AGENDA

THE MEETING OF THE

DISABILITY PROCEDURES AND SERVICES COMMITTEE
and
BOARD OF RETIREMENT*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 NORTH LAKE AVENUE, SUITE 810
PASADENA, CA 91101

9:00 A.M., WEDNESDAY, December 7, 2016 **

The Committee may take action on any item on the agenda, and agenda items may be taken out of order.

COMMITTEE MEMBERS:

Vivian H. Gray, Chair
William de la Garza, Vice Chair
Yves Chery
Les Robbins
David Muir, Alternate

I. APPROVAL OF THE MINUTES

A. Approval of the minutes of the regular meeting of September 7, 2016.

II. PUBLIC COMMENT

III. ACTION ITEMS

IV. FOR INFORMATION

A. Presentation by David L. Friedman, M.D., Ph.D. – Multi Axial Psychiatric Diagnosis.

V. GOOD OF THE ORDER

(For information purposes only)

VI. ADJOURNMENT

***The Board of Retirement has adopted a policy permitting any member of the Board to attend a standing committee meeting open to the public. In the event five (5) or more members of the Board of Retirement (including members appointed to the Committee) are in attendance, the meeting shall constitute a joint meeting of the Committee and the Board of Retirement. Members of the Board of Retirement who are not members of the Committee may attend and participate in a meeting of a Board Committee but may not vote on any matter discussed at the meeting. The only action the Committee may take at the meeting is approval of a recommendation to take further action at a subsequent meeting of the Board.**

****Although the meeting is scheduled for 9:00 a.m., it can start anytime thereafter, depending on the length of the Board of Retirement meeting. Please be on call.**

Assistive Listening Devices are available upon request. American Sign Language (ASL) Interpreters are available with at least three (3) business days notice before the meeting date.

Any documents subject to public disclosure that relate to an agenda item for an open session of the Committee, that are distributed to members of the Committee less than 72 hours prior to the meeting, will be available for public inspection at the time they are distributed to a majority of the Committee, at LACERA's offices at 300 North Lake Avenue, suite 820, Pasadena, California during normal business hours from 9:00 a.m. to 5:00 p.m. Monday through Friday.

Persons requiring an alternative format of this agenda pursuant to Section 202 of the Americans with Disabilities Act of 1990 may request one by calling the Disability Retirement Services Division at 626-564-2419 from 7:30 a.m. to 5:00 p.m. Monday through Friday, but no later than 48 hours prior to the time the meeting is to commence.

MINUTES OF THE MEETING OF THE

DISABILITY PROCEDURES AND SERVICES COMMITTEE
and
Board of Retirement**

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

GATEWAY PLAZA - 300 N. LAKE AVENUE, SUITE 810, PASADENA, CA 91101

Wednesday, September 7, 2016, 10:11 A.M. – 10:19 A.M.

COMMITTEE MEMBERS

PRESENT: Vivian H. Gray, Chair
William de la Garza, Vice Chair
Yves Chery
Les Robbins

ABSENT: David Muir, Alternate

ALSO ATTENDING:

BOARD MEMBERS AT LARGE

Anthony Bravo
William Pryor
Vito M. Campese, M.D.
Shawn Kehoe
Joseph Kelly

STAFF, ADVISORS, PARTICIPANTS

Gregg Rademacher
JJ Popowich
Steven Rice
Vincent Lim
Eugenia Der
Allison E. Barrett
Frank Boyd
Sandra Cortez
Angie Guererro
Maria Muro
Maisha Coulter
Michelle Yanes
Ricki Contreras
Vickie Neely
Tamara Caldwell
Anna Kwan
James Pu
Debbie Semnanian
Mario Garrido
Debra Martin
Marco Legaspi
Marilu Bretado
Thomas Wicke
Barbara Tuncay
Ricardo Salinas
Maria Silva
Danny Hang
Robert Hill
Mike Herrera
Karla Sarni
Hernan Barrientos

ATTORNEYS
Thomas J. Wicke

GUEST SPEAKER
None

The meeting was called to order by Chair Gray at 10:11 a.m.

I. APPROVAL OF THE MINUTES

A. Approval of minutes of the regular meeting of July 6, 2016

Mr. de la Garza made a motion, Mr. Chery seconded, to approve the minutes of the regular meeting of August 3, 2016. The motion passed unanimously.

