CORRECTED

REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE No. 1

INQUIRY INTO THE REVIEW AND MONITORING OF THE NEW SOUTH WALES WORKERS COMPENSATION SCHEME

———

At Sydney on Thursday, 7 March 2002

———

The Committee met at 10.15 a.m.

———

PRESENT

Reverend the Hon. Fred Nile (Chair)

The Hon Ron Dyer (substituting for the Hon Tony Kelly)
The Hon. Michael Gallacher
The Hon. Greg Pearce
The Hon. Dr Peter Wong

JULIAN PARMEGIANI, Forensic Psychiatrist, 1208/370 Pitt Street, Sydney, sworn and examined:

CHAIR: I welcome the media and members of the public to this public hearing of General Purpose Standing Committee No. 1 inquiring into the review and monitoring of the New South Wales Workers Compensation scheme. I ask that all those present turn off their mobile phones during the proceedings. The Committee has previously resolved to authorise the media to broadcast sound and video excerpts of its public proceedings. Copies of the guidelines governing the broadcast of proceedings are available from the table by the door. I point out that in accordance with the Legislative Council guidelines for the broadcast of proceedings, members of the Committee and witnesses may be filmed or recorded. People in the public gallery should not be the primary focus of any filming or photographs.

In reporting the proceedings of this Committee the media must take responsibility for what they publish or what interpretation is placed on anything that is said before the Committee. Witnesses, members and their staff are advised that any messages should be delivered through the attendant on duty or through the Committee clerks. I advise that under Standing Order No. 252 of the Legislative Council evidence given before the Committee and any documents presented to the Committee that have not yet been tabled in Parliament may not, except with the permission of the Committee, be disclosed or published by any member of such Committee or by any other person.

In what capacity are you appearing before the Committee?

Dr PARMEGIANI: As a citizen, I presume. I have not been asked by anyone else to appear, apart from this Committee.

CHAIR: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act 1901?

Dr PARMEGIANI: Yes.

CHAIR: Are you conversant with the terms of reference of this inquiry?

Dr PARMEGIANI: Yes.

CHAIR: If at any point during your evidence you wish to have this become a closed session in camera the Committee is willing to accede to your request.

Dr PARMEGIANI: Thank you.

CHAIR: As you realise, other witnesses will be discussing the PIRS scheme. We thought we should hear from the author; then we know exactly what the aim of the PIRS scheme is. We would like you to present that information to us now.

Dr PARMEGIANI: I was one of the four authors of the PIRS, the others being Dr Derek Lovell, Dr Rod Milton and Dr Yvonne Skinner. We are four psychiatrists in private practice who were first brought together by a consultant in 1999, a Mr Jim Stewart, who obtained my name from Dr Michael Epstein from Victoria who is an expert on impairment. Dr Stuart had the brief at the time to assemble a group that would look at psychiatric impairment for the Motor Accidents Act. He had done some work in Victoria and he got my name from Dr Epstein, whom we had as a speaker. Because of my longstanding interest in psychiatric impairment, he suggested my name.

So we assembled this group and we looked at different methods of assessing psychiatric impairment. We looked at all methods available at the time, including various scales that had been used both in Australia and overseas, and we found that in a forensic setting none of those scales was suitable and I will explain very briefly why. First, we felt that in a forensic setting in an adversarial proceeding the normal scales that we use in private practice, which we all like and respect, were not appropriate because people had other incentives apart from getting better than to score highly on those scales. This was a problem that was already encountered in litigation over many, many years and I think also subject to a previous parliamentary committee into victims compensation that found that psychiatric claims were being abused to a large amount—over 70 per cent of claims to the VCT were actually psychiatric. The Committee found, after hearing evidence, that many of those claims were suspicious.

At that point we decided that we had to find a better instrument to rate psychiatric impairment. First of all we started from the principle that behaviour speaks louder than words. In other words, if you have a psychiatric illness it will affect you in a very visible way. If you are severely depressed it will have a major impact on your relationship, on your ability to travel, on your ability to enjoy life, recreational activities, concentrate, do purposeful things. We felt that it would be perhaps an innovative and better way to measure how people were affected by their psychiatric illness and we devised those criteria. Basically, we look at six areas. We could look at many more but the assessment had to be done within a certain amount of time and we could only focus on the major areas. For those areas we took inspiration from the AMA four guides and they mentioned things like relationships, travel, concentration, adaptation of pace and so on.

We developed descriptors from "normal" to "total and complete". Those were the two easy ones like zero, what is normal, and what is total. So we only had to develop mild, moderate and severe for each area of function, and we did that. We also focused on behaviours that were observable independently. In other words, if someone said they could not do all these things they were things that were observed or not observed quite publicly. In other words, if someone said, "I am too depressed to go out and enjoy myself", that commits them to that symptom or that behavioural manifestation of illness. So if they are observed by private investigators, neighbours or other people to be going out to the pub or dancing or going to football games, that is inconsistent and it is visible and basically means that they have perjured themselves if they say that.

When you replicate that across six areas you end up with a fairly clear and verifiable description of how people function in a very public setting, in a setting that can be confirmed and observed. We put the scale together and circulated it to numerous people back then, including professors of psychiatry, solicitors. Some of the feedback led to some mild to moderate changes to the scale until we will all happy with it. Eventually it was gazetted by an Act of Parliament in early 2000. That scale then went on to be adopted by Tasmania. It is going to be adopted, as I hear from Comcare; the Australian Government Solicitor has accepted it as a preferred instrument. For that reason I assume WorkCover contacted me and the other parties to be part of a committee to look at rating scales and to see whether we could apply the PIRS to WorkCover.

We came together and we felt that it had to be extended for the purposes of assessing injured workers. The Motor Accidents Authority legislation was only interested in a threshold of greater than 10 per cent or less than 10 per cent. WorkCover New South Wales was interested in a score of between zero and 100. So we had to develop a method of making those six areas of functions add up to a score of between zero and 100. That is how the PIRS was created. By way of background, I have had a long-term interest in the assessment of psychiatric impairment and I will be happy to table my CV for the Committee to see that I have not come into this six months ago or a year ago, as has been alleged, but that in fact this is what I do for a living.

CHAIR: We are happy for you to table that CV.

Dr PARMEGIANI: To explain how the PIRS works, I brought the scoring I did on my last assessment, which was for the Motor Accidents Authority. It is the case of a young woman with a child who was injured in a motor vehicle accident. By the time she came to my assessment approximately a year later she was basically living at home. Her mother was looking after her, preparing food for her, encouraging her to dress, otherwise she would spend the whole day in her pyjamas. Her mother had taken over full care of her child. She never left the house unless her mother came with her because she was too anxious, too nervous. She tried to study but could not make it to TAFE and she could not concentrate. In terms of social functioning, she had not formed any relationships. In fact, she lost all her friends, which in turn made her more depressed. The diagnosis was that she had become severely depressed. Basically she could not work.

I will table this. The woman has been de-identified. I will call her Mrs Smith. You will see how it is scored. Basically, she has an impairment score of 44 per cent, so she was quite impaired. This is my report to WorkCover and anyone can ring up and get a copy if they wish, suitably identified. People do get above 10 per cent. They do get above 15 per cent. Clinically, they do get above the threshold of 15 per cent but they are impaired.

CHAIR: You say the lady came to you a year after the accident.

Dr PARMEGIANI: She was referred to me as an independent assessor by the Medical Assessment Service, which is part of the Motor Accidents Authority, saying they had lodged a dispute, the insurer and the plaintiff, and they would like the issue of psychiatric impairment assessed because if she is greater than 10 per cent she gets compensation for non-economic loss. Clearly, the woman is 44 per cent impaired.

CHAIR: How do you relate the disorder to the accident?

Dr PARMEGIANI: The temporal relationship is the most crucial thing. This woman was happily getting on with life. She was in a relationship and looking after a child. She was very social. After the accident she changed completely. After interviewing her I interviewed her mother, who confirmed the story. She said, "My daughter is very sick; what should I do?" I said, "That is not my task, but I will give you a copy of the report and hopefully there will be a treatment." That is the setting in which I saw that woman.

CHAIR: Are you aware of the criticism, which we have heard in other forums, that other psychologists misunderstand how the PIRS works? One comment is that your scheme is harsh and excludes the most severe cases. I do not understand what they mean by that. Do they not understand your system?

Dr PARMEGIANI: That is a problem, as is lack of experience with it. I have dealt with a number of cases for the Motor Accidents Authority, as have a number of my colleagues—about 60 psychiatrists have been trained. I tried to obtain figures from the Motor Accidents Authority as to how many people get over the 10 per cent threshold. At present, more than one in 10—or about 12 per cent or 13 per cent—people get over the 10 per cent threshold. That does not seem like many, but in private practice most of my patients would get much more than that. Many claims are made by people who do not score very highly because they are getting on with their lives: their relationships are the same, many are working, going on holidays and travelling overseas. That is a distinct and different population from the one I see clinically. Many claims are rejected because there are no manifestations of the disorder claimed. Claims are easily verifiable. People may claim to have disorders but they have not changed at all; when they have, it is measurable, verifiable and there is no argument about it.

The Hon. RON DYER: Do you believe the scale is working well in practice?

Dr PARMEGIANI: It is certainly differentiating between people with genuine illnesses and people who want a lump sum at the end of the process. Some people are angry and want some sort of recompense. They have no mental illness; their life is normal. However, they believe they should receive something for what has happened to them. That is understandable—people may have lost their car, it may have been a very frightening experience and the other person may have been negligent. People are very angry and think they deserve something but they are suffering no psychiatric illness or disorder. I understand where they are coming from and I have suggested to the Motor Accidents Authority that perhaps it should set aside something for pain and suffering to acknowledge this problem. However, it should be kept apart from psychiatric impairment.

I think it is cruel to make people jump through hoops to prove they are mentally ill when they are not; they are just angry. They feel hard done by and they want justice and financial compensation, but they are not mentally ill. They are labelled as having some mental illness from which they do not suffer. Sometimes they have to lie. I do not think it is particularly good to make people who are angry go through the psychiatric gateway—it makes psychiatrists appear foolish, solicitors appear dishonest and judges seem not very wise. If a mental illness is not observable the community and relatives and friends of the person will see that he or she has nothing wrong but has made a psych claim and received $15,000, $20,000 or $50,000. That sends the wrong message to the community and awards to people not suffering psychiatric illness money that they may or may not deserve.

The Hon. RON DYER: Do psychiatric practitioners generally consider the guidelines to be appropriate?

Dr PARMEGIANI: We have had very good feedback from those who completed the training and are applying it for the Motor Accidents Authority. Before the legislation was passed last year I circulated a letter to that effect from one of my colleagues and many other colleagues have subsequently either spoken or written to me saying that this is a good system. They are happy with it and support it.

The Hon. MICHAEL GALLACHER: You talked about the six areas that you look at. Can people be on an emotional roller-coaster: feel good one day and be spotted having a great time at a restaurant or a barbecue, and then fall into an emotional trough again? Can people suffer highs and lows such as that?

Dr PARMEGIANI: I would be highly suspicious of a history like that. People who suffer from a psychiatric disorder tend to be affected consistently to the point where it is reflected in their life. Look at the criteria for PIRS: first, there must be a diagnosis. This means that a person must have symptoms that are consistent with some clinically recognised condition. If a person has that impairment he or she will have an impairment score for a permanent condition. I think it would be very unusual for a person to be a Jekyll and Hyde—which is the media

perception of someone with a mental illness—and be normal one minute and mad the next. That occurs in cases of severe schizophrenia, but such people are also impaired in many other areas.

