MINISTERIAL REVIEW RELATING TO ESTABLISHING ENTITLEMENTS UNDER THE WORKERS REHABILITATION AND COMPENSATION ACT 1988 FOR WORKERS SUFFERING POST TRAUMATIC STRESS DISORDER (PTSD)

Reviewers:

Mr. Stephen Carey
Dr Jacqui Triffitt

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1. INTRODUCTION

In late 2017 the Government introduced into Parliament a Bill which was subsequently passed and came into effect as the *Workers Rehabilitation and Compensation Amendment (Presumption of Cause of Disease) Act 2017.*

This amendment removed the then existing qualifying requirements applicable to volunteer fire-fighters to access compensation based on the presumption that certain cancers may be linked to occupational exposure.

In 2013 amendments to the *Workers Rehabilitation and Compensation Act 1988* (the Act) established a rebuttable presumption that particular forms of cancer developed by fire-fighters are taken to be work related for the purpose of claiming workers compensation under the Act. This 2017 amendment removed the requirement for volunteer fire-fighters to attend a specified number of exposure events. In addition, the amendments (S 162A) required the Minister for Building and Construction to commission a review by 30 June 2018 as to whether a presumption that post-traumatic stress disorder is occupationally linked for relevant workers should be included into the Act. Section 162A requires as follows:

> *"162A. Review in relation to presumption in respect of PTSD in relation to certain workers*
>
> *(1) In this section –*
>
> *relevant disease means post-traumatic stress disorder;*
>
> *relevant workers means workers –*
>
> > *(a) who are employed or appointed under an Act of the State; and*
> >
> > *(b) the nature of whose occupation as such workers places them at significant risk of contracting, in the course of their employment, the relevant disease;*
>
> *review means a review carried out by persons who –*
>
> > *(a) in the Minister's opinion, are appropriately qualified for that task; and*
> >
> > *(b) include one or more persons who are not employees of the State or Commonwealth or of*

any agency of the State or Commonwealth.

(2) The Minister is to cause to be commenced by 30 June 2018 a review as to whether this Act should be amended to include provisions to the effect that, for the purposes of this Act, the employment of relevant workers, specified in the terms of reference for the review, who contract the relevant disease is, in the absence of evidence to the contrary, taken to have contributed to a substantial degree to the relevant disease.

(3) The persons who carry out the review are to complete the review and give to the Minister a written report on the outcome of the review, as soon as practicable but in any case before 1 October 2018.

(4) The Minister is to cause a copy of the report to be tabled in each House of Parliament on or before 1 October 2018."

Following an expression of interest process Mr. Stephen Carey (retired past Chief Commissioner of the Workers Rehabilitation and Compensation Tribunal) and Dr Jacqui Triffitt (Clinical Psychologist) were appointed to conduct this review. The legislation required that this review be commenced by 30 June 2018 and that a report be provided to the Minister by 1 October 2018. The appointments were not conveyed to the appointees until 31 May 2018 and detailed work was not able to commence until early June 2018. Initially the team were to have their draft report to WorkSafe Tasmania by 17 July, this was later extended until 23 July 2018.

The Terms of Reference provided to the Review Team were:

"<u>Scope of the Review</u>

The review will be evidence based and make recommendations on potential amendments, as and required, to the Workers Rehabilitation and Compensation Act.

In undertaking the review , the reviewer/s will have regard to the objectives of the Act (Section 2A) and consult with the community and key stakeholders.

The review will consider:

a) which persons covered by the Act , employed or appointed under the Act of the State and placed at significant risk of contracting post-traumatic stress disorder in the course of their employment;

b) whether there are persons covered by the Act but not employed or appointed under an Act of the State, that are placed at significant risk of contracting post-traumatic stress disorder in the course of their employement or involvement in activities covered by the Act;

c) *whether the Act should be amended to include provisions ("presumptive provisions") to the effect that for the purposes of the Act , a person's employment , appointment or other activity covered by the Act is, in the absence of evidence to the contrary , taken to have contributed to a substantial degree to the contraction of that person of post-traumatic stress disorder;*

d) *the qualifications that ought to be applied to the presumptive provisions(if any); and*

e) *the persons for whom presumptive provisions (if any) ought to apply.*

The report of the review will be finalised and provided to the Minister by 17 August 2018."

The Review team provided a **Review Scope and Project Outline** to WorkSafe Tasmania on 12 June 2018. This was accepted and detailed work commenced by the team. In summary the team determined to proceed as follows:

"Limitation: Project team having considered the issues raised by the Terms of Review have determined that the time line does not provide sufficient time to consult, research and analyse to the extent that the project team considers necessary to confidently address the issues raised. It is therefore possible that conclusions or opinions reached may be conditional and predicated upon the time limitation. It is possible for that reason that our research may led to recommendations for further consideration of aspects determined but not fully developed by this review.

Matters listed from the Terms of Reference

1. *Consult with community and key stakeholders.*

   Project team have determined that time limitation does not allow community engagement. Team consider that focus group engagement with workers who have suffered PTSD and been involved in the workers compensation system would have been advantageous. It is hoped that feedback from other stakeholders will provide the necessary insights.

   Consult with clinical practitioners, medical practitioners (GP), psychiatrists, psychologists as to diagnosis and related issues raised in the Safework Australia Paper. In particular their experience in dealing with PTSD patients involved within the workers compensation system in particular as to establishing initial entitlement and likely impact of a deeming provision. Also consult with sample of rehabilitation providers as to their experience if involved before causation determined and processes generally in dealing with PTSD matters.

Consult with Insurers, Employers, Unions involved in the first responder employment types as to their experience as to prevalence, and matters dealt with upon making a workers compensation claim and impact of a deeming provision. Based on data research expand stakeholder group to cover employment types other than first responder. Consider the existence of and likely impact of existing helping behaviour, organsational culture, EAP and helping strategies in those employment types where increased PTSD assumed.

Consult with Workers Rehabilitation and Compensation Tribunal as to experience with PTSD claims in particular, prevalence, issues as to entitlement, claims relating to PTSD as a result of a physical injury as primary compensation claim and likely impact of deeming provision.

Consult with specific lawyers dealing with first responder employment types as to prevalence of PTSD claims, issues as to establishing entitlement and likely impact of deeming provision. Expand sample group to include other employment types if identified in data.

2. *Identify persons covered by the Act, employed or appointed under an Act of the State, that are placed at significant risk of contracting PTSD in the course of their employment:*

    - *determine level of exposure to be accepted as "significant";*
    - *data details from Tasmania scheme, analyse and draw conclusions;*
    - *data and scientific publication research as to identified employment types and relevant increased risk exposure;*
    - *analyse first responder type and other prevalent employment types of employment exposure as compared to wider community prevalence;*
    - *Critically evaluate the actuarial data in relation to specific information provided, the potential masking of PTSD prevalence due to inconsistent diagnosis, only primary injury noted, delayed PTSD, or classifying psychological injury in general mental health (anxiety/ depression);*
    - *Examine the relationship between PTSD and experience of violence, assault, MVA, fatalities and suicide, death and injury.*

3. *Identify persons covered by the Act, but not employed or appointed under an Act of the State that are placed at significant risk of contracting PTSD.*

    - *As per 2 for data research and analysis*
    - *Initial attention to data locally on SES personnel.*

4. *Research on other jurisdictions where PTSD deeming provision has been enacted, eg Canada. Analyse the nature and type of compensation system in which such provision exists and the practical effect of that provision.*

5. *Research any material from other Australian jurisdictions as to whether this proposal has been considered and if not why not. Obtain and consider any material used by such jurisdictions in determining whether or not to introduce a deeming provision.*

6. *Consider and determine the practical impact of the DSM-5 diagnostic criteria that places limitations upon the diagnosis of PTSD, in particular the time delay and symptom/sign continuance before PTSD diagnosis can be made. Consider impact of PTSD by cumulative exposure or delayed expression. Consider the impact of and issues raised by concomitant mental illness suffered in tandem with PTSD.*

7. *Determine and identify occupational groups that are placed at significant risk of contracting PTSD. As per Para 2 data research indicates first responder style but data, scientific paper research and stakeholder engagement may indicate wider scope, eg after hours retail sales, emergency room medical and ancillary staff, disability and youth support workers.*

8. *Determination of qualifications that ought to be applied to presumption provision, determined on basis of clinical assessment and feedback from health practitioner engagement feedback.*

9. *Consider (if particular issues are identified with respect to PTSD claims) whether these are legal issues or whether they can be addressed by revising or improving claims process, eg claims form description of relevant facts and GP description of diagnosis.*

10. *If it is concluded that a presumptive provision is required, consider nature and extent of any transition provision especially retrospective application and seek actuarial advice on same.*

11. *If it is concluded to recommend a presumption provision -*

    - *determine the employment types or nature that should be included;*
    - *determine a qualifications limitation as to such employment types;*
    - *determine retrospective effect of any such provision;*
    - *seek actuarial advice on recommendations.*

12. *If recommendation is to provide deeming provision consider the nature and extent of the ability to challenge the effect of that provision."*

The Review process was conducted in accordance with that scope outline.

2. <u>CURRENT LEGAL CONSIDERATIONS IN CONSIDERING A CLAIM FOR COMPENSATION MADE PURSUANT TO THE WORKERS REHABILITATION AND COMPENSATION ACT 1988 ("THE ACT")</u>

The Act provides that where a worker makes a claim for compensation there is a provisional entitlement to receive workers compensation entitlements. The onus is upon the Employer to dispute the claim if the employer considers that there is a reasonable basis to do so (s81A). Such action must be taken within 84 days of the claim having been made. Upon referral of such dispute to the Workers Rehabilitation and Compensation Tribunal the employer must show that "*a reasonably arguable case exists*". This term has been described as follows:

"On the face of s81A, a reasonably arguable case will exist concerning the liability of an employer to pay a worker if it is reasonably arguable on the material available in relation to the claim or identified deficiencies or weaknesses in the claim that, following a contested hearing it may be rejected, ("*St Helens Oysters Pty Ltd v Coatsworth")* [2007]TASSC 90.

It is by no means certain that if at this s81A stage an employer could present factual material that challenged the history (ie the nature and extent of alleged work incidents) provided by the worker and relied upon for the PTSD diagnosis, or was able to provide factual details of significant non work issues not disclosed in the diagnosis process, a deeming provision would deny the determination that a reasonably arguable case existed. In other words it is arguable that even with a deeming provision an employer might well at this s81A stage establish that a reasonably arguable case existed if there were factual issues that brought the validity of the PTSD diagnosis into doubt or challenged the factual matters relied upon for the diagnosis. If a reasonably arguable case is determined by the Workers Rehabilitation and Compensation Tribunal ("*Tribunal*") then orders are made relieving the obligation upon the employer to continue to pay weekly payments and the costs of medical and ancillary expenses. If the worker wishes to pursue the entitlement to workers compensation entitlements a further referral must be made to the Tribunal

A deeming provision establishes a deemed fact or circumstance unless the contrary is established, and if the employer can show an arguable issue as to the application of the deeming provision by contradictory material, then the beneficial effect of the deeming provision is devalued. It could well be that to ensure that a deeming provision provided the full benefit sought by its proponents it may well be that such claims ought be relieved of the s81A process and be accepted without this review process. This would open up a number of issues that do not arise with the other diseases to which a deeming provision currently apply. By way of illustration:

- Providing a specific pathway for PTSD when there are other significant psychological injuries that arise within a person's employment including as arising from exposure to traumatic incidents; and

- The suffering of other deemed diseases is determined by way of clear objective diagnosis. Research material summarised in the SafeWork Australia Deemed Diseases in Australia Report, August 2015 raises issues about the appropriateness of PTSD as a deemed disease, as follows (para 5.4);

> *"A specific psychological disease of interest in the occupational setting is Post-Traumatic Stress Disorder (PTSD). This has overlap with the diseases just considered but is a separate condition with specific risk factors and diagnostic features. Post-Traumatic Stress Disorder appears to be more common (than in the general public) in military personnel and emergency service workers (police, ambulance officers and fire fighters) and in some areas of nursing, such as mental health nursing. The proportion of PTSD in these vulnerable populations that is probably due to work appears not to be well known. A recent review highlights the importance of personal factors in terms of who develops the condition and who does not despite apparently similar psychologically traumatic exposures. This makes the causal connection to work difficult to establish in many situations. In addition, the diagnosis is made largely on self-report of symptoms and much of the exposure measurement in relevant studies has been based on self-report. This leaves considerable room for measurement bias, making it difficult to be confident in the findings of the studies. Like anxiety and depression, there is often difficulty characterising the causative exposures, and the influence of personal psychological factors can make the work-related component, contribution or cause difficult to establish with confidence. Given the uncertainty in the risk associated with specific exposures that appear related to the risk of PTSD, issues with establishing the diagnosis, and uncertainty about the prevalence of the disorder in apparently at-risk populations, PTSD does not seem appropriate to include on the List with the current state of knowledge, and is not recommended for inclusion on the List."*

- Clinicians advise that PTSD can be an evolving diagnosis and so it may not be identified as such or be able to be diagnosed as such during the initial stages of a workers compensation claim or initial assessment and may not become the diagnosis until some later stage of the psychological illness.

