Submission No 29

INQUIRY INTO PROPOSED CHANGES TO LIABILITY AND ENTITLEMENTS FOR PSYCHOLOGICAL INJURY IN NEW SOUTH WALES

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Proposed changes to liability and entitlements for psychological injury in New South Wales

NSW Legislative Council
Standing Committee on Law & Justice

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1. Introduction

I make this submission as a solicitor who has spent his entire career working for injured workers in NSW. I am an Accredited Specialist in Personal Injury, sub-specialising in work injuries. I have worked at various law firms, large and small, including Maurice Blackburn, Turner Freeman and Masselos & Co, and have come to be uniquely familiar with this area of practice.

I am now in sole practice. The overwhelming majority of my busy practice deals with workers compensation psychological injuries. I offer my perspective as someone dealing with these claims 'at the coalface'. I will comment on the whole terms of reference but particularly the Exposure Draft (b).

When things go wrong, it is solicitors like me that workers turn to desperate for help. That is why I look on these proposed reforms with dread. I can picture the faces of the vulnerable workers who will be abandoned for the totally arbitrary reason that the injury is to their mind rather than their bodies.

2. Executive Summary

- The proposed 31% threshold is grossly unjust and will exclude almost all psychological injuries from payments after 130 weeks, lump sum compensation, or damages for negligence. The threshold changes need to be rejected in their entirety, and existing thresholds reduced

- The proposed requirement to resolve court/tribunal proceedings before victims of sexual harassment, racial harassment or bullying can make workers compensation claims will increase injuries, lead to unaffordable, unnecessary hearings, and will exclude genuine victims. Unless these extensive issues can be addressed, this proposal should not proceed.

- Removing liability for stress and overwork is a retrograde step that permits exploitation of workers. This proposal should not proceed until a fully comprehensive plan is developed to replace it.

- The proposed narrow definition of vicarious trauma risks creating considerable unfairness and removing incentives to prevent harm. The proposed 'close work connection' requirement for vicarious trauma should not proceed.

- Reasonable management action reforms allow an employer to use performance management to escape any liability. 'Significant cause' is too broadly defined and the definition of 'predominantly caused' should be retained.

- Too little consultation has been made with injured workers as to what is preventing their recovery. A detailed inquiry into the actual reasons that psychologically injured workers are not recovering needs to be made before any reforms are made to the legislation.

3. The impossible 31% threshold

I will comment first on the new proposed Sections 38(9), 39A, 59A, 65A and 151H, which imposes an impairment threshold of 31% on primary psychological injuries. This is probably the most harmful aspect of the proposed reforms.

The present thresholds

The present workers compensation legislation is filled with impairment threshold tests. At present, a worker must be:

- More than 20% impaired to have access to income support after 260 weeks, *even if they are unable to work*: s 39
- More than 20% impaired to have access to medical expenses after five years from the last weekly payment (or 10% for more than two years), *even if they still have medical needs*: s 59A
- 15% or more impaired to be able to claim lump sum compensation for permanent psychological injury: s 65A
- 15% of more impaired to be able to sue their employer for damages, *even when their employer negligently caused their injury*: s 151H

When the O'Farrell government brought in the Section 39 and 59A thresholds above, they were widely criticised as being overly punitive and arbitrary, particularly by NSW Labor, who opposed the reforms. Many long-injured workers were pushed onto disability support or into poverty.

Part of the injustice seemed to arise from a fundamental misunderstanding about impairment percentages that seems to be repeated in the proposed reforms.

What the impairment percentages *mean*

The 'whole person impairment' (WPI) percentage system can be misleading. One might imagine that 10 or 20% WPI is 'mild'. This is *not* the case.

To obtain a whole person impairment rating under the Guidelines, a worker must first have a permanent injury. That means an injury that will be lifelong.

To use an example for physical injuries, lifelong chronic back pain, where surgery it not obtained, might attract less than 10% whole person impairment. A similar injury requiring

surgical repair might be between 10-15% WPI. A total knee replacement might attract 20% WPI, and a spinal fusion surgery 25%.

You can see that some of the most serious injuries barely scrape over the restrictive 21% thresholds in the legislation. The higher percentages are reserved for multiple system injuries, with 70-100% reserved for total paraplegia and terminal illnesses.