II. PUBLIC COMMENT

III. ACTION ITEMS

A. Consider Application of Richard C. Rosenberg, M.D., as a LACERA Panel Physician.

Mr. Chery made a motion,
Mr. de la Garza seconded, to approve to accept staff's recommendation and submit the application of Richard C. Rosenberg, M.D. to the Board of Retirement for approval to the LACERA Panel of Examining Physicians. The motion passed unanimously.

Mr. Chery asked if there was any discussion regarding parking fees with Dr. Rosenberg. Ms. Contreras stated that the parking fee for Dr. Rosenberg is $6.00 and no further discussion took place because this doctor was interviewed before the Committee discussed parking fees.

IV. FOR INFORMATION

V. GOOD OF THE ORDER

Mr. Okum stated that he and Mr. de la Garza wanted to remind everyone that USC plays on Saturday morning.

Ms. Gray – Go Bruins!

Ms. Contreras asked if the Committee or the Board would like staff to bring up topics for training for future meetings. Ms. Contreras stated that staff can bring in speakers such as doctors.

Ms. Gray asked if there was a topic that was given to legal office that was supposed to come back for discussion and Mr. Boyd stated that someone in legal office is already handling that matter.

Mr. Kelly suggested topic of "Accommodation, Evaluations, and Processes".

Dr. Campese suggested a "Wellness" topic.

Mr. Kelly stated that wellness is a serious issue and he gave an example he experienced where there was a poster advertising wellness but next to it there was another poster advertising a pizza party. Mr. Kelly stated that we are either for wellness or not for wellness.

Mr. de la Garza stated that retirees are offered wellness programs and he tries to attend regularly and encouraged Committee members to attend.

VI. ADJOURNMENT

With no further business to come before the Disability Procedures and Services Committee, the meeting was adjourned at 10:19 a.m.

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** All Correspondence & Telephone Calls To Culver City

December 7, 2016

Multi Axial Psychiatric Diagnosis Presentation for LACERA

Psychiatry is complex and is often seen as mysterious and inexact.

With today's presentation I hope to leave you with a clearer idea of how mental health problems are defined and described.

Over the last century, leaders in the field have tried to organize and clarify our understanding of the various psychiatric illnesses and conditions.

This led to the American psychiatric Association systematically gathering statistics about mental disorders in approximately 1917 for inclusion in the American medical Association's standard classified nomenclature of disease.

This involved primarily diagnosing patients with severe psychiatric and neurological disorders.

The first Diagnostic and Statistical Manual for mental disorders (DSM I) was published in 1952, describing diagnostic categories in psychiatry.

The second edition (DSM II) was published in 1975, and implemented in 1978.

The DSM III was published in 1980, and was the first to include the multi axial system.

Many of the diagnostic criteria were not entirely clear, and there was a revised edition of the DSM III in 1987.

The DSM-IV was initially published in 1992, and the text was revised in the year 2000, yielding the DSM-IV TR (Text Revised).

Each of these DSM's was produced after extensive research and collaboration between study groups of eminent specialists in each family of psychiatric disorders, arriving at a consensus regarding definition and diagnostic criteria for each condition.

Each subsequent edition reflected new information, research, and clinical experience that enabled clearer classification of the various mental disorders.

The most recent addition of the Diagnostic and statistical manual is the DSM-V, published in 2013.

Of interest, this most recent edition no longer utilizes the multi axial system, having developed different methodology for describing the various components, dimensions and severity of psychiatric illness.

Nevertheless, you are still going to see many reports from psychiatrists and psychologists that use the multi axial diagnostic system.

The underlying reason for adopting the multi axial system was straightforward.

In essence, the purpose was to provide in summary fashion, usually no more than half a page in length, an individual's psychiatric diagnosis or diagnoses (Axis I), Personality traits or disorders, if present (Axis II,), coexisting physical problems (Axis III), the various stressors associated with the psychiatric difficulties (Axis IV), and the degree of impairment that is present (Axis V).

Each "Axis" addressed one of these areas.

This would offer a relatively brief, standardized method of communication regarding an individual's psychiatric status and all the factors related to it between mental health professionals, or between mental health professionals and third parties.

Despite the fact that the DSM-V no longer suggests that the multiaxial system be utilized, you will still see it very frequently in psychiatric reporting that comes to your attention.

There are a number of reasons for this.

First, it is a system that a generation of mental health professionals (myself included) has been utilizing our entire professional lives, as it has been in existence since the DSM-III was published in 1980, and we see it as a convenient way to convey, in summary fashion, our opinions regarding an individual's overall condition.

Another reason you will see it is that much of the reporting that you get for review has been generated in the Workers Compensation system.

