

Ontario Psychological Association

Proposed Amendments to Insurance Act Regulation
34/10 (Statutory Accident Benefits Schedule - Effective
September 1, 2010)

Catastrophic Impairment Criteria & Assessment
Guidelines

Ontario Psychological Association (OPA)

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Problem and Solutions

The proposed changes to the catastrophic impairment definition are in addition to the announcement that the catastrophic level of benefit will be cut by 50%. At the present time, individuals with catastrophic impairments have access to \$1,000,000 in med/rehab benefits and \$1,000,000 in funding for attendant care. These are to be cut to a total of \$1,000,000 of funding for combined med/rehab and attendant care benefits. It is expected that this will result in significant reductions in funds spent on individuals with catastrophic impairments.

In addition to this very significant reduction in available funding to each person who is found to have a catastrophic impairment, the proposed changes will significantly reduce the number of individuals found to have catastrophic impairments.

Importantly, the changes to the definitions introduce serious inequity and discrimination against accident victims with impairments due to mental and behavioural disorders (including brain injuries). The changes in the definitions for impairments due to mental disorders will have the most significant negative effect. Accident victims with serious disorders and genuinely catastrophic impairments will not meet the tests of the proposed definitions.

There was limited information available regarding the proposed definition for impairments due to mental disorders. We hope to have further opportunity for more informed comment. In this document, we review the proposed changes in detail. Wherever we highlight problems or concerns we also offer detailed scientific evidenced-based solutions in the body of this submission.

Key Recommendations

Provide equity for accident victims with impairments due to mental disorders.

Reject proposals that would unfairly discriminate against accident victims with mental disorders (compared to accident victims with physical disorders).

- We propose science-based alternatives that improve the use of current catastrophic definitions, but do not discriminate against accident victims with serious mental disorders.

Improve accident victims' access to qualified experts to complete catastrophic impairment applications by reinstating provisions in the SABS to allow psychologists to conduct assessments and independently certify catastrophic impairment applications.

- The current requirement to utilize physicians creates barriers to access to catastrophic determination for accident victims with impairments due to mental disorders.



Do not introduce discrimination into the mental and behavioural definition.

Retain the stand-alone definition for impairments due to mental and behavioural disorders.

- Impairments due to mental and behavioural disorders (including brain injuries), are not adequately reflected in WPI ratings. Therefore it is not reasonable to rely on the 55% WPI definition.
- A stand-alone definition for impairments due to mental disorders is required to provide access to the higher level of funding for accident victims with impairments due to mental disorders.

Retain the use of the term “mental and behavioural” for impairments due to mental and behavioural disorders rather than using the term “psychiatric”.

Retain Guides 4, not Guides 6, to determine impairments due to mental and behavioural disorders.

- Guides 6 introduces a number of arbitrary restrictions, excluding some mental disorders, that will discriminate against some individuals who have legitimately catastrophic impairments due to mental and behavioural disorders.
- Guides 6 introduces quantification but bases it on unscientific methods.

Retain the use of marked or extreme impairment according to AMA Guides 4, Chapter 14, to determine catastrophic status for impairments due to mental and behavioural disorders.

- A marked impairment *significantly impedes* useful function and is equivalent to the definitions for other physical disorders that meet the catastrophic impairment threshold.
- Require compliance with Assessment Guidelines (which are described later in the document) to address any concerns regarding inconsistent or inaccurate examination results.

Establish a threshold of 50 on the Global Assessment of Functioning (GAF) if the GAF is adopted as a measure for impairments due to mental and behavioural disorders.

- A GAF threshold of 40, as recommended by the Superintendent, is discriminatory and inequitable. It requires a much higher threshold for impairments due to mental disorders than for impairments due to physical disorders and unfairly disadvantages accident victims with impairments due to mental disorders.
- Most of the other catastrophic impairment definitions are more consistent with impairments that *significantly impede* but do not *preclude* useful functioning.

Include all mental disorders in catastrophic impairment determination.

- Limiting consideration of impairments to a specific list of mental and behavioural diagnoses is unscientific and discriminatory.
- Include impairments resulting from mental disorders which are due to brain injury.



- Include impairments resulting from diagnosed pain disorders.

Remove the discriminatory list of “indicia” proposed by the Superintendent or, if retained, revise.

- A list of indicia is an additional discriminatory requirement for accident victims whose impairments are due to mental and behavioural disorders that will arbitrarily eliminate some individuals with legitimately catastrophic impairments.
- A number of factors, not related to the severity of impairment, influence utilization of and access to health care and support services. Therefore, if a list of indicia is included in the definition, it must only be for illustrative purposes, but not a requirement.
- The proposed indicia require a much higher threshold for impairments due to mental disorders than for impairments due to physical disorders, creating an unfair disadvantage for accident victims with impairments due to mental disorders.
- Adopt the OPA recommended alternative list of indicia for illustrative purposes.

Provide more equitable access to catastrophic impairment assessments and applications.

- Accident victims with impairments due to mental and behavioural disorders are required to have a physician certify their applications. The limited number of physicians with the appropriate expertise creates a barrier to access.
- Psychologists have appropriate expertise to conduct the assessment and complete the applications.
- Include psychologists, along with physicians, as sole experts to diagnose and rate impairments to complete catastrophic impairment applications for impairments due to mental disorders to provide more equitable access.

Adopt a fair and equitable method to rate and combine impairments.

It is fair and equitable to combine all impairments, but use of Guides 6 introduces inequity.

- The use of Guides 6 to quantify impairments due to mental disorders introduces inequity and discrimination due to disproportionately low and unreasonable ratings for mental disorders compared to physical disorders.
- Rating by analogy within Guides 4 or using the California Method are alternatives that are fairer and more equitable and should be adopted.

Improve reliability and validity of assessments.

Require compliance with Assessment Guidelines.



- Compliance with Assessment Guidelines is the more scientific approach to address concerns regarding catastrophic impairment determination rather than making the definitions more restrictive and discriminatory.
- Compliance with Assessment Guidelines will increase reliability and quality of assessments.
- Compliance with Guidelines will address issues raised regarding “double counting”.

Provide opportunity for further involvement in the development of any changes to the regulations.

We seek an opportunity to provide informed input prior to the final drafting of the regulations.

- We would like to engage with the government and other stakeholders to address flaws in the proposals and offer alternative solutions.
- Our primary focus is on the definitions where the expertise of psychologists is most relevant: impairments due to mental and behavioural disorders (including brain injuries).

Introduction

Government’s stated intentions vs unintended consequences

The government has stated that it intends to “*Update the definition of catastrophic impairment (CAT) to reflect the most up to date medical information and knowledge*”. While it is reasonable to strive to incorporate relevant new medical information, “updating” must provide real improvement rather than incorporating newer, but more flawed and discriminatory methods.

The government also stated, “*Amendments will be proposed based on the Superintendent's Report on the Definition of Catastrophic Impairment in the Statutory Accident Benefits Schedule, subject to modifications*”. The Superintendent’s report stated, “*The recommendations... aim to improve the fairness...of the process for determining catastrophic impairments... to improve the accuracy, relevance, clarity, validity, reliability and predictive ability of catastrophic impairment determinations*”. However, some of the proposed changes actually reduce fairness and equity. The proposed changes inequitably reduce access and disadvantage accident victims whose impairments are due to mental and behavioural disorders. The more scientifically sound approach to improve accuracy, validity and reliability of impairment determinations is to require compliance with explicit Assessment Guidelines by all examiners. Failure to follow appropriate methodology is the largest contributor to problems with the reliability and validity of assessment outcomes rather than the definitions themselves. The need for sound and consistent methodology is applicable whether or not there are any changes made to any of the definitions.

The Superintendent’s report also expresses the intention to improve the “*predictability of the process for determining catastrophic impairments*”. Predictability should not be achieved by making the criteria even more restrictive and/or inequitable. At this time only a very small number of accident victims (less



than 1%) satisfy the catastrophic impairment criteria and these are, in fact, determined with a high level of predictability. More restrictive and/or inequitable criteria are not a solution that meets the goals of the catastrophic impairment criteria: to fairly and accurately identify those severely injured accident victims who require access to the highest level of benefits. Such more restrictive criteria leave out accident victims with legitimately “catastrophic” impairments. For example, if only those accident victims who are quadriplegic (in the physical sphere), or whose impairments preclude useful functioning (in the mental and behavioural sphere) meet the threshold, predictability would increase to virtually 100%. We note that this increased restrictiveness and inequitably higher threshold, to “preclude useful functioning”, is what is being proposed for accident victims whose impairments are due to mental and behavioural disorders. In contrast, accident victims with serious bodily impairments such as those with paraplegia or single limb amputations who are *significantly impeded*, but are *not precluded* from useful function will continue to meet the catastrophic impairment definition.

We are in agreement with the stated intentions. We appreciate the effort to formulate new up to date and scientifically sound definitions. In the remainder of this submission we offer evidence based solutions which avoid the unintended negative consequences.

Impairments due to mental and behavioural disorders

Required compliance with Assessment Guidelines to ensure the robust method in Guides 4, Chapter 14 is followed would address concerns regarding determination of marked impairment due to mental and behavioural disorders. However, if the government determines to shift from the use of determination of marked impairment according to Guides 4, Chapter 14 to a GAF-based model, the required GAF threshold should be 50, not 40. A GAF of 40 suggests that useful functioning is *precluded*. It sets a more onerous threshold in comparison to impairments due to physical disorders which *significantly impede* useful functioning, unfairly disadvantaging those accident victims whose impairments are due to mental disorders.

In addition, if the government shifts to the model recommended by the Superintendent, it must be made clear that any indicia included are illustrative but not required and the list of indicia provided must be reflective of individuals whose impairments *significantly impede* but do not *preclude* useful functioning (we provide an alternative list of indicia in the body of this submission). Further, the suggestion of a restricted list of diagnoses will arbitrarily exclude individuals with catastrophic impairment due to a mental disorder as a result of a motor vehicle accident if the diagnosis is not included on the list.

A shift to Guides 6, while being more “up to date”, would introduce significant inequity for accident victims with impairments due to mental disorders. The artificial restrictions on mental disorder diagnoses and the disproportionately low ratings are highly discriminatory.

55% WPI

We agree with the government’s proposal to continue to rely on a 55% WPI threshold according to Guides 4 for combined physical impairment ratings and to allow consideration of impairments due to mental and behavioural disorders within the WPI. However, the proposal to use Guides 6 for quantification of impairments due to mental and behavioural impairments creates a new level of inconsistency and discrimination against those whose impairments are due to mental disorders.



Guides 6 is based on a different impairment rating system than Guides 4. Guides 6 introduces methods and conversion tables that result in drastically and unscientifically reduced WPI ratings for impairments due to mental disorders. As a result, rather than achieving fairness by explicitly mandating combining impairments due to mental and behavioural disorders with impairments from physical disorders, the use of Guides 6 inequitably reduces the contribution of impairments due to mental and behavioural disorders to the combined WPI.

A sounder, more equitable, and internally consistent method for quantification of impairments due to mental disorders for inclusion in the WPI is to rate by analogy using Guides 4, Chapter 4, Table 3 to convert the qualitative ratings determined according to Guides 4, Chapter 14. Alternatively the WPI can be determined by converting the qualitative ratings determined using Guides 4, Chapter 14, to a GAF score and then using the California Method to determine the corresponding WPI.