In summary other circumstances such as dealt with s27 dealing with the link between certain cancers and firefighters deal with establishing a causative link between an objectively identified condition and certain employment where there is scientific evidence that such employment demonstrates a higher instance of such condition within that employment type than the general public. The deeming provision bridges the scientific gap from possible to probable causation. The deeming provision cannot address any challenge as to actual diagnosis of PTSD, and the deeming

provision would only be applicable where "*a person is diagnosed with PTSD...*". It is noted that presumptive provisions such as those in some Canadian Provinces have the diagnosis by a specialised clinician as a prerequisite before the deeming provision applies.

The Act provides that where liability is in dispute either generally or as to incapacity for work, (after a s81A determination) the worker may refer the claim for compensation to the Tribunal for appropriate determination (s42). The deeming provision would also be applicable at such hearing and would require the employer to prove that the PTSD was not caused by the employment rather than the lower threshold at s81A stage that merely an arguable case existed in that regard. This would be advantageous for the affected worker.

Should the employer accept a claim for compensation, then during the course of the management and administration of the claim, the employer already bears the onus of proof in respect to matters raised concerning the claim, eg s 81A(5) to revisit the initial liability to pay benefits; s86 to terminate the payment of weekly payments, s88 to review the quantum of weekly payments.

It is important to note that under our scheme, the acceptance of the claim for compensation by the employer or determination of entitlement to benefits by the Tribunal in respect of a claim initially disputed does not necessarily bring to an end issues between the parties in respect of the claim. The Act provides obligations upon both the employer and worker relating to rehabilitation and return to work and allows employers to oblige workers to undergo periodic medical assessments to gauge such things as the current nature and extent of the workers condition, the need for medical and pharmaceutical assistance and the capacity for work. These matters can be problematic in all claims but more so in respect of psychological injury claims and PTSD in particular.

3. OVERVIEW OF PTSD LITERATURE

Diagnosis, Nature and Course of PTSD

Post-Traumatic Stress Disorder (PTSD) was classified in previous editions of the Diagnostic and Statistical Manual of Mental Disorders (ie DSM-111 and DSM-IV) as an Anxiety Disorder. In the DSM-5 (2013), PTSD is classified in a new diagnostic category, Trauma-and Stressor-Related Disorders. This category "*includes disorders in which exposure to a traumatic or stressful event is listed explicitly as a diagnostic criterion*" (2013, p265). This diagnostic category recognises the variability of symptom presentation and symptom mix, including anxiety-based symptoms, externalised anger, dissociative, and anhedonic and dysphoric symptoms, following exposure to traumatic and stressful events.

A diagnosis of PTSD is commonly made using DSM-5 diagnostic criteria, which, as summarised, requires exposure to actual or threatened death, serious injury, or sexual violence experienced in one (or more) ways including directly experiencing or witnessing the traumatic event(s) as it occurred to others, learning that the traumatic event(s) occurred to a close family member or close

friend; or experiencing repeated or extreme exposure to aversive details of the traumatic event(s). Symptom presentation can vary, however needs to meet the criteria for the presence of intrusion symptoms; persistent avoidance of trauma-related stimuli; negative alterations in cognition and mood; and marked alterations in arousal and reactivity, causing significant clinical distress and impairment to functioning. There may also be the presence of persistent or recurrent dissociative symptoms. Symptoms may have immediate onset and expression following the event but must be present for more than a month and there can be delayed expression, that is "*if the full diagnostic criteria are not met until at least 6 months after the event*" (DSM-5, 2013, p272). Acute stress disorder is "*distinguished from PTSD because the symptom pattern in acute stress disorder is restricted to a duration of 3 days to 1 month following exposure to the traumatic event*" (DSM-5, 2013, p.279)

There is co-morbidity between PTSD and other mental disorders. "*Individuals with PTSD are 80% more likely than those without PTSD to have symptoms that meet diagnostic criteria for at least one other mental disorder (eg depressive, bipolar, anxiety, or substance use disorders). ..... there is considerable co-morbidity between PTSD and major neurocognitive disorder and some overlapping symptoms between these disorders*". (DSM-5, 2013, p. 280).

There is individual variability in the relative predominance of symptoms, as PTSD can evolve over time. "*Duration of the symptoms also varies, with complete recovery within 3 months occurring in approximately one-half of adults, while some individuals remain symptomatic for longer than 12 months and sometimes for more than 50 years. Symptom reoccurrence and intensification may occur in response to reminders of the original trauma, ongoing life stressors, or newly experienced traumatic events*" (DSM-5, 2013, p.277).

The DSM-5 states that peritraumatic risk and protective factors for PTSD include *"...severity (dose) of the trauma (the greater the magnitude of trauma the greater the likelihood of PTSD), perceived life threat, personal injury, interpersonal violence..."* and, for military personnel, " *being a perpetrator, witnessing atrocities, or killing the enemy*" (DSM-5, 2013, p.278). Post-traumatic risk and factors include "*negative appraisals, inappropriate coping strategies and development of acute stress disorder.... subsequent exposure to repeated reminders, subsequent adverse life event and financial or other trauma-related losses. Social support is a protective factor that moderates outcome after trauma"* (DSM-5, 2013, p. 278).

Prevalence of PTSD in Occupational Settings

The DSM-5 states that the *"Rates of PTSD are higher among veterans and others whose vocation increases the risk of traumatic exposure (e.g. police, firefighters, emergency medical personnel)"* (p, 276). Skogstad, Skorstad, Lie, Conradi, Heir and Weisaeth, (2013) note "*the risk of developing PTSD depends on the nature of the critical incident, the individual's personality and life history, and events that occur in the aftermath of the trauma*" (p.175). There are functional consequences of PTSD. The DSM-5 states that "*PTSD is associated with higher levels of social, occupational and physical disability, as well as considerable economic costs and high levels of medical utilization. Impaired functioning is exhibited across social, interpersonal, developmental, educational, physical health and occupational domains*" (2013, pp 278-279). However, Skogstad

et al comment that "*in a significant proportion of those exposed to severe stressors, the outcome is increased resilience, acceptance, and post-traumatic growth*" (2013, p.175).

In relation to PTSD in occupational settings, McFarlane and Bryant (2007) noted that there are occupations that have "*a predictable and foreseeable risk of being exposed to threat, horrific injury and death*", including emergency services, military, acute medical services, bank officers and train drivers. Skogstad et al conducted a literature search and review of research on occupational groups at particular risk of developing work-related PTSD. They concluded that "*professional first responders such as police officers, firefighter and ambulance personnel, have an increased risk of being exposed to traumatic events through their daily work*" (p.178). However, the prevalence of PTSD varies across the first responder occupational groups. They found that police officers had a lower prevalence of PTSD, less than 10%, across the occupational group of first responders. Firefighters had a prevalence of 20%, with prevalence of PTSD symptoms in firefighter volunteers being more than their professional counterparts. Similarly, ambulance staff show a prevalence rate of approximately 20%. The researchers noted the influencing role of individual vulnerability, nature of the trauma and personality traits in the development of PTSD. The research also identified the influence of organisational support, the functionality of work relationships and social support, on the severity and intensity of PTSD symptoms.

In a recent study by Carleton et al (2018) focusing on Canadian public safety personnel (eg correctional workers, dispatchers, firefighters, paramedics, police officers), who are exposed to potentially traumatic events as part of their work, they showed that 44.5% of this occupational population screened positively for clinical symptom clusters consistent with one or more mental disorders and that the frequency of these positive screens was higher than the general population.

In their review, Skogstad et al identified other occupational groups at risk of PTSD. These occupational groups were train drivers, especially when experiencing "*person under train*" events, health care workers, particularly mental health care workers who are exposed to violence or suffering and death of patients, journalists who have been in war zones, sailors subject to the risk of "*hijacking and hostage-taking*", customer service workers exposed to armed robbery, and occupational exposure to industrial disasters. McFarlane and Bryant (2007) also refer to industries such as mining, agriculture and fishing as being "*accident- prone industries*" that also deserved focus.

Fuller and Ng (2017) reviewed a sample of victims of armed robbery in the workplace using the Australian Institute of Criminology database of Victimisation Experiences. They reported that whilst the most common post-incident mental health issue was anxiety, workers also experienced depression, PTSD and panic attacks and reported symptoms such as flashbacks, hypervigilance and fear of being in the public.

Mealer, Burnham, Goode, Rothbaum and Moss (2010) identified burnout syndrome, PTSD, anxiety and depression as common symptoms for nurses, and found that specific triggers for PTSD symptoms were dependant on the symptom and the specific nursing work environment. They found that the presence of both burnout and PTSD impacted on the nurse's perception of their work colleagues and their relationships and leisure participation outside work. Donnelly and

Siebert (2009) found that emergency medical technicians exposure to traumatic events was between 80-100% and rates of PTSD were greater than 20%.

The Australian Principal Occupational Health, Safety and Well-being Survey (Riley, 2017) showed that the prevalence rate for threats of violence toward principals and deputy/assistant principals had risen from previous surveys to 44%, with the prevalence rate of actual physical violence being 8.4 times the rate of the general population. Health and well-being measures for principals and deputy/assistant principals including cognitive and somatic stress symptoms, burnout and depressive symptoms were higher than the general population. This information indicates that whilst this type of exposure to violence is not inherent in a principal's work role or type of work, the survey data showed a predominantly upward trend across all Australian states.

Skogstad et al identified methodological difficulties when reviewing the research of organisational groups at risk of PTSD including low response rates, variability of questionnaires, and the potential influence of self-report bias.

PTSD treatment and Help-seeking behaviour

Treatment of PTSD includes pharmacological, psychotherapeutic and behavioural interventions. The *Australian Treatment Guidelines for the Treatment of Acute Stress Disorder and Post-traumatic Stress Disorder* (2013) recommend trauma-focused cognitive behavioural therapy, or eye movement desensitisation and reprocessing (EMDR) as first-line treatment for PTSD. There is a continual need for empirical research on the effectiveness of non-trauma-focused interventions or adjunct approaches such as mindfulness and acceptance and commitment therapy, including interventions such as the STAIR (Skills Training in Affective and Interpersonal Regulation) programme which aims to improve emotional regulation and interpersonal functioning by developing an individual's adaptive skills. McFarlane and Bryant emphasise the need for early identification and diagnosis and to seek the "*window of opportunity*" and the potential gains from early intervention.

Treatment outcomes for PTSD are variable and this has prompted researchers to focus on identifying factors that may influence treatment response and efficacy. Papazaoglou and Chopko (2017) focused on the role of moral distress and moral injury in PTSD and compassion fatigue for police. They stated the need for further empirical research and development of assessment tools and evidence-based PTSD treatment that addresses moral suffering. Phelps et al (2018 emphasised the importance of trauma-focused therapy that centres on guilt and depression-related cognitions, given their findings that these types of cognitions can influence patterns and predictors to treatment of veterans with PTSD. Cloitre, Petkova and Weiss (2016) reported that the benefits of PTSD intervention may be moderated by patient characteristics such as symptom burden and emotion regulation strength.

