# WORKERS COMPENSATION COMMISSION

## CERTIFICATE OF DETERMINATION

Issued in accordance with section 294 of the *Workplace Injury Management and Workers Compensation Act 1998*

| | |
|---|---|
| **Matter Number:** | **5941/19** |
| **Applicant:** | **Karen Bunce** |
| **Respondent:** | **State of New South Wales - Central Coast Local Health District t/as Gosford Hospital** |
| **Date of Determination:** | **4 March 2020** |
| **Citation:** | **[2020] NSWWCC 62** |

The Commission determines:

1. The psychological treatment afforded Mrs Bunce by way of the supply of an assistance dog is "therapeutic treatment" as defined by s 59(b) of the *Workers Compensation Act 1987*.

2. The psychological treatment afforded Mrs Bunce by way of the supply of an assistance dog is reasonably necessary medical treatment.

3. Accordingly, the respondent will pay for the cost of and reasonably associated with the provision and maintenance of an assistance dog.

A brief statement is attached setting out the Commission's reasons for the determination.

John Wynyard
**Arbitrator**

I CERTIFY THAT THIS PAGE AND THE FOLLOWING PAGES IS A TRUE AND ACCURATE RECORD OF THE CERTIFICATE OF DETERMINATION AND REASONS FOR DECISION OF JOHN WYNYARD, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Reynolds

Antony Reynolds
Senior Dispute Services Officer
**As delegate of the Registrar**

# STATEMENT OF REASONS

## BACKGROUND

1. The applicant, Karen Bunce, brings an application pursuant to s 60(5) for a declaration that the provision of an assistance dog is reasonably necessary medical treatment. The respondent, State of New South Wales - Central Coast Local Health District t/as Gosford Hospital, issued a s 74 notice denying liability.

2. An Application to Resolve a Dispute (ARD) and Reply were duly lodged.

## ISSUES FOR DETERMINATION

3. The parties agree that the following issues remain in dispute:

    (a) is the provision of an assistance dog medical treatment within the definition provided by s 59 of the *Workers Compensation Act 1987* (the 1987 Act), and

    (b) if so, is such provision reasonably necessary.

## PROCEDURE BEFORE THE COMMISSION

4. This matter was heard on 7 February 2020 at Wyong. Mr Bruce McManamey of counsel appeared for the applicant and Mr Tony Baker of counsel appeared for the respondent. I am satisfied that the parties to the dispute understand the nature of the application and the legal implications of any assertion made in the information supplied. I have used my best endeavours in attempting to bring the parties to the dispute to a settlement acceptable to all of them. I am satisfied that the parties have had sufficient opportunity to explore settlement and that they have been unable to reach an agreed resolution of the dispute.

## EVIDENCE

### Documentary evidence

5. The following documents were in evidence before the Commission and taken into account in making this determination:

    (a) ARD and attached documents**, and**
    (b) Reply and attached documents**.**

### Oral evidence

6. No application was made with regard to oral evidence but during Mr McManamey's submissions oral evidence was given and the applicant cross-examined.

## FINDINGS AND REASONS

7. The facts are within a short compass. Mrs Bunce is a highly qualified and experienced Registered Nurse working in the Emergency Department at Gosford Hospital, where she has been working for many years.

8. Mrs Bunce has experienced a catastrophic reaction to an incident on 21 March 2017 when a patient within the hospital became aggressive and threatened Mrs Bunce, although he was restrained before she came to any harm. However, she had witnessed in 1999 a similar incident which resulted in a homicide by an aggressive patient. It was undisputed that the experience in February 2017 caused Mrs Bunce to develop a psychiatric condition as a result not only of her experiences in 1999 but also of childhood trauma. She had functioned normally until the subject injury.

9. She is a married woman with two teenage sons at home, and her 20 year old daughter lives locally.

**Mrs Bunce's statement**

10. In her statement of 16 April 2019 she described that, following the incident of 21 March 2017, she went off work after suffering a number of panic attacks. She came under the care of Dr Natalie Cordowiner, GP and Ms Tilda Patton, Psychologist. Mrs Bunce did not recall the exact day she returned to work but said it was in early May 2017. She had a relapse following a camping trip shortly after and took a further week off. From 10 June 2017 she underwent regular and intensive psychological sessions. She returned to work around that time, although the evidence was vague as to her duties and the time of her recommencement. However she said that in October 2017 she was declared unfit for work in Emergency Department, and was transferred to the Patient Flow sector of the hospital. In November 2017 she applied for the position of Counter Disaster, which she moved into in early 2018. In January 2018 her medication regime consisted of Citalopram, Endep and Seretide.

11. At about this time Mrs Bunce's son obtained a dog as a pet, and she spoke to Dr Cordowiner on 23 February 2018 about obtaining an assistance dog, as she found the presence of her son's pet dog "quite helpful" when travelling. Mrs Bunce also spoke to Ms Patton, who endorsed the idea of obtaining an assistance dog and who said that assistance dogs had been shown to improve anxiety and depressive symptoms in patients.

12. Mrs Bunce described her symptoms, and referred to the support she had from Dr Cordowiner, and Ms Patton. Mrs Bunce said:[1]

> "I feel that I should receive an assistance dog because I believe that the dog will give me the comfort, security and companionship that will allow me to continue my day to day life to the greatest capacity I can."

13. Mrs Bunce said at [47] of her statement that she was heavily reliant on her husband, her mother and her best friend as she was very anxious when alone. Mrs Bunce then spoke of her observations of how her son's dog gave her "accompaniment" and expressed the hope that an assistance dog would have the same effect. She said:[2]

> "I now feel as though an assistance dog will provide me with the same accompaniment that my son's dog does, but in many places where a regular pet cannot join me. An assistance dog is also specifically trained to assist me in situations where I feel overwhelmed or panicked, which I believe is essential to my safety."

