Discovering The Elusive CAT for Post June 1/16 MVAs: Shining a light

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RTW Integrated Health Management/
Rehabilitation Research, Education & Evaluation Services
Dr. Salmon Bio Sketch

- Masters Vocational Rehabilitation – Michigan State U (MSU)
- Doctorate, Rehab Psych, Clinical/Counselling, Neuropsychology – MSU
- Author – “Recovery from Whiplash, Concussion and mTBI”, Rehab. Outcome Measurement System & tests, numerous scientific articles, chapters, rehab educational resources
- FSCO CAT DAC Development Committee Member – Chair, Mental/Behavioural Subcommittee; Member, GOS Subcommittee
- Consultant to Minister of Finance’s DAC Committee
- FSCO REC DAC Committee member
- Assoc. Canadian Vice President, Association for Scientific Advancement in Psychological Injury and Law
- Board of Directors/Advisor, Ontario Rehab Alliance
- Senior lecturer CMCC AMA Guides/CAT Certification – Mental/Behav., GOS, GCS
- Co-Chair, Interdisciplinary IE/Rehabilitation Certification Development Committee
- Opinions fully supported by landmark Ont. Court of Appeal decisions: Liu (GCS), Pastore (1 Marked, Chronic Pain)
DISCOVERING THE ‘CAT’
More challenging under the new SAB...
Current CAT Brain Injury Criteria

- GCS (<10) within “reasonable time” by appropriately trained personnel
- GOS calls for loss of independence
- WPI rating under Chapter 4 (Neurology)
- Also rated under Mental and Behavioural Disorders Chapter 14 of AMA Guides
Glasgow Outcome Scale (GOS)

- **Level 1:** Death
- **Level 2:** *Persistent Vegetative State*
- **Level 3:** *Severe Disability* - dependent; *often institutionalized*
- **Level 4:** Moderate Disability - disabled but independent
- **Level 5:** Good Recovery - not necessarily working
## GOS Revised – Comparison Chart

### GOS definitions.doc

S Comparison Table: The 1981 article on the right in the table below provides more detailed descriptions of the categories and was written by the same authors as the first, as a means to clarify the meaning and operationalization of the respective GOS levels (Death/vegetative state omitted below).

<table>
<thead>
<tr>
<th>GOS Reference</th>
<th>For Further Clarification Purposes Only</th>
</tr>
</thead>
</table>

- **Severe Disability:** This is used to describe patients who are dependent for daily activities due to a severe combination of mental and physical disabilities.
- **Moderate Disability:** These patients are independent but disabled, able to look after themselves at home, travel by public transport, and participate in social activities. However, some previous activities, either at work or in social life, are now no longer possible by reason of either physical or mental disability. Some patients in this category are able to return to certain kinds of work, even to their own job, if this happens not to involve a high level of performance in the area of their major deficit.
- **Good Recovery:** This indicates the capacity to resume normal occupational and social activities, although there may be minor physical or mental deficits. However, for various reasons, the patient may not have resumed all his previous activities, and in particular may not be working.

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#### Severe Disability:

This is used to describe patients who are dependent for daily activities by reason of mental or physical disability, usually a combination of both. They will be in a wheelchair, or in a bed. Exceptional family efforts may enable such patients to be looked after at home. An assessment is to recognize that severe mental disability may occasionally present in a patient with little or no physical disability.

- **Severe Disability (conscious but disabled):** This is used to describe patients who are dependent for daily support by reason of mental or physical disability, usually a combination of both. They will be in a wheelchair, or in a bed. Exceptional family efforts may enable such patients to be looked after at home. An assessment is to recognize that severe mental disability may occasionally present in a patient with little or no physical disability.

- **Severe Disability:** This indicates that a patient is conscious but needs the assistance of another person from some activities of daily living every day. This may range from continuous total dependency (for feeding and washing) to the need for assistance with only one activity – such as dressing, getting out of bed, or moving about the house, or going outside to a shop. Moderate disability is less easily described category of survivor. Such a patient is able to look after himself at home, to get out and about to the shops and to travel by public transport. However, some previous activities, either at work or in social life, are now no longer possible by reason of either physical or mental disability. Some patients in this category are able to return to certain kinds of work, even to their own job, if this happens not to involve a high level of performance in the area of their major deficit.

