SASOP Guidelines to the Management of Impairment Claims On Psychiatric Grounds

Third Edition

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- They have read and understood the terms and conditions of the informed consent document.
- Refusal to answer specific questions may influence the assessment and may be reported to the referral source.

The independent psychiatric impairment assessment

All available sources of information should be used in an assessment.

Taking into account the details of the specific case, the psychiatric assessment should include the following, where appropriate:

- A full psychiatric history (including highest level of education) and mental status examination
- Full occupational history and current occupational duties.
- Collateral information – from family members, employers, or any other appropriate sources
- Perusal of previous medical documentation
- Appropriate special investigations (e.g. neuro-imaging and neuropsychological testing in cases of dementia or other cognitive disorders)

The independent psychiatrist

- It should be made clear to the patient that the purpose of the interview is to perform a psychiatric assessment. This will form the basis of a psychiatric report, which will be forwarded to the insurance company who requested the assessment. The patient must be alerted that any information divulged may be included in the report.
- In cases where the psychiatrist deems it necessary to discuss aspects of the case with another party (such as the treating doctor, or an employer), prior informed written consent must be obtained from the patient.
- Patients are entitled to a copy of your report. However, the report should be requested through the insurance company and only released with the psychiatrist's written permission.
- The emphasis of the treating physician should be on return to work, based on the recovery model.
- Furthermore, the independent psychiatrist:

- Will be perusing all previous medical documentation including a full psychiatric report by the treating psychiatrist(s) and all other documentation thought relevant by the insurer.
- May contact the treating mental health care professionals for additional information.

Assessing the degree of impairment

The 2001 SASOP Guidelines were based on the 5th edition of the AMA Guides to the Evaluation of Permanent Impairment and the current edition is based on the 6th edition. In the 6th edition of the AMA Guides to the Evaluation of Permanent Impairment, there is a paradigm shift adopting a contemporary model of disablement: it is simplified, functionally based and internally consistent. Also, it uses the terminology and conceptual framework of disablement of the International Classification of Functioning, Disability and Health (ICF), a World Health Organization document.

The newest (6th) edition of the AMA Guides to the Evaluation of Permanent Impairment aims to be more diagnosis and evidence-based and attempts to optimize inter-rater and intra-rater reliability. Rating percentages are functionally based. It stresses conceptual and methodological congruity within and between organ system ratings and it has as its primary purpose the rating of impairment to assist adjudicators and others in determining the financial compensation to be awarded to individuals who, as a result of illness or injury, have suffered measurable physical and/or psychological loss.

The relationship between impairment and disability remains complex and difficult, if not impossible, to predict. In some conditions there is a strong association between level of injury and the degree of functional loss expected in a patient's activity for example mobility and activities of daily living.

But the same level of injury is in no way predictive of an affected individual's ability to participate in major life functions (including work) when appropriate motivation, technology and accommodations are available. Disability may be influenced by physical, psychological and psychosocial factors that can change over time.

In assessing impairment for a mental disorder, the first critical step is to make a definitive diagnosis based on the DSM. The presence of a diagnosis does not necessarily suggest the patient is impaired.

Despite the wide range and availability of psychological tests and ratings scales, the patient interview, review of records and mental status examination remain the foundation for evaluation of the patient and determining impairment.

In order to assess the degree of functional impairment, it is necessary to make a detailed exploration of all of the symptoms, and the effects that they have on the patient.

The American Medical Association Guides to the Evaluation of Permanent Impairment suggested method for assessing the severity of functional impairment in patients with psychiatric disorders uses three rating scales namely:

1. The Brief Psychiatric Rating Scale
2. The Global Assessment of Functioning Scale
3. The Psychiatric Impairment Rating scale

Special considerations

- Attention must be given to the effects of medication on signs and symptoms and ability to function (e.g. benzodiazepines may be responsible for such symptoms as drowsiness, lethargy, impaired concentration and memory and impulsivity)
- Unemployment and its resultant inactivity may be confused with psychiatric symptoms such as lack of motivation, listlessness, reversed sleep-cycle, and poor self-esteem
- The assessment of motivation is problematic. It is often difficult to distinguish from mental impairment, e.g. anhedonia. Underlying personality traits may be a major determinant of motivation. For many patients with poor motivation, proper rehabilitative programs may significantly improve function.

