Supplementary Submission

to

the Productivity Commission's

Inquiry into National Workers' Compensation and Occupational Health and Safety Frameworks.

by

The Australian Psychological Society Ltd (APS)

Australia's premier association of Australian psychologists in professional practice, and academic teaching and research.

2 September 2003

(APS National Office, 11th Floor, 257 Collins Street, Melbourne, 3000
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The scope of this submission:

This supplementary submission has been written primarily to respond to the Commissioners' request that we provide some feedback about psychologists' experiences with Alternative Dispute Resolution processes (hereafter ADR) in various contexts in Australia including but not restricted to Workers' Compensation claims.

However we also wish to:

(a) expand briefly on the issue of more rational decision-making about claims using contemporary "decision-making theory" (as outlined in the Swets et al. article provided to the Commission after our oral presentation on 26 June 2003).
(b) provide some further research data and views about some dysfunctional consequences of psychiatric diagnoses in the Occupational Health and Safety and Workers' Compensation arenas, and the dubious practice of making "blind" professional assessments.

Psychologists' Experiences with Alternative Dispute Resolution Processes:

Our emphasis in regard to Workers' Compensation claims is strongly on *preventing or avoiding* disputes, rather than on handling disputes once they occur. The old adage that *"an ounce of prevention is worth a ton of cure"* certainly applies here.

Thus we urge the widespread adoption of new processes such as are being considered by WorkCover South Australia (as one response to the Stanley Report's many recommendations for change), to reduce the incidence of disputes by *avoiding creating an adversarial, confrontational set of processes from the outset* (the initial reporting of an injury).

Nonetheless we have considered the issue of ADR, and asked our members to provide us with anecdotal material about their experiences. We proffer the following comments with the caveat that they are based on a hastily gathered set of subjective brief commentaries, from a small sample that may not be representative. We therefore have added some references to empirical research into ADR that should be used to supplement the anecdotal accounts. This research is not specifically about psychologists or psychological issues. We have also listed some specialists in the ADR area whom you may wish to consult (Appendix 2).

Feedback From Psychologists about types and characteristics of WC disputes:

(a) The impact of the "cause" of the dispute:

The features of disputes seem to vary according (in part at least) to the type of "cause" of the dispute. Different causes appear to have at least some different features; and the different types of disputes require different solutions. (More research is needed into this apparent association.)

So far as we can establish from our members' comments, and from an examination of many reported WC case transcripts, WC disputes are usually about one or more of the following: whether the injured worker has indeed suffered an injury or disease; whether that injury is compensable (i.e. is genuine, work-related, and falls within the legislative definition of injury or disease); the whole person impairment percentage to be assigned, and/or its constituent "regional impairments"; the quantum of compensation; and the degree of apportionment of "cause" to the workplace[1].

These issues vary in degree of claimant-perceived personal involvement, influence, and threat to basic human needs. Most disputes are seen as largely "technical" (professional or legal), in which the claimant is effectively an onlooker, feeling uninvolved, often frustrated, helpless but expected to undertake demanding and often hostile interrogation and examination. Examination is often undertaken in places difficult for some injured workers to reach (e.g. geographically distant, or not accessible to the disabled), and at times seriously inconvenient (e.g. interfering with medication schedules) and sometimes stressful for them (e.g. at peak hour times when trains or trams are crowded, highly anxiety provoking for people with certain kinds of psychological conditions).

Research has clearly demonstrated that strong psychological stress reactions occur when people are placed in situations where important goals or needs are threatened, they have little control or influence in the situation, and there is a lack of clarity about processes and low predictability about potential outcomes.

(b) Comments on the different types of disputes and possible solutions:

(i) Disputes over recognition:

Disputes over ***recognition*** of the injury (unlike most of the other dispute types) appear to be highly involving of the claimant psychologically (high "ego involvement"), and to generate considerable emotion, and motivation to contest rejection. Yet (like the other dispute types) there is little sense of genuine participation or influence in the assessment process, which is often conducted in what is perceived by claimants as an attitudinally hostile fashion that may be reflected in tone of voice, and in the form, implications and thrusts of questions.

Respondents who are denied recognition of injury (even if this decision is appealed and there is subsequent assessment as to severity and duration) often feel personally insulted, demeaned and devalued, and perceive themselves as being accused of fabrication and fraud (whether this is made explicit or not). Basic human needs for social acceptance, recognition as a worthwhile person, and positive self-esteem may be significantly frustrated at this stage. These perceptions and feelings may persist for years, and be associated with persistent efforts to persuade workcover authorities or the courts to change their decisions (a phenomenon known as "obstacle dominance"). Our members have noted this pattern particularly in regard to some injured workers who are referred as being long-term and unresponsive to conventional treatments.

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[1] However, for a more extensive listing, see Pace,N.M, et al. (2003). *Improving dispute resolution for California's injured workers. Rand Institute for Civil Justice*. (Prepared for the California Commission on Health and Safety and Workers' Compensation.)

Current procedures should be adapted so that, without prejudicing later judgments and decisions, the claimant is assisted to feel that s/he is being taken seriously and treated respectfully and supportively, and that the claim of injury is being treated *prime facie* as worthy of investigation rather than (as at present) with suspicion. Such procedures would predictably be more feasible within a "no fault" system such as South Australia's (although the insurers' pressures there to encourage redemption of entitlements reportedly creates disputes) or California's system (see Pace et al. 2003, *op. cit*.).

To reduce the incidence of dysfunctional "game playing " (as outlined in our main submission to the Commission), the claimant should be encouraged to feel part of an objective yet valuing, collaborative investigation process of the source and extent of injury and any impairments arising therefrom. This process should include investigation of the workplace factors that may have caused the injury. That is, a workplace assessment must either precede or accompany any clinical assessment of the individual claimant, and the two foci of assessment (workplace and clinical) must be integrated, not separate.

(ii) Disputes over whether the injury is compensable (genuine, work-related, etc):

The issue of genuineness is closely coupled with the "recognition" dispute. However the other question, of the degree to which it is work-related, is one of the "technical" questions in which the claimant feels uninvolved and helpless. Questions from assessors sometimes imply exaggeration ("Did you really carry those responsibilities?"), concealment of past injuries ("Surely this is not the first time that you've suffered stress at work?"), or refusal to accept personal responsibility for one's actions, with the implication of deceit or immaturity. ("Surely at your age you're thick-skinned enough to cop some stick from your manager?")

