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.

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PREAMBLE AND OUTLINE OF THE THRUSTS OF THIS SUBMISSION

We thank the Productivity Commission for the opportunity to be able to give input into its deliberations, as the issues involved are enormously important to injured people and their families, our and other professions, employers, unions, insurers and the community at large. We hope our input may be of some value.

The APS, with over 13,000 members in all forms of professional employment and practice, and in universities undertaking teaching and research, is reasonably well-informed about the systemic features of, and the significance of psychological issues in, the Occupational Health and Safety (hereafter OHS) and Workers' Compensation (WC) systems in Australia. We have also reviewed a substantial amount of the available literature on OHS and WC issues, encompassing local and overseas research, statements and analyses of government policy and relevant legal developments, and reports by previous Inquiries.

We are keenly aware that OHS and WC systems cannot be fully understood from a single disciplinary or professional perspective, and that our views comprise only a part of the total picture that the Commission will be constructing. We have taken our task to be to present our part of the total picture as clearly, objectively and candidly as possible.

The following features of the current systems are in our judgment less than optimally effective, add to the burden suffered by injured people, and waste scarce resources:

- the current low level of coordination between the OHS and WC systems
- dysfunctional regional boundaries, and inequitable regional differences regarding WC provisions
- the inherently adversarial character of the WC systems, involving concepts, attitudes, measures and processes that seem actively to promote manipulative behaviours by all classes of participants, and generate mutual mistrust and negativity
- under-coordinated (and in key areas under-staffed) professional sub-systems, especially in the WC arena
- fragmented (and in some aspects inexpert) administrative sub-systems especially in the insurance companies involved in WC
- unnecessary tardiness in recognising and dealing with the impacts of injuries, especially of a psychological or psychiatric kind, with consequent avoidable damage to injured people and costs to the community, employers and insurers, and
- inadequate research orientation and funding in the WC area generally, and in some specific regards in the OHS systems (notably "benchmarking" and the development of databases useful for comparing systems and for understanding and evaluating their performance levels).

The thrust of our recommendations is to support the further development of an agreed national framework of ideals, values and purposes, more specific objectives, and approaches to key issues, in pursuit of closer integration and improvement of Australia's

OHS and WC systems[1].

Better integration would include:

- a much stronger and better-balanced multi-disciplinary (including multi-professional) focus,
- an associated increase in the scale and level of multi-disciplinary cooperation and coordination, in planning, delivering, evaluating and improving professional services, within and across the OHS and WC systems,
- ensuring that professional staff involved in treatment, rehabilitation and assessment themselves have adequate experience in workplace operations
- involving OHS operational staff more in assessment and return-to-work processes
- a more cohesive, planned and funded research orientation.

These improvements would help to ensure:

- better protection of workers,
- greater speed and effectiveness of professional and administrative service delivery, to the benefit of injured people, their families and their employers,
- more realistic plans for return to work by injured workers, consistent with the characteristics of the workplace as well as the injured worker's health status and prognosis,
- much-needed systemic economies and efficiencies benefitting governments, employers, insurers and the community at large.

Eventually full integration might be feasible, including of structural and staffing aspects. The fact that all but three of the developed nations have national systems of some form suggests that this goal is not unrealistic. However whether this extent of integration (i.e. into one single structure in addition to an agreed national framework of ideals, purposes, more specific objectives, and approaches) would be optimal for Australia must remain an open question, pending more experience with the integration process and depending on the achievement of particular earlier reform steps.

Full integration would not remove the need for complex internal differentiation. However the type or types of internal differentiation most suited to any new system would probably be different from and hopefully simpler and closer-linked than the present complex and loosely-linked combination of regional (State, Territory and Comcare/Seacare) and functional forms of differentiation. The latter are of at least three types: prevention v income protection and compensation; regulation v service-provision; and "public" v "private" service providers including and especially insurance services. Some simplification and cross-regions standardisation of the structural arrangement of the total OHS/WC system seems desirable and achievable.

There are many possible structural re-arrangements that would need to be very carefully

[1] We are aware that the Heads of the Workers' Safety and Compensation Authorities were actively pursuing such development until the late nineteen nineties – see Appendix A for more detail.

considered and pre-tested where and as possible such as an industry level of coordination of OHS and WC actions, as one major dimension of a multi-dimensional "matrix organisation" approach. Some "thinking outside the square" would be particularly appropriate here in considering the possible shape(s) of a better overall system to be trialled. A number of professions (including our own) should be invited to contribute to this process.

We are acutely aware that closer integration is a complex, multi-faceted and long-term change goal. It must be tackled progressively, generally in small, achievable steps and with regular reviews of progress, although it may be appropriate at times to take a "revolutionary" approach (e.g. paradigm-shift) rather than an "evolutionary" (e.g. incremental) one.[2]

The suggested change from an adversarial to a non-adversarial system is likely to be of a paradigm-shift kind. It would involve crafting a different role for lawyers and insurers, towards an approach much more like that now being employed in the Family Court context - reliant initially on careful evaluation of all claims, and making use of conciliation and conflict-resolution methods rather than making early use of formal legal avenues. The latter would be the basis for subsequent appeals if required.

Some of the many difficulties confronting this change process and possible strategies for handling them are briefly alluded to in our submission.

Our suggestions include changing people's thinking about OHS and WC. In the WC systems in particular, there are many false or inadequate premises, wrong assumptions, defective mental models and associated biases and prejudices, that stand in the way of full system productivity and social value. Indeed they are actively damaging to some injured workers. These cognitive, emotional and attitudinal features, if left unaddressed, would seriously impede integration efforts with the OHS systems (which seem very different in these respects). In large part those features are part and parcel of an adversarial system, and could be expected to be modified through changing to a non-adversarial system. However some other kinds of actions are also likely to be desirable, such as direct attitude change programs (based on good research data).

We also emphasise the need for more evaluation and other kinds of research, to conceptualise and measure the impacts of change and progress towards the agreed objectives, and to underpin appropriate accountability mechanisms.

In addition to observations about systemic matters we make some "meso" and "micro" observations based on practising psychologists' experiences over many years with and in Australia's WC systems (as salaried employees and contractors of services). In the main these observations are about the direction of administrative and related operational changes desirable in those systems, such as and especially closing some serious gaps in

[2] We recognise that observations similar to these were expressed by the Industry Commission in its comprehensive 1994 Report on Workers' Compensation in Australia. We generally support (almost a decade later) its analyses of the OHS and WC systems, and the associated recommendations.

the speed and quality of crucial decision-making, about injured persons' conditions and their treatment, particularly but not only by insurance companies' administrative staff.

In doing so we draw attention to important linkages between some of these problems and changes wrought in the health sector and the higher education sector in recent years.

In regard to the health sector, we believe that there may well be merit in the view often expressed informally in the WC field, especially by insurance and workcover staff, that they often have to deal with workers with "pre-existing" psychological adjustment problems which do not stem fundamentally from although they may be exacerbated by OHS defects. The WC system (so the view extends) is being required to serve as a kind of safety net for some of the people who drop through the gaps in the health (especially mental health) sector's service arrangements. We suggest that research be undertaken to explore the validity of this view even though the manifold gaps in the health system are already evident in a general way.

We also emphasise the importance of integrating the various health, including mental health, and accident compensation systems to a greater degree, and more transparently, consciously and purposively managing the linkages among them. Currently covert cost-shifting tactics may in the short term advantage one or a few players but they serve no overall benefit, conceal the scale of the problems confronting the total health and accident compensation framework, and help create or maintain mutual distrust among the players.

Such integration would of course need agreement about "States' rights" issues including cost-sharing among the States/Territories and with the Commonwealth. That agreement predictably would be difficult to achieve but is of such importance that in our view it must be attempted.

In regard to the higher education sector, we point to the trends of:

- serious reduction in its funding over the last decade at least;
- increased emphasis on output- and outcome-based funding especially in research funding; and
- policies of further deregulation of higher education course provision, fee levels and student numbers.

These trends have provoked some unintended negative consequences. In particular we note erosions in availability and breadth of formal and informal professional training and other supports offered by the higher education sector to the professions (beyond just psychology), and distortions in research emphases relevant to the professions, as well as an increase in the stress experienced by staff in the higher education sector.

Such defects in the range of specialised professional training and supports available (formally and informally), and the distortion of research directions and emphases away from professional issues, have led indirectly but significantly to problems of quality assurance, quality control and continuing professional education in the professional

service delivery areas relevant to the OHS and WC systems. The responses by the WC systems in particular to those problems have been sub-optimal, especially in the medium and long term, partly because these connections between the higher education system and the WC systems seem not to have been fully appreciated, and no effective and sustained interventions have been undertaken to address those problems. Integration of the OHS and WC systems must, we submit, take into account their valuable linkages with and the desired roles of the higher education sector.

We also comment about some related legal issues seriously impinging on our profession directly and indirectly in working in the OHS and WC arenas, which need to be resolved if better integration is to be achieved. These issues include:

- problems of legal terms and definitions of various aspects of mental health (whose relevance is much broader than just WC)
- public and professional liability "reforms" and associated insurance issues, and
- that national competition policy (NCP) has been ignored, indeed breached in non-trivial ways, in recent WC legislation, by mandating "psychiatrist exclusivity" in (i.e. excluding psychologists from) the assessment of permanent psychological impairment. The very deleterious effects of that WC legislation on the professional practices of psychologists are already evident. The future workforce implications of these effects are serious.

However the core of our submission is the better prevention of psychological injuries and trauma in the workplace, and more effective and efficient (including speedier) treatment of injured workers, through an enhanced role for psychologists, as one of the small, achievable early change steps.

In outlining an enhanced role for psychologists we summarise considerable data from Australian and international research showing the effectiveness and efficiency of psychological services in OHS and accident compensation contexts.

Those data clearly indicate that:

- psychological services, already demonstrated to be effective and efficient, are being continuously improved through national and international research in many contexts, but
- they are nonetheless seriously underutilised and understaffed in Australia, especially in the WC area,

and

- there is much potential gain to be realised from their optimum use, in terms of benefits to psychologically injured workers through more prompt attention to them, more accurate diagnosis and prognosis, greater effectiveness and efficiency of treatment, rehabilitation and return to work programs, and better targetted OHS activities. There are also broader benefits in terms of reduced impacts of injuries on families and the community, and major associated cost reductions.

More details of this research base are available on request including references to research reports if the Commission wishes to read those reports for itself.

In the following sections we refer to numerous defects in the current systems but also to positives. Wherever possible we have sought objective data to inform our views and recommendations. However there is a dearth of good research, especially regarding the WC systems, and about the organisational functioning of both the OHS and the WC systems. Our search for data (such as deidentified and broad actuarial data from the NSW Motor Accident Authority about its assessments of psychological and psychiatric impairments) has been unsuccessful. Past enquiries and reports have encountered and reported on the general problem of inadequate data, and lack of sharing of the data that is available, yet little has been done about those problems.

Impressionistic and anecdotal data, on which at times we (and no doubt others) have had to rely, are of course less than ideal, with likely defects such as limited experience of the commentators, truncated and possibly biased samples, and subjective opinions rather than hard data. The latter are particularly dangerous as a basis for action in the WC systems where emotions run high, and there are many biases and prejudices, and much negativity. Therefore we have indicated where and as appropriate the status of the evidence base for our views (and recommend prompt action to overcome the problem of inadequate data). Where the evidence is not strong, we have been duly cautious and tentative in interpretation.

We emphasise that, where we have made criticisms, they should not be taken to be of the people operating the current systems. Most of them know only too well the defects to which we allude and would dearly like to remedy them. The problems we identify are essentially systemic and work-role-related, not problems of individual staff performance, competence or motivation. Also our observations about those systemic and work-role problems are statements of broad trends that do not necessarily apply to all individuals or groups participating in the OHS and WC systems.

Where the problems are self-evident (such as the inequitable differences across regions in WC features), or have already been recognised (as in earlier Commission inquiries and other reviews such as the recent Stanley Review of the South Australian WC system[3]) we have not gone much beyond simply identifying the problem. We have concentrated our detailed comments on those matters of concern to us that are not self-evidently problematic to others. In doing so, we have opened briefly only a small number of the many “Pandora’s Boxes” involved in a fundamental review of the OHS and WC systems into which the Commission will have to look more thoroughly.

We have highlighted seven recommendations (in Section 1), but other explicit or implicit lines of development are alluded to in our commentary that we hope will also be of interest to the Commission.

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[3] Review of Workers’ Compensation and Occupational Health, Safety and Welfare System in South Australia chaired by Mr Stanley.

SECTION 1: RECOMMENDATIONS

Recommendation 1: That the Productivity Commission's Inquiry into Australian's OHS and WC systems supports and commends, as broad goals, restructuring those systems over time into a single national system, and changing the traditional adversarial features of the WC systems into non-adversarial form where:

(a) the task is to identify accurately, and treat quickly and effectively, impairments and consequent disability, wherever they occur, and of whatever level (minor as well as major).
(b) the opportunities and incentives for injured persons to exaggerate impairments and disabilities, or for employers and insurers to minimise or deny them, or delay their assessment in order to frustrate legal action, are removed or at least substantially reduced.
(c) common national, systemic and multi-disciplinary approaches are taken to assessing workplace injury/disease and developing workplace improvements.
(d) identical statutory benefits and (if an adversarial WC system is maintained) lump sum compensation and damages provisions (including thresholds and quanta) are applied irrespective of the geographical location of the injured worker, and irrespective of the type of injury/impairment/disability (physical or psychological).
(e) the linkages between accident compensation schemes and federally-funded and -operated social security provisions and health services be made more explicit and be managed more consciously and transparently, with minimal opportunities for cost-shifting and other distortions (e.g. of data).
(f) the level of workers compensation premiums payable by employers not be treated as a cost factor to be manipulated in order to enhance a region's "competitive advantage" in attracting employers. Instead a uniform national premium structure should apply, containing three components: a common component payable by all employers; an industry component based on the injury record of the particular industry; and an individual employer component based on the particular employer's OHS and rehabilitation record.

Recommendation 2: That the Productivity Commission's Inquiry adopts the following specific aims as a means of implementing Recommendation 1 specifically in regard to psychological injury:

(a) psychological and psychiatric impairment and consequent disability be uniformly recognised (legislatively and in other ways) for the purposes of statutory benefits (and if an adversarial system is retained, for the purpose of giving access to lump-sum compensation and/or damages), for access to funded treatment and rehabilitation, and for inclusion in suitably designed and operated return-to-work programs.
(b) the focus of such assessment should be on functional loss (impairments of functional capabilities and associated disability), not on psychiatric diagnostic categories.
(c) assessment of psychological and psychiatric impairment and disability, including initial, progressive and the ultimate (permanent, stabilised) levels of

impairment/disability, be made by a multi-disciplinary team of health professionals comprising at least one psychologist and one psychiatrist, and at least one other professionally qualified person experienced in assessing workplace impacts of psychological and psychiatric impairment and disability, and knowledgeable about return-to-work and job redesign issues.

(d) legislation should use a broad definition of "assessor" to include the above-named non-medical professions.

(e) assessments made by medical and non-medical professionals be provisional, i.e. open to challenge or appeal where the assessment is disputed and the consequences of the provisional assessment are arguably seriously harmful to the injured person's claim. If the overall system remains adversarial, the final decision - where the injured person disputes the assessment - should be left to judgment by the appropriate court/tribunal. Health professionals (individually or as a panel) should not be given final (legally binding) determination powers or responsibilities.

(f) accurate details of the source or sources of the psychological or psychiatric injury or disease (established by the multi-disciplinary assessment team and suitably deindentified) be communicated back to those responsible for occupational health and safety improvements in the workplace so that action can be taken at the local level to prevent further occurrences of that type of injury or disease; and the OHS and WC authorities collectively develop and maintain a data base of such injuries and diseases, and their sources, in a form able to be used for research purposes.

(g) the WC and OHS authorities make joint appointments of senior psychologists to:
    i. oversee the use of other psychologists (salaried or contracted) in assessment, treatment and rehabilitation of psychologically or psychiatrically injured workers,
    ii. oversee and/or conduct research into the sources of such injuries or diseases and into the efficacy of treatments and rehabilitation programs for them,
    iii. develop improved methods of assessing and treating such injured persons,
    iv. contribute to the transmission of information back to employers about poor workplace design or "people" practices that produce psychological problems,
    v. ensure that best practice assessment, treatment, rehabilitation and return-to-work methods are employed by the psychologists engaged by the authorities.

