**

44. Legal Aid NSW considers it vital that the Impairment Tables are properly used by any person who is charged with providing information in connection with a DSP claim in
order to strive for a fairer system of assessment. This aim should not be limited to JCAs. It should include all doctors and health professionals.

45. In our experience, there is a serious lack of knowledge of the Impairment Tables amongst doctors, especially treating doctors and treating specialists. In our view, this is one of the major reasons that claims for DSP claims are often inadequately assessed.

46. While targeted printed information about the use of the Impairment Tables may assist, one of the critical factors in this area is the inadequate design of the forms issued by Centrelink for the claimant to obtain medical information from her/his treating doctor (called Medical report - Disability Support Pension). The completed medical report forms part of the claim for a DSP.

47. It continues to be the experience of Legal Aid NSW that the treating doctor's report is of limited value, principally because it is often deficient in addressing the matters required to be addressed under the legislation. The detail asked for does not appear sufficient to carry out an impairment assessment in terms of what is required by Schedule 1B Social Security Act 1991.

48. Some of the areas in which the current form is problematic include:

(i) It does not request any clinical examination findings in relation to spinal or neck movements or indeed any clinical examination findings at all.

(ii) The form fails to direct the doctor’s attention to the Impairment Tables, and does not ask their opinion of an appropriate impairment rating.

(iii) The form focuses on the impact of a condition on a person’s ability to function, but does not ask the doctor his/her opinion about the impact of the condition on their patient’s ability to work, study or attend re-training.

(iv) Vague terms are used in the form which only serves to obscuring any clear assessment of a person’s condition. For example:

a. In Part A of Question 3, a doctor is asked if a diagnosis is “confirmed” or “presumptive”. No explanation of these terms is offered in the form. The difficulty with using such ill-defined terms is illustrated in the AAT decision of Re Roberts and Secretary, Department of Families, Housing, Community Services and Indigenous Affairs [2010] AATA 94 (10 February 2010), Senior Member Britton. The Tribunal found that:

21. Diagnosis Mr Clifford’s conclusion that a diagnosis of depression had not been made was apparently based on Dr Chandler’s characterisation of his diagnosis as “presumptive”. The meaning of this term is unclear. More to the point, it is unclear what meaning Dr Chandler intended to convey. It could be that he meant that his diagnosis had not been confirmed by specialist opinion, or alternatively, that he was unsure of the diagnosis. The latter sits at odds with his actions in prescribing anti-depressant medication over an extended period; recording symptoms consistent with a diagnosis of depression; and, providing an opinion that the impact of the condition on Ms Roberts’ ability to function was likely to remain unchanged for the ensuing 24 months. Coupled with his subsequent recorded diagnosis, it seems more likely that he meant that the diagnosis had not been confirmed by specialist opinion.
(b) The doctor is given a seven (7) options in Part J of Question 3, which relates to the effect of the condition in the next 2 years. While this may, on its face, appear to address the definition of “permanent”, the options given to the doctor and the way the responses are interpreted by a JCA are unhelpful. There is no guidance given to the doctor regarding what information the question is aimed at eliciting.

49. On this issue we refer to the detailed critique by the Commonwealth Ombudsman in the report *Assessment of claims for disability support pension from people with acute or terminal illness* – see especially paras 2.11 to 2.15. The Case Study cited at para 21 also demonstrates the problems in assessment caused by the use of vague terms.

50. We note that similar criticisms have been made of the form by the Commonwealth Ombudsman in the two reports referred to above. For example, the Ombudsman observed:

3.22 As mentioned earlier, the pro forma DSP medical report does not seem to facilitate the provision of complete and meaningful opinion from an appropriately qualified practitioner on a patient’s medical condition. The format of information collected in the DSP medical report seems to be inconsistent with the level of information that is required to accurately assess the appropriate impairment rating under the impairment tables. There also appears to be insufficient instruction or guidance for treating doctors to assist with completing the form. Based on the examination of the DSP medical report by the Ombudsman’s office, it was difficult at times to work out what kind of response a particular question sought. (*Implementation of job capacity assessments for the purposes of Welfare to Work initiatives, June 2008*)

51. Similar observations are made by the Ombudsman in the report *Assessment of claims for disability support pension from people with acute or terminal illness*. Even though that report focuses on claimants with terminal or acute illnesses, the critique of the treating doctor form at paras 2.7 – 2.19, the comments and recommendations of the Ombudsman apply, in our view, to all claims. The recommendations with which we agree include:

(i) Recommendation 1: The DSP medical report should be amended to include a guide to answering each of the questions, inducing how the various answers might be interpreted by a ACA assessor or Centrelink officer.

