Dr. Brian E. Levitt, Psy.D., C. Psych.
Kaplan and Kaplan Psychologists and Assessment Centre

ABSTRACT

This article explores the criteria for catastrophic impairment with respect to mental and behavioural functioning as defined by the Ontario Statutory Accident Benefit Schedule (the “SABS”) in s. 2(1.1)(g). It reviews the relevant areas of the SABS, along with key arbitrations and court rulings. This article also explores Designated Assessment Centre (“DAC”) guidelines and conventions as applied to determination of catastrophic mental and behavioural impairment. It concludes with a perspective from rehabilitation psychology, utilizing the framework and approaches offered in the American Medical Association’s Guides to the Evaluation of Permanent Impairment, fourth edition, 1993 (the “AMA Guides”), and offers a comparison with these other sources.

THE SABS

The Ontario Statutory Accident Benefit Schedule (the “SABS”) is remedial in nature and intended to protect consumers, supporting the intention of returning motor vehicle accident victims to their pre-accident functioning. Healthcare benefits covered under the SABS include attendant care, medical and rehabilitation expenses, income replacement, and housekeeping expenses. The SABS provides for two tiers of benefits. This two-tier system follows the assumption that, in general, those with more significant impairment levels potentially will require access to a higher level of benefits. When a person meets criteria set out in the SABS for catastrophic
improvement, the second, significantly increased tier of benefits becomes potentially available. The SABS enumerates eight different tests for catastrophic impairment. If any of the tests are met, the person is considered catastrophically impaired. This article concerns itself specifically with the eighth test, defined according to s. 2(1.1)(g) of the SABS as follows:

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.¹

The relevant chapter in the 4th Edition of the AMA Guides is Chapter 14, Mental and Behavioral Disorders.² Chapter 14 lays out a system for the qualitative rating of mental and behavioural impairment. It describes four functional classes: activities of daily living; social functioning; concentration, persistence and pace (task completion); and deterioration or decompensation in work or work-like settings (adaptation). Clinicians rate impairment in each of these classes qualitatively, using an ordinal scale: none, mild, moderate, marked, and extreme. Differences of opinion exist with respect to how many classes of marked or extreme impairment are required to meet the SABS g test for catastrophic impairment, as the wording of the test is open to interpretation.

COURT RULINGS AND FSCO ARBITRATIONS

A number of court rulings and arbitrations address the issue of how many classes of marked or extreme impairment satisfy the SABS g test for catastrophic impairment. Here I review briefly the cases that most directly address this issue, pointing to a single class of marked or extreme impairment as sufficient to satisfy this test.

In the court case of Desbiens v. Mordini, Justice Spiegel notes the following in para. 129 with respect to a single class of marked impairment being sufficient to meet the SABS g test for catastrophic impairment:

In the area of adaptation (deterioration or decompensation in a work-like setting), Dr. Finlayson found that Mr. Desbiens’ impairment fell within a Class 4 (marked impairment) in which the impairment levels “significantly impeded useful functioning”. It is not disputed that it is sufficient for Mr. Desbiens to establish that his impairment in any one of the areas of functioning meets the requirements of clause (g).³

H. and Lombard General Insurance Company of Canada is a FSCO Arbitration heard before Arbitrator Renahan.⁴ This arbitration notes that Ms. H.’s
DAC assessors found it “unfortunate that Justice Spiegel did not clarify the context of his statement in Desbiens that it was not disputed that one class 4 marked impairment was sufficient to satisfy the definition of ‘catastrophic impairment’ in clause (g)”. In other words, there is potential ambiguity whether Spiegel J. concludes that only one marked class of function is needed to establish catastrophic impairment, or whether he is simply noting that the parties did not dispute that one class was sufficient for Mr. Desbiens to satisfy the SABS g test. In Ms. H.’s case, Arbitrator Renahan leaves no doubt in his conclusion regarding the number of spheres of marked impairment required to satisfy the SABS g test for catastrophic impairment:

Since she satisfies a marked impairment under one of the aspects of functioning described in (sic) chapter in the Guides dealing with mental and behavioural disorders, she has suffered a catastrophic impairment with the meaning of section 2(1)(g) of the Schedule. 8