Recommendation 3: That (as one action to operationalise the principles and specific aims espoused in Recommendation 1 and Recommendation 2) the Commission recommends to the States, Territories and Comcare/Seacare that their existing or draft workers' compensation legislation and public liability legislation be amended where necessary, in order to remove or prevent anti-competitive features, and replace them with multidisciplinary provisions; and that this be achieved by (*inter alia*):

(a) broadening the legislative definition of "medical assessors" to include psychologists (in respect to assessment of brain functioning, and "mental and behavioural problems") and, where appropriate (for other types of injuries and impairments) other non-medical health professionals (e.g. speech therapists, podiatrists, optometrists, occupational therapists, physiotherapists and social workers).

(b) amending guidelines for the evaluation of permanent psychological impairment to remove the requirement for a "psychiatric diagnosis", and in its place substitute "a recognised impairment of psychological functioning".
(c) inserting a broad definition of "medical treatment" to include services provided by psychologists, speech therapists, podiatrists, optometrists, occupational therapists, and physiotherapists, with the safeguard that where state registration exists, the professional must be registered, and where it does not, the person must be a member of the relevant professional association.
(d) if thresholds are retained (which we do not support in their present form), identical standards be set for physical/organic impairments and for psychological and psychiatric impairments.

Recommendation 4: That the high level of employer default and the much lower but still significant level of deliberate employer fraud in workers compensation systems should receive prompt and very active attention.

Recommendation 5: That psychological issues be considered carefully in future occupational health and safety planning, legislation and programs including:

(a) preventing or minimising workplace stress (chronic, acute and post-traumatic) by acting on the preventable sources of such stress;
(b) reducing the incidence of workplace harassment, bullying, and violence;
(c) giving more adequate attention to human factors in the design and operation of equipment and other "technologies"; and
(d) promoting better human resource management including improving defective work practices that lead to unnecessary fatigue, potential for dangerous error, and workplace conflicts.

Recommendation 6: That the Commission commends that a greater degree of integration across the various health and accident compensation arenas be pursued, by such means as:

(a) greater dialogue among Federal and State/Territory Ministers across the various health-related portfolio areas, not just within Ministerial Councils, but between those Councils;
(b) greater sharing of ideas and information across health (including OHS and accident compensation) jurisdictions, by way of joint conferences, publications and Internet-based communications.
(c) greater consultation by those Councils, authorities and government departments with the relevant professions.

Recommendation 7: That the Commission emphasises in its Report(s) the critical importance of an active, comprehensive, coordinated and well-funded research orientation, developed and overseen by a representative Research Council.

Section 2: The need for an overarching conceptual and values framework for OHS and WC.

This Section explains our overall rationale for Recommendations 1, 2 and 3. Subsequent sections explain specific aspects of our Recommendations.

2.1 THE DESIRABILITY OF SUCH A FRAMEWORK:

Developing a national framework - a concept that we broadly support – is both very necessary and highly ambitious. Its necessity has long been recognised in most other countries. Australia is one of only three developed countries with sub-national WC and OHS systems, the other two being the USA and Canada.

The need for national integration of the USA's WC systems has also long been identified in that country but has been strenuously and successfully opposed by various vested interests there. The Commission is urged to read (if it has not already done so) Christopher Howard's analysis of the history of this thwarted policy development effort. There are, we believe, remarkable parallels between Australian and US trends. Howard's analysis offers valuable insights and explanations of US trends ranging from the macro to the micro that seem to us to transfer readily to the Australian context. (See References in Appendix F.)

The reasons why we believe an integrated national system is needed include:

(a) there is very costly duplication of effort in developing and enacting OHS and WC legislation (although not necessarily duplication of its features) and associated costs to parliaments, parliamentarians and their staff, departments and authorities, and various interested groups including professional associations and unions. The WC area has been a particularly active one legislatively, and is likely to continue to be so.
(b) the different pieces of legislation may have much in common but still involve some very significant and often contentious and inequitable differences, such as (in WC legislation) in thresholds, access to and quantum of compensation for injury, and definitions of important terms.
(c) there are regionally different legal avenues in regard to WC appeals, and somewhat different judicial principles and decisions regarding some matters.
(d) notionally OHS and WC may be housed within the one regional authority but appear to function as separate "silos" that are effectively participants in two different "industries". These industries appear to be of more significance, in terms of values, goals, perspectives, attitudes and methods, than are their internal organisational links.
(e) the WC authorities appear to differ[4], one from the other, in their organisational

[4] Unfortunately there appears to be a lack of comparative evaluative research into these "organisational climate" matters.

“climates”, procedures and practices, perhaps due at least partly to differences in their fundamental roles (regulatory versus “hands-on” operational), and the associated issue of the roles of employers and insurers.

(f) the current regional and function-based (OHS v WC) differentiation involves very costly duplication of administrative structures, policy development effort, and staffing arrangements within the relevant authorities and the insurers. While some regional and functional differentiation would still be needed in an integrated national system, major economies of scale (as well as gains in effectiveness of system functioning) are in our view achievable in the short term in regard to the legislative, policy development and administrative areas, and in the medium to long term in regard to structural and staffing aspects.

(g) there is confusion in the WC arena about responsibility for and processes of handling injured workers’ claims where there are national or international/multinational employers; injured workers may have restricted job mobility geographically without “mutual recognition” provisions across the regions; and some employers (and – less probably - injured workers) may undertake “jurisdiction-hopping” to maximise potential or actual gain.

(h) there are regional jurisdictional differences in the OHS area (such as in the incidence of prosecutions and the issuing of improvement notices). Many of these differences have no apparent rationale although some may be related to differences in industry composition and size of organizations. Some of the differences may be functional within the particular local system, but others appear potentially dysfunctional, e.g. confusing to a national or global business, or indicative of a lack of focus on OHS matters (such as occurs in many public sector bodies).

In endorsing the development of an integrated national system, we are nonetheless conscious that there is a genuine and in some respects strong case to be made for retaining separate systems. Opposition to a national integrated system may be well-founded and not just an expression of vested interest in the current separate systems.

Our support for national integration is premised on having an approach that identifies the valued benefits of the currently separate systems and makes provision for their preservation in the integrated national system.

We believe this is possible to achieve, but can appreciate that others may equally validly arrive at a different view.

Some arguments put forward for separate systems are:

- ***fundamental incompatability*** between the OHS and the WC systems even though they may be co-located within the same workcover authority.
- ***excessive complexity*** of an integrated system covering both OHS and WC, and also having national coverage. This complexity (the arguments runs) would lead to confusion and clouding of key objectives and great difficulty in obtaining agreement about priorities when “trying to be all things to all people”. Conflict of priorities and

excessive bureaucracy going with increased size may lead to organisational ineffectiveness if not outright paralysis.

- ***a greater sense of ownership of and influence*** in the separate systems by their various stakeholders, including and especially State and Territory governments, that might be lost with a national system.
- a strong likelihood that the ***positive features of the separate systems will be lost*** in a national system, by such processes as "averaging" or "using the lowest common denominator", and/or that ***negative features may be too readily introduced*** without the "checks and balances" inherent in separate, loosely-linked systems.
- a single system will be ***too readily controlled*** by whichever political party is in office in Canberra.
- separate systems provide a ***"natural laboratory"*** for trying different variants of WC or OHS schemes or projects and evaluating their outcomes, such as the Self Managed Employer Network in South Australia, which the State's workcover authority and the Stanley Report have recommended be closed down after evaluation revealed a poor set of outcomes. (See Stanley Report Vol. 2.)
- ***beneficial competition*** is provided by separate systems in terms of relative WC premiums charged to employers and associated benefits to injured workers.
- ***jobs and careers will be lost***, particularly in specialised fields such as in the OHS area, leading to loss of important expertise and organisational effectiveness.

We consider that these concerns are not mere "catastrophising" but indeed generally have merit. In the development of any integrated national system, serious and effective steps must be taken to address them and to ensure that these negative outcomes do not occur.

The potential negatives, sensibly treated, may indeed serve to produce positives in an integrated national system.

For example the "natural laboratory" argument (which fails in the current separate systems because there is little or no systematic planning of variants such that lessons can really be learned from their operations) could in an integrated national system be developed into a major applied research theme, properly conceptualised, coordinated, planned, evaluated and funded.

Another example is the concern about losing the benefits of the separate systems through "averaging" or "lowest common denominator" thinking. Addressing this concern in a positive way should be a valuable process, of identifying clearly what is valued now and must be preserved, and focusing on how to preserve them in a new, integrated system.

Some form of differentiation of functions will be necessary in any system, so that (as an example important to us) the management of injury assessment, treatment and rehabilitation is not made subservient to other functions, especially financial (which is a major defect of some of the current WC systems). But they must still be undertaken as part of an integrated total system with accountability for performance, including in financial terms.

However, to the extent that development of an integrated national system may move the workers compensation arena towards a North American "managed care" type of system, we commend great care, in light of a number of research reports emerging in the professional literature about the manifold problems with US managed care systems.[5]

2.2 THE SCOPE OF A NATIONAL FRAMEWORK

It hardly needs to be said that the scope of a national framework will be very wide, ranging from the very abstract and conceptual, to the very practical. It will have to address complex and manifold social justice, political, economic, professional, legal and administrative issues. The developmental process will be long-term – years.

Again it hardly needs to be said that, if such a process is to succeed, it will need to be very soundly conceptualised, well-planned, well-structured, well-funded and well-managed which includes being very flexible, responsive and adaptive, to ensure the successful flow of desired changes down, up and within the macro, meso and micro levels of the OHS/WC systems.

A high level of support and contribution from all interested parties will be vital, which can be obtained only by: clarity and broad acceptability of purposes; excellent rapport, trust and communication with the various stakeholders and vested interest groups; and respectful and prompt responses to inputs and expressions of concern from them about overall directions or specific issues.

One key issue affecting acceptability will be whether the goal of such integration is genuinely consensual and is to create a better OHS/WC system, embodying "best practice" services and "continuous improvement" philosophy. If it is seen simply as controlling costs (e.g. by cutting staff numbers) and keeping employer premiums as low as possible (e.g. by paring back entitlements and benefits and providing only minimal services), strong resistance may be expected from many stakeholders, or at least a very damaging lack of motivation to help. On the other hand, if there are no direct financial benefits to employers and insurers, in at least the medium term if not the short term, they may not be motivated to help.

Integration is a task to which the Productivity Commission would of course make major and sustained contribution but which the Commission perhaps ought not attempt to direct or control itself. Only the Federal Government has the powers and resources to attempt this complex and difficult task, and then not with great prospect of eventual success, such are its complexities and the powerful vested interests, sunk capital and other kinds of commitments in the current regional systems that will oppose or make difficult the achievement of a fully-integrated national system.

[5] We understand that the Commission has recently been involved in close consideration of this issue, at least to the extent of publishing the report "Managed Competition in Health Care - Workshop Proceedings" (23 August 2001).

One essential ingredient in pursuit of the goal of an integrated national system must be an overarching conceptual and values framework to give a sense of mutuality of purpose, direction and clarity.

2.3 ELEMENTS OF A CONCEPTUAL AND VALUES FRAMEWORK:

What might be the possible elements in such an overarching conceptual and values framework? The following ingredients seem to us to be essential:

- ***the primacy of beneficial purposes*** – that OHS and WC systems are designed first and foremost to protect workers from injury or illness, and to provide (psychologically as well as financially) for those who are harmed.
- ***an equitable and internally coherent framework*** – where the degree of protection/prevention is consistent with the degree of risk and the seriousness of the injury/illness and its impacts on the victim (and family), as is the degree of nurturance and compensation. This framework should not have elements of the "zero-sum game" kind as is the case at present, where WC insurers' profits are seen as linked negatively to claimants' success.
- ***a respectful, responsive and caring framework*** – where there is a presumption of innocence of injured claimants and employers, respect for people's rights, and a fast and comprehensive response to injury and its impacts (both in regard to the welfare and rehabilitation of the injured person, and to correct the workplace defects leading to the injury).
- ***a collaborative, scientifically investigative system***, not one marked by adversarial orientations and behaviours and associated legalistic manipulation of narrowly-based and selective evidence.

Adoption of this kind of framework would have serious consequences. For example, thresholds would have either no place in such a system, or a very different place. Currently thresholds (both explicit and covert, the latter including the requirement for a diagnostic category to be assigned as a prelude to giving treatment) are used in essence as an adversarial concept and decision-making method. This use of thresholds, we suspect, is a major factor, among others, that collectively promote manipulative behaviour by all classes of the system's participants.

The current adversarial character of the WC systems is also a major cause of avoidance behaviour, e.g. by some injured persons (who choose not to make a claim because of the trauma involved), and by some professionals (who refuse to work in the WC assessment area).

2.4 IMPORTANT LEGAL ISSUES:

Better framed and more consistent legislation and case law across OHS and WC systems and legal jurisdictions, we consider, also very important, especially in regard to the

intersection of the professions and the law. Desired improvements include: better definitions of key legal and professional terms relating to mental health, and clearer and more insightful delineation of appropriate professional roles, especially for the various non-medical professions, based on a better understanding of their roles in the modern era, and on better legal understanding of the nature of mental illness and dysfunction. (This argument is made in more detail in Section 5 and Appendix C.)

A prime example of a crucial legal issue is the case law distinction between "psychiatric injury" (which includes psychological injury) and "physical injury". Differential legal concepts and precepts have been applied. The Australian case law has proceeded "step by cautious step", through experience rather than logic (according to Spigelman CJ) leading in this context to the view that "psychiatric damage is a different kind of damage from personal bodily injury" (see Morgan v Tame [2000] NSWCA 121 (12 May 2000).)

These legal views, we submit, have helped produce adverse discrimination against psychologically-injured workers by (for example) unnecessarily and dysfunctionally limiting the definition of "pure psychiatric injury" to "shock in the sense of sudden sensory perception". Yet in other legal contexts (including in the superior courts) these precepts have been rejected explicitly, or psychological and psychiatric injuries of "non-shock" forms (e.g. chronic stress) have been recognised.

To implement our recommendations about equal treatment of psychiatric and psychological injury with physical injury, specific legislative provisions would be needed to overcome some of the adverse (and contentious) differentiations historically embedded in Australian case law, and to modernise the law more speedily and accurately than is inherent in the "step by cautious step" process. We say "more accurately" because the latter process has recently produced such conceptually strange notions as that every impairment requires an underlying "patho-physiological condition" (our underlining)[6]. How such a concept (not further explicated in the case law) might jell with other legal concepts such as "sudden shock" (which has no explicit connection with "physiology") is very obscure.

Moreover we note the inconsistency in case law, and in recent NSW and Tasmanian WC legislation, with legal concepts and standards in the USA where the "bible" for impairment assessment (the American Medical Association's Guides) originated. In particular the Americans with Disability Act explicitly bans the use of "mental disorders" as a basis for assessing disability, recognising their lack of relationship with impairment and disability and their damaging "baggage" by way of negative stereotypy (as we elaborate in Appendix B). Yet psychiatric diagnoses of "mental disorders" are a (very dysfunctional) requirement in Australian WC legislation, and are treated as essential in some judicial interpretations of WC legislation.

The judiciary and the legal profession more generally, the various professions, and the parliaments must, we suggest, be actively involved in the construction of the

[6] See for example Comcare Australia (Department of Defence) v Maida [2002] FCA 1284 (29 October 2002).

professional-legal elements of an agreed national framework. Of course other stakeholders with an interest in these matters should not be excluded.

The requirements of the Federal privacy legislation (especially regarding secondary use of information collected) and State health records administration must also be observed. Such issues must be recognised for the operation of integrated data-collection schemes so those participants providing information are aware of possible secondary uses and are appropriately advised before their agreement is sought. Duress must be avoided, including covert duress arising from perceptions that failing to agree to provide all requested information (not just that directly relevant for claim assessment) will harm one's claim.

The impacts of such privacy and health records administration on professional assessments and the secure keeping of professional records and reports should be explored with the relevant professional associations (and perhaps the relevant state registration boards) as a matter of some urgency.

Some other legal issues are also crucial here, such as:

- the legal liability of an independently-practising professional, compared with a government-employed, salaried professional when assessing or treating an injured worker, and
- scientific compared with legal standards of proof of causation.

Both these issues are particularly relevant to the contentious (and to us unacceptable) use of medical or broader professional panels to determine final (i.e. legally binding) assessments of permanent impairment.

Later in this submission and in Appendix C we elaborate on these legal concerns.

2.5 USING THE EXPERIENCES OF OTHER OHS/WC SYSTEMS:

We commend an evidence-based approach to the task of developing a national framework, rather than an ideological one.

The experiences of not only our States and Territories, but also other countries, in operating their OHS and WC systems should be drawn on, although below we indicate some caveats. We commend to the Commission, for example, the technical reports by Hunt, H.A. and Klein, R.W., of the Upjohn Institute for Employment Research, circa 1996-98 (see References in Appendix F) which *inter alia* compared the Victorian WC system with WC systems in North America and Canada. They provide, in our view, a balanced and evidence-based assessment of those systems, and employ concepts and criteria that appear to be very valuable for the creation of a national framework for Australia.

