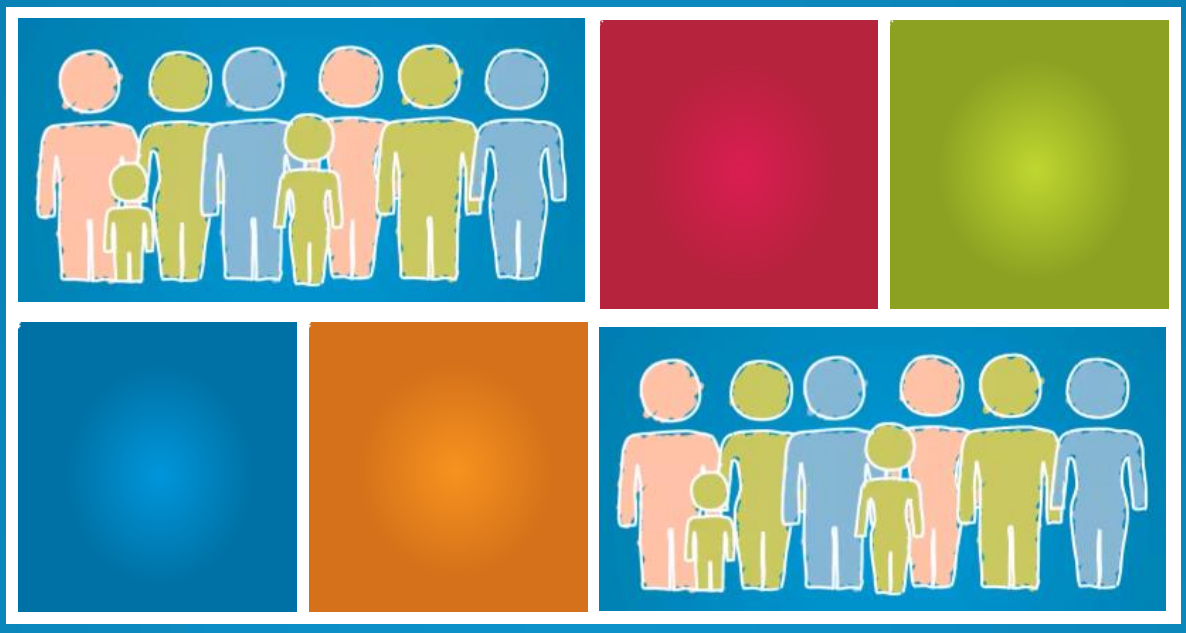
Mental Injury Assessments for ACC



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Introduction

Approved assessors reported in their provider application that they have the academic qualifications, skills and experience to carry out comprehensive psychological/psychiatric assessments. Specifically, approved assessors stated that they are knowledgeable, skilled and experienced in:

- Assessment, classification and formulation.
- Abnormal Psychology.
- Skills in one or more models of therapeutic intervention.
- Human development.
- Knowledge and skills in using psychometrics (if using psychometrics).

Therefore, the information provided here is not aimed at teaching providers how to carry out mental injury assessments, but rather to clarify those aspects of the assessment which are relatively unique to ACC, and the administration and scoring of the WHODAS 2.0 and Personal Wellbeing Index.

If you are completing a mental injury assessment for a sensitive claim (i.e., where the injury events involve sexual abuse), this information should be read in conjunction with the guidelines attached to the ACC6429 Supported Assessment – Adults and ACC 6424 Supported Assessment – Child and Young Person.

If you are completing a mental injury assessment for a physical injury or work-related traumatic incident, this information should be read in conjunction with the guidelines attached to the ACC4247.

Assessors new to doing mental injury assessments are required to have one-to-one supervision from ACC experienced assessors following approval on the ISSC and the Psychological Services contract.

What is a mental injury?

Mental injury is a legal concept rather than a clinical concept and as such is defined by legislation.

Accident Compensation Act 2001

A mental injury is defined as:

"a clinically significant behavioural, cognitive or psychological dysfunction" (s27).

ACC can provide cover for mental injury arising from:

- Sexual abuse (sensitive claims),
- A covered physical injury,
- A work related traumatic incident, and
- Treatment injury.

These will be discussed in detail below.

ACC cannot provide cover for mental injuries:

- Caused only by traumatic events that happen outside of work,
- Caused by stress or other gradual processes at work,
- If a mental health specialist identifies that the mental condition occurred before the accident or event,
- If the accident had only a limited effect (e.g., was a trigger or "final straw" after a series of stressful events),
- Where a minor physical injury in traumatic circumstances was not a significant cause of the mental injury.

Mental Injury caused by physical injury

For a mental injury from physical injury to be covered by the Accident Compensation Act 2001 it must be a personal injury. There are three main criteria for determining whether a mental injury qualifies as a personal injury:

- There must be cover for the physical injury claim.
- There must be a clinically significant mental condition.
- The physical injury must be a material cause of the mental injury.

With injuries involving particularly traumatic circumstances, such as serious motor vehicle accidents or violent assaults, it may not always be clear whether the mental injury is attributable to the physical injury, the accident or the surrounding circumstances. The mental injury may have resulted from a combination of those factors.

ACC can cover a mental condition if the mental injury assessor advises that the physical injury was a significant cause of the mental injury even if there were other contributing factors such as the surrounding circumstances.

Work-related Mental Injury

ACC has been able to consider claims for work-related mental injuries since 1 October 2008. We can accept claims for cover where a person suffers a clinically significant mental injury caused by a traumatic work related event.

The work-related mental injury must have been caused by a single, sudden event that occurred in a client's employment, and gradual onset workplace stress would not be considered a work-related mental injury.

There will usually be information that can be gathered from workplace incident reports, and police or emergency services reports. A work-related mental injury does not need to be linked to a physical injury. If the client receives a physical injury you may also be asked to consider whether there is any mental injury resulting from the physical injury or whether any mental injury is solely a work related mental injury as the two claims have different criteria and dates of injury.

Example:
A bus driver in Manukau swerves to avoid hitting a pedestrian who deliberately steps in front of the bus. The pedestrian is killed instantly when clipped by the front end of the bus. As the bus driver is suffering from severe clinical depression because of this event his General Practitioner lodges a claim for a work-related mental injury.

Criteria for work-related mental injury:

The criteria for determining if a claim for work-related mental injury can be accepted for cover are:

- The event occurred after 1 October 2008.
- The client is diagnosed with a clinically significant mental injury.
- The mental injury must be diagnosed as being a clinically significant behavioural, cognitive, or psychological dysfunction. Temporary distress that constitutes a normal reaction to trauma is not covered.
- The mental injury has a causal link to a work-related traumatic event.
- The work-related mental injury must be significantly or substantially caused by an event that occurred in a person's place of employment.
- The injury is caused by a single event.

