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Stress and mental injuries – how to compensate?

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Stress and mental injuries – how to compensate?

1 Introduction

Mental injuries are increasing in prevalence and cost, and are noted by a number of compensation schemes as a pressure point.

We contend that:

- Historical treatment paradigms ("recovery before return to work") do not work well for mental injuries. Further, the reinforcement of personal beliefs and perceptions through repeated retelling has the potential to exacerbate the original injury.
- Under more modern treatment paradigms ("work is good for you, complete your recovery at work") mental injuries have much to gain when compared to current practice.

In this paper, the authors propose a compensation framework for mental injuries based upon:

1. an underlying assumption that work is good for you, and that this is particularly true for mental stress injuries
2. creating an expectation that claimants must actively seek return to work from the commencement of a claim
3. providing the right specialist care at the earliest possible intervention point
4. minimising the potential for legal involvement in claim decisions
5. identifying industrial issues as early as possible for decision on resolution and/or response.

Implicitly we will draw out (what we believe are) shortcomings with current systems.

That said, we readily acknowledge that we are not medical professionals and so therefore may not have identified some relevant considerations.

This paper was motivated by various media and discussions we have been a part of in recent years and in particular a 2013 paper by Safe Work Australia "The Incidence of Accepted Workers' Compensation Claims for Mental Stress in Australia".

The aim of the paper is to open a discussion about how mental injuries should be compensated and why – while a strawman is presented, it is only intended for use as a reference point and should not be regarded as a recommended model. The financial implications of any potential changes to benefit structures have not been considered.

1.1 Acknowledgements

The authors acknowledge the contribution of many colleagues in developing our thinking, however the views expressed in this paper are those of the authors and do not necessarily represent the views of our employer or any other person.

2 Mental Injuries

2.1 What is a mental injury?

“Mental injuries” are psychological conditions, resulting from an event, that interfere with an individual’s normal ability to function. This includes a range of conditions such as: stress, depression, anxiety, post-traumatic stress disorder and adjustment disorder.

The events which cause a mental injury can range from sudden and traumatic events (for example, being held hostage in a bank robbery) to ongoing and more subjective events (for example, perceived low level harassment).

There will normally be a multitude of factors that influence whether an individual develops a mental injury in response to an underlying event, including:

- Underlying personality traits – resilience, self-confidence, ability to cope with change, catastrophising, conflict avoiding, etc
- Personal circumstances – relationship stability, financial pressure, physical health, community engagement, recent grief, substance reliance, etc
- Any existing psychological conditions – anxiety, depression, obsessive disorders, etc
- Workplace issues – job satisfaction, sense of control, bullying, reasonableness of demands, employment stability, etc.

In a workplace situation there are a range of psychosocial hazards that have been identified by the World Health Organization and British Standards Institute as being the primary hazards for mental stress claims, as shown in Table 2.1 below. We expect there to be very few employees who do not experience any of these hazards in the course of a normal working year!

[NB: these hazards are psychosocial and so do not include events and traumatic incidents that can also lead to mental injury claims]

Table 2.1 – World Health Organization and British Standards Institute 10 Primary Psychosocial Hazards and Indicative Mapping to Mental Stress Sub-categories

Psychosocial hazards	Definition	Probable alignment to Mental stress sub-categories
Job content	Lack of variety or short work cycles, fragmented or meaningless work, under use of skills, high uncertainty, continuous exposure to people through work	Work pressure Other mental stress factors
Work load & work place	Work overload or under load, machine pacing, high levels of time pressure, continually subject to deadlines	Work pressure
Work schedule	Shift working, night shifts, inflexible work schedules, unpredictable hours, long or unsociable hours	Work pressure Other mental stress factors
Control	Low participation in decision making, lack of control over workload, pacing, etc.	Work pressure
Environment & equipment	Inadequate equipment availability, suitability or maintenance; poor environmental conditions such as lack of space, poor lighting, excessive noise	Other mental stress factors
Organisational culture & function	Poor communication, low levels of support for problem solving and personal development, lack of definition of, or agreement on, organizational objectives	Work pressure
Interpersonal relationships at work	Social or physical isolation, poor relationships with superiors, interpersonal conflict, lack of social support, bullying, harassment	Work-related harassment &/or workplace bullying
Role in organization	Role ambiguity, role conflict, and responsibility for people	Work pressure
Career development	Career stagnation and uncertainty, under promotion or over promotion, poor pay, job insecurity, low social value to work	Other mental stress factors
Home-work interface	Conflicting demands of work and home, low support at home, dual career	Other mental stress factors

Sourced from Leka & Jain (2010) and ASCC (2008)

The more hazards/stressors that apply the greater the likelihood of encountering difficulties in responding to a mental injury, and the more opportunities there are for mental conditions to compound over time. Where possible, it is important to try and prevent claimants moving to more severe depressive or anxiety states (or worse), as these conditions tend to require longer term treatment and reduce the motivation toward, and likelihood of achieving, return to work.

2.2 Mental “injuries” and mental “disorders”

There are around 10,000 compensated mental injuries in Australia annually, compared to around 3.2 million Australians with a mental disorder (around 1 in 5 adults). This suggests that less than 1% of mental disorders are compensated as mental injuries.

Over time there have been an increasing number of people diagnosed with mental disorders. It appears this is mostly a result of changing community attitudes, social norms and increased profile, although changes in diagnostic practices (for example changes in the DSM) are also thought to have contributed to the increase. With even greater focus again in the last 2-3 years, it is unlikely these trends will recede.

Turning the question around, are all mental injuries regarded as mental disorders? We think not always, as some mental injuries would not be regarded as a diagnosable mental disorder (for example, the need for a ‘timeout’ after being subject to unreasonable work pressures is not considered a diagnosable mental disorder). Regardless, if mental injuries are not properly treated they clearly have the potential to develop into a mental disorder.

Overall, we expect the majority of mental injuries will also be regarded as mental disorders.

While most mental disorders are not work related, it is important to understand the interaction between these two groups given the existence of an underlying psychological condition can increase to the risk of developing a mental injury. This is particularly relevant given the size of the mental disorder population. Further, Lifeline Australia's national Stress Poll in 2009 showed that work caused more stress than other factors such as finances, health, concerns about the future or relationships.

With greater focus on what is and isn't acceptable workplace behaviour, it is likely there will continue to be pressure on mental injury claim numbers.

2.3 Understanding 'Recovery'

Recovery is defined in the Oxford dictionary as "a return to a normal state of health, mind, or strength". In a compensation environment recovery from a:

- Physical injury is likely to be mostly about the return to 'normal strength and health'.
  - And, there will tend to be general acceptance as to what is 'normal' based on a person's circumstances.
- Mental injury is more likely to be about return to a 'normal state of mind'.
  - There are likely to be a much greater range of views as to 'normal', and it is possible the injured individual's perception of normal may change over time due to the influences of the injury itself (for example an inability to cope with activities they previously would not have had issues with).

Research shows the path of recovery is influenced by many factors, including:

- The availability and quality of treatment options (usually a positive influence)
- The availability of compensation (often a negative influence)
- Individual psychosocial factors (can be positive or negative influences, but in a compensation environment are more often associated with negative outcomes).

In many instances a recovery can be less than "full" (i.e. a complete return to normal) and yet still enable a person to partake in their normal everyday activities.

Findings from one study, the Cardiff Health Experiences Survey, showed that symptoms of injury and disease are *"ubiquitous and omnipresent"*, and that when people are provided with an 'inventory' (checklist) around three times as many (66% vs 21%) will register one or more health complaints than when answering an open ended question (NB: for mental health complaints there were 5 times as many responses when an inventory was provided). In a compensation environment, where there is an active community of advisors who know the 'checklist', this presents interesting social questions about how far compensation should extend before responsibility is transferred back to the individual.