The Hon. MICHAEL GALLACHER: Have you looked across occupations to see which tend to have a higher level of psychiatric or psychological disorders?

Dr PARMEGIANI: Absolutely. It may be bias from my practice, but I have seen many police officers and teachers. It is the nature of their job that police officers are exposed to a lot of trauma and as a result develop severe and debilitating symptoms. Many officers will pass the lower threshold and some may be completely disabled. As for teachers, unfortunately the composition of our schools has changed and they are now subjected to violence and abuse. As a consequence, they also develop psychiatric conditions such as depression and post-traumatic stress disorder.

The Hon. MICHAEL GALLACHER: How many police officers do not make the 15 per cent threshold?

Dr PARMEGIANI: I do not have those figures. I tend to see those in the most severe range.

The Hon. MICHAEL GALLACHER: Are you aware that the Opposition tried to exempt emergency service workers during the passage of the legislation?

Dr PARMEGIANI: Yes, I am aware of that.

The Hon. MICHAEL GALLACHER: Do you have a view about that?

Dr PARMEGIANI: Yes, I think ultimately it would do them a disservice. Frankly, many police officers are not happy in the Police Service at present and are looking for a way out. I understand and sympathise with them. They say, "I've served my time and put my life on the line and this is the thanks I get." Regardless of what people say, I think there are still problems with the structure of the Police Service and many officers are making psychiatric claims—it has been happening for some time. Employers and solicitors are aware of this and so they fight the claims.

However, the problem is that some officers who have been genuinely traumatised and who develop symptoms—they become alcoholics, their marriages break down, they cannot watch the news because there might be a story about a shooting involving police officers and they feel sick and vomit—are labelled as dishonest by their employers, who say, "There's no such thing as a stress claim; you guys are all the same." If we can differentiate those with a genuine disorder, compensate them adequately and treat them and so on, I think the Police Service as a whole would be better served. That is better than getting all claims through or knocking them all back as is happening at present.

The Hon. Dr PETER WONG: To be fair, there is a difference between psychological and psychiatric disorders. A person who is involved in an accident could be psychologically affected and his or her mood could change. That is possible. From time to time we become depressed without suffering from depression. Dr Parmegiani talked about depression, which is a mental illness and involves a much higher scale. People with a psychological disorder could feel well enough to go to a restaurant occasionally. Depression is totally different.

Dr PARMEGIANI: People have a range of emotional states. That is normal and is part of the human condition. People get very angry, upset and down when something bad happens but eventually, in time, they feel better and get on with their lives. That is not an illness; an illness is when 10 people like us are presented with the facts of a case and say, "You should have come out of it by now. The accident occurred two years ago and you are still moping; what's wrong with you?" That is an illness: it is not the normal psychological response to stress.

The Hon. Dr PETER WONG: The problem in this case is that impairment must be associated with severe mental or psychiatric illness before people receive compensation.

CHAIR: The current scheme seems to exclude psychologists from doing assessments. The assessment process appears objective so why could psychologists not do it?

Dr PARMEGIANI: I was never asked about that. WorkCover decided a number of things without input from psychiatrists—one is the threshold and another is who does the assessments and so on—so I am not in a position to answer that question. It is a matter for WorkCover. On the surface it is a simple scale designed to be

understood by non-psychiatrists. One of the principles of the scale is that it should be fairly clear and transparent to solicitors who must handle the claims, to claims managers from insurance companies and ultimately to all parties involved. I think there is an argument that psychologists should be able to do the assessments. That is not a decision for me—although I have certainly been attacked a lot on that point.

CHAIR: Earlier you referred to those who have done the training so that a psychologist would know how to use this method.

Dr PARMEGIANI: I suspect that psychologists will do them, but not for either WorkCover or the Motor Accidents Authority. As the legislation stands the only people who do them are doctors with a medical degree. However, before a person sees an independent medical assess that person has been through the system, seen legal counsel, insurance companies have had to assess the claim and probably a lot of psychologists will examine and manage those claims because they have an understanding. There will be a magnitude of work between the people doing assessments for government authorities and the number of assessment done out there. The number of assessments doctors do will be only a minor component of the overall picture. The majority will be done out there by others.

CHAIR: The psychiatrist will have the final word?

Dr PARMEGIANI: If there is a dispute between the plaintiff and insurer there will be referral to a psychiatrist, as the sole arbiter or what have you. But if there is no dispute—and that is what everyone is hoping for—the plaintiff will go to a solicitor and/or be referred to a psychologist and get a rating, which is transparent. That rating then goes to the insurer. The insurer will look at it and may have a psychologist or other health professional who uses the system say, "It is obvious." They may decide to put surveillance on the person and find out that the person really does have those symptoms, and then there is no conflict and it is never referred to the psychiatrist in WorkCover or the Motor Accidents Authority. The more transparent and easy it is the more likely it is not to degenerate into the adversarial process, which is a big problem when people use the narrative to decide what the level of impairment will be.

CHAIR: In some ways it will be a trial period, and if it breaks down it will have to be reviewed.

Dr PARMEGIANI: Absolutely. One of the things that people have said is that PIRS is not validated. It is a new instrument. It has been used now for two years in Motor Accidents. People are happy with it. It seems to be doing what it is meant to do. Having said that, I have yet to see research articles to support the use of other measures in terms of percentage. In the beginning, as part of this working group—in fact two years ago—I did a lot of searches and a lot of database searches looking at instruments, and there really is not anything that is used in the forensic setting where people say, "We have given this to 100 people. We have measured everything out and we think this is a good instrument." I have not seen that.

The Hon. RON DYER: Are you referring to jurisdictions generally, distinct from New South Wales?

Dr PARMEGIANI: No, I am referring to psychiatric and psychological literature to show that a particular instrument has been studied with a group of people within a forensic setting where it actually shows that it is working. It would have made our job a lot easier to follow that, if it existed.

The Hon. RON DYER: You are referring to international experience, though?

Dr PARMEGIANI: Anywhere and everywhere. It is international because all journals can be searched electronically.

CHAIR: If other questions arise during the day would you be happy for us to send them to you in writing?

Dr PARMEGIANI: More than happy. I probably should table a couple of other things in response to various things. I am sorry I have to defend myself but, as you know, there have been conferences in New South Wales on psychiatric impairment. I would like to stress that I was a delegate on behalf of the Royal Australian and New Zealand College of Psychiatrists on psychiatric impairment. This is the list of participants to the conference, which was held in October 2000, one by WorkCover another by Motor Accidents and all stakeholders. I was the college representative back then before this whole thing became politicised.

CHAIR: From that comment do you understand that the college is supporting your position, or is there some division among psychiatrists?

Dr PARMEGIANI: Again, I wish I did not have to do it, but I would like to table two more documents in relation to that. The college, unfortunately, has become very political and that has attracted a lot of criticism from its members and the public. The latest one was an article published in yesterday's *Sydney Morning Herald*, which some of you may have read, about the influence of politicians on the college on the issue of the Governor-General. I am sorry to do it again, but there is a letter in today's paper, again by the college, that really encompasses my feelings about what has happened to the college and the feelings of a lot of my colleagues. It is a letter by Bill Carpenter, which I would really like to table. At the moment hundreds of emails are going backwards and forwards between members about what is happening with our college.

CHAIR: Is there any other material to table?

Dr PARMEGIANI: No, that is all. Thank you very much for the opportunity to let me speak.

CHAIR: We appreciate your time. We will get back to you if we need an answer to issues raised by other witnesses.

(The witness withdrew)

Clarifications

"I was asked whether psychologists could use the PIRS to perform impairment assessments. It is my belief that psychiatrists and psychologists' skills are complementary, but no interchangeable. A psychiatrist has a medical degree, which would allow a thorough assessment of physical conditions. This is particularly relevant to work accidents, which may lead to a combination of physical and psychiatric injuries.

A psychiatrist has unique skill sin determining the contribution of medication such as narcotic analgesics or tranquillisers to the injured worker's psychological state. A psychiatrist could also clarify whether the worker has a pre-existing dependence on alcohol, by interpreting results of liver function test, the full blood count and records of medical examinations. A psychiatrist would be able to clarify the effect of future psychiatric treatment, where it includes psychotropic medication (antidepressants, anti-psychotics etc).

Psychologists have unique skills in the administration of psychometric tests. These tests are useful in quantifying problems with memory or concentration. Some tests are useful in detecting malingering.

Unfortunately, the representatives of the Australian Psychological Society adopted a different position. They insisted psychologists should be able to perform impairment assessments independently, and they did not consider a medical degree to be useful. The WorkCover meetings became polarised, and no further progress could be made to integrate the two professions in the assessment of psychiatric impairment.

~ Dr Julian Parmegiani, 13 March 2002

ROBERT JAMES JACKSON STEWART, Private Consultant, 22 Elvina Ave, Newport, affirmed and examined:

CHAIR: In what capacity are you appearing before the Committee?

Dr STEWART: As Chair of the Permanent Impairment Co-ordinating Group.

CHAIR: Did you receive a summons issued under my hand in accordance with the Parliamentary Evidence Act 1901?

Dr STEWART: Yes.

CHAIR: Are you conversant with the terms of reference?

Dr STEWART: Yes.

CHAIR: If, at any stage, you wish to give evidence in camera we would be happy to accede to your request. Would you like to make an opening statement?

Dr STEWART: No. I am happy if I could be asked questions that were suggested and forwarded to me. I would like to make one point clear at the start: although you will see I am Dr Jim Stewart, I am not a medical doctor. I am a scientist by training. It is a Ph.D. I am not a medical doctor. That can cause some arguments.

CHAIR: You are a doctor in the scientific area?

Dr STEWART: That is correct.

CHAIR: What area would that be?

Dr STEWART: Way back in life I was a nuclear physicist.

CHAIR: Would you explain to the Committee what role you played in the development of the permanent impairment guidelines currently being used by the New South Wales Workers Compensation Scheme?

Dr STEWART: Yes. Initially I was approached by WorkCover to manage the development of the WorkCover guidelines, and it is worth giving just a little bit of background so you can see why I am involved at all. For a number of years I was the Director of Policy for the Victorian WorkCover Authority and, in fact, I was de facto second in charge of the Victorian WorkCover Authority. While I was down there I had a role in introducing impairment guidelines. On retiring from the job and coming back to Sydney I was asked by the Motor Accidents Authority two or three years ago to manage the development of impairment guidelines for them, and I did that work.

Out of that work arose this invitation to manage the development of the New South Wales WorkCover impairment guidelines. In fact, I was too busy to do that on a full-time basis, so although I assisted with that and, in fact, chaired perhaps the most contentious committee, which was that committee developing the psychiatric guidelines, my role, apart from that, was general advice, and as chair of this co-ordinating committee, which received documents from all the subgroups that were working on various aspects, working on the spine and the upper limb and so on, and sorting out in that committee, any residual problems.

CHAIR: The Committee notes that various stakeholders were represented on the Permanent Impairment Co-ordinating Group, of which you were the chairman. Were there varying opinions within the group about the appropriateness of the permanent impairment scale chosen? What concerns, if any, did you detect? Did the group finally reach a consensus on the issue?

