

HOW TO ASSESS AND COMPENSATE PSYCHIATRIC INJURIES IN THE WORKPLACE

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Introduction

Mental illness has become a major health problem in Australia. Work-related mental injuries have also become prevalent. Personal injury claims, and specifically those relating to mental injuries, are frequently made by affected workers. The success of those claims largely depends on whether the claimant can establish that they have suffered a mental injury at work, and whether that injury was caused by the negligence of the employer. Sufficient evidence needs to be presented by the claimant to succeed in such a claim.

The legal concepts of duty of care, breach of that duty, causation and foreseeability will not be discussed in this paper. The purpose of this paper is to analyse the methods that are generally used to assess psychiatric and psychological injuries in common law claims, and how the medical expert evidence can best be utilised to prove the claimant's case. First, a brief discussion on the prevalence of mental illness and work-related mental injuries in Australia follows.

Mental illness and work-related mental injuries in Australia

Mental illness affects 1 in 5 Australians each year.² Approximately 4% of the population will experience a major depressive episode and about 14% will be affected by an anxiety disorder in any 12 month period.³ Further, almost half the total population (45.5%) experiences a mental health disorder at some point in their lifetime.⁴ Although statistics often discuss which gender is more prevalent to suffer from a mental illness, mental illness itself does not discriminate.⁵ It affects people of all ages, cultural backgrounds, and facets of life.

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² Mindframe, <http://www.mindframe-media.info/for-media/reporting-mental-illness/facts-and-stats>; and
<http://www.blackdoginstitute.org.au/docs/Factsandfiguresaboutmentalhealthandmooddisorders.pdf>, accessed 25 May 2015.

³ Mindframe <http://www.mindframe-media.info/for-media/reporting-mental-illness/facts-and-stats>, accessed 25 May 2015.

⁴ Mental Health Council of Australia, *Fact Sheet: Statistics on Mental Health*,
http://mhaustralia.org/sites/default/files/imported/component/rsfiles/factsheets/statistics_on_mental_health.pdf,
accessed 25 May 2015.

⁵ Ibid.

Mental illness includes any illness that affects the mind, and the way a person thinks, feels and acts.⁶ It can be caused by genetic, physical, chemical, biological, psychological, or social and cultural factors.⁷ It can therefore be caused by, contributed to, or triggered by an incident or an injury a person suffers in their workplace.

The most common mental disorders in Australia are depression and anxiety.⁸ Work related mental disorders, on the other hand, are generally associated with, or linked to, mental stress. Mental stress is caused by exposure to factors such as:

- work pressure including heavy workloads, deadlines, interpersonal conflicts and performance issues;
- exposure to workplace violence including assault or robberies;
- exposure to traumatic events including witnessing fatal accidents;
- work related harassment and/or workplace bullying including verbal abuse or threats; and
- other types of harassment such as sexual or racial harassment.⁹

Research indicates that prolonged exposure to any of these factors can contribute to the development of a serious mental illness including a post-traumatic stress disorder, an adjustment disorder, and depression and anxiety.¹⁰ Mental stress claims are considered to be the most expensive form of worker's compensation claims, generally due to the lengthy periods of absence from work.¹¹

Although the full extent of the prevalence of mental disorders suffered by workers is not known, it is likely to be greater than indicated by statistics. This is because not all workers who suffer mental stress or a consequential mental disorder at work apply for or receive

⁶ Mental Health Australia, http://mhaustralia.org/search/node?search_fulltext=mental+illness&=, accessed 25 May 2015.

⁷ *Mosby's Medical, Nursing and Allied Health Dictionary*, 4th ed. (1994) p. 979.

⁸ Mental Health Council of Australia, *Fact Sheet: Statistics on Mental Health*, http://mhaustralia.org/sites/default/files/imported/component/rsfiles/factsheets/statistics_on_mental_health.pdf, accessed 25 May 2015.

⁹ *The Incidence of Accepted Worker's Compensation Claims for Mental Stress in Australia*, April 2013, Safe Work Australia, p. 1.

¹⁰ *Work-related Mental Disorders in Australia*, April 2006, Australian Safety and Compensation Council, p. 7; *The Incidence of Accepted Worker's Compensation Claims for Mental Stress in Australia*, April 2013, Safe Work Australia, p. 4.

¹¹ *The Incidence of Accepted Worker's Compensation Claims for Mental Illness in Australia*, April 2013, Safe Work Australia, p.iii.

compensation.¹² For example, statistics indicate that 70% of worker's who reported a work related mental injury did not apply for worker's compensation.¹³

In Queensland, injured workers must first apply for worker's compensation through the Queensland Worker's Compensation Scheme. The Scheme is established by the *Worker's Compensation and Rehabilitation Act 2003 (Queensland)* ('the Act') and is regulated by Q-Comp.¹⁴ In some circumstances, after the requirements of the statutory compensation scheme have been satisfied, and depending on the degree of seriousness of the injury, they may proceed with a common law claim for compensation.¹⁵

The following part discusses the methods used to assess psychiatric and psychological injuries. It applies to both statutory and common law claims.