In her review of Britain's working population Dame Carol Black observed that there *"[needs to be] fundamental change in the widespread perception around fitness for work; namely that it is inappropriate to be at work unless 100% fit and that being at work normally impedes recovery"*.

2.4 The role of the GP

General Practitioners (GPs) are at the front line of medical diagnosis and treatment of illness and injury in Australia.

In a compensation environment, GPs usually have a 'gatekeeping' role in relation to both the initial diagnosis (and thus commencement of benefits for time away from work) and ongoing certification of injury (and thus continuation of benefits).

Given this role, the GP is crucial in influencing and determining how an injury will be treated, and when and how RTW activities are undertaken. Particularly when there is a discretionary element to whether or not ongoing work absence is appropriate – as is generally the case with mental injuries – the GP's approach can make significant difference to the outcomes achieved.

In making these decisions it will generally be the case that the GP has limited knowledge of the workplace. In effect they will often rely on the injured worker's re-telling of the events related to the injury to form their opinion of whether it is a work related injury or not (thus reinforcing the workers perception).

A recent study by ISCRR provided fabulous insight into how GPs handle these responsibilities. In particular:

- GPs are more likely to certify workers with mental health conditions as unfit for work than those with physical conditions – only 6% of mental health conditions were certified as having any ability to return to suitable duties, compared to 28% for non-mental health conditions.
- The median duration of unfit-for-work certificates issued to mental health condition patients was longer than in patients with musculoskeletal injuries, back pain and other traumatic injuries.
- Women with mental health conditions were more likely to receive certificates than men.

The ISCRR study also noted research that health professionals are more likely to perceive people with mental illness as having poorer health outcomes than they really have, which may explain some of these observations.

This leads to an interesting potential paradox – are GP's potentially causing longer term harm in their bid to look after patients' short term interests?

2.5 When is mental injury compensable?

Determination of whether or not a mental injury is compensable is primarily based on the establishment of a causal link between employment and the injury (or disease), subject to any specific legislative exclusions. In concept, mental injuries are no different to physical injuries in this regard. However, in practice, the nature of mental injuries makes it more difficult.

In establishing a link between the mental injury and employment each scheme has its own entitlement rules about how employment needs to relate to the injury for it to be eligible for compensation. For example:

- In Victoria, injury is defined as "an injury arising out of, or in the course of, any employment."
- Other jurisdictions go further and differentiate between personal injuries and disease injuries. For example, in NSW, injuries are defined as:

  (a) "personal injury arising out of or in the course of employment

(b) disease injuries, which means:

(i) a disease that is contracted by a worker in the course of employment but only if the employment was the main contributing factor to contracting the disease, and

(ii) the aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease, but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease."

In some cases, even when an injury can be demonstrated it will not be compensable due to legislative "exclusions" (discussed further below).

2.5.1 When isn't a mental injury compensable?

Exclusionary provisions for psychological injury vary by jurisdiction but generally state that mental injuries resulting from "reasonable management action", taken on reasonable grounds in a reasonable manner, will not be compensable. Management actions typically include:

- Transfers and redeployment
- Demotions and promotion
- Appraisals and performance management
- Retrenchment
- Provision of leave.

In New Zealand, mental injuries are not compensable unless the mental injury is caused by a physical injury, caused by a sudden traumatic event or as a consequence of certain criminal acts.

There can also be different entitlements available for mental injuries compared to physical injuries, for example the use of different (higher) severity thresholds for the payment of permanent impairment lump sums. In some instances there can even be a total exclusion of the impact of mental injuries, particularly around the treatment of "secondary" mental injury.

2.5.2 What happens in the grey area?

When a workers' compensation claim is denied due to the lack of a causal link between employment and the injury, the avenues open to the claimant include dispute resolution processes associated with the scheme, and if permitted, pursuit through common law.

Dispute resolution systems vary, however the ultimate binding decision regarding liability is generally made by an arbitrator, Court or Tribunal, which may include the ability to refer to an expert medical specialist or panel of medical specialists to assist in determining 'medical questions'. The decision is made based upon documentation and material provided to the review authority such as expert opinion from psychiatrists, psychologists or counsellors (i.e. it is not inquisitorial).

There is much precedent about whether or not employment has been a significant contributing factor to a mental injury. A common thread among these cases is the general reliance on expert testimony of psychiatrists, psychologists and/or counsellors in making the determination.

For example:

- Mullett v Ramahyuck – Magistrate Garnett preferred the opinion of consulting psychiatrist Dr Gill to that of consulting psychiatrist Dr Grant (who represented the Insurer), that the plaintiff "suffered from an acute stress reaction or an adjustment disorder with mixed anxiety and depressed mood as a result of the conflict between her and her supervisor and manager" and that the plaintiff sustained an injury which arose out of or in the course of her employment.
- Sitaris v Illesinghe & Prsantha – Magistrate Garnett dismissed a claim, stating that he was not persuaded that the plaintiff's employment with the defendant was a significant contributing factor causing an aggravation of her pre-existing psychiatric condition and leading to any incapacity for work. In this case, the defendant tendered medical reports prepared by consulting psychiatrists, although medical reports from the plaintiff's earlier treating psychiatrist were not presented.

Generally it appears that when the existence of a mental injury or the causal link with employment is contentious, it is qualified psychiatrists, psychologists or counsellors who provide the critical input to the dispute resolution process. Often there will be more than one such professional opinion. In many circumstances, the involvement of these professionals is late in the day and is retrospective rather than contemporaneous.

2.6 So what makes mental injuries different?

While there are always 'grey areas' in the diagnosis and treatment of compensable injuries, particularly when causation must be established, these grey areas impact a much higher proportion of mental injuries than physical injuries.

Table 2.2 attempts to draw out some of the differences across the spectrum of claims. For the sake of comparison we have generalised into four claim types, from acute physical injuries (generally the least subjective on most accounts) through to perception based mental injuries (where there are often subjective elements throughout the injury lifecycle).

Table 2.2 – Characteristics of Mental vs Physical Injuries

	Physical Injuries		Mental Injuries	
	Acute	Degenerative	Event Based	Perception Based
% of all claims	60-70% of all claims	30-40% of all claims	1-2% of all claims	2-3% of all claims
Causation	Easy to demonstrate a specific work activity which caused the injury	Often linked to a recurrent work activity. Non-work factors are also likely to influence the injury (eg. age, obesity)	Able to nominate a specific work event which caused the injury, with general acceptance that the event was 'traumatic'. Different people are likely to have different responses to the event	Could be a one-off or ongoing exposure to undesired actions, and there will be different opinions as to whether the action was or wasn't inappropriate. Different people will have different responses to the actions. Exclusions may apply such that the injury is not compensable even if established.
Initial Diagnosis	Supported by objective evidence	Often subjective as to severity, although usually supported by objective evidence as to type.	Type of injury will be more objective (based on the event), but extent of injury is subjective.	Subjective as to both type and extent.
Claim Acceptance (averages)	< 1 week to determine >90% accepted	<2 weeks to determine 80-90% accepted	2-6 weeks to determine 60-70% accepted	
Treatment, & recovery	Usually a strong consensus on best practice treatment and expected recovery times	May be differing views on appropriate treatment. Complexities can arise with ongoing 'pain' management	Usually some consensus on appropriate treatment, although it needs to be 'individualised'	Depends on the individual and will be impacted by other psychosocial factors. The worker's perception of the workplace is key.
Claim Duration	40% have >1 week of lost time. Median of <0.5 weeks off	50% have >1 week of lost time. Median of 0.5 to 1 week off	60-80% have >1 week of lost time. Median of 3 weeks off	>80% have >1 week of lost time. Median of 9 weeks off

While we could not source statistics to back it up, we expect there would also be higher rates of dispute/litigation for mental injury claims than for physical injuries.