A series of events that arise from the same cause or circumstance can still be considered a single event. In these situations, take care to ensure that all parts of an event are clearly identifiable and occur at a precise point in time. This is different to a gradual process, which refers to a series of recurring events over a longer period that have had a cumulative effect.

The mental injury must be caused by an event that could reasonably be expected to cause mental injury to people generally. Such events would:

- Provoke extreme distress, horror or alarm in almost everyone.
- Be outside the normal range of human experience.

For the mental injury to be covered, the event that caused it must be sudden in onset. A sudden event is one that occurs quickly with little or no warning, but the event itself may last a short or longer time. An event lasting a short time might include a drive-by shooting, while an event lasting a longer time could be a hostage situation lasting many hours. Irrespective of their duration, both are sudden events.

The client must directly experience the event that caused the mental injury. That is, they must be in close physical proximity to the event and see or hear it in order to experience it. A person cannot experience an event directly if they:

- See it on television, including closed circuit television,
- See pictures, or read about it, in the news media,
- Hear the event on radio or by telephone,
- Hear about the event from radio, telephone, or another person.

In most cases, a person will see an event directly. In cases where a person experiences the event less directly, extra care will be required to establish a work-related mental injury.

If the person does not directly witness the event as it occurs, they can still be eligible for cover for a mental injury if they are involved in, or witness, the direct outcome of the event. To be directly involved in, or witness, the outcome of a sudden event means the person must be physically present at the scene of the event.

Mental Injury caused by treatment injury

The criteria for mental injuries caused by treatment injuries are essentially the same as those for mental injuries caused by physical injuries. There must be:

- A clinically significant mental condition, and
- The treatment injury must be a material cause of the mental injury.

Mental Injury and sensitive claims

Within the Sensitive Claims Unit, for a client to receive cover and entitlements, the mental injury must be significantly linked to specific sexual offences described in the Crimes Act 1961.These are referred to as Schedule 3 events. Schedule 3 events do not include witnessing others being abused or behaviours that would be part of appropriate parenting (e.g., bathing or toileting a young child), or developmentally normal behaviour.

The full list of schedule 3 events can be accessed via the following website:

http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM100693.html

There does not need to be a physical injury for a mental injury of this type to be covered. However, to receive cover there must be a mental injury and the sexual abuse events must be a significant or material cause of the diagnosed mental injury(ies).

Mental Injury Assessment Contracts

Supported assessments (mental injury caused by sexual abuse) are carried out under the Integrated Services for Sensitive Claims contract (ISSC) and the Clinical Psychiatric Services contract.

Assessments for mental injury caused by physical injury, treatment injury and work related mental injury are carried out under the Psychological Services and the Clinical Psychiatric Services contracts.

Mental injuries, causal links and the mental injury assessment

The purpose of the mental injury assessment is to establish:

- A comprehensive assessment of a client's cognitive, psychological and behavioural functioning from which appropriate intervention can be planned and delivered.
- The nature of any clinically significant behavioural, cognitive or psychological dysfunction experienced by the client.
- The extent to which there is a causal link between the specified event(s) reported (e.g., physical injury, workplace event, treatment injury or sexual abuse event), and the clinical dysfunction assessed as being present.

You will need to consider:

- The onset or development of the presenting symptoms and how soon after the events these developed.
- How the client's difficulties have developed and progressed within the client's wider context to be able to identify and fully consider all factors that have contributed to the presentation.
- Whether or not there are/were other developmental or environmental factors that might explain the development or severity of any presenting symptoms (e.g., attachment issues often result in personality difficulties).
- Whether the extent and severity of the difficulties experienced is greater or lesser than you would expect given the nature of the events reported and to what extent other non-event related factors have contributed to this.

Cultural Considerations in Assessment

ACC has produced the following document:

ACC 1625 Guidelines on Maori Cultural Competencies for Providers. You can access and download this via the ACC website using the search function and typing in ACC 1625.

A culturally responsive assessment will consider the following questions:

Where is the assessment being held and what is my role?

There are different processes and responsibilities to consider depending on whether you are inviting clients/whanau into your office or seeing them in settings where you may be a guest. Forward planning/thinking may go a long way to assist with facilitating engagement and ensuring your clients/whanau feel welcome and at ease.

What kawa/protocols/guidelines/frameworks do I need to consider in planning my assessment and why?

Do you have accurate ethnicity data? How will you check this? How will you adapt your assessment to ensure that you can provide a holistic formulation of the case, giving consideration to the ways in which cultural factors are pertinent for treatment purposes? Will you be using a framework – such as the Meihana Model to guide your assessment? How will you ensure that this information once obtained from the client/whanau is honoured and reflected within your report?

What does the epidemiological data tell me about base rates and outcomes for the ethnic group I am assessing?

Does the existing epidemiological data predict increased symptom severity, morbidity, and worse outcomes for the ethnic group of the client/whanau I am assessing? What service provision factors might have contributed to this disparity where it exists (e.g., conscious and unconscious biases, different referral practices)?

What is the significance of this data in terms of my assessment and treatment recommendations?

How can I seek to minimise the impact of conscious and unconscious bias in my work with this client/whanau? What are my training/supervision needs in this area? How can I seek to address them? What benefit might there be of seeking advice from a cultural advisor in this case?

Formulation

Formulation is different from diagnosis in that diagnosis provides the answer to the question "what mental injury(ies) is the client experiencing?", and formulation provides the answer to the questions "why has the client developed these difficulties?" and "what is maintaining them?"

The formulation requires a narrative summary of all the factors, both positive and negative, specific to an individual client that clearly explains why and how the client has developed the difficulties they are currently presenting with and why these difficulties have persisted. It should also include discussion of any barriers to recovery that might exist.

Formulations will likely range from simple to complex depending on specific client circumstances and should provide an explanation for all the presenting difficulties such that it is clear which have been caused by the accident/event which have not, and which act as rehabilitation barriers.

Below are some examples of simple and complex formulations for adults and children for sensitive claims, and for mental injury caused by physical injury and work-related injury claims.

Sensitive Claims

Example One:

"Ms C reported no early childhood difficulties, abuse or trauma and experienced positive parental attachment and sibling relationships. Throughout her life she has been high functioning having achieved well academically and occupationally. There was no evidence of any mental health, relationship, or behavioural difficulties up until the rape that occurred in her work car park in late 2014. Since that time she has experienced strong intrusive imagery and thoughts of the rape, has sought to avoid any activities or situations that remind her of this event, and has experienced intense anxiety and panic attacks when she has been unable to do so. As a result she has avoided returning to work, has avoided sexual intimacy with her partner and has increasingly managed symptoms of anxiety via benzodiazepines prescribed by her General Practitioner. Additionally she is feeling increasingly hopeless about her situation and capacity for recovery. It is considered that the avoidance via actual avoidance and avoidance via the anxiolytics is acting to maintain the intensity of all current symptoms."

This formulation would support a diagnosis of PTSD significantly linked to sexual abuse in the Section 7 Opinion section of the Supported Assessment report.

