

WorkSafeBC  
Psychology Guidelines  
for Assessment  
Service Providers



WORKING TO MAKE A DIFFERENCE

# Table of Contents

<b>INTRODUCTION.....</b>	<b>1</b>
<b>Ψ Purpose of the guidelines .....</b>	<b>1</b>
<b>Ψ WorkSafeBC Overview.....</b>	<b>1</b>
Roles and Responsibilities .....	1
The Claim Process .....	1
Case Management Team.....	2
Psychological Services .....	4
<b>Ψ WSBC Context.....</b>	<b>5</b>
Clinical-Adjudicative Interface.....	5
No-Fault.....	6
Worker Consent .....	6
Access to Claim Information .....	6
Advocacy .....	6
Standard of Proof.....	7
Accepted Injury Types.....	7
WSBC Claim Terminology.....	7
<b>ASSESSMENT SERVICES .....</b>	<b>11</b>
<b>Ψ Types of Assessment Services .....</b>	<b>11</b>
Psychological Assessment .....	11
Neuropsychological Assessment .....	11
Permanent Functional Impairment Assessment .....	11
Supplemental Consultation .....	11
Case Management Meeting.....	12
<b>Ψ Performance Standards .....</b>	<b>12</b>
Provision of Authorized Services .....	12
Professional Registration .....	12
Competence .....	12
Ethical Practice .....	12
Consent .....	13
Confidentiality .....	13
Advocacy .....	14
<b>Ψ Assessment Requirements.....</b>	<b>15</b>
Expert Opinions .....	15
Impartiality .....	17
Answering Standard Referral Questions.....	18
Diagnosis .....	20
Causality .....	21
Recommendations.....	26
Client Debriefing .....	26
Report Format .....	26
Permanent Functional Impairment Assessments .....	27
<b>CONCLUSION .....</b>	<b>33</b>

<b>APPENDICES</b> .....	<b>34</b>
Appendix A: <a href="http://www.worksafebc.com">www.worksafebc.com</a> .....	35
Appendix B: WSBC Contact Information.....	36
Appendix C: Sample Assessment Report Format.....	37
Appendix D: Sample Consent Form .....	38

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# Introduction

## Ψ Purpose of the guidelines

These guidelines contain important information for those who provide psychological and neuropsychological assessment services to injured workers referred by the WorkSafeBC (WSBC). The guidelines provide an overview of the stages of a WSBC claim, the roles and responsibilities of various WSBC personnel, the business procedures involved in the provision of psychological assessment, the roles and responsibilities related to contracting with WSBC for the provision of psychological assessment services and their clinical requirements.

## Ψ WorkSafeBC Overview

### Roles and Responsibilities

The WSBC is a complex system governed by provincial legislation and its own internal policies and practice directives. A detailed description of the functioning of the WSBC is beyond the scope of these Guidelines. We have, however, endeavoured to provide an overview of those aspects of the system most relevant to external providers.

WorkSafeBC of British Columbia has been responsible for administering the provincial Workers Compensation Act since 1917. The workers' compensation system is funded entirely by the employers of British Columbia.

The origin and fundamental value of workers' compensation rests on the principle of mutual protection arising from the historic compromise in which workers relinquished their right to sue their employer and employers agreed to fund a no-fault insurance system. The principle of mutual protection balances the interests of workers, employers, and the people of British Columbia.

The mandate of the WSBC is to return the injured worker to their pre-injury health and assist with return to work. Psychological interventions are one way in which this is accomplished. The WSBC is not a comprehensive insurance plan and is not meant as an alternative to social service agencies.

### The Claim Process

Determination of an injured worker's benefit entitlement is made through an adjudicative process resulting in a claim decision. Benefits may include wage-loss replacement, clinical treatment, vocational assistance and financial compensation for permanent functional impairment.

When a worker has experienced a personal injury arising from job activities, he/she files an Application for Compensation and Report of Injury or Occupational Disease (Form 6). The employer also submits an Employer's Report of Injury or Occupational Disease (Form 7) and

the attending physician completes a Physician's Report (Form 8/11). See Appendix A for samples of these forms.

If there is sufficient information on file, the application is adjudicated for initial entitlement. It is important to understand that initial adjudication is only the first step in a claim. Adjudication is an ongoing process and each issue of entitlement and benefit is adjudicated separately over the duration of the claim. Also, previously adjudicated issues may be revisited for a number of reasons, resulting in changes to the injured worker's entitlement.

If there is insufficient information for adjudication, additional information may be collected from multiple sources. This may include referral for a psychological assessment to assist in determining causality.

The WCB Act gives WCB the authority to direct the treatment and rehabilitation of injured workers.

After the claim has been accepted, treatment and rehabilitation will be provided in conjunction with appropriate return to work activities. At some point it will be

determined that the person has recovered from the injury, or that they have reached a point of maximal clinical recovery. When the person reaches a point in his/her recovery where no significant improvement in clinical status is expected to occur within approximately a year the Case Manager (CM) may determine that the person has reached *plateau*.

Once the Case Manager has determined that plateau has been reached, the worker may be assessed to determine the extent of any residual functional impairment related to the work injury. This may result in a permanent functional impairment award based on the degree of impairment. In most cases, this award is deemed appropriate compensation for the residual impairment. In some exceptional circumstances, the worker may be eligible for consideration of a loss-of-earnings pension.

## Case Management Team

WSBC claims are managed by a multidisciplinary case management team. The case management team brings together administrative and clinical specialists who can provide a comprehensive understanding and oversight of the issues relevant to an injured worker's situation.

### Case Manager

The Case Manager is a Board officer responsible for the overall administration and management of a claim from the time of injury through to recovery or clinical stability. The Case Manager is charged with the authority to decide:

- whether a presenting problem is compensable (i.e. has been caused in part or in whole by a workplace incident resulting in injury)
- whether and to what extent treatment services will be provided by WSBC (i.e., entitlement to benefits)
- and whether and to what extent vocational assistance will be offered (i.e., return to work)

In making these decisions, the Case Manager has access to a number of experts to assist them in understanding the relevant clinical and vocational issues.

### **Disability Awards Officer and Claims Adjudicator Disability Awards**

The Disability Awards Officer (DAO) and the Claims Adjudicator Disability Awards (CADA) are Board Officers responsible for the overall management of a claim from the point of clinical recovery or stability forward.

### **Psychology Advisor**

The Psychology Advisor serves as a consultant to the Case Managers CADAs and DAOs, providing psychological opinions and advice based on a review of information documented in the claim file. Opinions cover such areas as clarifying psychological diagnosis and presenting symptoms, treatment, anticipated recovery and psychological capacities as they relate to return to work. The Psychology Advisor also acts as the professional liaison to the mental-health community, arranging for appropriate diagnostic and causality assessments, psychological treatment/counselling and return to work planning. Psychology Advisors do not provide direct clinical care to injured workers. When appropriate, they may conduct assessments for the purpose of confirming a diagnosis or sorting out issues of causality. Psychology Advisors are all doctoral level Registered Psychologists.

### **Medical Advisor**

The Medical Advisor serves as a consultant to the Case Manager, CADAs and DAOs, providing medical opinions and advice based on a review of information documented in the claim file. Opinions cover such areas as medical diagnosis, treatment, anticipated recovery and physical capacities as they relate to return to work. The Medical Advisor also acts as the professional liaison to the medical community, arranging for appropriate diagnostic and causality assessments, treatment and physical rehabilitation. Medical Advisors do not provide direct clinical care to injured workers. When appropriate, they may conduct assessments for the purpose of confirming a diagnosis or sorting out issues of causality. Medical Advisors are all members of the College of Physicians and Surgeons.

### **Nurse Advisor**

The Nurse Advisor serves as a consultant to the Case Manager, providing professional opinions based on a review of medical information documented in the claim file. Opinions cover such areas as the nursing and health aspects of recovery and return to work planning. They also liaise with the attending physician, external health-care providers and employer. Nurse Advisors are all Registered Nurses.

### **Vocational Rehabilitation Consultant**

The Vocational Rehabilitation Consultant is responsible for assisting the injured worker return to the workforce. They provide practical help with job search skills, graduated return-to-work plans and, if necessary, vocational redirection.

## **Psychological Services**

Psychological services are provided to injured workers through a combination of internal and external professionals.

### **Psychology Services**

Psychology Services is part of Clinical Services at WSBC. Psychology Advisors report to the Manager of Psychology Services for clinical direction. Psychology Advisors are assigned to a Service Delivery Location (SDL) where they report to a Client Services Manager (CSM) for administrative issues and participate as members of the Case Management teams.

In addition, the WSBC contracts for psychological assessment and treatment/counselling of an injured worker as appropriate within the context of a WSBC claim. This is most often provided by a clinician from the Psychology Provider Network located in or near the worker's community. All services are authorized by the Case Manager. The referral and monitoring of external psychological services is co-ordinated by the Psychology Advisor.

### **Psychology Provider Networks**

The WSBC provides authorised assessment and treatment services through external clinicians. Injured workers may be referred to established hospitals, clinics, treatment programs and individual practitioners as appropriate.

Psychological services are provided through two networks of providers; one for psychological/neuropsychological assessment and one for psychological treatment/counselling.