Kim et al (2018) noted that "*stigma and perceived obstacles such as lack of knowledge about PTSD or treatment routes and financial and time burden have been reported to play important roles as barriers to mental health treatment*", (2018, p.2), and that it is more of a concern in male-dominated occupations including war veterans and first responders more than other populations.

In their research on firefighters, they identified a gap between the probable rate of PTSD in firefighters and seeking treatment, and for those that didn't seek treatment, perceived stigma and perceived barriers of accessibility to treatment were influencing factors. They found that even though firefighters with higher PTSD severity and functional impairment sought treatment, these severity features were also associated with increased concerns about potential stigma. They noted that cultural and social circumstances may influence the generalisability of these findings.

Barratt, Stephens and Palmer (2018), in a recent publication called **When Helping Hurts: PTSD in First Responders** comment "*Of vital importance is the shift in emphasis from regarding PTSD as an illness to the emerging focus on well-being*" (2018, p. 59) in order to build a healthy first responder workplace and assist in help-seeking behaviour. This shift in focus acknowledges that inherent in the work of responders is exposure to potentially traumatic events and situations which require support, the notion of mental health as a continuum rather than a binary notion, and the recognition of post-traumatic growth as a potential trajectory following exposure to a traumatic event or the impact of cumulative exposure.

Barratt, Stephens and Palmer also emphasised the importance of a whole of system approach to the preventative and responsive management of PTSD for first responders, including the role of information, communication and education about PTSD, appropriate training and professional development for managers, consistent administrative processes and protocols, prevention and management plans, and best treatment and care practice.

4. WORKERS COMPENSATION CLAIMS DATA

The reviewers had access to workers compensation claim data which captures any claims where the injury classification was Post-traumatic Stress Disorder (PTSD). The data has been sourced from claims data reported by licensed and self-insurers during the period 1/01/2008 to data extraction date of 4/06/2018. The claims are classified at the lowest level of the ANZSCO codes (Australian New Zealand Standard Classification of Occupation) which is a standard coding system.

The data is presented as:

- PTSD claim data;
- Occupational analysis (ie count by year, type of incident, claim status and total current total cost and total lost days by occupation);
- Incident type analysis (ie, count by year, count by claim status, proportion by status, and days lost to date and cost to date (total and average) by incident cause);
- Claim data for Mental Disease claims (ie number of claims, injury type, mechanism type and days lost to date and cost to date)

At best the claim data presents information that is observable as there are limitations to the data and its interpretation. The reasons for these limitations include:

- Low numbers of claims recorded as PTSD, preclude interpretation and comment on significance and trends in the claims data;
- We are unable to determine the proportion of PTSD claims made by volunteers as the claims information does not identify a worker as volunteer or otherwise;
- An "industry split of occupation" is provided in the claim data which provides the industry where the event happened, not where they are employed or their specific role;
- The different claim status of accepted, pending and rejected refer to the insurer decisions around liability rather than directly relate to whether a claim was disputed or not;
- The claims data only reports the primary injury and so does not capture co-morbidity, co-existence with a physical injury or changes in diagnosis;
- Whilst the ANZSCO is a standard coding system, the coding system may also be influenced by the information available to the insurer and its interpretation.
- Sick leave data may have provided additional contextual information when considering the workers compensation PTSD claims data, however we understand that this information is rarely available.

PTSD Claims Data

During the period 2008-2018, there have been a total number of 195 claims recorded as PTSD claims, across 79 occupational groups, averaging 19.5 claims per year. PTSD constituted 3.4% of all mental disease claims during this period, a significantly low number in the context of 4987 reported claims of psychological injury. The data shows that 83.6% of PTSD claims are accepted, compared to 93% of total workers compensation claims accepted over the same 10 year period**.** The primary reported incident type and cause of PTSD being violence and/or verbal assault, with 94% of claims with this incident type being accepted. The PTSD incident type, number of claims and claim status is shown in Table 1.

Table 1:

PTSD incident type, number of claims and claim status

Incident type	**Number of claims**	**Accepted**
Violence and/or verbal assault	69	94.2%
Workplace conflict or stress	23	65.2%
Cumulative	20	80.0%
Involved in vehicle accident	16	93.8%
Co-worker injury/fatality	12	66.7%
Other traumatic event	12	91.7%
Attending traumatic scene	11	72.7%
Bullying/harassment	10	70.0%
Unspecified	9	55.6%
Attendance at suicide/attempted suicide	8	100.0%
Client death/injury	5	100.0%
Status total	195	83.6%

It is interesting to note that there were 9 PTSD claims coded as "*unspecified*" for incident type. When examining the "*unspecified*" incident type claims data, there were three examples of rejected claims that provided a diagnosis or descriptor, such as "*stress*", in the event description, but there is no incident detail, even though the mechanism was coded as "*exposure to a traumatic incident*". PTSD claims coded as "*unspecified*" had 55.6% claim acceptance, compared to more specific incident type coding of "*attendance at suicide/attempted suicide*" (100%) and *client death/injury* (100%), "*violence and/or verbal assault*" (94.2%), and "*involved in vehicle accident*" (93.8%).

PTSD Claims Data for Occupational groups

Claims data was examined for the occupational groups positioned within the top 10 rankings for claims reported as PTSD (Table 2). The range of claims across occupational groups, ranged from 6-17, with the highest number of PTSD claims recorded for ambulance officers and paramedics. All PTSD claims were accepted for sales assistants, bar attendants and baristas, special care workers and other miscellaneous labourers.

Table 2:

PTSD Claim data for occupational groups

Rank	Occupation	No of claims	Accepted claims
1	Ambulance officers and paramedics	17	16/17 (1 pending)
2	Prison Officers	15	13/15 (2 rejected)
3	Police	12	11/12 (1 pending)
4	Sales assistants	8	8/8
5	Primary school teachers	8	6/8 (2 rejected)
6	Special Care workers	7	7/7
7	Bar attendants and Baristas	7	7/7
8	Welfare support workers	6	5/6 (1 rejected)
9	Registered Nurses	6	5/6 (1 rejected)
10	Other Miscellaneous labourers	6	6/6

First Responders PTSD Claims Data

First responders, that is ambulance officers and paramedics, police officers, and fire and emergency services are referred to in the PTSD literature and are an occupational category where exposure to traumatic incidents is inherent in their work and role. First responders have also been deemed in PTSD presumptive legislation in some Canadian provinces. For these reasons, we have examined their data separately.

During the period 2008-2018, there were 31 claims reported by first responders, which constituted 15.9% of PTSD claims, across the range of occupational groups. The PTSD claim data indicates low numbers of PTSD claims for first responders over a 10 year timeframe, particularly fire and emergency services, who were ranked 22 in the list of occupational groups, with 2 PTSD claims. The data also shows that 90 % of first responder PTSD claims were accepted over this 10 year time frame, with one claim pending for each first responder occupational group.

The worker figures of first responders in 2016/17 (as provided in September/October 2017 by agencies and Tasmania Fire website), was approximately 7661, consisting of 1236 Police Officers, 338 Firefighters (paid), 338 Ambulance operatives (salaried), 460 Volunteer Firefighters (paid)*, 4800 Fire fighters Volunteers, 457 Volunteer Ambulance Officers, and 32 Community first responders. There were 13 PTSD claims for first responders from 2016-2017, albeit the difference between financial year and full year data for this period. There were no claims from firefighters, paid or volunteer, for this period; they account for 5598 first responders. As mentioned, we are unable to determine the proportion of PTSD claims made by volunteers as the claim data does not identify a worker as volunteer or otherwise.

*Paid firefighter volunteers refers to firefighters who are doing a volunteer position but being paid a quarterly retainer to occupy senior position such as brigade chief etc.

The record of cause of PTSD claims for first responders were: cumulative stress (25.8%), attending traumatic scene (25.8%), other traumatic event (12.9%), violence and/or verbal assault (9.7%) unspecified (9.7%), attendance at suicide/attempted suicide (9.7%), and motor vehicle accidents (6.4%).

The impact of PTSD claims within the first responders group was reflected in total days lost and cost to date (Table 3)

Table 3:

Total days lost and cost to date for first responders

Rank	Occupation	Total days lost	Total payments reported
1	Ambulance officers and Paramedics	5780	3,226,002
3	Police	1331	587,906
22	Fire and Emergency workers	n/a	142,663

This data suggests that the impact of PTSD on productivity and cost is greatest for ambulance officers and paramedics within the first responder group. This could be for a variety of reasons. It might reflect that ambulance officers and paramedics require more recovery and/or treatment time before returning to operational duties. It might also be that the more specialised operational nature and requirements of return to pre-injury duties for ambulance officers and paramedics can impact the type and availability of suitable graduated return to work duties, whereas police may have a greater range of alternative non-operational duties available to assist a graduated return to work.

PTSD Claim data for Occupational Groups

Prison officers require consideration as they were ranked two in the PTSD claims data across the occupational categories, with 15 PTSD claims. The PTSD claims for prison officers showed violence and/verbal assault (46.7%), as the primary record of cause, with the remaining proportion of claims being equally distributed and recorded as unspecified, cumulative, workplace conflict or stress and bullying/harassment. Only 2 claims were rejected and these related to bullying and unspecified incident type, with 86.6% claims accepted. In relation to impact of PTSD, there were 2776 total days lost.

Notwithstanding that low numbers make interpretation difficult, the PTSD claims data identified other types of occupational groups potentially at risk of PTSD due to exposure to events in the course of their employment. These occupational groups need to be flagged and monitored, particularly sales assistants, special care workers and bar attendants and baristas, given that

violence and verbal assault is recorded as the primary cause of the PTSD claims (Table 4). The type of violence for all PTSD claims for the bar attendants and barista occupational group was armed hold-up and/robbery and the violence and verbal assault incidences for sales assistants also included incidents of armed hold-up and being confronted for money. These types of occupations may have specific risk factors such as face to face contact with customers, night trade and possession of money on premises, which may make these type of service industries at risk of arm hold-ups or robbery.

Table 4:

PTSD claim data per occupation per cause

Rank	Occupation	Violence and verbal assault
4	Sales Assistants (general)	8/8
6	Special Care workers	5/7
7	Bar attendants and Baristas	7/7

Incidents for the Special Care Workers involved violence and assault incidents by clients. Registered Nurses and Welfare Support Workers reported violence and verbal assault in half (3/6) PTSD claims, with other causes including client death/injury, workplace conflict or stress and other traumatic event. All these occupational groups can be exposed to challenging, aggressive, and unpredictable client and customer behaviour by providing frontline customer or client service in the course of their employment.

The primary cause of PTSD for Other Miscellaneous Labourers was co-worker death/injury and for primary school teachers a mix of cumulative, violence and verbal assault, and workplace conflict or stress.

There were 93 PTSD claims for Tasmanian government employees over the 10 year period, ranging from 3 to 22 claims per year. PTSD claims for Tasmanian government employees was 47.6% of total PTSD claims for this period. The highest concentration of claims was 24 claims in 2015 and 2016, and these were primarily ambulance officers (7), police (7) and prison officers (4), whilst in 2012, there were 13 claims, spread across 11 different occupations. This indicates that during this 10 year period, there has been variability of PTSD claims between years and across occupations for Tasmanian government employees.

Mental Disease Claims

There were 4,987 mental disease claims between 2008-2018 (Table 5). There were 3433 mental disease claims (69%) with no disputes, compared with 83.6% PTSD accepted claims. The most prevalent psychological injury type was anxiety/stress disorder. Given the significant difference in number of claims in this category compared to other psychological injury type, it is possible that this category may represent either a "*catch all*" category or reflect the symptom presentation

rather than a diagnosis, at the time of initial record of primary injury. It is also possible that through the life of the claim and course of the injury, these symptoms within this anxiety/stress disorder injury type either become formally diagnosed when there is specialist involvement or symptoms develop or evolve into a more specific diagnosis at a later stage of the workers compensation process, however the primary injury class may not change or be updated. If the latter is the case, then it is possible that PTSD may be embedded in other psychological injury types. It is also possible that "*short-term shock from exposure to disturbing circumstances*" in some cases could equate to "*acute stress disorder*", which may or may not develop into PTSD.

