

ReturnToWorkSA & MAIAS

Impairment Assessment Guidelines Training -
PSYCHIATRY

Guide to the Evaluation of Psychiatric Impairment for
Clinicians (GEPIC)



Presenter: Dr Michael Epstein

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- Psychiatric impairment assessment plays a critical role in determining the long-term impact of work-related and accident-induced mental health conditions. Unlike incapacity assessments, which focus on limitations in daily functioning, impairment assessments aim to quantify the loss of psychological capacity in a structured, objective manner.
- The Guide to the Psychiatric Impairment for Clinicians, the GEPIC provides a comprehensive framework for clinicians to evaluate psychiatric impairment using standardized criteria. Grounded in diagnostic systems such as the DSM-5-TR and informed by the principles of the AMA Guides, this approach ensures consistency, reliability, and fairness in clinical decision-making.
- By the end of this training, participants will be equipped to:
 - Identify eligible psychiatric conditions for assessment
 - Apply structured methods to evaluate impairment severity using the prescribed templates.
 - Ensure assessments meet legal, ethical, and clinical standards
 - Interpret and communicate findings with clarity and confidence

The Program

Reasons for measuring psychiatric impairment.

The referral.

Importance of mental status examination.

Apportionment.

Stability.

Pure Mental harm and Consequential Mental Harm.

Neurology/psychiatry overlap.

Pain disorder

Impairment assessment using the GEPIC.

Different method using GEPIC for ReturnToWorkSA and the MAIAS.

Recording the psychiatric impairment rating using the appropriate template.

Case examples.

Common Errors.


Frequently asked questions.

Worked examples: work injuries; motor accident injuries.

Question & answer session.

The benefit of familiarity with the GEPIC

- Use of the GEPIC by ReturnToWorkSA and the MAIAS involves specific populations who have had work or transport accidents or injuries.
- With use of the GEPIC scores and patterns within the Guide that are common and repeat themselves become identified.
- This is because the psychiatric results from work related injuries tend to be somewhat specific so that certain scores keep coming up.
- Commonality of clinical scenarios and hence psychiatric impairment scores become more apparent with experience.



Reasons for Measurement of Psychiatric Impairment

- ReturnToWorkSA uses the assessment to determine if a worker's psychiatric injury has resulted in impairment and whether that impairment is permanent.
- ReturnToWorkSA uses the percentage of impairment to determine if a worker meets the threshold to be considered a seriously injured worker under the RTW Act (30%WPI or greater).
- Workers whose impairments meet the criteria to be considered seriously injured have additional entitlements to compensation under the RTW Act, including income support to retirement age and medical and rehabilitation services ongoing.
- The MAIAS uses the median GEPIC class to determine the ISV item number that helps determine eligibility for compensation, depending on the ISV.

In South Australia - Expert Witness Code of Conduct

An expert witness's primary duty is to the court, not the party instructing them.

They must provide objective, unbiased opinions within their area of expertise.

Expert witnesses must comply with all directions given by the court, including conferring with other experts.

Experts must also abide by any directions regarding the timely submission of reports.

Expert reports must clearly state the expert's opinion(s).

They should also include details about the expert's qualifications, the materials they reviewed, and any assumptions made.

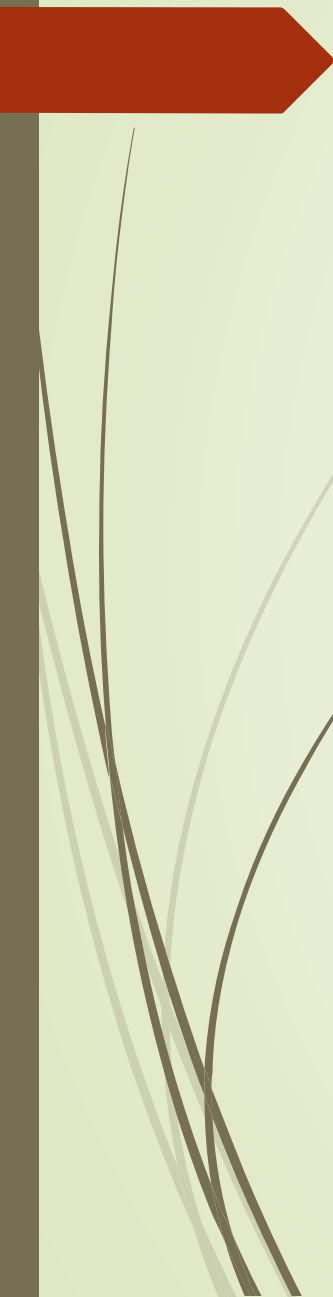
If an expert changes their opinion, a supplementary report is required.

An expert must disclose any potential conflicts of interest.

Parties engaging expert witnesses must provide them with a copy of the relevant code of conduct.

Experts must acknowledge in writing that they have read and agree to be bound by the code.

Common Work/Accident Psychiatric Disorders:

- 
- Acute stress disorder
 - Post-traumatic stress disorder
 - Generalised anxiety disorder
 - Adjustment disorder with depressed mood (and/or anxiety)
 - Adjustment disorder with mixed emotions and conduct
 - Specific phobia (driver and passenger anxiety)
 - Panic disorder
 - Agoraphobia
 - Obsessive compulsive disorder
 - Major depressive disorder
 - Somatic symptom disorder with predominant pain
 - Functional neurological disorder
 - Post concussion syndrome (usually with transport accidents)
 - Substance use disorder
 - Persistent depressive disorder
 - Prolonged grief disorder (usually with transport accidents)

Overview GEPIC Use - ReturnToWorkSA

- Interview and review of documentation
- Use ReturnToWorkSA template
- Past and Family History
- Describe Injury or accident
- Current condition and treatment
- Pre-injury level of function vs. current level of function
- Refusal of treatment – assess as is noting the potential for change
- Possible future deterioration – make no allowance for this but note the potential in the report
- Mental State Examination (MSE)
- Correlate GEPIC descriptors to MSE
 - ⇒ Diagnosis(es) using DSM5
 - ⇒ Pre-existing or Unrelated diagnoses
 - ⇒ Stability and prognosis
- Use GEPIC method to find overall Whole Person Impairment (WPI)
- Disregard (deduct) impairment unrelated to work injury and Consequential Mental Harm
- Result is impairment from Pure Mental Harm

Adjustment for the effects of Treatment

- ReturnToWorkSA

- ▶ If long term treatment of a work injury results in substantial reduction or total elimination of the impairment, but the worker will relapse to the original degree of impairment if treatment is withdrawn, the assessor may increase the percentage of whole person impairment by up to 3%WPI providing reasoning for the choice of value in the report.
- ▶ This applies to the use of medications for treatment of psychiatric conditions.