Dr STEWART: There was no disagreement that I detected about using impairment guidelines and the American guidelines as the basis for what was being done. They were matters of detail about various things that we resolved very amicably, and the group worked well. But the one major issue where the group did not agree was psychiatric impairment guidelines, as you are probably aware. I heard just a bit of Dr Parmegiani's evidence. There were different views in the committee about the appropriateness of the PIRS guide, and that was not resolved in the

committee. We could not come to an agreement. In the end the Minister decided, I guess on advice from WorkCover, that the PIRS guide should be introduced. That was the one matter that was not done by agreement.

CHAIR: Why were the AMA guidelines chosen as a basis for WorkCover's permanent impairment guidelines?

Dr STEWART: I think it is because they are the best, best known, most used and most appropriate guidelines internationally. They are used by more than 40 States of the United States. They are used widely in the Canadian provinces. They are used in one form or another by, I will say every State in Australia, certainly close to every State in Australia. They are used in Victoria, both the Motor Accidents Scheme and workers compensation. They are used in New South Wales, although, unfortunately, the fourth edition is used by the Motor Accidents Scheme and the fifth edition is used by WorkCover. Tthey have just been introduced into Tasmania. They are used in Queensland and a different edition is used in South Australia. They really are for all their imperfections, and I am sure you have heard lots about the imperfections, the best tool available. It was logical to go this way.

CHAIR: What did the changes made to the current impairment scheme in New South Wales mean for the number of injured workers able to access common law, the amounts available to injured workers for compensation through common law and, finally, savings or costs to the scheme?

Dr STEWART: I am not sure I can really answer that. It is a question for the actuaries, perhaps, WorkCover. As I understand it, previously you could come to common law through narrative, that is it could go before a court and argue that you were severely injured and you should have access to common law. In this new scheme you have a 15 per cent permanent impairment threshold to exceed before you can go to common law. That requires you to have a moderately severe permanent injury. It is a lot less severe than in Victoria where you have to have 30 per cent impairment and in Tasmania where you have to have 30 per cent impairment. But, still, 15 per cent permanent impairment is a reasonably severe injury, whether physical or psychiatric.

CHAIR: Did your committee recommend the 15 per cent threshold?

Dr STEWART: No.

CHAIR: Did you make any recommendations at all?

Dr STEWART: We made none at all. We were concerned about getting the guides themselves to be as effective and as good as we could get them. We may come back to the psychiatric issue, but I have a view on the psychiatric scale that I would like to put to the Committee. You are aware of this because there has been a lot of debate and correspondence about it and I am sure you have been bombarded with correspondence from various lobby groups. I have had a lot of experience in impairment guides now and my view is that the PIR scale that is being used at the moment or is proposed to be used is reasonably comparable in severity to the physical impairment scales in the AMA guides.

The difference is—and I think some people are confusing this—that there is a 15 per cent threshold before you get any permanent impairment compensation if you are psychiatrically injured. So people with only minor psychiatric injuries are not going to get any lump sum for their permanent impairment. I think it is that difference which makes the psychiatric scale seem, to a lot of people, tougher—the fact you have to hit a 15 per cent threshold. It is my view that it is not the scale itself that is more or less tough than the various physical scales, it is the fact that because there was not a scale at all previously and WorkCover was nervous about how many people would access psychiatric benefits. They put on a 15 per cent threshold so that makes it tough to get an impairment benefit if you are psychiatrically injured. It is not the scale that is the problem, if there is a problem, it is the 15 per cent threshold.

The Hon. RON DYER: What are the reasons for psychologists, as distinct from psychiatrists, being excluded from applying PIRS?

Dr STEWART: That is a good question. Again, it was not a matter that came before the co-ordinating committee but I would say this: WorkCover has decided that the people who will do these assessments in every area have to be medical specialists so you would be varying from that if you let psychologists apply the scale. I think psychologists in many cases could apply the scale sensibly, just as general practitioners could apply the scale for impairment of the back, the knee or whatever it might be. WorkCover has taken the view that medical specialists should do this.

The other point with psychologists is that it is a requirement for any permanent impairment assessment, not just psychiatry, that you have a clinical diagnosis and the psychiatrists are the people in that field—and you can argue about whether or not that should or should not be—who can give the clinical diagnosis, not the psychologists, just as in a physical impairment it is normally an orthopaedic surgeon who will give a diagnosis of a ruptured disk or whatever in the back, not a general practitioner, let alone a physiotherapist. I think they have gone that way to keep parity with the rest of the system that they have introduced.

The Hon. RON DYER: So there are supportable or rational reasons for that decision?

Dr STEWART: Yes.

The Hon. Dr PETER WONG: Ordinarily we are talking about ordinary things and psychiatrists are those dealing with abnormal human behaviour—of course, it is not always like that—whereas psychologists often deal with normal behaviour of a milder nature. When you define impairment as an illness, I suppose automatically you go the psychiatry path rather than the psychology path?

Dr STEWART: Yes.

The Hon. MICHAEL GALLACHER: Could you give the ill informed and laymen on the Committee a rough idea of the symptoms of someone who is, say, between 10 per cent and 15 per cent impaired?

Dr STEWART: In psychiatry or anything else?

The Hon. MICHAEL GALLACHER: Using the PIR scale?

Dr STEWART: I think it is the moderate scale—could I refer to it?

The Hon. MICHAEL GALLACHER: By all means.

Dr STEWART: I am a layman too in this sense in that I am a former public servant.

CHAIR: I think the point is how conversant you are with it.

Dr STEWART: Yes. I am certainly conversant, I guess I am more conversant than you guys.

The Hon. MICHAEL GALLACHER: Could you detail to the Committee, so that we have some understanding, what someone who has a 10 to 15 per cent impairment would look like and what someone with a 15 to 20 per cent impairment would look like?

Dr STEWART: I guess the other thing people have said to you is that the PIR scale was developed by a group of forensic psychiatrists, people who deal in this area constantly, but it is based on principles and stays pretty close to the AMA guides that all the other body systems use. There is a table in the fifth edition of the AMA guides, which has the categories that are used in PIRS. So really these psychiatrists, in introducing this, have put percentages on those categories. They have not introduced new categories. I heard when I was sitting in the audience a comment that this was a world first and had not been validated. I will say two things about that. One, it has not just come out of the air. It is based on what is already in the guides but the guides authors did not want to put percentages on it because psychiatry can be imprecise.

The other thing I would say—and this comes from my former life as a physicist way back—is that there are lots of fields where Australia should be introducing new things. We should not have a cultural cringe about the fact that we have introduced something new that might be better than anything else. Certainly in the physics area that I worked our views were sought after around the world in lots of areas, but that is a little off the point. What sort of a person would be 10 per cent or more? The five categories of the scale go from normal, mild, which is 4 to 10 per cent, and moderate actually runs from 11 to 30 per cent, and it depends on the scores you get on these various capabilities to do things in your daily life where in that scale you sit, but you are moderately damaged and you are in class three.

In terms of self-care, you might have someone coming in to see you once or twice a week to help with meals, showering, to make sure you actually get up and shave, that sort of thing. If you do not have a family member or someone coming in or staying with you, you might let those things go. That is one of the categories. In the social

area, you are dropping away your friendships. You might go out but you do not participate as much in activities as you used to. You might have to be persuaded to go out. In the travel area, again you do not go out and go around the town as a normal person would; you have some difficulty doing that. You might want someone to go with you or you might have to be persuaded. You might have strains in your marriage or close personal relationships. You might have arguments or you might be difficult. You go to work but you have difficulty working in the area that you worked previously. If enough of those things pertain to you—not all of them but three out of the six possible categories, then you would get into that area of greater than 10 per cent so you have some measurable problems. With between 10 and 15 per cent you have a few more of those problems.

The Hon. MICHAEL GALLACHER: Sounds a bit of a lucky dip to me. When assessing impairment, from what you have said, I suspect the person who is diagnosing the condition would sit there with a checklist and work out that there is deterioration in certain areas. Do they work on the basis of points?

Dr STEWART: Yes, they do. On each of the six categories they will give a rank from one to five.

The Hon. MICHAEL GALLACHER: It concerns me that someone may be 10 to 12 per cent impaired on points, not quite up there but around that. However, if they had been assessed another five months later and there had been a deterioration in their family life, they may have reached 20 per cent but that is tough luck as they are already out of the system because they did not qualify for the 15 per cent.

Dr STEWART: No, as I understand it you can come back if you deteriorate but bear in mind that before you have this assessment you are supposed to have been assessed at maximum medical improvement—you might deteriorate—and you are stable. They do not see that you are going to improve or get worse over the foreseeable future, the next 12 months at least. They have to make that decision before they will assess you, in physical things as well as in psychiatric. You are right, it is difficult and that is one reason that WorkCover has put on a 15 per cent threshold, bearing in mind that previously there was no way to get anything for psychiatry. In Victoria until 1998 there was no compensation at all for psychiatric injury. They have introduced a scale that is like this in that you rate over a number of criteria where someone is on a scale from one to five. It is different criteria. The American guides say, "This is too hard. We can't do it."

That is partly why it is new and partly why there is a lot of debate about it. I think WorkCover is trying to give an impairment benefit, a lump sum, to people who really have been damaged by their work in a permanent way. It is not perfect and people will be able to poke holes through it, but they have tried to be as objective as they can. Over time experience will grow with it and it will be seen to be either working well or not working. It seems to have worked reasonably well in the motor accident area. Again, people say it is too tough but I think it is because there is a 10 per cent threshold with motor accidents before you get anything, so I think they confuse the fact that you have to get over a threshold with the scale itself.

The Hon. MICHAEL GALLACHER: Dealing with the overall number of psychiatric claims in the scheme, how many would fall between that 10 to 15 per cent?

Dr STEWART: I do not have the figures, sorry. Dr Parmegiani might but I do not have them. In WorkCover there would be no experience at all. Of motor accident people, I just do not know.

The Hon. Dr PETER WONG: An earlier speaker said about 10 to 12 per cent.

Dr STEWART: I have heard that 10 to 20 per cent of people get over that threshold, so it is going to be around that.

The Hon. Dr PETER WONG: I think we should bear in mind that such workers previously were not able to receive any compensation whereas at least now 10 to 12 per cent are likely to receive compensation as a result of psychiatric or psychological impairment, which is a positive thing.

Dr STEWART: That is true.

CHAIR: You referred to the narrative system in common law. In assessing a person for psychiatric damage would much weight be placed on what actually happened to the person. Say the person was a teller in a bank who had been held up three times and had a gun held at her head. On the scale she may look as if she is only 14 per cent not 15 per cent. Does what happened to her have any bearing on the assessment?

Dr STEWART: In going to common law or under the old narrative system?

CHAIR: Even under the new system and a psychiatrist is assessing it, would the psychiatrist place weight on that. The lady may be a tough person who is coping but is submerging some trauma within her.

Dr STEWART: My view is that if a person is 13 per cent or 14 per cent on this scale most doctors will whack it up to 15 per cent. That is what happens in other areas out there. They have a consultation. They look at the person. They look at the whole situation. Sure, they do this scale but it would be a pretty hard doctor if someone came up at 14 and they did not kick them up to 15 which is done in most cases. Someone who came along at 14 and was knocked back would certainly be disputed and go to the commission, and I would be surprised if they did not go to 15.

