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Dear Sir/Madam

The Australian Psychological Society (APS) welcomes the opportunity to provide a submission to the State Insurance Regulation Authority of New South Wales (SIRA) consultation around the regulatory requirements for health care arrangements.

The APS is the largest professional organisation for psychologists in Australia representing over 24,000 members. Many of those members deliver psychological services to injured workers with treatment entitlements under federal, state or territory workers compensation and accident schemes as sole providers or members of a service providing entity.

This submission is based on feedback sought from those members. It addresses the consultation questions where relevant to psychology and member feedback.

Yours sincerely

Ros Knight FAPS GAICD
President

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)?

The application of high quality, evidence-based health care interventions is critical to the psychological wellbeing, functioning and capacity of those who sustain workplace and road traffic accident (RTA) related injuries. The most common psychiatric injuries treated under such systems are anxiety, mood and stress-related disorders, as defined by the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DMS 5; 2013). Pain disorders are also common among those who receive services under such schemes.

The fourth edition of the Commonwealth Government funded *Review of Evidence-Based Interventions in the Treatment of Mental Disorders* authored by the APS (2018) underscores the efficacy of psychological interventions for those disorders. In summary, it emphasises that for:

- anxiety disorders - imaginal and behavioural exposure therapy are the first line psychological interventions
- depressive disorders - behavioural activation is the evidence-based intervention of choice and
- stress-related disorders - the gold-standard treatment is (stress and) trauma focused CBT (which encompasses that described immediately above) and
- pain disorders - cognitive coping strategies and behavioural rehearsal have the strongest efficacy

Despite robust evidence emphasising the efficacy of this evidence-based practice (EBP) and clear guidelines supporting the implementation of such treatments, their uptake and application remains low in compensable systems. For example, despite the existence of appropriate general protocols and manuals (see Foa & Rothbaum, 2010), it is estimated that only 25% of practitioners offer imaginal exposure as a treatment to PTSD sufferers (see Becker, Zayfert & Anderson, 2004; McLean & Foe 2013; Olatunji, Deacon & Abramowitz, 2009; Phoenix, 2018). Consequently, many clients miss out on best-practice psychological remedies.

Researchers there have turned their attention to the science of how to implement best practice as part of routine care (Lau, Merideth, Bennett, Crompton & Dark, 2017; Levin & Chisholm, 2016; McHugh & Barlow, 2010; Ordway, McMahon, Kuhn & Suchman, 2018; and Powell, Proctor, Bruno & Glass, 2013). Examples of this include *Improving Access to psychological therapies* (IAPT) model in the UK and the *VHA and National Child Traumatic Stress Network* in the USA (McHugh & Barlow, 2010).

The research emphasises that for effective practice implementation, mental health services and practitioners must apply evidence supported treatment models with appropriate delivery methodologies. It notes that effective implementation of EBP requires programs which take account of:

- evidence of cost and cost effectiveness (Levin & Chisholm, 2016)
- the challenges and barriers specific to the practice context and tailoring Implementation strategies to address them (Powell et al., 2013)
- stakeholder consensus on the best procedures for successful adoption and implementation of EBP (McHugh & Barlow, 2010) and

- an examination of training and clinical outcomes in ongoing fidelity monitoring (McHugh & Barlow, 2010).

The APS has identified that there is a lack of data demonstrating the extent to which the implementation of such interventions is occurring in third party funded accident and injury systems across Australia. In its submission to the Safe Work Australia National Return to Work Strategy Discussion Paper in December 2018 (Safework Australia Submission), the APS observed that the overall outcome of this

> *is the common, deleterious, long delay in workers being diagnosed and obtaining effective treatment. This stands in opposition to the paramount role evidence-based psychology interventions play in the recovery from workplace injury. Through focusing psychological treatment interventions more and earlier on work-related aspects and RTW, functional recovery in work can be substantially accelerated (Lagerveld & Blonk, 2012). Any delay in the implementation of these interventions inevitably contributes to the burden of psychological injuries.*

In the absence of evidence to the contrary, it is likely that such weaknesses apply similarly to SIRA and NSW compensable health care arrangements.

Nevertheless, the APS contends there is no logical reason nor any impermeable barrier to injured workers and RTA-affected members of the public receiving high quality, evidence-based health care in the personal injury schemes SIRA oversees in NSW. What is required to address the current under-performance is a commitment to improvements and strategies to address it.

