Training Course in the use of the Guide for the Evaluation of Psychiatric Impairment for Clinicians (the GEPIC)

Reasons for measurement of psychiatric impairment

- Gate-keepers
- Accident Compensation Act
- To determine “serious injury”
- To determine compensation for non-economic loss
- Transport Accident Act
- To determine impairment benefits
- Wrongs Act Certification of Impairment (only non secondary is counted)

Comparison of methods for the assessment of psychiatric impairment in Victoria

Jurisdiction		
Workers' compensation	GEPIC for **assessments** first done on or after 26 July 2006 *Clinical Guidelines to the Rating of Psychiatric Impairment*, 1997, for **injuries** on or after 12 November 1997; 30% threshold for psychiatric impairment (cf 10% physical). Only impairment not secondary to physical injury counts	
Transport accidents	GEPIC for accidents on or after 26 July 2006 *Clinical Guidelines to the Rating of Psychiatric Impairment*, 1997, for accidents on or after 19 May 1998 to July 2006 10% threshold for psychiatric impairment is combined with other physical body impairments to derive overall whole person impairment.	

Comparison of methods for the assessment of psychiatric impairment in Victoria

Jurisdiction	
Wrongs Act Claims	*GEPIC*, only for impairment not secondary to physical injury and not from unrelated injury or causes with a threshold of more than10 per cent for common law claims.

Problems with measuring psychiatric impairment

- No ‘gold standard’
- Blurring of impairment and disability
- Relies on self-reporting
- Inherent absurdity of collapsing a complex pattern of behaviour into a single number

In the beginning

- **AMA 2 Chapter 12 from 1985**
- Table, no means of determining final score. Widely varying results
- **User's Manual (1994) unofficial**
  - To provide more descriptors and to develop a way of determining the final score – median method

Impairment Assessment Using AMA 4 Guides
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The Clinical Guidelines

- The Clinical Guidelines, a development of the manual – gazetted 1997
- Based on AMA 2: mental and behavioural impairment chapter focuses on mental status assessment
- add definitions
- remove anomalies: ability and potential
- median method to combine scores

RANZCP Practice Guideline #9
CONDUCTING INDEPENDENT MEDICAL EXAMINATIONS AND PREPARING REPORTS

Mental status examination

A mental status examination for medico-legal purposes generally contains
the minimum core elements of:

- appearance and general behavior
- mood
- affect
- speech and language
- psychomotor behaviour
- thought content
- thought form or associations
- perceptual abnormalities (if any)
- suicidal, homicidal, violent, or self-injurious thoughts or impulses
- examinee or patient's understanding of his or her current situation, and
- elements of the cognitive status (Systematic assessment of cognitive functions is an essential part of the general psychiatric evaluation, the level of detail necessary and the appropriateness of particular formal tests depend on the purpose of the evaluation and the psychiatrist's clinical judgment).

CLINICAL GUIDELINES TO THE RATING OF PSYCHIATRIC IMPAIRMENT

Prepared by

Members of

MEDICAL PANEL (PSYCHIATRY)

Melbourne, Vic, Australia

October 1997

Table for the Clinical Guidelines to the Rating of Psychiatric Impairment

Class of Impairment	1	2	3	4	5
Percentage of Impairment	**0% to 5%**	**10% to 20%**	**25% to 50%**	**55% to 75%**	**over 75%**
MENTAL FUNCTION					
Intelligence *(Capacity for understanding)*	Normal or better	Mildly Retarded	Moderately Retarded	Moderately Severely Retarded	Severely Retarded
Thinking *(The ability to form or conceive in the mind)*	No Deficit	Slight Deficit	Moderate Deficit	Moderately Severe Deficit	Severe Deficit
Perception *(The brain's interpretation of internal and external stimuli)*	No Deficit	Slight Deficit	Moderate Deficit	Moderately Severe Deficit	Severe Deficit
Judgment *(Ability to assess a given situation and act appropriately)*	No Deficit	Slight Deficit	Moderate Deficit	Moderately Severe Deficit	Severe Deficit
Mood *(Emotional tone underlying all behaviours)*	Normal	Slight Problem	Moderate Problem	Moderately Severe Problem	Severe Problem
Behaviour *(Behaviour which is disruptive, distressing or aggressive)*	Normal	Slight Problem	Moderate Problem	Moderately Severe Problem	Severe Problem

Note: 1. In evaluating the "whole person psychiatric impairment" intermediate values which are not included in the "classes" which rate individual impairments may be used.

THE GUIDE TO THE EVALUATION OF PSYCHIATRIC IMPAIRMENT FOR CLINICIANS

(GEPIC)

Prepared by

M.W.N. Epstein, G. Mendelson, N.H.M. Strauss

Revised December 2005

Changes from the clinical guidelines 1

- **Inappropriate language**. Removal of words such as retarded.
- The **definition** of mental functions **expanded**.
- The **descriptors** have been **reworded**, some highlighted aggressive behaviour rather than withdrawn behaviour.
- descriptor for **mood, class 3** changed from "***monitor all of the below***" to **"*some or all of the below*".**

Changes from the Clinical Guidelines 2

- The note under the table removed "***In evaluation of "whole person psychiatric impairment" intermediate values which are not included in the classes which rate individual impairments may be used***.". The intention of this note was to allow for a claimant to be given a 7% impairment, for example. However a number of situations have occurred where impairments have been given for class 2 up to 24%.
- The **Global Assessment of Functioning** (GAF) scale removed, a failure.
- A **new table** on page 12 gives a **low**, **mid**, and **high** range for **each class** indicating the appropriate percentages for each range for each class. Provides more specificity in determining the final percentage impairments.