In a more recent FSCO arbitration, Anna Pastore and Aviva Canada, 9 Arbitrator Nastasi comments at length regarding the issue of how many classes of marked impairment are sufficient to satisfy the SABS g test for catastrophic impairment. She concludes clearly, “I find that one marked impairment is adequate to meet the definition of catastrophic impairment”. 10 In coming to this conclusion, she bases her reasoning on the highly interrelated nature of the four functional classes described in Chapter 14 of the Guides, as well as the awareness that each of the classes represents functioning “in a basic and core area of life”. 11 She also states, “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 one marked impairment is in line with a remedial approach to the Schedule”. 12

DAC GUIDELINES

The SABS provided for a system of Designated Assessment Centres (“DACs”), which an amendment then phased out, effective March 1, 2006. DACs carried out assessments and produced reports under a set of guidelines drafted by The Minister’s Committee on the Designated Assessment Centre System. DAC guidelines addressed catastrophic impairment assessments, and initially provided specific direction with respect to the issue of how many marked or extreme classes of functioning are required to meet SABS g criteria for catastrophic impairment.

In December 1997, FSCO released a CAT DAC Interim Manual (the Interim Guidelines) 13 offering the first detailed protocol for assessment of catastrophic impairment. This manual advises the use of a staged assessment with respect to mental and behavioural impairments, looking first at impairment in the domains of activities of daily living, social functioning, and concentration, persistence and pace. The Interim Guidelines indicates that two marked impairments among these classes would meet the definition of catastrophic, and that the claimant would be classified “at (4) Marked overall. 14 The Interim Guidelines further suggests that if only one class is classified as marked, then the assessment would proceed to determine the level of impairment in the fourth class of functioning, adaptation. If the claimant then were also found to have marked impairment with respect to adaptation, they would meet the definition of catastrophic. It is not clear why the Interim Guidelines suggests such a staged approach to the assessment of mental and behavioural impairment. Chapter 14 of the AMA Guides does not support such an approach. Chapter 14 suggests that functioning be assessed with respect to all four classes.

Subsequent DAC guidelines removed the language with respect to a staged assessment of mental and behavioural impairment. They also removed language with respect to how many classes of marked impairment would be required to meet the definition of catastrophic. The April 2002 Catastrophic Impairment Designated Assessment Centre Assessment Guidelines, 15 which is the last drafted revision, provides the following language:

Final classification of impairments due to mental and behavioural disorders will take into consideration the four functional domains of ADL; social functioning; concentration, persistence and pace; and, work adaptation, under five levels of severity ranging from no impairment to extreme impairment. The SABS directs that catastrophic impairment is met when an individual reaches marked or extreme impairment (Class IV or Class V impairment) due to mental or behavioural disorder. 16

Though the language in the revised Guidelines is unclear with respect to the number of classes of marked impairment required for catastrophic designation, the convention of requiring two classes of marked impairment remained general practice among catastrophic DAC assessors. The original reasoning for the guideline requiring two classes of marked or extreme impairment appears to come directly from an interpretation of a few sentences in Chapter 14 of the 4th edition of the AMA Guides, rather than from a broader psychological perspective on the chapter’s approach to impairment analysis as it is nested in the overall context of the AMA Guides. The relevant passages in Chapter 14 are as follows:

marked: is a level of impairment that significantly impedes useful functioning. Taken alone, a
“marked” impairment would not completely preclude functioning, but together with marked limitation in another class, it might limit useful functioning.\textsuperscript{17}

and:

Marked limitation in two or more spheres would be likely to preclude performing complex tasks without special supports or assistance, such as that provided in a sheltered environment.\textsuperscript{18}

RAISING QUESTIONS

From a psychological perspective, it is not clear that the decision to require two marked or extreme classes (as suggested in the \textit{Interim Guidelines}) follows sound clinical reasoning. It may also be discriminatory with respect to people suffering mental and behavioural impairments by placing a higher bar to be met for catastrophic impairment than the requirements for physical impairments. For example, a person whose arm is amputated at the shoulder as a result of a motor vehicle accident is assigned a whole person impairment (“WPI”) rating of 60 per cent.\textsuperscript{19} This rating exceeds the \textit{SABS f} criterion that require a whole person impairment rating of 55 per cent or more to be considered catastrophically impaired.\textsuperscript{20} Assuming a healthy emotional adjustment (no mental or behavioural impairment), loss of the entire arm may “significantly impede useful functioning”, but likely would not “completely preclude functioning”.\textsuperscript{21} This person would be considered catastrophically impaired according to \textit{SABS f}.

