Ontario Psychological Association

OPA Response to: Enabling Recovery From Common Traffic Injuries: A Focus On The Injured Person

July 2015

ONTARIO PSYCHOLOGICAL ASSOCIATION

Table of Contents

1. Introduction and Key Recommendations:

1.1 Introduction:

Thank you for the oportunity to comment on the Common Traffic Injuries Report (the Report). As a profession that strongly supports evidence-based approaches to assessment and treatment, we appreciate the intention to use the scientific evidence to better enable the recovery of injured persons with common traffic injuries. The focus of the OPA response is on the impact of the recommendations on individuals with mental and behavioural disorders. *(Note in this submission we use the term psychologists to refer to members of the College of Psychologists of Ontario, including both Psychologists and Psychological Associates.)* The impacts will largely depend upon the government's policy determinations and the development of specific Guidelines and regulations.

In the body of this submission we discuss a number of concerns and make recommendations including: a more accurate and clinically appropriate understanding of evidence-based care; greater attention to the characteristics and choices of individual patients; incorporation of the expertise and responsibility of the health professional providing the treatment.

We note that the Report makes a distinction between symptoms such as distress and upset, and psychological disorders. Initial symptoms such as these are included within the Type I injuries and psychological and mental disorders are classified as Type II injuries. MTBI, Concussion and Post Concussion Syndrom/Disorder must also be distinguished from Type I injuries. These are essential distinctions to avoid harm to individuals with psychological and mental disorders caused by misclassification and dismissal of their disorders. We support the recommendation for referral of individuals showing signs of psychological and mental disorders and the use of screening instruments in this process.

In the body of this submission we have elaborated a process which would be helpful to curtail frivolous referrals for psychological diagnostic evaluation and at the same time not create an inequitable barrier for individuals with psychological and mental disorders requiring diagnostic evaluation and treatment.

The Report also appears to include a regressive recommendation of a physician gate-keeper model for access to all care that is not included within the Care Pathways. While we support integrated health care and communication between the health professionals providing care to a patient, adoption of such an approach would be especially problematic for patients with psychological and mental disorders for reasons outlined in the submission. In addition, it is entirely unnecessary as psychologists have the expertise and authority to provide diagnositic assessments and treatment of their patients. Imposition of a physician gate-keeper model would have a negative impact on access to necessary care and health outcomes for patients with psychological and mental disorders.

1.2 Overview of our key recommendations:

Apply an accurate understanding of evidence-based medicine

- Consistent with current understanding and intent of evidence-based medicine, include the role of patient characteristics and choice to foster positive outcomes; health professional expertise and responsibility; the multiple goals of health care interventions, and; the appropriate incorporation of a range of interventions with various levels of support from research evidence.
    - Correct the description of evidence-based care in the Report to more closely match the intent in the Sackett definition which includes providing interventions for which A level evidence is not available as necessary in order to positively impact patient outcomes.
    - Acknowledge that it is an essential component of all health care to manage conditions, support function, and reduce suffering. Health care is not limited to interventions that cure or accelerate healing. Symptom relief may be an essential goal of health services for some patients.

Correct the problematic aspects of the current MIG and corresponding regulations

- Confirm the classification of individuals with psychological, mental, and behavioural disorders as having Type II injuries, with access to funding from the auto insurer for reasonable and necessary assessment and treatment.
- The term "psycho-social issues/symptoms" should be used to describe the types of upset and distress that may accompany Type I injuries.
    - Avoid reference to potentially confusing terms that may suggest a diagnosed disorder such as, "depression", "anxiety", and "post traumatic stress".
- Use the terms "supportive" and/or "educational" interventions to describe the services included to address psychosocial issues/symptoms in the Care Pathways
    - In Ontario, by law, any services considered to be "psychological" can only be provided by a registered psychologist. Generally, psychological services, as opposed to psychosocial, supportive, or educational interventions are not required in the initial treatment of the physical conditions included as Type I injuries

Health professionals providing physical treatment should monitor and screen their patients to make appropriate referrals for diagnostic evaluation and treatment

- Patients with continuing, new, or worsening psychological and mental symptoms should be referred to a psychologist, psychiatrist, or physician with appropriate expertise for diagnostic evaluation and treatment.
- Appropriate screening instruments should be utilized to help to identify individuals requiring referral (See further discussion and recommendations for specific screening instruments in the body of the submission)
- Individuals whose pre-existing impairments due to mental and psychological conditions/disorders interfere with their ability to participate in or benefit from the standard course of treatment provided in the Care Pathways for Type I injuries should be classified as having Type II injuries.

Do not require a physician gate-keeper for access to psychological diagnostic evaluation and treatment

- Acknowledge that psychologists have the expertise and authority to function as "gate keepers" to psychological and other health care services
- Continue to allow self–referral to a psychologist with appropriate expertise
- Allow direct referral by the treating health professional to a psychologist with appropriate expertise without creating the additional barrier/delay and costs of a physician gate-keeper

Remove barriers to appropriate diagnostic evaluation and treatment experienced by patients with psychological and mental disorders on the basis of their physical injuries

- Improve education regarding the nature of mental disorders, with the aim of reducing discrimination and overcoming the continued narrow focus on severity of physical injury as a proxy for mental injury;
- Create and enforce standards for proper adjudication, including consideration of the relevant evidence-based guidelines when making decisions; and,
- Require insurer examiners to have appropriate education, training and experience. When obtaining insurer examinations, insurers should utilize health professional peers to comment on assessment and treatment.
    - Use psychologists as as one of two professions qualified to diagnose mental disorders, to comment on reasonable and necessary treatment and comment on disability and catastrophic impairment due to these disorders
- Applications for psychological services (diagnostic evaluation and treatment) should be routinely approved if:
    - An appropriate screening instrument has been completed and provides scores indicating a need for referral for psychological diagnostic evaluation and treatment.
        - Administration of appropriate screening instrument and referral by the health professional providing the physical treatment has been completed; *OR*
        - for patients who self refer, (or when it has not been completed by the physical treatment provider) the psychologist, psychiatrist, or physician completes an appropriate screening instrument;

AND

    - An appropriate intake screening interview is completed:
        - the psychologist, psychiatrist, or physician with appropriate expertise diagnosing and treating mental/psychological disorders has completed an intake screening interview to confirm indications of psychological and mental disorders and obtained informed consent for the application and further communication;

AND

    - An appropriate application is submitted by the psychologist certifying that the proposed services are reasonable and necessary.
        - This certification requires that the psychologist has spoken directly with the patient and determined the patient is reporting symptoms that are likely to be interfering with the patient's functioning and for which treatment is likely required.
        - Introduce Guidelines and mechanisms to enforce these expectations as discussed in the body of the submission.

Confirm that all mental and psychological conditions/disorders diagnosed by a psychologist, psychiatrist, or physician with appropriate expertise are classified as Type II injuries with access to funding from the auto insurer for reasonable and necessary services as per the standard level of benefits for Type II injuries.

- Assessments regarding mental and psychological disorders should be completed by a psychologist, psychiatrist, or physician with the appropriate expertise and authority to communicate a diagnosis of a psychological or mental disorder.
- Treatment of patients with psychological and mental disorders should be completed by a psychologist, psychiatrist, or physician with the appropriate expertise and authority to perform psychotherapy and to conduct ongoing diagnostic evaluation for modification of the treatment plan.

Adopt the *Ontario Neurotrauma Foundation Guidelines for Concussion/ Mild Traumatic Brain Injury & Persistent Symptoms* (Second Edition) (ONF Guidelines)

- The ONF Guidelines are an up-to-date and appropriate Guideline regarding management and treatment of individuals with mTBI/concussion as well as Post-Concussive Syndrome/Disorder.
- Remove Concussion/mTBI from consideration as a Type I injury
- Classify MTBI/Concussion and Post-Concussion Syndrome/Disorder as Type II injuries

2. Review of the Report and Recommendations: Basic Assumptions

2.1 Examination of assumptions underlying the research and development of Care Pathways

The Report provides some information regarding the assumptions that structured the research process and led to the development of the Care Pathways. Necessarily, these assumptions played a significant role in shaping the data that was collected, the collation and interpretation of the data, and the translation into the Care Pathways. Therefore we comment on the assumptions which have shaped the conclusions prior to addressing the content of the Care Pathways.

2.2 Evidence- based care

The report stresses the Collaboration's intention to create evidence-based care pathways. It provides the following definition,

> According to Sackett et al (Sackett DL, Rosenberg WMC, Gray JAM, Haynes RB, Richardson WS. BMJ 1996;312:71): "Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating *individual clinical expertise* with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the *proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care.* By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence

both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer." (italics added)

We note that an additional article by Sackett (Evidence based medicine: what it is and what it isn't, *BMJ* 1996; 312 doi: http://dx.doi.org/10.1136/bmj.312.7023.71 (Published 13 January 1996), provides context and further clarification. In this update, Sackett stresses the need to take into consideration the needs of the individual patient when making informed decisions about health care. Importantly, the limitations of relying solely on randomized trials to make treatment decisions are also addressed. As stated by Dr. Sackett,

> Good doctors use both individual clinical expertise and the best available external evidence, and neither alone is enough. *Without clinical expertise, practice risks becoming tyrannised by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient*. Without current best evidence, practice risks becoming rapidly out of date, to the detriment of patients.
>
> *Evidence based medicine is not "cookbook" medicine. Because it requires a bottom up approach that integrates the best external evidence with individual clinical expertise and patients' choice, it cannot result in slavish, cookbook approaches to individual patient care. External clinical evidence can inform, but can never replace, individual clinical expertise, and it is this expertise that decides whether the external evidence applies to the individual patient at all and, if so, how it should be integrated into a clinical decision. Similarly, any external guideline must be integrated with individual clinical expertise in deciding whether and how it matches the patient's clinical state, predicament, and preferences, and thus whether it should be applied. Clinicians who fear top down cookbooks will find the advocates of evidence based medicine joining them at the barricades.*
>
> *Evidence based medicine is not restricted to randomised trials and meta-analyses. It involves tracking down the best external evidence with which to answer our clinical questions*. To find out about the accuracy of a diagnostic test, we need to find proper cross sectional studies of patients clinically suspected of harbouring the relevant disorder, not a randomised trial. For a question about prognosis, we need proper follow up studies of patients assembled at a uniform, early point in the clinical course of their disease. And sometimes the evidence we need will come from the basic sciences such as genetics or immunology. It is when asking questions about therapy that we should try to avoid the non-experimental approaches, since these routinely lead to false positive conclusions about efficacy. Because the randomised trial, and especially the systematic review of several randomised trials, is so much more likely to inform us and so much less likely to mislead us, it has become the "gold standard" for judging whether a treatment does more good than harm. However, some questions about therapy do not require randomised trials (successful interventions for otherwise fatal conditions) or cannot wait for the trials to be conducted. *And if no randomised trial has been carried out for our patient's predicament, we must follow the trail to the next best external evidence and work from there.* (Italics added)

2.3 OPA's support of evidence-based approaches to improve delivery of treatment and address problematic aspects of the MIG

We note that while the Sackett definition has been cited in the Report, many of the Care Pathways provide little room for the exercise of individual clinical expertise or "more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care". There are only very limited considerations of individual patient characteristics to direct the therapeutic process; rather the focus appears to be more narrowly on the specific diagnosis determining the treatment interventions.

