

WorkSafeBC

The Psychology Assessment
Services
Reference Manual



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1.0 Contact Information

1.1 **General Contract Notices:**

For questions related to the Agreement terms and conditions, change in licensing requirements and notices:

Corporate and Health Care Purchasing

Fax #: (604) 276-3260

Phone: (604) 276-3344

Toll free: 1 (888) 967-5377 extension 7464

Email: purchase@WorkSafeBC.com

1.2 **Board Officer or Case Manager or Psychology Advisor:**

For questions regarding entitlement, or individual Injured Worker related questions, please refer to the Call Centre (see below) to get Board Officer contact information.

1.3 **WorkSafeBC Provider Referrals Department**

For questions regarding referrals:

Phone: (604)231-8887

Toll free: 1-866-481-8887

1.4 **Health Care Services:**

For questions regarding contract processes, forms or reports, clinical questions and service quality issues, contact the Quality Assurance Supervisor or Program Manager at:

Phone: (604) 232-7787

Toll free: 1 (866) 244-6404

Fax: (604) 231 8424

1.5 **Assessment Registration:**

For questions regarding registration letters, registration status or clearance letters:

Phone: (604) 244-6181

Toll Free: 1 (888) 922-2768

On-line: Information may be found on WorkSafeBC's website at www.WorkSafeBC.com. Click on "Insurance" tab.

1.6 **Additional Phone Numbers:**

WorkSafeBC Call Centre

Phone: (604) 231-8888

Toll free: 1 (888) 967-5377

WorkSafeBC Payment Services

Phone: (604) 276-3085

Toll free: 1 (888) 422-2228

1.7 WorkSafeBC Corporate Security Department:

For issues related to threats:

(604) 279-7578

1.8 Forms

All forms can be downloaded at www.WorkSafeBC.com under Forms - Health Care Providers.

2.0 Purpose of Reference Manual

This manual is intended to assist with specific business processes related to providing psychology assessment services to WorkSafeBC. The manual is not a stand-alone document, but is intended to be used in conjunction with the Mental Health Providers for Psychology Assessment Agreement.

The Psychology Assessment Reference Manual may be updated during the term of the Agreement, with revisions becoming part of the Manual and Service terms. The Psychologist is responsible for maintaining the Reference Manual, including incorporation of any updates and communications from WorkSafeBC.

3.0 Overview of WorkSafeBC

WorkSafeBC (The Workers' Compensation Board of British Columbia) is an employer-funded government-regulated organization responsible for administering the workers' compensation system in British Columbia. The mandate of WorkSafeBC is to return the injured worker to their pre-injury health and assist with return to the workforce if possible. If a worker's claim is accepted, benefits and services may include wage-loss replacement, clinical assessment and treatment, vocational assistance, and financial compensation for permanent functional impairment.

WorkSafeBC claims are managed by a multidisciplinary case management team which includes, but is not limited to, the following individuals:

- Case Manager – Responsible for the overall administration and management of a claim from the time of injury through to recovery or clinical stability.
- Psychology Advisor – Serves as a consultant to the Case Manager by providing psychological opinions and advice based on a review of available information, in addition to acting as the professional liaison to the mental-health community and arranging for appropriate psychological assessments and treatment.
- Medical Advisor – Serves as a consultant to the Case Manager in providing medical opinions and advice, as well as acting as the professional liaison to medical professionals in the community and arranging for appropriate assessment, treatment and physical rehabilitation.
- Vocational Rehabilitation Consultant - Responsible for assisting the injured worker to return to the workforce, providing practical help with job search skills, graduated return-to-work plans and, if necessary, vocational redirection.

Psychological assessments may be requested at various points throughout a worker's claim including at initial adjudication (to assist in determining diagnosis and causality), after a claim is accepted (for case management and treatment planning purposes), after psychological treatment (to review treatment progress and determine need for further services), during the Vocational Rehabilitation phase (to determine limitations and restrictions), and near the end of a claim (for pension purposes).

Psychological treatment may also be provided for psychological disorders arising from work-related injuries. It is beyond the scope of WorkSafeBC's mandate to provide treatment for pre-existing psychological conditions or concurrent issues that are problematic but not related to the claim. Essentially, WorkSafeBC is responsible for helping the injured worker return to his or her pre-injury psychological status, whatever that might have been. This may 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.