[1] ARD page 16.
[2] ARD page 17.

**Oral evidence**

14. At this point in the narrative I interpolate to note that Mrs Bunce's statement was made on 16 April 2019 and during Mr McManamey's submissions it became apparent that Mrs Bunce's statement had been misleading and incomplete. Oral evidence from Mrs Bunce was then taken to elicit quite significant details.

15. Firstly, Mrs Bunce's statement failed to mention that in fact she obtained a dog on 25 March 2018[3], being a cavalier cross female puppy, so that at the time she made her statement she had owned her dog "Nala" for almost a year. Secondly, she also neglected to state that her dog was a 12 week old puppy at that stage, and that when it was six months old, in about August 2018, it underwent specialist training as an assistance dog with Mind Dogs Australia. Thus the factual situation is that at the time of the hearing Mrs Bunce had owned her assistance dog for almost two years, and it had undergone training some 18 months before.

16. Mrs Bunce said in her evidence that within eight weeks of the injury she returned to work, working one to two-hour shifts. Her condition meant that she was unable at that point to drive, and she had the support of her mother who drove her there and waited in the car for the limited periods she was then working.

17. Mrs Bunce said that after about six months she was able to drive herself to work when her hours increased. This occurred before she obtained her dog at the end of March 2018. She said that it was effective having her dog with her and made a significant change to her condition. She said she was able to travel further and she found the responsibility of having the dog in the car distracted her from her fear of driving, and particularly she mentioned that at one stage she wanted to jump out of the car at a red light, but was distracted by the dog.

18. Mrs Bunce's claim was denied by a s 74 Notice dated 8 August 2018.

**Ms Jacinta Bell, Occupational Therapist**

19. It is not clear when the application for an assistance dog was made to the insurer, however Mrs Bunce lodged a report obtained by the respondent dated 4 April 2018 from Wise OT Solutions Pty Ltd (Jacinta Bell).

20. Ms Bell reported that she visited Mrs Bunce on 28 March 2018 for an occupational therapy report, which included an assessment of Mrs Bunce's application for an assistance dog. Ms Bell had available a report from Ms Tilda Patton, Psychologist dated 10 June 2017, and a supporting letter from Ms Patton dated 7 March 2018. Neither document was before me, but I note that the s 287A Notice dated 31 July 2019 stated:[4]

> "Ms Patton, psychologist, provided a report dated 7 March 2018. She recommended you have the opportunity for additional assistance being provided by a 'service dog' for treatment of your panic disorder resulting from your workplace injury."

21. Ms Bell seemed to assume that Mrs Bunce had "dogs" as Ms Bell reported that Mrs Bunce found that when she transported "her dogs" in her vehicle it improved her concentration on driving, which made her look into interventions and options for an assistant dog. Ms Bell was aware that Mrs Bunce had a dog called "Nala," which at that stage had not been de-sexed or immunised nor had undergone any "puppy pre-school or formal training."

[3] Receipt for purchase at Reply page 1.
[4] Reply page 9.

22. Ms Bell advised[5]:

> "Mind Dog Australia defines an assistance dog as follows 'An assistance dog (also known as a service dog)' is covered by the Commonwealth Disability Discrimination Act 1992. An assistant dog who is trained to assistant their handler in public….. these dogs assist people with mental health disorders [whose] lives are often severally compromised by anxiety and fear."
>
> "An assistant dog is different to a regular family pet (companion animal) or an emotional support animal. An ESA may support a person through depression, anxiety or another medical condition but this does not mean the animal is specifically trained to do so; rather, they do so merely by their presence. ESAs under law are pets, while assistant dogs are medical aids) (mindDog Australia)".

23. Ms Bell said in considering alternatives available to Mrs Bunce[6]:

> "In the case for Mrs Bunce, her current levels of anxiety and panic attacks are exacerbated when attending new or unfamiliar places which is a requirement for her employment and when accessing the community to maintain pre-injury roles and responsibilities. These symptoms are becoming increasingly difficult to for her to manage and if her dog does not become an accredited assistance dog, it is feared she will regress and require formal care for emotional support when accessing the community and work place."

24. I assume therefore that Ms Bell's opinion was obtained following a claim made by Mrs Bunce around March/April 2018, and that it was supported by Ms Patton in her letter of 7 March 2018 - some two weeks or so before Mrs Bunce purchased her dog.

25. Be that as it may, Dr Cordowiner on 18 August 2018 wrote a reference in the following terms:[7]

> "This letter is written as Mrs Bunce's treating GP over the past 18 months and is in strong support of her need for an assistance dog in her treatment. I would consider an assistance dog in this case a medical treatment tool.
>
> In order to treat her panic disorder, anxiety and PTSD as a result of her workplace injury I feel that Mrs Bunce's functioning at work and in day to day life would significantly benefit from an assistance dog and is a form of therapy."

**Ms Tilda Patton, Psychologist**

26. In a report to the insurer dated 26 August 2018, Ms Patton noted Mrs Bunce's frequent attendances for her psychology sessions. She spoke of Mrs Bunce's hard work and described, to paraphrase, an intelligent and committed approach by Mrs Bunce to her recovery and functioning. Ms Patton reported that Mrs Bunce was continuing to experience her panic symptoms in many different circumstances. Ms Patton was aware that Mrs Bunce had actually obtained an assistance dog. Ms Patton said:[8]

> "Despite Karen's action towards recovery she does continue to experience symptoms of panic disorder including the onset of panic symptoms, anxiety relating to experiencing another panic attack, avoidance of locations and situations which precipitate symptoms of anxiety/panic, avoidance of social and recreational activity with friends and family members, avoidance of unfamiliar locations, anxiety related to

[5] ARD page 285.
[6] ARD page 286.
[7] ARD page 31.
[8] ARD page 32.

