Consultation area 1. Ensuring best outcomes for injured people

1.1 Do you think that injured people are receiving high quality, evidence-based health care in the personal injury schemes (workers compensation and motor accidents schemes)?

Across three decades of working in a variety of compensable schemes (e.g., those administered by Comcare, DVA, ADF, Victims of Crime systems in Victoria and Western Australia, TAC and WorkSafe in Victoria and SIRA) as a practitioner and consultant [redacted], it is my experience that the implementation of evidence-based practice (EBP) occurs far less than warranted in such schemes. This has had, and continues to have, deleterious impacts upon on the outcomes of psychology treatment for claimants across those schemes.

Absence of evidence demonstrating the approved of such interventions is occurring with sufficient frequency and impact in third party funded accident and injury systems to have been a concern in parliamentary and government inquiries across all jurisdictions in Australia. There is no reason to believe that the schemes under SIRA's specific jurisdiction are not subject to this problem or that those injured at work and as motorists in NSW (hereafter referred to as claimants) are not negatively impacted upon by such shortcomings.

1.2 Which issues need to be addressed to ensure injured people receive high quality, evidence-based health care?

There are many barriers which hamper the implementation and translation of high-quality evidence-based health care under compensable health schemes across Australia. There is no reason to assume that these do not apply to the schemes under SIRA's jurisdiction. Examples of these barriers include:

- the insufficient application of early intervention by practitioners - while the situation has improved from a decade ago, when it took far too long for injured customers of such schemes to seek assistance, there is still considerable room for better-reporting the virtues of early of psychological intervention and thus reducing injury chronicity and overall treatment
- the well-established finding that delay in the application of early intervention leads to a greater downstream treatment need. There are various factors which contribute to this delay; namely, the
    1. Failure of systems to support early intervention (e.g., through the early detection of the signs and symptoms of psychological ill-health of at-risk workers by employers).
    2. Wariness about/lack of confidence in what might be gained from psychological treatment among potential consumers (i.e., the idea that they can't be helped and that mental health intervention is not for them).
    3. Lack of awareness by claimants, employers and systems, as to who has the capacity to promptly and effectively treat those who are injured.
    4. Unreasonable or unrealistic expectations among claimants around what is best to occur and what might be achieved in psychology (e.g., complete elimination of symptoms and companionship) and

5. Poor matching of client health need(s) with practitioners with expertise and experience.

Such barriers strongly negatively affect claimants, who have little capacity to make informed choices about what constitutes best practice in psychology. They also compromise the decisions of referrers, which can be influenced by knowledge limitations, poor practitioner availability - as happens in regional, rural and remote Australia - and the convenience of "in house" arrangements.

Those barriers must be addressed, if high quality evidence-based care is to be efficiently and effectively provided to injured people with entitlements under the scheme SIRA administers.

1.3 How can SIRA, insurers and providers help injured workers and motorists access the best outcomes?

A range of actions are open to SIRA and insurers to enable injured workers and motorists access the best outcomes health outcomes. Some of these actions are described here. Other actions are described under "Consultation area 4" (and specifically consultation question 4.2)

Initially, it is important that SIRA act in partnership with experts and expert, policy and research organisations and professional associations, to create a SIRA knowledge-climate that will enable best outcomes. The knowledge creation involved could range from simple educational information pieces (for clients and treaters), through to practitioner-guidance materials (e.g., around diagnosis and treatment using hypothetical scenarios and case illustrations for referrers and treaters) and guidelines for the assessment and treatment of the conditions that commonly occur in at risk populations (Harvey, Bryant & Forbes, 2018) and descriptions of care bundles for cases with multifaceted needs and, especially, complex cases with significant need for psychological treatment input.

To achieve best outcomes, it will also be critical for SIRA to develop mechanisms for the better identification of skilled practitioners who are prepared to implement evidence-based practice (EBP). A government-lead protype of this exists in the current work of the Victorian Department of Health and Human Services to develop a Network of Specialist Clinicians for the treatment of trauma related mental conditions (TRMHCs) in Police and Emergency Services Personnel and other first responders.

As part of that development of mechanisms, it will be important for SIRA to work with key stakeholders to better-identify pathways and means via which primary health practitioners may refer claimants in need of treatment to highly efficacious allied health professionals. As things currently stand, the pathways to effective care are not as well-known as they might be in compensable systems across Australia. Ways forward exist. One important possibility with the potential to improve claimant connection to high-quality treaters, but a potentially modest fiscal impact upon SIRA, involves the implementation of action-based research - via collaboration with expert policy and research organisations and professional associations and colleges (the APS, RACGP and RANZCP) - that investigates and designs more effective

conduits from referrers to allied health practitioners known to apply effective evidence-based treatment approaches.