Clinically, it is not clear why such a high bar, completely precluding functioning, was then applied by the \textit{Interim Guidelines} with respect to the number of mental and behavioural classes of marked or extreme impairment required to be considered catastrophically impaired by \textit{SABS g} criteria. The remainder of this article explores further a psychological perspective with respect to the number of marked or extreme classes of functioning required for catastrophic impairment.

RE-EXPLORING \textit{CHAPTER 14} OF \textit{THE AMA GUIDES}

The framers of the \textit{AMA Guides} chapter on mental and behavioural impairments (\textit{Chapter 14, 4\textsuperscript{th} edition}), turned to the model used by Social Security for disability assessments in the United States. The chapter describes four functional classes. Though they each focus on human functioning through a unique lens, they also overlap considerably. As noted earlier, these four classes are activities of daily living, social functioning, task completion, and adaptation. Each class represents an essential domain of mental and behavioural functioning, or as Arbitrator Nastasi puts it, a basic and core area of life. Because they overlap, any significant impairment in one class likely means some degree of impairment in the other three. Shopping is an activity that illustrates this overlap, as it can be considered in an impairment analysis in the first three functional classes. It is an activity of daily life, and there are social elements involved. It is also a sample of a person’s ability to complete tasks in an uncontrolled environment, requiring concentration and the ability to persist, and can be explored in terms of pace. Cooking is another example of an activity that can be viewed in more than one domain, as it is an activity of daily life and also requires an ability to concentrate, persist and pace in order to complete. There are social elements involved in many activities of daily life, as well as in work and work-like settings. Concentration is an element that is essential to most daily activities, social interactions, and work activities.

Given that the \textit{AMA Guides} is grounded in a framework for social security disability assessments, it is not surprising that \textit{Chapter 14} places a significant focus on adaptation to work or work-like settings, which typically is seen as the most complex domain of human behaviour. Assessment of a person’s ability to function in the first three classes provides useful information in forming an inference about that person’s ability to function in the complex realm of a work or work-like setting. Functioning in a work or work-like setting can be seen to subsume many of the essential elements of functioning in the other three classes.

ASSESSING MENTAL AND BEHAVIOURAL IMPAIRMENTS

Justice MacKinnon points out that, “The Guides were clearly not designed by the AMA for the purpose directed by the Ontario legislature. They must be interpreted in a manner that is contextually consistent with the language of the \textit{SABS}”.\textsuperscript{22} That language is remedial in nature, providing a context that assumes a consideration of healthcare needs in the assessment of impairment. Justice Spiegel, in \textit{Desbiens v. Mordini}, also reminds us of the remedial nature of the legislation, and in particular the emphasis on fairness to recognize the significantly greater healthcare needs of those victims who are catastrophically impaired.\textsuperscript{23} In other words, impairment determinations are not simply intellectual exercises, as they are nested in the very human context of healthcare needs. Though the \textit{AMA Guides} may not have been designed to assess treatment or care needs, when assessing psychological impairment a consideration of such needs helps inform more fully an understanding of the severity of mental and behavioural impairments.

\textit{Chapter 14} of the \textit{AMA Guides} provides an outline for assessing mental and behavioural impair-
ments. The approach described in this chapter includes the formulation of a complete multi-axial DSM diagnosis. A multi-axial diagnosis is not complete without a Global Assessment of Function, or GAF. The GAF is often misunderstood and misapplied narrowly as only an assessment of symptom severity, but the scale ranges include ratings for both symptom severity and mental and behavioural functioning. It can be applied specifically to arrive at a solely functional rating. In fact the name of the scale itself (Global Assessment of Function) highlights its use in the assessment of function. As applied to an analysis of mental and behavioural impairments across four classes of functioning, the GAF is useful in providing a global, or overall, indicator of mental and behavioural functioning.