WSBC endeavours to maintain sufficient numbers of external practitioners to meet the needs of its clients. Practitioners are added or removed from the network based on service requirements and provider training, licensure and performance. A clinician may be eligible to join both networks, however, each network is managed under a separate contract and requires a separate application. Those wishing to join a network should contact WSBC for more information. Appendix B contains a contact list to help direct your inquiry to the appropriate person.

Where a suitable clinician from the Psychology Provider Network is not available, other arrangements may be made at the discretion of WSBC. Clinicians who accept such referrals are expected to adhere to these guidelines.

If a person requires a clinical service, an ethical provider makes every reasonable effort to provide that service. However, the WSBC must consider those needs through the filter of entitlement under the WCB Act. Only those services related to the claim can be funded. This can lead to a situation in which a recognised clinical need cannot be funded due to legal and administrative requirements.

If information comes to the attention of WSBC that a worker's claim may include a "psychological injury" or significant psychological issues are present, the file will be referred to the attention of the Psychology Advisor in the appropriate SDL for assistance

The WCB must consider the person's clinical needs through the filter of entitlement under the WCB Act. Only those services related to the claim can be funded.

in understanding these issues. If psychological assessment is required, it may be provided by a WSBC Psychology Advisor or by a suitable psychologist designated by the WSBC. If psychological treatment/counselling and intervention are authorized, the WSBC Psychology Advisor will refer the injured worker to a psychologist or other appropriate clinician in the worker's community.

Psychological assessments and neuropsychological assessments are undertaken for a number of reasons including, but not limited to:

- diagnosis
- causality
- treatment planning
- prognosis
- clinical progress
- psychological functional capabilities, limitations and restrictions

Treatment may be provided for psychological disorders arising from work-related injuries. It is beyond the scope of WSBC's mandate to provide treatment for pre-existing psychological conditions or concurrent issues that are problematic but not related to the WSBC claim. Essentially, the WSBC is responsible for helping the injured worker return to his/her pre-injury psychological status, whatever that might have been. This can sometimes appear to be at odds with the ethical responsibilities of the clinician, as clinicians typically address treatment issues from the perspective of the whole person.

WSBC realises that it is sometimes difficult for clinicians to limit treatment to "only" those aspects of a presenting problem that are related to a work injury, but this is required under applicable policy and legislation.

## Ψ WSBC Context

Clinical assessments conducted within the context of a WSBC claim occur within a quasi-judicial context. The assessment is best thought of as being of the nature of a court-ordered assessment. This type of assessment is sometimes referred to as a medical-legal or psychological-legal assessment.

### Clinical-Adjudicative Interface

As in other legal contexts role of giving testimony is separate from the role of trier of fact. In the WSBC system, the Case Manager is the trier of fact and must base decisions on the evidence available.

Factual evidence may be given by anyone with direct knowledge of the event (e.g., worker, employer, witness), however, expert witnesses may offer professional opinions based on their specialized knowledge, training and expertise. This places a special burden on expert witnesses to ensure that the opinions they offer are in fact, based in their area of expertise.

In providing clinical opinions it is essential that clinicians avoid the use of adjudicative terminology and avoid comments that are adjudicative in nature. Clinical opinions inform the Case Manager's adjudicative decisions but should not attempt to direct them.

## **No-Fault**

Unlike a court setting the issue of "guilt" or "innocence" as it pertains to cause or responsibility for the injury is irrelevant to the issue of entitlement for benefits. In other words, WSBC compensation is a "no-fault" system that serves workers and employers regardless of responsibility for the injury. Safety and health regulations are monitored and enforced through a separate branch of WSBC.

## **Worker Consent**

In applying for compensation the worker completes and signs a Form 6 authorizing the Board to obtain and disclose any information it deems necessary to the management of the worker's claim.

Clinicians are advised to obtain a separate consent from the worker before providing any service.

## **Access to Claim Information**

The worker can obtain access to his/her claim file at any time. Small numbers of documents can be obtained directly from the Case Manager. Larger numbers of documents or a complete copy of the file can be obtained through a simple request to Disclosures.

Employers can obtain access to a worker's claim file if there is an appeal of a decision on the claim by either the worker or the employer. The intent is to provide access to the evidentiary basis on which the adjudicative decision was made so that the parties may more clearly articulate their case.

## **Advocacy**

WSBC is a large and complex organization and it is recognized that those unfamiliar with its workings may have difficulty understand how best to interact with the system. For this reason, professional Worker's Advocates are available at no cost to assist all injured workers in their interactions with WorkSafeBC.

Clinicians must avoid advocating for the employer or worker with respect to legal, adjudicative, entitlement and benefits. Engaging in advocacy compromises the impartiality of the clinician and may open them to complaints of practicing outside their area of expertise.

## **Standard of Proof**

In the WSBC system where the evidence is mixed, the issue is resolved based on the concept of “the balance of probabilities” rather than the higher test of “beyond reasonable doubt.” In situations where the probabilities are evenly balanced, the issue is resolved in accordance with the decision that favours the worker. This is intended to ensure the availability of WSBC coverage in cases of uncertainty. The concept of “balance of probabilities” is intended to apply only to the adjudication process. Professional opinions must meet a higher standard.

Clinical opinions should be based on reasonable clinical probability and clearly address any concerns regarding the certainty of the opinion. That something is “possible” is insufficient. It must be “probable” and meet the additional criteria of being clinically “plausible.” To be clinically plausible, the opinion must be based on sufficient evidence and the application of generally accepted psychological principles.

An argument based solely on a sequence of events is insufficient. This is sometimes referred to as the “but for” argument. It is sometimes argued that because a condition was not present before the event and is present after the event, it follows that “but for” the event the person would not have developed the condition. This line of reasoning is based on a misunderstanding of correlation and causation and in the absence of a clinically plausible explanation does not constitute a valid expert opinion.

## **Accepted Injury Types**

The WSBC’s mandate is to compensate for work-related personal injury and disease. The Act does not allow acceptance of conditions that arise out of work-related stresses including performance requirements, labour-relations issues or human rights violations.

WSBC compensates for both physical and psychological injuries that are determined to arise during and in the course of work and for conditions that arise directly as a consequence of the original injury. Psychological injuries arising directly in the course of work are typically those involving psychological trauma from a horrific event. Other anxiety and depressive disorders may be accepted if they are determined to be a direct consequence of another accepted injury. Typically, this would be a psychological disorder arising from the stress of coping with a significant physical injury.

## **WSBC Claim Terminology**

In order to communicate clearly, it is important that clinicians become familiar with and understand the terminology commonly used with WSBC and on claim files. However, it must be kept in mind that some terms such as compensability, plateau, employability and disability have specific adjudicative meaning within the WSBC context and should not be used by psychologists in stating clinical opinions.

### **Forms**

WSBC uses a number of standard forms to collect information regarding a claim. These forms may be disclosed to clinicians as background documents they receive as part of a referral. The most common forms are listed below:

*Form 6: Application for Compensation and Report of Injury or Occupational Disease:* This form is completed by the worker electing to claim compensation for a work injury. It contains contact information for the worker and employer, employment information and a description of the event and injury.

*Form 7: Employer's Report of Injury or Occupational Disease:* This form is completed by the employer of the worker claiming compensation. It contains contact information for the employer and worker, employment information and a description of the event and injury.

*Form 8/11: Physician's Report:* Physicians complete a Form 8 the first time they see a worker for a work-related injury or disease. A Form 11 is completed for each subsequent visit if the condition or treatment has changed from the last report. The report contains clinical and return-to-work planning information.

### **Describing Claim Events**

Clinicians should avoid the use of adjudicative terminology in their clinical opinions. For example, clinicians should not refer to a diagnosed condition as “compensable” as this implies adjudicative acceptance of the injury as a work-related injury under the Act.

In describing events related to a WSBC claim it is helpful to make a distinction between the incident and the injury. The *incident* is the event or series of events that occurred in the context of work. The *injury* is the disease or disorder resulting from the event(s). Use of these terms allows greater clarity in distinguishing the circumstances surrounding a claim from any potential consequences of the event.

When a client's clinical condition has stabilized and there is no reasonable expectation of further recovery the clinician may state this and refer to the situation as maximal clinical recover. At that point the Case Manager may consider making the adjudicative determination that the person has plateaued.

### **Describing the Clinical Consequences of Injury**

By definition a diagnosable psychological condition is characterised by a constellation of symptoms resulting in some degree of impaired functioning. As most diagnostic criteria for any condition allow for various combinations of symptoms, it is helpful to specify the symptoms and describe the *symptom severity* in terms of *intensity, frequency and duration*. For example, a panic attack might be describe as being of moderate intensity characterised by rapid heart rate, hyperventilation and dizziness, occurring once per day for approximately 10 minutes.

Symptoms are typically associated with some level of impaired functioning; that is, they interfere with some aspects of a person's psychological functional capacity. Not all aspects of functioning are impacted by all symptoms, and care should be taken to specify the areas of functioning affected by the diagnosed condition. Levels of *impairment* can range from none to severe. Use of these terms should adhere to standard diagnostic

definitions. Terminology that lacks such standard definitions, (e.g., “significant” or “major”) should be avoided or carefully defined, as they lack clarity.

