ISCRR Research Forum
“Does Injury Compensation Cause Harm?”
Impact of compensation on the injured person

Ian Harris
Whitlam Orthopaedic Research Centre
Ingham Institute for Applied Medical Research
UNSW, SWSLHD
Definitions

Compensation

Injured
Overview

Some evidence,

and some stories
The good news

“I’m glad that at least I have the opportunity to have some sort of recompense out of this, I would probably find it harder to face if there was nothing at the end of it but more bills.”

“I thought, there’s no way I could have done this on my own”

Murgatroyd, Injury Prevention 2011
The trigger

43, female, picture fell onto leg in 2005

30, female, bilateral hip pain, for approval for surgery
“And what is upsetting also, the whole time that I was in hospital and the whole 12 months I was recovering he was driving around”

“I want money, that’s it”

Murgatroyd, Injury Prevention 2011
Historical view

Steel nib syndrome

“is a disease easily imagined by those who have witnessed the disorder”

Telegrapher’s cramp

RSI
Some evidence

Association Between Compensation Status and Outcome After Surgery
A Meta-analysis

“Compensation status is associated with poor outcome after surgery.
This effect is significant, clinically important, and consistent”
• Harris et al

Back pain, neck pain, psychological distress, general health

After MVA or orthopaedic trauma
The Effect of Financial Compensation on Health Outcomes following Musculoskeletal Injury: Systematic Review

Darnel F. Murgatroyd\textsuperscript{1,*}, Petrina P. Casey\textsuperscript{1}, Ian D. Cameron\textsuperscript{1}, Ian A. Harris\textsuperscript{2}
<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Physical Function</th>
<th>Psychological Function</th>
<th>Pain</th>
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<tbody>
<tr>
<td>Strong evidence</td>
<td>Lawyer involved</td>
<td>Compensation claim</td>
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<tr>
<td>Moderate evidence</td>
<td>Compensation claim</td>
<td>Lawyer involved</td>
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<td>Compensation at 2 years</td>
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<td></td>
<td>Fault</td>
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<tr>
<td>Limited evidence</td>
<td>Number of sick days in prior 3 years</td>
<td>Compensation claim</td>
<td>Number of sick days in prior 3 years</td>
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<td>Prior claim</td>
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<td>Prior claim</td>
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**Factors not associated with an outcome**

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<thead>
<tr>
<th>Evidence Level</th>
<th>Physical Function</th>
<th>Psychological Function</th>
<th>Pain</th>
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<tbody>
<tr>
<td>Limited evidence</td>
<td>Claim type</td>
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<tr>
<td>Inconsistent evidence</td>
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<td>Claim type</td>
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<tr>
<td>Physical function</td>
<td>Psychological function</td>
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<td>Compensation claim</td>
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<tr>
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<td></td>
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<tr>
<td>Fault</td>
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What are the predictors of claim / legal?

- Socioeconomic status
- NOT injury severity or pre-injury health
- All outcomes worse for compensated group, despite similar injuries
The relationship between compensable status and long-term patient outcomes following orthopaedic trauma

Belinda J Gabbe, Peter A Cameron, Owen D Williamson, Elton R Edwards, Stephen E Graves and Martin D Richardson

Disability, physical health, mental health, return to work, all worse
Do you really need the evidence?
Paradox

Aim of compensation system

Effect of compensation system
Unintended consequences

Compensation proportional to injury
Perverse incentives

• Back pain
• Lumbar fusion surgery
• Increasing direct costs
• Increasing compensation (WPI)
• Net harm
Medicare data, Australia, lumbar fusion
Overall trend (public)

Public Spinal Fusions (NSW)
Spine surgery outcomes?
UNSW invention set to revolutionise back surgery

26 Nov 2015 | Dan Wheelahan

Medical scientists have invented a new spinal fusion device to reduce chronic back pain, the most common reason for pain and disability in people aged under 50.
What are we treating?

- Back pain

<table>
<thead>
<tr>
<th>Factors</th>
<th>The conclusion of evaluated systematic reviews</th>
<th>Overall</th>
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</thead>
<tbody>
<tr>
<td>Post injury MRI or radiologic findings</td>
<td>N, N</td>
<td>Not predicting, limited data</td>
</tr>
<tr>
<td>Motor dysfunctions</td>
<td>N</td>
<td>Not predicting, limited data</td>
</tr>
<tr>
<td>Collision factors</td>
<td>N, N, N, N, C</td>
<td>Not predicting</td>
</tr>
</tbody>
</table>
The injury paradox

• Rates of verifiable physical injury are falling

• Rates of non-verifiable, subjective ‘injury’ are rising
Solutions

• Dismantle system?

• Disconnect payments for treatment?

• Compensate for initial and objective diagnoses only?
Solutions

• Dismantle system?
• Disconnect payments for treatment?
• Compensate for initial and objective diagnoses only?

• **Reduce medicalisation** (demand evidence of injury, evidence for treatment)
• **Recognise and address harms** and perverse incentives inherent in system
Using registry data and patient perception studies to better understand the impact of compensation on patients’ lives

BELINDA GABBE
MONASH UNIVERSITY
Using registry data and patient perception studies to better understand the impact of compensation on patients’ lives

Professor Belinda Gabbe
Head of Pre-hospital, Emergency and Trauma Research
Background

- Complex and multi-dimensional
- Limited understanding of patterns of recovery
- Health care is only one component of the recovery process
- Compensation commonly identified as a risk factor for poorer outcome but why?
Opportunities

- Victorian State Trauma Registry (VSTR)
  - All major trauma patients in Victoria
  - Follow-up at 6, 12 and 24 months
  - Receives TAC claim data

- Victorian Orthopaedic Trauma Outcomes Registry (VOTOR)
  - Orthopaedic trauma patients admitted >24h to Alfred, RMH, UHG, TNH
  - Follow-up at 6, 12 and 24 months
  - Receives TAC data

- NHRMC funded REcovery after Serious Trauma- Outcomes, Resource use and patient Experiences (RESTORE) study
  - Follow-up of ≈2,500 major trauma patients from the VSTR at 3, 4 and 5 years
  - Nested, longitudinal qualitative study of ≈170 patients
What is the association between compensable status and long term outcome in Victoria?