(The witness withdrew)

(Luncheon adjournment)

(Public hearing resumed)

PAUL RUSSELL MARTIN, President, Australian Psychological Society, Level 11, 25/7 Collins Street, Melbourne,

ROBERT LEWIS WILKS, Psychologist, Australian Psychological Society, Suite 604, 530 Little Collins Street, Melbourne, and

LEONARD JACK WHITE, Registered Psychologist, Australian Psychological Society, 71 Angas Street, Adelaide, sworn and examined:

CHAIR: Did you each receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act 1901 and are you conversant with the terms of reference of this inquiry?

Professor MARTIN: Yes.

Mr WILKS: Yes.

Dr WHITE: Yes.

CHAIR: If you should consider at any stage during your evidence that in the public interest certain evidence or documents that you may wish to present should be seen or heard only by the Committee, the Committee will be willing to accede to your request. We will go in camera and the public will leave the room. Do you have anything that you wish to highlight to the Committee or bring to its attention relating to the terms of reference of the inquiry?

Professor MARTIN: Yes. I thought I would comment first about my background to help you see where I am coming from. I am currently President of the Australian Psychological Society and was previously Director of Science, so I have been on the board of directors of the APS for about five years. I did a bachelor's degree at the University of Bristol, a post-graduate professional qualification in clinical psychology through the British Psychological Society and my doctorate at Oxford University. I have held staff positions at Oxford, Monash University and the University of Western Australia and I am currently professor and head of school at the University of New England. In addition to these positions I have held a number of honorary positions in hospitals in both Britain and Australia.

My main areas of research interest are in the areas of pain—headache, migraine and stress—and postnatal depression. I have written books, as well as journal articles, in both of these areas. Although I have always been an academic, I have also always been a practising clinician. So I have been in continuous practice for about 25 years. My practice experience has been in the United Kingdom, the United States of America as well as in Australia—in Victoria, Western Australia and New South Wales.

Thank you for this opportunity to appear before the Committee. It is hard for me to understate the degree to which the Australian Psychological Society considers the WorkCover New South Wales guidelines and the assessment of permanent impairment a very important issue. Therefore, we obviously consider the work of this Committee extremely important. Local office holders have devoted an enormous amount of time to this area, as have paid staff in the national office. A reflection of the importance that we attach to this area is the fact that three people have been flown to Sydney to attend today's Committee meeting.

I will give a little of the society's background as there seems to be some confusion about it. The Australian Psychological Society was founded in 1944, so we have been in operation for just over half a century. We have about 13,000 members, which represents about 60 per cent of registered psychologists nationally and about 70 per cent in New South Wales. That is a very high ratio: in most other countries psych societies have a small proportion of psychologists as members. Our membership is very diverse reflecting the fact that psychology is both a science and a profession. We have academics in the society as well as practitioners in both the private and public sectors, although quite a lot of our members' expertise spans the science and professional sides. Our national office is located in Melbourne. In fact, we recently located to new premises in Collins Street, which only this week was opened by the Commonwealth Minister for Health and Ageing.

We have branches in all States and Territories. We publish a number of learned journals—three general and the number of specialist journals—and we hold an annual general conference and a number of specialist

conferences. We accredit training programs around the country, and the registration board uses our accreditation process to decide whether people have trained adequately as psychologists. Training to be a psychologist involves essentially four years plus two years, and in some cases plus another two years. It involves first completing a four-year accredited sequence in psychology at university. Then you must do another two years, which can be completed one of two ways: either via post-graduate training—a master's degree or a doctoral degree—or in most States it can be done in an alternative manner via a supervised practice route. The supervised practice routes are modelled on the master's program, so they are quite similar in composition.

To be a member of our society you must have done a higher degree; we do not accept the alternative training route. The society involves nine professional colleges, and to become a member of a professional college you need to do another two years supervised training beyond the four plus two years. Postgraduate training in psychology is done in different professional specialties: there are clinical psychologists, forensic psychologists, organisational psychologists and so on. We believe a very distinctive aspect of our training is our emphasis on science. For example, as part of the four-year degree everyone must do an individual research project and then do another project at postgraduate level. There has always been a strong emphasis on science in psychology so psychologists tend to be very wedded to what is called the "scientist practitioner model"—in other words, practice should reflect current science. These days this serves us very well in the health sector, which has moved more and more towards evidence-based medicine and thus fits very well with where psychology places itself.

I want to talk about the difference between psychologists and psychiatrists, and then about whether psychologists are qualified to do impairment assessments. I preface my remarks by saying that psychologists are very committed to a multidisciplinary approach. The last thing we wish to do is try to detract from any of the other health professional groups in stating our own case regarding what we can offer. People sometimes talk about psychology and psychiatry as warring factions, and certainly there are times of friction between the two professions. However, this can disguise the fact that we generally have very good working relationships with our colleagues in psychiatry. I have known the President of the Royal College of Psychiatry for 20-odd years and we have a very good working relationship and are highly supportive of each other in many ways.

The point about psychologists versus psychiatrists is that the work that some psychologists finish up doing overlaps very much with the work of psychiatrists. Having said that, psychologists do plenty of work that does not overlap at all and our training is completely different. Becoming an APS college member involves six years study at university, an undergraduate degree, higher degree and then two years of supervised practice, after which you get into the area of professional development. This does not mean you can then stop learning—that would obviously make no sense whatsoever. Our members are required to complete professional development [PD] activities and submit them to the society for approval. Members must do such PD activity in order to continue as members of the society.

Psychiatrists on the other hand complete six years at university—although there are now alternative models, such as a four-year postgraduate degree and so on—a year of registration, a year as a house officer and then a five-year in-service training scheme. In terms of length of training, an APS college member must train for eight years and psychiatrists train for 13 years—which is longer but in some ways it is not. Both of us do the six plus two years after which psychiatrists are paid to do a job but expected to continue training at the same time, which is not hugely different from our professional development activities. One can also point out that you need to complete a higher degree to become a psychologist, which is not the case with a doctor. In their six years at university doctors do a Bachelor of Medicine and a Bachelor of Surgery but not a master's or doctoral degree. So in that sense our qualifications are quite high level.

Some people seem to think of clinical psychologists as second-rate psychiatrists. That model is not fair to psychologists; it is an understatement. Our background is simply different. In our four-year training in psychology we educate psychologists in different subdisciplines of psychology. For example, we teach them developmental psychology, which is about how people develop across their lifespan from conception to death; we teach them social psychology, which is how people perceive and relate to each other; we teach them cognitive psychology, which is about how people learn, remember and forget; we teach them physiological psychology, which is about the physiological basis of behaviour; and we also teach them abnormal psychology, which is about psychopathology, illness and dysfunction. In the postgraduate years we teach them professional specialisations, which is very much how to apply all this knowledge. I emphasise that the early training about how people learn, think and remember is a critical context for the later professional work.

Medicine is quite different: it is all about health and illness, particularly the different forms of disease and illness and how to diagnose them and so on. Psychologists and psychiatrists come together in the particular

subsample of psychologists who go on to work with people who have mental disorders. Are psychologists qualified to do impairment assessments? We would not claim that all psychologists are. We are a diverse group. We have psychologists working in the arenas of sport and industry, for example, and not all of them would be qualified to do impairment assessments. However, some of our members—clinical psychologists, for example—certainly would be. Clinical psychology programs give quite extensive training in psychiatric diagnosis, the use of DSM-IV and so on. In fact, many clinical psychologists in the public and private sectors use these sorts of assessments all the time.

Perhaps the closest analogy to some of this work is the victims of crime. As you are probably aware, victims of crime in New South Wales must be seen by an authorised report writer. There are two professional groups that are eligible to become authorised report writers, psychiatrists and clinical psychologists. Many of us, including myself, do those reports on a regular basis. It is requirement when doing those reports that we complete any psychiatric diagnosis that is necessary for the case. In America, in the private sector, patients cannot get rebated unless the psychologist has done this type of diagnosis, because for many years the requirement of health insurance companies has been that that is part of the accounting procedure. That is all I would like to say as my opening statement.

CHAIR: Would you outline what the Australian Psychological Society sees as the pros and cons in utilising the PIRS method for assessing psychological injury?

Professor MARTIN: Do we follow a sequence here?

CHAIR: No, anyone of you can answer any question, or you can share an answer to a question. It is up to you.

Professor MARTIN: I would like to turn to my colleague Dr White because this is an area in which he is really expert.

Dr WHITE: Perhaps if I could ask that this paper be distributed to members of the Committee. I hope it summarises for the Committee a basic distinction between the various approaches. If possible I would also like to put in context my situation and how I came to be involved in this, if that is appropriate at this time. Back in 1996 the Australian Psychological Society area of private practitioners requested the president at the time, after a survey among its members—they were concerned about the way in which the AMA guidelines were written, they did not necessarily always help psychologist doing these sorts of assessments—to form a subcommittee to look at the way in which psychologists go about these sorts of assessments. At that stage we had the AMA guidelines edition 2 and subsequently edition 4, because this is how they were included in a lot of the jurisdictions. In Victoria there was a proposed model that was being put up, which we also intended to look at.

The working committees started back in 1997, and we probably spent the best part of three years, on a regular basis, meeting, usually monthly; sometimes it was more, depending on the work involved. We were essentially, first of all, breaking down what the AMA guidelines say, particularly how they relate to psychologists. Second, we were looking at options in terms of different types of measuring tools. The culmination of the work of the subcommittee was at the beginning of 2000 when a paper was presented to the Board of Directors of the Australian Psychological Society and accepted by the board as a standing paper for the society in terms of advising our members of the best practice approach for psychologists in doing this sort of assessment. Essentially the study reviewed the AMA guidelines and the Victorian model that was being applied within the Motor Accidents Authority, and it looked at the pros and cons in those cases.

Subsequent to that and assessment and recommendation as to an alternative way of looking at the final stage, we essentially found that the society was quite happy with the AMA guidelines for most of the stages. It is very important to understand that there are a number of critical stages that have to be gone through in doing this type of assessment. Critically, some of this is being ignored, perhaps, in the current climate. First of all we have to establish the person's level of impairment prior to the accident. Was there are level of impairment or not? Having established that, it is a matter of determining whether that person has a mental impairment. This is an area where, perhaps, psychologists and psychiatrists use different tools. One of the main instruments psychologists use is psychological tests, whereas psychiatrists have a tendency to use mental state examinations as one of their principle instruments in determining whether a person has a diagnosis.

After it has been established that the person has some sort of mental impairment, it is a matter of determining whether the impairment is a consequence of the accident. That is fairly fundamental. If it is not then you do not go to the next stage. The next stage is to determine whether there has been any treatment and how much

time has elapsed since the accident. Those are critical factors, too, to establish how permanent it is with this particular type of impairment. Once we have gone through all those stages and we have decided that the person has an impairment, this is where the contentious issue comes. The question is: As a consequence of that impairment how does it affect that person's life? How does is affect their daily function? This is where all the different sorts of models vary. This is where PIRS differs from the model we were looking at. Essentially, we decided that we needed to say there was a relative change in the person, so that we could see what the person was like before the accident and what the person was like after the accident.

