RANZCP Position Statement 94

December 2017

Public insurance schemes: advocating for mental injury claimants

Summary

Aspects of personal injury and workers compensation schemes impose disadvantages on people with mental injuries, delaying recovery and compounding suffering.

Purpose

There are multiple public insurance schemes in Australia and New Zealand that perform an important service to the community by providing support to injured people. However, many aspects of these personal injury and workers' compensation schemes impose serious disadvantages on people with mental injuries, with the frequent result that their recovery is delayed and their suffering is compounded. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has developed this position statement in order to highlight these aspects of the schemes and the harms that they can cause and to make recommendations to governments and insurers to help ensure that claimants receive the support that they need, without jeopardising the financial viability of the schemes.

Key messages

- Claimants with mental injuries can experience discrimination in a number of ways due to the legislative design of the public insurance schemes and the practices of scheme agents.
- In the RANZCP's view, this discrimination unjustifiably stigmatises claimants with mental injuries, compounds their injuries, denies them necessary compensation and timely access to rehabilitation services, and places extra strain upon their families and carers.
- The RANZCP advocates amending relevant laws to end this discrimination.
- The RANZCP supports efforts to change industry practice by introducing and enforcing mandatory guidelines for agents.

Definitions

A variety of public insurance schemes for compensable injuries operate in Australia and New Zealand. In New Zealand, the Accident Compensation Corporation (ACC) provides personal injury cover to all residents and visitors. In Australia, the states and territories operate separate schemes to cover workplace injuries and motor vehicle accidents. Three workers' compensation schemes also operate at the Commonwealth level, covering seafarers, military

personnel, and other Commonwealth employees (in addition to private employers with employees in two or more jurisdictions). The schemes are generally funded by compulsory insurance premiums paid by employers and motorists, and claims are managed by scheme agents.

For the purpose of this position statement, the RANZCP has adopted the term 'mental injury' which is commonly used in the law that underpins public insurance schemes.1 'Mental injury' refers to any psychiatric disorder excluding traumatic brain injury, including well-known conditions such as post-traumatic stress disorder (PTSD), anxiety, and depression. In Australia, mental injuries account for 6% of accepted serious workers' compensation claims (conditions which caused incapacity for a week or more) (Safe Work Australia, 2016a).

This position statement concerns mental injury claimants under the established public insurance schemes. The Australian National Disability Insurance Scheme, though based on insurance principles, does not provide compensation for injuries and therefore is not within the scope of this publication.

Background

Public insurance schemes for compensable injuries generate a great deal of controversy in Australia and New Zealand. In attempting to reduce costs, governments frequently amend the schemes in order to restrict eligibility for compensation and reduce payouts, and often fail to effectively monitor the activities of scheme agents. These factors often combine to produce troubling outcomes for claimants, as documented in public inquiries into workers' compensation schemes – most recently in Victoria and NSW. In Victoria, the Ombudsman identified 'a disturbing pattern of agents working the system to delay and deny seriously injured workers the financial compensation to which they were entitled – and which they eventually received if they had the support, stamina and means to pursue the case through the dispute process' (Victorian Ombudsman, 2016). According to the former SA Workcover Director, Dr Kevin Purse, 'all states and territories would benefit from similar investigations into whether workers were having their payouts cancelled or limited because of financial incentives offered by governments to insurance agencies, as a way to limit costs' (ABC News, 2015).

A growing body of research has documented the ways that compensation systems themselves can promote worse health outcomes, especially for people with mental health problems (Grant et al., 2014). Psychiatrists interact with the schemes both as treating clinicians and as independent medical examiners (IMEs). IMEs are engaged by the agent, but their duty is to provide a professional, impartial medical assessment that assists others to determine the claim (RANZCP, 2016a). The RANZCP recognises the health benefits of returning to work after an injury, and is a signatory to the Health Benefits of Good Work Charter of Principles (RACP, 2015), although effective compensation schemes are necessary to support people while they cannot work. In the considered view of the RANZCP, the schemes operate reasonably well for less serious claims, but claimants with more severe mental health conditions face additional challenges in trying to obtain due compensation. These challenges contribute to the stigma surrounding mental illness and discourage many people from making claims after being diagnosed with a work-related mental injury (AMA, 2012).

