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Road-testing psychiatric impairment guides

Improved access to payments through accident, crime and the common law has led to a backlash from governments, concerned that claims are getting out of control. Part of this backlash reflects a prejudice about the validity of 'stress claims' and the potential for fraud, and the merits of rewarding the 'moral weakness' of someone who 'gets stressed'. Politicians mirror these prejudicial community attitudes towards people with psychiatric disorders.

Impairment assessment aims to distribute benefits in an equitable way to people who have suffered a psychiatric injury. The alternative to such methods, no matter how flawed, is no method and hence no access to benevolent schemes.

Methods for measuring psychiatric impairment have been used for years in Victoria, in both the operation of the ComCare scheme and setting pension rates for veterans. More recently, methods for assessing psychiatric impairment have been developed for the NSW Motor Accident and WorkCover scheme, for providing access to personal injury claims in Victoria, for workers' compensation claims in Tasmania, and now in Queensland with the Civil Liability Act.

THE PROCESS OF ASSESSMENT

Before compensation can be paid in any jurisdiction, a number of hurdles have to be cleared.

- There has to be an injury.
- The injury must be encompassed by the legislation.
- The injury must have occurred within the jurisdiction.
- The impairment arising from the injury must reach a certain threshold.

Assessing psychiatric impairment first involves a comprehensive interview, review of documentation, and evaluation of data. A report is then prepared that indicates the presence or absence of a psychiatric disorder, its relationship to the event and the level of impairment suffered. ▶

Dr Michael Epstein has been assessing psychiatric impairment for the last 15 years and is a co-author of *The Clinical Guideline to the Rating of Psychiatric Impairment*, which is used in Victoria.

WHAT IS A PSYCHIATRIC DISORDER?

A person with a mental disorder (ie, a psychiatric disorder) has a condition that would benefit from appropriate treatment and is associated with feeling bad, or making others feel bad, a reduced capacity for coping, and which may have a profound effect on a person's physical health, relationships, and work capacity. This is more than a transient level of distress associated with a normal human event, such as a death. Deviant behaviour and/or conflict with society do not mean a person has a mental disorder, unless the behaviour has other features of a mental disorder.

Psychiatrists have quantified psychiatric disorders as 'mild', 'moderate', or 'severe'. The courts, however, regard these terms as unsatisfactory:

> 'A psychiatric disorder may be mild to moderate, yet have devastating consequences for the particular plaintiff in terms of the disruption of his or her life and diminution of its quality.'[1]

IMPAIRMENT VERSUS DISABILITY

The difference between impairment and disability is exemplified by the concert pianist who has lost a finger impairment is 1%, but the level of disability is 100%.

"The difference between impairment and disability is exemplified by the concert pianist who has lost a finger. Impairment is 1%, but the level of disability is 100%."

'Impairment' is any loss or abnormality of psychological, physiological, or anatomical structure or function (WHO), and 'disability' is an alteration of an individual's capacity to meet personal, social, or occupational demands because of an impairment.[2]

Whereas doctors measure impairment, courts determine disability.

> 'It is the judges' opinion as to the seriousness of the impairment or loss - not that of the applicant or his medical practitioners which is decisive (p137).'[3]

PSYCHIATRIC IMPAIRMENT ESSENTIALS

No method of psychiatric impairment assessment has contextual or predictive validity -ie, there is no gold standard or crystal ball in impairment assessment. However, it can have content and face validity – ie, the content refers to psychiatric symptoms and appears to be measuring psychiatric impairment.

Any method of assessing psychiatric impairment requires:

- Content and face validity for psychiatric impairment.
- A way of producing a final score.
- Fairness (the more severe the symptoms, the greater the impairment).
- Ease-of-use.
- Reliability (consistent results with the same claimant).

Psychiatric rating scales in Australia

The psychiatric rating scales used in Australia fall into three groups:

- Hospitals and universities use international scales to measure psychiatric symptoms for treatment and research purposes. They are short, rapidly completed questionnaires that are designed to be either self-administered or used by clinicians in hospitals or clinics. They are reliable and have

content and face validity. They struggle, however, with lower levels of symptoms and do not measure impairment. They are not useful in any medico-legal context.