This is of significance, because the assessment of permanent psychiatric disability for all injuries after 1/1/05 utilizes the Global assessment of functioning (Axis V) as the measure of permanent impairment pursuant to the Permanent disability rating schedule.

The following is an **outline of what each axis entails** (for your review and reference, I have reproduced pages 27 through 37 of the DSM-IV TR which describes in detail the multiaxial system)

Axis I delineates all the **major disorders or conditions** that an individual may have, and includes psychotic disorders, mood disorders, anxiety disorders, substance abuse disorders, and various other conditions.

Each of these disorders is diagnosed according to the diagnostic criteria for the condition found in the diagnostic and statistical manual. The diagnostic criteria for many of these conditions remains much the same in DSM-V as DSM-IV; for other conditions there have been significant changes in terms of diagnostic criteria and description.

They are outlined on page 28 of the DSM-IV TR as follows:

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence (excluding Mental Retardation, which is diagnosed on Axis II)
Delirium, Dementia, and Amnestic and Other Cognitive Disorders
Mental Disorders Due to a General Medical Condition
Substance-Related Disorders
Schizophrenia and Other Psychotic Disorders
Mood Disorders
Anxiety Disorders
Somatoform Disorders
Factitious Disorders
Dissociative Disorders
Sexual and Gender Identity Disorders
Eating Disorders
Sleep Disorders
Impulse-Control Disorders Not Elsewhere Classified
Adjustment Disorders
Other Conditions That May Be a Focus of Clinical Attention

Axis II delineates the various **personality disorders**, as well as mental retardation.

Personality disorders and personality traits involve the presence of long-standing maladaptive personality features, and are defined as personality disorders when specific criteria for each are met.

These are delineated on page 29 of the DSM-IV TR as follows:

Paranoid Personality Disorder
Schizoid Personality Disorder
Schizotypal Personality Disorder

Antisocial Personality Disorder
Borderline Personality Disorder
Histrionic Personality Disorder
Narcissistic Personality Disorder
Avoidant Personality Disorder
Dependent Personality Disorder
Obsessive-Compulsive Personality Disorder
Personality Disorder Not Otherwise Specified
Mental Retardation

The reason that these conditions are placed in their own category (axis) is that the authors wanted to make certain that the more prominent conditions noted under Axis I would not overshadow and cause these conditions to be overlooked.

These conditions and their descriptions are largely unchanged between DSM-IV and DSM-V.

Axis III depicts the **physical conditions** that are present, and may be related to the Axis I psychiatric condition, either as a contributing cause of the psychiatric condition, or as a result of it. These are listed on page 30 of the DSM-IV TR as follows:

Infectious and Parasitic Diseases (001 – 139)
Neoplasms (140 – 239)
Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240 – 279)
Diseases of the Blood and Blood-Forming Organs (280 – 289)
Diseases of the Nervous System and Sense Organs (320 – 389)
Disease of the Circulatory System (390 – 459)
Disease of the Respiratory System (460 – 519)
Disease of the Digestive System (520 – 579)
Diseases of the Genitourinary System (580 – 629)
Complications of the Pregnancy, Childbirth, and the Puerperium (630 – 676)
Diseases of the Skin and Subcutaneous Tissue (680 – 709)
Diseases of the Musculoskeletal System and Connective Tissue (710 – 739)
Congenital Anomalies (740 – 759)
Certain Conditions Originating in the Perinatal Period (760 – 779)
Symptoms, Signs, and Ill-Defined Conditions (780 – 799)
Injury and Poisoning (800 – 999)

Axis IV delineates the various **psychosocial and environmental problems** that may affect diagnosis, treatment, prognosis, and causation of the Axis I and Axis II mental disorders.
These are described on pages 31 and 32 of the DSM-IV TR as follows:

Problems with primary support group

Problems related to the social environment
Educational problems
Occupational problems
Housing problems
Economic problems
Problems with access to health care services
Problems related to interaction with the legal system/crime
Other psychosocial and environmental problems

This becomes quite significant when we are discussing **causation of impairment**, central to the decision making process in determining service connection in a disability retirement case.

The mental health evaluator should always list **all** of the factors in a person's life that are contributing to their emotional disturbance, be they employment related or not.

Since it is the psychiatric evaluator's job to determine whether there is a connection between impairment and employment related stresses, these concerns must be carefully evaluated, with their potential contributions to the psychiatric illness considered.

Finally, **Axis V** is the **Global assessment of functioning**.

As described in detail in the DSM-IV discussion on pages 32 through 34, this number gives us a quick snapshot of the level of impairment created by the individual's condition.