> having to enter unfamiliar workplace locations, anxiety in relation to travel to workplace locations in her car and travelling distances from her home …Karen has had the opportunity to find a suitable service dog (Nala) and has informally begun familiarising Nala with accompanying her in the car, accompanying her during social activities, during moments where symptoms of anxiety/panic have previously been precipitated, Karen has reported that she finds considerable comfort in having Nala beside her, being able to touch her soft fur and twirl her ears is particularly grounding and calming for Karen's anxiety/panic symptoms during specific moments. Based upon the ongoing symptoms that Karen is experiencing and the benefits that a service dog may provide specifically for these ongoing symptoms, I do recommend that a service dog be included as treatment, to address Karen's workplace injury."

**Associate Professor Michael Robertson, Consultant Psychiatrist**

27. Ms Patton's above extract was incorporated into the report of Associate Professor (A/Prof) Michael Robertson, Consultant Psychiatrist. He was retained as Mrs Bunce's medico-legal referee, and reported on 25 January 2019. He took a consistent history, noting the effect of the March 2017 incident which caused Mrs Bunce's mental state to deteriorate catastrophically in April 2017.

28. He noted Mrs Bunce's treatment with Ms Patton[9]:

> "The psychological therapy has involved various combinations of Imaginal Exposure In Vivo, In Vivo Exposure, Eye Movement Desensitisation and Reprocessing therapy. Recently the tenets of Acceptance and Commitment Therapy have been introduced into the treatment program. It seems that the well-conducted psychological therapy in combination with escitalopram, 20 mg has brought about some restitution in Mrs Bunce's symptoms to the point where she is able to attend to Emergency Planning and Response Unit duties involving travelling to multiple sites within the Area Health Service."

29. A/Prof Robertson noted that Mrs Bunce acquired Nala and "sought having her trained through Mind Dogs Australia". I interpolate to note that it is not clear whether A/Prof Robertson appreciated that Nala had experienced some training with that organisation during 2018.

30. A/Prof Robertson reproduced the portions of Ms Patton's report of 26 August 2018 which I have reproduced above at [28].

31. He noted that Mrs Bunce had been with her husband for 20 years, married for 18 years and that the marriage was stable and supportive.

32. His diagnosis was[10]:

> "Mrs Bunce presents with a primary diagnosis of panic disorder with agoraphobia which reflects the view of her treating psychologist. There are some cross-cutting features of post-traumatic stress disorder."

33. A/Prof Robertson said[11]:

> "Mrs Bunce impresses as a resilient woman, who seemed to have endured a considerable store of traumatic stress dating from childhood but declined into a catastrophic state of psychological distress following a critical incident in April 2017. Per Mrs Bunce's account and that of her psychologist, she has engaged well in

[9] ARD page 36
[10] ARD page 39
[11] ARD page 39

psychological therapy that has been extremely successful in enabling her to return to modified duties. Indeed it is remarkable to note that she has been able to return to multi-site work given the degree of phobic anxiety she has experienced.

On the question of an assistance dog as being categorised as 'reasonable medical treatment', I disagree with the position taken by the insurer. The presumption underlying their position is that 'deficiency of evidence is evidence of deficiency'."

34. A/Prof Robertson then gave a most interesting and informative opinion regarding the respective positions taken by Dr Ng and himself. He said:

> "Much of what is considered psychiatric treatment is conducted on a limited evidence base including many of the quite costly psychotherapy treatment programs routinely funded by insurers. The efficacy of anti-depressant medication has a weak evidence base, as it is apparent from meta-analyses that antidepressants minimally distinguish from placebo."

35. A/Prof Robertson referred to Kirsch I, et al (2008) Initial severity and antidepressant benefits: a meta-analysis of data submitted to the Food and Drug Administration. PLoS Med, 5(2):e45.

36. He also referred to funding given by insurers for exercise programs, again on a comparatively equivocal evidence base, which he argued had the same level of evidence of efficacy as for companion animals. He referred to Rimer J, et al (2012). Exercise for depression. Cochrane Database Syst Rev 11 (7):CD004366 as authority for that proposition. He referred to other studies which demonstrated that there was some support for the proposition that companion animals were a beneficial form of therapy.

37. A/Prof Robertson commented:[12]

> "Beyond this *tu quo que* argument, there is sufficient evidence to indicate that through therapeutic gains, this patient has been able to return to limited hours of employment. This progress can be built upon through an assistance dog to augment the gains she has made in psychotherapy. The alternative is permanent restrictions to hours or the potential failure of this current process of return to work after a catastrophic psychological injury. Ultimately I have taken a pragmatic view that provision of a assistance dog appears to have enabled this patient to re-engage with employment and improve on her clinical progress."

38. He said:[13]

> "Mrs Bunce will require ongoing treatment with her psychologist. I would recommend at some point she consult a psychiatrist about the adequacy of her pharmacotherapy but the mainstay of treatment has been psychological therapy which has proven to be most effective."

**Dr Bradley Ng, Consultant Psychiatrist**

39. The respondent relied upon the report of Dr Bradley Ng dated 31 July 2018. Dr Ng did not interview Mrs Bunce but rather gave a report based on questions asked of him by the respondent's insurers. He was asked to assume that QBE had been requested to pay for an assistance dog and his opinion was sought as to whether such assistance was reasonably necessary treatment. He was asked to comment on firstly on whether a particular treatment was appropriate. In that regard Dr Ng acknowledged that service dogs amongst Veterans

[12] ARD page 44.
[13] ARD page 43.

suffering from Post-Traumatic Stress Disorder and other mental illnesses was known in Australia, and it was not uncommon to find a Veteran accompanied by such a dog. He said:[14]

> "There is face validity to such an idea and indeed it is a very attractive idea. It is a unique treatment that on the surface probably has no major side effects. However, the cost of it is quite significant and the evidence base is lacking."

