SASOP Guidelines to the Management of Impairment Claims On Psychiatric Grounds

Third Edition

2017

Issued by the South African Society of Psychiatrists (SASOP)

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PREFACE TO THE THIRD EDITION

The need for a standardised approach to the assessment of patients with psychiatric disorders for medical disability was initially addressed in 1995 by a task-team comprising nominated psychiatrists from the South African Society of Psychiatrists and medical advisors of the Life Insurance Industry.

With the advent of time, the resulting Second Edition was drawn up by the participants, distributed widely for comments, and approved by the executive committee of the South African Society of Psychiatrists.

It was felt by the Life Insurance Industry, in light of significant developments in diagnosis, management and therefore outcomes of psychiatric patients, that the Guidelines required updating to include reference to new diagnostic tools and management techniques in order to be as fair as possible to all parties.

INTRODUCTION

Psychiatric causes of disability now comprise the largest proportion of disability claims admitted in the S.A. Insurance Industry.

Among these, mood disorders, anxiety and post-traumatic stress disorders are leading the diagnosis list. Work-related stress is invariably cited as a major contributing factor.

Psychiatrists are being put under increasing pressure to declare a patient disabled on psychiatric grounds. However, lack of a standard approach to dealing with these patients has led to frustration among treating professionals and the insurance industry. SASOP and members of the Medical and Underwriting Subcommittee of the Association of Savings and Investments of South Africa (ASISA) have compiled these peer-reviewed guidelines, to aid the assessment and reporting on psychiatric disability.

The assessment of disability has become increasingly difficult due to:

- Inconsistencies in diagnosis, management and prognosis between medical professionals.
- Lack of objectivity in reports.
- Informing the patient they have a permanent condition before allowing sufficient time for the treatment plan to work.
- Inadequate treatment in terms of:
    - Dosages of medication either inappropriately low, excessive or mix of medications making it impossible for a patient to work.
    - Duration of any treatment modality whether medication or other.
    - Appropriateness of the treatment modalities applied (i.e. evidence-based best treatment approach).
    - Lack of referral to rehabilitation specialists (e.g. psychologists, occupational therapists.
    - Lack of return to work and vocational rehabilitation programs.
- Using work-related or psychosocial conditions as a reason for disability, when the claimant could function in another occupational environment.
- Affording extended time off work without adequate reason for doing so.

PURPOSE OF THIS DOCUMENT

The primary aim of all insurers is pay all valid claims, however this is becoming increasingly difficult for the reasons listed above. Psychiatric conditions by their nature can lend themselves to symptom-exaggeration by the claimant or sympathy by the treating psychiatrist. Therefore the aim of this document is to assist in identifying those people who should be paid their benefit for the right reasons.

This guideline will assist the understanding by the psychiatric community, as to what is expected from a psychiatric assessment and report and why the information is necessary:

- To standardise the psychiatric evaluation and report for a disability assessment, by providing a list of the minimum psychiatric information requirements necessary for a third party to make an informed decision on disability.

- To provide a guideline for insurance companies that allows for the application of a consistent approach to disability claims assessment on psychiatric grounds based on standardised reporting by treating and independent professionals.

- To assist psychiatrists in understanding the importance of assessing only the impact of the disorder on occupational and social functioning.

- Ultimately to:

    - Relieve pressure on the treating psychiatrist / patient relationship

    - Prevent patients from being labelled prematurely as disabled

    - Ensure that all parties are aware that insurance claims are dealt with according to the principles of Treating Customers Fairly.

    - Provide an opportunity for re-entry into the workplace; even after a period of prolonged disability, considering the negative impact of not working vs. the benefits of working,

CRITERIA FOR ASSESSING PSYCHIATRIC DISORDERS

Basic principles

These guidelines reflect current international best practice with regard to the assessment of impairments due to mental disorders. It must be emphasized that the presence of a diagnosis does not necessarily suggest the patient is impaired. When mental illness is severe and profound, occupational impairment may usually be obvious but it is more difficult to assess occupational impairment when mental illness is subtler and combined with personality factors as well as possible monetary- and other secondary gain.