Example Two:

"James is a four-year-old Pakeha male who was referred by ACC for an assessment as to whether contact with an alleged sexual offender had resulted in a mental injury secondary to a sexual assault. James's mother noted his increased difficulty regulating his emotions and sexualised behaviour and this heightened her concern that James had been sexually assaulted. James did not disclose sexual abuse when interviewed in April 2014. The assessment included an interview with James's mother, an observation of James, interviews with early childhood teachers and James's ACC counsellor, and completion of psychometric questionnaires.

James lives with his mother, his mother's partner and his two older brothers and one older sister. His parents separated a year ago and he has regular contact with his father and his father's new partner although there has been acrimony between the two sets of parents, and inconsistencies in their approach to parenting the children. The family have experienced considerable stress and change over the last 12 months including the parental separation, moving house, a change in care giving arrangements as James's mother returned to work, and the introduction to and ultimately living with his mother's new partner. At the time of the referral to ACC, James's mother was concerned about his frequent tantrums, non-compliance, social withdrawal and reports of sexualised behaviour. These issues resolved with counselling support and intervention. Over the last three or four months, there has reportedly been a regression in his behaviour at home but not in any other settings. James's mother continues to be concerned that the recent regression is directly related a sexual assault by the alleged perpetrator.

The current assessment suggests the behaviours reported are an age appropriate response to the stressors and considerable change the family and James have experienced over the last 12 months. While concerning for the family, these behaviours do not meet the threshold of a mental injury.

James's positive response to the counselling and support provided to date would suggest that if there has been any sexual assault, the support and intervention received to date has enabled the resolution of any difficulties associated with the experience. James will likely benefit from any on-going efforts by his parents and step-parents to resolve the issues that underlie some of the stressors impacting on the family. These efforts would be supported by attendance of a parenting programme that focuses on strengthening relationships and helping children to better manage their feelings and behaviour."

This formulation would support an opinion of no mental injury significantly linked to sexual abuse in the Section 7 Opinion section of the Supported Assessment report.

Example Three:

"Mrs X is a 47-year-old mother of three teenage children and reports poor relationships with all three who she lost custody of at various points in their childhoods. She presents with a history of severe neglect and abuse by her parents who were substance dependant and heavily involved in gangs and an offending lifestyle. In this context she was subject to and witnessed severe acts of physical violence throughout her childhood and early adolescence when she was "passed around" her parents and wider family and at times coming to CYFS attention. She was also subject to frequent sexual abuse involving three discrete episodes by three perpetrators when she was aged 4-5 years, a single event when aged 7 years, and on-going abuse when aged 7-12 years.

Mrs X noted that she had become sexually active on a consensual basis in her early teens, had spent a period working in the sex industry when aged 13-15 years, had been introduced to cannabis by cousins when aged approximately 10yrs and had used this more or less ever since to manage negative affect, calm herself and as a recreational activity. She also noted that she had been drawn to "bad boy" partners who had been violent but not sexually abusive. In this context she noted three significant violent relationships. Her most recent relationship has been with a cannabis dealer and, although he has not been violent, they argue often and she considered that she had often sought to "goad him" into hitting her to prove that he cared. His responses had been to simply leave the house which in turn provoked increased emotional dysregulation and some episodes of self-harm. She reports strong anxiety at the thought of losing him.

Ms X reported symptoms of PTSD with strong visual and auditory intrusive symptoms that almost exclusively arise from an incident when she was quite young and witnessed her father and three other men beat a man to the point of unconsciousness with softball bats and then beat the victim's dog to death with the bat.

The current assessment supports diagnoses of PTSD, cannabis dependence, and borderline personality disorder. It is the assessor's opinion that the PTSD is not significantly linked to the sexual abuse but is clearly and significantly linked to the childhood experience of violence and has been exacerbated by subsequent exposure to violence. Similarly the cannabis use is not considered to be linked to the sexual abuse and appears to have developed and been maintained through a combination of familial propensity for substance abuse, parental and familial modelling, the pleasurable effects associated with use, and the distress and agitation associated with not using. With regard to the borderline personality disorder it is considered that the sexual abuse is a significant factor in the development of this albeit that it is not the only significant factor with the violence,

neglect, and poor attachment also acting as important causal factors. Although neither the PTSD or cannabis use is linked significantly to the sexual abuse, both act as barriers to treatment for the personality issues and will likely need some addressing as part of treatment for this."

Example Four:

"Ms S is a 15-year-old girl who presents as the oldest of three children with a history of having been raised in an environment where her father was demanding and verbally abusive, highly critical of her mother, her and the younger children. Her mother was supportive but passive, tried hard not to upset her husband, and encouraged the children to try their hardest not to upset their father. Ms S is reported to have been an anxious child who nevertheless excelled academically and had several good friends. At age 11 she appears to have withdrawn socially and exhibited clear symptoms of depression following an incident in which she was raped by the teenage son of a family friend. She does not appear to have ever fully recovered from this with sub-threshold symptoms of depression present ever since but has been prone to more severe episodes of depression whenever things have gone wrong. (e.g., after the separation of her parents when she was aged 12 years, and when she did not achieve the grades she was expecting at the end of last year).

Most recently Ms S has increasingly developed high levels of anxiety about her academic performance and her weight, has become very rigid in her habits and very distressed when there are unexpected disruptions to her routine, and has developed restrictive eating patterns with significant weight loss. There have been similar concerns expressed by her school and the GP confirms problematic weight loss.

The current assessment supports diagnoses of persistent depressive disorder, anorexia nervosa-restricting type, and obsessive compulsive personality traits. The persistent depressive disorder is opined to be clearly and significantly linked to the sexual abuse event albeit that the discrete episodes of major depressive disorder may not be. The obsessive-compulsive personality traits that appear to be developing and the anorexia-nervosa are not considered to be significantly linked to the sexual abuse event reported. Rather they appear to have arisen out of the low self-esteem and anxiety about negative evaluation that have developed because of her father's critical and demanding interpersonal style and her mother's modelling and encouragement of unhelpful perfectionistic strategies for responding to this. Both disorders appear to be the result of her use of over-controlling, perfectionistic strategies to avoid anxiety and negative outcomes such as failure or criticism."

Physical Claims

Example One:

DSM IV Diagnosis:

Mr Y meets the Diagnostic and Statistical Manual for Mental Disorders Fourth Edition Text Revision (DSM-IV-TR) diagnostic criteria for Dysthymic Disorder as he and his wife report that he has had depressed mood for most of the day, for more days than not, since the accident in 2008. He has had

accompanying symptoms of poor appetite, fatigue and poor sleep and feelings of hopelessness over this time also.