Some of these challenges are inevitable given the nature of mental injury, because most symptoms are self-reported, and a subjective element is inescapable when determining the

cause and degree of such injuries (Safe Work Australia, 2015; RANZCP, 2017). These factors alone can make it more difficult to successfully claim compensation; in October 2015, for example, 44.5% of mental health claims by Victorian police officers were rejected, as opposed to 4.7% of claims involving physical injuries (The Age, 2016). The high level of rejection creates a barrier to receiving adequate treatment, and may have contributed to the tragic toll of 35 suicides among Victorian police officers since 1995 (Four Corners, 2016).

In the view of RANZCP, the schemes themselves also create unnecessary hardship for mental injury claimants. Some of the problems arise from the practices of agents, and some of the problems stem from the legislative design of the schemes.

Agent practices

After being involved in a hostage situation, a prison officer developed PTSD, ceased employment, and sought compensation for work-related mental injury. The diagnosis was confirmed by an IME (IME1), and the agent accepted the claim. Later, the agent arranged for the claimant's work capacity to be assessed by two more IMEs (IMEs 2 and 3). Both IMEs confirmed that the worker had experienced severe trauma and was unable to resume work, but IME3 stated that the worker 'may' be able to return to work in the future. The agent terminated the compensation payments on this basis of IME3's report. The agent's internal correspondence confirmed that there was no basis for refusing compensation to the claimant. However, the agent did not restore payments until being directed to by the conciliation service, and afterwards the agent continued to challenge this direction (page 76). This is one of dozens of case studies documented in the recent Victorian Ombudsman report. Most concern people who sought compensation for work-related mental injury and experienced highly adversarial behaviour from agents. Claimants with serious conditions are more likely to have their claims challenged by agents and rejected without a proper basis – in Victoria, for example, three quarters of decisions to terminate payments after 130 weeks were overturned by the courts (Victorian Ombudsman, 2016). In one particularly tragic case, the claimant was denied psychiatric treatment and medical expenses for months while she sought to have them restored; although her claim was eventually accepted, she took her life soon afterwards.

The case studies confirm a pattern that has long been evident to RANZCP members: mental injuries are frequently made worse by the prolonged contest to obtain compensation (RANZCP, 2016b). As the Mental Health Council of Australia (MHCA) observed, people with mental illness caught up in disputes with insurers 'face distinctive barriers in engaging with a complaints process, which can be complicated, drawn-out, often adversarial in nature, and daunting for consumers who may be worried about the symptoms of their illness worsening' (MHCA, 2014).

Part of the problem is the way that agents may utilise IMEs. In many case studies, agents appear to have engaged in 'doctor shopping' – sending claimants to as many as five IMEs in order to elicit a diagnosis that helps the agent to reject the claim. This practice was often accompanied by selective case history being provided to the IMEs by the agent, and the use of leading questions put to the IMEs (Victorian Ombudsman, 2016; Standing Committee on Law and Justice, 2017).

For people struggling to cope with mental health issues and fearful that their compensation will be terminated, it can be especially difficult to resist requests to visit IMEs. For claimants with PTSD, it can also be traumatic to repeatedly retell the events that gave rise to their condition, and clinical progress can be set back greatly as a result.

When agents genuinely believe that mental injury claimants need to visit IMEs, the RANZCP believes that treating clinicians should be consulted first, to ensure that patients are prepared and supported as much as possible. The use of covert surveillance by agents is also a concern for the RANZCP. In addition to media coverage (Four Corners, 2016), a recent NSW parliamentary inquiry brought to light examples where emergency workers claiming compensation for PTSD were subject to invasive surveillance practices:

[The agent] conducted surveillance upon me over the years which has had a very detrimental effect upon my mental health. Due to being very paranoid as a result of the PTSD and my policing experience, I could detect surveillance easily. I have had panic attacks and gone into fits of rage at the surveillance operatives. This has caused me to approach them and be very aggressive towards them. Once I was triggered by the surveillance, it would take days and sometimes weeks to settle down. The surveillance has had a very detrimental effect on my condition and thus my recovery (Standing Committee on Law and Justice, 2017).

