COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (ACT NO 130 OF 1993)

REGULATIONS ON POST-TRAUMATIC STRESS DISORDER FOR THE COMPENSATION FUND MADE UNDER COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

The Minister of Employment and Labour, after consultation with the Compensation Board, has made the regulations under section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No 130 of 1993) in Schedule A. These regulations are published for public comments only.

Interested and affected parties are hereby invited to submit written representations on the proposed Regulations. The aforesaid representations must be marked for the attention of **Mr TH Maphologela** and sent by registered post or emailed or hand delivered within 60 days of publication of this notice to the following addresses:

Compensation Fund
167 Thabo Sehume Street
Pretoria
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PO Box 955
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Email addresses: Kimbly.Makgoba@labour.gov.za or Harry.Maphologela@labour.gov.za

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Copies of the Regulations are herewith attached.

MR TW NXESI, MP
MINISTER OF EMPLOYMENT AND LABOUR
DATE: 26/03/2020

SCHEDULE A

REGULATIONS ON POST-TRAUMATIC STRESS DISORDER FOR THE COMPENSATION FUND MADE UNDER THE COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

ARRANGEMENT OF REGULATIONS

1. Definitions

In these regulations, a word or expression to which a meaning has been assigned in the Act or these Regulations shall have the meaning so assigned and, unless the context otherwise indicates—

causality" means an association between a given cause and an effect, which requires that each of the following criteria is met to a reasonable degree of medical probability:

(a) a causal event took place;

(b) the person who experienced the event has the condition, that occurred as a result of an injury, impairment or disease;

(c) the event could cause the condition; and

(d) the event caused or materially contributed to the condition within medical probability.

"**chronology**" means the medico-legal phenomenon that requires that the series of events leading to the event, incident, injury or occupational disease must have a chronological sequence that justifies the link to the cause. In essence, the cause must precede the effect;

"**Clinician Administered PTSD Scale (CAPS)**" means a semi-structured interview that is designed to assess the essential features of Acute Stress Disorder and Post-traumatic Stress Disorder as defined in the DSM-IV and DSM-V and as edited or

revised from time to time by the American Psychiatric Association, 1994. In addition, the CAPS can also be used to assess the essential features of Acute Stress Disorder as currently defined by DSM-IV. The interview is designed to accommodate different time spans post-trauma as the referent point for diagnosis.

Specifically, the CAPS affords the clinician flexibility to inquire about symptoms and diagnostic status over the past week, most recent month, and or for lifetime diagnosis;

"**Evidence-based Medicine (EBM)**" means the conscientious, explicit, judicious and reasonable use of modern, best evidence in making decisions about the care of individual patients and a movement which aims to increase the use of high quality clinical research in clinical decision-making;

"**Independent Medical Examination (IME)**" means an examination for legal, insurance or financial reasons completed by a non-treating physician, who will not be involved in any further treatment or care of the beneficiary beyond the examination;;

"**managed healthcare**" means the clinical and financial risk assessment and management of healthcare through use of rule-based & clinical management based programmes;

"**Man-Job Specifications Traumatic Incident**" means any event that has significant emotional power , which involves any situation or event faced by emergency or public safety personnel, that causes a distressing, dramatic or profound change or disruption in their physical and or psychological functioning;

"**Maximum Medical Improvement (MMI)**" means a status where a patient is fully recovered and the treating medical practitioner is satisfied that no further improvement is anticipated on available surgical or medical treatment..The MMI is reached on a date from which further recovery or deterioration is not anticipated,

although over time there may be some expected changes;

"**medical probability**" means the link between the cause and effect which must satisfy the requirements for medical probability, which stipulates that the likelihood that an association between a cause and an effect be greater than 95% for the relationship to be considered probable. Anything below that is medically just "possible";

"**Occupational Risk Exposure Profile (OREP)**" means the report that profiles all the hazards an employee is exposed to, which are inherent to his or her occupation. These hazards are linked to the inherent requirements of the job and the inherent tasks and duties of the job. They include exposure to physical, chemical, biological, psychological and ergonomic hazards;

"**permanency**" means the condition whereby an impairment or disablement becomes static or well stabilised with or without medical treatment and is not likely to remit in the future despite medical treatment, within medical probability;

"**Post-Traumatic Stress Disorder(PTSD)**"means a mental disorder that represents a pathological response to a traumatic event, characterised by symptoms of recurrent and intrusive distressing recollections of the event namely nightmares, a sense of reliving the experience with illusions, hallucinations or dissociative flashback episodes, intense psychological or physiological distress at exposure to cues that resemble the traumatic event; avoidance of stimuli associated with the trauma ,e.g. inability to recall important aspects of the trauma, loss of interest, estrangement from others and increased arousal sleep disturbances, irritability, difficulty in concentrating, hyper vigilance, and exaggerated startle response;

The DSM–V Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of the four symptom

clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. It follows exposure to actual or threatened death, serious injury or sexual violation. The exposure must result from one or more of the following scenarios in which an employee:

(a) directly experiences, witnesses the traumatic event in person, or was confronted with an event or events that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others;

(b) learns that a violent or accidental, traumatic event occurred to a close family member or close friend;

(c) experiences first-hand repeated or extreme exposure to aversive details of the traumatic event, not through media, pictures, television or movies unless work-related and the condition causes significant distress or impairment in the employee's social, occupational, or other important areas of functioning; and

(d) the person's response involves intense fear, helplessness, or horror.

"Regulations" means the Regulations on Post-Traumatic Stress Disorder for the Compensation Fund made under the Compensation for Occupational Injuries and Diseases Act, 1993;

"traumatic event" means an event that is generally outside the range of usual human experience and would evoke significant symptoms of distress in the majority of people exposed. It is an intensely stressful event during which a person suffers serious harm or the threat of serious harm or death, or witnesses an event during which another person or persons is killed, seriously injured or threatened.

2. Diagnosis of PTSD

(1) Clinical diagnosis of medical conditions, including PTSD, must be based on approved evidence-based medical guidelines as guided by the medical scientific community as updated from time to time. The ICD-10 diagnosis of PTSD requires that the patient, firstly, must have been exposed to a traumatic event and secondly, suffers from distressing re-experiencing symptoms. For the purpose of these regulations, the diagnosis of PTSD must be made in accordance with the latest applicable version of the Diagnostic & Statistical Manual of Mental Disorders for PTSD.

(2) Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood and alterations in arousal and reactivity. Criterion F concerns duration of symptoms; Criterion G assesses functioning and Criterion H clarifies symptoms as not attributable to a substance or co-occurring medical condition.

(3) All suspected PTSD cases must be referred to a psychiatrist for assessment and confirmation of diagnosis within three (3) months from the date of the provisional diagnosis or date of accident or traumatic incident. The Medical Officers in the Compensation Fund, shall determine if the diagnostic analysis was reached in accordance with the acceptable medical standards.