In addition, symptoms may be *temporary* or *permanent*. Temporary symptoms are those anticipated to improve with recovery from the condition. Permanent symptoms are those not expected to change even once the person reaches maximal clinical recovery.

*Disability* may result from impairment and describes the person’s ability to accomplish specific tasks. The level of disability takes into account the person’s coping skills, adaptive aides and supports, etc. that may in part mitigate the impact of impairment. For example, a person with mild memory impairment may have little or no disability regarding accomplishing household tasks with the use of to-do-lists and calendar reminders. The degree of disability can range from *partial* to *total*. Partial disability indicates the person retains some ability to accomplish specific tasks. Because the degree of disability is a combination of the level of impairment in conjunction with the availability of remedial strategies and adaptive aides, the assessing clinician is not in a strong position to comment on the person’s ultimate degree of disability. A clinical focus on the degree of impairment will assist in directing rehabilitative efforts.

When asked to comment on *limitations*, clinicians are asked to describe of the individual's capacity to perform tasks related to the worker’s occupation. The clinician should comment on the clinical reason for, and the plausibility of the worker's stated or observed limitations. For example, a person with impaired concentration and attention may be limited in their ability to maintain pace on an assembly line. They would be described as limited due to impaired attention and concentration.

Abilities may also be limited as a result of the worker’s reluctance to engage in the activity. A person’s *tolerance* to engage in an activity is a complex combination of limitations, motivation and perceived benefit and cost of engaging in an activity at a particular time and under particular circumstances. For example, under certain circumstances a person in chronic pain may be reluctant or resistant to engage in physical activity as a way of trying to avoid or reduce pain, yet may be willing to engage in similar activities under different circumstances. While variation in individual tolerance is well documented and increasing tolerance to symptoms is often a goal of therapy, there is no clinical basis on which to objectively assess a person’s level of tolerance.

In some situations, the limitations may be such that engaging in an activity would place the worker at undue risk of harm. The clinician may consider it appropriate to direct that the worker avoid the situation. A *restriction* is a clinical prescription to avoid an activity due to foreseeable and significant harm. The foreseeable and significant harm must arise out of a psychological condition. Restrictions tend to be general to the clinical condition rather than specific to the individual’s situation. For example, a worker with multiple concussions should avoid contact sports because of the foreseeable risk of permanent head injury.

It is important to emphasize that the risk must arise from the injury-related condition and not simply from a potentially dangerous situation. To extend the example above, it would be inappropriate to restrict a person without a history of multiple concussions from playing football on the basis that they are at significant risk of receiving a concussion.

Limitations and restrictions may be *temporary* or *permanent* and it is important to describe them with the appropriate qualifiers. Temporary limitations and restrictions may require work accommodation during treatment that can be removed at the point of recovery. Permanent limitations and restrictions may have significant consequences to the individual's ability to return to their pre-injury job, engage in alternate employment and maintain their income. For this reason, conditions should not be prematurely described as permanent and restrictions should not be recommended without good reason.

### **Describing Recovery**

It is anticipated that with appropriate treatment and rehabilitation, most clinical conditions will resolve, resulting in full recovery. However, in those situations where full recovery is not possible, a point is reached where a person's clinical condition, though improved, is not expected to change significantly within the foreseeable future (approximately one year). WSBC refers to this point as *plateau*.

Plateau is an adjudicative determination made with clinical input from assessing and/or treating clinicians. Clinicians may be asked to comment on whether the client has reached a point of clinical stability or maximal recovery. Clinical stability can also refer to the stability of a cyclical condition such as Bi-Polar Disorder. Once the Case Manager determines that the client has recovered or reached plateau, remaining impairments may be considered for a permanent functional impairment award.

### **Permanent Impairment**

A psychological *impairment* is the loss of, reduction of, or disturbance in cognitive, emotional and behavioural functioning of an individual that is attributable to a psychological disorder.

A permanent impairment occurs when the degree of impairment becomes static or well-stabilized and is not likely to decrease in spite of continuing psychological, medical or rehabilitative measures (see *Describing Recovery*).

*Disability* is a decrease in, or the loss or absence of the capacity of an individual to meet personal, social or occupational demands, or to meet statutory or regulatory requirements. The distinction between impairment and disability can be illustrated by the example of two concert violinists who lose the tip of the little finger of their right hand. Both have experienced the same injury and have the same degree of impairment. The violinist who fingers the strings with his left hand has no work disability. The violinist who fingers the strings with his right hand is disabled from that occupation.

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# Assessment Services

## Ψ Types of Assessment Services

In the context of this document the term “psychological assessment” is used in the generic sense to refer to all types of assessment including emotional, behavioural, cognitive, neuropsychological and learning disability assessments. The nature of the assessment requested by WSBC will be clarified at the time of referral.

### **Psychological Assessment**

Psychological assessment is for the purposes of obtaining a diagnostic formulation regarding a person’s emotional and personality functioning, the aetiology of any diagnosed conditions, the impact of those conditions on the person’s functioning and recommendations for treatment.

### **Neuropsychological Assessment**

Neuropsychological assessment is for the purposes of obtaining a diagnostic formulation regarding a person’s cognitive, intellectual and personality functioning as a function of their neuropsychological status, the aetiology of any diagnosed conditions, the impact of those conditions on the person’s functioning and recommendations for treatment.

Neuropsychological assessment is usually undertaken when there is reason to believe the worker may have experienced a brain injury.

### **Permanent Functional Impairment Assessment**

A permanent functional impairment (PFI) assessment is a psychological or neuropsychological assessment for the purpose of determining any permanent functional impairment resulting from a psychological condition. The worker may be entitled to some compensation for residual functional impairment related to accepted conditions.

### **Supplemental Consultation**

These consultations are requested only subsequent to a psychological assessment conducted by the same psychologist. A supplemental consultation is for the purpose of addressing new questions raised by WSBC after an assessment has been completed and the report submitted. Supplemental consultations may be related to any type of psychological assessment or permanent functional impairment assessment. Requests for clarification to questions already asked, but not fully answered are not considered to be supplemental consultations even though the psychologist must provide a second document answering the original referral questions.

The consultation may or may not require review of additional documentation or additional contact with the client. Supplemental consultations typically involve review of additional documentation and an opinion integrating the new material into a previously provided opinion. Supplemental consultations for PFI may occur subsequent to a regular assessment to assist in understanding the functional impairments related to accepted psychological

conditions where the original assessment provides sufficient information to answer such questions and re-assessment is not clinically warranted.

## **Case Management Meeting**

At the WSBC's discretion, a psychologist may be asked to attend a case management meeting with WSBC staff to discuss the results of an assessment for the purposes of case management planning.

## **Ψ Performance Standards**

All services must be provided in accordance with the contractual agreement and within the context of ethical clinical practice. Efforts have been made to minimize any potential conflict between contractual and ethical standards; where such conflicts are perceived to exist, please contact the WSBC Manager of Psychology Services.

### **Provision of Authorized Services**

Inclusion in one or both of the Psychology Provider Networks indicates that the individual clinician has been approved to receive referrals from WSBC to provide specific services to injured workers. Inclusion in a network does not guarantee any volume of referrals.

All services provided to a specific injured worker are done so only with the authorization of WSBC. The clinician is not authorized to provide services based on referral from other sources including but not limited to community physicians or other health care practitioners or worker self-referral.

Referrals are always made by WSBC to a specific provider. Services must be provided only by the contracted provider. The contracted provider may not sub-contract assessments within a group practice or to other colleagues under any circumstances. This does not apply to the typical practice of using psychometrists to administer and score standard psychological tests. When a provider will be unavailable for an extended period, they should notify WSBC of the dates of the absence.

### **Professional Registration**

Providers will maintain themselves in good standing with their regulatory body. Any conditions or limits to, or loss of professional registration must be reported immediately to WSBC.

### **Competence**

Providers are obligated to maintain technical/professional competency at a level that ensures the client receives the highest quality of care that the provider is capable of offering. Services must be evidence based and outcome oriented.

### **Ethical Practice**

Providers are obligated to provide professional services within the context of their professional ethics. They are obligated to withdraw from a professional relationship where

continued participation would result in violation of their professional ethical standards or there is an actual or potential conflict of interest.

## **Consent**

Workers applying for WSBC benefits sign a release form authorizing WSBC to obtain and share any information relevant to the claim (see Form 6, Appendix A). Workers may not be aware that the consent also applies to external clinicians and it is strongly recommended you obtain signed consent from the worker to obtain and/or release all relevant information to WSBC. A sample consent form is provided in Appendix D and you may wish to use a similar format.

## **Confidentiality**

Limits of confidentiality and informed consent issues must be clearly addressed with the client and documented.

In order to appropriately address this, clinicians providing services through the WSBC must understand how information on a claim is collected and used as well as under what circumstances the information may be shared with others within the scope of the WCB Act.

Under the WCB Act, the WSBC is empowered to collect and share information deemed relevant to the adjudication and management of the WSBC claim. The WSBC has the authority to request and obtain copies of hospital records, physician and therapist case notes, employment and school records and any other information it requires to perform its duties under the Act.

When workers file a WSBC claim, they consent to the collection and use of their personal information for the purposes of adjudicating and managing their claim. By accepting WSBC referrals the external provider agrees to provide detailed and accurate reports to the WSBC regarding patient assessment and treatment. The external provider should explain the issues related to the limits of confidentiality and informed consent to the injured worker in accordance with their own professional ethical code.