As they outline in detail, comparisons across WC systems are difficult to make. Putting their apparently desirable features together into a national framework is even more difficult. Hunt (1998) wrote, *"..each system is an organic whole that has its own internal logic, which is why it is not possible to just lift features from one system that seems to work and insert them in another system that doesn't work"* (p.4.) The Industry Commission in its 1994 report shared a similar view.

This caveat applies particularly to adversarial versus non-adversarial features that generally do not mix.

Another source of concepts relevant to a national framework is the American Administrative Inventory, a product of the Workers' Compensation Research Institute. See Hunt and Klein (1996) p.3. for details of its nature and use.

However we urge a broader review than only of US, Canadian, British and Australian OHS and WC systems, of at least the scale covered by the Industry Commission in its 1994 report. Other European forms (partly because of their different legal histories) appear to us to have a much less adversarial character than US, Canadian, British and Australian systems and are worth detailed examination in regard to how they have developed since 1994.

Examples include:

- the European Agency for Safety and Health at Work whose principal tasks are *"bringing together, and sharing, occupational safety and health (OSH) information from Member States of the European Union"*; and

- the Finnish system with components such as the Finnish Institute of Occupational Health, whose organisational structure includes a Department of Psychology.

This Department's task is *"to carry out research and to offer scientifically grounded consultation services and training in the following areas:*

- *Promotion of well-being*
- *Management of change*
- *Development of work organizations."*

2.6 A PRIVATE OR A PUBLIC NATIONAL INSURANCE SYSTEM, OR A HYBRID ONE?

This is perhaps the most important single question about Australia's WC systems. As Hunt and Klein (1996) point out regarding North American WC systems, *"…there is a continuum of systems and of system features that might affect the basic judgment as to whether a particular system is more public or private in its orientation."* (p.1.) This

statement is certainly true in Australia where the various State and Territory WC systems are not identical in terms of the degree to which they embody “private market” and “state monopoly” features. Thus one of the difficult tasks confronting any effort to develop a national system would be to achieve a consensus among the participating parties as to its desired common features including those relevant to the “private market” versus “state monopoly” issue.

Hunt and Klein pose some very relevant questions to assess the nature of existing systems that may in our view be adapted to apply in attempting to secure consensus (among all the stakeholders, not just governments and insurers) about desirable features in this aspect of a national framework:

Who carries the underwriting (insurance) risk for workers’ compensation benefits?
How is workers’ compensation insurance priced, and by whom?
What fundamental principles guide the insurance pricing system?
Who monitors benefits for compliance with statutory requirements?
Are the availability of coverage and the payment of insurers’ claims obligations guaranteed?
Is self-insurance allowed, and, if so, for whom?
How are incentives for prevention of accidents, and resulting workers’ compensation claims, maintained?
What is the performance of the overall system?
In summary, how are these questions answered and what do the answers reveal about how these responsibilities are allocated among government agencies, other public entities and private firms?

Answers to these questions should, we consider, be sought in a transparent, public way. They should not be left unaddressed, or answered “behind closed doors”. We are therefore reassured to note that the Commission has raised many of them in its Issues Paper.

They are not questions for which our professional expertise is directly relevant. But we do observe that psychologists generally have a strong “social justice” orientation and value system that results in high priority being placed by them on prevention of injury at work, and a fair, equitable and just post-injury rehabilitation and compensation system. The latter’s continuity and delivery of benefits should be guaranteed by the state, not left exposed to variable market operations and conditions.

Psychologists would therefore, we suggest, expect the questions about insurance arrangements and other system features to be answered in ways that serve those priorities.

Section 3: The need for greater uniformity and consistency between general health care delivery and accident compensation.

This Section** inter alia **explains the basis for:

Recommendation 1 (e): (that) the linkages between accident compensation schemes and federally-funded and -operated social security provisions and health services be made more explicit and be managed more consciously and transparently, with minimal opportunities for cost-shifting and other distortions (e.g. of data).

and

Recommendation 6: That the Commission commends that a greater degree of integration across the various health and accident compensation arenas be pursued, by such means as:

(d) greater dialogue among Federal and State/Territory Ministers across the various health-related portfolio areas, not just within Ministerial Councils, but between those Councils;
(e) greater sharing of ideas and information across health (including OHS and accident compensation) jurisdictions, by way of joint conferences, publications and Internet-based communications.
(f) greater consultation by those Councils, authorities and government departments with the relevant professions.

The APS supports and commends to the Commission the view that any recommended changes to the OHS and WC systems should be consistent with the more general goal of developing a uniform national approach to health. In particular, we urge that there be appropriate uniformity and consistency of health care access and health care delivery, across the various health arenas including accident compensation.[7]

Greater uniformity is important not for its own sake but in pursuit of equity of access by injured and ill persons to achieve:

(a) recognition of their injuries or illnesses (an important element in recovering from injury or illness);
(b) early professional intervention for accurate evaluation of injuries or illnesses, appropriate treatment, effective and efficient rehabilitation, and (where necessary) job redesign or work reallocation; and

[7] In our earlier submissions to the Sheahan Inquiry and the NSW Parliament's General Purpose Standing Committee No. 1 regarding Workers Compensation legislation in NSW, and to the Stanley Inquiry in South Australia into both OHS and WC, (available on request) we made the point that greater integration was urgently needed across the various levels of government and other players in the health care system including accident compensation authorities (traffic as well as workplace accidents). More recently we made a submission to the NSW Parliament's Select Committee on Mental Health Review in which we commented on the NSW mental health system in some detail and made the same general point. (A copy of the latter submission is available on request.)

(c) adequate income support and compensation where warranted.

Injured workers are, we believe, entitled to have access to the full range of "best practice" health care (including "best practice" assessment methodologies). They must not be treated as separate from the rest of the community and subjected to sub-optimal care, as is now the case, through systemic deficiencies in WC schemes.

Injured workers tend to be treated less well than persons injured in motor accidents, especially but not only in terms of public and within-authority suspicion of fraud and exaggeration of injuries and their impacts (sustained and nurtured by the media's portrayal of alleged cases), as we outline in more detail in Section 5.

The Stanley Report (especially in pages 89 and 90) arrives at a similar conclusion about the SA WC system, and observes that *"The process of investigation and determination (of claims) of itself may reduce the effectiveness of rehabilitation and return to work"* (p.90). The intrusion of claim investigation (an administrative, quasi-legal process often involving covert surveillance of claimants) into the professional arenas is a serious problem (not just in SA) that must be addressed whether the current systems are or are not integrated.

In some regions psychological injury is still not legislatively recognised. Where it is recognised, it is typically treated non-uniformly across regions, and in an adversely discriminatory way compared with physical injuries and impairments. (See the HWCA document *Comparisons of Workers' Compensation Arrangements in Australian Jurisdictions July 2001*.)

Thus we consider that the drive for uniformity and consistency should include principles and processes for assessing and treating ***impaired psychological functioning*** in workplace injury contexts.

There are particular problems in the newly-introduced or proposed processes for assessing psychological injuries in some of Australia's WC systems (notably NSW and Tasmania, and potentially Comcare/Seacare). The NSW/Tasmanian model is a poor one and should not be considered to represent the way forward, as we now explain.

Accurate assessment of psychological (or any other) injury or illness, and associated impairment and consequent disability, is important throughout the whole *initial assessment-treatment-rehabilitation-compensation* process. Continuity and integration of assessment methods across that spectrum are most important. Assessment is inextricably intertwined with treatment, and review of rehabilitation progress, as well as with eventual prognosis about the impairments suffered.

It is dysfunctional to use an entirely different assessment approach and different assessors for evaluating permanent impairment – as NSW and Tasmania are now doing - divorced from the assessments developed in the earlier initial-evaluation, treatment, rehabilitation and work modification stages.

The justification offered for using separate assessors is that they are more "independent" (which is presumed to lead to greater accuracy) than those professionals undertaking the treatment and rehabilitation work. Unfortunately this view is wrong empirically in two ways: employing different perspectives and methods for permanent impairment assessment is dysfunctional; and the assumption of "independence" cannot be sustained.

The use of different perspectives and assessment methods for assessing permanent impairment from those earlier employed creates many problems. Comparisons of patient progress are rendered very difficult. Different judgements are reached, and especially in the legal context for permanent impairment become subject to dispute which incurs unnecessary legal costs and illwill among the parties involved. We elaborate on these and related problems later in this submission.

The assumption of "independence" is unsustainable empirically. There is evidence of strong "role effects" and other pressures on such allegedly "independent" assessments. Assessments are carried out too briefly, on too little understanding of the case, and with too much of an eye to politico-economic considerations, to be as accurate as the treating practitioners' assessments. Moreover assessment methods in use are often defective, especially the Psychiatric Impairment Rating Scale (adopted in NSW and Tasmania despite much professional objection) with its unacceptable scoring method. (It uses the median score of six ratings of the individual claimant's functioning, which effectively ignores their main areas of impairment.) Also we know of some instances where psychiatrists carrying out mental state examination use symptom check lists in a "leading question" way (e.g. "Do you suffer ….?") which inadvertently "cues" the claimant.

The latter kind of defect in assessment methods adds to the impression that claimants fake or exaggerate, because (unwittingly) it encourages and aids such behaviour. The defects in the Psychiatric Impairment Rating Scale, on the other hand, add weight to the view that the insurers and authorities are intent on denying as many claims as possible, whatever their merits, because the effect of the PIRS's scoring is to at least halve the real impairment level, and in the worst case reduce it to about one-sixth of the true level.

Of course "role effects" are found on both sides of the adversarial system. Treating practitioners may have their own biases, resulting at times in understandable but inappropriate advocacy for the injured person in legal contexts. Training in functioning as an independent assessor and as an expert witness should be part of Professional Development programs, as these are currently areas of rapid change. The Commission is no doubt aware that the courts have recently embarked on the development of expert evidence guidelines to overcome some of the problems with allegedly independent experts including those involved in injury and impairment assessment.

Those guidelines certainly do not endorse the removal of treating practitioners from the assessment process. Indeed the Family Court guidelines, for example, enable the calling of treating practitioners as witnesses even where they are reluctant to be so involved.

We note that Australian courts and tribunals have generally preferred the assessments reached by treating practitioners to those of allegedly independent assessors (usually paid by the insurers) in WC cases, on the basis of their much longer acquaintance with and more detailed knowledge of the injured person and his/her conditions. We also note that in some US legal jurisdictions the concept of "treating physician presumption of correctness" operates - assuming the validity of treatment-based clinical judgments in the absence of compelling evidence to the contrary. In British Columbia, psychologists and other non-medical professionals are included, with medical practitioners, in the assessment of permanent psychological impairment whenever they have been involved in earlier assessment or treatment.

This issue is also addressed in the Stanley Report regarding the South Australian WC system, where it has been recommended (Recommendation 9.13 in Vol.2 of the Report, p.94) *"That s 53 of the Act be amended to provide that before rejecting a claim for compensation in respect of the nature, extent and probable duration of a disability that the compensating authority must obtain a report from the worker's treating medical practitioner".* (In the area of psychological impairments, we would of course add "treating psychologist" to this recommendation.)

Yet in the recent changes in the NSW and Tasmanian WC legislation regarding psychological and psychiatric impairments, the treating practitioners' assessments are ignored, a matter to which we shall refer again later in this submission.

We turn now to the issue of equitable access to mental health services. Inequitable access has long been a major problem in Australia, especially in that, despite much community and professional representations to ensure otherwise, *psychological* services are not rebatable by Medicare whereas *psychiatric* services are.

Over recent years the APS and other professional bodies have been working together to promote better mental health strategies and service quality, especially of the multi-disciplinary kind necessary for fully effective and efficient service delivery to people in need. Many government departments and agencies, and the universities, have also been involved.

For instance, the national Better Mental Health Outcomes project involves "best practice" multi-disciplinary models of mental health assessment and management. The de-stigmatisation of mental ill-health such as depression and anxiety is being very actively sought through efforts such as the *beyondblue* and Black Dog campaigns.

Another important and very positive example of government involvement in promoting better mental health is that the NSW Department of Health actively co-sponsored The Mental Health Services Conference 2002.

Among the themes in this Conference were:

- improving equity of access to mental health services;

- using evidence-based best practice for intervention in disaster and mass violence contexts;
- how to develop a better equipped multi-disciplinary mental health workforce;
- meeting the service provision needs of rural and remote Australia; and
- challenging stigma regarding and discrimination against sufferers of mental ill-health, including in mental health services.

Despite these years of collaborative effort, unfortunately progress in the health and accident compensation arenas has been hampered by (amongst other problems) insufficient cross-portfolio communication at Ministerial Councils level.

New understandings of mental health issues, and associated change goals, strategies and action plans in the health portfolio, in particular, seem to be inadequately appreciated in the accident compensation portfolios leading to people often acting at cross-purposes.

The pillorying of psychologically impaired workers in WC contexts, in the courts in terms of adverse legal concepts, and in the WC authorities' and insurance companies' treatments of claimants, runs directly counter to the efforts outlined above to destigmatise and prevent discrimination against sufferers of mental ill-health. The Stanley Report supports this view, saying: *"Some recent, unpublished research, available to the Review on a confidential basis, shows that there is a distinct reluctance of many workers to lodge stress claims for a range of reasons (stigma, etc.)"* (pp 89-90.)

The Stanley Report alludes to various problems in regard to stress claims. It says: *"The stricter causation test and the defences available to the employer/insurer under s30A frequently means that there is a longer investigation phase prior to determination, and sometimes this puts the employer and worker in adversarial positions from the start. More extensive investigation and medical examination and reporting also affect compensation costs even where the claim is not accepted."*

The approach recently taken to the assessment of psychological and psychiatric injury and impairment by NSW and Tasmania – restricting such assessment work to psychiatrists only - is diametrically opposed to the modern, multi-disciplinary, "best practice" emphases being promoted by the Mental Health Services Conference 2002 and the other activities to which we have alluded above. This is so despite WorkCover NSW being a co-sponsor of an important multidisciplinary conference in 2001 that strongly urged greater multidisciplinary cooperation.

Clearly little if any inter-Departmental (and indeed intra-Departmental) dialogue of real substance concerning these professional issues has taken place. We include "intra-Departmental" because we are aware that many WC and OHS authority staff have been working assiduously and knowledgeably to promote modern multidisciplinary approaches to treatment, rehabilitation and improved workplace safety, but some of their colleagues appear ill-informed about them.

A much more consultative approach is necessary for effective and efficient change management, to promote the development of a high level of shared understanding and a commitment to joint problem-solving. As one example, but a very important one, the issue of having an adequate multi-professional workforce for future community needs including in rural and remote areas, is as relevant to the accident compensation areas as to the broader health and mental health areas. Yet the serious negative impacts of the accident compensation developments (especially psychiatrist exclusivity) on the psychologist workforce have been neither anticipated by the compensation authorities nor (to our knowledge) discussed at broader meetings with the other health bodies.

We ask the Commission to commend an open, widely-consultative approach in regard to OHS and workers' compensation issues, in place of the low-involvement, low-communication, "cards close to the chest" approach that appears to have found favour in recent times in some parts and at some levels of the accident compensation arena. (See Appendix A for details.)

SECTION 4: WORKERS' COMPENSATION SYSTEMS: DYSFUNCTIONAL ADVERSARIALISM.

This Section explains the basis for our emphasis in Recommendations 1, 2 and 3 regarding changing to a non-adversarial system.

It also provides the rationale for our ***Recommendation 4:*** ***That the high level of employer default and the much lower but still significant level of deliberate employer fraud in workers compensation systems should receive prompt and very active attention.***

Adversarial state-level WC systems exist in the USA, Canada and Australia. They are remarkably similar in history and current features including the impositions of arbitrary thresholds restricting access to compensation. They are all marked by high levels of mutual distrust, suspicion, bias, prejudice and maltreatment of injured workers.

Many dysfunctional "mental models" of human behaviour and motivation operate. The use of thresholds (of which a requirement for diagnostic categorisation is a covert form as is explored in more detail in Appendix B) appears to play a significant role in promoting manipulative "game playing" behaviors by all participants, thus helping to sponsor and reinforce prejudices and mistrust in a tragic "self-fulfilling prophecy".

For example, the Californian Department of Industrial Relations' Division of Workers' Compensation and the (independent) Public Health Institute jointly reported (November 2001) the results of focus group discussions about improving the quality of care to injured workers.[8] This Report covered the views of injured workers, employers, judges, attorneys, physicians, nurse case managers, claims adjusters and information/assistance officers.

