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Submitted via: CTPPolicy@sira.nsw.gov.au

Dear Dr Casey,

APS Response to the SIRA consultation on the Australian Clinical Guidelines for Health Professionals Managing People with Whiplash-Associated Disorders

The Australian Psychological Society (APS) welcomes the opportunity to provide a submission to the SIRA consultation on the Australian Clinical Guidelines for Health Professionals Managing People with Whiplash-Associated Disorders (the Guidelines).

The APS and SIRA work collaboratively to achieve the best psychological outcomes for people in NSW who have experienced a motor accident or work-related injury. The APS is supportive of the SIRA Compensation Scheme and its aim to deliver expert and quality care to injured people.

In making this submission, the APS has reviewed the Guidelines and consulted APS members with expertise in providing psychological services to injured people. The feedback provided is specific to the recommendations in the Guidelines and consultation questions posed by SIRA.

General comments

Overall, we commend SIRA for the robust and collaborative process of developing the Guidelines and believe it is a positive step forward for the Guidelines to include both acute and chronic whiplash-associated disorders (WADs). We are also pleased that the Guidelines have integrated the psychological perspective into a broad range of areas with a specific focus on anxiety, depression, and PTSD, while also acknowledging the role of perpetuating factors such as fear, avoidance and catastrophising.

The psychologically specific recommendations within the Guidelines appear positive and we consider the recommended care pathways to be feasible to implement. However, we note there is a considerable number of conditional recommendations within the Guidelines, which we understand is largely due to the paucity of national and international psychological research specific to WADs. While the development of the Guidelines is methodologically sound, drawing on research with a specific focus on WADs has resulted in a potential limitation in terms of the guidance provided to psychologists.

Future reviews of the Guidelines may benefit from considering the effectiveness of psychological therapies for broader chronic pain and trauma related conditions. This would enable guidance on evidence informed psychological assessment and treatments for whiplash-associated disorders. Clearly there is a need for funding to encourage more research to better understand the role of psychology in supporting people with WADs.

To ensure the Guidelines are being implemented appropriately and as intended to achieve desired outcomes, it will be important to undertake an evaluation of the pathways model.

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In order to enable practical application of the Guidelines, there needs to be access to appropriate services and psychologists who are able to deliver suitable assessments and interventions to meet individual requirements. For example, the addition of further guidance and education to inform health practitioners about referral pathways may be beneficial. This may include providing information about specific services such as pain management programs, or more general information about practitioners, e.g., psychologists, with experience in the assessment and treatment of specific WAD presentations (i.e., chronic pain). This is particularly relevant within the context of access to services (e.g., psychological) for people in rural and remote areas and/or those with reduced mobility.

Additional feedback

The table below provides specific feedback and comments on the Guidelines from a psychological perspective.

We would like to thank SIRA for the opportunity to include the APS in the development of the Guidelines as well as the opportunity to provide feedback to the consultation. Should any further information be required, please do not hesitate to contact me on (03) 8662 3300 or at z.burgess@psychology.org.au.

Yours sincerely,

Dr Zena Burgess FAPS FAICD
Chief Executive Officer

Table 1: APS Feedback on the Guidelines.

Part	Section	Page	APS Feedback
11.4. Psychological factors: Post-traumatic stress symptoms, expectations of recovery	Implementation *How to measure and interpret:* ▪ Screen for Post-Traumatic Stress Symptoms (PTSS) with the PCL 5. Scores of ≥34/80 could indicate a diagnosis of Post-Traumatic Stress Disorder. ▪ Other tools such as the DAR-5 can be used. Scores of ≥12/25 could indicate dysfunctional post-traumatic anger.	70	• The APS acknowledges that the PCL-5 can provide useful information about PTSD at the screening stage, although it is important to note that this tool, or any other self-report measure, should not be used as the primary measure for diagnosis of PTSD.[1] • We suggest the Guidelines would benefit from noting that the Primary Care PTSD Screen (PC-PTSD) is also a well-validated screening tool for PTSD. We recommend the inclusion of the PC-PTSD as a screening tool for PTSD to be used by psychologists.[2] • Further, there appears to be some variability within the Guidelines for the cut-off score for a provisional diagnosis of PTSD with the PCL-5. For example, on Page 70 the Guidelines outline a cut off greater than or equal to 34 *"could indicate a diagnosis"* of PTSD (again, it is important for the Guidelines to be mindful that this tool should not be used in isolation to diagnose PTSD). Whereas Page 141 specifies that *"Scores of 31-33 or higher suggests that the person may benefit from PTSD treatment and is considered as a threshold for referral to psychologists."* Other research the APS is aware of specifies 38 as a raw cut-off score for a provisional diagnosis, which has high sensitivity (.78) and specificity (.98).[3] The variation in these figures may result in confusion. We recommend due consideration when using the PCL-5 to screen for PTSD.