Assessors need careful training in interviewing and other assessment skills to:

- be able to avoid sending such negative messages,
- be able to deal constructively with claimants' anxieties, fears, perceptions, and expectations, and
- not add to the injured person's psychological distress or exacerbate any "obstacle dominance" reaction.

Such training must also address the misperception that a thorough and searching evaluation requires overt confrontation and challenge. Certainly issues should be explored thoroughly, with awareness of the potential for exaggeration, misrepresentation, innocent misunderstandings or miscommunication. However this exploration does not require, indeed is frustrated by, overt confrontation and challenge that promotes an adversarial relationship with all the attendant problems.

(iii) Disputes over WPI% and regional assessments:

Our impression is that such disputes, while of keen interest to the claimants and of great importance for subsequent outcomes, are not well understood by claimants, who

generally feel excluded from assessment decisions and see themselves as merely onlookers and passive recipients of interrogation and other forms of (sometimes hostile) investigation. They may not even be aware that such judgments are being made, and very few are likely to understand what a “whole person impairment percentage” in fact is. Psychological factors similar to those outlined above regarding “work-relatedness” disputes appear to operate.

Partly through this lack of information, understanding and involvement, claimants may misinterpret, over-generalise, and develop dysfunctional “black and white” perceptions regarding the roles of others in this process (as do the other participants including the case managers). In particular claimants may not understand that medical and other assessors may be also under scrutiny and may be compelled to follow procedures with which they (the assessors) are not themselves comfortable. Early provision of information and objective explanation of assessment goals and processes may be one small step towards reducing the psychological trauma many claimants experience with this kind of dispute.

Assessors should, more broadly, explain the assessment system clearly to claimants, deal with them objectively (which includes respectfully), and respect their rights to know the goals and processes of assessment and the possible outcomes. The requirements of privacy legislation should be adopted, including the provision of written (multi-lingual) explanations of key questions, processes and possible outcomes.

Unfortunately (our feedback indicates) claim managers, case managers and indeed professional assessors may all too often become embroiled emotionally with claimants, often negatively. They may suffer “cognitive dissonance” (a stressful phenomenon where the person experiences internal conflict between two or more sets of his/her perceptions, expectations or understandings, e.g. where a loved one acts aggressively towards them without obvious cause, or where a claimant being treated sympathetically does not respond in the same vein).

Instead of patient explanation and guidance to injured people (who are often not able to absorb much information readily, or remember it all at once), they may resolve their cognitive dissonance by distancing themselves emotionally from and depersonalising the claimant, such as by resorting to convenient but inaccurate explanations of their apparently resistant behaviour (unresponsiveness to treatment, or inability to return to work). Failing to give the injured worker feedback about the progress or the results of the assessments being made of the worker’s conditions is another instance of such behaviour.

This pattern may include overt or covert aggression, as claimants have the three attributes typical of “scapegoats”: they are near at hand, safe to attack (seen as weak, powerless etc.), and “in need of punishment” (i.e. rationalisations are available to the aggressor to justify the aggression).

One possible solution to this problem is to include the case or claim managers and (arguably) the assessors, as well as the claimant, in a special kind of case conference conducted by a psychologist or other appropriately trained professional. (By contrast, in an adversarial system the inclusion of the assessor would be seen as inappropriate

in that the assessor would be regarded as biased by personalised contact.) During this conference or as an adjunct to it, the psychologist may work with the case/claim managers to help them deal productively with the negative perceptions, frustrated expectations and associated emotionality such as aggression that was outlined above. (See comments on ADR below.)

One key reason for insurers disputing claims appears to be a perception (perhaps also a fact) that there is a direct and relatively immediate negative link between the success of the claim and the insurers' profitability, i.e. a "zero-sum game" perspective. Their reasoning is seen by many claimants and their lawyers to be that the greater the number of successful cases, the lower their profitability, and that the more cases they contest, the higher their profitability. (These seem to be two separate albeit linked arguments.)

The solution here does not appear to lie in changing the claimants' and their lawyers' perceptions (which are probably realistic), but is to alter the system so that there is clearly no such linkage.

(iv) Dispute about quantum of compensation:

Our members report that in such disputes claimants experience the previously-outlined powerlessness of the onlooker and the sense of "depersonalisation" associated with being treated as an impersonal "object". In addition there seems to be often unrealistic expectations about quantum generated in particular by their lawyers and other advocates but also by media reports of large payouts. There is heavy reliance on this stage on one's lawyers, both instrumentally (the processes are obscure to the claimant) and emotionally. By this time there is a strong bond with the lawyer and other supporters; and court appearances are generally traumatic to witnesses, both in the immediate experience of giving evidence and being cross-examined, and in the post-appearance process of self-recrimination where the claimant feels s/he has not given a good account of themselves.

(v) Dispute about apportionment of "cause"

Dispute sometimes centres on apportionment of "cause" of injury to the workplace. The insurers' view here is seen by claimants (and others including many professionals) to be that the lower the degree of apportionment to the workplace, the lower the amount of compensation achievable, hence the greater their profitability. Employers appear to share this kind of perspective if also with a personal component (issues of blaming, guilt, etc.). Thus claimants' lawyers, perhaps more so than the claimants themselves, expect the "other side" to seek low apportionment and to try to find selective "evidence" to support that tactic.

One solution might be to separate the individual claim outcomes from the employer's premium level. The latter should be set in regard to number and seriousness of avoidable workplace incidents and accidents, not in regard to the compensation quantum involved. Thus the motivation of the employer to contest individual compensation claims would hopefully be reduced, and redirected to prevention of unsafe workplace operations and behaviours.

For the insurers, the current direct dysfunctional link perceived between individual case outcomes, in terms of compensation awarded, and insurance financials, could perhaps be broken by using broad actuarial criteria as the basis for insurance premiums.

Members' experiences with various forms of ADR/PDR:

The terms "Alternative Dispute Resolution" and "Primary Dispute Resolution" refer to a number of quite different approaches with little in common save their aim of resolving disputes outside the formal court/tribunal hearing process, hopefully in a manner that is enduring.

Even this aim is not universal. For example counselling is used for PDR in the Family Court. (However there are a number of forms of counselling with significant differences – see Brown 2000[2].) While one outcome from conciliation counselling may be resolution of points of dispute (say over rights of access to children, or over property), other outcomes may be more important, such as agreement about processes for amicable separation, or achieving greater understanding of the basis of the parties' relationship difficulties, or appreciating better the parties' attitudes and expectations about the future. Dr Carole Brown's article (cited above) provides valuable empirical data about counselling, joint Registrars' and Counsellors' conferences, Registrar's conciliation conferences about financial matters, and mediation (court and community-based).