It indicated serious problems in a number of areas, including the intrusion of medico-legal concerns and processes into the treatment area. It said there was widespread distrust *"pervading the workers compensation system…widely viewed as both a quality of care problem and a barrier to quality improvement"*. (Report, p.4.) It went on (p.13 ff) to refer to *"Claims adjusters and employers voiced suspicion of .. claimants…Workers are sensitive to and resentful of these suspicions. They report that they feel criminalised and that their own physicians don't trust them…Workers and others distrust the company doctors…"* and much more.

The situation in Australia is no better. Justice Strong (in the case of Fisher v. Keys Road Clearance Centre involving the Victorian WorkCover Authority) felt compelled to say: *"Workers Compensation cases are to some degree being conducted in a manner more akin to a criminal proceeding where a person before the Court stands accused of some*

[8] "Improving the quality of care for injured workers in California: Focus group discussions." Research Report 2001-3 (available on the Internet).

serious wrongdoing." So bad has the legal situation become that one genuinely injured worker (a Mr Boxsell) committed suicide following a hostile cross-examination where he felt he had failed to present his case adequately, and apparently then feared the loss of his home and life savings from the costs of unsuccessful legal action. His widow attempted (unsuccessfully) to take legal action against the barrister involved. (See AMP v RTA & Anor; RTA v AMP & Anor [2001] NSWCA 186 (2 August 2001).)

This very negative climate should not be attributed to individual staff or other individual participants in those systems. It is part and parcel of a longstanding adversarial system with associated social and organisational roles rather than of individual predilections. The problem is at heart a sociological one, not a personnel one. The same workcover and insurer staff would probably be able to operate a non-adversarial system effectively, providing the adversarial culture and associated roles and inculcated beliefs and mental models were removed or substantially amended, and adequate training was given for the new or amended roles.

A prime example of the defects of the system being the essential problem rather than the staff is that, in most Australian WC systems, the level of professional training of employer and insurance company claim-handling staff is low. Yet a crucially important role of these staff is to make initial assessments of claims and early decisions about injured persons' health status and treatment. Even where it is not officially so, as in many US jurisdictions, *"claims administrators..continue to insert themselves into the authorization process in spite of regulatory requirements for physician review.."* (Californian WC Report referred to above, p.21.)

Yet these claims-handling positions are typically underclassified as relatively low-level clerical-administrative roles, and are advertised and remunerated accordingly, resulting in professionally unqualified appointees. As an extension of the undervaluing of their functions in recruitment terms, they are not given much relevant induction training in this "triage" kind of decision-making.

Their too-low level of expertise in this key "triage" function leads to many misclassifications of injured people, both "false positives" (people identified as seriously injured when they are not) and "false negatives" (people who are classified as not seriously injured when in fact they are seriously injured). This is particularly so with stress and other forms of psychological dysfunction, where the evidence of dysfunction is often obscure to a lay person, and where the scope for misinterpretation of behaviour is considerable.

Misclassifications are the source of avoidable "down the track" inefficiencies and costs of some magnitude. The "false positive" people are given unnecessary or wrong treatment. The "false negative" claimants may undertake legal action to secure recognition of their injuries (usually successfully), and/or endure pain and suffering without the sense of validation flowing from recognition of injury, and often without support.

The accuracy of the insurance claims officers' judgment may be further adversely

affected by the stress many of them experience. Many recognise the mismatch between their competencies and the demands of the role, and feel under pressure from the insurance companies' general policy of "taking a hard line" with claimants.[9] There appears to be a belief in the WC insurers that the best decision strategy at this stage is to reject all but the most obvious or politically potentially embarrassing cases, in the expectation that this will help deal with the perceived problems of fraudulent or exaggerated claims, and a feared excessive number of claims.

This "hardline" strategy, so the thinking seems to run, will deter the cheats and exaggerators, but genuinely injured people will try again, i.e. the strategy is thought (in part at least) to test motivation and genuineness. In fact (as many claims officers appreciate) a "hardline" strategy fails in these terms, and unfairly penalises many innocent injured workers. A different strategy is needed, as is suggested in Appendix.E.

This insurer "hardline" approach extends to the post-rehabilitation treatment, in insurance terms, of injured workers. For example, an employee (senior in managerial status) has recently advised us that she experienced a traumatic work episode from which she suffered PTSD. She quickly recovered after only four counselling sessions, and has resumed her full work role. But the insurer providing her with additional personal income insurance cover then sought to alter the insurance policy to reflect a specific "mental health exclusion" for her, as she was now considered to constitute a risk the insurer was not prepared to continue to cover. She was then concerned that despite her "best practice rehabilitation" she would be unfairly disadvantaged if she sought insurance related to health.

Fortunately the insurer relented, and the matter appears now to be as satisfactorily resolved for the person as such a process allows. However the potential for this kind of "eggshell psyche" ***assumption*** by insurers about claimants is still worrying, e.g. about servicepeople with traumatic combat experiences returning to the civilian workforce. The insurers appear generally not to take into account that at least some people have stronger coping mechanisms after trauma than before. There should not be an automatic assumption of greater risk for those exposed to trauma, either compared with others not so exposed, or compared with themselves pre-trauma.
.
One of the ironies of such a negative adversarial climate in the WC arena is that it has a blinkered individualistic "blame the victim" orientation that tends to obscure systemic perspectives. Consequently systemic problems are not recognised adequately such as employer fraud and evasion of financial and other responsibilities.

Employer fraud and evasion are much more significant problems than is injured worker fraud, in terms both of incidence and quantum of money involved. They have been found in the NSW WC system (see the reports of the General Purpose Standing Committee No.1, available on the NSW Parliament's website), and in South Australia (see the

[9] We do not have good research data on such issues although Associate Professor Maureen Dollard and colleagues at the University of South Australia, and Wendy McDonald of Latrobe University have undertaken valuable research into specific aspects of work stress relating to such mismatches in contexts other than workers' compensation and its administration. Psychologists practising in the WC area are often told of these matters by WC staff with whom they have contact.

Stanley Report). In saying this, we do not support employee fraud, malingering or exaggeration. Indeed we consider that psychologists can play an effective role in their detection, as we outline in Appendix D and in Susan Balinger's electronically-appended article. But they must be put in perspective.

The problems of employer fraud and evasion are probably more widespread than just NSW and SA. The loopholes for fraudulent employer acts are in the main generic and may be subtle, e.g. employers delaying admission of claims in order to require injured workers to use up their sick leave for the period of delay, without subsequent re-crediting of the sick leave; or employers encouraging injured employees to accept informal arrangements for dealing with their health problems and treatment costs so that reports to the workcover and OHS authorities (and associated premium increases) are avoided. Other abuses may be region-specific, due to different systems, e.g. in the South Australian WC system, employers abusing the re-coding of disabilities as "secondary" in order to reduce the levy payable. (The Stanley Report provides more detail.)

We also note various reports that some employers attempt to use employment relationships of a purported "contractor" kind, partly and sometimes wholly in order to avoid WC insurance premiums and other on-costs associated with salaried employment. The Stanley Report outlines the misuse of employment relationships in WC terms in South Australia, in some detail.

We have some limited personal experience of such matters. Complaints have been made by APS members to staff of the APS National Office about misuse of alleged "sub-contractor" status in private psychological practices, where the number of employed psychologists is typically small and the gains from such employment definitional devices are minor.

We are reassured to note from the Commission's Issues Paper that the Commission is already much more familiar than we are with the varieties and nuances of such abuses, and the data available about them.

We recommend:

Recommendation 4: That the high level of employer default and the much lower but still significant level of deliberate employer fraud in workers compensation systems should receive prompt and very active attention.

Section 5: Recent legislation breaches National Competition Policy Principles and must be amended.

This Section is especially relevant to ***Recommendation 3: That the Commission recommends that workers compensation legislation and public liability legislation be amended where necessary, in order to remove or prevent anti-competitive features, and replace them with multidisciplinary provisions; and that this be achieved by:***

(a) broadening the legislative definition of "medical assessors" to include psychologists in respect to assessment of mental and behavioural problems and, where appropriate (for other types of injuries and impairments) other non-medical health professionals (e.g. speech therapists, podiatrists, optometrists, occupational therapists, physiotherapists and social workers).
(b) amending guidelines for the evaluation of permanent impairment to remove the requirement for a "psychiatric diagnosis", and in its place substitute "a recognised impairment of psychological functioning".
(c) inserting a broad definition of "medical treatment" to include psychologists, speech therapists, podiatrists, optometrists, occupational therapists, and physiotherapists, with the safeguard that where state registration exists, the professional must be registered, and where it does not, the person must be a member of the relevant professional association.

In particular we provide a detailed explanation of why we consider the exclusion of psychologists from assessing psychological and psychiatric impairment to be unwarranted professionally, and a clear breach of NCP principles.

5.1 THE BREACH:

Amended workers' compensation legislation was recently adopted by the NSW and Tasmanian Governments as part of *a generally very positive development – finally recognising psychological impairments in those States' WC provisions*. Comcare and possibly other regions are currently considering similar legislation and methodology, also to recognise psychological dysfunctions.

However parts of that legislation, we submit, unfortunately and unnecessarily conflict with national competition policy (NCP) in important respects affecting psychologists very adversely.

NCP expectations include that *"..any standards established or underwritten by legislation do not needlessly restrict competition. They could restrict competition if they introduce inflexibilities that <u>stifle innovation in service provision or exclude service providers who could effectively service specified needs at low cost</u>."* [3] (Our underlining.)

The Productivity Commission's Issues Paper (p. 8) also relevantly says:
"A CPA (Competition Principles Agreement) review is bound by the principle that

legislation should not restrict competition unless it can be demonstrated that the benefits of the restriction to the community as a whole outweigh the costs, and that the objectives of the legislation can only be achieved by restricting competition."

Unnecessary, unsought and highly counterproductive "restriction of trade" WC legislation has been passed in NSW and Tasmania that gives exclusive preferment to psychiatrists for the task of assessing permanent (or arguably any other kind of) psychological impairment, over psychologists and other non-medical service providers, substantially damaging the public interest.[10]

This is, we consider, a paradigm case of the anti-competitive legislation that NCP was designed to prevent.

The NSW and Tasmanian legislation also adopted an outmoded conceptualisation of psychological and psychiatric functioning that is in itself damaging to the public interest (including stifling innovation in professional services and associated methodology) as we shall shortly show.

Of some importance is lack of prescribed process. Neither government undertook the open and thorough assessment of this anti-competitive restriction of professional involvement, or of the crucial public interest questions that should have been addressed in terms of NCP expectations about new or amended government legislation.

Instead, the decision to impose the restriction (particularly the last-minute change to the definition of "assessor" to exclude psychologists) was made very privately, without notice, and certainly without any opportunity being offered to the APS or the public to debate or contest it.

5.2 THE HARM TO THE PUBLIC INTEREST:

We submit that this legislative mandating of the exclusive use of psychiatrists for assessment of psychological and psychiatric impairment is anti-competitive, and harms the public interest in the following ways:

(a) "Psychiatric disorders" (especially where narrowly defined according to a "biomedical model"[11]) do not constitute the whole of, indeed are generally not suitable for assessment of, "psychological and psychiatric impairments". Psychiatric diagnostic categories were developed for broad clinical use with people demonstrating abnormal behaviours (originally in the sense of being a socially problematic pattern of behaviour beyond comprehension simply as a typically human response to particular circumstances), and not for impairment assessment purposes.

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[10] A similar anti-competitive element in previous Commonwealth legislation was removed by its recent broadening of "medical treatment" to include non-medical service providers - yet (under the influence of the NSW and Tasmanian legislation) the draft Comcare Guide has reverted back to a narrow definition of "medical"!

[11] A "bio-medical model" involves "biological reductionism" and "medicalisation" of problems, such that every problem is defined as a biological one, caused by biological factors, and treatable primarily by bio-medical means, especially drugs and rest.

Their inadequacies for impairment assessment have long been recognised. Very significantly, the Diagnostic and Statistical Manual IV (DSMIV) (the widely-recognised authority regarding psychiatric diagnoses) specifically warns not to use them for impairment assessment as they are not indicative of either the type or the severity of impairment.

In the USA, such usage of psychiatric classifications is explicitly banned under the Americans for Disability Act. Cille Kennedy, Assistant Director for Disability Research, National Institute of Mental Health (USA) described it thus: "*An example of participation in work would include an individual who is capable of working at the level of performing all the activities required of and related to a job, but is not hired because of a diagnosis of a mental disorder. This situation is one the Americans for Disabilities Act (ADA) was enacted to eliminate. The person might not be considered as disabled for the activity, but is systematically denied participation in work.*"

Alternative impairment-based classification systems of international standing and use have been developed that are much more suitable. (In Appendix E we refer to one particularly valuable system, ICIDH-2, as the basis for a better assessment methodology.) These impairment-based systems provide data that may then be used to set *multiple* thresholds for decision-making purposes (in a scientifically more valid and objective way than the current arbitrary *single* threshold approach), enabling use of modern "decision theory". (See Swets, Dawes and Monahan 2000.) This (conceptually more contemporary) approach would result in greater effectiveness and efficiency of decision-making about claims (as outlined in Appendix E). The binary categorical system of the psychiatric classification type is virtually unusable in these terms, and would not stimulate innovation in assessment and diagnostic accuracy and utility to the same extent.

(b) Psychiatrists are "thin on the ground" (just over 1000 nationally) and their numbers are dwindling, hence injured people will wait even longer for assessment. For example, at present the average waiting period in NSW is about 2 years. Since almost all psychiatrists are located in the capital cities (there is only one psychiatrist in NSW west of the Blue Mountains, in Orange), access to them is an associated serious difficulty. The costs of access are high, whether met by the claimant or the WC authority. A similar situation exists elsewhere including South Australia as the Stanley Report indicates, and in Victoria where psychologists have had to be employed to overcome the shortage of psychiatrists (see Final Report of the NSW General Purpose Standing Committee No.1). In Tasmania, we are advised, the ludicrous situation obtains where the workcover authority is now obliged to fly psychiatrists in from the mainland to carry out assessments!
(c) Psychologists make unique contributions to the assessment process (as they do in the treatment, rehabilitation and return-to-work areas), not only through their training in psychometric testing but also in a number of other ways that psychiatrists cannot provide, either by dint of qualifications and training, or legally (not being registerable as psychologists). Psychiatrists are not "super-psychologists", and psychologists are not professionally subordinate to psychiatrists. Psychologists offer biopsychosocial

(rather than bio-medical) approaches, which have been widely adopted in other health jurisdictions (including in Europe where the European Week for Safety and Health at Work focused on "*the prevention of psychosocial risks*"). These evidence-based cognitive-behavioural and other non-medical interventions developed and provided by psychologists are being employed widely in Australia (albeit only patchily in our WC systems) and overseas, to substantial benefit in the early assessment, diagnosis and treatment of trauma from motor vehicle accidents, non-sexual assault, rape, workplace injuries and other sources of acute stress, Post-Traumatic Stress Disorder or other dislocations of psychological functioning.

(d) These special competencies of psychologists include being able to provide more accurate indications of rehabilitation directions for conditions such as stress - see WorkCover Queensland's recent pilot study, whose success led to an expansion of the involvement of psychologists State-wide[12]. Their exclusion from assessment removes these innovative contributions and benefits.

(e) Multi-professional assessment is more accurate than single-profession assessment, hence use only of psychiatrists will mean a lower level of accuracy of claim evaluation than is easily achievable and affordable, indeed multi-professional assessment saves money immediately and "down the track" by reducing the number and costs of misclassifications of claimants[13]. This better assessment includes of cases of possible fraud, malingering or exaggeration, although it is important to respect the boundaries between professional assessment and legal judgment in these matters (see Dr Ballinger's article). Also see Appendix C for more details about the over-use of multiple psychiatrist witnesses in contested cases and the high level of disagreement among them regarding diagnoses. Appendix B also provides some research data about misclassifications of patients suffering chronic fatigue syndrome, and misclassification of mentally healthy people as seriously mentally ill in an operational test of psychiatric diagnosis (Rosenhan's research work). These research results indicate the low level of reliability and validity of psychiatric diagnostic categories. *Please note that our presentation of these data should not be taken to be a reflection on the competence of psychiatrists, but is a commentary on the problems arising from inappropriate use of "all or none" psychiatric diagnostic categories rather than continuous dimensions of functioning as the basis for assessing impairment.*

(f) Additionally multi-disciplinary approaches can provide much more useful feedback to OHS people about the nature and sources of psychological problems than do psychiatrists' reports based on classic psychiatric diagnostic categories. For example, what does an OHS officer or an employer do, in terms of trying to make workplace improvements, with a psychiatrist's (deidentified) report of a worker suffering "schizo-affective disorder" (even if such a report is in fact transmitted back to the OHS area)? A multi-professional report cast in terms of workplace-related injury and associated specific impairments can be much more meaningful (with some caveats about the professional training and competence of those staff involved in this process

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[12] Pilot study briefly reported in the APS Queensland State Newsletter v.4, No. 4, 1999 by Tony Hawkins, WorkCover Qld Chief Executive.