Applying the reasoning used in determining a GAF to analyzing a patient’s level of functional impairment across the four classes described in the AMA Guides chapter on mental and behavioural impairment results in a more holistic understanding of the four classes. The more severe the functional impairments are across the four classes, the lower the patient’s GAF will be. How the GAF might be useful in determining a quantitative WPI with respect to mental and behavioural impairments is not explored here. This article raises the notion of the GAF simply to facilitate understanding of the differences among overall, average and combined approaches to rating. It is important to understand that the GAF is a global measure, not an average assessment of function. This is an essential distinction. A global or overall approach to the assessment of impairments takes all impairments into account, unlike an averaging approach, and thus helps the clinician to develop more sound treatment and care planning. For example, using an averaging approach to assess a patient with the ability to do self-care on a daily basis, but unable to function in the work place, underestimates the severity of overall impairment, and does not allow for adequate treatment/rehabilitation planning or provision of care.

A parallel example from the physical realm is a patient who has lost his or her entire arm and also has total loss of vision in one eye. A WPI of 60 is applied for the arm being amputated, and a WPI of 24 is applied to the total loss of vision in one eye.

An averaging approach applied to separate impairments establishes a WPI for this patient of 42, which clearly underestimates the patient’s overall impairments (the patient with the loss of an arm and an eye ends up with a lower rating than a patient who has only lost an arm). The AMA Guides uses a combining approach to capture better the overall physical impairment when there are two or more separate impairments, resulting in a WPI of 77 in the example above.

It bears stating that Chapter 14 of the AMA Guides applies ordinal rating categories (nil to extreme) to the four classes of functioning. As such, basic statistics informs us we cannot average these ordinal ratings. Further, the domains, as noted earlier, have a significant amount of overlap. As such, again from a statistical perspective, an average of overlapping ordinal ratings is even less meaningful.

The one example provided in Chapter 14 again from a statistical perspective, an average of overlapping ordinal ratings is even less meaningful.

The AMA Guides combines quantitative impairment ratings as a common method for arriving at overall impairment ratings. In the case of the four qualitative classes in Chapter 14, this is statistically meaningless. Further, because of the substantial overlap among classes, it may result in an overestimation of impairment. When we look to other chapters in the AMA Guides for assistance with the issue of an alternative to combining the ratings for the four classes of mental and behavioural impairment, we find the idea of taking the person’s highest impairment rating among a number of overlapping rated areas to stand for the patient’s level of impairment. For example, when rating cerebral impairment, Chapter 4 (The Nervous System), advises

A patient may have more than one of the types of cerebral dysfunction noted above. The most severe of the first five categories shown above should be used to represent the cerebral impairment.

Clinically, this also is most consistent with the notion that an assessment of impairment points ultimately to a patient’s treatment and care needs, which are underestimated if an average rating is chosen, and overestimated if overlapping categories are combined. It is seen as enough to take the most severe impairment or, as each category represents a significant, or core, aspect of cerebral functioning. However, it should be noted that a person with impairments in multiple classes may well be more impaired and require more services than a person with impairments in only one class. Thus it is meaningful and important to detail all classes of impairment, while being mindful that the class with
the highest level of rated impairment represents only the minimal overall level of impairment that can be counted on as reliably present.

Returning to Chapter 14, we remain faced with determining an approach to overall impairment rating, given four overlapping classes of mental and behavioural functioning that are rated. We already have seen in the AMA Guides that combining is not used in such situations. Also, statistically it makes no sense to apply a combining method to the ordinal ratings on the four classes found in Chapter 14, just as it makes no sense to average them. We are left with the method used elsewhere in the AMA Guides when impairments overlap: choosing the highest level of impairment among these four classes as standing for the patient’s level of impairment, as the patient will exhibit at least that level of impairment, along with whatever levels of impairment are determined in the other classes. If one class is markedly impaired, then useful functioning is, at least, significantly impeded in a basic and core area of life.

The arbitral decision to take one class of marked or extreme impairment as satisfying the SABS g test for catastrophic impairment is most consistent with the approach found in the AMA Guides when impairments overlap: choosing the highest level of impairment among these four classes as standing for the patient’s level of impairment, as the patient will exhibit at least that level of impairment, along with whatever levels of impairment are determined in the other classes. If one class is markedly impaired, then useful functioning is, at least, significantly impeded in a basic and core area of life.

[Editor’s note: Dr. Brian Levitt, Psy.D., C.Psych., is registered in Ontario as a Rehabilitation and Clinical Psychologist. His full-time practice is with Kaplan and Kaplan Psychologists and Assessment Centre in Hamilton, Ontario.]