CLINICAL GUIDE TO MENTAL DISABILITY EVALUATIONS pdf

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The Clinical Guide to Mental Health Disability Evaluations fills a need of increasing importance for practitioners in all mental health fields and at all levels of training, including general clinical psychologists and psychiatrists and forensic mental health specialists.

October 20, by Workcovervictims The guide to the evaluation of psychiatric impairment for clinicians G. By popular demand, here is the Guide to the evaluation of psychiatric impairment for clinicians G. Strauss, Revised December For citation: In general the Clinical Guidelines has performed very well but some concerns have emerged that this revision intends to correct. The name has been changed to distinguish the new edition from its predecessor, and to provide a convenient acronym. The basic aim of the Clinical Guidelines remains, being to improve the inter-rater reliability of psychiatric impairment assessments. It has been made explicit that the descriptors associated with each class for a particular mental function are intended to be indicative examples of the type of symptoms one could expect to see in that class range. The list of descriptors is not intended to be all-encompassing, as the Guide is designed to be used only by qualified psychiatrists who have completed the prescribed training course. To provide an exhaustive list of descriptors would be an impossible and ultimately unnecessary task. Furthermore, such a document would be so voluminous as to be practically useless as a handy guide for the clinician, and would amount to a textbook of psychiatry. There has been some re-wording of the definitions of some mental functions, and some descriptors have been added to provide a more comprehensive range of examples for each class. The changes implemented in this revision are designed to further improve the inter-rater reliability of the GEPIC. There had been considerable concern about the lack of reliability of impairment assessment by psychiatrists using the second edition of the AMA Guides. The changeover in various legal jurisdictions from the second to the fourth edition of the AMA Guides proved to be a particular concern with regard to psychiatry. Chapter 14 of the fourth edition of the AMA Guides provides a classification which is impossible to quantify, and it fails to provide any method of maintaining reliability of assessments. The six terms which had originally been used to assess mental function, that is, Intelligence, Thinking, Perception, Judgement, Affect, and Behaviour, have remained substantially the same. The table in the Clinical Guidelines included a footnote: This footnote has been removed from the GEPIC as it undermined the intention of the authors to force assessors to make clear choices in determining both individual classes and whole person psychiatric impairment. Psychiatric Impairment Evaluation The assessment of psychiatric impairment is based on the systematic application of empirical criteria, and takes into consideration both the diagnosis and other factors unique to the individual. It is also relevant to consider motivation, and to review the history of the illness, as well as the treatment and rehabilitation methods. These considerations can be summarised in the following five principles: 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. 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. 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. 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. A careful review must be made of the treatment and rehabilitation methods that have been applied or are being used. Use of the Guide The presence and extent of impairment is a medical issue, and is assessed by medical means. The descriptors associated with particular classes for each mental function are intended to be indicative only. They are intended to provide an overview of the type and severity of symptoms expected for each particular class. It would be futile to attempt to list all relevant symptoms and would be onerous for the assessor. The absence of a particular symptom in the list of descriptors does not mean that that symptom is to be disregarded. It is ultimately for the clinician, and no one else, to make the clinical judgement whether a specific rating criterion is present. If the clinician doubts that a

