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Got Any Friends?

What To Make Of The New Psychiatric Permanent Disability Rating

The new rules for rating permanent disability for psychiatric patients have been approved. *Out* are the Eight Factors of disability. *In* is a new rating schedule called Global Assessment of Functioning (GAF) which has been adopted by the administrative director. All psychiatric work injuries found to be permanent and stationary as of 01/01/05 are to be rated according to the new method. Not just cases with injury dates after 01/01/05, but all cases that conclude with disability after the first of this year.

I don't know how or why these changes have come about. As a psychology QME, I have been providing reports for rating for the last eight years. Acting in this capacity, I was not aware that there were problems with the eight factor system that were significant enough to necessitate revision or abandonment.

In my view, it is not worth the time speculating on something already decided. The work injury resolution system in California is continually changing. All parties must and will eventually make a successful adjustment to the new system. However, it is worth familiarizing yourself now with the GAF rating system since it will appear on the last page of psychological reports for the foreseeable future. First some history.

History of the GAF

The Diagnostic and Statistical Manual (DSM) is the diagnostic bible for psychiatry and psychology, containing a code number for virtually all mental problems, from alcohol abuse to zoophilia. It is published periodically by the American Psychiatric Association to keep up with the latest research and trends in mental health.

The DSM-III (1980) was the first manual to present the 5 Axis coding system, but not the GAF. Back then, after coding the diagnosis for clinical syndromes (Axis I); personality disorders (Axis II); physical disorders and conditions (III) and psychosocial stressors (IV), the clinician was to indicate his or her judgment of an individual's highest level of adaptive functioning. The clinician picked a number on a 1 - 7 scale, from superior to grossly impaired. Adaptive functioning was conceptualized *as a composite of three major areas: social relations, occupational functioning and use of leisure time.* The three areas were to be considered together, with social functioning given the greatest weight of the three.

The DSM-III-R (1987) introduced the full GAF scale (Figure 1). None of the other five axes were changed significantly. The new scale permitted the clinician to indicate his or her judgment of " a person's psychological, social, and occupational functioning" that assessed "mental health-illness" from 1 to 90. Note that leisure time dropped out, replaced by psychological functioning. *Ratings were to reflect the current need for treatment or care* for two time periods, current and past year.

The DSM-IV (1995) instructions were to rate the same three domains of functioning but suggested that other time periods might be described by the rating, for example, rating at discharge. The GAF score was now described as information "useful in planning treatment and measuring its impact, and in predicting outcome".

The GAF was designed as an assessment tool that could be easily and quickly administered with minimal training. Since its introduction, it has been criticized for its low inter-rater reliability (do two raters arrive at the same score?) and validity (does it measure what it says it measures?). Despite these problems, it's use has grown rapidly. It is now thought to be the most commonly used global assessment instrument for psychiatric patients.

It was clearly not originally intended to be a measure of disability or impairment, but that is how it is now going to be used by treaters and evaluators of workers' compensation cases in California. So, what are the quick and easy instructions one needs to know in order to arrive at a rating?

The GAF rating process as per the DSM-IV

The GAF Scale is to be rated with respect only to psychological, social, and occupational functioning. The instructions specify, "Do not include impairment in functioning due to physical or environmental limitations." The GAF scale is divided into 10 ranges of functioning. Making a GAF rating involves picking a single value that best reflects the individual's overall level of functioning. The description of each 10-point range in the GAF scale has 2 components: the first part covers symptom severity and the second part covers functioning. The GAF rating is within a particular decile if either the symptom severity *or* the level of functioning falls within the range.

It should be noted that in situations where the individual's symptom severity and level of functioning are discordant, the final GAF rating always reflects *the worse of the two.* For example, the GAF rating for an individual who is a significant danger to self but is otherwise functioning well would be below 20. Similarly, the GAF rating for an individual with minimal psychological symptomatology, but significant impairment in functioning *(e.g., an individual who has loss of job and friends, but no other psychopathology) would be 40 or lower.*

Global Assessment of Functioning (GAF) Scale

Consider psychological, social and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental limitations).The GAF score equates to a Whole Person Impairment score. The lower the GAF score, the higher the Whole Person Impairment.

AMA Class 1 No Impairment Noted 0% Whole Person Impairment

Code 91- 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.

Code 81- 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).

Code 71- 80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (temporarily falling behind in schoolwork).

AMA Class 2 Mild Impairment 0 - 14% Whole Person Impairment

Code 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.

AMA Class 3 Moderate Impairment 15 - 29% Whole Person Impairment

Code 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 peers or co-workers).

AMA Class 4 Marked Impairment 30 - 69 % Whole Person Impairment

Code 41-50 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, unable to keep a job).

Code 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 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)

AMA Class 5 Extreme Impairment 70 - 90% Whole Person Impairment

Code 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 pre-occupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home or friends).

Code 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).

Code 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.

After the GAF score is determined, it is translated into a whole person impairment score (WPI). This score then will be modified by age, occupation and projected loss of future earning capacity, but the numbers below reflect approximate dollars for an average case (39 years old, occupation F).

	2004	2005
10%	$8,050.00	$6,655.00
15%	$13,050.00	$11,055.00
20%	$18,050.00	$16,610.00
30%	$29,150.00	$28,820.00
40%	$43,150.00	$44,220.00
50%	$57,200.00	$59,675.00

"Hey Judge, how much do I get?"