Clinical evidence shows that beliefs aggravate and perpetuate illness and disability, and that the more subjective the injury the more central the role of beliefs. Combining this with the areas of subjectivity within mental injuries – the cause of injury, the impact of prior conditions, appropriate treatment, what constitutes suitable duties, when there has been recovery – it is easy to see why such claims can be difficult to manage in a compensation environment.

While we have made no effort to normalise for severity of claim, the claim acceptance and claim duration statistics demonstrate there are clear differences between mental and physical injuries, and further that the 'perception' based mental injuries are different again from 'event' based mental injuries. While they are no more than 5% of total injuries in most schemes, mental injuries are clearly at the most difficult end of the claims spectrum.

2.7 Conclusion

Mental Injury claims are different, as they involve much greater subjectivity in all aspects of decision making.

Under the current system GP's tend to keep mental injury claimants away from work. This appears to be contrary to the research that says 'work is good for your health and wellbeing.'

3 Mental Injury Claim Statistics

3.1 Workers Compensation

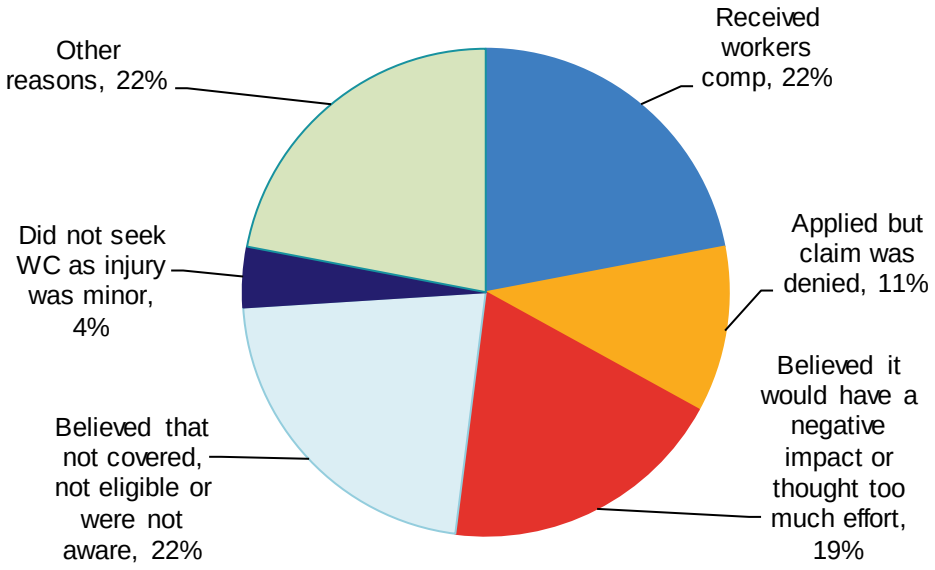
3.1.1 Introduction

The Australian Bureau of Statistics Work Related Injuries Report estimates there are 31,500 people annually who experience a work related injury as a result of “stress or another mental condition”. Of these 31,500 mental injuries:

- 21,800 (69%) are female
- 14,800 (47%) require 5 or more days off work
- 24,400 (78%) did not receive workers compensation (i.e. only 22% or 7,000 workers received workers compensation).

Picking up on the last bullet point, it is surprising (at least to us) that less than a quarter of these injured workers receive workers compensation given nearly half have 5 or more days off work. Additional information from the ABS survey show only 4% did not seek workers compensation because of the ‘minor nature of the injury’, as shown in Figure 3.1 below.

Figure 3.1 – Use of Workers Compensation after Mental Injury



This suggests there is a significant ‘claim propensity’ risk in relation to future workers compensation claims, if those who chose not to seek workers compensation (whether intentionally or not) begin to do so.

We further note that the same survey question in 2006 showed only 11% of mental injuries received workers compensation (compared to 22% now), so, over 5 years the proportion of work related mental injuries receiving workers compensation has doubled, and there is a lot more room for further growth.

The remainder of this section is based on research conducted by Safe Work Australia for its report “The Incidence of Accepted Workers’ Compensation Claims for Mental Stress in Australia” and we gratefully acknowledge their assistance with allowing us to make use of their research.

Claim Segmentation

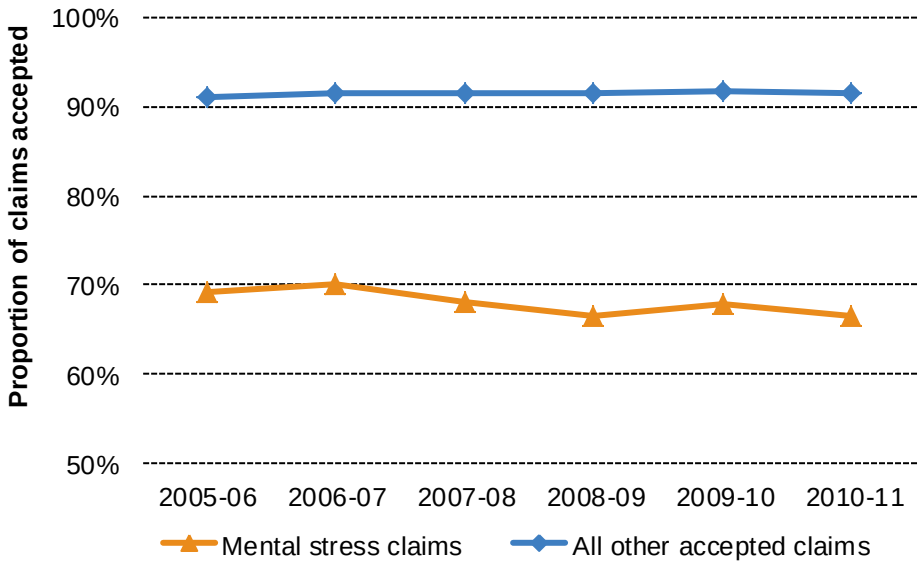
Workers' compensation claims in Australia are coded according to the Type of Occurrence Classification System 3rd Edition Revision 1, where the mechanism of "Mental Stress" is assigned to claims where an employee has experienced an injury or disease because of mental stress in the course of their employment. Sub-categories distinguish Mental Stress claims into the following sub-categories, which we have judgmentally categorised as 'event based' or 'perception based'.

	Sub-Category	Description
Event Based	Exposure to workplace or occupational violence	includes being the victim of assault by a person or persons who may or may not be work colleagues; and being a victim of or witnessing bank robberies, hold-ups and other violent events
	Exposure to traumatic event	disorders arising from witnessing a fatal or other incident
	Suicide or attempted suicide	includes all suicides regardless of circumstances of death and all attempted suicides
	Other mental stress factors	includes dietary or deficiency diseases (Bulimia, Anorexia)
Perception Based	Work pressure	mental stress disorders arising from work responsibilities and workloads, deadlines, organisational restructure, workplace interpersonal conflicts and workplace performance or promotion issues
	Work-related harassment &/or workplace bullying	repetitive assault and/or threatened assault by a work colleague or colleagues; and repetitive verbal harassment, threats, and abuse from a work colleague or colleagues
	Other harassment	being the victim of sexual or racial harassment by a person or persons including work colleague

3.1.2 Claim Acceptance

The proportion of mental stress claims accepted as a proportion of claim lodgements has remained relatively stable over recent years. There is however a significantly higher rejection rate for mental stress injuries than for other injury types, with around one in three lodgements not accepted for workers compensation benefits, as shown in Figure 3.1 below.