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			• We believe that it would be beneficial to thoroughly review the research around the PCL-5 cut-off points to ensure there is a strong rationale within the Guidelines for these suggestions, along with consistent statements about the cut-off points throughout the Guidelines to minimise confusion. • It is also important to note that while a raw cut-off score is one method for determining a provisional PTSD diagnosis when using the PCL-5, the other method is to examine items rated as 2="Moderately" or higher as an endorsed symptom, then following the DSM-5-TR diagnostic rule which requires at least: 1 B item (questions 1-5), 1 C item (questions 6-7), 2 D items (questions 8-14), 2 E items (questions 15-20). • Further, if the PCL-5 is being used to monitor symptom change over time, a minimum 10-point change represents clinically significance.
11.4. Psychological factors: Post-traumatic stress symptoms, expectations of recovery	Implementation *Indications:* ▪ Measure approx. 3-4 weeks after injury. Indicated when people show signs of PTS symptoms in interview (e.g., nightmares, flashbacks or anxiety driving)	70	▪ While many people exposed to a traumatic event experience initial distress, not everyone will go on to develop PTSD. As such, we agree with the position within the Guidelines that psychologists do not need to be immediately involved following a potentially traumatic experience. Rather, we recommended that people are offered practical and emotional support and encouraged to use their existing personal resources and social supports.

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	What to do: ▪ Consider referral to psychologist by 6 weeks if not improving.		▪ However, it is critical for psychologists to become involved with individuals who are very distressed or do not start to return to their usual functioning within the first or second week post trauma. We therefore recommend reconsidering the position within the Guidelines to wait until 6 weeks to refer to a psychologist if PTS symptoms are not improving. ▪ This is particularly relevant given the ongoing and systemic workforce issues that have led to a chronic undersupply of psychologists nation-wide.[4] A consequence of this is significant wait times for appointments, which has been well-documented by the APS.[5] Our member-based data shows that many clients are having to wait up to three to six months before they can access a psychologist. Therefore, waiting until 6 weeks to make a referral to a psychologist may result in the patient waiting even longer to receive the treatment they need, thereby delaying recovery.
11.5. Psychological factors: Depression, pain catastrophising, and coping strategies	Implementation *How to measure and interpret* ▪ Measure depressive symptoms with the DASS 21. When moderate or severe consider referral to psychologist. ≥ 15 out of 63 could indicate a probable major depressive disorder (Guest et al., 2018)	71	▪ In addition to the using the DASS-21 to measure symptoms we also recommend using the DASS-42, the longer version of the DASS-21 which can be useful to yield meaningful discrimination between symptoms. The DASS-42 is readily available and will meet the needs of clinicians wishing to measure current state or change in state over time. ▪ We also note that the in-text reference of *"Guest et al., 2018"* does not appear to be in the reference list of the Guidelines and hence we are unclear about the statement in the

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			Guidelines that a score on the DASS-21 greater than or equal to 15 out of 63 indicates a probable MDD. ▪ It is important to note that the total score on the DASS-21 (out of 63) reflects the negative emotional states of the combined three subscales, Depression, Anxiety and Stress. We therefore assume the statement in the Guidelines is referring to an interpretation of the raw score on the depression subscale only (i.e., out of 21), rather than a total raw score across the three subscales combined. ▪ Further, the statement that a DASS-21 score greater than or equal to 15 out of 63 indicates a probable MDD may be misleading, particularly as the DASS is based on a dimensional rather than a categorical conception of psychological disorders, and scores emphasise the degree to which someone is experiencing symptoms rather than having specific diagnostic cut off points. ▪ Ultimately, the severity labels are used to describe the full range of scores in the population, so someone who scores 'mild' on the depression subscale for example means that the person is above the population mean but probably still below the typical severity of someone seeking help (i.e., it does not mean a mild level of the disorder). ▪ We recommend that the Guidelines ensure care be taken by health practitioners when using and interpreting the results of the DASS, and that it is used in the way it is intended, that is, as a mental health screener, and to *assist* in diagnosis and outcome monitoring by psychologists.