- **Severe Disability:** This indicates the capacity to resume normal occupational and social activities, although there may be minor physical or mental deficits. However, for various reasons, the patient may not have resumed all his previous activities, and in particular may not be working.

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#### Moderate Disability:

- **Moderate Disability:** These patients may be summarized as “independent but disabled,” but it is perhaps the least easily described category of survivor. Such a patient is able to look after himself at home, to get out and about to the shops and to travel by public transport. However, some previous activities, either at work or in social life, are now no longer possible by reason of either physical or mental disability. Some patients in this category are able to return to certain kinds of work, even to their own job, if this happens not to involve a high level of performance in the area of their major deficit.

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#### Good Recovery:

- **Good Recovery:** This implies resumption of normal life, even though there may be minor neurological and psychological defects. Return to work is regarded as an index of recovery, because it may lead to false impressions in other directions. Local socioeconomic circumstances may make it difficult for anyone who has been seriously ill to return to work, even though fully recovered. On the other hand, some patients with considerable disability may be fully employed, either because their work is compatible with their particular disability, or because their employers are showing generosity by providing what really represents sheltered employment. Other aspects of social outcome should be included in the assessment, such as leisure activities and family relationships.

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December 16 | Dr. Salmon - CAT Training | www.SynergyIntegratedAssessments.com
Reconciling Original and 1981 Revised GOS Criteria

- Review of both
- DACs held consensus around using revised GOS
- Loss of DACs, potential argument against maintaining revised GOS
  - Loss community consensus (DACs)
  - Despite elapsed time, no case law to date
  - Intuitive sentiment, new version “too liberal” (for CAT)
  - Many IE assessors unaware of revised GOS
A Hybrid Approach

“It’s a hybrid. It runs on Mom or Dad.”
A Hybrid Approach

- Pragmatic operationalization of “independent functioning” and broad life impact
- Literal “any” daily assistance too liberal (e.g. daily assistance with socks, due to mild hemiparesis)
- Key sole independent functional losses would appropriately meet criteria
Arguable qualifying single ADL daily functions if brain impairment related:

- Inability to initiate/maintain/integrate Daily Routine
- 24 hour safety concerns e.g. re cigarettes, emergency responsiveness
- Daily financial transactions (banking not daily)
- Independent parenting
Other Examples

- Seizure disorder – mother of infant, remote rural: lost licence, unable bath/carry child, even though Sz about 1-2/month – IE agreed

- Seizure disorder – poorly controlled unable to take TTC, drive, leave home beyond 10 mins
June 2016 GOS New Definition

June 2016 GOS New Definition
The Glasgow Outcome Scale (GOS) is a global scale for functional outcome that rates patient status into one of five categories: Dead, Vegetative State, Severe Disability, Moderate Disability or Good Recovery. The Extended GOS (GOSE) provides more detailed categorization into eight categories by subdividing the categories of severe disability, moderate disability and good recovery into a lower and upper category:

Table 1: Extended Glasgow Outcome Scale (GOSE)

<table>
<thead>
<tr>
<th>GOS LEVEL</th>
<th>Time Criterion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Death</td>
</tr>
<tr>
<td>2</td>
<td>Vegetative state</td>
</tr>
<tr>
<td>3</td>
<td>Lower severe disability</td>
</tr>
<tr>
<td>4</td>
<td>Upper severe disability</td>
</tr>
<tr>
<td>5</td>
<td>Lower moderate disability</td>
</tr>
<tr>
<td>6</td>
<td>Upper moderate disability</td>
</tr>
<tr>
<td>7</td>
<td>Lower good recovery</td>
</tr>
<tr>
<td>8</td>
<td>Upper good recovery</td>
</tr>
</tbody>
</table>
Table 1.