Figure 3.2 - Accepted Workers Compensation Claims in Australia

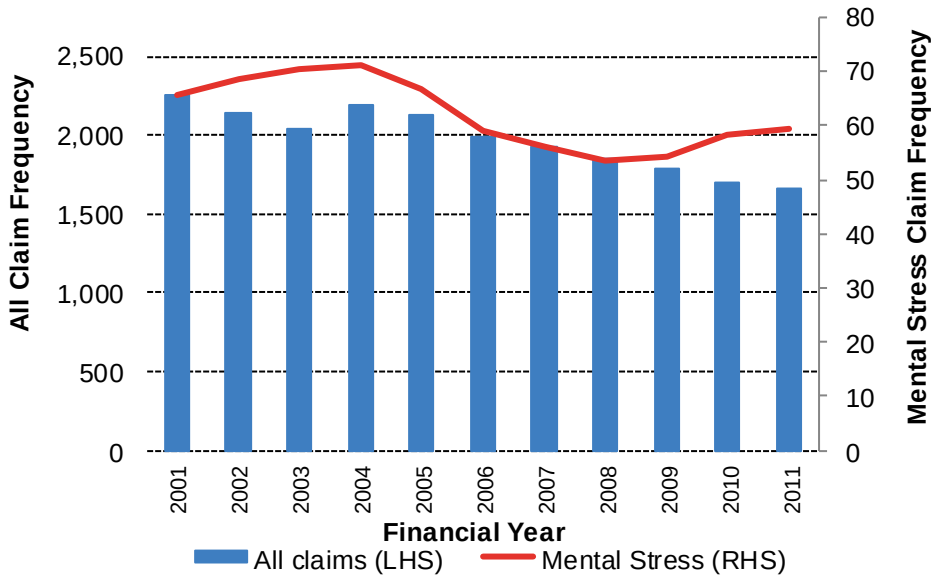


3.1.3 Claim Frequency

There has been a long term downward trend in the claims frequency for All Claims, which has been evidenced by most if not all Australian workers compensation schemes.

For mental stress claims the trends have been less consistent. Between 2001 and 2004 there was an increase in the mental stress claims frequency, before reductions were seen between 2004 and 2008. Since 2008 the claims frequency has increased again, and there are currently around 10,300 accepted mental stress claims in Australia (as per the inclusions in the Safe Work data this covers most, but not all, employment situations in Australia).

Figure 3.3 – Mental Stress Claim Frequency vs All Claim Frequency (accepted claims per 100 million hours worked)

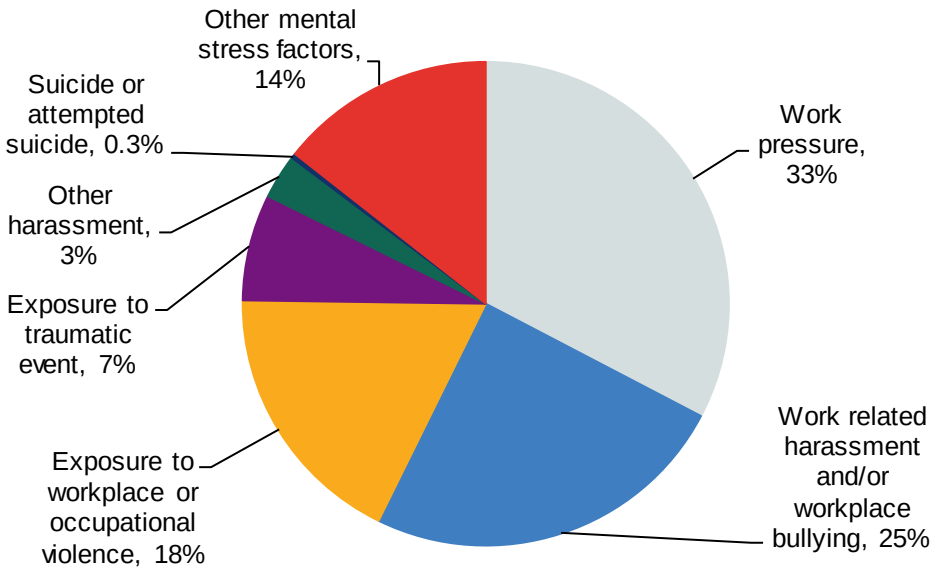


While it is difficult to get this information at the jurisdiction level, our analysis of the available raw claim statistics suggests significant differences between schemes: at least two schemes appear to have increases of around +40% (or more) in mental injury claims, while one or two may even have had small reductions in claim numbers. At this stage we have not had the time to further investigate these differences, for example to see whether they are linked to legislative or policy changes.

3.1.4 Claim Mechanism

Figure 3.3 shows the sub-categories for accepted mental stress claims in 2010/11. As this shows, the largest two categories account for over half of all mental stress claims, these being “work pressure” (33%) and “work related harassment or bullying” (25%). Interestingly, the proportion of mental stress claims from work related harassment or bullying has increased from 15% to 25% over the last five years.

Figure 3.4 – Split of 2010-11 Mental Stress Claims by Sub-Category (mechanism)



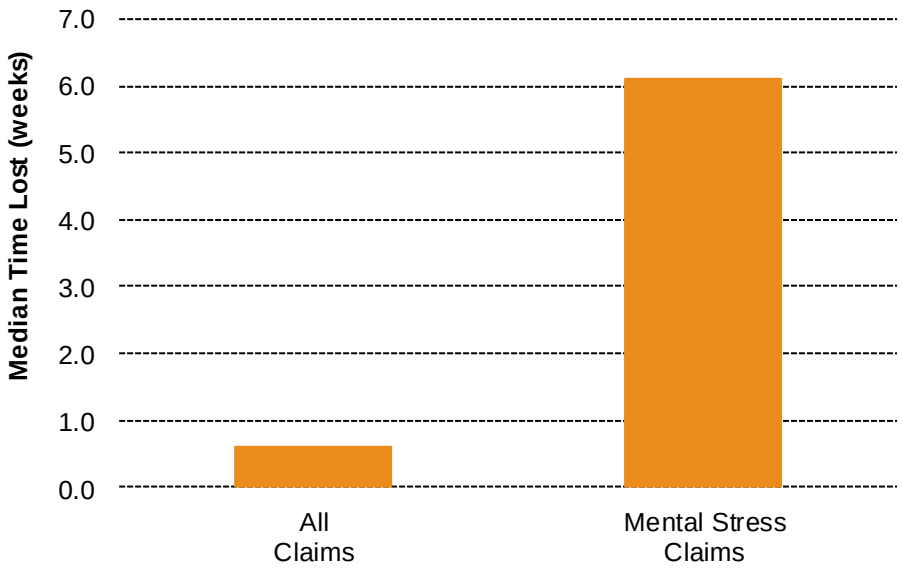
*Excludes Victoria as their data is not coded at the sub-category level

In accordance with our (judgmental) categorisation of the claim sub-categories (as shown in Table 3.1), 58% of mental stress claims could be regarded as 'perception based' and 42% as 'event based'.

3.1.5 Time Lost and Cost

Given time off work is the biggest driver of longer term claims costs, we have focused on 'lost time' in examining mental injury claims. Figure 3.4 compares the median lost time in weeks for mental stress claims to all claims.