Our members' experiences suggest that most ADR especially in the WC arena is still legalistic, adversarial and bureaucratic in nature (if muted in the first two respects). It may be a prelude to rather than a substitute for formal court or tribunal hearing. It may be a dangerous prelude in that the claimant's legal rights may not be explained or respected to the extent that they are in court. That is, ADR may in some circumstances be simply an inferior legal process – a "kangaroo court". It might also be inferior because of lack of financial resourcing rather than inherent design features. (See Pace et al. 2003, *op. cit.*)

However our members' experiences include many positive ones, such as (in the Family Court setting) clarification of important issues that might be left unexplored in formal court hearings (especially attitudes, expectations, needs and frustrations thereof, and the like). Where failure to understand such issues has been an important contributor to the problems, this airing of them usually proves very conducive to settlement or other positive outcomes.

Our members report generally positive experiences with early mediation (before workplace problems become entrenched, such as where a supervisor is in conflict with a subordinate), and with special forms of case conferences. Mediation, however, appears most often successful when carried out by people with mediation training who are perceived as genuinely impartial and independent. Mediation may be difficult

[2] Brown, C. (2000). *Diversity in primary dispute resolution services: What are the choices for clients?* Family Court of Australia Publications Unit. (Available electronically on www.familycourt.gov.au/papers/html/diversity.htm)

to arrange in remote areas or in small organizations with limited staffing or financial resources.

Case conferences of the kind outlined above appear (on admittedly very limited sampling[3]) to have a high success rate (75%+), if success is based on criteria such as reduced psychological distress, reduced reliance on medication, improved social interaction (with family and workmates) as well as on the more problematic criterion of “return to work” (which is too “binary” and subject to too many influences other than effectiveness of psychological interventions to be a really valuable criterion on its own).

This form of case conference appears to be effective by bringing claims and/or case managers into (or back into) the process, and encouraging a change by all parties from an adversarial to a cooperative orientation. Social interaction and personal contact are primary drivers of this process, although full explanation of “the system” (of evaluation by the workcover authority) is crucial, *including of the checks and balances in it*.

This explanation helps to reduce the “overpersonalisation” process that many claimants suffer when seeking to make sense of what is happening to them. Mutual discussion of the case by the contesting parties is advantageous, *even in long lasting disputes with previous poor outcomes for the claimant.*

FURTHER MATERIAL REGARDING MORE RATIONAL AND OPEN DECISION-MAKING ABOUT THRESHOLDS FOR ACCESS TO BENEFITS AND COMMON LAW ACTION

The significance of this issue can hardly be overstated. One illustration of the lack of sophistication about threshold-setting in the workcover authorities is the recent Comcare report of its trial of its proposed revised assessment procedures (based on AMA4), compared against the assessments made using its current methodology.

Comcare’s report reached inappropriate conclusions because of unfounded interpretation of the results of the trial – asserting that it demonstrated that the “new” approach is fairer and more accurate than the old methodology. Their limited data in fact show that the use of AMA4 “ratchets up” the medical standards needed to be reached by injured workers to achieve the same 10% threshold as under the “old” methodology. In short, the revised guide makes it harder for injured workers to qualify.

Such a change should be decided only after careful, scientifically sound and professionally conducted evaluation. The evaluation should not be designed and written to justify policy decisions already taken. The decisions should be made as a matter of explicit social policy, not implicitly and arbitrarily (as has been the case in NSW, Tasmania and now Comcare).

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[3] Most of our information here comes from one group of psychologists dealing with long-established and severe cases of impairment including severe pain.

Our evaluation of the Comcare trial is attached, as is a copy of our letter of response to Comcare (Appendix 1).

Another important illustration of the need for rational and professional methods is that (our members report) workcover authority staff *often classify claims themselves* before referring the claim for professional assessment, and this classification remains in place whatever the actual specific diagnosis reached by the professional assessor.

This is particularly so with "stress" claims. The term "stress" appears to have become a synonym for "mental and behavioural disorders" rather than a specific diagnostic category or set of categories. Thus the actuarial data for psychological and psychiatric claims are fundamentally flawed by such "lay" classifications. For example assertions about a massive increase recently in stress claims may reflect, in part at least, this dysfunctional bureaucratic practice.

Professor John Taplin, Head of the Psychology Department at Adelaide University, is expert in disability assessment and has assisted the Department of Family and Community Services to develop conceptually good procedures for such assessment, based in part on the "science of diagnostics". They appear readily adaptable to WC claims processing and management.

He has agreed to be available to the Commission's staff for discussion of this aspect. His contact details are appended (Appendix 2).

THE DYSFUNCTIONALITY OF PSYCHIATRIC DIAGNOSES IN WC CONTEXTS

The legal requirement in the NSW and Tasmanian legislation for a "recognised psychiatric disorder" is dysfunctional, as we outlined in detail in our main submission.

We wish to add to that exposition the following comments based on recent empirical research conducted by psychologists at the University of South Australia for the Office of the Commissioner for Public Employment, and published by that Office in 2002[4]. (Available electronically on the OCPE website, or from us on request.)

Among its recommendations and conclusions (all consistent with our main submission) were the following:

"Consideration be given to the naming of the claim, currently with its emphasis on psychiatric (individual) to something more balanced: eg ***work-mental health injury****." (p.4.)*

"We see the medicalisation of a work environment problem as a psychiatric disorder shifts the burden of responsibility to the worker. Greater links need to be made between the psychological injury and its genesis in the work environment: diagnosis

[4] Dollard, M.F et al. (2002). *Evaluation of psychologically based workers' compensation claims in the public sector*. OCPE, Adelaide.

*of the individual condition needs to be **matched** with a diagnosis of the work condition….Lengthy time off could almost be preventable if psychological reactions to adverse work conditions were normalised….”* (p.7.)

*“To continue to improve processes related to the management of psychological injury, regular forums should be held with **all** key stakeholders to discuss issues relating to the processing of claims, the rehabilitation of the injured worker and issues associated with returning to work.” (p.7.)*

Discussions with Associate Professor Dollard and Professor Tony Winefield (he is a co-author of the report) confirmed that the use of psychiatric diagnostic labels seriously impedes the return-to-work process and the attempted arrangement of alternative employment with another employer, due to the stigma and the “catastrophising” that such labels stimulate.