(ii) Recommendation 2: Question 1 and sections H, I and J of Question 3 of the DSP medical report should provide doctors with more information about the context in which their report will be applied........

52. Legal Aid NSW believes that a better and clearly construed *Medical report - Disability Support Pension* will go some way to ensuring that doctors and other health professionals are better able to understand and apply the Impairment Tables.

53. Information which is provided on the basis of an understanding of the requirements of legislation can only lead to better decision making and a fairer system.

54. We note in this context that there should be better training of JCAs to avoid some of the difficulties with assessment that arise repeatedly, some of which have been highlighted in this submission.
Conclusion

55. Legal Aid NSW welcomes the opportunity to provide these comments. Should you require further information, please contact Bill Gerogiannis at bill.gerogiannis@legalaid.nsw.gov.au or telephone (02) 9219 5903.
APPENDIX A

Referred to at paragraph 21 submission of Legal Aid NSW.

- Extract from *Medical report - Disability Support Pension (by treating doctor)*

- Job capacity assessment

The documents have had any identifying information deleted.
This report must be completed by the customer's treating doctor

Instructions for the customer

1. Complete your details above.
2. Make an appointment with the doctor or specialist. When you make your appointment, please let the receptionist know that you will need this report completed.
   The time taken to complete the medical report may be claimed by your doctor under a Medicare item when included as part of a consultation. If your doctor does not bulk bill, your consultation fee may be more than usual because of the extra time taken to complete the report.
3. Read and sign this Authority to release information.
   • I authorize Centrelink to obtain any relevant medical information necessary to decide my qualification for pension, allowance, eligibility for employment assistance or access to the Supported Wage System from my doctor(s), or other registered medical practitioner(s) whom I have consulted, or to whom I may be referred by Centrelink upon the recommendation of a Job Capacity Assessor; and
   • I give permission for any relevant medical details and clinical notes about me to be supplied to a Job Capacity Assessor; and
   • I give permission for my doctor(s) to exchange relevant information with Centrelink, and/or a Job Capacity Assessor about my medical condition(s) and any other relevant barriers impacting on my ability to participate in assistance programs in order for Centrelink to decide correct payments and suitable services and programs for myself and where relevant third parties; and
   • If I am required to have a further assessment in addition to the assessment by the Job Capacity Assessor, I authorize Centrelink or the Job Capacity Assessor to release this medical report and other relevant documents to the assessing practitioner or agency.

Customer’s details:

Name: [Redacted]
Address: 55 [Redacted] Street, [Redacted]
Date of birth: 10/11/19[Redacted]
Phone number: (02) 9[Redacted]

Instructions for the doctor

This report may be used to:
• decide which payment your patient may be medically eligible for
• decide if your patient could benefit from vocational rehabilitation or training
• decide if your patient is able to enter the Supported Wage System.

Payment for your report

We have asked your patient to let you know at the time of making their appointment that they require you to complete this report. This is to ensure that you have sufficient time for the examination.

The time taken to complete the medical report may be claimed under a Medicare item when included as part of a consultation.

Completing this report

In this report you will be asked to provide details of your patient’s medical condition(s). Please complete all the required questions in this report. If you have any questions about this report, call Centrelink on 13 2717.

Returning this report to us

You can give this report and any attachments to your patient or you can return this report directly to Centrelink.

For information about confidentiality and disclosure of information

See questions 11 and 14.

Thank you for your assistance

This report is to be given to the doctor to complete.

Customer’s signature

[Signature]

Date

10/11/09

Give this report to the doctor to complete.
1. Does the patient have a terminal condition with a prognosis of less than 24 months?
   - No [X] Go to next question
   - Yes [ ] Diagnosis

   Diagnosis
   
   Rectal cancer

   The diagnosis is...
   - Confirmed [X]
   - Presumptive [ ]

   Are further investigations/tests planned to confirm the diagnosis?
   - No [ ]
   - Yes [X]

   Date of onset (if known) 10/08
   Date of diagnosis (if confirmed) 10/08

2. Does the patient have one or more medical conditions that have a significant impact on their ability to function?
   (e.g. ability to sit/stand/move, endurance, communication, cognitive function, ability for self care, need for support in activities of daily living)
   - No [ ] You do not need to complete question 3. Go to 4
   - Yes [X] Go to next question

3. Give details about the conditions that have a significant impact on the patient's ability to function.
   List conditions in order of degree of impact on ability to function, starting with condition with most impact.