Overview GEPIC Use MAIAS

- Interview and review of documentation
- Complete current template (June 2025) :
 - Pre accident level of function
 - Accident, injuries, treatment, current level of function and treatment, current symptoms; current level of function
- Mental State Examination (MSE)
- Diagnosis(es) using DSM5-TR
- Eliminate all symptoms not due to Pure Mental harm from accident
- Determine Stability of Pure Mental Harm (Stability re Consequential Mental harm and unrelated diagnoses is not relevant)
- Correlate GEPIC descriptors re Pure Mental Harm to MSE
- Use GEPIC method to find Median number
- If no PMH then GEPIC not required
- Correlate Median number to ISV item number (10-13)

The Referral

- ▶ You must be provided with:
 - ▶ documentation describing the circumstances of the injury or accident
 - ▶ records or reports of treating practitioners, specialists and relevant hospital information
 - ▶ details of current medications and treatment
 - ▶ For MAIAS, the stated cause of the psychiatric injury
 - ▶ questions to be answered
- ▶ Reference to multiple and objective sources of information can assist to eliminate error introduced by an incomplete history
- ▶ Request information if not provided/insufficient
- ▶ The absence of required information could result in an assessment being discontinued or deferred for work related impairments in the Return to Work scheme.

The diagnostic process

- ▶ History and documentation information
- ▶ Functional status immediately before the accident or injury
- ▶ Current functional status
- ▶ MSE
- ▶ Influence of underlying character and environmental factors
- ▶ Stability and prognosis timeframes to determine permanency
- ▶ Diagnosis(es) resulting from the injury or accident (using DSM-5-TR or ICD11 criteria) – ReturnToWorkSA requires use of DSM-5 only.
- ▶ Diagnosis of disorders unrelated to the injury or accident
- ▶ The RANZCP states in statement 77 the following:
- ▶ *In legal settings, diagnostic manuals should be used with caution.... inclusion of a diagnostic category does not imply that the condition meets legal or other nonmedical criteria for what constitutes a mental disorder.*

The GEPIC is based on the MSE

- The GEPIC is based on the MSE because it is the objective aspect of the Psychiatric assessment as opposed to the history.
- The MSE will never give the assessor the complete picture
- The assessor is trying to estimate the individual's mental state in other circumstances and situations by relying on history and independent information.
- When determining an impairment assessment the findings in the MSE must match the classes selected for each category in the calculations.
- The descriptors of the Categories as included in the Guides (or equivalent descriptors) must be followed keeping in mind that they are not all inclusive.
- Diagnosis important but less important than MSE.

The Royal Australian and New Zealand College of Psychiatrists Practice: Guideline #9 - **Mental status examination**

- ▶ appearance and general behavior.
- ▶ mood
- ▶ affect
- ▶ speech and language
- ▶ psychomotor behavior
- ▶ 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,
- ▶ cognitive status



Developing reports and conducting independent medical examinations in medico-legal settings

PPG #11

Psychiatrists must:

1. provide evidence in the report to assist a court or tribunal to come a decision.
2. adhere to relevant scientific and clinical psychiatric principles.
3. observe relevant laws and regulations concerning keeping medico-legal records and reports.
4. understand and comply with the applicable expert witness codes of conduct.
5. comply with relevant professional codes of conduct and ethical standards so as to
 1. uphold the principles of honesty and objectivity,
 2. provide defensible evidence,
 3. avoid misleading the recipient of the report or other relevant body and
 4. manage or avoid conflicts of interest as appropriate.

My own view re Reports

- ▶ A report should tell a story, the report should start with a brief overview of the claimant and the claim.
- ▶ The story should be easily accessible and understandable
- ▶ The reader will be an educated layperson who has probably read many reports and will want the story to be inclusive, decisive but brief
- ▶ The reader should be told of:
 - ▶ any issues the claimant had before the incident
 - ▶ the claimant's level of function just before the incident
 - ▶ Injuries/diagnoses/treatment after and now/ current symptoms and current level of function in work, recreation and relationships
 - ▶ Any Pure Mental Harm (PMH), if so, is it stable?
 - ▶ No GEPIC assessment if there is no PMH



**THE GUIDE TO
THE EVALUATION OF PSYCHIATRIC
IMPAIRMENT FOR CLINICIANS**

(GEPIC)

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Revised December 2005



Why the GEPIC

- Used to substitute Chapter 14 in AMA 4 which lacked rating methodology and focused on disability
- Emphasis on assessing mental and behavioural *impairment*
- Further development of a proven method which improved reliability and consistency of assessments as an adjunct to AMA 2 Mental and Behavioural evaluations



GEPIC

Principles of Psychiatric Impairment Assessment 1

Principle 1:

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 but is not the sole criterion.

Principle 3:

Consideration should be given to other factors including, level of functioning, educational, health status, financial, social and family situation



GEPIC

Principles of Psychiatric Impairment Assessment 2

Principle 4:

The underlying character and value system of the individual is important in assessing prognosis. Motivation for improvement is a key factor in the outcome.

Principle 5:

Impairment can only be determined when a person reaches maximum medical improvement (MAIAS) or when the work injury has stabilised (ReturnToWorkSA).

Use of the GEPIC

- Used by consultant psychiatrists using clinical judgment.
- A data base developed from clinical information, documentation and the mental state examination.
- Descriptors are indicative. Other symptoms can be used if they can be justified as associated with a particular class of severity.
- Clinician's decision if a specific rating criterion is present. If the clinician has doubts the item should not be rated as present.

The GEPIC Method

- This method involves the assessment of the severity of
 - 6 specific mental functions
 - Into 5 classes of increasing severity.
 - The different classes are combined to produce a total psychiatric impairment.

Different use of the GEPIC re ReturnToWorkSA and MAIAS claims

ReturnToWorkSA

- ▶ Using diagnosis(es) and MSE determine WPI
- ▶ Then deduct impairment due to Consequential Mental Harm and/or pre-existing/unrelated impairment
- ▶ The result is a whole person impairment %age due to Pure Mental Harm

MAIAS

- ▶ Make diagnosis(es)
- ▶ Eliminate diagnoses and symptoms that are unrelated to the accident or are due to Consequential Mental Harm
- ▶ Resultant symptoms are due to Pure Mental Harm
- ▶ If no Pure Mental Harm then the GEPIC is not done.
- ▶ Score GEPIC and determine Median class (not psychiatric impairment percentage) correlate Median class with ISV item number.

Definitions

Impairment: AMA5 defines as “a loss, loss of use, or derangement of any body part, organ system, or organ function”.

Permanent:

MAIAS: “In relation to an injury, means the impairment an injured person has, or is likely, to have after maximal medical improvement (MMI) within the meaning of AMA5”.

ReturnToWorkSA: Defines permanent as for a long and indeterminate time but not necessarily forever and more likely than not to persist for the foreseeable future.

Definitions cont'd

Stability:

MAIAS: Impairment can only be rated when MMI has been reached. AMA5 defines MMI as “well stabilized and unlikely to change substantially in the next year with or without medical treatment”.