Axis I	300.4 Dysthymic Disorder
Axis II	No abnormal personality, some depressive tendencies
Axis III	Pain Disorder Associated with a General Medical Condition (right knee pain since 2008); Asthma
Axis IV	Stressors related to reduced income; marital disharmony over the last year
Axis V	GAF 61 – 70

Formulation

Mr Y is a 46-year-old hardware store employee who has been married for 22 years. Mr Y has a history of twisting his knee in 2008. He has had surgery on two occasions but has had on-going problems with persistent right knee pain which has impacted on his engagement in work and leisure pursuits. He has presented with depressed mood over the last three years, accompanied by poor appetite, fatigue, poor sleep and hopelessness. He also presents with stress related to reduced income and over the last year with marital problems. He would currently meet DSM-IV-TR diagnostic criteria for Dysthymic Disorder.

There is no history of significant mental health concerns predating the injury. From what information is available, it appears that following Mr Y's injury, pain and functional difficulties began to impact on his ability to engage in physical and social activities that he previously enjoyed, including work and leisure pursuits such as golfing, swimming and hockey. This reduced his opportunity to engage in activities that were pleasant to him and as a result he began to experience periods of lowered mood. Over this period a number of cognitions became evident, related to his perceptions of high disability (that his injury has had extreme impacts on his life in all areas, he is "emotionally ruined") and fear of re-injury, which appear to have further reduced his engagement in activities he previously enjoyed and further reduced his mood. Evidence also suggests that over time when Mr Y attempted to engage in prior activities he previously enjoyed that he attempted to achieve his prior levels of functioning and outputs, without pacing himself or taking appropriate breaks to enable himself to engage in enjoyed activities for longer periods. As a result he was unable to engage in these tasks for any length of time, and this further increased his hopelessness about his future and further reduced his mood, in particular in the context of his tendency to attribute this "failure" to personal failings. Mr Y's depressed mood has been reflected in irritability with colleagues and customers and he currently has concerns that these issues will have an impact on his on-going employment. In addition Mr Y's says he is increasing irritable with his wife and this is having an impact on his marriage (his wife is reportedly now often tearful herself and is less able to support her husband at present), and Mr Y's worry about his employment and marriage is now also impacting negatively on his mood.

Factors that will likely currently maintain or perpetuate Mr Y's lowered mood are cognitions evident that reduce his willingness to engage in activities, and his lack of knowledge about methods to pace himself in activities so as to be able to engage in them for longer periods, without increases in pain. It is also noted he is preoccupied with the thought that his pain is "the result of a failed operation" and this limits his willingness to engage in self management strategies. Mr Y's wife has actively supported him to engage with rehabilitation services offered. As she becomes overwhelmed with issues related

to Mr Y's situation she will be less able to offer this support which is essential to Mr Y's successful rehabilitation.

Example Two:

DSM IV diagnosis:

Axis I	Chronic Adjustment Disorder with Depressed mood Chronic Pain Disorder associated with Psychological factors and a General Medical Condition
Axis II	Nil
Axis III	Obesity, Possible Ischaemic heart disease
Axis IV	Financial stress
Axis V	GAF 80

Formulation

Mr O is a 50-year-old single man who presented as mildly dysphoric in mood and with persisting depressive themes primarily related to his functional limitation due to physical and pain symptoms. Mr O appears to have engaged over the years in heavy manual work. He reports multiple past injuries and accidents most of which occurred during his teenage years and twenties whilst living in Australia prior to the designated injury in August 2005 when he slipped and suffered a back sprain. Following this injury, Mr O reports persisting pain symptoms that have been exacerbated by a further injury to his hand in 2011. The medical history indicates that, while degenerative pathology has been demonstrated on imaging, the pathology does not appear to explain completely his persisting symptoms. Mr O indicated that, following the 2005 accident, he developed significant depressive symptoms in context of financial stress and was prescribed antidepressants. His personal history was notable for witnessing the traumatic death of his older brother who was hit by a motor vehicle when he was 11. He described that this event had a dramatic impact on him and his family. Mr O developed significant anxiety symptoms and re-experiencing phenomena related to this prior traumatic event for which he has not sought treatment. These symptoms have lessened over the years but have not remitted. Mr O has limited literacy which impacts on his ability to seek non labouring types of employment.

A review of corroborative records indicates that the accident in 2005 was associated with an increase in pain symptoms. Mr O's medical records indicate that during the period 1998-2001 he experienced pervasive depressive and stress related symptoms due to interpersonal and financial difficulties; at this time he was referred to mental health services. At this time obesity was thought to be his major physical health problem and during this period there were no references to persisting pain symptoms. His records indicate that by 2002 his mood improved and that he successfully engaged in a number of construction and horticultural roles. From 2003 onwards there are consistent references to lower back pain which were attributed to obesity. His records indicate that Mr O experienced a progressive escalation of back pain and primary care records at the time of the accident in 2005 indicate that this resulted in an aggravation of his back pain. Following his accident he was assessed by an Orthopaedic surgeon who formulated that Mr O had mechanical back pain and this was compounded by obesity.

The aetiology of Mr O's Pain Disorder is likely to be multifactorial. The history of childhood psychological trauma is likely to have created underlying vulnerability to pain and stress and this was likely further triggered by lifestyle issues including significant obesity and recurring injuries including the injury of August 2005. In the opinion of the assessor it is not possible to conclude that the 2005 injury is a significant cause of Mr O's Pain Disorder; rather this appears to be one of a series of events that negatively impacted on the trajectory of his chronic back pain.

Although this was not disclosed at the time of the interview Mr O's has a well documented past history of significant depressive symptoms; these appear to temporally correlate with exposure to interpersonal and psychosocial stressors. His mood symptoms were thought to be in remission at the time of his accident in 2005. I consider that the depressive symptoms represent a recurring Adjustment Disorder secondary to persisting pain symptoms and functional limitations due to this as well as the psychosocial consequences of unemployment. As is the case with the Pain Disorder, Mr O's Adjustment Disorder has multifactorial aetiologies including the accident in 2005 but in my opinion the 2005 accident is not a significant cause.

Example Three:

DSM 5 Diagnosis:

(1) Mild neurocognitive disorder secondary to traumatic brain injury.
(2) Dysthymia (differential diagnosis Major Depressive Disorder in partial remission).

Formulation

Mr D is a 46-year-old man who was involved in a significant motor vehicle accident on 11 May 2015. His hospital and rehabilitation records indicate that his Glasgow Coma Scale score (GCS) was 14 on admission to the Emergency Department and the duration of Post Traumatic Amnesia (PTA) as judged by the Westmead Post Traumatic Amnesia Scale was thought to be approximately 3 days. The mechanism of the injury suggests a combination of a high velocity impact as well as direct impact to his shoulder, neck and head region; this mechanism would indicate a high likelihood of a diffuse axonal type injury. Mr D presents with significant retrograde amnesia, amnesia for the impact and for some days following the event and this is consistent with a moderate traumatic brain injury. CT head imaging did not demonstrate any intracranial contusions; however it is noted that CT is not a particularly sensitive examination for detecting suspected diffuse axonal injury.