THE PROBLEMATIC NATURE OF “BLIND” ASSESSMENTS

We have noted with mounting concern the growth of the seriously problematic practice of carrying out “blind” assessments (based on medical and other records rather than on direct examination and/or interviewing of the claimant).

An example is the Comcare trial of its revised guide for the assessment of permanent impairment, outlined earlier. As indicated in our evaluation of the report of the trial (Appendix 1), the methodology used appears to have involved “blind” assessments of “old” cases by “new” assessors, using the “old” assessors’ medical records. Our evaluation outlines the reasons why this methodology is flawed.

The use of “blind” assessments is, in our view, professionally undesirable except possibly in very limited and special circumstances. In medico-legal assessments, we consider that failure to examine or interview the claimant (and often desirably other persons involved in the case such as family and co-workers) constitutes sub-standard professional behaviour. Certainly no significant decisions or actions should be taken on the basis of “blind” assessments alone.

We thank the Commission for the opportunity to make this supplementary submission.

Dr L. Littlefield, OAM, MAPS
Executive Director.

Appendix 1: The Comcare Trial.

(a) Copy of letter to Comcare CEO.

Mr N Swails
Deputy Chief Executive Officer
Comcare
GPO Box 9905
Canberra ACT 2601

(Copy to: Mr Barry Leahy
Chief Executive Officer
Comcare)

3 September 2003

Dear Mr Swails,

The revised draft of the Comcare permanent impairment guide.

I am responding on behalf of the Australian Psychological Society (hereafter APS) to your letter of 12 August 2003 in which you:

(i) advised of some important decisions taken by Comcare about its revised approach to impairment assessment,
(ii) forwarded a copy of the revised draft guide for the assessment of permanent impairment of injured workers,
(iii) reported a trial of that revised draft guide, and
(iv) invited comments in response.

I note that Comcare administers impairment assessment processes for Seacare, hence Seacare will also be adopting these changed policies and practices. I also note that the Military Compensation and Rehabilitation Service (MCRS) is described in your letter as being involved and presumably will follow Comcare's path.

Therefore Comcare's decisions will have very serious ramifications for Defence Force personnel, mariners, Commonwealth public servants and other groups covered by Comcare, Seacare and the MCRS. Hence I am copying this letter to the senior officers of those organisations. I am also copying it to the CPSU and the Maritime Union of Australia, with whom I understand you have an agreement regarding consultation about significant changes to workers' compensation arrangements.

In your letter you advised not only that Comcare staff had carried out a trial of the assessment procedures contained in the draft guide, but also had:

(a) decided to persist with the proposed exclusion of psychologists from assessing psychological and psychiatric impairments, and

(b) decided to continue to mandate the immediate use of the seriously flawed and professionally contentious Psychiatric Impairment Rating Scale (PIRS) for assessing psychological and psychiatric impairments, and to restrict recognition of psychological impairments to "psychiatric disorders".

I shall now comment on each of these matters in turn.

The Comcare trial of the revised guide's assessment methods:

Our Working Group on Workers' Compensation Legislation (a group of psychologists with substantial expertise and experience in workers' compensation and OHS matters, from around Australia), has carefully and thoroughly reviewed the report of this very important trial of the revised draft guide.

Unfortunately I have to advise that our Working Group's review (attached as Appendix A) concluded that even elementary research principles and methods had not been employed in the trial, and scientific standards of reporting had not been observed:

- the trial was inadequately designed, and skimpily reported, with much important information not included.
- the sample of claims (not randomly chosen) was unrepresentative (not typical of impairment claims), and far too small for any conclusions to be drawn.
- the data were not properly analysed.
- the alleged results were not tested for statistical significance.
- the conclusions that were drawn were not supported by the data, and represented hope and aspiration rather than evidence-based scientific conclusions.

Unfortunately because of these various defects, little can be gathered from the trial, other than that ***the "new" assessment methodology would disqualify from benefits about half of the claimants who now qualify under the current methodology***.

In other words, the new methodology involves a significant "ratcheting up " overall of the medical standards set for qualifying for the 10% threshold. To describe this outcome as fair to injured workers (as is asserted in the report) is contrary to the evidence from the trial.

Whether such an increase in medical standards is appropriate requires public debate (with professional input). It and the related issue of the appropriate threshold level should be transparent public policy decisions made in the light of the positive and negative outcomes of setting particular levels, and a consideration of the available alternatives. The modern "science of diagnostics" should be employed as the conceptual and technical framework for this process, as has been the case in other disability arenas here and overseas, to very good effect.

We have made strong representations to the Productivity Commission on this particular matter (applying the "science of diagnostics" to impairment assessment) as well as on changing the Workers' Compensation systems in Australia to be much less

adversarial. A copy of our submission to the Productivity Commission is publicly available on the Commission's web site.

I now wish to comment on:

(i) ***the decision to persist with the proposed exclusion of psychologists from assessing psychological and psychiatric impairments; and***

(ii) ***the decision to use the professionally contentious and unvalidated Psychiatric Impairment Rating Scale (PIRS) for assessing permanent psychological impairment, and to restrict recognition of psychological impairments to only*** *psychiatric disorders****.***

The APS put substantial time and effort into developing a major submission to Comcare in response to the first draft of the guide, covering a number of very important professional concerns. These concerns included objecting to the proposed exclusion of psychologists from assessing psychological impairments, and to the requirement to use the PIRS. We also outlined how the restriction of recognition of impairments to only "psychiatric disorders" serves as a covert additional threshold, and is not in our view consistent with the legislature's intention to recognise mental and behavioural impairments (which are not to be equated with "psychiatric disorders").

We requested:

- reinclusion of psychologists (along with, not in place of, psychiatrists) as assessors,
- allowing the use of measures of impairment other than the PIRS, and
- recognising all psychological impairments of a serious nature, without the requirement that they fit into a specific psychiatric diagnostic category.

Your letter provides no explanation of the grounds for Comcare's lack of recognition of these concerns and its non-acceptance of our requests. Indeed there was no explicit response to any of the issues addressed in our submission.

The decision to exclude psychologists:

The decision to exclude psychologists from assessing impairments of psychological functioning (such as stress reactions, depression, anxiety and other forms of psychological trauma or distress) lacks sound justification and rational grounds. It is contrary to the development of coordinated multidisciplinary work in the mental health field generally and in the military context in particular. (See for example various articles in the journal *ADF Health.*)

This decision will exclude about half of the professional workforce available for making assessments. Because of the relative unavailability of psychiatrists, it will ensure that the assessment and treatment of psychologically injured people will be needlessly delayed for long periods, with consequent exacerbation of their conditions, and unnecessary costs to governments, insurers and employers.