The Report and interventions included in the Care Pathways also focus on randomized trials and meta-analysis even though so few of the conditions and interventions are addressed in these investigations. We share a concern that is noted by Cutforth, in one of the reference articles included in the Report. Cutforth states,

> First, *a lack of evidence of effectiveness does not necessarily mean that there is evidence of a lack of effectiveness*; in the case of LBP, there are significant gaps in the knowledge base around the effectiveness of many of our traditional interventions. This lack of evidence does not indicate that a particular intervention is ineffective; rather, it means only that there is a lack of evidence to support its efficacy. Clinicians can apply that understanding to their clinical decision making. (Italics added)

As described above, the absence of evidence regarding a clinical intervention does not mean that it is not effective and/or would not be the most appropriate intervention for an individual patient. We note that absence of evidence is not the same as evidence of a lack of effectiveness. Interventions for which there is relevant evidence of a lack of effectiveness should not be used. However, given the assumptions underlying the work of the Collaboration, interventions which may be effective but for which there is not the level of evidence required by the Collaboration, are not included as options within the Care Pathways. The Report states in each Care Pathway, "This guideline does not include interventions for which there is a lack of evidence of effectiveness". This limitation does not allow the patient and their treating health professional to make the most appropriate decisions for care.

This is true for all areas and disciplines in health care, including medicine. There are considerable limitations on the populations, conditions, and interventions for which good quality studies have been conducted. In addition, individual patients routinely present with a multiplicity of conditions and personal characteristics that cause them to be excluded from the patient population of the studies. Although treatment must be informed by evidence, consideration must also be given to the other factors in the Sackett definition, including clinical expertise and sound clinical decision-making for individual patient care in the absence of relevant/definitive studies.

Use of interventions for which there has not yet been a robust body of research evidence collected does not mean an unscientific approach to treatment. On the contrary, the intervention must be selected based on the expertise of the health professional in the context of the characteristics of the individual patient. In addition, evidence-based practice requires monitoring of the effectiveness of the interventions and adjustments of treatments as indicated by patient response.

OPA Recommendation

- **Incorporate a more complete and accurate understanding of evidence-based practice, giving greater emphasis to consideration of all of the available evidence including the expertise of the health professional and characteristics and preferences of the patient.**
- **Correct the description of evidence-based care in the Report to more closely match the intent in the Sackett definition which includes providing interventions for which A level evidence is not available as necessary in order to positively impact patient outcomes**.

2.4 Why

The Report states,

> We addressed the *Why* in accordance with the ethical principle of *primum non nocere (first do no harm).* We asked: is treatment necessary to improve outcomes? If yes, then we asked: do the currently available interventions meaningfully accelerate the natural recovery time of an injury?

Yes, all health care professionals must strive to "do no harm". However, the health care professional and the patient must engage in an informed process to weigh the potential benefits and risks of any interventions for the individual patient. It is an unfortunate reality that many commonly used and generally helpful health care interventions, for example, surgery, hospitalization, and many medications also carry considerable risk of harm. It is impossible to avoid the risk of ever doing harm; every health intervention, including the most benign, includes the risk of doing some kind of harm. This is one of the reasons why it is important to include informed patient choice in every health care decision. Patients must be presented with, and educated about, the *range of treatment options* available to them, and then, together with their provider, choose which to try (based on their individual sensitivies, needs, and circumstances) and evaluate.

We also question the requirement that an intervention "meaningfully accelerate the natural recovery time of an injury". An intervention may be clinically appropriate (reasonable and necessary) if it reduces suffering, relieves pain, improves quality of life, allows greater functioning, or prevents deterioration even if it does not "cure" or "accelerate natural healing time". Again, this is the focus of much of vitally important health care. Many, if not most, health care interventions manage conditions and support functioning, but do not cure or accelerate healing. As examples, consider the role of medications to manage cholesterol, high blood pressure, diabetes, etc, in spite of the fact that each of these also carries some risk of harm. There is also considerable investment by our public health care system in interventions which reduce pain and suffering for musculoskeletal conditions without curing them, but which are intended to maintain function in life roles.

OPA Recommendation

- **Acknowledge that it is an essential component of all health care to manage conditions, support function, and reduce suffering.**
- **Acknowledge that heath care is not limited to interventions that cure or accelerate healing.**

2.5 What

The Report states,

> We looked at the *What* by asking whether there was high quality evidence indicating that any specific intervention improved recovery? If the answer was 'yes' then we asked: does this intervention improve long-term recovery or is the benefit restricted to short-term symptom relief?

The assumption that an intervention must "improve long term recovery" is also an inappropriate requirement for health care. As discussed above, symptom relief may be a clinically appropriate goal for intervention and may allow the person to maintain functioning in personal, home and/or work life. Relieving pain and reducing suffering may be a goal in and of itself to improve quality of life. These treatments may also prevent deterioration and development of secondary problems, and allow the person to engage in other treatment.

OPA Recommendation

- **Acknowledge that it is an essential component of all health care to manage conditions, support function, reduce suffering, and provide symptom relief.**

2.6 Who

The Report states,

> We use the evidence to determine *Who* would benefit from specific interventions. We further focused on the injured person by asking: what personal and societal factors can influence recovery?

Some of the discussion in the Report appears to support a patient-centered approach to selecting interventions. However, we do not find inclusion in the Report of any research addressing these issues or a discussion of how to modify the Care Pathways to accommodate patient needs, characteristics, and preferences.

2.7 Stated ``focus on the injured person``

Consistent with current understanding of health care and rehabilitation, the language of the Report conveys an appreciation of a "patient- centred" approach and the document is titled, a "focus on the injured person".

However, the bulk of the research and the construction of the Care Pathways are diagnosis and stage-based. There is very little actual discussion or consideration of individual patient characteristics or of ways in which these individual characteristics determine the appropriate utilization/application of the various Care Pathways.

As William Osler famously stated, "it is much more important to know what sort of a patient has a disease than what sort of a disease a patient has." Unfortunately, we find that the focus in this Report is on the condition, not the injured person who has the condition.

3. Review of the Report and Recommendations: Development of Care Pathways- Evidence-Based and Patient-Focused?

3.1 Discussion of the "Evidence" relied upon to develop the Care Pathways

The Report states,

> Understanding patients' experiences and giving a voice to their recommended directions are important when developing patient-centered, evidence-informed clinical practice guidelines.
>
> We begin with the position that people have the right to contribute to the creation of knowledge used to make decisions about their health. [1] When developing clinical practice guidelines, qualitative research can provide an understanding of what is important and relevant to patients. Knowledge pooled from injured persons and that from scientific evidence on the effectiveness of clinical interventions provides a strong foundation for guideline development.
>
> These two forms of evidence complement each other to ensure that guideline recommendations are informed by the experiences of injured persons. Consequently, the recommended clinical care becomes an evidence-informed experience and a partnership between providers and patients.

Combined sources of information should provide a more complete perspective. However, there are significant limitations in both the literature review and the survey of patient experiences. In addition, it is not clear how these were integrated into the resultant Care Pathways.

3.2 Review of clinical practice guidelines for the management of traffic injuries

We obtained and completed a preliminary review of Jessica J. Wong, et al, Clinical practice guidelines for the management of conditions related to traffic collisions: a systematic review by the OPTIMa Collaboration. The abstract stated,

> We retrieved 9863 citations. Of those, 16 guidelines were eligible for critical appraisal and eight were scientifically admissible (four targeting whiplash-associated disorders (WAD), one addressing anxiety and three addressing MTBI). Major recommendations included: (1) Advice, education and reassurance for all conditions; (2) Exercise, return-to-activity, mobilization/manipulation, analgesics and avoiding collars for WAD; (3) Psychological first aid, pharmacotherapy and cognitive behavioral therapy as first-line interventions for anxiety; and (4) Monitoring for complications, discharge criteria, advice upon discharge from the emergency room and post-discharge care for MTBI. Conclusion: Fifty percent of appraised guidelines were scientifically admissible, but most need updating. Most guidelines focus on WAD and MTBI. Few guidelines make comprehensive recommendations on a wide range of consequences from traffic collisions.