40. With regard to the evidence base, Dr Ng referred to *Australian Guidelines for the Treatment of Acute Stress Disorder and Post Traumatic Stress Disorder* published by Phoenix Australia in 2013. Dr Ng noted that service or companion dogs (or for that matter, pets), were not mentioned in those guidelines, which were however quite dated. Dr Ng said that those studies that were more recent, whilst being suggestive of most positive results, had small sample sizes and were not randomised trials with a suitable comparator. He referred to a questionnaire study by Yarborough et al (*An Observational Study of Service Dogs for Veterans for Post Traumatic Stress Disorders*. *Psychiatric Services* 2017; 68: 730-734).

41. A further study referred to by Dr Ng was Vincent et al (*Effectiveness of Service Dogs for Veterans with PTSD: Preliminary Outcomes. Studies in Health Technology and Informatics* 2017; 242: 130-6).

42. Dr Ng also referred to the O'Haire and Rodriguez paper referred to by A/Prof Robertson. Dr Ng regarded it as a "very encouraging non-randomised efficacy trial" which compared service dogs with the usual care for Veterans suffering from those conditions. It emphasised symptom reduction and increased functioning, but did not establish any change in employment status. In "Psychology Today" on 15 February 2018 an editorial by Hal Herzog cautioned the robustness of the report, whilst being optimistic.

43. The authors of that study highlighted many limitations, but concluded there was preliminary evidence to warrant further trials.

44. Dr Ng also referred to a review conducted by La Trobe University entitled "*Reviewing Assistance Animal Effectiveness, Final Report to the National Disability Insurance Agency*", published in 2016. The test was based on small sample sizes and methodological limitations which made it difficult to draw any positive conclusions. On three qualitative studies made, positive results were found.

45. Dr Ng concluded that whilst a service dog or companion dog was "a very attractive idea", it was not mainstream accepted medical practice. There was no strong evidence that service dogs affect the employment status. Moreover the studies had been focused on military personnel.

46. Dr Ng considered however that there was certainly preliminary evidence that it was a very attractive idea with some face validity. That did not however equate to solid evidence based research.

47. The second subject Dr Ng was invited to address was the availability of alternative treatment and Dr Ng referred to treatment such as psychiatric treatment, medication, group psychology therapy and neurostimulation treatment.

48. As to the cost of the treatment Dr Ng indicated that the cost of standard psychiatric treatment, post traumatic stress disorder and anxiety disorders would be already known to the solicitors. He said service and companion dogs had the potential to attract very high costs. Dr Ng acknowledged however that the costs quoted were not unreasonable.

[14] Reply page 4.

49. As to the actual effectiveness of the treatment Dr Ng accepted that there was a solid evidence base that standard psychiatric/psychological treatments are effective, although there remained a high degree of disability and comorbidity. Dr Ng said that in contrast the evidence for service and companion dogs suggested some benefits in symptomatology but no marked improvement in functioning and even change in employment status. He said:[15]

> "This is with less than robust non-randomised clinical evidence. Therefore, in my opinion, there is no solid evidence base to suggest that service or companion dogs are markedly effective."

50. Dr Ng then said:

> "What complicates Ms Bunce's matter is the potential for an assistance dog to be in an emergency department. That is just not practical. I would be very surprised if management of an emergency department and a hospital would allow a service assistance dog in any emergency department by an employee. This would need to be cleared on multiple levels, and I would like to see the documentation if such advice was confirmed."

51. In answer to question as to whether the treatment was accepted by medical experts, Dr Ng said that the literature did not indicate that service or companion dogs were a mainstream treatment. Dr Ng repeated that the published papers were only preliminary evidence, in the case of the O'Haire and Rodriguez report, and that the optimism in "Psychology Today" by Howe Herzog of 15 February 2018 needed to be tempered by some caution at the robustness of the research as well.

52. Dr Ng also said that the use of service companion dogs in military veterans was a very different scenario from that of non-military personnel.

**Recare Services, Occupational Therapists**

53. Mrs Bunce relied on a report dated 28 October 2019 from Recare Services, written by Ms Kira Ferry, Occupational Therapist and Mr Martin Hollings, Supervising Psychologist.[16] They reported:

> "Ms Bunce advised that she was not allowed to take her assistance dog to work with her due to guidelines set by her workplace. She advised that she had developed other coping strategies over time but believed that if her assistance dog was able to accompany her she would be able to perform her pre-injury role with minimal difficulties."

54. The authors noted that Mrs Bunce drove her own automatic car for up to 40 minutes, and that she was always accompanied by her assistance dog, "unless travelling to and from work as the dog was not allowed to attend her workplace." They further recorded that Mrs Bunce was able to shop within a 40 minute radius of her home with her assistance dog, but not without such company.

55. "The core role of an occupational therapist," the authors wrote, "is to facilitate a client's ability to independently engage in their daily occupations." They put the price of purchase of an assistance dog at $2,000 (Mrs Bunce in fact paid ~~$1,100~~). Other costs were assessed at $650 annually, averaged over the life of the dog.

[15] Reply page 6.
[16] ARD page 46.

56. An application for review was declined pursuant to s 287A of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) on 31 July 2019[17]. The matters disputed were that an assistant dog was not "medical related treatment" as defined in s 59 of the 1987 Act. It also denied liability on the basis that such a treatment was not reasonably necessary pursuant to s 60 of the 1987 Act. It further submitted that the employer was not liable because of the provisions of s 60(2A) of the 1987 Act.