The graph, attached for your review on page 34 of the DSM-IV TR, outlines the various ranges of GAF and how they are described, with examples of the various ranges.

Incapacitation for work requiring significant concentration and attention is usually present, in my experience at GAF below the low 50s. This will depend, of course, upon the nature of the job under consideration. By definition, as you will see on the range of impairments on page 34 of the DSM-IV TR, a GAF of 50 or less indicates, by definition, that a person is "unable to keep a job."

A number of **examples** are found on page 35 of the DSM IV TR, which I have attached for your review.

In summary, the multi axial system of the Diagnostic and Statistical Manual of the American psychiatric Association, beginning with the third edition and ending with the fourth edition, TR (text revised), provides in a standard format a summary of an individual's psychiatric illnesses (Axis I),Personality disorders or traits, if present (Axis II), physical illnesses(Axis III), stress factors that are related to the psychiatric

condition (Axis IV), and a number, the GAF (Axis V) that gives you a quick description of the level of impairment.

I hope that this will be of assistance to you in understanding this element of the mental health evaluation process.

Thank you for your kind attention.

Multiaxial Assessment

A multiaxial system involves an assessment on several axes, each of which refers to a different domain of information that may help the clinician plan treatment and predict outcome. There are five axes included in the DSM-IV multiaxial classification:

Axis I	Clinical Disorders
	Other Conditions That May Be a Focus of Clinical Attention
Axis II	Personality Disorders
	Mental Retardation
Axis III	General Medical Conditions
Axis IV	Psychosocial and Environmental Problems
Axis V	Global Assessment of Functioning

The use of the multiaxial system facilitates comprehensive and systematic evaluation with attention to the various mental disorders and general medical conditions, psychosocial and environmental problems, and level of functioning that might be overlooked if the focus were on assessing a single presenting problem. A multiaxial system provides a convenient format for organizing and communicating clinical information, for capturing the complexity of clinical situations, and for describing the heterogeneity of individuals presenting with the same diagnosis. In addition, the multiaxial system promotes the application of the biopsychosocial model in clinical, educational, and research settings.

The rest of this section provides a description of each of the DSM-IV axes. In some settings or situations, clinicians may prefer not to use the multiaxial system. For this reason, guidelines for reporting the results of a DSM-IV assessment without applying the formal multiaxial system are provided at the end of this section.

Axis I: Clinical Disorders
Other Conditions That May Be a Focus of Clinical Attention

Axis I is for reporting all the various disorders or conditions in the Classification except for the Personality Disorders and Mental Retardation (which are reported on Axis II). The major groups of disorders to be reported on Axis I are listed in the box below. Also reported on Axis I are Other Conditions That May Be a Focus of Clinical Attention.

When an individual has more than one Axis I disorder, all of these should be reported (for examples, see p. 35). If more than one Axis I disorder is present, the principal diagnosis or the reason for visit (see p. 3) should be indicated by listing it first. When an individual has both an Axis I and an Axis II disorder, the principal diagnosis or the

reason for visit will be assumed to be on Axis I unless the Axis II diagnosis is followed by the qualifying phrase "(Principal Diagnosis)" or "(Reason for Visit)." If no Axis I disorder is present, this should be coded as V71.09. If an Axis I diagnosis is deferred, pending the gathering of additional information, this should be coded as 799.9.

Axis I
Clinical Disorders
Other Conditions That May Be a Focus of Clinical Attention

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence
(*excluding Mental Retardation, which is diagnosed on Axis II*)
Delirium, Dementia, and Amnestic and Other Cognitive Disorders
Mental Disorders Due to a General Medical Condition
Substance-Related Disorders
Schizophrenia and Other Psychotic Disorders
Mood Disorders
Anxiety Disorders
Somatoform Disorders
Factitious Disorders
Dissociative Disorders
Sexual and Gender Identity Disorders
Eating Disorders
Sleep Disorders
Impulse-Control Disorders Not Elsewhere Classified
Adjustment Disorders
Other Conditions That May Be a Focus of Clinical Attention

Axis II: Personality Disorders
Mental Retardation

Axis II is for reporting Personality Disorders and Mental Retardation. It may also be used for noting prominent maladaptive personality features and defense mechanisms. The listing of Personality Disorders and Mental Retardation on a separate axis ensures that consideration will be given to the possible presence of Personality Disorders and Mental Retardation that might otherwise be overlooked when attention is directed to the usually more florid Axis I disorders. The coding of Personality Disorders on Axis II should not be taken to imply that their pathogenesis or range of appropriate treatment is fundamentally different from that for the disorders coded on Axis I. The disorders to be reported on Axis II are listed in the box below.