Immediate attention to psychological conditions is *imperative* if they are to be effectively handled and are not to become permanent - in both civilian workplaces and military combat situations.

Additionally, because psychiatrists do not provide the same professional skills and competencies as psychologists, the assessment of psychological problems and their workplace causes will be incomplete. Also their treatment and the quality of remedial action in the workplace or combat context will be sub-optimal.

In short, the proposed Comcare system will be, in our opinion, highly dysfunctional.

I should also point out that excluding psychologists from professional work that they are clearly qualified to do (much of which work psychiatrists are **not** qualified to perform) is contrary to National Competition Policy. We have already made a strong case to this effect in our submission to the Productivity Commission.

Another of our concerns is that, depending on judicial interpretations of the legislation and subsidiary regulations and guides, and definitions of terms such as "medical assessor", "medical treatment" and the like, the legal position of psychologists who are asked to assist in assessment (even of neurological impairment under Chapter 2 of the AMA Guides) may be unnecessarily ambiguous and possibly compromised.

Comcare should, we suggest, use this opportunity to give certainty to the legal position of psychologists, and not leave it to the less predictable, "step by cautious step" process of development of common law precedents. If it does not, Comcare' s capacity to use psychologists would predictably be inhibited, unnecessarily and unproductively.

We wish to see stronger links between the OHS and Workers Compensation (hereafter WC) arenas (outlined in detail in our submission to the Productivity Commission), including:

- better feedback from the WC area to the OHS area about the nature of psychosocial injuries and the causes thereof,
- better indicators of necessary workplace improvements in psychosocial terms so that further cases of such injuries do not occur, and
- clearer guidance by psychologists as to the rehabilitation of the individual injured worker.

We do not wish to see the erection of a barrier to these contributions. Unfortunately there will be, unless the decision to exclude psychologists from assessment of psychological and psychiatric injury and impairment is modified. We stress that this reinclusion is not at the expense of psychiatrists' involvement, but is part of the multidisciplinary team approach that "best practice" workplace psychosocial risk assessment and rehabilitation now involve.

The Society (representing over 13,000 psychologists around Australia) would have no option but to protest this decision wherever possible, including to bodies with NCP responsibilities. We must do so to:

- protect injured workers from the consequent problems of access to the appropriate professionals, especially the avoidable defects in the assessment and treatment of mental and behavioural problems that arise when psychologists are excluded.
- seek redress on behalf of our members involved professionally in the Workers' Compensation and Occupational Health and Safety arenas, whose legal status and professional roles are now likely to be seriously compromised.
- preserve the opportunities for further significant professional contributions by psychologists to the improvement of the OHS/WC systems.

The forced use of the PIRS and of psychiatric diagnostic labels:

Comcare's second decision (mandatory use of the PIRS and restriction of recognition to psychiatric disorders only) is a matter of grave concern to the Society (and to some other professional bodies and groups including the Australian Plaintiff Lawyers' Association and some unions) due to their inherent defects, especially but not solely the PIRS's unethical scoring method (using the median, i.e. the middlemost of the six ratings of an injured worker's psychological functioning rather than the most impaired areas of functioning, to calculate the "whole person impairment percentage"). That scoring method (as was explained in detail in the Society' s recent submission to Comcare) is most unfair and unjust because *it severely understates the real level of impairment.*

Also the PIRS is not appropriate for many assessment situations. Other professional measures should be used, at the discretion of the professional.

In the "organic" (i.e. physical) areas of impairment, various assessment methods are provided for. There is no attempt to impose a single, overall scale covering all physical injuries. Why then is a single scale to be imposed for psychological and psychiatric impairments? The range and complexity of psychological and psychiatric injuries and impairments is just as great as for physical ones. (As just one example, there are some eleven distinguishable syndromes under the aegis of the term "Post Traumatic Stress Disorder".) The need for different impairment assessment tools for different psychological and psychiatric disorders and impairments is just as compelling as it is for the physical disorders and impairments.

Moreover, using a single scale that employs only a narrow perspective inhibits the expansion of understanding of the nature and course of development of those disorders and impairments.

Given the PIRS's indisputably serious defects, including the lack of reliability and validity of the PIRS's ratings (based on research work [1] which Comcare appears not to have taken into account), your letter's description of it as "a fair, clear and transparent instrument" is diametrically opposed to the assessment made of it by qualified professionals on empirical grounds.

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[1] Psychiatrists Epstein, Mendelsohn and Strauss reported a study with the Victorian Clinical Scales, the forerunner to the PIRS. This research showed substantial variations among psychiatrists in their ratings, immediately after specialised training in the use of those Scales, with between-psychiatrist differences in the percentages awarded to 5 "vignette" cases ranging between 0 and 65 on some scales. We are able to provide a copy on request.

Should psychologists (or indeed psychiatrists other than those who have developed and are promoting the use of the PIRS) be called upon to act as expert witnesses in courts and tribunals regarding disputed psychological impairment ratings, their advice would have to be that the PIRS does not reach the Frye and Daubert legal standards concerning reliability and validity, as well as being wrongly scored.

Comcare's position regarding immediate adoption of the PIRS is also inconsistent with Comcare's involvement in the Heads of Workers Safety and Compensation Authorities (HWSCA) research project in which the PIRS and alternative measures of psychological and psychiatric impairment are currently being reviewed and evaluated.

Your letter implies that the HWSCA research is seen by Comcare as irrelevant, or that Comcare is not prepared to be influenced by the outcomes of the HWSCA project if it recommends a measurement process that does not include the PIRS.

I assume that this was not your intention, and expect that some lack of internal communication within Comcare is responsible for the problematic phrasing of this part of your letter. *I now seek your explicit assurance of Comcare' s commitment to the HWSCA project and its willingness to discard the PIRS if it is found to be defective.*

We object to the **restriction of psychological impairment assessment to "recognised psychiatric disorders"** partly*:*

- because it constitutes another (and a covert) threshold for injured workers to reach; and also
- to protect injured workers from the stigma and often the unfair discrimination that is associated with the use of psychiatric diagnostic labels. They impede return-to-work and other reemployment efforts. The Americans with Disability legislation prohibits the use of such labels in disability assessment for those kinds of reasons. Our submission to the Productivity Commission explains this matter in detail.