Psychological impairment

The same is true for psychological injury. Allow me to present, through my experience working with many hundreds of psychologically injured workers, a very rough guideline for the sort of impairment of each level of WPI:

- 5% - these workers have some lifelong psychological symptoms as result of their injury that may sometimes totally incapacitate them from work. However, in other aspects of life they continue living mostly normally.

- 10% - these workers have lifelong psychological symptoms that quite often totally incapacitate them from work. These symptoms affect many other aspects of their life, but they can often get by with a partly normal life.

- 15% - these workers have lifelong and severe psychological symptoms that usually totally incapacitate them from work. Their symptoms severely impair much of their life. Many have periodic stays in inpatient or outpatient psychiatric facilities, and suicidality can occur.

- 20% and above – these workers are the among the most severely psychologically impaired and have a recognised need for lifetime income support. Most are hospitalised at various points and suicidality is common.

- 30% and above – these workers do exist in the system but are rare. They are even more severely impaired. In my career I have only represented one such individual, who was terrified to leave the home, unable to speak to strangers, or perform any aspects of her pre-injury life.

Of course, the above is only a broad-brush example from my personal experience. However, the actual Guidelines used by a psychiatrist to assess WPI are publicly available. These are relatively easy for a layperson to understand. I provide an optional explanation in the box below.

The relevant extract of the Guidelines including the Psychiatric Impairment Rating Scales (PIRS) is attached as **Appendix A** to this submission.

The first thing you might notice is that they are completely arbitrary. There is no obvious scientific rationale for the scales being selected as they have been. The second thing is that a 31% impairment rating requires a median of Class 4 on the PIRS scales (11.16 on Page 58 of the Guidelines, see Appendix A).

Here are the examples of Class 4 from the PIRS:

- **Self-care and personal hygiene**: Severe impairment: Needs supervised residential care. If unsupervised, may accidentally or purposefully hurt self.
- **Social and recreational activities**: 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 come to visit family or flat mate.
- **Travel**: Severe impairment: finds it extremely uncomfortable to leave own residence even with trusted person.
- **Social functioning**: Severe impairment: unable to form or sustain long term relationships. Pre-existing relationships ended (eg lost partner, close friends). Unable to care for dependants (eg own children, elderly parent).
- **Concentration, persistence and pace:** Severe impairment: can only read a few lines before losing concentration. Difficulties following simple instructions. Concentration deficits obvious even during brief conversation. Unable to live alone, or needs regular assistance from relatives or community services.

These are the levels of permanent (lifelong) impairment that are required (as a median) for a 31% whole person impairment rating.

Who would be excluded under a 31% (or another) threshold?

As we can see above, a 31% threshold excludes just about any injured worker except those suffering from uncommonly severe psychological injury.

The threshold, in practice, would eliminate almost all income support for primary psychological injures after 130 weeks (new s 39A), and then all medical expense one year after that (new s 59A). Lump sum claims for almost all psychological injuries would be abolished (new s 65A).

The ability for a worker to sue an employer whose negligence caused a psychological injury would be all but eradicated (new s 151H).

With the permission of my clients, consider some real case examples of injured workers (*names changed) who will be affected by these reforms in the box below:

Mark worked as a brand ambassador for a multi-national company. When the Covid-19 pandemic hit his team was reduced and he was pressured to take on more work. He ended up working more than 14-15 hours per day, traveling extensively for work, where he was pressured constantly to drink with clients. His employer did not respond to his requests for help, even when he developed suicidal thoughts. He was eventually admitted to a psychiatric hospital, diagnosed with major depressive disorder and has been assessed as permanently disabled from work. He struggles to care for himself, avoids socialising, and has lost his ability to do complex tasks.* ***Mark has a certified WPI of 20%. Under these reforms he would be cut off his benefits and never permitted to bring a claim for damages for his employer's negligence.***

Jane is a worker with who overcame pre-existing combined Autism and ADHD to become a contractor for independent schools on prevention programs. In the role she was overloaded with work, violently threatened by a co-worker, and suspended from work for manifestly unfair reasons. She developed severe depression and anxiety. She now struggles to shower, socialise without a support person, or concentrate for long periods.* ***Jane has a suspected WPI of 15%, which could be lower after certification. Under these reforms she would lose the income support she needs to recover and return to the work force. She will never be permitted to bring a claim for damages against her employer.***

The proposed changes to thresholds appear to apply to all workers, whether or not they have already been injured. Some who have planned their lives around ongoing support will be left to fend for themselves. Others have put years of their life into work injury damages litigation that will have to simply be abandoned.