GEPIC & CGRPI are part of the Guides

- All references in the AMA Guides to psychiatric impairment link directly to CEPIC or CGRPI
- Principles and rules of evaluations in AMA4 do apply to GEPIC & CGRPI, and psychiatric assessment must take account of the those principles and rules

  For example:
  - Having access to appropriate clinical information to verify that an impairment exists, including information about unrelated conditions

Principles of psychiatric impairment assessment 1

Principle 1:

In assessing the impairment that results from any mental or physical disorder, readily observable empirical criteria must be applied accurately. The mental state examination **as used by consultant psychiatrists**, is the prime method of evaluating psychiatric impairment.

Principle 2:

Diagnosis is among the factors to be considered in assessing the severity and possible duration of the impairment, but is by no means the sole criterion.

Principle 3:

The evaluation of psychiatric impairment requires that consideration be also given to a number of other factors including, but not limited to, level of functioning, educational, financial, social and family situation.

Principles of psychiatric impairment assessment 2

Principle 4:

The underlying character and value system of the individual is of considerable importance in the outcome of the disorder, be it mental or physical. Motivation for improvement is a key factor in the outcome.

Principle 5:

A careful review must be made of the treatment and rehabilitation methods that have been applied or are being used. No final judgment can be made until the whole history of the illness, the treatment, the rehabilitation phase, and the individual's current mental and physical status and behaviour have been considered.

Use of the GEPIC

- Used by consultant psychiatrists.
- Documentation, history and mental state form the data base.
- clinical judgment critical, the specific rating criteria are not to be used in a“cookbook” fashion.
- The descriptors are indicative. Other symptoms can be used if it can be justified that the symptom(s) is/are associated with a particular class of severity.

Use of the GEPIC

- 6 mental functions assessed for severity into 5 classes.
- median class determined
- total psychiatric impairment is selected within the median class.
- items should not be rated if the assessor has doubts.
- This approach is consistent with the rules for evaluations on page 8 of AMA4.

Table for evaluation of psychiatric impairment

Class of Impairment	1	2	3	4	5
Percentage of Impairment	**0% to 5%**	**10% to 20%**	**25% to 50%**	**55% to 75%**	**over 75%**
MENTAL FUNCTION					
Intelligence *(Capacity for understanding)*	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Thinking *(The ability to form or conceive in the mind)*	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Perception *(The brain's interpretation of internal and external stimuli)*	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Judgement *(Ability to assess a given situation and act appropriately)*	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Mood *(Emotional tone underlying all behaviours)*	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Behaviour *(Behaviour that is disruptive, distressing or aggressive)*	Normal to Slight	Mild	Moderate	Moderately Severe	Severe

Definitions

Impairment: World Health Organization (WHO) has defined impairment: “In the context of health experience, an impairment is any loss or abnormality of psychological, physiological, or anatomical structure or function”.

Permanent impairment is impairment that has become static or well stabilised with or without medical treatment and is not likely to remit despite future medical treatment. If an impairment is not permanent, it is inappropriate to characterise it as such.

Disability: The WHO has defined disability: “In the context of health experience, a disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being”.

Hallucinations. Disorders of sensory perception in the absence of stimuli.

Illusions. Misinterpretations of real sensory stimuli – illusions can be a normal phenomenon as well as indicating psychopathology.

Determining Whole Person Psychiatric Impairment

- 6 mental functions in 5 classes
- Each function is allotted a class
- Determine the median class; the median number is the middle no (shows central tendency).
- E.g. 11 22 33, the middle number is 2.
- The final percentage lies within the range of the median class. Class 2 is between 10-20%.

Why use the ‘Median method”

	Nominal	Ordinal	Interval	Ratio
Central Tendency	Mode	Median	Mean	Mean

Determining Whole Person Psychiatric Impairment (exceptions from the rule)

- Median number may not be a whole number e.g.11 12 22, the median number is 1.5
- In this situation the median class becomes class 2 and the percentage is the bottom of that class, here to class 2 and 10%
- With a skewed series, e.g. 11 11 41, the median number is 1 but the impairment may be up to 10 percent

Discriminating within Median Classes page 1569 Gazette

Each median class includes descriptors which indicate a range of symptoms within that class. Each class has a low range, a mid range, and a high range.

The indicative ranges for each class are as follows:

	Low range	Mid range	High range
Class One	0-1%	2-3%	4-5%
Class Two	10-12%	14-16%	18-20%
Class Three	25-30%	35-40%	45-50%
Class Four	55-60%	65-70%	70-75%
Class Five	75-80%	85-90%	95-100%

Factors to be considered

- consider both the descriptors for each class and equivalent symptoms that might not be listed
- assess the severity of each symptom or descriptor and/or the number of symptoms or descriptors present
- consider in which part of the median class these descriptors and/or equivalent symptoms would fall
- symptoms which lie within median class 2,
- symptoms relatively minimal in severity or only a few symptoms
- final value in the low range for class 2 (10-12%).
- these indicative ranges are to provide guidance to clinicians and do not preclude the use of final values lying between them, e.g., 13%.