The Report summarizes the recommendations they found in the high quality guidelines (half of which were outdated),

- Advice, education and reassurance be offered to patients to manage whiplash-associated disorders, anxiety and mild traumatic brain injuries;
- Exercise, return-to-activity, mobilization/manipulation, and analgesics be used to manage whiplash-

associated disorders;
- Collars should not be used to treat whiplash-associated disorders;
- Support (e.g. provide comfort, information, and give opportunity to discuss the experience), pharmacotherapy and cognitive behavioural therapy be used as first-line interventions for anxiety;
- Patients with mild traumatic brain injuries be monitored for complications and provided advice (about common symptoms and strategies to manage symptoms and resume activities) upon discharge from the emergency room;
- Patients with mild traumatic brain injuries be followed every 2-4 weeks until symptom resolution/reassessment;
- Patients with mild traumatic brain injuries should be referred to a specialist if symptoms persist for more than three months.

As a result of their review, the Collaboration concluded that there is a need for an up-to-date guideline of adequate methodological quality to provide comprehensive recommendations on a wide range of consequences from traffic collisions.

3.3 Review of the published literature

The Report states,

> We screened 234,995 abstracts and conducted in depth review of 597 scientific papers. This effort was summarized in 43 new systematic reviews of the literature.

We note that in spite of the wide screening, relatively few articles were found that met the Collaboration's inclusion criteria. As a consequence, some of the Care Pathways rely on results of very few studies and no replications. We are not in a position to comment on the reviews or conclusions drawn regarding physical treatments.

We have obtained and completed a preliminary review of many of the reference materials regarding "psychological interventions". We found that most of the studies did not include actual psychological interventions. Rather they were using the term loosely to describe supportive, educational activities and relaxation training. In most of these studies, the services were not provided by a psychologist. The one exception we have identified, the studies by Turner et al on TMD, did use clinical psychologists to deliver 4 sessions of cognitive behavioural therapy. However, the patients in the Turner et al, study (2005) were an average of 14 months post-onset of their current episode of facial pain. Therefore, the relevance to the patient population in the Care Pathways in the first 6 months post-injury has not been confirmed.

3.3 Study of the narratives of Ontarians who have sustained injuries in traffic collisions and received health care

The Report states,

> We included injured persons within three months of a motor vehicle collision, whose injuries were classified as minor, over 18 years of age, and English-speaking. Eleven participants were randomly recruited from rehabilitation clinics across Ontario: 4 from the Greater Toronto Area, 3 from the Kingston Area, 2 from the Niagara Region, and 2 from the Sudbury Area. All injured persons provided informed consent. The research was approved by the University of Ontario Institute of

Technology Research Ethics Board. Each person was interviewed twice between August and November 2013. Consistent with this methodology, the number of participants and interviews was sufficient to reach saturation (i.e. no new information emerged).[6-8]

We agree that review of patients' experience is a critical component of the evidence that should be considered in development of Guidelines. Some of the statements included in the Report from their interviews are very disturbing about the patient's experience of the MIG and the need to address these issues. While the Report emphasizes the importance of the patient reports as a source of data for Guideline development, the limited nature of the participants and the brief time frame post injury, raise serious questions about the completeness of this information. We note that the compiled case narrative and the individual case studies were not available to review as it has been submitted for publication.

From the description provided, we note that the sample was limited to 11 participants. All were English speakers, which may have failed to reflect the experience of non-English speakers from the diverse cultures that make up Ontario. Thus, the experiences reported in the sample do not reflect the need to incorporate cultural sensitivity into the Care Pathways and variation in acceptability of the active rehabilitation strategies included.

We also note that the survey was completed within three months post-injury. Therefore, it is not possible to have captured the experience of the subset of individuals who do not have good recovery and continue to have impairments due to their auto accident injuries. The survey respondents indicated frustrations with early obstacles to access to services they required. However, given the limited time frame, we cannot know the experience of those who went on to have persistent impairments. This would have provided an additional and necessary perspective. A longer time frame would also have allowed identification of the development of any secondary problems resulting from lack of access to sufficient treatment and transfer of costs of care to OHIP and other public systems.

It is also important to note that a summary of patient reports, even if based on a representative and broad sample, does not replace the need for the input of the individual patient into the decision-making regarding their own care. Patient perception of control over the health care process is itself a positive influence on engagement, compliance, and outcome.

OPA Recommendation

- **To achieve more positive patient outcomes, provide greater emphasis on patient choice and decision-making in their own care.**

The Report defines Care Pathways as "The sequence and options of health care services a patient with traffic injuries receives during a particular episode of care".

As the authors of the Report acknowledge, there was very little research that they found of acceptable quality to rely on for many of the conditions contemplated to be Type I injuries. Many interventions have not been the subject of the type of research evaluation required to be considered A-level studies for inclusion as best evidence. Although Care Pathways are described as the sequence and "options," the options within some of the Pathways are very limited and do not reflect the full range of recommendations

that would follow from a true evidence-based approach that includes all scientific evidence, not just relying on gold standard studies when deciding how to proceed.

In addition, clinical reality is that patients often present with multiple conditions resulting from the auto accident as well as with other pre-existing and concurrent conditions. This is acknowledged to some extent with the statement in the discussion of each of the Care Pathways indicating that if there is another condition, the Care Pathway for the other condition should also be followed. The Report states,

> Patients with multiple injuries should be managed using all appropriate care pathways. For example, patients with upper extremity soft tissue disorders commonly suffer from neck pain. Patients with upper extremity soft tissue disorders and neck pain and its associated disorders (NAD) should also receive care as recommended in the NAD care pathways described in Chapter 4.

However, there is no indication that a review was carried out of the ways in which various conditions may interact and amplify each other, compounding and altering treatment needs. Similarly, the process for the actual implementation of combinations of Care Pathways for individuals with multiple conditions resulting from auto injuries is not addressed.

In addition, the Report also does not address the applicability of the Care Pathways for individuals who have concurrent Type I and Type II injuries as is often the case. Many injuries may potentiate each other and create increased needs for care for each injury such that the usual Care Pathway may be insufficient.

3.4 Applicability of Care Pathways to Individuals

3.4.1 Individuals with multiple common MSK injuries arising from the same MVA

The research included in the Report and the Care Pathways focuses on single injuries and the interventions recommended for the specific injury. There is mention that if patients have multiple injuries, the services in the relevant Care Pathways should be provided. However, there is no reseach reviewed regarding patients with multiple injuries and the ways in which these mulitiple injuries may interact to complicate treatment.

In practice, many patients will present with multiple Type I injuries. The health professional must apply the evidence based on treatment for single disorders to real patients who have multiple injuries. (We also note that some of these patients will also have pre-existing/co-existing disorders that need to be considered when providing treatment of the Type I injuries). It is often not a matter of simply adding these Care Pathways together or providing the Care Pathways in sequence. Sound care requires the treating health professional's clinical judgement and decision making with the patient to determine how to to proceed to achieve the best outcome for the patient.

3.4.2 Individuals with pre-existing psychological disorders

A brief list of pre-existing conditions that would exclude a person from the Care Pathways is included in the Report,

> Disabling conditions that interfere with recovery, which are either pre-existing or that develop during the course of patient management, such as:
>
> > Neurological disorders (for example, cervical spondylotic myelopathy);
> >
> > Autoimmune arthritis in an uncontrolled state (for example, rheumatoid arthritis);

Other autoimmune disorders and Type I Diabetes;
Disabling psychiatric conditions (for example disabling psychoses, disabling PTSD).
Other pathologies (for example, cancer/neoplasms, systemic infections);

We note that some psychological and mental disorders are included in the list of pre-existing conditions. These pre-existing conditions exclude a person from being appropriately treated within the Care Pathways described for Type I injuries. We assume that the specific diagnoses are listed as examples only. Other psychological and mental disorders may also interfere with treatment and recovery from Type I MSK injuries (Eg, A patient with Unipolar Depression having difficulty getting to physical treatment appointments due to lack of motivation; patient with Generalized Anxiety Disorder missing appointments due to difficulties with attention and concentration, etc.). Exclusion must be determined by the severity of the current impairments caused by the pre-existing disorder and the degree to which the impairments interfere with the patient's ability to participate in and benefit from the standard course of treatment outlined in the Care Pathway. Therefore, the need for exclusion cannot be determined by the diagnosis of the pre-existing disorder or limited to certain pre-exisiting disorders. Individuals with current impairments due to pre-existing psychological and mental disorders are likely to require treatment that is more individualized, intensive, and of longer duration and therefore should be classified as having Type II injuries.

OPA Recommendation

- **Individuals whose pre-existing impairments due to psychological, mental, and behavioural conditions/ disorders interfere with their ability to participate in or benefit from the standard course of treatment provided in the Care Pathways for Type I injuries should be classified as having Type II injuries.**

3.4.3 Individuals with co-existing psychological, behavioural, and mental disorders

Some individuals will present with indications of co-existing psychological, behavioural, and mental disorders arising from the same MVA that resulted in the common Type I physical injury. As described in other sections of this submission, these disorders, which require specialized and individualized diagnosis and treatment are appropriately considered Type II injuries which require specialized diagnostic evaluation and treatment.

OPA Recommendation

- **Confirm that all mental and psychological conditions/disorders diagnosed by a psychologist, psychiatrist, or physician with appropriate expertise are classified Type II, not type I injuries.**

3.4.4 Selection of specific interventions based on health professional expertise, and patient characteristics and choice

In addition, there is very little information in the Report provided to focus or guide the clinician on what patient characteristics make which interventions more likely to be helpful to the specific patient. Nor is there a process described to guide this decision making. Rather the Report focus seems to be on matching the intervention to the diagnosis and stage.