ReturnToWorkSA: An assessment of the degree of Impairment must not be made until there is evidence that the injury has stabilized. Impairment Assessment Guidelines Third Edition defines stabilized as “if the worker’s condition is unlikely to change substantially in the next 12 months with or without medical treatment (regardless of any temporary fluctuations in the condition that might occur).”

Disability: AMA5 defines as “An alteration of an individual’s capacity to meet personal, social, or occupational demands or statutory or regulatory requirements because of an impairment”.

Eg Loss of finger 5% impairment

Concert pianist 100% disability

Bureaucrat 0% disability

More Definitions

Possibility, Probability. Refer to likelihood or chance that an injury or illness was caused or aggravated by a particular factor. Possibility is sometimes used to imply a likelihood of less than 50%. Probability sometimes used to imply a likelihood of greater than 50%.

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.

Pseudohallucinations. Hallucinations that are recognised by the person as being imaginary (not real, lacking an external source or stimulus).



Reference for Clinicians

- ▶ Annotations for Determining Non-Secondary Psychiatric impairment:
 - ▶ Dr Michael Epstein
 - ▶ Dr Nigel Strauss



Categories of Pure Mental Harm and Consequential Mental Harm 1-5

Category 1: Impairment from a psychiatric injury which is not consequential to a physical injury is Pure Mental Harm (PMH) and counts both with ReturnToWorkSA and MAIAS assessments.

Category 2: Impairment from a psychiatric injury which is consequential to a physical injury is Consequential Mental Harm (CMH) and does not count for assessments under MAIAS but for assessments for ReturnToWorkSA, the assessor must assess the total overall impairment then disregard (deduct) the CMH component.

Category 3: Impairment from a psychiatric injury or disorder which has arisen from a previous psychiatric disorder or injury is Pure Mental Harm. For assessments for ReturnToWorkSA, the assessor must assess the total overall impairment then disregard (deduct) the pre-existing condition. A formal diagnosis for the pre-injury condition is not required

Category 4: Impairment from a delayed psychiatric disorder due to a work injury or motor accident is Pure Mental Harm. i.e. post traumatic stress disorder.

Category 5: Impairment from a psychiatric injury or disorder arising directly from trauma, whether or not there is a physical injury, counts as Pure Mental Harm i.e. from an assault.

Categories of Pure Mental Harm and Consequential Mental Harm 5-9

Category 6: Any brain injury leading to mental harm (like any other physical injury or condition) is Consequential Mental Harm.

Category 7: Impairment from a psychiatric injury or disorder due to a workplace response to a physical injury is Consequential Mental Harm. If a separate claim has been made for mental harm arising from the workplace response then this is likely to be Pure Mental Harm.

Category 8: Impairment from a psychiatric injury or disorder arising from a complication of treatment for a physical injury is Consequential Mental Harm.

Category 9 : Pain is almost always due to a physical injury (that may have resolved) and so any psychiatric impairment due to pain is Consequential Mental Harm

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 <i>(Capacity for understanding)</i>	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Thinking <i>(The ability to form or conceive in the mind)</i>	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Perception <i>(The brain's interpretation of internal and external stimuli)</i>	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Judgement <i>(Ability to assess a given situation and act appropriately)</i>	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Mood <i>(Emotional tone underlying all behaviours)</i>	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Behaviour <i>(Behaviour that is disruptive, distressing or aggressive)</i>	Normal to Slight	Mild	Moderate	Moderately Severe	Severe

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 13 of the 5th edition American Medical Association Guides.)

Guides for the rating of impairment of intelligence:

Class	Impairment	Description
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1	0 - 5%	Normal to Slight <i>- 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</i>
2	10 - 20%	Mild (Mildly reduced) <i>- some interference with everyday functioning</i>
3	25 - 50%	Moderate (moderately/mildly reduced) <i>- a reduction in intelligence that significantly interferes with everyday functioning.</i>
4	55 - 75%	Moderately Severe (moderately severely reduced) <i>- a reduction in intelligence which makes independent living impossible.</i>
5	over 75%	Severe (severely reduced) <i>- needs constant supervision and care</i>

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
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1	0 - 5%	Normal to Slight - <i>-includes mild transient disturbances that are not disruptive and are not noticed by others.</i>
2	10 - 20%	Mild <i>- mild symptoms that usually cause subjective distress, for example:</i> <ul style="list-style-type: none"><i>-thinking may be muddled or slow;</i><i>- may be unable to think clearly;</i><i>- mild disruption of the stream of thought due to some forgetfulness or diminished concentration;</i><i>-may have some obsessional thinking which is mildly disruptive;</i><i>- may be preoccupied with distressing fears, worries or experiences, and by inability to stop ruminating;</i><i>- increased of self-awareness or a persistent sense of guilt;</i><i>- some other thought disorder that is minimally disruptive (such as overvalued ideas or delusions; some formal thought disorder, that does not interfere with effective communication)</i>

Thinking (cont...)

3 25 - 50%

Moderate

- 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

-disorders of thinking that cause difficulty in functioning independently & may require some external assistance.

5 Over 75%

Severe

- disorders of thinking that cause such a severe disturbance that independent living is impossible.



Mistakes confusing Intelligence and Thinking

- The definition of Intelligence is:
- *Capacity for understanding and for other forms of adaptive behaviour. Impairments of intelligence are a consequence of brain injury or disease.*
- Impairments of intelligence are rare in the absence of brain disease or injury.
- Psychomotor retardation seen in major depression may lead to an impairment of intelligence.
- A number of assessors have scored symptoms of disturbed thinking e.g. concentration and memory issues as impairments of Intelligence.
- e.g. Thinking 3, *severe problems with concentration and marked disruption of the stream of thought*

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:

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

Issues with 'Perception'

“There can be few areas where the work of assessment by the psychiatrist is more misunderstood than in the psychopathology of perception”. Andrew Sims ‘Symptoms of the Mind’.

Perceptual Disturbances are disturbances of:

- Hearing
- Vision
- Smell
- Taste
- Touch

Mistakes about Perception in the GEPIC quotes from different reports

- Regarding perception, there is a heightened awareness of the accident, there is reported driver and passenger anxiety, and nervousness and hyper-vigilance.
- From a perception point of view, there is hypervigilance when driving . There is a consistent history of nightmares. The experiences are consistent with a class 2 rating.
- She says she has lost her identity and does not know who she is. She did think she was Superwoman but has now discovered that she is not.
- “I have to take a lot of painkillers every morning although I was very tolerant of pain, but this pain is so constant that it has worn me down.”
- She denied any disorders of perception such as delusions or hallucinations.
- She has a heightened perception of her illness symptoms.