Details of the GEPIC and Changes from the Clinical Guidelines

- The following slides are from the GEPIC
- These include expanded definitions of specific mental functions and changed descriptors.
- Changed previous definitions and descriptors are in **bold**
- New definitions and descriptors are <u>underlined</u>

Intelligence

Capacity for understanding and for other forms of adaptive behaviour. Impairments of intelligence are a consequence of brain injury or disease. Generally, before impairment of intelligence is confirmed neuropsychological assessment should be undertaken. (Care has to be exercised to ensure that there is no overlap between an assessment of impairment of intelligence made during a psychiatric evaluation and an assessment of impairment of higher cerebral functions made by an assessor in accordance with Chapter 4 of the 4th edition American Medical Association *Guides*.)

Guides for the rating of impairment of intelligence:

Class	Impairment	Description
1	0 - 5%	**Normal** to Slight *- there is no evidence of cognitive impairment on mental state examination, and the individual does not report any difficulties in everyday functioning that can be attributed to cognitive difficulties*
2	10 - 20%	Mild **(Mildly retarded)** *- some interference with everyday functioning*
3	25 - 50%	Moderate **(moderately/mildly retarded)** *- a reduction in intelligence that significantly interferes with everyday functioning.*
4	55 - 75%	Moderately Severe **(moderately severely retarded)** *- a reduction in intelligence which makes independent living impossible.*
5	over 75%	Severe **(severely retarded)** *- needs constant supervision and care*

Thinking

The ability to form thoughts and conceptualise. Impairment is both a matter of degree and type of disturbance, which may involve stream, form and content.

Class	Impairment	Description
1	0 - 5%	Normal to Slight ***(no deficit)***
		- includes mild transient disturbances that are not disruptive and are not noticed by others.
2	10 - 20%	Mild **(slight deficit)**
		- mild symptoms that usually cause subjective distress, for example:
		- thinking may be muddled or slow;
		- may be unable to think clearly;
		- mild disruption of the stream of thought due to some forgetfulness or diminished concentration;
		- may have some obsessional thinking which is mildly disruptive;
		- may be preoccupied with distressing fears, worries or experiences, and by inability to stop ruminating;
		- increase of self-awareness or a persistent sense of guilt;
		- some other thought disorder that is minimally disruptive (such as overvalued ideas or delusions; ***some formal thought disorder, does not interfere with communication)***

Thinking (cont…)

3	25 - 50%	Moderate **(moderate deficit)** *- manifestations of thought disorder, to the extent that most clinicians would consider psychiatric treatment indicated, for example:* *severe problems with concentration due to intrusive thoughts or obsessional ruminations;* *marked disruption of the stream of thought due to significant memory problems or diminished concentration;* *persistent delusional ideas interfering with capacity to cope with everyday activities, e.g., severe pathological guilt;* *formal thought disorder that interferes with verbal and other forms of communication.*
4	55 - 75%	Moderately Severe **(Moderately Severe deficit)** *- disorders of thinking that cause difficulty in functioning independently and usually require some external assistance.*
5	Over 75%	Severe **(severe deficit)** *- disorders of thinking that cause such a severe disturbance that independent living is impossible.*

Impairment of Perception

Disturbances of one or more of

- Hearing
- Vision
- Smell
- Taste
- Touch

• Hallucinations are subjective sensory perceptions without an actual external stimulus

• Illusions are distorted perceptions of real external stimuli, usually visual.

Perception

The individual's interpretation of internal and external experience received through the senses. Stimuli arise from the five senses – the form is relevant, not necessarily the content. (Refer to discussion above of the concept of perception in clinical psychiatry.)

Definitions:

Hallucinations	Abnormalities of sensory perception in the absence of external stimuli.
Illusions	Distortions of real sensory stimuli – illusions can be a normal phenomenon as well as indicating psychopathology.
Pseudohallucinations	Hallucinations that are recognised by the person as being imaginary (not real, lacking an external source or stimulus).

Perception

- The individual's **(brain's perception of exogenous an endogenous stimuli)** interpretation of internal and external experience received through the senses. Stimuli arise from the five senses - the form is relevant, not necessarily the content. (Refer to discussion above of the concept of perception in clinical psychiatry.)

Definitions:

- *Hallucinations*
  - Abnormalities of sensory perception **(subjective sensory perceptions)** in the absence of **(an actual or adequate)** external stimuli
- *Illusions*
  - Distortions of real sensory **(external)** stimuli **(usually visual) –** illusions can be a normal phenomenon as well as indicating psychopathology.
- *Pseudohallucinations*
  - Hallucinations that are recognised by the person as being imaginary (not real, lacking an external source or stimulus).

Perception:

Class	Impairment	Description
1	0 - 5%	Normal to Slight **(no deficit)** - *transient heightened, dulled or blunted perceptions of the internal and external world, but with no or little interference with function*
2	10 - 20%	Mild **(slight deficit, for example)** - *persistent heightened, dulled or blunted perceptions of the internal and external world, with mild but noticeable interference with function - pseudohallucinations*
3	25 - 50%	Moderate **(moderate deficit)** - *presence of hallucinations (other than hypnagogic or hypnopompic) that cannot be attributed to a transitory drug-induced state;* - *obvious illusions (when associated with a diagnosable mental disorder).*
4	55 - 75%	Moderately Severe **(moderate severe deficit)** - *hallucinations and/or illusions (as above) cause subjective distress and disturbed behaviour.*
5	Over 75%	Severe **(severe deficit)** - *hallucinations and/or illusions (as above) cause disturbed behaviour to the extent that constant supervision is required.*

Judgment

Ability to evaluate and assess information and situations, together with the ability to formulate appropriate conclusions and decisions. This mental function may be impaired due to brain injury, or to conditions such as schizophrenia, major depression, anxiety, dissociative states or other mental disorders.