OPA Recommendation

- **Provide greater emphasis on the treating health professional's expertise and responsibility to consider individual patient characteristics and choice when determining treatment interventions.**

4. Review of the Report and Recommendations: Review of Injury Classification Model

4.1 Three level classification system

The Report states,

> Over the course of our work, we have conducted qualitative research and carefully listened to the narratives, concerns and suggestions of injured persons who were actively receiving or who had received care under the current MIG. These injured persons consistently shared with us their belief that the term "minor injury" is unrepresentative of the actual experiences associated with traffic-related injuries. Many narratives emphasize the perception that vague terms such as "benign", "temporary", "transient", and "non-serious", and the categorization of "minor injury", were not helpful; to the contrary they seemed to trivialize and dismiss very real experiences of distress or suffering. Injured persons described to us their experiences of unplanned, sudden onset intense pain, and subsequent occupational or domestic disability, sleep disruption and daytime exhaustion, family stress, and psychological and emotional distress. These persons also reported encountering frustration and uncertainty during the course of their recovery. We found it of particular importance that injured persons shared the belief that the provisions of the current MIG were not ensuring that they would receive what they needed; instead their concern was that guidelines seemed to limit what they would be permitted to receive, on the basis that their injuries and associated experiences were 'minor', and thus inconsequential.

While it is correct to acknowledge that the term "minor" is offensive to many who experience these injuries, the analysis in the Report fails to explicitly address the critical comments cited from the participants and real barriers encountered when funding was not available for further/other reasonable and necessary services.

The Report does not acknowledge the fundamental shift that occurred in the Accident Benefits system with the introduction of the minor injury definition and funding cap in 2010. Essentially the regulations created a three level benefit system for medical and rehabilitation benefits. These are: minor injuries at $3500, standard benefits at $50,000, and catastrophic level benefits at $1,000,000. The "minor injury" regulations are a diagnosis-based cap on the amount of funding available for treatment. The comments from the respondents in this study speak to the concerns that diagnosis-based caps limit injured people's ability to access additional reasonable and necessary services.

The Report states,

> Having considered the narratives of persons who have experienced injuries and received care under the MIG, we have concluded that it is not appropriate to categorize either the injuries or their associated symptoms as minor injuries, inasmuch as they can be associated with a broad range of symptomatology and with some degree of disability for activities of daily life or work. It is our view that there is no scientific rationale or merit in continuing to employ the term "minor injury". We propose a new classification that categorizes automobile collision injuries as Type I, Type II, or Type III injuries.

We agree that it is not helpful to use the term “minor injury”. However, simply changing the term “minor” to “Type I” will make little difference to the experience of individuals with these injuries unless there are fundamental changes in the model which allow access to reasonable and necessary care.

4.2 Time Frames: Addressing Recent (0-3 months post collision) and Persistent (4-6 months post collision) Injuries

The Report also states,

> Moreover, given the important temporal considerations outlined above, there is merit in further characterizing the injury, in order to optimize the approaches and interventions, by phase: Recent (0-3 months post-collision), or Persistent (4-6 months post-collision).

We agree that it is consistent with the scientific literature and clinical experience to extend the treatment Guideline beyond the 12 week time frame of the present MIG. Rather than being limited to the first 12 weeks of post accident recovery and care, the Care Pathways are limited to interventions for the first 6 months post injury. The Report states,

> “This guideline covers recent onset (0-3 months post-collision) and persistent (4-6 months post-collision) NAD grades I-III; it does not cover NAD that persists for more than 6 months post-collision”.

The research supports different approaches and interventions during the first three months post-accident than those that are appropriate for the patient group that has persistent symptoms during months four through six.

The Collaboration determined that the Care Pathways would terminate at the 6 month point post injury. As such, The Report does not address treatment or rehabilitation of patients after the 6 month period of the Care Pathways. Those patients with more chronic conditions are more likely to require more specialized and individualized treatment and rehabilitation.

OPA Recommendation

- **Confirm that patients whose conditions become chronic and continue post 6 months are more likely to require individualized and specialized treatment and rehabilitation**

4.3 Patients who require further treatment beyond 6 months

All of the Care Pathways assert that the scientific literature and clinical experience reveal that some individuals will not be recovered at the six month point. The descriptions and flow charts of the Care

Pathways, reflect that this subset of individuals may require further treatment to address their continuing symptoms. The Report states,

> Patients who have not improved significantly or recovered should be referred to their physician for further evaluation.

We strongly support the acknowledgement that some individuals who present with what initially appear to be only Type I physical injuries, may fail to recover. However, it is clinically inappropriate to limit their further care to referral and management by a physician. It is possible that further treatment by the same health professional may be indicated. If referral is warranted, the treating health professional and the patient should jointly determine the most appropriate health professional to provide the next stage of care.

It is not clear whether the acknowledgment that some individuals will have incomplete recovery at the end of 6 months and require referral is intended to allow a mechanism for funding of further/other services under the auto insurer. Alternatively, there is a suggestion that the Care Pathway is intended to replace the MIG with another diagnosis based "hard cap", and after the Care Pathway the person would be limited to publically-funded health services under the direction of their physician.

OPA Recommendation

- **Acknowledge that further care beyond the 6 month Care Pathway may be required by some individuals**
- **Allow direct referral from the treating health professional to other health professionals as determined with the patient**

4.4 Referral of patients identified as having major symptom change or development of serious pathology (new or worsening physical, mental or psychological symptoms) at any point in the Care Pathways

4.4.1 Referral of patients with psychological, mental, and behavioural symptoms that are not resolving

It is consistent with sound clinical practice that all of the Care Pathways incorporate an expectation that the health professional providing the treatment, monitor and screen for indications of new or worsening physical, mental, or psychological symptoms, and make appropriate referrals. It is also essential that the health professional monitor and screen for individuals whose initial symptoms of mental or emotional distress are not resolving as anticipated. These continuing symptoms may be indications of mental and psychological disorders that are not Type I injuries but rather Type II injuries. As Type II injuries, they require specialized evaluation and treatment not included in the Care Pathways. It is also appropriate that the health professional make an appropriate referral so that these individuals can be appropriately investigated and treated.

OPA Recommendation

- **Health professionals providing physical treatment should monitor and screen patients to identify and refer individuals whose continuing, new, or worsening mental, behavioural, and/or psychological symptoms indicate a need to refer to a psychologist, psychiatrist or physician with appropriate expertise for diagnostic evaluation and treatment**

4.5 Direction to identify individuals with worsening or new mental or psychological conditions for referral for further evaluation

The research reviewed and structure of the Care Pathways correctly include direction to the health professional to monitor the patient for signs of mental or psychological conditions requiring further evaluation. We note that in addition to new and worsening symptoms, individuals whose mental and psychological symptoms are not showing anticipated improvement also require referral for evaluation.

OPA Recommendation

- **Confirm that patients with persisting symptoms and impairments, who are not showing anticipated improvement also should be referred to a psychologist, psychiatrist, or physician with appropriate expertise for diagnostic evaluation and treatment.**

The Report includes screening instruments that can be used to help the health professional providing the physical treatment to identify individuals who require referral for diagnostic evaluation and treatment. (We include further discussion of the process for identification of patients with signs of mental and psychological disorders requiring referral and additional screening instruments later in this submission.)

OPA Recommendation

- **Health professionals providing physical treatment should monitor and screen their patients to identify and refer individuals with continuing, new or worsening psychological and mental symptoms to a psychologist, psychiatrist, or physician with appropriate expertise for diagnostic evaluation and treatment.**
    - **Appropriate screening instruments should be utilized to help to identify individuals requiring referral.**

4.6 Physician gate-keeper model vs appropriate reliance on the expertise of psychologists

4.6.1 Implicit inclusion of physician gate-keeper model in the Care Pathways

The direction in the Care Pathways state,

> Patients with worsening of symptoms and those who develop new physical, mental or psychological symptoms (other than NAD III) should be referred to a physician for further evaluation at any time point during their care.

We note that the Care Pathways indicate only, “refer to physician” in these situations, except one that includes Dentistry. However, sound, effective, efficient care relies on direct referral between other regulated health professions. Referral among health professionals in Ontario results in creation of virtual teams in the community who have the unique skill sets required for this patient population. This would include, for example, that if indications of a mental, behavioural, or psychological condition are identified by the Chiropractor or Physiotherapist, they could initiate directly a referral to a Psychologist for further assessment/intervention. This is current practice.

It is correct to reinforce the treating health professional's responsibility to monitor for conditions that require clinical attention and to make appropriate referrals for further evaluation/intervention when they notice persisting, new, or worsening symptoms that may be indicative of psychological or mental disorders, which are considered Type II injuries. However, it is inappropriate to restrict the referral to a physician. When the health professional identifies worsening or new mental or psychological symptoms, direct referral to a psychologist is an appropriate option. In many instances, direct referral to a psychologist is a better option which is both more efficient for the individual patient and less costly for the system than imposing a physician gate-keeper model.

4.6.2 Modern health care incorporates increasing appreciation of the roles and responsibility of non-physician disciplines

The Report's apparent recommendation to limit referral by the treating health professional to a physician seems to reflect an idealized and archaic view of the health care role of the family/primary care physician. We are at a time when direct access to and services by other health professionals are being fostered. We note across North America increasing scopes of practice, and direct access and utilization of many health professionals. This shift is necessary to address a shortage of physicians, to provide better access to needed services, and to make more appropriate use of the expertise of other health care disciplines. As an example, vaccinations and flu shots are now are administered by pharmacists without requirement of referral by a physician. Yet, this apparent recommendation of requiring a physician gate-keeper goes in the opposite direction.

4.6.3 Psychologists are autonomous health professionals

As autonomous health professionals, psychologists have authority and responsibility for diagnosis and treatment of their patients. Therefore, many patients self-refer and/or are referred by practitioners from a variety of health disciplines for psychological services, in both the self-pay and auto insurer context. This is parallel to the practice of individuals choosing their own dentist or optometrist without requirement of a referral from a physician. As such, psychologists are expected to be aware of the need for referral and coordination with other health professionals, including the family physician, as determined by patient need and with patient consent. In fact, psychologists function as gate-keepers. Psychologists provide gate-keeping both to their own services and to services of other health professionals. When completing an initial intake with a patient, the psychologist must determine if they are the appropriate discipline and health professional to provide diagnostic evaluation/treatment. If not, they direct the patient to other more appropriate health professionals. In addition, when providing care to patients, psychologists monitor, screen, and identify patients who need to be referred to other health professionals. Psychologists make these referrals in order to provide integrated care and/or address issues outside of the scope of practice of psychology.