Required compliance with Assessment Guidelines is a better way to address any issues regarding validity and reliability than changing the definitions

Changing the definitions may actually create more inconsistency, confusion and disputes. In contrast, requiring compliance with Assessment Guidelines will improve the overall quality of assessors, ensure a more scientific approach to the examinations, and result in reports that are more helpful to resolve disputes. Similarly, specific Assessment Guidelines would increase consistency and accuracy in the application of each of the criteria.

Identification of problems in the proposed changes to the definitions and alternative solutions

In the remainder of this paper we discuss the proposed changes to the mental and behavioral criteria and to the method to be used for combining and offer alternatives. We also suggest Assessment Guidelines that are applicable to all of the criteria to improve reliability and validity for catastrophic impairment determinations.

Request for opportunity for further involvement in the development of any changes to the regulations

There was limited information in the announcements regarding the definition of catastrophic impairments due to mental and behavioural disorders. We hope to have further opportunity to analyze the actual proposals to offer more informed input.

Our comments are based on extensive knowledge of the clinical and scientific literature underpinning the tools for measurement of impairment and 18 years of experience with catastrophic impairment determination in the most complex cases. We stress that what may appear to be “minor” changes in the regulations will have profound effects on the application of the definition to real accident victims with serious disorders.

Some options that superficially appear to be reasonable, such as the use of a GAF of 40 for impairments due to mental disorders and Guides 6 to quantify these impairments, will in fact have unintended adverse consequences and reduce equity in determinations for accident victims whose impairments are due to mental disorders.



We seek an opportunity to provide informed perspective regarding the flaws of these proposals, as well as to provide constructive input, and offer sounder, science-based alternatives. Our primary focus is on the criteria where the expertise of psychologists is most relevant, impairments due to mental and behavioural disorders.

As a part of our process we have also consulted with Dr. William H. Gnam, Senior Psychiatrist and expert in Catastrophic Impairment assessment. Dr. Gnam previously consulted with the Expert Panel regarding the catastrophic impairment definition. He has indicated his agreement with the concerns regarding discrimination against accident victims with impairments due to mental disorders in the government's proposals and the solutions we recommend (see Appendix 11, Letter from Dr. William H. Gnam).

Case Example

A woman with catastrophic impairments due to mental disorder who: would fail to satisfy the proposed definition; and would be assigned a low WPI under Guides 6 for combining.

We present this case study (14-2) from Guides 6, Chapter 14 to provide a concrete example of the inequity and disproportionately high threshold that is being proposed for accident victims with impairments due to mental disorders as well as the arbitrary and unfair reduction in the WPI attributed to the impairments.

We find it useful to illustrate our concerns with a case example. Guides 6 and the accompanying case book do not include an example specifically resulting from an auto accident. As such, we are presenting an example of an individual whose mental disorder did not result from an auto accident. However it is relevant because the ratings applied would be the same for impairments of a similar level from disorders that did result from an auto accident. We are relying on an example from Guides 6 itself so there can be no question that the ratings shown were correctly calculated since they were produced by the Guide's authors.

The woman in the case example below would not satisfy the proposed definition of a catastrophic impairment due to a mental or a behavioural disorder. Her GAF is 41-50 and not 40 or less, as required in the proposed definition. In addition, while she appears to be dependent and to require a very high level of care and supervision from her family and lives a highly sheltered and protected life, the example does not document the utilization the health care and other services listed in the indicia. Similarly in spite of her serious impairments, when the GAF is converted to a WPI according to the conversion table in Guides 6, she is only given a WPI of 15%, which is far lower than the WPI of 30-48% which would be determined by other GAF/WPI conversion methods. These new requirements create an unfair barrier to catastrophic impairment determination for accident victims whose impairments are due to mental disorders.

We provide science-based alternatives to address these inequities. We recommend a GAF of 50 or less, an alternative list of indicia more illustrative of person's with impairments that seriously impeded useful functioning, determination of WPI for mental impairment ratings by using Guides 4, Chapter 4, Table 3 or using the California Method to convert GAF to WPI for combining with physical impairment ratings.



EXAMPLE 14-2: IMPAIRMENT DUE TO SCHIZOPHRENIA

A 32-year-old woman had her first psychotic break at age 19 years, when she required hospitalization. Organic workup revealed no medical cause for the psychosis. Subsequent follow-up supported a diagnosis of schizophrenia, chronic undifferentiated type. Over the years of treatment her "positive" symptoms of schizophrenia subsided, and she required lower doses of long-acting neuroleptics. She stopped taking her medications on several occasions and had an exacerbation of auditory hallucinations and thought disorder. She continued to live with her parents without trouble. She had no history of substance abuse. On evaluation she seemed very organized and well put-together, reporting that over the last year she had not suffered from any delusions, hallucinations, or thought flow difficulties. She stated that she was able to complete her ADLs, including feeding, bathing, dressing, and grooming. She described her appetite as good and sleep as restful. However, her affect appeared flat during most of the interview. When asked about ADLs and social roles outside the home, she looked surprised and stated she did not think she could function outside her home. When questioned about social interaction, she indicated she got along very well with family and people that she was meeting for the first time. When questioned whether she went out in public and interacted with new people, she stated "no" but she did meet new people at her parents' house. When asked about concentration, she stated that she enjoyed working out detailed problems, reading mysteries, and working puzzles. She admitted that she did not feel she would do well in a highly structured setting where any "stress" was involved.

Because of possible variance among the appearance, statements, and typical course of schizophrenia, permission was obtained to speak with her family. The family supported some of her statements but placed many in a different light. They agreed that she had not had symptoms of psychosis in the last year. They also indicated that while she was able to meet her basic needs, she required a checklist in her room, which she reviewed before leaving. She also had to have reminders about her appearance. When questioned whether she left the home, her mother indicated it would take 2 weeks to prepare her to leave the house for a physician's appointment, and she required accompaniment by a parent whenever she went out.

When asked about meeting new people in the home, the mother indicated her daughter would meet people but left the room shortly after the introduction. When questioned about concentration, the mother stated that her daughter did seem to be interested in "problems, mysteries, and puzzles" but she did not offer solutions. When questioned about structured situations and stress, she indicated her daughter could not tolerate forced organization, timetables, or conflict of any type in the home. Her mother felt one of the main problems was lack of motivation. Apparently, the family needed to keep her moving toward her basic activities. Her mother indicated that this was in contrast to her teen years, when she was focused and motivated. Her personality style had continued for the first 5 years of the illness, but over the last 7 she seemed a different person. Several temporary employment positions through a mental health vocational agency were unsuccessful.

Diagnosis:

Axis I: Schizophrenia, undifferentiated type, with prominent negative symptoms.

Axis II: None.

Axis III: None.



Axis IV: not included in case example

Axis V: GAF= 41-50

Impairment Rating: 15%

Impairments Due to Mental and Behavioural Disorders

The current definition for impairments due to mental and behavioural disorders states:

(f) subject to subsections (4), (5) and (6), an impairment that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder.

Proposed changes to definition for impairments due to mental disorders

The proposed changes to the catastrophic impairment definition included:

For mental and behavioural impairments, revise the definition to include updated detailed criteria and new diagnostic tools.

Details were not provided regarding the “updated detailed criteria” and the “new diagnostic tools”. The introduction to the proposed changes states, “*Amendments will be proposed based on the Superintendent's Report on the Definition of Catastrophic Impairment in the Statutory Accident Benefits Schedule, subject to modifications.*” Therefore we have assumed that the proposal relates to the recommendations in the Superintendent's report December 15, 2011(released June 2012). We provide science-based recommendations to address flaws the Superintendent's recommendations.

If on the other hand, “updated detailed criteria and new diagnostic tools” relates to other alternatives, such as a shift to Guides 6, we also provide analysis and scientifically sound recommendations. The Guides 6 approach to consideration of mental disorders is unscientific and arbitrary. Artificial restrictions on diagnoses included in impairment determination and disproportionately low ratings lead to inequity for accident victims with impairments due to mental disorders, including brain injuries. We recommend a more scientific approach to address any concerns regarding the application of the definition for impairments due to mental disorders that does not introduce discrimination.

Superintendent's recommendations

The Superintendent's report recommended inequitable and discriminatory changes which would require a significantly higher level of impairment due to mental and behavioural disorders than for impairments due to physical disorders.

According to the Superintendent's recommendations:

4. 2 (f) psychiatric impairment that meets the following criteria:

i. The post-traumatic psychiatric impairment(s) must arise as a direct result of one or more of the following disorders, when diagnosed in accordance with the DSM IV TR criteria: (a) Major



Depressive Disorder, (b) Post Traumatic Stress Disorder, (c) a Psychotic Disorder, or (d) such other disorder(s) as may be published within the Government Guideline.

ii. Impairments due to pain are excluded other than with respect to the extent to which they prolong or contribute to the duration or severity of the psychiatric disorders which may be considered under Criterion (i).

iii. Any impairment or impairments arising from traumatic brain injury must be evaluated using Section 2(d) or 2(e) rather than this Section.

iv. Severe impairment(s) are consistent with a Global Assessment of Function (GAF) score of 40 or less, after exclusion of all physical and environmental limitations.

v. For the purposes of determining whether the impairment is sufficiently severe as to be consistent to Criterion (iv) – a GAF score of 40 or less – at minimum there must be demonstrable and persuasive evidence that the impairment(s) very seriously compromise independence and psychosocial functioning, such that the Insured Person clearly requires substantial mental health care and support services. In determining demonstrability and persuasiveness of the evidence, the following generally recognized indicia are relevant (see list in discussion of indicia below).

Impairments due to mental and behavioural disorders vs “psychiatric impairments”

We note that the Superintendent had referred to “psychiatric impairments”. We previously commented that it was inappropriate to replace the terms “mental and behavioural” with “psychiatric”. It is technically and scientifically incorrect to refer to these disorders as psychiatric rather than continuing to rely on the more appropriate terms “mental and behavioural”. There is no scientific or technical basis to make such a change.

It appears that the Superintendent made the incorrect assumption that the term psychiatric conveys more severe disorders. In fact both psychiatrists and psychologists provide assessment and treatment to the entire spectrum of mental and behavioural disorders. Consequently, these disorders may commonly be referred to as psychological and/or psychiatric disorders in everyday conversation. We note that the full spectrum of these disorders is described in the Diagnostic and Statistical Manual of Mental Disorders and are classified under Mental and Behavioural Disorders in the World Health Organization’s International Classification of Diseases. These are the two classification systems developed and employed by both psychiatrists and psychologists and utilized under auto insurance in Ontario, as well as most other jurisdictions.

OPA Recommendation: Continue to use “mental and behavioural” to describe these disorders.

Potential change from marked impairment in AMA Guides 4 to GAF and indicia

It appears that the proposals retain the change from marked or extreme impairment (according to the Guides 4, Chapter 14) to the Global Assessment of Functioning (GAF) recommended by the Superintendent. However, the change from the AMA Guides to the GAF is unnecessary. Guides 4, Chapter 14 describes a robust methodology to diagnose disorders and classify impairments, with classifications ranging from No Impairment to Extreme Impairment.

