Disclaimer

The Long Term Incapacity Allowance (LTIA) Determining Officer's Guideline has been written solely as an internal guide for the use of decision makers of the Social Security Department. The guideline provides a reference and further detail to determining officers in the interpretation of the Social Security (Incapacity Benefits) (Jersey) Law 1974 and its associated regulations, in line with Ministerial policy.

The guideline is comprised of a number of webpages held in a wiki format and is divided into key headings, as many areas cross-reference. The guideline provided is in alphabetical order on topic/section sub headings. All Determining Officers and Medical Board Doctors receive comprehensive training on the principles of decision making and the legislation under which they are required to make decisions, before undertaking actual [LTIA] assessments.

The guideline is regularly updated as legislation and policy changes are implemented, therefore, it is only correct at the time of publishing (16/09/2015). It illustrates the guidance provided at that time and is not a legal document, nor does it constitute legal opinion.

The full guideline contains a number of specific examples to illustrate points. These may be based on real cases as experience is gained and may often be the only example. As such, there is concern that individuals may be identified, or identity assumed. Therefore, to protect the privacy of those who have claimed Long Term Incapacity Allowance and any possible breach of the Data Protection (Jersey) Law 2005, the specific examples have been redacted from the guideline extract provided in response to the FOI request.

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Long Term Incapacity Allowance

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LTIA Determining Officer's Guide

About

Long Term Incapacity Allowance (LTIA) is a weekly benefit, payable as a compensation for a loss of faculty as assessed by a medical board.

Who to contact if you have any questions:

- If you have any questions about the content of this site, please contact your team leader.
- If you have any questions about the site layout or functionality, please contact a member of the Governance team.

LTIA Determining Officer's Guide

Help

Administrators, contributors and approvers should refer to the following document:

Social Security SharePoint Wiki Approver and Contributor Guide

LTIA Determining Officers Guide

Related benefits

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Medical assessment

Scheduled and non-scheduled conditions

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Claim administration

Contribution credits whilst claiming LTIA

Contribution credits may be awarded following an assessment for LTIA.

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Short term fluctuations should be dealt with as above, but when it is possible to identify major changes, either of improvement or deterioration, persisting for substantial portions of the period to be considered, it will be necessary to make separate assessments for these portions.

Examples are a person:

1. who has had a serious injury from which there has been substantial, although incomplete, recovery;
2. whose severe mental illness has entered a prolonged period of remission in response to depot injections or other treatment;
3. with severe osteoarthritis of a joint such as the hip or knee, who has undergone successful arthroplasty; or
4. with ischaemic heart disease, who may have been fairly active (perhaps assessable at 30 per cent) until the occurrence of a myocardial infarction left him with angina on slight effort (perhaps 100 per cent), but may, some months later, have been restored by a 'bypass' operation to a state assessable at a lower figure.

Claim administration

How claims are made

If a person has claimed Short Term Incapacity Allowance (STIA) for the maximum 364 days they will then be sent a form to claim LTIA. However, if they have some loss of faculty but return to work or their doctor does not consider that they are incapable for work prior to claiming STIA for 364 days they may obtain and submit a claim form LTIA. They do not need to send in medical certificates to claim LTIA.

The claimant will be sent a letter asking them to attend an appointment with the medical board. They may submit to the medical board any evidence in support of their claim.

The claimant will also be sent a medical report form to be handed to their doctor to complete with information relevant to their claim. The claimant is advised to arrange to give this to their doctor as soon as possible to ensure that the doctor is able to completed and return it to the department before the date of the medical board appointment.

Claim administration

Increase of LTIA for spouse or partner

An increase in the amount of LTIA can be claimed if a claimants spouse or partner is residing with them and has claimed Home Responsibility Protection for the care of a child under the age of 5 years.

The amount of the increase payable is the same percentage of the standard rate of the dependency increase as the percentage assessment given to the claimant by the medical board.

Therefore a claimant awarded 50% LTIA by the medical board who is eligible for a dependency increase will also receive 50% of the standard rate of the dependency increase.

Claim assessment

Meaning of 'loss of faculty', 'disablement' and 'incapacity'

These terms are not defined in the Social Security legislation but from decisions of the UK Courts and the Social Security Commissioner they have been interpreted as follows:

Loss of faculty

This is best described as any loss of power or function of an organ or part of the body which is a cause of inability to do things. A loss of faculty may be physical or mental.

Any reference to loss of faculty is taken as including reference to disfigurement whether or not accompanied by any actual loss of physical faculty.

Disablement

Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within a range considered normal for a human being

Sum of disabilities by comparison with a normal person is then expressed as a percentage.

Incapacity

Inability to do things or to do them equally well as a person of the same age and sex whose physical condition is normal, which arises from a loss of faculty.

The Commissioner has said that the availability of artificial aids should be taken into account in deciding whether and for how long a loss of faculty would result in incapacity. This is usually where spectacles are prescribed for the correction of errors of refraction and, as far as their use can be tolerated, contact lenses. A successful joint replacement would normally be taken into account in the assessment of incapacity.

The inconvenience of having to use spectacles or a hearing aid may itself be regarded as an incapacity, but the wilful refusal to use a suitable and available aid to mitigate a loss of faculty must not lead to a higher assessment than that given to a person who reasonably agrees to make use of such an aid.

The overall effect of the relevant incapacity, i.e. the overall inability to perform the normal activities of life - the loss of health, strength and power to enjoy a normal life.

Claim administration

Medical Board assessment

At the medical board the doctor assess the claimant's percentage loss of faculty within the relevant legislation and agreed guidelines. If a claimant is entitled to more than one claim to LTIA for separate and unconnected conditions then the percentages awarded for each claim are added together. However a person cannot receive more than 100% of the standard rate of benefit. Therefore if the combined total of the awards is greater than 100% this is capped at 100%.

The duration of the award should consider the likely progress of the loss of faculty taking into account the medical progress of the condition and any likely treatment. An initial assessment will usually be provisional i.e. for a limited period. Subsequent assessments may be final, indicating that the percentage loss of faculty is unlikely to change.

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If a decision on the probable prognosis cannot be made, an assessment should be made for as long a period as seems reasonable, having regard to the customer's condition and any likelihood of change.

Where a provisional assessment is given and LTIA has been awarded, the case will be referred to the medical board for a further assessment before or as soon as reasonably practicable after the end of the period which that provisional assessment takes into account.

Claim assessment

Meaning of permanent and permanently incapable of work

For the purposes of LTIA a condition is considered to be permanent if it is likely to last for at least 6 months.

Separatley wherever the medical board assesses that improvement is improbable, the claimant is not working and is deemed by the medical board to be permanently incapable of work, the LTIA assessment should be made and a percentage awarded.

The board should then also indicate on the medical board report that Incapacity Pension should be considered. The department will then contact the claimant concerning this.

