Newsletter

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GEPIC 20 Years On - Impairment Assessment Training
Current Issues Regarding the GEPIC

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Introduction

It is now 20 years since the GEPIC was incorporated into legislation in July 2006. A Newsletter was published in September 2010. Across Victoria the instrument has been widely accepted as fair, practical, and forensically robust, underpinning hundreds of thousands of assessments for WorkCover, the Transport Accident Commission (TAC), and Wrongs Act 1958 claims. Despite its maturity and the profession's broad familiarity, recurring problems persist: definitional confusion, calculation errors, inconsistent linkage between symptoms, mental state and ratings, misuse of rare exceptions, and ongoing difficulty with apportionment—particularly distinguishing secondary from non secondary psychiatric impairment.

It is appropriate to update the Newsletter now, 16 years after the 2010 Newsletter and 20 years after the GEPIC was implemented. This document summarises current issues, legal updates relevant to thresholds, and practical guidance for trainees, with focused discussion on apportionment, stability, neurological–psychiatric overlap, and common errors.

Background and evolving legal context

The 2010 Guidelines catalogued early implementation problems: misunderstanding of definitions, inconsistent scoring across domains, and failure to use the within class refinement feature intended to anchor class placement to real world functioning. These issues remain salient.

Thresholds under the Wrongs Act 1958 have shaped practice. A 2003 amendment introduced "significant injury" gateways, deeming some injuries as significant without further assessment (loss of a foetus or breast; specified perinatal psychiatric injury). The significant injury thresholds required >10% WPI for psychiatric injury not secondary to physical injury. A 2015 amendment reduced the impairment levels required to establish "significant injury," with current thresholds at 10% for psychiatric injury not secondary to physical injury.

In Victoria, March 2024 WorkCover reforms materially changed access to ongoing weekly payments. Certain entitlements now require a whole person impairment (WPI) greater than 20% (i.e. 21% or more). Psychiatric impairment can be counted only when it is not secondary to physical injury, and physical and psychiatric impairments cannot be combined. This elevates the importance of rigorous apportionment and precise separation of secondary from non secondary psychiatric components.

Reliability and forensic maturity

A 2016 statistical analysis of trainee scoring across five case studies showed over 70% reliability—encouraging, yet indicative of room for improvement. Familiarity, experience, and disciplined adherence to the GEPIC methodology improve inter-rater consistency over time; clear forensic reasoning and transparent documentation remain essential.

Persistent problem areas

Apportionment- separating unrelated and secondary psychiatric impairment from non secondary psychiatric impairment.

This is more difficult than apportioning physical injuries, partly because the distinction is artificial and often overlaps. For example, a claimant involved in a car accident regains consciousness and is horrified to see that a leg has been traumatically amputated. Is there a non secondary component? Usual indicators of a non secondary component include symptoms of trauma: nightmares, flashbacks, hypervigilance and so forth.

The core questions include:

- Is there a work , transport , or personal injury related psychiatric condition causing impairment?
- Are there unrelated psychiatric contributors to impairment?
- What proportion of impairment is secondary or consequential to physical injury?
- What is the whole person psychiatric impairment (WPI)?
- After excluding unrelated impairment and all impairment secondary to physical injury, what is the final non secondary psychiatric impairment?

Using a structured, descriptor-based approach, the assessor should identify the number and severity of descriptors and symptoms attributable to:

- The claimed injury (non secondary psychiatric injury).
- Any secondary (consequential to physical injury) psychiatric injury.
- Unrelated mental and behavioural disorders.

WPI is then apportioned in reasoned percentages reflecting those components.

Determining secondary and non secondary impairment can be difficult. If there is no physical injury, then any impairment from the injury is non secondary. If there is a physical injury leading to a psychiatric injury and no other cause, then the impairment is secondary to physical injury. Apportionment becomes particularly challenging with Wrongs Act claims involving medical misadventures, such as the consequences of a failed operation. There is likely to be secondary psychiatric impairment, but there may also be non secondary psychiatric injury from the shock of being informed of the failed procedure.

The "Annotations for Determining Non Secondary Psychiatric Impairment" (Epstein, Strauss) discuss seven categories and should be kept at hand for reference.

Category 5 clarifies that brain injuries—as with any physical injury—can lead to secondary mental harm or, in rare circumstances, be regarded as not secondary; careful differentiation is required. Accordingly, Intelligence very rarely scores more than 1.

Complex apportionment challenges include:

- **Neurological–psychiatric overlap:** head injuries, functional neurological disorders, post-concussion syndrome. Establish whether the mental harm is a direct psychological injury (non-secondary) or consequential to physical/neurological injury (secondary).