The guidelines are intended, on the one hand, to prevent premature and inappropriate recommendations being made concerning permanent functional impairment, and on the other hand, to ensure that genuine cases are not discriminated against. We believe that this is the best way of safeguarding the rights of people with mental disorders. They are intended to assist the psychiatrist who is often placed in a difficult situation when having to assess patients for medical disability.

There are no specific psychiatric disorders that will necessarily result in permanent disability. Degrees of functional impairment vary widely among individuals suffering from the same psychiatric disorder and many other factors interact to determine the functional capacity of an individual in a specific work-situation.

Any psychiatrist performing an independent psychiatric examination is presumed to have a neutral, unbiased position with regard to the patient. It is accepted and even expected that mental health care practitioners align themselves closely with their patients in an environment of unconditional positive regard, hence it may be even more difficult for psychiatrists to reach the neutral, unbiased position that is expected of all independent examiners, yet it is vital to do so.

It stands to reason therefore that the treating psychiatrist should avoid serving as an independent medical examiner on behalf of their own patients. The dual role can be detrimental to the therapeutic relationship and a considerable source of bias for the examiner.

The treating psychiatrist should therefore not be involved in assessing their own patients for the purpose of insurance and other disability applications and psychiatric impairment assessments. The roles of therapist and forensic assessor are fundamentally incompatible and may lead to complications for both patients and clinicians.

Occupational therapists may play a major role in the work rehabilitation process through Functional Capacity Assessments and rehabilitation of workers with an injury or disability for return-to-work. Functional Capacity Assessments is a method commonly used in practice for assessing the residual capacity of the injured worker for returning to work.

The work rehabilitation process usually involves an assessment of the match between the demands of the worker's job in his or her workplace and the residual functional capacity of the worker, the results of which then guide interventions such as what constitutes reasonable accommodation for the individual involved. This is usually the domain of the occupational therapist.

Vocational rehabilitation is a process whereby those disadvantaged by illness or disability can be enabled to access, maintain or return to employment, or other useful occupation. This applies to those with temporary and permanent impairments. It is strongly recommended that occupational therapists be involved as early as possible in the sick leave process to facilitate interaction between the employer and the patient with a view to return to work.

In fact, it is suggested that the moment a psychiatrist issues a sick leave certificate recommending sick leave of one month or more, the psychiatrist has an obligation to immediately introduce a return-to-work plan in line with a recovery- and disability prevention model. It cannot be stressed enough that work is generally good for an individual and that work-absence may potentially lead to disability.

The very first time any patient is granted sick leave for a month or more the treating psychiatrist should consider the possibility that the patient may potentially end up permanently disabled. Permanent disability is associated with increased mortality and decreased quality of life in all domains of living including physical, emotional and financial. Every effort should thus be made to prevent permanent disability.

Both treating and independent psychiatrists are encouraged to engage in discussions about a case in a respectful and professional manner avoiding an adversarial approach and respecting each other's role in the process of assessing impairment.

A fundamental shift in this guide is the focus on the recovery model, adoption of a disability prevention model and the importance of remaining in employment

- All mental health care practitioners' including the treating psychiatrist's efforts should be focussed on strengthening resilience with a view to early return to work.
- Involvement of occupational therapy services as early as possible with a view to assessment of functional capacity, vocational rehabilitation and liaison with the employer
- The psychiatrist should never lead a patient to believe that he or she will be declared permanently medically unfit on the basis of a psychiatric report.
- The psychiatrist's function is to assess the areas of impairment and to indicate whether it is permanent or not, while the actual decision regarding disability is taken by a separate panel of assessors in the insurance industry.
- Impairment vs. Disability; It is important in the context of insurance disability claims, to distinguish between the concepts of impairment and disability.
    - Disability is the alteration of capability to meet personal, social or occupational demands due to impairment and is assessed by non-medical means.
    - Impairment is the alteration of normal functional capacity due to a disease, and is assessed by medical means after a diagnosis has been established, and appropriate and optimal treatment applied.
    - In practical terms, impairment assessment entails examining the diagnosis and current and future treatment options before determining on medical grounds which functions the person is still able to do and which not. Occupational therapists are well positioned to assess functional impairment in mentally ill patients through functional capacity assessments and hence play an important role prior to taking a final decision regarding extent of impairment.
    - To assess disability entails assessing the extent of the person's impairment needs in conjunction with their job description, policy disability clause conditions and personal factors such as education and experience.