The solution is not some lower threshold either. You will see from my above examples that WPI percentages are not well-correlated to a worker's actual needs. WPI thresholds are arbitrary and unnecessary.

Income benefits already cease when a worker regains capacity to work, regardless of their permanent impairment level. Existing thresholds already serve to limit legitimate claims and should never have been introduced.

Recommendation: The threshold changes need to be rejected in their entirety, and existing thresholds reduced.

4. Requiring proceedings before harassment & bullying

The Exposure Draft proposes that workers compensation claims for primary psychiatric injuries resulting from sexual harassment, racial harassment and bullying cannot be brought unless findings of a tribunal, commission or court are first obtained (new s 8F).

I commend the Treasurer for recognising the need to prevent injuries rather than respond to them. However, as this new body proposed to handle such matters is yet to be established or described, it is difficult to comment on how this would work in practice.

In the meantime, the following critical concerns must be addressed:

- As a practitioner, my first and urgent task for victims of harassment and bullying is to ensure they are removed from the situation of harassment and bullying, before a minor injury becomes a major one. The effect of this proposed amendment will be the opposite – to prevent the provisional compensation that provides the means for the worker to get to safety. The result will be more serious injuries.

- Victims of harassment and bullying tend to seek legal help as a *last resort*, when the worker has already reached breaking point. This will mean that, in most cases, the injury will have already occurred when this section is engaged. As such, the purpose of preventing injuries will not be achieved.

- No litigated process, no matter how well-designed, is quick. At the quickest, processes take months. The AHRC discrimination jurisdiction, and the Federal Court, as examples, regularly take years to resolve harassment claims. This proposal would leave psychologically injured victims of harassment or bullying without income for that entire time.

- Most harassment and bullying matters through existing tribunals involve settlement before hearing. This is the most efficient way to resolve most matters for all parties involved. This proposed amendment creates an incentive to proceed to costly, time-consuming and unnecessary hearings.

- Workers will not have the financial means to pursue these claims. Unless it is included in the ILARS scheme, workers will not have access to the means to hire private solicitors to pursue claims in other tribunal, commissions or courts.

- Nothing is more deleterious to an injured worker's psychological health than a further set of stressful legal proceedings. These proposed reforms risk making psychological injuries far worse.

The most likely result of these proposed reforms as they stand will be countless psychologically injured, *genuine* victims of sexual harassment, racial harassment and bullying being fully excluded from workers compensation.

Recommendation: Unless these extensive issues can be addressed, this proposal should not proceed.

5. Removing liability for stress and overwork

The Exposure Draft proposes limiting primary psychological injury to those resulting from a 'relevant event' (new s 8E), which no longer includes stress or overwork.

This is a retrograde step. 170 years after the introduction of the 8-hour work day, 10-20% of the Australian workforce is still working more than 45 hours a week, and a significant percentage more than 60 hours (source). Although often illegal, there are a number of unscrupulous sectors in which workers are pressured to into overwork and suffer significant breakdowns as a result.

In my experience, these workers tend to be driven people who are otherwise well-placed to re-enter the workforce, but only if they receive the support of the workers compensation system at the critical time they need to recover.

I note proposed 'work pressure disorder' (new s 148B). There is insufficient detail as to how this system will work so it is difficult to comment, but it appears not to address the income support required to keep overworked employees from deteriorating and allow them to return quickly to the workforce.

Further, workers who are overworked and exploited by negligent employers will be unable to sue for work injury damages under the proposed changes. This removes one of the few effective accountabilities to prevent overwork.

Recommendation: This proposal should not proceed until a fully comprehensive plan is developed to replace it.

Sally was approaching the final years of her working life in real estate. She has always been a hard worker and was happy to work overtime for her employer. The director of her company knows this and decides to give Sally significantly more work. Her overtime escalates until her work takes over her life – she is working more than 70 hours per week. She feels it is too close to retirement to find a new job. Despite her complaints her employer continues to exploit her. She suffers a major breakdown and is diagnosed with persistent depressive disorder.* ***Sally lost out on the final years of income she was relying on for retirement. She hopes to recover this from her employer by suing in work injury damages. Under the proposed changes, because her injury was caused by stress, she has no entitlement to compensation, despite the negligence of her employer.***

6. Vicarious trauma

The Exposure Draft proposes reducing the scope of primary psychological injury for vicarious trauma (new s 8H).