3. The DSM-V Diagnostic Criteria

The DSM-V Diagnostic Criteria are stipulated below and must be used and met in all cases of suspected PTSD.

Note: The latest edition of the DSM must always be used.

Criterion A: Stressor

Where a person was exposed to: death, threatened death, actual or threatened serious injury or actual or threatened sexual violence in one or more of the following circumstances:

(a) direct exposure;

(b) witnessing, in person;

(c) indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental in nature;

(d) repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties, for example, first responders, collecting body parts; professionals repeatedly exposed to details of child abuse; and

(e) excluding indirect non-professional exposure through electronic media, television, movies, or pictures.

Criterion B: Intrusion symptoms

The traumatic event is persistently re-experienced in one or more of the following way(s):

(a) recurrent, involuntary and intrusive memories;

(b) traumatic nightmares;

(c) dissociative reactions, for example, flashbacks which may occur on a continuum from brief episodes to complete loss of consciousness;

(d) intense or prolonged distress after exposure to traumatic reminders; and

(e) marked physiological reactivity after exposure to trauma-related stimuli.

Criterion C: Avoidance

Persistently effortful avoidance of distressing trauma-related stimuli after the event in one or more of the following:

(a) trauma-related thoughts or feelings; and

(b) trauma-related external reminders, for example, people, places, conversations, activities, objects or situations.

Criterion D: Negative alterations in cognitions and mood

Negative alterations in cognitions and mood that began or worsened after the traumatic event, must be in two or more of the following indications:

(a) inability to recall key features of the traumatic event, usually a dissociative amnesia; not due to head injury, alcohol or drugs

(b) persistent and often distorted negative beliefs and expectations about oneself or the world, for example, . "I am bad," "The world is completely dangerous.";

(c) persistent distorted blame of self or others for causing the traumatic event or for resulting consequences;

(d) persistent negative trauma-related emotions, for example, fear, horror, anger, guilt or shame;

(e) markedly diminished interest in pre-traumatic significant activities;

(f) feeling alienated from others, for example, detachment or estrangement; and

(g) constricted affect or persistent inability to experience positive emotions.

Criterion E: Alterations in arousal and reactivity

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event in two or more of the following:

(a) irritable or aggressive behavior;

(b) self-destructive or reckless behavior;

(c) hyper vigilance;

(d) exaggerated startle response;

(e) problems in concentration; and

(f) sleep disturbance.

Criterion F: Duration

Persistence of symptoms in Criteria B, C, D and E for more than one (1) month.

Criterion G: Functional significance

Significant symptom-related distress or functional impairment, for example, social or occupational.

Criterion H: Attribution

(a) disturbance is not due to medication, substance use, or other illness, for example, organic causes; and

(b) it must be specified if it is associated with dissociative symptoms.

Additional Considerations

In addition to meeting criteria for diagnosis, individuals may experience high levels of either of the following in reaction to trauma-related stimuli:

(a) depersonalization: experience of being an outside observer of or detached from oneself, for example, feeling as if "this is not happening to me" or being in a dream; and

(b) derealisation: experience of unreality, distance, or distortion, for example, "things are not real"

4. PTSD as an Occupational Disease

(1) An occupational disease is defined as any disease arising out of and in the course of an employee's employment. A disease would have arisen out of and in the course of employment if it has a broad causal connection to employment and that the employee must have contracted the disease while performing duties that he or she is contractually obliged to perform.

(2) Compensable PTSD is regarded as the result of an occupational injury or an occupational disease depending on individual circumstances, in terms of the Act. Therefore, the traumatic event(s) leading to the diagnosis of PTSD must be an accident or a series of accidents as defined in section 1 of the Act.

(3) A claim for PTSD shall not be eligible for benefits under the Act unless:

(a) the employee was exposed to traumatic event(s) arising out of and in the course of employment;

(b) the employment-related trauma was a pertinent factor in the development of the PTSD or played an active role during the development of PTSD; and

(c) notice of the claim for compensation was made to the employer or the Compensation Commissioner or the employer individually liable or the

licensee concerned within one (1) year from date of diagnosis of occupational disease or PTSD.

(4) When delayed-onset PTSD is diagnosed, the claim will be considered if notice of the claim for compensation was made to the employer or Compensation Commissioner within one (1) year of the date of diagnosis.

5. Occupations at risk of PTSD

Whether or not people develop PTSD depends on their subjective perception of the traumatic event as well as on the objective facts. Furthermore, those at risk of PTSD include not only those who are directly affected by a horrific event, but also witnesses, perpetrators and those who help PTSD sufferers namely, vicarious traumatisation. People at risk of PTSD include but not limited to:

(a) victims of violent crime, for example, physical and sexual assaults, sexual abuse, bombings and riots.;

(b) members of the armed forces, police services, journalists and prison service, fire service, ambulance and emergency personnel, health care personnel, including those no longer in service;

(c) victims of war, torture, state-sanctioned violence or terrorism, and refugees;

(d) survivors of accidents and disasters; and

(e) women following traumatic childbirth and individuals diagnosed with life-threatening illnesses.

6. Evolutionary Stages of PTSD

(a) Acute Stress Disorder

In the first month after trauma, trauma survivors may be diagnosed as having Acute Stress Disorder according to DSM–V, which is characterised by symptoms of PTSD and dissociative symptoms such as depersonalisation, derealisation and emotional numbing. The duration which specifies the disturbance must last at least two days but not more than four weeks, and must occur within four weeks of the traumatic event. The symptoms must resolve within four weeks after the traumatic event, otherwise the diagnosis must be reconsidered.

(b) Acute PTSD

This type of PTSD is characterised by classic symptoms that appear in the first month after the traumatic event, but last for less than three months in duration.

(c) Classic PTSD

Classically, PTSD tends to develop insidiously over a period of three to six months after the initial traumatic event.

(d) Delayed-onset PTSD

(i) The symptoms of Delayed-onset PTSD must surface at least six months or more after the traumatic event(s); and

(ii) A proper medical and occupational history must be taken to ensure that diagnosis is objectively made. The assessment and treatment of late-onset PTSD must therefore follow the same protocols as the early-onset type.

(e) **Persistent or Chronic PTSD**

For the condition of PTSD to be regarded as permanent the employee must have received appropriate treatment for a period of 24 months or an extended period of time as a treating doctor may determine.

7. Differential Diagnosis

(1) The Fund may provide treatment for the aggravation of pre-existing PTSD if it is proved that the aggravation is attributable to the employee's work environment.