Guides 4, Chapter 14 Classification of Impairments Due to Mental and Behavioural Disorders					
Area or aspect	Class 1:	Class 2:	Class 3:	Class 4:	Class 5:



of functioning	No Impairment	Mild Impairment	Moderate Impairment	Marked Impairment	Extreme Impairment
<ul style="list-style-type: none"> • Activities of daily living • Social functioning • Concentration • Adaptation 	No impairment is noted	Impairment levels are compatible with most useful functioning	Impairment levels are compatible with some but not all, useful functioning	Impairment levels significantly impede useful functioning	Impairment levels preclude useful functioning

(See Appendix 1: Guides 4 Chapter 14, Table, Classification of Impairments Due to Mental Disorders)

The decision to reject the continued use of the AMA Guides 4, Chapter 14, to diagnose and rate mental and behavioural disorders while retaining Guides 4 for physical disorders appears to be based on several flawed assumptions. It appears that it was incorrectly assumed that there is less validity and reliability for diagnosis of mental disorders than there is for the other chapters of Guides 4. In addition it appears that it was assumed that Guides 4 do not provide adequate description of impairment level or sound methodology to provide WPI. These are incorrect assumptions.

OPA Recommendation: Retain Marked or Extreme impairment according to Guides 4, chapter 14, as the definition for catastrophic impairment due to mental and behavioural disorders.

Replacing Guides 4 with Guides 6

While some may suggest that a more “up to date” version of the Guides be used, replacing Guides 4 with Guides 6 would actually be a regressive change for accident victims with impairments due to mental disorders. The Guides 6 approach to consideration of mental disorders is unscientific and arbitrary. Artificial restrictions on diagnoses and disproportionately low ratings lead to inequity for accident victims with impairments due to mental disorders.

Detailed review of Guides 6 rating of impairments due to mental disorders is addressed in the section below, “Combining impairments due to mental disorders with impairments due to physical disorders”. In that section we provide analysis of why Guides 6 should be rejected as a method to rate impairments due to mental disorders for combining and offer sounder alternatives. The same critique is relevant to why Guides 6 should be rejected as an alternative to Guides 4 for determination of catastrophic impairment status due to mental disorders.

OPA Recommendation: Retain the use of Guides 4, not Guides 6.

The concerns raised by some regarding the reliability of diagnosing and rating impairments due to mental and behavioural disorders is more related to failure by some examiners to follow the robust methodology described in Guides 4, Chapter 14 and is better addressed by requiring compliance with Assessment Guidelines.

OPA Recommendation: Require compliance with Assessment Guidelines to address any issues of quality of determinations



Global Assessment of Functioning (GAF) Scale

The GAF itself is a way to summarize assessment findings and does not require or describe any particular assessment methodology. The following are the GAF descriptions and ranges:

Global Assessment of Functioning (GAF) Scale

Consider psychological, social, and occupational functioning on hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

- 100 **Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.**
- 91
- 90 **Absent or minimal symptoms** (e.g., mild anxiety before an exam), **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g., an occasional argument with family members).
- 81
- 80 **If symptoms are present, they are transient and expectable reactions to psycho-social stressors** (e.g. difficulty concentrating after family arguments); **no more than slight impairment in social, occupational or school functioning** (e.g., temporarily falling behind in schoolwork).
- 71
- 70 **Some mild symptoms** (e.g., depressed mood and mild insomnia) **OR some difficulty in social occupational, or school functioning** (e.g., occasional truancy, or theft within the household) **but generally functioning pretty well, has some meaningful interpersonal relationships.**
- 61
- 60 **Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school functioning** (e.g., few friends, conflicts with peers or co-workers).
- 51
- 50 **Serious symptoms** (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (e.g., no friends,
- 41 unable to keep a job).
- 40 **Some impairment in reality testing or communication** (e.g., speech is at times illogical obscured, or irrelevant) **OR major impairment in several areas, such as work, or school, family relations, judgment, thinking, or mood** (e.g. depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
- 31
- 30 **Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home, or friends).
- 21
- 20 **Some danger of hurting self or others** (e.g., suicide attempts without clear expectation of



- 11 death; frequently violent; manic excitement) **OR occasionally fails to maintain minimal hygiene** (e.g., smears feces) **OR gross impairment in communication** (e.g., largely incoherent or mute).
- 10 **Persistent danger of severely hurting self or others** (e.g., recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**
- 1
- 0 **Inadequate information.**

It is essential that all examiners be expected to follow a common method when conducting a mental and behavioural assessment for catastrophic impairment determination. It cannot be assumed that the examination methodology generally used for clinical purposes provides sufficient data to adequately address the question of catastrophic impairment determination. The robust method described in Guides 4, Chapter 14, is specifically intended to provide the necessary information for reliable and valid impairment determination.

We note that experts conducting assessments of individuals with mental disorders routinely include GAF scores. There is a common understanding of the clinical meaning associated with each range, as documented in the descriptors for each range, providing good reliability.

OPA Recommendation: Retain the assessment methodology described in Guides 4, Chapter 14, even if the government determines a GAF score is required.

GAF level

The Superintendent's report indicates that the requirement of a GAF of 40 or less was selected because *"it likely captures individuals with severe psychiatric impairment, as claimants who meet this threshold have a tenuous capacity for living safely within the community without substantial mental health supports"* It is correct that this threshold has virtually no risk of including anyone whose impairments due to mental disorder are not catastrophic. However this high threshold will discriminate against accident victims with impairments due to mental and behavioural disorders. A threshold of a GAF of 40 is far more severe than the threshold definitions required for some physical disorders. A required GAF of 40 is clearly discriminatory. It is the mental and behavioural equivalent of the impact of quadriplegia, *precluding* useful function. In contrast, a GAF of 50 is the mental and behavioural equivalent of the impact of paraplegia or loss of a single limb, *significantly impeding* useful function.

A description of the impairment level associated with various GAF ranges is provided by Othmer and Othmer (1994):

1. *Range 21-40 represents the patient whose reality testing is severely impaired by delusions or hallucinations (21-30) or several areas such as work, school, family or impaired judgment, thinking, or mood (31-40). Such a patient cannot function without continuous supervision and a continuous support system. He should be treated as a psychiatric inpatient.*
2. *Range 41-60 represents a patient who has serious, nonpsychotic symptoms that interfere with his time management, such as obsessional rituals; leading to severe avoidance behaviour and panic attacks; and impair (41-50) or interfere (51-60) with social, occupational, or school*



functioning. Patients with this rating usually need continuous pharmacotherapy and psychotherapy in a partial hospitalization or outpatient setting.

According to Othmer, an individual with a GAF of 40 or less “*should be treated as a psychiatric inpatient*”. The expectation of required ongoing inpatient psychiatric hospitalization is far more severe than required for the many of the other physical definitions and equivalent to quadriplegia. As can be seen in Othmer’s description, a GAF of 40 is consistent with impairments that *preclude* rather than *significantly impede* useful functioning and is inequitably severe for those whose impairments are due to mental disorders. Therefore, if the GAF is adopted as a required rating tool, the threshold should be a GAF of 50 or less so that it does not unfairly disadvantage accident victims with impairments due to mental disorders.

OPA Recommendation: A GAF of 50 or less is an appropriate threshold, if a GAF score is incorporated into the definition.

List of diagnoses

A restricted list of diagnoses is unscientific and discriminates against individuals with catastrophic mental and behavioural disorders. It is an additional inequitable barrier for accident victims with mental and behavioural disorders and is not similarly imposed on those with physical disorders.

There appears to have been an incorrect assumption that it is possible to pre-determine a fixed list of certain diagnoses of mental disorders that may be caused by an accident and would result in a catastrophic impairment. In addition, an accident victim may have a diagnosis of a pre-existing mental disorder that is worsened as a result of an accident. Whatever mental disorder is diagnosed, the causal relationship to the MVA and the subsequent severity of impairment must be established. A restrictive list of diagnoses risks arbitrary harm to some seriously injured individuals if their specific diagnosed disorder is “not on the list”. This is an unnecessary limitation that creates an additional unfair restriction that is not applied to other definitions.

Further, just as with patients with bodily injuries, the typical patient referred for catastrophic impairment determination for mental disorder has multiple mental and behavioural disorders, all contributing to the patient’s functional limitations. It is common for patients to have disorders that range in severity and together synergistically produce more significant functional limitations in carrying out normal activities, establishing, maintaining and engaging in social relationships, concentrating on activities and completing tasks, and adapting to everyday challenges including those of a workplace.

Since a specific list of mental and behavioural diagnoses is unnecessary, as well as unscientific and discriminatory, it should be not be included as part of a criterion to establish catastrophic impairment.

OPA Recommendation: Include consideration of impairments resulting from all mental disorders due to an accident.

Brain injury

The superintendent recommended, “*Any impairment or impairments arising from traumatic brain injury must be evaluated using Section 2(d) or 2(e)*”. This is discriminatory and a fundamentally unscientific



recommendation. It is contrary to the clinical reality that accident victims may present with multiple mental and behavioural disorders that cannot be separated in terms of their overall impact on impairment. These include brain injuries and the mental and behavioural disorders they produce. It is a misunderstanding that the synergistic impact of multiple mental and behavioural disorders with different etiologies cannot be measured on a common scale. Indeed the GAF scale in the Diagnostic and Statistical Manual of Mental Disorders (DSM) is intended to be used as a summary scale to express the overall impact of *all* mental and behavioural disorders on the individual person including mental disorders resulting from brain injuries. Similarly, the rating system in Guides 4, Chapter 14 allows for the consideration of the overall impact of *all* diagnosed mental and behavioural disorders, including those due to brain injury.

Concerns have been raised regarding “double counting”. Some have suggested that without exclusion from consideration in the mental disorder definition, impairments due to brain injuries would be double counted. They suggest that without this restriction, ratings would be provided for the same impairments due to the mental disorder resulting from the brain injury under the mental and behavioural definition and again in the neurological section. If the ratings are combined, it inflates the impairment ratings arising from the brain injury. This is contrary to the instructions in Guides 4, Chapter 3 for considering overlapping impairments to take the highest rating to stand for the impairment level and not to “double-count” or combine. However, concerns regarding potential “double counting” are better addressed by requiring compliance with Assessment Guidelines specifically addressing this issue rather than unscientific restriction of full consideration of the impact of all mental disorders.

OPA Recommendation: Include impairments due to mental disorders arising from brain injuries when determining impairment level.

Pain

The Superintendent’s recommendations stated, “*Impairments due to pain are excluded other than with respect to the extent to which they prolong or contribute to the duration or severity of the psychiatric disorders which may be considered under Criterion (i)*”. This recommendation is once again unscientific and discriminatory as it precludes consideration of legitimate diagnosable mental disorders due to an accident, which are clearly included in DSM IV and DSM-5. This thinking is out of step with contemporary clinical/ scientific understanding of pain.

As above, concerns regarding potential “double counting” are better addressed by requiring compliance with Assessment Guidelines specifically addressing this issue.

OPA Recommendation: Include impairments due to pain disorders when determining impairment level.