(VSTR)
Function (GOS-E)
Significantly lower adjusted odds of a better functional outcome at each time point

BUT

Significantly higher adjusted odds of improvement in GOS-E at each time point
Return to work

% of cases

- No
- Yes

<table>
<thead>
<tr>
<th>Compensable</th>
<th>Medicare</th>
<th>Private</th>
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<tbody>
<tr>
<td>6</td>
<td>12</td>
<td>24</td>
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<td>6</td>
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<td>6</td>
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Significantly lower adjusted odds of a return to work at each time point

BUT

Significantly higher adjusted odds of improvement in return to work at each time point
Fault as an explanatory factor for poorer outcome in TAC patients (VOTOR)
Agreement between patient and police

<table>
<thead>
<tr>
<th>Patient-report</th>
<th>Police report</th>
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<tbody>
<tr>
<td></td>
<td>Patient’s vehicle not at fault</td>
<td>Patient’s vehicle at fault</td>
<td></td>
</tr>
<tr>
<td>Another person at fault</td>
<td>1,152</td>
<td>191</td>
<td></td>
</tr>
<tr>
<td>No other person at fault</td>
<td>92</td>
<td>1,170</td>
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</table>

- **Kappa 0.78 (95% CI: 0.76, 0.81)** - consistent by road user group
- **50% not at fault**
  - 29% of motor vehicle drivers
  - 85% of motor vehicle passengers
  - 37% of motorcyclists
  - 90% of pedal cyclists
  - 76% of pedestrians
Adjusted for age, sex, comorbidities, education level, geographic remoteness, major trauma status, prior work history, orthopaedic injury group, and presence of non-orthopaedic injuries.
Denies fault group vs. At fault group

Adjusted for age, sex, comorbidities, education level, geographic remoteness, major trauma status, prior work history, orthopaedic injury group, and presence of non-orthopaedic injuries
<table>
<thead>
<tr>
<th>Fault category</th>
<th>N</th>
<th>Mean (SD)</th>
<th>Adjusted change from at fault group</th>
<th>p Value</th>
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<tbody>
<tr>
<td>EQ-5D-3L summary score</td>
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<tr>
<td>At fault (reference)</td>
<td>996</td>
<td>0.72 (0.28)</td>
<td>0</td>
<td></td>
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<tr>
<td>Admits fault</td>
<td>77</td>
<td>0.63 (0.30)</td>
<td>−0.06 (−0.13 to 0.002)</td>
<td>0.06</td>
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<tr>
<td>Denies fault</td>
<td>159</td>
<td>0.66 (0.30)</td>
<td>−0.07 (−0.12 to −0.03)</td>
<td>0.002</td>
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<tr>
<td>Not at fault</td>
<td>966</td>
<td>0.65 (0.30)</td>
<td>−0.09 (−0.11 to −0.06)</td>
<td>&lt;0.001</td>
</tr>
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*Adjusted for age, sex, comorbidities, education level, geographic remoteness, whether patient was major trauma, prior work history, orthopaedic injury group, head injury, chest/abdominal injury, other injury and cause of injury.
†If working for income prior to injury.
ARR, adjusted relative risk; GOS-E, Glasgow Outcome Scale—Extended.
Patient experiences with the TAC (RESTORE)
<table>
<thead>
<tr>
<th>Group</th>
<th>Key themes</th>
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<tbody>
<tr>
<td>Positive themes</td>
<td>Financial assistance provided</td>
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<td></td>
<td>Good service</td>
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<td>Needs met</td>
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<tr>
<td>Negative themes</td>
<td>Problematic communication and interaction with the TAC</td>
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<td></td>
<td>Issues with TAC processes</td>
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<td></td>
<td>Difficulty accessing treatment and services</td>
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<td></td>
<td>Financial burden</td>
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<tr>
<td>Mixed views</td>
<td>Good and deficient aspects of TAC services</td>
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<td>Change in service approach at 3-years</td>
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<tr>
<td>Suggestions for improvement</td>
<td>Communication and information</td>
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<tr>
<td></td>
<td>Needing an advocate to engage with the TAC</td>
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<td>Needing flexibility in TAC policies</td>
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<td>Greater accountability for contractors employed</td>
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</table>
"I was given a case manager at the very beginning, that case manager never spoke to me. It was six months in to being looked after that I actually rang up and spoke to the case manager for the very first time. I had to initiate contact. She didn’t want to know anything."

"And without the lawyers telling me that I was able to contest things, I would have just been bulldozed into accepting what the TAC has told me as fact."

"If you don’t do the research and find out your entitlements, because these p#$@ don’t tell you anything. When I ring them up and say we’re entitled to this, they say yes you are. But it’s something that I’ve come across, somehow, through other people."

"But TAC, they didn’t help me one little bit. Everything I did with them was a disaster....But in the end I thought the stress it’s causing me I could be putting in to getting well. So I just chose to stop even making any claim for anything. And, financially, it’s really impacted me hugely."
“In one area they penny pinch and the other area they waste money.... I found out with TAC, they screw you on the $10 items and don’t worry about the big items.”

“Physiotherapy, I’m on the tail end of physiotherapy now, because apparently they could only offer me physiotherapy if it’s going to improve the condition....If it comes to maintaining my condition, they won’t pay for it anymore. I think that’s just absolutely incredible.”

“I just don’t understand how they cannot take on board advice from treating professionals. It must be pretty difficult to be a physiotherapist who says I think this person needs to have this service and this service, and the TAC says we disagree. It’s like the doctor says I think this person needs antibiotics for this infection, and the TAC says no they don’t.”

“The TAC sent me to some other mob (name of employment agency), who are absolutely useless. I found my own job, basically. She came in and I said a few things, and these are my injuries, and this is where I’m at. I didn’t hear nothing for months.... If I was on the tools I’d find something, but I’m not officially trained in the position or anything. (Name of employment agency), didn’t offer anything like that. Even a typing a course. I don’t know what they were doing. They just disappeared off the planet.”
Patient recommendations for improvement

- Communication
  - Single point of contact
  - Regular and clear communication
  - Transparency
  - Empathy

- Need for an advocate to engage with TAC on their behalf

- Flexibility in TAC policies

- Greater accountability for service providers/contractors
Closing comments
Outcomes are poorer for compensable patients but improvement continues over time

- Catch up to non-compensable patients?