57. In both the s 74 and s 287A notices reference was made to a quote provided by a Ms Eve McKenzie. Ms McKenzie was certified in dog training and was a behaviour consultant with Dogaholics and, according to the notice, provided a quote of 5 April 2018 which said that training and testing of the assistance dog would be $4,625 for one year and $7,875 for two years. That quote was not in evidence.

**SUBMISSIONS**

**Mr Tony Baker**

58. Mr Baker submitted there were two aspects to the case and referred to the s 74 notice. He referred to the psychological condition. He submitted that s 59 did not envisage the provision of services of an assistance dog. He said that the only possible subparagraphs were either (b) or (e) relating to therapeutic treatment or the provision of a curative apparatus respectively.

59. He submitted firstly that the recommendation being made by the psychologist disqualified the application of s 59(b) as a clinical psychologist was not a medical practitioner. He said it was intrinsic within the definition of a medical practitioner that such a person be entitled to prescribe treatment. Although clinical psychologists offered techniques in support of therapy, such a practitioner was not able to make prescriptions in the form of medication or other treatment, he contended, and accordingly could not be described as medical practitioner.

60. Mr Baker referred to the report of Dr Cordowiner dated 18 August 2018, and submitted that Dr Cordowiner did not direct that the provision of an assistant dog was required as medical treatment. Dr Cordowiner simply endorsed the idea.

61. He referred to the report of A/Prof Robertson noting the applicant was currently working and had been in receipt of well conducted psychological therapy, from which she had made significant gains.

62. Mr Baker submitted that just having a dog as a pet did not qualify as therapy. He submitted that Dr Robertson did not address the question of s 59(b) as to whether the therapeutic treatment had been given by direction of a medical practitioner, but rather concentrated on dealing with the question of the whether the assistance was reasonably necessary.

63. He submitted that the deficiency in Mrs Bunce's case in any event was not as to reasonable necessity, but rather that Mrs Bunce had not satisfied her onus to prove that the provision of an assistance dog was "therapeutic treatment".

64. Mr Baker referred to Dr Robertson's concession that there was a limited evidence base with regard to psychiatric treatment and the efficacy of anti-depressant medication. He referred to Dr Robertson's opinion that the mainstay of Mrs Bunce's treatment had been psychological therapy and pharmacotherapy.

[17] Reply page 8.

65. Mr Baker submitted that Dr Robertson thereby conceded that the treatment given by Ms Patton was the most effective treatment. He submitted that Dr Robertson at no point said that the provision of an assistant dog was appropriate treatment within the definition of s 59(b). He submitted that the argument advanced by Dr Robertson that just as there is a limited evidence base for the effectiveness of a companion dog, so there was an inadequate evidence base for the effectiveness of psychotherapy treatment, was unacceptable

66. Mr Baker argued that that argument by Dr Robertson did not address the fundamental issue in the case which was whether the proposed treatment complied with s 59(b).

67. Mr Baker referred to the occupational therapist report from "Recare Services." He submitted that the cost estimate of $7,500 for the provision of food and vet care was an unrealistic figure. He submitted that the eventual cost of having a service dog could be more expensive, and the potential cost was untested as a medical treatment.

68. Mr Baker relied on A/Prof Robertson's opinion that the present psychological therapy had been proven to be the most effective, although with the rider that there should be a referral to a psychiatrist about the adequacy of her pharmacotherapy. Mr Baker argued that although A/Prof Robertson was asked to give a medico-legal opinion regarding the provision of an assistance dog, he failed to mention that in his report.

69. Mr Baker referred to the evidence that Mrs Bunce was not allowed to take her assistance dog to work with her due to workplace guidelines. Mr Baker submitted that if, as it appeared to be the case, Mrs Bunce was not permitted to have her assistance dog at work with her, it followed that she had not established that having such a dog was a necessary therapeutic treatment tool. Mrs Bunce was already able to perform her current duties. A prime therapeutic value of having such a dog would be to enable a return to work. Mrs Bunce had already achieved that, without needing her dog to be with her.

70. Accordingly, Mr Baker submitted, the various recommendations that the provision of an assistance dog would provide Mrs Bunce with a tool to distract her from the situations that triggered anxiety and panic attacks, and would provide her with confidence to participate in daily occupations, was an indulgence, rather than a therapeutic necessity.

71. Mr Baker relied on the report of Dr Ng that the provision of an assistance dog was not an accepted mainstream treatment of psychological injury, and that there was no solid evidence base established to show that service or companion dogs were effective. The evidence was largely anecdotal and not of such weight as to support the proposition that an assistance dog was therapeutic treatment within the definition referred to in s 59(b).

72. Mr Baker referred to an Arbitral Decision of Arbitrator Phillip Young in *Damien Parsons v Corrective Services NSW*.[18] This determination was lodged by the applicant as part of the ARD, and concerned a successful claim that the provision of an assistance dog was reasonably necessary medical treatment.

73. Mr Baker submitted that the present case was distinguishable, as the issue as to whether the provision of an assistance dog was "therapeutic treatment" as defined in s 59(b) had not been raised. Mr Baker relied on a case cited within *Parsons*, *Western Suburbs Leagues Club Illlawarra, Ltd v Everill,* [19] in support of his submission that I would not be satisfied that Mrs Bunce's claim related to "medical treatment" as defined by the Court in that case.

[18] [2018] NSW WCC 227 (*Parsons*).
[19] [2001] NSWCA 56 (*Everill*).

74. Mr Baker submitted that I would not be satisfied either that Mrs Bunce had established that her claim for medical treatment was reasonably necessary. He submitted that A/Prof Robertson had not included the provision of an assistance dog as being reasonably necessary in his report of 25 January 2019. His argument was circuitous, Mr Baker contended, and did not deal with the issue.

