Change • Challenge • Opportunity

Injury & Disability Schemes Seminar

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Meaningful Assessment of Mental Health Conditions – is there a better way?

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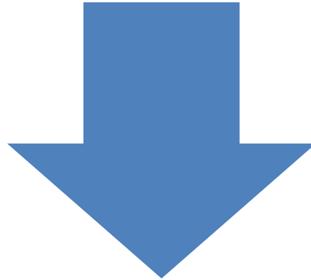
Why is this important?

- Claims for mental health conditions are increasing across all insurance lines, driving increases in claim costs
- Claims for mental health conditions tend to be more costly than for other conditions
- Actuaries Institute's Green Paper looks across all insurance products – including TPD, income protection, travel, private health insurance
- Focus of this presentation is workers compensation and CTP in particular, where RTW is a key goal

- High prevalence – 20 % of people in any 12 month period
- The main cause of long term work incapacity in Australia since 2013
- W/C claims relating to mental stress have ten times longer off work than other claims

Why is this important?

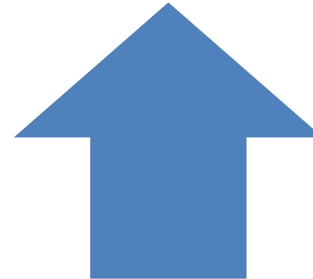


Deal with the claim in a way that is:

- Sensitive
- Effective
- Outcome focused
- Not discriminatory

Rigorously test the claim

- Don't get taken for a ride
- Don't pay out more than we should



So what's the problem?

- Poorer outcomes than for other common conditions
  - Certified unfit for longer than musculo-skeletal
  - Poorer pre-claim mental health – 75%
  - 16% TAC claimants had a pre-existing chronic mental health condition
- Limited access to specialist treatment
- Pre-existing conditions & Co-morbidities
- May be associated with high levels of disadvantage
  - Childhood abuse, Domestic violence
  - Substance abuse
  - Family breakdown; Financial distress

- Insurance underwriting and claims management practices have developed around physical conditions
- Are these models appropriate for mental health conditions?

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What's different about mental health?

At the highest level:	Physical conditions (mostly)	Mental Health conditions (mostly)
Diagnosis	Known symptoms and prognosis	Very broad – huge variation in symptoms, severity and prognosis
	Generally relies on objective signs	Relies on subjectively reported symptoms and clinical judgement
	Diagnosis generally stable	Diagnosis may vary over time
	Generally predictable course	Often fluctuating / unpredictable course
	Good reliability – experts generally agree	Poor reliability – experts may disagree

What's different about mental health?

At the highest level:	Physical conditions (mostly)	Mental Health conditions (mostly)
Treatment	Medical Specialist care	Most often GP managed. (May not refer to diagnostic criteria)
	Evidence-based clinical protocols	Psychology/counselling - various qualifications and approaches, some not evidence-based
	Reasonable compliance	Variable compliance
Cause	Usually known risk factors and aggravators	Blurry – can a work environment or a trauma cause a mental illness?
	Clear distinction between illness and normality	Grey area – what is normal and what is illness?

What's different about mental health?

Attitudes of key stakeholders:

- GP / Psychologist/Psychiatrist may be:
  - Uncertain how duties can be modified to minimise stress / risk of exacerbation
  - Reluctant to certify fitness
  - Likely to expect poor outcomes
- Employers may have:
  - Minimal understanding of condition
  - Uncertainty re how to modify duties or provide support
  - Likely to requite full fitness before RTW
- Claimant may be:
  - Uncertainty about what is best
  - Apprehension about RTW
    - Trust
    - Stigma
  - Fear of exacerbation
  - Potential to avoid / withdraw from participation

Assessment of mental health conditions

Why do we assess?

- **To make claim decisions and prevent claim leakage**
- **To understand claimant's needs and inform claim management**

Assessment – why?

Focus on decisions and prevent claim leakage	
Accept the claim – Liability & Causation	What caused the condition? Are there pre-existing or co-morbid conditions?
Validation of condition	Is the diagnosis confirmed? Is the symptom severity and work capacity confirmed?
Mitigation	Is the treatment evidence-based? Reasonable & Necessary? Is the person complying with treatment plans?
Costs	Progress? Over-servicing? Provider Management issues?
Long term claims	Is incapacity for work confirmed? Are there other contributing factors?

Assessment – why?

Understand claimant needs and claim management
Understand status and prognosis, especially capacity for work
Appropriate triage – understand and address needs
Ensure appropriate treatment / intervention
Understand prognosis - response to treatment
Develop appropriate goals
Appropriate Case Management – don't make things worse! When to intervene and when to get out of the way?