particular symptom or abnormality of mental function is present, even after hearing the patient describe it, the item should be rated as not present. The method described in this Guide involves the assessment of the severity of six specific mental functions listed in the picture above into five classes of increasing severity. The different classes are combined to produce a total psychiatric impairment. Use is made of a modified form of the table that was in the second edition of the AMA Guides. How did these new Psychiatric Guides come about? The 2nd Edition had a system that used the basic building blocks of any psychiatric examination, the mental state examination. That method was just workable and with considerable development, an amended version and its successors have been in use in Victoria since This method has been workable, equitable and without controversy. However that process was abandoned starting with the 3rd Edition This and the next 2 Editions have a system that is unusable. Because of this, every jurisdiction which uses the AMA Guides has been forced to develop some modification. This has led to a veritable Tower of Babel in terms of methods of assessing psychiatric impairment. By contrast disability is the reduction in ability arising from an impairment and is a matter for the courts. These definitions have been developed by the World health Organization. The classical example of the difference is amputation of a little finger. Why Measure Psychiatric Impairment? Impairment measurements are used in two ways. To provide a threshold so that claimants with impairments that lie below the threshold cannot proceed. To provide a level of whole person impairment using a percentage to determine the level of benefits provided. Various legislatures that implement and control these schemes have shown considerable uncertainty and ambivalence about dealing with psychiatric injury. This concern arises from a number of sources. There is some prejudice against the people experiencing a psychiatric injury, at times with disbelief that such injuries occur. There are also concerns that since psychiatric injury is regarded as subjective it is capable of being misused by fraudulent claims, so-called gaming. Most jurisdictions have developed methods of limiting claims for psychiatric injury. Some jurisdictions simply exclude psychiatric injury from benefits. Other schemes require claimants with a psychiatric injury to meet a higher level of threshold of impairment before they can access the scheme. The third method, used extensively in Australia, is to reject claims for psychiatric injury which are secondary to physical injury, for example depression arising from a chronic back injury. Successful claimants have to demonstrate that they have an injury arising from the incident itself, such as a post traumatic stress disorder. In a number of jurisdictions in Australia the latter two methods are combined. A reliable means of measuring psychiatric percentage impairment is critical for courts, tribunals, and claimants. In some methods, which we will see later, disability is used as a surrogate for impairment, this is inappropriate. This should be the core of any system of psychiatric impairment. It should be easily and rapidly administered using data arising from the clinical interview. This is preferable to a checklist which is susceptible to cheating by claimants. It should be able to produce a percentage figure which is reliable. The term reliable in this context means that different examiners, seeing the same claimant, come to a similar identical figure for percentage impairment. It should be transparent and readily understood by courts and tribunals and the figures emerging from such a method should make sense. There is no objective measure such as in physical science. There is a means of accurately determining the length of a metre which is reproducible and is the standard throughout the world. Such a situation cannot apply in psychiatry. Despite the requirement that any method should only measure impairment and leave disability for the courts and tribunals there is inevitably a blurring between impairment and disability, this is difficult to avoid. Inevitably psychiatrists rely on behaviour to inform their opinion. Behaviour is a manifestation of disability. Furthermore any method relies, to a large degree, on self reporting. This causes problems for people who are deliberately misleading the examiner or who, for a variety of reasons, are unable to provide an accurate account of their situation. Furthermore there is a fundamental absurdity in collapsing a complex pattern of behaviour into a single number. This is inescapable and is a basic problem with psychiatric impairment. There are also special problems in psychiatric impairment assessment when dealing with the overlap between psychiatric injury and neurological injury and with assessing pain disorders and psychiatric injury. Methods of Psychiatric Impairment There are two basic methods of measuring psychiatric impairment. Method 1 is to assess specific functions and combine these assessments to determine whole person psychiatric impairment. This is the method used in the American Medical Association Guides. The second method is to group combinations of

symptoms assumed to be present at specific levels of impairment. The table assesses 4 areas of functioning including activities of daily living, social functioning, concentration, and adaptation. The impairment for each area lies within one of five classes, ranging from class one, no impairment to class five, extreme impairment. There is a generalised account of what each of these areas involve but no specific descriptors relevant to each class. There are two basic problems with this table. Three of the four areas are measures of disability, not impairment. The only measure of impairment is concentration. This is a fundamental problem. From an operational point of view there is no method for combining the overall classes. Guide users have no guidance on how to combine the classes. Quite deliberately, the authors have rejected providing percentage impairments. There are five reasons given for this lack of percentages There are no precise measures of impairment in mental disorders. The use of percentages implies a certainty that does not exist. Percentages are likely to be used inflexibly by adjudicators. No data exists that shows the reliability of the impairment percentages.

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