Perception of fault an important predictor of outcome

- Does this explain the difference between compensable and non-compensable patient outcomes?

Injury impacts are numerous and far reaching

Patient interviews tell of a stressful, challenging interaction with compensable agencies

- Room to improve?
Acknowledgements

- VSTORM and VOTOR investigators and project personnel
- RESTORE study investigators
- Participating hospitals and patients
- NHMRC, ISCRR, TAC and the State Government of Victoria
This project is proudly supported by the Transport Accident Commission
This project is funded by the Transport Accident Commission (TAC), through the Institute for Safety, Compensation and Recovery Research (ISCRR).
Injury, compensation & perceptions of injustice: A pain that deserves more attention

Dr Melita Giummarra

School of Psychological Sciences, Monash University

Caulfield Pain Management & Research Centre, Caulfield Hospital
Overview

• Compensation and pain

• Just world beliefs, perceived justice and trauma
  – Fault and trauma impacts
  – Procedural justice

• Implications of our findings for compensation and healthcare systems
  – Consideration of treatments in the context of perceptions of injustice
  – Enhancing the experience of procedural justice
Pain after compensable road injury

What is the evidence?

- 70% of studies reported adverse pain outcomes in relation to compensation
- The remaining studies reported no major differences, and no studies reported positive outcomes
- Compensable injury was consistently related to:
  - Self-reported chronic pain: incidence, intensity or disability
  - Incidence of related mental health disorders (PTSD, depression)
  - Poorer return to work
- Pain outcomes were especially related to:
  - Lawyer involvement
  - Tort or common law-based
- The quality of evidence is poor
  - 37% studies were low quality with high potential for bias
  - 44% did not control for confounding factors
  - Control group often not equivalent to the compensable group

Inclusion criteria:
- Compared comp/ non-comp groups or schemes
- Measured pain as outcome

5619 studies (Oct 2013)
230 studies met initial criteria
27 studies included for review

(Giummarra et al., revision under review, Clin J Pain)
Pain after compensable road injury

- These insights are not ground breaking nor are they informative
- They do not tell us a lot about WHY compensable injuries lead to poorer outcomes.

- Factors that are implied include:
  - Perceptions of injustice
  - Attributing blame to another
  - The stressful nature of seeking compensation especially in adversarial systems
Pain, recovery…. Just world beliefs

The world is an orderly, predictable and “just” place

People get what they deserve

Our actions have predictable consequences

Why do these “just world” beliefs matter during/after trauma?

• We behave in ways that are consistent with the beliefs we hold about the world and ourselves. They are the road map to human behaviour.

• Beliefs will play a major role in recovery from traumatic injury, informing perceptions of injustice, feelings of retribution, acceptance, external vs internal locus of control, assumption of “sick” vs active role, responsibility over injury and self-management in recovery.

• …. Beliefs may even be more in predicting outcomes than objective ability.
Just world beliefs, trauma and pain

- Procedures involved to seek/receive compensation or healthcare are fair & equitable

TRIUMA INCIDENT

- Communication and information provided is reasonable, timely & specific.

PROCEDURAL JUSTICE

- Communication is bidirectional.

DISTRIBUTIVE JUSTICE

- The processes for communication and decision making allow the client to feel that they have been treated with respect & dignity.
- Decisions and outcomes are perceived to be fair (e.g., when client feels that decisions were made using fair procedures, and/or when the healthcare/entitlement decisions match the actual/perceived severity of their injury).

• Fault & attributions of blame
• Loss of property
• Functional impairments
• Lost income
• Emotional and social impact
• Impact of the incident on other victims and/or person at fault
Perceived injustice and pain-related outcomes

- Perceived injustice
  - Irrreparability
  - Blame
  - Back injury
  - Days in hospital
  - Length of claim

- Therapeutic alliance
  - Anger
    - Depression
    - PTSD
    - Return to work
    - Quality of life
    - Pain severity/intensity
    - Pain-related disability
  - Pain Catastrophising

Institute for Safety, Compensation and Recovery Research (ISCRR)
Our research partnership with the TAC (2013-16)

Overarching aims of the research were to:

Aim 1. Understand the association between psychological distress, perceived injustice and return to pre-injury function (i.e., return to work) after traumatic injury.

Aim 2. Investigate the role of compensation system experience in recovery from traumatic injury, especially pain and pain-related disability.

To identify modifiable aspects of compensation system and/or healthcare delivery to improve trauma recovery.
METHODS: Study design

Recruitment

- 208 injured persons admitted to The Alfred Hospital for traumatic injury and part of VOTOR or VSTR registries.
- Participants were invited to take part during the 12-month registry interview.

Registry data:

- injury severity score
- Information about the trauma
- SF-12
- fracture determined from ICD-10-AM
- days hospitalised
- discharge location
- work status

Additional data collected:

- Brief Pain inventory (intensity; interference)
- Pain Self Efficacy Questionnaire
- Pain Catastrophising Scale
- Roland Morris Disability Questionnaire
- Hospital Anxiety and Depression Scale
- Posttraumatic Stress Disorder Checklist
- Injustice Experience Questionnaire
Injustice Experience Questionnaire

1. Most people don’t understand how severe my condition is.
2. My life will never be the same.
3. I am suffering because of someone else’s negligence.
4. No one should have to live this way.
5. I just want to have my life back.
6. I feel that this has affected me in a permanent way.
7. It all seems so unfair.
8. I worry that my condition is not being taken seriously.
9. Nothing will ever make up for all that I have gone through.
10. I feel as if I have been robbed of something very precious.
11. I am troubled by fears that I may never achieve my dreams.
12. I can’t believe this has happened to me.
Injustice Experience Questionnaire

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Subscales

Severity
Blame

Rated from:
0 = never
1 = rarely
2 = sometimes
3 = often
4 = all the time

Sullivan et al. (2008)
Cohort overview

- Two hundred and eight participated (51.2% response rate)
  - **Sex**: Predominantly male (n=158, 76%)
  - **Education**: Two thirds were tertiary educated (n=127, 65.1%)
  - **Aged**: 17-65 years old (m=45.28, sd=14.05)
  - **Work before injury**: 183 (88%) were working before injury
  - **At Fault**: 106 (51.5%)
  - **Compensable (n=76)**
    - TAC n=66 (86.8%)
    - WorkSafe: n=9 (11.8%)
    - Other: n=1 (1.3%)
  - **Injuries**
    - Injury Severity Score: 1-59 (m=13, sd=10.03; 95% CI: 11.63, 14.37)
    - Fractures n=190 (91.3%)