Proposed list of indicia

We note that the Superintendent’s recommendations included a list of “indicia”, as follows:

For the purposes of determining whether the impairment is sufficiently severe as to be consistent to Criterion (iv) – a GAF score of 40 or less – at minimum there must be demonstrable and persuasive evidence that the impairment(s) very seriously compromise independence and psychosocial functioning, such that the Insured Person clearly requires substantial mental health



care and support services. In determining demonstrability and persuasiveness of the evidence, the following generally recognized indicia are relevant:

- a) Institutionalization:
- b) Repeated hospitalizations, where the goal and duration are directly related to the provision of treatment of severe psychiatric impairment:
- c) Appropriate interventions and/or psychopharmacological medications such as: ECT, mood stabilizer medication, neuroleptic medications and/or such other medication that are primarily indicated for the treatment of severe psychiatric disorders:
- d) Determination of loss of competence to manage finances and property, or Treatment Decisions, or for the care of dependents:
- e) Monitoring through scheduled in person psychiatric follow-up reviews frequency equivalent to at least once per month.
- f) Regular and frequent supervision and direction by community-based mental health services, using community funded mental health professionals to ensure proper hygiene, nutrition, compliance with prescribed medication and/or other forms of psychiatric therapeutic interventions, and safety for self or others.

This list of indicia recommended by the Superintendent is discriminatory and reflects impairment that is the equivalent of the impact of quadriplegia, which is consistent with *precluding* useful functioning. This is again a much higher threshold than for other physical disorders defined as catastrophic, which only *significantly impede* useful functioning. If a list of indicia is required as a part of the catastrophic impairment definition, it should reflect impairment levels that are consistent with disorders that *significantly impede* useful function, not *preclude* it.

The following list is recommended as more appropriate to reflect individuals with impairments due to mental disorders which *significantly impede* useful function:

For the purposes of determining whether the impairment is sufficiently severe as to be consistent to Criterion (iv) – a GAF score of 50 or less – at minimum there must be demonstrable and persuasive evidence that the impairment(s) seriously compromise functioning in socialization, daily activity, task completion, or, occupation (work, education, or work-like activity), such that the Insured Person clearly requires mental health care and support services.

In determining demonstrability and persuasiveness of the evidence, the following generally recognized indicia are relevant:

- a) Lack of mental healthcare and support services is likely to lead to further deterioration in psychological functioning as indicated by increased psychological symptoms and/or decreased capacity to engage in activities of daily living, social functioning or completing tasks.
- b) Mental healthcare and support services are required on an ongoing basis, or the patient is so isolated and inactive or sheltered as to not seek them out
- c) Appropriate interventions and/or psychopharmacological medications such as: mood stabilizer medication, neuroleptic medications and/or such other medication that are primarily indicated for the treatment of mental and behavioural disorders consistent with a GAF of 50 or less.



- d) Inability to maintain employment, inability to maintain appropriate social interactions, significantly impeded in daily activities, or significantly impeded in task completion.
- e) Ongoing monitoring and medication review, frequency equivalent to at least once per 6 weeks would be appropriate and/or scheduled in person psychological treatment equivalent to at least twice monthly would be appropriate.
- f) Frequent use of community-based mental health and other support services would be appropriate.

Access to and utilization of health and other services are dependent upon a variety of factors. Unfortunately some individuals with the most severe impairments do not have resources available to them or are unable to utilize health care or other resources. A few examples include:

- The individual's condition may cause them to withdraw from all or most services
- The individual has achieved maximum recovery and less frequent maintenance care may be more appropriate
- Cultural factors may lead the person or the person's family to address issues within the family and avoid publicly available resources
- Services may not be available in the person's local and/or long waiting lists may exist
- Lack of transportation
- Lack of linguistically or culturally appropriate services
- Treatment failure may result in discouragement and disengagement from further services.

As a result, requiring any "check list" of indicia will discriminate against accident victims who have not utilized these services for whatever reason. Therefore if indicia are included as illustrative, they cannot be used as a requirement for catastrophic impairment determination.

OPA Recommendation: Utilize our alternative list of "indicia" to illustrate the types of services that may be appropriate.

Recommendation to require use of Assessment Guidelines for impairments due to mental and behavioural disorders

Unfortunately the government's approach to create more restrictive definitions results in discrimination against accident victims with impairments due to mental and behavioural disorders. In contrast, requiring that all assessors follow methodological Assessment Guidelines is the most important factor in ensuring reliability of assessments and opinions and does not introduce discrimination.

We recommend the following Assessment Guidelines to determine catastrophic impairments due to mental disorders:

In determining whether an Insured has a catastrophic impairment due to mental and behavioural disorder, an evaluator (qualifications as per general guidelines) will follow the explicit method of assessment described in Guide 4, chapter 14, utilizing multiple sources of data and a multi-method approach as indicated in the Guides:

- administer and interpret appropriate tests in a professionally correct, standardized manner;
- document their data;



- address issues of effort, exaggeration and malingering; provide clear formulations that explain the basis for their diagnoses and impairment ratings.

Should the government opt to include a GAF criteria, we recommend that the GAF be added to criteria that incorporate a marked impairment according to the Guides 4, chapter 14, as follows:

- follow all of the recommendations above
- provide clear formulations that explain the basis for the GAF rating (see Appendix 4: Assessment Guidelines).

OPA Recommendation: Require compliance with Assessment Guidelines.

Allow more equitable access to catastrophic impairment assessments and applications: The role of psychologists

Psychologists were historically included as experts to determine catastrophic impairment due to mental and behavioural disorders. This was changed in 2010, when catastrophic determination was limited to physicians (*except for a doctorate-level neuropsychologist in the case of traumatic brain injuries*) despite psychologists having the appropriate education, training and experience to assess and diagnose impairments due to mental and behavioural disorders. Along with physicians, psychologists are the only regulated health care providers authorized under the RHPA to do so. In addition, the psychological method is the one adopted in Guides 4, Chapter 14. It is recommended that the government's review of the definition be utilized as an opportunity to redress the situation so that psychologists' expertise may be appropriately utilized to make these determinations, providing more equitable access for accident victims with impairments due to mental disorders, as well as adding efficiency and accuracy to the process.

The superintendent's report states, "*An Evaluator conducting assessments of catastrophic impairments must be a medical doctor or a doctorate level neuropsychologist (in the case of traumatic brain injuries), with a minimum of five years of licensing or registration in Canada.*" This requirement to rely on a physician is unfairly restrictive for accident victims with impairments due to mental disorders especially in the context of the limited number of physicians with appropriate expertise. The requirement precludes accident victims with mental disorders relying solely on assessment and application for catastrophic impairment determination from the expert psychologist of their choice. This restriction to physicians creates a barrier for some accident victims with mental disorders to a sound determination and application when the most appropriate experts with relevant training and expertise and/or the most in-depth knowledge of their condition cannot fulfill this role.

We note that assessment and diagnosis of the full range of mental and behavioural disorders is within the scope of practice of psychologists. Psychologists are experts in a variety of diagnostic procedures and have specific training in consideration of multiple sources of information. This includes test administration and interpretation, which is most often useful in complex determinations that must also consider issues of differential diagnosis, causation, exaggeration and malingering. It is contrary to the scientific literature and present practice in many jurisdictions regarding the role and acknowledged expertise of psychologists to preclude psychologists from being relied on as the sole expert to conduct the assessment and complete the catastrophic impairment application regarding mental and behavioural impairments.



We also note that there is a shortage of psychiatrists available to provide OHIP-funded clinical treatment services in the community. The unnecessary requirement of a physician for catastrophic impairment applications regarding mental disorders likely diverts some of these physician resources, compounding the shortage.

In summary, it is more consistent with focus on appropriate education, training, experience, expertise, and legal authority to re-instate psychologists' authority to conduct assessments and make determinations regarding catastrophic impairments due to mental and behavioural disorders. Inclusion of psychologists to make these determinations is also more consistent with present practices in a range of contexts and jurisdictions as well as with established acceptance as experts in court and arbitration in Ontario.

Reinstating psychologists in this role would also remove an unnecessary barrier to claimant access to the most appropriate expert for these assessments and determinations. Increasing the available pool of appropriate assessors may also help to avoid delays and cost pressures. Therefore it is recommended that the government include psychologists to conduct catastrophic examinations, make determinations, and complete applications for accident victims with impairments due to mental and behavioural disorders (see Appendix 5 Further discussion re inclusion of psychologists to conduct Catastrophic Impairment assessments and complete Catastrophic Impairment applications).

OPA Recommendation: Reinstate accident victims' ability to rely on psychologists, along with physicians, as sole experts to diagnose and rate impairments to complete catastrophic determination applications for impairments due to mental disorders.

Combining Impairments Due to Mental Disorders with Impairments Due to Physical Disorders

The current definition for combined whole person impairments states:

(2)(e) subject to subsections (4), (5) and (6), an impairment or combination of impairments that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in 55 per cent or more impairment of the whole person.

Retention of the 55% impairment definition

The proposals correctly retain the definition to address accident victims whose impairments are not addressed in the specific individual definitions and whose multiple impairments combine to result in a catastrophic impairment determination.

OPA Recommendation: Retain the 55% whole person impairment definition.



Retention of Guides 4 and clarification of the appropriateness of combining

The Superintendent recommended retaining the 55% WPI rating according to Guides 4 but imposed explicit restrictions on the impairments to be combined, excluding consideration of impairment ratings due to mental and behavioural disorders. At that time we provided a response indicating that while it was sound to retain the 55% impairment criteria and the use of Guides 4, it is unscientific and lacking in equity to preclude consideration of impairment ratings due to mental and behavioural disorders.

The government's proposal appears to have attempted to address this issue and included combining of impairments due to mental disorder:

Combination of impairments: For other physical impairments not listed retain current definition and adopt new diagnostic tool (6th Edition of AMA Guides to the Evaluation of Permanent Impairment) for quantifying mental and behavioural impairments for the purposes of combining

We understand from this statement that the government intends to retain the use of Guides 4 for all other ratings, both bodily and due to brain injury, but will require use of Guides 6 for quantifying impairments due to mental and behavioural disorders.

The decision to retain Guides 4 and not to make an overall switch to Guides 6 seems to reflect the understanding that Guides 6 is not an improvement over Guides 4. In fact, Guides 6 is problematic, with flawed methodology and arbitrary changes in some of the WPI ratings. We note that the chapters on Brain Injury (The Central and Peripheral Nervous System, Chapter 13) and Mental and Behavioural Disorders (Chapter 14) are among the most problematic in Guides 6. Both chapters have drastically reduced impairment ratings even for those accident victims with the most profound disorders. Guides 6, Chapter 14, page 349 states, "*Patients with severe mental illness may have a greater role impairment than a patient with a severe physical ailment*". However, WPIs provided for impairments due to mental disorders do not reflect this reality. No impairment rating over 50% is possible, according to the Guides 6 ratings, for impairments due to mental disorders.

OPA Recommendation: Retain Guides 4, not Guides 6 for determination of the 55% WPI definition.

In spite of the overall rejection of Guides 6, the government is proposing to use Guides 6 for quantification of impairments due to mental and behavioural disorders. This creates a new inequity which will drastically reduce only the impairment ratings provided for mental disorders without changing the 55% overall threshold when these are included in the combined WPI.