Methods for assessing psychiatric and psychological injuries

The methods for diagnosing mental disorders have been evolving for many decades¹⁶ as assessing psychiatric injuries is more challenging than assessing physical injuries.¹⁷ There are a number of psychological tests such as the Minnesota Multiphasic Personality Inventory-2 ("MMPI-2") or the Personality Assessment Inventory which assess the psychological functioning of the person.¹⁸ However, the tools most commonly used for assessing mental disorders today are:

1. the International Statistical Classification of Diseases and related Health Problems tool, on a 10th version ("the ICD-10"); and
2. the Diagnostic and Statistical Manual of Mental Disorders, on a 5th version ("the DSM-5").

The DSM-5 claims to be the most comprehensive resource used by specialists to diagnose and classify mental disorders.¹⁹ This tool has been developed over six decades with the

¹² Ibid, p. vii.

¹³ Ibid.

¹⁴ Previously "WorkCover Queensland".

¹⁵ See ss 10, 189, 190, 237, 239 and Chapter 5 of the *Worker's Compensation and Rehabilitation Act 2003 (Qld)*.

¹⁶ Hoffman, B. F. (1986) "How to Write a Psychiatric Report for Litigation Following a Personal Injury". *American Journal of Psychiatry* 143:2, pp. 164- 169, at p. 164.

¹⁷ Samuels, A. (2011) "Psychiatric Injury. The Lawyer's View". *Medico-Legal Journal*. V. 79, part 2, pp. 64-66, at P. 64.

¹⁸ See for example *Joyson v State of Queensland* [2004] QSC 154 at [84] and [91] where this was one of the tests undertaken to assess the plaintiff.

¹⁹ Published by the American Psychiatric Association, and available at <http://www.dsm5.org/Pages/Default.aspx>.

input of hundreds of international experts in all aspects of mental health. It is widely used by the Australian medical profession in diagnosing psychiatric disorders.

The ICD-10 is a medical classification list developed by the World Health Organization (WHO) over two decades.²⁰ It claims to be the standard diagnostic tool used by health professionals. The ICD-10 contains codes for the various diseases, and describes their signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.

A comparison between the ICD-10 and the DSM-5 tools can be demonstrated by their respective references to post-traumatic stress disorder ("PTSD"):

1. The DSM-5 classifies PTSD as a trauma and stressor related disorder and not an anxiety disorder. It identifies the trigger to PTSD as exposure to actual or threatened death, serious injury or sexual violation. The exposure must result from one or more listed scenarios, for example, in which the individual directly experiences, witnesses, or learns about the traumatic event from a family member or a close friend. The disorder causes clinically significant distress or impairment in the individual's social interactions, capacity to work or other important areas of functioning. It is not considered to be a physiological result of another medical condition, medication, drugs or alcohol. This tool pays more attention to the behavioural symptoms that accompany PTSD.²¹
2. The ICD-10 classified PTSD as a delayed or protracted response to a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. It views predisposing factors (such as compulsive or asthenic personality traits) and previous history of neurotic illness as having the ability to either decrease or increase the threshold for the development of the syndrome. Typical features include flashbacks, dreams or nightmares, and a persisting background of a sense of numbness and emotional blunting, detachment from other people, and avoidance of activities and situations reminiscent of the trauma. Anxiety, depression, and suicidal tendencies are commonly associated with the syndrome. The ICD-10 classifies the onset as following the trauma with a latency period that may range from a few weeks to months. It states that recovery can be

²⁰ Available at <http://www.who.int/classifications/icd/en/>.

²¹ At <http://www.dsm5.org/Documents/PTSD%20Fact%20Sheet.pdf>, accessed 25 May 2015. See also Gaughwin, P. "PTSD in DSM-5: Implications for lawyers and plaintiffs". *Bulletin*, April 2014, pp. 24-25.

expected in majority of cases, but in a small proportion of cases the condition may become chronic and persist over many years, with eventual transition to an enduring personality change.²²

A medico-legal report will frequently refer to the tool that was used to classify and assess the mental disorder. Some specialists will only use the particular tool, whereas others will go beyond the tool to determine whether the claimant is suffering from a mental disorder.

This is what occurred in *Groos v Workcover Qld*.²³ Dr Chalk, called by Workcover Queensland, did not go beyond DSM-4 when the appellant failed to meet its threshold. Dr Mulholland, called by the appellant, however, did. President Hall stated that the question whether the appellant was suffering from a psychiatric disorder or a psychiatric injury is a questions of mixed fact and law, and although medical evidence is helpful to determine this question, it is not decisive. Further, there was no obligation in the relevant Act or Regulations that a particular standard be used to determine whether a worker has suffered an injury. The court will, instead, consider all of the evidence before it, including that of the claimant.