Vicarious trauma occurs when individuals develop Post-Traumatic Stress Disorder distress from being exposed to other people's traumatic experiences.

I am concerned about the proposed definition that requires a 'close work connection' between the worker and the trauma victim. It is difficult to how the judiciary will interpret 'real and substantial connection'.

My experience with post-traumatic stress is that it strikes largely at random. A worker may be exposed to heinous violence and have no symptoms. On another occasion, a recount of events of a stranger may trigger major decompensation. Most cases I have seen typically involve a build-up of various events culminating in a relatively sudden decompensation.

By requiring a 'close work connection', entitlement to compensation will become as unpredictable as vicarious trauma itself, compounding unfairness. People with legitimately harrowing experiences will be excluded from compensation.

There are whole industries at risk that are yet to adequately provide training or protect workers from the risks of vicarious trauma. The proposed reform removes the incentive to introduce these protections.

Recommendation: The proposed 'close work connection' requirement for vicarious trauma should not go ahead.

Craig is a first year solicitor employed in an abuse law firm. As part of his role he spends all day reading statements of childhood sexual abuse. Craig begins to develop intrusive thoughts and nightmares about what he has read. He was never told that he could develop PTSD from hearing about others trauma and his employer never trained or provided any support to protect him. Luckily, Craig moves on from the role before suffering serious harm. Had Craig been less lucky, he may have ended up with severe psychological injury.* ***Under the proposed reforms, it is unlikely he has the 'close work connection' to claim for vicarious trauma. He would be left to deal with his psychological injury alone, delaying his return to the workforce. His employer would never be held to account for their negligent lack of care.***

7. Reasonable management action

The Exposure Draft proposes amending the defence of reasonable management action (new ss 8D, 11A).

The prior section may not have been operating as intended, however the new proposal threatens to swing the pendulum too far in the opposite direction.

How it currently works

A worker cannot obtain workers compensation where they suffered an injury as a result of 'reasonable action with respect to transfer, demotion, promotion, performance appraisal, discipline, retrenchment or dismissal of workers' (s 11A).

This has the obvious effect of preventing workers from evading performance management by making a workers compensation claim for psychological injury.

However, a key protection is that the performance management has to be at least the 'predominant cause' of the injury. This protection serves an important purpose: it prevents the employer from bringing performance management against a worker solely to evade an anticipated workers compensation claim.

The changed section

The new proposed section changes that protection. Now management action only needs to be a 'significant cause' of the injury. This wording change may appear minor, but the consequences will be wide-reaching.

An employer can now commence a performance management process on a worker if they anticipate potential workers compensation claim. There is little doubt that this would make a 'significant' impact on a developing psychological injury. Employers are therefore incentivised to exacerbate injuries to avoid liability.

The proposal will also greatly increase litigation in this area, as more claims will litigated over the 'reasonableness' of the management action.

Recommendation: 'Significant cause' is too broadly defined and the existing definition of 'predominantly caused' should be retained.

8. What will actually help workers recover?

The Terms of Reference of this inquiry call for a consideration of the overall financial sustainability of the NSW workers compensation system. The Treasurer's stated concern is low recovery rates of workers with psychological injuries.

It is therefore surprising to me that none of the proposed reforms seem to address any concerns that I hear from actual injured workers every day. If you ask them, they will tell you why they are not recovering.

Here are some things I hear from psychologically injured workers every day:

1. The complexity of the system creates numerous disputes that lead to major distress and prolongs psychological injury. Too many workers require extensive legal assistance to attain modest entitlements.

2. There is no genuine assistance with finding suitable alternative employment. There is no access to retraining initiatives. Workers who do return to work do so almost entirely on their own initiative.

3. Attempts to return to work are punished with harsh benefit reductions rather than encouraged with incentives.

4. Rehabilitation providers are appointed by insurance claims managers and focus heavily on gathering evidence to cut workers off payments, rather than providing them with genuine recovery assistance.