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

There is a range of issues that need to be addressed to ensure injured workers and RTA-affected members of the public receive high quality, evidence-based health care. Across this submission, the APS emphasises that inability to achieve the timely, efficient and effective implementation and translation (hereafter abbreviated to implementation) of best practice psychological interventions to the issues of injured workers and RTA-affected members of the public is the obvious, critical gap that compromises the delivery of mental health services within the SIRA-oversighted schemes. The APS believes that the best practice methods for addressing the psychological issues of injured workers and RTA-affected members of the public are well-documented and that what is required to address this deficiency is the application of:

1. robust implementation mechanisms (especially early intervention with the promotion of the health benefits of recovery at work),
2. oversight and quality assurance processes,
3. elegant and robust outcome measurement and
4. the ongoing dissemination of findings about system effectiveness to the full range of stakeholders.

The APS contends that it is only through the development and introduction of mechanisms that address these requirements that SIRA can reasonably expect to identify and promote the:

- ability and willingness of practitioners to deliver EBP

- timely provision of clinically justifiable, efficient, effective and intensity and duration interventions
- attainment of objective, functional outcomes by injured workers and RTA-affected members of the public
- recovery and the restoration of the wellbeing and independence of injured workers and RTA-affected members of the public and
- authenticate that such treatments are actually being delivered.

This will not be achieved without a workforce supported to deliver EBP and strong objective outcomes within the scheme. The APS is unaware as to whether SIRA has system-generated data to illuminate the practices of participating practitioners. In the absence of such data, the current capacity of SIRA to identify the extent to which psychologist practitioners are able to utilise EBP treatments will remain unclear.

The APS proposes that to obtain data capable of informing action on this issue, a workforce capability analysis is required. It believes that a workforce capacity-building strategy will be key to achieving the delivery of the high-quality, evidence-based mental health care that SIRA seeks to fund for its clients. That can only occur successfully with meaningful consultation and partnership with the APS around targeted (survey based) research.

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

Consistent with the above observations, the APS believes there are a range of mechanisms which, if introduced by SIRA, will influence service provider willingness and capacity to work more effectively with SIRA and its clients to deliver best practice outcomes. These include:

1. Encouragement of earlier uptake of EBP by injured workers and RTA-affected members of the public. An early intervention approach to managing workers claims is essential where there is an accepted primary or secondary injury mental health condition. An example of this exists in Victoria, in a police mental health early intervention pilot around psychological injuries, involving VicPol, the WorkSafe authorised insurance agent and WorkSafe itself. Known as the *Victoria Police Pending Claim Intervention Project*, this project is aimed at ensuring the injured worker is steered towards receiving timely and appropriate treatment under the care of their treating health practitioner. It has achieved strong results since its introduction.
2. Clarification of system requirements and expectations around reporting, EBP and objective outcomes of recovery.
3. Provision of materials around mental health literacy early in the history of a claim to all stakeholders (including referrers, treaters, claimants, family and significant others and industrial bodies).
4. Educating of primary providers and other referrers as to what constitutes sound psychological practice[1]. This will need to target the most common psychological conditions.
5. Nuancing of the current SIRA delivery/entitlements model from one which focuses squarely on the individual with no regard to their social context to one which captures

[1] For example by reference to the Clinical Framework for and crucial practice guidelines - such as the Australian Guidelines on the treatment of Acute Stress Disorder and PTSD (Phoenix, 2013) and the Clinical Guidelines on the Diagnosis and Treatment of PTSD in Emergency Service Workers (in NSW) (Harvey, Devilly, Forbes, Glozier, McFarlane, Phillips & Bryant, 2015).

the full scope of the biopsychosocial approach. This would permit the extension of treatment entitlement to working with spouses, family members and carers. There is significant evidence that those parties are impacted upon by personal injuries to workers and RTA-survivors, and in turn affect the progress of treatment for these individuals. Models for the extension of care in this fashion exist in other third-party compensable systems such as the DVA funded Open Arms counselling service for current and former serving military personnel.

6. Creation of practice-influencing-incentives, including differential remuneration scales and accredited education and training opportunities for practitioners prepared to: (a) base their work with injured workers and RTA-affected members of the public on EBP and (b) engage in consultation and review around this work. Examples of this exist in other jurisdictions with a range of professions; for instance, in the WorkSafe Victoria early intervention physiotherapy framework and its expectations around governing KPIs.
7. An important consideration in developing such incentives will be to adequately address issues of practitioner supply and skill in regional, rural and remote (R, R & R) areas.
8. The introduction of a suite of distance-technology interventions that augment face-to-face work so that there is an increased capacity to intervene early and increase treatment intensity when required.
9. Introduction of robust and well-underpinned quality assurance and audit mechanisms; for example, in the form of clinical panel(s) which exist in schemes in other jurisdictions.