Judgment

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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 <i>- may lack some insight/ misconstrue situations but with little interference with function</i>
2	10 - 20%	Mild <i>-persistently misjudges situations in relationships, occupational settings, driving and with finances. The misjudgments are noticed by others but are accommodated.</i>
3	25 - 50%	Moderate <i>-misjudging social, work and family situations repeatedly leading to some disruption in relationships, occupational settings, living circumstances and financial reliability.</i> <i>- inappropriate spending of money or gambling</i>
4	55 - 75%	Moderately Severe <i>-moderately severe misjudgment with regular failure to evaluate situations or implications, causing actual risk or harm to self or others</i> <i>-failure to respond to regular guidance/ requirement constant supervision.</i>
5	Over 75%	Severe <i>- persistently assaultive -misinterpretation behaviour/ motives of others</i> <i>- sexually disinhibited (may occur following a head injury).</i>

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 over time, the affective range is restricted.

Amplitude: Energy expended 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 affect and situation.


Quality of Affect: Suspicious, sad, happy, anxious, angry, apathetic.

Relatedness: Ability express warmth, interact emotionally & establish rapport.

Mood

Class	Impairment	Description
1	0 - 5%	Normal to Slight <ul style="list-style-type: none">- relatively transient expressions of sadness, happiness, anxiety, anger and apathy;- normal variation of mood associated with upsetting life events.
2	10 - 20%	Mild <ul style="list-style-type: none">- mild symptoms: some or all of the belowmild 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 derealization/depersonalisation.

Mood (cont...)



3 25 - 50%

Moderate Impairment

- moderate symptoms: some 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

- 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 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.

1 0 - 5%

Normal to Slight

- transient disturbances in behaviour in context of this person's situation, excessive fatigue, intoxication, family/work disruption.

2 10 - 20%

Mild

- persons who generally function well, but regularly manifest disturbed behaviour under 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

- occasional disruptive or withdrawn behaviour requiring attention or treatment;
- obsessional rituals interfering but not preventing goal-directed activity;
- repeated antisocial behaviour leading to conflict with authority.

Behaviour

4 55 - 75% Moderately Severe

- *persistently aggressive, disruptive or withdrawn behaviour requiring attention or treatment ;*
- *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 own bodily needs.*

5 Over 75% Severe

- *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.*

Determining Whole Person Psychiatric Impairment

- ▶ 6 mental functions in 5 classes
- ▶ Each function is allotted a class (and severity rating for ReturnToWorkSA assessments) – an explanation is required as to why that class and severity rating was chosen. This must be consistent with the MSE. e.g. MSE no perceptual problems yet Class 2 in GEPIC!
- ▶ Determine the median class; the median number is the middle number.
- ▶ 11 22 33, the middle number is 2.
- ▶ 12 33 33, the middle number is 3.
- ▶ 11 22 22, the middle number is 2.
- ▶ The final percentage lies within the range of the median class. Class 2 is between 10-20%.

Determining Whole Person Psychiatric Impairment (exceptions from the rule)

- ▶ Median number may not be a whole number e.g. 1 1 12 22, the median number is 1.5
- ▶ In this situation the percentage is the bottom of the next highest class, here to class 2 and 10% percent.
- ▶ If scores are 1 1 2 3 3 3 then median score is 2.5. then promoted in the lowest level in Class 3 - 25%. His WPI is 25%.
- ▶ With a skewed series, e.g.. 1 1 11 41, the median number is 1 but the impairment may be up to 10 percent. This rarely if ever occurs.
- ▶ 1 1 1 1 1 2 or 1 1 1 1 1 3 are not skewed series

Table for Evaluation of Psychiatric Impairment

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Perception <i>(The brain's interpretation of internal and external stimuli)</i>	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Judgement <i>(Ability to assess a given situation and act appropriately)</i>	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Mood <i>(Emotional tone underlying all behaviours)</i>	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Behaviour <i>(Behaviour that is disruptive, distressing or aggressive)</i>	Normal to Slight	Mild	Moderate	Moderately Severe	Severe

Severity Ratings to determine intraclass % re ReturnToWorkSA Impairments

	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%

Return to Work Act 2014

8) An assessment must take into account the following principles:

- (b) impairments from pre-existing or unrelated injuries or causes are to be disregarded (deducted) in making an assessment;
- (d) impairment resulting from physical injury is to be assessed separately from impairment resulting from psychiatric injury;
- (e) in assessing impairment resulting from physical injury or psychiatric injury, no regard is to be had to impairment that results from consequential mental harm;
- (f) in assessing the degree of permanent impairment resulting from physical injury, no regard is to be had to impairment that results from a psychiatric injury that is consequential mental harm;

Apportionment - ReturnToWorkSA

1. Is there a work-related psychiatric condition leading to a psychiatric impairment?
2. Are there pre-existing or unrelated psychiatric issues also leading to an impairment?
3. What percentage of the impairment is secondary or consequential to a physical injury?
4. What is the Whole Person Psychiatric Impairment?
5. The Final impairment is $4 - (2+3)$


Apportionment - MAIAS

1. Is there an accident related psychiatric condition leading to a psychiatric impairment?
2. Are there unrelated psychiatric issues also leading to an impairment?
3. Is there Consequential Mental Harm?
4. Strip out 2 and 3.
5. This leaves only Pure Mental Harm
6. If there is no PMH then no GEPIC assessment
7. What is the Median Class?
8. The Median Class determines the ISV item number
9. Class 1 & 2 = ISV 13; Class 3 = ISV 12; Class 4 = ISV 11 and Class 5 = ISV 10



Example of Apportionment MAIAS

- ▶ Rick has OCD and still has treatment. He had a transport accident leading to soft tissue injuries but no fractures and no aggravation of his OCD. He has PTSD from the accident requiring treatment. He has chronic pain and is depressed.
- ▶ OCD impairment is unrelated and not aggravated by the accident
- ▶ Depression due to chronic pain is Consequential Mental Harm
- ▶ GEPIC impairment due to Pure Mental Harm = Median Class 2
- ▶ Median Class 2 = ISV item number 13



Example of Apportionment ReturnToWorkSA

- Rick has OCD and still has treatment. He had a fall at work leading to soft tissue injuries but no fractures and no aggravation of his OCD. He has PTSD from the accident requiring treatment. He has chronic pain and is depressed.
- WPI = 20%
- OCD impairment = 5%
- Chronic pain and depression = 10%
- Final impairment $20 - (5 + 10) = 5\%$

Examples of Impairment Formulation 1

- ▶ **Intelligence class 1:** there is no evidence of any disturbance of intelligence.
- ▶ **Thinking class 3:** there are disturbances of stream of thought due to diminished concentration and an inability to stop ruminating about the accident. This leads to considerable interference with effective communication.
- ▶ **Perception class 2:** the claimant experiences flashbacks without dissociation
- ▶ **Judgement class 3:** there are disturbed relationships, occupational functioning reduced and financial difficulties but the claimant spends money on gambling.
- ▶ **Mood class 3:** there is a moderate impairment of mood with self blame, guilt, social withdrawal, appetite disturbance, psychomotor agitation and suicidal ideation.
- ▶ **Behaviour class 3:** The claimant has been unable to return to work because of the injuries arising from the accident and her behaviour has alienated her family and friends and has been gambling to excess.