In the common situation in which an individual has more than one Axis II diagnosis, all should be reported (for examples, see p. 35). When an individual has both an Axis I and an Axis II diagnosis and the Axis II diagnosis is the principal diagnosis or the reason for visit, this should be indicated by adding the qualifying phrase "(Principal Diagnosis)" or "(Reason for Visit)" after the Axis II diagnosis. If no Axis II dis-

order is present, this should be coded as V71.09. If an Axis II diagnosis is deferred, pending the gathering of additional information, this should be coded as 799.9.

Axis II may also be used to indicate prominent maladaptive personality features that do not meet the threshold for a Personality Disorder (in such instances, no code number should be used—see Example 3 on p. 37). The habitual use of maladaptive defense mechanisms may also be indicated on Axis II (see Appendix B, p. 811, for definitions and Example 1 on p. 37).

Axis II
Personality Disorders
Mental Retardation

Paranoid Personality Disorder	Narcissistic Personality Disorder
Schizoid Personality Disorder	Avoidant Personality Disorder
Schizotypal Personality Disorder	Dependent Personality Disorder
Antisocial Personality Disorder	Obsessive-Compulsive Personality Disorder
Borderline Personality Disorder	Personality Disorder Not Otherwise Specified
Histrionic Personality Disorder	Mental Retardation

Axis III: General Medical Conditions

Axis III is for reporting current general medical conditions that are potentially relevant to the understanding or management of the individual's mental disorder. These conditions are classified outside the "Mental Disorders" chapter of ICD-9-CM (and outside Chapter V of ICD-10). A listing of the broad categories of general medical conditions is given in the box below. (For a more detailed listing including the specific ICD-9-CM codes, refer to Appendix G.)

As discussed in the "Introduction," the multiaxial distinction among Axis I, Axis II, and Axis III disorders does not imply that there are fundamental differences in their conceptualization, that mental disorders are unrelated to physical or biological factors or processes, or that general medical conditions are unrelated to behavioral or psychosocial factors or processes. The purpose of distinguishing general medical conditions is to encourage thoroughness in evaluation and to enhance communication among health care providers.

General medical conditions can be related to mental disorders in a variety of ways. In some cases it is clear that the general medical condition is directly etiological to the development or worsening of mental symptoms and that the mechanism for this effect is physiological. When a mental disorder is judged to be a direct physiological consequence of the general medical condition, a Mental Disorder Due to a General Medical Condition should be diagnosed on Axis I and the general medical condition should be recorded on both Axis I and Axis III. For example, when hypothyroidism is a direct cause of depressive symptoms, the designation on Axis I is 293.83 Mood Disorder Due to Hypothyroidism, With Depressive Features, and the hypothyroidism is listed again and coded on Axis III as 244.9 (see Example 3, p. 37). For a further discussion, see p. 181.

In those instances in which the etiological relationship between the general medical condition and the mental symptoms is insufficiently clear to warrant an Axis I diagnosis of Mental Disorder Due to a General Medical Condition, the appropriate mental disorder (e.g., Major Depressive Disorder) should be listed and coded on Axis I; the general medical condition should only be coded on Axis III.

There are other situations in which general medical conditions are recorded on Axis III because of their importance to the overall understanding or treatment of the individual with the mental disorder. An Axis I disorder may be a psychological reaction to an Axis III general medical condition (e.g., the development of 309.0 Adjustment Disorder With Depressed Mood as a reaction to the diagnosis of carcinoma of the breast). Some general medical conditions may not be directly related to the mental disorder but nonetheless have important prognostic or treatment implications (e.g., when the diagnosis on Axis I is 296.30 Major Depressive Disorder, Recurrent, and on Axis III is 427.9 arrhythmia, the choice of pharmacotherapy is influenced by the general medical condition; or when a person with diabetes mellitus is admitted to the hospital for an exacerbation of Schizophrenia and insulin management must be monitored).

When an individual has more than one clinically relevant Axis III diagnosis, all should be reported. For examples, see p. 35. If no Axis III disorder is present, this should be indicated by the notation "Axis III: None." If an Axis III diagnosis is deferred, pending the gathering of additional information, this should be indicated by the notation "Axis III: Deferred."