By contrast, the second and third groups have not been subject to any scientific studies and are used only in particular contexts.

- The second group determines levels of disability for claimants applying for pensions and consists of the guides incorporated in Schedule 1B of the *Social Security (Disability and Sickness Support) Amendment Act* 1991 and the *Guides to the Assessment of Rates of Veterans' Pensions* (The GARP).
- The third group is used only in a medico-legal context, the *ComCare Guides*, the Psychiatric Impairment Rating Scale (PIRS) and the *Clinical Guidelines to the Rating of Psychiatric Impairment*.

The *Clinical Guides* are used in Victoria, the PIRS in New South Wales, Tasmania, and Queensland, and the *ComCare Guides* for Commonwealth claimants.

COMCARE GUIDES

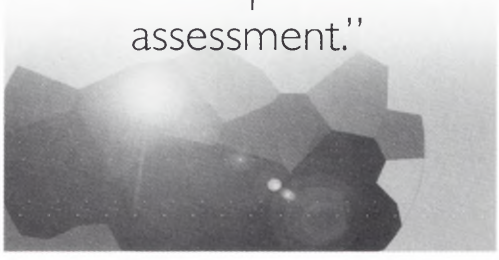
Table 5.1 in the *ComCare Guides* assesses psychiatric disorders that have stabilised on appropriate medication and uses a whole-person approach. Levels of severity increase at 5% intervals and use the same four descriptors with suitable modifications for increased impairment:

- Reactions to stresses of daily living.
- Capacity to perform activities of daily living.
- Disturbances in behaviour.
- Disturbances in thinking.

These *Guides* appear to be equitable, but they lack content validity; the descriptors are so vague as to be almost meaningless. For example, what does 'need for some supervision and direction in activities of daily living' mean, and what does that have to do with psychiatric disorders specifically?

Definitions and suitable descriptors related to psychiatric symptoms would make this *Guide* more workable.

"...there is no gold standard or crystal ball in impairment assessment."



WHY NOT USE THE AMA GUIDE?

Since a number of jurisdictions now use these *Guides* for assessing all medical impairment, why not for psychiatric disorders? The problem is the chapter on Mental and Behavioural Disorders, Chapter 14.

The Third Edition of the *Guides* (1988) changed the method of rating psychiatric impairment, and this has been retained in the Fourth Edition. The previous categories were replaced by:

- Activities of daily living.
- Social functioning.
- Concentration.
- Adaptation.

Each of these categories is rated on a five-class scale, ranging from 'no impairment' (Class 1) to 'extreme impairment' (Class 5). But the authors have failed to provide a percentage range for each class.

> '...the use of percentages implies a certainty that does not exist; percentages are likely to be used inflexibly by adjudicators, who then are less likely to take into account the many factors that influence mental and behavioural impairment. No data exist that show the reliability of the impairment percentages, it would be difficult for Guides users to defend their use in administrative hearings.'[4]

This approach effectively renders the chapter unusable. Every jurisdiction that uses the Fourth Edition of the *AMA Guides* has had to find some way of making this chapter workable, leading to the development of first the *Clinical Guidelines* and then the PIRS.

CLINICAL GUIDELINES TO THE RATING OF PSYCHIATRIC IMPAIRMENT

The Victorian view was that, even with percentages, Chapter 14 was fatally flawed because three of the four factors to be measured - activities of daily living, social functioning, and adaptation - are measures of disability. Instead, it had continued to use the Second Edition of the *AMA Guides*. The Mental and Behavioural Disorders chapter in that edition described five principles and set out eight categories to be measured:

1. Intelligence
2. Thinking
3. Perception
4. Judgement
5. Affect
6. Behaviour
7. Ability
8. Potential

Six of these categories refer to core mental functions that are assessed by all psychiatrists in a standard clinical interview, and are measures of impairment, not disability. However, ability is a measure of disability and potential is forecasting the future. There were no definitions and no method for combining scores. A working group of psychiatrists, including myself, wrote a 'users' manual', which became the de facto guide. It provided appropriate descriptors defining different levels of impairment within each category, and a method of combining the score for each category - the so-called 'median method'. There was general satisfaction with this 'users' manual', which was updated along with the Fourth Edition and forms the basis of the *Clinical Guidelines to the Rating of Psychiatric Impairment*, which replaces Chapter 14 in the Victorian legislation. The major difference was that 'ability' and 'potential' were dropped.