With such knowledge, mechanisms and incentives available to influence practice, providers need only follow such guidance to better implement best-practice knowledge. As elaborated across this document, SIRA, however, needs to clearly, routinely and repetitively articulate such forms of knowledge, while simultaneously expressing it expectations for treating health professionals (THPs) and making clear its intention to enforce mandated consequences for those practitioners who fail to reflect the uptake of this information in their approach to care.

It is important that all targets for action and associated improvement mechanisms are implemented by a collaborative approach between SIRA, insurers and experts, expert, policy and research organisations and professional associations.

1.4 From your observation what are some of the reasons for the increase in service utilisation (ie the increase in the amount of services each injured person is receiving)?

The first and most obvious explanation for the increase in claims of a psychological nature within the schemes under SIRA's jurisdiction and utilisation of psychology on those claims ("psychology busyness") is the Zeitgeist in which SIRA and other compensation schemes across Australia operate. Thus, a potentially unintended consequence of the increased mental health literacy in the general community, is that those who have taken its messages onboard can tend to seek treatment more often.

Another reason for the observed increase in psychology busyness is that that the improvements recently set in place within the schemes under SIRA's jurisdiction have made it easier for injured workers and motorists to access assistance. This is a significant and warranted development, but, unfortunately, this increased access has not been accompanied by sufficient education and information around what constitutes reasonable treatment (an opaque legal term). The effect of this absence of guidance has been significant for claimants and practitioners alike.

One possible explanation for the increase in psychology busyness could be that the nature of the injuries suffered by claimants has changed and that there has been an increase in the incidence of more severe injuries (e.g., PTSD, major depressive disorder and more complex multiply co-morbid presentations). That is not my experience, however. Rather, what appears to have occurred is an increase in the level of workplace antagonism toward those who have been injured and a reduction in the ability of claimants to maintain coping skills.

Consistent with this, is the 2012 report of the Australian Federal Parliament Committee on Education and Employment into workplace bullying entitled "Workplace Bullying: We just want it to stop", which noted the International Labour Organisation (ILO) definition of workplace bullying

> as *a form of psychological violence and that Workplace bullying constitutes offensive behaviour through vindictive, cruel, malicious or humiliating attempts to undermine*

an individual or groups of employees. Such persistently negative attacks on their personal and professional performance are typically unpredictable, irrational and unfair.

Examples of bullying cited by the Committee included:

- *abusive, insulting or offensive language or comments*
- *undue criticism*
- *excluding, isolating or marginalising a person form normal work activities*
- *withholding information that is vital for effective work performance*
- *unreasonably overloading a person with work or not providing enough work*
- *setting unreasonable timelines or constantly changing deadlines*
- *setting tasks that are unreasonably below or beyond a person's skill level*
- *denying access to information, supervision, consultation or resources such that it has a detriment to the worker*
- *spreading misinformation or malicious rumours*
- *changing work arrangements, such as rosters and leave, to the detriment of a worker or workers and*
- *unreasonable treatment in relation to accessing workplace entitlements such as leave or training.*

None of these explanatory factors, alone or in combination, however, fully explain the increase in psychology busyness. In my experience, further explanatory possibilities demand consideration. The first, somewhat unpalatable, possibility is that, as they have operated, third party funded schemes can be environments where non-evidence-based practitioners consolidate their existence. To exemplify this possibility, the fees and charges SIRA mandated fees are respectively almost $60 and $90 per hour above the Medicare bulk-billing rate for clinical and generally registered psychologists. This difference in remuneration inevitably influences where some THPs are prepared to ply their trade.

Another possibility is that the increase in service utilisation reflects the unknown competency of THPs to quickly and effectively treat the common conditions with which claimants present in the schemes which fall within SIRA's jurisdiction. Currently, there is no formal verification of that capacity. This is because, historically, schemes have not opted to undertake competency assessment and/or have left such a function to AHPRA via its registration requirements. Based on its behaviour to date, however, AHPRA appears to neither recognise the role it could play in causing practitioners to demonstrate competency nor have an appetite for addressing this gap if it recognises it. Added to this, schemes and oversighting bodies, like SIRA, have not been eager to be involved in competency scrutiny.

Thus, there has been little concerted action to guarantee provider expertise and although schemes and bodies with oversight roles, have occasionally made enquiries of professional associations and expert bodies around the possibility of jointly working to address credentialing, to my knowledge nothing has been locked in an any scheme across Australia.