We agree that inclusion of impairments resulting from mental and behavioural disorders in whole person impairment rating is necessary. Combining is consistent with current scientific understanding of mind body integration and improves clarity of the definition. Clinical experience and scientific research confirm that co-existing mental disorders multiply the impairment burden of physical disorders. This is well documented in many sources including in *Global Perspectives on Mental-Physical Co-Morbidity* in the WHO World Health Surveys. The government's proposal to include impairments due to mental and behavioural disorders addresses the arbitrariness and inequity in a system which excludes these impairments. The clarification of the correctness of inclusion of



impairments due to mental disorders should also eliminate needless and wasteful disputes over this issue. Similarly, clear direction regarding the methodology to be employed for quantification will eliminate disputes over this question.

There are some parties who have resisted inclusion of impairments due to mental and behavioural disorders due to concern there will be large increases in the number of accident victims who will satisfy catastrophic impairment criteria. They have asserted that allowing combining will result in a “flood” of accident victims determined to have catastrophic impairments. They claim that any one with a minor physical injury and a mild impairment due to a mental and behavioural disorder will be found to have a catastrophic impairment. However, this is not the case. A 55% WPI relying on the quantification and combining methods of Guides 4 is a very high threshold that is met by very few accident victims.

Scientific understanding of the reality of body-mind integration and basic fairness requires that impairments due to mental disorders be included in rating of the whole person. The progressive discounting method incorporated into the the combining table gives a lower value to each additional impairment so that no combination of impairments can ever exceed 100%. Extremely few individuals who do not satisfy the catastrophic impairment criteria, either on the basis of their impairments due to physical disorders or on the basis of their impairments due to mental disorders, will achieve 55% WPI when these are combined using current methods for rating, quantification and combination (see Appendix 6 for combining table illustrating progressive discounting of additional impairments).

OPA Recommendation: Retain the use of Guides 4 and explicitly include impairments due to mental disorders in the WPI.

Problematic requirement of use of Guides 6 to quantify impairments due to mental disorders

While use of the quantification methodology in Guides 6 may superficially appear to be a reasonable and readily available solution, it is not. There are a number of reasons why requiring Guides 6 for the quantification is not only inappropriate but contrary to the intention to introduce equity and fairness to the 55% WPI criteria.

No rationale or evidence is offered for the drastic and unreasonable reduction of impairment ratings for brain injuries and mental disorders provided in Guides 6. While our discussion in this submission focuses on the WPI impairment scores provided for the GAF according to the conversion method in Guides 6, the other two rating methods in Guides 6, Chapter 14, the Brief Psychiatric Rating Scale (BPRS) and the Psychiatric Impairment Rating Scale (PIRS), also are scientifically unsound and result in ratings inequities. The following is a brief summary of the concerns regarding these two other instruments:

The BPRS (1962, Overall and Gorham) was developed with the expressed purpose of providing a “highly efficient, rapid evaluation procedure for use in assessing treatment change in psychiatric patients while at the same time yielding a rather comprehensive description of major symptom characteristics (p. 799).” However, as noted by Leucht et al (2005), it is not clear what the total score and cut-off values mean from a clinical perspective. This is made



even less clear when the BPRS score is converted in Guides 6th to a WPI with no empirical basis.

The PIRS was developed as a modification of the rating scale used in Guides 2nd. Davies (2008) offers an extensive critique of the PIRS, concluding that the scoring is neither proportionate nor statistically meaningful. This is of course compounded in Guides 6th by converting PIRS scores to WPIs that are not supported empirically. Also of note, Davies states that “The developers of the scale specifically stated that the aim was to reduce the level of rated impairment and thus insurance payouts (2008, p. 206).” With respect to the PIRS using a median-based scoring system, he notes, “the data from the present study clearly show that the use of this method significantly biases the assessed impairment downward...” (Levitt, 2010).

The Guides 6 decision to use three methods, each which produce unreasonable and disproportionately low ratings for impairments due to mental disorders, does nothing to compensate for the problems inherent in each of the three methods.

The problematic nature of Guides 6 is evident in the conversion table provided (without any research or explanation) for converting Global Assessment of Functioning (GAF) scores to WPIs. The conversion table for GAF to WPI scores in Guides 6 provides significantly lower WPI scores than methods for determining WPI scores in Guides 4, Chapter 4, Table 3 or using the California Method for conversion.

The Guides 4, Chapter 14, method for conversion of classification to WPI according to Chapter 4 yields highly similar WPI ratings to using the California Method for converting GAF scores to WPI. In contrast, Guides 6, Chapter 14, provides conversion of GAF to WPI that are disproportionately and inequitably lower without providing any rationale or evidence for this reduction.

The following three tables are used for determination of WPI scores according to Guides 4, the California Method, and Guides 6:

Table 1

Guides 4, chapter 4, table 3 Emotional or Behavioral Impairments	
Impairment Description	WPI*
Mild limitation of daily social and interpersonal functioning	0-14
Moderate limitation of <i>some</i> but not all social and interpersonal daily living functions	15-29
Severe limitation impeding useful action in <i>almost all</i> social and interpersonal daily functions	30-49
Severe <i>limitation of all daily functions</i> requiring total dependence on another person	50-70
<p>Note: Page 4/142 <i>The criteria for evaluating these disturbances (table 3) relate to the criteria for mental and behavioural impairments (chapter 14, page 291).</i></p> <p>* Specific WPI scores are determined within the range by interpolating as per Guides 4, chapter , page 2/9, which states, “<i>in general, an impairment value that falls between those appear in a table or figure of the Guides may be adjusted or interpolated to be proportional to the interval of the table or figure involved, unless the book gives other directions</i>”)</p>	



Table 2

California GAF to WPI table from the SCHEDULE FOR RATING PERMANENT DISABILITIES, January 2009: Psychiatric Impairment GAF to WPI Conversion						
GAF=WP	GAF=WP	GAF=WP	GAF=WP	GAF=WPI	GAF=WPI	GAF=WPI
1 = 90	2 = 89	3 = 89	4 = 88	5 = 87	6 = 87	7 = 86
8 = 85	9 = 84	10 = 84	11 = 83	12 = 82	13 = 82	14 = 81
15 = 80	16 = 80	17 = 79	18 = 78	19 = 78	20 = 77	21 = 76
22 = 76	23 = 75	24 = 74	25 = 73	26 = 73	27 = 72	28 = 71
29 = 71	30 = 70	31 = 69	32 = 67	33 = 65	34 = 63	35 = 61
36 = 59	37 = 57	38 = 55	39 = 53	40 = 51	41 = 48	42 = 46
43 = 44	44 = 42	45 = 40	46 = 38	47 = 36	48 = 34	49 = 32
50 = 30	51 = 29	52 = 27	53 = 26	54 = 24	55 = 23	56 = 21
57 = 20	58 = 18	59 = 17	60 = 15	61 = 14	62 = 12	63 = 11
64 = 9	65 = 8	66 = 6	67 = 5	68 = 3	69 = 2	>70 = 0

We note that research done on the California conversion method has demonstrated that even the California WPIs for impairments due to mental disorders are unrealistically low in comparison to the ratings provided for impairments due to physical disorders. Adjustment modifiers have been introduced in California to increase the ratings for impairments due to mental disorders.

Table 3

Guides 6: GAF / WPI conversion table		
GAF	Description	WPI
91-100	No symptoms; superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities.	0%
81-90	Absent or minimal symptoms (e.g. mild anxiety before an exam); good functioning in all areas, interested and involved in wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g. an occasional argument with family member).	0%
71-80	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g. difficulty concentrating after family arguments); no more than slight impairment in social, occupational, or school functioning (e.g. temporarily falling behind in school work)	0%
61-70	Some mild symptoms (e.g. depressed mood and mild insomnia) or Some difficulty in social, occupational, or school functioning (e.g. occasional truancy or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.	5%
51-60	Moderate symptoms (e.g. flat affect and circumstantial speech, occasional panic attacks) or Moderate difficulty in social, occupational, or school functioning (e.g. few	10%



	friends, conflicts with coworkers)	
41-50	Serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting) or Any serious impairment in social, occupational, or school functions (e.g. no friends, unable to keep job)	15%
31-40	Some impairment in reality testing or communication (e.g. speech is at times illogical, obscure, or irrelevant) or Major impairment in several areas, such as work or school, family relations, judgment thinking, or mood (e.g. depressed adult avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school)	20%
21-30	Behavior is considerably influenced by delusions or hallucinations or Serious impairment in communication or judgment (e.g. sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) or Inability to function in almost all areas (e.g. stays in bed all day; no job, home, or friends)	30%
11-20	Some danger of hurting self or others (e.g. suicide attempts without clear expectation of death, frequently violent, manic excitement) or Occasionally fails to maintain minimal personal hygiene (e.g. smears feces) or Gross impairment in communication (e.g. largely incoherent or mute).	40%
1-10	Persistent danger of severely hurting self or others (e.g. recurrent violence) or Persistent inability to maintain minimal personal hygiene or Serious suicidal act with clear expectation of death	50%

Guides 6, Chapter 14 provides case examples that illustrate the disproportionately low WPIs resulting from the conversion methods in that version of the Guides. Guides 6, Chapter 14, page 361, Example 14-2: Impairment Due to Schizophrenia, is included earlier in this submission. In the case description the person is described as having impairments due to a mental disorder and a GAF of 41-50 (serious symptoms or serious impairment in social, occupational, or school functioning). As shown in the tables above using Guides 4, Chapter 4, Table 3; this would result in a WPI of 30-48%, and using the California Method it would also result in a WPI of 30-48%. However, using Guides 6, the individual in this case example is given a WPI of only 15%.

This case example demonstrates that according to the methods of Guides 6, in spite of her serious impairments, she would be found to have a WPI rating of only 15%. This rating is profoundly inequitable in comparison to WPI ratings for physical disorders as well as to other methods for determining WPI for impairments due to mental disorders. Use of this Guides 6 method would discriminate against those whose impairments are due to mental disorders.

As an example of the inequity between the mental impairment ratings in Guides 6 and the physical impairment ratings in Guides 4 we note Guides 4, Table 36, page 76, under “Lower limb impairment from gait derangement,” a 15% WPI is provided for a mild impairment (patient requires part time use of a cane or crutch for distance walking but not usually at home or in work place)” Example 14-2, of a 15% WPI, above, from Guides 6, of the woman with a serious impairment due to schizophrenia, clearly describes an individual with significantly more than mild impairments.

The inequitable and disproportionately low ratings (WPIs) provided according to the methodology of Guides 6 will make combining impairments due to mental and behavioural disorders virtually meaningless. The disproportionately low impairment scores provided by Guides 6 will result in a



negligible number of patients achieving 55% based on combining. This is contrary to the scientific literature which indicates that mental impairments not only add to, but multiply the impairment burden of physical injuries.

We recommend use of Guides 4, Chapter 4, Table 3, to quantify mental impairments. This is most consistent with the use of the Guides 4 for determining whole person impairment ratings, as all ratings would come from a single text. Neuropsychologists, neurologists, neuropsychiatrists and other experts have used the tables in Chapter 4 to rate brain impairments since the inception of the SABS CAT definition, and there is considerable familiarity with the tables, including Table 3. Psychologists and psychiatrists have for decades rated impairment using a single rating scale (GAF) whether the impairment is due to brain injury or disease or other psychological disorders.

Another method that allows for quantification and combining with other impairment ratings in Guides 4 is to use a GAF score and apply the conversion table used by the State of California to determine a WPI for combination with other impairment ratings. The State of California uses this conversion table to provide scores that can be used to combine with the WPI for the physical impairments. The RAND Institute conducted outcome research and determined that the GAF converted ratings significantly underestimate impairment compared to other impairment ratings by a factor of 40%. In other words, using this method would not be likely to result in inflated mental and behavioural impairment scores in comparison to physical WPIs.