Glasgow Outcome Scale (GOS) and Extended Glasgow Outcome Scale (GOSE)

<table>
<thead>
<tr>
<th>Category</th>
<th>Key definition</th>
<th>Key criteria</th>
<th>Category</th>
<th>Key criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good recovery (GR)</td>
<td>A patient is capable of resuming normal occupational and social activities with or without minor physical or mental deficits</td>
<td>1. Returns to work at the same level of performance as pre-injury and 2. Resumes at least more than half of the pre-injury level of social and leisure activities</td>
<td>Upper (GR+)</td>
<td>Returns to normal life with no current problems related to the head injury that affect daily life</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lower (GR−)</td>
<td>1. Returns to pre-injury normal life, but has minor problems that affect daily life and/or 2. Resumes more than half the pre-injury level of social and leisure activities and/or 3. Disruption is infrequent (less than weekly)</td>
</tr>
</tbody>
</table>

### Table 1.

Glasgow Outcome Scale (GOS) and Extended Glasgow Outcome Scale (GOSE)

<table>
<thead>
<tr>
<th>Category</th>
<th>Key definition</th>
<th>Key criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe disability (SD)</td>
<td>A patient is conscious but needs the assistance of another person for some activities of daily living every day</td>
<td>1. Requires the help of someone to be around at home with activities of daily living and/or 2. Unable to travel or go shopping without assistance</td>
</tr>
</tbody>
</table>

From: [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2943940/table/T1/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2943940/table/T1/)


doi: 10.1089/neu.2010.1293
# Table 1.
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<th>Key definition</th>
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<th>Key criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate disability (MD)</td>
<td>A patient is fully independent but disabled</td>
<td>1. Work capacity is reduced or unable to work</td>
<td>Upper</td>
<td>Work capacity is reduced</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and/or</td>
<td>Lower</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Resumes less than half the</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>pre-injury level of social and leisure activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe (SD)</td>
<td>A patient is conscious but needs the assistance of another person for some daily activities every day</td>
<td>1. Requires the help of someone to be around at home with activities of daily living</td>
<td>Upper</td>
<td>Can be left alone at least 8 h during the day, but unable to travel and/or go shopping without</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lower</td>
<td></td>
</tr>
</tbody>
</table>

From: [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2943940/table/T1/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2943940/table/T1/)
POST DISCHARGE STRUCTURED INTERVIEW FOR GOSE

Respondent: 0 = Patient alone  1 = Relative/friend/caretaker alone  2 = Patient plus relative/friend/caretaker

Consciousness:

1. Is the head-injured person able to obey simple commands or say any words?
   - Yes
   - No (VS)

Note: anyone who shows the ability to obey even simple commands or utter any word or communicate specifically in any other way is no longer considered to be in vegetative state. Eye movements are not reliable evidence of meaningful responsiveness. Corroboration with nursing staff and/or other caretakers. Confirmation of VS requires full assessment.

Issue: Currently GOS based on neuropsych and OT In Home – this precludes both; will IEs abandon?
### Independence at home:

**2a. Is the assistance of another person at home essential every day for some activities of daily living?**
- [ ] Yes
- [ ] No (VS) **If no: go to 3**

Note: For a NO answer they should be able to look after themselves at home for 24 hours if necessary, though they need not actually look after themselves. Independence includes the ability to plan for and carry out the following activities: getting washed, putting on clean clothes without prompting, preparing food for themselves, dealing with callers and handling minor domestic crises. The person should be able to carry out activities without needing prompting or reminding and should be capable of being left alone overnight.

**2b. Do they need frequent help of someone to be around at home most of the time?**
- [ ] Yes (lower SD)
- [ ] No (upper SD)

Note: For a NO answer they should be able to look after themselves at home up to eight hours during the day if necessary, though they need not actually look after themselves.

**2c. Was the patient independent at home before the injury?**
- [ ] Yes
- [ ] No
Independence outside home:

3a. Are they able to shop without assistance?
   - Yes
   - No (upper SD)

Note: This includes being able to plan what to buy, take care of money themselves and behave appropriately in public. They need not normally shop, but must be able to do so.

3b. Were they able to shop without assistance before?
   - Yes
   - No

4a. Are they able to travel locally without assistance?
   - Yes
   - No (upper SD)

Note: They may drive or use public transport to get around. Ability to use a taxi is sufficient, provided the person can phone for it themselves and instruct the driver.

4b. Were they able to travel locally without assistance before the injury?
   - Yes
   - No
Work:

5a. Are they currently able to work (or look after others at home) to their previous capacity?
   - Yes
   - If yes, go to 6
   - No

5b. How restricted are they?
   - a. Reduced work capacity?
   - b. Able to work only in a sheltered workshop or non-competitive job or currently unable to work?
     - a. (Upper MD)
     - b. (Lower MD)

5c. Does the level of restriction represent a change in respect to the pre-trauma situation?
   - Yes
   - No
Social and Leisure activities:

6a. Are they able to resume regular social and leisure activities outside home?