If such mechanisms are to have the desired effect, it is important that SIRA makes every effort to untie compensation entitlements from the need for treatment. The gains that will ensue from this for all parties (worker/accident survivor employer or employing organisation and insurer) by the adoption of a less adversarial approach to dealing with worker's compensation and RTA claims are significant. It is well documented that too often workers' compensation schemes across Australia act as illness schemes, the agents who administer them act in a counter-productive, confrontational and adversarial manner and the outcome of workers making compensation claims are disputes. Various reviews of the conduct of workers' compensation schemes conducted across Australia in the last decade support this view. The *APS Safework Australia Submission*, for example, noted the Victorian Ombudsman's (2016) *Investigation into the Management of Complex Workers Compensation Claims and WorkSafe oversight* observed the:

- unnecessary claim disputation that was doomed to failure and ultimately did not succeed, but occurred over extended periods of time up to and including quasi-legal fora
- prejudicial (via ignoring or omitting) use of evidence and quotations from the reports of Independent Medical Examiners (IMEs) in its justifications for decisions
- selective use of IME opinions that suggested fishing expeditions when the overwhelming evidence obtained was to the contrary
- reaching of incorrect decisions based on the facts
- posing of leading questions by IMEs (to obtain preferred answers, thus rendering those experts non-independent)
- impact of these practices on the worker's recovery and
- more-than-occasional description by claimants of the behaviour of the insurer as bullying.

The Victorian Ombudsman's report of 2019 reinforced the findings of the 2016 report and found ongoing problems requiring 'wholesale changes to the system'.

Such an environment leads to worker disgruntlement and anger, which in turn creates or exacerbates mental health problems and results in poorer treatment outcomes.
The APS emphasises that it is critical that the take up of any such mechanisms occurs with involvement of key stakeholders, including expert practitioners and entities and professional associations. Given (a) the rise in SIRA's claim treatment profiles pertains to mental health claims and (b) the fact that psychological treatment is the core EBP intervention for the conditions involved in workers compensation and accident schemes, that consultation must include peak bodies who represent practitioners in the mental health field. This inevitably includes the APS.

Members have stressed the importance of injured workers and RTA-affected members of the public who are psychologically impacted by stress and trauma related mental health conditions (S&TRMHCs) or their symptoms having access to psychological interventions provided by expert treaters. To this end, it is vital that insurers and oversighting authorities (like SIRA) can confidently identify practitioners who have demonstrated expertise in the use of EBP for S&TRMHCs. The development of commonly shared authenticated lists of practitioners is one option that could be explored.

As part of this, it will, at a minimum, be critically important that expert and professional peak bodies are used to design and deliver training and drive practice informed by the science of implementation that is reviewed for its effectiveness.

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)?

It is critical that the reasons for the significant increase in service utilisation are identified by SIRA. While the APS has no evidence on which it can base its response to this question, anecdotally it is aware of several factors that may possible be contributing to it.

The APS understands that a marked increase in service utilisation was first observed in the 2015-16 year. Given that the reform to the administrative arrangements in NSW (resulting in the creation of SIRA) occurred in 2015, the possibility that some change to the management of administrative data sets is a contributor to the observed increase should (if not already) be explored.

The APS considers that increasing service utilisation also reflects a known general increase in mental ill-health awareness and service seeking. In addition, commonly seen conditions (such as PTSD and chronic pain) are conditions known to require significant treatment to bring about clinical change. These factors in combination could be expected to influence service utilisation, although not to the magnitude observed. The APS acknowledges the investment SIRA is making in NSW around the consolidation of knowledge regarding what contributes a mentally health workplace.

The APS suspects that there is a need to enhance the knowledge of some practitioners around how to effectively and efficiently treat "psychology" presentations that are common to SIRA environment. The APS is also aware that there can be an inability among practitioners to meaningfully influence the frequency with which injured workers and motorists seek treatment. It has heard from members about scenarios involving isolated, angry and (often quasi) suicidal injured workers and RTA-affected members of the public who challenge clinical decisions about service provision.

Under circumstances where there is a lack of knowledge about what represents dose-effectiveness relationship and a lack of guidance from the professions around what works and in what intensity, it can be difficult for practitioners to speak with authority around limit setting.

Consequently, treaters can feel pressured to agree to see claimants beyond what they might judge to be a sufficient intensity and detrain of service.