Class	Impairment	Description
1	0 - 5%	Normal to Slight **(no deficit)** - *may lack some insight and misconstrue situations but with little interference with function*
2	10 - 20%	Mild **(slight deficit)** - *persistently misjudges situations in relationships, occupational settings, driving and with finances. The misjudgments are noticed by others but are accommodated* ***(socially inappropriate at times leading to embarrassment but generally able to cover up such gaffes)***
3	25 - 50%	Moderate **(Moderate deficit)** - *misjudging social, work and family situations repeatedly leading to some disruption in relationships, occupational settings, living circumstances and financial reliability* ***("getting into trouble repeatedly")*** - *inappropriate spending of money or gambling*
4	55 - 75%	Moderately Severe **(Moderately Severe deficit)** - *moderately severe misjudgment with regular failure to evaluate situations or implications, causing actual risk or harm to self or others* *-failure to respond to any regular guidance and requirement for constant supervision.* **-(hypomanic or disinhibited patient who is physically threatening or aggressive, or indulges in risk-taking activities e.g. driving dangerously)**
5	Over 75% *behaviour or motives of*	Severe **(Severe deficit)** *- persistently assaultive due to misinterpretation of the others* *- Sexually disinhibited (****towards members of the opposite sex****) (may occur following a head injury).*

Mood

Mood is a pervasive lasting emotional state

Affect is the prevailing and conscious emotional feeling during the period of the mental state examination.

Affect observed during the mental state examination is a reflection of the subject's mood, and has a number features, including:

Range:	Variability of emotional expression over a period of time, i.e., if only one mood is expressed over a period of time, the affective range is restricted.
Amplitude:	Amount of energy expended in expressing a mood, i.e., a mild amplitude of anger is manifested by annoyance and irritability.
Stability:	Slow shifts of mood are normal. Rapid shifts (affective lability) may be pathological.
Appropriateness:	The "fit" (or congruency) between the affect and the situation.
Quality of Affect:	Suspicious, sad, happy, anxious, angry, apathetic.
Relatedness:	Ability to express warmth, to interact emotionally and to establish rapport.

Mood

Class	Impairment	Description
1	0 - 5%	Normal to Slight **(normal mood)** *- relatively transient expressions of sadness, happiness, anxiety, anger and apathy;* *- normal variation of mood associated with upsetting life events.*
2	10 - 20%	Mild **(slight problem)** *- mild symptoms: some **(any)** or all of the below* *mild depression;* *subjective distress leading to some mild interference with function;* *reduced interest in usual activities;* *some days off; reduced social activities;* *fleeting suicidal thoughts;* *some panic attacks;* *heightened mood;* *- may experience feelings of derealisation or depersonalisation.*

Mood (cont…)

3	25 - 50%	Moderate Impairment **(moderate problem)** *- moderate symptoms: <u>some</u> **(most)** or all of the below:* *frequent anxiety attacks with somatic concomitants;* *inappropriate self-blame and/or guilt;* *persistent suicidal ideation or suicide attempts;* *marked lability of affect; significant lethargy;* *social withdrawal leading to major problems in interpersonal relationships;* *anhedonia;* *appetite disturbance with significant weight change;* *psychomotor retardation/agitation; hypomania;* *severe depersonalisation.*
4	55 - 75%	Moderately Severe **(moderately severe problem)** *- cannot function in most areas:* *constant agitation; violent manic excitement; repeated suicide attempts; remains in bed all day; extreme self neglect; extreme anger /hypersensitivity;* *requires supervision to prevent injury to self or others.*
5	Over 75%	Severe **(severe problem)** *- severe depression, with regression requiring attention and assistance in all aspects of self care;* *- constantly suicidal;* *- manic excitement requiring restraint.*

Behaviour

Behaviour is one's manner of acting. It is considered with regard to its appropriateness in the overall situation. Disturbances vary in kind and degree. Behaviour may be destructive either to self and/or others, it may lead to withdrawal and isolation. Behaviour may be odd or eccentric. Particular mental disorders may be manifested by particular forms of behaviour, e.g., compulsive rituals associated with Obsessive Compulsive Disorder.