   **Condition 1 — condition with most impact**

   **Diagnosis**

   Rectal cancer

   The diagnosis is...
   - Confirmed [X]
   - Presumptive [ ]

   Are further investigations/tests planned to confirm the diagnosis?
   - No [ ]
   - Yes [X]

   Date of onset (if known) 10/08
   Date of diagnosis (if confirmed) 10/08

   **Clinical features**

   **B History**
   Provide details including etiology, precipitating factors, underlying causes, results and dates of investigations/procedures and specialist consultations (e.g. radiology, pathology, RRTs, specialist reports).

   **Rectal bleeding**
   **Altered bowel habits**
   **Weight loss**
   **Loss of appetite**

   **C Current symptoms**
   Provide details of the current clinical features and symptoms, including frequency and severity, experienced by the patient due to this condition. Be specific in indicating the severity of the medical impairment.

   **Active stoma — watery**
   **Loss of appetite**
   **Weak**

   85
**Condition 1—continued**

**Treatment**

**D Current treatment**
Provide details of all current treatment for this condition (e.g. surgery, medication, counselling, physical therapy, rehabilitation)
Include specific details such as dates of commencement of treatment, frequency, duration, types, etc.

*Await for surgery - due on 11/09*

**E Past treatment**
Provide details of all significant past treatment, duration and responses.
Include specific details such as dates of commencement of treatment, frequency, duration, types, etc.

*Colonoscopy
Radio + chemotherapy / Surgery (tempory stoma)*

**F Future/planned treatment**
Provide details of any further scheduled or proposed treatment with estimates of likely dates of commencement and expected duration.

*Closure of stoma*

**G Patient's compliance with recommended treatment**
Very compliant [ ] Usually compliant [ ] Rarely compliant [ ] Uncertain [ ]
Detail any issues related to assessing or undertaking suitable treatment that affect the level of compliance.

**Impact on ability to function**

**H Details about how this condition currently affects the patient's ability to function**
Be specific and consider the effects due to the condition alone.

Consider:
- ability to sit/stand/move
- endurance
- communication
- cognitive function
- ability for self care
- need for support in activities of daily living
- need for high levels of care (e.g. nursing home level of care)
- any adverse effects of treatment.

*Poor concentration
Feels weak*

**I The current impact of this condition on the patient's ability to function is expected to persist for:**
Less than 3 months [ ] 3-24 months [ ] More than 24 months [ ]

**J Within the next 2 years the effect of this condition on the patient's ability to function is expected to:**
Significantly improve [ ] Somewhat improve [✓] Fluctuate [ ]
Remain unchanged [ ] Deteriorate [ ] Uncertain [ ] Not applicable [ ]
Provide details, if relevant

For a second condition that has a significant impact on ability to function, go to the next page.
If there are no other conditions that have a significant impact on ability to function, go to 4.
### Client Details

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### Referral Details

| Date of referral: | 11/2009 |
| Reason for assessment: | DSP New Claim |
| Referring organisation: | Centrelink |
| Referring officer: |      |
| Referring on behalf of: | Centrelink |
| Phone: | |
| Supporting documentation: | Medical reports at Centrelink for collection |
| Nominee details: | |
| Client's preferred language: | English |
| Interview requirements: | |

### Assessment Details

| Provider name: | Health Services Australia Limited |
| Site code:     |                                  |
| Assessor's name: |                                      |
| Professional discipline: | Accredited Rehabilitation Counsellor |
| Secondary discipline: | |
| Location: | H                                    |
| Assessment Dates: | 11/2009 |
| Form of assessment: | Face-to-face |
Medical Conditions
A medical condition/s temporarily prevents the client from undertaking any suitable activity:

Medical Condition Details
Condition: Cancer/Tumour - Other Type: Temporary
Source: Treating Doctor's Report
Treatment details: Rectal Cancer - Client was initially diagnosed in 2008 and has undergone chemotherapy, radiotherapy and surgery. Client is under specialist care and has been using a colostomy bag for 6 months. He is waiting for surgery (11/2009) to remove the colostomy bag and close stoma. Client will require ongoing specialist review to monitor his condition.
Verified by medical evidence: Yes Fully diagnosed, treated and stabilised: No

Condition: Anxiety Type: Permanent
Source: Treating Doctor's Report
Treatment details: Treating Doctor reported long-term history of Anxiety. Client has been prescribed Efexor XR, since 2009. He has recently commenced counselling with a psychologist and has attended one session thus far. As was reported in the previous JCA, "client has not received any treatments for his Anxiety until this year."
Verified by medical evidence: Yes Fully diagnosed, treated and stabilised: No

Condition: Depression Type: Permanent
Source: Previous Assessment (BA, JSA or JCA)
Treatment details: As was reported in the previous JCA: Client has been prescribed Efexor XR, since 2009. He has recently commenced counselling with a psychologist and has attended one session thus far. As was reported in the previous JCA, "client has not received any treatments for his Depression until this year."
Verified by medical evidence: Yes Fully diagnosed, treated and stabilised: No

The client's medical condition/s does not prevent them from using public transport without substantial assistance.