Using either of these systems, mental and behavioural impairment ratings can be combined readily with ratings for other impairments based on the Guides 4, using the combination tables, to yield a comprehensive WPI. We note that these methods yield highly similar impairment ratings (see Levitt, 2010 for relevant references).

In Guides 4, Chapter 4, Table 3, the range of WPIs is from 0- 70% and in the California methodology and GAF/WPI conversion table, provides WPIs that range from 0-90%. These reflect the range of impairments that can result from mental disorders, from nil to most severe. In contrast, the highest possible rating for persons with the most profound impairments due to mental disorders according to Guides 6 is 50% and all other WPIs for impairments due to mental disorders are proportionately reduced resulting in highly inequitable ratings. We note that these arbitrarily lower ratings are contrary to the scientific literature indicating the higher impairment burden of mental disorders (including brain injuries) in comparison with bodily disorders and no explanation for this reduction in WPI is given in Guides 6. In fact, it contradicts the statement in Guides 6, regarding the potential severity of impairments due to mental disorders, Guides 6, Chapter 14, states *“Patients with severe mental illness may have a greater role impairment than a patient with a severe physical ailment”* (page 349).

OPA Recommendation: Reject Guides 6 as a method to determine the WPI for impairments due to mental disorders.

Recommendation of equitable methods to quantify using Guides 4 Chapter 4 Table 3 and/or the California Method

To address the issue of combining impairments due to mental disorders with impairments due to physical disorders, adopt a sounder, more consistent, nondiscriminatory model to quantify



impairments due to mental disorders to combine with impairments due to physical disorders. There are two readily available and well established methods to quantify impairments resulting from disorders diagnosed and categorized according to the assessment methodology in Guides 4, Chapter 14, that do not introduce inequity.

1. Rely on Guides 4, Chapter 4, Table 3, to rate by analogy.
 - a. Use Guides 4, Chapter 4, Table 3, to determine the appropriate WPI for the categorization determined in Guides 4, Chapter 14, (*see Appendix 1, Guides 4 Chapter 14, Classification of Impairments Due to Mental Disorders and Appendix 7, Guides 4, Chapter 4, Table 3: Emotional or Behavioral Impairments*)
2. Use a GAF score and the California Method for conversion of GAF to WPI
 - a. Determine the appropriate GAF score (*see Appendix 2, Description of GAF scores*)
 - b. Use the California conversion table to determine the WPI (*see Appendix 8 California method for conversion of GAF to WPI*)

The use of either of these methods results in almost equivalent WPI ratings for impairments due to mental disorders which can then be combined with the impairment ratings for the physical disorders to determine the combined WPI.

While it is correct to include impairments due to mental disorders in a WPI rating, the method used to rate those impairments must be equitable in comparison to the ratings provided for impairments due to physical disorders. Guides 6 does not meet this requirement. To use Guides 6 in the Ontario context would require development of a new lower threshold for the combined WPI when a mental impairment is included, or a multiplier factor for the impairment rating produced by Guides 6 Chapter 14 (*see Appendix 9, re Guides 6, GAF/WPI conversion*).

OPA Recommendation: Rely on Guides 4, Chapter 4, Table 3 or the California table for conversion of GAF to WPI to quantify impairments due to mental and behavioural disorders.

Recommended Assessment Guidelines re: quantification and combining

In addition to clarifying the method for quantifying and combining requiring assessors to follow assessment guidelines will address the concerns that have been raised regarding combining, especially issues of duplication or “double-dipping”.

We recommend that all assessors will be expected to comply with Assessment Guidelines for combining impairment ratings to address potential concerns regarding “double-counting” which would reinforce the following principles:

- Impairments due to mental and behavioural disorders are rated by analogy to Table 3 in Chapter 4 of the American Medical Association’s *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993 or using the California method for conversion of GAF scores to WPI.
- Whole person impairment rating follows the Guides principle of not combining overlapping impairments. The most severe impairment rating among the four Chapter 14 classes of impairment is taken to stand for the overall level of impairment due to mental and behavioural disorder.



- Where impairment ratings are offered as ranges in the *Guides*, evaluators clearly explain their rationale for choosing a specific rating within a range.
- Combining ratings for impairment due to mental and behavioural disorders with ratings for impairment due to physical disorders also follows the *Guides* principle of not combining overlapping impairments. Evaluators do not combine impairment ratings due to physical disorders and impairment ratings due to mental and behavioural disorders that overlap. Where impairment ratings overlap, assessors follow the *Guides* principle of taking the higher impairment rating to stand for the impairment (see *Appendix 4: Assessment Guidelines*).

OPA Recommendation: Require compliance with Assessment Guidelines.

WHODAS 2.0

We note that the most current version of the Diagnostic and Statistical Manual of Mental Disorders, the Fifth edition (DSM-5) no longer includes a GAF. However, the government's recommendations for determination of catastrophic impairments due to mental disorders and many jurisdictions continue to rely on the GAF and use the California Method to convert the GAF to WPI.

The DSM-5 includes a description of the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0), as well as a scoring methodology based on field studies. The WHODAS appears to have potential to be adopted as a more up-to-date, universally utilized instrument to determine if a person has a catastrophic impairment due to a mental disorder (described in the WHODAS as severe) and to generate WPI ratings. We are undertaking further study of the WHODAS at this time (see *Appendix 10, the World Health Organization Disability Assessment Schedule 2.0*).

OPA Recommendation: Further study of the WHODAS 2.0 is required to determine if it is a useful tool for future application.

Addressing pain

In addition, the Superintendent's report also recommended that catastrophic impairment definition should not allow pain to be quantified as a separate impairment or added to the rating generally provided for the physical condition. However, the *Guides* 4 indicates that the physical impairment ratings are intended to include the pain that is *generally associated* with that physical impairment. In determining whether chronic pain contributes to impairment ratings beyond what is generally captured in the physical impairment ratings, the *Assessment Guidelines* would require that an evaluator follow the explicit method of assessment described in *Guides* 4, Chapter 15, to modify impairment ratings in Chapter 3-14 where appropriate.

The Superintendent's report represents a retrogressive step given the science of the impairments produced by pain. Not allowing pain ratings, where appropriate, may also be inconsistent with the Supreme Court of Canada in *Donald Martin v Worker's Compensation Board of Nova Scotia*, 2003.

OPA Recommendation: Allow consideration of impairments due to pain according to Guides 4, Chapter 15 to modify impairment ratings when pain is beyond that generally captured in the physical impairment ratings.



Recommended Assessment Guidelines for completing 55% WPI assessments

To address issues regarding the quality of assessments to determine 55% WPI we strongly recommend requiring compliance with Assessment Guidelines. This will address the most fundamental cause of problematic assessment reports: poor method. Assessment Guidelines will improve the usefulness of reports to resolve disputes.

We recommend the following Assessment Guidelines, to determine impairments according to the 55% WPI definition.

In determining whether an Insured has a catastrophic impairment due to a 55% WPI an evaluator (qualifications as per general guidelines) will follow the explicit method of assessment described in the relevant chapters of the 4th edition of the AMA Guides:

- follow the explicit method of assessment described in the relevant chapter(s) of the Guides, utilizing multiple sources of data and a multi-method approach as indicated in the Guides.
- administer and interpret appropriate tests in a professionally correct, standardized manner
- document their data
- address issues of effort, exaggeration and malingering,
- provide clear formulations that explain the basis for their diagnoses and impairment ratings (see *Appendix 4: Assessment Guidelines*).

OPA Recommendation: Require compliance with Assessment Guidelines.

Children

Regarding children the SABS currently state:

(3) Subsection (4) applies if an insured person is under the age of 16 years at the time of the accident and none of the Glasgow Coma Scale, the Glasgow Outcome Scale or the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, referred to in clause (2) (d), (e) or (f) can be applied by reason of the age of the insured person.

(4) For the purposes of clauses (2) (d), (e) and (f), an impairment sustained in an accident by an insured person described in subsection (3) that can reasonably be believed to be a catastrophic impairment shall be deemed to be the impairment that is most analogous to the impairment referred to in clause (2) (d), (e) or (f), after taking into consideration the developmental implications of the impairment.

The Superintendent made specific recommendations regarding paediatric traumatic brain injury, utilizing the KOSCHI. Further study was recommended. However, in attempting to provide greater specificity the proposed definition appears to be excessively arbitrary and restrictive.



Whether or not specific additional definitions are brought in regarding paediatric traumatic brain injury these current subsections in the SABS are essential to adequately address the unique developmental issues of insureds who are under the age of 16 at the time of the accident who develop a variety of disorders as a result of an MVA.

OPA Recommendation: Retain the provisions in the SABS addressing the needs of children and developmental implications.

Time Frame for Completing Catastrophic Impairment Applications

The SABS currently state:

or (b) two years have elapsed since the accident.

Two years post-MVA

The criteria for two years post-accident is essential to allow for clarity regarding when the determination may be made. This benchmark at the two-year point avoids disputes about whether or not an impairment is permanent.

OPA Recommendation: Retain the provision in the SABS that allow for determination at the two-year point post-MVA.

Analogous Impairment

The SABS currently state:

(6) For the purpose of clauses (2) (e) and (f), an impairment that is sustained by an insured person but is not listed in the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993 is deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person.

This clause should be retained as is, given the evolving nature of diagnostic understanding and nomenclature.

Need to retain explicit reference to analogous impairments

The Expert Panel incorrectly asserted that the section of the SABS regarding analogous impairments was redundant as the AMA Guides 4 provides for rating of “analogous” impairments. However, the AMA Guides are insufficiently explicit on the issue of rating by analogy. Guides 4, Chapter 1 states:

It should be understood that the Guides does not and cannot provide answers about every type and degree of impairment, because of the considerations noted above and the infinite variety of human disease, and because the field of medicine and medical practice is characterized by



constant change in understanding disease and its manifestations, diagnosis, and treatment. Further, human functioning in everyday life is a highly dynamic process, one that presents a great challenge to those attempting to evaluate impairment.

The physician's judgment and his or her experience, training, skill, and thoroughness in examining the patient and applying the findings to Guides criteria will be factors in estimating the degree of the patient's impairment. These attributes compose part of the "art" of medicine, which, together with a foundation in science, constitute the essence of medical practice. The evaluator should understand that other considerations will also apply, such as the sensitivity, specificity, accuracy, reproducibility, and interpretation of laboratory tests and clinical procedures, and variability among observers' interpretations of the tests and procedures (page 1/3).

This is a matter of great importance as Guides 4 is incomplete regarding the range of injuries and impairments resulting from MVAs. No catastrophically injured claimant should suffer discrimination on the basis that the most accurate diagnosis of their disorder was not identified at the time the Guides was written.

OPA Recommendation: Retain the provision to rate by the most analogous impairment.

Assessment Guidelines

Required compliance with Assessment Guidelines to address concerns re: catastrophic impairment determination

Introduction of a requirement to follow explicit Assessment Guidelines regarding methodology will address the most fundamental problem contributing to poor quality and variability of some assessment results: poor methodology used by some assessors. Required compliance with Assessment Guidelines would make the impairment determination process more scientific, increase reliability of assessment results, increase the confidence of all parties that those with catastrophic impairments are accurately identified, and therefore reduce disputes.