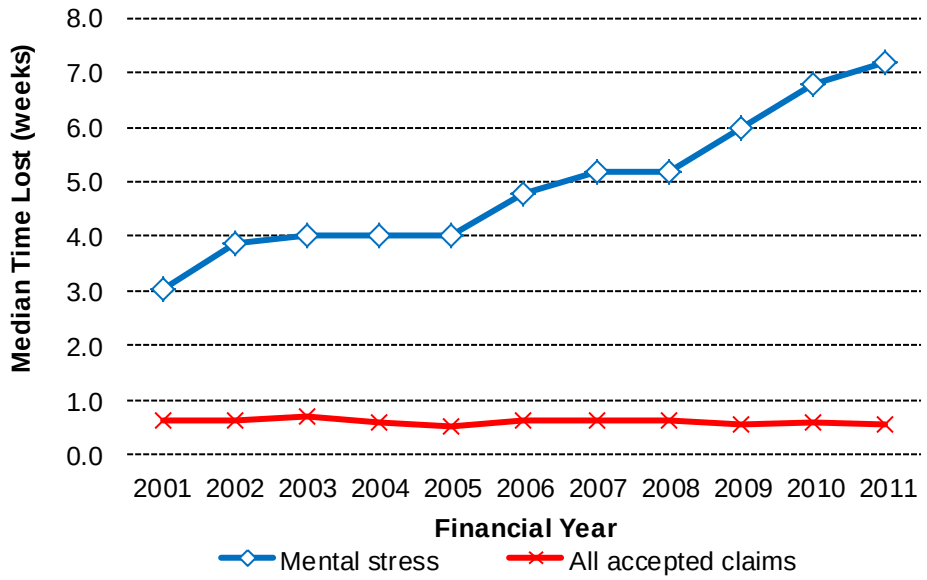
Figure 3.5 – Median Lost Time: Mental Stress vs All Claims



As this shows, the median mental stress claim has 10 times longer off work than the median across all claims. If nothing else, the notification of a claim for mental stress should be an immediate flag for triaging to a 'high risk' claims management team!

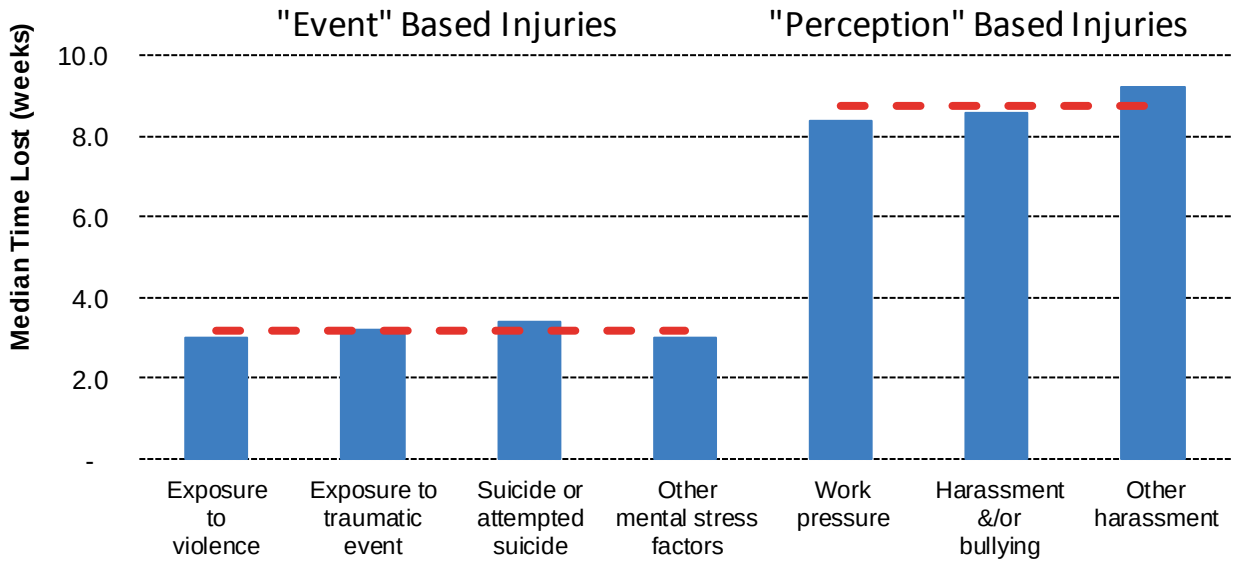
Further, the median lost time for mental stress claims has been on a continuing upward trend, as shown in Figure 3.5 below.

Figure 3.6 – Median Lost Time (time series): Mental Stress vs All Claims



To try and further understand where these differences come from, lost time has been analysed by mental stress sub-category, which we have then grouped into our own event/perception based categorisation, as shown in Figure 3.6 below.

Figure 3.7 – Median Lost Time for Mental Stress Claims by Sub-Category



*Excludes Victoria as their data is not coded at the sub-category level

To the authors at least, this was a surprising result and was a key consideration in the development of our strawman in section 6. In particular we note:

- It was not surprising to us that many claimants with exposure to traumatic events and/or violence would require a number of weeks off work, and we saw nothing untoward in this.

- A median of nearly nine weeks lost time for perception based injuries seems high, particularly when compared to the roughly three week median for event based injuries.
    - Given this group covers nearly 60% of mental stress claims, we believe a systemic response is required to address this, which we discuss in the following sections.

Not surprisingly, the cost of mental stress claims (not shown) is also significantly higher than for all claims, with similar orders of magnitude in difference to that shown above. As concluded by Safe Work in their report: *"mental stress claims are the most expensive form of workers' compensation claim because of the often lengthy periods of absence from work typical of these claims"*.

3.1.6 Other Observations

Without going into detail we also make the following observations from the Safe Work report in relation to Mental Stress claims:

- Claim frequency rates for females are around double the male rate. Women have a higher claim frequency than men on all sub-categories apart from exposure to a traumatic event.
- Claim frequencies tend to increase with age, and are around three times higher for 40-60 year olds as they are for those in their 20s.
- Occupations with a high level of personal responsibility for the welfare of others and/or where there is a potential exposure to dangerous situations tend to have higher claim frequencies.
    - The health and community services, education and government administration industry groups have higher than average mental stress claim frequencies, which may also suggest there is a bias toward government sector employees (although there is no information available with which to confirm this).

3.2 CTP Schemes

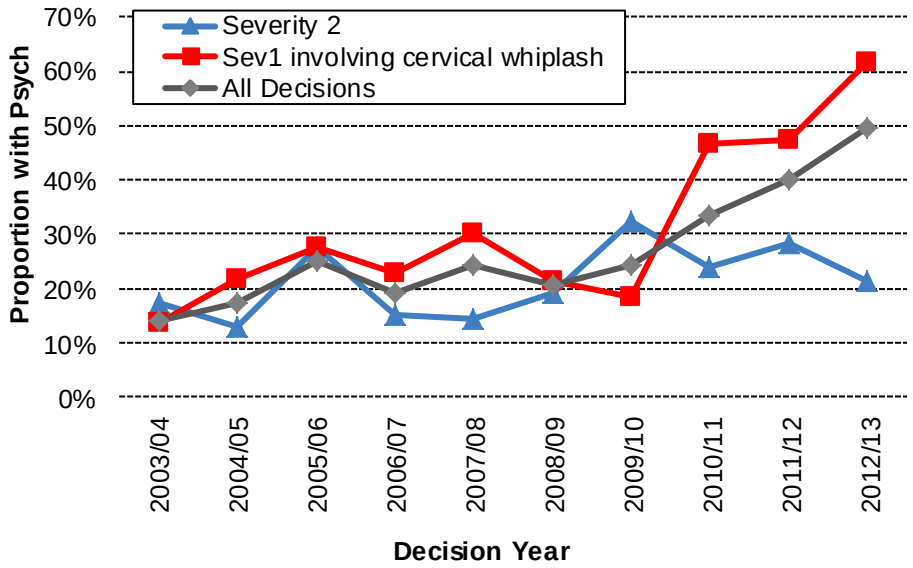
While there are significant amounts of publicly available material from workers compensation schemes, there is far less for CTP. Anecdotally at least, we and our colleagues have noted an increase in comments relating to the influence of mental injuries on CTP claims.

That said, we suspect mental injuries are less of a 'claim frequency' issue in CTP and are more likely to be a 'claim severity' issue – that is, the psychological impairment is an 'add on' to the existing physical impairment claim, meaning claim numbers do not increase but average sizes are larger.

In an attempt to investigate this we contacted the Insurance Council of Australia who, on behalf of its insurer members, have allowed us to use the following graph showing the proportion of CARS decisions in the NSW CTP scheme where a psychological issue has been raised by the claimant (i.e. the injury coding as recorded by the insurers includes codes in respect of anxiety, depression or PTSD).