Claim assessment

Pre-existing or congenital conditions

The legislation introducing LTIA came into force on 1 October 2004. This specifically excluded persons from claiming LTIA for conditions that were either congenital or pre existed the introduction of the benefit. This is therefore taken to be prior to 1 October 2004.

However if a person is able to provide sufficient medical evidence to demonstrate that a congenital or pre existing condition has deteriorated since 1 October 2004 then a claim to LTIA can be made and considered by the medical board.

This evidence would normally need to be in the form of a letter from the claimant's doctor and also any other consultant or specialist treating the person.

It might also include the person having claimed STIA since 1 October 2004 for an incapacity for work as a result of a deterioration in the relevant condition. However the presence of any STIA claims would only be one indicator. Therefore the absence of any STIA claims does not necessarily indicate that there has been no deterioration.

Claim administration

Prolonged deterioration and early reviews

If a claimant feels that since the last review their relevant condition has deteriorated they can request an early review of their claim. This request must be accompanied by a letter from their Doctor or treating consultant confirming the deterioration of their condition.

The relevant legislation stipulates that an early review of an assessment can only be made if the medical board doctor is of the opinion that there has been a substantial and unforeseen aggravation of the result of the relevant disease or injury. Also that if due to the probably duration of the aggravation substantial injustice will occur if the assessment is not revised.

If at an early review the medical board the doctor is of the opinion that the condition has deteriorated and an award is increased then this is applicable from the date the claimant's letter requesting an early review was received at the department.

Should the award be reduced by a review medical board the new award is effective from the date of the review board or the paid up to date whichever is later.

Claim administration

Rates and payment of LTIA

LTIA is always assessed as a percentage of the standard rate of benefit based on the person's loss of faculty as determined by the social security medical board. To qualify for the payment of LTIA the person must have an assessment of at least 5%. An assessment of between 5% and 15% inclusive is paid as a lump sum.

Assessments of 20% and above are paid four weekly in advance into a claimant's bank account and may continue to be paid until the claimant reaches pension age.

The medical board doctor should not tell the claimant the level of their percentage award during the medical board. The department will advise the claimant of this in writing within a few days of the medical board being held.

Claim administration

Redeterminations and appeals

If a claimant disagrees with the decision of the medical board, they can ask a medical board to look at it again. This is referred to as a redetermination and is held with a different doctor from the one who conducted the medical board that produced the disputed decision.

This gives the claimant the opportunity to supply additional medical evidence from their GP or the consultant treating them in support of their claim. In addition it gives the claimant the chance to explain afresh how their condition affects them.

Therefore prior to holding a redetermination a dissatisfied claimant is advised that as the award of LTIA is based on medical fact they should obtain a more detailed letter from their clinician explaining the medical facts of the case.

However the supplying of additional medical evidence is not a legal requirement and so should a claimant not submit this a redetermination is still be held.

In addition, as on occasion's medical opinion may differ as to the degree of disability a claimant suffers with, the reconsideration process also allows for any such discrepancy to be addressed without the need for a Medical Appeal Tribunal.

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However the claimant may as a result of the flare up be suffering from a greater loss of faculty than could have been anticipated by the medical board doctor during the last review.

To address this the department is able to accept as evidence of a flare up a letter from the persons GP or consultant treating them outlining the reasons for the flare up and its expected duration. Alternatively a medical certificate can be issued for this purpose.

However if a medical certificate is issued for a condition that is already included on an LTIA claim this can only be accepted as a request for a review of the existing LTIA awarded due to a flare up and not as a separate claim to STIA.

The legal requirements for an early review in respect of a prolonged deterioration also apply to flare ups. Therefore where evidence of a flare up is received this must be referred to a medical board doctor to determine whether the flare up is of sufficient severity and will last a sufficient period to warrant a revised assessment being awarded.

The only exception to this is where the evidence submitted is in the form of a medical certificate issued by a doctor at the General Hospital. In this case it has previously been agreed with the medical board doctors that any such claims can be accepted for an increase in the LTIA assessment to 100% without referral to the medical board.

This is however restricted to a maximum of two medical certificates for a single period of incapacity however long the period is for. Therefore the maximum period that can be covered by this procedure is where the first medical certificate is issued for a period of 4 weeks with a second certificate issued for the following 3 months.

See Example 3.

Claim administration

What is Long Term Incapacity Allowance?

Long Term Incapacity Allowance (LTIA) is a weekly benefit, payable as a compensation for a loss of faculty as assessed by a medical board. Persons claiming LTIA may undertake paid or voluntary work whilst receiving this allowance.

To receive LTIA claimants must meet two contribution conditions:

- First - They must have paid sufficient contributions for at least six months at any time before the end of the relevant quarter applicable to their claim.
- Second - They must have paid (or have been credited) sufficient contributions in the relevant quarter to their claim.

Sufficient contributions means their earnings must have been more than the lower earnings limit for a particular month. If they are a Class 2 contributor they must have paid contributions at the required level. The amount of the lower earning limit changes each January. If any of the necessary contributions in the relevant quarter to their claim have been paid late a person will not be entitled to Long Term Incapacity Allowance.

The relevant quarter can be established from the table below:

If the LTIA claim is received at the Social Security Department during the quarter:	The relevant quarter that affects payment of benefit is:
January - March	July - September in the previous year
April - June	October - December in the previous year
July - September	January - March in the same year
October - December	April - June in the same year

Related benefits

Disablement Benefit

Disablement benefit claims show on Nessie as LTIA claims and can only be differentiated from actual LTIA claims by their start date.

If the claim starts prior to 1 October 2004 the claim is Disablement benefit not LTIA and the claimant has retained rights under the legislation applicable to that benefit.

However any letters sent to Disablement benefit claimants will refer to the benefit as LTIA, as this is the benefit name on Nessie and the title on all payments made.

The claims criteria for Disablement benefit are also different to LTIA claims in that;

1. Disablement benefit is payable anywhere in the world.
2. It can be paid after pension age (but without any dependency increase)
3. It is not an overlapping benefit with old age pension or survivors benefit
4. Awards of 5% - 15% (previously known as Gratuity Benefit) are not overlapping with any Social Security Benefit.
5. Dependency increases can still be applied prior to pension age.
6. Credits are automatically awarded to any claim(s) where the aggregate assessment is 50% or greater for the duration of the assessment period(s).
7. Any assessment or credits awarded cannot be amalgamated with any other LTIA claim.

Disablement benefit claimants dissatisfied with an assessment following a scheduled medical board can still appeal against the decision in the same way as an LTIA claimant and the appeal procedure is also the same.

However as the benefit is payable anywhere in the world, if the claimant is in a country that Jersey does not have a reciprocal agreement with, then a report from the individual's treating doctor or consultant can be accepted as medical evidence for referral to the Jersey medical board to assess the award.