Specialist Assessments
No Specialist Assessments were required.

Barriers
Job Capacity Assessment Report

Currently Addressed Barriers

Barrier: Awaiting medical/health intervention (H15)
How is it being addressed: Client has ongoing treatment demands and will be having surgery on 20th.

Barrier: Psychological/psychiatric condition (H02)
How is it being addressed: Client has commenced taking antidepressant medication as well as seeing a psychologist for counselling.

Barriers to be addressed

Barrier: Endurance limitations (H07)
Impact on employment: Client experiences fatigue and tiredness associated with his condition. This limits his capacity to participate in work and activities of daily living.

Barrier: Limited physical abilities (H01)
Impact on employment: Client is limited physically in what duties he can perform in the workplace, due to his conditions and associated pain.

Barrier: Anxiety Disorder (ANX)
Impact on employment: Ongoing and significant symptoms of depression/anxiety will impact social interaction, concentration, capacity for work, work obtainment and work sustainability.

Barrier: Social interaction (U08)
Impact on employment: Client has long-term social phobias which impact his ability to perform well in public settings or new work environments. Client would require ongoing support in a new workplace to overcome this anxiety symptom.

Barrier: Confidence (U02)
Impact on employment: Client lacks confidence when considering a return to the workforce.

Barrier: Physical limitations restricting type of work (V03)
Impact on employment: Client's colostomy bag restricts the type of activities he is able to perform. Due to ongoing symptoms from his condition, client will require support to identify appropriate employment options.

Support Requirements

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<tr>
<th>Requirement</th>
<th>Duration</th>
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<tr>
<td>Interact with others</td>
<td>12 to 24 months</td>
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<tr>
<td>Cope with work related stress and pressure</td>
<td>12 to 24 months</td>
</tr>
<tr>
<td>Physically complete work tasks</td>
<td>12 to 24 months</td>
</tr>
<tr>
<td>Build work capacity</td>
<td>12 to 24 months</td>
</tr>
<tr>
<td>Maintain sustainable employment</td>
<td>12 to 24 months</td>
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</table>

Based on the level of support required the client requires specialist disability employment interventions.

The client is best suited to Disability Employment Network.

Work Capacity
The client's work capacity is temporarily limited to 0-7 hours:

Start date: 11/1/2009   End date: 11/1/2010
Rationale: Client's capacity for work is restricted due to his current health conditions, rectal cancer and anxiety. Client is impacted by low endurance, frequent treatment demands (colostomy bag, upcoming surgery and ongoing specialist reviews), high levels of anxiety, periods of depression, social phobia, panic attacks and poor concentration.

Current Work Capacity

Current (baseline) capacity for work: 8-14 Hours per week
(Excludes any temporary impacts noted above)
Rationale: All permanent conditions rationale: The client has a limited baseline work capacity due to the functional limitations associated with his permanent medical conditions which include reduced stress tolerance and coping ability; limitations with social interaction due to difficulties being in public places; reduced concentration, memory, fatigue and low mood; episodic fluctuations in which the client will have periods when he is unfit for work due to panic attacks and social phobia.

Suitable work: Light less skilled (W03)
Examples: office cleaner, ticket collector

Future Work Capacity

Future capacity for work within 2 years without intervention: 8-14 Hours per week
Rationale: All permanent conditions rationale: Without intervention, the client's capacity for work is likely to remain limited due to the functional limitations associated with his permanent medical conditions which include reduced stress tolerance and coping ability; limitations with social interaction due to difficulties being in public places; reduced concentration, memory, fatigue and low mood; episodic fluctuations in which the client will have periods when he is unfit for work due to panic attacks and social phobia.

Future capacity for work within 2 years with intervention: 15-22 Hours per week
Rationale: All permanent conditions rationale: With ongoing psychological intervention, the client's capacity for work is likely to improve somewhat. Although he will remain impacted by the functional limitations associated with his permanent medical conditions which include reduced stress tolerance and coping ability; limitations with social interaction due to difficulties being in public places; reduced concentration, memory, fatigue and low mood; episodic fluctuations in which the client will have periods when he is unfit for work due to panic attacks and social phobia. With DEN intervention, client will be assisted to identify suitable employment, and supported to maintain employment, given his functional limitations.