4.6.4 Practical obstacles to a physician gate-keeper model for referral for diagnostic evaluation and treatment from a psychologist

We note that many individuals still do not have a family physician and rely on walk in clinics/emergency room services. They see various physicians, and only when required to respond to acute needs. They do not

receive on-going management by a physician. In addition, even for those patients who have regular care from a primary care physician, many physicians limit the patient to discussion of a single problem at each appointment.

Requirement of physician referral in order to facilitate further care would require additional separate appointments creating: greater demands on already limited and insufficient physician time; an additional delay and obstacle for the patient to access other/further care; and additional to costs to the OHIP and/or auto insurance system.

4.6.5 Specific need for direct access to psychologists

Despite significant progress in Ontario to encourage greater awareness of mental and psychological concerns in family practice settings, many Ontarians still do not have access to appropriate mental health services through primary care practices. Many practices continue to be fee-for-service solo practitioners; in such traditional settings, we are aware that the research shows reduced identification and treatment of mental health concerns. Research supports that while psychological disorders often are the most disabling condition, these disorders are too rarely identified and treated.

In addition, cultural norms and continuing stigma contribute to patients' reluctance to raise concerns regarding their psychological condition. In many situations, (especially true in certain cultural groups and close-knit communities) patients do not feel comfortable disclosing psychological problems to their family physician due to stigma, shame, and embarrassment. Since many patients continue to find it very challenging to discuss their psychological status, any perceived additional barriers, such as needing to discuss their condition with the family doctor first, in order to obtain a referral before speaking with someone who will assess and treat their condition, may be sufficient to dissuade them from seeking treatment.

Anecdotally, when we ask MVA patients whether they had discussed their psychological concerns with their family physician, we often hear responses such as:

> "No, I was in so much pain and I know the doctor only has a little bit of time. I need medication."
> "No, I don't feel comfortable talking about such things with him. He treats my friends and family also."
> "I did a little bit but we didn't discuss it much."

4.6.6 Consequences of models of access for patients with psychological and mental disorders

We also note that the Panel did not conduct any research into models of delivery of health care comparing the cost-effectiveness and health consequences of physician gate-keeper vs direct access models. In particular there is no research referenced or discussion identifying any positive rationale for this model or system costs and negative health consequences associated with the physician gate-keeper model.

We also note that at a time of cut backs in health care funding, it does not make sense to create additional burden on limited physician resources and increased costs to the auto insurance and/or OHIP system.

OPA Recommendation

- **Acknowledge that psychologists have the expertise and authority to function as "gate keepers" to psychological and other health care services**
- **Do not require a physician gate-keeper**
    - **Continue to allow self–referral to a psychologist with appropriate expertise**
    - **Continue to allow direct referral by the treating health professional to a psychologist without creating the additional barrier/delay and costs of a physician gate-keeper**

4.7 Remove barriers to diagnostic evaluation and treatment by psychologists for patients with psychological and mental disorders

Current barriers to necessary patient-centred care should also be removed to ensure achievement of the direction in each Care Pathway to identify and refer individuals with new or worsening psychological, mental, or behavioural symptoms. At the present time, it is almost a universal experience for insurers to deny all applications for psychological services for individuals based on the diagnosis of their physical injuries. This insurer denial occurs even when the patient has been referred by their physicial treatment provider and/or their family physician and the psychologist has conducted an appropriate clinicial screening interview and completed an appropriate application. (Injuries now classified as "minor" and that are suggested to be classified as Type I in the new model).

The assumption that one can determine if there is a mental or psychological condition based on the diagnosis of the physical injury is incorrect. This erroneous belief results in delays and additional stress for the patient when the Insurer requires an Insurer Examination. This process too often results in further deterioration of the patient's condition even when the Insurer Examination confirms the indications of the mental or psychological condition and approves the services. It also creates unnecessary costs of the Insurer Examination to the system. The Report recommends making referrals for diagnostic evaluation when patients show new or worsening psychological and symptoms. It is contrary to this recommendation for insurers to routinely deny applications for psychological services following these referrals.

OPA Recommendation

- **Remove barriers to appropriate psychological diagnostic evaluation and treatment for patients with psychological and mental disorders**
    - **Improve education regarding the nature of mental disorders, with the aim of reducing discrimination and overcoming the continued narrow focus on severity of physical injury as a proxy for mental injury;**
    - **Create and enforce standards for proper adjudication, including consideration of the relevant evidence-based guidelines when making decisions; and,**
    - **Require insurer examiners to have appropriate education, training and experience. When obtaining insurer examinations, insurers should utilize health professional peers to comment on assessment and treatment.**

- **Use psychologists as as one of two professions qualified to diagnose mental disorders, comment on reasonable and necessary treatment, and comment on disability and catastrophic impairment due to these disorders**

4.8 Recommended process to approve appropriate applications for diagnostic evaluation and treatment for patients with psychological conditions

We are aware of the need for a clear process to support adjusters in providing sound adjudication of applications from psychologists for diagnostic evaluation of patients regarding psychological and mental conditions.

We propose a new model to assist in the process for approval of appropriate applications without routine insurer denial and requirement of Insurer Examinations. While we are concerned about inappropriate barriers to services for patients with legitimate needs; we also are aware of the need to eliminate frivolous applications for psychological services. *Therefore it is incumbent on the proposing psychologist to ensure that their standards of practice are in accordance with The OPA Guidelines, relevant requirements from the College of Psychologists, and the FSCO licensing process. Psychologists should understand that failure to comply with these requirements could result in complaints to and censure by the College of Psychologists, as well as loss of license and penalities through the FSCO process.* The model we are proposing would curtail inappropriate applications and at the same time remove barriers to reasonable and necessary psychological services.

We support the recommendation in the Report to use appropriate screening instruments with norms/threshold scores for identification of patients who require referral for psychological diagnostic evaluation and treatment. (We note that screening instruments may not be appropriate/available for some patients due to language or other concerns. Exceptions will need to be made in these situations) These screening instruments should be completed either by the health professional providing the physical treatment or by the psychologist proposing the diagnostic evaluation if the patient self-refers or, it has not been completed by the physical treatment provider. Following the referral from the treating health professional or the patient's self referral, the psychologist will review the information provided by the screening instrument. The psychologist should also complete an appropriate intake screening interview to confirm the indications of a mental or psychological condition requiring diagnostic evaluation and treatment and obtain informed consent for the application. Insurers should be able to routinely approve applications for psychological services when these processes are followed.

OPA Recommendation

- **Remove barriers to appropriate psychological diagnostic evaluation and treatment for patients with psychological and mental disorders**

Applications for psychological services (diagnostic evaluation and treatment) should be routinely approved if:

- **An appropriate screening instrument has been completed and scores provided that indicate a need for referral for psychological diagnostic evaluation and treatment.**

- **Administration of appropriate screening instrument and referral by the health professional providing the physical treatment has been completed; *OR***
- **For patients who self refer, (or when it has not been completed by the physical treatment provider) the psychologist or psychiatrist or physician completes an appropriate screening instrument;**

AND

- **An appropriate intake screening interview is completed:**
  - **the psychologist, psychiatrist, or physician with appropriate expertise diagnosing and treating mental/psychological disorders has completed an intake screening interview to confirm indications of psychological and mental disorder and obtained informed consent for the application and communication;**

AND

- **An appropriate application is submitted by the psychologist certifying that the proposed services are reasonable and necessary.**
- **This certification requires that the psychologist has spoken directly with the patient and determined the patient is reporting symptoms that are likely to be interfering with the patient's functioning and for which treatment is likely required.**

4.9 Six month duration of Care Pathways

The Report states, "As an overview, therefore, we propose that a consistent approach be adopted to manage Type I injuries over the entire course of their recovery process." However, the Report does not explicitly state if the Care Pathways, in addition to directing care for the first 6 months post-accident, are intended to be translated into diagnosis-based funding caps for each condition.

The Report did not review interventions and outcomes for individuals whose conditions persist beyond six months. The Report states,

> This guideline covers recent onset (0-3 months post-collision) and persistent (4-6 months post-collision) NAD grades I-III; it does not cover NAD that persists for more than 6 months post-collision.

The continuing nature of some patients' conditions was also identified in the Report's data analysis:

> For the purpose of the development of this guideline, the population of interest included injured persons with injuries commonly caused or exacerbated by a traffic collision. These are injuries that lead to a physical, mental, or psychological impairment for which the scientific evidence suggests that at least 50% of patients recover within six months.

This would suggest that as many as 50% of individuals are not recovered at the six month point at the end of the Care Pathways. In addition, each of the Care Pathways indicates that if the patient is "unrecovered or incomplete recovery to refer to the physician" at the end of the Care Pathway. This seems to suggest that the person's physician may be expected to provide/direct any needed post-Care Pathway health services. It is not addressed if funding for these services will be available from the auto insurer or if the person will be limited to rely on what ever is available under the OHIP system.

4.10 Small percentage of patients who develop chronic regional or more widespread pain

In addition, the Report identifies that some patients continue to have chronic pain conditions:

> Our research also highlights that despite intervention, a small percentage of patients with Type I injuries will experience residual problems over the long term; and, *a small proportion of these patients seem to develop chronic regional or more widespread pain,* again regardless of the intervention they might have or continue to receive. (italics added)

However, it is not evident in the Report if these individuals are then considered to have Type II injuries with access to funding for further/other services from the auto insurer.

5. Review of the Report and Recommendations: Type I Injuries and Care Pathways

5.1 Injuries included in Type I

The Report describes Type I injuries,

> Type I injuries are those traffic injuries which have been shown in epidemiological studies to have a favourable natural history (recovery times ranging from days to a few months). These injuries include musculoskeletal injuries (such as Neck Pain and Associated Disorders Grades I-III, Grades I and II sprains and strains of the spine and limbs); traumatic radiculopathies; mild traumatic brain injuries; and post-traumatic psychological symptoms such as anxiety and stress. The proposed *Care Pathways* outlined in our report pertain to Type I injuries.