The APS also considers that there is insufficient quality assurance within workers third party compensatory systems generally. Thus while there are clear policies and protocols within schemes like those that SIRA administers, there is a need for practical checks and balances across the system to ensure compliance.

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?

The APS acknowledges that fee-setting provides a clear mechanism for influencing behaviour. It is the view of the APS that the current fee structure does not align with other insurers nor does it reflect a market rate that would encourage psychologists (particularly those with Area of Practice Endorsements who are required for complex cases) to participate in the scheme. SIRA may wish to consider the APS recommended fee schedule, and its blueprint for better mental health outcomes through Medicare (paper *The Future of Psychology in Australia*), both of which are available on the APS website (www.psychology.org.au).

The APS reiterates previous comments re incentives (see question 1.3) and what SIRA and its clients will gain by tying fees to demonstrated outcomes. It is also important to develop objective outcome measures for use by practitioners.

2.2 How could SIRA appropriately set and index private and public hospital fees with the aim of better outcomes?

[and]

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

It is important that SIRA sets fees that lead to better service delivery and objectively identifiable outcomes in private and public hospitals and among allied health professional.

Fees should be linked to outcomes that are objectively measurable. For hospitals this is more easily done in outpatient settings. Practitioners in these settings should be subject to the same requirements as generally apply to practitioners; that is, there should be no differentiation in what is expected of a practitioner based on the location from which they practise.

Inpatient admissions are more complex, but need to be subject to clear goals and expected outcomes. Given hospitals are multi-disciplinary environments, it is important that cross-profession collaboration occurs around the goals of treatment, the treatment intervention programs deployed and the outcomes of care. This can only be effectively achieved via collaboration with the professions.

With respect to indexation, the APS acknowledges that the current indexation arrangements are ensuring that fees are keeping pace with CPI pressures. However, as CPI does not measure changes in practice costs, the APS recommends that SIRA review the appropriateness of CPI as the indexation factor for psychological services.

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

The use of public money to fund treatment in third party funded compensable systems must be limited to those professions specifically trained in and willing to deploy EBP and subject to national regulation. It is contrary to the interests of all stakeholders to create and maintain systems which act otherwise.

The APS is not aware that there is a deficiency in the supply of practitioners overall (for example, as measured by supply-driven waiting times), although there are issues of geographic distribution that apply to all health professions. The APS is unaware of any data to demonstrate a deficiency in the overall supply of practitioners and therefore it is not clear what problem is being targeted in entertaining this possibility. To the extent that it relates to addressing issues of geographic spread, the APS considers the better response to be to incentivise the existing workforce to provide services in under-supplied areas.

The APS considers that SIRA does not need more health practitioners operating in its environment without a clear commitment to the implementation of EBP. Rather it needs professionals who are already trained in and understand the importance of EBP and will work diligently to implement it. The training, willingness and capability of other professionals to do this must be assessed on a profession-by-profession basis.

The APS Code of Ethics - which has been adopted as a matter of national law - and its subsidiary Ethical Guidelines make clear that psychologists have an obligation to deliver EBP. The Code states

> *General Principle B: Propriety*
> *Psychologists ensure that they are competent to deliver the psychological services they provide. They provide psychological services to benefit, and not to harm. Psychologists seek to protect the interests of the people and peoples with whom they work. The welfare of clients and the public, and the standing of the profession, take precedence over a psychologist's self-interest.*
>
> *B.3. Professional responsibility*
> *Psychologists provide psychological services in a responsible manner. Having regard to the nature of the psychological services they are providing, psychologists:*
> *(a) act with the care and skill expected of a competent psychologist;*
> *(b) take responsibility for the reasonably foreseeable consequences of their conduct;*
> *(c) take reasonable steps to prevent harm occurring as a result of their conduct;*
> *(d) provide a psychological service only for the period when those services are necessary to the client;*
> *(e) are personally responsible for the professional decisions they make;*
> *(f) take reasonable steps to ensure that their services and products are used appropriately and responsibly;*
> *(g) are aware of, and take steps to establish and maintain proper professional boundaries with clients and colleagues; and*
> *(h) regularly review the contractual arrangements with clients and, where circumstances change, make relevant modifications as necessary with the informed consent of the client.*

Key to this is SIRA working with peak bodies to influence practitioners to deliver EBP in the NSW compensable health care system. Where this cannot be guaranteed, the APS believes that SIRA will do well to create a mechanisms to review the capacity of practitioners to work in SIRA auspiced compensable schemes.