[13] Analysts such as Hunt 1998 have concluded that in the "long-tailed" WC insurance field, costs deferred are costs increased, due to the rapid accumulation of treatment and rehabilitation needs and expenses where action is deferred, as well as to inflation and other financial effects. Actuarially it is better to spend now and get the injured person back to a satisfactory level of functioning to the extent possible, than to build up treatment, rehabilitation, income-replacement and other costs.

and about protection of confidentiality).

(g) Psychiatrist exclusivity was not sought by any members of the public or by the psychiatry profession. No significant level of complaints about psychologists' work in the accident compensation area has been received by psychologists' registration boards. Hence the NSW and Tasmanian legislation cannot be said to be a response to complaints from injured persons or other members of the public about psychologists, or an endeavour to protect the public from inappropriate or sub-standard service-provision.

5.2 A LEGAL RATIONALE FOR THE LEGISLATION?

The NSW and Tasmanian legislation's preference for psychiatrists may be said to stem from legal views and precedents about psychiatry vis-à-vis psychology, wherein a diagnosis of a psychiatric disorder may be seen to be required by courts and tribunals before access to compensation may be granted, and only psychiatrists are recognised to be expert (especially in the American Medical Association's Guides to the assessment of permanent impairment, now in its Fifth Edition and known as AMA5).[14]

Such an argument has more legitimacy in that it is or at least superficially appears to be broadly accurate descriptively of the history of WC case law. However it is incomplete, and in part wrong, concealing some important details about psychologists' history of involvement in workers compensation and disability assessment.

It also over-simplifies a very complex and evolving area of the law and its interface with the health and occupational safety professions where the role of non-medical service providers has been increasingly recognised, and where the particular problems of distinguishing between psychological and psychiatric dysfunctions have become topics for serious judicial concern.

To summarise the complex issues and arguments very briefly:

(a) The terms "psychiatry" and "psychology" (and their grammatical derivatives) are very often confused, and used interchangeably in the courts and tribunals as well as in legislation, in Australia and in the USA. In some circumstances the terms "psychiatrist" and "psychologist" may unfortunately also be used interchangeably. The term "medical" has sometimes been used to include psychologists (as in the South Australia and Queensland workers compensation arenas and now in the Commonwealth legislation), and sometimes has been restricted to mean only registered medical practitioners. Judgments based on such interchangeable or confused usage, or on misconceptions about the two professions, should not be used to try to justify and sustain discrimination against psychologists in regard to their independent role in the assessment of impairment of psychological and psychiatric functioning.

[14] The use of the AMA Guides is usually prescribed in Australian WC legislation although the courts have varied in their view of its standing (as a guide versus a more prescriptive "authority"). Different regions use different versions of the Guides. Only one (NSW) uses AMA5, and then incompletely, excising Chapter 14 which deals with "mental and behavioural disorders", probably because that Chapter expresses many concerns about conversion of assessments to "whole person impairment percentages".

(b) Legal precedents and concepts of actionable forms of mental illness are recognised by contemporary legal authorities to derive from antiquated thinking (such long-outdated terms as "nervous shock", "neurasthenia" and the like are still used) but thankfully are gradually being upgraded in various ways. The general term "mental illness" (to be distinguished from "disease") is being more often used in today's courts in preference to those outdated terms, as is the phrase "psychological and psychiatric disorders" and (often preferably) more precise descriptors of specific psychological or psychiatric conditions such as depression, anxiety and acute and post-traumatic stress disorders. (However, as earlier indicated, some fresh legal concepts such as requiring an "underlying patho-physiological condition" to underpin an impairment do not reflect real understanding of the nature and etiology of mental and behavioural disorders or disturbances of neurological functioning.)

(c) The terms "psychological and psychiatric disorder" and "actionable mental illness", as used in legal contexts, refer to distinguishable patterns of behaviour that are problematic for the person and/or those around her/him. Diagnostic systems (one way of classifying those patterns) are not unique to or "owned by" the profession of psychiatry, or psychology for that matter, and are certainly not detectable only by psychiatrists. The two main diagnostic systems are that contained in the Diagnostic and Statistical Manual Version IV (DSM-IV) and that outlined in the tenth version of the International Classification of Diseases (known as ICD-10). Psychologists have had as much to do as psychiatrists with the development of these classification systems; and they are equally capable of making such diagnoses clinically. Psychologists have also contributed to the development of AMA Guides including AMA5.

(d) However we recognise that the many contributions of psychologists to these developments and their independent diagnostic capacity are not uniformly appreciated in the various legal jurisdictions in Australia, whereas (somewhat ironically) in the USA, the "home" of the AMA Guides and DSM-IV, the role of psychologists in impairment assessment is clearly recognised. ***Psychologists are legislatively included under the term "physician" in almost all US states and in the District of Colombia.*** (Cocchiarella and Lord 2001.) That psychologists are not "medical practitioners" is an unpersuasive argument in this NCP context: such a requirement is merely an expression of ignorance and prejudice, not an evidence-based justification of the anti-competitive restriction.

(e) That psychologists may be used to assist in assessment if psychiatrists so choose (argued by WorkCover NSW) is not a counterargument to the NCP breaches. Placing the decision-making power about whether to use psychologists in the hands of their competitors is clearly not a remedy.[15] It is an unnecessary restriction of our professional involvement, impractical, and offensive to the professional independence of psychologists.

Psychiatric exclusivity as in the NSW and Tasmanian WC legislation also ignores the

[15] While we do not like to regard psychiatrists as our competitors, the NSW and Tasmanian legislation and WC practices treat us as such, and an NCP enquiry conducted in the Northern Territory has concluded that we are. See "NCP Review of the Northern Territory Health Practitioners and Allied Health Professionals Registration Act" (especially p.29), by the Centre for International Economics, prepared for the Territory Health Services circa 2000.

legal minefield of conflict between that legislation and other state-level legislation registering psychologists that aims to prevent non-psychologists from holding themselves out to be psychologists.

This conflict arises because (as the reverse side of the NSW and Tasmanian definitional coin) it may be argued that psychiatrists who present themselves as able to assess and treat psychological problems as distinct from psychiatric problems are holding themselves out to be psychologists, and are thus in breach of the State/Territory legislation regarding registration of psychologists. They do not qualify to register as psychologists, and must restrict themselves to psychiatric problems, i.e. to a particular group of (but not all) serious mental and behavioural abnormalities.

Many impairments, of the kinds the WC legislation was intended to recognise, are serious in terms of interfering with a person's work performance or daily living but are not definitively "psychiatric" and are certainly not "psychotic". Especially they do not fit the original psychiatric classification notion of "worrying behaviour of an incomprehensible kind not explicable as a reaction to known events". They do not fit readily into a classical psychiatric diagnostic category (hence the frequent resort by assessors to "miscellaneous" and fuzzy diagnostic categories such as "borderline personality disorder"). They may be more accurately termed "psychological", as they represent understandable (even if statistically rare and dysfunctional) human reactions to traumatic experiences. Their cause is typically readily identified as an event or a set of experiences, perhaps of short duration – Acute Stress is a prime example here - but sometimes occurring over a longer time span as in Post-traumatic Stress Disorder (PTSD) or chronic stress reactions.

We do not consider this line of argument (i.e. attempting to make fine legalistic and semantic distinctions between types of disorders that should be handled by psychologists versus psychiatrists) to be at all productive even though it has been attempted judicially. Indeed it is actively undesirable in terms of how the overlaps and differences between the two professions (potentially very valuable if properly combined) ought to be dealt with. However it is an unfortunate logical extension of the naïve legislative treatment of the terms "psychological" and "psychiatric", and of some judicial interpretations.

Multi-disciplinary assessment reduces the potential for this kind of unproductive and costly conflict because the psychiatrist and the psychologist work together in assessing and treating the injured person. Their *composite* perspectives and methods have much greater chance of achieving effective rehabilitation of the injured person than separate approaches. The legislation ought be updated to reflect and enable the use of this multi-professional approach.

5.3 "BEST PRACTICE" AND "CONTINUOUS IMPROVEMENT" ASPIRATIONS DENIED:

The NSW and Tasmanian WC legislation reflects a poor understanding of at least two "best practice" developments:

(a) modern multi-disciplinary approaches to health and particularly mental health issues and
(b) the move away many years ago from a purely "bio-medical model" of mental health, to the "biopsychosocial" model earlier described regarding the European Week of Safety and Health at Work 2002.

Regression back to the biomedical model also runs counter to developments regarding some other (organic) WC injury types, where psychologists and other non-medical professions have become heavily involved in their assessment and treatment, such as those relating to brain and central nervous system injuries, pain and its management, and musculo-skeletal and other organic injuries. The Forum conducted as part of the aforementioned European Week of Safety and Health at Work 2002 accurately assessed the impact of psychosocial risks thus: " *these issues are know to affect physical and psychological health in a variety of ways, from cardiovascular and gastrointestinal diseases to mental health problems*".

Psychologists have had to become involved in these apparently only "organic" areas because medical professional experience backed up by research have shown that psycho-social factors (including personal identity, self-esteem, motivation, and social support systems such as family and workmates) are important, diagnostically and in terms of effective treatment and rehabilitation (as has become particularly evident recently in the treatment of sporting injuries).

This line of development, of valuable biopsychosocial concepts, theories and methods, is well-explicated in Martin, Prior and Milgrom (2001), copies of which are being mailed by us to the Commission. An example in this book (Figure 5, p. 109) of a model of depression indicates how socio-cultural factors such as social supports, expectations and belief systems relate to vulnerability factors (e.g. personality and cognitive style factors), precipitating factors (such as medical conditions or loss of employment), and exacerbating and maintaining factors (such as marital conflict and social withdrawal). The model shows how these various factors combine to explain depression.

While drugs may have a part to play at some stage of the treatment process, the foregoing psycho-social factors must be addressed for effective long-term improvements.

Probably the absence of internal staff in WC authorities with psychological training and professional experience, able to provide expert information, perspectives and advice, has contributed to the current shortcomings of the WC systems. More generally, the WC systems are still dominated by bio-medical thinking as well as by financial (especially actuarial insurance) concepts and typically short-term goals and priorities that are often ultimately dysfunctional and self-defeating. The power of the biopsychosocial approach is unfortunately not being realised.

Appointments are needed in the workcover authorities of a wider range of professions (not only psychologists but the other non-medical professions), with "in-house" influence

on goals, values, perspectives in use, conceptual models, policy development, strategies, tactics and operations. An overdone “contracting-out” model of professional service provision leads to the unfortunate situation where the host organisation’s remaining staff (who play crucial decision-making roles) are all non-professional administrators. This situation has serious defects in terms of the host organisation’s capacity to understand the changes occurring in the professions and their relevance to its needs and obligations.

The adoption of a modern biopsychosocial approach, with an emphasis on multi-disciplinary collaboration, and associated enhancement of professional staffing levels should, we submit, be one of the main emphases in a national framework.

5.4 THE DELETERIOUS EFFECTS OF THE ANTI-COMPETITIVE LEGISLATION:

The very deleterious effects of this restriction on the practices of psychologists in NSW and Tasmania are already evident. Federal Government privatisation of Commonwealth health services, including psychological services, has been in operation for some years. It has led to the rapid growth of private psychological practice to replace in part services previously delivered by the public sector.

Many public sector psychologists have been retrenched and established private practices, typically solo and of a fragile, fledgling kind operationally and especially financially. It is a strange irony of governmental policy conflict that they now have their practice scope unnecessarily restricted by those states’ WC legislation, to the point where many of them are likely to be forced out of private practice.

The future workforce implications of this impact are serious for the entire health sector generally, and for the support of OHS and WC systems in particular, whether they are integrated or remain effectively separate. They must be considered in any attempt at national integration of the OHS and WC systems.

5.5 PUBLIC LIABILITY LEGISATION:

Hasty reforms have recently been made to most regions’ legislation regarding public liability. Of major concern to us has been the installation or reinforcement thereby of the out-of-date concepts of “mental harm” already outlined with regard to the WC systems, and of discriminatory and too-high thresholds regarding “mental health” problems compared with physical ones.

For example Victoria’s legislation sets a threshold of 5% to allow access to common law action for physical injuries, but 10% for “psychiatric” injuries. The misuse of psychiatric diagnostic categories as an additional but covert threshold (already outlined) is also of concern here.

5.6 IN SUMMARY:

To sum up this section, the recent changes to the NSW and Tasmanian workers compensation legislation, we submit, were based on retrograde "horse and buggy days" thinking about mental problems and their assessment. This retrograde thinking provides no defensible grounds for the anti-competitive exclusions in and arising from the legislation.

In our view the NSW and Tasmanian legislation clearly and seriously breaches the NCP principles and must be amended to remove the unjustified and unfair discrimination against psychologists and the consequent restriction of professional "trade" to psychiatrists.

The recent public liability legislation should be included in this review and amendment process.

SECTION 6: HIGHER EDUCATION PROBLEMS RELEVANT TO OHS AND WC SYSTEMS.

This Section addresses inter alia our

Recommendation 7: That the Commission emphasises in its Report(s) the critical importance of an active, comprehensive, coordinated and well-funded research orientation, developed and overseen by a representative Research Council.

It also provides some further information and perspectives concerning the potential difficulties of integrating the OHS systems with the WC systems, and outlines some of the important linkages between the higher education sector and the OHS/WC areas.

Academic roles have historically involved tenured employment, high job autonomy and task discretion, colleagueship, challenge, and opportunities for nurturance of others. Over the last two decades these positive features have been eroded by periodic "reforms" and other less-publicised changes, especially seriously reduced funding, and the introduction of "user pays" notions. After various institutional amalgamations in the 1980s and 1990s, further funding cuts occurred coupled with efforts to persuade senior academic staff to take early retirement (including financial inducements) that have denuded the universities of much of their professional expertise, directly and by their loss as mentors for professionally-inexperienced junior staff.

Other (often internally contradictory) pressures have included:

- revitalisation of suggestions about some institutions becoming "teaching only", with consequent damage to the morale of staff in the newer and smaller institutions (those outside the Group of Eight) which in recent years have been valued sources of professional training
- stronger pressures for University staff to treat other institutions and their staff as competitors rather than collaborators, reducing inter-institution collaboration and communication, again impacting on some forms of professional training and collaborative applied research
- greater use of short-term contracts of employment, and increased casualisation of the workforce with associated staff turnover and largely unpredictable changes in staff mixes in terms of levels and types of professional competencies and experience
- greater pressures to be entrepreneurial and be paid for any work done outside the university
- heavier non-research workloads including more course administration at a time when the pressures to be an active researcher and to "publish or perish" are stronger than ever
- the emergence of new industrial demands (e.g. enterprise bargaining) and professional stressors including those from the "virtual university" (such as time and other workload provisions for learning the competencies required to operate effective electronic teaching-learning processes, and not having the financial capacity to renew equipment and programs to stay up to speed), and

- increased “accountability” requirements.

The impacts of these changes on the working conditions of Psychology (and other) academics has been profound, affecting their capacity to provide the kinds of theoretical, research and other professional training that our profession so greatly needs.

In particular the loss of senior staff with substantial professional experience through early retirement packages has been compounded by their replacement (where indeed they have been replaced) with junior staff with strong research backgrounds associated with gaining research doctoral qualifications, but lacking in professional experience and expertise. This kind of junior staff member is very important for succeeding in obtaining ARC and NHMRC research grants (still the lifeblood of university research despite strong efforts to attract private sector funds), whereas professionally-experienced staff without a strong research background have much poorer chances of obtaining grants.

Staffing apart, shortage of funds has immediate and direct impacts on professional training as well as delayed and indirect ones. As a minor example, how can students be trained in the highly dynamic area of psychological testing if the department has no money to buy the latest tests and accompanying texts? Also the costs of arranging and supervising professional placements for students is often not funded specifically, and the staff member doing so may be obliged to add this work to other, more formally recognised workload, without any real allowance for it.

Academic staff managing external professional placements in post-graduate professional training programs (Graduate Diploma, Masters and professional doctorate levels) may (despite University assurances to the contrary) also feel exposed to legal action for breach of their professional duty of care (independently of the university) if things go wrong with clients being dealt with clinically by their students in the placement “trainee” roles, especially if they themselves have relatively little professional experience. Hence they may feel obliged to acquire independent professional indemnity and legal insurance cover. The salaries paid to academics (now comparatively poor) make no provision for such expenses.

