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FACSIMILE TRANSMITTAL SHEET

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TO  
*Mirela Sharrock*

FROM:  
*Dr Michael Epstein*

COMPANY:  
*Comcare*

DATE:  
*31 AUGUST 2009*

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*02 6274 8503*

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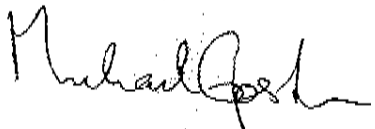
Dear Mirela Sharrock

Please find attached the documents emailed to your department today as PDF documents.

Do not hesitate to contact my office should you have any further problems.

With kind regards,

Yours sincerely,



Michael W N Epstein MBBS FRANZCP

Please advise the sender if this confidential communication is received in error. Thank you.

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ME/sam

31 August 2009

Michael Epstein MB.BS. FRANZCP

Ms Denise Lowe-Carlus  
Comcare  
GPO Box 9905  
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Dear Ms Lowe-Carlus,

I have read the options paper with interest. I am particularly interested in Chapter 11 on psychiatric conditions.

You have discussed the issues raised including those provided in my previous submission. You have discussed three options, I have paraphrased the options:

1. Adopt the Psychiatric Rating Impairment Scale (including 15% WPI threshold for psychiatric conditions).
2. Adopt the Guide to the Evaluation of Psychiatric Impairment for Clinicians (GEPIC). The paper states that there is a 30% threshold for psychiatric conditions in Victoria and a person cannot claim for a psychiatric condition at all where it arises secondary to physical injury and therefore there may be some issues about whether GEPIC is suitable for the SRC scheme.
3. The third option is to "Work with psychiatrists to update the manner in which a psychiatric impairment for psychiatric conditions is assessed."

The preferred option is to adopt the Psychiatric Impairment Rating Scale including a 15% WPI threshold for psychiatric conditions.

In my view, the authors of the options paper have been placed in a difficult situation. The only two viable options were the PIRS and the GEPIC. As a co-author of the GEPIC I believe it has worked well in Victoria but it is vague with regard to lower ranges of impairment. I do not intend to discuss the GEPIC any further.

My concerns are with the preferred option.

There is a fundamental problem with the PIRS and two additional concerns. I will deal with each of these.

#### THE FUNDAMENTAL PROBLEM

The Safety, Rehabilitation and Compensation Act 1988 (C'th) states that claims for PI and NEL can only be determined where an injury has been accepted in accordance with S14 of the SRC Act. In addition, the injury must be:

- permanent
- there must be an impairment

The SRC Act defines *impairment* "as the loss, the loss of the use, or the damage or malfunction, of any part of the body or of any bodily system or function or part of such system or function". *Permanent* is defined as likely to continue indefinitely.

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The World Health Organization defines "**Disability**": In the context of health experience a disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

The options paper states "it is noted that PIRS measures the *disability* of an individual, rather than the *impairment* of that individual".

This appears to be an insurmountable obstacle, the SRC Act requires that impairment be measured not disability, how can an instrument used to measure disability be considered in this context?

### THE PIRS AND CHEATING

Furthermore there are very real concerns about the prospects of cheating with the PIRS as it involves answers to a questionnaire about behaviour outside the interview setting that is readily available and does not depend on a mental state examination. This problem is compounded because the lead author of the PIRS has established a website at <http://www.pirs.com.au>

The website states:

*A client (usually a legal firm, insurer, or government authority) can purchase e-PIRS vouchers for end-users.*

*Typically, end-users are people who have been involved in accidents and are now considering a personal injury claim. The end-user logs onto the e-PIRS website with a unique ID and password and completes the e-PIRS, a self-administered questionnaire which takes 30 to 40 minutes. The subject answers a combination of multiple choice questions and provides some free-text answers. e-PIRS then performs a number of calculations, and generates a report in pdf format. The report is emailed to the Client.*

*The e-PIRS is a web-based questionnaire, based on the PIRS methodology and philosophy. While it is not a substitute for a thorough clinical examination, the result can help a claimant or insurer make a decision about a psychiatric injury claim. For example, many compensation systems exclude small claims by the use of thresholds. When the e-PIRS indicates a low impairment rating, significant additional expenses can be avoided. Conversely, when there is doubt, e-PIRS could help identify significant impairment and provide a basis for further specialist examinations. While the e-PIRS relies on complex algorithms, the results are explained in clear and easily understood terms.*

Without in any way questioning the motives of the person who has established this website, nevertheless the existence of this website provides an opportunity for claimants to refine their answers to increase their impairment levels.