4.0 Service Description

General overview

When information comes to the attention of WorkSafeBC that a worker's claim may include a "psychological injury" or that significant psychological issues are present, the file may be referred for a psychological or neuropsychological assessment. These assessments are undertaken for a number of reasons including, but not limited to:

- diagnosis
- causality determination
- treatment planning
- clinical progress/review
- evaluation of permanent functional impairment

The types of Psychology Assessments that may be requested by WorkSafeBC include:

- Psychology Assessment - including assessment for Permanent Functional Impairment (PFI);
- Neuropsychology Assessment - including assessment for Permanent Functional Impairment (PFI); and,
- Supplemental Psychology/Neuropsychology (PFI) Consultations.

Description of assessment services

Psychological Assessment

A Psychology Assessment is a comprehensive assessment with a "medical-legal" focus answering a variety of referral questions including but not limited to diagnosis, causality, prognosis, work-related psychological functioning and need for treatment.

Neuropsychological Assessment

A Neuropsychology Assessment is a specialized comprehensive Psychology Assessment designed to determine the extent of any work-related brain injury, its effect on the individual's functioning, and the type of treatment that may be required.

Permanent Functional Impairment (PFI) Assessment

The Psychology PFI Assessment is a psychological or neuropsychological assessment with a greater focus on the presence of psychological functional impairment associated with a work injury. These assessments are requested once a worker's accepted psychological condition has reached clinical stability ("plateau"), and there is reason to believe the person has been left with some degree of permanent impairment.

Supplemental Consultation

A Supplemental Consultation is an additional brief report requested by WorkSafeBC in order to address additional questions subsequent to a Psychology/Neuropsychology Assessment or Psychology/Neuropsychology PFI Assessment of an injured worker.

5.0 Referral Process

Once it is determined that a psychological assessment is required in a particular case, the following process will be followed:

- The Injured Worker must be referred for Service by a Board Officer via WorkSafeBC's Provider Referrals Department. The Provider Referrals Department will verbally contact the Psychologist to advise them of a potential referral.
- The Psychologist shall advise Provider Referrals within two (2) business days of receiving the verbal referral whether he or she can accept the referral. If this communication is not received within this timeframe, Provider Referrals may redirect the referral.
- If the Psychologist accepts the referral, then he or she will give Provider Referrals the tentative appointment date/time. If the Psychologist cannot provide the Injured Worker with an appointment within ten (10) business days of the verbal referral, Provider Referrals may redirect the referral.
- Once confirmation of referral acceptance is received, Provider Referrals shall fax to the Psychologist the Psychology Assessment referral and the WorkSafeBC Psychology Advisor's referral letter, outlining the type of service requested.
- The Psychologist shall call Provider Referrals within five (5) business days of receiving the referral and referral letter to communicate the Worker's confirmed

- appointment date. If the Psychologist cannot reach the Injured Worker within this time frame, the Psychologist must inform Provider Referrals immediately.
- WorkSafeBC will send the Psychologist the Worker's claim file background information (disclosure).
 - Appointments must be booked at least two (2) business days in advance to allow for receipt of the claim file background information.
 - If the Injured Worker cannot keep his/her scheduled appointment or is a 'no show', the Psychologist is responsible for reporting to Provider Referrals within one (1) business day.

6.0 Interpreter Services

WorkSafeBC has contracted with interpretation/translation service Providers throughout BC. If your organization has an in-house Interpreter, these services must not be billed to WorkSafeBC.

In most cases, Provider Referrals will arrange the initial appointment with the interpretation Provider. The Psychologist is responsible for advising Provider Referrals of the number of hours and days that the Interpreter will be required for the initial appointment. Subsequent appointments will be booked by a WorkSafeBC Team Assistant.