There is also much greater difficulty these days for staff to find the time and obtain the institutional supports for their own Professional Development (hereafter PD), or to contribute to the PD activities of the APS. The APS’s nine specialist Colleges have PD requirements for continuation of College membership, and historically have relied heavily on University staff to provide (voluntarily) PD sessions covering theory and research in their specialised areas. Nowadays University staff are too overworked and stressed to have much time or inclination to add this voluntary level of work to their already too-heavy agendas, even if they have enough professional background to qualify for College membership (which many of the new junior staff do not).

The impact of changes in research funding (not just quantum but also how funds are distributed) is substantial on the orientation adopted (e.g. “pure” or “applied” research), the foci of interest, and the quality of research. In particular, the Research Training

Scheme (RTS) is outcome- and output-based, rewarding a high rate of completions (students finishing research degrees) and a strong publications outcome as well as previous research income – a “the rich get richer and the poor get poorer” process. Students in Professional Masters and doctoral programs do not qualify for RTS funding even though they have a requirement for a research project.

Because of the RTS focus on established research programs and the publications and research income record of the supervising staff member, established research programs that are highly structured, “programmatic” and have a good “track record” become better funded than those that are not. This may be so even where the latter’s research activities are potentially superior in terms of importance of the research questions being addressed or the quality of the research design. Individualised research topics or those which are uncertain of outcome (e.g. very innovative research into new topic areas) or very timeconsuming (e.g. longitudinal research) are discouraged by this funding formula. Solo researchers or departments with a broad and diverse rather than a united (necessarily narrow) research orientation are unlikely to be competitive. Also some topic areas (e.g. brain-behaviour links and gene research) have been more attractive to ARC and NHMRC or private sector organisations than are others (e.g. social or historical research). (See Martin, Prior and Milgrom 2001 especially Ch. 1 for a detailed exposition on NHMRC and other health-related research funding.)

One of the complex dynamics here is perceived saleability of research results in market terms (which has raised difficult issues of ownership of intellectual property rights not adequately resolved by institutions too simply asserting complete ownership). Genetic research and brain-behaviour research are currently popular areas attracting high funding levels because of their potential for global commercial applications worth billions. In psychology, finding sources of research funding for specific clinical or other professional research issues, for broad system-level research especially that not of a health kind (e.g. into organisational functioning), or for research into the more abstract theory-building questions has always been difficult. But it is now especially so under RTS criteria, because it is not seen as likely to generate much saleable “product”. It also takes a long time if properly conducted (often through large-sample and longitudinal rather than small-sample and/or cross-sectional research).

The WC systems have, so far as we can judge, historically underinvested in university (or other) research. The OHS systems, by sharp contrast, appear to have made substantial investment in such research, and employ a nationally well-coordinated mechanism for planning and making decisions about funded research activities. Thereby they have ensured that OHS issues remain on the universities’ research agendas (and thus if indirectly on professions’ PD agendas) despite the problems outlined above, whereas the WC systems’ inaction has contributed to the low emphasis on WC-related university research and little PD focus on WC issues.

The WC systems have not been even users of others’ research to any significant extent, and may be characterised as passive and largely uninformed and indirect beneficiaries of improved knowledge and techniques, and relatively unfocused on the latest developments

in most professional areas relevant to WC issues. Whereas the OHS systems have systemic linkages with the higher education sector, in research and other ways, the WC systems appear to have fewer linkages of a systemic kind.

Among the reasons for this difference appears to be that the WC systems are part of an “industry” that is structurally inhibited in its capacity to make such linkages in any meaningful way (even though its individual participants may have some linkages). It is a loosely-connected system with diversely (often antagonistically) motivated participants, as the Industry Commission noted in 1994. They do not all share the same values, goals or preferences regarding WC issues, and cannot agree on basic philosophies, superordinate goals and directions.

Some employers are reluctant participants whose concerns are mainly about premium levels, cross-subsidisation of poorly-performing employers and other micro-economic and internal management matters. The insurance companies appear motivated primarily by profitability considerations that do not readily encompass research into non-actuarial WC matters such as the assessment of psychological impairment, beyond a concern that such assessment may lead to a worrying level of successful claims. Public sector regulatory and/or administrative units have primarily regulatory, administrative and politico-economic perspectives and motives. Those units have little if any professional infrastructure and little by way of integrating mechanisms to enable sustained professional input or internal processes allowing them to develop coherent and up-to-date research questions, strategies and agendas.

In this system, professional associations and the higher education sector are treated as external vested interest groups (along with injured worker associations, plaintiff lawyers, and unions) operating on the boundaries, rather than as potential research partners or at least valuable if indirect resources of knowledge and skill.

One can readily understand why there may well be strong objection in many quarters to an attempt to integrate the better-coordinated, more outward-looking, more research-oriented and more benignly-perceived OHS systems with the poorly integrated, internally-focused and negatively-perceived WC systems.

Nonetheless we consider that in any national framework there ought be a single coordinating Research Council (or some other term), with the authority to determine broad research directions, and a substantial budget to provide research funding to higher education and other research units for both OHS and WC research projects. Membership of this Council should be broadly representative of the research and professional communities.

Section 7: Incentives to improve OHS, achieve early intervention, rehabilitation and return to work, and for the care and reemployment of the long-term incapacitated.

The use of incentives in the complex and difficult areas of promoting and reinforcing safe behaviours, early intervention with and treatment of injuries, and the care and reemployment of the long-term incapacitated is very important but would require a separate submission from us for proper treatment. Here we confine ourselves to brief summary statements of principles based on sound research data and properly-constructed and validated theories.

Many of the Productivity Commission's questions about incentives are cast at the broad "industry" level, where the Commission appears to have greater experience and expertise than we do. Most of our comments relate to levels below the "industry" level.

Incentives in OHS and WC generally – an overview:

Incentives may be conceptualised and targetted at various levels of organisation, from the macro (e.g. the "industry" level) to the micro (e.g. individual behaviour in particular work situations). Also there are three parties involved in effective implementation of OHS: the employer, the employees and the relevant union(s) on the worksite. Some similar and some different concepts and models are involved in the operation of incentives at these different levels and with these different participants.

Also incentives may differ according to the type of behaviour change being attempted: whether it is the initiation of new behaviour patterns where none now exist (e.g. learning a totally new skill set), the reinforcement of desirable existing behaviours (such as safe behaviours), or the extinction of undesirable existing behaviours (such as unsafe behaviours).

Human behaviour of any complexity is typically multi-determined and interactive. Any programmatic approach (such as statutory incentives) to achieving behaviour change must be multi-level in focus, consistent and to a degree standardised, yet flexible enough to allow for actions to be tailored to change goals relevant to the particular dynamics of the work situation and the participants therein.

Incentives re OHS:

Strategically the first question to ask about any unsafe behaviour problems "at the coal face" (rather than in "industry" terms) being tackled by use of incentives is whether they are the product of poorly designed work systems (including technology) rather than human preferences and choices. The assumption should not be made of individualistic "human error" (as unfortunately still happens too often, due in part to a human propensity to explain others' problematic behaviour in terms of personal defects while explaining one's own problematic behaviour as an unavoidable reaction to difficult circumstances).

Many apparently indidualistic problems are the result of social and/or technical work arrangements that promote the problematic behaviour.

For example, crashes by Fleet Air Arm pilots in a particular type of aircraft were found to be products of poor layout of controls, not (as was initially thought) “pilot error”. The solution was better cockpit design, not better pilot selection or training. Another example is where conflict between two cook supervisors in a large kitchen was found to be a result of poor role delineation and role overlap, leading inevitably to conflicts and stresses, not a “personality clash”. The solution was not to separate the two supervisors permanently or replace them with other supervisors (two options that management considered), but to restructure the roles to avoid the overlap of responsibilities.

Incentives to improve OHS should not be confined to individual incentives, nor indeed should individualistic interpretations of unsafe behaviour have precedence over socio-technical perspectives. Solutions to persistent OHS problems may be a mix of technology (e.g. providing nurses with better lifting devices) and induction training. Incentives need to encourage organisations to develop OHS policy and action strategies which recognise these kinds of solutions, such as ensuring that managers and supervisors are trained in their roles and responsibilities in OHS, and building into performance appraisal schemes dimensions relating to these aspects.

The OHS area appears to be much more alert to such problems of misinterpretation of accidents and incidents than the WC area, partly due to differences in “mental sets” associated with types of training in such matters. The training of WC people, including many of the professional practitioners such as psychiatrists contracted to provide services, is typically “clinical” with a strong individualistic focus, and rarely deals with the nature of socio-technical work systems and their contribution to problematic behaviours that OHS people (if properly trained) receive. Thus, in the second example cited above (the cooks), it is certainly possible that a “mental set” would operate wherein the clinically-trained assessor would look immediately for personality or social skill defects in the supervisors rather than at the situational aspects. Such differences in mental sets may help to explain the apparently low level of communication between the WC and the OHS systems.

These differences would need to be explored and addressed in any attempted integration of the OHS and WC systems.

Rewards and punishments as incentives:

Generally speaking, attempts to use punishments (e.g. individual or organisational penalties) and retributive approaches (e.g. requiring apologies for unsafe or damaging acts) as incentives regarding improved work health and safety do not succeed, for a number of reasons.

These reasons include that punishment needs to be seen by the actor as close at hand if its threat is to be effective in modifying behaviour, and then only if the behaviour to be

modified is indeed modifiable, and the desired alternative behaviour is within the capacity of the actor and is acceptable to him/her, in terms of values, self-concept, perceived organisational role expectations, and other such "individualistic" factors. (Thus the use of inspectors whose powers are limited and whose arrival in the workplace is known in advance is less effective than where the inspector is empowered to punish in a way meaningful to the workplace and its workers (e.g. spot fines), and enters the workplace unpredictably, because now the prospect of punishment is seen as much more immediate and personally relevant. This comment should not be taken to be support for greater use of inspectors or an increase in their powers of punishment, both of which could well have unwanted negative effects.)

At the individual level, basic learning theory of this "carrot and stick" kind helps explain much (but by no means all) unsafe behaviour. A detailed analysis of specific situations, in terms of rewards and punishments (or absence thereof), leading to remedial action focused on changing the pattern of rewards and punishments, has been shown to be very effective.

For example, research has shown that in many work settings safe behaviour is often unrewarded and indeed unrecognised by managers or supervisors; and unsafe behaviour may actually be rewarded in some way (e.g. may be less timeconsuming and socially more accepted than safe behaviour, as in the case of not wearing safety goggles). Risky actions may be treated officially by an organisation's members as unacceptable but in the same breath admiration is expressed to the actor about the skill and courage required for the daring act (as in some officially-banned military flying manoeuvres). If actual injuries from unsafe behaviours are rare, unsafe behaviour is not deterred, even where the nature of injury may be serious.

However there are caveats to a simple "carrot and stick" type of analysis and action. For example, positive goals tend to be more motivating over time than avoidance of punishment – the "carrots" are generally more effective than the "sticks". The pattern including timing of reinforcement is crucial; and the status (for the recipient) of the person providing the reinforcement is also important (e.g. the CEO is much more likely to be influential than a safety officer at much the same status level as the recipient). In addition, some behaviours are better understood if "socio-cognitive" perspectives are added to a "learning" perspective.

Cognitive processes in OHS:

A broad "cognitive" perspective allows explanation of the occurrence and persistence of unsafe behaviours in terms of problems with understanding, memory encoding (especially with complex and non-routine work where actions cannot be encoded and overlearned through repetition and are especially vulnerable to disruption by stress), cognitive misappraisals (e.g. of risks), vigilance and its susceptibility to fatigue effects, and a number of other cognitive processes involved in unsafe behaviour that are too detailed to explain here.

Social (group, organisational and broader community and cultural) factors:

Many of the target behaviours in the OHS and WC arenas that are problematic are collectively driven and are not readily modifiable by individuals.

Group and organisational values, goals, norms, expectations and other pressures may combine to sustain unsafe behaviour, even where the individual worker is alert to the undesirability of the behaviour and, left to her/his own devices, would act appropriately. These complex collective issues (which may include gender and ethnic issues as well as small group factors such as the influence of cliques and cabals at work) have to be addressed rather than or in addition to the individual actor's behaviours.

Thus it is often better to focus on establishing consensually-valued behavioural goals and norms, and reinforcing progress towards their achievement, than on individual misbehaviours and punishment thereof (which *inter alia* may generate resentment and unintended perverse consequences). One problem with legislative approaches to accident and injury prevention is that they focus on undesirable behaviour (usually at the "individual" level although some penalties are of the organisation as a whole, are actuarially triggered, and have little meaning or immediacy for the individual employee or the work group) rather than on outlining and reinforcing better alternatives; and the threat of punishment is too remote to most people (who often do not even know about or understand the legislation in any detail).

A major task of OHS staff is to ensure the development of an organisational and work group "culture" involving positive-goal approaches to prevention of accidents, incidents, and injuries, rather than or as well as "noxiants". Involvement of staff (especially in their work groups) in setting safety norms and targets, planning, and monitoring achievement of those safety targets and standards, well-focused intra-organisation safety training, and other efforts to communicate and persuade people to act more safely are much more effective than written orders, and TV and radio advertisements or other generic messages about unsafe practices directed at the diffuse "public" or to company employees at large. These "shotgun" approaches may raise awareness and challenge stereotypes about unsafe behaviours (important outcomes) but are only a small part of the behaviour change task.

"Socio-cognitive" perspectives:

"Socio-cognitive" perspectives incorporate the preceding understandings of cognitive processes with those concerning social processes, to generate an amalgam especially valuable in explanation and prediction of health-related behaviours. These perspectives include beliefs about control (and internal and external locii thereof), invulnerability ("it won't happen to me"), self-efficacy, social identity effects and the social conditions under which they are more influential on behaviour than personal, individualistic factors. (See Martin, Prior and Milgrom 2001 for more detail.)

One effective and efficient mechanism for enhancing OHS awareness and effective action at this social ("local culture") level may be enterprise bargaining (EB), involving

the union and the local workforce with management. Future gains are possible from better union-workforce-management collaboration in the EB context. Changing the WC system to a non-adversarial form would predictably enhance such collaboration.

Other explanatory models:

Various other explanatory models are useful in the OHS and WC fields, including biological models, stress including life stress models, and sociological models. For example such models have been very influential in regard to helping to explain shift work effects (an applied research area in which psychologists have made a major contribution over many years).

The importance of multi-disciplinary cooperation:

We hope the foregoing account, limited though it is, does give the flavour of psychological perspectives about the operation of incentives in the OHS and WC fields and explains the great importance of using multi-disciplinary perspectives, research methods and action plans. The APS has had a long involvement in multi-disciplinary cooperation, as is evidenced and described by Martin, Prior and Milgrom (2001). Indeed their book was supported and co-published by the APS and the Academy of the Social Sciences in Australia.

Any integrating framework that threatens this coordinated partnership of various disciplines and professions would understandably be resisted in the OHS field. Put more positively, there is a substantial reservoir of goodwill towards and experience in multi-disciplinary cooperation in the OHS field that may be drawn on to help promote such cooperation with the WC field in an integrated system.

Insurance premiums as organisational incentives to improve their OHS focus:

The theory underlying attempts to use WC insurance premiums as incentives to improve workplace health and safety is undeveloped and not well explicated or evaluated by sound applied research. Much of what is said in this arena has the status of untested assertions and expectations, not proven facts, although there are some notable exceptions such as the KPMG Consulting Report *"Key management motivators in Occupational Health and Safety (Research for the CEO and Supervisor Drivers Project)"*, February 2001.

This Report provides some empirical evidence to test various hypotheses about OHS motivators at CEO and supervisor level, of both an actuarial and an "attitude and opinion survey" form. However even this Report does not answer satisfactorily the question of whether espoused values, motives and motives translate into actual safety improvements. The Report certainly addresses that question within the limits of the purposes for which it was commissioned, and its research methods. It points out the gap that often occurs between espoused attitudes and actual safety behaviours in OHS but does not attempt to

explain the gaps in any theoretical depth.

Attitude research more generally has indicated that attitudes may be genuinely held (rather than merely saying what is expected or cued by how the survey questions are framed). Nonetheless they may not be translated into actual behaviours, for various reasons of the kinds already alluded to – social or technical influences and barriers (including managerial "philosophies" as expressed in the workplace).

Generally speaking, in Australia, WC insurance premiums tend to be important considerations only at the top of organisational hierarchies. Even at the CEO level, lower WC premiums are only one of a number of "moral" and commercial considerations. (See KPMG Report 2001.)

Middle-level operational managers and supervisors – the levels where the specific OHS action takes place – are typically not affected, or even consulted, about premium-related issues, and are not rewarded for improved premium levels, even though they may accept some personal responsibility for safety in the work area. Such a lack of personally-meaningful linkage cripples any attempt to use insurance premiums as an effective driver of better OHS performance at those middle and lower levels.