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<th>Compensable</th>
<th>Non-compensable</th>
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<tr>
<td>ISS</td>
<td>m (sd)</td>
<td>17.67 (11.96)</td>
</tr>
<tr>
<td>Days in hospital</td>
<td>m (sd)</td>
<td>2.28 (4.42)</td>
</tr>
<tr>
<td>Discharged to rehabil</td>
<td>N (%)</td>
<td>32 (42.1)</td>
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Perceived injustice: Severity & Blame

• **Severity/irreparability of loss**
  – Greatest in those with lower education ($\leq$ Year 11) & low household income ($20-40k$)

• **Blame**
  – Lowest in the group with the highest household income ($>100k$)

• **Both Severity and Blame scores were higher in those:**
  – Not working at 12-months
  – Injured in a road accident
  – Not being at fault in their accident
  – Who consulted a lawyer
Predictors of perceived injustice

Consulting a lawyer and work status were significant indicators of perceived injustice (41.9% of variance), when adjusting for age, sex, education, accident type (MVC/other), household income at 12-months, fault & ISS.

Additional variance was explained by:

- Mental and physical functional status at 12-months (10.8%)
- Pain catastrophizing (8.9%)
- Pain interference (8.3%)
- Pain self-efficacy (5.2%)
- Pain-related disability (2.5%)
- Pain intensity (1.6%)
Perceived injustice only significantly predicted **clinically elevated PTSD symptoms** (not anxiety and depression) when controlling for age, sex, road trauma, lawyer, RTW, fault, ISS, pain catastrophizing, interference, intensity).
Perceived injustice and return to work

- 41% of the variance in failure to RTW was explained, with 87.1% accuracy, by older age at injury, limb fracture severity (severe c.f. none, minor), brain injury, hospitalisation (days), discharge to rehabilitation (c.f. home) and compensation status.
- Symptoms of depression, anxiety, PTSD and perceived injustice explained an additional 13.4% of the variance, and identified who would return to work with 96.0% accuracy, and who would fail to return to work with 53.6% accuracy.
- Only perceived injustice uniquely predicted RTW when adjusting for all other factors.

The likelihood of returning to work in compensable participants was mediated by perceptions of injustice.
Overview of findings

• The present cohort was functioning well and had a high rate of return to work.

• Perceived injustice was associated with:
  – Consulting a lawyer
  – Not working 12-months following injury
  – Reporting higher emotional and physical functioning impairments
  – Pain interference
  – Pain catastrophising
  – Elevated symptoms of PTSD

• Perceived injustice mediated the relationship between receiving compensation and returning to work.
Implications: Early detection

Early detection of clients who are more vulnerable to experiencing perceived injustice.

**Early Risk Factors:**
- Attributions of blame
- Disabling/severe injury (e.g., long hospitalisation, required rehab, limb #)
- Work status following injury
- Household income at time of injury
- Prior embitterment and/or psychological disorders
- Rumination about the injury/incident
- Sense of hopelessness
- Consulting a lawyer

**Delayed Risk Factors:**
- Consulting a lawyer
- Failure to return to work/study

**Justice in the compensation process**
- Procedural justice
- Informational Justice
- Interactional justice
Implications: ↑ Procedural Justice

- Some procedures will be perceived to be a greater barrier to clients who already feel like they’ve experienced injustice
  - Independent medical examinations The TAC IME panels should help reduce the incidence of disputes about medical examination
  - Complicated paperwork
    - Especially for those with poor health literacy or reading/writing
  - Long waiting times for claim outcomes
  - Fault vs No-fault entitlements

(Kilgour et al. 2015, Elbers et al., under review, MJA)
Implications: ↑ Interactional Justice

• Communication style is important:
  – **Content** of verbal communication (i.e., what is said)
  – The **paralinguistic characteristics** (i.e., how it is said, such as tone and volume)
  – **Motivational interviewing** – engage intrinsic motivation in clients to change their behaviour

• Do not **validate** embitterment: This will escalate behaviour.

• Avoid **dismissing** feelings of injustice/embitterment or giving the impression that the person should “just move on”
  – This may also escalate feelings of anger and retribution, and reinforce the sense that the severity of their condition is not taken seriously.

• There is a fine line between listening empathically and acknowledging the client’s feelings and reinforcing feelings of injustice.

(Sensky, 2010)
Implications for healthcare

• Early identification

• Acceptance and Commitment Therapy
  – Focuses on the processes of thinking rather than the content (similar to mindfulness) to change how the client responds to symptoms and feelings.

• Progressive Goal Attainment Therapy

• Anger management
  – Use cognitive behavioural therapy to improve recognition, reappraisal & coping
  – Relaxation/mindfulness to improve control over physiological reactivity & arousal

• Trans-diagnostic treatments to improve emotion regulation
  – These treatments are symptom- rather than disorder-focussed

• Forgiveness-oriented therapy
Forgiveness therapy to attenuate blame

- Forgiveness-oriented therapies involve
  - Recalling painful emotions associated with event and release emotions;
  - Explore other perspective and motivations to build empathy;
  - Think about forgiveness received from others, work towards forgiveness (e.g., as an altruistic gift);
  - Commit to forgiveness, build empathy and compassion exploring other viewpoints and universality of human error;
  - Maintain forgiveness and gain a sense of meaning about the event as a life experience.

(Wade et al., 2005, 2014)
Summary

• Injury, compensation & perceptions of injustice: Is this a pain that deserves more attention?

Most definitely!