Mr D gives an articulate account of his presenting complaints that is consistent with the cognitive impairment demonstrated by Dr Neuropsychologist.

Mr D has a significant family history of mood disorder. In 2009 he was diagnosed with a Major Depressive Disorder and was still receiving treatment for this at the time of the injury. On cross-section, Mr D does not endorse prominent depressive symptoms or pervasive anhedonia. However it is my opinion that Mr D demonstrates persisting low-grade mood symptoms and these are probably more in keeping with Dysthymia or alternatively a Major Depressive Disorder in partial remission. The background history suggests that Mr D has experienced decompensation in his mood when he is exposed to stressful circumstances. Mr D describes premorbid perfectionistic, mildly anxious and

possible pessimistic traits that may represent predisposing vulnerability to develop mood and anxiety symptoms.

Given the mechanism of injury and the consistency of neuropsychological findings, it is reasonable to assume that the primary factor that is impacting on Mr D's cognitive performance relates to subtle injury related cognitive difficulty. It is noted that prior to his accident Mr D consulted his general practitioner for a number of non-specific somatic symptoms including fatigue and pain symptoms associated with stressful exposures. It would be difficult if not impossible to differentiate the potential aetiology of these, but the fact that his current symptoms are persisting in the absence of overt depressive features would indicate that injury related variables are relevant.

The history indicates a significant premorbid mood disorder and this has persisted since the accident. It is likely that some components to Mr D's mood disorder may reflect persisting adjustment difficulties to the circumstances that have arisen following his accident. I do not consider that the 2015 injury is a significant cause of Mr D's mood disorder; the trajectory of his mood symptoms is consistent with the documented premorbid pattern.

On balance the mechanism of injury, injury severity parameters and the cause of the symptoms all indicate that Mr D has experienced a moderate traumatic brain injury. The probable injury mechanism is more likely to be a diffuse axonal injury. Mr D continues to experience cognitive inefficiency relating to his injury which manifests as reduced cognitive capacity with increased resources required to sustain activities at a high level and this feeds into a pattern of fatigue and mild neurobehavioural symptoms. Therefore, I consider the 2015 injury is a significant cause of the Mild neurocognitive disorder.

Example Four:

DSM IV Diagnosis:

Axis I	Social Anxiety Disorder Polysubstance Abuse, Alcohol and Cannabis
Axis II	Provisional diagnosis of low average intellectual functioning and/or mild learning difficulty
Axis III	Fractured mandible; possible mild peripheral nerve damage with persistent sensory impairment
Axis IV	Notable psycho social stressors including financial constraints, sub optimal housing, limited social connection, long-term unemployment
Axis V	GAF 75

Formulation

Mr E is a 39-year-old single man who has no children. Mr E was referred for an opinion with regards to the possible psychological impact of an assault he experienced in 2012. This involved Mr E being assaulted on the street by a person with gang affiliations. He was hit on the jaw and suffered a fractured mandible. There was no evidence of TBI documented. Prior to the assault, there is a documented history of significant psychosocial stressors, depressive symptoms, significant social

anxiety, alcohol and cannabis misuse and a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD).

Current diagnoses are Social Anxiety Disorder, Polysubstance Abuse, Alcohol and Cannabis. Subsequent to the assault there have been references to Post Traumatic Stress Disorder/symptoms but this is not documented in any corroborative medical records. Mr E did not articulate any specific features suggestive of post traumatic stress symptoms, specifically no re-experiencing phenomena, no defined hyper-vigilance and he is also not exhibiting any specific avoidant behaviours.

During the current assessment Mr E endorsed a long-standing pattern of mood instability, usually in context of psychosocial precipitants and long-standing variable mood symptoms which he attributed to his social situation. He described a pattern of long-standing social anxiety but again did not endorse any specific post-traumatic stress symptoms. Mr E has experienced some isolated hypnopompic hallucinations that do not seem to relate to his assault and/or injury. Note is made of very regular use of cannabis and excessive alcohol use in a binge drinking type pattern. At the assessment Mr E did not seek any symptomatic treatments. On inquiry he felt that some financial assistance may be helpful with regards to transport or possibly even getting his vehicle warranted which may improve his chances of obtaining gainful employment and improving his financial status.

In summary, I was not able to elicit any specific signs or symptoms suggestive of injury related psychiatric or psychological conditions. My impression is that Mr E has a pre-existing social anxiety disorder and this at times manifests in difficulties with poor self esteem and low mood. This seems to be compounded by a number of persisting psycho social stressors, primarily related to limited social connections, lack of resources and unemployment and also by persisting regular use of cannabis and heavy use of alcohol.

Example Five:

DSM 5 Diagnosis:

(1) Somatic Symptom Disorder with predominant pain
(2) Panic Disorder in partial remission.

Formulation

Miss X is an 18-year-old woman who bruised her hip during a car accident in June 2011. She currently has a diagnosis of Somatic Symptom Disorder with predominant pain and Panic Disorder in partial remission. She was referred for a psychiatric opinion in the context of persisting and disabling pain symptoms.

The car accident in 2011 occurred during a lunch break and involved Miss X being hit at low speed by a vehicle whilst crossing the road. Ms X was not knocked to the ground and at the time only recalled mild tenderness on palpitation in her hip area, and in the hours following she only reported minimal discomfort. She did not sustain any injury to her head or symptoms of TBI following the injury.

Approximately 24 hours following her accident, Miss X started experiencing mild discomfort in her lower back, progressing to shooting pain and subsequently to limitations in functioning. Extensive medical investigations, including scans and orthopaedic and neurological assessments were all

normal. Miss X has engaged with a pain programme and reports that this is helpful to her, but has been making very slow progress and continues to experience exacerbations of pain symptoms associated with activity including daily activities. At times Miss X reports being virtually bedbound, and has had to rely on her partner to provide more support at home.

Miss X has a complex medical history. She indicated that she suffers from a number of sensitivities to chemicals, substances (including prescribed medications) and certain foodstuffs. She reports a history of Irritable Bowel Syndrome (IBS), dysmenorrhoea and endometriosis, and past diagnoses of migraine, fibromyalgia and a possible repetitive strain injury whilst working as a kitchen hand. Her records indicate multiple pre-accident consultations and specialist referrals as well as investigative tests and procedures which did not reveal any underlying abnormalities. Miss X is taking a range of medications including laxatives and analgesia for symptomatic control of her various physical complaints as well as Fluoxetine.

Miss X has not had any formal psychiatric contacts in the past. She reports a strong maternal family history of mood disorder and that both her mother and grandmother also suffered from IBS and endometriosis. She reported background trait anxiety and during puberty developed panic attacks and agoraphobia. She indicated that since the age of 16 she no longer experiences overt panic attacks but she remains avoidant of bridges and shopping centres. When she is exposed to these stressful precipitants, she reports experiencing an 'anxious trance' which was suggestive of dissociative episode/s.