Guides for the rating of impairment of Behaviour:

Class	Impairment	Description
1	**0 - 5%**	Normal to Slight ***(normal)*** *- transient disturbances in behaviour that are understandable in the context of this person's situation, excessive fatigue, intoxication, family or work disruption.*
2	**10 - 20%**	Mild **(slight problem)** *- persons who generally function well, but **(may show)** regularly manifest disturbed behaviour under (**stress, while nevertheless acceptable to others as "normal")** little extra pressure that nevertheless is able to be accommodated by others* *- persistent behaviour that has some adverse effect on relationships or employment*
3	**25 - 50%**	Moderate **(moderately severe problem)** *- occasional **aggressive, disruptive** or withdrawn **behaviour** requiring attention or treatment;* *- obsessional rituals interfering with but not preventing goal-directed activity;* *- repeated antisocial behaviour leading to conflict with authority.*

Behaviour

4	**55 - 75%**	Moderately Severe **(Moderately Severe Problem)** - *persistently aggressive, disruptive or withdrawn behaviour requiring attention or treatment (new);* - *behaviour significantly influenced by delusions or hallucinations;* - *behaviour associated with risk of self harm outside the hospital setting, but not requiring constant supervision* - *manic overactivity associated with inappropriate behaviour;* - *significantly regressed behaviour, e.g., extreme neglect of hygiene, inability to attend to bodily needs* ***(staying in bed all day)***
5	**Over 75%**	Severe **(Severe problem)** - *requiring constant supervision to prevent harming self or others (repeated suicide attempts, frequently violent, manic excitement);* - *catatonic excitement or rigidity;* - *incessant rituals or compulsive behaviour preventing goal-directed activity.*

Secondary and non-secondary psychiatric impairment

The Legislation

- *Section 46B Transport Accident Act* 1996:

  "In determining a degree of impairment of a person, regard must not be had to any psychiatric or psychological injury, impairment or symptoms arising as a consequence of, or secondary to, a physical injury."

- *Section 91(2) Accident Compensation Act* 1985:

  "In assessing a degree of impairment under sub-section (1), regard must not be had to any psychiatric or psychological injury, impairment or symptoms arising as a consequence of, or secondary to, a physical injury."

- *Wrongs Act directs that Section 91(2) of Accident Compensation Act applies to psychiatric assessments.*

Secondary and non-secondary psychiatric impairment

28LJ *Wrongs Act* 1958:

> regard must not be had to any psychiatric or psychological injury, impairment or symptoms arising as a consequence of, or secondary to, a physical injury.

Excluded Impairments from unrelated injuries or causes

For ACC and Wrongs Act only

Section 91(7)(c) *Accident Compensation Act* 1985:

impairments from unrelated injuries or causes are to be disregarded in making an assessment;

28LL(3) *Wrongs Act* 1958:

impairments from unrelated injuries or causes are to be disregarded in making an assessment.

Reference for Clinicians

- Annotations for Determining Non Secondary Psychiatric impairment:
  - Dr Michael Epstein
  - Dr Nigel Strauss
- The Annotations are not part of the Gazetted methodology of the CGRPI or GEPIC, but provide some helpful guidance to ensure consistent consideration of Secondary/ Non-Secondary Impairment.

Methods for scoring non-secondary impairment

1. Determining total psychiatric impairment and subtracting secondary psychiatric impairment from that, the residue is then regarded as the non-secondary psychiatric impairment.
2. Determining total psychiatric impairment and also separately determining the non-secondary psychiatric impairment.
3. Determining psychiatric impairment by scoring only those symptoms which derive from a non-secondary psychiatric injury or disorder.

This Guide recommends that option 2 be used.

Non-secondary and secondary psychiatric impairments are additive. If the total impairment is 20%, and the non-secondary impairment is 10% then the secondary impairment is 10%.

Categories 1 - 4

- Category 1:
  - Psychiatric Impairment from a psychiatric injury which is secondary to a physical injury does not count.
- Category 2:
  - Psychiatric impairment from a psychiatric injury or disorder which has arisen from a previous non-secondary psychiatric disorder or injury does count.
- Category 3:
  - Psychiatric impairment from a “pain disorder” may count as arising from a non-secondary psychiatric injury.
- Category 4:
  - A psychiatric impairment from a delayed psychiatric disorder or injury arising from an accident may count as a non-secondary psychiatric impairment.

Categories 5 - 7

- Category 5:
  - Psychiatric impairment from a psychiatric injury or disorder arising directly from trauma, whether or not there is a physical injury, may count as a non-secondary psychiatric impairment.
- Category 6:
  - Psychiatric impairment from a psychiatric injury or disorder, which has arisen within twelve hours of an accident or acute injury, counts as a non-secondary psychiatric impairment. (This is an inclusive category and does not restrict measurement of impairments after that time.)
- Category 7:
  - Psychiatric impairment from a psychiatric injury or disorder arising directly from an acquired brain injury may count as a non-secondary psychiatric impairment.
  - However, the psychiatric impairment arising from the brain injury itself is, for the purpose of calculating whole person impairment, deemed to have emanated from Chapter 4, Table 2 or 3 of the AMA4 Guides and is subject to the Chapter 4 combining algorithm.

Categories 8 - 10

- Category 8:
  - A psychiatric impairment from a psychiatric injury or disorder arising from work place response occasioned by a physical injury can count as a non-secondary psychiatric impairment, but it is usually a separate injury.
- Category 9:
  - A psychiatric impairment from a psychiatric injury or disorder arising from a complication of treatment for a physical injury does not count under section 91(2) (ACA) and section 46B (TAA).
- Category 10:
  - A psychiatric impairment from an acute psychiatric injury or disorder which has arisen from an acute exacerbation of a previous physical injury may count as a non-secondary psychiatric impairment.