• Attenuating perceptions of injustice early following injury will:
  – Prevent chronic embitterment (e.g., rumination and catastrophising)
  – Improve psychological wellbeing (e.g., depression)
  – Reduce disability
  – Increase return to work
  – Facilitate self-management of health, pain and function
  – Reduce healthcare costs and compensation claim benefits
Acknowledgements

Funding
NHMRC (Clinical) Early Career Fellowship (2012-2016)
ARC Linkage Grant in partnership with the Transport Accident Commission (2012-2015)

Co-investigators
Prof. Nellie Georgiou-Karistianis (Monash University)
Prof. Stephen Gibson (NARI & CPM&RC)
Prof. Jennie Ponsford (Monash University)
Prof. Peter Cameron (Monash University)
Dr Paul Jennings (Monash University)

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Dr Liane Ioannou
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Acknowledgements
Barbara Hill (TAC)
David Attwood (TAC)
Anne Daly (WorkSafe, Austin Health)
Clarissa Martin, Alex Collie (ISCRR)
A/Prof Belinda Gabbe & registry team
A/Prof Carolyn Arnold (CPMRC)

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Impact of Compensation on the Injured Person: Reverse Causality?

Luke Connelly, PhD
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Faculty of Health and Behavioural Sciences

2015 ISCRR Research Forum
Introduction: Concepts and Measures

• Clinical literature: “compensation is bad for health”.
• Is it?
• Concepts and measures of them
  – Health is a latent variable: how is it measured?
  – What do we mean by “compensation”?
    • The person lodged a claim?
    • The person received compensation?
      – for which type(s) of loss?
Introduction: Concepts and Measures

• What measures of compensation are to be used?
  – A problem may be that heterogeneous concepts are employed as if they are homogeneous
    • Lodged a claim?
    • Received compensation?
    • Retained a lawyer?
    • Filed a lawsuit?
    • Proceeded to litigation?
Introduction: Concepts and Measures

• What if we assume away differences in concepts?
• Assume we agree on the phenomenon of interest (e.g., retained a lawyer in connection with a compensation claim).
  – Assume this is the measure we are interested in, for argument’s sake.
Assuming Conceptual Homogeneity

• This eliminates one source of variation in the literature (in which concepts and measures are sometimes/often pooled).
  – Suppose, further, that we are dealing with a single jurisdiction.
  – And, suppose we have an indicator of “health outcome” that we agree represents the true latent health state.
• What is the optimal study design?
Randomised Controlled Trial

• We conduct a randomised controlled trial (RCT).
• We randomise injured individuals
  – to legal representation
  – or, no legal representation
  – and observe the health states of the two groups at some agreed end-point (and perhaps some intermediate point if we have secondary hypotheses to test).
• Easy!?
Is This Feasible?

- Of course not.
- So we have to rely on observational data.
- We observe people who do and do not retain a lawyer to pursue a personal injury compensation claim.
- The problem?
The Problem?

• We then have a problem to solve, viz.:

• Observed effect of legal representation on health outcomes =

• **Causal effect** of legal representation (if any) on (indicator(s) of) health outcomes + (1)

• **Selection effects** + (2)

• **Stochastic error** (3)
The Problem?

• We are interested in the causal effect...
• …but to “identify” it, we need to purge the correlation of:
  – Selection effects and
  – Unobserved heterogeneity.
Selection Bias

• The variable we are interested in is not randomly allocated.
• It is a **choice** variable…
• …and a range of factors could affect that choice:
  – Prognosis?
  – Self-efficacy?
  – Income?
  – Education?
  – etc.
But we can control for that!

- Well, that’s true, but not using the “standard” methods that have been commonly applied in this literature.
- For instance, including measures of each of these things does not really get us off the hook.
- Why?
- Because *unobserved heterogeneity* may still be at work.
Unobserved Heterogeneity

• There are some things that researchers typically don’t observe
  – e.g., “self-efficacy”
  – e.g., characteristics of the person’s income-earning activities and entitlements, e.g.
    • sole trader?
    • employee?
    • entitled to sick leave?
  – And lots of other factors that may influence the choice variable
Forget about Unobserved Heterogeneity for a Moment

• Assume away a role for unobserved heterogeneity
  – even though we shouldn’t!
• What should we do to try to account for selection?
• Acknowledge the possibility that our variable of interest is not an independent variable.
A Simple Formulation

• A simple formulation might look like this:
  \[ HS = f(ISS, DVLAWYER, ..., \epsilon) \]
  \[ DVLAWYER = f(ISS, HS, DVLAWYER, ..., \epsilon) \]

• Where HS is health status
• DVLAWYER=1 if lawyer retained; =0 otherwise.
• The system acknowledges that “lawyers may ‘cause’ health” and that “health may ‘cause’ lawyers”.
A Simple Formulation

• A simple formulation might look like this:

\[ HS = f(ISS, DVLAWYER, \ldots, \varepsilon) \]
\[ DVLAWYER = f(ISS, HS, DVLAWYER, \ldots, \varepsilon) \]

• Where HS is health status
• DVLAWYER = 1 if lawyer retained; = 0 otherwise.
• The system acknowledges that “lawyers may ‘cause’ health” and that “health may ‘cause’ lawyers”.
BUT WE CONTROLLED FOR HEALTH STATUS!!!

• Controlling for baseline health status, or even health status measured at some future point in a single equation regression does not get us off the hook.
  – It does not admit of the possibility of reverse causality (or, more broadly, endogeneity).
  • Technically, the regressor may be correlated with the error term and the CLRM is violated.
• Estimates will be biased and inconsistent.
An Example
Research on injury compensation and health outcomes: ignoring the problem of reverse causality led to a biased conclusion

Natalie M. Spearing\textsuperscript{a,*}, Luke B. Connelly\textsuperscript{a,b,c}, Hong S. Nghiem\textsuperscript{b}, Louis Pobereskin\textsuperscript{d}

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Accepted 9 May 2012
Briefly…

• Note: this is intended as a “demonstration” piece, not the final word on compensation and health outcomes!