Related benefits

Incapacity Pension

What is Incapacity Pension (ICP)?

Incapacity Pension (ICP) is paid as a compensation for the loss of earnings to people who, because of their loss of faculty, are unlikely to work again. Whilst claiming ICP they must not work even in a voluntary or honorary capacity. ICP is payable up to pension age.

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The remainder should be completed when the claimant has left.

Medical terminology

The use of medical terminology should be avoided. When there is no alternative to the use of a medical expression, it should be clearly explained. For example, "Aortic stenosis (a defective heart valve)".

Some terms have passed into general use, and will be generally understood, such as angina, asthma, migraine, and schizophrenia. However, it is good practice to explain briefly the nature and effects of an unfamiliar condition.

Certain expressions should never be used, such as "Functional overlay". If you think that the disability is less than claimed, you must say so explicitly, supporting your opinion by the medical evidence.

Abbreviations

Do not use technical abbreviations in your reports, such as "LBP"; "IHD". However, abbreviations in common usage are acceptable, for example "etc". and "e.g.". "R" and "L" may be used for right and left, so long as the meaning is clear from the context. If you need to use a medical term frequently, you can abbreviate it once it has been first explained and defined. For example, Non-insulin Dependent Diabetes Mellitus (NIDDM) can then be referred to as NIDDM in the rest of the report.

Harmful Information

This is information which has not been disclosed to the claimant by their medical attendant and of which they are unaware. It is information which would be considered as seriously harmful to their health if divulged to them and is the only type of information which may be withheld from the claimant in the event of a review or appeal.

Examples are details of:

- Malignancy
- Progressive neurological conditions
- Major mental illness.

Try to avoid writing Harmful Information in your reports. If, however, it is unavoidable, it should be entered on a separate page to the report headed Harmful Information with the name of the person and the date of the report to which they refer.

So you should write down the harmful information clearly identifying it as such and, if omitting an entry from the body of the report would leave a gap, write a "harmless synonym" at the relevant place. For example:

On the report:

"Bronchial trouble and persistent headache".

On the harmful information page:

"HARMFUL INFORMATION

True Diagnosis: Bronchial carcinoma with cerebral metastases."

Embarrassing Information

This is information which could not be considered harmful to the claimant's health, but which may well upset or anger them and embarrass you and the Department. If recorded in a report such information may not be withheld from the claimant.

Examples of this type of sensitive information include:

- Criticism of treatment given elsewhere
- Suspicion of malingering which you cannot substantiate
- Reference to any conviction

Medical assessment

Examining the claimant

Before the examination

You should seek the claimant's express permission before proceeding to carry out any physical examination that you deem to be necessary. It is vitally important that all doctors should understand that they must not assume consent.

Explicit consent to the examination and its different parts must be obtained verbally from the claimant, and the fact that this has been done should be noted in the report. A suitable form of words would be along the lines of, "The details of the physical examination were explained to the claimant, who gave consent for the process to proceed."

However if a claimant refuses consent or for any other reason an examination is not possible this must be fully recorded in the report.

The precise extent and nature of the examination will depend entirely on the circumstances of each individual case. You must use your medical professional judgement to decide what examination is indicated, and also whether the claimant should be asked to remove any clothing in order to complete this assessment effectively. Full general examinations are inappropriate in the LTIA assessment and should be avoided.

A further important thing to remember when recording your clinical examination findings is to interpret them by explaining in plain English the significance of the findings, e.g. "Forward flexion of L shoulder restricted to 90 degrees (about half the normal range) and this means that the claimant cannot reach upwards above shoulder level with the L arm."

Conclusion of the examination

After the interview and examination, the claimant should be invited to ask any questions regarding the procedure. It is appropriate to advise that the social security department will be in touch with the claimant as soon as possible but a specific period of time in which this will happen should not be given. No indication should be given of the likely outcome of the claim.

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'No person shall be entitled to be present during the consideration of any question by a medical board other than the claimant and any other person whom the medical board may, with the consent of the claimant, allow to be present as being a person who, in its opinion, is likely to assist it in the determination of that question'

Recording the interview

The time of start of examination is when you first make contact with the claimant. The time the examination ends is the time when the claimant leaves you. You should also add the time at which the form was finally completed.

List all the current diagnoses. Ensure that all conditions entered in the claimant's claim form and GP medical report are included. Previously unidentified conditions which are revealed during the assessment should also be added.

In many instances the entries will be symptoms rather than exact diagnoses. Your role is to assess disability and for that reason precise diagnoses do not add to the determining officers understanding of the report. Only be specific if you have good evidence of the diagnosis. If you write "Lumbar disc protrusion" rather than "Low back pain" and it transpires at an appeal that investigations revealed spondylolisthesis then the whole value of the evidence you have provided for the Department may be undermined.

Medication

Record all regular medication whether prescribed or bought over the counter. Record the dose, if known, without using shorthand or abbreviations.

It is helpful to comment on any analgesics being taken. This may give an insight into the variability of the condition as most people take them when required rather than on a regular basis. "He takes an average of 12 paracetamol (painkillers) a week, usually over three days" provides a picture for the determining officer that will support your description of variability and pain later in the report. It is also useful to comment on the potency of the analgesic.

Note also any side-effects of medication reported by the claimant and explain any additional medication used to ameliorate them; e.g. the use of cimetidine in dyspepsia related to the use of NSAIDs.

It is also helpful to explain the purpose of any medication if known.

Details of any hospital treatment or investigations within the last 12 months

Details of any hospital treatment or investigations within the last 12 months should be recorded. It is most important to keep this information brief, concise and relevant to the present disabilities. Note whether the claimant continues to attend hospital, and the likely date of any proposed treatment procedure or investigation; for example "Is being admitted for lumbar spine operation within the next 6 weeks"; "Due to have a scan in 2 weeks' time".

Details of specific therapy for mental health problems and of mental health professional

It is important that details of therapy relating to a mental health problem are recorded. The name of the person providing such treatment should also be recorded.

Clinical history

A good history is the basis of the assessment medical examination, and the following structure should be used:

- Brief clinical history.
- Brief details of the claimant's domestic situation, for example; "Lives in a 2-storey house with husband and two children aged 10 and 12".
- A brief outline of the claimant's problems and the limitations imposed by the loss of faculty due to them, for example "Variable pain both elbows which the claimant states restricts his/her ability to lift and reach".
- Most important is an outline of how a typical day is spent in the light of the reported limitations.

The typical day

Although not always easy to elicit, a careful and well-focused history of a typical day will greatly help you in completing the rest of the report. If you obtain and record appropriate information at this stage, it will provide you with factual evidence of the effects of the claimant's loss of faculty, which you can then use to support your choice of percentage award.