5. Insurance claims managers change too frequently, have too little time for workers, and there is deep distrust between them and psychologically injured workers.

6. Essential psychological support is not approved in a timely fashion by insurers and is not sufficiently regular or intensive.

7. Nobody ever appears to be held to account for causing psychological injuries. Bullies continue in their roles while the victims are forced out.

Recommendation: a detailed inquiry into the actual reasons that psychologically injured workers are not recovering needs to be made before any reforms are made to the legislation.

11. Psychiatric and psychological disorders

AMA5 Chapter 14 is excluded and replaced by this chapter. Before undertaking an impairment assessment, users of the Guidelines must be familiar with (in this order):

- the Introduction in the Guidelines
- chapters 1 and 2 of AMA5
- the appropriate chapter(s) of the Guidelines for the body system they are assessing.

The Guidelines replace the psychiatric and psychological chapter in AMA5.

Introduction

11.1 This chapter lays out the method for assessing psychiatric impairment. The evaluation of impairment requires a medical examination.

11.2 Evaluation of psychiatric impairment is conducted by a psychiatrist who has undergone appropriate training in this assessment method.

11.3 Permanent impairment assessments for psychiatric and psychological disorders are only required where the primary injury is a psychological one. The psychiatrist needs to confirm that the psychiatric diagnosis is the injured worker's primary diagnosis.

Diagnosis

11.4 The impairment rating must be based upon a psychiatric diagnosis (according to a recognised diagnostic system) and the report must specify the diagnostic criteria upon which the diagnosis is based. Impairment arising from any of the somatoform disorders (DSM IV TR, pp 485–511) are excluded from this chapter.

11.5 If pain is present as the result of an organic impairment, it should be assessed as part of the organic condition under the relevant table. This does not constitute part of the assessment of impairment relating to the psychiatric condition. The impairment ratings in the body organ system chapters in AMA5 make allowance for any accompanying pain.

11.6 It is expected that the psychiatrist will provide a rationale for the rating based on the injured worker's psychiatric symptoms. The diagnosis is among the factors to be considered in assessing the severity and possible duration of the impairment, but is not the sole criterion to be used. Clinical assessment of the person may include information from the injured worker's own description of his or her functioning and limitations, and from family members and others who may have knowledge of the person. Medical reports, feedback from treating professionals and the results of standardised tests – including appropriate psychometric testing performed by a qualified clinical psychologist and work evaluations – may provide useful information to assist with the assessment. Evaluation of impairment will need to take into account variations in the level of functioning over time. Percentage impairment refers to whole person impairment (WPI).

Permanent impairment

11.7 A psychiatric disorder is permanent if, in your clinical opinion, it is likely to continue indefinitely. Regard should be given to:

- the duration of impairment
- the likelihood of improvement in the injured worker's condition
- whether the injured worker has undertaken reasonable rehabilitative treatment
- any other relevant matters.

Effects of treatment

11.8 Consider the effects of medication, treatment and rehabilitation to date. Is the condition stable? Is treatment likely to change? Are symptoms likely to improve? If the injured worker declines treatment, this should not affect the estimate of permanent impairment. The psychiatrist may make a comment in the report about the likely effect of treatment or the reasons for refusal of treatment.

Co-morbidity

11.9 Consider comorbid features (eg bi-polar disorder, personality disorder, substance abuse) and determine whether they are directly linked to the work-related injury, or whether they were pre-existing or unrelated conditions.

Pre-existing impairment

11.10 To measure the impairment caused by a work-related injury or incident, the psychiatrist must measure the proportion of WPI due to a pre-existing condition. Pre-existing impairment is calculated using the same method for calculating current impairment level. The assessing psychiatrist uses all available information to rate the injured worker's pre-injury level of functioning in each of the areas of function. The percentage impairment is calculated using the aggregate score and median class score using the conversion table below. The injured worker's current level of WPI% is then assessed, and the pre-existing WPI% is subtracted from their current level, to obtain the percentage of permanent impairment directly attributable to the work-related injury. If the percentage of pre-existing impairment cannot be assessed, the deduction is 1/10th of the assessed WPI.