In recent years governments have passed a number of pieces of legislation regarding the collection and dissemination of private information. The Freedom of Information and Protection of Privacy Act (FIPPA) is the legislation that applies to WSBC and anyone providing services at the direction of WSBC. This includes clinicians providing services to injured workers at the direction of WSBC. Please refer to the legislation for details. WSBC has also produced a booklet outlining the issues affecting health care providers. Please see Appendix A for details.

Often the injured worker will ask the external clinician for a copy of the reports submitted to WSBC. If you receive such a request, you may provide the information. However, you should be aware that this can lead to confusion and misinformation; e.g., if the report is in any way different from the report sent to WSBC or is received by the worker before receipt by WSBC. It is usually best for the worker to obtain copies of any reports submitted to the WSBC through the WSBC.

The injured worker is able to request a copy of any single document or small number of documents directly from their Case Manager. Larger numbers of documents or a complete copy of the claim file can be obtained by the worker making a request through the WSBC Disclosures department. This is not meant to discourage or limit discussion between client and therapist regarding the content of the reports. Clear communication on these issues is encouraged and can be an important part of the clinical service.

On occasion, a worker may request all information contained in the clinical file kept by the clinician including session notes and raw test data. While the worker undoubtedly has the right to access this information, clinicians are directed to their professional codes of conduct for guidance on ensuring the information provided is understood by the worker.

In addition to the injured worker, the worker's employer may also have the right to access the documents in the claim file. If a decision on the file is appealed by either the worker or the employer, the contents of the file are disclosed to both the worker and employer. This is to provide both parties (injured worker and employer) access to the information used in the adjudication of the claim for preparation of their appeal arguments.

These confidentiality issues can directly affect external clinicians in a number of ways:

1. The WSBC has the right to obtain clinical records of a worker who has applied for benefits with the WSBC. The records may relate both to care required as a result of the work injury and care related to other conditions. Clinicians are expected to respond to such requests in a timely manner.
2. External clinicians providing services to injured workers for the WSBC are required to provide accurate and complete clinical reports as part of the service.
3. Information collected by the WSBC may be shared with external parties to assist in the adjudication and management of a WSBC claim. As an external clinician, you may be sent documents for review and consideration in providing the requested service, or your documents may be sent to other clinicians for their review.

## Advocacy

The WSBC system is complex and it is recognised that injured workers may need assistance to ensure they receive the benefits to which they are entitled. Many unions provide such

If you find yourself sounding like a lawyer, you are probably not acting like a clinician.

assistance for their members. In addition, the Ministry of Labour provides independent professional advocates for injured workers through the Workers' Advisors office. If you believe an injured worker could benefit from such assistance, please encourage them to contact the Worker's Advisors office nearest them. General complaints can be directed to the WSBC Complaints Office.

Most professional codes of conduct address the issue of clinical advocacy. Clinicians often have detailed knowledge of the clinical needs of their clients and should provide objective

observation and reasoned clinical opinion through written and verbal reports. This type of *clinical advocacy* is appropriate and encouraged. However, it must be clearly distinguished from *claim advocacy*. It is critical for clinicians to refrain from advocating for the worker or employer with respect to legal, adjudicative, entitlement and benefit issues, as well as non-injury-related clinical needs.

WSBC depends on the reports of clinicians to understand the *clinical status* of an injured worker. Adjudicative decisions made by a Case Manager are based on this and other available information.

The professional opinions of clinicians are accepted as expert testimony specifically because they are impartial and based on specialized professional training, knowledge and experience. Clinician must not take on a legalistic/claim advocacy stance or provide opinions outside their area of expertise. For example, it is inappropriate for the external provider to make such comments as “The worker needs to be re-trained,” “This worker’s claim should be reopened,” “the worker needs a motorized wheelchair,” “...should be sent for a second orthopaedic opinion,” etc. Such comments may be construed by the worker as confirmation of entitlement and may lead to unrealistic expectations regarding the claim. Claim and entitlement issues must be distinguished from clinical need or benefit, and must be adjudicated within the context of applicable policy and law. Such opinions are not based on expert knowledge and can also call into question the basis of the clinician’s other opinions and conclusions.

## **Ψ Assessment Requirements**

This section describes the generic clinical requirements for all types of psychological assessments as well as special requirements for permanent functional impairment assessments.

### **Expert Opinions**

It is unusual in the WSBC context to call expert witnesses to give oral testimony. Instead, there is a reliance on written reports to document the clinician’s expert opinion. It is therefore essential that responses to referral questions take the form of an expert opinion.

#### **Evidentiary Basis for Opinions**

As discussed previously, expert opinions that meet the test of impartiality are of the greatest utility in a psychological-legal context. In providing a rationale for an opinion, the psychologist should take due care to explain the evidence considered and the basis for their weighing of the evidence, including issues of validity of the sources of information, the reasons for excluding or minimizing the significance of evidence, and the rationale for preferring one professional opinion over another.

In a psychological-legal context an expert must provide not just an opinion, but also present the clinical evidence on which the opinion is based. In the context of a WSBC requested assessment, the evidentiary basis includes but is not limited to a review of relevant existing documentation, a clinical interview with the client and psychometric data when possible.

In documenting evidence it is critical to clarify the source of the information. Care must be taken to clarify the information as being from documents, client report, clinical observation, test results or other sources.

The use of multiple sources of information can assist in verifying and contextualizing subjective reports, resulting in increased objectivity and enhanced clinician confidence in the opinions offered.

### *Documentation Review*

As part of the referral, and prior to the assessment date, WSBC forwards relevant documents from the worker's claim file to the assessing psychologist for review and consideration in formulating answers to the referral questions. This information must be treated as confidential and not disclosed to third parties.

While we make every effort to obtain relevant background information prior to referral for assessment, the assessing psychologist may feel that additional information would be helpful. The possible utility of the additional information must be balanced against the consequences of delaying the assessment report and pending decisions regarding entitlement to benefits. Whenever possible, the psychologist should provide an opinion based on the information available from the file at the time of the current assessment with appropriate cautions regarding any limitations to their opinions. WSBC has the authority to reconsider decisions in light of new information and psychologists may be asked to consider new information in the context of a supplemental opinion.

While it is important to cite sources of information in the report, it is not necessary to provide a complete list of all documents reviewed. Summary statements may be used with specific reports cited in the body of the report where they contain critical information. For example, it may be sufficient to indicate that "weekly medical updates from March to June of 2003 indicate no significant change in the condition" and that "the client was first diagnosed with a Major Depressive Episode by Dr. A in her report of May 12, 2003."

### *Clinical Interview*

The purpose of a clinical interview is to allow the examiner a sustained period of observation and interaction with the client in order to collect first-hand information relevant to the assessment and referral questions. It allows the examiner to focus on the client's presenting complaints and elicit detailed information about the signs and symptoms of conditions under consideration.

The clinical interview should be comprehensive and include behavioural observations, history of the current WSBC claim and any associated symptoms, occupational history, labour relations issues, developmental, family and social history and any relevant "pre-claim" psychological and medical history. It is highly recommended that a structured or semi-structured format be used for the clinical interview.

In some circumstances it may be helpful to conduct collateral interviews. A client's spouse or good friend may provide a useful perspective on the client's functioning particularly where the client is unable to provide accurate information as a result of the condition under examination. Care should be taken to document the consent of all parties involved in such interviews.

### *Psychometrics*

Psychological testing provides an important source of clinical information in conjunction with a clinical interview. Of greatest utility are the well constructed and validated tests with appropriate normative samples. These tests often come with the additional benefit of integrated client response validity and reliability measures. Most major personality and cognitive test batteries fall into this category.

While symptom checklists can provide a quick survey of relevant symptoms to be followed up with further investigation, they should not be taken as diagnostically significant in themselves.

### **Degree of Certainty**

A clinical opinion optimally describes a level of confidence in the conclusions provided. In formulating an opinion the clinician sorts relevant from irrelevant facts, considers conflicting evidence, and weighs the opinions of multiple clinicians and the context of the current assessment.

Generally, the clearer and more consistent the evidence, the greater the clinician's confidence in the conclusion. That a conclusion is "possible" is not sufficient. The standard to be met is one of "reasonable clinical probability." The conclusions reached should appear reasonable to another qualified clinician reviewing the same material.

### **Impartiality**

Psychological assessments by psychologists provide expert clinical opinion and evidence used in the adjudicative process. Written psychological reports are considered expert testimony and therefore should be written with the utmost care to ensure accuracy and clarity.

Within the WSBC system, the purpose of expert testimony is to provide an objective and unbiased professional opinion. Clinicians are expected to provide opinions that are impartial and that avoid advocating for the benefit of any parties involved. In order to achieve this balance of clinical advocacy and neutrality, reports should reflect the qualities outlined below.

### **Relevance of Information**

In conducting a thorough assessment, psychologists will obtain many details regarding a person's history and functioning. An important question to consider is which details should be included in the report and which details should be left out. The defining issue in this decision should be one of relevance.

The report should detail any facts or data that are relevant to the expert opinion. The inclusion of all relevant information forms the foundation on which an opinion rests. This

applies to evidence that adds *or* subtracts weight from the opinion given in answer to a referral question.