The APS position:

I wish to emphasise that the Society is committed to using professional assessment methods that:

- are scientifically sound (conceptually and technically[5]),
- are appropriate to the conditions and impairments being assessed, and
- gauge an injured worker's real level of impairment as accurately as possible.

We do not seek to act as advocates for claimants, or to make it unrealistically easy for them to qualify for benefits or common law action.

[5] I.e. have been professionally constructed, validated in the field under controlled conditions, and evaluated psychometrically in regard to crucial criteria such as reliability, validity, sensitivity, discriminatory power, and factorial composition.

But we do object in the strongest possible terms to continued use of an assessment tool whose scoring method is known to understate the real level of impairment – as we would, equally strongly, to one whose scoring method deliberately overstated the impairment level.

Such improper scoring not only disadvantages genuinely impaired workers, but brings the whole process of professional assessment into disrepute, to the ultimate disadvantage of ***all*** participants in the workers' compensation system including governments and the workcover authorities. There is already enough disputation and adversarialism in the workers' compensation field without adding to it by the adoption of an instrument with known defects that seriously penalise genuinely impaired claimants.

You may ask why psychologists care about the use of the PIRS when (it is proposed) only psychiatrists will be allowed to use it?

In additions to the reasons already given, there is also the probability that, because people (including on occasion regulatory bodies and some of the judiciary) confuse psychologists with psychiatrists, we will be tarred with the PIRS brush even though we strongly object to its use.

Future action:

The Society regrets that Comcare has chosen to continue with the guide virtually unaltered in the psychological and psychiatric impairment assessment area, despite grave dissatisfaction among professionals (including many psychiatrists) about the assessment methods to be employed. We are also bemused as to why Comcare has chosen to use the rather contentious American Medical Association's Guides Version 4 (known as AMA4) when the latest and much-improved edition AMA5 has been available for the last two years.

Tensions, and probably political and legal conflicts are now likely to escalate. Future improvements, especially more effective psychosocial risk assessment and better links between the OHS and WC areas, could be frustrated.

We would much prefer to discuss with you how the problems might be jointly resolved, than to become embroiled in an ultimately unproductive battle.

We therefore urge you to review the contentious position that Comcare staff have developed on the matters outlined above, or at least to meet personally with our President Professor Paul Martin (a widely-recognised expert in pain management), myself, and one of our senior National Office staff (Mr Arthur Crook, our Principal Policy Analyst) to plan an alternative and more collaborative and constructive course of action.

We would be very happy to be joined in such a meeting by the President of the RANZCP and the Chair of the Health Professions Council of Australia to ensure that the views of the psychiatry and other allied health professions are heard on these crucial matters.

Yours sincerely

Dr L. Littlefield OAM, MAPS
Executive Director

Copies to:

- CEO of Seacare
- Chair Health Professions Council of Australia
- Director General of the Military Compensation and Rehabilitation Service
- Director General Defence Health Service
- President RANZCP
- President and Secretary, CPSU and Maritime Union of Australia
- Productivity Commission

Appendix A (to Executive Director's letter to Comcare):

FOR THE BOARD OF DIRECTORS OF THE AUSTRALIAN PSYCHOLOGICAL SOCIETY

THROUGH THE EXECUTIVE DIRECTOR

EVALUATION OF THE REPORT OF THE COMCARE TRIAL OF THE REVISED DRAFT GUIDE FOR THE ASSESSMENT OF PERMANENT IMPAIRMENT

by the Working Group on Workers' Compensation Legislation

A report on this very important trial was appended to a letter from Mr Noel Swails, Deputy CEO of Comcare, to Dr Lyn Littlefield, Executive Director of the APS, dated 8 August 2003, and received on 12 August.

The revised draft guide was also enclosed, with a request that any comments on it be received by Comcare by 29 August.

Contrary to the Society's explicit recommendations and requests, in our initial submission to Comcare concerning its first draft of the revised guidelines, the subsequently revised draft still contains the "psychiatrist exclusivity" provision already adopted in the recent changes to the NSW and Tasmanian workers' compensation legislation. It also similarly mandates the use of the Psychiatric Impairment Rating Scale, for the assessment of permanent psychological and psychiatric impairment, with its unacceptable scoring method (using the median of the six ratings of an injured worker's psychological functioning).

The Executive Director requested the Working Group on Workers' Compensation Legislation to examine the report and advise her and the Board of Directors of its adequacy. The Working Group considered the following (italicised) questions as the basis for its evaluation of the report.

What did the trial attempt to do?

The trial purports to compare results from the assessment methods and processes currently in use by Comcare and the Military Compensation and Rehabilitation Service (MCRS) (hereafter referred to by us as the "old" assessment system), with those obtained by using the "new" assessment system (as outlined in the revised draft guide).

We assume that (as implied in the report) the assessment methodology used by MCRS is identical with that used by Comcare, but the report provides no detail on this aspect.

What specific research questions was the trial seeking to answer?

Judging from the wording of the report, research questions were not specified.

Consequently the research design for the trial appears to be poor (as is the reporting of the features of the trial).

It seems it was assumed in the design of the trial and the analysis of the ratings than any differences between the "old" and "new" ratings were solely due to the two different assessment methodologies. The report does not say so explicitly, but we can only conclude, that the "new" ratings were not fresh re-assessments of the claimants at a later time, but were merely a re-scoring of the medical records on which the "old" ratings were based.

Such a process would not be an acceptable trial, as the "new" ratings would not be independent of the "old" ones. The medical records used would be the same, although the "new" assessor would not have direct access to observational data (e.g. how the claimant appears, and how s/he expresses herself verbally and non-verbally). Moreover those records may contain clinical **judgments** (rather than just factual material) that would predictably be heavily influential in the making of the "new" assessments. This influence would inflate any apparent correlation between the two sets of ratings and the apparent level of agreement as to diagnoses, while the absence of direct observational data might make for unexplained disagreements between the two assessors, or for greater uncertainty on the part of the "new" assessor.

Further, the actual data collected under the "old" regime might well not be adequate for making assessments under the "new" regime in at least some "regions". This is particularly so for psychiatric claims. The PIRS's coverage is very different from that of the "old" system.