Psychiatric impairment rating scale (PIRS)

11.11 Behavioural consequences of psychiatric disorder are assessed on six scales, each of which evaluates an area of functional impairment:

1. Self care and personal hygiene (Table 11.1)
2. Social and recreational activities (Table 11.2)
3. Travel (Table 11.3)
4. Social functioning (relationships) (Table 11.4)
5. Concentration, persistence and pace (Table 11.5)
6. Employability (Table 11.6).

} Activities of daily living

11.12 Impairment in each area is rated using class descriptors. Classes range from 1 to 5, in accordance with severity. The standard form must be used when scoring the PIRS. The examples of activities are examples only. The assessing psychiatrist should take account of the person's cultural background. Consider activities that are usual for the person's age, sex and cultural norms.

Table 11.1: Psychiatric impairment rating scale – self care and personal hygiene

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population
Class 2	Mild impairment: able to live independently; looks after self adequately, although may look unkempt occasionally; sometimes misses a meal or relies on take-away food.
Class 3	Moderate impairment: Can't live independently without regular support. Needs prompting to shower daily and wear clean clothes. Does not prepare own meals, frequently misses meals. Family member or community nurse visits (or should visit) 2–3 times per week to ensure minimum level of hygiene and nutrition.
Class 4	Severe impairment: Needs supervised residential care. If unsupervised, may accidentally or purposefully hurt self.
Class 5	Totally impaired: Needs assistance with basic functions, such as feeding and toileting.

Table 11.2: Psychiatric impairment rating scale – social and recreational activities

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population: regularly participates in social activities that are age, sex and culturally appropriate. May belong to clubs or associations and is actively involved with these.
Class 2	Mild impairment: occasionally goes out to such events eg without needing a support person, but does not become actively involved (eg dancing, cheering favourite team).
Class 3	Moderate impairment: rarely goes out to such events, and mostly when prompted by family or close friend. Will not go out without a support person. Not actively involved, remains quiet and withdrawn.
Class 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 come to visit family or flat mate.
Class 5	Totally impaired: Cannot tolerate living with anybody, extremely uncomfortable when visited by close family member.

Table 11.3: Psychiatric impairment rating scale – travel

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population: Can travel to new environments without supervision.
Class 2	Mild impairment: can travel without support person, but only in a familiar area such as local shops, visiting a neighbour.
Class 3	Moderate impairment: cannot travel away from own residence without support person. Problems may be due to excessive anxiety or cognitive impairment.
Class 4	Severe impairment: finds it extremely uncomfortable to leave own residence even with trusted person.
Class 5	Totally impaired: may require two or more persons to supervise when travelling.

Table 11.4: Psychiatric impairment rating scale – social functioning

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population: No difficulty in forming and sustaining relationships (eg a partner, close friendships lasting years).
Class 2	Mild impairment: existing relationships strained. Tension and arguments with partner or close family member, loss of some friendships.
Class 3	Moderate impairment: previously established relationships severely strained, evidenced by periods of separation or domestic violence. Spouse, relatives or community services looking after children.
Class 4	Severe impairment: unable to form or sustain long term relationships. Pre-existing relationships ended (eg lost partner, close friends). Unable to care for dependants (eg own children, elderly parent).
Class 5	Totally impaired: unable to function within society. Living away from populated areas, actively avoiding social contact.

Table 11.5: Psychiatric impairment rating scale – concentration, persistence and pace

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population. Able to pass a TAFE or university course within normal time frame.
Class 2	Mild impairment: can undertake a basic retraining course, or a standard course at a slower pace. Can focus on intellectually demanding tasks for periods of up to 30 minutes, then feels fatigued or develops headache.
Class 3	Moderate impairment: unable to read more than newspaper articles. Finds it difficult to follow complex instructions (eg operating manuals, building plans), make significant repairs to motor vehicle, type long documents, follow a pattern for making clothes, tapestry or knitting.
Class 4	Severe impairment: can only read a few lines before losing concentration. Difficulties following simple instructions. Concentration deficits obvious even during brief conversation. Unable to live alone, or needs regular assistance from relatives or community services.
Class 5	Totally impaired: needs constant supervision and assistance within institutional setting.