Table 5:

Mental disease claims, injury type, days lost and cost to date

Nature class	Number of claims	Days lost	Total cost
Anxiety/stress disorder	3,791	244,717	$132.722.359
Anxiety/depression combined	528	42,221	$21.745.313
Post-traumatic Stress Disorder	195	30,692	$ 15,220,203
Other mental diseases, not elsewhere classified	132	14,850	$ 8,433,467
Reaction to stressors other, multiple or not specified	125	8,268	$ 3,453,467
Depression	98	8,747	$ 4.790,955
Mental diseases unspecified	81	4,590	$ 2.393,605
Short-term shock from exposure to disturbing circumstances	37	944	$ 770,929
Total	4,987	355,029	$ 189,530,742

The examination of the PTSD and Mental Disease Claims data also provides recommendations in relation to administrative coding of PTSD claims data and targeting specific workplace issues that may influence the presence and management of work-related psychological injury and specifically PTSD:

- The presence of the "*unspecified*" incident type in the PTSD claims data suggests an administrative need for the psychological injury to have an event description and specific incident type or, in the case of it being cumulative, a precipitating event in the context of

ongoing exposure to events. The claims data information suggests that more specific incident type coding is associated with a higher claims acceptance.

- There were 2082 mental disease claims for "*work pressure*", and "*other mental stress factors*". Organisations need to acknowledge, monitor and manage occupational stressors across individual, interpersonal and organisational levels to build and maintain a resilient and mentally healthy work environment.
- Workplace conflict and bullying and harassment can result from unresolved interpersonal conflict, challenging work behaviour, and work relationship issues. There were 1294 mental disease claims for work-related harassment and/or workplace bullying over a 10 year period. Some may argue that these types of work-related incident types do not meet Criterion A of DSM-5 criteria, which is a requirement for a diagnosis of PTSD, albeit that the worker may be reporting PTSD-like symptoms.

5. STAKEHOLDER FEEDBACK

The reviewers acknowledge the assistance of stakeholder representatives who freely and at short notice gave their time not only to seek relevant data but also to discuss their individual or corporate views, opinions and observations in relation to this topic. Due to the informal nature of our discussions owing to time limitations and a wish for complete openness we have not identified the individuals involved. The following is a summary or snapshot of the detailed information conveyed to the reviewers but accurately reflects in general terms the nature of the information, views and opinions provided.

A. Key Clinical Stakeholders

Key clinical stakeholders, totalling 15 respondents, including General Practitioners (GPs) (n=5), psychologists (n=6) and psychiatrists (n=4) were interviewed, either face to face or by telephone. The interview centred around the nature of PTSD, its diagnosis and issues that may arise generally and within the workers compensation system and process and their view of PTSD presumptive legislation in relation to the worker and their clinical role and responsibilities. Clinical stakeholders were told that all information would be de-identified and pooled to provide information for the report.

The key clinical stakeholders had an average of 22 years clinical experience in their role and all had clinical experience with PTSD and working both within the workers compensation system and in the private sector. Psychologists and psychiatrists, who will be referred to as specialist clinicians, also had a range of experience, including working with military, first responders and civil cohorts.

PTSD Diagnosis

Some patients come to GP's with an existing diagnosis of PTSD whilst others will consult a GP as the first medical point of contact for the impact of a work-related traumatic incident. In relation to the latter, those GP's interviewed will either form a working diagnosis**,** based on their

understanding of DSM criteria, which may be acute stress disorder, adjustment disorder, anxiety, depression, or informally or intuitively from their own clinical experience form an opinion, and then refer to a specialist clinician to formalise a diagnosis or to obtain a psychiatric opinion. Factors that can influence the role of the GP in the initial diagnosis process, include mental health background, confidence by the GP to make a diagnosis and whether the GP considers their role to make a diagnosis or to assist in stabilising the patient's symptoms and referring them for specialist assessment and treatment.

The interval between a GP referral and being seen by a specialist clinician depends on factors such as availability and accessibility of specialist services and also whether the GP has developed a core referral relationship, particularly with individual psychologists or a group practice, which can assist in facilitating a referral and often reduce the time it takes to see a specialist clinician. The timeframe can vary and sometimes a specialist clinician may not see a client and do an initial assessment until 6-12 months into the workers compensation process and by this stage people can become entrenched in the process and effective treatment can be difficult. A waiting time may also mean that the GP needs to take on primary responsibility for the patient's psychological well-being.

Most PTSD diagnosis for specialist clinicians, that is psychologists and psychiatrists, is from information accessed by clinical interview. This may require 1-3 sessions to obtain a good clinical history and to form an initial or working diagnosis, and the workers compensation system provides time for this, without financial burden for the client. Some specialist clinicians also use a semi-structured interview, symptom screening checklist, mental state examination or psychometric testing and then match the information to DSM-5 criteria. The role of psychometric tests, when used, is to support diagnosis rather than as a diagnostic tool. Clinicians will also rely on the client's spontaneous account of events.

Specialist clinicians also emphasised the importance of assessing and establishing the client's level of functioning, and any functional impairment in relation to PTSD, as this information is often as important, if not more important, than the diagnosis. It is important to recognise and capture the human spectrum of traumatic experience, and assess the severity of the reaction, interaction with a person's vulnerability, and its impact on functioning, not just focus on the psychological distress of PTSD. Information about the client's functioning is relevant to early treatment intervention and determining an appropriate treatment approach and developing adaptive functioning skills. Information about the client's functioning assists in forming specialist advice and recommendations to key stakeholders within the workers compensation process including GP's, insurers, employers and most importantly the worker themselves. This is particularly important with avoidance behaviour which can influence both short term and long term functioning, and if not treated early or effectively can become chronic and embedded and influence the trajectory of recovery and work and life functioning. Also if a client is functional and has adaptive coping strategies, albeit still experiencing PTSD symptoms, it is probable that the client can manage treatment and distress symptoms more effectively, which in turn may influence return to work sustainability and the overall cost of the workers compensation claim. PTSD can also be viewed as a moral injury, as reflected by the presence of guilt and shame, so there is a need not only to focus on assessing and treating symptomatology but also to separate out the moral injury components of PTSD.

PTSD can be an evolving diagnosis and so its nature during the initial stages of a workers compensation claim or initial assessment may change over the course of the psychological injury. These changes may include neurobiological alterations (eg attention, concentration and memory). During the initial claim process, information pertaining to the claim may be limited and differ from information that emerges over time or as other specialist clinicians become involved. Sometimes it can be hard for clients to articulate and elucidate on symptoms. With PTSD there can be avoidance of memories and clients may not want to talk about the event(s). Their heightened arousal may also affect recall and they can actively avoid or not be able to access these memories as part of their illness, and this can influence the history.

PTSD requires a clinical diagnosis and until that diagnosis is made, acute stress disorder or adjustment disorder is often used as an initial working diagnosis. Diagnostically, acute stress disorder is time lined to be from 3 days to 1 month after exposure. Some clinicians who see PTSD as evolving and requiring time and adequate information to unfold, continue to use a working diagnosis until it is confirmed by a specialist, clinical diagnosis. The value of this approach is that the working diagnosis gives notice that a significant trauma has occurred, and it provides hope for treatment and recovery. It also leaves open, treatment options and a differential diagnosis. It also accounts for variation of response in that people exposed to trauma don't always go on to develop PTSD.

A variant of PTSD is with delayed expression, that is, if the full diagnostic criteria is not met until at least 6 months after the event, although the onset and expression of some symptoms may be evident immediately. It was noted that sometimes PTSD is recorded as a diagnosis too early give the requirement of DSM-5 duration criterion (Criterion F), specifies that symptoms must persist for at least one month before PTSD can be diagnosed.

Specialist clinicians note that identifying cumulative PTSD can at times be more complex. A person may present with PTSD symptoms but can't connect the symptoms to a specific work-related event. The event may not be clear to them initially but can crystallise over time, however a lack of connection to an event or incident initially, may have a bearing on whether Criterion A of the PTSD diagnostic criteria is met. It was noted that some cumulative presentations can be confused with burnout, where over time the worker has less psychological resources to cope. There is also variation in response to trauma and a client can be convinced that they have PTSD, when they don't, whilst another client can have a severe traumatic reaction, but is resistant to a diagnosis. It was also noted that the diagnosis being accepted is the perceived issue in the workers compensation process rather than the diagnostic process itself.

Self-diagnosis of PTSD, based on self-education and the accessibility of PTSD information and symptoms checklists in the public arena, can be an influencing factor in the diagnosis of PTSD. It is often difficult to undo an inaccurate self-diagnosis of PTSD, and this can create difficulties for GP's and specialist clinicians to dissuade a client who is invested in a PTSD self-diagnosis so as not to compromise the therapeutic relationship, however it is essential that clinicians do so, given the medico-legal context. Sometimes through self-diagnosis of PTSD, employment can be seen by the worker as the sole reason for their PTSD and it is difficult for them to see the contribution of other factors.

PTSD in the Workers Compensation System and Process

The workers compensation process can be stressful and given that some symptoms of PTSD are anxiety-based, the process can be an influencing factor in the trajectory of recovery. The workers compensation process is seen as an adversarial process and is associated with secondary distress and the need for workers to justify symptoms. During the period of dispute, workers feel unsure if their claim will be accepted and this can influence engagement in treatment, as they can get derailed in their fight for recognition, role security and financial security. The treatment process aims to get workers as functional as possible, but also plays a role in buffering the impact of the workers compensation process.

Secondary gain can be an issue within the workers compensation process, not with ill-intent, but because people know that their occupational functioning has been impacted, they can feel aggrieved and feel entitled to compensation. A workers compensation claim can be a maintaining factor in illness, as getting better may give rise to worry about the claim being closed or terminated and concerns about income. The need to establish liability and re-proving liability with medico-legal assessments and reports, sometimes multiple, can be stressful for the worker and trigger reactivity.

Clinicians perceived that it can be relatively easy to establish whether employment is the significant contributing factor, once the traumatic event has been identified and a clear history has been obtained about the event and its impact, coupled with pre- and post- functioning information. The nature of some occupational groups, such as first responders, is that they are exposed to chronic stressors so it may not need a major significant event or incident, but it can be the cumulative impact of a series of sub-acute events over time. The workers compensation form requires an injury date and time and appears best suited for acute injury. There is usually a crystallising event- "*one too many*"- and it will usually be this precipitating event that is referred to on the workers compensation form. Sometimes the precipitating event that leads to a workers compensation claim for PTSD is a seemingly innocuous event, leading to a subjective judgement about its severity.

Some workers have also been exposed to multiple traumatic events across a range of roles and situations both inside and outside work (eg an individual could be a veteran, employed in emergency services, and involved in a serious transport accident) and so it can be challenging to identify the relative contribution of different types of exposure to their PTSD. It can also be difficult for employers and insurers to understand the complexity and breadth of PTSD reactivity in the work environment. For example, the traumatic event is no longer, yet triggers can still remain in their work environment or generalise to other environments and continue to impact on their functioning.

Occupational Groups at Risk of PTSD

The sample of key clinical stakeholders were asked, based on their clinical experience, are there any occupational groups who are exposed to traumatic events in the course of their employment and at risk of PTSD. The occupational groups noted were:

- First responders and emergency services (ie police, ambulance, paramedics and fire service)
- Front-line medical staff- emergency department and nurses
- Medical and health care professionals
- Truck and train drivers
- Disability and youth support workers
- Public servants with direct public contact
- Customer service, retail and hospitality
- Teachers
- Construction and labouring
- Armed services
- Prison officers
- Humanitarian aid workers
- Child care workers
- Child protection workers
- Security guards
- National Parks and Wildlife Officers

For some clinicians, PTSD still needs to be considered as an individual experience rather than as an occupational group experience and it can be risky to single out occupations and have certain occupations permitted and others not. Certain occupation groups such as first responders may be more vulnerable, but they may not necessarily develop PTSD. For example, some people will continue coping and remain functional and their exposure buffered by being in their workplace around people with shared experiences.