5. 2 Common features of Type I injuries

The Report states,

> Type I injuries have a number of common features. There is typically either no significant loss of anatomical alignment or no loss of structural integrity. Most often, Type I injuries improve within days to a few months of the collision, leaving no permanent, serious impairment. Typically, the impact of even the most effective treatment for Type I injuries is modest, and usually limited to a reduction in symptom intensity. The evidence concerning the effectiveness of current interventions for Type I injuries can be summarized as follows:
>
> 1. most interventions produce, at best, short-term benefits in the form of symptom relief and/or increased function;
> 2. for such interventions, there is no evidence that effectiveness can be increased through higher dose intensity, more frequent attendance or prolongation of course of treatment;
> 3. there is no evidence supporting a 'piling on' of complex combinations of clinicians, therapists, or therapies; and
> 4. many commonly used interventions provide no more benefit than sham or placebo.
>
> Common features are not confined to physical injuries alone. It is important for health care professionals and injured persons alike to understand that the experience of psychological

> symptoms such as anxiety, distress and anger is natural and not-atypical after a traffic collision; most psychological symptoms are temporary.

Again, we note the assumptions that appear to be reflected in the interpretation of the research and the translation into Care Pathways. There appears to be a dismissal of the value of interventions that provide "short-term benefits in the form of symptom relief and/or increased function". However, services addressing symptoms and increasing function may be critical to the insured person's ability to engage in a healing and recovery process as well as preventing the development of secondary problems.

We also note that some of the criteria for Type I injuries in the Report do not fit Psychological Disorders, Acute Stress Disorder, Concussion/MTBI, and Post Concussive Syndrome/Disorder. (This is further discussed in other sections of this submission.)

5.3 Psycho-social issues vs psychological impairments and psychological disorders

The Report includes a description of "Psychological Impairments" within Type I injuries which are included within the Care Pathways:

> Psychological impairments: early psychological signs and symptoms that include poor expectations of recovery, post-collision depressive symptomatology, fear, anger and frustration.

It is correct that upset and distress are not uncommon after an auto accident. The distress generally does not interfere with function and tends to resolve rapidly without requiring psychological interventions. However it is confusing and incorrect to label these types of symptoms, complaints, and concerns as *psychological impairments.*The terms "psychological" and "impairment" both have defined meanings within the SABS and other regulations and need to be used more specifically.

By definition, "impairment" means some interference in usual functioning as a result of the symptom or condition. Symptoms can be present without causing significant distress or impairment (e.g., headaches that may be annoying, but respond to medication and do not result in one limiting one's activity; nervousness when in a vehicle that doesn't result in the need to pull over, take side streets, or stop driving). If any cluster of symptoms rises to the level of producing "impairment", we would suggest that this likely indicates the need for evaluation and intervention. We note that the Diagnostic and Statistical Manual (DSM) and the corresponding disorders in the International Classification of Disorders (ICD) only codes symptom clusters as a disorder/condition if they are associated with impairment in functioning personal, home, or work life.

In addition, we need to be mindful of potential confusion when commonly used language such as "post-traumatic psychological symptoms such as anxiety and stress" or "depressed mood" can easily be confused with diagnostic terms for psychological (mental) conditions/disorders which are not Type I injuries. (See discussion in section on Type II injuries.

We note that the International Classification of Diseases (ICD), the system that has been mandated to be utilized for classication under the auto insurance regulations also makes a distinction between Signs and Symptoms vs Diagnosed Disorders.

In the ICD 10 system, the psychological and mental disorders are classified in Chapter 5 and given F codes. The ICD 10 diagnostic codes include both higher level codes and also more specific sub-types. Some examples of F codes used to provide diagnosis of psychological and mental disorders include the following:

F32 Depressive episode
F40 Phobic anxiety disorders
F40.0 Agoraphobia
F41 Other anxiety disorders
F41.0 Panic disorder [episodic paroxysmal anxiety]
F41.1 Generalized anxiety disorder
F43 Reaction to severe stress, and adjustment disorders

The ICD 10 classification system also includes codes for "Symptoms and signs involving cognition, perception, emotional state and behaviour (R40-R46)" It is noted that these codes for symptoms and signs explicitly, "Excludes: those constituting part of a pattern of mental disorder (F00-F99)" The following are examples of some of the R symptoms and associated codes:

R45 Symptoms and signs involving emotional state
R45.0 Nervousness, Nervous tension
R45.1 Restlessness and agitation
R45.2 Unhappiness
Depression, not yet clinically diagnosed
Feeling depressed
Sadness
Worries NOS
Excludes: depression, diagnosis confirmed clinically (F32.-)
R45.3 Demoralization and apathy
R45.4 Irritability and anger

OPA Recommendation

- **The term "psycho-social issues/symptoms" should be used to describe the upset and distress that may accompany the Type I injury and be addressed within the Care Pathways**
- **Avoid reference to potentially confusing terms that may suggest diagnosis of psychological and mental disorders such as "psychological impairment", "anxiety", and "post traumatic stress".**

The resolution of these psycho-social issues/symptoms generally occurs through time and supportive/educational interventions by the health professional providing the physical treatment. The Report states,

> It is also important to reassure patients that it is normal to feel some anxiety, distress or anger following a traffic collision. In the presence of such symptoms or emotions, the health care professional should listen to the patient's concerns, discuss them and adjust the care plan accordingly.

However, some individuals will not experience the expected resolution of their mental or psychological symptoms. Individuals who fail to show anticipated recovery or who present with new or worsening symptoms should be referred for evaluation.

OPA recommendation

- **Individuals whose mental or psychological symptoms are not resolving as expected or who are presenting with new or worsening symptoms should be referred to a psychologist, psychiatrist or physician with appropriate expertise for diagnostic evaluation and treatment .**

5.4 Acute Stress Disorder (ASD)

Some individuals present immediately post injury with severe initial emotional distress that is interfering with their functioning in addition to a common physical injury. These individuals may not show the expected rapid improvement experienced by most people. They will require referral for evaluation and intervention to address ASD. This psychological disorder is diagnosable within the first month post injury. Rapid appropriate psychological treatment has been shown to reduce rates of subsequent Post Traumatic Stress Disorder. Although, supportive/educational interventions can be provided for many individuals presenting with psycho-social concerns within the Type I Care Pathway, early screening and referral is essential to address ASD as a Type II injury in this subset of individuals.

From our analysis, we have concluded that ASD does not fit most of the criteria for Type I injuries. The only criterion that is applicable is that most of the people who present with initial upset/distress experience a resolution of symptoms. Review of the evidence indicates that the criterion that the condition does not produce clinically significant functional impairments is incorrect for ASD, as many people experience functional impairment, even if this is short-lived for many. For those who experience persisting symptoms, the impairments can be lifelong. We also see from the evidence that the criteron that interventions do not produce clinically important outcomes, cure, or accelerate healing, and are not required, also does not apply in this case. We note that treatment guidelines for ASD are clear on the need for early intervention to reduce impairments, suffering, and future disability.

OPA Recommendation

- **Classify Acute Stress Disorder as a Type II injury**

5.5 Mild Traumatic Brain Injuries

We agree with the decision to adopt the Ontario Neurotrauma Foundation Guidelines for Concussion/ Mild Traumatic Brain Injury & Persistent Symptoms (Second Edition) as an up-to-date and appropriate Guideline regarding management and treatment of individuals with mTBI/concussion as well as Post-Concussive Syndrome/Disorder. We agree with the statements within the Report about the quality of the ONF Guideline.

However, analysis of the ONF Guideline indicates that mTBI/concussion and post concussion syndrome/disorder and the management and care of these patients does not fit within the criteria in the Report for Type I injuries.

We provide preliminary comment on the Report's handling of mBTI/ Concussion and the science summarized in the ONF Guideline at this time.

First, we note the inclusion of Mild Traumatic Brain Injuries as Type I injuries in the Report.
The Report provides the following definition,

> Mental impairments: concussion/mild traumatic brain injury as defined by the American Congress of Rehabilitation Medicine (MTBI is defined by loss of consciousness of less than 30 minutes, with altered consciousness < 24 hours, and post-traumatic amnesia < 1 day, and a Glasgow Coma Scale of 13 to 15) and normal structural imaging.

While we note that the report indicates that the Collaboration is unanimously endorsing the ONF Guideline, the Report does not incorporate the definition of MTBI/Concussion from the ONF document.
The ONF definition of Concussion/MTBI is,

> Concussion/mTBI is defined as a complex pathophysiological process affecting the brain, induced by biomechanical forces. Several common features that incorporate clinical, pathologic and biomechanical injury constructs that may be utilised in defining the nature of a concussion/mTBI include:
>
> 1. Concussion/mTBI may be caused either by a direct blow to the head, face, neck or elsewhere on the body with an "impulsive' force transmitted to the head.
> 2. Concussion/mTBI typically results in the rapid onset of short-lived impairment of neurological function that resolves spontaneously. However, in some cases, symptoms and signs may evolve over a number of minutes to hours.
> 3. Concussion/mTBI may result in neuropathological changes, but the acute clinical symptoms largely reflect a functional disturbance rather than a structural injury and, as such, no abnormality is seen on standard structural neuroimaging studies.
> 4. Concussion/mTBI results in a graded set of clinical symptoms that may or may not involve loss of consciousness. Resolution of the clinical and cognitive symptoms typically follows a sequential course. However, it is important to note that in some cases symptoms may be prolonged.
>
> ** Adapted from* McCrory P, Meeuwisse WH, Aubry M, et al. Consensus statement on concussion in sport: the 4th International Conference on Concussion in Sport held in Zurich, November 2012. British Journal of Sport Medicine. 2013;47(5):250-8.