    - Disability assessment is a legal and not a medical decision, taken by a panel of experts including a
        - medical advisor,
        - legal advisor
        - claims consultant.
    - The doctor treating the patient cannot express an opinion on disability as the policy disability clause conditions are a vital part of the assessment.

- The difference between “permanence of impairment” and “maximum medical improvement” can be explained thus: A decision is not taken whether the mental illness is permanent, which it is in most instances, but rather whether the impairment is permanent. Whilst a decision on maximum medical improvement is taken when no significant improvement is expected to take place in the next 12 months, permanent impairment is a more difficult decision and may have to be reviewed after two or three years as it is known that conditions such as schizophrenia or severe major depressive disorder may improve over time and that that impairment may become less over an extended period of time in some instances.

- The treating psychiatrist is expected to have a clear treatment- and return-to-work plan from the outset and be able to communicate these plans clearly to the insurer.

- The accuracy of the information provided by the treating psychiatrist is of paramount importance. Hence the need for an independent assessment to diminish the role-conflict in terms of doctor-patient relationship and advocacy role.

- The diagnosis of a psychiatric disorder does not necessarily indicate the severity of impairment.

- Subjective distress is not equivalent to functional impairment.

- Employment dissatisfaction and the presence of psychosocial stressors do not mean that the subject is functionally impaired.

- Psychiatric evaluation relies heavily on the honesty, accuracy and completeness of the patients’ self-reporting as well as the objectivity of the information provided by the treating psychiatrist. Distortions, both intentional and unintentional, may frequently occur when compensation is a factor.

Any inconsistencies in the history, symptoms, diagnosis, or treatment must be noted in the report by the treating or independent psychiatrist.

- The therapeutic relationship necessarily leads to an empathic stance by the treating psychiatrist to always consider their patients' best interest. Therefore the insurance industry may call for an independent opinion.

- Even though a disorder may be in remission, a patient may be at risk of future relapse, particularly due to reduced stress tolerance as a residual symptom. Psychiatric disorders by nature are often chronic relapsing disorders. It is important though to realise that the risk of relapse per se is not grounds for disability. This is determined by the mismatch between the patient's remaining functionalities and the job requirements.

Another important principle is that any medical or psychiatric condition cannot be regarded as treatment resistant, and therefore permanent and irreversible, unless all reasonable and recognised treatment options have been exhausted. It is therefore recommended that treating psychiatrists regularly consult recognised treatment guidelines, such as those published by SASOP, or other guidelines which are freely available online for example:

- National Department Standard Treatment Guidelines
- World Federation of Societies of Biological Psychiatry Guidelines
- The NICE Guidelines
- AMA expert consensus guidelines
- The Texas Medication Algorithm Project
- Other contemporary guidelines e.g. UpToDate

Psychiatric diagnosis and reasonable medical treatment

It is important to supply as much information as possible in order for the insurer to assess the claim according to the diagnosis and treatments prescribed. This will assist where permanence is a condition of the policy.

The extent to which an insurer can insist that a claimant must undergo certain psychiatric treatment or procedures, depends on:

- The risks, if any, attached to such treatment and whether for the average patient the risks outweigh the potential benefits of the treatment.
- The degree of success which can be expected by undergoing such treatment and
- It must be in accordance with what the average reasonable patient with a similar condition would be prepared to undergo.

It is assumed that the most recent SASOP Treatment Guidelines will be a reference guide for treatment protocols and timeframes regarding expected recovery periods.

Informed consent

All psychiatrists performing a psychiatric impairment assessment are urged to obtain full informed consent from the patient prior to conducting a psychiatric impairment assessment.

An informed consent document provided by the psychiatrist should cover the following points:

- The purpose of the assessment is to provide an opinion about the mental state and level of impairment and not for treatment purposes.
- All observations and interactions may be recorded by the doctor from the time of entry into the doctor's premises.
- The information and results obtained from the assessment are not confidential. They will be shared with the referral source and may be disclosed to the court, administrative body or agency that makes the final decision regarding disability.
- They were made aware of any potential conflicts of interest the doctor may have.
- They have read and understood the terms and conditions of the informed consent document.