The sample of key clinical stakeholders were asked, based on their clinical experience, what are the types of traumatic events or exposure in the course of their employment that put these occupational groups at risk of PTSD. The types of occupational events or exposures include:

- National disaster
- Violent events- physical assault, shooting incidents
- Motor vehicle accident
- Attending situations where children have been harmed or killed
- Unpredictable behaviour that can’t control or plan for, and impact of anger
- Physical injury and death
- Threat to life or perceived threat to life or menacing behaviour with weapon or assumed weapon
- Aftermath of events and accidents
- Cumulative impact of multiple events and exposure of sub-acute events over time
- Chronic occupational or recurrent exposure
- Bullying

- Held-up or threatened at knifepoint or gunpoint
- Chronic stressors and anticipation of events and incidents
- Working in isolation in remote areas exposed to MVA's, suicide, emergency situations, and injury

It was noted that there are a range of events or incidents that workers can be exposed to and there are a range of individual reactions to these exposures. Trauma can be experienced, witnessed or be vicarious. It was also noted that it is important to separate those incidents, events and exposures that are inherent in a job and occur in the usual course of work and role, and those that are an exceptional event outside the usual course of work and role.

Clinician's Views of Presumptive PTSD in a Workers Compensation Claim Process

The sample of key clinical stakeholders were asked their views if PTSD was made presumptive within workers compensation legislation and whether this would make a difference for workers and clinicians.

- Presumptive PTSD legislation could provide a quicker entry point to treatment, provided specialist clinicians are accessible and available.

- Presumptive PTSD may facilitate a "*whole person*" approach to PTSD and provide clarity to clients about the contributing role of other underlying events or factors outside their employment. This could change the approach clinically as it would create context for the work-related event, an acceptance of a range of contributing factors and address this clinically straight away, and treatment could focus on the "*whole person*" rather than being defined by a work experience. It could also reduce resistance to disclosing and discussing these other contributing factors which may influence the effectiveness of treatment. It could also contribute to developing better therapeutic rapport, characterised by transparency and openness.

- It would take away the burden or onus of proof from the worker and potentially reduce the anxiety associated with this responsibility, given PTSD has an anxiety component. It may be better for the client clinically as they are implicitly believed and feel more validated.

- Presumptive PTSD legislation could make it easier for people to come forward and access help, making it less personalised. It would provide a message to employees that this is what happens in your line of work, it arises in the work that you do, and it can lead to PTSD.

- It could reduce fear and stigma that workers may have about the impact of a workers compensation claim on their job prospects, or how they may be perceived in the workplace. They may also not want to have third party involvement. As a result of fear and stigma, some workers may be choosing to access treatment through other pathways such as a

Mental Health Care Plan. A Mental Health Care plan allows access to ten consultations, which is likely to be insufficient for effective treatment of PTSD.

- It would reinforce the need for employers to be supportive and encourage pathways for workers to seek early intervention and access assistance.

- The specialist clinician and client can spend more time focusing and engaging in treatment rather than managing the fallout from issues or stressors arising from being in a worker's compensation process and the perceived need to validate their psychological injury. It could also lessen the need for and cost of key clinical stakeholders providing reports about liability which is not focused on helping the client.

- Clients can be more "*treatment-ready*" as they will probably have better understanding of their symptoms and the impact of traumatic events or cumulative stress on their functioning. They would potentially be more open, resourced and ready to engage in treatment to improve management of symptoms, learn adaptive coping strategies and improve functioning. Currently due to the interval between their claim and referral or access to specialist clinicians, the client can enter the treatment phase already feeling worn down by the workers compensation process and this can influence their level of engagement in the treatment process.

- Provide an avenue for key clinical stakeholders to be clearer about their roles and responsibilities in relation to assessment and treatment of PTSD and to work together more effectively, with regular contact and communication.

- Presumptive PTSD legislation allows cumulative stress and the impact of multiple trauma to be acknowledged more easily, given that it is deemed to be part of the worker's employment.

- There may be a risk, if PTSD is presumptive, of PTSD becoming an "*over-used diagnosis*" in response to work-related trauma, and this could dilute the significance of other mental illnesses, the presence of co-morbidity, and differential diagnosis. For example, other Trauma- and Stressor-Related Disorders, such as Adjustment-like disorders with delayed onset or prolonged duration can "*cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the other disorders in the trauma-and stressor-related disorders diagnostic class*" (DSM-5, 2013, p 289). These disorders outside PTSD, related to trauma exposure, may not meet the diagnostic criteria of PTSD yet can also have a similar significant impact on a person's capacity to function and have a chronic trajectory.

B. Legal Practitioners

Selected lawyers experienced in workers compensation matters, representing both the employer and the employee position, saw no reason to amend the Act in respect of providing a deeming provision. Although it was accepted that claims involving psychological injury might on occasion pose difficulties insofar as the injured worker was concerned, especially by application of aspects of the Act dealing with the administration of accepted claims, there was thought to be no particular issue in addressing the threshold question of entitlement. None of those spoken to (all with many years experience in the workers compensation environment) could recall particular cases where the establishment of entitlement after a valid diagnosis of PTSD suffered by a worker as a result of traumatic exposures had been challenged. The common view was that where a valid diagnosis of PTSD had been made, the diagnosis itself identifies the facts that are claimed to meet the diagnostic criteria. Where those facts arose out of or in the course of the workers employment and there were no other significant contributors, then the work would have contributed to a substantial degree and the workers compensation entitlement would be established. It followed that if the factual circumstances relevant to meeting the PTSD diagnostic criteria were not employment based there could be a challenge to any workers compensation claim.

In the case where there is a link to one or more specific traumatic incidents occurring within the work environment the establishment of liability was described as clear cut. It is accepted that this decision may be less clear cut where PTSD arose as a result of the cumulative effect of a number of events or circumstances. PTSD as a result of cumulative exposure may face issues of more than one employer over the relevant period and uncertainty as to the date condition "*suffered*".

However, it was stated the clinical process of diagnosis ought to identify the claimed traumatic events or incidents and in the normal course identify whether or not the work related matters contributed to a substantial degree. If the diagnosis process identified non work related matters, that arguably contributed to a substantial degree to the development of PTSD, the employer would have a basis to challenge, notwithstanding the deeming provision. Once a claim for workers compensation is made there is already a presumption of entitlement and it is for the employer to identify a basis sufficient to justify a dispute of the claim.

If there are hidden numbers of PTSD in cases where there is the development of the condition after an initial physical injury or a change of diagnosis of an initial psychological injury claim, they are not an issue as they do not show up in disputed matters during management of a claim.

Other suggestions and comments raised by lawyers were:

- Why limit to "*first responders*" when many styles of employment are increasingly exposed to traumatic events? Where as a direct result to exposure to traumatic event/s, why treat "*first responders*" differently from anyone else suffering from similar exposure.
- Why restrict to PTSD when a range of psychological conditions might be suffered following traumatic, frightening or violent incidents within the workplace?

- There is more value in providing a specific and tailored claims management system for PTSD claims after acceptance of claims.
- The real issue in PTSD cases is restoring earning capacity and achieving effective recovery.
- There is a need to improve the awareness of employers in the work place to symptoms of acute distress disorder and PTSD, and in the insurer, to provide a more supportive network and at the same time encouraging workers to seek help from suitably qualified mental health professionals as soon as possible.

Qualifications of type of employment or length of employment for special consideration in respect of PTSD is not appropriate as the causative event could occur in any circumstance and at any stage of employment history.

C. Insurers

It is important to note that the bulk of the employment types identified in research literature on this topic (Police, Ambulance officers, Firefighters, Correctional staff) are covered by the Tasmanian State Government; Treasury Risk Management Fund. At the present time only the Tasmanian Fire Service is privately indemnified for workers compensation. The private insurers within Tasmania therefore have varying exposure to the more general employment types that create circumstances that may generate PTSD claims.

In general terms those insurers express the view there are few issues with PTSD claims as generally they tend to be the easiest of psychological injuries to establish work causation. In the private sector PTSD claims predominately flow from a specific traumatic incident and are rarely disputed. Currently the clinical diagnosis process identifies the work connection or not and if a condition follows a traumatic event/s then claims always accepted. The main area of challenge to psychological injury claims revolves around application of exclusions in s 25 (1A) and when considering a cumulative effect, especially where the final contributing factor is of a type to fall within s 25(1A) such as a reaction to a performance management action.

Note: Section 25(1A) provides that notwithstanding that a mental illness is caused by a person's employment there is no entitlement to workers compensation benefits if the illness was as a result of certain circumstances as follows;

> *"1A) Compensation is not payable under this Act in respect of a disease which is an illness of the mind or a disorder of the mind and which arises substantially from–*

(a) reasonable action taken in a reasonable manner by an employer to transfer, demote, discipline or counsel a worker or to bring about the cessation of a worker's employment; or

(b) a decision of an employer, based on reasonable grounds, not to award or provide a promotion, transfer or benefit in connection with a worker's employment; or

(c) reasonable administrative action taken in a reasonable manner by an employer in connection with a worker's employment; or

(d) the failure of an employer to take action of a type referred to in paragraph (a), (b) or (c) in relation to a worker in connection with the worker's employment if there are reasonable grounds for not taking that action; or

(e) reasonable action taken by an employer under this Act in a reasonable manner affecting a worker."

Issues can also arise with the diagnosis of PTSD. One of the difficulties is that a worker may present to a GP with symptoms consistent with PTSD arising from exposure to a traumatic event, and by the very nature of the combination of symptoms presentation and an identifiable event, a diagnosis of PTSD may be made too early. A diagnosis should be dependent upon specialist (psychiatrist) diagnosis. Issues arise with questionable diagnosis where, for example, there has been a reaction to performance management action.

There was comment that claims for psychological injuries are more difficult to manage for a number of reasons and the Act is not geared well for such injuries as the process can be very counterproductive for injured workers. A finding in respect of a large proportion of claims for psychological injuries is there is a lot of underlying and pre-existing issues and diseases. There can be issues with PTSD as result of cumulative events, although these types of cases seem to be less likely in the non "*first responder*" type employments.

In relation to claims management, where there is an early indication that the claim is likely to be accepted all needed action is taken to assist the worker and the $5000 limit on medical expenses in the first 84 days is not applied, (eg, to all hospital-based treatment). Each psychological injury claim is triaged and a strategy developed for each claim. Early intervention is key, and process' rea revised to engage with the worker during any assessment process. A referral for an independent medical assessment is determined on a case by case basis.

There is a need to change the work culture to ensure the employer accepts the validity of PTSD as a bona fide illness and the need to manage the risk to employees and provide proper support for treatment and eventually return to work.

It was noted that disability care workers, and other employees dealing directly with the public have exposure to traumatic events.

Other issues and suggestions raised by insurers were:

- Where there is PTSD and other co- morbidity conditions, would deeming provision apply to those other conditions or just PTSD? How do you differentiate the effects of different conditions in such circumstances?
- If the real issue is about the management or administration of claims then address that by standardizing how PTSD and perhaps psychological illness claims are managed and administered, this could be done by means other than legislation. This would make that aspect of a claim less litigious.
- If PTSD is accepted as a significant issue in some employment types or in respect to some forms of psychological injuries following traumatic incident/s in a work environment, then perhaps consider having an open ended provisional entitlement (not limited to 84 days) which remains until the employer proves to the contrary;
- Given that the vast majority of first responder type workers are Government employees or covered by the Government self insurance scheme, it allows a discretion for the Government to implement psychological and mental health programs in these employment areas and also to standardise how any PTSD or serious psychological injury claims are assessed, administered and managed.