The Psychologist is responsible that the following conditions are met:

- Communicating the need for interpreter services with the Board Officer, if this need is determined during the initial appointment (or later);
- Requesting interpreter services for as accurate time frames/durations as possible;
- Accurate documentation of the interpreter's service hours following each Interpreter Service. The hours should not be rounded, but should be documented to the minute on the Interpreter Assignment Sheet;
- Providing as much notice as possible (ideally 24 hours) for all bookings and cancellations;
- Notification of the Provider Referrals Department regarding cancellation/rescheduling of the Initial Assessment;
- Notification of the WorkSafeBC Team Assistant regarding cancellations of any appointments following the Initial Assessment;
- Contacting the Quality Assurance Supervisor in Health Care Services responsible for Interpretation with any quality concerns with respect to the interpreter services, including if the interpreter is late or does not attend the scheduled appointment; and,
- Making every effort to ensure the cost effective use of interpreter services.

7.0 Reporting and Communication Requirements

When an assessment referral has been accepted, the psychologist must adhere to the following reporting and communication requirements:

Written reports

- Written reports shall respond clearly and objectively to the specific referral questions presented by the WorkSafeBC referral letter and must follow the format provided by WorkSafeBC (10D5). (Please see section 8 below for a more detailed description of required report content.)
- Reports not meeting the expectations outlined in this reference manual shall not be reimbursed.
- Assessment reports must meet the timeliness expectations outlined below:
 - The Psychological Assessment Report shall be received by WorkSafeBC within **ten (10) business days** of the confirmed appointment date.
 - The Psychological Assessment PFI Report shall be received by WorkSafeBC within **ten (10) business days** of the confirmed appointment date.
 - The Neuropsychology Assessment Report shall be received by WorkSafeBC within **twenty (20) business days** of the confirmed appointment date.
 - The Neuropsychology Assessment PFI Report shall be received by WorkSafeBC within **twenty (20) business days** of the confirmed appointment date.
 - The Supplemental Consultation Report shall be received by WorkSafeBC within **ten (10) business days** of the confirmed appointment date.
- Reports meeting these timeliness expectations will receive a timely report fee (if invoiced) of \$100.00.

Verbal communication

The Psychologist must contact the Board Officer/Psychology Advisor by telephone:

- Within one (1) business day when the Worker has withdrawn from the assessment.
- Within one (1) business day regarding any Injured Worker absences, no shows, or cancellations.
- Within one (1) business day when the Provider becomes aware that the assessment requirements are out of his/her area of expertise.
- Immediately and without delay when an incident occurs of accidental or traumatic nature during the assessment.
- Immediately and without delay when there are indications that the Injured Worker is at risk of imminent harm to self or others.

8.0 Assessment Service Requirements

This section outlines service expectations for all types of psychological assessments that a provider may be requested to provide to WorkSafeBC.

Assessment content

Each assessment conducted for WorkSafeBC should consist of, but is not limited to:

- Review of background reports and other documentation provided by WorkSafeBC (including surveillance video and/or documentation as required);
- Structured clinical interview with the Injured Worker to assess the presence of any relevant mental disorders and/or personality conditions;
- Collateral interviews with other parties to obtain additional corroborative information regarding the Injured Worker's psychological functioning;
- Psychometric assessment using standardized psychological measures (including comprehensive measures with validity scales i.e. MMPI-2, PAI, etc.);
- Written report documenting and integrating the assessment results.

If the provider is unable to complete parts of the assessment, the reasons for this should be documented in the assessment report.

Neuropsychology Assessments

In addition to the items noted above, a Neuropsychology Assessment should also include:

- A battery of neuropsychological tests selected on the basis of the referral question and individual worker characteristics.
- Use of several well-validated and generally accepted neuropsychological measures of symptom validity.

Psychology/Neuropsychology PFI Assessments

In addition to the items noted above, the PFI assessment should also ascertain the presence of any psychological and/or neuropsychological dysfunction related to the accepted conditions in the areas of: a) activities of daily living; b) social functioning; c) concentration, persistence and pace; and d) functioning in work or work-like settings. (See the section below for a more detailed description.)

Supplemental Consultations

Supplemental consultations typically involve review of additional documentation subsequent to a psychological assessment, as well as an opinion integrating the new material into a previously provided opinion. (The consultation may or may not require additional contact with the client.) Supplemental consultations for PFI may occur

subsequent to a regular assessment to assist in understanding permanent functional impairments where a full re-assessment is not clinically warranted.