In the view of RANZCP, surveillance very rarely aids diagnosis, because cameras cannot capture emotional states (Gold et al., 2008). On occasion, surveillance may help to establish whether a claimant has accurately reported their limitations, but this potential benefit must be balanced against the inherent risks – such as exacerbating mental injury and paranoia, and placing extra strain upon families and carers (RANZCP, 2017). The RANZCP also shares the Australian Medical Association's (AMA) view that insurers are increasingly likely to make excessive demands for sensitive, highly personal information contained in patient records (AMA, 2014). Agents have a legitimate interest in accessing some of this information, but this access can undermine the confidentiality of the patient-psychiatrist relationship, and consequently undermine treatment (RANZCP, 2016c).

Even when claimants authorise access to their information by insurers, as is normally the case, the RANZCP believes that claimants are entitled to a degree of privacy. As noted by the New Zealand Privacy Commissioner, '[claimants] have little real choice in how they deal with insurers, and what they are required to provide if they are to get cover, or have a claim paid'. The RANZCP agrees that the whole medical record is rarely necessary for the insurer's purposes: 'not all the information contained in medical notes is necessarily relevant to an insurance decision. For instance, medical notes may contain family or relationship information – the medical practitioner may have treated a person as a whole, in their individual circumstances and context' (Privacy Commissioner, 2009).In the view of RANZCP, all these practices not only create special disadvantages for mental injury claimants, they can also interfere with treatment and discourage people from seeking help they need and are entitled to.

The central problem is the adversarial nature of the claims process, and we welcome the proposal by the Victorian Worksafe Executive to 'reduce unnecessary interventions (such as the need for visits to an IME) and assist workers to return to work and recover in a more supportive environment, noting that the majority of workers will naturally recover and return to work without difficulty' (Victorian Ombudsman, 2016). The NSW Parliament has also acknowledged that doctor shopping 'encourages poor outcomes for injured workers and is

economically unsound', and has recommended penalties for agents who breach guidelines regarding the use of IMEs (Standing Committee on Law and Justice, 2017). The RANZCP supports this recommendation, and also supports the introduction of mandatory guidelines to regulate surveillance and direct agents to act as model litigants (Standing Committeeon Law and Justice, 2017). Model litigants are required to handle claims promptly and fairly, and avoid pursuing appeals that have no prospect of success; where agents are already required to act as model litigants – as in Victoria – these guidelines may need to be better enforced (Victorian Ombudsman, 2016).

Legislation

In response to the growing cost of public insurance schemes, governments across Australia and New Zealand have passed amendments that target mental injury claimants by restricting their eligibility for compensation. These amendments are known as 'exclusionary provisions' (Guthrie, 2010). By singling out a category of people with disabilities for worse treatment under law, they may be in violation of the right to equal treatment and non-discrimination (Parliamentary Joint Committee on Human Rights, 2015). This right is recognised by the International Covenant of Civil and Political Rights (Articles 2, 16 and 16) and the Convention on the Rights of Persons with Disabilities (Articles 5 and 12).

One common exclusionary provision in Australia denies or limits compensation to people who suffer a 'secondary mental injury' – a condition such as depression that develops as a result of a physical injury. This provision disproportionately affects people who have suffered the most severe injuries (Australian Lawyers Alliance, 2015). It also poses diagnostic challenges to psychiatrists, because their clinical work does not involve the division of mental injury along primary and secondary lines; the distinction is 'a legal truth but a clinical fiction' that gives rise to endless complications when put into practice (Epstein, 1999).

For example, a person may be psychologically affected by scarring which constantly reminds them of the accident. When head injuries are involved, the distinction can be especially difficult to apply (Epstein, 1999). In New Zealand, by contrast, public insurance does not cover mental injuries unless they were caused by physical injuries, being in close proximity to a traumatic event, or being a victim of a sex crime: Accident Compensation Act 2001: s26 (1). The legal tests for deciding if one of these events caused a mental injury are far from clear (Manning, 2014); in practice, the uncertainty allows the public insurer body ample opportunity to challenge the claim in court, which often occurs when more serious claims are made (Law Foundation, 2017). A variety of other exclusionary provisions exist in Australian and New Zealand public insurance schemes, including provisions which do the following:

- force claimants to choose between claiming compensation for physical or mental injuries set higher minimum thresholds for whole person impairment that must be reached before mental injury can be compensated
- set different causation tests – for example, where work must be a contributing factor for physical injuries, and the major contributing factor for mental injuries (Safe Work Australia, 2016b).