How did the accident affect the person's level of function? We sought to find an instrument that could answer that question. We wanted an instrument that was consistent and straightforward, acceptable to all clinicians—which included psychologists, psychiatrists, medical practitioners and health professionals—had universal application, had good inter-rater reliability, was clear to see how you could use it in relation to the person's premorbid status, there was good literature in relation to the instrument, and was in usage and had wide acceptance. They were all the factors we considered to be important in looking for an instrument that would be able to provide us with a relevant measure. At that stage, initially, in the first paper we also looked at the Victorian model, and that model very closely compares with the PIR. It was a model where ratings were made of different criteria and a median was used to calculate the person's level of impairment. There were some very fundamental psychometric problems with this approach, and it is where I come to the answer to your question. I refer to page 5 of that report to summarise, the section under "Proposed New South Wales Medical Committee Approach".

Some of the objections were that the approach, one, did not implicitly ensure that the accident was a direct consequence of the impairment; two, there were problems applying the computation for adjustment for pre-existing condition, so a person could have a pre-existing condition and it did not necessarily follow that it would be included in the calculation; three, there were logical problems in taking into account the persons premorbid state; four, the categories identified continuous, although not logically balanced, for example, some categories had 3 per cent, some involved 6 per cent, others 19 per cent, 29 per cent and 39 per cent; five, the median measure, and I guess this is ultimately what we consider to be a very major flaw with this particular instrument—although it has been argued it was the fairest approach, we would argue in fact that it is a very unfair approach because it has the potential to seriously distort the actual outcome; six, the conversion table proposed has no psychometric basis to it whatsoever and is essentially just a collection of numbers that have been put together without any scientific basis whatsoever; seven, there seems to be no statement about the duration that has elapsed since the accident; and, eight, and this follows on what Professor Martin was saying before, the approach recommends that the psychiatrist explicitly should be involved with the assessment. Clearly, from the perspective of the Psychologist's Association we find that totally untenable.

CHAIR: Why do you think PIRS was chosen by WorkCover New South Wales as the most appropriate for measuring psychological injury?

Professor MARTIN: I would like Dr White to answer that, but I will answer one of the points, if I may, what is collecting his thoughts about that one. We do have all sorts of problems with PIRS, that is for sure, but we want to emphasise that this issue about using the median, is, fundamentally, what we feel is the most inappropriate thing about it. The guidelines specifically say that the median class score method was chosen as it is not influenced by extremes. That is a problem with the scale. It is as simple as that. When people judge ice-skating or whatever they discard the lowest and highest scores, and that makes sense. It is assumed that outliers should not influence, that they are like aberrant or deviant scores that you want to exclude from the process of averaging. But, of course, in the area of impairment that makes no sense because the aberrant scores are the most important. Some may well not be impaired in a number of different domains, but the point is they may be very severely impaired in a particular domain and far from the sense of wanting a scoring system that discounts or ignores it, that has to be something that features very much in the case made for compensation.

Mr WILKS: If I could answer in relation to questions 2, 3 and 4 together, I will commence my answer by very briefly describing my background. I guess I am primarily a practitioner by nature and activity. I have been a psychologist since 1984, but over the years I would have conducted some 300 or 400 assessments on average per year of workers compensation and crimes compensation claimants across a variety of professions. I am on the panel of psychologist examiners for the Victorian WorkCover Authority, being one of 15 in that category. I am on the panel of crimes compensation psychology examiners for the Victorian crimes compensation system. I have been on the Victorian Australian Psychological Society working party, which negotiates with Victorian WorkCover, for some 15-plus years. I have conducted many assessments for the Police Association of Victoria, solicitors and a number of other groups like that, which has given me extensive background in the assessment of WorkCover and similar claimants.

For some years in the late 1980s and early 1990s I was the manager and principal of a rehabilitation centre under the WorkCover system. My perspective today is a relative wealth of experience in the hands-on involvement of psychologist in the assessment of WorkCover claimants. In terms of impairment assessment, again, my experience is probably a little bit unique in that for many years, or for some years, I was the only psychologist in Victoria who was conducting AMA 2 assessments. As you are probably aware, AMA 2 assessments are very similar to AMA 4, which is quite similar to PIRS, which has a median system at its heart. At a practical level, I do not have Dr White's academic and psychometric expertise, but it was very clear at a practical level that a number of workers were massively disadvantaged by a median-based system, that is workers who had an injury that was, in a sense, narrow but very intense and occupationally debilitating

A classic example would be a police officer who was assaulted by an offender and it turned out that the offender was HIV-positive and that information became available. The officer may become virtually phobic about dealing with offenders of that nature and is crippled in his job, yet he is able to conduct his social life relatively normally. His mood in terms of day-to-day life may seem relatively normal, although moderately affected. He would receive ratings under a median type system of ones and twos. His median score would be 1.5, 2.0 or even just 1.0 and he would receive very low percentage of impairment yet in reality be occupationally crippled. I found that an obvious impractical, unfair outcome of the median-based system.

The other problem that Dr White has alluded to was in fact there is not really a "pre" versus "post" situation or provision of information by a PIRS-type system. A person may be very high functioning, dare I say it, a mental health worker or someone of that ilk in a white-collar profession who has difficulty with coping with the stress and nature of their clientele. If you look at them afterwards they have come from here to here but in an absolute sense their level of functioning is reasonable but their deterioration from a previous high level is quite marked. That information is not captured by a PIRS-type scheme, which does not look at the before and after relative to the injury situation.

Also having been involved in rehabilitation and policy advice to the Victorian WorkCover Authority I found that the PIRS-AMA type system is somewhat sterile. It is becoming very apparent that it is critical in many injury cases to capture early cases that are going to be difficult. Certain signposts are there in some cases, such as a soft tissue injury case where depression comes into play very early. That can be a very predictive signpost of future difficulties. The centrality of the PIRS cum AMA system in Victoria meant that this became the be-all end-all statistical figure but it had no practical utility in terms of getting a result, saving money and saving personal suffering.

The Victorian WorkCover Authority is now moving through a program they have developed—"The Case for Change"—where they now have statistical predictors of difficult, protracted claims. They implemented a management program for those difficult cases early in the piece involving multidisciplinary teams within the insurance side of the authority to actually deal with these cases early, get a work focus early before these problems develop. That is the emphasis in Victoria now, to work towards what are the really significant variables, which are blowing out costs, causing human suffering and causing employment loss, rather than focusing on a somewhat narrow system such as the PIRS-type system.

CHAIR: How do you assess the precondition? You criticised PIRS for not doing that but how do you establish what they were like beforehand?

Mr WILKS: As a psychologist and clinician I am trained in taking a full and detailed history of the person by means of an interview, by means of interviewing third parties, relatives, friends, families, et cetera, and carrying out a variety of methods to derive a full history of the person.

The Hon. RON DYER: Mr Chairman, no witness has in fact responded to your question, that is, why in your view did the WorkCover Authority adopt PIRS?

Dr WHITE: If I could try to answer this.

CHAIR: Because it is only your opinion.

Dr WHITE: Yes. I am not privy to the decision-making process with WorkCover. I am aware that they attempted to set up a working committee to work through this issue and I felt that having attended one of those meetings at least, there was obviously some friction between members who were representing the WorkCover

position and others. Clearly, that matter never really got resolved I think, and probably there would be others here who would be better able to speak to it, but the debate never really became a debate but a walkout essentially, so by default almost that method was accepted, except, I can assure you, that the psychological society was very opposed to that in principle for a number of reasons that we have tried to identify.

The Hon. RON DYER: It would be true though, would it not, that the WorkCover Authority has adopted this rating scale for reasons that to it appear to be appropriate?

Professor MARTIN: I suppose inevitably they must think it is the right way to go. Why they do is certainly something of a mystery to me.

CHAIR: Your society really has two basic criticisms. First, you are not happy with the PIRS system to start off with, and, second, you are not happy that psychologists have been left out of the loop?

Professor MARTIN: Exactly.

The Hon. RON DYER: Professor Martin, I readily accept that psychologists are very well qualified and I note that you referred to the requirement for a higher degree to be held. However, I thought that your description of medical practitioners' qualifications was somewhat disingenuous or incomplete in that you referred to their basic qualification MB,BS but chose not to refer to their specialist training in appropriate cases, which clearly would include psychiatrists. Do you not think it would be fairer to present it that way?

Professor MARTIN: I am sorry, I did. I said they do six years at university, MB,BS, they do a year for registration, a year's house job and a five-year in-service training scheme in psychiatry or other specialities.

The Hon. RON DYER: If you said that I missed hearing it.

Professor MARTIN: Which is why I was saying that if you add that up it is 13 years, it is longer than psychologists and we obviously readily accept that.

The Hon. RON DYER: Do you think—and I am not personally qualified to say whether it is correct or not—that the WorkCover Authority has formed a view that perhaps psychiatrists are better able to exercise clinical judgment in regard to conditions that come before them perhaps to a greater extent than psychologists are, who have a rather different background?

Professor MARTIN: It is difficult for me to comment on why they have made their decisions. I really do not know, but frankly the idea of only allowing medically trained people to make those sorts of assessments strikes me as stunningly at odds with where we are in the health industry today. Obviously, if you go back historically, first of all a number of the health-care professions around today did not even exist. Clinical psychology is a post Second World War phenomenon and many of the health professions historically were a rather low level. Nursing is an old profession but all they used to do was change beds and empty bedpans. Occupational therapists taught people how to make baskets. To say that has changed is a slight understatement. To get into occupational therapy now you have to have cut-off scores in the high 90s. Nursing is a graduate profession and so on.

Many years ago you could justify the notion that there were doctors, medical practitioners and then the rest, and the rest were at a very much lower level but that cannot be sustained today. The health care system more and more has recognised that there are now a whole range of highly trained professions and they operate in a complementary way. Each has something to contribute.

Mr WILKS: I point out that in my training and the training of virtually all clinical psychologists, as I understand it, we were given rigorous training in the use of DSM-IV in diagnosing and assessing psychopathology. Also, way back in 1986 there was a Federal health department review of the relative treatment effectiveness, cost-effectiveness and assessment capacity of all the health professions. The chapter on psychology specifically concluded that the capacity of clinical psychologists and psychiatrists in those areas was equal. This was in the context of Medicare and the possibility of introducing clinical psychologists in Medicare. The conclusion was that the fee for the two professions should be the same because they are identical in skill and complementary in what they do. Sad to say the Medicare rebate for psychologists never came for political reasons, but that was a fairly exhaustive Federal Government review that reached those conclusions.

The Hon. RON DYER: It is my understanding that in the society's submission dated 20 August last year you stated that the powers of insurers in the injury management process should be reduced. Why do you say that? Who should manage the injury management process if they do not, or if they retain a residual role, who should manage it if they vacate the field, at least to some extent?

Mr WILKS: I think I alluded to this point in my earlier answer in that in a sense the preoccupation with deriving percentage cut-off scores is missing the big picture in that for reasons not fully explicated it is clear—and I might refer to another document entitled "Commensurable Injuries and Health Outcomes" of the Australasian Faculty of Occupational Medicine, which points out that persons suffering all forms of disorders involved in the compensation system fare less well in terms of health outcomes when they are involved in the compensation system. There is something about a compensation system that makes people less healthy, and that is the big issue in my humble opinion.

The Hon. RON DYER: That might be an argument for a measure such as a commutation to get them out of the system immediately rather than a medical type argument?