Examples of Impairment Formulation 2

- ▶ **Intelligence** **Class 1:** *there is no head injury so no disturbance of intelligence*
- ▶ **Thinking** **Class 2:** *thinking is muddled and slow; unable to think clearly; mild disruption of his stream of thought due to problems with memory and concentration.*
- ▶ **Perception** **Class 2:** *daily flashbacks, no dissociation*
- ▶ **Judgment** **Class 3:** *misjudges social, work and family situations repeatedly leading to some disruption in relationships, occupational settings, living circumstances and financial reliability, gambling*
- ▶ **Mood** **Class 3:** *marked lability of affect; significant lethargy; social withdrawal leading to major problems in interpersonal relationships; anhedonia*
- ▶ **Behaviour** **Class 2:** *behaviour that has had some adverse effect on relationships and employment*

Adrian – Work Injury

- Adrian – a 47-year-old married man with three children.
- no significant individual or family health problems.
- process worker in a food factory for 5 years. Active sports

THE INJURY

- dominant right arm caught in conveyor belt with degloving injury

SUBSEQUENT PROGRESS

- hospital for a week and had skin grafts.
- visited by his manager and workmates.
- off work 4 weeks.
- saw GP medication for anxiety, sleep and depression
- saw psychologist and had rehabilitation
- returned to work on a graduated return to work program.
- very anxious in the factory and avoided machinery.
- resumed production work
- fearful and weakness and pain in his arm.
- dreaded going to work
- could not cope and was placed off work.

Current Condition

Physical

- ▶ pain constant and avoids moving his arm
- ▶ needs help with ADLs
- ▶ sex life ceased because of lack of libido and pain
- ▶ grooming deteriorated

Thinking

- ▶ confused and hesitant, thoughts about the accident are distracting, ruminates most days

Perception

- ▶ sounds seem louder and lights brighter
- ▶ daily flashbacks

Adrian Current Condition II

Mood

- ▶ jumpy and on edge
- ▶ twice weekly nightmares
- ▶ mood fluctuates markedly – like walking on eggshells
- ▶ irritable with his family
- ▶ tearful at times

Judgement

- ▶ gambling on the internet and losing significant amounts of money

Behaviour

- ▶ marriage in trouble/ his children avoid him
- ▶ poor grooming
- ▶ ceased all his recreational and sporting activities
- ▶ isolated
- ▶ uncomfortable in crowds and supermarkets
- ▶ avoids leaving home
- ▶ prefers not to drive because it frightens him



Adrian - Diagnostic Formulation and MSE leading to GEPIC Impairment

➤ **MENTAL STATE EXAMINATION**

- Sad -tearful, soiled track suit, unshaven, obese, co-operative, limited eye contact, holding right arm across body.
- Well orientated- affect restricted - depressed and anxious.
- Perception disturbed daily flashbacks, no hallucinations
- Intellectual functioning normal.
- Speech slow, monotone, volume low, fluctuated when distressed.
- Memory/concentration disturbed. No thought disorder, no delusions
- Judgment reduced.
- Behaviour significantly disturbed.

➤ **DIAGNOSTIC FORMULATION**

1. Permanent disability of right arm associated with chronic pain.
2. Post traumatic stress disorder
3. Chronic Adjustment Disorder with Depressed Mood

Adrian - Impairment Assessment

- **Intelligence** **Class 1:** *nil*
- **Thinking** **Class 2:** *mild symptoms that causing subjective distress: thinking muddled/slow; not thinking clearly; disruption of stream of thought due to forgetfulness/diminished concentration.*
- **Perception** **Class 2:** *persistent heightened perceptions of the internal and external world, daily flashbacks*
- **Judgment** **Class 3:** *misjudging social, work and family situations repeatedly leading to some disruption in relationships, work, living circumstances, financial reliability, gambling*
- **Mood** **Class 3:** *marked lability of affect; significant lethargy; social withdrawal leading to major problems in interpersonal relationships; anhedonia*
- **Behaviour** **Class 2:** *persistent behaviour that has some adverse effect on relationships or employment*

Scoring of Mental Functions


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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 <i>(Capacity for understanding)</i>	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Thinking <i>(The ability to form or conceive in the mind)</i>	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Perception <i>(The brain's interpretation of internal and external stimuli)</i>	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Judgment <i>(Ability to assess a given situation and act appropriately)</i>	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Mood <i>(Emotional tone underlying all behaviours)</i>	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Behaviour <i>(Behaviour that is disruptive, distressing or aggressive)</i>	Normal to Slight	Mild	Moderate	Moderately Severe	Severe

Adrian - Whole Person Psychiatric Impairment (WPI) Method 1


- ▶ Classes 1 2 2 3 3 2
- ▶ Classes in order 1 2 2 2 3 3
- ▶ Median Class is Class 2 (10%-20%)
- ▶ He is at the upper end of the range.
- ▶ In Class 2 the high range is 18-20%

- ▶ He has a WPI of 20%.



Adrian - Whole Person Psychiatric Impairment (WPI) Method 2

- ▶ Using the severity rating for each function, Low (L), Medium (M) and High (H). Determine the median class, any severity rating below the median class becomes L in the median class, any severity rating above the median class becomes H in the median class
- ▶ Classes 1L 2H 2H 3L 3L 2H
- ▶ Classes in order 1 2 2 2 3 3
- ▶ Median Class is Class 2 (10%-20%),
- ▶ Severity ratings become L H H H H H, median severity rating is H
- ▶ In Class 2 the high range is 18-20%
- ▶ He has a WPI of 20%.



Adrian WPI and Impairment after apportionment

- ▶ post traumatic stress disorder
- ▶ moderate adjustment disorder with depressed mood due to arm pain and dysfunction
- ▶ WPI is in median class 2 at the upper end of that range i.e. 18-20%. His final impairment is 20%
- ▶ The assessor has decided that half, 10% of the whole person impairment is Consequential Mental harm.
- ▶ He has a compensable psychiatric impairment due to Pure Mental Harm of 10%

Denise – Motor Accident

- ▶ 27-year-old full time medical receptionist
- ▶ Defacto no children
- ▶ Enjoys – running, cycling, water sports and skiing

Transport Accident

Commuting in small sedan, hit by truck behind, car pushed into tree. Cut out, conscious, car destroyed.

Injuries

Fractured pelvis, fractures L3-L5, fractured left ribs with hemopneumothorax, fractured right (dominant) humerus. Degloving injury left lower leg.

Treatment

Hospitalised 3 weeks – ORIF pelvis, humerus, fusion L3-L5, chest tubes, skin grafts from left thigh. MRSA infection.