• Source population
  – All people in Cornwall, over a 1-year period, without high-severity injuries, who reported a rear-end collision to police.
1147 police reports of rear end collisions

Respondents = 503/1147 (44%)

Respondents with "early whiplash" = 403/503 (80%)

Non-claimants = 138/403 (34%)

Claimants = 265/403 (66%)

Fig. 1. Participant flow diagram.
Table 1. Description of the variables

<table>
<thead>
<tr>
<th>Variable label</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>nkvas24</td>
<td>Severity of neck pain at 24 mo measured using VAS (0–100)</td>
</tr>
<tr>
<td>comp</td>
<td>1 if a compensation claim made, 0 otherwise</td>
</tr>
<tr>
<td>gender</td>
<td>1 if female, 0 otherwise</td>
</tr>
<tr>
<td>age</td>
<td>Mean age</td>
</tr>
<tr>
<td>nkvas1</td>
<td>Severity of neck pain at baseline measured using VAS (0–100)</td>
</tr>
<tr>
<td>head1</td>
<td>1 if headache was present post-RTC, 0 otherwise</td>
</tr>
<tr>
<td>prvnkp</td>
<td>1 if history of neck pain, 0 otherwise</td>
</tr>
<tr>
<td>aware</td>
<td>1 if aware of impending RTC, 0 otherwise</td>
</tr>
<tr>
<td>unskill</td>
<td>1 if in “unskilled employment” (proxy of educational level), 0 otherwise</td>
</tr>
<tr>
<td>workoff6</td>
<td>1 if off work at 6 mo, 0 otherwise</td>
</tr>
<tr>
<td>mgeprof</td>
<td>1 if “management professional” (proxy of income), 0 otherwise</td>
</tr>
<tr>
<td>gap(^a)</td>
<td>Days from RTC to answering the first survey (mean 83 d, 21–269)</td>
</tr>
</tbody>
</table>

*Abbreviations: VAS, visual analogue scale; RTC, road traffic crash.*

\(^a\) “gap” is included as an instrumental variable in the treatment effects regression model.
Two Models: Single Equation and Simultaneous Equations

• We do what many others have done and estimate a single-equation model that links the compensation claim to the health outcome measure.
• We show that there is evidence of a correlation.
• Conclusion: compensation claimants have worse health outcomes than non-claimants.
### Table 3. The “standard” approach: estimation of Equation (1) only by ordinary least squares

<table>
<thead>
<tr>
<th>Variable</th>
<th>Coefficient</th>
<th>Standard error</th>
<th>95% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>nkvas24</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>comp</td>
<td>8.171***</td>
<td>1.799</td>
<td>4.633 - 11.708</td>
</tr>
<tr>
<td>age</td>
<td>0.302***</td>
<td>0.062</td>
<td>0.179 - 0.425</td>
</tr>
<tr>
<td>gender</td>
<td>4.637***</td>
<td>1.867</td>
<td>0.965 - 8.309</td>
</tr>
<tr>
<td>nkvas1</td>
<td>0.243***</td>
<td>0.047</td>
<td>0.151 - 0.335</td>
</tr>
<tr>
<td>head1</td>
<td>2.571**</td>
<td>1.870</td>
<td>-1.107 - 6.249</td>
</tr>
<tr>
<td>prvnkp</td>
<td>-0.732*</td>
<td>2.370</td>
<td>-5.392 - 3.928</td>
</tr>
<tr>
<td>aware</td>
<td>1.566**</td>
<td>2.090</td>
<td>-2.542 - 5.676</td>
</tr>
<tr>
<td>unskill</td>
<td>-1.443**</td>
<td>1.964</td>
<td>-5.305 - 2.418</td>
</tr>
<tr>
<td>constant</td>
<td>-20.605***</td>
<td>3.604</td>
<td>-27.690 - 13.519</td>
</tr>
</tbody>
</table>

Observations = 403; $F(8, 394) = 13.16$; Probability > $F = 0.000$; $R$-squared = 0.236; root Mean Standard Error = 17.842.

* $P$-value < 10%.
** $P$-value < 5%.
*** Level of significance ($P$-value) < 1%.
Now, For the 2-Equation Model

• We then estimate a 2-Equation simultaneous-equations model.

• This model explicitly acknowledges the possibility of bidirectional causation between our health status indicator and compensation.

• We do not even control for unobserved heterogeneity in this paper…
Table 5. Mixed process simultaneous equations regression [estimation of Equations (1) and (2)]

<table>
<thead>
<tr>
<th>Variable</th>
<th>Coefficient</th>
<th>Robust standard error</th>
<th>95% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>nkvas24</td>
<td>-19.013***</td>
<td>2.452</td>
<td>-21.860 -16.166</td>
</tr>
<tr>
<td>age</td>
<td>0.271***</td>
<td>0.072</td>
<td>0.129 0.412</td>
</tr>
<tr>
<td>gender</td>
<td>6.177***</td>
<td>2.242</td>
<td>1.782 10.571</td>
</tr>
<tr>
<td>nkvas1</td>
<td>0.464***</td>
<td>0.052</td>
<td>0.361 0.566</td>
</tr>
<tr>
<td>head1</td>
<td>3.544**</td>
<td>2.263</td>
<td>-0.892 7.981</td>
</tr>
<tr>
<td>prvnkp</td>
<td>-0.286*</td>
<td>1.796</td>
<td>-3.807 3.234</td>
</tr>
<tr>
<td>aware</td>
<td>2.484**</td>
<td>2.106</td>
<td>-1.644 6.612</td>
</tr>
<tr>
<td>unskill</td>
<td>-1.802**</td>
<td>2.301</td>
<td>-6.312 2.707</td>
</tr>
<tr>
<td>constant</td>
<td>-11.036***</td>
<td>4.187</td>
<td>-19.244 -2.828</td>
</tr>
<tr>
<td>comp</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>age</td>
<td>0.005**</td>
<td>0.004</td>
<td>-0.002 0.013</td>
</tr>
<tr>
<td>gender</td>
<td>0.230***</td>
<td>0.125</td>
<td>-0.016 0.477</td>
</tr>
<tr>
<td>nkvas1</td>
<td>0.023***</td>
<td>0.002</td>
<td>0.018 0.029</td>
</tr>
<tr>
<td>head1</td>
<td>0.144**</td>
<td>0.146</td>
<td>-0.141 0.431</td>
</tr>
<tr>
<td>workoff6</td>
<td>0.612***</td>
<td>0.242</td>
<td>0.137 1.087</td>
</tr>
<tr>
<td>mgeprofes</td>
<td>0.058**</td>
<td>0.081</td>
<td>-0.100 0.218</td>
</tr>
<tr>
<td>unskill</td>
<td>-0.064*</td>
<td>0.139</td>
<td>-0.338 0.208</td>
</tr>
<tr>
<td>constant</td>
<td>-0.847***</td>
<td>0.229</td>
<td>-1.296 -0.398</td>
</tr>
<tr>
<td>sig_1</td>
<td>21.117***</td>
<td>0.925</td>
<td>19.379 23.010</td>
</tr>
<tr>
<td>rho_12</td>
<td>0.882***</td>
<td>0.061</td>
<td>0.686 0.958</td>
</tr>
</tbody>
</table>

Observations = 403; Wald chi2(8) = 190.06; Probability > chi2 = 0.000; Log pseudolikelihood = -1897.523.