Worker Assist Program

Worker Assist program provides free generalised advice and assistance to workers on workers compensation issues. This service reports that during the period 2012-2018 they have dealt with 7 enquiries from workers reporting PTSD. Of those enquirers who are known to have made a claim for compensation (5), all bar one was accepted.

The practical benefit of a deeming provision was questioned, however it was considered that there may have been an educational benefit to encourage workers to seek medical assistance at an early stage and also to make claims in circumstances where they might otherwise believe success was unlikely, (e.g. cumulative exposure cases). Particular difficulties are reported in return to work endeavours with psychological injury cases, with both employers and workers lacking knowledge and understanding as to that process. It is recognised that there are problems where the functional or behavioral changes that occur to a worker suffering an undisclosed or undiagnosed mental illness leads to performance or disciplinary attention and the application of s25(1A).

Early intervention is seen as the key and there does not appear to be an obvious basis for treating PTSD differently than other serious psychological conditions that arise within the work

environment, in particular after traumatic events. Issues apparent to Workers Assist are the reluctance of workers to make a claim for a psychological injury and poor claims administration including Return to Work.

It is submitted that there is a considerable education deficit for PTSD and psychological injuries generally for employers, workers and general practitioners. An accepted claim does not mean that this is the status forever and workers need to be aware of this.

Unless you stay within the normal accepted recovery parameters there will be tension during the management of the claim. Psychological illness does not necessarily fit well into "*normal* " parameters and are of their nature unpredictable at times.

It is believed that there is significant underreporting of psychological injuries generally and particularly within "*uniformed*" workplaces, an analysis of sick leave data from those areas may give some insight into this aspect.

D. Unions

Health and Community Services Union (HACSU) and United Firefighters Union (UFU) submitted strongly in favour of a deeming provision to support their uniformed members (Ambulance Officers and Firefighters respectively). Both unions reported that "*nearly everyone made*" or " *the majority*" of workers compensation claims made for PTSD were disputed. This was not consistent with the data on initial claims for compensation recorded for the WorkSafe Tasmania (see paragraph 3, Claims data.)

<u>HACSU</u>

They stressed that research data established that the incidence of PTSD was much higher in "*first responder*" employment situations and that of ambulance officers are the highest proportion. It sought inclusion of support staff, eg Communication room staff, as well as officers on the scene given the vivid information that is communicated during an incident.

Employment environments have to be changed in order to encourage and support early disclosure. They described a workplace culture that did not support early disclosure of PTSD effects and people continue until such time that they are totally overwhelmed and they collapse. Making such a disclosure in this present employment environment is seen as a life decision as it is considered that their vocation and life commitment to serving others will be placed at risk.

They sought to have a situation where an ambulance officer (due to the prevalence of their exposure to traumatic events) who is diagnosed with PTSD is deemed to have a genuine claim. They described a significant issue for ambulance officers getting through the gate to initial acceptance of a claim. After discussion and reference to the claims data their description of

"*disputed claims*" was explained as intended to describe the dispute culture throughout the life of a claim and its administration. Members feel that the genuineness of their claim is never accepted as they are required to continually justify their position, by being subjected to numerous medical assessments that require them to revisit the traumatic incidents and justify their illness.

It is submitted that diagnosis of PTSD is clear and this condition should be treated differently from other low level psychological conditions where other non work factors can be relevant to causation.

There is a particular issue with how Return to Work efforts proceed as the employer is reluctant to positively engage due to a purported belief that there may be a risk of exposure to traumatic events.

There need to be changes in order to normalise the disclosure of psychological injury in particular PTSD and the making of a claim for compensation. There needs to be a respectful environment in those circumstances.

If in fact the data shows a low level of dispute of initial claims for compensation then they submit that there would be little harm in introducing a deeming provision, the effect of which would be educational and help to address negative cultural issues. They commented that people need to seek assistance when they need to, as workers compensation can be seen as the last resort and by then they feel they are a failure and that they will treated as a liar.

The intent of the Act must be paramount so as to maximise recovery and return to work. The linear recovery from injury to return to work as established by the Act does not work for psychological injuries where there are "*bad periods*" or where reminder events cause significant changes in symptom level (eg anniversary date of incidents).

Because of the high level of non-disclosure surrounding mental health issues and illness such as PTSD, it may not become apparent until there is a change in occupational functioning or coping which brings the worker to notice for performance management or disciplinary matters, when the application of s25(1A) becomes problematic.

See also their submission to the Tasmanian Government July 2017, "*Trauma doesn't end when the shift does: Post Traumatic Stress Disorder as a Presumptive Illness for Paramedics*".

United Firefighters Union

The UFU made similar representations although they highlight that there are other mental illnesses that arise within the work environment as well as PTSD, and also symptom presentations that do not meet a PTSD diagnosis. They submit that a deeming provision is sought to assist firefighters to access entitlements under the Act, not to create new or different entitlements. A detailed description was provided as to the changes that have occurred over recent years to the duties of a firefighter which can include assistance at motor vehicle accidents, clearance of chemical spills,

and in some jurisdictions medical assistance as first arrivers at scenes. They summarise mental illness arising either as a result of the general style of duties over a period of time or specific traumatic incidents.

Three interrelated issues were identified:

- the initial gateway to entitlement by assisting the acceptance of claims for compensation;
- difficulties with claim administration and management;
- workplace cultural and industrial issues.

It is submitted that mental illness in the workplace needs to be destigmatised so people declare problems rather than feeling weak or letting down their colleagues. There can be complicating features that would be assisted by a deeming provision, as the effects of a developing condition can lead to flow on effects of self medication, family issues and social issues. Members are concerned that if they disclose mental illness or make a workers compensation claim in that regard their service future is placed in doubt.

The UFA provided a written submission and arranged for the reviewers to discuss by telephone the Canadian experience with Mr Ken Block, Fire Chief, City of Edmonton, Alberta and Mr Alex Forrest, Captain, Winnipeg Fire Paramedic Service who were in Australia to make submissions to the current Senate Inquiry (details Section 7).

Police Association of Tasmania

Consistent with the other employee organizations, the Police Association of Tasmania confirm that they are aware of issues affecting their members only when specific matters are reported to them and that such instances are not recorded in a way that allows for data production on these issues. It is submitted that although there have been some steps taken in recent times to address mental wellness within the workforce these have not been fully actioned to date.

There is still significant workplace culture that limits disclosure of mental health issues and the making of workers compensation claims. Under reporting remains an issue. It is submitted that there remains a significant underreporting of mental health issues and the stigma of mental illness remains within the workplace. Many do not wish to engage in the workers compensation process as this involves dealing with layers of management and their work colleagues. Many also believe the process affects their career development and is a disempowering process.

There are particular issues with circumstances where there has been a recovery, return to work, but then a recurrence of a psychological injury at some future time which needs to be reestablished rather than accepted as a natural event related to the original claimed illness.

They mentioned that care be taken not to treat PTSD as a "*catch all*" for the range of psychological injuries that can be suffered. All serious psychological injuries suffered as a result of the nature of employment need to be considered not just those which may develop further to PTSD.

In conclusion it was submitted that any changes that made someone with PTSD comfortable about making a workers compensation claim was a good thing.

<u>Community and Public Sector Union (SPSF Group) Tasmania</u>.

The Community and Public Sector Union submits that PTSD can be triggered by a single event or by a build-up of events over time. They believe that highly stressful workplaces that exhibit signs of work overload or bullying reduce the resilience of workers and their capacity to deal with events and therefore increase the occurrence of PTSD.

The CPSU submits many employment types are exposed to the risk of exposure to traumatic incidents, including:

- Child Safety Officers – often exposed to situations of neglect, in high pressure environment where decisions are potentially life or death, often abused or threatened undertaking work, trauma can build up over years;
- Family Violence Counsellor – often exposed to violent situations and people who have been traumatised;
- Court staff, legal aid lawyers, public prosecutions staff – regularly exposed to material of an explicit sexual or violent nature, observe impact on witnesses;
- Correctional Officers – stressful workplace, often threatened and abused and occasionally assaulted, work every day with the risk of being kidnapped, deal with violent criminals, trauma can build up over years;
- Animal welfare officers – regularly exposed to animals that have been maltreated;
- Unsworn Police staff - regularly exposed to material of an explicit sexual or violent nature, stressful workplace;
- Forensic Scientist – attends crime scenes that often display signs of violent crime;
- Worksafe inspectors – involved in examining worksites where death or serious injury has occurred;
- Transport Inspectors – perform assessments of vehicles involved in road deaths or serious injury usually still in situ.

<u>United Voice</u>

They strongly submit that the nature of the work environment and the events that occur in the workplace provides a constant exposure of correctional officers to traumatic incidents. Members

report difficulties navigating the workers compensation system. There is significant under reporting of mental illness and a workplace culture of not making claims. The work environment is described as highly charged with the constant threat of violence. Return to work endeavours are hampered by the need to return to the location where causative incidents had occurred and the necessity to deal with inmates who may have been the perpetrators of the violence. Workers suffering mental illness are obliged to defend their position throughout the workers compensation process.

United Voice believe the PTSD data is incomplete and that there are many more incidents than indicated, submitting that many claims for a physical injury later involve PTSD and other claims are not captured in the data where there is a change in diagnosis to PTSD.

There needs to be more attention to preventing mental illness in the workplace and there is a current need for training for both management and workers. The "*uniformed*" work culture is not helpful for positively dealing with mental illness in the workplace.

Other employment types where significant exposure to traumatic events:

- Security officers, especially at Accident and Emergency sections of Hospitals and at Courts;
- Cleaners;
- Nurses;
- Disability care workers;
- Staff at Group homes, youth and disability.

Shop Distributive & Allied Employees Association.

The SDA confirmed that there is an increasing number of traumatic incidents witnessed by or involving those working in service industries. Incidents of PTSD suffered by shop assistants and similar are on the rise, possibly reflective of our society generally. All claims for compensation for PTSD by members have been accepted and handled well by the large employers who were self insurers.

The handling of claims relating to mental illness needs to be considered not just treating PTSD as special. They agree early intervention is needed and self insurers are well placed to do this as intervention is not necessarily contingent upon a workers compensation obligation.

A standardised approach (best practice) for the management of workers compensation claims dealing with mental illness would be beneficial.

6. EMPLOYER COMMENTS

Given the limited time available for this review and the indication from the data as to what employment types provided material exposure to traumatic events, input was sought from a

national retailer (self insured) together with specific State Government Agencies. As stated previously, save for the Firefighters the first responders including correctional officers are all covered by the Treasury Risk Management Fund. This Fund is administered by Jardine Lloyd Thompson Pty Ltd (JLT). JLT pay the workers compensation expenses incurred by those Government Agencies covered by the scheme and initiate management action in regard to a particular claim upon the request of the relevant Agency. Issues do not arise within the claims by Government employees due to "*decisions made by different Insurers*" as described in other jurisdictions but rather by decisions made by the individual employing government Agency. Insofar as the management of workers compensation claims go and psychological injury (including PTSD) in particular, there is no standardised claims management process across government with each Agency approaching matters in their own way.

A. The Department of Police and Emergency Management

The Injury Management and Advisory Service have responsibility for assessing all claims for compensation made by Sworn Police Officers, State servants within the Department and State Emergency Service employed personnel. Claims are either accepted or with legal advice referred to the s 81A process.

It is accepted that career Police officers have been exposed to numerous traumatic events and in the normal course a PTSD claim is accepted. The exception is when the cause description is questionable together with more recent workplace circumstances that have initiated a claim, eg performance management or counseling. They are that there are a number of claims that initially involve a physical injury but later a psychological injury may become apparent including PTSD. There is now readily available data as to these or where there is a change of diagnosis from an initial psychological illness to PTSD, but belief is that these circumstances do not give rise to any particular disputation.

They do not see need for presumptive provision as the present situation requires the employer to identify material issues to challenge a claim made and for PTSD, they would not consider to challenge unless there is overwhelming material that challenges the assertion as to causation. Such a situation would still allow a challenge with a deeming provision.