Assessing whether impairment can be regarded as permanent or not

- Permanency is where the impairment becomes static or well stabilized and is not likely to remit in the future despite medical treatment. Decisions regarding the permanence of impairment cannot be made lightly. Impairment can only be regarded as permanent after optimal treatment has been applied; i.e. sufficiently high doses of the most effective medication for a long enough period of time, plus appropriate psychotherapy by a suitably qualified therapist and sufficient time allowed for recovery during which continued vocational rehabilitation took place administered by an occupational therapist.

A patient should not be considered permanently ill until all reasonable treatment options have been exhausted. Treatments applied need to be those generally recognised as appropriate for the psychiatric disorder in question, and known/acceptable treatment algorithms for treatment resistance be followed. These days, there are many lines of treatment that can be explored that are effective in treating even refractory patients and for this reason, as mentioned earlier, treating psychiatrists are encouraged to make use of the SASOP Treatment Guidelines for Psychiatric Disorders.

Patient compliance is also important – a patient who does not keep psychotherapy appointments, or who does not take medication regularly, cannot be said to be non-responsive to treatment.

Sometimes patients cannot afford expensive private prescription medication, especially when these are not covered by their medical aid options. In such cases reasonable optimal treatment should be evaluated in terms of the medication available at local government institutions.

THE PSYCHIATRIC REPORT

Treating psychiatrist's report

Care should be taken in drawing up the psychiatric report, as important decisions are made based on the information provided. It needs to be kept in mind that the report may be scrutinised by, among others, the patient, insurance company claims assessors, other doctors and legal representatives. The report should be comprehensive, objective and accurate. Financial advisors are not entitled to receive the report directly from the author. The report will only be released by the insurance company to the patient if the author has given consent for release in line with prevailing legislation.

The following psychiatric interview template is recommended for use by the treating psychiatrists:

PSYCHIATRIC IMPAIRMENT ASSESSMENT INTERVIEW TEMPLATE

Member Name **:** …….

Date of Birth **:** …….

Marital Status **:** …….

Occupation **:** …….

Last Worked **:** …….

Scheme Name and Code **:** …….

Treating Psychiatrist **:** …….

Primary-Care Doctor **:** …….

Date of this examination:

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Date of first consultation with the claimant:

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Appointment schedule over the past year e.g. 4-weekly:

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What is the psychiatric diagnosis for which the patient had been treated prior to referral for independent psychiatric opinion?

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Current psychiatric symptoms?

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Chronological history of events leading up to cessation of work:

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What is the Claimant's current job? Describe responsibilities briefly.

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What does the Claimant find particularly stressful about the work?

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Which work responsibilities would the Claimant have difficulty with and why?

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Which work responsibilities would the Claimant not have difficulty with?

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Employment history:

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Does the Claimant get along with superiors/colleagues at work?

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Has the Claimant ever been involved in any disciplinary hearings?

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When last did the Claimant work? How long has the Claimant been on sick-leave?

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Please comment on any occupational therapy assessments or functional capacity assessments received:

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What kind of vocational rehabilitation measures has thus far been implemented to assist the Claimant to return to work?

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Has the Claimant's made any requests for or been offered reasonable accommodation at work?

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Which reasonable accommodative measures would the Claimant like to see being implemented at work to decrease pressure on the claimant? (Examples include a phased return to work, restructuring jobs, adjusting working time and providing support in the workplace)

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Current treatment and response thereto. Please specify names and dosages of all medication and provide details of all adjuvant therapy.

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Does the Claimant know the names and dosages of all their psychiatric medications?

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Does somebody else administer their medication?

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Does the Claimant experience any side-effects on their psychiatric medication?

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Clinical examination / mental state examination findings (please record general appearance, mood, anxiety, psychotic features, mental state, cognitive and social functioning etc.).

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Please comment on any psychological treatment received, consultations with psychologists etc.:

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Please comment on the Claimant's compliance with treatment (medication, follow ups with psychiatrist, consultations with psychologist etc.)

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Please provide details of any hospitalizations over the past 12 months. Please indicate the dates of admission and discharge, provide the name of the hospital to which the claimant was admitted and the reasons for admission.