Treatment

- Rehabilitation 3 months inpatient, 1 year outpatient.
- Physiotherapy.
- Graduated return to work 9 months after accident.
- 15 months post accident returns to driving,
- Work hours increase to 4 hours 5 days a week.
- Completes rehabilitation,
- Attends 12 week Pain Management Program involving
- OT, HT, Gym, psychologist and Pain Specialist – limited benefit

AMP Assessment 4 years post accident

► **Social**

Not resumed any recreational activities

Conceals scarring

Unsociable, has had conflict with staff and patients at the clinic

Struggles with housework because of pain and lack of motivation

► **Physical**

Constant pain in her pelvis and lower back, worse with sitting and walking

Constant pain with weakness and restricted movement of her right(dominant) arm

Some urinary incontinence

No chest pain now

Pain at graft donor site

AMP Assessment 4 years post accident II

► Psychological

Depressed and frustrated with passive suicidal thoughts

Disturbed sleep and appetite, has gained weight due to lack of activity and comfort eating

Embarrassed about the appearance of her left calf and her limp

Frequent flashbacks about the accident

Frequent nightmares with disturbed sleep

Very anxious in cars, avoids driving if possible

Very anxious passenger

Avoids the scene of the accident

Frequent panic attacks especially with triggers such as sirens, hearing or seeing accidents

AMP – Mental State Examination

- ▶ Appearance – short mildly obese woman looking older than her stated age, unkempt, wearing slacks, walks with a slight limp, changes position several times during the interview and appears in discomfort.
- ▶ Well orientated but disjointed history and problems with chronology. Tearful at times.
- ▶ Her speech is slow, low in volume and she speaks in a monotone but her speech fluctuates when she is distressed.
- ▶ Her thinking is slow and, at times confused and she broods about the accident leading to problems with memory and concentration. There is no thought disorder.
- ▶ Her thought content is the daily struggle of dealing with her accident symptoms and that her life has been ruined. She admits to suicidal thoughts but has no intent.
- ▶ Her perception is disturbed by frequent flashbacks with dissociation.
- ▶ Her affect is restricted and she appears depressed and anxious during the course of the interview.
- ▶ Her judgement seems disturbed and her behaviour had changed, she is irritable, fatigued and isolated.

Denise – Diagnoses

- Post Traumatic Stress Disorder
- Panic Disorder
- Major Depressive Disorder (partly contributed to by her physical injuries and partly from her PTSD)
- Questions
 - any psychiatric impairment unrelated to the accident? No
 - Is there any Consequential Mental Harm? Yes – She has a major depressive disorder from her physical injuries.
 - Does she have symptoms due to Pure Mental Harm – Yes, her PTSD including depression and her Panic Disorder

What is her impairment due to Pure Mental Harm?

Intelligence:

no brain injury = Class 1

Thinking

severe problems with concentration due to intrusive thoughts and obsessional ruminations;

marked disruption of the stream of thought due to significant memory problems or diminished concentration;

= Class 3

Perception

Frequent flashbacks to the accident with dissociation

= Class 2

Judgment

misjudging social, work and family situations repeatedly leading to disruption in relationships, occupational settings, living circumstances and financial reliability.

= Class 3

Denise's impairment 2

Mood

frequent panic attacks, persistent suicidal ideation; significant lethargy; social withdrawal leading to major problems in interpersonal relationships; anhedonia; appetite disturbance with significant weight change. = Class 3

Behaviour

generally function well, but regularly manifest disturbed behaviour under little extra pressure that nevertheless is able to be accommodated by others

persistent behaviour that has some adverse effect on relationships and employment = Class 2

Classes 1 3 2 3 3 2 in order 122333, Median 2.5 = 3 therefore ISV item number 12


Some common examples

1. Back injury at work, back pain and depression – psychiatric impairment
Consequential Mental Harm – is deducted from the overall impairment assessment.
2. Worker returns to work and is bullied due to light duties- depression and anxiety from bullying, separate claim. Impairment is Pure Mental Harm from this new injury.
3. Transport accident with multiple fractures and PTSD – PTSD Pure Mental Harm and counts. Depression from physical injuries is Consequential Mental Harm and does not count for MAIAS assessments.
4. Transport accident as above but claimant's husband killed– PTSD and distress about death of husband all Pure Mental Harm and counts.
5. Motor accident – TBI –marked changes in cognition and behaviour - some insight leading to depression – some symptoms traumatisation: Neurology chapter 13 AMA5 re TBI impairment, depression from TBI is Consequential Mental Harm - does not count for MAIAS assessments.

Common mistakes

- ▶ **Error 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 was assessed as having no impairment from Pure Mental harm.
- ▶ **There is no physical injury from the accident so there cannot be any Consequential Mental Harm. The impairment is either due to Pure Mental Harm or is unrelated to the accident.**
- ▶ **Error 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 was assessed as having a 20% impairment which was all 'Pure Mental Harm.'

- ▶ **Any psychiatric impairment, including from the harassment, is related to the back injury and is a combination of Pure Mental harm and Consequential Mental Harm.**

- 
- ➔ **The Cardinal Rules are that any psychiatric impairment consequential to physical injury from the accident or injury does not count for assessments for **MAIAS** and is included in the overall assessment but then deducted for assessments for ReturnToWorkSA.**




Factors involved in apportionment

- At the time of the impairment assessment:
 - Unrelated impairment
 - Physical injury leading to Consequential Mental Harm
 - Problems with:
 - Neurological/psychiatric overlap e.g. head injuries
 - Pain disorders
 - Work place response to worker's physical injuries e.g. bullying



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 13 AMA5 and/or the GEPIC
- Strong likelihood of overlap.
- Behavioural disturbance measured using Chapter 13, AMA5.



Overlap Psychiatric/ Neurological 2

Functional Neurological Symptom Disorder/ post concussion syndrome

- ▶ FND
- ▶ One or more symptoms of altered voluntary motor or sensory function.
- ▶ Clinical findings provide evidence of incompatibility between the symptoms and recognised neurological or medical conditions
- ▶ The symptom or deficit is not better expressed by another medical or mental disorder.
- ▶ The symptom or deficit causes clinically significant distress or impairment in social, occupational or other important areas of functioning or warrants medical evaluation.
- ▶ DSM5TR notes 'Post concussive symptoms' (headaches, light/noise sensitivity, irritability, concentration deficits) can occur in TBI and non TBI and with an Acute Stress Disorder, Persistent disorientation and confusion more typical of mild TBI



Pain and psychiatric impairment

- ▶ Chapter 18 (pain) AMA 5 is excluded
- ▶ 'psychologically based pain' is a complex/multi-factorial process,.
- ▶ psychological pain is "real" and involves suffering. It is not imaginary pain or malingering
- ▶ hallucinated pain may occur.
- ▶ pain 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



DSM5 Somatic symptom disorder with predominant pain

- A. One or more somatic symptoms (predominantly pain) that are distressing or result in significant disruptions of daily life.
- B. Excessive thoughts, feelings, or behaviours related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
 - 1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
 - 2. Persistently high level of anxiety about health or symptoms.
 - 3. Excessive time and energy devoted to these symptoms or health concerns.
- C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than six months).