### DIFFERENT THRESHOLDS FOR DIFFERENT DISORDERS

The options paper states that if the PIRS is adopted then the 15% WPI for psychiatric conditions must also be adopted. Providing different thresholds for different types of impairment is fundamentally unjust and confusing. Different thresholds should only be adopted when limitations of methods of impairment assessment make it too easy for people with a psychiatric impairment to exceed the threshold for physical impairment if they are the same.

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In my previous submission I wrote extensively on the problems of the 6<sup>th</sup> Edition and the fact that a form of the PIRS is included in the three methods used in chapter 14 is, in my view, no recommendation.

### A WAY AHEAD

There is a third option described above. "Comcare could work with psychiatrists to develop a model that meets the following criteria:

- Measures impairment rather than disability
- Simple to administer
- Is accurate without being invasive

For a number of years I have been concerned about this issue of psychiatric impairment assessment. I have written and lectured extensively on the subject. There are problems with both the GEPIC and the PIRS as I have indicated above.

I have been developing an impairment guide for psychiatric impairment for some time with the assistance of senior psychiatrists in Victoria. This instrument has now been completed. It is called -

The Rating of Psychiatric Impairment Derived from the Mental State Examination (RAPID - MSE). A copy of the RAPID - MSE is enclosed separately

- It measures impairment rather than disability
- it uses the mental state examination
- it does not require any change in the impairment threshold
- it is resistant to cheating
- it is simply administered and quickly calculated to produce a reliable WPI level
- it appears to be accurate without being invasive

Testing appears to indicate that it is reliable and uncomplicated.

I recommend that the RAPID-MSE be considered before a final decision is made.

I would be happy to discuss this with you further.

With kind regards,

Yours sincerely,



Michael Epstein MB.BS. FRANZCP

**Rationale for the Development of  
THE RATING OF PSYCHIATRIC IMPAIRMENT DERIVED from the  
MENTAL STATE EXAMINATION (RAPID-MSE)**

Dr Michael Epstein

The **RAPID-MSE** is a new method of psychiatric impairment assessment.

**Problems with Systems of Psychiatric Impairment Assessment**

There are significant problems with most systems of psychiatric impairment assessment.

These problems include

- assessment of disability rather than impairment
- assessment of symptoms that may be unrelated to any mental or behavioural disorder
- assessment that is unrelated to mental state examination
- assessment that is open to 'gaming'
- assessment that is unnecessarily complicated and time-consuming

**The American Medical Association Guides**

The American Medical Association Guides to the Evaluation of Permanent Impairment Chapter 14 Mental and Behavioural Disorders as it exists in the third, fourth, and fifth editions of the AMA Guides is unworkable because:

- it measures disability rather than impairment
- it provides no percentages

Chapter 14 in the Sixth Edition is also unsatisfactory because:

- it continues to measure disability rather than impairment
- it utilises three different methods (normally used in other clinical contexts)
- it imposes percentages on each of the methods that do not exist in the original methods
- it is time-consuming
- it is open to 'gaming' (as all the methods are readily available on the Internet and include self reporting)

**Common Methods for Assessing Psychiatric Impairment in Australia**

Most States in Australia have beneficent schemes that require impairment of assessment of various organ systems including mental and behavioural dysfunction to determine threshold levels to access benefits and to provide lump-sum payments for non economic loss.

Some States have opted to legislate for the use of successive editions of the American Medical Association Guides to determine percentage impairment of various organ systems. The impracticality of Chapter 14 has led most jurisdictions to use alternative methods of assessing the degree of psychiatric injury.

The major methods used are the Psychiatric Impairment Rating Scale (the PIRS), the Guide to the Evaluation of Psychiatric Impairment for Clinicians (the GEPIC) and the Guide to the Assessment of Rates of Veterans' Pensions (GARP), Fifth Edition

Each method has its own problems.

### **The Psychiatric Impairment Rating Scale**

The PIRS (despite its title) measures disability and not impairment, it has prescriptive descriptors, many of which do not refer to specific psychiatric symptoms, it uses a questionnaire format that is open to 'gaming' and it does not rely on the mental state examination.

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

The GEPIC does measure impairment, it does rely on mental state examination, it is quick to use and appears to be reliable but it is not precise, especially at lower levels of impairment.

### **Guide to the Assessment of Rates of Veterans' Pensions (GARP), Fifth Edition**

This guide is used to assess the extent of incapacity from war-caused or defence-caused injury or disease. Its provisions are binding on the Repatriation Commission, the Veterans' Review Board, and the Administrative Appeals Tribunal. It measures

- subjective distress
- manifest distress
- functional effects
- occupation
- domestic situation
- social interaction
- leisure activities
- current therapy

Most of these are measures of disability rather than impairment.