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Past psychiatric history:

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Past Treatment

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Pre-morbid functioning:

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Motivation for recovery and return to work:

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Medical history:

Allergies, diabetes, epilepsy, asthma, TB, tested for HIV (and results), hypertension, hypercholesterolemia, head injuries and surgical procedures.

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Substance history (habits):

Type of substances (cigarettes, alcohol, cannabis, OTC pain tablets e.g. Adco-Dol etc). Pattern of use, longest periods of abstinence and use of self-help or professional resource.

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Family history of mental illness:

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Educational history and highest level of education:

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Results of any relevant rating scales or bedside cognitive assessments e.g. the Brief Psychiatric Rating Scale (BPRS), Psychiatric Impairment Rating Scale (PIRS), Global Assessment of Functioning Scale (GAF) or Montreal Cognitive Assessment (MOCA).

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Results of any special investigations or specialist consultations. Only provide copies of results available on file.

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Your comment on how the claimant's condition has progressed over the last 12 months. Has there been any improvement / deterioration? Please provide details.

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Is any further treatment planned or anticipated? Please provide details.

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Please comment on the claimant's ability to look after him/herself and perform everyday tasks:

Grooming and personal Hygiene: ……

Bathing/ showering: ……

Brushing teeth: ……

Dressing: ……

Sexual activity: ……

Health management: ……

Relationships: ……

Care of others / Child rearing: ……

Preparing meals and other domestic tasks: ……

Shopping: ……

Travel and Driving: ……

Leisure activities: ……

Physical exercise: ……

Social interaction: ……

Managing finances: ……

Communication device use: …… ……

Final diagnosis.

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What are the chances of this Claimant returning to work?

	Excellent	**Good**	**Fair**	**Poor**
Three months				
Six months				
One year				
Two years				

Reasons for your opinion;

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Have all treatment options been exhausted?

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If not, why?

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In your opinion, what aspects of the impairment may influence the Claimant's current job specifically and what would you suggest to address those problems?

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Any other comments you feel may be of assistance to prevent permanent disability from occurring?

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Signature: …… Date:…….

Name (please print)…… Qualifications……..

Contact Number ……..

Confidentiality

As with all medical reports, confidentiality is of paramount importance and the contents are never disclosed to unauthorised parties. They may only be disclosed to a third party with the consent of the client. Should a claimant wish to obtain a copy of the psychiatric report they may apply to the insurer who will release it to them in accordance with procedural requirements as per the Protection of Personal Information Act.

It must be noted that because of the necessity for a close therapeutic relationship between doctor and psychiatrist, a second opinion from an independent psychiatrist may be sought. This is done to alleviate pressure on this relationship and is in accordance with international practice.

Future directions for becoming an independent psychiatric medical assessor

- Psychiatrists interested in becoming independent psychiatric examiners are encouraged to do the Foundation for Professional Development's (FPD) Short course in the evaluation of permanent medical impairment rating (based on the AMA Guides' 6th edition).
- In future it is envisaged that a curriculum for a psychiatry-specific course will be drawn up by SASOP.
- It remains the prerogative of the insurance companies as to whom they approach for independent opinions.

Closing remarks

At least twenty per cent of employees will experience some form of mental illness during their working lives. On balance, work is linked to good health rather than ill health and is good for psychological well-being. The effects of loss of work on the other hand can include social isolation, poverty, deterioration in physical- and mental health, and increased mortality.

The longer a person is off work, the less likely they become to ever return to work and once a person commences on certified work absence, they commonly start down a slippery slope that could end in long-term worklessness. Recovery is often faster and more successful if people can do some work while recovering.

Psychiatrists are encouraged to manage the impairments associated with mental illness that may result in cessation of work and do everything possible to prevent permanent disability from developing. This goal can be reached through:

- Frequent communication with all stakeholders including the insurance case manager, the employer and all members of the multidisciplinary team
- Effectively addressing the psychiatric condition
- Educating patients regarding the benefits of staying at work or returning to work as soon as possible.

Current available evidence undeniably points towards the benefits of keeping people productively employed. It stands to reason that everything possible should be done to avoid the unfortunate outcome of permanent cessation of work and psychiatrists are well positioned to play a leading role in managing the impairments associated with mental illness and preventing permanent disability.

Suggested reading

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