There is at times a misunderstanding of action taken in managing a claim, (eg there may have been a protracted period of some form of treatment and then a request by a treater for authorisation for a further period). A claims manager has a responsibility to expend funds in accordance with the law and may feel it necessary to obtain a medical opinion as to whether that further period of treatment is "*reasonable and necessary*" as provided by the Act. Such action is sometimes taken as a challenge as to whether the condition is suffered or not, rather than seeking advice on treatment options. There needs to be some form of checks and balances to the payment of entitlements.

They accept that there is still a degree of under reporting within the Police Force with mental illness stigmatized, but believe this is starting to break down as a result of education initiatives within the department.

They strive to make an early decision as to any claim so as to be able to concentrate on treatment, recovery and return to work. There is little contact with claims management personnel in other Agencies and claims management approaches might be quite different. This section also has a form of oversight of claims made by firefighters although the private insurer has the claims management role. Action taken by the insurer would be advised back. Work is being done in an attempt to improve the knowledge of supervisors and to address a very clear culture within the workplace that results in under reporting and reluctance to make claims for compensation.

The insurer for the Tasmanian Fire Service stated that the work environment of firefighters is recognised and that therefore the attitude taken is that PTSD claims are accepted unless there is very strong evidence to the contrary.

The Department considers that there could well be significant issues in particular cost exposure to giving retrospective effect to a deeming provision if that in effect significantly increased the number of claims from past years especially where persons had retired before making a claim.

B. Department of Justice

The Department of Justice has no data on initial physical injury claims where a psychological illness becomes apparent later, nor those where PTSD becomes the diagnosis after acceptance of the claim. They consider that the Department deals with many more cases of PTSD than shown in the available data. It is accepted that the Prisons work environment is difficult and that Correctional officers have ongoing exposure to traumatic circumstances. It is very rare that a claim for PTSD is disputed and there would need to be particular circumstances to justify dispute. They accept at face value that correctional officers have been exposed to traumatic events and if there is a link to particular event alleged, then the claim is accepted. If the claim is a result of cumulative matter, they may seek a medical report from the treating doctor or sometimes an independent specialist opinion.

During administration of claims they would only seek updated medical opinion for treatment options and return to work plans. They have had a number of claims where it becomes apparent that the PTSD may have been present from previous employment (eg ex-military or police personnel) but such cases have been disputed. They accept that there are some ongoing cultural issues within the Prison workplace and work needs to be done on achieving openness to mental illness within the workplace and support at all levels for those suffering psychological illness. The Department agrees that Correctional officers ought be included in the description of front line

responders but submit that there has not been any legal barriers to the acceptance of claims for compensation. They provided significant detail as to the difficulties faced in return to work options for corrections officers and the redeployment of officers to other areas within the State Service.

C. Tasmanian Health Service (including Tasmania Ambulance Service)

They confirmed that accurate data on number of actual claims that include PTSD would require a manual examination of all workers compensation files. They submit that there is a very low dispute level on PTSD claims and the main basis of dispute for psychological injury claims is the s25(1A) exclusions.

They have issues with inaccurate initial PTSD diagnosis which later reverts back to another psychological illness diagnosis when formal assessment is carried out. The term PTSD is a bit of a catch phrase and on occasions workers are dissatisfied as they personally believe they have PTSD but formal diagnosis does not support this. If the prerequisite is that there is a specialist PTSD diagnosis before the deeming provision is applicable then they would have no material issue with there being a deeming provision that applied to high risk employment types.

Whilst they accept that ambulance officers have high risk, there are also growing incidents of trauma events affecting, mental health orderlies, child protection officers, youth workers, Ashley Youth Detention Center workers, Housing Support officers, staff in Hospital Accident and Emergency areas.

Their experience is that there is no difficulty in successfully claiming workers compensation where there has been a diagnosis of PTSD, as the diagnostic criteria identifies the cause. As a rule, they require a formal diagnosis of PTSD before accepting a claim on that basis. The use of independent medical assessments is usually related to return to work endeavors or determining whether to seek a settlement of a claim.

Return to work endeavors for workers suffering PTSD can be problematic especially in specialist areas such as paramedics where there may be conflicting medical advice, that on the one hand a return to work would be a positive step whereas on the other, the worker must not be re exposed to traumatic circumstances. Redeployment options for an Agency or a part of an Agency are limited without a whole of government approach.

7. RELEVANT PUBLICATIONS

It is important that this Report not be considered in isolation to the many studies and reports produced in recent years relating to mental health within the workplace and PTSD in relation to emergency service style employment. In particular we draw attention to:

- Australian Senate Committee Inquiry - "*The role of Commonwealth, State, and Territory governments in addressing the high rates of mental health conditions experienced by first responders, emergency service workers and volunteers*". Report due December 2018;
- "*Expert Guidelines, Diagnosis and treatment of post traumatic stress disorder in emergency service workers*" (Harvey, Devilly, Forbes et al, October 2015);
- When helping hurts: PTSD in first responders; Australia21 Ltd, June 2018;
- Work-related post-traumatic stress disorder;
  - M. Skogstad M. Skorstad A. Lie H. S. Conradi T. Heir L. Weisæth
  - *Occupational Medicine*, Volume 63, Issue 3, 1 April 2013, Pages 175–18
- Victoria Police Mental Health Review; An Independent review into the mental health and wellbeing of Victorian Police employees, May 2016;
- Heads Up ; Good practice framework for mental health and wellbeing in first responder organisations; Beyond Blue;
- Mental Disorder Symptoms among Public Safety Personnel in Canada – The Canadian Journal of Psychiatry, 2018, Vol. 63(1) 54-64;
- Eurogrip: What recognition of work related mental disorders; A study of 10 European countries, February 2013;
- NSW Legislative Council Standing Committee on Law and Justice; First review of the workers compensation scheme, March 2017, see in particular pg 116 para 7.37 and pg 117 para 7.44.

8. THE POSSIBLE EFFECT OF "*HOWE PTY LTD.V MOTOR ACCIDENTS INSURANCE BOARD*" [2017] TASSC 27

This case involved an attempt by the Workers Compensation Insurer and employer to recover workers compensation payments made to a worker injured as a result of a motor vehicle accident which they conceded occurred in the course of the workers employment as he was travelling at the time of the accident at the direction of the employer. In the recovery action His Honour Blow CJ determined that in fact the journey the worker was on at the time of the motor vehicle accident did not arise out of or in the course of the workers employment. The motor vehicle accident was as a result of the negligence of the other driver who died as a result. The worker suffered Post Traumatic Stress Disorder as a result of this accident. His Honour determined that PTSD was a disease rather than an injury and therefore to be compensable it must not only arise out of or in the course of the employment but also the employment must contribute to a substantial degree. He determined that the journey the worker was on at the time of the accident did not arise out of or in the course of the workers employment but also that :

"His PTSD was caused by the fatal collision. The fatal collision was caused by the negligence of the of the motorcyclist (other driver). That negligence was the major or most significant factor in the causation of the PTSD . The fact that (the worker) was driving home after performing certain employment duties does not warrant a conclusion that his employment was the major or most significant factor in the causation of the PTSD."

It is uncertain as to whether His Honour would have characterised the negligent or illegal acts of another person as the substantial contributing factor to the suffering of a disease if the third person's action occurred in the course of someone's employment, eg driving in the course of employment or serving in a retail area which is subject to an armed robbery. The possible impact of this decision needs to be assessed and legislative amendment made if it is determined that the effect of this decision might deny workers compensation entitlement for a disease arising out of or in the course of employment but due to the action of a third person. Such an interpretation would be contrary to a long line of judicial authority and the accepted understanding of those within the workers compensation environment.

Information provided to this Review is that this decision has already been sought to be relied upon in a s81A dispute of a claim for compensation.

9. THE CANADIAN EXPERIENCE

A number of Canadian Provinces have amended their workers compensation type legislation to address the issue of PTSD and in some cases make provision for presumption of cause to certain specified employment types. These amendments are referred to by many as instructive as to what jurisdictions in Australia should do. A summary of the Canadian position is set out in a Paper titled "*Presumptive Workers Compensation Coverage for First Responders with Occupational Stress Injuries including Post traumatic Stress Disorder", A written Submission*, Paul Davis MHA, Newfoundland and Labrador, Feb 2018" at *https://www.pcpartynl.ca/article/201802021/*

What is apparent from a consideration of the Canadian position is that there were specific reasons as to why some provinces made changes, such reasons not existing in our workers compensation system. In particular their treatment of diseases as opposed to physical injuries was different to ours. PTSD is as a recognised mental illness classified as a "*disease*" to which a claim for compensation can be made. Care must be taken to identify the nature and type of workers compensation coverage and the system supporting same before advocating that provisions from one jurisdiction be implanted in another jurisdiction. This is clearly the case here for example a cursory examination of the Ontario legislation identifies significant differences with our own. Ontario legislation does not cover diseases generally but rather specified occupational diseases, together with "*chronic mental stress*" and "*traumatic mental stress*". It was in that setting that PTSD was dealt with specifically as it might not have qualified under the requirements of "*traumatic mental stress*".

What was required in the Canadian legislation was that to qualify as "*traumatic mental stress*" the mental illness had to be as a result of an acute reaction to a sudden and unexpected traumatic event. A worker was obliged to identify the cause as a particular traumatic event. The development of such a condition by reason of the cumulative effect of traumatic events generally was not accepted.

In order to establish traumatic mental stress the event(s) must arise out of and occur in the course of the employment, and be:

- clearly and precisely identifiable, and
- objectively traumatic

These requirements appear to be more restrictive than PTSD and may have been a reason why PTSD was dealt with specifically. In our Act PTSD is already included as a disease to which the Act applies whereas the Canadian Provinces included a specific provision making the condition as a diagnosed condition for which a claim for compensation could be made. By limiting the employment types to which this applied means those employment types or circumstances do not get the benefit of claims for PTSD but rather need to satisfy as traumatic mental stress. Only Manitoba and Saskatchewan provided for the PTSD inclusion to apply to all workers.

What is of note however is that these legislative changes did not occur in isolation as obligations were imposed upon employers to implement mental health strategies within their workforce so as to prevent PTSD occurring within those workplaces.

These amendments for example the Ontario legislation appear to do more than merely provide a deeming provision on causation, they create a clear entitlement to benefits for certain workers suffering PTSD (which may not have previously existed), and speed the assessment process,. see *https://www.pcpartynl.ca/article/201802021/*

It was described to the reviewers that before the amendments to legislation in some Canadian provinces it was not unusual for a person diagnosed with PTSD to be engaged in medico legal processes for in excess of a year before a claim would be accepted.

10. OTHER AUSTRALIAN JURISDICTIONS

In general terms other Australian jurisdictions report that they are either engaged in or developing a range of mental health strategies to bolster and safe guard the mental health of workers within the workplace. The topic of PTSD as it relates to first responders or frontline employment types has been considered or discussed at various levels with most jurisdictions noting the debate on this issue. No other jurisdiction has taken direct legislative action or specially considered taking such action in relation to amending the entitlement pathway such as a deeming or presumptive provision for PTSD suffered by designated employment areas.

11. CONCLUSION

We should be cognisant that change needs to be evidence-based. The PTSD claims data provided by Worksafe indicated the following:

- PTSD claims data is characterised by low frequency, and variability in concentration and consistency of claims across a 10 year timeframe for all coded occupational groups, including first responders.
- There is 83% PTSD claim acceptance across all coded occupations over a 10 year period, under the current system. Specific incident types related to exposure to a traumatic incident are associated with higher claim acceptance.
- For the first responders group, there is a 90% PTSD claim acceptance rate covering a range of traumatic incident types that ambulance and paramedics, police and firefighter would likely be exposed and /or be inherent in their line of duty and work role, including violence and/ verbal assault, cumulative, attending traumatic scenes and traumatic events
- A range of occupational groups such as prison officers, teachers, frontline customer service and health and client support occupations are exposed to traumatic events. Customer service occupations deal with challenging and aggressive customers and the prevalence of criminal activity such as armed hold-ups which puts them at risk in their retail, hospitality and customer service work. Health and client support services also have a prevalence of violent and verbal assault incidents. Labourers are at risk of psychological injury from exposure to traumatic incidents associated with injury or death.