GEPIC and pain

- **Intelligence** - normal.
- **Thinking** – up to Class 2 (unless part of a psychotic illness).
- **Perception** - Pain only relates to touch, usually class 1.
- **Judgement** - chronic pain sufferers reduced insight – may have mild deficit in judgement no more than Class 2.
- **Mood** - depression and anxiety are associated with chronic pain and those symptoms should be scored in the appropriate class
- **Behaviour** - Chronic pain leads to changes in behaviour - this can be scored accordingly.

Apportionment

Pain disorders almost always arise from a physical injury and so any psychiatric impairment due to pain is Consequential Mental harm (CMH).

CMH does not count for assessments for MAIAS and would be assessed as part of the overall assessment then disregarded (deducted) for assessments for ReturnToWorkSA.

Stability

- ▶ This is a critical part of the process:
- ▶ If the examiner finds that the psychiatric condition is 'not stable' then a GEPIC impairment should not be done (there are exceptions to this).
- ▶ What is stability in this context?
- ▶ MAIAS: Impairment can only be rated when MMI has been reached. AMA5 is defined as "well stabilized and unlikely to change substantially in the next year with or without medical treatment".
- ▶ For MAIAS assessments, if the psychological injury includes both Pure Mental Harm and Consequential Mental Harm, then only stability of the Pure Mental harm matters. If the CMH is not stable, it does not matter.
- ▶ ReturnToWorkSA: An assessment of the degree of Impairment must not be made until there is evidence that the injury has stabilized. Impairment Assessment Guidelines Third Edition defines stabilized as "if the worker's condition is unlikely to change substantially in the next 12 months with or without medical treatment (regardless of any temporary fluctuations in the condition that might occur).
- ▶ ReturnToWorkSA Psychiatric impairment, both CMH and PMH need to be stable.



Stability and the GEPIC - MAIAS

- ▶ Persons with permanent and significant residual impairment may have additional entitlements to compensation over and above loss of earnings and medical and rehabilitation services
- ▶ For claimants with a stable psychiatric impairment, that is due to Pure Mental Harm, this impairment is measured using the GEPIC
- ▶ If there is no impairment due to Pure Mental Harm then no GEPIC assessment is required.
- ▶ *“although the claimant had not received adequate psychiatric or psychological treatment based on the duration of his symptoms since the accident in 2021. I considered that he has reached maximum medical improvement.”*



Indicators stability unlikely

- ▶ The claimant's accident or onset of psychological condition was in the last 12 months
- ▶ The claimant has just commenced a new course of treatment for Pure Mental Harm symptoms
- ▶ The claimant has had a recent unrelated accident or work injury causing or aggravating any Pure Mental Harm symptoms .
- ▶ The claimant is participating in a pain management program with psychological counselling that may improve any Pure Mental Harm symptoms
- ▶ The claimant is experiencing significant changes in their personal and work life such as a recent return to work. just returned to work. How are they coping e with the work and how are they managed in the work place

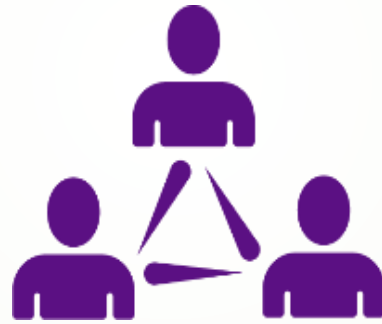
Common Report Deficiencies

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- Insufficient information about pre-injury level of function:
 - Employment
 - Relationships
 - Recreational enjoyment
- Too much emphasis on other reports so failure to provide a complete history
- Failure to obtain a history of the incident “I did not go into details about the mechanism of the MVA so as not to re-traumatize him”. While understanding the concerns of the AMP, the AMP must sensitively obtain independent information and not rely solely on other reports
- If a review, the AMP assumes the reader has access to the initial report and provides very limited information about the claim.
- Failure to make a DSM5TR or ICD11 Diagnosis eg Traffic anxiety is not a diagnosis.
- Equivocation about stability:
 - *Mr X has injuries that are not permanent and stable given that he has not had any treatment and he might benefit from psychological therapy with some psychiatric input. However he lives remotely and is not psychologically minded. Due to the efflux of time I have completed the assessment!*
- AMP -no Pure Mental Harm so no GEPIC assessment. “ I find no compelling evidence of there being a ratable pure mental harm condition” GEPIC not done



Learning Activity: 2 Group Case Studies



FAQs

1. Why don't we use the AMA Guides 5: Chapter 14: Mental Disorders

- ▶ Chapter 14 assess 4 areas of functioning in 5 classes
 - *activities of daily living,*
 - *social functioning,*
 - *concentration, and*
 - *adaptation.*
- ▶ only *concentration* is a measure of impairment, the other 3 measure disability
- ▶ There are no descriptors.
- ▶ not restricted to impairment arising only from psychiatric injury
- ▶ no method for combining the areas of functioning
- ▶ no percentage for different classes

FAQs 2

2. What is the origin of the GEPIC?

- In 1985 AMA 2 Chapter 12 with the following table was used . The GEPIC came from that, spaces between percentages left but 'Ability' and 'Potential' out and definitions and descriptors added

**Table 1
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 STATUS					
Intelligence	Normal or better	Mildly Retarded	Moderately Mildly Retarded	Moderately Severely Retarded	Severely Retarded
Thinking	No Deficit	Slight Deficit	Moderate Deficit	Moderately Severe Deficit	Severe Deficit
Perception	No Deficit	Slight Deficit	Moderate Deficit	Moderately Severe Deficit	Severe Deficit
Judgment	No Deficit	Slight Deficit	Moderate Deficit	Moderately Severe Deficit	Severe Deficit
Affect	Normal	Slight Problem	Moderate Problem	Moderately Severe Problem	Severe Problem
Behavior	Normal	Slight Problem	Moderate Problem	Moderately Severe Problem	Severe Problem
ACTIVITIES OF DAILY LIVING					
Ability	Self-sufficient	Needs Minor Help	Needs Regular Help	Needs Major Help	Quite Helpless
REHABILITATION OR TREATMENT POTENTIAL					
Potential	Excellent	Good	Good for Partial Restoration	Condition Static	Condition Will Worsen

FAQs 3

3. How do you separate out impairment from the accident or injury and non related impairment?

Answer: For MAIAS - Identify the number and severity of the descriptors and symptoms referable to the accident/injury and those referable to the non related mental and behavioural disorders and only assess the symptoms related to pure mental harm related to the accident.

For ReturnToWorkSA assess the total impairment related to all psychiatric injuries/conditions and deduct the impairment attributable to the unrelated impairment.

4. Do you estimate pre existing impairment as at the time of the accident/injury or at the time of assessment?

Answer: At the time of Assessment

5. Do you estimate the impairment if the claimant was to have treatment or as the claimant is at presentation?

Answer: Must assess current impairment at the time of presentation

FAQs 4

6. How do you deal with Pure and Consequential mental harm if there are several accidents or injuries?

Answer: Identify the number and severity of Pure and Consequential mental harm descriptors and symptoms referable to each accident/injury. For MAIAS claims only assess PMH to find the Median class, for ReturnToWorkSA claims apportion the total WPI to reflect those components for each injury.