**The RAPID-MSE** has been developed to meet the problems described above.

- It measures impairment rather than disability
- it utilises the basic tool of the psychiatric interview, the mental state examination
- it is quick to use and easy to understand
- it provides precision and transparency
- it appears to be equitable
- it appears to be reliable

Field testing has confirmed that the **RAPID** is easy to use and appears to be reliable, different examiners obtain similar scores when assessing the same person.

**RATING OF PSYCHIATRIC  
IMPAIRMENT  
DERIVED from the  
MENTAL STATE EXAMINATION  
(RAPID-MSE)**



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## **THE RATING OF PSYCHIATRIC IMPAIRMENT DERIVED from the MENTAL STATE EXAMINATION (RAPID-MSE)**

The **RAPID-MSE** is a new method of psychiatric impairment assessment. It has been designed to measure impairment rather than disability. It is designed to be precise. It relies on the mental state examination, it is quickly and easily administered, transparent and equitable.

### **PRINCIPLES OF THE RAPID-MSE**

The following principles underlie the method developed.

1. The method aims to measure impairment rather than disability.
2. The presence and extent of impairment is a medical issue, and is assessed by medical means. This method has been designed for use by consultant psychiatrists.
3. The basis of this method is the clinical interview as used by consultant psychiatrists together with a mental state examination.
4. The mental state examination, through a detailed assessment of mental functions such as thinking, perception, judgement, mood and behaviour, evaluates departures or deviations from the normal range of these five aspects of psychological function due to psychiatric illness (as required by the C'th legislation) and thus it is congruent with the definition of impairment both in the SRC Act and the WHO classification of impairments, disabilities and handicaps.
5. The diagnosis is a significant factor but is not the only factor. Only specific DSM IV TR Axis 1 disorders can be assessed, with one exception. (See definitions)
6. This method is designed to measure impairment arising from psychiatric injury. Impairment due to mental or behavioural disturbance arising from brain injury is better measured using chapter 4 of the fourth edition of the AMA guides or an equivalent neurological impairment assessment. It is also unsuitable for use with claimants experiencing a temporary alteration to mental state such as that due to alcohol intoxication or delirium. This method, like all methods of measuring psychiatric impairment is unsuitable for assessing pain disorders (see FAQs).
7. The condition should be stable although an impairment assessment can be done before stability has been reached if this is noted in the assessment report.
8. The presence or absence of appropriate treatment is important but if treatment has been rejected or is unavailable and the condition is stable then an impairment assessment is appropriate.
9. The method does not rely on responses to a questionnaire and hence is much less open to 'gaming'.
10. It is up to the assessor to determine the presence or absence of psychiatric impairment relying on clinical judgement. This method is not a "cookbook" approach.

### THE METHOD

The method involves assessment of five aspects of mental function, thinking, perception, judgement, mood, and behaviour. Each of these is rated according to 6 classes and allotted a level of severity within each class, either low, intermediate, or high. Intelligence has been excluded as it is usually a manifestation of brain injury and better assessed using measures of neurological impairment.

Symptoms are listed for each mental function. These symptoms are indicative and not prescriptive. Severity relates to both the intensity of the symptom and the number of symptoms. In each class at the lower end, only some symptoms are required, at the higher end most symptoms should be present or if only some symptoms are present they should be particularly intense e.g. persistent suicidal behaviour that may occur in the absence of most or other behavioural disturbances at that class level.

The assessor may use other symptoms indicating severity of impairment that are not included in the descriptors. This must be noted. The presence or absence of the symptom and the degree of severity of the symptom is a clinical judgement of the assessor.

### IMPAIRMENT ASSESSMENT FORMULATION

The assessor must write an assessment formulation. The assessment formulation should include a diagnosis. The assessor must then give a concise explanation of the scoring of each mental function. The assessor should also describe those symptoms caused or exacerbated by the designated injury or accident and those that are unrelated. It is expected that this assessment formulation should be no more than one or two paragraphs.

An independent observer should be able to read this formulation and understand the scores recorded in the table.

The impairment assessment formulation should form part of the opinion but is separate from questions of causation and treatment.

## DEFINITIONS

### ***Impairment***

The **Safety, Rehabilitation and Compensation Act 1988 (C'th)** defines "***Impairment***" as the loss, the loss of the use, or the damage or malfunction, of any part of the body or of any bodily system or function or part of such system or function.

### ***Permanent***

The **Safety, Rehabilitation and Compensation Act 1988 (C'th)** defines "***Permanent***" as likely to continue indefinitely.