The answer to the above question may be $28,820 even if the person only reports that he DOESN'T

HAVE ANY FRIENDS. Check the chart above. Having no friends, according to the instructions for the GAF, is one of the examples of serious social impairment. Remember the instructions for rating are to rate the symptom OR level of functioning, whichever is worse.

There are no *specific* GAF rating instructions to take into account as to whether this is a just a subjective or objective report of "lacking friends". What if the patient is driven to the appointment by someone else; is this a friend or a ride? What if co-workers report that the claimant has many friends but the patient insists he does not? There is no direction about weighting this score if the patient felt that he had no friends for only 1 day vs. the entire last year. If the patient can complete all the duties of his employment without any difficulty, but has no friends, does he still deserve a GAF in the 50's with a WPI of 30%? What if he has no friends because his friends disagreed with his filing of a frivolous claim?

Do you hear anything that others don't hear?

Lets take a look at rating a psychotic symptom on the GAF. A patient claims that he or she hears voices once a week for about one minute at a time, usually when he or she is alone in the house and feeling down. The patient has never been prescribed psychiatric medication and wouldn't want it if it were prescribed, since the side effects might be much worse than the target symptom. She denies that these voices were ever heard before the injury but they happen now, even though she has returned to her usual and customary duties as a supervisor in a circuit board manufacturing plant. They do not interfere with any part of her life. They are an annoyance but result in no impairment. Still, it is a symptom that is worse than any impairment she reports. Therefore she is to be rated on her symptom. Not much permanent disability you say?

Wrong. The instructions from the rating board include just this type of case: The new schedule adopted by the administrative director includes the following:

> **"For example, consider an individual who hears voices that do not influence his behavior (e.g., someone with long-standing Schizophrenia who accepts his hallucinations as part of his illness). If the voices occur relatively infrequently (once a week or less), a rating of 39 or 40 might be most appropriate. In contrast, if the individual hears voices almost continuously, a rating of 31 or 32 would be more appropriate."**

A 39 or 40 GAF rating would equal a WPI of 53 or 51 (without modification) which comes out to just less than $60,000.

Now, of all psychiatric symptoms, the most difficult to verify is the hallucinatory experience. If you say you hear things, I can't prove that you don't. This is why the DSM lists the criteria for each disorder almost exclusively in terms of behavior, not subjective experiences or self-report. I don't know the history of the "Eight Factors", but it is probable that much of the decision to adopt them had to do with limiting subjective reporting in favor of objective data. Those eight factors were observable, measurable, and objective. We now have unobservable, unmeasurable, and subjective symptoms as the basis for permanent disability ratings.

This may seem to be "sky is falling", "chicken-little" thinking. After all, hardly anyone knows about the new GAF system and these cases have not been adjudicated or appealed. Still, anyone who knows the nitty-gritty of worker' comp can see what the future holds. Of all the opinions rendered in an injury case, the most important opinion is the rating that determines the amount of money the claimant is to receive. For psych patients, what used to be eight numbers combined into a rating is now only one number, and the accuracy of how well that one number describes the actual impairment of the individual may provide fuel for many a dispute to come. Keeping in mind that we are trying to move the patient along through the

injury recovery system and not hold them up any more than necessary, how then can we as raters minimize the potential conflicts over GAF scores?

Discussion

Some of the new law changes may help in this regard. There may be fewer med-legal disputes anyway if the intent of the legislature actually plays out in practice. With this may come a reduction in the "us vs. them", defense vs. applicant posturing which reinforced the need for widely divergent opinions about issues of causation and permanent disability.

It is also good to remember that it is consistent with professional ethics and customary practice to include some discussion of any instrument used to measure a psychiatric patient's level of functioning. Evaluators should provide a paragraph or two in their report about the limitations of the GAF, some of which have been generally described in this article. I don't think refusing to use the scale will be very helpful. A better approach is to use the end of the report to instruct and teach adjusters, attorneys and judges who may be encountering the GAF score for the first time. Taking the time to present the new GAF score (binding) alongside the old eight factors scores (non-binding) may help bolster the reasonableness of the final GAF score/rating.

Although the GAF instructions do not include any specifics about taking into account frequency, severity and duration, clinicians should provide this information in order to substantiate their decision-making. For example, if a Mr. Smith has "infrequent suicidal thoughts that are not disruptive of his mood or relationships and they last only minutes at a time", this will help the argument that his suicidal thoughts, though present, equate to only minimal impairment.

Additionally, a very careful discussion of apportionment should be undertaken to discuss the evidence for prior or subsequent impairment. The employer should be held responsible for only the change in GAF that is reasonably attributable to the injury. For example, if Mr. Smith was at 65 (mild symptoms)pre injury and now is 55 (moderate symptoms) after his accident, his 10 point decrease should equate to a percentage somewhere between 0 and 14.

Finally, because of the highly subjective nature of complaints and symptoms, a careful and detailed discussion of the evidence for and against symptom exaggeration, embellishment and malingering must be undertaken by the evaluator. Credibility and secondary gain issues should always be addressed in both treatment and evaluation reports, but these issues are even more important now that GAF is here to stay.