(2) The medical service provider must ensure that all other potential differential diagnoses or pre-existing disorders are excluded before expressing opinion on PTSD and the work-relatedness of such a condition. The following differential disorders must be excluded before an occupational PTSD can be diagnosed:

(a) depression, for example, predominance of low mood, lack of energy, loss of interest, suicidal ideation;

(b) specific phobias, for example, fear and avoidance restricted to certain situations;

(c) adjustment disorders, for example, less severe stressor, different pattern of symptom;

(d) enduring personality changes after catastrophic experience or prolonged extreme stressor, different pattern of symptoms;

(e) dissociative disorders;

(f) neurological damage due to injuries sustained during the event; and

(g) psychosis, for example, hallucinations and delusions.

(3) If the report does not indicate or disclose the existence of a relevant pre-existing disorder or a significant co-morbid condition, if any, the Compensation Commissioner may not accept such report.

8. Management of PTSD

Treatment interventions must be evidence-based, scientifically valid and consistent with professional standards.

Early Interventions and Watchful Waiting

(a) The Fund will authorise treatment for acute reaction to traumatic events, the Acute Stress Disorder, arising out of and in the course of employment.

(b) A follow-up consultation should be arranged within one month of diagnosis of acute stress and a comprehensive report which includes prognostic details must be provided to the Fund after this consultation;

(c) A final consultation must be scheduled within two months for the purpose of final medical report.

(d) The treatment and management of Acute Stress Disorder must be finalised within three months of diagnosis and a final medical report must be provided at the end of this period.

(e) All cases of suspected PTSD must have a definitive diagnosis made within the first six months from date of first consultation.

(f) A medical practitioner who diagnoses an occupational PTSD must furnish the Compensation Commissioner or employer with a medical report indicating such diagnosis within three months and thereafter submit further medical reports at intervals set out in the Disease Monitoring and Reporting Table below.

(g) Where Acute PTSD is identified, the Fund shall extend the treatment to six months provided there is justifiable proof of need.

(h) Individuals who at the end of six months do not meet the full criteria for the diagnosis of PTSD, must have a differential diagnosis made and a Final Medical Report duly completed and sent to the Fund to finalise the claim.

Immediate Psychological Interventions for PTSD

(a) The treating general practitioner and treating psychiatrist must ensure that employees needing psychological support are identified early and are timeously referred to psychologist for assistance.

(b) The initial consultation with the psychologist will be automatically covered by the Fund, and the psychologist's treatment plan will then be pre-authorised based on a detailed assessment report prior to therapy being provided.

(c) The psychologist and medical practitioner must submit progress medical report to the Fund at the end of the authorised period.

Drug Treatment

(a) Healthcare practitioners must ensure that the treatment provided to patients is enlisted to the recommended drugs for PTSD as recommended by the South African Society of Psychiatrists and the South African Society of Psychologists.

(b) PTSD sufferers must be given sufficient information about the nature of these treatments to make an informed choice and patient preference should be an important determinant of the choice among the following and effective treatments:

(i) drug treatments for PTSD and change of treatment will only be authorised when prescribed by the treating psychiatrist;

(ii) adjunctive treatment will be approved where there is significant co-morbid condition, depression or hyperarousal that significantly impacts on the patient's ability to benefit from the recommended treatment;

(iii) this short-term treatment may be initiated by the general practitioner after thoroughly considering all drug interaction implications and where the benefit outweighs the risk;

(iv) subsequent drug modifications should be discussed with the relevant specialist in conjunction with the psychiatrist;

(v) a proof of compliance is required to support a claim of non-response to recommended lines of treatment where clinicians may recommend an item which is off code;

(vi) when an employee treated for PTSD has not responded to a drug treatment regime, and the treating psychiatrist considers adding further drugs after the maximum allowable dosages have been reached

on the initial recommended drugs, or the recommended lines of treatments have been exhausted, the Fund may at its own discretion, subject such further treatment plan to a peer review mechanism or refer an employee for further medical examination in terms of section 42 of the Act;

(vii) when an adult sufferer with PTSD has responded to drug treatment, it should be continued for at least 12 – 24 months before gradual withdrawal as recommended by SASOP;

(viii) the treating doctor, preferably the general practitioner must monitor treatment on a monthly basis for the first six months and provide monthly Progress Medical Reports to the Fund in the prescribed manner;

(ix) after the six months period, appropriate monitoring must be done on a lesser frequent basis not exceeding three monthly, where practicable. Six monthly reports from the psychiatrist must be submitted during this period and when maximum medical improvement has been achieved, a Final Medical Report from the treating psychiatrist must be provided;

(x) all PTSD patients requiring treatment beyond twenty-four (24) months shall be treated as chronic PTSD by the Fund. The Fund may at its own discretion, and after due processes, consider enrolling any particular employee with PTSD on its chronic treatment programme; and

(xi) a Final Medical Report from the psychiatrist indicating the need for continuing treatment on a lifetime basis must be provided to the Fund at the end of twenty-four (24) months.

(c) A detailed follow-up plan with appropriate motivation must also be provided at this point by the psychiatrist.

9. General Recommendations on treatment:

(1) All PTSD sufferers who are prescribed antidepressants or any psychotropic medication should be informed at the time that treatment is initiated, of potential side-effects and discontinuation or withdrawal symptoms as appropriate.

(2) For employees who are back at work, these must be communicated to the employer in the prescribed manner taking into account legal and ethical considerations governing the disclosure of confidential medical information.

(3) Where necessary and medically justifiable, employees doing shift work and safety-critical jobs must be accommodated in alternative placements while on such medications.

(4) For the purpose of sub-regulation 10.3, the services of an occupational therapist will be required.

10. Dealing with Comorbidities in PTSD

(1) In cases of high co-morbidity of PTSD with generalized physical and mental health problems, the multidisciplinary and interdisciplinary approach must be used.

(2) The treatment plan must be outlined and be in accordance with national credentialing policies and guidelines.

(3) The treating doctor must identify the comorbidities and the multidisciplinary and interdisciplinary teams and apply for authorisation of such treatment.

(4) Healthcare practitioners must clearly document their rationale for opting for such treatment, satisfy themselves that the potential benefits outweigh the known risks and that an informed consent has been duly obtained.

(5) Where beneficiaries are on other chronic medications, the Fund will only approve treatment for such chronic conditions during the acute phase and only where the dosage and form of such treatment is different from the usual treatment and where non-treatment of such has a negative impact on the treatment outcome of the PTSD.