The benefits to schemes, insurers, providers and claimants that would derive from active uptake of that competency assessment role would be considerable. Through this consultancy into *the regulatory requirements for health care arrangements*, SIRA can establish itself as the first body with scheme oversight to drive an increase in treatment efficiency and efficiency through sound competency assessment strategy. Successful implementation of such a strategy could act as a model for translation to other schemes across Australia and the creation of a default national competency test using a united and transferable single mechanism that could also be utilised across the various "third party" funding schemes that operate across Australia.

Another important factor with the potential to influence the rate of service provision is the disconnection apparent among some among THP's around critical practice implementation and translation issues which impact upon the efficacy and efficiency of the treatment(s) delivered. The following are several high-status illustrations of the impact of poor THP knowledge and failure to maintain awareness of the evidence base:

1. The status of the therapeutic relationship. While the early literature on the therapeutic alliance, derived as it was from the Freudian notion of transference and countertransference, attributed 30% of the treatment effect to the quality of the client-practitioner relationship, contemporary research (e.g., that by Horvath, Del Re, Flückiger & Symonds, 2011) has clarified that the causal impact upon of the therapeutic relationship on treatment is much lower than estimated and that it alliance may contribute as little as eight per cent to treatment outcomes.
2. The view that cognitive behaviour therapy (CBT) and EBP are failing. Neither of these propositions are tenable and both are erroneous. Research strongly supports CBT's status as the first line evidence-based approach to the delivery of psychology treatment for mental health disorders. It has long been established that, for mild-to-moderate presentations of mental health conditions, CBT has longstanding demonstrated superiority to pharmacotherapy (Jacobson & Hollon, 1996). When CBT is properly applied, its efficacy remains strong and commentators have argued that any failure to deliver the sought after mental health outcomes in the application of CBT relates to the failure to properly implement it (see Easdon & Karantzis, 2018) and translate EBP (see McHugh & Barlow, 2010). Superficial application of CBT and erroneous claims about it and EBP and disingenuous claims about the nature of outcome assessment in my experience has influenced THPs to utilise less effective, non-evidence-based treatment methods.
3. The propagation of fallacies and skill gaps. There are many examples of both, but the following misnomers and deficits are particularly common in my experience:
    a. the notion that treatment quantity is strongly positively correlated with treatment outcome - when psychological treatment is not exempt from the law of diminishing marginal returns and poorer outcomes are associated with elongated treatment delivery
    b. the belief that exposure work harms clients - when exposure therapy is by far the most

- efficient tool in the treatment of anxiety disorders and PTSD, is the most important advance in the psychological treatment of anxious distress in the last 70 years (McNally, 2007) and
- researched treatment of PTSD - its efficacy has been demonstrated
- across a broad sweep of trauma-exposed populations via a plethora of studies, over 50 randomised controlled trials with substantial sample sizes (e.g., Bryant et al., 2008; Mclean & Foa, 2017), multiple meta-analyses (e.g., Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010) and systematic reviews (e.g., Cusack et al., 2016)

c. the inability of practitioners to successfully challenge the treatment interfering effect of client anger - when self instruction training, conflict management skills and distancing strategies are effective, evidence-supported treatments for dysfunctional anger (see Benson, 1994) and

d. the poor understanding of what empirical evidence is, the use of "straw man" argument(s) to discredit the use of metrics and the lack of understanding as to what constitutes objective evidence.

Such ignorance and skills deficits are difficult to shift in THPs, once established. It is important that preventative action occurs early and is reinforced across practitioner's professional span of contact with schemes like those under SIRA's jurisdiction. SIRA, like all authorities with compensable scheme oversight, has a key role to play in influencing best-practice behavior.

Consultation area 2. Setting and indexing of health practitioner fees

2.1 How can fee-setting and indexation be better used to improve outcomes in the schemes?

[And]

2.3 How could SIRA appropriately set and index allied health fees with the aim of better outcomes?

Fees are a blunt instrument that can lead to unintended consequences if they are not "set" to fund best practice. As it currently exists, fee-setting in the schemes under SIRA's jurisdiction may be rewarding a less-than-appropriate-quality of service delivery and therefore continuing to an overall increase in the sessions.

The current fees set by SIRA are sufficient reward for good quality practices and appropriately indexed. Nonetheless, SIRA would do well to investigate the possible benefits that would flow from the application of contingencies designed to facilitate improved application of EBP.