We also note that, while it is correct that most individuals with these injuries have a good recovery, we are mindful that a subset will be identified who require more specialized, intensive and longer term interventions and should be classified as having Type II injuries.

The ONF Guideline states,

> In most cases, patients who experience mTBI will recover fully, typically within days to months. *The concern is that up to 15% of patients diagnosed with mTBI will continue to experience persistent disabling problems.*[13] *The consequences for these individuals may include reduced functional ability, heightened emotional distress, and delayed return to work or school.*[5]

The ONF Guideline also describes the need for very early support and monitoring of concussion symptoms and impairments in functioning. It suggests very early referral for intervention for specific symptom

presentations. Although only required by a subset of individuals with concussions/mTBI, these interventions are described as essential to help achieve more positive outcomes.

From our analysis, we have concluded that concussion/ mTBI does not fit most of the criteria for Type I injuries. The only criterion that is applicable is that most of the people who sustain a concussion/ mTBI experience a resolution of symptoms. Review of the evidence indicates that the criterion that the condition does not produce clinically significant functional impairments is incorrect for concussion/mTBI, as many people experience functional impairment, even if this is short-lived for many. For those who experience persisting symptoms, the impairments can be lifelong. We also see from the evidence that the criteron that interventions do not produce clinically important outcomes, cure, or accelerate healing, and are not required, also does not apply in this case. We note that the ONF Guidelines are clear on the need for early intervention to reduce impairments, suffering, and future disability.

We note that the ONF Guideline distinguishes Concussion/ mTBI from Post-Concussive Syndrome after 3 months of persistent symptoms. This also is not addressed in the Report.

OPA Recommendation

- **Adopt the Ontario Neurotrauma Foundation Guidelines for Concussion/ Mild Traumatic Brain Injury & Persistent Symptoms (Second Edition) as an up-to-date and appropriate Guideline regarding management and treatment of individuals with mTBI/concussion as well as Post Concussive Syndrome/Disorder.**
    - **Remove Concussion/mTBI from consideration as a Type I injury**
    - **Classify MTBI/Concussion and Post Concussion Syndrome/Disorder all as Type II injuries**

5.6 Interventions included in the Care Pathways for Type 1 injuries

We agree that psychological interventions (diagnostic evaluation, treatment, and rehabilitation) are generally not part of the initial treatment of the physical conditions included as Type I injuries. However, we note some contradictions regarding the inclusion ofpsychological interventions in the Care Pathways for Type I injuries in the Report. Section 1.5.5 states, the interventions considered in the new clinical practice guidelines include:

- Acupuncture
- Education and self-management
- Exercise
- Manual therapy
- Multi-modal care
- Passive physical modalities
- Pharmacologic treatments (analgesics, non-steroidal anti-inflammatory drugs (NSAIDs) and muscle relaxants)
- Soft tissue therapy

Despite this, mention is made of “psychological interventions” in some of the Care Pathways.

5.7 Psychological interventions

While not included in the overall list of interventions, some of the Care Pathways include what are labeled as "psychological interventions". However, it is incorrect to categorize as "psychological interventions" most of what is described in the research literature cited in the Report and included in the Care Pathways. The confusion regarding what services are correctly described as "psychological" intervention is seen in much of the research literature, as well as in this Report and Care Pathways. Too often, any services that are not directly providing physical interventions are incorrectly labeled as "psychological". It is necessary to distinguish these interventions, which are often provided by the health professional who carries out the physical treatment, from those that can legitimately be called "psychological" interventions.

Review of the available reference materials noted for the development of the Care Pathways suggests that the recommended interventions described as "psychological" would be more accurately described as supportive and/or educational.

The report includes the following definition for "psychological" interventions.

> Psychological Interventions: Psychological interventions are methods used to treat psychological distress, consequences of musculoskeletal injuries (such as pain), or psychological disorders; primarily (but not exclusively) by verbal or non-verbal communication. Psychological interventions can be broadly subdivided into several theoretical orientations, including but not limited to psychodynamic, psychoanalytic, behavioural/cognitive behavioural, humanistic and existential, family/systems approaches and combinations of these approaches. Psychological interventions can include (but are not limited to) in-person psycho-education; booklet/written material that includes a psycho-educational component; cognitive-behavioural interventions, or a guided psychological self-help intervention.

We requested the reference article that included this definition, however it was not available as it has been submitted for publication. This definition is both incomplete and does not accurately describe most of the interventions included in the literature reviewed and included in the various Care Pathways.

The definition included in the Report is not applicable in the Ontario context. *We note that the Psychology Act restricts the use of "psychological" to members of the College of Psychologists, therefore, by law, "psychological" interventions can only be conducted by psychologists or psychological associates.*

Psychology Act, 1991, states,

> Restricted titles
>
> 8(3) A person who is not a member contravenes subsection (2) if he or she uses the word "psychology" or "psychological", an abbreviation or an equivalent in another language in any title or designation or in any description of services offered or provided.
>
> Scope of practice
>
> 3. The practice of psychology is the assessment of behavioral and mental conditions, the diagnosis of neuropsychological disorders and dysfunctions and psychotic, neurotic and personality disorders and dysfunctions and the prevention and treatment of behavioral and mental disorders

and dysfunctions and the maintenance and enhancement of physical, intellectual, emotional, social and interpersonal functioning. 1991, c. 38, s. 3.

Authorized acts

4. In the course of engaging in the practice of psychology, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to communicate a diagnosis identifying, as the cause of a person's symptoms, a neuropsychological disorder or a psychologically based psychotic, neurotic or personality disorder. 1991, c. 38, s. 4.

Not yet proclaimed:
Authorized Acts
4.2. To treat, by means of psychotherapy technique delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning. 2007, c. 10, Sched. R, s. 18.

College of Psychologists of Ontario Standards of Professional Conduct
Psychological Services refer to services of a psychological nature that are provided by or under the direction of a member. Psychological services include, but are not limited to, one or more of the following:
a. Evaluation, diagnosis and assessment of individuals and groups
b. Interventions with individuals and groups
c. Consultation
d. Program development and evaluation
e. Supervision
f. Research

OPA Recommendation

- **Use the term supportive and/or educational interventions to describe the services included to address psychosocial issues/symptoms in the Care Pathways**
- **Psychological interventions, (diagnostic evaluation, treatment, and rehabilitation), provided by psychologists should not be included as generally provided components of the initial treatment of the physical conditions included as Type I injuries**

6. Review of the Report and Recommendations: Type II injuries

6. 1 Type II injuries are not addressed in the Care Pathways

The Report indicates that the Care Pathways do not address Type II injuries. It states,

> Type II injuries typically involve a substantial loss of anatomical alignment, structural integrity, psychological, cognitive, and/or physiological functioning. The majority of patients with such injuries will require (in addition to natural healing) a significant amount of medical, surgical, rehabilitation, and/or psychiatric/psychological intervention to ensure an optimal recovery. There is an evidentiary basis for major concern about both the extent of recovery and about the likelihood of complications

> developing and/or persisting in the absence of such expert care; significant impairment and disability are primary concerns. Examples of traffic collision-induced Type II injuries include fractures of the femur and hip, shoulder dislocation/fracture, facial fractures, depression or post-traumatic stress disorder. The management of Type II injuries is not within the scope of our report.

6.2 Psychological and mental disorders are appropriately classified as Type II injuries

We agree with the statement in the Report that psychological and mental disorders are more appropriately considered within the Type II injury framework. (We note that for a small subset of individuals these may also have catastrophic consequences and therefore be classified within this scheme as Type III).

We also agree with the description in the Report,

> A Type II injury is not likely to undergo spontaneous recovery, and the injured person may require medical, surgical and/or psychiatric/psychological care. …There is an evidentiary basis for major concern about both the extent of recovery and about the likelihood of complications developing and/or persisting in the absence of such expert care; significant impairment and disability are primary concerns.

We agree that individuals whose status includes diagnosed psychological and mental disorders require specialized psychological intervention and are not addressed within the Care Pathways. The disorders noted above, depression or post-traumatic stress disorder, are examples, but should not be construed as a complete list, as other mental and psychological disorders also cause significant impairment and require specialized diagnostic evaluation and treatment.

The following sections demonstrate that psychological and mental disorders are appropriately classified as Type II, not Type I, injuries and can be easily differentiated from most common physical ailments and the distress that may accompany them.

6.2.1 Onset and Prognosis

In most individuals, good recovery from initial distress and upset may be observed within days and usually within the general 12-week described in the first phase of the Care Pathways. In contrast, most other impairments due to psychological and mental conditions/disorders (aside from ASD and mTBI) are more likely to have later onset and tend to be persistent. While there are effective treatments for these pervasive and persistent psychological and mental disorders, reduction of impairments and restoration of functioning often requires months to years. The longer recovery times are dependent upon complicating factors and individual response to treatment. Early access to psychological interventions is known to be effective in mitigating complicating factors and since they are tailored to the individual patient's needs, individual responses tend to be positive.

Given the nature of client responses, the subset of accident victims with impairments due to psychological, mental and behavioural disorders cannot be considered to have predominantly Minor Injuries or Type I injuries or limited to services within the Care Pathways, as their onset is often delayed and prognosis is one of a more prolonged recovery. As such, the classification system should explicitly state that psychological

and mental disorders, diagnosed by a psychologist, psychiatrist, or physician with appropriate expertise are Type II injuries even when presenting early (within the first month) or accompanied by Type I musculoskeletal injuries.

OPA Recommendation

- **Confirm that all psychological and mental disorders diagnosed by a psychologist, psychiatrist, or physician with the appropriate expertise are classified as Type II injuries.**

6.2.2 Functional Limitations

In addition to their persistence beyond the early post-MVA period, accident victims with psychological and mental disorders can be differentiated from those with psychosocial issues/symptoms/complaints by the resultant functional limitations. While some accident victims with most common musculoskeletal injuries may have psychosocial issues/complaints, these psycho-social symptoms would not be expected to limit their functioning in their personal, home, or work life. The distinction occurs where psychological and mental disorders have developed to the degree that they result in impairments and limitations in functioning.