Exclusionary provisions have had mixed success in reducing the liabilities for public insurance systems (Guthrie et al., 2010), but they do not necessarily reduce the overall economic cost of mental injury, due to their unintended consequences:

- opportunities for early treatment are wasted, because adequate funds are not available, with the result that conditions become chronic
- people may ultimately stay out of the workforce for longer, or exacerbate their condition by working when it is unhealthy to do so ('presenteeism') (O'Keefe et al., 2014)
- costs are shifted to carers and the welfare and public health systems (Guthrie et al., 2010; Australian Lawyers Alliance, 2014).

Recommendations

The RANZCP believes that the compensation system needs to be understood as part of the health-care system to ensure that people receive proper treatment during the claims process and that the process does not undermine their recovery instead (RANZCP, 2016b).

To promote this principle, RANZCP will work with stakeholders to highlight the disadvantages faced by people with mental injuries, and we recommend that governments in Australia and New Zealand:

- introduce less adversarial pathways to compensation
- amend legislation that discriminates against people with mental injuries
- develop and enforce guidelines for agents regarding IMEs, surveillance and acting as model litigants
- limit the number of times claimants can be required to see IMEs, to reduce 'doctor shopping'
- minimise interference with treatment and rehabilitation that has been prescribed by treating clinicians.

- ABC News (13 November 2015) 'Fears workers missing out on compensation due to insurance industry bonuses.' Available at www.abc.net.au/news/2015-11-13/workers-missing-out-oncompensation-due-to-insurance-industry/6929588 (accessed 12 May 2017).
- Accident Compensation Act 2001 (NZ)
- AMA (2012) Workers shun compensation for psychological harm. Available at: ama.com.au/ausmed/workers-shun-compensation-psychological-harm (accessed 2 May 2017).
- AMA (2014) Doctor/patient confidentiality and third party access to medical records. Available at: ama.com.au/psychiatrists-newsletter/doctorpatient-confidentiality-and-third-party-access-medicalrecords(accessed 20 May 2017).
- Australian Lawyers Alliance (2015) Undermining the Comcare scheme: Submission to Senate Education and Employment Legislation Committee Inquiry into Safety, Rehabilitation and Compensation (Improving the Comcare Scheme) Bill 2015 (Cth). Available at: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Education_and_Employment/Improving_Comcare_Scheme/Submissions (accessed 12 June 2017).
- Epstein M (1999) 'Mental injury under the Victorian Workcover and TAC schemes'. Available at: www.tved.net.au/index.cfm?SimpleDisplay=PaperDisplay.cfm&PaperDisplay=http://www.tved.net.au/PublicPapers/December_1999,_Sound_Education_in_Law,_Psychiatric_Injury_Under_the_Victorian_WorkCover_and_TAC_Schemes.html (accessed 10 March 2017).