Axis III

General Medical Conditions (with ICD-9-CM codes)

Infectious and Parasitic Diseases (001–139)
Neoplasms (140–239)
Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240–279)
Diseases of the Blood and Blood-Forming Organs (280–289)
Diseases of the Nervous System and Sense Organs (320–389)
Diseases of the Circulatory System (390–459)
Diseases of the Respiratory System (460–519)
Diseases of the Digestive System (520–579)
Diseases of the Genitourinary System (580–629)
Complications of Pregnancy, Childbirth, and the Puerperium (630–676)
Diseases of the Skin and Subcutaneous Tissue (680–709)
Diseases of the Musculoskeletal System and Connective Tissue (710–739)
Congenital Anomalies (740–759)
Certain Conditions Originating in the Perinatal Period (760–779)
Symptoms, Signs, and Ill-Defined Conditions (780–799)
Injury and Poisoning (800–999)

Axis IV: Psychosocial and Environmental Problems

Axis IV is for reporting psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders (Axes I and II). A psychosocial or environmental problem may be a negative life event, an environmental difficulty or deficiency, a familial or other interpersonal stress, an inadequacy of social support or personal resources, or other problem relating to the context in which a person's difficulties have developed. So-called positive stressors, such as job promotion, should be listed only if they constitute or lead to a problem, as when a person has difficulty adapting to the new situation. In addition to playing a role in the initiation or exacerbation of a mental disorder, psychosocial problems may also develop as a consequence of a person's psychopathology or may constitute problems that should be considered in the overall management plan.

When an individual has multiple psychosocial or environmental problems, the clinician may note as many as are judged to be relevant. In general, the clinician should note only those psychosocial and environmental problems that have been present during the year preceding the current evaluation. However, the clinician may choose to note psychosocial and environmental problems occurring prior to the previous year if these clearly contribute to the mental disorder or have become a focus of treatment—for example, previous combat experiences leading to Posttraumatic Stress Disorder.

In practice, most psychosocial and environmental problems will be indicated on Axis IV. However, when a psychosocial or environmental problem is the primary focus of clinical attention, it should also be recorded on Axis I, with a code derived from the section "Other Conditions That May Be a Focus of Clinical Attention" (see p. 731).

For convenience, the problems are grouped together in the following categories:

- **Problems with primary support group**—e.g., death of a family member; health problems in family; disruption of family by separation, divorce, or estrangement; removal from the home; remarriage of parent; sexual or physical abuse; parental overprotection; neglect of child; inadequate discipline; discord with siblings; birth of a sibling
- **Problems related to the social environment**—e.g., death or loss of friend; inadequate social support; living alone; difficulty with acculturation; discrimination; adjustment to life-cycle transition (such as retirement)
- **Educational problems**—e.g., illiteracy; academic problems; discord with teachers or classmates; inadequate school environment
- **Occupational problems**—e.g., unemployment; threat of job loss; stressful work schedule; difficult work conditions; job dissatisfaction; job change; discord with boss or co-workers
- **Housing problems**—e.g., homelessness; inadequate housing; unsafe neighborhood; discord with neighbors or landlord
- **Economic problems**—e.g., extreme poverty; inadequate finances; insufficient welfare support
- **Problems with access to health care services**—e.g., inadequate health care services; transportation to health care facilities unavailable; inadequate health insurance

- **Problems related to interaction with the legal system/crime**—e.g., arrest; incarceration; litigation; victim of crime
- **Other psychosocial and environmental problems**—e.g., exposure to disasters, war, other hostilities; discord with nonfamily caregivers such as counselor, social worker, or physician; unavailability of social service agencies

When using the Multiaxial Evaluation Report Form (see p. 36), the clinician should identify the relevant categories of psychosocial and environmental problems and indicate the specific factors involved. If a recording form with a checklist of problem categories is not used, the clinician may simply list the specific problems on Axis IV. (See examples on p. 35.)

Axis IV
Psychosocial and Environmental Problems

Problems with primary support group
Problems related to the social environment
Educational problems
Occupational problems
Housing problems
Economic problems
Problems with access to health care services
Problems related to interaction with the legal system/crime
Other psychosocial and environmental problems

Axis V: Global Assessment of Functioning

Axis V is for reporting the clinician's judgment of the individual's overall level of functioning. This information is useful in planning treatment and measuring its impact, and in predicting outcome.

The reporting of overall functioning on Axis V can be done using the Global Assessment of Functioning (GAF) Scale. The GAF Scale may be particularly useful in tracking the clinical progress of individuals in global terms, using a single measure. The GAF Scale is to be rated with respect only to psychological, social, and occupational functioning. The instructions specify, "Do not include impairment in functioning due to physical (or environmental) limitations."