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Typical claim – first step

- Claim Form
  - Description of cause and symptoms
- Medical / Fitness certificate
  - Most often wholly unfit
  - (94% cf 78% for back pain)
- Treating GP or specialist report
- Treatment Plan

How useful is the information typically received?

For Claim Decisions?	CF	Cert	Rpt	Plan
Liability - causation	≈	X	≈	X
Diagnosis and severity - validation	X	X	≈	X
Evidence-based treatment; compliance	X	X	≈	√
Over-servicing, Provider Management	X	X	≈	√
Long term claims/contributing factors	X	X	X	≈
Secondary harm	X	X	X	≈

How useful is the information typically received?

For Claimant Needs?	CF	Cert	Rpt	Plan
Understand status, esp. work capacity	X	√	≈	√
Understand prognosis & expectations re work	X	X	≈	≈
Address claimant's needs	X	≈	√	√
Ensure treatment / intervention	X	≈	√	√
Understand response to treatment	X	X	≈	X
Formulate appropriate goals	X	≈	X	≈
Appropriate Case Management	X	X	≈	≈

Typical claim – next steps

More information from treating practitioners

- Specific questions
- Referrals for provider case management
- Influence treatment

More information from other sources

- Independent medical
- Investigation
- Surveillance

Typical claim – outcome

- Pages of reports
- Differing opinions
- Lack of clarity re
  - Response to treatment;
  - Prognosis & capacity;
  - Appropriate goals and expectations
  - Even diagnosis

Why is it so?

- Reliance on subjective symptoms & clinical judgement
- Variety of treatment approaches with uncertain efficacy
- Narrative-based assessments; opinions

What Assessment Methods are available?

- **Clinical tools to assess symptoms**
  - **Describe the condition and severity**
  - **Inform treatment options**
  - **Measure progress**

- **Methodologies to assess permanent impairment**
  - **Determine eligibility / entitlements**
  - **Distinguish ‘more serious’ from ‘less serious’ conditions**

Various clinical assessment tools are available

Instrument	Description	What does it tell you?	Usefulness?
DASS	21 item self completed – depression and anxiety	Self-perceived symptom frequency	Time / situation dependent?
GAF (DSM4)	Clinician completed – severity score out of 100	Severity of symptoms and impairments	Mild symptoms difficult to discriminate
WHODAS2	36 item self completed – all MH conditions (DSM5)	Functional difficulties experienced in 6 life domains	More comprehensive scoring
BPRS	24 item clinician completed symptom ranking	Symptom severity	Psychiatrists only?
Orebro	Pain / psychological impact	Yellow flags	Predicts secondary psych
Duration predictors	Risk factor & co-morbidity assessment	Predicted prognosis / poor recovery	Based on claims data – regressive?

How often do you get these?

- Baseline measures to understand needs?
- Follow-up measures to assess progress and response to treatment?
- Targets to inform goal setting and decision making?

- Rely on narrative 'Updates' and 'Progress Reports'
- May be minimal information on progress
- Maybe minimal information on goals, barriers, risk factors,

Permanent Impairment

- Thresholds
  - for continued entitlements
  - for lump sum
  - for legal costs

Requires:

- Stability
- Severity
- Permanence
- 'Scoring' relative to other cases

Various methods used to assess impairment

Instrument	Description	What does it tell you?
PIRS	Prescribed methodology	"Degree of permanent impairment" (%)
GEPIC	Prescribed methodology	"Severity of disability"? (Class = range of %s)
ISV	Range of scores for prescribed conditions with examples of what gets a higher score	"Severity of disability" based on GEPIC
Narrative Test	Whether considered a 'serious injury'	Impact on life
% worst case	How individual case compares to others	Ranking against other cases

PIRS

- Present for a period of time, static and well stabilised
- Unlikely to change by >3% in the next year with or without treatment
- Assesses extent/significance of dysfunction in each domain
- Essentially measures disability

- **DOMAINS:**
- Self-care & personal hygiene
- Social & recreational activities
- Travel
- Social functioning
- Concentration, persistence & pace
- Adaptation
- **SCORE:**
- 1-5 in each domain
- Takes median and aggregate score into account to derive % impaired