Cardinal Rules

- **Any psychiatric impairment secondary to physical injury from an accident or injury does not count.**
- **Where there is no physical injury, there can be no secondary psychiatric component according to the legislation**
- The following examples indicate where these rules have not been followed.
- Example 1. A woman was involved in a transport accident and was uninjured. The other driver systematically harassed her. She became deeply depressed and attempted suicide and has psychiatric treatment.
- **She is assessed as having no "primary" impairment.**
- Example 2. A man with a back injury is harassed after he returns to work. He is depressed by the back injury and by the harassment.
- **He is assessed as having a 20% impairment which is all primary**

Overlap Between Psychiatric and Neurological Impairment

- Acquired brain injury: impairment involves two disciplines, neurology and psychiatry.
- Cognitive Dysfunction and Behavioural Disturbance can be measured using Chapter 4 and/or the GEPIC
- Strong likelihood of overlap.
- Behavioural disturbance measured using Chapter 4
- Behavioural disturbance is a manifestation of physical injury and may not be secondary to physical injury. It may be counted using the GEPIC if there is **no** neurological assessment.

How to resolve overlap between neurological & psychiatric assessment

- Option 1
  - Neurologist, psychiatrist, neuropsychiatrist and neuropsychologist swap reports.
  - Consensus reached between different disciplines with regard to overlap.
  - TAC and WorkSafe will routinely cross reports.
  - Less frequent with plaintiff solicitors

- Option 2
  - Psychiatrist assesses impairment and discounts for overlap with Chapter 4 AMA Guides. Neurological and GEPIC impairment combined.

Emotional or Behavioural Impairments

(only people who have done the neurology module are accredited to use tables 4.2 and 4.3)

Table 3. Emotional or Behavioral Impairments.

Impairment description	% Impairment of the whole person
Mild limitation of daily social and interpersonal functioning	0 - 14
Moderate limitation of *some* but not all social and interpersonal daily living functions	15 - 29
Severe limitation impeding useful action in *almost all* social and interpersonal daily functions	30 - 49
Severe limitation of all daily functions requiring total dependence on another person	50 - 70

Table 3, Chapter 4, page 142

Option 1 Neurological and Psychiatric Impairment

- Motorcyclist in collision
- organic head injury, fractures, behavioural disturbance, some symptoms of traumatisation and resultant depression due to the combination of injuries.

  GEPIC Impairment of all injuries

  20% WPI

  10% secondary to organic brain injury

  5% not secondary to physical injury

  5% secondary to other physical injury

Combination of Neurological and Psychiatric Impairment 1

- Neurologist assesses claimant using
- Table 2.2 Mental Status Impairment =10%
- Table 4.3 Emotional or Behavioural impairment = 5%
- The most severe is used to represent the cerebral impairment, hence 10% WPI neurological impairment

End result: GEPIC 5% WPI and Neurological impairment 10% WPI

Option 2 Psychiatric Impairment

- Motorcyclist in collision: organic head injury, fractures, behavioural disturbance, some symptoms of traumatisation and resultant depression due to the combination of injuries.

  Only GEPIC Impairment used, discount for overlap with neurological impairment
- 10% WPI
- 5% not secondary to physical injury
- 5% secondary to other physical injury

  With comment 'no overlap between this and neurological impairment.'

Guidelines for assessment of pain disorder

Thanks to Dr Sandra Hacker, Dr Diane Neill and Dr Nigel Strauss

Pain and psychiatric diagnosis

- The cause of pain is not always clear cut or easily defined.
- pain is a totally subjective phenomena and cannot be accurately measured
- pain is a particular problem for an assessor when pathological findings cannot explain the pain described.
- each specialty has developed its own nomenclature
  - myofascial pain syndrome
  - fibromyalgia
  - myalgic encephalopathy
  - complex regional pain syndrome
- this situation leading to confusion about nomenclature.
- some specialist groups regard unexplained pain as indicating a psychiatric disorder.

Questions

- When should a diagnosis of a pain disorder be made?
- Does this diagnosis only mean that there is widespread unexplained pain and is this a psychiatric condition?
- How is the diagnosis made, and how can any impairment from a pain disorder be quantified.

Answers

- Pain after an injury usually diminishes with time
- The diagnosis of a Pain Disorder is based on the definition in DSMIVR (see next slide)
- Characteristics are that the pain:
  - is spreading or has spread
  - cannot be explained by organic pathology
  - associated with psychiatric symptoms
  - increasing dysfunction
  - focus of clinical attention
- Impairment due to pain cannot be directly assessed but concommitants of pain, e.g. depression can be measured

Definitions

- The **DSM IV** :pain disorder -pain is the predominant focus of the clinical presentation
  - the pain is severe enough to warrant clinical attention;
  - the pain interferes with social, relationship, recreational and work.
  - psychological factors seem to play a significant role.
  - the pain is not faked.
- pain disorder is not diagnosed if pain is better accounted for by mood, anxiety or a psychotic disorder.

Three sub groups related to pain disorders.

1. Pain disorder associated with psychological factors alone.
2. Pain disorder associated with both psychological factors and a generalised medical condition.
3. Pain disorder associated with a general medical condition, where psychological factors are not considered to be significant.

These conditions are defined as acute if they last for less than six months and chronic if they last for greater than six months.