### ***Disability***

The **World Health Organization** defines "***Disability***": In the context of health experience a disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

### ***Median***

The median is defined as the middle number of a series; 12345 3 is the median number.

The three statistical methods available by which centralising tendency can be calculated are the "mean" (or average), the "median", and the "mode" (the most frequent number in a series, 22345, the mode is 2). The advantage of using the median (the middle number of a series) is that it is not influenced by extreme scores (as is the "mean" or averaging method), yet it is significantly more sensitive to variability of scores than the mode.

**"Mental Disorder"** A mental disorder or mental illness is a psychological or behavioural pattern that occurs in an individual that causes distress or disability that is not expected as part of normal development or culture.

**"DSM IV TR"** is the Diagnostic and Statistical Manual of the American Psychiatric Association 4th Edition, Text Revision.

**Diagnosis "Axis 1: Clinical Syndromes"** This axis describes clinical symptoms that cause significant impairment. Disorders in this Axis that are assessed using the **RAPID-MSE** are:

- schizophrenia and other psychotic disorders
- mood disorders
- anxiety disorders
- substance related disorders
- somatoform disorders
- adjustment disorders

Symptoms in class 1 & 2 may not be sufficiently severe to warrant a diagnosis. Apart from this exception, a diagnosis, as listed above, must be present for an assessment to be made.

## **MENTAL FUNCTIONS**

The five mental functions to be assessed are thinking, perception, judgement, mood, and behaviour. The definition of these functions appears below.

### **THINKING**

**Thinking** allows us to form a view of our world that is shared by others and enables us to comprehend and deal with our world effectively. Impairment of thinking means there is likely to be reduced efficiency of thinking. Impairments of thinking involve:

- Rate of thinking
- Stream of thought
- Disruption of thinking e.g. memory, concentration, attention.
- Content of thinking
- Rationality of thinking

### **PERCEPTION**

**Perception** is the process of attaining awareness or understanding of sensory information. Impairment of perception involves disturbances of one or more of the five sensory modalities (hearing, vision, smell, taste and touch). There are problems in understanding the concept of perception, for example confusion between disorders of thinking and disorders of perception. "The perception of a situation" refers to the "understanding of a situation" and hence is related to thinking. Impairments of perception include:

- Intensity of perceptual changes, may be heightened or dulled
- Frequency of perceptual changes
- Disruption caused by perceptual changes

### **JUDGEMENT**

**Judgement** is the capacity to assess situations or circumstances and to draw sensible conclusions. Judgement also refers to the considered evaluation of evidence in the formation of making a decision. This requires the capacity to evaluate and assess information and situations. Impairments of judgement include:

- reduced capacity to assess situations accurately
- reduced capacity to make decisions
- altered speed of decision making (may be unusually slow or unusually fast)
- reduced capacity to implement decisions
- reduced capacity for insight
- reduced ability to postpone judgement/decisions

## MOOD

**Mood** is a relatively long lasting emotional state. Moods differ from simple emotions in that they are less specific, less intense, and less likely to be triggered by a particular stimulus or event. Unlike acute emotional feelings like fear and surprise, moods often last for hours or days. Mood also differs from temperament or personality traits which are even longer lasting. Affect is the mood state noted in the clinical interview. Impairments of mood involve:

- Range; the variability of emotional expression over a period of time, if only one mood is present over a period of time the mood range is restricted. If a variety of types of mood are present over a short period of time the mood range is expanded.
- Amplitude is the extent of mood swings, ranging from marked swings from very high to very low to flattened mood.
- Stability refers to the relative stability of mood, it is normal for there to be slow changes of mood over time. An alteration of stability of mood may be manifested by a more rapid rate of change or no variation in mood.
- Velocity of mood changes refers to the rate at which mood changes compare with normal mood
- Appropriateness refers to the fit between the mood and the situation e.g. inappropriate laughing at a funeral
- Type of mood refers to sad, happy, angry, manic etc
- Degree of empathy and responsiveness to others' moods

## BEHAVIOUR

**Behaviour** refers to the actions or reactions of a person, usually in relation to the environment. Behaviour can be conscious or unconscious, overt or covert, and voluntary or involuntary. Human behaviour can be common, unusual, acceptable, or unacceptable. Humans evaluate the acceptability of behaviour using social norms and regulate behaviour by means of social control. Impairments of behaviour include:

- Activity level-reduced or accelerated activity
- speed of behavioural change
- degree of disruption of normal behaviour
- physiological changes e.g. sleep, appetite, weight
- appropriateness of behaviour
- behaviour that is destructive to self or others
  - aggression
  - self-harm
  - gambling
  - substance-abuse
  - stalking
  - sexual abuse

