AUSTRALIAN CLINICAL PSYCHOLOGISTS (ACP)

Level 7, Park House
187 Macquarie Street
SYDNEY NSW 2000

Telephone: (02) 9221 9292
Facsimile: (02) 9221 9140
Mobile: 0411 159592

Joe Gubbay
Clinical Psychologist and Neuropsychologist
B.Sc.(Psychol.)(Hons.), M.Psychol., M.A.P.S.

Productivity Commission Inquiry –

National Workers' Compensation and

Occupational Health & Safety Frameworks

Submission by Joe Gubbay, Clinical Psychologist and Neuropsychologist, Australian Clinical Psychologists (ACP)

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Preamble

This submission is based on my experience as a clinical psychologist and neuropsychologist intimately involved in the assessment of workers for psychological or psychiatric injuries, as well as cognitive impairment secondary to brain injury. In addition, I have conducted research into malingering or feigning of psychological conditions and brain injury. While assessment work has been the majority of my work in private practice, I also provide treatment for a range of clinical conditions, often resulting from workplace accidents, and I continue to provide assessments to assist in the rehabilitation process. As a clinical psychologist, I have completed six years full-time training at university, two years supervision, and I am required to complete ongoing education.

Definition of Psychological or Psychiatric Injury

By far the most widely used system for diagnosis of psychological or psychiatric conditions is the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; American Psychiatric Association, 1994). It would be difficult to argue for a different system of diagnosing mental disorders, as this standard system is widely used in research, clinical practice and the legal system. Generally, a diagnosis can be made if a person has symptoms of emotional disturbance and either significant distress or functional impairment.

Once the presence of an injury has been established, the question of impairment must be addressed. It is possible to have a mental disorder, but to have little or no impairment of functioning. Meeting the criteria for a specific diagnosis does not indicate the degree to which a person might be impaired. Thus, a system to determine the degree of impairment is required. Such a system should meet scientific criteria, as demonstrated by research.

The most widely used systems are those developed by the American Medical Association Guides to the Evaluation of Permanent Impairment. While the latest version, the fifth edition, is used in some jurisdictions, like some predecessors it does not provide percentages for impairments relating to emotional disturbance, and it is not uncommon for assessors to resort to the second edition, which contains percentages. In practice, it would be simple to define a threshold based on the classification of a moderate impairment or worse. A numeric system could be transposed based on other sections and previous editions. The AMA Guides is my preferred system at present.

An alternative system currently in use in New South Wales is the Psychiatric Impairment Rating Scale. This scale fails basic requirements of rating scales, with no evidence of validity. The lack of science behind this scale renders it grossly inappropriate. Students conducting research would fail if they were to rely on instruments of such poor quality. One disturbing aspect of the scale is the failure to focus on impairment, with functioning across six domains averaged, ignoring the worst aspects of impairment. Percentages that are applied are arbitrary, and grossly inadequate. For example, take the case of a man who frequently fails to eat and cannot shower without prompting, cannot go out unless accompanied by someone, cannot get past the local shops alone, has had his children removed by the Department of Community Services, cannot read more than a newspaper article, but can work 20 hours a week. If these impairments were permanent, he would receive an impairment rating of only 11%.

The World Health Organisation (WHO) has developed a detailed assessment guide, the International Classification of Functioning, Disability and Health (ICIDH-2), though it is still considered in draft form because of the status of research. It must be pointed out that over 1000 researchers have been involved in researching this guide, compared with less than ten psychiatrists who developed the PIRS without any validation work. The Australian Institute of Health and Welfare, based in Canberra, can provide additional information. I suspect that some modifications would be required, but the system is much more comprehensive than any other.

Definition of Cognitive Impairment / Brain Injury

The gold standard for detecting and documenting impaired brain functioning is the neuropsychological assessment. What is most important is not the site or size of a lesion; what matters most is how the injury affects the person's functioning. Tests like IQ tests and memory tests provide a comprehensive profile of a person's functioning. Test performance is the best single predictor of future occupational functioning – stronger than duration of loss of consciousness or CT scan results.