There is no history of insecure attachment or exposure to early life adversity. Although the focus of this assessment was primarily on the physical injury, there is a history of an incident of sexual abuse during puberty. Miss X indicated that at the time of the sexual abuse there was a significant escalation of her mood and anxiety symptoms. At that same time there was also an escalation in physical symptoms and specifically her migraine disorder became more prominent and impacted negatively on her school attendance. Ms X's history suggests that reminders of the sexual abuse have triggered significant psychological symptoms later in her life, and there are indications that the sexual abuse is also likely relevant in terms of the genesis of her somatic symptoms.

Miss X currently presents as mildly anxious with a clear cycle of health anxiety and hypervigilant symptom monitoring that is associated with a catastrophic interpretation of symptoms at times. She accepts that she has not suffered a serious soft tissue or ligamentous injury but remains very avoidant of all activities she associates with symptomatic exacerbation. Miss X presents with a number of subjective symptoms in various bodily domains including pain that remain largely medically unexplained. In addition, she has evolved a range of beliefs and cycles of avoidant behaviours as well as some aspects of the illness role.

The corroborative records indicate that Miss X may have met criteria for Somatic Symptom Disorder prior to the accident occurring in June 2011, but this had not been explicitly established or diagnosed prior to this accident. Her anxiety spectrum symptoms and panic symptoms appear to be pre-existing conditions, and the current pain symptoms appear to represent an exacerbation of a pre-injury pattern and to have been triggered by the accident rather than caused by the actual physical injury. Therefore, it is not considered that Miss X's June 2011 injury is a significant cause of her current Somatic Symptom Disorder.

Work-Related Mental Injury Claim

DSM IV Diagnosis:

Mr J meets the Diagnostic and Statistical Manual for Mental Disorders Fourth Edition Text Revision (DSM-IV-TR) diagnostic criteria for PTSD

Axis I	309.81 Post-Traumatic Stress Disorder
Axis II	Deferred
Axis III	Left Rotator Cuff Injury, surgically repaired
Axis IV	Nil
Axis V	GAF 51-60

Formulation

Mr J is a 56-year-old European man who has been experiencing trauma related psychological symptoms following a train versus car accident in July 2016. The train which he was operating hit a car which had stalled on a railway crossing resulting in the death of the driver of the car. The PTSD symptoms developed within two weeks of the accident and Mr J continues to suffer post-traumatic symptoms meeting DSM-IV-TR criteria for Post Traumatic Stress Disorder. His symptoms have persisted and remained at a similar intensity since the accident; he has avoided psychological intervention for fear of having to recall and discuss the traumatic event. Mr J confronted a situation in which someone died and he feared that he would be seriously injured in the accident which fortunately was not the case. He has been suffering re-experiencing, avoidance and hyper-arousal symptoms. He experiences recurrent and intrusive recollections of the accident several times a week of moderate intensity, has recurrent distressing nightmares of the event occurring several nights a week and experiences intense psychological distress when exposed to any cues that symbolise/resemble the accident. Whenever possible, Mr J avoids activities/places/people which arouse recollection of the accident meaning that he stays at home and avoids listening to the television or radio or reading the news, has markedly diminished interest in previously enjoyed activities (tramping and fishing) and he feels detached/estranged from others. He is experiencing persistent symptoms of increased arousal involving difficulty falling asleep at night, irritability and outbursts of anger (causing difficulty in his relationship with his wife of 30 years and his two adult children), is having problems maintaining his concentration when engaged in everyday tasks and reports an increased startle response. He described the psychological symptoms he is experiencing as having detrimentally impacted most aspects of his life. Mr J has no other comorbid psychiatric or substance use problems, has experienced no childhood adversity and has generally faced difficult life situations in a proactive and functional manner. He has little genetic predisposition for mental illness as only one family member has suffered with a mood condition which arose in the context of facing a major life stressor. Ten years ago, Mr J suffered a six-month history of low mood associated with a shoulder injury which resolved once he returned to work. There has been no recurrence of low mood.

Mr J experiences considerable distress because of these symptoms and they impact on his ability to socialise and to manage his anxiety. He has not been able to return to work as a train driver for fear that a similar situation will occur again. He cannot envisage a future where he will be able to engage

in train driving. Currently, Mr J spends his time at home doing very little and ruminating about the accident.

Predisposing factors are largely absent as Mr J has no history of mental illness apart from a brief depressive episode ten years ago, there is no significant history of mental illness in the family and Mr J has previously coped well with life stressors. Mr J meets DSM-IV-TR diagnostic criteria for PTSD for which the traumatic accident is considered to be a significant cause/precipitant of the mental injury. Due to Mr J' previous history of depressive symptoms, he may be susceptible to developing further depressive episodes but he is not depressed currently although clearly distressed by the symptoms he is experiencing.

Symptom Validity

Symptom validity should be considered in any and every assessment. Issues to consider are:

- Whether or not there are any inconsistencies/differences between the various sources of information obtained from third parties, from self-report by the client, from psychometrics, from your own observations of the client,
- Explanations for these inconsistencies/differences,
- Unusual presentations or unusual amounts of distress/lack of distress given the reported difficulties.

Reporting on symptom validity

When you have no concerns:

It is not best practice to simply say "There were no symptom validity issues". Instead you should describe how you have reached this conclusion. For example you might say:

> "There were high levels of consistency between Ms X's presentation during the current assessment, her self-reported description of symptoms and their history, the collateral information provided by her GP and counsellor, and the information from the psychometric assessment. Additionally the Detailed Assessment of Post-Traumatic Stress (DAPS) validity scales did not indicate any areas of concern associated with under or over reporting of symptoms. On this basis there did not appear to be any basis for current concerns about symptom validity."

When some concerns are noted:

Clearly note the nature of the concerns:

Example:

> "There were some inconsistencies noted between Ms X's presentation during the current assessment, her self-reported description of symptoms and their history, the collateral information provided by her GP and counsellor, and the information from the psychometric assessment. In particular, her self-report at assessment indicated events that were significantly more intrusive and occurring over a significantly longer time period than

previously reported. Similarly she reported significantly higher levels of distress than was evident from the previous reports to her GP and previous providers."

Note any discussion of the inconsistencies with the client and their explanation for these if any:

Example:

"When asked about the differences between her descriptions of the events at the current assessment as compared with the reports at earlier assessments Ms X noted that over the years, and as she has felt angrier and less ashamed about the events, she has found it easier to disclose the full extent of the abuse and its impact on her life".

Example:

"When asked about the differences between her descriptions of the events at the current assessment as compared with the reports at earlier assessments Ms X became upset and angry stating that she felt that her personal integrity was being questioned. The matter was not pursued further by the assessor".