THE PIRS

New South Wales had no prior experience of impairment assessment and was confronted with the same problem: making Chapter 14 workable. There were great time pressures and, at short notice, a system was developed to flesh out Chapter 14: a percentage range with a series of descriptors was developed for the four categories, and the median method then applied to produce a whole-person psychiatric impairment assessment. This Psychiatric Impairment Rating Scale (PIRS) was modified for the New South Wales WorkCover Scheme by a system that aggregates scores to produce a final percentage.

Subsequently, in Tasmania, and now in the draft *ComCare Guides* the Fourth Edition of the *AMA Guides* has become the standard and again the PIRS has been used to make Chapter 14 workable.

PRIMARY AND SECONDARY PSYCHIATRIC IMPAIRMENT

The legal concept of primary and secondary psychiatric impairment, which originated in Victoria and has now become more widespread, adds to the complexity of psychiatric impairment assessment.

Legislation provides that any psychological injury arising as a result of physical injury is considered 'secondary' and will not be compensated (unless the physical injury is not compensated).

HOW DO THEY WORK?

The approach taken by the PIRS and the *Clinical Guidelines* is similar. There are a number of defined categories. Each category contains descriptors of increasing severity, gathered into five classes of increasing percentage ranges. The class for each category is determined and then the median class, which indicates the final percentage range for determining whole-person impairment. The assessor decides on the final percentage score using the *Clinical Guidelines* and some versions of the PIRS (other versions of the PIRS have a table to produce the final score).

In the Victorian system there are six categories: intelligence, thinking, perception, judgment, mood, and behaviour. These are assessed by psychiatrists during a clinical interview.

The PIRS has four categories:

1. Activities of daily living:
   - i. self-care and personal hygiene
   - ii. social and recreational activities
   - iii. travel
2. Social functioning
3. Concentration
4. Adaptation (Work ability in NSW WorkCover Scheme).

Each category has a short definition and a number of descriptors that demonstrate increased impairment. The descriptors are clustered into five classes according to the level of severity. The percentage range in the classes is different for the two systems.

In the *Clinical Guidelines*, Class 2 is 10-20 %. In the PIRS, Class 2 is 4-10 %.

The median class, the most common class, determines the range of the final percentage. In the *Clinical Guidelines* and some versions of the PIRS, the assessor uses clinical judgement to decide the final score within the median class range. In the versions of the PIRS used in the NSW WorkCover Scheme and the draft *ComCare Guides*, the scores for each class are aggregated and a conversion table used to produce a final percentage.

Each method of impairment operates within a specific legislative framework so that thresholds are different: ie, the NSW Motor Accidents Scheme is 10% plus, whereas the NSW WorkCover scheme is 11% plus.

In the Victorian schemes, the two cut-off points are 10% and 30%.

HOW DO THEY STACK UP?

The *Clinical Guidelines to the Rating of Psychiatric Impairment*

The *Clinical Guidelines* sit outside the *Fourth Edition Guides*, which is untidy. It is too easy to score a low level of impairment between 0-5% which is described as 'normal'. With the advent of primary and secondary psychiatric impairment, it has become more difficult to obtain even a low score.

The category of intelligence rarely rates more than class one, and then usually because of head injury. This category is the least useful of the six categories.

The descriptors have a gender bias and the language is outdated. It is theoretically more difficult to assess the combined neurological and psychiatric impairment in a person with an acquired brain injury because Table 4.3, in the neurology chapter of the *AMA Guides*, which measures emotional and behavioural effects, is linked to Chapter 14, which has been replaced. However, in practice, this does not seem to matter. Class 3 ranges from 25 – 50% and is regarded as too large. Again, theoretically, this could be a cause of concern. In fact, it is rare for someone to score 25% or more, and higher scores are very uncommon. An informal study of reliability done with psychiatrists newly trained in the use of the *Clinical Guidelines* does show a reasonable degree of consistency in scoring.