11. Case Management of PTSD

PTSD case must be managed in accordance with the table below:

Disease Monitoring and Reporting:

Type of Disorder (Evolutionary Stage)	Onset of Symptoms (Months)	Duration of Symptoms (Months)	Frequency of Medical Reports		Timing of Final Medical Report (Months)			
			GP	Psychiatrist	3	6	12	24
Acute Stress Disorder	Immediate	< 3 months	Fortnightly	1 & 3 months				
Acute PTSD	1 – 3 months	1 – 6 months	Monthly	3 and 6				
Classic PTSD	1 – 6 months	6 – 24 months	Monthly	1, then 6 monthly				
Delayed-Onset PTSD	>6 months	6 – 24 months	Monthly	1, then 6 monthly				
Chronic PTSD	1- 6 months	>24 months	Three monthly	1, then 6 monthly				

12. The Responsibilities of the Treating Psychiatrists

The responsibilities of the psychiatrists to whom the employee has been referred by the medical practitioner are:–

(a) to thoroughly assess the employee as referred to him or her in the prescribed manner and make appropriate diagnosis based on the approved evidence-based medical guidelines as guided by the medical scientific community and updated from time to time. The assessment of PTSD sufferers should be conducted by competent medical practitioners and be comprehensive, including physical, psychological and social needs and a risk assessment;

(b) to device a structured treatment and patient management plan taking into account all relevant personal, social, workplace and environmental circumstances, including the monitoring plan. This plan must include clear roles of key personnel and have measurable and realistic targets;

(c) to institute appropriate treatment taking into account relevant legislation governing the prescription and administration of medicines and related substances. Patient preference should be an important determinant of the choice among effective treatments;

(d) PTSD sufferers should be given sufficient information about the nature of these treatments to make an informed choice;

(e) to provide relevant reports on the progress and prognosis of the employee and motivate for the need for continuing treatment, change of treatment or addition of further treatment modalities as appropriate

and this will include the motivation for the employee to be consulted by other specialists and for further objective clinical testing; and

(f) to provide expert evidence in medico-legal platforms including during tribunal and court proceedings concerning disputes related to the diagnosis, treatment and management of PTSD.

13. The Responsibilities of the Psychologists

The responsibilities of the psychologists to whom the employee has been referred by the medical practitioner are to–

(a) thoroughly assess and determine the psychological needs of the patient and devise a structured management plan after appropriate referral from the treating doctor;

(b) identify the need for social support and advocate the meeting of this need;

(c) institute appropriate evidence-based treatments and therapies as guided by the medical scientific community and updated from time to time, after approval is obtained from the Fund;

(d) collaborate with both the general practitioner and the treating psychiatrist to ensure that there is alignment and coordination of care and monitoring of the patient;

(e) identify the need for appropriate information about the range of emotional responses that may develop and provide practical advice on how to access appropriate services for these problems;

(f) offer help or advice to the patient or relevant others on how continuing threats related to the traumatic event may be alleviated or removed;

(g) provide reports to the Fund and treating doctors; and

(h) provide expert evidence in medico-legal platforms including during tribunal and court proceedings concerning disputes related to the diagnosis, treatment and management of PTSD.

14. The role of the Independent Medical Examiner

(1) The Independent Medical Examiner must conduct an examination which consists of a review of medical documentation or records, that shall render as confirmation of relevant medical history and an in-person examination and assessments or objective tests if appropriate.

(2) For the purpose of these regulations, the Fund may refer an employee to any Independent Medical Examiner including but not limited to a Psychiatrist, Occupational Therapist and or a Clinical Psychologist with experience in treating and managing patients with PTSD.

(3) The Independent Medical Examiner is required to use the Clinician Administered PTSD Scale for DSM-V (CAPS 5) to aid him or her in making an objective assessment of the presence and or absence of PTSD, as well as to grade the severity of symptoms thereof if he or she concurs with the diagnosis.

Note: The latest edition of the DSM must always be used.

(4) The scoring of CAPS is given below:

Table 14-10: CAPS - 5 Scoring

CAPS – 5 PTSD Severity	Score
Asymptomatic/ Few Symptoms	0 - 10
Mild PTSD/ Subthreshold	11 - 22
Moderate PTSD / Threshold	23 - 34
Severe PTSD Symptomatology	35 - 46
Extreme PTSD Symptomatology	≥ 47

(5) An employee who claims compensation shall, if and when so required and at the discretion of the Fund, after reasonable notice, submit himself at the time and place mentioned in the notice to an examination by a designated Independent Medical Examiner in accordance with Section 42 of the Act.

(6) The Independent Medical Examiner will have the following roles:

(a) assess and examine the employee with the diagnosis of PTSD and determine if the diagnosis was appropriately made based on chronology, causality, medical probability, evidence-based medicine and current best practice;

(b) determine the current appropriate diagnosis if it differs from the treating doctors and establish causation of disease or mechanism thereof if appropriate, severity of symptoms, restrictions and limitations;

(c) assess the appropriateness of treatment proposed or provided based on current best practice and recommended protocols and guidelines for people with PTSD;

(d) provide treatment recommendations and objective medical findings regarding the person's ability to return to work, and identify any relevant safety considerations;

(e) formulate opinion and prognosis based on factual findings from the assessment and using current best practice and recommended protocols;

(f) provide a duly formulated report with recommendation(s) to the Fund on the best course of action; and

(g) provide expert evidence in medico-legal platforms including during tribunal and court proceedings concerning disputes related to the diagnosis, treatment and management of PTSD.

15. Patient Assessment Guidelines

(1) For the purposes of—

(a) assessing an employee for diagnoses, the medical practitioners must use the latest edition of DSM;

(b) assessing the need for an extended treatment, medical practitioners must use the latest edition of The Management of PTSD in Adults and Children in Primary and Secondary Care – 2005 and Treatment Guidelines for Psychiatric Disorders – Volume 19 (3) of 2013;

(c) assessing impairment and disablement for PTSD the Fund will use the latest edition of the "Guides to the Evaluation of Permanent Impairment" compiled by the American Medical Association

(d) advising all healthcare professionals to use the material mentioned above in the diagnosis, treatment, management and assessment of impairment and disablement of employees suffering from occupational PTSD; and

(e) indicating that the three scales are used by which impairment due to PTSD is rated. Each scale should be measured and the impairment score calculated and the final impairment shall be the median or middle value of the 3 scores.

16. Brief Psychiatric Rating Scale

(1) The Brief Psychiatric Rating Scale measures major psychotic and non-psychotic symptoms in a person.

(2) The BPRS form consists of 24 symptom constructs, each to be rated on a 7-point scale of severity ranging from "Not Present" to "Extremely Severe".

(3) Medical practitioners must circle the number headed by the term that best describes the employee's present condition, rated on the employee's self-report for items 1-6, 8-11 and 14 and on the basis of observed behavior and speech for items 7, 12-13 and 15-24.

(4) They must accordingly add the total of the 24 BPRS symptom construct scores and read the BPRS impairment score from the TABLE 15 – 11.