You must write this section in the third person. It is a record of the claimant's everyday life, without interpretation by the medical examiner. You should make it clear that this is the claimant's account of his disabilities and not your opinion. It is also a factual description of how the claimant's condition affects them in day to day life as elicited by careful interview, using the recommended techniques referred to in the relevant section of this handbook.

The account of the "Typical day" should be particularly focused on the areas of activity which the claimant claims are affected by their medical conditions, and areas likely to be so affected.

You should give specific examples of activities, e.g. "says she enjoys watching television sitting in an armchair for 30 minutes at a time".

Avoid making a statement such as "Can only walk 50 metres" as this may well be taken as fact by the determining officer or the Medical Appeal Tribunal. Better would be; "Says he only walks 50 metres", then give an example of what the claimant actually does, as far as walking is concerned, on an average day: "Walks to the shops and back (about 200 metres in all) but says he has to stop at least twice due to back pain".

Do not feel confined by the space restrictions on the report. If necessary, use an extra blank sheet and afterwards date and sign it and attach it to the report form.

Medical assessment

Introduction to the medical assessment

The medical assessment process as a whole differs in many respects from the traditional history taking and examination in the general practice and hospital setting. It entails bringing together information gained from observation, questionnaire, medical evidence and examination in order to reach an accurate assessment of the disability of a claimant and to provide the information which the departments determining officers require to explain the assessment to the claimant.

It is a complex procedure, involving careful consideration, structured interviewing, lateral thinking and accurate observation, as well as the application of medical skills. There are four stages in performing the LTIA assessment. These are:

- Reading the documents
- Interviewing the claimant
- Examining the claimant

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5/6	0	0	3	4	5	7	10	14	22	24	26	32
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5/9	3	4	5	6	7	10	14	19	26	29	32	37
6/12	4	5	6	7	8	12	17	22	28	32	36	41
6/18	6	7	8	10	12	16	20	25	31	35	40	45
6/24	9	10	12	14	17	20	25	33	42	47	52	57
6/36	12	14	16	19	22	25	33	47	60	67	75	80
6/60	20	22	24	26	28	31	42	60	80	85	90	95
4/60	23	24	26	29	32	35	47	67	85	92	95	97
3/60	25	26	28	32	36	40	52	75	90	95	100	100
NPL	30	32	34	37	41	45	57	80	95	97	100	100

Note 1: NPL = No perception of light

Note 2: These assessments are for defective vision without special features and are based on the visual defect as measured, after correction with glasses.

Visual acuity is measured using the 'Snellen scale'. A Snellen test usually consists of a number of rows of letters which get smaller as they are read down the chart.

On the Snellen scale, normal visual acuity is called 6 / 6, which corresponds to the bottom or second bottom line of the chart. If a person can only read the top line of the chart then this would be written as 6 / 60. This means they can see at 6 metres what someone with standard vision could see from 60 metres away.

The figures 6 / 60 or 3 / 60 are how the result of a Snellen test are written. The first number given is the distance in metres from the chart the person sits when they read it.

Usually this is a 6 (for 6 metres) but would be 3 if they were to sit closer to the chart, i.e. 3 metres away.

The second number corresponds to the number of lines that the person is able to read on the chart. The biggest letters, on the top line, correspond to 60. As they read down the chart, the numbers that correspond to the lines get smaller, i.e. 36, 18, 12, 9 and 6. The bottom line of the chart corresponds to the number 6. Someone with standard vision who can read to the bottom of the chart would have vision of 6 / 6.

See Example 4.

Sometimes visual acuity is recorded in other notations e.g. logMAR or cycles per degree. These other notations can (with care) be converted to a Snellen fraction for comparison.

If acuity has been recorded using logMAR or cycles per degree the tables below can be used to approximate the Snellen fraction. Also available in the tables is a conversion from metric (UK standard) to Imperial (US standard) recording.

Note: tests which use logMARf or cycles per degree to record acuity may not be measuring the same type of visual acuity as a Snellenormat change test and conversions must be treated with caution.

Snellen equivalent	LogMAR	Cycles per degree (cpd)
6/12 (20/40)	0.3	15.0
6/18 (20/60)	0.5	10.0
6/24 (20/80)	0.6	7.5
6/36 (20/120)	0.8	5.0
6/48 (20/160)	0.9	3.75
6/60 (10/200)	1.0	3.0
6/72 (10/240)	1.1	2.5
6/90 (20/300)	1.2	2.0
6/120 (20/400)	1.3	1.5
6/150 (20/500)	1.4	1.2
6/180 (20/600)	1.5	1.0
6/240 (20/800)	1.6	0.75
6/360 (20/1200)	1.8	0.50
6/480 (20/1600)	1.9	0.28

Measurement

Visual acuity is typically measured monocularly rather than binocularly with the aid of an optotype chart for distant vision, an optotype chart for near vision, and an occluder to cover the eye not being tested.

The medical board may also occlude an eye by sliding a tissue behind the patient's eyeglasses, or instructing the patient to use his or her hand. This latter method is typically avoided in professional settings as it may inadvertently allow the patient to peek through his or her fingers, or press the eye and alter the measurement when that eye is evaluated.

1. Place the chart at 6 meters and illuminate to 480 lux at that distance.
2. If the patient uses glasses, then the test is performed using them. If they do not have their glasses with them then the test using a pinhole should be done.

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- suprasellar meningioma

Homonymous quadrantanopia describes the loss of the same quadrant of the visual field in both eyes. An example might be a "left homonymous upper quadrantanopia" suggestive of a lesion in the right temporal lobe.

There are

two types:

- Upper quadrant - Loss of vision in both upper temporal quadrants is suggestive of an early lesion at the optic chiasm
- .
- Lower quadrant - Loss of the same upper quadrant from each visual field. Usually caused by damage to the optic radiation as it passes through the parietal lobes.

An assessment of between 30 to 50% would be reasonable for these field defects. These are in addition to the assessment for the loss of visual acuity.

Aphakia

This is where a person has an absence of the internal lens to the eye which causes the eye to be severely out of focus.

Although an eye into which an artificial lens has been implanted is not, strictly speaking, aphakic, it must be remembered that accommodation is impossible. An assessment in the lower part of the range usually accepted for aphakia may be appropriate.

Medical Appeal Tribunals have normally taken account of the degree of tolerance and sensitivity to the wearing of a contact lens in assessing the degree of incapacity - see the table below.

Conditi	on	Per cent
Unilateral aphakia with reasonable correction by a contact lens	15 - 24	
Bilateral aphakia with reasonable correction by contact lens(es)	25 - 30	

cheduled and non-scheduled conditions

Deafness

The medical board doctor should assess hearing loss clinically with the person using hearing aids if normally worn. Absolute deafness is covered by the prescribed degrees of incapacity.

If there is conflicting evidence on the degree of deafness, then it is advisable that the medical board should state the reason for its preference of that on which its assessment is based.