- **Pain disorders, especially Somatic Symptom Disorder with predominant pain:** evaluate whether psychiatric symptoms flow from pain (often secondary) or constitute an independent, non-secondary psychiatric disorder precipitated by work or transport events.

- **Workplace response to physical injury:** for example, bullying or adverse management may constitute non-secondary harm distinct from the index physical injury.

- **Medical negligence:** operative failure or delayed diagnosis can precipitate non-secondary psychological injury; distress linked to pain/disability is secondary.

- **Complex PTSD (only ICD-11 diagnosis) requires 3 components:**
  - Causation from multiple traumatic events such as:
    - multiple incidents of child abuse, prolonged domestic violence, concentration camp experiences, torture, slavery, and genocide campaigns
  - Satisfaction of all PTSD criteria plus
  - Disturbances of affect regulation, self-concept and relationships

It is unlikely that a single work or transport incident would cause CPTSD; however, such incidents may aggravate pre-existing CPTSD. The key task is to determine and quantify the increment in impairment above pre-injury baseline that is causally linked to the claimed event and is not a consequence of physical injury.

Stability

Stability is critical. If the non-secondary psychiatric injury is not stable, a GEPIC impairment rating should not be issued (rare exceptions aside). Stability means maximum medical improvement: the rating would not vary by more than 3% (AMA4) over the next 12 months with or without treatment, regarding any work- or accident-related non-secondary psychological injury. Instability of secondary psychiatric components does not preclude rating the non-secondary component if that component itself is stable.

Practical indicators:

- Stability is likely when symptoms and function related to the non-secondary injury have remained unchanged for years, irrespective of treatment level. A suggested formulation: "Although the claimant has not received adequate psychiatric or psychological treatment, given the five-year duration and unchanged symptomatology, I consider maximum medical improvement reached."

- Indicators of instability include: injury within the past 12 months; recent initiation of new treatment for the non-secondary condition; a recent unrelated accident affecting non-secondary symptoms; engagement in pain programs likely to alter non-secondary symptoms; recent return to work; recent major life disruptions (marital breakdown, serious illness or bereavement, homelessness, significant financial loss).

Clarification of some GEPIC terms

- **Mood**: The descriptors for Class 3 in Mood are headed by the phrase:
  - Moderate – moderate symptoms: some or all of the below
    The previous version, the Guide to the Rating of Psychiatric Disorders, stated:
  - Mood Class 3 moderate symptoms: most or all of the below
    This led to claimants with Class 3 descriptors such as persistent suicidal ideation or suicide attempts and no other Class 3 descriptors not meeting the criteria for Class 3, resulting in some inequitable scores. Accordingly, the heading was broadened by changing most to some. Some can refer to just one descriptor if it is regarded as severe and requires ongoing treatment.

- **Judgement**: One Class 3 descriptor is "inappropriate spending of money or gambling." This was an error; it is a descriptor that should have been in Behaviour as it recognises an action. This should not be scored in Judgement.

Common errors in applying the GEPIC

- **Double counting**: assigning the same symptom to multiple mental functions. Anchor each symptom to the single most appropriate domain.
- **Mishandling fractional medians:** follow the Guide's rules exactly for rounding and class selection.
- **Inconsistency with the Mental State Examination (MSE):** for example, recording "no perceptual disturbance" on MSE while rating Perception in Class 2. Ensure internal coherence among history, MSE, collateral, and domain ratings.
- **Misuse of Intelligence:** using descriptors regarding Thinking to score Intelligence. As stated above, impairments of Intelligence are almost always due to a brain injury and, if so, are secondary to a physical injury.
- **Allotting symptoms to the wrong class:** for example, nightmares reflect anxiety and are scored in Mood. Flashbacks, by contrast, are a perception issue and are scored in Perception in Class 2, and in Class 3 if there are flashbacks with dissociation causing significant distress.
- **Neglecting within-class refinement:** use the refinement mechanism of severity ratings to align class placement with the claimant's real-world function.
- **Global mismatch:** a low WPI that contradicts obvious severe dysfunction (e.g. an ill-health retired police officer, isolated, estranged, with alcohol misuse, living alone, scoring 15% WPI). Revisit domain descriptors, collateral information, and functional impacts to resolve discrepancies.

Methodological discipline for trainees

- **Causation first:** clearly delineate the event(s), exposure(s), and temporal relationship between symptoms and index events.
- **Diagnosis helps but does not determine WPI:** a psychiatric diagnosis is not required to assign impairment, though milder ratings are likelier without a defined disorder. The GEPIC rates criterion functions, not checklists of syndrome symptoms.
- **Use the median method:** the Guide relies on the median across domains as a more robust aggregate of functional severity than mean scores.
- **Document apportionment explicitly:** list descriptors/impairments attributable to each cause (non-secondary, secondary, unrelated), state percentages, and justify with evidence.
- **Collateral and records:** obtain treating summaries when feasible; they can inform prognosis and stability (e.g. expected plateau dates).