Report content

The written assessment report should include, but is not limited to, the following information:

- A brief history of the presenting complaint(s) including a description of the work incident and immediate reactions to the event;
- A review of relevant past personal and family psychological history, as well as previous social and vocational functioning;
- An overview of psychological, social and vocational functioning since the work incident (including review of any pertinent records and documents);
- An evaluation and interpretation of the results of any psychometric instrument(s) administered (including comment on the validity of the test results);
- Comments on the validity of the clinical presentation indicating if symptoms presented were plausible, straightforward, under-reported or over-reported;
- DSM-IV-TR diagnosis;
- An analysis of causation including:
 - A clear statement of the relationship, if any, of current psychological functioning to the workplace incident;
 - Description of pre-existing and/or concurrent factors and their impact on the current psychological functioning i.e. precipitating, maintaining, etc.;
 - Weighting of factors, and a clear summary statement;
- A detailed description of current work-related psychological functioning including psychological impairments, limitations and restrictions;
- A statement about prognosis including:
 - estimated likelihood and length of recovery;
 - comments on clinical stability and permanence as appropriate; and
 - the likelihood of a psychological permanent functional impairment;
- Treatment and rehabilitation recommendations, if any;
- Any other relevant information.

Neuropsychology Reports

In addition to the report content outlined above, the neuropsychology report should also include:

- A list of all the tests used (may be included in an appendix at the end of the report)
- All of the test scores (reported as percentiles) and the source of any normative data (may also be included in an appendix)

Psychology/Neuropsychology PFI Assessments

In addition to the report content outlined above, a PFI assessment should describe the degree of permanent psychological impairment caused by the work-related injury and render a clinically based opinion on the impact of the impairment on occupational behaviour. 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 should be utilized:

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, neighbours, 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.

In a work environment, 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 at work. "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)

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.

When describing permanent psychological impairments, providers should also take into account the following factors:

- **The potential effect of further treatment** – The assessment should be deferred if it is likely that more treatment may be effective in alleviating a psychological condition.
- **The effect of structured settings** – When making judgments on an individual’s functioning level, special consideration should be given to their functioning in an unstructured environment.
- **The potential effect of medication** – The effect of medications on functional limitations must be considered: direct effects on psychological symptoms, as well as potential side-effects (e.g. drowsiness, mental slowing, decreased motivation, etc.)
- **The effects of compensation** – Ongoing interaction with the compensation system, especially if prolonged and/or conflict-ridden, may result in exacerbation of the original symptoms or in development of new ones.
- **The potential effect of acute stressors** – Individuals being assessed may have recently suffered an acute exacerbation of their otherwise chronic symptoms due to acute stressors (e.g. death in the family, divorce, loss of a job, another injury, etc.).
- **The effect of motivation** - Level of motivation must be taken into consideration since the effects of an individual’s motivation are sometimes indistinguishable from symptoms of psychological disorders.
- **The potential effect of pain** – Chronic pain may serve as a confounding variable, and assessors must consider the adverse effects of pain on various psychological functions (e.g., concentration, thinking, memory, frustration tolerance, etc.).
- **The effects of demographic factors** - When evaluating functional impairment, the psychologist must be aware of the potential influence of such factors as age, gender, ethnic and cultural factors.
- **The potential effects of impairments not arising from the work injury** - The respective effects of impairments that arise from or do not arise from the accepted psychological injury need to be clearly distinguished as much as is scientifically and clinically possible.
- **The need for reassessment:** If clinically significant changes in psychological functioning are anticipated, the need for future review and the timing of it should be indicated in the report.

9.0 Clinical and Ethical Issues

Consent

Workers applying for WorkSafeBC benefits sign a release form authorizing WorkSafeBC to obtain and share any information relevant to the claim. However, workers may not be aware that the consent also applies to external clinicians. Therefore, it is strongly recommended you obtain signed consent from the worker to obtain and/or release all relevant information to WorkSafeBC.

Confidentiality

As per the Code of Conduct, limits of confidentiality and informed consent issues must be clearly addressed with the client and documented prior to beginning the assessment.

In order to facilitate this, the following information should be provided to the worker:

- All of the information obtained in the assessment could end up in a report which will be sent to WorkSafeBC and added to the claim file.
- WorkSafeBC has the right to obtain all of the provider's clinical notes if required for adjudication or management of the claim.
- Information from the claim file, including the assessment report, may be shared with other clinicians and professionals in order to better facilitate assessment or treatment services.
- In the case of an appeal, the employer has the right to obtain any and all claim file information, including the assessment report.
- Certain government agencies may also have the legal right to obtain claim information from WorkSafeBC.