Consultation area 3. Improving processes and compliance

3.1 What could help improve administrative processes - including reducing paperwork and leakage - for providers, insurers and other scheme participants?

The APS views the administrative processes employed by SIRA in relation to providers, insurers and other scheme participants as generally satisfactory. Nevertheless, it proposes that there are several actions which, if undertaken, could lead to improved administration of the compensable Schemes for which SIRA has oversight.

Initially, the APS believes that some redesign of existing forms and accompanying instructions (i.e., by the description of care bundles) will be important to the guiding practitioners more effectively.

It also believes that there could be enhanced claims management by the introduction of training for practitioners and claims managers by peak bodies around the issues around claim processes and claim administration. This could (and should) occur independently and jointly for both populations.

There are a number of practical, easily implementable actions that the APS strongly suggests that SIRA implements. These include:

- Reduction of IME usage and replacement of their reports with reports requested from THPs
- Automatic provision of IME, Medical Panels Australia etc. reports to THPs and
- Reduction of IME usage around treatment questions.

The APS would welcome the opportunity to assist SIRA in implementing such system improvements.

3.2 What enhancements to claims administration requirements would help ensure scheme sustainability and improve understanding of the outcomes being achieved?

The APS acknowledges that recently there have been several very helpful amendments to the SIRA claims administration system. These changes include:

- treatment pre-approval
- streamlined reporting
- better understanding among insurers of evidence-based practice, regular treatment reviews by experienced consultants
- case conferencing items for allied health professionals and
- the creation of plain language descriptions of scheme processes for claimants and practitioners.

These changes have improved the administrative elements of the system and removed key barriers to improved outcomes. Nonetheless, the APS believes that there is a range of activities which, if introduced by SIRA, is likely to lead to additional scheme improvements. Added to the business-as-usual improvements to processes identified in question 3.1 immediately above, the

APS believes that further system enhancement is required to ensure scheme sustainability and goals. Possibilities that SIRA may wish to explore include:

- collaboration of IMEs and THPs in reviews where they are related to treatment entitlements and
- better identification of secure transmission of information from and to scheme agents and the introduction of increased quality assurance mechanisms in a variety of forms, such as the aforementioned clinical panels and satisfaction surveys consumers.

The involvement of the APS is essential to the implementation of such enhancements.

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?

Monitoring, data collection and reporting are essential to scheme sustainability and improve understanding of the outcomes that are being achieved. The APS believes there are actions, which if adopted by SIRA, will lead to those outcomes. They include:

- Improved uptake of information and knowledge around processes and what is required for treatment approval
- Development of a set public domain suite of empirical psychological measures to guide review of treatment outcomes
- Development of a suite of objective measures for determining treatment outcome
- Training around such measures for clinicians and claims managers in relation to the requirement for evidence and
- The introduction of a “clinical panel” and teams of experts to collaboratively assess and review treatment needs for cases with highly complicated biopsychosocial presentations.

The involvement of the APS is essential to the implementation of such developments.

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?

The adoption of a value-based care approach is fundamental to the continued utility of SIRA. The funding of ineffectual treatment to those who sustain workplace and RTA-related injuries is contrary to the interests of all stakeholders.

Plain language descriptions and statements for claimants and practitioners about:

- what constitutes psychological evidence-based practice for the typical presenting conditions for the scheme (see question 1.1, page 1)
- claim/scheme processes and
- the bases on which treatment will be approved.

The involvement of the APS in promoting value-based care and training and educating practitioners about it is essential.

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

There are two highly important strategic actions that SIRA can undertake that are likely to lead to better understanding of personal injury schemes and lead to better outcomes and patient experiences within those schemes. The first of these is for SIRA to increase its top-down and bottom up consultative processes with stakeholders. Highly pertinent examples of good quality consultative processes which provide important feedback to government agencies exist elsewhere. The APS would be happy to expand upon its experience of the consultation that occurs in those schemes.

The other key strategic action is for SIRA to utilise the levers already at its discretion and the suggestions made available to it from this consultation to better enforce the requirements for health providers under the schemes it administers. Partnering with the APS to more assertively and promptly address the problem of workplace psychological injury via evidence-based preventive interventions and treatment will make this easier for SIRA to accomplish in the mental health space.

Consultation area 5. Any other issues

There are no new issues to introduce. The APS again thanks SIRA for the opportunity to submit to this consultation and emphasises its interest in working with SIRA to address the issues confronting it in “psychology claim” administration.

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