Standing 5 metres behind the person they should talk in a normal voice and ask whether the person can hear. If not move to 2 metre and repeat the test. If still cannot hear go to 30 cm and repeat the test. If still not able to hear shout at 1 metre.

It is important that the test is in keeping with the informal observations of the claimant's hearing.

Degree of hearing attained with both ears used together with average assessments for the degree of deafness which have been given by UK Medical Appeal Tribunals(figures in percentages):

Test	Per cent
Shout not beyond 1 metre	80
Conversational voice not over 30 centimetres	60
Conversational voice not over 1 metres	40
Conversational voice not over 2 metres	20
Conversational voice not over 5 metre	10
Otherwise	0

Notes on the assessment of deafness

Where the hearing in one ear is normal and there is significant deafness in the other ear the shout test as described above will show normal hearing and on this basis there is no loss of faculty. However the person may have difficulty detecting the direction of a shout so an assessment of around 5% would be appropriate.

The assessments given above apply to deafness only. Any additional features such as vertigo, tinnitus or chronic suppuration may warrant an addition to the assessment. When such additions are made, the reasons should be made clear in the report.

cheduled and non-scheduled conditions

Disfigurement

In assessing conditions of the face and scalp the factor of disfigurement is important.

cheduled and non-scheduled conditions

Flail joints

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7	Amputation through shoulder joint	90
8	Amputation below shoulder with stump less than 20.5 centimetres from tip of acromion	80
9	Amputation from 20.5 centimetres from tip of acromion to less than 11.5 centimetres below tip of olecranon	70
10	Loss of hand or of the thumb and four fingers of one hand or amputation from 11.5 centimetres below tip of olecranon	60
11	Loss of thumb	30
12	Loss of thumb and its metacarpal bone	40
13	Loss of four fingers of one hand	50
14	Loss of three fingers of one hand	30
15	Loss of two fingers of one hand	20
16	Loss of terminal phalanx of thumb	20
	Amputation cases - lower limbs	
17	Amputation of both feet resulting in end-bearing stumps	90
18	Amputation through both feet proximal to the metatarso-phalangeal joint	80
19	Loss of all toes of both feet through the metatarso-phalangeal joint	40
20	Loss of all toes of both feet proximal to the proximal inter-phalangeal joint	30
21	Loss of all toes of both feet distal to the proximal inter-phalangeal joint	30
22	Amputation at hip	90
23	Amputation below hip with stump not exceeding 13 centimetres in length measured from tip of great trochanter	80
24	Amputation below hip and above knee with stump exceeding 13 centimetres in length measured from tip of great trochanter, or at knee not resulting in end-bearing stump	70
25	Amputation at knee resulting in end-bearing stump or below knee with stump not exceeding 9 centimetres	60
26	Amputation below knee with stump exceeding 9 centimetres but not exceeding 13 centimetres	50
27	Amputation below knee with stump exceeding 13 centimetres	40
28	Amputation of one foot resulting in end-bearing stump	30
29	Amputation through one foot proximal to the metatarso-phalangeal joint	30
30	Loss of all toes of one foot through the metatarso-phalangeal joint	20
	Other losses of faculty	
31	Loss of one eye, without complications, the other being normal	40
32	Loss of vision of one eye, without complications or disfigurement of eyeball, the other being normal	30
A	**Fingers of right or left hand**	
	Index finger	
33	Whole	14
34	Two phalanges	11
35	One phalanx	9
36	Guillotine amputation of tip without loss of bone	5
	Middle finger	
37	Whole	12
38	Two phalanges	9
39	One phalanx	7
40	Guillotine amputation of tip without loss of bone	4
	Ring or little finger	

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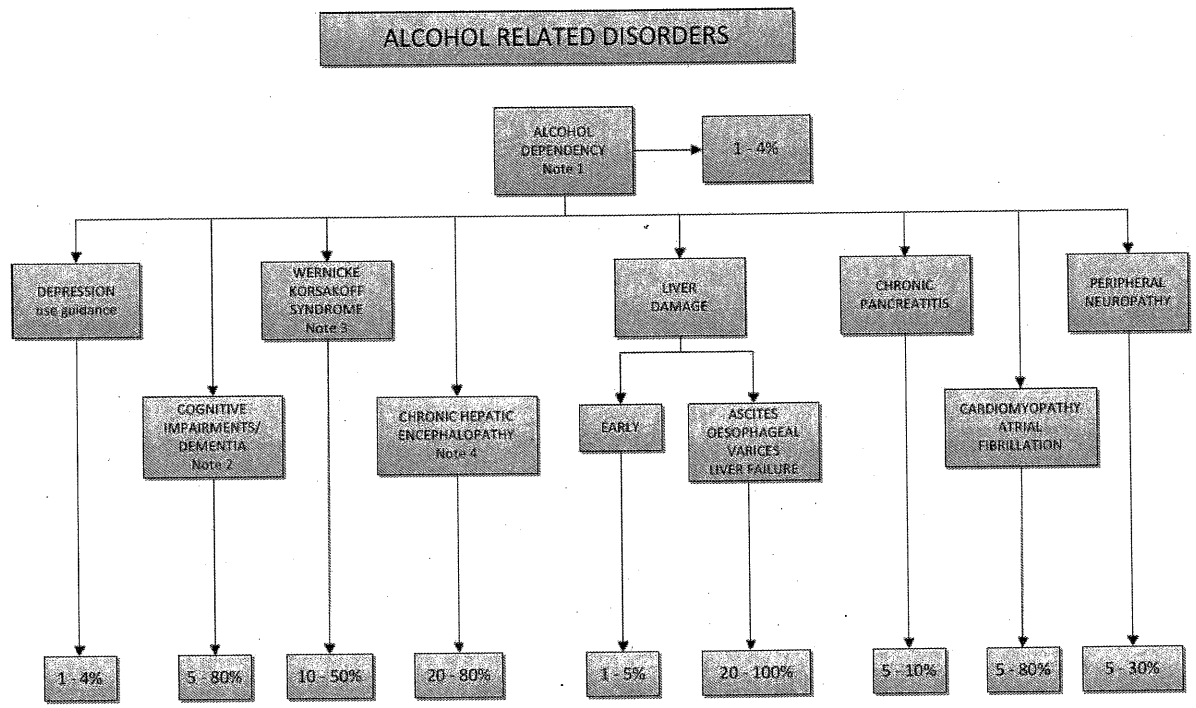
Page Content

General guide to assessments

Assessment	Degree of loss of faculty
Less than 1%	Virtually no disablement
1 - 4%	Minimal disablement (loss of toe through metatarsal – phalangeal joint)
5 - 10%	Very mild disablement (loss of 2 phalanges middle finger)
11 - 20%	Mild (loss of index finger)
21 - 30%	Mild/moderate disablement (loss of vision in one eye)
31 - 50%	Moderate disablement (below knee amputation)
51 - 80%	Moderately severe (upper thigh amputation)
81% +	Severe disablement (loss of both hands)

Assessment guides

Guide to alcohol abuse assessments



Note 1 – Alcohol dependency

The symptoms of alcohol dependence include:

- Unable to keep a drink limit.
- Increased tolerance to alcohol. However, in the later stages of alcohol dependence, there may be a decreased tolerance to alcohol as a result of liver and central nervous system damage.
- Difficulty in getting drunk.
- Spending a considerable time drinking.
- Organising the day around drinking.
- Missing meals.