- Refusal to answer specific questions may influence the assessment and may be reported to the referral source.

The psychiatric evaluation

All available sources of information should be used in an assessment.

Taking into account the details of the specific case, the psychiatric assessment should include the following, where appropriate:

- A full psychiatric history and mental status examination
- Full occupational history and current occupational duties, including highest level of education
- Collateral information – from family members, employers, or any other appropriate sources
- Perusal of previous medical documentation
- Appropriate special investigations (e.g. neuro-imaging and neuropsychological testing in cases of dementia or other cognitive disorders)

The independent psychiatrist

- It should be made clear to the patient that the purpose of the interview is to perform a psychiatric assessment. This will form the basis of a psychiatric report, which will be forwarded to the insurance company who requested the assessment. The patient must be alerted that any information divulged may be included in the report.
- In cases where the psychiatrist deems it necessary to discuss aspects of the case with another party (such as the treating doctor, or an employer), prior informed written consent must be obtained from the patient.
- Patients are entitled to a copy of your report. However, the report should be requested through the insurance company and only released with the psychiatrist's written permission.
- The emphasis of the treating physician should be on return to work, based on the recovery model.
- Furthermore, the independent psychiatrist:
    - Will be perusing all previous medical documentation including a full psychiatric report by the treating psychiatrist(s) and all other documentation thought relevant by the insurer.
    - May contact the treating mental health care professionals for additional information.

Assessing the degree of impairment

The 2001 SASOP Guidelines were based on the 5th edition of the AMA Guides to the Evaluation of Permanent Impairment and the current edition is based on the 6th edition. In the 6th edition of the AMA Guides to the Evaluation of Permanent Impairment, there is a paradigm shift adopting a contemporary model of disablement: it is simplified, functionally based and internally consistent. Also, it uses the terminology and conceptual framework of disablement of the International Classification of Functioning, Disability and Health (ICF), a World Health Organization document.

The newest (6th) edition of the AMA Guides to the Evaluation of Permanent Impairment aims to be more diagnosis and evidence-based and attempts to optimize inter-rater and intra-rater reliability. Rating percentages are functionally based. It stresses conceptual and methodological congruity within and between organ system ratings and it has as primary purpose the rating of impairment to assist adjudicators and others in determining the financial compensation to be awarded to individuals who, as a result of illness or injury, have suffered measurable physical and/or psychological loss.

The relationship between impairment and disability remains complex and difficult, if not impossible, to predict. In some conditions there is a strong association between level of injury and the degree of functional loss expected in a patient's activity for example mobility and activities of daily living.

But the same level of injury is in no way predictive of an affected individual's ability to participate in major life functions (including work) when appropriate motivation, technology and accommodations are available. Disability may be influenced by physical, psychological and psychosocial factors that can change over time.

In assessing impairment for a mental disorder, the first critical step is to make a definitive diagnosis based on the DSM. The presence of a diagnosis does not necessarily suggest the patient is impaired.

Despite the wide range and availability of psychological tests and ratings scales, the patient interview, review of records and mental status examination remain the foundation for evaluation of the patient and determining impairment.

In order to assess the degree of functional impairment, it is necessary to make a detailed exploration of all of the symptoms, and the effects that they have on the patient.

The American Medical Association Guides to the Evaluation of Permanent Impairment suggested method for assessing the severity of functional impairment in patients with psychiatric disorders uses three rating scales namely:

1. The Brief Psychiatric Rating Scale
2. The Global Assessment of Functioning Scale
3. The Psychiatric Impairment Rating scale

Special considerations

- Attention must be given to the effects of medication on signs and symptoms and ability to function (e.g. benzodiazepines may be responsible for such symptoms as drowsiness, lethargy, impaired concentration and memory and impulsivity)
- Unemployment and its resultant inactivity may be confused with psychiatric symptoms such as lack of motivation, listlessness, reversed sleep-cycle, and poor self-esteem
- The assessment of motivation is problematic. It is often difficult to distinguish from mental impairment, e.g. anhedonia. Underlying personality traits may be a major determinant of motivation. For many patients with poor motivation, proper rehabilitative programs may significantly improve function.