7. After a Motor Accident, what if there is no Pure mental Harm

Answer: The GEPIC is not done

8. What does Stability refer to?

Only Pure Mental Harm is required to be stable to do a GEPIC assessment for MAIAS claims. The entire psychological condition needs to have stabilised for ReturnToWorkSA claims.

9 What is a reasonable period of time before the condition can be regarded as stable?

Answer: 18 months +, will vary depending on need and access to treatment (treating psychiatrist may assist with prognosis), consider the definition of MMI for MAIAS claims and stabilised for ReturnToWorkSA.

FAQs 5

10. **What about people who don't speak English or who can't speak?**

Answer: Interpreter or signer will be provided

11. **Do people need to have a psychiatric diagnosis to gain an impairment level?**

Answer: MAIAS -No, however the severity is likely to be in the slight to mild grading.

ReturnToWorkSA - Yes, prior to the assessment, the worker must have had a psychiatric diagnosis made by a treating psychiatrist based on DSM-5.

12. **What is the situation with children?**

Answer: Assessment of children is done on an interim basis. No permanent impairment assessment can be made until after the age of 18 or when the injury stabilizes.

FAQs 6

13. **Can people fool the assessor?**

Answer: Yes

14. **Why do the Guides use the median rather than average scores?**

Answer: Considered by authors to be more indicative of aggregate severity of mental function.

15. **Why is it only used by psychiatrists**

Answer: The Statute requires impairment assessments to be conducted by Medical Practitioners. Judges, lawyers and insurance staff use the GEPIC to correlate assessment outcomes with the methodology as part of the legal process.

FAQs 7

16. Is there much consistency between examiners?

Answer: Consistency increases with familiarity and experience in applying the GEPIC in a forensic manner

17. Why doesn't GEPIC use a list of typical symptoms e.g. flashbacks?

Answer: Relies on ratings of criterion items, not answers to questions.

18. How long does it take?

Answer: An assessment will require a full interview. The GEPIC assessment emerges from that and takes little time.

FAQ8 for which we have no clear answers

- ▶ Functional Neurological Disorders FND - Pure or Consequential mental harm
- ▶ Post Concussion Syndrome PCS – a reality? , a manifestation of FND?
- ▶ Complex PTSD, not a DSM5-TR diagnosis. Specific criteria required over and above PTSD in ICD11
- ▶ *Complex Posttraumatic Stress Disorder Caused by:*
 - ▶ *multiple traumatic events*
 - ▶ *multiple incidents of child abuse*
 - ▶ *prolonged domestic violence*
 - ▶ *concentration camp experiences, torture, slavery, and genocide campaigns*
 - ▶ *Symptoms include emotional dysregulation, negative self-perception, relationship difficulties, and dissociation, in addition to core PTSD symptoms like flashbacks and hyperarousal.*

ReturnToWorkSA – Report Template

Sensitive: Medical (when complete)



[Replace with your own letterhead]

Date _____

Requestor's name _____
 Company _____
 Address _____
 City / Suburb _____

Whole person impairment - psychiatric assessment report

Name of injured worker _____
 Date of birth _____
 Claim number _____
 Date of injury _____

xx month xxxx /

Dear _____

My qualifications to make this report are _____

I advise that I have prepared this report in accordance with the South Australian Employment Rule 66 'Content of expert reports' which came into effect on 28 November 2024.

Further to your letter of xx month xxxx, I saw worker's name on xx month xxxx at location for a whole person psychiatric impairment assessment and report.

The worker attended unaccompanied/with [name of support person]. *[please select appropriate]*

An interpreter was not present at the consultation/An official interpreter {name and NAATI number} was present and assisted throughout the consultation.

I explained my role as an accredited assessor of psychiatric whole person impairment, and also that my report from this assessment would be sent to ReturnToWorkSA.

GEPIC worksheet

Determining compensable psychiatric impairment
 Determine the median class (the median number is the middle number in a series
 e.g. 12345, the middle number is 3).

Classes _____

Classes in order _____

Median Class _____

Assessment Outcome

1. The Median Class is _____
2. The Median Severity Rating is _____
3. The Total Psychiatric Impairment is _____ %
4. Impairments not related to the work injury = _____ %
5. Impairment from consequential mental harm = _____ %
6. The compensable psychiatric impairment is the total psychiatric impairment - unrelated impairment and impairment from consequential mental harm = _____ %

Equals: Compensable impairment from 'pure mental harm' (i.e. impairment that is not secondary to a physical work injury)	%
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ReturnToWorkSA Impairment Assessment Psychiatric report template – effective 1 December 2024

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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 Guides for the Evaluation of Psychiatric Impairment for Clinicians are required to assess impairments for ReturnToWorkSA and MAIAS claimants

Common problems in psychiatric impairment assessment:

- ▶ Not stable even if there has been no change for years
- ▶ Incorrect Use of the GEPIC
- ▶ **Lack of knowledge of the descriptors**
- ▶ Overlap with Neurological Chapter in AMA5
- ▶ Assessing Pain-related Impairment rather than comorbid abnormal mental functioning
- ▶ Apportioning Pure and Consequential Mental Harm

RTWSA CLAIM – Alan

Alan is a 59-year-old separated father of two adult children living with his widowed mother in her home. He is a CPA but for many years worked in much broader areas, effectively as a company doctor. He was brought into rundown businesses and resuscitated them. He was frequently on short term contracts always made redundant when the work he did was completed but always found other work at an equivalent level. He had been a keen cyclist and a later a keen motor cyclist. He was a very active motorcyclist and had started his own motorcycle club. He believes his marriage broke down because he was travelling so much and his wife developed other interests. He had an amicable relationship with his separated wife but had had no other long-term relationships. He had had no health problems.

In early 2022 he was brought into the division of a group of companies as chief financial officer for the division and was strongly supported by the CEO but found the owner, a 35-year-old whizzkid had no administrative experience and no understanding of governance. However the office was close to home and initially there was a policy that all work finished at five. Within 12 months the division profit had increased 100% with a commensurate increase in workload but no increase in resources. He had frequent clashes with the group chief financial officer and on several occasions complaints were made by others about her language towards him, she was subsequently terminated.

The CEO who supported him was unexpectedly terminated and his workload spread amongst the three senior officers including himself.

MOTOR ACCIDENT CLAIM - ERIC

Eric is a 27 year-old ex-motor mechanic who now lives alone. Second of three children. He had been living with his parents and is single. Used drugs socially in early 20's, no personal history of psychological injury. Work claim re back injury off work 2 months, recovered, occasional chiropractic treatment with flareups. Keen cricketer with brother, social life around cricket club moderate alcohol, no relationships.

Questions