Often the injured worker will ask the external clinician for a copy of the reports submitted to WorkSafeBC. If you receive such a request, you may provide the information; however, you should be aware that this can lead to confusion and misinformation (for instance, if the report is in any way different from the report sent to WorkSafeBC, or if it is received by the worker before receipt by WorkSafeBC). Therefore, it is usually best for the worker to obtain copies of assessment reports through WorkSafeBC, usually via their Case Manager.

Test Scores and Raw Test Data

As required by the Code of Conduct, test results should be reported as t-scores or percentiles and incorporated in the body of the report. If WorkSafeBC requires the raw data, we will request a copy of the raw test scores be sent separately.

Client Debriefing

Feedback by the service provider to the worker regarding the assessment results is considered to be an integral part of the assessment process, and may also be ethically necessary. This feedback should focus on specific clinical issues and recommendations, but avoid comment on or discussion of compensation-related issues. Particular care should be taken to avoid comment on what WorkSafeBC should or should not do, as these are matters of law and policy, and therefore outside the clinician's area of expertise. If the clinician anticipates difficulty with the debriefing, they may want to discuss this with the WorkSafeBC Psychology Advisor, or even schedule the debriefing at a WorkSafeBC office with the Psychology Advisor present.

Advocacy

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.

WorkSafeBC 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. When a clinician takes on a legalistic/claim advocacy stance, they have effectively provided an opinion 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," 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.

If you believe an injured worker could benefit from assistance with claims-related issues, please encourage them to contact the Worker's Advisor's office nearest them. In addition, many unions provide such assistance for their members. General complaints can be directed to the WorkSafeBC Complaints Office.

Expert Opinion

Given that the workers compensation system relies on written reports rather than oral testimony from expert witnesses, it is essential that responses to WorkSafeBC referral questions take the form of an expert opinion.

Evidentiary Basis for Opinions

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 veracity 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.

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. 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.

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 WorkSafeBC 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 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.

Diagnosis

All psychological diagnoses must be based on the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). 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 only 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 determination of the acceptability of a WorkSafeBC claim and provision of appropriate benefits is based on a number of criteria, including: a) The person must be a “worker” as defined in the Workers Compensation Act; b) The person must have sustained a “personal injury”; c) The injury must have occurred in the course of work; and d) The injury must have resulted in a period of disability.

The acceptability of an injured worker’s claim is decided through adjudication by a Board officer based on clinical evidence and guided by WorkSafeBC law and policy. In order to adjudicate a claim, a clinical diagnosis must be clarified and clinical causality must be understood. In addition, the extent of any resulting disability and appropriate rehabilitation is also based on clinical information.

While causality in the WorkSafeBC setting is understood to be multi-factorial, the relative impact of the multiple factors must be weighed in determining the compensability of the injury. It is the role of clinician 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 WorkSafeBC law and policy.

Specifically, the clinician should outline 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.

General Considerations

While it is easy to outline historical events or test scores, the challenge lies in delineating the clinical reasoning that moves one from facts to conclusions. It is recognized that causality opinions contain a large judgement component, which is why they require 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 precisely these that provide the basis for a convincing expert opinion.

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 other causative factors present for psychological condition to be accepted as part of a WorkSafeBC 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 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 a 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, these factors do not arise until some time after the work-injury, and 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.

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 should be able to apportion the causal importance of factors on a percentage basis. However, at present, the best that can often be done is to provide a cruder 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.

Clinical categories

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 any role the pre-existing condition may have played in the current symptomatology, as well as the role of the work incident in relation to the pre-existing condition.

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.

Reporting Causality

Taking all of the above-noted information into account, the causality section in the report should contain the following:

- A clear statement of the relationship, if any, of current psychological functioning to the workplace incident;
- Description of pre-existing and/or concurrent factors and their impact on the current psychological functioning e.g. precipitating, aggravating, perpetuating, etc.;
- Weighting of all relevant contributing factors e.g. minor, moderate, major, etc.;
- A clear explanation and summary statement.