- Four Corners (August 2 2016) 'Insult to Injury'. Available at www.abc.net.au/4corners/stories/2016/08/01/4509000.htm (accessed 1 May 2017).
- Gold L, Anfang S, Drukteinis A, Metzner J, Price M, Wall B, Wylonis L, Zonana H (2008) American
- Academy of Psychiatry and the Law Practice Guideline for the Forensic Evaluation of Psychiatric Disability. Journal of the American Academy of Psychiatry and the Law 36(4): S3–50.
- Grant G, O'Donnell M, Spittal M, Creamer M, Studdert D (2014) Relationship betweenstressfulness of claiming for injury compensation and long-term recovery: a prospective cohortstudy. JAMA Psychiatry 71(4):446-53.
- Guthrie R, Ciccarelli M, Babic A (2010) Work–Related Stress in Australia: The effects of legislative interventions and the cost of treatment. International Journal of Law and Psychiatry 33: 101-115.
- International Covenant on Civil and Political Rights, 16 December 1966, United Nations, Treaty Series, vol. 999, p. 171 (entry into force for Australia: 13 November 1980).
- Manning J (2014) Treatment Injury. In: Skegg P, Paterson R (eds) Health law in New Zealand. Wellington, New Zealand: Tompson Reuters New Zealand, pp. 1002-6.
- Mental Health Council of Australia (2014) Mental health and insurance: Submission to the Australian Law Reform Commission issues paper on Equality, Capacity and Disability in Commonwealth Laws. Available at: www.alrc.gov.au/sites/.../52._org_mental_health_council_of_australia.docx (accessed 1 June 2017).
- O'Keefe L, Brown K, Christian B (2014) 'Policy perspectives on Occupational stress'. Workplace Health and Safety 62(10): 432-438.
- Parliamentary Joint Committee on Human Rights (2015) Twenty-Fifth Report of the 44th Parliament. Paragraph 1.414. Available at: www.aph.gov.au/Parliamentary_Business/Committees/Joint/Human_Rights/Scrutiny_reports/2015/Twenty-fifth_Report_of_the_44th_Parliament/c02 (accessed 16 May 2017).
- Privacy Commissioner New Zealand (2009) Inquiry by the Privacy Commissioner: Collection of medical notes by insurers. Available at: www.privacy.org.nz/assets/Insurers-collection-of-medicalnotes-inquiry-by-the-Privacy-Commissioner.doc (accessed 25 May 2017).
- RACP (2015) Health Benefits of Good Work Principles. Available at: www.racp.edu.au/docs/default-source/advocacy-library/pa-health-benefits-of-work-charter-of-principles.pdf?sfvrsn=6 (accessed 20 May 2017).
- RANZCP (2016a) Submission to the Victorian Ombudsman's investigation into the handling ofworkers compensation claims. Available at: www.ranzcp.org/Files/Resources/Submissions/Victorian-Ombudsman.aspx (accessed 20 May 2017).
- RANZCP (2016b) National Mental Health Commission's review of the services available to veterans and members of the Australian Defence Force in relation to the prevention of self-harm and suicide. Available at: www.ranzcp.org/Files/Resources/Submissions/0531o-President-to-Prof-Fels-re-NMHC-Review-into-s.aspx (accessed 20 May 2017).
- RANZCP (2016c) Position Statement 89: Patient–psychiatrist confidentiality: the issue of subpoenas. Available at: www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/PS89-Access-to-clinical-records-without-patient-co.aspx (accessed 23 June 2017).

- RANZCP (2017) Re: Review of Activity Investigations. Available at: www.ranzcp.org/Files/Resources/Submissions/LTR-VIC-Opinion-of-RANZCP-on-surveillance-usage.aspx (accessed 2 June 2017).
- Safe Work Australia (2016a) Australian Workers' compensation statistics 2013-4. Available at: www.safeworkaustralia.gov.au/doc/australian-workers-compensation-statistics-2013-14 (accessed 1 June 2017).
- Safe Work Australia (2016b) Comparison of Workers' Compensation Arrangements in Australia and New Zealand. Available at: www.safeworkaustralia.gov.au/workers-compensation (accessed 10 May 2017).
- Standing Committee on Law and Justice (2017) First review of the workers compensation scheme.Sydney, Australia: NSW Legislative Council.
- The Age (2016) 'Dirty tactics by insurance companies make injured workers miserable'. Availableat: www.theage.com.au/victoria/dirty-tactics-by-insurance-companies-make-injured-workersmiserable-20160909-grd648.html (accessed 10 June 2017).
- The Law Foundation New Zealand (2017) Solving the problem: Causation, transparency and access in New Zealand's personal injury system. Available at: www.lawfoundation.org.nz/?page_id=2565 (accessed 5 May 2017).
- United Nations Convention on the Rights of Persons with Disabilities (entry into force 3 May 2008).
- Victorian Ombudsman (2016) Investigation into the management of complex workers compensation claims and WorkSafe oversight. Melbourne, Australia: Victorian Government Printer.