Note 2 - Cognitive impairment and dementia

- Damage to the brain occurs, especially the frontal lobe. This results in loss of memory, deterioration of personality and loss of intellectual ability. Interpersonal skills, attendance to usual interests and responsibilities may deteriorate and self-neglect may result.
- Depression caused by a direct effect of alcohol on the brain and exacerbated by social problems that include unemployment, divorce and debt. There is an increased incidence of deliberate self-harm. The suicide rate is increased six fold in people who are dependent upon alcohol.
- Anxiety. People often use alcohol to relieve symptoms of stress and anxiety. However, anxiety symptoms increase during periods of withdrawal, leading to a cycle of increased consumption.

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Page Content

Chronic fatigue syndrome (CFS) is also known as myalgic encephalomyelitis (ME) and post-viral fatigue syndrome. There is some difference of opinion over whether ME is different from CFS; however, most authorities refer to the condition as CFS/ME.

The symptom of fatigue is a feeling that can sometimes be difficult to describe and to measure. It is a feeling of exceptional or abnormal tiredness or lack of energy in excess of that anticipated in response to current activity. Fatigability in CFS/ME is the overwhelming feeling of exceptional tiredness exacerbated by exertion. CFS/ME is identified by its symptoms and disabling effects, and by excluding other medical conditions that could explain them. There are no confirmatory abnormal findings on physical examination, nor is there any specific investigation such as an abnormal blood test that is diagnostic. This does not mean that CFS/ME is not a real illness, and all medical authorities now accept the illness as being a severe and valid condition.

A consensus definition of CFS/ME has been agreed by international experts for the purposes of research and includes the following:

- A complaint of persistent or relapsing fatigue for 6 months or more that is:
  - Of new or definite onset,
  - Not the result of ongoing exertion,
  - Not substantially alleviated by rest,
  - Results in a substantial reduction in previous levels of occupational, education and social or personal activities.
- Four or more of the following symptoms for 6 months or more:
  - Impaired short-term memory or concentration
  - Sore throat,
  - Tender lymph nodes (neck or armpits),
  - Muscle pain,
  - Pains in a number of joints (without arthritis),
  - New headache,
  - Un-refreshing sleep,
  - Malaise lasting more than 24 hours after exercise
- Other physical causes of fatigue such as anaemia, thyroid disease, sleep apnoea, malignancy, liver disease etc. are excluded.
- Major mental health disorders are excluded, although as with other chronic conditions, people with CFS/ME may have conditions such as depression and generalised anxiety disorder occurring at the same time.

A number of other medical conditions such as fibromyalgia, irritable bowel disease and migraine may also occur in people with CFS/ME. These have some symptoms in common with those described in CFS/ME.

It is estimated that around 1 in 200 of the UK population have CFS/ME. It is predominantly a disease of young adults (commonest incidence between 25 to 50 years) and occurs in all socio-economic groups. It appears to be more common in women [female: male 2:1 or 3:2].

Causes of CFS/ME

A specific cause of CFS/ME has not as yet been identified. Possible causes of the condition have been the subject of much debate. It is likely that the term CFS/ME describes a spectrum of disorders in which physical and mental functioning are affected. In some cases infectious illnesses like glandular fever may trigger the onset of the condition. There is no evidence however that persistent infection is responsible for the continuation of the illness. Although the cause is not fully understood, changes associated with CFS/ME may include an altered stress hormone response, altered immune response, altered gene expression, sleep problems, alterations of mood, and coping strategies. Different factors are likely to be important in different people at different times.

There has previously been much debate as to whether CFS/ME is a physical illness or not. Some researchers have put forward the argument that it is a purely psychological disorder, citing in evidence the high rate of co-morbid depression. Others are equally sure that it is purely physical, citing the abnormal hormonal tests found in some or the triggering of the illness by certain infections. Both views are oversimplifications. The reality is that the disability of CFS/ME involves both physical and mental incapacity.

Risk of developing and maintaining CFS/ME

Although the cause of CFS/ME is unclear, certain factors may be important in its development. These are usefully divided into predisposing, triggering and maintaining factors. Some people may be predisposed to the condition, for example because of their genetic makeup, or gender. For example the condition is commoner in young women.

An infectious disease such as glandular fever (infectious mononucleosis) or a major physical illness may trigger the condition. Other stressful life events or difficulties may precede development of CFS/ME, particularly if the stress is ongoing. Finally some other factors may help to keep the illness going. For example, poor sleep, poor nutritional uptake, or a concurrent mood disorder.

Clinical features

The main symptoms are persistent mental and physical fatigue, tiredness or exhaustion that are characteristically made worse by activity. People often do not sleep well and find that sleep fails to refresh them. Often they feel symptoms more after physical or mental activity, even minor exertion within the home environment, and this effect is characteristically delayed until the next day or so, and is prolonged. Muscles and joints ache and are painful. Headaches, sore throat and tender lymph glands in the neck and armpits are described. People with the condition also report short-term memory loss and poor concentration. Their mood may fluctuate and they may be prone to feelings of anxiety. Hypersensitivity to everyday levels of noise and light are reported.

People with CFS/ME often describe variation in the level of symptoms and disability. Symptoms of fatigue and pain may vary in their severity during the course of the day, or may be considerably worse for several days after undertaking unaccustomed levels of physical or mental activities, even if these involve relatively simple tasks. Patients may be able to undertake a task for a short period of time, but then be unable to sustain or repeat it.

Those whose symptoms are mild may continue to undertake a range of normal daily activities. Some people will be able to carry out their occupation but have to reduce their social activities. Those with more severe forms of the condition are unlikely to be able to continue at work or in education. Daily living activities, hobbies, interests and social interaction are also likely to be considerably reduced. In the most severe cases the individual may spend almost all of the day resting, or be bed-ridden. Some people may use a wheelchair outside to minimise the fatigue and symptoms such as joint/muscle pain, or problems with dizziness/balance, engendered by walking.
Between, a quarter and a half of people with CFS/ME are in part-time or full time employment or education. When compared to people with other diseases like diabetes mellitus or arthritis seen in hospital clinics many people with CFS/ME are on average more disabled.