Required compliance by all assessors to Assessment Guidelines would raise the standard, accuracy and usefulness of all catastrophic impairment assessments. Given the small number of accident victims for whom catastrophic impairment determination is required and the complex nature of their injuries, it is reasonable to restrict this work to those assessors who have the required level of expertise and this requirement should not create a lack of access to qualified assessors.

Content of Assessment Guidelines

We provide examples of the type of content that might be included in Assessment Guidelines applicable to all of the criteria (we note that some of the specifics are modeled on the previous Catastrophic Impairment DAC Guidelines and others reflect emerging consensus).

We recommended the following Assessment Guidelines, applicable to all catastrophic impairment definitions:

All health professionals completing Catastrophic Impairment assessments should possess the following attributes and qualifications:



- A member in good standing and holds a current certificate of registration with the appropriate Ontario regulatory college.
- The necessary skills, knowledge, and ability to offer an opinion, considering the issue under consideration, the claimant's individual circumstances, age, impairment, and disability for each claimant assessed.
- A minimum of three years of current, continuing, and relevant practice.
 - Current means practice experience gained within the last seven years.
 - Continuing means the assessor is presently, or within the past five years, engaged in providing assessments either i) directly or ii) in supervising others or providing consultation to others in such provision.
 - Relevant means the assessor is or has been involved in the assessment of patients to identify impairments for the motor vehicle accident injured population.
- Experience working within multidisciplinary teams and with multidisciplinary decision-making.
- Fully conversant with the relevant sections of the SABS, and remains current with relevant arbitration and judicial decisions.
- Experience in generating well-supported and comprehensive assessment reports.
- Demonstrates ability to communicate assessment outcomes in plain language.

It is the responsibility of the health professional (s) to use his/her own clinical judgment in arriving at conclusions and to support these conclusions in a well-documented report.

When multiple assessors are required, a single health professional must assume responsibility for the overall integration of the assessment process and report. Each member of the team shall certify that they have read the exec summary and that it reasonably summarizes the impairments or lack thereof that they have identified (*see Appendix 4: Assessment Guidelines*).

OPA Recommendation: Require compliance with Assessment Guidelines.

Conclusion

Thank you for the opportunity to comment on the proposals for changes to the Catastrophic Impairment criteria.

We have summarized our Key Recommendations at the beginning of this paper. We appreciate that these definitions are necessarily complex and the specific details of the regulations will make significant difference in their application.

We would welcome an opportunity to further discuss the concerns we have raised and the alternative solutions we propose.

Please contact the OPA Auto Insurance Subcommittee c/o:

Dr. Ron Kaplan, Chair
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ron@kaplanpsychologists.com



Appendix 1

Guides 4 Chapter 14, Table: Classification of Impairments Due to Mental Disorders

Guides 4, Chapter 14 Classification of Impairments Due to Mental and Behavioural Disorders					
Area or aspect of functioning	Class 1: No Impairment	Class 2: Mild Impairment	Class 3: Moderate Impairment	Class 4: Marked Impairment	Class 5: Extreme Impairment
<ul style="list-style-type: none">• Activities of daily living• Social functioning• Concentration• Adaptation	No impairment is noted	Impairment levels are compatible with most useful functioning	Impairment levels are compatible with some but not all, useful functioning	Impairment levels significantly impede useful functioning	Impairment levels preclude useful functioning



Appendix 2

Global Assessment of Functioning (GAF) Scale

Consider psychological, social, and occupational functioning on hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code	(Note: Use intermediate codes when appropriate, e.g., 45, 68, 72.)
100	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
91	
90	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally
81	satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
80	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g. difficulty concentrating after family arguments); no more than slight
71	impairment in social, occupational or school functioning (e.g., temporarily falling behind in schoolwork).
70	Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social occupational, or school functioning (e.g., occasional truancy, or theft within the household)
61	but generally functioning pretty well, has some meaningful interpersonal relationships.
60	Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks)
51	OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).
50	Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting)



- 41 | **OR any serious impairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job).
- 40 | **Some impairment in reality testing or communication** (e.g., speech is at times illogical obscured, or irrelevant) **OR major impairment in several areas, such as work, or school,**
- 31 | **family relations, judgment, thinking, or mood** (e.g. depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
- 30 | **Behavior is considerably influenced by delusions or hallucinations OR serious impairment**
- 21 | **in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home, or friends).
- 20 | **Some danger of hurting self or others** (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) **OR occasionally fails to maintain minimal**
- 11 | **hygiene** (e.g., smears feces) **OR gross impairment in communication** (e.g., largely incoherent or mute).
- 10 | **Persistent danger of severely hurting self or others** (e.g., recurrent violence) **OR persistent**
- 1 | **inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**
- 0 | Inadequate information.



Appendix 3

The Clinical Interview Using DSM-IV-TR, Volume 1: Fundamentals (Othmer & Othmer, 1994)

Axis V

You report global assessment of functioning on Axis V. The Global Assessment of Function Scale (GAF) quantifies the clinician's judgment of the severity of symptoms and level of functioning. The worst of the two components must be used for the final score. The authors of DSM-IV-TR propose the inclusion of three further scales. They are: the Social and Occupational Functional Assessment Scale (SOFAS), the Global Assessment of Relational Functioning Scale (GRF), and the Defensive Styles Rating Scale (DSRS). The GAF rating summarizes the clinician's evaluation of only psychological, social, and occupational functioning:

1. Range 1-20 represents the patient who is persistently (1-10) or sometimes dangerous (11-20) and poses a threat to others or to himself, who has severe (-10) self-neglect or commits serious suicidal acts, or who has gross impairment in communication (11-20). Such a patient needs to be committed to a mental institution if voluntary hospitalization cannot be achieved.
2. Range 21-40 represents the patient whose reality testing is severely impaired by delusions or hallucinations (21-30) or several areas such as work, school, family or impaired judgment, thinking, or mood (31-40). Such a patient cannot function without continuous supervision and a continuous support system. He should be treated as a psychiatric inpatient.
3. Range 41-60 represents a patient who has serious, nonpsychotic symptoms that interfere with his time management, such as obsessional rituals; leading to severe avoidance behaviour and panic attacks; and impair (41-50) or interfere (51-60) with social, occupational, or school functioning. Patients with this rating usually need continuous pharmacotherapy and psychotherapy in a partial hospitalization or outpatient setting.
4. Range 61-80 represents a patient who has some mild (61-70) or transient symptoms (71-80), which cause difficulties in social, occupational, or school functioning. If they are transient and expectable reactions to stressors, the higher rating (71-80) is used. These are patients who may require occasional counseling and psychotherapy.
5. Range 81-100 represents a person who shows good functioning in all areas with a wide range of interests and activities and level of social effectiveness. Symptoms are absent or present in everyday occurrences such as examination anxiety (81-90). The highest rating is reserved for the person who manages all life problems successfully and is sought out by others for his positive qualities. Such a person requires no type of counselling

This scale provides a convenient way to measure the patient's psycho-social competence and rounds off the diagnostic assessment.



Appendix 4

Assessment Guidelines

We recommended the following Assessment Guidelines, applicable to all catastrophic impairment definitions:

All health professionals completing Catastrophic Impairment assessments should possess the following attributes and qualifications:

- A member in good standing and holds a current certificate of registration with the appropriate Ontario regulatory college
- The necessary skills, knowledge, and ability to offer an opinion, considering the issue under consideration, the claimant's individual circumstances, age, impairment, and disability for each claimant assessed
- A minimum of three years of current, continuing, and relevant practice
 - Current means practice experience gained within the last seven years
 - Continuing means the assessor is presently, or within the past five years, engaged in providing assessments either i) directly or ii) in supervising others or providing consultation to others in such provision
 - Relevant means the assessor is or has been involved in the assessment of patients to identify impairments for the motor vehicle accident injured population
- Experience working within multidisciplinary teams and with multidisciplinary decision-making
- Fully conversant with the relevant sections of the SABS, and remains current with relevant arbitration and judicial decisions
- Experience in generating well-supported and comprehensive assessment reports
- Demonstrates ability to communicate assessment outcomes in plain language.
- It is the responsibility of the health professional (s) to use his/her own clinical judgment in arriving at conclusions and to support these conclusions in a well-documented report.
- When multiple assessors are required, a single health professional must assume responsibility for the overall integration of the assessment process and report. Each member of the team shall certify that they have read the exec summary and that it reasonably summarizes the impairments or lack thereof that they have identified.

We recommend the following Assessment Guidelines to determine catastrophic impairments due to mental disorders:

In determining whether an Insured has a catastrophic impairment due to mental and behavioural disorder, an evaluator (qualifications as per general guidelines) will follow the explicit method of assessment described in Chapter 14 of the 4th edition of the AMA Guides, utilizing multiple sources of data and a multi-method approach as indicated in the Guides:

- administer and interpret appropriate tests in a professionally correct, standardized manner



- document their data
- address issues of effort, exaggeration and malingering
- provide clear formulations that explain the basis for their diagnoses and impairment ratings.

Should the government opt to include a GAF criteria, we recommend that the GAF only be added to criteria that incorporate a marked impairment according to the AMA Guides 4th edition chapter 14 as follows:

- follow all of the recommendations above
- provide clear formulations that explain the basis for the GAF rating.

We recommended the following Assessment Guidelines to determine impairments according to the 55% WPI definition:

In determining whether an Insured has a catastrophic impairment due to a 55% WPI an evaluator (qualifications as per general guidelines) will follow the explicit method of assessment described in the relevant chapters of the 4th edition of the AMA Guides:

- follow the explicit method of assessment described in the relevant chapter(s) of the Guides, utilizing multiple sources of data and a multi-method approach as indicated in the Guides
- administer and interpret appropriate tests in a professionally correct, standardized manner
- document their data
- address issues of effort, exaggeration and malingering
- provide clear formulations that explain the basis for their diagnoses and impairment ratings.

We recommend that all assessors will be expected to comply with Assessment Guidelines for combining impairment ratings to address potential concerns regarding “double-counting” which would reinforce the following principles:

- Impairments due to mental and behavioural disorders are rated by analogy to Guides 4, Chapter 4, Table 3 or using the California method for conversion of GAF scores to WPI.
- Whole person impairment rating follows the Guides 4 principle of not combining overlapping impairments. The most severe impairment rating among the four chapter 14 classes of impairment is taken to stand for the overall level of impairment due to mental and behavioural disorder
- Where impairment ratings are offered as ranges in the *Guides*, evaluators clearly explain their rationale for choosing a specific rating within a range
- Combining ratings for impairment due to mental and behavioural disorders with ratings for impairment due to physical disorders also follows the Guides 4 principle of not combining overlapping impairments
- Evaluators do not combine impairment ratings due to physical disorders and impairment ratings due mental and behavioural disorders that overlap. Where impairment ratings overlap, assessors follow the Guides principle of taking the higher impairment rating to stand for the impairment.



Appendix 5

Further discussion re: inclusion of psychologists to conduct Catastrophic Impairment assessments and complete Catastrophic Impairment applications

We fully support a requirement that all experts conducting catastrophic impairment examinations and completing applications have appropriate education, training and experience. However, the present SABS restricting the role regarding claimants with mental and behavioural impairments to physicians is arbitrary and without scientific basis, does not accomplish this goal and creates unnecessary barriers.