Table 15-10: Brief Psychiatric Rating Scale (BPRS)

SYMPTOM CONSTRUCT	SCORING						
1 Somatic concern	1	2	3	4	5	6	7
2 Anxiety	1	2	3	4	5	6	7
3 Depression	1	2	3	4	5	6	7
4 Suicidality	1	2	3	4	5	6	7
5 Guilt	1	2	3	4	5	6	7
6 Hostility	1	2	3	4	5	6	7
7 Elevated mood	1	2	3	4	5	6	7
8 Grandiosity	1	2	3	4	5	6	7
9 Suspiciousness	1	2	3	4	5	6	7
10 Hallucinations	1	2	3	4	5	6	7
11 Unusual thought content	1	2	3	4	5	6	7
12 Bizarre behaviour	1	2	3	4	5	6	7
13 Self-neglect	1	2	3	4	5	6	7
14 Disorientation	1	2	3	4	5	6	7
15 Conceptual disorganisation	1	2	3	4	5	6	7
16 Blunted affect	1	2	3	4	5	6	7
17 Emotional withdrawal	1	2	3	4	5	6	7
18 Motor retardation	1	2	3	4	5	6	7
19 Tension	1	2	3	4	5	6	7
20 Uncooperativeness	1	2	3	4	5	6	7
21 Excitement	1	2	3	4	5	6	7
22 Distractibility	1	2	3	4	5	6	7
23 Motor hyperactivity	1	2	3	4	5	6	7
24 Mannerisms and posturing	1	2	3	4	5	6	7

1 = Not Present 2 = Very Mild 3 = Mild 4 = Moderate 5 = Moderately Severe 6 = Severe 7 = Extremely Severe

Table 15-11: IMPAIRMENT SCORE OF BRIEF PSYCHIATRIC RATING SCALE (BPRS)

BPRS ADDED SCORE	BPRS IMPAIRMENT SCORE
24 – 30	0%
31 - 35	5%
36 - 40	10%
42 - 45	15%
46 - 50	20%
51 - 60	30%
61 - 70	40%
71 - 168	50%

17. Global Impairment of Functioning Scale

The Global Impairment of Functioning Scale is a 100 point single item rating scale for evaluating overall symptoms, occupational functioning and social functioning. Determine the GAF impairment score based on Table 15-20.

GAF	DESCRIPTION	GAF IMPAIRMENT SCORE
91 - 100	No symptoms; superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities	0%
81 -90	Absent or minimal symptoms(for example, mild anxiety before an exam); good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (for example, an occasional argument with family members)	0%
71 - 80	Is symptoms are present, they are transient and expectable reactions to psycho-social stressors (for example,difficulty concentrating after family argument); no more than slight impairment in social, occupational or school functioning (for example,temporarily falling behind in school work)	0%
61 -70	Some mild symptoms (for example, depressed mood and mild insomnia) or some difficulty in social, occupational or school functioning (for example, occasional truancy, or theft within the household) but generally functioning pretty well, has some meaningful interpersonal relationships	5%
51 - 60	Moderate symptoms (for example, flat affect and circumstantial speech, occasional panic attacks) or moderate difficulty in social, occupational or school functioning (for example, few friends, conflicts with co-workers)	10%
41 - 50	Serious symptoms (for example, suicidal ideation, severe obsessional rituals frequent shoplifting) or any serious impairment in social, occupational or school functioning (for example, no friends, unable to keep a job)	15%
31 - 40	Some impairment in reality testing or communication (for example, speech is at times illogical, obscure or irrelevant) or major impairment in several areas, such as work or school, family relations, judgement, thinking or mood, (for example, depressed adult avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home and is failing at school)	20%
21 - 30	Behaviour is considerably influenced by delusions or hallucinations or serious impairment in communication or judgement (for example, sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) or inability to function in almost all areas (for example, , stays in bed all day; no job, home or friends)	30%
11-20	Some danger of hurting self or others (for example, suicide attempts without clear expectation of death, frequently violent, manic excitement) or occasionally fails to maintain minimal personal hygiene (for example, smears faeces) or gross impairment in communication (for example, largely	40%

	incoherent or mute)	
1-10	Persistent danger of hurting self or others (for example, recurring violence) or persistent inability to maintain personal hygiene or serious suicidal act with clear expectation of death	50%

18. Psychiatric Impairment Rating Scale

The behavioral consequences of psychiatric disorders are assessed on 6 scales, each of which evaluates an area of functional impairment namely: Self-care and Personal Hygiene ,TABLE 15-30, Social and Recreational Activities, TABLE 15-31, Travel, TABLE 15-32, Interpersonal Relationships, TABLE 15-33, Concentration, Persistence and Pace, TABLE 15-34, and Employability TABLE 15-35, therefore:

(a) medical practitioners must allocate a score from 1 to 5 in each of the 6 impairment domains based on objective evidence;

(b) they must then arrange the 6 scores from the lowest to the highest;

(c) select the middle 2 scores and add the 2 together; and finally

(d) determine the Psychiatric Impairment Rating Scale impairment score from TABLE 15-36.

Table 15-30: SELF-CARE, PERSONAL HYGIENE AND ACTIVITIES OF DAILY LIVING

	ROLE FUNCTIONING, SOCIAL AND RECREATIONAL ACTIVITIES
1	No deficit or minor deficit attributable to the normal variation in the general population. Regularly participates in social activities that are age, sex, and culturally appropriate. May belong to clubs or associations and is actively involved with these
2	Mild impairment. Occasionally goes out to such events without needing a support person but does not become actively involved(for example, dancing, cheering favourite team)

3	Moderate impairment. Rarely goes out to such events, and mostly when prompted by family or close friend. Will not go out without a support person. Not actively involved, remains quiet and withdrawn
4	Severe impairment. Never leaves place of residence. Tolerates the company of family member or close friend but shall go to a different room or place when others come to visit family or flat / room mate
5	Totally impaired. Cannot tolerate living with anybody, extremely uncomfortable when visited by close family member

Table 15-32: TRAVEL

1	**No deficit or minor deficit attributable to the normal variation in the general population. Can travel to new environments without supervision**
2	Mild impairment. Can travel without support person but only in a familiar area such as local shops or a neighbour
3	Moderate impairment. Cannot travel away from own residence without support person. Problems may be due to excessive anxiety or cognitive impairment
4	Severe impairment. Finds it extremely uncomfortable to leave own residence even with trusted person
5	Totally impaired. May require 2 or more persons to supervise when travelling

Table 15-33: INTERPERSONAL RELATIONSHIPS

1	No deficit or minor deficit attributable to the normal variation in the general population. No difficulty in forming and sustaining relationships for example, partner, close friendships lasting years)
2	Mild impairment. Existing relationships strained. Tension and arguments with partner or close family member, loss of some friendships
3	Moderate impairment. Previously established relationships severely strained, evidenced by periods of separation or domestic violence. Spouse, relatives or community services looking after children
4	Severe impairment. Unable to form or sustain long term relationships. Pre-existing relationships ended (for example, lost partner, close friends). Unable to care for dependents (for example, own children, elderly parent)
5	Totally impaired. Unable to function in society. Living away from populated areas, actively avoiding social contact