The decision to include or not include information should not be influenced by who will benefit by it, but rather by its relevance to the expert opinion. This neutral stance enhances the clinician's credibility by making the evidentiary basis of the opinion transparent and more understandable to other clinicians and decision makers.

Not all facts obtained in an assessment are relevant. For example, information regarding people other than the person being assessed is relevant only to the degree and in how it affects the assessed person. Details regarding historical events should be included only to the degree they are relevant to the opinion offered. For example, the fact of childhood abuse and the person's subsequent coping may be relevant, while the details of the abuse may not be relevant.

### **Consideration of Multiple Perspectives**

In maintaining a neutral stance, clinicians consider the evidence from the perspectives of all parties involved. This may include differing descriptions of the work incident, conflicting diagnoses from previous assessments or disagreement regarding the client's current level of functioning. Psychologists should consider information from all sources which may support or refute the various perspectives offered.

### **Weighing of Alternative Explanations**

In considering the evidence and the perspectives of the parties involved, the psychologists are obligated to weigh the alternatives fairly. Placing undue weight on one piece of evidence or one perspective results in an unbalanced and biased opinion and is likely to reduce the perceived credibility of the expert.

### **Directness**

Psychological opinions should be presented in a straightforward a manner. Opinions should be justified and understandable with any qualifications or limitations regarding certainty of the opinions offered clearly articulated. Selectively disclosing or withholding relevant information, use of vague wording, or presenting multiple possible explanations without a clear conclusion call into question the veracity of the opinions offered.

## **Answering Standard Referral Questions**

A standard set of questions has been developed by WSBC to assist the psychologist to provide clinical opinions that may inform issues of adjudication and compensation without placing the clinician at risk of commenting on issues outside their area of expertise. While the questions are clinical in nature, they provide part of the evidentiary basis on which claim issues are adjudicated. It is critically important that referral questions be answered and explained fully.

Referrals for assessment will most often be accompanied by a standard set of referral questions, modified as necessary to address the specific issues under consideration. Clarification of any questions can be obtained directly from the WSBC Psychology Advisor.

In some circumstances a full psychological-legal assessment will not be required, in which case a brief assessment with more limited questions may be requested.

The standard questions for the psychological-legal assessment follow, with commentary.

1. Provide a multiaxial DSM-IV diagnosis as appropriate.

The multiaxial diagnosis should list all current and resolved psychological conditions. Diagnosis must be based on adherence to current Diagnostic and Statistical Manual of Mental Disorders criteria. Idiosyncratic and research criteria should be avoided.

2. Explain the aetiology of each disorder. As part of the explanation, specify the:

- chronology of the disorders with reference to the work incident
- factors that precipitated the disorder
- factors maintaining the disorder
- the presence of any pre-existing or co-existing psychological conditions/issues/stressors which may have contributed to the emergence and/or maintenance of the disorder

The response to this question should provide an integrated history of the person's psychological functioning. Please see the section on causation for more information.

3. Describe any difficulties the client may have in regard to work as a result of any diagnosed psychological condition(s). Please detail any:

- limitations (inabilities or difficulties) and
- restrictions (activities to be avoided)

If there are significant non-work-injury factors at play, comment should be made on the degree of change resulting from the work-injury.

4. Provide a prognosis, including anticipated length of recovery, and treatment recommendations.

This will assist in treatment and return-to-work planning. It is understood that the timelines outlined will need to be monitored and updated with additional clinical information as time passes.

Recommendations should be clinical in nature. Comments regarding type and length of treatment, readiness to participate in vocational activities including suggestions for return to work are appropriate. The clinician must avoid recommendations on non-clinical issues such as benefit and entitlement issues (e.g., wage rate, vocational re-training, etc.).

It is recognized that rehabilitation and return to work is best accomplished by a multidisciplinary, multi-track plan in which the client may be engaged with multiple coordinated services. Various treatments may occur in conjunction with return to work activities and continue after a return to full work duties.

5. Please comment on any other issues you think are clinically relevant.

The psychologist may comment on, or highlight other clinical issues of concern.

Provide a detailed description of the client's functioning in the following spheres:

- Activities of daily living
- Social functioning
- Concentration, persistence and pace
- Deterioration or decompensation in work or work-like settings
- Other considerations

This is an additional question asked for permanent functional impairment assessments. It will usually precede the question requesting comment on any other clinically relevant issues. Care should be taken to provide thorough descriptions of the person's current functional abilities in each area. For more information, please see the section on Permanent Functional Impairment Assessments.

A review of the standard questions shows that they request a detailed response on the general topics of diagnosis, causality and recommendations. Each of these will be discussed in detail.

## Diagnosis

All psychological diagnoses must be based on the most current edition of the Diagnostic and Statistical Manual of Mental Disorders. In addition to the diagnosis itself, the diagnostic opinion should cite the evidentiary basis for meeting the diagnostic criteria of the disorder. While this does not require a complete restatement of previously presented material it should provide a short summary of the most salient evidence. This may include client report of symptoms, client history, clinical observation, test results and file documents.

In addition to a detailed diagnostic opinion, the clinician should provide a structured five-axis DSM summary.

### **Axis I: Clinical Disorders & Other Conditions That May Be a Focus of Clinical**

**Attention:** Care should be taken to not over-pathologize normal variations in mood or temporary upset due to stressful events.

**Axis II: Personality Disorders & Mental Retardation:** It is recognized that appropriate diagnosis of personality disorders can be difficult within the context of a single assessment. Where diagnosis of a personality disorder is appropriate, it should be provided. Where there are strong personality disorder traits, but insufficient evidence to warrant a diagnosis they may be listed on Axis II as traits or as a "rule-out" diagnosis. While a description of personality functioning or "style" is useful and can be included in the body of the report, this should not be confused with a personality disorder diagnosis. Where personality disorders were not considered in the assessment it is appropriate to list "Not Considered in the Current Assessment" on Axis II. The term "none" or such variants, should not be used unless personality disorders were considered in the assessment and none were found.

**Axis III: General Medical Conditions:** This section should highlight any medical conditions that may affect the diagnosis or treatment of a mental disorder. Most medical conditions can be identified from the medical information on file or as reported by the worker during the course of the assessment. Exhaustive detail in this regard is not necessary, as it will be addressed by the appropriate medical experts. Consideration should be given to the impact

any medical condition might have on the worker’s psychological presentation and be described in the body of the report.

**Axis IV: Psychosocial and Environmental Problems:** This section should provide a brief summary of problems identified and discussed in the body of the report.

**Axis V: Global Assessment of Functioning:** A rating of both current functioning and pre-injury functioning should be provided.

## Causality

The Diagnostic and Statistical Manual of Mental Disorders cautions against possible misinterpretation of diagnostic information in a legal context owing to the imperfect fit between legal questions and clinical data. Clinical diagnosis of a mental disorder does not imply the existence of a mental disorder for legal or compensation purposes, nor its aetiology or compensability.

The determination of the acceptability of a WSBC claim and provision of appropriate benefits is based on the answers to these questions:

1. The person must be a “worker” as defined in the WCB Act.
2. The person must have sustained a “personal injury.”
3. The injury must have occurred in the course of work.
4. The injury must have resulted in a period of disability.

These are all questions that are decided through adjudication by a Board officer and yet many of the issues will be based in part on clinical evidence and in part on the application of WSBC law and policy. If the person has sustained an injury, the clinical issue of diagnosis must be clarified. To adjudicate the issue of the relation to work, the clinical causality must be understood. The extent of any resulting disability and appropriate rehabilitation is also based on clinical information.

By understanding the types of adjudication decisions a Case Manager makes, the clinician is better able to provide a relevant clinical opinion.

The more a clinician understands adjudication issues, the greater the temptation of making adjudicative statements.

Causality in a clinical setting is understood to be multi-factorial. Clinicians take for granted that the cause of a condition is the result of a number of interacting factors. In a clinical setting the reason for determining causality is to guide diagnosis and treatment.

The role of the clinician in determining causality is to provide a clinically plausible explanation of the individual’s reaction to a work event within the context of general psychological knowledge

and principles, the psychological factors unique to the worker and the nature and severity of the work incident. The clinician must go beyond temporal coincidence as an explanation and weigh the various clinical factors to determine the most likely causal mechanism and to explain any role the work incident may have had in the onset, aggravation and/or maintenance of the psychological symptoms.

Causality in the WSBC setting is also understood to be multi-factorial. However, the relative impact of the multiple factors must be weighed in the determination of compensability of the injury. This determination is made on the balance of probabilities, but once made, is a binary Yes-No decision.

Under some circumstances where both work and non-work related factors play a significant role, there may be an adjudication to apportion the costs of the claim. In such circumstances, the employer may be relieved of some of the costs of the claim; however, this decision has no effect on the benefits received by the injured worker.

In the WSBC setting it is the role of clinicians to provide a clinical opinion on the issues of both the diagnosis and the clinical causation of any current and past psychological conditions. It is the role of the Board officer to weigh that evidence and adjudicate the issues within the context of all additional evidence and WSBC law and policy.

### **General Considerations**

While many clinicians choose to practice in a legal setting, there is often little in the way of formal preparation or generally accepted guidelines to assist in undertaking this challenge. Much has been written on this topic and the reader is encouraged to avail themselves of this diverse literature.