Physical examination is normal in most cases. Some people may have postural hypotension. (Normally blood pressure is lower when sitting or lying in bed, on standing up it rises. In some people, in particular the elderly, there is a lag phase - a time interval - during which the pressure rises to the higher level. This may be experienced as a sensation of dizziness or light-headedness, and sometimes in the elderly leads to falls). Those who are the most chronically and severely disabled may have some observable generalised muscle wasting, most likely to be found in the lower limbs, although this is unusual.

Treatment / Management

Medication

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Virtually none Less than 1%	Able to work and engage in social activities Near normal exercise tolerance No cognitive impairment Under care of GP
Minimal 1-4%	Able to work and engage social activities Able to walk long distances may be reduced No cognitive impairment Under care of GP
Very Mild 5-10%	Able to work and engage social activities but fatigue may limit attendance at times Ability to walk long distances reduced Usually under care of GP
Mild 11-20%	Difficulty with work attendance due to fatigue Able to manage personal care Able to walk 100 to 200 metres Tasks may take longer than normal and may need to be followed by a period of rest
Mild/Moderate 21-30%	Unlikely to work due to fatigue and some cognitive impairment Able to walk around 100 metres but fatigued after Usually able to manage personal care although slowly and followed by a period of rest May have received specialist input
Moderate 31-50%	Unable to work due to fatigue and cognitive impairment Able to walk around 50 metres but may be followed by a period of fatigue Prescribed wheelchair for outdoor use Specialist input at some time during illness
Moderate/Severe 51 - 80%	Unable to work or engage in social activities Spends most of time in bed Poor attention/concentration Cognitive impairment Severe fatigue after mild physical/mental exertion Prescribed wheelchair – use indoors and out Prescribed environmental adaptations Generalised muscle wasting particularly lower limbs

Assessment guides

Guide to Chronic Obstructive Pulmonary Disease (COPD) assessments

What is COPD?

Chronic obstructive pulmonary disease (COPD) is an umbrella term for a group of disorders, which are progressive, long term and characterised by difficulty in breathing. This is due to airflow obstruction, which is progressive, not fully reversible and does not change markedly over several months.

COPD is the term encompassing chronic bronchitis and emphysema. In most people, there is considerable overlap in the two conditions although each condition may exist by itself. COPD does not include other obstructive lung diseases such as asthma.

COPD develops gradually over many years and usually is symptomatic, from middle age, (commonly the 5th decade) onwards, when the diagnosis is usually made. While it is present in 18% of male smokers in the UK, it is present in 14% of female smokers and is a significant reason for hospital admissions and lost working days.

It is one of the greatest causes of death in the world, being the 4th leading cause of death in the USA, was 4th in the year 2000 global mortality table and is currently rated 6th leading cause of death in the UK.

"Fifty percent of patients with severe breathlessness due to COPD die within 5 years."

"At least 25,000 people die each year in the UK from the end stages of COPD."

"A recent American Lung Association survey revealed that 51% of all COPD patients say that their condition limits their ability to work. 70% are limited in normal physical exertion, 56% in household chores, 53% in social activities, 50% in sleeping and 46% in family activities."

The statistics are gradually changing as smoking is decreasing in wealthy countries and increasing in poorer countries and as more women are smoking and at an early age.

There are two separate processes occurring; the process involved in chronic bronchitis and that involved in emphysema.

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Table 3 Clinical features differentiating COPD and asthma

	COPD	Asthma
Smoker or ex-smoker	Nearly all	Possibly
Symptoms under age 35	Rare	Often
Chronic productive cough	Common	Uncommon
Breathlessness	Persistent and progressive	Variable
Night time waking with breathlessness and/or wheeze	Uncommon	Common
Significant diurnal or day-to-day variability of symptoms	Uncommon	Common

Clinical features in COPD

Symptoms

Initially, there may be few symptoms except for a "smoker's cough" with sputum (productive cough). The frequency of the cough and the amount of sputum steadily increases as the disease progresses. At first, the attacks of productive cough occur in the winter after colds, but eventually, with increasing severity of the disease the cough is ever- present.

With progression of the disease, breathlessness on exertion occurs with morning cough, recurrent respiratory infections and a now constant "smoker's cough". The person becomes increasingly disabled by exertional breathlessness, and eventually in severe cases may become breathless at rest. People with COPD are more susceptible to bacterial infections and breathlessness may be exacerbated by smoke, atmospheric pollutants and respiratory tract infections.

In severe cases the heart failure occurs.

Signs

In the early stages there may be no abnormal signs, but rhonchi on breathing in and breathing out may be heard, as well as crackles in the lower zones of the lungs.

In a person with severe disease, there will be the signs of breathlessness at rest, leaning forward, using extra muscles in the neck, abdomen and chest to breathe, reduced chest expansion and a hyper-inflated chest. Loss of weight is common and there may be cyanosis (blueness) and oedema (swelling) suggesting right heart failure.

The "Blue bloater" is often representative of a person with COPD

Poor respiratory drive with the following features evident:

- Relatively mild breathlessness (dyspnoea)
- Obese and plethoric (high colour)
- Oedema (swelling) and congestive heart failure
- Large volume sputum (productive cough)
- Hypoxia (low O2) and hypercapnia (raised CO2)
- Polycythaemia
- Sleep apnoea
- Unexpectedly well- preserved lung function
- No emphysema on X-Ray
- Poor prognosis with 70% 5-year mortality.

Clinical features of Emphysema

Symptoms

- Emphysema develops gradually over a period of years.
- People with emphysema have great difficulty in exhaling (breathing out). Symptoms such as shortness of breath (sometimes associated with wheeze) occur initially on exertion and then as the disease progresses, with little exertion and ultimately at rest. The person eventually may not be able to carry out basic activities in a normal fashion. At end-stage disease the person may be dependent on oxygen for several hours a day.
- Weight loss caused by reduced eating and interest in eating because of poor breathing ability
- Feeling of tiredness because of chronic lack of oxygen in the body. Other symptoms may be impaired memory and concentration, irritability and excessive daytime sleepiness.

Signs

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- Oxygen therapy reduces the risk of pulmonary hypertension and nocturnal falls in oxygen concentration.
- Pulmonary Rehabilitation increases muscle fitness and improves (mental) outlook. It is not used just for improving lung function

Stopping Smoking

The acceleration of COPD & Emphysema can be reduced by stopping smoking.

The most important management factor is stopping smoking. This will help slow the rate of deterioration but will not reverse existing damage to the lungs.

However, it will extend life expectancy. The patient should try all strategies to stop and if they stop sufficiently early, this will prevent the continuing accelerated decline in lung function. Strategies include:

- Support and encouragement from the GP and Chest Clinic.
- Nicotine replacement in the form of chewing gum or patches absorbed through the skin.
- Bupropion tablets (to aid the cessation of smoking).