Table 15-34: CONCENTRATION, PERSISTANCE AND PACE

1	No deficit, or minor deficit attributable to the normal variation in the general population
2	Mild impairment. Can undertake a basic retraining course or a standard course of education or training at a slower pace. Can focus on intellectually demanding tasks for up to 30 minutes, then feels fatigued or develops headache

3	Moderate impairment. Unable to read more than newspaper articles. Finds it difficult to follow complex instructions
4	Severe impairment. Can read only a few lines before losing concentration. Difficulties in following simple instructions. Concentration deficits obvious even during brief conversation. Unable to live alone or needs regular assistance from relatives or community services
5	Totally impaired. Needs constant supervision and assistance in an institutional setting

Table 15-35: RESILIENCE AND EMPLOYABILITY

1	No deficit, or minor deficit attributable to the normal variation in the general population. Can work full time. Duties and performance are consistent with the injured employee's education and training. Able to cope with the normal demands of the job
2	Mild impairment. Can work full time but with modifications, or can work in the same position a reduced number of hours per week
3	Moderate impairment. Cannot work at all in same position. May be able to work in a less stressful occupation
4	Severe impairment. Cannot sustain work over time in any position
5	Totally impaired. Cannot work at all

Table 15-36: IMPAIRMENT SCORE OF PSYCHIATRIC IMPAIRMENT RATING SCALE (PIRS)

SUM OF PIRS MIDDLE SCORES	PIRS IMPAIRMENT SCORE
2	0%
3	5%
4	10%
5	15%
6	20%
7	30%
8	40%
9-10	50%

The final score will be determined by the Fund's adjudication panel after thoroughly examining the reports provided by the practitioners and having satisfied themselves of their objectivity and fairness.

19. Impairment

(1) The calculation of impairment at the time of diagnosis will solely be for the determination of the severity of the disease, the modality and extent of treatment required, and for providing tentative prognostic opinion.

(2) The Fund shall use such rating to monitor the impact of treatment and to evaluate the effectiveness thereof in collaboration with medical service providers.

(3) The final impairment calculation will only be determined after the employee has reached Maximum Medical Improvement

(4) The Compensation Fund's adjudicating medical panel shall determine if MMI has been reached based on the strength of the available medical reports by the treating psychiatrist and or other independent medical reports.

(5) The Final Medical Report will be required once the panel has adjudicated and concluded that the claimant has reached MMI, for purposes of deciding on impairment.

(6) The Final Medical Report must be based on scientifically-validated healing timeframes as determined by the medical scientific community as updated from time to time. Clinicians shall provide a Final Medical Report when so required by the Fund without any prejudice.

(7) The impairment shall be evaluated by the Fund using the latest edition of the "Guides to the Evaluation of Permanent Impairment", compiled

(8) Medical service providers must refrain from giving unsolicited opinion on impairment rating or permanent disablement

(9) The Fund carries the sole responsibility for determining impairment level and permanent disablement due to PTSD.

20. Compensation Benefits

The guidelines for benefits payable in terms of the Act are as follows:

(a) payment for temporary total or partial disablement shall be made for as long as such disablement continues, but not for a period exceeding 24 months and from the date of the accident or date of diagnosis and monthly progress reports must be submitted to the office of the Compensation Commissioner;

(b) this occurs when an employee's condition is such that he or she cannot perform his or her usual duties but is still capable of working at some job during the period of recovery and employers and medical service providers must collaborate to institute accommodation of the employee in modified duties as a critical element of the treatment plan and return-to-work strategy for such employees;

(c) the Compensation Fund must be satisfied that all measures have been reasonably considered before declaring an employee totally unfit to work on a temporary basis;

(d) temporary total disablement occurs when an employee is totally

expected to recover with treatment within a foreseeable period and Service providers who are advising employers on the employee's extent of unfitness and the length of time required for full recovery, must take into cognisance that work itself is also curative in nature, so as to guard against inadvertently disadvantaging employees with PTSD;

(e) periodic payments shall be made for as long as the temporary total disablement is deemed reasonable and shall continue for as long as evidence of continuing disablement is provided and this may not exceed twenty-four (24) months;

(f) the Fund may however at any point during this period and at its own discretion declare any such employee permanently impaired and where such a decision is made by the Fund, the medical service providers providing treatment and other services to the employee will then be required to furnish the Final Medical Report(s) as at that point in time;

(g) payment of permanent disablement shall be made, where applicable, when a Final Medical Report and or the report from the adjudication panel is received and the Final Medical Report must be submitted when an employee reaches the stage of MMI, whether or not he or she is on treatment;

(h) the Fund shall at its own discretion and where deemed necessary solicit such a report which shall be provided without reservation or prejudice.

(i) if total impairment score is zero to three, that is, permanent disablement less than or equal to 30%, permanent disablement shall be determined and a lump sum shall be paid in terms of the Act; and

(j) if total impairment score is more than three , for example, permanent disablement is higher than 30%, pension shall be paid in terms of the Act.

21. Medical Costs

(1) Medical costs shall be provided for a period of not more than 24 months from the date of accident or further 12 months, if in the opinion of the Director-General, further medical costs shall educe the extent of the disablement that an employee suffers from.

(2) Medical costs covers diagnosis of PTSD by a psychiatrist and any necessary treatment provided by any general practitioner or approved mental health provider, as well as hospitalisation and chronic medication when motivated for by the psychiatrist.

(3) The Compensation Commissioner must decide on the need for, the nature and sufficiency of medical costs to be provided, inclusive of chronic medication, if applicable.

(4) No treatment shall be automatically accepted by the Fund without prior authorisation, except in emergencies. In such cases, service providers must notify the Fund in the prescribed manner within seventy-two (72)

(5) All elective admissions and investigations shall require pre-authorisation by the Fund.

22. Reporting

Any consultation in respect of treatment for PTSD must be reported to the Fund in the prescribed manner as and when it happens.

No payments in lieu of any consultation or treatment shall be provided by the Fund without medical reports from practitioners. The following documentation must be submitted to the Compensation Commissioner or the employer individually liable or the licensee concerned:

(a) (W.Cl.2) Employer's Report of an Accident / Occupational Disease;

(b) (W.Cl.3) Notice of an Accident / Occupational Disease and Claim for Compensation;

(c) An W.CL.305 affidavit by the employee if an employer cannot be traced or the employer fails to timeously submit Employer's report of an Occupational Disease, W.CL.1.

(d) (W.Cl.4) First Medical Report in respect of an Accident or Occupational Disease, W.Cl.303 First Psychiatric Report

(e) (W.Cl.5) Progress Medical Reports in respect of an Accident / Occupational Disease or Progress Psychiatric Reports

(f) (W.Cl.5) Final Medical Report in respect of an Accident / Occupational Disease / Final Psychiatric Report

(h) detailed psychiatric and or psychological reports within the scope of practice of the therapist and or an occupational therapy report in the prescribed format

(i) any other relevant reports pertaining to the accident, diagnosis and treatment, where applicable and at the discretion of the Compensation Fund.