Suitable work: Light less skilled (W03)
Examples: office cleaner, ticket collector

Assessment Summary
The assessment was completed successfully.
General summary of the client, their circumstances and the findings and recommendations of the report:

This report has no permanent conditions that are fully diagnosed, treated and stabilised

The following information was used by the assessor to inform decision making for this assessment:

- Information available on EA300
- TDR completed by Dr [redacted] dated 04/11/2009
- JCA report completed by [redacted] dated 02/02/2009
- Discussion with the client

Additional information was reviewed by the assessor however decision making was based on information documented as above.

CLIENT PRESENTATION

The client is a 45-year-old man who arrived 15 minutes late to the assessment and was cooperative and open to discussion. The client attended the assessment alone and was observed to be somewhat anxious throughout the assessment. Client reported his reason for missing the first scheduled appointment was due to symptoms of depression preventing him from leaving the house. The reason for referral to JCA was discussed.

SOCIAL

The client currently resides with his partner and children in stable accommodation. Client reported his brother is providing full-time care to his elderly mother, and that his father is currently in a nursing home. He reported some difficulty undertaking daily household tasks and personal care due to his cancer and colostomy bag. The client reported he does not drive and reports no difficulty accessing public transport.

EDUCATION & WORK HISTORY

Client completed up to Year [redacted] of secondary education. The client reported last working in 2009, following 25 years working in the [redacted] trade. This work was reportedly ceased due to factory closure.

MEDICAL INFORMATION

Treating Doctor reported client was diagnosed with Rectal Cancer in 2008 following a history of symptoms of weight loss, rectal bleeding, altered bowel habits and loss of appetite. Client has since undergone radiotherapy and chemotherapy, as well as surgery to remove the cancer. Client reported being hospitalised on two occasions for dehydration, as a result of this condition. Client reported current symptoms of low energy, loss of appetite, fluctuating weight and difficulties with toileting. Client reported he has been using a colostomy bag for the past 6 months, and is scheduled to undergo further surgery to have this removed. Client is having regular specialist review and intervention through [redacted] Hospital, as well as taking daily medication. Treating Doctor reported this condition is likely to somewhat improve over the next 3-24 months.

Treating Doctor reported client has long-term history of Generalised Anxiety, including symptoms of anxiety, tremors, poor concentration and social phobia. Client further reported panic attacks, periods of depression which impact his ability to attend appointments, be in crowded or social environments. According to the previous JCA, client commenced taking medication (Efexor XR) for this condition in 2009. Client provided a copy of a referral to a psychologist for counselling, to address symptoms of anxiety.

CLIENT GOALS

The client reported that he is concentrating on engaging in treatment for his medical conditions.

ASSESSORS RECOMMENDATIONS

The client is currently undergoing significant treatment for his medical conditions and has been granted an incapacity for 12 months while he participates in ongoing reviews. Following this incapacity, client may benefit from further review to assess his capacity for work, as his response to treatment and recovery is at this stage, unknown.

The client's baseline work capacity has been assessed to be 8-14 hours per week due to the functional limitations associated with the clients medical conditions. The clients future work capacity with intervention from DEN has been assessed to be 15-22 hours per week. The client would benefit from a referral to DEN for assistance to identify suitable job placement and post-placement support.
REFERRALS
Once the client obtains some capacity to participate in a program he should be referred to DEN. It is anticipated that this should occur on 11/2010 and that Centrelink will action this referral after this time.

VULNERABILITY INDICATOR
6 months - High (IIIF), 12 months - Moderate (PPM) Client is engaged in ongoing treatment for his conditions.

This report does not contain any information, which if released to the client, might be prejudicial to his/her health.

The client's personal factors have a Low impact on their ability to work, obtain work or look for work.
Rationale: Limited employment history and transferable skills

Interventions
Interventions that were identified for this client

Intervention: Surgical treatment (M53)
Expected outcomes/improvements: Client is waiting on surgery, scheduled for 11/2010 and will require ongoing review and treatment following this.

Intervention: Psychiatric services/treatment (P54)
Expected outcomes/improvements: Client will benefit from consistent psychological and psychiatric intervention with compliance to treatment.

Intervention: Cognitive behaviour therapy(P56)
Expected outcomes/improvements: Client will benefit from counseling to discuss issues and understand the relationship between thoughts and actions and develop positive strategies to overcome.

Intervention: Injury management (H57)
Expected outcomes/improvements: Ongoing treatment for the impact of medical conditions is required for the client to maintain optimal level of functioning.

Intervention: Work experience (V58)
Expected outcomes/improvements: When the client has capacity for work, this will assist him to re-engage in work and be exposed to a work environment without pressure of employment expectations.

Referrals
A referral was recommended to Disability Employment Network.

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