75. Mr Baker expanded on his argument that A/Prof Robertson found that the psychological treatment already given had effectively treated her condition. The benefit of Mrs Bunce's psychological treatment had been achieved by virtue of the various psychological therapies administered by Ms Patton, independently of any additional benefit that might have been achieved by the fact that Mrs Bunce had a pet dog. Moreover, he argued that I would not be satisfied that the potential cost of an assistance dog was reasonable, when compared to the alternative treatment Mrs Bunce had already received.

**Mr Bruce McManamey**

76. Mr McManamey referred to the provisions of s 59, and accepted that the definition of "medical or related treatment" as therein defined by sub-paragraphs (a) to (g) were exhaustive and determinative.

77. Mr McManamey conceded that the relevant description relating to the provision of an assistance dog was under "therapeutic treatment" pursuant to s 59(b). He emphasised that the treatment was defined as "therapeutic", and not "medical." Mr McManamey submitted that a psychologist was a "medical practitioner" as required by the sub-paragraph, as Ms Patton was clearly registered by virtue of her having the provider number which she gave under her signature at ARD page 32. This related to the provisions of the *Commonwealth Income Tax Assessment Act 1970*, which included the current Medicare provisions, in respect of which Ms Patton's provider number had been issued.

78. Mr McManamey submitted that I would accept A/Prof Robertson's diagnosis that Mrs Bunce was suffering from a primary diagnosis of panic disorder with agoraphobia with "cross cutting" features of PTSD. I was referred to the report of Ms Bell (which Mr McManamey observed was the respondent's document) that having dogs in the car when travelling assisted Mrs Bunce's condition.

79. Moreover, Ms Bell had also supplied the definition of an assistance dog as set out in the Commonwealth Disability Discrimination Act 1992, and that it can be taken to the workplace, in much the same way as a seeing eye dog can.

80. At this point I indicated that I would be assisted by hearing more detail from Mrs Bunce herself, as I mentioned earlier in these reasons. Mr McManamey then submitted that I had before me qualitative evidence of the therapeutic benefit of the assistance dog.

81. Mr McManamey submitted that I would accept the opinion of A/Prof Robertson. Dr Ng had not examined Mrs Bunce and had no history of the effectiveness of the relationship between her dog and the amelioration of her symptoms had been taken by him.

**DISCUSSION**

**Reasonably necessary**

82. Section 60 of the 1987 Act provides relevantly:

> **"60 COMPENSATION FOR COST OF MEDICAL OR HOSPITAL TREATMENT AND REHABILITATION ETC**
>
> (1) If, as a result of an injury received by a worker, it is reasonably necessary that--

(a) any medical or related treatment (other than domestic assistance) be given, or
(b) any hospital treatment be given, or
(c) any ambulance service be provided, or
(d) any workplace rehabilitation service be provided, the worker's employer is liable to pay, in addition to any other compensation under this Act, the cost of that treatment or service and the related travel expenses specified in subsection (2).

….

(2) ….

(2A) The worker's employer is not liable under this section to pay the cost of any treatment or service (or related travel expenses) if--

(a) the treatment or service is given or provided without the prior approval of the insurer (not including treatment provided within 48 hours of the injury happening and not including treatment or service that is exempt under the Workers Compensation Guidelines from the requirement for prior insurer approval), or

(b) the treatment or service is given or provided by a person who is not appropriately qualified to give or provide the treatment or service, or

(c) ….
(d)

(2B) …..

(2C) The Workers Compensation Guidelines may make provision for or with respect to the following--

(a) establishing rules to be applied in determining whether it is reasonably necessary for a treatment or service to be given or provided,

(b) limiting the kinds of treatment and service (and related travel expenses) that an employer is liable to pay the cost of under this section,

(c) limiting the amount for which an employer is liable to pay under this section for any particular treatment or service,

(d) establishing standard treatment plans for the treatment of particular injuries or classes of injury,

(e) specifying the qualifications or experience that a person requires to be **'appropriately qualified'** for the purposes of this section to give or provide a treatment or service to an injured worker (including by providing that a person is not appropriately qualified unless approved or accredited by the Authority).

(3) ….
(4) ….
(5) …."

83. The insurer submitted that the provisions of s 60(2A(b) applied, as the applicant did not obtain prior approval of the insurer. This issue has been considered many times by the Commission.[20] Part 4 of the SIRA Workers Compensation 2019 reflects previous guidelines. By Table 4.2, an applicant is exempt if he/she has a determination from the Commission that any disputed treatment was payable. As will be seen, I shall make that determination.

84. I was not referred to any provision in the Guidelines that limited the kind of treatment here under consideration pursuant to s 60(2C)(b), and accordingly the ordinary principles regarding whether the provision and maintenance of an assistance dog is reasonably necessary, apply. The principles regarding s 60(1) are well known, and were summarised by DP Roche in *Diab v NRMA Ltd.*[21] The learned DP said from [86] (I have omitted the case citations in this passage):