MR TW NXESI, MP
MINISTER OF EMPLOYMENT AND LABOUR
DATE: 26/03/2020

the doj & cd

Department:
Justice and Constitutional Development
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Date: 09 December 2019

Mr Thobile Lamati
Director-General: Department of Employment and Labour
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Pretoria
0001

For Attention: Harry Mapholoela

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Dear Mr T Lamati

REGULATIONS ON POST-TRAUMATIC STRESS DISORDER FOR THE COMPENSATION FUND MADE BY THE MINISTER UNDER COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (ACT NO. 130 OF 1993): YOUR UNNUMBERED MAIL DATED: 14 OCTOBER 2019

INTRODUCTION

1. We have been requested by the Department of Labour ("the Department"") to scrutinise, and provide it with a legal opinion on, the draft post-traumatic stress disorder regulations ("the Regulations") to be made in terms of section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No. 130 of 1993) ("the Act").

2. In scrutinising the Regulations we have considered the following legal instruments:

(a) The Constitution of the Republic of South Africa, 1996 ("the Constitution");

(b) the Act; and

(c) the case law.

LEGISLATION

3. Section 65 of the Act deals with compensation for occupational diseases and state as follows:

***"65. Compensation for occupational diseases.**–(1) Subject to the provisions of this Chapter, an employee shall be entitled to the compensation provided for and prescribed in this Act if it is proved to the satisfaction of the Director-General–*

(a) that the employee has contracted a disease mentioned in the first column of Schedule 3 and that such disease has arisen out of and in the course of his or her employment; or

(b) that the employee has contracted a disease other than a disease contemplated in paragraph (a) and that such disease has arisen out of and in the course of his or her employment.

4. In terms of section 97(1) of the Act the Minister is empowered to make regulations in respect of the matters tabulated in paragraphs (*a*) to (*h*). Section 97 reads as follows:

***"97. Regulations**–(1) The Minister may make regulations, after consultation with the Board, regarding–*

(a) the place of meeting and the procedure to be followed at any meeting of the Director-General and assessors or at any proceedings in terms of this Act with which the assessors are concerned, or at any investigation in terms of this Act;

(b) subject to section 76, the fees payable to medical practitioners or chiropractors in respect of services rendered in terms of this Act;

(c) the procedure to be followed in paying assessments and fines to the Director-General;

(d) the persons to whom, the places where and the manner in which payment of assessments in terms of this Act shall be made;

(e) the determination of the amount and the conditions and manner of payment of benefits to assessors or classes of assessors;

(f) the disposal of moneys payable in terms of this Act to any person other than the Director-General and not claimed within the prescribed period by the person entitled thereto;

(g) any matter which shall or may be prescribed by regulation in terms of this Act;

(h) any other matter, whether or not connected with any matter mentioned in paragraphs (a) to (g), which he may deem necessary or expedient to prescribe in order to further the objects and purposes of this Act.

(2) Different regulations may be made under subsection (1) in respect of different classes of employers and employees and of different areas, and the Minister may, after consultation with the Board, in respect thereof differentiate in such manner as he or she may deem expedient.

(3) Any person who contravenes or fails to comply with any regulation made under subsection (1) shall be guilty of an offence and liable on conviction to a fine, or imprisonment for a period not exceeding six months.

DISCUSSION

Minister's powers to make Regulations

5. It is convenient at this stage to deal with the Minister's power to make the regulations. The Minister's power to make the regulations is a public power that must be exercised subject to the Constitution and the law. In exercising such public power, the Minister is thus required to comply with the principle of legality. This means that the Minister can only exercise the power to make the regulations within the parameters of the Act and the Constitution.

5.1 In *Fedsure Life Assurance Ltd and Others v Greater Johannesburg Transitional Metropolitan Council and Others*[1], the Constitutional Court stated the following in paragraph 56 of the judgment regarding the principle of legality:

> *"It is a fundamental principle of the rule of law, recognized widely, that the exercise of public power is only legitimate when lawful. The rule of law - to the extent at least that it expresses the principle of legality - is generally understood to be a fundamental principle of constitutional law."*(footnote omitted)

5.2 The Constitutional Court in *Fedsure* referred to above, further states the following in paragraph 58 of that judgment:

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[1] *Fedsure Life Assurance Ltd and Others v Greater Johannesburg Transitional Metropolitan Council and Others 1998 (12) BCLR 1458 (CC) ("Fedsure")*

"it seems central to the conception of our constitutional order that the Legislature and Executive in every sphere are constrained by the principle that they may exercise no power and perform no function beyond that conferred upon them by law. At least in this sense then, the principle of legality is implied within the terms of the interim constitution." (our underlining)

5.3 The Act authorises the enactment of delegated legislation, namely, the regulations. The power to make the regulations is vested in the Minister in terms of section 97 of the Act. Section 97 (1) of the Act sets out various matters the Minister is authorised to make regulations on. In terms of sections 97 (1) of the Act, the Minister may make regulations, after consultation with the Board regarding to various matters listed in that section.

5.4 From section 97 (1) of the Act it is clear that the Minister does not have the express authority to make regulations dealing with post-traumatic stress disorder. Therefore, in order to make the draft Regulations the Minister must be so authorised by paragraph *(g)* or *(h)* of subsection (1) of section 97 of the Act. We would in this regard like to expand slightly on this provision.

Minister's power to make the draft Regulations in terms of section 97(1)(g) of the Act

5.5 The Minister is authorised to make Regulations in terms of section 97 (1) *(g)* of the Act if another section in the Act authorises him to make regulations relating to the subject matter dealt with in that section. There are many sections in the Act which, when read with section 97 (1) *(g)* of the Act, authorise the Minister to make regulations. However, there are none that authorise him or her to make regulations regarding occupational diseases. Therefore, we are of the opinion that the Minster

cannot make the draft Regulations in terms of section 97 (1) *(g)* of the Act. If he does so, the Minister would be acting *ultra vires*.