When not to diagnose a pain disorder

- A pain disorder should not be diagnosed when the pain is:
  - Faked
  - Claims of pain without any obvious distress, impairment or treatment
  - Caused by a mood, anxiety or psychotic disorder
  - associated with dyspareunia
  - Probably due to a medical condition

Issues in understanding pain

Some areas of agreement across specialties. These include:

- psychologically based pain is a complex/multi-factorial process, about which there is only limited understanding.
- psychological pain is "real" and involves suffering. It is not imaginary pain or malingering
- hallucinated pain may occur.
- such pain cannot be ignored by clinicians and is a major signal of distress.
- pain is the commonest reason adults visit a healthcare provider
- pain is the primary reason most injured people cite for having any ongoing disability

Chronic pain, depression & anxiety

- chronic pain depression and anxiety are frequently linked
- chronic pain leads to depression and anxiety
- depression exacerbates chronic pain
- chronic pain is associated with an inability:
  - to function effectively in relationships and work
  - to enjoy recreational activities.
- this situation makes people feel miserable, pain leads onto depression
- depression arising from chronic pain is associated with:
  - reduced family support
  - referrals to psychiatrist or psychologist implying it is "all in my head"
  - an increased focus on pain leading to a negative feedback loop, more pain equals more depression equals more pain
  - reduced quality of life

Research on chronic pain

- early adverse life events can contribute to the development of psychologically based pain
- a link between childhood abuse, childhood illness and/or emotional deprivation and the development later in life of chronic pain which has no significant organic basis
- some people appear to be more pain prone from their early years and seem to lack resilience in dealing with pain. The term "pain prone personality" has been used to describe this situation. Such people may suffer from :
  - continuous or frequent (unexplained) pain
  - spreading pain in a non-anatomical distribution.
  - frequent use and abuse of analgesic medication.
  - frequent requests for surgery with lack of resolution of pain.
  - denial of emotional and interpersonal difficulties, denial of conflict, dependence

    traits, and/or an inability to cope with hostility.
  - chronic lowered mood.
  - A family history of chronic pain, chronic invalidism or other abnormal illness behaviour, depression or substance abuse.
- An assessment requires a developmental history especially regarding a history of pain

The use of the GEPIC in assessing pain disorders

- Psychologically based pain disorders follow patterns in mental status assessments and hence impairment assessments. There are significant exceptions to what follows.
  - **Intelligence**
- Usually normal.
  - **Thinking**
- Slight deficit in thinking unless there is pain as part of a psychotic illness.

  A pain disorder which is psychologically based may lead to a class 2 impairment due to preoccupation with pain.
  - **Perception**
- Perception relates to the five senses, taste, smell, touch, sight and hearing and can be endogenous or exogenous. Pain does not relate directly to the five senses except to touch and hence pain does not generally fit within any impairment of perception. The proxies of pain, depression and anxiety, may contribute to some changes in perception but at most in class two.

GEPIC and pain II

- **Judgement**
- people with psychologically based pain generally reject that concept and insist that the pain is organically based. This may reflect a slight deficit in judgement leading to a score in class two.
- **Mood**
- Mood disorders are often a concommitant of chronic pain.
- People with chronic pain frequently have significant symptoms of depression and anxiety that should be scored in the appropriate class
- **Behaviour**
- Chronic pain leads to changes in behaviour and this can be scored accordingly.

Secondary/non-secondary

- Usually pain disorders are secondary to physical injury
- If the physical injury has resolved and pain is still present any impairment is still secondary to physical injury.
- Pain conditions such as fibromyalgia can develop without prior physical injury or psychological stress and may count.

Summary re Pain

- either physically or psychologically based or both.
- May be manifestation of emotional distress.
- Chronic pain may lead to an unconscious exaggerated response to physical pain
- Medical practitioners see many people complaining of pain without organic pathology.
- The psychiatrist must assess the presence or absence of a genuine pain disorder
- measurement of the psychiatric impairment related to a pain disorder can be done by using pain produced symptoms such as impairment of thinking, judgement, mood and behaviour.

Questions

- When should a diagnosis of a pain disorder be made?
- Does this diagnosis only mean that there is widespread unexplained pain?
- Is there a psychiatric condition?
- How is the diagnosis made, and how can any impairment from a pain disorder be quantified?

Answers

- Pain after an injury usually diminishes with time
- The diagnosis of a Pain Disorder is based on the definition in DSMIVR (see next slide)
- Characteristics are that the pain:
  - is spreading or has spread
  - cannot be explained by organic pathology
  - associated with psychiatric symptoms
  - increasing dysfunction
  - focus of clinical attention
- Impairment due to pain cannot be directly assessed but proxies of pain, e.g. depression can be measured

Psychiatric impairment assessment in Victoria - time frame

(Summary: Implementation within Victorian Legislation)

The three psychiatric impairment assessment guidelines apply as follows:

- **Guide to the Evaluation of Psychiatric Impairment for Clinicians** (*GEPIC*)
- **Clinical Guidelines to the Rating of Psychiatric Impairment** (*Clinical Guidelines*)
- **AMA Guides to the Evaluation of Permanent Impairment, Second Edition** (*AMA2 Guides*)

Psychiatric impairment assessment in victoria - time frame

(Summary: Implementation within Victorian Legislation)

Accident Compensation Act 1985 (Victorian WorkCover Authority)		
•	GEPIC	initial impairment assessments undertaken on or after 28 July 2006
•	Clinical Guidelines	review assessment where an initial assessment was undertaken in accordance with *Clinical Guidelines* prior to 28 July 2006
Transport Accident Act 1986 (Transport Accident Commission)		
•	GEPIC	impairment assessments for accidents occurring on or after 26 July 2006
•	Clinical Guidelines	impairment assessments for accidents occurring on 19 May 1998 to 25 July 2006
•	AMA2 Guides	impairment assessments for accidents occurring on 1 January 1987 to 18 May 1998
Wrongs Act 1958 (Department of Treasury & Finance, Victorian State Government)		
•	GEPIC	initial impairment assessments undertaken on or after 28 July 2006
•	Clinical Guidelines	review assessment where an initial assessment was undertaken in accordance with *Clinical Guidelines* prior to 28 July 2006

Worked example part 1

- Adrian is a 47 year old right handed process worker with three children.
- no personal or family health problems
- process worker in a factory for 5 years.