* $P$-value < 10%.
** $P$-value < 5%.
*** Level of significance ($P$-value) < 1%.
What Does it Mean?

• In this study, the selection effect swamped the causal effect...

• ...so much so that when the selection effect was controlled, the estimated parameter on compensation changed sign.
Conclusions?

• There are genuine reasons to believe that selection bias is going to be a problem here.

• If we ignore it, we risk measuring the true effect of “compensation” (however defined and measured) on health status.
  – In our case, selection was so strong the direction of effect was reversed.

• What should we do?
What Should We Do?

• Create well-posed research questions:
  – don’t arbitrarily intermingle measures that refer to quite distinct conceptual constructs
  – be clear about the (null) hypothesis and theoretical model

• if we expect a negative (positive) relationship between the outcome and variable of interest, what is our theoretical reason for that expectation?
Stop Ignoring Measurement Problems

• Provided that we admit that health, recovery, prognosis or other factors could influence decisions about compensation-related factors, we should model that possibility.

• We should also try to identify or develop good panel (i.e., longitudinal) datasets that enable us to account for unobserved heterogeneity.
Compensable Injury and General Practice

DANIELLE MAZZA & BIANCA BRIJNATH
MONASH UNIVERSITY
Compensable Injury and General Practice: Evidence, Evaluation, Opportunities

Danielle Mazza Bianca Brijnath
Department of General Practice
Monash University
Impact of injury

- Physical
- Psychological
- Social
- Financial

Role of GP

- Diagnosis
- Monitor medical complications
- Manage psychosocial ‘yellow flags’
- Deliver, coordinate intervention
- Assess, facilitate return to work
Background

- Meaningful, safe and sustainable work is good for health
- ‘Work is the best medicine’ – the AFOEM Statement
- With almost 96% of injured worker claims originating in the general practice setting, GP’s are the key gatekeeper
- Few available studies on the role of healthcare providers in facilitating RTW

In 2012, when we began there were no Australian studies explicitly focusing on the role of GPs in facilitating RTW.
Generating the evidence: The GP RTW study (2012)

- **Aims:**
  - To understand GPs current sickness certification behaviours.
  - To provide an understanding of the GPs role in facilitating RTW and the barriers encountered in this process.

- **Methods:**
  - Quantitative study of sickness certification practices of GPs using WSV claims data.
  - Qualitative study of 93 participants (GPs, IWs, CAs, EMPs)
Key findings

- The role of the GP in facilitating RTW is recognised as critical by all parties.

- Need to change current certification practice because:
  - Increasing number of certificates being issued and for longer durations of time.
  - Most certificates issued are UFW and workers with mental health claims are most likely to be certified as unfit.

- Main barriers include:
  - Lack of a common definition on the GP’s role in RTW
  - GPs reliance only on injured workers feedback on capacity to work
  - Lack of availability of alternative/modified duties
  - Age and social circumstances of the injured worker and their family
  - Poor communication between GPs, employers and compensation agents
  - High administrative burden on GPs from compensation system and low remuneration of time and effort
  - Delayed payments, difficulty in referrals and conflicting medical opinions.
A highly successful collaboration

- First study of its type and size in Australia and internationally. Built capacity and collaboration in general practice-compensation injury.

- WSV and TAC were highly responsive to study findings

- Our team has forged linked with other state and national compensation authorities and key stakeholders (e.g. ComCare; Queensland MAIC; RACGP)

Peer review papers from this study:


What’s happening nationally? The GRIP Study (2014-15)

- **Aims:**
  - To determine at a national level the current knowledge, attitudes and practices of GPs in preventing and managing RTC injuries.
  - To identify education and training needs of GPs Australia wide to facilitate prevention and management of RTC injuries.

- **Methods:** A national survey of 429 GPs

- **Key findings:**
  - GPs were more confident in diagnosing and managing whiplash injury than compared to PTSD.
  - Further research and training may be required in PTSD assessment and diagnosis including prognostic indicators.
  - GPs do recognise the importance of RTW but the barriers they encounter in the RTW process may delay RTW and deter their desire to treat compensable injury patients.
  - Around half of GP respondents agreed that they should have the right to refuse to treat patients.
Monitor Knowledge Use

Select, Tailor, Implement Interventions

Assess Barriers to Knowledge Use

Adapt Knowledge to Local Context

Identify Problem

Identify, Review, Select Knowledge

Select, Tailor, Implement Interventions

Evaluate Outcomes

Sustain Knowledge Use

Knowedge Creation

Knowledge Inquiry

Synthesis

Products/Tools

Tailoring Knowledge

from: Graham et al: Lost in Knowledge Translation: Time for a Map?

Knowledge translation: Redesigning the new certificate of capacity (2013)

- **Aim:** To present the GPs, EMPs, IW and CA about the content and usability of the new Victorian sickness certificate.
- **Method:** Cross-sectional mixed-methods qualitative design comprising FGD and interviews.
- **Key findings:**
  1. All stakeholders viewed the new certificates as an improvement on the current one
  2. GPs saw the certificate as a form of communication; EMPs and CAs saw it as a therapeutic device
  3. GPs continued to certify based on incapacity and provided little information about what IWs could do on return to work
  4. All groups said that assessments for mental health needed more clarity and specificity
  5. GPs, EMPs and CAs also said that the new certificates must be electronically available and integrated into existing medical software to streamline uptake.

- **Results were used to:**
  1. facilitate external stakeholder buy-in
  2. make modifications to the draft certificate
  3. inform strategies for effective implementation and uptake

Read the paper:

A joint initiative of
Knowledge translation: The impact of the new certificate (2014-2016)

- HBoSW Programme, three studies:
  - Evaluation of the e-learning modules
  - Evaluation of the active engagement with Medicare Locals
  - Evaluation of the implementation of the new Certificate of Capacity

- Methods: a before-after non-randomised controlled study design utilising quantitative and qualitative data. The interventions and analyses will be based at the GP and patient level.