Moreover premium changes are poorly timed to effect changes in safety behaviour. They seem usually to be made in response to insurers' financial decision points, rather than as direct and temporally immediate reinforcement of particular improvements in a work unit's or an organisation's safety performance. Delayed reinforcement not tied directly and understandably to workplace behaviours is typically ineffective in producing or cementing in desired safety behaviours.

Perhaps more significantly, middle- and junior-level managers and supervisors appear from the KPMG Report to see a positive association between safe work conditions and lower operating costs. This "win-win" view in the OHS area stands in stark contrast to the "zero sum game" perspective apparently typical of the WC area (especially among insurers) about a negative link between insurer profitability and the rate of success of WC claims.

In an integrated system, it would be crucial to ensure the preservation of a "win-win" view, and to remove the conditions that justify a "zero-sum game" view.

Incentives for early intervention and treatment:

Again theory in this area is not well-developed, nor is there much coherent research. It is likely that there is general acceptance in the workplace, including by managers and supervisors, of personal responsibility for ensuring quick and effective response to any worker's physical injury in the short term. However this does not necessarily translate into actual helping behaviour. "Bystander" phenomena are known to occur under some conditions (such as when there are many other observers of the accident). Moreover, once

the injured person has been taken into professional care, the managerial/supervisory sense of responsibility may quickly diminish.

Managers’ and supervisors’ reactions to psychological injury may be very different from those for physical injury, and may not be at all “caring” in character. Often psychological injury goes undetected, and the worker's response to the injury (such as anger, anxiety or panic) is often not recognised or understood. Sometimes the managers or supervisors react to and become personally embroiled in the worker’s response (e.g. may themselves become angry or fearful), and a damaging “negative spiral” is set in train. This process may include “victim blaming” rationalizations about the injury sequence including lay versions of the legal notion of “an eggshell psyche”.

Important gender and ethnic differences exist in regard to OHS attitudes and behaviours, and have been the subject of considerable research by psychologists (and other professions, e.g. industrial sociologists). Unfortunately the knowledge and insights so derived have not been assimilated well by workcover authorities or employers for the kinds of reasons outlined earlier in this submission.

Section 8: Insurance issues:

Insurance issues are important generally, but are tangential to psychological services. We restrict ourselves, therefore, to some brief observations.

First, any simple notion that "private" employer-funded WC insurance schemes operate more effectively than "public" (e.g. "state monopoly") schemes, or vice versa, may be challenged by the available data. All insurance schemes, whether they are private or public, are hit by the same social factors and market forces. These include the very high costs of reinsurance nowadays to recover expenditures and losses due to terrorist attacks in New York, Bali and elsewhere, and the collapse of large insurers, and to provide for similar catastrophes in the future. All insurance companies have increased their premiums to cover these costs, affecting professional insurance among many other consequences.

Hence a hybrid form (canvassed in our comments in Section 2.6) appears to us more appropriate than a pure "public" or "private" form; and the choice should be based on the kinds of parameters outlined in Section 2.6, not on ideology.

A second matter is that of the structure of insurance premiums. We favour (primarily on "motivational" grounds) uniform premiums across regions, with a three-tier structure of: a common component paid by all employers; an industry-based component allowing for recognition of industry-level improvements in safety and compensation matters; and an individual employer component reflecting its particular OHS and WC "track record".

We do not favour any substantial employer-subsidisation (and especially cross-employer subsidisation) if such subsidisation waters down the motivating impact of the above three-tier structure. The following extract from the website of the Workers' Compensation Board of Alberta, Canada , an employer-funded scheme, shows some interesting issues concerning cross-subsidisation by well-performing employers of poorly performing employers in OHS terms, and other problems in this "private" scheme including escalating premium levels. (The statement is dated October 31, 2001 but is still on the current website.)

"<u>Employer premium rates to increase an average of 27.3% in 2002.</u>

Rising medical costs and a sharp decline in the equities market have forced the Workers' Compensation Board to re-evaluate the practice of subsidizing employer premium rates. Between 1997 and 2001, claims costs have almost doubled to $831 million. This sharp increase is largely due to escalating medical costs, which have risen 104% over five years.
Over the same time period, employer premiums did not keep pace with rising claims costs. Instead, WCB financial gains were used to subsidize rates by as much as 36%. However, with the recent global downturn in the markets, revenue from WCB investments has declined by 33.5% ($143.8M) this year, and is projected to drop an additional 9% ($25M) in 2002.

"In order to maintain the long-term financial stability of the workers' compensation system, and encourage employers to make significant improvements in workplace safety, the WCB is moving towards a rate that reflects the full cost of workplace injuries," says WCB president and CEO Mary Cameron.
The average premium rate will rise by 27.3% in 2002, to $1.68 per $100 of insurable earnings. To help employers adjust to this move, the WCB will still use financial gains to subsidize 2002 premium rates by 13 cents per $100 of insurable earnings. The rates would have increased by 37% without the WCB subsidy.
The WCB will work with stakeholders to develop a safety dividends program that increases the rewards to employers who have excellent safety records, and eliminates blanket subsidies for poor performers. This program would be in addition to a number of WCB safety and injury prevention incentive programs already in place.
"We already reward employers who have excellent safety records with rate discounts, but are planning to implement even more programs that reward good performers down the road. In the future, employers will pay rates that truly reflect safety performance," says Cameron. "Safety is the best business tool to improve productivity, reduce insurance rates and keep Albertans working."
The majority of Alberta employers will experience between a 10-50% increase in their industry base rate. Even with these increases, Alberta's rates will remain among the lowest in Canada.
Individual businesses can reduce their rates through their safety experience rating and participation in the Partners in Injury Reduction (PIR) program. Employers will receive their individual rate packages by the end of November."

However we do note the concerns expressed by insurer representatives to the NSW General Purpose Standing Committee No. 1 about self-insurance, adverse selection and related issues, and their manifold possible negative consequences for the viability of insurance provision in the WC arena. Hence we do accept the need for a three-tiered structure, rather than only two: an industry-tier and an organisation-tier. The third ("all employers") tier seems needed to provide a limited degree of subsidisation to address the concerns outlined above.

Our final observation about insurance matters is that they should not be allowed to dominate the total OHS and WC system, as we believe they tend to do in Australia, partly because of their importance, partly because they fit well with current political thinking about deregulation and "small government", and partly because of their apparent ready understandability by the public.

Our objection is conceptual rather than ideological. The total OHS/WC system must be considered and managed as a single if complex unity, with due consideration for all its elements and the welfare of all its participants. Domination by any one component is dysfunctional. National integration must mean *total* system integration in a genuinely balanced way. Insurance matters should continue to have a vital place in such a system, but not a dominating and thereby distorting one.

Appendix A: Comments on the role of the Workplace Relations Ministers Council and the Heads of Accident Compensation Authorities in planning and promoting a uniform approach to Workers Compensation legislative changes and the assessment of impairment.

The Commission is of course aware that the Workplace Relations Ministers Council (WRMC) began promoting a uniform approach to development of accident compensation legislation from at least 1994 (then as the Labor Ministers Council, LMC). The Heads of Workers Compensation Authorities (HWCA, or sometimes HWCSA to include the word "Safety") were subsequently collectively involved with the WRMC in this process, including in regard to impairment assessment, as is indicated in post-meeting communiqués from the WRMC, and related reports such as are available on the websites of some of the accident compensation authorities. However, the coherence and urgency of this push appear to have reduced since the mid to late nineteen-nineties, for reasons that the Commission may understand better than we do.

While we are generally very supportive about such national mechanisms, we consider the relative lack of transparency regarding the WRMC and the HACA/HWSCA meetings and background activities to be problematic, as is the failure of those bodies consistently to make public their objectives, agendas and activities, invite public comment on those matters and associated methodologies, and also, more specifically, invite professional bodies to contribute to their decision-making processes about impairment assessment and other professional matters.

Lack of involvement by the relevant professional bodies, injured persons' bodies, other interested groups, and the public is likely to result in a less-than-optimal set of goals for change. There is likely to be little understanding by the accident compensation authorities of developments in other health arenas, little motivation by the health-related professions and other bodies to assist with the change process in accident compensation jurisdictions, and generally sub-optimal planning and managing of change.

Failures of communication and consultation nationally and locally appear to have contributed to the development of the current unacceptable situation where:

- an outdated view of the roles of psychiatrists vis-à-vis psychologists and other non-medical professions in accident compensation settings has been adopted (i.e. preferment of psychiatrists only, in the face of general support in the health professions for a multidisciplinary team approach), and
- a new, untested but fundamentally flawed measure of psychological and psychiatric impairment (the Psychiatric Impairment Rating Scale, known as the PIRS), against explicit professional advice not to use that scale, apparently is to be mandated across the various accident compensation jurisdictions including New Zealand, although this mandate may be modified in light of an evaluation about to be carried out by an HWSCA- commissioned research team of the available measures of psychological and psychiatric impairment.

APPENDIX B: THE PROBLEM OF REQUIRING PSYCHIATRIC DIAGNOSES AND THE IMPORTANCE OF FOCUSING ON IMPAIRMENTS

1 The main problems with psychiatric diagnoses:

The NSW and Tasmanian legislation requires that a psychiatric diagnosis be reached before any real assessment of permanent impairment may be made. This "cart before the horse" requirement is seriously problematic:

(a) ***The requirement for psychiatric diagnoses is a covert threshold that sponsors actively manipulative or unconsciously biased behaviour by all classes of participants in the WC systems.*** Because of the subjective judgment involved in determining a diagnostic category, much room exists for "role effects" on assessors such that defendents' assessors fail to find any diagnosable condition about six times more often than do treating practitioners or plaintiffs' assessors, probably reflecting pressures from the relationships involved, but also bias-related expectations such as that the claimant is faking. (More of this research later.) Also claimants (and their advocates) are encouraged, perhaps even forced, by this system to "over-specify", i.e. to exaggerate symptoms and signs, to be sure of meeting the threshold requirement of a clear diagnosis. Some assessors, aware of the defects in such diagnostic methodology, and of potential challenges to their judgments, may either also ensure that the claimant's case is "over-specified" (by giving weight to even very minor symptoms), or go to the other extreme of denying the validity of the claim wherever possible.

(b) ***Psychiatric diagnoses are virtually useless for impairment assessment, treatment, rehabilitation and return to work programs, and for OHS remedial purposes.*** The authoritative text DSM-IV (so recognised by Australian courts and tribunals) explicitly warns that those diagnostic categories do not measure and are not indicative of kinds and levels of impairment, and *should not be used for the assessment of impairment or disability*. They are broad and global categories that provide little or no detail or dimensional feedback. They submerge rather than clarify vitally important individual differences. It is virtually impossible meaningfully to relate psychiatric categories (e.g. schizophrenia, or generalised adjustment disorder) to workplace matters. They are not related to, predictive of or useful in impairment assessment or treatment. People with some serious psychiatric disorders can still function effectively occupationally. People without major psychiatric disorders can still be seriously impaired psychologically in specific functions. It is for these kinds of reasons that the Americans for Disability Act bars the use of "mental disorder" diagnoses. This bar is one reason for AMA5's very cautious statements in Chapter 14 ("Mental and Behavioral Disorders") about this issue, and its refusal to translate clinical judgments in "whole person impairment percentages" – cautions that have not been understood and respected in NSW and Tasmania in their replacement of AMA5's Ch. 14 with their own methodology.

(c) ***They are not accurately determinable at the initial assessment stage***. Diagnostic decisions require substantial investigation and data about symptoms and signs.
(d) ***They have an inappropriate focus for OHS and WC systems***. They are mainly "abnormal" in nature, i.e. founded on pathology, usually with implications of longstanding (often genetically-based biological or early-learning) foundations that pre-date work involvement, hence in the WC arena expose claimants to biased assessment via assumption or expectation of pre-existing conditions. Also a subtle form of a "victim blame" approach is thereby encouraged. The person may be argued to have an "eggshell psyche", i.e. a pre-existing disposition. No reasonable employer (so the argument runs) could be expected to anticipate how such a person would react to normal workplace pressures and the management of the person on the job. Hence no responsibility can or should be sheeted home to the employer if the employer's actions would not stimulate a serious mental disorder in a "normal" employee.
(e) ***They lead to misclassifications of injured workers***. Disagreements about psychiatric categories are rife between psychiatrists in particular cases. Psychiatric diagnostic categories probably fail the Daubert legal standards for reliability and validity (applicable now in the USA but may be extended to Australian courts) as well as the earlier Frye standards. The outcomes of the use of psychiatric diagnostic categories in WC contexts include that many worthy people are denied recognition wrongly, but also that some are compensated who do not really qualify. If the reported rates of misclassification (which vary according to diagnostic categories) apply to WC, i.e. around 40%, this results in many injustices and much waste of money or effort on the wrong types of problems. (See Appendix D.)

2 The value of a focus on continuous dimensions of functioning:

The better approach (rather than insisting on a standard psychiatric diagnosis by only a psychiatrist) is to allow, *as a trigger of further and more detailed assessment*, the recognition of any serious impairment of psychological functioning that is identifiable by a psychiatrist or a psychologist, and appears to be possibly a consequence of a workplace injury. A psychiatric diagnostic category may be appropriate "down the track", but not at this early assessment and intervention stage (and perhaps never, depending on the nature of the impairment).

There is much greater agreement among professionals about specific impairments (which are typically expressed as gradations on continuous dimensions), thus there is likely to be less contention, and lower costs in terms of litigation and the need for competing evidence from expert witnesses, than is the case with psychiatric diagnostic categories. They also lead to better focused initial treatment and rehabilitation.

This impairment focus is consistent with the long-established legal view that the term "mental illness" is not confined to current understandings and contemporary classification systems, and that symptoms and signs are recognisable without having to fit into an existing diagnostic category. Serious dysfunctions ought to be potentially compensible in themselves even if each and every symptom and sign associated with a

particular psychiatric diagnostic category is not present in full-blown nature. (See for example Williams, C.R (2000).)

3 How psychiatric diagnoses are not consistent with the WC legislation:

Legally (in terms of the intent of the legislation as expressed in the specific words in the legislation and at the second reading speech and "committee" stages), functional impairments must be the prime focus, not the abstract and far too broad diagnostic categories that do not indicate the types or the degrees of impairments.

We submit that the "cart before the horse" requirement for a psychiatric diagnostic category to be assigned before thorough assessment can be undertaken is not a means of operationalising the notion of "serious injury" (as was argued by WorkCover NSW), but instead is another, unnecessary and unjustifiable threshold for the injured person to cross, over and above "serious injury" and consequent "impairment".

Not only has the psychologically injured person to prove seriousness of injury, but s/he has also to demonstrate the full pattern of signs and symptoms that fits snugly into a particular current psychiatric classification system before his/her case can be properly assessed. This is a wrong use of diagnostic systems.

It must be noted that the signs and symptoms listed for a particular diagnostic category are exemplary, not normative. That is, they illustrate and delineate the scope and complexity of the conditions covered by the diagnosis. But they do not constitute an empirically-established set of minimum conditions for the assignment of the diagnosis. Nor do they constitute any kind of average or other "norm" of behavior for people in that category. For example, a person may be a full-blown schizophrenic yet show only some of the signs and symptoms covered by the diagnostic category; and may exhibit a different pattern from that of another schizophrenic person. This is so partly because many diagnostic categories, of which schizophrenia is one, are multi-faceted, and contain many sub-varieties (e.g. hebephrenic, catatonic, and paranoid schizophrenia).

Thus requiring the use of a diagnostic category, especially as a prelude to early assessment and treatment, we submit, constitutes an unwarranted degree of onerousness of process not intended by the legislature.

The Commission may wish to consider the situation where an injured worker is denied any statutory benefits or common law access because s/he fails to fit exactly the usual signs and symptoms of a particular diagnostic category. This was recently the case with a firefighter claiming compensation in NSW.

As earlier stated, it has been found that defendant-hired experts are 6 times less likely to find a serious disorder than plaintiff experts and treating practitioners. Dr Large (2001) reported about MAA psychiatric claims: *"Experts disagreed on many claims, with treating practitioners and claimants' experts using the diagnoses of PTSD and depression (15% of claimants) more often than defendants' experts (2.5% of claimants), as described*

elsewhere."

This is a serious extent of disagreement, especially for a field of conditions that is relatively narrow (motor accidents provoking only a few conditions, not the full range). The injured worker may be seriously impaired, but because either the existence of psychiatric disorder or the type of psychiatric diagnostic category cannot be agreed, the claim is rejected.

The matter is further complicated by the existence of "co-morbidity" – the simultaneous occurrence of multiple conditions (e.g. of adjustment disorders, depression and anxiety). One diagnostic category is inadequate in such a situation. Consequently psychiatrists (and psychologists) may have real difficulties in agreeing on a specific diagnostic category in a particular case, especially where they are on "different sides of the fence".