If the trial did involve fresh assessments of the claimants independently of the "old" assessments, it apparently did not contemplate the distinct possibility that in the time between the "old" assessment and the "new" one, some effective professional help may have been given to the injured persons in the trial, or some other life experiences may have occurred affecting their conditions or there may have been spontaneous remission or other changes. The design of the trial (merely a comparison of impairment ratings using the "old" and "new" methodologies) did not allow the effects of such professional interventions or life experiences to be evaluated. The report does not indicate any attempt to assess what treatments or other experiences, occurred between the "old" and the "new" assessments. We therefore conclude that the trial did not involve fresh reassessments after an interval between the "old" and the "new" assessments.

Who carried out the trial?

Since the report uses the pronoun "I", the Working Group assumes that one person wrote the report. The author of the report is not identified and no information is given about her/him. There is no mention of other researchers except for the occasional (and unexplained) use of the pronoun "we".

What was the sample of cases?

The sample of cases is very small, in total, and category by category. The total number is **75** claims[6], covering **10** broad categories of injury and impairment, 9 of which are "organic" (physical). The other category is "psychiatric conditions". **The latter category contains only seven cases.**

The sample appears skewed in both types of injury and severity of impairment. The largest type category is "lumbar spine" (17 cases), and the three "spine" categories together (lumbar, thorasic and cervical) constitute 27 cases in all. Other organic categories are: knee (14), shoulder (11), and ankle (8). Wrist, elbow, fingers and hand categories contain only 8 cases in all. There are no cases in the feet and toes, hip, or lower or upper impairment amputations, or neurological impairment categories. There are no stated cases of co-morbidity (mixed categories). Although some of the brief case descriptions suggest some co-morbidity, the vexed issue of how to combine ratings when there is more than one diagnosis receives no explicit (or indeed implicit) attention.

So far as severity of injury or impairment is concerned, there is, once again, little information. Sixty-seven percent of the total number of claimants had been adjudged to have reached the Comcare (and presumably the MCRS) threshold of 10% impairment under the "old" assessment system, a much higher proportion than one would expect from a random sampling of all workers' compensation claims.

Moreover all of the 7 psychiatric claims had reached that threshold, while 65% of the physical claimants had done so. The psychiatric cases cannot be said to be similar in severity of impairment to the physical cases: they appear (on the very small sample available) to be collectively more severely impaired, as this proportion (100%) is exceptionally high. However 5 of the 7 "psychiatric" cases were rated at exactly 10% Whole Person Impairment under the "old" assessment system, and the other two "psychiatric" cases were rated exactly 50% WPI. This distribution of WPI% is most unusual. These cases are clearly not typical of psychiatric/psychological impairment claims generally. (Also see point (c) below.)

No differential diagnoses are reported in regard to the claims. For the seven psychiatric claims, for example, there is no information apart from the final WPI% ratings. It cannot be established whether the claims were for PTSD, anxiety, depression, or other "conditions".

Given that two claims were rated 50% WPI under the "old" system, they probably involved the more serious conditions and/or substantial co-morbidity, whereas the 5 cases rated as 10% WPI were presumably less serious and less complicated. Unfortunately the report is silent on these matters.

What was the source of the claims?

The trial does not describe the source of the claims, or provide any description of them, beyond the following information:

[6] The report says 74 cases, but its tables of cases add to 75. We have used the latter figure but the difference is not of significance for our evaluation of the trial.

(a) The trial involved the Military Compensation and Rehabilitation Service (MCRS) from March to June 2002, as well as Comcare from March 2002 to March 2003. It is not clear in what ways the MCRS was involved beyond providing some of the cases. No explanation is offered about the different time frames and of how MCRS was able to provide the same number of cases (41) as Comcare in only a quarter of the time taken by Comcare.

(b) Comcare and the MCRS each provided 41 claims, but 13 of the 82 cases so produced were said to be unusable because of missing data, leaving 69 usable cases. (There is no breakdown of useability by source.) Apparently only two psychiatric claims were found among the 41 Comcare cases and/or the 41 MCRS cases. (We say "apparently" because no breakdown of source by type of claim is given in the report.)

(c) Therefore an additional five psychiatric impairment assessments were arranged separately by Comcare. (No further description is given by Comcare of this process or of the time span for it. It is possible that Comcare went looking for specific levels of psychiatric impairment when it sought to add to the two cases provided initially, for reasons not explained in the report, as the seven cases of psychiatric impairment represent only two levels of impairment – 5 cases rated as10% WPI and 2 cases rated as 50% WPI - under the "old" assessment system.)

Who carried out the assessments?

Little information is given about the assessment process or the assessors involved. There is reference to *"claims managers, determining authorities and some medical specialists who conducted the trial assessments.."* but it is not clear who did what.

No details are given about the qualifications, training and experience of any of the assessors.

It appears that only a psychiatrist (or psychiatrists) assessed the psychological/psychiatric claims. It is not known whether he/she/they were among the group of forensic psychiatrists who developed and are actively promoting the use of the PIRS. It is not known whether they completed their assessments with or without the assistance of a psychologist. It is not known how trained and experienced they were in both the "old" and the "new" assessment methods.

Did the same assessor undertake both the "old" and the "new" assessments?

No detail is provided about the methodology used for the "old" ratings, and whether the same assessor rated the claim using the "old" and then the "new" assessment system, or whether two different raters were used for the "old" and the "new" assessments. There is no discussion of this very important issue.

What are said to be the results?

The report is superficially descriptive and does not state results in conventional research form. It merely describes some similarities and differences in the

assessments, usually in the form of "reductions" and "increases" in final WPI% ratings, using simple aggregates such as (for the 7 psychiatric cases") saying that *"There were 4 reductions and 3 increases. While one of the reductions was very pronounced, the others were closer and only two cases would not reach the threshold if assessed under the draft guide"*. The seriousness of even 2 cases out of 7 now being "disqualified" when they had previously reached threshold – especially if repeated on a larger scale - appears not to have occurred to the author of the report.

The report does not provide any statistical tests of asserted differences. It makes basic mistakes such as giving the same degree of emphasis to trivial differences in assessments (such as a change from 3% Whole Person Impairment to 4% WPI) as to large ones (51% WPI to 19% WPI). Awareness of the issue of "error variance" in assessment work, or of "sensitivity" of measurement is nowhere in evidence.