Be cautious about offering black and white opinions about the causes for symptom validity issues as it is typically difficult to establish clearly that symptom validity issues arise out of deliberate attempts to mislead (e.g., malingering, factitious disorder), rather than out of unconscious symptom production (e.g., somatoform disorder), personality characteristics, or "cries for help". Instead consider all the possibilities and outline your hypotheses regarding factors/processes other than the index injury/event that may be contributing to the client's current presentation and behaviour.

Example:

"It is noted that Mr X reports significant distress arising from his perception that over the years others have not believed his reports of the abuse, or have been dismissive of the impact that this has had on his life noting that he has even had responses that consider he had "got lucky" at an early age and that other adolescents may have been jealous of his early sexual activity. On this basis although it is possible that the symptom validity issues noted reflect deliberately exaggerated reports of his abuse and its impact, it is considered more likely that these arise from his expectation that no one will listen, believe him or assist him unless he is able to persuade them as to how bad and damaging the abuse was."

Work Related Incapacity

Work related incapacity is assessed if the client is struggling to maintain their usual work patterns or has had to leave employment due to their mental injury presentation. There are two types of earnings related compensation, (a) Weekly Compensation and (b) Loss of Potential Earnings (LOPE).

- When considering weekly compensation, ACC will be looking at whether the client is prevented from engaging in the employment he or she was engaged in when he or she suffered the personal injury. You will be asked to consider whether the client is unable to engage in that employment by reason of his or her mental injury.

- Loss of potential earnings may be payable when the client was under the age of 18 years or engaged in full time study or training that began prior to the age of 18 years at the date of injury. In the case of loss of potential earnings, ACC will be looking at whether the client is unable to engage in work for which he or she is suited by reason of experience, education or training. A list of jobs for which the client is suited by reason of experience, education or training will be given to you and you will be asked to consider whether the mental injury affects the client's ability to engage in the specified work types.

When seeking your opinion, ACC should be clear about the type of incapacity they are considering, and the relevant period for determining incapacity. If you are not clear on this aspect, you should ask the case owner to clarify.

Incapacity in relation to Mental Injury Assessments:

Incapacity is assessed in conjunction with a mental injury assessment and needs to consider the following questions:

- What are the client's diagnoses?
- Which, if any, of these are mental injuries caused by the index event (mental injury caused by physical injury, mental injury caused by sexual abuse, or work related mental injury), and which are other comorbid diagnoses not linked to the index event albeit possibly interacting with and/or exacerbating the mental injury?
- How are the activities of daily living affected by the functional effects of these diagnoses?
- How are various types of work tasks, work environments and work responsibilities affected by the functional effects of these diagnoses?
- Are there any recommendations in relation to workplace and activity changes which might assist rehabilitation and return to work?

Questions of capacity to work can become complex, and may require the input of specialists in occupational medicine. This is particularly so if the nature of the work is of a sort with which the assessor is not personally familiar. Occupational Physicians have had direct exposure to a wide variety of workplaces in their training and their on-going practice, and will likely have knowledge of the specific work demands, environmental considerations, or safety requirements that may be less obvious to psychologists or psychiatrists. On the other hand, psychologists and psychiatrists can provide essential information about the effects of a person's mental injury or comorbid disorders on the mental demands and safety requirements of a work type. In complex cases the final answer may

require a multidisciplinary approach, and assessors must understand the boundaries of these specialist roles.

Nevertheless, sometimes the question of incapacity can be quite straightforward. The two scenarios below provide examples:

The mental injury has severe functional effects on Activities of Daily Living:

If the person's activities of daily living are severely disrupted, it may be obvious that they cannot leave home or cannot function effectively in any meaningful type of employment. Examples would be if the person has Agoraphobia preventing them from reliably venturing from their home unless accompanied; or when panic attacks or frequent dissociation render them ineffective or unsafe.

The mental injury has important functional effects on the mental demands of work:

Some effects of mental injury or comorbid disorders may, in certain safety-critical work types, render the work unsafe for this person to perform. A safety-critical work type is one where the work includes responsibility for the safety of other workers or of the general public. This might include those operating or servicing heavy machinery; certain types of teaching; or health practitioners handling medication/equipment capable of harm if given/used incorrectly. Most importantly some occupations require that the person has a licence issued by a Safety Authority (e.g., drivers of heavy vehicles or passenger vehicles; airline or commercial pilots; air traffic controllers; and seafarers of various types). If a licence is involved, the assessor should carefully describe the possible hazards, but defer to assessors designated by the relevant Safety Authority for an opinion on capacity to work.

Even if a job is not strictly-speaking safety-critical, it may pose hazards to the individual and so be unsafe because of its mental demands or responsibilities. This may relate to work requiring them to have access to toxic materials or medications; to drive to areas not served by public transport; or work requiring prolonged vigilance and scrupulous safety compliance (e.g. working at heights; or repetitively using cutting/shaping tools).

In other cases the functional effects of the mental injury may not pose such immediate safety concerns, but the client's level of cognitive function makes the person unlikely to be effective. In this case the assessor should describe the effects of the mental injury on the person's ability to function and note the particular tasks or situations with which the client is likely to face difficulties.

Impairment Assessments

Clients can apply for lump sum payments/independence allowances when their injury is stable and has caused permanent impairment. To ascertain whether they meet criteria for an independence allowance, clients undergo impairment assessments to determine the extent to which their diagnosed mental injury/ies cause impairment for the client in terms of activities of daily living, social functioning, concentration, persistence and pace, and adaptation/decompensation. The assessments are carried out by medical practitioners trained in the use of the AMA Guides to the Evaluation of Permanent Impairment – 4th Edition. Following this assessment, a client is assigned an impairment rating and, if above 10%, clients receive monetary compensation depending on the extent of impairment. Impairment assessors need to determine the extent of impairment that is directly attributable to the covered mental injury/ies. In order to determine a client's impairment rating, the assessors are heavily reliant on the diagnosis and formulation provided in mental injury/supported assessment. The diagnosis and formulation need to be accurate and comprehensively outlined. If it is not clear how the mental injury assessor arrived at a diagnosis or the Impairment assessor has doubts about the diagnosis provided, the outcome of the impairment assessment is delayed which impacts on the client. It is also important that the validity of symptom reporting and extent of impairment are considered in both the mental injury/supported assessment and the impairment assessment

Outcome Measures

Two outcome measures are being used with the various mental injury assessments although both are not necessary in every instance.

1. World Health Organisation Disability Assessment Schedule – Second Edition WHODAS 2.0
2. Personal Wellbeing Index – PWI

Purpose of Using Outcome Measures

- To design and evaluate the impact of therapeutic interventions.
- To offer additional services that might be useful where this is possible (e.g., transport assistance, social work, whanau support).
- For better understanding of the client, their situation and pressures.