- Yes  If yes, go to 7  - No

Note: they need not have resumed all their previous leisure activities, but should not be prevented by physical or mental impairment. If they have stopped the majority of activities because of loss of interest or motivation, then this is also considered a disability.

6b. What is the extent of restriction on their social and leisure activities?

   a. Participate a bit less: at least half as often as before injury  - a. (Lower GR)
   b. Participate much less: less than half as often  - b. (Upper MD)
   c. Unable to participate: rarely, if ever, take part  - c. (Lower MD)

6c. Does the extent of restriction in regular social and leisure activities outside home represent a change in respect or pre-trauma

- Yes  - No
### Family and friendships:

7a. Has there been family or friendship disruption due to psychological problems?

- [ ] Yes
- [ ] No  If no, go to 8

Note: typical post-traumatic personality changes are: quick temper, irritability, anxiety, insensitivity to others, mood swings, depression and unreasonable or childish behaviour.

7b. What has been the extent of disruption or strain?

- a. Occasional - less than weekly
  - [ ] (Lower GR)
- b. Frequent - once a week or more, but not tolerable
  - [ ] (Upper MD)
- c. Constant - daily and intolerable
  - [ ] (Lower MD)

7c. Does the level of disruption or strain represent a change in respect to pre-trauma situation?

- [ ] Yes
- [ ] No

Note: if there were some problems before injury, but these have become markedly worse since the injury then answer yes to question
Return to normal life:

8a. Are there any other current problems relating to the injury which affect daily life?
   ○ Yes (Lower GR) ○ No (Upper GR)

Note: other typical problems reported after head injury: headaches, dizziness, sensitivity to noise or light, slowness, memory failures and concentration problems.

8b. If similar problems were present before the injury, have these become markedly worse?
   ○ Yes ○ No

9. What is the most important factor in outcome?
   ○ a. Effects of head injury
   ○ b. Effects of illness or injury to another part of the body
   ○ c. A mixture of these

Note: extended GOS grades are shown beside responses on the CRF. The overall rating is based on the lowest outcome category indicated. Areas in which there has been no change with respect to the pre-trauma situation are ignored when the overall rating is made.
Prerequisite for Adults

Positive (Confirmatory) findings on:
CT, MRI, “other medically recognized brain diagnostic technology indicating [MVA related] intracranial pathology...including, but not limited to, intracranial contusions or haemorrhages, diffuse axonal injury, cerebral edema, midline shift or pneumocephaly”
Event Related Potential (ERP) with Quantitative EEG (QEEG)

Normal Brain Injury
3-D SPECT (Single-photon emission computed tomography)

Normal

Brain Injury
Diffuse Tensor Imaging (DTI MRI)
2016 CAT TBI Criteria Issues

Which of these imaging technologies will be accepted:

- MRI - yes
- ERP/QEEG – in US, EEG accepted and QEEG contingent on EEG
- 3-D SPECT (gamma rays) – but much skepticism in Canada given very poor regular SPECT experience for TBI
- DTI MRI – Passed Daubert/Frye in US but medical resistance in Ontario (research focus)
Chapter 14: Mental/Behavioural Current Status

- Chapter 14 is *functional limitation* requiring robust OT assessments
- Applies to TBI as well as psych conditions
- Desbiens decision made Mental/Behavioural ratings additive to physical towards 55% (but means remains ambiguous)
2016 CAT Mental/Behavioural


- TBI still rateable chapter 14 AMA 4th ed (but 3 Marked need)
DSM IV vs DSM 5
Landis and Koch (1977): Controversial Inter-rater kappa interpretation

- 0 none
- 0–0.20 slight
- 0.21–0.40 **fair**
- 0.41–0.60 **as moderate**
- 0.61–0.80 as substantial
- 0.81–1 as almost perfect

Many consider fair/moderate interpretations as overly generous
Clinicain Agreement on DSM-5 diagnoses from field trials