> "86. Reasonably necessary does not mean 'absolutely necessary' (*Moorebank* at [154]). If something is 'necessary', in the sense of indispensable, it will be 'reasonably necessary'. That is because reasonably necessary is a lesser requirement than 'necessary'. Depending on the circumstances, a range of different treatments may qualify as 'reasonably necessary' and a worker only has to establish that the treatment claimed is one of those treatments. A worker certainly does not have to establish that the treatment is "reasonable and necessary", which is a significantly more demanding test that many insurers and doctors apply…
>
> 87. Giles JA added (at [49] in *O'Shea*) that the qualification whereby the necessity must be reasonable calls for an assessment of the necessity having regard to all relevant matters, according to the criteria of reasonableness. His Honour was talking in the context of whether an easement should be granted under s 88K of the *Conveyancing Act* 1919, which provides that 'the Court may make an order imposing an easement over land if the easement is reasonably necessary for the effective use or development of other land that will have the benefit of the easement'. However, his Honour's observations are applicable in the present matter and are clearly consistent with *Clampett*.
>
> 88. In the context of s 60, the relevant matters, according to the criteria of reasonableness, include, but are not necessarily limited to, the matters noted by Burke CCJ at point (5) in *Rose* (see [76] above), namely:
>
> (a) the appropriateness of the particular treatment;
>
> (b) the availability of alternative treatment, and its potential effectiveness;
>
> (c) the cost of the treatment;
>
> (d) the actual or potential effectiveness of the treatment, and
>
> (e) the acceptance by medical experts of the treatment as being appropriate and likely to be effective.
>
> 89. With respect to point (d), it should be noted that while the effectiveness of the treatment is relevant to whether the treatment was reasonably necessary, it is certainly not determinative. The evidence may show that the same outcome could be achieved by a different treatment, but at a much lower cost. Similarly, bearing in mind that all treatment, especially surgery, carries a risk of a less than

[20] See *Qantas Airways v Gittoes* [2017] NSWWCCPD 8.
[21] [2014] NSWWCCPD 72.

ideal result, a poor outcome does not necessarily mean that the treatment was not reasonably necessary. As always, each case will depend on its facts.

90. While the above matters are 'useful heads for consideration', the 'essential question remains whether the treatment was reasonably necessary' (*Margaroff v Cordon Bleu Cookware Pty Ltd* [1997] NSWCC 13; (1997) 15 NSWCCR 204 at 208C). Thus, it is not simply a matter of asking, as was suggested in *Bartolo*, is it better that the worker have the treatment or not. As noted by French CJ and Gummow J at [58] in *Spencer v Commonwealth of Australia* [2010] HCA 28, when dealing with how the expression 'no reasonable prospect' should be understood, '[n]o paraphrase of the expression can be adopted as a sufficient explanation of its operation, let alone definition of its content'."

85. Dr Ng thoughtfully addressed the categories outlined in [80] above. As to appropriateness, he endorsed the proposed treatment by acknowledging its face validity and its appeal as a "very attractive idea".

86. He discussed the potential effectiveness and availability of alternative treatment by referring to the evidence base regarding this type of treatment, saying that its effectiveness could not be judged generally as the literature was based on limited studies, although the preliminary results were encouraging. The studies concerning war veterans were particularly encouraging in producing improved outcomes for PTSD sufferers.

87. A/Prof Robertson's opinion was similar. He acknowledged that there was a small evidence base on which to make a generalised opinion, but argued that so too was there a small evidence base on which the "quite costly" psychotherapy treatment programs routinely funded by insurers was founded. He said that the efficacy of anti-depressant medication had a weak evidence base, as indeed did the exercise programs also funded by insurers, the latter which had the same evidence of efficacy as that for companion animals.

88. Notwithstanding such reservations as to the small evidence base for the effectiveness of treatment by the supply of an assistance dog, there was unanimity amongst all the medical professionals that in this case, there was a therapeutic benefit in the treatment of Mrs Bunce's condition by the presence of her dog.

89. Mr Baker argued that the supply of an assistance dog was in effect surplus to requirements, as the alternative therapies Mrs Bunce had undergone had been effective, and A/Prof Robertson did not refer to the presence of the assistance dog as part of the alternative therapies.

90. It is correct that A/Prof Robertson described the psychological therapy administered by Ms Patton as being "well-conducted" and that it had brought about an improvement in Mrs Bunce's symptoms to the extent that she was able to attend to Emergency Planning and Response Unit duties involving travelling to multiple sites within the Area Health Service. A/Prof Robertson commented that it was "remarkable" that she had been able to return to such duties, given the degree of phobic anxiety she had experienced.

91. It is also correct that A/Prof Robertson described the therapies administered by Ms Patton without referring to the assistance dog. It is apparent that he was aware that Mrs Bunce had an assistance dog when he wrote that opinion, as he reproduced a portion of Ms Patton's report that related the benefit Mrs Bunce obtained from having her dog in the car with her when travelling.

92. However, I do not agree however that I should interpret A/Prof Robertson's comments as supportive of the submission that the therapeutic regime he identified therefore excluded the supply of an assistance dog. A/Prof Robertson did not seem to be aware that the animal had indeed already had a degree of training by Mind Dogs Australia. His opinion was that he had ultimately taken a pragmatic view that the presence of her dog had "enabled this patient to re-engage with employment and improve on her clinical progress".

93. I concur with A/Prof Robertson that the question as to whether there was available alternative treatment and its potential effectiveness does produce a *tu quoque* argument. He agreed that there was a small evidence base for the effectiveness of an assistance dog, but replied that so too was there a small evidence base for the effectiveness of psychiatric treatment routinely funded by insurers. The relevant question thus becomes whether the alternative treatment and its potential effectiveness renders the additional therapy proposed - the assistance dog - unreasonable. I do not think it does. There is clearly a benefit conveyed to Mrs Bunce in the calming and comforting presence of the dog when she is driving. The alternative treatment does not provide that benefit, and it is reasonable for her to have it, as it assists her to do the travelling that A/Prof Robertson found so remarkable, given the extent of her phobic anxiety.