- Outcomes:
  - The reach of key HBoSW messages and education to GPs and other practice staff
  - GP and other practice staff reported change in knowledge and attitude as a result of training received within the HBoSW programme
  - Change in GP certification behaviour as a result of the redesigned certificate of capacity and training
New opportunities: National clinical guidelines for GPs on work-related MHCs (2016-19)

- Key outcomes will be:
  - A clinical guideline to improve GP management of patients with work-related MHCs.
  - A guideline that is approved by the NHMRC and RACGP
  - National dissemination of the guideline
  - An evidence-based implementation plan to facilitate the translation of the guidelines into clinical practice.
Future vision – it’s all about provider performance

- Identify, localize and pilot in general practice:
  - incentives (financial, regulatory, educational etc.) to improve GP performance in the management of compensable injury patients
  - screening tools for the early detection of compensable injury patients at risk of poor health and employment outcomes.
  - post-injury therapeutic interventions that target compensable injury patients at risk of poor health and employment outcomes.

- Conduct a cost-effective analysis of the above three pilot interventions
Future vision

- Investigate among new claimants (claim is >3months):
  - The links between injury sequela and key predictors of recovery, relapse and enduring health problems over time with a focus on health co-morbidities, social participation/support/disadvantage, substance abuse, treatments and health service use patterns.
  - Patient journeys with a view to identifying areas for improvement in current practice.

- Assess the long-term sustainability of health provider participation in the compensable injury landscape.
Impact of Compensation Process on Others: Family, Case Managers & Psychologists

ALEX COLLIE

INSTITUTE FOR SAFETY COMPENSATION AND RECOVERY RESEARCH
Acknowledgments

Co-investigators
• Dr Elizabeth Kilgour
• Dr Sharon Newnam
• Dr Agnieszka Kosny
• Dr Adam Vogel
• Prof Helen Keleher
• Prof Alan Peterson
• Prof Rod McClure
• Prof Niki Ellis

Funders
• Australian Research Council
• WorkSafe Victoria
• Transport Accident Commission
• Comcare

Participants
• Injured people
• Family members
• Insurance case managers
• Psychologists
Participants in injury recovery

Recovery & RTW
3 x Qualitative Studies

- Family
- Insurance Case Managers
- Psychologists

- Do compensation processes affect these groups?
  - If so, how?
  - If so, what impact can this have on injured person recovery?
Injury and Family relationships

• Family structure and support has a positive impact on physical health, persistent pain and return to work following injury (Prang KH et al, Health Qual Life Outcomes. 2015; 13: 97).

• Injury is associated with substantial changes in family systems, including:
Family Study

• Three compensation systems
  – TAC, WorkSafe, Comcare

• Participants
  – 16 injured people (8 male / 8 female)
    • 1 to 10 years post injury / range of conditions
  – 8 family members (3 male / 5 female)
    • Spouses, siblings, children

• Qualitative interviews
  – 30 min to 2 hour duration

• Thematic analyses of interview data
Family Study - themes

• Family Support
  – Instrumental Support
  – Administrative Support
  – Emotional Support

• Family as a source of stress

• Importance of Context

• Impact on Family
  – Financial Consequences
  – Change in Roles / Responsibilities
  – Emotional ‘workload’
  – Changes in sexual relationship
  – Positive effects
Case management in an insurance model

“In the field of work injury rehabilitation, case management is a collaborative process which includes evaluating, planning, implementing, coordinating and monitoring the options and services required to meet injured workers’ health and work-related service needs.”


• While containing claim costs, managing relationships with multiple parties (often with competing interests), navigating complex regulation and policy, and working within rigid organisational processes.
A case manager?
Case Managers Study

• Three compensation systems
  – WorkSafe, TAC, Comcare

• Participants
  – 13 front-line case managers / 8 claims team managers
  – 8 males / 13 females
  – Duration of experience = 5 months to 10 years

• Data collection
  – 3 x 2 hour focus groups

• Thematic Analyses

Case Managers - Themes

• Extra-role behaviour
• Frustration / Stress
• Emotional commitment
• Complexity
• Defensiveness/anger
Frustration

“And in the end you sort of go, okay I'm at capacity with this, I don’t know where else to go. I'm not getting the information. So you may make the choice to deny [the claim] until I get further information... it’s quite frustrating because you think gee there’s a person there that may need something.”

(Female participant, MVCS)
Emotional attachment

“I’ve seen case managers …[can] have quite a close relationship with their injured workers…..it’s hard to not have that empathy for somebody. But it’s when you start feeling, actually having sympathy and stuff, feeling sorry for them that it can impact on how you manage that claim.”

(Female participant, WSC2)
Psychologist Study

• Single jurisdiction
  – State of Victoria

• Participants
  – 19 psychologists
  – 3 male / 16 female
  – Avg = 57 years of age
  – Avg = 13 years experience (range 2.5 to 25 years)

• Semi-structured interviews
  – Nov 2013 to March 2014

• Thematic analyses
Psychologist Study - themes

• Psychologists face professional, organisational and personal challenges when providing services to injured workers within the workers’ compensation system.

• Clinical Work
  • Counselling injured workers
  • Provision of advocacy
  • Return to work involvement
  • Treatment thwarted by the system

• Additional challenges
  • Reporting to insurers
  • Remuneration for services rendered
  • Involvement with the legal system
  • Personal impact on the psychologist

Kilgour E, Kosny A, Collie A.(submitted)
Impact on treatment

“I wanted the client to do a course...he was isolated, he needs to get out, do something...and he was not fit to go to work. The claims manager said: “We know he’s not fit to go to work, but you as the doctor need to say he’s fit to go and do a training course, so you need to say, ‘fit for modified duties’” [on the medical certificate]. The doctor did it. The next thing we know, the insurance company who was at the meeting tried to take him off [income] payments because the doctor said he’s fit for work. ....The things I’m trying to do to get this fellow better, the insurance company are just thwarting.”
Summary

• Compensation processes can impact on family members, case managers and psychologists.

• Compensation processes affect the interactions between these groups and the injured person in ways that affect social support, clinical service provision and claims decision making.

• This can complicate injury recovery.
ISCRR Research Forum

“Does Injury Compensation Cause Harm?”