Clinician Agreement on DSM-5 diagnoses from field trials

Mental and Behavioural Disorders
CAT Criteria/Severity

- **Class 1:** No impairment
- **Class 2:** Mild: impairment compatible with *most* useful function
- **Class 3:** Moderate: impairment compatible with *some* but not all, useful function
- **Class 4:** *Marked:* impairment *significantly* impedes useful function
- **Class 5:** *Extreme:* impairment *precludes* useful function
Areas of Assessment

- ADL
- Social functioning
- Concentration, persistence, pace
- Deterioration in work like setting
- Each domain & overall evaluated from “no” to “extreme” impairment
Stability

- **Stability:**
  - *AMA Guides:* Impairment duration of at least 12 months following course of *appropriate* treatment; necessitates treating clinician contact at times

- **SABS:** Pre Oct/03: 3 years post MVA
- **SABS:** Post Oct/03: 2 years post MVA
- **SABS:** Post June 1/16: 2 years post MVA
Assessment Components

- Review of documented history
- Psychometrics: Psych diagnostics plus abbreviated neuropsych/cognitive tests
- In-Home ADL evaluation
- Multiday Situational Work Assessment: social, concentration, work adaptation
Adaptation: Deterioration in work-like setting (Situational)

- Failures to adapt to stressful circumstances
- Problems with: decisions, attendance, task completion, interactions, schedules
- Withdrawal from situation
- Signs/symptoms elevated
- Deterioration in other 3 domains
Evolution of Required Domains to Meet CAT

- J. Spiegel (Desbiens) initially suggested 1 domain; but didn’t rule on this

- Pastore and AVIVA (FSCO A04-002496, Feb. 2009) Decision:
  
  "If an individual has reached a marked level of impairment in any one area, then they are being deprived of a level of function in a basic and core area of life. This amounts to a serious loss. It is highly unlikely that in such a case the other areas of function would not also be negatively affected in some way. Given the importance of each area of function the loss of any one alone is significant and adequate to meet the definition of catastrophic impairment. To accept that one marked impairment is adequate is in line with a remedial approach to the Schedule."
Pastore: One Domain cont…

- One domain supported in Pastore Appeal (Dec. 2009)

- “Overall assessment of marked impairment”
  Pastore Divisional Court Review, 2011 (ONSC 2164)

- One domain supported in Pastore Ontario Court of Appeal, 2012 (ONCA 642)
“My arm hurts.”
Pastore: 1st Addressing Pain Disorder

- Pastore and AVIVA (FSCO A04-002496, Feb. 2009) Decision:

- I was involved DAC psychologist.

“I agree with the principle enunciated in both McMichael and Belair and Ms. G and Pilot that it is important to deal with a person as a whole and not a mere list of quantifiable impairments. In doing so, it is necessary to take a step back to get a sense of the full picture of a person’s impairments individually as well as how they interact with each other – the affect of pain is part of this picture. Therefore, a complete assessment must consider the affect of pain and Ms. Pastore’s Pain Disorder on her activities of daily living.”
Desbiens v. Mordini
2004 CanLII 41166 (ON S.C.)

- 1st case to support combining physical and mental/behavioural impairments for 55% WPI, in context of controversy over CAT status for individual with pre-morbid paraplegia
Deebiens: Ontario Court of Appeal

- Overturns Kusnierz, generally citing same principles as J. Speigel in Desbiens (Nov /11)

- This is current state of case law i.e. Desbiens is applicable
Translating Psych to WPI %

"Numbers don’t lie. That’s where we come in."
Desbiens Rating Methodologies

-Desbiens methodology (page width)
Desbiens Rating Methodologies

- Case law remains non-definitive:
  - 4th Edition – Chapter 4 by analogy (Desbiens sited)
  - 2nd Edition – Leads to high ratings (Desbiens sited)
  - California – Commonly used, not Desbiens sited, appropriately criticized
2016 Combined ratings:
Seems only insurers were invited…

WE’RE HAVING A FOCUS GROUP TO TEST WHICH QUESTIONS TO ASK IN OUR NEXT FOCUS GROUP.
2016 CAT Mental/Behavioural


- Appears TBI still rateable chapter 14 AMA 4th ed (but 3 Marked need)
New CAT Mental/Behavioural Criteria

7. mental or behavioural impairment, excluding traumatic brain injury, determined in accordance with the rating methodology in Chapter 14, Section 14.6 of the American Medical Association’s *Guides to the Evaluation of Permanent Impairment, 6th edition*, 2008, that, when the impairment score is combined with a physical impairment described in paragraph 6 in accordance with the combining requirements set out in the Combined Values Table of the American Medical Association’s *Guides to the Evaluation of Permanent Impairment, 4th edition*, 1993, results in 55 percent or more impairment of the whole person.