The GAF scale is divided into 10 ranges of functioning. Making a GAF rating involves picking a single value that best reflects the individual's overall level of functioning. The description of each 10-point range in the GAF scale has two components: the first part covers symptom severity, and the second part covers functioning. The GAF rating is within a particular decile if **either** the symptom severity **or** the level of functioning falls within the range. For example, the first part of the range 41–50 describes "serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting)" and the second part includes "any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job)." It should be noted

that in situations where the individual's symptom severity and level of functioning are discordant, the final GAF rating always reflects the worse of the two. For example, the GAF rating for an individual who is a significant danger to self but is otherwise functioning well would be below 20. Similarly, the GAF rating for an individual with minimal psychological symptomatology but significant impairment in functioning (e.g., an individual whose excessive preoccupation with substance use has resulted in loss of job and friends but no other psychopathology) would be 40 or lower.

In most instances, ratings on the GAF Scale should be for the current period (i.e., the level of functioning at the time of the evaluation) because ratings of current functioning will generally reflect the need for treatment or care. In order to account for day-to-day variability in functioning, the GAF rating for the "current period" is sometimes operationalized as the lowest level of functioning for the past week. In some settings, it may be useful to note the GAF Scale rating both at time of admission and at time of discharge. The GAF Scale may also be rated for other time periods (e.g., the highest level of functioning for at least a few months during the past year). The GAF Scale is reported on Axis V as follows: "GAF = ," followed by the GAF rating from 0 to 100, followed by the time period reflected by the rating in parentheses—for example, "(current)," "(highest level in past year)," "(at discharge)." (See examples on p. 35.)

In order to ensure that no elements of the GAF scale are overlooked when a GAF rating is being made, the following method for determining a GAF rating may be applied:

STEP 1: Starting at the top level, evaluate each range by asking "is **either** the individual's symptom severity OR level of functioning worse than what is indicated in the range description?"

STEP 2: Keep moving down the scale until the range that best matches the individual's symptom severity OR the level of functioning is reached, **whichever is worse.**

STEP 3: Look at the next lower range as a double-check against having stopped prematurely. This range should be too severe on **both** symptom severity **and** level of functioning. If it is, the appropriate range has been reached (continue with step 4). If not, go back to step 2 and continue moving down the scale.

STEP 4: To determine the specific GAF rating within the selected 10-point range, consider whether the individual is functioning at the higher or lower end of the 10-point range. For example, consider an individual who hears voices that do not influence his behavior (e.g., someone with long-standing Schizophrenia who accepts his hallucinations as part of his illness). If the voices occur relatively infrequently (once a week or less), a rating of 39 or 40 might be most appropriate. In contrast, if the individual hears voices almost continuously, a rating of 31 or 32 would be more appropriate.

In some settings, it may be useful to assess social and occupational disability and to track progress in rehabilitation independent of the severity of the psychological symptoms. For this purpose, a proposed Social and Occupational Functioning Assessment Scale (SOFAS) (see p. 817) is included in Appendix B. Two additional proposed scales that may be useful in some settings—the Global Assessment of Relational Functioning (GARF) Scale (see p. 814) and the Defensive Functioning Scale (see p. 807)—are also included in Appendix B.

Global Assessment of Functioning (GAF) Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health–illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code **(Note: Use intermediate codes when appropriate, e.g., 45, 68, 72.)**

100 | 91 **Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.**

90 | 81 **Absent or minimal symptoms** (e.g., mild anxiety before an exam), **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g., an occasional argument with family members).

80 | 71 **If symptoms are present, they are transient and expectable reactions to psychosocial stressors** (e.g., difficulty concentrating after family argument); **no more than slight impairment in social, occupational, or school functioning** (e.g., temporarily falling behind in schoolwork).

70 | 61 **Some mild symptoms** (e.g., depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy, or theft within the household), **but generally functioning pretty well, has some meaningful interpersonal relationships.**

60 | 51 **Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school functioning** (e.g., few friends, conflicts with peers or co-workers).

50 | 41 **Serious symptoms** (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job).

40 | 31 **Some impairment in reality testing or communication** (e.g., speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

30 | 21 **Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home, or friends).

20 | 11 **Some danger of hurting self or others** (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) **OR occasionally fails to maintain minimal personal hygiene** (e.g., smears feces) **OR gross impairment in communication** (e.g., largely incoherent or mute).