Table 11.6: Psychiatric impairment rating scale – employability

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population. Able to work full time. Duties and performance are consistent with the injured worker's education and training. The person is able to cope with the normal demands of the job.
Class 2	Mild impairment. Able to work full time but in a different environment from that of the pre-injury job. The duties require comparable skill and intellect as those of the pre-injury job. Can work in the same position, but no more than 20 hours per week (eg no longer happy to work with specific persons, or work in a specific location due to travel required).
Class 3	Moderate impairment: cannot work at all in same position. Can perform less than 20 hours per week in a different position, which requires less skill or is qualitatively different (eg less stressful).
Class 4	Severe impairment: cannot work more than one or two days at a time, less than 20 hours per fortnight. Pace is reduced, attendance is erratic.
Class 5	Totally impaired: Cannot work at all.

Using the PIRS to measure impairment

11.13 Rating psychiatric impairment using the PIRS is a two-step procedure:

1. Determine the median class score.
2. Calculate the aggregate score.

Determining the median class score

11.14 Each area of function described in the PIRS is given an impairment rating which ranges from Class 1 to 5. The six scores are arranged in ascending order, using the standard form. The median is then calculated by averaging the two middle scores eg:

Example A: 1, 2, 3, 3, 4, 5 Median Class = 3

Example B: 1, 2, 2, 3, 3, 4 Median Class = 2.5 = 3*

Example C: 1, 2, 3, 5, 5, 5 Median Class = 4

*If a score falls between two classes, it is rounded up to the next class. A median class score of 2.5 thus becomes 3.

11.15 The median class score method was chosen as it is not influenced by extremes. Each area of function is assessed separately. While impairment in one area is neither equivalent nor interchangeable with impairment in other areas, the median seems the fairest way to translate different impairments onto a linear scale.

Median class score and percentage impairment

11.16 Each median class score represents a range of impairment, as shown below:

Class 1 = 0–3%

Class 2 = 4–10%

Class 3 = 11–30%

Class 4 = 31–60%

Class 5 = 61–100%

Calculation of the aggregate score

11.17 The aggregate score is used to determine an exact percentage of impairment within a particular median class range. The six class scores are added to give the aggregate score.

Use of the conversion table to arrive at percentage impairment

11.18 The aggregate score is converted to a percentage score using the conversion Table 11.7, below.

11.19 The conversion table was developed to calculate the percentage impairment based on the aggregate and median scores.

11.20 The scores within the conversion table are spread in such a way to ensure that the final percentage rating is consistent with the measurement of permanent impairment percentages for other body systems.

Table 11.7: Conversion table

% Impairment	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																66	65	70	74	78	83	87	91	96	100

Conversion table — explanatory notes

a. Distribution of aggregate scores

- The lowest aggregate score that can be obtained is: 1+1+1+1+1+1=6.
- The highest aggregate score is 5+5+5+5+5+5= 30.
- The table therefore has aggregate scores ranging from six to 30.
- Each median class score has an impairment range, and a range of possible aggregate scores (eg class 3 = 11-30 per cent).
- The lowest aggregate score for class 3 is 13 (1 + 1 + 2 + 3 + 3 + 3 = 13).
- The highest aggregate score for class 3 is 22 (3 + 3 + 3 + 3 + 5 + 5 = 22).
- The conversion table distributes the impairment percentages across aggregate scores.

b. Same aggregate score in different classes

- The conversion table shows that the same aggregate score leads to different percentages of impairment in different median classes.
- For example, an aggregate score of 18 is equivalent to an impairment rating of
  - 10% in Class 2,
  - 22% in Class 3,
  - 34% in Class 4.
- This is due to the fact that an injured worker whose impairment is in median class 2 is likely to have a lower score across most areas of function. They may be significantly impaired in one aspect of their life, such as travel, yet have low impairment in social function, self-care or concentration.
- Someone whose impairment reaches median class 4 will experience significant impairment across most aspects of his or her life.

Examples: (Using the previous cases)

Example A

PIRS scores						Median class
1	2	3	3	4	5	= 3

Aggregate score						Total	% Impairment
1 +	2 +	3 +	3 +	4 +	5 =	18	22%

Example B

PIRS scores						Median class
1	2	2	3	3	4	= 3

Aggregate score						Total	% Impairment
1 +	2 +	2 +	3 +	3 +	4 =	15	15%

Example C

PIRS scores						Median class
1	2	3	5	5	5	= 4

Aggregate score						Total	% Impairment
1 +	2 +	3 +	5 +	5 +	5 =	21	44%