PIRS

Class	Social & Recreational	Adaptation
1. No deficit	Able to go out regularly to cinemas, restaurants or other recreational venue. Belongs to clubs or associations and is actively involved with these.	Able to work full time. Duties & performance consistent with education and training. Able to cope with normal demands of a job
2. Mild impairment	**Able to occasionally go out to social events without needing a support person**, but does not become actively involved eg dancing, cheering on team	**Able to work full time in a different environment** requiring comparable skill and intellect. **Can work in same position but no more than 20 hpw** e.g. no longer happy to work with specific persons, in specific location
3. Moderate impairment	Rarely goes to social events, and mostly when prompted by family or close friend. Unable to go out without a support person. Not actively involved, remains quiet and withdrawn	Cannot work at all in previous position. Can perform less than 20 hpw in different position which requires less skill or is qualitatively different eg less stressful
4. Severe impairment	Never leaves place of residence. Tolerates the company of family member or close friend, but will go to a different room or garden when others visit family or flat mate	Cannot work more than one or two days at a time, less than 20 hours per fortnight. Pace is reduced, attention is erratic
5. Totally impaired	Cannot tolerate living with anybody, extremely uncomfortable when visited by close family	Totally impaired. Cannot work at all

PIRS scoring

- Median class (rounded up): 1 – 5
- Aggregate – sum of classes: 6 – 30
- Read % impairment off table
- No leeway
- Threshold for NEL = >10%

Table 7.7: Conversion Table

	Aggregate score																								
	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
Class 1	0	0	1	1	2	2	2	3	3																
Class 2				4	5	5	6	7	7	8	9	9	10												
Class 3								11	13	15	17	19	22	24	26	28	30								
Class 4												31	34	37	41	44	47	50	54	57	60				
Class 5																61	65	70	74	78	83	87	91	96	100

Examples:

- mostly mild impairment but severe in one domain: 1 1 2 2 2 4
  median = 2 aggregate = 12
  Impairment = 6%
- moderate impairment in 3 domains:
  1 1 2 3 3 3
  median = 3 aggregate = 13
  Impairment = 11%
- at least moderate impairment in all domains: 3 3 3 3 4 4
  median = 3 aggregate = 20
  Impairment = 26%

GEPIC

- Based on AMA2
- static and well stabilised with or without treatment and is not likely to remit despite future treatment
- Assesses significance of dysfunction in each domain
- Specifically excludes 'impairment to 'ability' (ADL) or 'potential (rehab/treatment)

- **DOMAINS:**
- Intelligence
- Thinking
- Perception
- Judgement
- Affect
- Behaviour
- **SCORE:**
- 1-5 in each domain
- Takes median score

GEPIC

Class	Perception	Judgement
1. Normal to slight: 0 – 5%	Transient heightened, dulled or blunted perceptions of the internal or external world, with little or no interference of function	May lack some insight and misconstrue situations but with little interference with function
2. Mild impairment 10 – 20%	Persistent heightened, dulled or blunted perceptions of the internal or external world, with mild but noticeable interference of function	Persistently misjudges situations (relationships, occupational settings, driving, finances) – noticed by others but accommodated
3. Moderate impairment 25 – 50%	Presence of hallucinations ; obvious illusions	Misjudges family, work & social situations repeatedly leading to some disruption in relationships, occupational settings, living circumstances & financial reliability
4. Moderately Severe Impairment 55 – 75%	Hallucinations and /or illusions that cause subjective distress and disturbed behaviour	Regular failure to evaluate situations or implications, causing actual risk or harm to self or others; failure to respond to guidance; requirement for constant supervision
5. Severe Impairment >75%	As above, to the extent that constant supervision is required	Persistently assaultive due to misinterpretation of the behaviour or motives of others; sexually disinhibited

GEPIC scoring

- Take the median class
- Determine where in the range the impairment lies, using clinical judgement and taking account of the number and severity of symptoms

	Low range	Mid range	High range
Class One	0–1%	2–3%	4–5%
Class Two	10–12%	14–16%	18–20%
Class Three	25–30%	35–40%	45–50%
Class Four	55–60%	65–70%	70–75%
Class Five	75–80%	85–90%	95–100%

- If the median is not a whole number, use low range of the next class
- "Serious Injury" = 30% impairment

Examples:

- mostly mild impairment but severe in one domain: 1 1 2 2 2 4
  median = 2
  Impairment = 10 – 20%

- moderate impairment in 3 domains:
  1 1 2 3 3 3
  median = 2.5
  Impairment = 25 – 30%

- At least moderate impairment in all domains: 3 3 3 3 4 4
  median = 3
  Impairment = 35 - 50%

Criticisms

- No scientific basis
- Poor inter-rater reliability
- Questionable validity
- Middle-class norms?
- Fluctuating course of many mental health conditions?
- Amenable to ‘coaching’?
- But – effective and stable over time -

Is there a better way?