Psychologists have the education, training and expertise, as well as legal authority, to diagnose the full range of mental and behavioural impairments required to conduct these examinations and complete applications.

These competencies and legal authority are outlined in several documents including the following: Chapter 18, Section 27. (2) of the Regulated Health Professions Act states:

(2) “A controlled act” is any one of the following done with respect to an individual: Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely upon the diagnosis.

The qualifications to conduct these examinations are reflected in the descriptions in the Psychology Act, 1991:

In the course of engaging in the practice of psychology, a member is authorized...to communicate a diagnosis identifying, as the cause of a person’s symptoms, a neuropsychological disorder or a psychologically based psychotic, neurotic or personality disorder.

The practice of psychology is the assessment of behavioral and mental conditions, the diagnosis of neuropsychological disorders and dysfunctions and psychotic, neurotic and personality disorders and dysfunctions and the prevention and treatment of behavioral and mental disorders and dysfunctions and the maintenance and enhancement of physical, intellectual, emotional, social and interpersonal functioning.

Clinical Psychology is defined as:

“the application of knowledge about human behaviour to the assessment, diagnosis and/or treatment of individuals with disorders of behaviour, emotions or thought.”

Clinical Neuropsychology is defined as:



“the application of knowledge about brain-behaviour relationships to the assessment, diagnosis and treatment of individuals with known or suspected central nervous system dysfunction.”

Rehabilitation Psychology is defined as:

“the application of psychological knowledge and skills to the assessment and treatment of individuals with impairment in their physical, emotional, cognitive, social, or occupational capacities as a result of injury, illness or trauma in order to promote maximum functioning and minimize disability.”

As indicated in the above Acts, psychologists have the education, training, expertise and legal authority to conduct the relevant assessments and communicate these diagnoses (further detailed information regarding the specific skills sets and educational and training requirements for registration in the various areas of competence is available on request).

The current restriction to physicians creates a barrier to some claimants with mental disorders for preparation of the most appropriate and accessible expert assessments and applications. This results in delays and barriers for the claimant. Restriction to a very limited group of potential physician experts may also contribute to increased costs to the system. Therefore, the arbitrary restriction to physicians to conduct assessments and make determinations regarding mental and behavioural impairments should be removed and psychologists' ability to function in these roles should be included in the regulations.

There are multiple precedents for inclusion of psychologists in the role of conducting assessments and making determinations regarding mental and behaviour impairments. The expertise of psychologists has been acknowledged in the courts in both Canada and the US. Early confirmation of this expertise and authority was noted in *Jenkins v. United States* in 1962. The issue at hand was whether a psychologist is competent to state professional opinions as an expert witness concerning the nature, and existence or non-existence, of mental disease and defect. The result of this case indicated that the court stated that some psychologists are qualified to render expert testimony on mental disorders. The court further stated that the determination of a psychologist's competence to render an expert opinion based on his findings as to the presence or absence of mental disease or defect must depend upon the nature and extent of his knowledge and not simply on the claim to the title "psychologist."

In addition, in a large number of contexts and jurisdictions, psychologists are relied upon to conduct assessments to diagnose and rate mental and behavioural impairments.



Appendix 6

Combining Table Illustrating Progressive Discounting of Additional Impairments

Combined Values Chart

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39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80									
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41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82									
42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83									
43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84									
44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85									
45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86									
46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87									
47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88									
48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89									
49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90									
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	

The values are derived from the formula $A+B(1-A) = \text{combined}$ value of A and B, where A and B are the decimal equivalents of the impairment ratings. In the chart all values are expressed as percents. To combine any two impairment values, locate the larger of the values on the side of the chart and read along that row until you come to the column indicated by the smaller value at the bottom of the chart. At the intersection of the row and the column is the combined value.

For example, to combine 35% and 20% read down the side of the chart until you come to the larger value, 35%. Then read across the 35% row until you come to the column indicated by 20% at the bottom of the chart. At the intersection of the row and column is the number 48. Therefore, 35% combined with 20% is 48%. Due to the construction of this chart, the larger impairment value must be identified at the side of the chart.

If three or more impairment values are to be combined, select any two and find their combined value as above. Then use that value and the third value to locate the combined value of all. This process can be repeated indefinitely, the final value in each instance being the combination of all the previous values. In each step of this process the larger impairment value must be identified at the side of the chart.

Note: If impairments from two or more organ systems are to be combined to express a whole-person impairment, each must first be expressed as a whole-person impairment percent.



Appendix 7

Guides 4, Chapter 4, Table 3: Emotional or Behavioral Impairments

Guides 4, chapter 4, table 3 Emotional or Behavioral Impairments	
Impairment Description	Percent impairment of the whole person
Mild limitation of daily social and interpersonal functioning	0-14
Moderate limitation of <i>some</i> but not all social and interpersonal daily living functions	15-29
Severe limitation impeding useful action in <i>almost all</i> social and interpersonal daily functions	30-49
Severe <i>limitation of all daily functions</i> requiring total dependence on another person	50-70
Note: Page 4/142 <i>The criteria for evaluating these disturbances (table 3) relate to the criteria for mental and behavioural impairments (chapter 14, page 291).</i>	



Appendix 8

California Method for Conversion of GAF to WPI

California GAF to WPI table from the SCHEDULE FOR RATING PERMANENT DISABILITIES, January 2009: Psychiatric Impairment GAF to WPI Conversion

GAF=WPI	GAF=WPI	GAF=WPI	GAF=WPI	GAF=WPI	GAF=WPI	GAF=WPI
1 = 90	2 = 89	3 = 89	4 = 88	5 = 87	6 = 87	7 = 86
8 = 85	9 = 84	10 = 84	11 = 83	12 = 82	13 = 82	14 = 81
15 = 80	16 = 80	17 = 79	18 = 78	19 = 78	20 = 77	21 = 76
22 = 76	23 = 75	24 = 74	25 = 73	26 = 73	27 = 72	28 = 71
29 = 71	30 = 70	31 = 69	32 = 67	33 = 65	34 = 63	35 = 61
36 = 59	37 = 57	38 = 55	39 = 53	40 = 51	41 = 48	42 = 46
43 = 44	44 = 42	45 = 40	46 = 38	47 = 36	48 = 34	49 = 32
50 = 30	51 = 29	52 = 27	53 = 26	54 = 24	55 = 23	56 = 21
57 = 20	58 = 18	59 = 17	60 = 15	61 = 14	62 = 12	63 = 11
64 = 9	65 = 8	66 = 6	67 = 5	68 = 3	69 = 2	>70 = 0



Appendix 9

Guides 6 GAF/WPI Conversion

Guides 6: GAF / WPI conversion table		
GAF	Description	WPI Impairment Score
91-100	No symptoms; superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities.	0%
81-90	Absent or minimal symptoms (e.g. mild anxiety before an exam); good functioning in all areas, interested and involved in wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g. an occasional argument with family member).	0%
71-80	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g. difficulty concentrating after family arguments); no more than slight impairment in social, occupational, or school functioning (e.g. temporarily falling behind in school work)	0%
61-70	Some mild symptoms (e.g. depressed mood and mild insomnia) or Some difficulty in social, occupational, or school functioning (e.g. occasional truancy or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.	5%
51-60	Moderate symptoms (e.g. flat affect and circumstantial speech, occasional panic attacks) or Moderate difficulty in social, occupational, or school functioning (e.g. few friends, conflicts with coworkers)	10%
41-50	Serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting) or Any serious impairment in social, occupational, or school functions (e.g. no friends, unable to keep job)	15%
31-40	Some impairment in reality testing or communication (e.g. speech is at times illogical, obscure, or irrelevant) or Major impairment in several areas, such as work or school, family relations, judgment thinking, or mood (e.g. depressed adult avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school)	20%
21-30	Behavior is considerably influenced by delusions or hallucinations or Serious impairment in communication or judgment (e.g. sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) or Inability to function in almost all areas (e.g. stays in bed all day; no job, home, or friends)	30%
11-20	Some danger of hurting self or others (e.g. suicide attempts without clear expectation of death, frequently violent, manic excitement) or Occasionally fails to maintain minimal personal hygiene (e.g. smears feces) or Gross impairment in communication (e.g. largely incoherent or mute).	40%
1-10	Persistent danger of severely hurting self or others (e.g. recurrent violence) or Persistent inability to maintain minimal personal hygiene or Serious suicidal act	50%



with clear expectation of death	
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Appendix 10

World Health Organization, Disability Assessment Schedule 2.0

The DSM-5 provides the following regarding the WHODAS2.0:

The adult self-administered version of the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2I.0) is a 36-item measure that assesses disability in adults age 18 years and older. It assesses disability across six domains, including understanding and communicating, getting around, self-care, getting along with people, life activities (i.e., household, work, and/or school activities), and participation in society. If the adult individual is of impaired capacity and unable to complete the form (e.g., a patient with dementia), a knowledgeable informant may complete the proxy-administered version of the measure, which is available at www.psychiatry.org/dsm5. Each item on the self-administered version of the WHODAS 2.0 asks the individual to rate how much difficulty he or she has had in specific areas of functioning during the past 30 days.



Appendix 11

Dr. William Gnam, Letter of endorsement

W. GNAM ASSESSMENTS
Psychiatric, Insurance and Medical/Legal Assessments & Consulting Services

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June 29, 2015

To Whom It May Concern:

My name is Dr. William Gnam. In 2010 the Government of Ontario put together an Expert Panel tasked with making recommendations to update the Catastrophic Injury definition as defined under the Statutory Accident Benefits Schedule. As a Psychiatrist with considerable expertise in the science of clinical decision making and in the assessment of catastrophic disability, I was asked by the Expert Panel to provide professional consultation.

I understand based on the Government of Ontario's recent April 2015 budget that there is a plan to update the catastrophic definition in the near future and that consideration is being given to utilizing the 6th Edition of the American Medical Association Guides to the Evaluation of Permanent Impairment for purposes of quantification for combining mental/behavioural and physical impairments and to utilizing a GAF of 40, a restricted list of diagnoses, and the listed indicia as outlined in the 2010 Expert Panel's submission for a stand-alone mental/behavioural definition for catastrophic impairment.

I have significant concerns that the utilization of the 6th Edition of the Guides and the use of the indicia as proposed by the Expert Panel will result in a lack of equity for individuals with mental disorders. The utilization of Guides 6 for the purposes of quantification for combining physical and mental/behavioural impairments, the GAF of 40 score as outlined in the Expert Panel Report and the examples offered in the Expert Panel's listed indicia set the bar too high. Quite simply, the use of these definitions will result in the clear discrimination of individuals with mental disorders and unfairly limits their access to much needed funding for services.

I was asked by the Ontario Psychological Association to review their submission to you (as dated June 29, 2015). I have carefully reviewed their document and I am in full support of its contents and of their recommended solutions.

Respectfully,

William H. Gnam, PhD, MD, FRCPC
Evaluating Psychiatrist



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Re: The education, training, expertise and authority of psychologists to assess and diagnose mental and behavioural impairments

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The College of Psychologists of Ontario, Appendix B, Definition of Areas of Practice

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