The higher level of disability due to mental and behavioural disorders is documented in *"Disability and Treatment of Specific Mental and Physical Disorders, Ormel, Petukhova, Von Korff, and Kessler, Global Perspectives on Mental – Physical Comorbidity in the WHO World Mental Health Surveys, edited by Michael R. Von Korff, et. al., Cambridge University Press, 2009*". The key message is that "*Disability ratings for mental disorders were generally higher than for physical disorders. Of the 100 possible pair-wise disorder-specific mental- physical comparisons (Table 18.4), mean ratings were higher for the mental disorder in 91 comparisons in developed and 91 in developing countries".* Therefore, a key component of appropriate mental health expert diagnosis of a psychological disorder involves evaluation of the impact on functioning. The psychological, mental, and behavioural disorders require treatment in their own right to reduce impairment, restore function, and reduce the likelihood of the disorder becoming a life- altering, chronic condition.

6.2.3 Assessment by a Health Professional with Expertise in Diagnosis of Mental and Behavioural Disorders

It is generally assumed that the screening for psychosocial issues and the needed supportive/educational interventions can be provided by the health professional carrying out the assessment and treatment of the musculoskeletal injuries. However, the determination of impairments/disorders due to psychological, mental, and behavioural disorders requires specialized expertise and authority to communicate the diagnosis (authority to perform this controlled act is limited by law to members of the psychological and medical professions). Assessments of accident victims with psychological, mental, and behavioural disorders should follow the processes outlined in the Ontario Psychological Association Guidelines for Assessment and Treatment Guidelines in Auto Insurance Claims (OPA, 2010). When appropriately conducted, the psychological diagnostic process can be compared to medical laboratory testing and history-taking to guide treatment/rehabilitation. If the health professional providing the physical treatment for the musculoskeletal injury suspects a psychological/ mental impairment, the patient should be referred for

screening interview and determination of the need for diagnostic assessment/treatment to a psychologist, psychiatrist, or physician with appropriate expertise in diagnosis and treatment of psychological, mental, and behavioural disorders.

OPA Recommendation

- **Diagnostic evaluations regarding mental, behavioural, and psychological disorders should be completed by a psychologist, psychiatrist, or physician with the appropriate expertise and authority to communicate a diagnosis of a psychological or mental disorder.**

6.2.4 Treatment by Health Professional with Expertise in Treatment of Mental and Behavioural Disorders

It is assumed that the physical treatment provider can provide the supportive/educational interventions required by accident victims with most common musculoskeletal injuries. In contrast, patients with psychological, mental and behavioural disorders present with a variety of highly specialized treatment and rehabilitation needs. Effective, efficient treatment/rehabilitation must incorporate both evidence-based guidelines, when appropriate, and individual factors. This requires health professionals with specialized expertise. Extensive specific education and training is required to provide the treatment/rehabilitation in a sound manner. In addition, it is essential to continuously evaluate and monitor the effect of treatment and modify as needed. Therefore only health professionals with this specialized expertise, such as psychologists, should provide treatment/rehabilitation of patients with impairments due to psychological, mental, and behavioural disorders (in coordination with other treatment, if required, for the patient's physical disorders).

OPA Recommendation

- **Treatment for patients with psychological, mental and behavioural disorders should be completed by a psychologist, psychiatrist, or physician with the appropriate expertise and authority to perform psychotherapy and to conduct ongoing diagnostic evaluation for modification of the treatment plan.**

6.2.5 Psychological, Mental, and Behavioural Disorders are not the "Clinically Associated Sequelae" of Type I Musculoskeletal Injuries

As discussed above, an accident victim with a psychological disorder has a distinct disorder/condition, not a "clinically associated sequelae" of the common musculoskeletal injury. The nature and severity of the mental and behavioural disorder is independent of the severity of the physical injury.

6.2.6 Predominance of Psychological and Mental Disorders

In patients with the most common musculoskeletal injuries as well as psychological/mental and behavioral disorders, the mental and behavioral disorder usually comes to overshadow that of the physical injury and becomes the predominant cause of functional limitations in home, personal, and work life and creates the greater health care needs. Therefore, in accident victims with psychological/mental and behavioural

disorders, as well as most common musculoskeletal injuries, the psychological disorder is the *predominant* condition.

6.3 Screening instruments to facilitate referral to evaluate psychological and mental disorders

6.3.1 Screening instruments for Depression

We agree that the following are appropriate screening measures for depressed mood:

Patient Health Questionnaire-9 (PHQ-9)
Center for Epidemiologic Studies Depression Scale Revised (CESD-R)
Depression scale of the Hospital Anxiety and Depression Scale (HADS)
Beck Depression Inventory-II

However, we do not recommend the instrument included in the Report for screening "feelings of depression about the pain"; this requires more specific assessment than can be accomplished by using simple screening measures of depressed mood.

OPA Recommendation:

- **Include the following instruments to screen for potential depressed mood affecting functioning that may indicate need for referral to psychologist, psychiatrist or physician with appropriate expertise for diagnostic assessment and treatment**
  - **Patient Health Questionnaire-9 (PHQ-9)**
  - **Center for Epidemiologic Studies Depression Scale Revised (CESD-R)**
  - **Depression scale of the Hospital Anxiety and Depression Scale (HADS)**
  - **Beck Depression Inventory-II**

6.3.2 Screening instruments for ASD and PTSD

We are concerned regarding the suggestion in the Report to use the Impact of Events Scale – Revised and Trauma Screening Questionnaire to screen for symptoms of Acute Stress Disorder or Post-Traumatic Stress Disorder. Neither of these measures have been validated against DSM criteria for Acute Stress Disorder (ASD).

As alternatives for screening for ASD, we recommend the Acute Stress Disorder Scale (ASDS) and the Stanford Acute Stress Reaction Questionnaire (SASRQ).

For Post Traumatic Stress Disorder we recommend the PTSD Checklist – Civilian version (PCL-C).

OPA Recommendation:

- **Include the following instruments to screen for potential acute or post-traumatic stress affecting functioning that may indicate need for referral to psychologist, psychiatrist or physician with appropriate expertise for diagnostic evaluation and treatment**
  - **the Acute Stress Disorder Scale (ASDS) and/or the Stanford Acute Stress Reaction Questionnaire (SASRQ) to screen for ASD symptoms**
  - **the PTSD Checklist – Civilian version (PCL-C) to screen for PTSD symptoms**

6.3.3 Screening instruments for coping style

We have some concerns regarding the choice of screening measures included in the Report for measuring anger/frustration about pain, and "passive coping". We recommend not using the measures suggested in this report. Again, we reinforce, that as suggested in the Report, individuals presenting with continuing, new, or worsening mental, behavioural, or psychological symptoms should be referred to a psychologist, psychiatrist, or physician with appropriate expertise for diagnostic evaluation and treatment.

OPA Recommendation:

- **Do not include specific measures of anger/frustration about pain and "passive coping"**
- **All individuals presenting with continuing, new, or worsening mental or psychological symptoms should be referred to a psychologist, psychiatrist, or physician with appropriate expertise for diagnostic evaluation and treatment.**

6.3.4 Screening instruments for Concussion/mTBI and Post-Concussion Syndrome

Concussion/mTBI in the setting of closed head injury should be diagnosed as soon as possible because early recognition is associated with better health outcomes for patients. Therefore, appropriate early and ongoing screening to identify those patients who require referral for diagnostic evaluation and/or management is essential.

On presentation, the primary care provider should conduct a comprehensive review of every patient who has sustained a mTBI. The Acute Concussion Evaluation (ACE): Physician/Clinician Office Version is recommended by the ONF Guideline and we support this recommendation. Determination regarding need for neuroimaging and safe discharge home should be made according to ONF Guideline recommendations.

The health professional providing the treatment of the physical injury should continue to monitor symptoms due to the concussion. The ONF Guidelines recommend the Rivermead as a screening instrument and we concur with this recommendation. Referral to an appropriate health professional with training in diagnostic evaluations and management/treatment of patients with concussion, mTBI, Post Concussion syndrome/disorder should be initiated when symptoms are associated with functional impairment and are not resolving.

OPA Recommendation

- **We recommend the ACE for initial screening**
- **We recommend the Rivermead for screening to identify patients with persistent symptoms and functional impairments**

6.4 Robust evidence supporting psychological treatment for psychological disorders

We agree with the statements in the Report classifying psychological disorders as Type II injuries partly on the basis of the need for specialized interventions to reduce to morbidity of these disorders. The report states,

> A Type II injury is not likely to undergo spontaneous recovery, and the injured person may require medical, surgical and/or psychiatric/psychological care. …There is an evidentiary basis for major concern about both the extent of recovery and about the likelihood of complications developing and/or persisting in the absence of such expert care; significant impairment and disability are primary concerns.

Without appropriate treatment, psychological disorders are likely to become chronic and worsening, producing significant suffering and disability for the individual, in addition to significant social costs. A growing body of evidence is producing consistent results indicating that psychological interventions are not only at least as clinically effective as medications for some disorders, they may actually be more effective, and save valuable dollars, as well. Research data also indicate that psychotherapies produce lasting effects and prevent relapse, making them economically, as well as clinically viable alternatives to medication, especially as the cost of medications increases.

7. Conclusion

In the body of this submission we have elaborated a process which would be helpful to curtail frivolous referrals for psychological diagnostic evaluation and at the same time not create an inequitable barrier for individuals with psychological and mental disorders requiring diagnostic evaluation and treatment. We also understand that there is to be further separate consultation regarding the translation of this research into policy, and the proposed Care Pathways into Guidelines and regulations. The potential impacts of the recommendations in the Final Report will largely depend upon the translation of the evidence cited into actual Guidelines for care of patients with common injuries and the associated regulations. We look forward to an opportunity to contribute to this process.