In presenting an opinion, one can easily cite the dates of historical events or the scale scores from tests, but the challenge is in laying out the clinical reasoning that moves one from facts to conclusions. While it is recognized that causality opinions contain a large judgement component it is precisely because of this that it requires the most careful thought and explanation. A recitation of facts followed by a conclusion is of little use without the links of analysis and explanation. It is the basis of a convincing expert opinion.

What follows here is only the briefest overview of what is obviously a large and complex topic. It is hoped that the comments and suggestions have some broad utility even though they pertain most directly to assessments conducted in a WSBC context.

### **Causative Factors**

It is generally accepted that psychological conditions arise from a combination of environmental, situational and individual factors. It is not necessary that the person have no causative factors other than the work incident present for a psychological condition to be accepted as part of a WSBC claim. The role of the clinician is to make reasonable inquiry into potential causative factors and present their findings. The purpose is to clarify which factors are plausible and relevant to the current clinical picture. In many cases, the result is to rule-out other factors rather than to uncover some non-work-related cause.

**The Work Incident:** A thorough examination of the circumstances of the work event is required. Was there an identifiable event? Did it result in an injury? These may seem like

simple questions, however, without a clear understanding of the circumstances, comment on their causative significance is impossible. Descriptions of the event may change over time due to faulty memory or inaccurate reporting. Did the person hit her head in a fall from five feet or five meters? Did the person see the co-worker being struck by robber, or did he hear about it later?

It is also important to explain the relationship of the work incident to the psychological symptoms. The incident may have had a direct causative role in the onset of symptoms; it may have set additional stressors in motion; or may have resulted in removal of a protective factor in the person's typical coping strategies.

**Individual Factors:** The assessment should review the person's psychological resources, coping strategies and typical level of functioning, their family and social resources and any relevant cultural factors. The person's presentation style in the interview should be considered. Does the person tend to magnify or deny problems? Are there any concerns regarding the accuracy of the information the person provides?

**Iatrogenic Factors:** In many cases, the worker has sustained physical injuries in addition to a psychological injury and has had substantial involvement with health care providers. The impact of these activities may play a significant role in the person's understanding of their injury, and expectations regarding treatment and anticipated length of recovery. In some instances the person may be taking psychotropic and other medications that have an impact on mood and cognitive functioning.

**Current Life Stressors:** The work injury is not the only thing happening in the person's life. Good and bad things are happening all of the time and should be considered part of the larger context in which the work injury occurs and plays itself out. Are there other current medical or psychological conditions present? Is the person undergoing a major life transition? Are there complicating employment issues such as job satisfaction or performance? How are the significant others in the person's life doing?

**Historical Factors:** Consideration should be given to the role of factors that pre-date the work injury. Are there developmental issues or other pre-existing vulnerabilities? Is the current presentation influenced by a continuation or recurrence of a prior condition?

### **Role of a Factor**

Once the relevant factors have been identified it is necessary to consider the role they play in the current clinical presentation. Not all factors will play a role in the initial onset of symptoms.

**Pre-existing:** Some factors are present before the work incident and become part of the setting in which a new condition presents. They may have no direct causative significance to the work-injury but may explain a greater than usual reaction to what might have been a minor event, exacerbate an evolving condition or complicate the clinical recovery. It is also possible that a pre-existing factor has resulted in a pre-work-injury condition that has been unidentified until the time of the assessment.

*Example:* A person with a pre-existing Obsessive-Compulsive Disorder, involving concerns about infection and cleanliness, receives a minor cut injury at work. His “cleaning” of the wound results in delayed healing.

**Precipitating:** These are what are typically thought of as “the cause” of a diagnosed condition. This makes sense when the precipitating factor has played a major role in the onset of a condition; however, it is not always the case. In some situations, other factors have played the major role and the precipitating event is the proverbial “last straw” or trigger event.

*Example:* A person has three fingers amputated in a punch-press at work. She becomes depressed about her appearance and future employability.

**Perpetuating:** Some factors are not involved in the development of a psychological condition, but serve to exacerbate the symptom presentation or perpetuate them beyond what might otherwise be considered a typical recovery time. In some cases, the factors themselves may not arise until some time after the work-injury. These may, in themselves be a consequence of the work-injury, or totally unrelated.

*Example:* A cashier is assaulted during a robbery and experiences significant anxiety. After six weeks of treatment the symptoms are improving until he is mugged while getting out of his car at home. The mugging results in an increase in anxiety and delays the scheduled return to work.

**Confounding:** In some circumstances, concurrent events are so intertwined as to make it very difficult to impossible to determine the role of any one factor.

*Example:* A person reports marital stress as a result of loss of the “bread-winner” role. Concurrently, the couple’s only child leaves home to attend university.

### **Importance of a Factor**

In commenting on the importance of a factor, the clinician provides a clinical weighting of the importance of the factor to the condition under discussion. In an ideal world, clinicians would be able to apportion the causal importance of factors on a percentage basis. Until that time, the best that can often be done is to provide a more crude ranking.

**Unrelated:** These factors, while present, have no significant role in the onset, maintenance or exacerbation of the current condition or symptoms.

**Minor:** These factors have only a minor role to play in the current symptom picture. Removal of such factors would result in a negligible change in the clinical picture.

**Moderate:** These factors are related to the current condition and play a clinically significant role in the onset, maintenance or exacerbation of the symptoms. A moderate

factor is not sufficient to be the sole cause of the onset of a condition; however, in combination with other moderate factors it may be sufficient.

**Major:** It is unlikely the symptoms would be present without the presence of this factor.

### **Causality Paradigms**

As stated previously, clinicians are used to thinking in terms of multiple causes. For each clinical condition the clinician must consider the relevant factors and their relative weightings. For each condition three possibilities present themselves.

**Single Cause:** There is a major factor in isolation sufficient to account for the clinical presentation. Minor factors may also be present.

**Multiple Causes:** There is a major factor or more than one moderate factor sufficient in combination to account for the clinical presentation. Other minor factors may also be present.

**Competing Causes:** Two or more major factors are present or multiple moderate factors are present such that more than one cause could independently account for the symptoms.

### **Causality Formulation**

The causality formulation is more than the sum of what has come before. Relevant causes have been identified, their relative importance has been ranked and consideration has been given to the potential interaction of multiple factors. This information is then combined with the history and current functioning of the individual to provide one or more diagnoses which may refer to pre-existing conditions or new conditions.

**New Condition:** In the absence of any evidence for pre-existing symptoms, the clinician will likely diagnose a new condition and provide an explanation of the relevant causative factors with particular attention to the role of the work incident. It must be emphasized that the diagnosis of a condition, even arising after a work incident, does not automatically imply a direct causative link to the work-incident.

**Pre-Existing Condition:** When identifying a pre-existing condition, the clinician must be clear regarding the role any pre-existing condition may have played in the current symptomatology. The pre-existing condition may have been evident before the work incident or have become evident only after the incident.

**No Change:** The clinical condition was present before the work-incident and there has been no significant change in the symptom presentation. For example, the person was depressed before the work-incident and remains depressed.

**Normal Clinical Progression:** The worsening or improvement of the symptoms is consistent with the normal progression of the condition. For example a person with a pre-existing Bipolar Disorder continues to experience cyclical mood swings.

**Aggravation of a Pre-Existing Condition:** A pre-existing condition has become worse as a result of the work-incident. Temporal sequence is insufficient evidence of aggravation. Consideration should be given to the possibility of a normal fluctuation in the severity of the symptoms of the pre-existing condition. Evidence of a clinically plausible mechanism for the exacerbation must be provided. This may take the form of an added stressor (e.g., unemployment) or the removal of a protective factor (e.g., physical exercise).

## Recommendations

Recommendations should be clinical in nature and specific to the clinician's area of expertise. Recommendations should be directed toward assisting the worker return to productive activity and recognize the advantages of combining treatment with return to work activities.

## Client Debriefing

In most situations feedback by the service provider to the worker regarding his/her assessment results is considered to be an integral part of the assessment process. Giving the worker feedback on his/her assessment in the normal course of service delivery is highly recommended and may be ethically necessary.

Feedback should focus on specific clinical issues and recommendations. The clinician should avoid commenting on or being drawn into a discussion of compensation issues. In particular care should be taken to avoid comment on what WSBC should or should not do as these are matters of law and policy and hence outside the clinician's area of expertise.

The psychologist's report is one source of information that informs an adjudication. It cannot be assumed that the conclusions or recommendations in a report will be accepted or implemented.

In most cases clients are interested and open to feedback regarding the results of the assessment. However, given the legal context of the assessment there will likely be situations in which the client is likely to be dissatisfied with the feedback. If the clinician anticipates difficulty with the debriefing the issue should be discussed with the WSBC Psychology Advisor to determine an appropriate course of action. The debriefing may be scheduled for a separate session in a more suitable setting. In some cases the debriefing may be scheduled at a WSBC office with the Psychology Advisor present.

## Report Format

The purpose of the Psychological Assessment report is to provide written testimony of the expert opinion and the evidentiary basis and rationale for the conclusions offered. Reports must follow the outline provided. Minor variations from the format to increase clarity are acceptable. Sections not used in a particular assessment should be omitted from the final report. Please see Appendix C for a sample assessment report layout.