As this shows, there has been a significant upward increase in the proportion of CARS decisions with a psychological injury component, which we expect would be placing upward pressure on claim sizes (superimposed inflation in actuarial speak). Interestingly, this is being driven by the less severe claims rather than those with higher severity physical injuries.

Figure 3.8 – Proportion of CARS Assessments with a Psychiatric Injury Component



It is also worth noting the Transport Accident Commission in Victoria has recently announced reforms related to the compensation available for psychiatric injuries (among other changes) to provide clinical criteria of what constitutes a severe long-term mental or severe long-term behavioural disturbance or disorder for the purpose of defining serious injury. In proposing the bill to Parliament the Victorian Treasurer stated "The clinical criteria will encourage people who were directly exposed to a transport accident and who have suffered a recognised mental illness or disorder to seek treatment by a registered mental health professional, to improve their chances of getting their life back on track as soon as possible."

Given it is arguably somewhat of a thought leader in the compensation environment, it will be interesting to see if the TAC changes lead to a new round of legislation amendments in relation to mental injury claims.

4 Compensation for Mental Injury Claims

4.1 Current compensation framework

Australia's various workers' compensation schemes provide eligible workers with a range of benefits, with goals of:

- Providing financial assistance while the worker is absent from work and recovering from their injury
- Providing the support to help the worker return to employment in a timely and responsible way through rehabilitation.

Benefits may be broadly classified into two groups: periodic benefits and lump sum benefits. Table 4.1 below sets out the main benefit types available in Australian worker's compensation schemes.

Table 4.1 – Benefit Types for Compensation Injuries

Periodic Benefits	
Weekly	Income replacement benefits usually calculated on the basis of the worker's pre-injury earnings. Time limits to entitlements depending on the degree of incapacity. For workers who return to work but not to full capacity, weekly benefits usually "top-up" income to pre-injury levels.
Medical and Treatment	Medical and hospital costs associated with recovery from injury and appropriate rehabilitation. For mental injury claims, this would include psychiatric treament.
Lump Sum Benefits	
Permanent Impairment	In the case of permanent impairment, worker may be entitled to a lump sum payment for each impairment sustained to cover non-economic loss. Impairment thresholds
Common Law	Injured workers in some jurisdictions have the ability to sue their employers if they have been negligent. In most jurisdictions where common law access is available there are resitirictions on the heads of damage able to be sought, threshold tests (with respect to impairment) and/or caps on damages that can be awarded.

There are generally also benefits available to help cover the cost of legal advice if a dispute arises.

Table 4.2 below provides a brief summary of the benefits available in the largest of the domestic schemes, focussing on benefits available to workers who have suffered a mental stress injury.

Table 4.2 – Compensation for Mental Illness Claims

	Weekly Benefits		Medical	Lump Sum - Permanent Impairment		Common Law
Scheme	Duration	Minimum Benefits for Total Incapacity (as % of Weekly Earnings[1])	Treatment by "Psych" professionals covered and for how long?	Impairment Threshold	Maximum Benefit for Mental Illness	Access?
NSW	0 - 13 weeks 14 - 130 weeks 131 - 260 weeks 260 weeks	95% 80% Benefits cease unless working >15 hours per week or no capacity for work Benefits cease unless WPI > 20%	Covered - Yes. Medical benefits cease 12 months after receipt of last weekly payment, except for workers with WPI>30%	15%	$220,000	Yes Benefits uncapped, no pain and suffering Worker must have at least a 15% WPI
Victoria	0 - 13 weeks 14 - 130 weeks 130 weeks	95% 80% Benefits cease unless working >15 hours per week or no capacity for work	Covered - Yes. Requires approval from WorkSafe Agent	30%	$543,920	Yes Benefits capped, and includes pain & suffering Must first be granted a 'serious injury' certificate, which is granted if WPI of 30% or more (based on combined physical and mental impairments), or as determined based on a narrative test
Queensland	0 - 26 weeks 27 - 104 weeks 105 - 260 weeks 260 weeks Benefits commute to a lump sum once 'stable and stationary' conditions are met	85% 75% 75% of normal weekly earnings if WRI > 15% Benefits cease	Covered - Yes. Paid up to amount set out in Table of Costs	1%	$200,000	Yes Benefits capped, and includes pain & suffering If the worker has WRI of less than 20% or no WRI, they must decide to either accept the lump sum payment or seek damages
SA	0 - 13 weeks 14 - 26 weeks 27 - 130 weeks 130 weeks	100% 90% 80% Benefits to age 65 pending results of Work Capacity Assessment	Covered - Yes. Reasonably necessary medical expenses are payable for life	No lump sum compensation for mental injuries		No
WA	0 - 13 weeks 14 weeks +	100% 85%; overall limit 1.75 x $206,742 if total permanent incapacity	Covered - Yes. (up to scheduled fee amount)	1%	$198,365	Yes Benefits capped unless >25% WPI, includes pain & suffering Worker must have at least 15% WPI. Secondary psychological, psychiatric and sexual conditions are excluded
Comcare	0 - 45 weeks 46 weeks +	100% 75% if not working, minimum $425.72 pw.	Covered - Yes. (up to scheduled fee amount)	10%	$232,000	Yes (partly) Benefits capped, non-economic loss only Must be permanently impaired to be eligible for Common Law

[1] *Definitions of "Weekly Earnings" differ by state. E.g. in NSW it is Average Pre-Injury Average Weekly Earnings, in Qld it is Normal Weekly Earnings*

There is little tailoring of benefits for mental injury claims. While impairment thresholds for access to lump sums are provided specifically for mental illness claims in some instances, there is no obvious delineation of mental injury claims as requiring any different benefits (as opposed to serious injury claims for example, which are beginning to be recognised as a unique set of claims in some schemes).

In our view, any mechanism that incentivises the pro-longing of a claim is a negative feature in a benefit structure. As such, the passage of time associated with administering Common Law access is unattractive.

4.1.1 International Comparisons

While all Australian schemes allow benefits for psychological injuries, this is not universally the case abroad. The following summary has been taken from the Hanks review and to the best of our knowledge represents the current situation:

- In New Zealand, workers compensation benefits from the ACC are only payable for psychological injuries that are an acute reaction to a sudden and unexpected traumatic event arising out of and in the course of the worker's employment (for example, a bank employee witnessing a shooting or a train driver involved in a fatal accident).
- Similarly, some Canadian provinces provide only limited access to compensation for psychological injuries.
  - In British Columbia and Ontario, a psychological injury must be caused by an acute reaction to a sudden and unexpected traumatic event.
  - In Quebec, the cause of a psychological injury must be beyond the normal scope of the work and outside the normal and foreseeable relationship between the employer and employee. Claims involving interpersonal conflict or involving the employer's right to manage employees will not usually be accepted.

4.2 Case Studies

The following three case studies have been shown to demonstrate what we believe are undesirable characteristics of current scheme designs.

4.2.1 Case Study 1 – Common Law resolution of workplace conduct

In the case of Swan v Monash Law Book Co-operative, Mrs Swan suffered a psychiatric injury as a result of bullying, harassing and intimidating conduct. This conduct was from her manager (they were the only two permanent staff at the book store) and took place over a number of years. The conduct was not continual, although it was worse when the manager was stressed, particularly in the peak periods of trade when new university semesters commenced.

