

Disability claims on psychiatric grounds

Recent years have seen an alarming increase in South Africa in applications for medical disability on psychiatric grounds. Psychiatric disorders now rank as the second most common indication for these applications, after musculoskeletal disorders (mainly chronic back problems). Despite its high incidence in South Africa, ischaemic heart disease features as only the third most common cause of medical disability. Of the psychiatric disorders, major depression, post-traumatic stress disorder and other anxiety disorders are the most frequently diagnosed conditions, and work-related stress is usually the major precipitating factor (Life Offices Association of South Africa — unpublished statistics).

Many of the recent disability claims are from civil servants, particularly those in the security forces. It has been suggested¹ that the changing sociopolitical order in South Africa has much to do with this state of affairs. Ongoing violence, increased workload, affirmative action, uncertainties regarding career opportunities and the changing roles of the security forces may all play a role. The costs of 'medical boarding' are high in terms of loss of human resources, often skilled and experienced. Of further concern is the substantial burden placed on the taxpayer. For example, the cost of boarding 904 police officials in the first 6 months of 1994 amounted to R250 million.¹

Practitioners (usually psychiatrists, general practitioners and clinical psychologists) are frequently faced with requests to provide reports for medical boarding and disability claims in patients with psychiatric disorders. The lack of a standardised approach and several prevalent misconceptions often complicate matters. For example, patients, their family members and employers often have premature expectations that they will be medically boarded. Once this is seen as the solution to their problems, they are less likely to be motivated for treatment, and the disorder is less likely to have a favourable outcome. Practitioners should never lead a patient to believe that he or she will be declared medically unfit on the basis of their report. Determining disability is in fact a legal decision, taking into account not only the medical condition but also the claimant's job description, experience, qualifications and relevant policy contract definitions. Disability concerns the loss of capability to meet occupational demands due to an impairment, and is usually determined by a panel of experts including a medical adviser, claims consultant and legal adviser. Impairment refers to the alteration of normal functional capacity due to a disease or injury, and is assessed by medical means, after a diagnosis has been established and appropriate and optimal treatment applied. The clinician should therefore limit his assessment to an estimate of impairment only.

A further source of confusion is the fact that patients are often not aware that medical boarding from a workplace is unrelated to the process of claiming insurance disability. The two procedures will not necessarily have comparable outcomes, since there may be differences in disability criteria due to different contractual wordings. Employers and

employees should be made aware of this and practitioners should warn their patients of the possibility of finding themselves unemployed and without an adequate income.

Perhaps the biggest problem has been the lack of a consistent approach to the assessment process. Opinions often differ when deciding at what stage a disorder should be regarded as unresponsive to treatment and likely to cause permanent impairment. It is important to remember that today many psychiatric disorders — including depression, post-traumatic stress disorder and other anxiety disorders — have a favourable outcome if treated correctly. A disorder can therefore only be regarded as treatment-refractory once optimal treatment has been tried and has failed. To regard someone as permanently disabled after only a few months or even weeks of treatment, often without optimal dosages of medication or other appropriate therapeutic intervention, is obviously incorrect. Treatment methods need to be appropriate for the condition (for example, sleep therapy is not generally recognised as an appropriate form of treatment). Modern psychiatry² emphasises specificity. Specific diagnoses require specific treatments. Pharmacotherapy can only be regarded as optimal once the medication has been taken in adequate dosage and for sufficient duration of time. Psychotherapy needs to be provided by suitably qualified individuals using recognised psychotherapeutic techniques. The *Guidelines to the Management of Disability on Psychiatric Grounds* issued as an insert to this issue of the SAMJ have been drawn up by the Society of Psychiatrists of South Africa and the Life Offices Association of South Africa, after wide consultation. They attempt to provide a practical and consistent approach to the assessment of psychiatric disability claims. The approach entails making an accurate diagnosis utilising standardised criteria according to the *Diagnostic and Statistical Manual of Mental Disorders* (4th edition),³ assessing the degree of occupational impairment, deciding whether the disorder is refractory to treatment, and estimating whether the condition is likely to be permanent.

Great care needs to be taken before declaring an individual to be totally and permanently impaired, as this may have a profound influence on his or her future mental health. Owing to the subjective nature of many psychiatric symptoms, the avenue of claiming for medical disability on psychiatric grounds is open to abuse. By admitting invalid claims, the growth potential of all policies is negatively influenced. It is therefore in the interests of all policy holders that claims be treated fairly and objectively. We believe that the *Guidelines* will contribute significantly to this end.

Robin Emsley

Department of Psychiatry
University of Stellenbosch
Tygerberg, W. Cape

Pieter Coetzer

Sanlam
Bellville, W. Cape

1. Nel JA. A contextual approach to post-shooting trauma in the South African Police Services. M.A. dissertation (unpublished), University of South Africa, Pretoria, 1994.
2. Emsley R. The new psychiatry. *S Afr Med J* 1993; **83**: 314.
3. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington, DC: American Psychiatric Association, 1994.