Bronchodilator Medication

"The effectiveness of bronchodilator therapy should not be assessed by lung function alone but should include a variety of other measures such as improvement in symptoms, activities of daily living, exercise capacity and rapidity of symptom relief."

Therefore, the continuing use of bronchodilators depends on both the subjective feedback from the patient (i.e. that the symptoms have eased) and objective assessment.

Types of bronchodilators used are:

- Beta agonist inhalers such as Salbutamol (Ventolin), Terbutaline (Bricanyl), which are short- acting, Salmeterol (Serevent), Formoterol (Oxis or Foradil) which are long- acting
- Anti-cholinergic or anti-muscarinic inhalers (such as Ipratropium (Atrovent or Respontin), which are short-acting) and Tiotropium (Spiriva), which is long- acting.

However, the two drugs may be taken in combination and this has been shown to be effective in some patients. Such combinations are combivent (salbutamol and ipratropium) and Duovent (fenoterol and ipratropium).

- For mild disease, short- acting bronchodilators should be the initial treatment for the relief of breathlessness and exercise limitation.
- Patients who remain symptomatic should have their inhaled treatment intensified to include long- acting bronchodilators or combined therapy with a short- acting beta2 – agonist, and a short- acting anticholinergic. (Long-acting bronchodilators should be used in patients who do not respond to short-acting bronchodilators, because they appear to have additional benefits over combinations of short-acting drugs).
- Long-acting bronchodilators should also be used in patients who have 2 or more exacerbations a year.

Theophylline (in slow- release formulations)

Theophylline should only be used after a trial of short-acting bronchodilators and long-acting bronchodilators or in persons who are unable to use inhaled therapy. There is a need to monitor plasma levels and interactions with this drug.

Corticosteroids

Inhaled corticosteroids are mainly used for reducing the frequency of exacerbations (relapses) and to slow the decline in health status - not to improve lung function.

Inhaled corticosteroids should be used in patients:

- Who have an FEV1 of less than, or equal to, 50% of predicted
- Who are having 2 or more exacerbations requiring treatment with antibiotics or oral corticosteroids in a 12- month period.

There is a potential risk of developing osteoporosis and increased susceptibility to pneumonia in patients treated with high dose inhaled steroids. Maintenance use of oral corticosteroid treatment in COPD is not normally recommended.

Combination Therapy

If a patient still has symptoms on monotherapy, combination therapy may be tried, and these may include:

- Beta2 agonist and anticholinergic (Salbutamol and Ipratropium known as Combivent).
- Beta2agonist and theophylline.
- Anticholinergic and theophylline.
- Long-acting beta2agonist and inhaled corticosteroid (Seretide).

Again, the clinical effectiveness of combined treatments is assessed by:

- Symptoms,
- Activities of daily living,
- Exercise capacity,
- Lung function.

Antibiotics

When a bacterial infection is suspected by the GP, antibiotics should be used. There are many antibiotics to choose from and newer antibiotics may be used for more severe or resistant infections.

Pulmonary Rehabilitation

Most patients are middle-aged to elderly with associated problems of increasing age. Pulmonary rehabilitation should be considered for those with moderate to severe disease.

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Mild (11-20%)	Regular antimuscarinic bronchodilator (short or long-acting) (eg Ipratropium (short acting) Tiotropium (Spiriva) (long acting) plus • Long- acting Beta2 agonist • Salmeterol (Serevent) or • Formoterol Oxis (Foradil) or In combination Combivent (Salbutamol and Ipratropium and Duovent (Fenoterol and Ipratropium) or Inhaled Steroids (for those with frequent exacerbations and reversibility)	May have difficulty walking with peers. Can walk several hundred metres at own pace without stopping	Early X Ray changes present Loss lung function 10-20%
Mild/Moderate (21-30%)	Regular antimuscarinic bronchodilator (short or long-acting) (eg Ipratropium (short acting) Tiotropium (Spiriva) (long acting) plus • Long- acting Beta2 agonist • Salmeterol (Serevent) or • Formoterol Oxis (Foradil) or In combination Combivent (Salbutamol and Ipratropium and Duovent (Fenoterol and Ipratropium) or Inhaled Steroids (for those with frequent exacerbations and reversibility)	Can walk 500metrs on the flat at own pace without stopping	Established X-Ray changes. Loss of lung function 25-40%
Moderate (31-50%)	This may include: • Inhaled short-acting beta agonist, or antimuscarinic bronchodilator – Regular treatment (such as three times a day) • Inhaled steroids • Nebulized bronchodilator • Short course of oral steroids • Antibacterial treatment (antibiotics) • Combination of long-acting beta2 agonist, and inhaled corticosteroid (Seretide) • Theophylline (often used when other treatments have failed to adequately control symptoms) (Nuelin, Slophyllin, Uniphyllin) • Combinations of Salbutamol and Ipratropium (Combivent)	Manages 50 to 100 metres on the flat without stopping. Short of breath at the top of house stairs Likely to be under specialist care	Moderate X Ray changes Loss lung function 45-50%
Moderate/ Severe 51-80%	• Inhaled short-acting beta agonist, or antimuscarinic bronchodilator – Regular treatment (such as three times a day) • Inhaled steroids • Occasional oxygen • Nebulized bronchodilator • Short course of oral steroids • Antibacterial treatment (antibiotics) • Combination of long-acting beta2 agonist, and inhaled corticosteroid (Seretide) • Theophylline (often used when other treatments have failed to adequately control symptoms) (Nuelin, Slophyllin, Uniphyllin) • Combinations of Salbutamol and Ipratropium (Combivent)	Able to walk 20-50 metres slowly on the flat. Stops on stairs due to breathlessness Under specialist care	Major X Ray changes Lung function 55 to 60%
Severe 81+%	• Inhaled short-acting beta agonist, or antimuscarinic bronchodilator – Regular treatment (such as three times a day) • Inhaled steroids • Nebulized bronchodilator • Short course of oral steroids • Antibacterial treatment (antibiotics)	Short of breath at rest Unable to manage stairs (stair lift or sleeps downstairs)	Severe X Ray changes Loss lung function 70+%

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51 - 80%	Social withdrawal
	Severe depressed appearance
	Slow, hesitant monotone speech
	Psychomotor retardation
	Serious impairment judgement
	Morbid pessimistic thoughts
	Suicidal preoccupations
	Self neglect
	Poor attention/concentration
	Psychotic feature (consider 70-80% if present)

LTIA Determining Officers Guide

Form templates

LTIA Determining Officers Guide

Claim administration

Section Index

What is Long Term Incapacity Allowance?	Rates and payment of LTIA	How claims are made
Medical Board assessment	Increase of LTIA for spouse or partner	Contribution credits whilst claiming LTIA
Redeterminations and appeals	Prolonged deterioration and early reviews	Short term deterioration and flare-ups
Multiple claims or medical conditions		

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