The PTSD claims data suggests the need to recognise the risk of psychological injury for any worker in any occupational group exposed to a traumatic incident.

Numerous studies have identified that in various jurisdictions members of "*first responder*" style employment types are prone to suffer a higher percentage of PTSD than general forms of employment. These findings are consistent with the data in the Tasmania scheme save for firefighters which unexplainably on the raw data initially present with lower numbers than expected. The work of correctional officers in our prison system is accepted as exposing officers to a significant risk of exposure to traumatic incident/s and the data supports that this form of employment be included with first responder style employment.

Generally there are a number of employment types that have been subject to traumatic circumstances which have resulted in a not insignificant number of PTSD claims and stakeholders report that this trend on current indications is likely to continue. Key stakeholders identified a number of occupational groups at risk including, disability services workers, sales assistants, especially in licensed bottle shops and after hours retail outlets, teachers, youth support workers and security officers.

There is emotional resonance with PTSD and certain groups that we identify as deserving of support and recognition for their contribution and self- sacrifice in putting their lives on the line for the community and wider good. This is the case for veterans and also for first responders. It is also reflected by the passion of advocates to represent their workers and ensure that they have navigable pathways of support for sustainable mental health and well-being. This sentiment is expressed by (Barratt, Stephens and Palmer 2018) in **"When Helping Hurts: PTSD in First Responders"**

> *"The community owes these men and women a huge debt. We expect them to be ready and available at all times day and night and in all circumstances. The least we, as community members, can do in return is listen to what they are telling us and support initiatives, that will allow them to stay healthy and capable of continuing to do the demanding job we ask of them (p.29)".*

Barratt, Stephens and Palmer comment "*the moral case is that everything reasonably possible should be done to protect the health and well-being of those who put themselves at risk on behalf of their community and the health and well-being of their families*" (p.55) and that from a public policy perspective "*Organisations have a responsibility to take all reasonable steps to ensure that employees with first responder duties enjoy and maintain high levels of physical and mental health.....maintaining all first responder personnel at high levels of physical and mental health goes to the heart of organisation capability*". (2018, p.55).

However, we also need to recognise that we run the risk of diluting the need for a broader and deeper understanding of the range of reactions and impact of traumatic events for individual workers across different occupations that requires multiple intervention initiatives. If we go down one path of change, for one type of psychological injury, for one identified occupational group then we can run this risk.

This review based on current claims data and anecdotal findings from key stakeholders, does not indicate that there is a need for a deeming or presumptive provision to assist any workers to successfully claim workers compensation benefits having suffered PTSD. The dispute rate for PTSD claims is very low and does not warrant legislative amendment to the Act.

A limitation of the review, was the current state of the data held in respect of the Tasmanian workers compensation system, particularly factors influencing its accuracy, which in turn does not permit any meaningful assessment or analysis of particular aspects of the scheme or for conclusions to be drawn. Of particular relevance to this review, the reviewers were unable to determine with certainty, the total number of claims for compensation that involved a diagnosis of PTSD. Claims for compensation when made are coded in a manner that describes the description of injury (disease) and the circumstances in which the injury (disease) was suffered. This initial coding of information remains as such for the duration of the claim. The data therefore does not permit a determination of those cases where an initial diagnosis of a mental illness is later changed to one of PTSD, or initially the claim is made for a physical injury but at some later time PTSD emerges either as a result of that injury or as a result of the incident in which the injury was

suffered. This lack of accurate data was a significant limitation for the reviewers in conducting this review. Some examples that illustrate the nature of this deficit are:

- Although WorkSafe data shows there have been 12 PTSD claims by Police in the period 2008 – 2018, the Department records 24 such claims with 4 disputed;
- Currently Tasmania Health Service is administering 42 open workers compensation files for PTSD, 11 of which are from the Tasmania Ambulance Service;
- Although Tasmanian Fires Service is recorded as having 2 initial claims for PTSD, a manual search of files identified that there were at least 5 others where PTSD became apparent during the course of the claim.

Save for Police, none of these additional files however related to disputed matters and all were being administered as accepted claims.

The prevention and management of psychological injury in the workplace, with specific reference to PTSD, incorporates three aspects:

a. Proactive and preventative strategies including mental health awareness and education to de-stigmatize mental illness and provide an open and supportive work environment for disclosure of mental illness, to encourage help-seeking and to make available early intervention and treatment options;
b. Submission of a workers compensation claim;
c. Effective management of claims designed for sustainable recovery, functioning, and return to work.

Although this review was centered on para b, other aspects were clearly of significant importance to stakeholders and highlighted the need to focus on developing safer, healthier and supportive workplaces and that claims are managed using a standardised, best practice approach and dealt with in a positive, non-judgmental way.

As indicated in this Report there has been considerable work done internationally and in other Australian jurisdictions, developing and implementing workplace mental health programs, particularly in at risk work places such as first responder. These mental health awareness and education programmes highlight the importance of mental wellness and equip employers, supervisors and workers to recognize the psychological impact of workplace events and to seek early intervention for mental health issues. It is realised that workplace culture needs to shift and factors that are influencing the development and implementation of a constructive and supportive approach to mental health and mental illness in the workplace need to be identified and addressed. This will play an important role in de stigmatising mental health issues and contribute to addressing the under reporting of mental health claims, including PTSD.

There needs to be a clear process and guidelines for diagnosis of PTSD and for this to be applied consistently across key clinical stakeholders. General Practitioners are the first medical point of contact for the impact of a work-related traumatic incident, however there appears to be variation in general practitioner's mental health background and understanding of PTSD and how it presents, and whether the GP considers their role to make a diagnosis. An initial working diagnosis or opinion is required of a GP, rather than a descriptor, until a specialized, clinical diagnosis is made, recognizing that a diagnosis may evolve over time. This not only reflects an appropriate clinical process but it also allows the more accurate coding of the type and nature of psychological injury, for which workers compensation claims are being made.

In relation to treatment, any form of agreed intervention relating to the assessment of a claim for compensation or treatment protocols must have the valid diagnosis of PTSD as a prerequisite. Of note is that some of the Canadian legislation referred to require diagnosis of PTSD by a psychiatrist or psychologist. Specialist resources need to be available and accessible. When engaged, the treating clinicians need to be experienced with PTSD so there is a clear and consistent assessment, diagnosis and evidence-based treatment path. Currently there is no inpatient PTSD treatment facility in Tasmania. This type of facility could provide localized access to a specialised and structured assessment and treatment process for PTSD.

Employee representatives report numerous instances of workers suffering PTSD being adversely affected emotionally or psychologically by action taken by the employer/insurer in the ongoing administration of an accepted workers compensation claim. The review has highlighted what are unnecessary disputes concerning treatment options and return to work aspects. It is unhelpful in relation to psychological injury to have disputation where each party has support from medical or psychologist support. There are best practice, evidence-based treatment guidelines such as *The Australian Treatment Guidelines for the Treatment of Acute Stress Disorder and Post-traumatic Stress Disorder* (2013) and these could be referenced in the treatment and management of PTSD claims, removing the issue as to whether treatment is "*reasonable and necessary*". Such an approach could well also assist in return to work endeavours.

Occupational stress and interpersonal conflict associated with psychological injuries need to be a targeted area for employers and insurers and addressed with immediacy, clear processes and support within the workplace. These issues may be a factor which influence workers' capacity to verbalise issues, seek support and access assistance in relation to their mental health and well-being. There is a presence of "*social and interpersonal traumas*" such as bullying and harassment, which can be associated with trauma like symptoms, (e.g. hypervigilance, avoidance, hyperarousal) entering PTSD diagnostic consideration, as evidenced by PTSD claims data. This is notwithstanding many would argue that such circumstances cannot satisfy DSM-5 Criteria A for PTSD diagnosis.

Recommendations

1) The Workers Rehabilitation and Compensation Act 1988 not be amended in order to provide a deeming or presumptive provision to provide in respect of certain styles of employment that the employment of those persons contributed to a substantial degree to the suffering of PTSD.
2) Action be taken to redress the data gaps as to claims for compensation within the Tasmanian workers compensation scheme to ensure that accurate factual data is recorded. This concerns not only the nature and type of injury (disease) and injury circumstances of the initial claim, but also any changes in material facts during the course of the claim, in particular changes in injury (disease) description or diagnosis. It is important to identify and address factors influencing early referral to treating specialists access to treatment, including availability, waiting time, and specific needs of a client.
3) Given that General Practitioners are the first point of medical contact in workers compensation claim process, there needs to be professional development opportunities for General Practitioners to reinforce a consistent framework of understanding of PTSD, its presentation and diagnostic requirements, particularly within the workers compensation system, and the importance of early referral and access to a specialist clinician and evidence-based intervention and treatment.
4) With the assistance of appropriate professional bodies, that a clear and consistent framework and process be implemented by clinicians for the diagnosis of PTSD.
5) There be professional development opportunities for insurers and injury management personnel to build an understanding of the potential complexities of PTSD within a workers compensation process, identify issues that can arise and develop strategies for how these can be effectively managed.
6) Workplace culture needs to be conducive to psychological well-being, help seeking behaviour and access to support and early intervention. Factors or issues that are influencing the development and implementation of a constructive and supportive approach to mental health and mental illness in the workplace need to be identified and addressed. Mental health education and professional development initiatives, will play an important role in destigmatising mental health issues and contribute to addressing the under reporting of mental health claims, including PTSD.
7) Notwithstanding that the evidence-based findings of our review indicate no current need for legislative change, it could be argued that there is a social basis for and social value arising from presumptive legislation. Presumptive legislation would recognize, leading to an increasing acceptance by employees and employers that psychological injury can arise from exposure to traumatic events whether they be inherent in the nature of a person's work role and duties, or as a result of a traumatic event that could occur in any workplace. Presumptive legislation could help alleviate factors that influence help seeking such as stigma surrounding mental health, and perceived impact on career prospects and judgments from others, and create an objective and accessible pathway to workplace support, early

intervention and effective treatment. However presumptive legislation is only one initiative in a range of necessary proactive and response interventions to support workers at risk of psychological injury arising from traumatic exposure in the workplace, and to assist in the making and course of a workers compensation claim.

8) Occupational stress and interpersonal conflict associated with psychological injuries need to be a targeted area for employers and insurers, as these issues may influence a worker's capacity to seek support and access assistance in relation to their mental health and well-being.
9) Given that The State Government is the sole employer of the first responders and correctional officers, together with front line medical and nursing staff, youth workers and other at risk employment types it is recommended that the Government determine whether to administratively direct how employing Agencies are to assess PTSD claims for compensation and how such claims are to be administered. Without the need to amend the Act the Government could instruct Agencies as to the acceptance of such claims from workers engaged in certain employment types thereby limiting or removing the reasons that might be relied upon to dispute a claim. The Government must consider the full range of suitable employment positions within the State Service for rehabilitation of a worker unable to return to pre injury duties and not restrict Agencies to identifying options only within that Agency.
10) Claims administration of psychological injury claims pose particular issues. It is recommended that with reference to recent research material, eg "*Expert Guidelines, Diagnosis and treatment of post traumatic stress disorder in emergency service workers*" (Harvey, Devilly, Forbes et al, October 2015), that in respect of its employees the Government adopt standardised treatment principles and protocols applicable to all workers diagnosed with PTSD. This will ensure treatment and claim administration is not only best practice but also consistent across the Government workforce. This would be offered for use to private employers or made mandatory in all cases of PTSD by imposing the requirement upon licensed insurers.
11) The limited timeframe to complete this review, precluded consultation with other key community stakeholders, that is those community members with PTSD and/or other psychological injury, arising from work-related traumatic exposure. It is recommended that consideration be given to a further process or public submissions to ensure the worker's perspective is captured in the context of this current review. This would also provide a more formal opportunity for all stakeholders to provide detailed submissions in respect of the range of matters articulated in this Report.

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