Assessing whether impairment can be regarded as permanent or not

- Permanency is where the impairment becomes static or well stabilized and is not likely to remit in the future despite medical treatment. Decisions regarding the permanence of impairment cannot be made lightly. Impairment can only be regarded as permanent after optimal treatment has been applied; i.e. sufficiently high doses of the most effective medication for a long enough period of time, plus appropriate psychotherapy by a suitably qualified therapist and sufficient time allowed for recovery during which continued vocational rehabilitation took place administered by an occupational therapist.

Definitions of treatment-refractoriness usually refer to refractoriness to first-line treatments. These days, there are many other lines of treatment that can be explored that are effective in treating even 'refractory' patients. In other words, a patient should not be considered permanently ill until all reasonable treatment

options have been exhausted. Treatments applied need to be those generally recognised as appropriate for the psychiatric disorder in question, and evidence-based. (N.B. sleep therapy and other forms of alternative treatment options as per the SASOP treatment guideline are not recognised forms of treatment for any psychiatric disorder).

Patient compliance is also important – a patient who does not keep psychotherapy appointments, or who does not take medication regularly, cannot be said to be non-responsive to treatment.

Sometimes patients cannot afford expensive private prescription medication, especially when these are not covered by their medical aid options. In such cases reasonable optimal treatment should be evaluated in terms of the medication available at local government institutions.

THE PSYCHIATRIC REPORT

Treating psychiatrist's report

Care should be taken in drawing up the psychiatric report, as important decisions are made based on the information provided. It needs to be kept in mind that the report may be scrutinised by, among others, the patient, insurance company claims assessors, other doctors and legal representatives. The report should be comprehensive, objective and accurate. Financial advisors are not entitled to receive the report directly from the author. The report will only be released by the insurance company to the patient if the author has given consent for release in line with prevailing legislation.

The following psychiatric interview template is recommended:

PSYCHIATRIC IMPAIRMENT ASSESSMENT INTERVIEW TEMPLATE

Member Name **:** …….

Date of Birth **:** …….

Marital Status **:** …….

Occupation **:** …….

Last Worked **:** …….

Scheme Name and Code **:** …….

Treating Psychiatrist **:** …….

Primary-Care Doctor **:** …….

Date of this examination:

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Date of first consultation with the claimant:

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Appointment schedule over the past year e.g. 4-weekly:

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What is the psychiatric diagnosis for which the patient had been treated prior to referral for independent psychiatric opinion?

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Current psychiatric symptoms?

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Chronological history of events leading up to cessation of work:

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What is the Claimant's current job? Describe responsibilities briefly.

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What does the Claimant find particularly stressful about the work?

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Which work responsibilities would the Claimant have difficulty with and why?

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Which work responsibilities would the Claimant not have difficulty with?

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Employment history:

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Does the Claimant get along with superiors/colleagues at work?

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Has the Claimant ever been involved in any disciplinary hearings?

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When last did the Claimant work? How long has the Claimant been on sick-leave?

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Please comment on any occupational therapy assessments or functional capacity assessments received:

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What kind of vocational rehabilitation measures has thus far been implemented to assist the Claimant to return to work?

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Has the Claimant's made any requests for or been offered reasonable accommodation at work?

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Which reasonable accommodative measures would the Claimant like to see being implemented at work to decrease pressure on the claimant? (Examples include a phased return to work, restructuring jobs, adjusting working time and providing support in the workplace)

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Current treatment and response thereto. Please specify names and dosages of all medication and provide details of all adjuvant therapy.

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Does the Claimant know the names and dosages of all their psychiatric medications?

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Does somebody else put out their medication to take?

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Does the Claimant experience any side-effects on their psychiatric medication?

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Clinical examination / mental state examination findings (please record general appearance, mood, anxiety, psychotic features, mental state, cognitive and social functioning etc.).

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Please comment on any psychological treatment received, consultations with psychologists etc.:

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Please comment on the Claimant's compliance with treatment (medication, follow ups with psychiatrist, consultations with psychologist etc.)

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Please provide details of any hospitalizations over the past 12 months. Please indicate the dates of admission and discharge, provide the name of the hospital to which the claimant was admitted and the reasons for admission.