All in all, she hadn't been treated well in the workplace, and after a serious altercation in July 2007 she suffered 'a breakdown'. After which:

- A mediator was engaged by the employer to meet with Mrs Swan and the manager in the week after the incident, when she was to return to work. The mediation was unsuccessful as Mrs Swan's health had deteriorated over the week and the manager was judged to "not have the appropriate attitude for a successful mediation" by the mediator.
- Mrs Swan's GP referred her to a clinical psychologist in August 2007.
  - After not initially lodging a compensation claim, her medical advisors suggested this would be appropriate.
- A RTW was arranged in November 2007, four months later, with the agreement of her GP. This was totally botched by the WorkSafe provider and Mrs Swan did not RTW again.
- By around 15 months off work there was essentially an adversarial relationship between Mrs Swan and the system – the system was no longer trying to help her, it was fighting her claim for compensation.
- The Common Law claims process commenced in 2008.

- Over five and a half years following her injury, at the various requests of her GP, her lawyers, WorkSafe and her employer, Mrs Swan saw (at least) 24 medical/medico practitioners:
  - 10 psychologists and psychiatrists
  - 1 dermatologist
  - 1 dentist
  - 1 osteopath
  - 2 cardiologists
  - 1 physician,
  - 1 specialist musculoskeletal physiotherapist,
  - 2 ear nose and throat specialists
  - 1 dental specialist
  - 1 occupational physiotherapist
  - 1 physiotherapist
  - 1 audiologist
  - 1 oral medicine specialist.

  In the early periods there was some disagreement about whether she had any work capacity or not, although after a number of years it became almost universally agreed that she had little prospect of returning to work.
- A Common Law award was made on 26 June 2013, some 6 years after the injury, for $592,000 plus costs (for a 14 sitting day trial). The judge found that Mrs Swan now suffers from a major depressive disorder and a generalised anxiety disorder, with:

  "somatic symptoms including temporomandibular joint dysfunction with bruxism and tinnitus, chronic insomnia, pain, including migraine and headache, anxiety, a disabling sensitivity to antidepressants, high blood pressure, and debilitating rashes and skin irritations".

After six years in the compensation system Mrs Swan is in a dreadful position, and her life has been reduced to one of isolation and disconnection from the world around her. She has almost no hope of a RTW. This situation was particularly compounded by the continual re-telling of her story through the Common Law process.

As a final observation, we note Mrs Swan's words in talking to the judge about her work future when she said *"I don't have the capacity to work"*. Perhaps this was an innocent choice of words, but perhaps also it was that 5+ years of involvement with a compensation system had taught her very neatly how the legislation was phrased.

4.2.2 Case Study 2 – "Perception" of employment impacts

As noted in section 3, nearly 60% of Mental Injury claims arise from what we have classified as 'perception' based injuries. This presents challenges, given one employee's perception can be different to another employee's perception of and reaction to the same event.

In Wiegand v Comcare, the Federal Court held that an employee's perception about something related to her or his employment would be a sufficient basis to connect the employee's psychological reaction to her or his

employment, provided that the perception was a perception about an incident or state of affairs that actually happened and *regardless of whether the perception was reasonable or itself reflected reality*.

This is an extremely high expectation to place upon the employer, and to us represents a substantial drift from the intent of a workers compensation scheme.

4.2.3 Case Study 3 – Long term incapacity for work following workplace bullying

Andrew (not real name) suffered a mental injury in 2006 after he was stressed due to the pressure of an excessive workload.

He has since had over 90 visits to his GP and seen 8 different independent medical specialists. So far he has received $350,000 in weekly benefits and obtained medical and treatment services costing $95,000.

In 2011 there was a disagreement about Andrew's capacity to work which led to a dispute about his ongoing entitlement. The dispute took 15 months to resolve, cost $14,000 in legal fees and required numerous doctors to provide evidence.

Despite having $40,000 worth of vocational rehabilitation and training, Andrew remains off work and is certified as being "fully incapacitated" some seven years after his workplace injury. It is not expected that he will return to work in the foreseeable future.

4.3 Conclusion

There are generally a broad range of benefits available to workers with mental injuries, including in some cases access to Common Law.

In many instances the Australian compensation systems allow benefits to continue for extended periods after an injury occurs, even when the original injury did not appear to be significant.

5 Interaction with other systems

Worker's rights to workers' compensation insurance co-exist with their rights to other benefits, including sick leave, government sponsored benefits and those obtained through holding private insurance.

If workers' compensation benefits are not available for an injury, or if payments have ceased, then these other options may provide some level of income and/or expense relief to the injured worker, as summarised in Table 5.1 below.

Table 5.1 – Overview of Alternative Benefit Regimes

Benefit	Provided by	Benefits available	Benefit generosity	How accessed
Workers' Compensation	Employer	Income replacement (generally >80% of normal earnings), medical and treatment costs, lump sums for permanent impairment & potentially common law benefits	In line or better than international standards	Condition of employment
Employer Leave	Employer	10 days paid sick leave and 4 weeks annual leave at normal pay. Requests for flexixible working conditions.	In line or better than international standards	Condition of employment
Private Insurance	Individual purchase	Income Protection - usually around 75% of normal wage, subject to duration caps. Total and Permanent Disability - lump sum benefit if no longer able to work. Health Insurance - covers a limited amount of medical costs.	Benefits vary according to policy (and associated premium)	Individuals must have previously purchased the product, and may need to go through an underwriting process and/or be subject to waiting periods.
Superannuation	Individual (enforced savings)	Workers normally have an accumulation account, from which lump sum or periodic payments can be drawn. Benefits stop when the money runs out.	In line or better than international standards	Funds are normally not available until preservation ages are reached, although these restrictions can be waived in the case of permanent disability.
Disability Support Pension	Federal Government	Maximum rate $375 per week (single person). Potential access to other benefits including: mobility allowance, pharmaceutical allowance, telephone and utilities allowance, rent assistance	Below the Poverty Line[1]	Permanently blind or have been assessed as having a physical, intellectual, or psychiatric impairment, and unable to work, or to be retrained for work, for 15+ hours per week at or above the relevant minimum wage within the next two years because of impairment. Income and asset tested.
Newstart Allowance (unemployment benefits)	Federal Government	Maximum rate of $250 per week (single person). Potential access to other benefits including: mobility allowance, pharmaceutical allowance, telephone and utilities allowance, rent assistance	Below the Poverty Line[1]	Looking for paid work and prepared to meet the activity test while you are looking for work. Income and asset tested.
Medicare	Federal Government	Free or subsidised medical treatment and public hospital costs (costs capped based on Medicare fee schedules).	In line or better than international standards	Everyone who lives in Australia—except Norfolk Island residents—is eligible for a Medicare card. A New Zealand citizen who is living in Australia may also enrol if they provide the required documentation
Better Access initiative	Federal Government	Access to up to 12 mental health professional visits and team-based mental health care.	In line or better than international standards	Referal from GP
National Disability Scheme	Federal Government	Lifetime care and support needs	In line or better than international standards	Yet to commence

[1] *As defined in Melbourne Institute of Applied Economic and Social Research "Poverty Lines: Australia June Quarter 2013"*

In certain circumstances other remedies may also be available under employment law, via the Fair Work Commission, employer liability, discrimination legislation and/or other industrial relations rules. Under these

systems, benefits are not available per se, but orders may be made to restrain conduct in the workplace and/or damages may be payable in some instances.

5.1 Conclusion

Overall, workers compensation benefits are the most financially attractive in that they provide close to full pay for an extended period, cover most medical and treatment related costs and are relatively accessible.

While private insurance can provide similar financial compensation, the cost of putting this cover in place (which is a cost to the individual) means only a minority of injured workers have this option available (although we note that the broad coverage of superannuation in Australia means many people have some level of 'group cover' of which they might not be aware.)

Beyond this the benefits available are more in the form of government 'safety nets' and are at a much lower level of generosity.

6 A “strawman” for compensating mental injury

6.1 Some guiding principles

Our aim is to develop a compensation system which is in the best long term interests of injured workers.