Reporting issues

The two commonest reasons the TAC and WorkSafe seek a supplementary report are:

- The operator reading the report does not understand why the assessor has decided on the scores for the different classes.
- The operator does not understand the assessor's reasoning regarding apportionment of secondary and non-secondary psychiatric impairment.

The assessor must write a brief "impairment assessment" paragraph clarifying the reasoning behind the scoring. The opinion should also make clear the reasoning involved in determining secondary and non-secondary psychiatric impairment.

Special populations and practicalities

- **Children:** assessments are interim; no permanent impairment rating should be issued until age 18 or until the injury stabilises.
- **Language or communication barriers:** arrange accredited interpreters or signers; ensure reliability of history and MSE.
- **Feigning and non-credible presentation:** deception is possible. Triangulate with records, behavioural observations, psychometrics where appropriate, and functional consistency checks.

Wrongs Act claims

Wrongs Act claims are dealt with differently. There has to be a "significant injury" for the claim to proceed. Familiarity with deemed "significant" injuries obviates further assessment in limited categories (loss of a foetus, loss of a breast, specified perinatal psychiatric harm). For other claims, the current thresholds for a "significant injury" are:

- 5% or more (AMA4) for spinal injuries.
- More than 5% for other physical injuries.
- 10% or more non-secondary psychiatric impairment (GEPIC)

A Certificate of Assessment is completed that must state whether the degree of impairment resulting from the injury satisfies the threshold level but must not state the specific degree of impairment.

Implications of the 2024 WorkCover changes

- Psychiatric WPI is counted only when it is not secondary to physical injury; psychiatric and physical WPI must not be combined.
- The >20% WPI eligibility test heightens the importance of accurate, defensible non-secondary ratings. Over- or under-attribution can inappropriately include or exclude claimants from entitlements.
- Increased scrutiny from all parties—treaters, insurers, lawyers, and tribunals—should be expected regarding apportionment and stability reasoning.

Frequently asked issues—practical answers for trainees

- **Separating accident-related and unrelated impairment:** enumerate descriptors and their severities for each source; apportion WPI accordingly.
- **Pre-existing impairment timing:** estimate pre-existing impairment at the time of assessment, not at the time of injury.
- **Treatment assumptions:** rate current impairment at presentation, not hypothetical outcomes with **treatment.**
- **Multiple accidents/injuries:** repeat the attribution process for each event, distinguishing secondary vs non-secondary for each, then apportion.
- **Stability timeframes:** 18+ months is a reasonable guide but depends on access to care and prognosis; treating input can assist.
- **Diagnosis requirement:** a formal diagnosis is not strictly required; expect slight to mild impairment in such cases.
- **Consistency across assessors**: improves with disciplined application to the descriptors and experience.
- **Terminology:** "non-secondary" is preferred over "primary," aligning with legislative intent and avoiding ambiguity (cf. "pure mental harm" vs "consequential mental harm" in other jurisdictions).
- **Time demands:** a full clinical–forensic interview is essential; the GEPIC scoring itself is relatively brief once the evidence base is established.

Checklist for a defensible GEPIC report

- Clarify index events, exposures, and timeline.
- Identify all psychiatric conditions; specify which are non-secondary vs secondary vs unrelated.
- Determine stability of the non-secondary condition; defer permanent rating if not stable (with rare exceptions).
- Conduct a thorough MSE; ensure alignment with domain ratings.
- Assign domain classes without double counting; use within-class refinement.
- Calculate the median correctly; apply rounding rules precisely.
- Apportion WPI transparently: show your working and percentages.
- Cross-check global functioning with the numerical WPI; reconcile discrepancies.
- Address legal thresholds relevant to the claim type (WorkCover, TAC, Wrongs Act).
- State limitations, uncertainties, and the basis for opinions.

Conclusion

Two decades on, the GEPIC remains an effective, fair, and trusted framework for psychiatric impairment assessment, but it demands methodological rigour. The core challenges—apportionment (especially distinguishing non-secondary from secondary components), stability determination, and internal consistency—are solvable through disciplined application of descriptors, transparent reasoning, and careful documentation. Legal changes, particularly Victoria's 2024 WorkCover reforms prohibiting combination of psychiatric and physical impairment and setting a >20% WPI eligibility bar, intensify the need for precise non-secondary ratings. Trainees who anchor their assessments in clear causation analysis, accurate domain scoring, appropriate within-class refinement, and explicit apportionment will produce reliable, defensible reports that align with statutory intent and real-world functioning.