8. ...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) in three or more areas of function that precludes useful functioning or a class 5 impairment (extreme impairment) in one or more areas of function that precludes useful functioning, due to mental or behavioural disorder.

Overturns Pastore (OCA) re requiring only 1 Marked Impairment
2016 CAT Mental/Behavioural

- 6th Edition – max 50% vs 70% WPI now
  - Chronic pain, substance use/dependence not ratable

- Overturns Pastore (OCA-Salmon):
  - 3 vs 1 Marked Impairment will be required in 4th Ed
  - Chronic pain not ratable in 6th, but appears still in 4th
6th Edition AMA Guides CHAPTER 14

Mental and Behavioral Disorders
Impairment rating in the Sixth Edition will be limited to 1 of the following diagnoses:

- **Mood** disorders, including major depressive disorder and bipolar affective disorder.
- **Anxiety** disorders, including generalized anxiety disorder, panic disorder, phobias, posttraumatic stress disorder, and obsessive compulsive disorder.
- **Psychotic** disorders, including schizophrenia.
Disorders that are *not* ratable in this chapter include:

**Psychiatric reaction to pain:** It is inherent in the AMA *Guides* that the impairment rating for a physical condition provides for the pain associated with that impairment. *The psychological distress associated with a physical impairment is similarly included within the rating.*

**Somatoform disorders.** - includes Pain/Somatic Symptom Disorders

Dissociative disorders.

- Personality disorders.
- Psychosexual disorders.
- Factitious disorders.
Substance use disorders: Affective or other mental disorders due to substance abuse are not rated.

Sleep disorders: Primary sleep disorders are covered in Chapter 13, the Central and Peripheral Nervous System. Many M&BD are associated with disordered sleep and should be considered as a feature of the M&BD impairment rating in this chapter.

- Where does this leave Pastore (OCA), which allows Pain Disorder rating in Chpt 14, AMA 4th

- Also rating of Substance Disorders not precluded in Chpt 14 AMA 4th Ed & traditionally sleep disorders merged with Mental/Behavioural ratings
- Issue: BPRS and PIRS much less psychometrically robust than traditional Psychodiagnostic measures which psychiatrists generally don’t use (and GAF abandoned in DSM 5)
Brief Psychiatric Rating Scale

The BPRS, measures **major psychotic** and **nonpsychotic symptoms** in patients with major psychiatric illnesses. It is probably the most researched instrument in psychiatry. The 24-item iteration of the scale used in the *Guides*
Global Assessment of Functioning Scale

The GAF constitutes Axis V of the DSM-IV. The GAF is a 100-point single-item rating scale for evaluating overall symptoms, occupational functioning, and social functioning.
Psychiatric Impairment Rating Scale

Behavioral consequences of psychiatric disorders are assessed on 6 scales, each of which evaluates an area of functional impairment (Table 14-5).

**TABLE 14-5**

*Functional Impairment Scales for Patients With M&BD*

<table>
<thead>
<tr>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-care and personal hygiene</td>
</tr>
<tr>
<td>Social and recreational activities</td>
</tr>
<tr>
<td>Travel</td>
</tr>
<tr>
<td>Interpersonal relationships</td>
</tr>
<tr>
<td>Concentration, persistence, and pace</td>
</tr>
<tr>
<td>Employability</td>
</tr>
</tbody>
</table>
The purpose in including all 3 of these scales is to provide a broad assessment of the patient with M&BD. The BPRS focuses solely on symptom severity, the PIRS on role function, and the GAF is a blend of the 2.
<table>
<thead>
<tr>
<th>BPRS Summed Score</th>
<th>BPRS Impairment Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>0%</td>
</tr>
<tr>
<td>25-30</td>
<td>5%</td>
</tr>
<tr>
<td>31-35</td>
<td>10%</td>
</tr>
<tr>
<td>36-40</td>
<td>15%</td>
</tr>
<tr>
<td>41-50</td>
<td>20%</td>
</tr>
<tr>
<td>51-60</td>
<td>30%</td>
</tr>
<tr>
<td>61-70</td>
<td>40%</td>
</tr>
<tr>
<td>71-168</td>
<td>50%</td>
</tr>
</tbody>
</table>
### TABLE 14-10