Also there have been legal frustrations with psychiatric diagnoses, such as the workers compensation case of Ronald Leonard Power and Comcare AAT No 12538 [1998] AATA 8 (16 January 1998).

Here the Tribunal *"notes the conflict of expert opinion as to whether the Applicant continued to suffer from a work-related PTSD. Dr Robbie*[16] *favoured a diagnosis of generalised anxiety disorder and dysthymia but he questioned whether the distinction he was making appeared "churlish". Dr Polen's*[17] *assessment (of PTSD) occurred in 1993, and although his report was comprehensive and consistent with the history reflected in other parts of the evidence, the Tribunal's concern is in relation to whether as at September 1995 the Applicant continued to need and receive treatment for PTSD.....In any event, the Tribunal finds Dr Skinner's*[18] *opinion unhelpful insofar as she made a distinction between suffering from PTSD and continuing to suffer from some residual effects of the condition. At one point in her evidence she referred to the Applicant not now having an acute PTSD. That is not the issue. Ms Lightfoot*[19] *considered that the Applicant suffered from chronic PTSD and one could infer from the evidence of Dr McMurdoo*[20] *that he too considered that the Applicant's PTSD was chronic. The distinction which Dr Skinner attempted to make was analogous to saying that a person who had at one time had a stroke no longer suffered from a stroke even though he continued to have some residual effects of the stroke, for example, hemiplegia. .....The Tribunal finds on the weight of the evidence before it that the Applicant continued to suffer from the effects of the post-traumatic stress disorder sustained by the Applicant as a result of the assault on him at work on 15 November 1988, and that he continued to need therapeutic treatment for that condition."*

A focus on the identified impairments of functioning rather than a psychiatric diagnostic category is much preferred. It is less onerous and more consistent with Parliamentary

[16] A psychiatrist engaged by the Respondent in this case.
[17] A psychiatrist who carried out the initial assessment.
[18] A psychiatrist employed by the respondent.
[19] Treating psychologist.
[20] Consultant psychiatrist.

intent.

Failure to agree on an "all or none" diagnostic category may lead to the denial of a claim altogether, or seriously diminish the scope of the claimant's case to the point of failing to achieve the threshold value. By contrast, a focus on impairments is not "all or none", but allows for graduated levels of impairment, and is thus a fairer evaluation. It does not necessarily lead to more costly assessments (an assumption sometimes wrongly made about using such a "dimensional" approach rather than "all or none" categories as the basis for assessment.)

As indicated above, much greater agreement among assessors can be achieved because impairment categories are much more specific and measurable than broad and imprecise psychiatric diagnostic categories.

Using an impairment approach rather than psychiatric diagnostic categories also helps to avoid the very damaging consequences of "labelling" injured workers with psychiatric diagnostic labels. The Stanley Report (Vol.2) recognises this problem in the SA WC system. Injured claimants may have access to reports containing diagnoses, and the problems associated with such "labelling" must be recognised. These problems include encouraging the claimant to fall into the role of "sick person", and to provide an excuse for inaction on the adjustment problems created by the injury ("I'm (diagnostic label), therefore I can't be expected to behave otherwise").

Other consequences include reluctance by employers to retrain the injured person, psychiatric diagnostic categories generally having some stigma attached and false stereotypes about associated behaviour (e.g. wrong expectations such as that the person will be violent or uncontrollable at work, unreliable, prone to stress, and so on). A focus directly on serious dysfunctions (i.e. functional impairments) helps avoid these problems.

There are also potentially serious legal consequences for workers compensation authorities, insurers and employers from the above-listed misuses of diagnoses, e.g. legal action to recover damages for loss of reputation of an employee whose recorded psychiatric diagnosis is disclosed to others not legally entitled to know. While the same may be said for any information in an assessment report, psychiatric diagnoses are particularly worrying because they are easily miscommunicated by lay people (e.g. "he's got schizophrenia"), and surrounded by stigma and stereotyping in a way not attached to other information and to functional impairments.

The Stanley Report makes a number of valid observations on such matters, and also makes pertinent recommendations about access to medical assessment reports – access by the injured worker is recognised but otherwise should be very restricted. We generally support them with the caveat that we wish medical and psychological data to be used in a deidentified form for OHS purposes, a usage that the Stanley Report in these particular recommendations appears not to have taken into consideration.

4 Evidence concerning psychiatric misdiagnosis:

In this sub-section we proffer some research data concerning inaccuracy of psychiatric diagnoses. We do so not as an attack on the psychiatry profession, but as an objective assessment of the reliability and validity of such classifications. The problem lies in the system, not the assessors. Psychologists are likely to do little or no better in making such classifications than psychiatrists especially if they do not use their "tools of trade", viz. psychological testing and other assessment methods.

(a) Low inter-psychiatrist agreement using the Victorian Clinical Scales:

Dr Epstein (psychiatrist-trainer involved in training psychiatrists to use these Clinical Scales for assessment of accident-related mental and behavioural disorders) reported on the accuracy of clinical ratings achieved by the psychiatrists following a special training program.

His evaluations showed very low inter-assessor agreement by those psychiatrists on the same 5 vignettes even after their just-completed specialised training in its use, and a strong "centralising tendency" in their ratings (undesirable in an assessment measure).

The problem here lies in the Scales and particularly how they are scored (using the median, an inappropriate statistic when assessing impairments that ignores the extreme aspects of the person's impairment and, for any set of people, sponsors "centralising effects" in their comparative scores), rather than the competence of the psychiatrists.

(b) Difficulties in assessing Chronic Fatigue Syndrome:

Deale and Wessely[21] reported that *"Psychiatric disorder is often misdiagnosed or missed in routine clinical evaluations of CFS patients"*, in their comparison of clinical versus "gold-standard" diagnoses. To quote them:

"SUMMARY

Overlap in symptoms of Chronic Fatigue Syndrome (CFS) and psychiatric disorders such as depression can complicate diagnosis. Patients often complain that they are wrongly given a psychiatric label. This paper compares psychiatric diagnoses made by general practitioners and hospital doctors with "gold standard" diagnoses established according to research diagnostic criteria. Sixty-eight CFS patients referred to a hospital fatigue clinic were assessed, and psychiatric diagnoses were established using a standardised interview schedule designed to provide current and lifetime diagnoses. These were compared with psychiatric diagnoses previously given to patients.

Two-thirds of the 31 patients (46%) who had previously received a psychiatric diagnosis were misdiagnosed: in most cases there was no evidence of any past or current psychiatric disorder. One-third of the 37 patients who had not previously received a psychiatric diagnosis actually had a treatable

[21] Of the Chronic Fatigue Syndrome Research Unit, Department of Psychological Medicine & Institute of Psychiatry, King's College, London.

psychiatric disorder in addition to CFS. These findings highlight the difficulties of routine clinical evaluation of psychiatric disorder in CFS patients referred to specialist settings. We recommend doctors should focus on subtle features that discriminate between disorders, and use a brief screening instrument such as the Hospital Anxiety and Depression Scale. Above all, they should proceed with caution, paying particular attention to clarity of communication and accuracy."

(c) The Rosenhan studies:

In 1973 Rosenhan (a North American psychologist) and seven other volunteers of normal mental stability gained admission to psychiatric hospitals by complaining of hearing a voice saying the word "one" repeatedly. They gave no other indication of any problem, and on admission stopped the complaint of hearing a voice.

Nonetheless they were all classified as "abnormal": seven as schizophrenic, and one as manic-depressive.

While in hospital some of the other patients recognised them as "normal" but the staff did not detect them as such. They were all ultimately discharged as having "schizophrenia in remission" – the diagnostic label stuck despite absence of evidence during hospitalisation of any aberrant behaviour.

Subsequently Rosenhan carried out other research that confirmed the low validity of psychiatric diagnostic categorisation.

Appendix C: Legal issues elaborated.

As indicated in the main body of the submission, desired law-related improvements include: better definitions of key legal-professional terms relating to mental health, and clearer and more insightful delineation of appropriate professional roles, especially for the various non-medical professions, based on a better understanding of their roles in the modern era and a better understanding by the legal profession of modern views of mental illness and injury.

Key legal and professional terms requiring better definition include:

- psychological c.f. psychiatric injury; psychiatric c.f. psychological illness/disorder/problem
- mental harm
- mental illness
- abnormal behaviour or conditions
- mental and behavioural disorders or conditions
- mental impairments
- emotional damage (in regard to organic injury)
- normal fortitude
- typical presentation
- “shock of the moment” (legally equated with PTSD)
- primary v secondary impairments
- distinguishing between impairments and symptoms (and signs)

Some other legal issues are also crucial here, such as:

- the concept of “whole person impairment” and its consequences compared with the “table of injuries (or “maims”)” approach
- the legal liability of an independently-practising professional, compared with a government-employed, salaried professional when assessing or treating an injured worker
- scientific compared with legal standards of proof of causation
- the acceptability of various methods of combining impairment ratings to achieve “whole person impairment” percentages.

Appendix D: Malingering and fraud in workers' compensation claims.

Our members working in the WC systems report some instances of deliberate false claims about psychological injuries, and (more often) exaggeration of their impacts. But we believe it is very important to keep the problem of plaintiff fraud in perspective, not generating or reinforcing myths about the prevalence of fraudulent claims, and not elevating this issue to an undeserved level of prominence.

Qualified psychologists are capable of detecting dissimulation by claimants through careful psychometric testing. Because of the nature of such tests, it is very difficult to fake successfully. However dissimulation is not to be equated with fraud. We note the immense difficulty of determining if and when a claim is definable legally as fraudulent rather than exaggerated, especially once one moves away from the obvious deliberate and provable cases of fraud.

For example:

- Is a claim more likely to be treated as fraudulent if made by a claimant diagnosed as hypochondriacal than one diagnosed as schizophrenic?
- Is someone judged by the assessor to not suffer any diagnostically recognisable form of injury automatically to be declared to be acting fraudulently (rather than suffering a difficult-to-detect condition, or simply being misassessed)?
- Is an unsuccessful claim automatically to be treated as potentially a fraudulent claim, hence in danger of double jeopardy?
- Is the opinion of the assessor as to the degree of "faking" to be taken as expert evidence in the hearing of a fraud allegation?
- What legal standing would such an assessment hold, especially with an instrument such as the Psychiatric Impairment Rating Scale, which fails the Frye and Daubert legal tests of scientific adequacy?
- What constitutes a serious case of fraud - degree of deception involved, quantum of compensation sought, or what?

Attached to the e-mail forwarding this submission is a pdf file containing an important article by Susan Ballinger, an APS member, on the topic of malingering and exaggeration. This article was recently published in the APS bulletin ***InPsych***.

As she indicates, the psychologist (or other professional assessor) may be legally vulnerable if s/he accuses claimants of fraud or malingering, allegations that could be said to damage the claimant's reputation and claim.

We strongly commend Dr Ballinger's article to the Commission for detailed consideration.

Appendix E: Alternative decision-making and classification models for WC systems.

Alternative classification models:

We commend ICIDH-2[22] as the foundation for an impairment-focused approach, as it has become in the USA for assessing impairment and disability.

What is ICIDH-2? It is *"a refined and expanded taxonomy that is intended for application in social security programs. Each item in the ICIDH-2 has an operational definition and at least one rating scale. In addition, research disablement assessment instruments, being developed in an independent project, are based on the ICIDH-2 and are intended for use both in surveys and in clinical settings."*[23]

Dr Kennedy further observed:" *…ICIDH-2 conceptualizes three key dimensions of disablement. Each dimension is subclassified into domains and items that are each more detailed aspects of each dimension. The first dimension, impairments, classifies body parts or body systems (such as mental functions, including attention and memory) or organ systems (such as cardiovascular and respiratory functions). The second dimension, activities, classifies the activities in which people are typically engaged. These range from the very basic activities of movement of limbs through such fundamental activities of daily life as grooming and bathing (commonly known as activities of daily living) to more complex activities such as work. The third dimension classifies participation, the involvement of the person in life situations. (A fourth dimension, context, has been proposed by ICIDH-2 and is conceptualized as extrinsic factors that have positive or negative impact on functioning, performance, and involvement.) For the purpose of SSA's determination of disability claims based on mental disorders, the ICIDH-2 Impairment chapter on mental functions and the Activities chapter that includes work are appropriate and applicable. They contain components that can be rated for purposes of adjudicating disability claims. Indeed, SSA's standards and guidelines were reviewed for input in developing the Activities section on work. It is not difficult to understand that mental impairment items such as attention, for instance, are necessary to work. Focusing attention, sustaining attention, and shifting attention are needed skills in both manual and nonphysical occupations. It is stating the obvious to note that recent memory and remote memory are also fundamental to all types of employment. The mental impairment of executive functioning may not apply to all types of work. As delineated in ICIDH-2, it includes concept formation, planning, flexibility, and judgment. Although the name of the mental function (i.e., executive function) is not intended to reflect the employment hierarchy, it does more suitably describe professional and supervisory work requirements than basic manual labor.*
In the ICIDH-2 Activities dimension, work is currently classified along with school-

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[22] World Health Organization's (WHO) International Classification for Impairments, Activities, and Participation (ICIDH-2).
[23] Cille Kennedy, Assistant Director for Disability Research, National Institute of Mental Health (USA) at Symposium on "Linking Components of Functional Capacity Domains with Work Requirements" (see http://www.nap.edu/html/mfc/ch4.html).

related activities, since they tend to be differentiated by age rather than the actual task the person is performing. For example, among the basic work activities are following directions, working independently, and working in groups. Both work and school require such other generic activities as attending regularly, being punctual, and responding to feedback. ICIDH-2 has a section on work acquisition and retention skills: it is not enough for a person to be able to get a job, the person has to be able to maintain it. Furthermore, there are items in other Activities chapters that classify work-related activities already acknowledged by SSA. For example, the ICIDH-2 chapter on Interpersonal Behaviors includes a section on interacting with persons in formal settings, that contains interaction with coworkers, superiors, and subordinates. The ICIDH-2 dimensions, domains, and items—along with their operational definitions—could be used by SSA to document relevant functions and activities, rate the person's performance on each item, and calculate the person's ability to work.

The above examples of ICIDH-2 Impairments and Activities highlight some of the basic functional capacities generic to work. The statutory definition of disability does not specify certain jobs; it states "substantial gainful activity" and can be understood to mean paid employment in the general economy. In the determination process, items such as those from ICIDH-2 would need to be assessed on the basis of being able to perform them on a continuous basis, over workweeks, over time, once the connection of ICIDH-2 Impairments and Activities to actual work is made.....Finally, the ICIDH-2 is linked to WHO research instruments that assess disablements, as noted above. At present, along with the two versions of the WHO Disability Assessment Schedule (DAS-II) (instruments intended for clinical and survey research), there is a checklist for use in clinical practice that can provide an overview of a person's disablement, and a 12-item screening questionnaire…The advantage they offer is that the assessment instruments are being developed based on a research protocol that will determine their scientific and psychometric properties.

In summary, aspects of functional capacity, components of work, and ways of fitting the two together have been depicted with mental health examples. The WHO ICIDH-2 offers a conceptual model and taxonomy that is substantiated by research. In addition, there are disablement assessment instruments based on ICIDH-2 that can be adapted to SSA's disability determination. As mentioned, mental health has been used illustratively; the ICIDH-2 and the research instruments are designed for use with all health conditions."

Critical decision paths:

The issue of critical decision paths is very important for attempting to improve some important aspects of the current WC systems, as the Commission already appreciates. "Critical path analysis" is a well-established approach (as the Commission is no doubt aware) that should, we commend, be more systematically adopted.

Some work, we understand, has already been done of this kind. We draw attention to the Victorian approach of early identification of high-risk cases requiring special attention, and the benefits thereof. We also draw attention (again) to the WorkCover Qld pilot study using specialist psychologists in the clinical assessment of stress claims. This study led to

"improvement in the quality of decisions, time-to-determination and work-days-lost" and remarked that *"In some cases the psychologists were able to de-escalate the situations which was of benefit for all parties concerned."* (Tony Hawkins, WorkCover Qld Chief Executive, quoted by Lyn Andersen writing in the APS Qld State Newsletter, Sept. 1999.)

However a more systematic usage appears to be in order. It should focus not only on what decisions are made, and criteria and processes for making them, but also on the sequence (or multiple sequences) of decisions, their interrelationships, and the benefits and advantages of the various decision options and strategies along the way. Optimising decision path outcomes cannot be done intuitively – it requires objective data, and the use of a number of statistical, mathematical and associated computing tools. These features are outlined in Swets at al. (2001).

As part of a non-adversarial approach this approach may involve the use of multiple thresholds (rather than a single threshold), linked to various action paths, to optimise the decision outcomes.

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