An example of this analysis is Justice Mullins in *Binns v Thomas Borthwick & Sons*²⁴ who, when presented with numerous medical experts and inconsistent diagnoses and opinions, stated that “it was helpful to have had the opportunity of observing the plaintiff during the course of his giving evidence”. Her Honour then went to explain her analysis of the evidence and her consequent decision.

Where there is conflicting expert medical evidence, it is not only the expertise of the expert witness that is to be taken into account, but the substance of the opinion expressed must be examined.²⁵ The court or tribunal must then apply logic and common sense to the best of its ability to decide which view is to be preferred or which parts of the evidence are to be accepted.²⁶ Therefore, although one body of evidence may be preferred to the other, the grounds and reasons for the preference must be fairly discerned and expressed.²⁷

²² At <http://apps.who.int/classifications/icd10/browse/2015/en#/F43.1>, accessed 5 June 2015.

²³ [2000] QIC 52; 165 QGIG 106 (21 September 2000).

²⁴ [2005] QSC 237 at [69]-[72].

²⁵ *Tyson v Blackwood* [2014] QIRC 191 at [27].

²⁶ *Ibid.*

²⁷ *Ibid.*

Although methods for assessing mental disorders such as the DSM-5 and the ICD-10 are frequently used by medical specialist, they are not a necessary tool for the court or tribunal to determine whether a claimant is suffering from a mental disorder. They are tools designed to provide guidance and consistency for medical professionals who are assessing a claimant, not for the courts or the legal profession.

It is, nevertheless, prudent for legal practitioners to become familiar with the tools used by the medical experts. This familiarity will assist them not only in understanding their client's medical condition, but in preparing cross examination of the expert witnesses, and convincing the court or tribunal to accept a particular body of evidence. Utilising expert medical witnesses effectively is another way this can be achieved, and this will be discussed next.

Utilising expert medical witnesses

It has been said that the “essential skills and organisation for writing consultations are rarely taught during medical school or postgraduate training”, and that many physicians therefore experience difficulty communicating medical knowledge to a nonmedical audience, including in writing.²⁸ However, they still attempt to provide reports which are objective, unbiased, and scientific, irrespective of which party commissioned the report.²⁹ A biased report will raise “the question of credibility of the report, the practitioner, and the profession”.³⁰ The writer of such a report recognises that ultimately the court decides “whether harm has actually occurred, whether it was the result of some action or inaction by the defendant, and how much compensation is fair”.³¹

The expert's report will address the questions raised by the instructing solicitors. For example, the expert may be asked to assess the claimant and diagnose his or her condition, to comment on causation, or to provide an opinion on prognosis and his or her ability to work. Psychiatrists consider the purpose of the medico-legal report to “describe and explain to the lawyer, the judge, or the jury the patient's symptoms and disability and their connection to a specific accident”.³²

²⁸ Hoffman, B. F. (1986) “How to Write a Psychiatric Report for Litigation Following a Personal Injury”. *American Journal of Psychiatry* 143:2, pp. 164- 169, at p. 164.

²⁹ Ibid, p. 166; Hoffman, B. F. and Spiegel, B. A. (1989) “Legal Principles in the Psychiatric Assessment of Personal Injury Lawyers”. *American Journal of Psychiatry* 146:3, pp. 304-308, at p. 309.

³⁰ Hoffman, B. F. (1986) “How to Write a Psychiatric Report for Litigation Following a Personal Injury”. *American Journal of Psychiatry* 143:2, pp. 164- 169, at p. 166.

³¹ Ibid, p. 166.

³² Ibid, p. 165.

The medical experts instructed in these types of cases may include:

- general psychiatrists;
- forensic psychiatrists;
- general psychologists;
- clinical psychologists;
- neuropsychologists;
- neurologists;
- neurosurgeons;
- job placement consultants; and/or
- occupational medicine specialists.

It is crucial that the correct expert is selected and instructed to provide the medico-legal report. Further, the letter of instruction must be given thorough consideration. Complete reliance on a precedent is not appropriate as each client's case differs. Giving proper consideration to the questions that the expert is asked to answer in the report will provide clarity and avoid the need for further supplementary reports.

The purpose of cross examining expert witnesses should not be to discredit their evidence but to obtain concessions from them that there are other possible conclusions that can be drawn based on all of the medical evidence available. A thorough understanding of the medical evidence is essential. If a lawyer struggles with understanding the medical terminology or the conclusions reached, a shadow expert should be considered.

A shadow expert will advise the lawyer and explain complex medical evidence. This expert may also suggest other evidence the lawyer should obtain, or guide counsel on the line of questioning that could be taken in examination in chief or in cross examination. The shadow expert does not become a witness and should not provide their own reports to prevent them becoming discoverable.

Conclusion

Claims for psychiatric or psychological injuries are common. However, they are more complex than claims for physical injuries. Therefore, diligence and thorough preparation is needed to assist the client succeed in their claim. Understanding the assessment and

diagnosis, and utilising expert witnesses effectively, are just some of the ways that lawyers can assist their clients in these difficult cases.

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References