**Impairment Score of Global Assessment of Functioning Scale (GAF)**

<table>
<thead>
<tr>
<th>GAF</th>
<th>GAF Impairment Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>91-100</td>
<td>0%</td>
</tr>
<tr>
<td>81-90</td>
<td>0%</td>
</tr>
<tr>
<td>71-80</td>
<td>0%</td>
</tr>
<tr>
<td>61-70</td>
<td>5%</td>
</tr>
<tr>
<td>51-60</td>
<td>10%</td>
</tr>
<tr>
<td>41-50</td>
<td>15%</td>
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<tr>
<td>31-40</td>
<td>20%</td>
</tr>
<tr>
<td>21-30</td>
<td>30%</td>
</tr>
<tr>
<td>11-20</td>
<td>40%</td>
</tr>
<tr>
<td>1-10</td>
<td>50%*</td>
</tr>
</tbody>
</table>

**DSM IV - Serious symptoms/impairment-social, work, school**

**WPI (4th Ed)**

### 6th Edition

| 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%* |

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4th Edition (Chapter 4 - Table 3. Emotional or Behavioural Impairments)

- Severe limitation of all daily functions requiring total dependence on another person | 50% - 70%

*Note maximum 50% for each scale used vs 75% WPI for full Paraplegia (4th Edition)
<table>
<thead>
<tr>
<th>Sum of PIRS Middle Scores</th>
<th>PIRS Impairment Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>3</td>
<td>5%</td>
</tr>
<tr>
<td>4</td>
<td>10%</td>
</tr>
<tr>
<td>5</td>
<td>15%</td>
</tr>
<tr>
<td>6</td>
<td>20%</td>
</tr>
<tr>
<td>7</td>
<td>30%</td>
</tr>
<tr>
<td>8</td>
<td>40%</td>
</tr>
<tr>
<td>9-10</td>
<td>50%</td>
</tr>
</tbody>
</table>
Step 4: List BPRS, GAF, and PIRS

Based on the work in steps 1 to 3, list the BPRS, GAF, and PIRS impairment scores

BPRS impairment score _____
GAF impairment score _____
PIRS impairment score _____

Of the 3 impairment scores listed in step 4, the Med-BD impairment rating is the median (middle) value of the BPRS, GAF, and PIRS impairment scores.
On the challenge of CAT assessment costs…
Combining CAT/P104 on OCFs

- Referral for OCF 18 just prior to 2 year point to preempt P104 IE with subsequent rightful refusal of our OCF 18
Common Occupational Disability Tests and Case Law References:
An Ontario MVA perspective on interpretation and best practice methodology supporting a holistic model, Part I of III (Pre-104 IRB)

Dr. J. Douglas Salmon, Jr., Dr. Jacques J. Gouws & Corina Anghel Bachmann

Abstract

This three-part paper presents practical holistic models of determining impairment and occupational disability with respect to common “own occupation” and “any occupation” definitions. The models consider physical, emotional and cognitive impairments in unison, and draw upon case law support for empirically based functional assessment of secondary cognitive symptoms arising from psychological conditions, including chronic pain disorders. Case law is presented, primarily in the context of Ontario motor vehicle accident legislation, to demonstrate how triers of fact have addressed occupational disability in the context of chronic pain; and interpreted the “own occupation” and “any occupation” definitions. In interpreting the definitions of “own occupation” and “any occupation”, courts have considered various concepts, such as:

- work as an integrated whole
- competitive productivity
- demonstrated job performance vs. employment
- work adaptation relative to impairment stability
- suitable work
- retraining considerations
- self-employment, and
- remuneration/socio-economic status.
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“OK, I’ve shown you the ropes, given you the low down, and gotten you up to speed. All that’s left is actually training you.”
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  - Dr Vince Basile – Neurologist/Co-founder new *Concussion* journal
  - Ms. Heather Pickin- OT
  - Dr J Douglas Salmon, Jr – Host
    (contact: dr.salmon@rrees.com)