Mr WILKS: I think it is an argument to treat these people well and to handle them most effectively. Coming back to the issue of insurance companies, there is, to some degree, a preoccupation with saving costs at all costs and some short-sighted thinking comes into it. In Victoria, not that Victoria is the centre of the universe, but a complementary or related program to that which I referred to earlier is that insurance companies then are required to set up management teams which are quasi-independent within insurance companies, staffed by allied health professionals, doctors and somebody with a legal background and an overall team manager to take cases which are likely, on the basis of statistical predictors, to prove difficult, and handle those cases more intensely early to try to normalise the function of those people, keep them job-focused, et cetera, to deal with the real core problem, which is the institutionalisation that occurs when somebody is involved in a compensation system.

That step of having the independent injury management teams for difficult cases can be taken a step further. I guess the end point to that is to have injury management teams which are separate from insurers, which are relatively uninfluenceable by the short-term, cost-cutting mentality that sometimes pervades insurance companies.

CHAIR: As you know, the Motor Accidents Authority only uses psychiatrists in the assessment. Were you as concerned over that development as you are now over the WorkCover situation?

Mr WILKS: Certainly our colleagues in New South Wales, as that was perceived as a New South Wales issue as it was a New South Wales body, were very concerned.

Professor MARTIN: The simple answer to the question is yes.

CHAIR: I just do not recollect it.

Dr WHITE: We are from different States. I am from South Australia. Certainly psychologists do a lot of that assessment in South Australia. It is a New South Wales issue and certainly I am sure that they would feel as strongly about that matter as they do about WorkCover.

CHAIR: Under this system, as you realise, they have restricted motor accident assessment to psychiatrists and you could argue that WorkCover has decided to follow the same pattern and/or they may have found it difficult to use the word psychologist—if they included psychology—when there is such a wide range of experience with psychologists. You have made a strong argument about clinical psychologists. Do you think that WorkCover could have had psychiatrists and clinical psychologists as a group that are clearly identified with some status, some document or some classification?

Mr WILKS: I come back to the Victorian experience. I will not bore you with the history in great detail but the essence of the history was when the Victoria WorkCover system was set up in 1985 psychologists were precluded not only from assessment but from treatment. Within a year that was seen as untenable and psychologists were included in the treatment role. Psychiatrists were the only ones able to deal with assessment under the Act. To a degree that proved untenable also in that it started off with a narrow demand for neuro-psychological assessments where there was a head injury case, and specific skills of a neuro-psychologist in psychometrically quantifying the brain damage and the functional loss of the individual with a head injury. It just proved essential as no other profession could provide that service.

The demand for psychologist assessors grew from there. There was a recognition that the reports of psychiatrists on the whole tended to be somewhat narrower. They would produce a diagnosis under DSM-IV, or its predecessor DSM-III, but given the training of psychiatrists there would be relatively little of a practical nature as to how to rehabilitate this person. So in those years there was a steady build up of long-term claimants, and the number of people that were on benefits just grew and grew and grew as they were being stuck in the system for some of the reasons I have alluded to.

So the demand grew for psychologists to do assessments. There was a trickle in, starting with myself. I was the only psychologist doing assessments for a long time even though under one section of the Act psychologists were specifically precluded but another section of the Act said the relevant tribunal could accept evidence in any form it wished. There was a ruling on one of my reports which was that the tribunal wished to receive psychologist's evidence, and on that basis I did thousands of reports. Then more psychologists came in. Then the inevitable happened: the WorkCover Authority agreed to establish a formal system of having psychologist assessors, and to amend the legislation accordingly. The path they chose to go though, was to do it on a case-by-case basis to establish a panel of psychologist assessors who, in practice, tended to be people with clinical qualifications or with clinical neuro-psychologist qualifications on the whole, with a few exceptions.

You can go by blanket title, if you like, a clinical psychologist or a clinical neuro-psychologist would be appropriate titles or qualifications to look at. If you are establishing psychologist assessors, you could go case by case and have a review system to establish those appropriate people, which would be carried out by the authority, and advice taken from the profession. In Victoria, myself and one other psychologist are the advisors to the WorkCover Authority on selecting the panel of psychologists—who the individuals are.

CHAIR: Was that in the legislation?

Mr WILKS: Yes, the legislation was changed eight or nine years ago.

Professor MARTIN: It is easy enough to identify clinical psychologists: they are basically people who have completed training in clinical psychology. It should be remembered that under the registration Act there is a code of conduct. It is very clear in the code of conduct that you cannot practice outside your area of expertise. In that sense, any psychologist putting up their hand in this area, who did not have suitable training and experience, is in breach of the code and would also be in breach of the APS code for the same reason.

I would also like to illustrate the craziness of a system which says the assessments should be limited to a psychiatrist. If someone sustains a head injury at work then obviously the key questions to ask are: What impact has that had on their functioning? What sorts of intellectual activities can they still do as well as before, and what sorts can they not do as well as before? It is very clear how that is done: It is done by a neuro-psychological testing. Psychiatrists, as far as I am aware, would not even have access to being able to purchase some of those tests because the tests are only available to people who have had appropriate training in the test. To suggest that psychiatrists could do that sort of work makes no sense whatsoever and I do not believe psychiatrists would claim such a thing. That would be one example where involving psychologists would be critical to making any sort of a sensible assessment.

CHAIR: It seems that it is not related to head injuries so much as trauma experienced by police officers in bank robberies, that you mentioned before, and the impact that has had on their psychological make-up?

Mr WILKS: Yes, a useful report not only diagnoses but gives some signpost and guidelines for treatment and particularly rehabilitation. A source of frustration in my work in Victoria is a worker coming along with post-traumatic disorder after a bank robbery, or whatever. It is very clear to you, as the independent assessor, what sort of treatment and rehabilitation activities are required, and you present that in a report. But it is very difficult, in fact impossible it seems, to actually get that implemented. Again, I emphasise the big picture is to devise some method which can deliver effective treatment and rehabilitation to these potential long-term claimants.

Dr WHITE: I refer to the remarks of the Hon. Ron Dyer. The courts are much more aware of data, and the importance of data, than clinical opinion in many of these sorts of cases. What psychology offers, and what is stressed within the AMA fifth edition, is the need for psychological tests to support certain types of conditions, certain types of diagnostic status and certain types of functionality. That is where psychologists, in particular, have a lot to be offering in this area.

CHAIR: The dilemma is, if the legislation were changed to include clinical psychologists would they be happy to use PIRS, if that is retained as the measurement? Would you make it work or would you object to it?

Dr WHITE: We would be happy to try to make it a much more appropriate measure. There are some fundamental problems with PIRS, and we would be most happy to work through that with groups. But psychologists would have to say that—somebody used the analogy it is like using a diseased scalpel on an operation—it would be negligent almost to use that in its current form.

Professor MARTIN: My answer would be that it would put us in an interesting situation. Obviously as President of the Australian Psychological Society part of my mission is to support psychologists. Of course, the single thing that most distresses me about all this is how psychologists are being left out. That, of course, is bad for the profession and is also very bad for the public. We also feel that PIRS is not the right instrument to use. We really feel that some injured workers will lose as a result. If we were involved, but the tool we had to use was this, we would find it a very difficult situation to be in. The PIRS, as it is, is a real problem—that is our judgment.

Mr WILKS: It is obviously a step in the right direction from our point of view to have psychologists involved, with all the benefits they can induce, as I said, but we would hope that would be in the context of working onwards from here to improve the PIRS, or possibly even coming up with another system further down the track because at the end that has a real world outcome for workers. Yet again, I refer to the College of Physicians document in the conclusions of which they emphasise what is needed to improve health outcomes for injured workers and the development of nationally assessment guidelines. Those guidelines are to emphasise accepted scientific standards of evidence. We would hope that psychologists could be involved in the system and work with the other professions to develop guidelines of scientific credibility.

The Hon. RON DYER: Would psychiatrists and psychologists be compatible operating under this scheme?

Professor MARTIN: I would think so, in the same way as victims of crime. As I said, victims of crime, there are two professional groups that could be authorised to report. They are psychiatrists and clinical psychologists. Sometimes we defer to one, sometimes the other. I would see it in a similar way.

The Hon. RON DYER: I do not want to be too cynical, but it sounds to me as though you might need mediators because you have cast a lot of doubt on the efficacy of the PIRS measure. In practice, I really do not see how the two groups working under the system would co-exist.

Professor MARTIN: As I flagged earlier, there is often friction between the two professional groups, but again it should not be exaggerated. There is also lots of co-operation. My understanding, in fact, in terms of the case that we are making is that psychologists are united on this and psychiatrists are a little bit more divided. My understanding is that the Royal College of Psychiatrists, the national body, and the New South Wales section, in fact, is in line with our arguments on this. But there is a part of the college, namely forensic psychiatrists who have a different view. In a sense, the Australian Psychological Society is united and in agreement with our colleagues in the Royal College of Psychiatrists, except for one particular small sub-group.

Mr WILKS: In Victoria, there has not really been a problem, certainly not in the past decade at least. The two professions have worked quite amicably on this area. To be brutally pragmatic there is a workforce numbers issue here. There are only so many psychiatrists in Australia, some 2,200 I understand, of which 400 or 500 are in New South Wales. In Victoria the situation was—and this was another force which led to psychologists being included as assessors—there simply were not enough psychiatrists to do the assessments with the rapidity which is required and the various deadlines under the system. That was actually a major factor for psychologists coming into the system.

Professor MARTIN: Is it correct there has been talk of doing a trial of the PIRS? Our reaction to that would be that we are all for trialling.

CHAIR: And then assess its success?

Professor MARTIN: It reflects our scientific background that we are very much into assessing and evaluating instruments and so on. If consideration is being given to trialling the PIRS we would very much like to throw in two caveats. One is that very careful consideration would have to be given to how compensation was going to be awarded during the trial. In other words, given our very significant concerns about it, I think a lot of people could really miss out if the trial simply meant that it was used exactly as it is at the moment and that determines their

compensation. Careful thought would have to be given to try to make sure that no-one missed out. The second caveat is that we would hope such a trial would consider an alternative like the GAF system developed in America, but for which we have done an Australian modification, and possibly other alternatives.

The reason for that is that at the end of the day this is not about absolutes, it is about relativities. There is no such thing as a great scale here and a useless scale there. They will all have pros and cons. The question is which is the best scale for the job. If a trial with PIRS simply meant that the PIRS was given, and nothing else was, at the end of the trial no-one would really know whether it was a good scale. I would certainly plead, if there is going to be a trial, for those two things: the worker's rights being safeguarded and, at least, one other instrument being used concurrently.

CHAIR: Is there any problem in trying to be accurate in having this threshold established? Does PIRS help? Is it the simpler and more accurate way to get a threshold of 15 per cent?

Professor MARTIN: It is not the threshold that is our major concern. As Dr White pointed out, we have many concerns. I am never sure in a setting like this how familiar people are with different terms but we are not aware of any psychometric data testifying to the value of the PIRS. We are not aware that anyone has ever shown it is reliable. For example, if you give it on two occasions do you get the same result? Or if two different people use the instrument, do they come up with the same result? They are very fundamental things for assessing the scales, and we are not aware that that data has been collected. It may have been, but it has certainly not been made public, whereas we know the GAF has been tested extensively, and there is reliability data. It is that medium score. This idea of eliminating extremes is really what will make some people miss out.