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16.6. Psychological: Trauma focused cognitive_behavioural therapy	Question: ▪ Is trauma focused cognitive behavioural therapy in addition to usual care effective for the management of people with chronic WAD and post-traumatic stress disorder? ▪ Cognitive behavioural therapy (CBT) delivered by a psychologist for people with chronic WAD and post-traumatic stress disorder (PTSD) with elements such as psychoeducation, exposure, cognitive restructuring, anxiety management, and relapse prevention. Recommendation: ▪ The guideline panel suggests that healthcare professionals (psychologists) use trauma-focused cognitive behavioural therapy for the management of people with chronic WAD and diagnosed motor vehicle collision-related post-traumatic stress disorder.	140	▪ We agree with the recommendation to use trauma focused CBT interventions by psychologists for the management of people diagnosed with PTSD. It is important to note that there are a variety of treatments which commonly fall under the umbrella term of trauma-focused cognitive-behavioural therapy. These interventions commonly include: o Trauma-focused cognitive therapy (CT-PTSD). o Prolonged exposure (PE). o Eye movement desensitization and reprocessing (EMDR), and o Cognitive processing therapy (CPT). ▪ There is scope for the Guidelines to be more specific and expand on the well-established and evidence based recommended psychological treatments for PTSD.
16.6. Psychological: Trauma focused cognitive_behavioural therapy	Implementation *Indications* ▪ People with full diagnostic criteria for MVC-related PTSD are not met until at least six months after the trauma.	141	▪ We are unclear about the rationale for specifying that full diagnostic criteria for MVC related PTSD cannot be met until at least six months after the trauma. The DSM-5-TR criteria specifies that PTSD can be diagnosed when the "*Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month*".[6] ▪ We therefore recommend that the Guidelines be amended from specifying "*at least six months*" to "*more than one*

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			month" to align with the DSM-5-TR criteria for a PTSD diagnosis. ▪ Within this context, as well as the broader context of the Guidelines, we also suggest that there is an opportunity to better recognise Acute Stress Disorder (ASD). That is, ASD and PTSD share the same physiological and stress symptoms. However, ASD is only differentiated from PTSD by its limited duration, with symptoms present for more than three days, but less than one month. Where symptoms persist beyond a month, a diagnosis of PTSD should be considered.6
16.6. Psychological: Trauma focused cognitive_behavioural therapy	Implementation *Considerations:* ▪ Psychologists are recommended to use the DSM-5 to diagnose PTSD.		▪ The APS recommends utilising a structured clinical interview to assist with making a clinical diagnosis of PTSD according to DSM-5-TR criteria. ▪ The following interview tools are recommended by the APS for use in the diagnosis of PTSD: o Clinician Administered PTSD Scale (CAPS) o PTSD Symptom Scale - Interview Version (PSS-I), and o Structured Interview for PTSD (SI-PTSD).1 ▪ It is also important to note that while self-report measures can also provide useful information at the screening stage (i.e., PCL-5, PTSD Symptom Scale - Self-Report Version (PSS-SR) or the Davidson Trauma Scales (DTS)), these should not be used

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			as a primary tool for diagnosis as they do not routinely provide an accurate picture of a client's symptoms or their severity.1 ▪ Further, we recommend updating the Guidelines to ensure all references to the "DSM-5" are amended to refer to the most recent version, the DSM-5-TR.
17.5. Additional symptoms: Jaw symptoms, upper limb disabilities, and sleep quality	Implementation *How to assess:* ▪ Sleep Quality: Pittsburgh Sleep Quality Index (PSQI) *What to do:* ▪ If sleep quality is impaired: It's important to help clients understand that sleep issues are common and manageable and that negative thoughts about sleep can worsen symptoms. Encourage small steps towards better sleep routines and check how sleep issues are affecting physical therapy. If sleep deprivation is severe, check their safety for certain activities (e.g., driving). Suggest they speak to their GP about sleep issues and consider seeing a psychologist for targeted support. Self-guided sleep resources can also be helpful as a starting point or while waiting for professional help.	170	▪ We are unclear about the rationale to include 'sleep quality' within the category of jaw symptoms and upper limb disabilities. ▪ Sleep is an essential pillar of good health and while sleep disturbances may initially appear as a symptom of another disorder (e.g., depression, PTSD) or injury, this is not always the case. ▪ It is important to acknowledge that sleep disturbance can be an independent problem that should be assessed or treated by appropriately experienced medical practitioners, sleep physicians or psychologists. ▪ Note: other scales commonly used by psychologists to assess sleep disturbance include the Epworth Sleepiness Scale (ESS), STOP-BANG Sleep Apnea Questionnaire, and the Dysfunctional Beliefs and Attitudes about Sleep (DBAS).

References

[1] Australian Psychological Society (2017). *Post-traumatic disorder practice guide*. https://psychology.org.au/for-members/resource-finder/resources/assessment-and-intervention/clinical-guide/post-traumatic-stress-disorder-practice-guide

[2] Phoenix Australia. (2021). Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder, and Complex Posttraumatic Stress Disorder.

[3] Cohen, J., et al. (2015). Preliminary Evaluation of the Psychometric Properties of the PTSD Checklist for DSM–5. (Conference Presentation). doi: 10.12140/2.1.4448.5444

[4] ACIL ALLEN. (2021). National Mental Health Workforce Strategy—Background Paper.

[5] Australian Psychological Society. (2022). *APS News Update: 1 in 3 psychologists are unable to see new clients, but Australians need help more than ever*. Retrieved from https://psychology.org.au/for-members/news-and-updates/news/2022/australians-need-psychological-help-more-than-ever#:~:text=Australians%20left%20waiting%20for%20services&text=Clients%20are%20often%20waiting%20up,waiting%20more%20than%206%20months.

[6] American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787