Impairment

As defined by the World Health Organization, impairment is any loss or abnormality of psychological, physiological, or anatomical structure or function. Impairment represents a deviation from usual human ability, and compares one individual's function to that of an idealized "normal" individual.

In the psychological realm, impairments can be observed when psychological symptoms interfere with a person's psychological functioning. For instance, hypervigilance is an impairment because it is a loss of usual human ability. It may impact the person's ability to function socially or in the community because of their heightened anxiety and suspiciousness. Levels of impairment can range from absent to severe.

When rendering an opinion regarding an injured worker's psychological impairment, 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. Descriptions of impairment must be anchored in observed or reported behaviour, and may be further clarified by describing them in terms of frequency, intensity and severity.

Many injured workers 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. In addition, care must be taken to differentiate between impairments related to the psychological conditions that have been accepted by WorkSafeBC as a work-injury, and any other psychological or physical conditions that may be present.

It is important to note that an impairment is not equivalent to a work disability. For instance, reduced concentration may be an impairment, but does not necessarily limit an individual from working. An air traffic controller with reduced concentration is likely disabled from work as an air traffic controller. A general labourer with reduced concentration may be somewhat impaired, but would not be disabled from his work.

For this reason, 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 or her income.

Another specific example related to impairment and disability would be the issue of employability. It is important to note that 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, but rather delineate the ways in which 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.

Limitations and restrictions

Psychological limitations and restrictions are descriptions of how injured workers' psychological impairments impact their work functioning. These descriptions are used by WorkSafeBC staff to make claim decisions, which can have a significant impact on ongoing benefits and/or pension entitlements. For example, case managers and vocational rehabilitation consultants use these functional descriptions to create return to work or vocational rehabilitation plans.

Definitions

Limitations: Psychological limitations are defined as a reduction of the individual's capacity to perform job-related tasks as a result of a psychological condition. The person can still do their job from a psychological point of view, though with reduced capacity e.g. the worker is slower, less productive, less efficient, or can do the work activity for a shorter duration – but they can still do that activity.

For instance, the worker with poor concentration may be limited in tasks in which an increased error rate is unacceptable e.g. a production line, or from tasks which demand a high degree of productivity e.g. assembling a certain number of items within a time limit. While there may be no danger of immediate harm, the worker is likely to significantly slow down production, create problems for co-workers, or be fired for lack of adequate performance.

Restrictions: Psychological restrictions are clinical prescriptions to avoid an activity due to immediate likelihood of significant harm that arises out of a psychological condition. If the work participates in the work activity, there is a significant

probability of immediate harm. Even if the worker stated they wanted to do the activity, the clinician would advise against it.

For example, an individual with significantly reduced concentration may be restricted from tasks involving dangerous machinery, as participating in such work activities would likely result in immediate injury to themselves or others.

Describing limitations or restrictions

The description should be detailed, but clear and easy to understand for the reader. For example:

“Due to the worker’s cognitive difficulties (concentration problems, memory difficulties, impaired judgment, and poor decision-making abilities), they are likely to have limitations in positions in which a significant component of the job involves complex activities, high-level decision-making, or multi-tasking i.e. supervisory or managerial positions, high-level clerical or analyst positions, etc.. For the same reasons, they are also restricted from any position involving operation of high-speed or dangerous machinery, due to the risk for injury to themselves or others.”

It is important to comment on the clinical reason for, and the plausibility of, the worker's stated or observed limitations. For example:

“Given the level of cognitive impairment resulting from the head injury (as outlined in neuropsychological testing, collateral information from spouse, and the functional capacity assessment), the above-noted limitations and restrictions are reasonable and may reduce the likelihood of a failed return to work.”

The description of limitations should be based on the provider’s review of the available information and their clinical judgment, not simply the worker’s self-report. For example:

“While the worker reports that they have severe memory impairments and cannot work at all, collateral information and psychological testing places these impairments in the mild to moderate range. Therefore, the worker is not totally impaired, but may be limited in, or even precluded from, the positions outlined above.”

Opinions on non-psychological conditions and limitations should not be included i.e. physical limitations, lack of education, etc.

Comments on psychological conditions and limitations unrelated to the work incident should be clearly noted as such. For example:

“While the worker’s depression is clearly impacting his ability to work, this pre-existing condition had already resulted in a partial disability 6 weeks prior to the work incident.”