Both of these outcome measures are appropriate to use with clients regardless of their circumstances (e.g., they can be used with prisoners or hospital in-patients). This is because they are holistic measures that do not consider the cause or reason for the client's difficulties with functioning but are simply a means of establishing that there are difficulties. It is also important that administrating clinician does not make any assumptions about whether any particular item will be relevant for a client based on their circumstances. For example it would be easy to assume that some WHODAS 2.0 items about community participation or the PWI item "how satisfied are you with feeling part of your community?" are irrelevant for many prisoners yet, in fact, many will continue to/begin to participate in community activities with community agencies around activities such as education, cultural and

religious activities while they are imprisoned. It is recommended that all questions are put to all clients so that they can decide themselves how best to respond to each item.

World Health Organisation Disability Assessment Schedule – Second Edition WHODAS 2.0

The WHODAS 2.0 was developed by the World Health Organisation and based on the International Classification of Functioning, Disability and Health (ICF). It is an instrument for assessing disability in everyday functioning in adults aged over 18yrs. The WHODAS 2.0 assesses the activity limitations and participation restrictions experienced by an individual irrespective of medical diagnosis – physical or mental. This instrument was developed and tested in a variety of different cultural settings and health populations. The WHODAS 2.0 has been found to be psychometrically robust. A children and young person's version is in the process of being developed.

The WHODAS 2.0 measures six domains with items within domains being rated on a five-point scale ranging from "none" to "extreme" difficulty relating to the last 30 days

- Domain 1: Cognition – Understanding and communicating
- Domain 2: Mobility – moving and getting around
- Domain 3: Self-care – attending to one's hygiene, dressing, eating and staying alone
- Domain 4: Getting along – interacting with other people
- Domain 5: Life activities – domestic responsibilities, leisure, work and school
- Domain 6: Participation – joining in community activities, participating in society

Administration

The version we are asking providers to use is the 36-item self-administered version. The 36-item interviewer-administered version can be used if the client has literacy or fine-motor problems. When a client has a cognitive disability which prevents them from filling out the form, the proxy-administered version can be used.

Self administration takes on average five minutes and the interviewer-administered version takes about 20 minutes. These times are approximate as there is the expectation that the assessor would enquire further if the client reported experiencing significant problems in particular areas.

The WHODAS 2.0 should be administered in the Supported Assessment or when developing the Wellbeing Plan for those who have not had a Supported Assessment within the last three months. It should also be administered at the completion of treatment.

To administer the WHODAS 2.0, it is highly important that the assessor has read the manual and knows how to respond if clients ask questions about particular items. The manual has been distributed to all suppliers but can also be accessed via the following link

http://www.who.int/classifications/icf/whodasii/en/

Scoring

- **Total Disability Score**

There are two forms of scoring: simple or complex

Please use the simple method – the 36-item instrument scoring sheet, simple scoring calculation to obtain the Total Disability score which is expressed as a percentage.

This can be obtained using the above link

- **Scoring each Domain**

Each of the six domains needs to be scored separately

The scores assigned to each of the items within each domain

- None (0)
- Mild (1)
- Moderate (2)
- Severe (3) and
- Extreme (4)

Need to be summed and averaged for each domain.

Some domains have four, five, six or eight questions, so ensure that you are dividing by the right number of questions to obtain the average score for that domain.

Please record the average score for each domain and place in the appropriate boxes on the report forms.

Example:

> If the item scores on the Understanding and Communicating Domain are 4, 3, 2, 2, 1 and 1, the total is 13.
>
> Because there are six items, you divide this score by the number of items in the domain (6) to get the average score for this domain.
>
> 13/6 = 2.166 which is rounded up to 2.17.

Qualitative data needs to be provided in reports. What we are asking is for you to describe the quantitative data obtained especially when the client reports having significant difficulty in areas of functioning. It is very important that qualitative data is obtained as otherwise the scores lack meaningfulness for the reader of the report.

Example:

On the Mobility Domain, if a client who is physically healthy reports that he has 'extreme difficulty' in getting out of his home, this may not make a lot of sense unless it was explained by the assessor that the reason he has problems leaving his home is that he has fears that he might be triggered by seeing someone who looks like his abuser outside of his home environment.

Personal Wellbeing Index (PWI)

This quality of life outcome measure assesses subjective wellbeing. The PWI Scale contains seven items of satisfaction, each corresponding to the following domains:

- Standard of living
- Personal health
- Achieving in life
- Personal relationships
- Personal safety
- Community connectedness; and
- Future security

There is an optional spiritual/religious domain item. This item is optional because it did not make any unique contribution in the Australian population but clinically it may have relevance for the New Zealand population.

There is also a global question which asks about Client satisfaction with life as a whole. This is **not** used in the scoring but it adds useful clinical information.

Parallel forms of the PWI have been developed for population sub-groups.

- **PWI-A**

  Designed for use with the general adult population, aged at least 18 years.

- **PWI-SC**

  Designed for use with school-age children and adolescents. If a child is developmentally incapable of completing the PWI-SC, this should be noted and the scale should not be administered.

- **PWI-ID**

  Designed for use with people who have an intellectual disability or other form of cognitive impairment. The administration of this scale is restricted to psychologists who are experienced in the administration of psychometric instruments. The PWI-ID differs from other versions in that it incorporates a very detailed "pre-testing" protocol to determine whether, and to what level of complexity, the person is able to use the scale.

Note the PWI-PS (Pre-school) will not be used.

It is important that the respective manuals are read carefully. Manuals and the forms for PWI versions have been provided to suppliers but can also be obtained from Deakin University website.

http://www.acqol.com.au/instruments

These scales can be administered in a verbal or written format. Significant others must not respond on behalf of the client as it is important that the client assesses his/her own subjective well-being.

While the manual says the caregiver must not be present, ACC considers that it is appropriate for a client to have the person of their choice in the room.

Scoring

When scoring, convert the score out of 10 to one out of 100 by moving the decimal point to the right – e.g. 7 becomes 70% or an average score of 6.56 becomes 65.6%. Data can be reported at the level of individual domains and averaged to form the Personal Wellbeing Index (PWI). However, the Happiness with Life as a Whole and Spirituality or religion is not used to calculate the PWI and is reported separately. The seven items that follow Happiness with Life as a Whole are totalled and divided by 7, 235/7 = 33.57.

Please provide qualitative data to explain and/or elaborate on the quantitative information obtained.

Getting specialist Psychology Advisor support and advice

The Psychology/Psychotherapy/Psychiatry Advisors (PA's) are always happy to be contacted to provide support and answer questions. It is useful to know that all of the PA's are engaged in other clinical work outside of ACC and all work part-time as a result. If there is a specific PA you wish to talk to the best way of doing this is to ring the help desk number 0800 735 566 and ask to be put through to that person. You may need to ask to be put through to leave a message if you have rung on a day that the person doesn't work. If you don't mind who you talk to then you can simply ask to be put through to any of us. The other effective way to contact a specific PA is to email them. Their email address is first name.surname@acc.co.nz.