Reports should clearly identify the name, highest degree, business address and telephone number of the assessing psychologist. Typical business letterhead is usually suitable.

**Type of Assessment:** The type of assessment should be clearly stated and is the same as the type of report indicated on the coversheet. The type of assessment should be followed by the assessment dates and date of the report.

**Client Information:** Provide the worker's last and first name and claim number, date of birth and date of injury. The purpose is to ensure identification of the correct client.

**Reason for Referral:** The type and purpose of the assessment should be briefly stated. Specific referral questions should be stated in the Discussion and Conclusion section in conjunction with the corresponding responses.

**Documentation Review:** This is the clinician's review of relevant claim file documents. The sources should be cited and the facts summarized. An exhaustive list of all documents reviewed is not required. It is acceptable to make a collective reference to a series of events or reports by a single source. Avoid long quotes from material provided by WSBC.

**Clinical Interview:** State the location, date, and length of the assessment. Provide a physical description of the client and behavioural observations. Quotes should only be used when the exact words of the client are recorded. Paraphrasing is acceptable without quotations. Identify all people present during the interview including anyone accompanying the client, clinical assistants, interpreters, etc.

**Interviews with Other Sources:** Include the names and relationship to the client of any other people interviewed in person or by telephone. Include the time and place of the interview if different from the client interview. Clarify whether the client was present or absent during the interview with the other person.

**Psychometric Findings:** For all tests used, specify the name and version of the test and any deviation from standard administration, scoring or interpretation procedures. Cite scale scores or percentiles in the report and provide an interpretation.

Test protocols and interview notes should not be incorporated into the assessment report or sent with the report as an addendum. If the WSBC requires the raw data we will request a copy be sent separately. Due to the potential for misunderstanding by non-clinicians, raw data sent to WSBC is filed separately from the worker's claim file.

**Discussion & Conclusions:** This section documents the psychologist's response to the referral questions. Questions should be repeated verbatim from the referral letter and interleaved with the answers. Provide specific answers to all questions and provide a rationale for the opinions offered. It will be necessary to repeat some information to ensure clarity.

## **Permanent Functional Impairment Assessments**

Psychological permanent functional impairment (Psychological PFI) assessments are conducted only after a number of adjudicative conditions have been met:

1. One or more psychological conditions have been accepted.

2. The psychological conditions are at plateau.
3. There is reason to believe the person has been left with some degree of impairment.

### **Assessment Requirements**

The requirements of a PFI assessment are similar to those of the Psychological or Neuropsychological assessment. There is less focus on causality (as this has already been adjudicated) and a greater focus on the evaluation of impairment.

The focus of a PFI assessment is to describe the degree of permanent psychological impairment caused by the compensable injury and render a clinically based opinion on the impact of the impairment on occupational behaviour. The clinician should comment on the type and degree of impairment and the impact of the impairments on the person's ability to perform tasks. In considering this question, care must be taken to distinguish between impairments related to the psychological conditions that have been accepted by WSBC as a work-injury, and any other psychological or physical conditions that may be present.

The clinician must be careful to avoid making statements that go beyond impairment and into the area of disability as this broader issue will be influenced by factors outside the clinician's knowledge and expertise. For example the impact of a worker's impairment (and hence the degree of disability) may be reduced by modified duties, change in job, or flexible work schedule, etc. Without knowledge of what vocational and work options are available, it is easy for the clinician to describe a worst-case scenario, inadvertently eliminating real job possibilities and reducing the likelihood of a client maximizing his/her income.

### **Describing Psychological Impairment**

Past practice in WSBC psychological assessments has been to categorize the impairments into one of three groups (Aphasia, Mental Status & Integrative Functioning and Emotional & Behavioural Disturbances) and to classify the degree of impairment as Mild, Moderate, Marked or Extreme. However, this has led to some confusion due to the vague definitions for the categories and the inconsistent application of the terms among clinicians and conflict with some WSBC terminology and we request that these terms not be used.

In categorizing the psychological impairment, the clinician should provide a full functional description of the impairment. Descriptions should be anchored in observed or reported behaviour. Daily routines are often a valuable source of information as are observations during the course of the assessment. The description of symptoms can also sometimes be clarified by describing them in terms of frequency, intensity and severity.

Many clients will have both physical and psychological impairments and it is important that clinicians distinguish between impairments related to a physical condition and those related to a psychological condition.

According to the AMA Guides (Fifth Edition), when assessing the severity of a permanent impairment and residual functional capacity, four areas of the individual's functioning (1) activities of daily living; (2) social functioning; (3) concentration, persistence and pace; and (4) deterioration or decompensation in complex or work-like settings. These functional areas should continue to be used in describing the impairments.

1. **Activities of daily living:** includes self-care, personal hygiene, communication, ambulation, physical activity, sensory function, hand functions, travel, sexual function, sleep, and social and recreational activities.

In the work environment, special attention needs to be paid to issues of understanding and memory of work procedures and specific detailed instructions.

2. **Social functioning:** entails the individual's capacity to interact appropriately and communicate effectively with other individuals.

In the work environment, social functioning *“refers to an individual's capacity to interact appropriately and communicate effectively with other individuals. Social functioning includes the ability to get along with others. Such as family members, friends, neighbors, grocery clerks, landlords, or bus drivers. Impaired social functioning may be demonstrated by a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, social isolation, or similar events or characteristics...Social functioning in work situations may involve interactions with the public, responding to persons in authority such as supervisors, or being part of a team”* (AMA Guides, Fifth Edition, 2001, p. 362).

3. **Concentration, persistence and pace:** refers to the ability to sustain focused attention sufficiently long to permit the timely completion of tasks commonly associated with activities of daily living and in work settings.

These may include, the capacity to carry out short, simple instructions; carry out detailed instructions; perform activities within a set schedule; maintain regular attendance and be punctual; maintain a routine without special supervision; work with or near others without being distracted; make simple work-related decisions; complete a normal workday and workweek without interruptions from psychologically-based symptoms and perform at a consistent pace without an unreasonable number of and unreasonably long rest periods.

4. **Deterioration or decompensation in complex or work-like settings:** is a demonstrated, repeated failure to adapt to stressful circumstances. *“In the face of such circumstances the individual may withdraw from the situation or experience exacerbation of signs and symptoms of a mental disorder; that is, decompensate and have difficulty maintaining activities of daily living, continuing social relationships, and completing tasks. Stresses common to the work environment include attendance, making decisions, scheduling, completing tasks and interacting with supervisors and peers.”* (AMA Guides, Fifth Edition, 2001, p. 362)

In considering the four functional areas, any stated limitations should be related to the mental disorder and not other factors such as physical impairments or financial constraints. Clarifying the nature of the impairment can be facilitated through the use of examples and describing the impairment in terms of:

- **Independence:** how independent the individual is in the evaluated clinical area (e.g., social or vocational functioning).
- **Appropriateness:** how functionally and socially appropriate is the individual's behaviour in the evaluated clinical area.
- **Effectiveness:** how effective the individual is in his/her functioning in the evaluated area.

In psychological impairment evaluation, all attempts will be made to determine the actual underlying psychological (i.e., cognitive, emotional and behavioural) impairment and not simply evaluate a disability arising from the impairment. It has to be recognized, however, that in clinical practice psychological impairment may not be readily evaluated, and clinical judgment needs to be exercised in inferring the psychological impairment from its behavioural manifestations, functional limitations and presenting disability.

It is critical to recognize that there may be no direct or even causal relationship between an individual's impairment and their psychological disability. The latter may be either a response to factors not arising at all or only partly from the psychological injury accepted on the claim and/or factors related to the personal, social and occupational demands or barriers placed on the individual. Such demands or barriers may produce an increase or decrease in disability, even though the underlying impairments remain unchanged.

### **Special Considerations**

In making permanent psychological impairment determinations, special consideration is given to the following factors:

**Effects of Rehabilitation and Treatment:** Potential and past effects of rehabilitation and treatment need to be taken into account in determining permanent psychological impairment. If it is likely that intensive treatment or rehabilitation is going to be effective in alleviating a psychological condition, a permanent impairment rating is deferred until the completion of such treatment or intervention.

**Effects of Structured Settings and Social Support:** The presence of psychological disorders is greatly controlled or altered by structured, supportive and low-stress settings. In making judgments on an individual's functioning level, special consideration is given to the individual's functioning in an open-ended unstructured environment.

**Effects of Medication:** Medication that affects a person's mental state may or may not affect the functional limitations imposed by the psychological disorder. If overt

symptoms are affected by these medications, attention needs to be paid to the persisting functional limitations. Any side effects of medication such as drowsiness, slowing of mental function and decreased motivation also need to be considered.

**Effects of Compensation:** Interaction with the compensation system of any type, particularly when prolonged and conflict-ridden may be stressful and result in exacerbation of the original symptoms or in development of new ones. Those factors need to be carefully considered while making permanent impairment determinations in compensation cases since they are usually of a transient nature.

**Effects of Acute Stressors:** Individuals referred for a permanent impairment evaluation may have recently suffered an acute exacerbation of their otherwise chronic symptoms due to acute stressors such as a death in the family, divorce, loss of a job, another injury, etc. In such cases, deferring impairment evaluation until the effects of acute stressors dissipate may be advisable.