Nor are the percentages associated with each class continuous. For example, class one is 0-5%, class two is 10-20%, class 3 is 25-50%, and so on. This is to force assessors to make a decision as to which class each category belongs.

The *Clinical Guidelines* are difficult to cheat, as the matters to be rated are those observed by the assessor in the clinical situation, and considerable discretion is given in determining the final score within the median class. Used since early 1998, the *Clinical Guidelines* provide a surprising degree of consistency, and there seems general satisfaction and little incentive for change. A draft revision has changed some of the language, redressed the gender bias, and dealt with other minor problems.

THE PIRS

The PIRS uses the existing format of the *AMA Guides* Fourth Edition to make it consistent with the other chapters. The fundamental problem with the PIRS is that it is a measure of disability and not impairment.

The descriptors are prescriptive, relate to events occurring outside the interview and depend on the truthfulness of the claimant. They allow no leeway for the examiner, and are not specific to psychiatric disorders. Class 3, with regard to self-care and personal hygiene, reads:

'Cannot live independently without regular support. Needs prompting to shower daily and wear clean clothes. Does not prepare own meals, frequently misses meals…'

This descriptor is typical of a person with an acquired brain injury. Although a psychiatric disorder has to be diagnosed to use the PIRS, the descriptors do not have to relate to that psychiatric condition. Furthermore, the PIRS is available over the Internet and the prescriptive nature of the descriptors ensure that cheating is likely.

The four versions of the PIRS have caused some confusion; in the WorkCover Scheme version, 'adaptation' has been renamed 'work ability' and the final percentage score is determined by using a combined value table, also present in the draft *ComCare Guides*. The Tasmanian version has removed percentages.

The PIRS raises issues of equity. It was written to meet the requirements of specific legislation; classes one and two are squeezed between 1-10% and class three, moderate impairment, ranges from 11 – 30% and includes such descriptors as 'cannot live independently without regular support'. Most would regard this descriptor as referring to a very significant level of impairment indeed.

> "An informal study of reliability done with psychiatrists newly trained in the use of the *Clinical Guidelines* does show a reasonable degree of consistency in scoring."

There have been deep concerns expressed about the PIRS by interested parties, including the Royal Australian and New Zealand College of Psychiatrists and the Australian Psychological Society. As a result:

'The Heads of Workers Compensation Authorities have commissioned research into the reliability and validity of existing scales that purport to measure permanent impairment arising from mental and behavioural disorders. The researchers' task is to examine the reliability and validity of such scales, and to recommend modifications to the scales if these recommendations will increase the reliability and/or validity of a scale.'[5]

VALUE FOR MONEY

The three methods for assessing psychiatric impairment are easy to use, quick and come up with a final figure. The *ComCare Guides* are skeletal and probably of doubtful reliability. Concerns have centred on the PIRS. It does not appear to assess psychiatric symptoms or impairment and neither does it appear to be fair. It has been in use for a relatively short time only and there is little clinical information about its reliability. The *Clinical Guidelines* are long established, anecdotally have some reliability (also demonstrated with a small unpublished study). Let's hope the research study mentioned above looks at these issues.

Understandably I have a clear preference for the *Clinical Guidelines*, even leaving aside my role in its development. It was important that the *AMA Guides* were made workable; it is a shame that we have the equivalent of two rail gauges and that the PIRS is such a curate's egg. Of course, we should blame the authors of the *AMA Guides* for squibbing their responsibility to make the damn thing work. PL

Endnotes: 1 *Graham vs. Nadrasca Inc.*; judgment delivered 24 March 1997, Strong J (unreported). 2 *AMA Guides*, Fourth Edition. 3 *Humphries v Poljak* (1992) Vol. 2 V.R. 129 4 *AMA Guides* 4th Edition, p14/301-4/302. 5 http://www.workcover.nsw.gov.au/WorkersCompensation/WorkplaceInjury/Benefits/impairment_research.htm