Third party systems of tiered fees that provide incentives to practitioners who are prepared to apply EBP and targeted objective outcomes exist in Australian schemes. Such a tiered approach to remuneration that encourages best practice exists in the WorkSafe Victoria in

relation to physiotherapy provision. That approach, known as the *early intervention physiotherapy framework*, provides differentiation remuneration based on a "a service model that recognises the importance of early treatment in facilitating return to work and return to health outcomes".

2.4 Should consideration be given to the schemes having fee setting mechanisms for additional health practitioners? If so, which ones, and why?

It is my view that, given the current state of affairs and problematic pattern of service delivery problems that have emerged, funding additional health practitioners would be very unwise at the present time. I think it is imperative that before adding other groups of allied health practitioners to the list of those already funded to deliver health services, it is important that SIRA clean up its house in relation to the behaviour of allied health practitioners. In reality, "the piper plays the tune" and SIRA would do well to invoke its authority to obtain THP adherence. It is improper for funders to pay practitioners who are incapable of or unwilling to delivery effective treatment.

In short, I believe that SIRA must be clear about what problem it is attempting to solve. I do not believe the problem is one of insufficient supply of practitioners; rather it is the quality of the services providers are delivering. That needs to be SIRA's focus.

Consultation area 3. Improving processes and compliance

3.3 What improvements to monitoring, data collection and reporting would help ensure scheme sustainability and improve understanding of the outcomes that are being achieved?

In my experience, the problems which arise in the application of health care under compensatory schemes like those withn SIRA's jurisdiction, do not primarily occur as a result of the policies that underpin them, which are typically fit for purpose. Rather, the problem is that the protocols and processes which derive from those policies are either inadequately described or described in an opaque fashion that lends itself to slippage in THP compliance and that there is insufficient monitoring of such compliance. This permits the development of unhelpful practices.

Practice monitoring and supporting data collection and reporting of the information available from both has a crucial role in improving adherence to health policy and processes and preventing the development of unhelpful practices. This is the case for the schemes under SIRA's jurisdiction. With this in mind, I offer several propositions for action that have the capacity to prevent and curtail unhelpful practitioner behaviour.

The first action suggested is for SIRA to increase the level of case-by-case scrutiny applied to the delivery of health practices. Without definite and publicly visible levels of oversight (via a "copper on the block"), the best policies will be to some degree be subject to compromise.

Based on the operating models of WorkSafe and the TAC in Victoria, there is strong evidence that the most effectively case scrutiny is best achieved via autonomous panels of

experts that operate with visibility and autonomy. Such panels work best if they are supported to pool and analyze knowledge, publicly make known their findings and are robustly supported to recommend actions around treatment and, where necessary, the appropriateness of THP practices.

A robust and well supported "clinical panel" can have a level of system influence that that is not available when case reviews are conducted by individual reviewers working in isolation. Through their accumulated experience, panels can also play important roles in defining treatment needs for cases with highly complicated biopsychosocial presentations and specific populations like first responders and RTA survivors.

A second proposed action, is for SIRA to regularly make public analyses of the data it has around patterns of treatment delivery within the schemes under its jurisdiction. Those analyses will ideally be targeted to the critical disconnections that have occurred around frequency and longevity of treatment provided by THPs within the schemes under SIRA's jurisdiction. Where possible, analysis should also be provided of the relationship between diagnosis and treatment intensity and duration and patterns of behaviour in service provision and especially that of outliers. It is my experience that when such information is made known and adequately explained to professional audiences it is well received and provides an opportunity for professional reflection.

A third proposition is that SIRA undertakes work with experts and expert policy and research organisations to develop robust objective outcome measures, trial those measures and make known their utility to allied health THPs

Consultation area 4. Implementing value-based care

4.1 What opportunities does a value-based care approach present for the personal injury schemes? How could these be implemented?

Value-based care is the only form of treatment intervention that is clinically justifiable and should be funded in the schemes under SIRA's oversight. The funding of ineffectual treatment to those who sustain workplace and RTA-related injuries is contrary to the interests of all stakeholders.

This can be addressed by the initiatives already described within this submission and those shortly described in response to consultation question 4.2. It is important to emphasise that detailed communications plain language descriptions and statements for claimants and practitioners are created to describe those initiatives and their rationales. At a minimum, such statements would be best to cover:

- what constitutes psychological evidence-based practice for the presenting conditions that typically apply to the schemes under SIRA's jurisdiction
- the expectations SIRA has around the implementation of EBP and
- the bases on which treatment will be approved.

4.2 What options are there to better understand and influence the health outcomes and patient experiences within the personal injury schemes?