**Effects of Motivation and Coping:** There are significant individual differences in human motivation to cope with disability, to adapt to changing life circumstances, and to benefit from treatment and rehabilitation. Sometimes the effects of motivation are indistinguishable from symptoms of psychological disorders. Poor motivation and a psychological disorder may co-exist. In all cases, motivational factors need to be taken into account when making permanent impairment rating determinations.

**Effects of Pain:** Psychological components of pain are occasionally difficult to distinguish from psychological disorders such as depression or anxiety. Psychological permanent impairment ratings must therefore be provided for psychological disorders associated with or independent of pain rather than for the pain itself. It should also be noted that pain may serve as a confounding variable in a psychological assessment and special care must be taken to consider adverse effects of pain on a multitude of psychological functions, e.g., concentration, thinking, memory, or frustration tolerance.

**Effects of Demographic Factors:** In the determination of psychological impairment, when evaluating behavioural functioning, the psychologist must be aware of the potential influence of such factors as age, gender, ethnic and cultural factors.

DSM-IV (1994) emphasizes the need to supplement the multi-axial diagnostic assessment and to address difficulties in applying DSM-IV criteria in a multicultural environment. *“The cultural formulation provides a systematic review of the individual’s cultural background, the role of the cultural context in the expression and evaluation of symptoms and dysfunction, and the effect that cultural differences may have on the relationship between the individual and the clinician”* (DSM-IV, 1994, p. 843). The Glossary of Culturally-Bound Syndromes which *“may or may not be linked to a particular DSM-IV diagnostic category”* (DSM-IV, 1994, pp. 844-849) may be reviewed in the process of determining the effects of cultural factors.

**Effects of Impairments Not Arising From the Injury:** Psychological impairment determination in a workers' compensation setting focuses on measuring the severity of cognitive, emotional and behavioural impairments arising from the accepted psychological injury. There may be a multitude of psychological impairments not arising from the accepted injury. This could include pre-existing or concurrent conditions or disorders. Impairments that arise from or do not arise from the accepted psychological injury and their respective effects need to be clearly distinguished as much as is scientifically and clinically possible. While a clear and accurate distinction between injury and non-injury factors is always the goal, in psychological practice the ability to distinguish between those factors, regardless of the psychological expertise of the evaluator, may be compromised. This happens particularly in the presence of significant factors complicating assessment such as language problems or ongoing pain. Information from multiple sources increases objectivity of assessment in these cases.

In cases where impairment arises from injury and non-injury conditions, the portion of the overall impairment attributable to the disorder arising from work injury needs to be specifically determined.

**Employment:** There is no one-to-one relationship between a psychological impairment and employability. A wide range of socio-economic and demographic factors such as job availability, job demands, education, skills and past employment experience affect this relationship. For this reason, psychological assessments should not comment specifically on issues of employability.

Psychological assessment should delineate the ways in which permanent psychological impairments are likely to affect an individual's ability and capacity to perform work. A separate employability assessment which considers job-market factors is conducted by the vocational rehabilitation consultant.

**Reassessments:** Due to the dynamic nature of psychological impairment, it is important to periodically review the client's status if clinically significant changes in psychological functioning are anticipated. If the need for the review is anticipated, the timing of it should be indicated in the report.

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## Conclusion

These Guidelines are intended to provide essential information to clinicians conducting psychological assessments for WorkSafeBC. They have been written to be consistent with the highest standards of ethical conduct in what is surely a most challenging area of clinical practice.

As in all areas where complex decision making is required, there are no simple answers or “cookbook” solutions. It is highly recommended that you contact the WSBC Psychology Advisor to discuss any concerns and to consult or obtain clarification on any specific case.

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# Appendices

## **Appendix A:** **[www.worksafebc.com](http://www.worksafebc.com)**

The WSBC website has a great deal of information of use to external service providers. We have included some of the more relevant links here, but encourage you to take some time exploring the site.

**Workers' Compensation Act of British Columbia:**  
[http://www.qp.gov.bc.ca/statreg/stat/W/96492\\_00.htm](http://www.qp.gov.bc.ca/statreg/stat/W/96492_00.htm)

**Psychologists and WorkSafeBC**  
[http://www.worksafebc.com/for\\_health\\_care\\_providers/health\\_care\\_practitioners/psychologists/default.asp](http://www.worksafebc.com/for_health_care_providers/health_care_practitioners/psychologists/default.asp)

**Psychologist Policy and Practice**  
[http://www.worksafebc.com/for\\_health\\_care\\_providers/health\\_care\\_practitioners/psychologists/policy\\_and\\_practice/default.asp](http://www.worksafebc.com/for_health_care_providers/health_care_practitioners/psychologists/policy_and_practice/default.asp)

**WCB Standards of Conduct**  
[http://www.worksafebc.com/bid\\_opportunities/Assets/PDF/standards\\_of\\_conduct.pdf](http://www.worksafebc.com/bid_opportunities/Assets/PDF/standards_of_conduct.pdf)

**Privacy Protection and the Health Care Provider**  
[http://www.worksafebc.com/publications/how\\_to\\_work\\_with\\_the\\_wcb/Assets/PDF/FIPPA\\_health\\_care\\_providers.pdf](http://www.worksafebc.com/publications/how_to_work_with_the_wcb/Assets/PDF/FIPPA_health_care_providers.pdf)

**Form 6: Application for Compensation and Report of Injury or Occupational Disease**  
<http://www.worksafebc.com/forms/assets/PDF/6.pdf>

**Form 7: Employer's Report of Injury or Occupational Disease**  
<http://www.worksafebc.com/forms/assets/PDF/7.pdf>

**Form 8/11: Physician's Report**  
<http://www.worksafebc.com/forms/assets/PDF/7.pdf>

## **Appendix B: WSBC Contact Information**

For inquires regarding joining the Psychology Provider Network contact:

Bonnie Germyn  
Corporate Supply  
(604) 279-7439

If you are already a member of the Psychology Provider Network and would like to update your contact or service information, send the changes in writing to:

Bonnie Germyn  
Corporate Supply  
WorkSafeBC  
PO Box 5350 Stn Terminal  
Vancouver BC V6B 5L5

For clarification of contract issues contact:

Sara Gilbert, Program Manager  
(604) 231-8841

Or

Dr. Shirley Louth, Psychology Quality Assurance  
(604) 231-8852

For inquires regarding invoicing or payment issues please contact:

Payment Services  
Lower Mainland: 604-276-3085  
Toll Free: 1-888-422-2228

For clarification of procedures or additional copies of these guidelines please contact:

Kerri Fraser  
Psychology Services  
(604) 214-5424

For clinical and practice issues please contact:

Dr. Greg Meloche  
Manager, Psychology Services  
(604)-279-7654

To report missed appointments of authorised assessments, please contact the Case Manager whose name appears on the Treatment Program and Psychology Referral Form.

To discuss clinical issues pertinent to the authorised referral, please contact the Psychology Advisor whose name appears on the Psychology Referral Letter.

To contact WSBC staff toll-free please dial 1-888-967-5377  
and provide the last four digits of the person's telephone number as the extension.

## **Appendix C: Sample Assessment Report Format**

Alan Back, Ph.D.  
12-345 6<sup>th</sup> Street  
Vancouver BC  
Phone: 604-123-4567  
Fax: 604-123-7890

### **Psychological Assessment for Permanent Functional Impairment**

Date of Assessment:  
Date of Report:

#### **Client Information:**

**Name:**

**Claim Number:**

**Date of Birth:**

**Date of Injury:**

**Reason for Referral:**

**Documentation Review:**

**Clinical Interview:**

**Interviews with Other Sources:**

**Psychometric Findings:**

**Discussion & Conclusions:**

## Appendix D: Sample Consent Form

### **Caveat**

This form is an example only for the purposes of illustrating the kinds of issues that should be addressed in the content of such a form.

This form should not be relied upon as providing either direct or indirect legal advice. Clinicians should seek and obtain legal advice if they have any concerns about the legal appropriateness or sufficiency of any forms that they use in their practice.

### **Consent for Psychological Assessment**

I the undersigned, \_\_\_\_\_ have read the following and agree to participate in a psychological assessment of myself with Dr. \_\_\_\_\_.

It has been explained to me that this assessment is for the purpose of assisting with the administration of my Workers' Compensation Claim. I understand that this is an independent assessment that will be sent to the WSBC of BC and become part of my permanent claim file.

All products of this assessment, including all records produced by the psychologist provided by me and other sources (e.g., physicians, family) and the psychologist's verbal and written testimony regarding this assessment may be obtained by the WSBC.

Beyond the limitations on confidentiality posed by the WSBC Act and Policy, the psychologist may be required to reveal information from this assessment to relevant authorities due to court subpoena, or concerns of potential violence to others, acts of child abuse, or impairment of ability to operate a motor vehicle.

While legal counsel or others may have led me to expect that this assessment will have a very specific benefit to me, there is no guarantee that the product of this assessment will be beneficial to me, nor that I will like or agree with the facts, opinions or conclusions of the report.

My signature below acknowledges that I have had the opportunity to carefully read this document, and to ask and have answered any questions or concerns I have about it or arising from it. I further acknowledge that I have read and understood the information contained in this document, that it records my consent

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_