An interesting question to consider is what constitutes the “best interests” of injured workers? While usually we’d expect they themselves are best placed to judge their own best interests, in a complicated environment where other psycho-social and economic factors are at play, is it reasonable to assume the worker knows best? While the evidence clearly suggests the best thing is for a worker to return to work (and further that being off work is bad for your health), this does not appear to be the accepted view amongst claimants, certifying GPs’ or claimant advisors.

The principles we have attempted to build the strawman around are:

- Work is good for you, and long term worklessness is bad for you, noting:
  - There need to be appropriate mechanisms to deal with ‘serious’ injuries
  - You do not need to be fully recovered to commence a RTW, although RTW should not cause additional injury (i.e. some work situations can cause more harm)
- Prompt intervention is key
- Injured workers need access to appropriate care – there are specialist skills required in treating mental injuries, and these should be made available from early in the life of a claim
- The claimant should expect they will be required to return to work as soon as possible and know there are hard boundaries on benefit duration from claim commencement
- The strawman must be financially viable.

Perhaps the strawman can most simply be summarised as building a set expectations that “you need to return to work” rather than one based on enabling the claimant to focus on “what can’t you do?”.

To the extent possible we have tried to keep industrial issues separate from compensation issues. One difficulty we have then faced is determining what requirements should be placed on employers. While our preference is to keep industrial issues out of the compensation environment, arguably this transfers responsibility to the injured worker to commence claims in other jurisdictions if there are both industrial and workers compensation issues. In short, we couldn’t identify any particular incentives to encourage employers to appropriately engage in the RTW process, so the best we could come up with is penalties for failing to provide safe workplaces and/or to undertake required actions. More work is needed here!

Like any system, there will be individual circumstances that do not fit well within the proposed framework, however we suggest these be dealt with under a scheme administered discretionary power rather than via prescriptive rules.

6.2 A strawman…

The following strawman is provided as a starting point to commence the discussion on how mental injuries should be compensated. As noted earlier, it should not be interpreted as a recommended model.

- Compensability – that there be two types of mental injury claims:

1. Exposure to a traumatic event
2. Other mental injury, where:
    (a) the injury was not the result of reasonable management actions, and
    (b) the injury is not the result of a perception that a reasonable employee (a dangerous approach?) would not have, and
    (c) employment was the substantial contributor to the injury.

- Claim acceptance:
    - Employer has 2 business days to report a mental injury claim (after notification) or else they are fined.
    - Benefits initially provided on a provisional liability or interim acceptance basis for weekly and treatment benefits; if claim is rejected then benefits cease, and if claim is accepted then other benefits are available
- Early intervention:
    - Tripartite review within 2 days of claim receipt by specialist mental injury case manager
    - Compulsory mediation within 1 week if workplace issues are identified by either the employer or the worker (bullying, harassment, personality conflict, etc).
        - If the mediation identifies workplace barriers that indicate a RTW within 4 weeks of injury is unlikely then a decision to focus on a new employer RTW should be made.
    - Immediate referral to specialist mental injury medical services if:
        - GP expects more than 4 weeks of lost time, or
        - Claimant expects more than 4 weeks of lost time, or
        - Case manager considers it is required

      [NB: the scheme may need to bulk fund sufficient services to ensure there is immediate availability of such services].
- Decision making (‘gateway’ management):
    - GP certificate is required for commencement of provisional liability benefits
    - Beyond 4 weeks all compensation decisions are to be made by an approved expert medical specialist – that is, the GP has no ongoing role in the certification of incapacity, although they can continue to treat the injured worker in a private capacity if desired by the worker.
        - Timely decisions will be required here, and so consideration needs to be given as to how the experts get prompt access to existing information.
- Weekly benefits – “exposed to a traumatic event”
    - as per current benefit structure
- Weekly benefits – “other mental injuries”
    - Initially capped at 4 weeks (and no past economic loss)
    - Extension available to 13 weeks if:

        - work search is being undertaken with an approved job search provider (i.e. the job search activity must be genuine, and require that the injured worker is actively participating for the equivalent of all/most of a work week), or
        - RTW is more than 15 hours per week and the worker is receiving treatment that is expected to lead to a full RTW by 13 weeks
    - Extension beyond 13 weeks is only available with approval of the scheme under a discretionary power that is not reviewable. Under no circumstances are benefits payable beyond 65 weeks (=13 + 52).
- Treatment benefits:
    - Benefits beyond 4 weeks only if provided by an approved mental injury specialist, to a maximum of 1 year after the cessation of weekly benefits
- Permanent impairment:
    - Only payable for exposure to a traumatic event injuries, with a threshold to be met before benefits are available
    - Secondary mental injury is not considered in the assessment of permanent impairment
    - Maximum of one medical report paid by the scheme (expert specialists to have a determinative review role in instances of dispute) – no doctor shopping. Also, permanent impairment is assessed on a once and for all basis.

    [an alternative would be to remove permanent impairment benefits altogether for mental injury claims]
- Dispute resolution:
    - Aim is to be more inquisitorial than adversarial
    - Medical expert determination on all 'medical decisions', with these expert decisions not reviewable, except on questions of law.

Some implications of the above strawman:

- Common Law benefits would not be available for mental injuries
- 'Secondary' mental injuries would not be compensable (nor should they be considered in determining suitable employment under work capacity type assessments for physical injuries)
- While we propose that interim payments start as soon as a claim is notified, there may need to be some additional safeguards to deal with the relatively high claim rejection rate
- The GP is not considered to be an appropriate gateway for managing workplace mental injuries – the skills required are too specific and current (apparently) passive approaches to the treatment of mental injuries and RTW may be doing longer term harm.
- The framework depends on prompt access to specialist mental illness treatment. Any undersupply of this type of care or bottlenecks ensuing from poorly managed implementation would be a significant risk to the model.

6.3 Getting Return to Work Right

The most significant risk associated with this framework (proactively seeking early RTW) is what happens when RTW is not done right. Of the many observations to be made from Swan v Monash Law Book Co-operative, one of the most saddening was that the plaintiff did actually attempt to return to work, but the return was not managed appropriately and ultimately led to further deterioration in the plaintiff's well-being.

Table 6.1 below gives three examples of RTW management following mental injuries, two of which are positive (and thus are the type of behaviours we seek to encourage) and one of which is negative.

Table 6.1 – Examples of Return to Work Activities Following Mental Injury

	RTW Done Well		RTW Done Poorly
Who	Insurer specialising in hotel industry	Unamed Self Insurer	*Swan v Monash Law Book Co-operative*
Type of Injury	Exposure to a Traumatic Event	"Preception Based" mental injury	"Preception Based" mental injury
Use of Specialist Intervention	Very prompt	Prompt, prior to RTW	Delayed until it's too late
Specifics	Insurer employs a "Critical Incident" team, who in the event that an employee of an insured hotel or club is involved in an armed holdup or some other tragic event will respond to provide immediate counselling to the employee and begin to manage their journey back to health and work. In most cases this proactive management of the employee's wellbeing after their exposure to a significantly traumatic event by appropriate specialists has led to potential workers' compensation claims being avoided.	Once a worker has been away from work, a multi-disciplinary team is estalished to facilitate a successful transition back to employment. A collaborative effort from the employee, employer (with suitable management and OH&S staff) and external psych professionals set out what the employee's return to work should look like, including suitable duties, workloads, supervisory support, appropriate / reasonable removal of stressors and any re-training requirements. The priority is to get some form of RTW as an initial step toward a return to normal duties, with management required to facilitate the removal of obstacles against this occuring.	There were a number of features of Mrs Swan's RTW that were sub-optimal, including: - it was 4 months until a RTW was commenced - the initial RTW was badly managed, and the RTW provider did not turn up at the scheduled time - the workplace was a shambles, and nobody had progressed her normal work while she was away - she was locked out of the IT system as passwords had been changed while she was away - her reference materials had been removed while she was away - the RTW provider criticised the workers treating psychologist, accusing her of "illegal practices".

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