THE INJURY

- right arm caught in a conveyor belt
- severely bruised with skin loss requiring skin grafts.

INITIAL TREATMENT

- hospital for a week.
- flashbacks and nightmares to the accident. Support from employer
- off work 4 weeks.

RETURN TO WORK

- graduated return to work on modified duties.
- weakness and pain in his right (dominant) arm
- very anxious and avoided machinery.
- saw psychologist briefly.
- resumed production work, very supportive employer
- dreaded going to work could not cope
- placed off work and has not improved despite rehabilitation program.

CURRENT CONDITION

- arm pain and does very little with his right hand.
- very jumpy and on edge.
- weekly nightmares about accident, frequent flashbacks.
- ruminates about accident most days and finds these distracting
- confused and hesitant
- sex life ceased because of pain and no libido.
- irritable with his family.
- tearful, feels hopeless, helpless and useless
- no recreational activities, very isolated.
- uncomfortable in crowds and supermarkets, avoids leaving home rarely drives
- sounds louder and lights brighter.
- gambling on the internet, losing significant amounts of money.

MENTAL STATE EXAMINATION

- sad man holding his right arm across his body in a protective position.
- psychomotor retardation, speaks slowly in a monotone
- affect restricted appears depressed and anxious.
- mild perceptual distortions.
- problems with memory and concentration.
- thought content bleak, no thought disorder.
- no delusions or hallucinations.
- passive suicidal ideation

Scoring of Mental Functions

EVALUATION OF PSYCHIATRIC IMPAIRMENT					
Class of Impairment	**1**	**2**	**3**	**4**	**5**
Percentage of Impairment	**% to 5%**	**10% to 20%**	**25% to 50%**	**55% to 75%**	**over 75%**
Mental Function					
Intelligence *(Capacity for understanding)*	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Thinking *(The ability to form or conceive in the mind)*	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Perception *(The brain's interpretation of internal and external stimuli)*	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Judgment *(Ability to assess a given situation and act appropriately)*	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Mood *(Emotional tone underlying all behaviours)*	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Behaviour *(Behaviour that is disruptive, distressing or aggressive)*	Normal to Slight	Mild	Moderate	Moderately Severe	Severe

Determining Level of Psychiatric Impairment

- post traumatic stress disorder
- moderate adjustment disorder with depressed mood from arm pain and dysfunction and PTSD.
- His WPI median class 2 (blue highlights).
- upper end i.e. 18-20%.
- WPI is 20%.
- The assessor decided half, 10% of the whole person impairment is non-secondary
- secondary psychiatric impairment from his arm injury of 10%.
- In accordance with Section 91 he has a psychiatric impairment of 10%.

Problematical Diagnoses and Symptoms

- A diagnosis is usually a syndrome, a collection of symptoms.
- A number of diagnoses and symptoms can cause difficulties.
- These difficulties arise for 4 reasons:
  - Presence of symptoms that are not listed
  - Absence of symptoms
  - Symptoms straddle mental functions
  - Secondary or non secondary symptoms

Problematical Diagnoses 2 some examples

- Somatoform disorders
- Pain disorder
- Conversion disorder
- Pathological grief reaction
- Eating disorders
- Panic attacks
- Nightmares
- Flashbacks

Frequently asked questions 1

- Why is there a gap between the percentage range for each class eg. Class 2: 10-20% and Class 3: 25-50%?
- What about people who don't speak English or who can't speak?
- Do people need to have a psychiatric diagnosis to gain an impairment level?
- What is the situation with children?
- Why doesn't GEPIC use a list of typical symptoms eg flashbacks?
- What if you think the claimant is lying?

Frequently asked questions 2

- How do you separate out impairment from the accident or injury and non related impairment?
- Do you estimate pre existing impairment as at the time of the accident/injury or at the time of assessment?
- Do you estimate the impairment if the claimant was to have treatment or as the claimant is at presentation?
- How do you deal with secondary and non secondary impairment if there are several accidents or injuries?
- What is a reasonable period of time before the condition can be regarded as stable?

Conclusions

Measurement of psychiatric impairment is an important part of all benefits schemes.

Psychiatric illness can arise from a number of causes including work injury and transport accidents.

The precursor to the Guides for the Evaluation of Psychiatric Impairment for Clinicians has been used extensively and appears to be reliable.

The GEPIC is a revision of the Clinical Guidelines.

Common problems in psychiatric impairment assessment:

- Incorrect Use
- Overlap with Neurological Chapter in AMA4
- Assessing Pain-related Impairment rather than comorbid abnormal mental functioning
- Non-Secondary and Secondary Psychiatric Impairment