The AMA Guides provides percentages for impairment secondary to brain injury, but the relevant section is poorly organised, reflecting a rather outdated conception of brain function,

and is heavily reliant on impairments of activities of daily living. Alternatively the ICIDH-2 utilises a modern organisational structure for brain functioning, and with some minor modification a system for rating impairment could be derived. In any event, a neuropsychological assessment will be a prerequisite to any impairment assessment.

Implications of Loss of Access to Multiple Opinions

The assessment of both psychological and brain injury is imprecise. It is not unusual for opinions to differ markedly. I believe that it is not feasible to expect a claimant to have to rely on one opinion if the claimant believes it to be incorrect. Forcing a claimant to abide by one and only one assessment renders the claimant unable to seek redress when an error has been made. Some might argue that the high level of disagreement between assessors is a function of the referral source; I must disagree. The vast majority of assessors, in my opinion, conduct assessments fairly. Nor do I believe that a panel of experts will solve this problem, as research shows that groups tend to have more extreme views than constituent individuals, and it is likely that peer pressure will see minority opinions being suppressed. I believe that one consequence of the NSW legislation is that claimants can no longer seek a second opinion, apart from extreme circumstances. Claimants must be able to provide their views, and insurers must be able to provide theirs.

Appropriate Treatment for Psychological Injuries

The most common psychological or psychiatric injuries in the workplace include Major Depressive Disorder, Adjustment Disorder and Posttraumatic Stress Disorder and other Anxiety Disorders. The treatment of choice for these disorders is generally psychological in nature. There is a wealth of research demonstrating that cognitive-behavioural therapy in particular is the most effective treatment for Posttraumatic Stress Disorder, Panic Disorder, Agoraphobia, Specific Phobias and other similar conditions. It is equally effective to medication in the treatment of depression.

Given that psychological treatment is most likely to be the treatment of choice following a work-related psychological injury, and given that psychologists are generally cheaper per session and require fewer treatment sessions than psychiatrists, any rehabilitation system should include psychologists in the assessment and treatment process. Psychologists should be utilised early in the claim process, given that the likelihood of success diminishes the longer a condition remains untreated.

Medicare and Psychological Treatment

It is inevitable that a proportion of work-related treatment costs will be borne by Medicare. While not within the scope of this inquiry, psychological treatment is not covered by Medicare, whereas psychiatric consultations are covered at a rate of about $140 per session. One consequence is that states tend to shift costs to the Federal Government by focusing on psychiatrists. Psychological treatment is cheaper and more effective for the vast majority of work-related injuries. This cost-shifting therefore results in increased cost and a reduction in efficacy, and a resultant increase in time off work.

Fraudulent Claims

It is no secret that a significant number of claimants exaggerate or feign impairment. This phenomenon is not limited to Australia. The assessment of malingering is a scientific endeavour based on a large and growing body of research, including work by Australian researchers. Malingering of brain damage and psychological injury can be assessed using specific tools designed for that purpose. In some jurisdictions in Canada, assessments following head trauma must include the administration of at least two such tests.

Standardised assessment of malingering is restricted to psychologists. I have personally identified at least 50 individuals over the past five years who were feigning impairment and who otherwise could have been successful. Conversely, relying on unsubstantiated opinion can result in genuine claims being incorrectly rejected. Brain and psychological injuries tend to be among the most expensive. Any system should ensure that assessors are able to assess malingering using validated instruments and techniques.

Inclusion of Psychologists

It should be clear to the Commission that psychologists have played an important role in the assessment and treatment of injured workers for many years. Recent legislation in NSW took a surprising and unique step in excluding psychologists. The Productivity Commission should ensure that any national system include psychologists, for several reasons. We are trained and experienced in the assessment process. We have relevant experience in assessments within workers' compensation and other forensic, clinical and research arenas. We are the providers of the treatments of choice for psychological injuries sustained in the workplace. As the treaters of choice, we are in the best position to assist in rehabilitation, and to determine emotional and functional prognosis, including permanent impairment, secondary to psychological injury. In the case of brain injury, only psychologists are able to conduct neuropsychological assessments that provide the only standardised measures of cognitive function, which in turn are the best predictors of outcome. Only psychologists are able to assess malingering using scientifically validated tools.

I would be happy to provide additional information to the Commission. While these views are my own, they are shared by many psychologists.

Yours faithfully

Joe Gubbay.