Nor does the report provide genuine qualitative data that might have helped overcome some of the problems with a very limited sample. For example the two psychiatric cases rated 50% WPI under the "old" system were re-rated using the "new" system to 41% in one case and 19% in the other. No further information is offered about the basis of these re-ratings. The use of the median in the "new" system (the PIRS's defective scoring method) probably accounts for much of the savage reductions in WPI%, but no one can be sure in the absence of more information. Alternative or additional explanations are that there may have been a change in the ***diagnosis*** of the condition being assessed (whether or not the "old" medical records were used, or fresh reassessments were made), or (if the reassessments were made afresh after an interval) a significant improvement in the injured worker's condition due to psychotherapy or other treatment since the first assessment, or simply to some degree of spontaneous remission or improvement. We are left to wonder whether the reductions in WPI% in these (and other) cases were due just to differences in assessment methods, differences in who was making the assessment (inter-rater variability), changes in the conditions affecting the injured people, or perhaps some combination of these sources of variability.

The report then reaches conclusions that are not justified by the data examined. The most striking example of unjustified conclusions is the statement that *"While the results of the trial confirm earlier comments that the 10% threshold would be more difficult to reach in some musculoskeletal and psychiatric conditions, they also show a more accurate assessment of impairment compared with the limited approach offered by the current guide"*. (Penultimate page.)

This conclusion is completely unjustified. None of the data (ratings of impairment) refers in any way to "accuracy" of assessment, and none of the results can be interpreted as measuring the comparative accuracy of the "old" versus the "new" assessment methodology. There is no evidence that the "new" system represents a more accurate way of assessing impairments than the "old". Additionally, even if the data were useable to compare accuracy, the number of cases is so small as to make such a comparison statistically impossible.

For example in the psychiatric area, the number of cases (7) is far too small to support the conclusion that the 10% threshold is more difficult to meet under the "new" assessment system – or *any other conclusion*.

We note that the "new" ratings for the psychiatric claims were lower on average (average of 16.3 WPI%) than the "old" ratings (average of 21.4 WPI%), and the range of the "new" ratings was more truncated (6% to 41%) than the "old" range (10% to 50%). While these data are consistent with our criticisms of the PIRS's median scoring method (that it reduces the overall WPI% and restricts the range of possible scores through an undesirable "centralising effect"), the number of cases is too small to say that these defects are conclusively demonstrated.

Another totally unjustified conclusion is that the "new" assessment system *"should result in more objective, consistent and durable assessments of permanent impairment*". This statement may be an expression of the author's hope and aspirations, but it is certainly not an evidence-based conclusion supported by the results of this trial.

If all categories are combined, in order to have a sufficient number of cases to try to reach some statistically valid conclusions (see Table 1 below), the only results of any worth (and even they are dubious on sampling skew and statistical grounds) are:

(i) there was considerable disagreement between the "old" and the "new" assessments, in terms of reaching or not reaching the 10% threshold level. Only 26 cases (35% of the total sample) reached the threshold level on both the "old" and the "new" systems; and 20 cases (27% of the total sample) failed to reach threshold under both systems. That is, there was agreement regarding reaching or not reaching threshold for 46 of the 75 cases. There was disagreement about the other 29 cases.

(ii) **the most compelling statistic** is that **of the 51 cases who reached threshold under the "old" system, 25 (almost 50%) were rejected under the "new" system**. Whereas the "old" system accepted some 67% of the 75 claims, only 40% were accepted under the "new" system. Only 4 cases who had not reached threshold under the "old" system succeeded in reaching threshold under the "new" system.

Table 1: Cross-break analysis of cases under the "new" and "old" assessment systems

		New		
		Qual.	Did no qual.	Sub-total
Old	Qual.	26	25	51
	Did not qual.	4	20	24
	Sub-total	30	45	Grand Total = 75

These data are strongly suggestive, **not** of improved accuracy, but of a considerable **"ratcheting up" of the medical standards applied to determine whether the threshold is reached in the "new" system.**

It appears much, much harder to reach the thresholds for statutory benefits or common law action under the "new" system than it has been under the "old" system. Certainly the "new" system cannot be described as fairer or more accurate than the "old" one.

However it must be said that this evaluation applies only when the various impairment categories are combined. It may not be accurate for each and every separate impairment category. The numbers in each category are too small to reach any such judgment.

Moreover until it is known whether the "new" assessments were carried out after some substantial professional help had been given to the injured persons in the trial, we cannot tell whether the fewer numbers qualifying under the "new" system are a product of a "harder" assessment methodology or of effective professional interventions, or other influences between "old" and "new" assessments.

In summary the trial is so weak in research design terms, so limited and skewed in sampling terms, and so inadequately reported, that no conclusions can properly be drawn from it.

In its conclusions, the report reads as "political", not scientific, in that it makes assertions not demonstrated by the data. Some conclusions are of a "should be" kind that have no place in an evaluation report.

Signed by A.E.Crook, BA (Hons), MA (Occ Psych), FAPS, Principal Policy Analyst, as Convener and on behalf of the APS Working Group on Workers' Compensation Legislation.

Appendix 2: Experts recommended for consultation; and important reference works.

(a) Experts:

Bryant, Richard, Professor: University of NSW, Psychology, re PTSD assessment and treatment. Phone 02 9385 3640.

Cameron, Camille Dr. University of Melbourne, Law, re ADR/PDR research and practice. E-mail: c.Cameron@unimelb.edu.au

Cotton, Peter, Dr. Private consultant/clinical psychologist re WC assessment and treatments; and workcover regulation and management. Phone 0400 200 725

Dollard, Maureen Associate Professor, University of South Australia, Psychology, re research into OHS and return-to-work processes and outcomes. E-mail: Maureen.Dollard@unisa.edu.au

McMahon, Marilyn, University of Melbourne, psychologist with legal expertise, re the psychology-law interface. Phone: 03 9479 2284

Reddy, Prasuna, Dr., Univerity of Melbourne, psychologist with legal expertise, re ADR/PDR.
Phone 03 8344 0222

Taplin, John Professor, Head of Department of Psychology University of Adelaide, re disability assessment and the science of diagnostics. Phone 08 8303 5229.

Thornton, Ann, private psychological practitioner, Adelaide, re effective treatment of the long-term injured. Phone 08 8267 6469.

(b) Some important reference works:

A Framework for ADR Standards (2001). National Alternative Dispute Resolution Advisory Council, Canberra ACT.

Altobelli, T. (2002) *Reflections on Primary Dispute Resolution.* Available electronically from the Bond University website.

Steven, I.D. and Shanahan, E.M. (2002). *Work-related stress: care and compensation.* Medical Journal of Australia, v. 176, Apr.