10 | 1 **Persistent danger of severely hurting self or others** (e.g., recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**

0 Inadequate information.

The rating of overall psychological functioning on a scale of 0–100 was operationalized by Luborsky in the Health-Sickness Rating Scale (Luborsky L: "Clinicians' Judgments of Mental Health." *Archives of General Psychiatry* 7:407–417, 1962). Spitzer and colleagues developed a revision of the Health-Sickness Rating Scale called the Global Assessment Scale (GAS) (Endicott J, Spitzer RL, Fleiss JL, Cohen J: "The Global Assessment Scale: A Procedure for Measuring Overall Severity of Psychiatric Disturbance." *Archives of General Psychiatry* 33:766–771, 1976). A modified version of the GAS was included in DSM-III-R as the Global Assessment of Functioning (GAF) Scale.

Examples of How to Record Results of a DSM-IV Multiaxial Evaluation

Example 1:

Axis I	296.23	Major Depressive Disorder, Single Episode, Severe Without Psychotic Features
	305.00	Alcohol Abuse
Axis II	301.6	Dependent Personality Disorder Frequent use of denial
Axis III		None
Axis IV		Threat of job loss
Axis V	GAF = 35	(current)

Example 2:

Axis I	300.4	Dysthymic Disorder
	315.00	Reading Disorder
Axis II	V71.09	No diagnosis
Axis III	382.9	Otitis media, recurrent
Axis IV		Victim of child neglect
Axis V	GAF = 53	(current)

Example 3:

Axis I	293.83	Mood Disorder Due to Hypothyroidism, With Depressive Features
Axis II	V71.09	No diagnosis, histrionic personality features
Axis III	244.9	Hypothyroidism
	365.23	Chronic angle-closure glaucoma
Axis IV		None
Axis V	GAF = 45	(on admission)
	GAF = 65	(at discharge)

Example 4:

Axis I	V61.10	Partner Relational Problem
Axis II	V71.09	No diagnosis
Axis III		None
Axis IV		Unemployment
Axis V	GAF = 83	(highest level past year)

Multiaxial Evaluation Report Form

The following form is offered as one possibility for reporting multiaxial evaluations. In some settings, this form may be used exactly as is; in other settings, the form may be adapted to satisfy special needs.

AXIS I: Clinical Disorders
Other Conditions That May Be a Focus of Clinical Attention

Diagnostic code	DSM-IV name
___ ___ ___.___ ___	_____
___ ___ ___.___ ___	_____
___ ___ ___.___ ___	_____

AXIS II: Personality Disorders
Mental Retardation

Diagnostic code	DSM-IV name
___ ___ ___.___ ___	_____
___ ___ ___.___ ___	_____

AXIS III: General Medical Conditions

ICD-9-CM code	ICD-9-CM name
___ ___ ___.___ ___	_____
___ ___ ___.___ ___	_____
___ ___ ___.___ ___	_____

AXIS IV: Psychosocial and Environmental Problems

Check:

- ❑ **Problems with primary support group** *Specify:* _____
- ❑ **Problems related to the social environment** *Specify:* _____
- ❑ **Educational problems** *Specify:* _____
- ❑ **Occupational problems** *Specify:* _____
- ❑ **Housing problems** *Specify:* _____
- ❑ **Economic problems** *Specify:* _____
- ❑ **Problems with access to health care services** *Specify:* _____
- ❑ **Problems related to interaction with the legal system/crime** *Specify:* _____
- ❑ **Other psychosocial and environmental problems** *Specify:* _____

AXIS V: Global Assessment of Functioning Scale

Score: ___ ___ ___

Time frame: _____

Nonaxial Format

Clinicians who do not wish to use the multiaxial format may simply list the appropriate diagnoses. Those choosing this option should follow the general rule of recording as many coexisting mental disorders, general medical conditions, and other factors as are relevant to the care and treatment of the individual. The Principal Diagnosis or the Reason for Visit should be listed first.

The examples below illustrate the reporting of diagnoses in a format that does not use the multiaxial system.

Example 1:

296.23 Major Depressive Disorder, Single Episode, Severe Without Psychotic Features
305.00 Alcohol Abuse
301.6 Dependent Personality Disorder; Frequent use of denial

Example 2:

300.4 Dysthymic Disorder
315.00 Reading Disorder
382.9 Otitis media, recurrent

Example 3:

293.83 Mood Disorder Due to Hypothyroidism, With Depressive Features
244.9 Hypothyroidism
365.23 Chronic angle-closure glaucoma
Histrionic personality features

Example 4:

V61.10 Partner Relational Problem