Is there a better way?

Guiding principles for assessment:

What is the purpose of the information?	
Assistance	**Entitlements**
Progressive, ongoing , flexible	Evaluation at a decision-point
Assessment through treatment and rehabilitation	One-off evaluation against a standard
Close collaboration with treaters with possible peer review	Independent but taking account of treaters reports

Classification of mental health conditions

- Current approach not useful – does not indicate appropriate treatment pathways
- ‘As diagnoses are made at non-specific time points along complex illness pathways …they often **relate poorly to the actual stage of illness.**
- ‘There is a wealth of evidence indicating that patients at different points along the (mental) illness continuum ... show quite different patterns of response to various interventions.
- **‘Persistence or recurrence of symptoms appears to have greater predictive significance than cross-sectional observation of specific symptoms**

*Hickie, McGorry, Glozier et al BMC Medicine 2013, **11**:125
http://www.biomedcentral.com/1741-7015/11/125

‘Clinical Staging’ approach to classification

- in oncology, coronary & inflammatory diseases “it is totally inadequate to choose treatments or plan health care …simply on the basis of a broad diagnostic category…
- ‘Staging’ approach imported from general medicine
- A general framework for clinical staging of mood and psychotic disorders:
- Encourages more active health care for those at lower levels of illness
- Takes account of response to treatment

Stage	Descriptor
1a	Help-seeking subjects with symptoms
1b	Attenuated syndromes
2	Discrete disorders (not necessarily DSM or ICD)
3	Recurrent or persistent disorder
4	Severe, persistent and unremitting illness

“Independent assessment”?

- Repetition of the history is not useful
  - Who wants this? Self-fulfilling prophecy?
- Assessment in the absence of full details from treaters is not useful
- Keep independent assessments to a minimum
  - Agreed timeframes for milestone reviews
  - Assess against individually defined goals
- Expert neutral evaluation/Joint Assessments

Expert Neutral Evaluation?

- Ideally chosen from approved panel
  - Both sides agree
  - Reporting standards – impartial and evidence based
- Ideally can involve psychologist or rehab case manager too – provide questions to be answered?
  - Will be useful for the assessor and less difficult for the claimant
- Questions to be answered can be suggested by either and known to both sides

To inform claim management:

- Risk-based segmentation
  - use known predictors for triage & monitoring
- Expectation Management:
  - For claimants and treaters
- Clear Objectives
  - health benefits of good work
  - early establishment of appropriate goals
- Assessment through treatment and rehabilitation
  - Collaborative milestone reviews
  - Assessment against agreed goals

Collaboration with Providers

- Start on the right foot – introductory letter
  - Roles and Expectations
- Expect vocational planning from treating psychologists
- Ensure Rehab Case Managers have appropriate skills & experience – ask for the senior / psych qualified
- Regular contact
  - Collaborative goal setting – realistic goals!
  - Insurance contact person also needs appropriate skills & experience
- **Difficult cases require expertise, time and care**

Best practice claim management*

- Customer-centred processes
- Procedures, documents, communications – focused on the customer experience
- Collaboration with stakeholders – to ensure consistent support mechanisms for the person on claim
- Right support / intervention – using a biopsychosocial approach to understand the person on claim and implement tailored support
- Outcome-focused decision-making – process supports an outcome-focused strategy

* SuperFriend (2015) Taking Action – A Best Practice Framework for the Management of Psychological Claims

Case Management Tools

- Appropriate personality, skills, training, support and mentoring
- Access to expert advice
- Risk assessment tools, Duration predictors
- Milestone setting – guidelines for collaborative planning and decision making
- Instant view of chronology

Holistic Approach to Assessment

DON'T:

- Require frequent repetition of the history
- Arrange unnecessary IME's
- Set appointments without discussion re timing, purpose, questions to be asked
- Rely solely on impairment assessments

DO:

- Strive to understand person's changing situation
- Build trust with treaters
- Manage expectations – process and outcomes
- Start planning early
- Agree on assessment timing and approach
- Assess against specified goals and abilities

Conclusion

- Appropriate risk-based triage and monitoring is essential
- Genuine engagement with treaters is essential
- Collaboration is essential
  - planning goals, milestones and appropriate timing and method of assessment
- More relevant diagnostic and assessment criteria:
  - Assessment against specified goals / abilities
  - Clinical Staging?

- Some claims will be costly and prolonged – but not all
- Investment in the right tools and expertise is worth it

QUESTIONS?

WHAT DO YOU THINK?