The Hon. Dr PETER WONG: It is probably fair to say that both psychologists and psychiatrists take into account the previous history of the patient. There are cases, such as neuro-psychological assessment and psychometric, probably from time to time where it is more appropriate to be done by psychologists. My impression is that the psychological assessment is usually done by psychologists. They are hard to assess. They take into account the objective/subjective evidence and, therefore, are more difficult to categorise and often it is closer to normality, whereas a psychiatry, is based on mental assessment, on pathology—purely on evidence virtually. As a result, it is simplistic but it will cost WorkCover much less because there is no room for argument to present objective evidence. I agree that is not the totality of the whole picture.

Professor MARTIN: With respect, I would take a completely different view. The strong point of psychologists is their objectivity. They use the scientific method. I would have to say that I have been before many courts and, frankly, I get told repeatedly that the courts understand what I say which is rather more than they do with much of the submissions they get from psychiatrists. Because I think psychologists—I mean all disciplines have areas of jargon—talk much more in terms of jargon than psychologists. The rather broad assessments that psychologists do, which go beyond diagnosis, in my experience the courts find very easy to understand.

The Hon. Dr PETER WONG: In the PIRS system they are purely talking about objective evidence—they have insomnia, they have lost interest, they do not go out. If a person is caught going out to a pub that is taken as evidence that the person is not depressed. It is that type of evidence we are talking about. We are not talking in jargon; we are talking about hard, cold facts. This is simplistic and not the whole picture. But that is the PIRS system. You can assess it, you can look at it. It is probably totally unscientific and only part of the picture. But that is the evidence that WorkCover relies on, not the whole picture of psychiatry but these objective facts, which is not the totality of the picture, to save WorkCover money.

Mr WILKS: I would disagree very strongly that it saves WorkCover money. You can ask the Victorian WorkCover authority if that sort of approach has saved it money, because it has not. Their costs have blown out by billions. They have introduced the injury management system I mentioned, the *Sprains and Strains* model, which takes the complete opposite approach. The approach of getting an excuse to keep them off the system does not work because it induces an adversarial approach. The worker locks in harder to their illness role and to fighting the system. Their physical recovery is much slower because of the stress factors involved. Most people tend to stick in the system. Their lawyers help them to fight through the system. Models like this look not so much at cold, hard facts in the sense you are talking about but cold, hard facts in terms of what actually is our experience. Certain factors predict the long-term, difficult claims. They are factors such as early onset of psychological disorders such as depression, unsupportive work environment for a return to work, et cetera. They are the cold, hard facts that blow out costs.

CHAIR: Mr Wilks, could you help the Committee by tabling the documents you have been holding up? They can then be studied by the Committee.

Mr WILKS: Yes. This is the *Sprains and Strains* care model which is based on Canadian research in the province of Alberta. It has been a very successful program in reducing costs over there. It focuses on early intervention, particularly psychosocial factors.

CHAIR: And the other document?

Mr WILKS: This is a summary of the injury management system within insurers.

CHAIR: A moment ago when you held it up you said that there was a blowout in the Victorian costs. But that is the Alberta report.

Mr WILKS: That is a response thereto. The need was to come up with—

CHAIR: So the Victorian one is in that document, is it?

Mr WILKS: In those three documents, yes.

Dr WHITE: If I could make a further point, I think psychologists are aware of a whole range of areas that need to be looked at and measured, not simply one interview. Particularly in testing, you might be looking at personality factors. What classically happens in studies is that it is found that some people are more emotionally unstable. That is the nature of their personality trait. We know that that type of person is likely to experience stress more harshly and is likely to be much slower in recovering. We can make these sorts of predictions. With many of these tests we can get an idea of the distribution of the types of symptoms that they are experiencing. All of the data together is going to put you in a better position to forecast what is going to happy to the person than less data.

The Hon. Dr PETER WONG: I am saying exactly the same thing. In one page of A4 a psychiatrist will give you a less realistic diagnosis, whereas a neuro-psychologic or psychometric assessment usually comes in three or four pages and three sessions. You have much more detail and you are more accurate. I agree. I am saying exactly the same thing. But they are using simple, cold facts, which is not the totality. I am saying exactly the same thing.

Mr WILKS: But that simplicity is counterproductive if it creates costs down the line. If a more complex yet accurate and predictive picture is provided by a psychologist it has been shown that will save you money.

CHAIR: So PIRS is too rigid in a sense and you want flexibility in making of assessments to take into account many other factors.

Mr WILKS: To take into account factors which the evidence indicates are relevant and predictive factors of future difficulty.

(The witnesses withdrew)

OLAV NIELSSEN, Psychiatrist, 326 South Dowling Street, Paddington, sworn and examined:

CHAIR: In what capacity are you appearing before the Committee?

Dr NIELSSEN: I am currently the Chairman of the New South Wales Forensic Section of the Royal Australian and New Zealand College of Psychiatrists.

CHAIR: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act 1901?

Dr NIELSSEN: Yes, I did.

CHAIR: Are you conversant with the terms of reference of this inquiry?

Dr NIELSSEN: In general terms, yes.

CHAIR: If you should consider at any stage during your evidence that in the public interest certain evidence or documents you may wish to present should be heard or seen only by the Committee, the Committee would be willing to accede to your request, that is, we will go into camera.

Dr NIELSSEN: Thank you. I hope that will not be necessary.

CHAIR: Do you have anything you wish to highlight to the Committee or bring to the Committee's attention relating to the terms of reference for the inquiry, particularly given that the issue of psychiatrists performing the assessments and the PIRS scheme seem to be the two areas of contention?

Dr NIELSSEN: Not other than to say that I have spoken to most of the members of my section about the application of the PIRS, so I am hopefully able to present their opinions here. But I would perhaps be guided by your questions.

CHAIR: In what way are psychiatrists currently involved in workplace injury management, consultative forums, the administration of the workers compensation scheme and injury assessment?

Dr NIELSSEN: Psychiatrists are closely involved in workplace injury management through referral by general practitioners for treatment and also for assessments along the way. We have been consulted by WorkCover at various points during the development process for our opinions. With regard to injury assessment, a big part of our work is to provide opinions about the causation, treatment and prognosis of work-related injuries.

CHAIR: What skills do you believe psychiatrists bring to the assessment of psychological injuries?

Dr NIELSSEN: I think the skills begin with medical training and the practice of general medicine. Often there is psychological injury with physical injury—a psychiatric disorder. There is more and more scientific evidence showing that different disorders such as depression, psychotic illness and even anxiety disorders have a biological basis. That also applies to treatments. Biological treatments are also one of the mainstays of treatment; medications and other treatments. I think the experience of psychiatrists through their training—it is five years of closely supervised and intensive training, where you have exposure to thousands of patients—also makes psychiatrists quite skilled for assessing injuries and treatments, and providing opinions regarding prognosis.

CHAIR: It is the Committee's understanding that not all psychiatrists are in agreement that the PIRS, as utilised in the New South Wales workers compensation scheme, is the best method for measuring psychological injury. What are the pros and cons of utilising the PIRS method of assessing psychological injury?

Dr NIELSSEN: Firstly, as I understand it, it is only for measuring permanent impairment, so it is really a very small part of the whole business; only those who are permanently impaired are measured by that scale. The pros of it are that, firstly, it has been produced through a very exhausting process for the Motor Accidents Authority and it has widespread acceptance amongst psychiatrists. More than 80 psychiatrists have been trained in its use. As I understand it, there was some assessment of its reliability, and the reliability was actually quite good. The early use of it has shown some satisfaction by the people using it; that is, the psychiatrists are quite pleased with the way it works, and, as I understand it, the consumers on both sides have been fairly satisfied with the outcome so far. So it

has worked quite well in the two years that it has been in use in the Motor Accidents Authority. I think that is the main pro.

The cons are that there is no perfect system, and I think this is the best we have come up with. It is based on very extensive and widely accepted American Medical Association guidelines of impairment, so it is not as though it has just been created out of the air last week. I suppose another con is that some people are not happy about it, but I think it is really a matter of coming to understand it and see that it is being used.

CHAIR: We understand that psychologists are critical of the PIRS scale, but why would some psychiatrists be critical of it? Are you aware of any criticism of it within your own field?

Dr NIELSSEN: I only know of two people who have expressed an open opinion. Only a very small group of psychiatrists have been involved with its use, and it has only been in use for two years. I think one of the problems is that the wider group of psychiatrists are not familiar with it; it is only the forensic section, which is about 110-strong.

CHAIR: So the criticism is coming from those who are not familiar with the scheme and have not been trained in it?

Dr NIELSSEN: Yes.

CHAIR: You are fairly certain of that?

Dr NIELSSEN: One person who has expressed some doubts is actually a member of the section, but I understand she has not had the PIRS training and has not had much involvement. She is certainly not a practising forensic psychiatrist in the civil area, in this WorkCover and Motor Accidents Authority area.

CHAIR: It seems that even though a psychiatrist or psychologist may be highly trained, they need to be trained in the PIRS system to understand it; they need some training. What training is involved?

Dr NIELSSEN: The whole forensic area is a fairly specialised area, I think. The training is a training program in its use, involving many examples over several days. But training in forensic psychiatry is quite a long process; it is a distinct sub-specialty of psychiatry, in my view.

CHAIR: What training would be required to understand the PIRS system?

Dr NIELSSEN: They have had courses where they have trained people who have applied to the Motor Accidents Authority—

The Hon. GREG PEARCE: Who runs the course?

Dr NIELSSEN: The Motor Accidents Authority.

CHAIR: What is the duration of the course?

Dr NIELSSEN: As I understand it, it is two separate days. But I have not done it myself, because I do mainly criminal forensic psychiatry, which gives you an idea of how distinct the specialisation can be in these areas.

CHAIR: Do you use the PIRS scale at all yourself?

Dr NIELSSEN: No, I have not. I am speaking largely for the psychiatrists in the section, the people who do mainly civil work. I have been involved in a study of reports prepared for the Motor Accidents Authority, having a look at the reports and the whole industry. I am happy to table the study. It shows some quite extraordinary findings which relate very much to injury management. The PIRS is just the assessment of permanent impairment.

The Hon. GREG PEARCE: Could you outline the conclusions from the study?

Dr NIELSSEN: It is a study of 227 reports in Motor Accidents Authorities by Dr Matthew Large and myself. They were NRMA cases. There were some extraordinary findings. One of them was that the conclusions reached by the experts for the plaintiff and the defence were different—which is not surprising, but this is the first

study of its kind in the common law world to show it. But what I thought was extraordinary was that there was very little overlap between those experts; they were all for one side or the other, apart from six out of the 227. The time of the assessments was, on average, two years later for the plaintiff and 30 months later for the defence, so it was way after the injury.

We could not really work out the quality of the report reliably, according to our study, but we could work out the completeness. It showed that psychiatrists did significantly better reports than psychologists, apart from a few elite psychologists, particularly neuro-psychologists and those who were established in the industry. There were a number of findings but I am happy to give you the whole thing rather than summarise it. One of the distressing findings was that in post traumatic stress disorder there is no agreement even among experts on the same side, where two experts have been qualified by the defence and the plaintiff, and they did not agree.

The Hon. Dr PETER WONG: Do you agree that the PIRS system is based only on certain criteria and not a holistic picture of the assessment of the client as a result of injury?

Dr NIELSSEN: I think it is reasonably holistic in how the injury affects their life but it is based on fairly objective criteria which can be observed. Many psychiatric disorders are diagnosed entirely on subjective criteria, for example, post traumatic stress disorder.