Minister's power to make the draft Regulations in terms of section 97(1)*(h)* of the Act

5.6 In view of our conclusion in the preceding paragraph, it must be determined whether the Minister is authorised to make Regulations in terms of section 97(1)(h) of the Act. This section makes it clear that the "objects and purpose" of the Act must be determined before the question whether the Minister has the power in terms of section 97(1)*(h)* of the Act to make the draft Regulations can be addressed. In **Road Accident Fund v Makwelane** 2005 (4) SA 51 (SCA), (hereinafter after referred to as "the **Makwetlane** case") the Court discussed the power of the Minster of Transport to make regulations to "achieve or promote the objects" of the Road Accident Fund Act, 1996 (Act No. 56 of 1996) and remarked as follows at pp. 58-59:

> "Section 26 empowers the Minister to make regulations in order to achieve or promote the objects of the Act. It does not confer authority on him to traverse terrain outside that limited scope and ambit. All regulations promulgated by the Minister must thus be reasonably necessary to achieve those objects and goals. It is indeed so that the possibility of fraud is greater in cases where the identity of the driver or owner of the vehicle in question has been established, as it would usually be difficult for the RAF to secure evidence to dispute a claim (see *Mbatha* at 718H). Stricter requirements would thus be justified in unidentified vehicle cases. It follows that regulations designed to eliminate fraud and facilitate proof of legitimate claims, falling as it does

> within the Minister's power to regulate, would be permissible. No other reason has been suggested for such a requirement and I can think of none. That legitimate end, may not, however, be achieved by means that sweep too broadly. ...
>
> The Constitution places significant restraints upon the exercise of public power. It is a requirement of the rule of law that the exercise of public power should not be arbitrary. It follows that the exercise by the Minister of the regulatory power conferred upon him had to be rationally related to the purpose for which the power was granted – rationally being the minimum threshold requirement. (See *Pharmaceutical Manufactures* paras [85] and [86].) Conduct that fails to pass that threshold requirement would fall below the standards set by our Constitution and would therefore be unlawful."

5.7 We are of the opinion that, in view of the remarks in the **Makwetlane** case, quoted above, the following deductions can be made regarding the Minister's power to make regulations in terms of section 97 (1) *(h)* of the Act:

(a) Section 97 (1) *(h)* of the Act limits the power of the Minister to making regulations that relate to the achievement of the objects and purposes of the Act.

(b) The regulations made under section 97(1)*(h)* of the Act must be rationally connected to the objects and purposes of the Act.

5.8 This purpose is reiterated in section 97 (1) (*h*), where it is provided that 'The Minister may make regulations, after consultation with the Board, regarding any

other matter, whether or not connected with any matter mentioned in paragraphs (*a*) to (*g*), which he may deem necessary or expedient to prescribe in order to further the objects and purposes of this Act.' (Our emphasis)

5.9 As regards to section 97 (1) (*h*), this section is also phrased in such broad terms that it appears to be all encompassing. It is an omnibus provision. While section 97 (1) (*g*) undoubtedly covers the Minister's power to make the regulations, we are of the view that section 97 (1) (*h*) is the most apt provision in so far as the acts stipulated in regulation 3 are deemed to be occupational diseases contracted by employees.

5.10 Considering the subject matter of the regulations, we are of the view that sections 97 (1) (*h*) read with 65 (1) of the Act are the appropriate provisions in so far as the Minister's power to make the regulations is concerned.

5.11. We now turn to deal with the regulations as set out in the Schedule. We have suggested tracked changes with regards to the drafting style and form of the Regulations. This is done in order to align the Regulations with common drafting principles.

***Ad* Regulation 1**

6. Regulations 1 and 2 provide for the definition of some of the words used in the Regulations and we have suggested the removal of purpose of Regulations to Regulation 2 for the Department's consideration.

***Ad* Regulation 3**

7. Regulation 3 provides for the diagnosis of PTSD and requires that clinical diagnosis of medical conditions, including Post-Traumatic Stress Disorder, must be based on approved evidence-based medical guidelines as guided by the updated

medical scientific community as updated from time to time and be categorised in line with applicable criteria.

***Ad* Regulation 4**

8. Regulation 4 provides for the Diagnostic & Statistical Manual and diagnostic criteria that must be used and met in all cases of suspected PTSD. We have suggested that the Department should clarify the Regulation for legal certainty.

***Ad* Regulation 5**

9. Regulation 5 relates to PTSD as an occupational disease arising out of and in the course of an employee's employment. The Regulation further states that, a disease would have arisen out of and in the course of employment if it has a broad causal connection to employment and that the employee must have contracted the disease while performing duties that he or she is contractually obliged to perform.

***Ad* Regulation 6**

10. Regulation 6 provides for the occupational risk of PTSD, whether its development is dependent on people's subjective perception of the traumatic event as well as on the object facts, and that the effect of PTSD can extend to witnesses and perpetrators.

***Ad* Regulation 7**

11. Regulation 7 provides for the evolutionary stages of PTSD's, focusing on Acute Stress Disorder, Acute PTSD, Classic PTSD, Delayed-onset PTSD and Persistent or Chronic PTSD.

***Ad* Regulation 8**

12. Regulation 8 provides for differential diagnosis where the Compensation Fund may undertake to provide treatment for the aggravation or pre-existing Post-

management plan taking into account all relevant personal, social, workplace and environmental circumstances including the monitoring plan.

***Ad* Regulation 14**

18. Regulation 14 relates to the responsibilities of the Psychologists that they must thoroughly assess and determine the psychological needs of the patient and devise a structured management plan after an appropriate referral from the treating doctor.

***Ad* Regulation 15**

19. Regulation 15 deals with the role of the independent medical examiner, which role involves conducting an examination consisting of a review of medical documentation or records that shall render as confirmation of relevant medical history and in-person examination and assessments or objective tests if appropriate.

***Ad* Regulation 16**

20. Regulation 16 deals with patient assessment guidelines, which provides that when an employee is assessed for diagnosis, the medical practitioners must use the latest edition of the Diagnostic Statistical Manual.

***Ad* Regulation 17**

21. Regulation 17 relates to brief psychiatric rating scale, which is a tool designed to measure major psychotic and non-psychotic symptoms in a person. The brief psychiatric scale consists of 24 symptom constructs, each to be rated on a 7-point scale of severity ranging from "Not Present" to "Extremely Severe".

***Ad* Regulation 23**

27. Regulation 23 provides for the reporting processes, noting that, any consultation in respect of treatment for PTSD must be reported to the Compensation Fund in the prescribed manner as and when it happens.

***Ad* Regulation 24**

28. This is a new regulation for the Department to consider. Regulation 24 provides for the short title of the Regulations and that after having discussed with the Department, these Regulations shall be sent to the relevant stakeholders for commentary and later incorporation of inputs into the Regulations. Therefore, we have suggested to the Department that upon completion, to resend the Regulations to our office for further scrutiny.

CONCLUSION

29. In light of the exposition above, we are of the view that the Minister has the requisite authority to make the regulations under consideration. Subject to our suggested amendments made directly on the text of the regulations, we are satisfied that the regulations are in order and conform to the form ad style of legislative drafting.

30. We attach hereto a soft copy of the Regulations with track changes incorporating our suggested amendments for your consideration.

Yours sincerely

FOR THE OFFICE OF THE CHIEF STATE LAW ADVISER
Z. NTSHWANTI / X. MDLUDLU / S. MASAPU / A. JOHAAR