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Past psychiatric history:

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Past Treatment

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Pre-morbid functioning:

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Motivation for recovery and return to work:

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Medical history:

Allergies, diabetes, epilepsy, asthma, TB, tested for HIV (and results), hypertension, hypercholesterolemia, head injuries and surgical procedures.

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Substance history (habits):

Type of substances (cigarettes, alcohol, cannabis, OTC pain tablets e.g. Adco-Dol etc). Pattern of use, longest periods of abstinence and use of self-help or professional resource.

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Family history of mental illness:

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Educational history and highest level of education:

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Results of any relevant rating scales or bedside cognitive assessments e.g. the Brief Psychiatric Rating Scale (BPRS), Psychiatric Impairment Rating Scale (PIRS), Global Assessment of Functioning Scale (GAF) or Montreal Cognitive Assessment (MOCA).

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Results of any special investigations or specialist consultations. Only provide copies of results available on file.

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Your comment on how the claimant's condition has progressed over the last 12 months. Has there been any improvement / deterioration? Please provide details.

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Is any further treatment planned or anticipated? Please provide details.

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Please comment on the claimant's ability to look after him/herself and perform everyday tasks:

Grooming and personal Hygiene: ……

Bathing/ showering: ……

Brushing teeth: ……

Dressing: ……

Sexual activity: ……

Health management: ……

Relationships: ……

Care of others / Child rearing: ……

Preparing meals and other domestic tasks: ……

Shopping: ……

Travel and Driving: ……

Leisure activities: ……

Physical exercise: ……

Social interaction: ……

Managing finances: ……

Communication device use: …… ……

Final diagnosis.

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What are the chances this Claimant returning to work?

	Excellent	**Good**	**Fair**	**Poor**
Three months				
Six months				
One year				
Two years				

Reasons for your opinion;

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Have all treatment options been exhausted?

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If not, why?

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In your opinion, what aspects of the impairment may influence the Claimant's current job specifically and what would you suggest to address those problems?

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Any other comments you feel may be of assistance to prevent permanent disability from occurring?

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Signature: …… Date:…….

Name (please print)…… Qualifications……..

Contact Number ……..

Confidentiality

As with all medical reports, confidentiality is of paramount importance and the contents are never disclosed to unauthorised parties. They may only be disclosed to a third party with the consent of the client. Should a claimant wish to obtain a copy of the psychiatric report they may apply to the insurer who will release it to them in accordance with procedural requirements as per the Protection of Personal Information Act.

It must be noted that because of the necessity for a close therapeutic relationship between doctor and psychiatrist, a second opinion from an independent psychiatrist may be sought. This is done to alleviate pressure on this relationship and is in accordance with international practice.

Future directions for becoming an independent psychiatric medical assessor

- Psychiatrists interested in becoming independent psychiatric examiners are encouraged to do the Foundation for Professional Development's (FPD) Short course in the evaluation of permanent medical impairment rating (based on the AMA Guides' 6th edition).
- In future it is envisaged that a curriculum for a psychiatry-specific course will be drawn up by SASOP.
- It remains the prerogative of the insurance companies as to whom they approach for independent opinions.

Closing remarks

At least twenty per cent of employees will experience some form of mental illness during their working lives. On balance, work is linked to good health rather than ill health and is good for psychological well-being. The effects of loss of work on the other hand can include social isolation, poverty, deterioration in physical- and mental health, and increased mortality.

The longer a person is off work, the less likely they become to ever return to work and once a person commences on certified work absence, they commonly start down a slippery slope that could end in long-term worklessness. Recovery is often faster and more successful if people can do some work while recovering.

Psychiatrists are encouraged to manage the impairments associated with mental illness that may result in cessation of work and do everything possible to prevent permanent disability from developing. This goal can be reached through:

- Frequent communication with all stakeholders including the insurance case manager, the employer and all members of the multidisciplinary team
- Effectively addressing the psychiatric condition
- Educating patients regarding the benefits of staying at work or returning to work as soon as possible.

Current available evidence undeniably points towards the befits of keeping people productively employed. It stands to reason that everything possible should be done to avoid the unfortunate outcome permanent cessation of work and psychiatrist are well positioned to play a leading role in managing the impairments associated with mental illness and preventing permanent disability from developing.

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Suggested reading

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