Various propositions with significant potential to improve the delivery of health services in schemes under SIRA's jurisdiction have already been advanced in this submission. They relate to the need for SIRA to:

- create a knowledge-climate that will enable best outcomes
- develop mechanisms for the better identification of skilled practitioners who are prepared to implement EBP
- work with key stakeholders to better-identify pathways and means via which primary health practitioners may refer claimants in need of treatment to highly efficacious allied health professionals
- jointly work with experts, expert bodies and professional associations to better address practitioner credentialing and
- increase monitoring practice trends via autonomous expert panels that operate with visibility and certainty and better use available data and release public analyses of that data around patterns of treatment delivery - and especially those of outliers - within the schemes under its jurisdiction.

Those propositions have significant potential for addressing the problems of the schemes under SIRA's jurisdiction, but will not be further expanded upon here. Instead, further options for reform will be briefly described. They relate to the use of education, practitioner support, process-focused research, practice influencing incentives and disincentives and enforcement of scheme expectation and are as follows.

Education. There will be considerable potential benefit from SIRA acting to increase education and advice to practitioners about the expectations that apply to the schemes under its jurisdiction. Such education can range from information and advice about scheme compliance to what constitutes EBP.

Practitioner support - various possibilities present themselves, including:

- development of a practitioner advice line to assist THPs around difficult cases and stuck points and what constitutes best practice for individual cases
- availability of mentoring via the provision of a network of scheme-subsidised supervisors
- provision of assistance to claimants
    - to find effective treaters via a "shoppers guide" and
    - around what it is important to expect in treatment via WWW and telephone-based advice.

Undertaking focused research - for instance, around:

- pathways to best care
- predictive modelling around the effect of serious physical and occupational injury - for example, via serious infectious disease, amputation and loss of vocation, role or function

- effectively working with individuals whose claims involve both primary and secondary causation factors and
- conditions and possible causal pathways involved, such as PTSD and anger (see McHugh 2018) and dissociation (see van der Hart, Wang, Solomon, & Ross, 2012) and their differential impact upon on treatment outcomes.

Enforcing expectations - for example, viaV

- registration and (e.g., triennial) re-registration processes supported by (financial and other) incentives
- making clear the ethical obligations of practitioners in relation to the treatment and the inappropriateness of unhelpful behaviours - for example, advocacy and adversarial roles - and, where justified
- reporting aberrant THP behaviour and, as a justifiable last resort, ceasing THPs eligibility for funding for work in the schemes under SIRA's jurisdiction.

To maximise the effectiveness of any propositions adopted as a result of this consultancy and avoid "wheel re-creation", it is critical that uptake of any such mechanisms by SIRA that emerge from this consultation occurs via partnership with key stakeholders. Thus, it is ideally is best to include expert practitioners and expert policy and research bodies (like Phoenix Australia and the Black Dog Institute) and professional associations as partners. The power of collaboration between such parties cannot be under-estimated.

Consultation area 5. Any other issues

For the kinds of reasons described across this submission, compensatory schemes like those which fall under SIRA's jurisdiction can often inadvertently function in sub-optimal manners. Such an outcome is clearly at odds with the stated recovery-focused intentions of those schemes.

Concerted action by SIRA, in partnership with peak bodies, field experts and industry leading policy, research and advisory bodies are required to address this problem. SIRA is in an ideal position to create leverage for better outcomes for individuals who sustain psychological injuries at work or in RTAs.

While SIRA's *consultation around the regulatory requirements for health care arrangement* is focused on the behaviour of practitioners, it is important to acknowledge that all stakeholders at times contribute to the malaises in schemes and at times engage in contrary-to-scheme behaviour. A telling example of this on the "agent" side is documented in the findings of the Victorian Ombudsman's 2016 and 2019 Inquiries into the management of complex (often psychological) claims under WorkSafe Victoria. Those Inquiries emphasise the need for scrutiny of the behaviour of all players involve in the schemes under SIRA's jurisdiction, to ensure that all relevant parties (SIRA, insurers, THPs, the professionals and experts) are contributing to the solutions required. Joint work focused on the functional and objective outcomes can establish progress towards efficient and effective outcomes becoming the norm for SIRA's ultimate population of interest.

Game changing possibilities like this consultation and what may emerge from it offer not-to-be-missed (re)design opportunities that are rare in the mental health field. SIRA is to be congratulated on seeking to consult. However, failure to make significant change as a consequence of this consultation, will entrench problems within the schemes concerned and be contrary to claimant's recovery of their mental health. While taking action will sometimes require difficult decisions by SIRA - for example, in referring THPs for sanction - to continue the current state of affairs is unconscionable.

Thank you again for the opportunity to submit to this consultation. [redacted]

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