Submission No 1

INQUIRY INTO 2020 REVIEW OF THE WORKERS COMPENSATION SCHEME

Name: Name suppressed

Date Received: 8 May 2020

Submission: 2020 Review of the Workers Compensation Scheme

Forensic Psychiatric Assessment of WorkCover Claims

1) *Requirement for claimants to have a choice of 3 specialists for assessment of their claim.*

Claimants often wish to defer or delay being examined; alternately, the communication of the examination from lawyer or insurance is unreliable. The result is that cancellation of the bookings with the two rejected specialists is done late, after at the last moment, leaving an appointment slot that cannot be filled – bearing in mind the requirement for three week notice before a booking can be made for a claimant.

It is clear that this ruling was made without any consideration of the problems caused for all parties, most notably the examining specialist.

The resulting waste of time and inconvenience creates a situation that is antithetical to professional work, interferes with the smooth running of the SIRA process and a loss of confidence in the system.

A number of claimants have told me that their solicitor or union official told them to choose a particular specialist as being 'a good one' for their claim. While every assessor has to maintain their

responsibility as a servant of the court, this process profoundly undermines the requirements for complete objectivity of assessments.

2) *Claimants providing copies of their medical certificates*

A recent practice is getting claimants to provide and copy their medical certificates. The results are often poor, if not unreadable and it is a practice that should be discontinued.

3) *Workplace Bullying claims*

Based on my own experience and that of my colleagues, 90% of Workers' Compensation psychiatric claims now arise from allegations of workplace bullying. This creates an untenable situation for assessors. Cases are accompanied by much documentation giving both sides of the dispute. The assessor is then required to make a finding as to which party is in the right, followed by the clinical diagnosis.

Forensic psychiatrists have to consider all the available evidence, including the history and documentation. Time and time again the case consists of a claimant giving an impeccable account of being subject to appalling bullying, while the employers provide multiple statements from all their parties denying every claim made by the worker and how they took reasonable steps for discipline, termination, etc. It is simply not possible to tease out the issues involved without having the skills of a prosecutor, solicitor or investigator in the confines of a standard psychiatric assessment.

There is no recognition that a psychiatric examination is *not* the place to determine the verity of a workplace dispute; this should be done in the appropriate tribunal or court. Once this is done, then the clinical assessment of the claimant can proceed without the distorting factor that currently exists.

Added to this is that multitude of bullying claims now flooding the system have not been considered as leading to huge cost blow-outs to the system.

4) *Adjustment Disorder and its dangers*.

The commonest diagnosis made at a psychiatric examination of a work injury case is *Adjustment Disorder*. It is in fact the commonest psychiatric diagnosis in the world, but there are serious scientific doubts about its reliability and validity. Two leading authorities who have expressed criticised the diagnosis are James Strain and Richard McNally.

The diagnosis did not exist before 1980, when it was inserted into the DSM-111 as a wild-card diagnosis. While some regard it as an offspring of the old conditions of situational crisis, reactive depression or anxiety, the criteria are so vague that the boundaries are virtually infinite. It gives some idea of what a leading authority referred to as 'bracket creep' that the original diagnosis was intended for a condition that lasted 3-6 months, after which another diagnosis was required. This criterion was then abandoned for Chronic Adjustment Disorder which can last forever and becomes a perfect means to lock a claimant

into a lifetime of psychiatric invalidity. This is utterly contrary to the aims of the scheme which is to rehabilitate and get workers back to employment.

Excessive and inappropriate diagnosing of AD is the main psychiatric reason why the scheme's costs have blown out, as well as not being in the interest of the claimant.

The result, as any random assessment of psychiatric claim reports will show, is that it is used to encompass virtually any human emotion, ignoring that most distress is a typical reaction to a stressful situation, such as work dispute, without constituting a psychiatric disorder and settles over time.

DSM, in fact, provides for this contingency with the *V-Code Disorder*, a condition of clinical interest but not constituting a disorder; ie., it is not a psychiatric injury. It can be said with certainty that claims swamped by diagnoses of Adjustment Disorder as the convenient and instinctive finding – too often a reflection of diagnostic laziness, rather than critical assessment.

5) There needs to be a reassessment of the criteria for Complex Persistent Bereavement Disorder as listed in the DSM-5 which is so often used in Nervous Shock cases. According to this category, the first year of grieving is *Normal Bereavement*, immediately after that it becomes *Complex Persistent Bereavement Disorder*. This goes against all clinical experience. The time that bereavement lasts in highly variable, depending on the individual concerned and a range of other factors. If

bereavement takes several years to resolve, it is rebarbative to pathologize such a profoundly human reaction as a psychiatric disorder. As an assessor of numerous bereavement claims, I am struck how often claimants still in the grip of grief one to two years after the loss after being listed with CPBD. This is another reason why the scheme's costs have blown out.