94. Although argument was advanced that the cost of the provision of an assistance dog was prohibitively high, there was no evidence before me to that effect. Whilst the ss 74 and 287A Notices referred to a quote provided by Ms Eve McKenzie, it was not before me. The only evidence of cost came from Ms Bell in her report of 4 April 2018, which came to a total of $7,895 over the life of the dog. No evidence was given as to what the anticipated lifespan of Mrs Bunce's dog was, but assuming it to be 10 years, that amounts to an annual sum of $78.95. I do not find that to be unreasonable.

95. For the reasons given regarding the availability and effectiveness of alternative treatment I find that the actual effectiveness has been demonstrated. Mrs Bunce said she obtains great benefit from her assistance dog, Ms Patton confirmed that statement, and A/Prof Robertson also endorsed the benefit Mrs Bunce was actually receiving.

96. Dr Ng did not see Mrs Bunce and, in the circumstances where she had already been using the proposed therapy to her advantage, the weight to be given to his opinion, inasmuch as it could be seen to be negative, is minimal. Dr Ng's main objection was that Mrs Bunce's dog would not be allowed into an emergency department where Mrs Bunce used to work, in any event. Allied to that barrier was his opinion that in the literature he referred to, the provision of an assistance dog had not resulted in a return to full employment in any of the cases surveyed. The test to be applied, however, is not whether the proposed treatment was reasonably necessary to return an injured worker to his/her pre-injury employment. The section is concerned with reasonably necessary medical treatment for the particular injury in order to ameliorate the symptoms it caused.

97. Seen in that context, the evidence of the medical experts is unanimous that the proposed treatment was appropriate, and likely to be effective – indeed was actually effective.

98. Accordingly I would find that the proposed treatment was reasonably necessary.

**Medical Treatment**

99. Section 59 of the 1987 Act provides relevantly:

> **"'medical or related treatment'** includes--
>
> (a) treatment by a medical practitioner, a registered dentist, a dental prosthetist, a registered physiotherapist, a chiropractor, an osteopath, a masseur, a remedial medical gymnast or a speech therapist,
> (b) therapeutic treatment given by direction of a medical practitioner,
> (d) ….
> (e) ….
> (f) ….
> (f1) ….
> (g) ….

(h) treatment or other thing prescribed by the regulations as medical or related treatment, but does not include ambulance service, hospital treatment or workplace rehabilitation service."

100. It was agreed that the supply of an assistance dog could only be covered by the definition contained (b), above. Mr Baker's suggestion that a "curative apparatus" was another possible definition was not pressed.

101. Mr Baker submitted that Mrs Bunce had not established that the treatment had been given at the direction of a medical practitioner, as Ms Patton, who had given the direction, was a psychologist. Ms Patton was not a medical practitioner, Mr Baker asserted, as she was not authorised to give prescriptive medication. No authority was given for that proposition, and indeed the term "medical practitioner" has not been defined in either the 1987 or the 1998 Acts.

102. When considering the term in 1997, Burke J said in *Bartolo v Western Sydney Health Service*[22]:

> "'Medical practitioner' is defined to mean a medical practitioner registered under the law of a State or Territory of the Commonwealth."

103. However, His Honour did not refer to the authority for that proposition, and it may be that such a definition is no longer apposite. In any event, I am satisfied that it was the letter of 7 March 2018 from Ms Patton that Mrs Bunce relied upon to make her claim, and that it was therefore Ms Patton who gave the direction. Again, in regard to the term "direction" Burke J said in *Bartolo*:

> "'Direction' in the context of paragraph (b), in my view, has much the same connotation as the more commonly used 'referral'. Direction usually connotes an order, requirement, command or instruction. The doctor/patient relationship has not as yet come to the stage where the doctor can order the patient to do anything. He advises, and, in this type of situation, if the advice is accepted, he refers the patient for appropriate tests, investigations or active treatment."

104. I accept that the provider number supplied by Ms Patton is an indication that she was duly registered pursuant to the *Commonwealth Income Tax Assessment Act 1970* for the purposes of psychological treatment under the Medicare system, and that I can infer that she was a medical practitioner for the purposes of s 59(b).

105. I am satisfied that the treatment was therapeutic. Although Mr Baker submitted that it was not "medical" treatment as described in the sub-heading of the s 59 definition, the use of the word "therapeutic" at s 59(b) puts the matter beyond doubt. Again, all the medical professionals agreed that having an assistance dog was therapeutic to Mrs Bunce's psychological condition. It is correct that A/Prof Robertson did not address the terms of s 59(b), but as I have indicated, he found that Mrs Bunce's assistance dog performed a therapeutic role in her being able to travel confidently.

***Parsons***

106. Finally, I concur with Arbitrator Young in *Parsons* that an assistance dog can be a reasonably necessary medical treatment. I note his comments as to the effect that s 59(b) would have had on the proceedings, had it been raised in defence. Each case must be decided on its merits, and the facts the learned Arbitrator was considering were different from those before me. That is in itself a distinguishing factor. Moreover, his comments regarding the application of s 59 were obiter in any event.

[22] [1997] NSWCC 1.

107. That said, the learned Arbitrator's conclusion that the treatment by way of assistance dog was not within the exhaustive definition of "medical treatment" provided by s 59(a-g), I respectfully disagree with. Section 59(b) specifically defines therapeutic treatment as a form of medical treatment, subject to the proviso regarding "direction."

110. For these reasons I find that the psychological treatment afforded Mrs Bunce by way of the supply of an assistance dog is "therapeutic treatment" as defined by s 59(b) of the 1987 Act.

111. I find also that the psychological treatment afforded Mrs Bunce by way of the supply of an assistance dog is reasonable necessary medical treatment,

112. Accordingly the respondent will pay for the cost of and reasonably associated with the provision and maintenance of an assistant dog. Such a dog has been variously described as a companion dog, a therapy dog, or a service dog. I have used the term "assistance dog" to cover all such descriptions.