CHAIR: You are aware that psychiatrists are the only people who can do the assessment under the WorkCover legislation.

Dr NIELSSEN: Yes.

CHAIR: Would you recommend that that be extended to include clinical psychologists who have been trained in the PIRS system?

Dr NIELSSEN: Assessment of permanent impairment has always been the domain of medical specialists. A psychologist's input is very valuable, particularly as mentioned by my colleagues here earlier, in neuro-psychological assessment and assessment of brain damage, for example. Psychological input is very important but it has always been the domain of medical specialists to determine permanent impairment, because that is all PIRS does. It determines permanent impairment.

The Hon. Dr PETER WONG: The evidence presented earlier to the Committee was that psychologists are able to analyse more in detail the whole psychological component both before and after the accident and they are looking at it in totality. In fact, they were saying that they are perhaps even more objective than a simplistic version of PIRS.

Dr NIELSSEN: It is still based on self-report questionnaires. All psychological tests are based on self-report questionnaires. If you feed a person the symptoms, of course they give them to you, depending on their tendency to answer a certain way.

The Hon. RON DYER: Were you present earlier this afternoon when the representatives of the Australian Psychological Society were giving evidence to the Committee?

Dr NIELSSEN: Yes, I was here for the latter half of it.

The Hon. RON DYER: I think you would agree that they appear to have a heightened sense of grievance that they are not involved in this assessment process. How justified or otherwise do you think that grievance is, or would you prefer not to comment?

Dr NIELSSEN: I would probably prefer not to comment after what I have heard today, but I do feel for them. They do have a very valuable role to play but it is not in the assessment of permanent impairment. That has to be the domain—it always has been in the past—of medical specialists.

The Hon. Dr PETER WONG: Is there a philosophical view that the angle taken by psychiatrists in many ways is totally different from the standpoint of psychologists, coming from a different angle, looking at the whole thing, and therefore the PIRS system in many ways would be not unacceptable to them as a standard because of the different philosophy?

Dr NIELSSEN: No. You find that the similar areas of impairment come up in the scale, the global assessment of functioning in DSM. It has its problems too. I do not accept that it is a better scale at all. You are talking perhaps the difference of psychologists coming from the humanities background and psychiatrists coming very much from a medical and scientific background reaching a similar area of interest in the clinical problems.

The Hon. Dr PETER WONG: In some instances the interpretation is totally different, such as in the assessment of impairment now.

Dr NIELSSEN: I do not see those huge differences in practice, to be honest. When you are in multidisciplinary teams you find that there is agreement. You mentioned that there is a sense of grievance about the choice of scale but I do not think that is a very important problem. I do not think the GAF is a suitable scale.

The Hon. RON DYER: This afternoon the psychologists were asked whether, if for the sake of argument they were included in this process—that is, the assessment process that WorkCover is responsible for—they would have difficulty in operating under the PIRS system, and the answer was very definitely in the affirmative. They would and they would require another measure to be applied. There does not seem to be, so far as I can tell, much compatibility between their approach to the matter and that of the psychiatrists.

Dr NIELSSEN: I suppose one of the problems they will have with it is coming to a medical diagnosis before you can start the assessment. Clearly they are not qualified to do that—they are not qualified to do that in courts—and obviously that will be a problem.

CHAIR: You used the words "total impairment" earlier. Is it "total impairment" or "permanent impairment"?

Dr NIELSSEN: Permanent impairment—I beg your pardon.

CHAIR: Another matter raised is that there is only a limited number of psychiatrists and we should expand this so that there are more people doing the assessments. How many people are involved? I suppose it is hard to say because you would have a lot of injuries and so on. But just taking average figures, are there sufficient psychiatrists to do the assessments, particularly in regional areas? Is there a problem with the supply of those specialised people?

Dr NIELSSEN: I guess there might be in regional areas. A lot of people do come from the country for reports. I think as the process of case management is improved, because that is where the real problem is—the problem is with case management, not with the assessment of impairment—and as other ongoing assessments and treatments are improved the demand for these kinds of assessments and hopefully the cost to the system will go down. I think there are enough psychiatrists. I cannot think of any psychiatrist who is fully employed doing this sort of thing, and neither should they be.

The Hon. RON DYER: In relation to case management, in their submission the psychologists said that the powers of insurers in the injury management process should be reduced. Do you have any view on that?

Dr NIELSSEN: I think their duties should be increased, their duties to take an active role in assessing a person early and making sure that they are getting treatment early, rather than sitting around for 24 and 30 months before they get assessed.

The Hon. RON DYER: The view that the psychologists seemed to be putting to us was that perhaps the insurers do not do the right thing by the patient or the client. Do you share that view, or do you think that by and large clients are appropriately managed in the system by the professionals who are involved?

Dr NIELSSEN: It very much falls on to the general practitioner to co-ordinate it, their nominated doctor to co-ordinate it, without getting much guidance or communication from the insurance company. I think that is the problem. In my experience of treating patients who have been injured at work, they just sit around until the insurance company gets sick of them. Then the insurance company cuts them off and they are furiously angry and of course in difficulty, and then they are in an adversarial setting. They have never spoken to anyone from the insurance company except the person to whom they are submitting bills.

The Hon. Dr PETER WONG: As a general practitioner I would like to add a comment. At no stage has either WorkCover or an insurance company ever encouraged a GP for early reporting or encouraged early return to work. No such brochure or propaganda has ever been published. Maybe they have been published but they have

never been widely distributed to general practitioners. That is one thing. Often it is partly also the lawyers. In my experience a lawyer will very nicely see a client for the first time and subsequently it is hard to get hold of them and they drag on and on and on.

CHAIR: Just to clarify something I raised earlier, do you have any objection to clinical psychologists being included in the availability of assessment? The legislation forbids it but if it was amended would you have any objection? Do you think that is a helpful proposition?

Dr NIELSSEN: Do you mean in the assessment of impairment?

CHAIR: Yes, in this area of permanent impairment. Could they do it? In your honest opinion do you see any problems with clinical psychologists doing assessments if they were carefully selected—not all psychologists but those who are selected by a panel?

Dr NIELSSEN: Yes, the highly qualified ones on a panel. I think perhaps a psychological opinion as well could be quite valuable.

The Hon. RON DYER: Would they be happy or comfortable operating within the PIRS environment?

Dr NIELSSEN: Because they would be working with a psychiatrist who would make the initial diagnosis and then for them to give an additional opinion of the psychological issues, I think that would be quite helpful because it is a big step to make someone permanently impaired, particularly on the grounds of a psychological or psychiatric disorder.

CHAIR: Why do you think WorkCover chose the PIRS method of assessment?

Dr NIELSSEN: I think because of the thoroughness with which the Motor Accidents Authority investigated and developed it and its initial success. I think they are the main reasons. Also, there was a ready group of trained people who were familiar with its use, that they have overlapping kind of problems to motor accident type victims, people subject to work accidents or work-related harm.

CHAIR: Are you aware of any criticism of the use of PIRS in the motor accident area?

Dr NIELSSEN: No I am not.

The Hon. RON DYER: You would regard it as an appropriate and objective measure of impairment, would you?

Dr NIELSSEN: It is not perfect but I think it is quite appropriate. I think the criticism of using medians is actually misguided. That is a good way of getting an estimate across a whole range of impairment.

The Hon. Dr PETER WONG: Do you think it is cost saving as far as the WorkCover system is concerned? Will introducing PIRS save the taxpayer and the Government?

Dr NIELSSEN: I am not the person to inform you on that. As I understand it, people still become permanently impaired. There is still quite a comparable number on psychological and psychiatric grounds to those assessed as permanently impaired because of physical injuries. It is not, as I understand it, stopping people from becoming permanently impaired but it is not the area where cost is. Cost is very early on—the waste is in the injury management to start with. Indeed, if injuries were managed properly the number of people eventually found to be permanently impaired would be greatly reduced in my view.

The Hon. RON DYER: What would need to happen for injuries to be managed properly as you say?

Dr NIELSSEN: I think the moment a person lodges a claim it is a case manager who has some training in occupational health or psychology, where appropriate depending on the nature of the injury, is then in regular contact with their general practitioner. Remunerate the general practitioners properly for their time in being the co-ordinators and starting an active program there and then. It is a little bit perhaps like battle stress. To deal with post traumatic stress in battle you do not take them back; you deal with it at the front line. I think the same should apply to psychological problems after a work accident.

The Hon. RON DYER: So you are saying that the role of the general practitioner is crucial, are you?

Dr NIELSSEN: Yes, because they have an existing relationship usually with the person in most cases and they are certainly in the best position to co-ordinate all the different specialists involved, because there is usually physical as well as psychological and other rehabilitation problems.

CHAIR: Some of the criticism that has been raised about the PIRS scale goes something like this: It is not a good scale because it leaves out, ignores the most severe measuring category. Do you understand that? From your viewpoint is that a valid criticism, or does it mean that people do not understand how the PIRS scale works?

Dr NIELSSEN: It is over a whole range of functions. It is not just in one area and I think you rarely get impairment in one area without significant impairment in the other areas. I think it is quite a reasonable way of assessing overall impairment. We are looking at permanent impairment and it should be in all areas. You will not get permanent impairment if you cannot get into a train to go to work—if impairment only in the area of transport, for example—and that is high because your anxiety is in that area. That is very likely to the treatable. They are very likely to recover. However, if you have impairment across all areas of function then it is more likely to be a permanent impairment. In scientific studies if you have an extreme result you often exclude that because it is not representative. I think the same perhaps applies in this type of assessment.

The Hon. Dr PETER WONG: An earlier witness referred to the case of a person who suffered from a phobia that prevented her from travelling and therefore she could not return to work. Her other functions were totally normal and thus she was excluded under PIRS, which deemed her normal and able to return to work. In reality, she can never return to work because of her phobia. How do you explain a case such as that?

Dr NIELSSEN: That is a good example. On the whole, phobias are quite treatable and do not produce total impairment—they produce impairment only in the area where the phobia exists. You do not want to make permanently impaired people with treatable or remitting disorders or those in situations where rehabilitation is possible. The person in that case could use alternative transport or work from home, for example.

CHAIR: Would you like to add anything to your evidence that might assist the Committee?

Dr NIELSSEN: No, I cannot think of anything. Thank you for allowing me to contribute to the inquiry.

CHAIR: Have you had discussions with the author of PIRS?

Dr NIELSSEN: Dr Parmegiani is the lead author of the scale; it was a group effort. Julian was my predecessor in this role and I have sought his advice, and that of others, about it.

CHAIR: Have you worked with him?

Dr NIELSSEN: Our biggest association was when we trained together as psychiatrists. We were recently co-conveners of the forensic section conference and I am familiar with some of the issues as I met with him every month.

CHAIR: Did you help to develop PIRS? Dr Parmegiani is the author; are you a co-author?

Dr NIELSSEN: No. His name is attached to it but I understand it was a team effort. I am involved mainly in the criminal area; I have not been involved in the development of PIRS.

CHAIR: Thank you for giving us your valuable time today. We appreciate it. If any Committee members have further questions, may they send them to you?

Dr NIELSSEN: Of course. I will be pleased to assist them.

Report entitled "Australia and New Zealand Journal of Psychiatry, August 2001, Vol. 35, No. 4" tabled.

(The witness withdrew)

(The Committee adjourned at 4.33 p.m.)