“The worker’s anxiety and related limitations appear to be more a result of ongoing labour relations issues that the compensable work incident”.

Any statement of significant limitations, restrictions or disability must be accompanied by significant supporting clinical information. It is not appropriate to make statements that a claimant is partially or totally disabled while providing little or no supporting information and few limitations or restrictions.

Limitations and restrictions may be *temporary* or *permanent* and it is important to describe them with the appropriate qualifiers.

- i) Temporary limitations and restrictions may require work accommodation during treatment that can be removed at the point of recovery.
- ii) Permanent limitations and restrictions are not removed even after the person has reached their point of maximum recovery.

Assessment of validity

While there may be a tendency by professionals to take their clients’ presentations at face value, there are actually a number of possible sources of information bias in any assessment or treatment setting. Research has shown these to include distorted beliefs and perceptions, unconscious exaggeration of symptoms, diagnosed psychopathology (such as factitious disorder), and malingering. In addition, studies have found that the likelihood of such biases affecting an individual’s presentation is increased in a forensic/medico-legal context, given the high stakes that are often involved i.e. wages, pension, etc. Therefore, in order to provide the most accurate and unbiased description of a WorkSafeBC claimant, it is vitally important that the validity of their presentation and information is investigated and reported by the assessing or treating professional.

Clinical judgment

One approach of many professionals is to rely on clinical judgement; however, this has not proven to be either accurate or effective. For instance, there is no research evidence that professionals have any ability to detect simple deceit much above chance, let alone determining an individual’s general character and level of honesty. Nonetheless, professionals generally think they are making more accurate judgments than they actually are. In addition, professionals who assume that a person is being truthful simply because no signs of deceit could be detected are making a significant logical error; for instance, a person may simply be a very skilled liar, or have come to believe what they are saying. Finally, studies investigating the ability of experienced forensic mental health professionals to detect malingering of mental disorders found

only a 50% accuracy rate. Therefore, if professionals are not very good at detecting outright deceit and malingering, it is quite likely that they will be even less accurate in catching the more subtle biases or distortions that occur in any given situation.

Systematic assessment of validity

In order to combat the inherent unreliability of clinical judgment and to effectively investigate the validity of a claimant's information, it is important to implement a systematic approach.

Psychometric testing – recommended tests and scales

(These are generally accepted as good psychological measures of validity)

1. General validity
 - a) MMPI-2: Fp scale
 - b) PAI: MAL/RDF scale
 - c) MMPI-2: Ds scale
 - d) PAI: NIM scale
 - e) MMPI-2: F/Fb scales
2. Additional validity tests for specific diagnoses
 - a) Cognitive impairment
 - i. Word Memory Test (WMT)
 - ii. Test of Memory Malingering (TOMM)
 - iii. DOT Counting Test
 - b) Depression
 - i. MMPI-2: Md scale
 - ii. Structured Inventory of Reported Symptoms (SIRS)
 - iii. TOMM/WMT
 - c) PTSD
 - i. Trauma Symptom Inventory (TSI): Atypical Responding Scale – PTSD symptoms
 - ii. Structured Inventory of Reported Symptoms (SIRS)
 - iii. TOMM/WMT

Note: The use of the MMPI-2 FBS Scale is currently under debate and therefore, clinicians should apprise themselves of all the issues prior to utilizing it in a medico-legal context.

Examination of consistency vs. inconsistency

1. Consistency of presentation during interview
 - e.g. Individual indicating pain as constantly 10 of 10, but no other pain behaviours observed
2. Consistency of interview presentation with file data

- e.g. File indicates the individual cannot drive due to cognitive deficits, but drives to appointment
- 3. Consistency of interview presentation with psychometric data
 - e.g. MMPI-2 strongly suggests severe anxiety, but the individual is completely relaxed for duration of assessment
- 4. Consistency of interview presentation with known clinical constructs
 - e.g. Taxi driver complains of driving phobia, but can drive an RV
- 5. Consistency of presentation and information with reports from collateral sources of information (i.e. family, employer, co-workers, school/work records, surveillance data, etc.)
 - e.g. Individual reporting good work performance prior to incident, but employer records show otherwise

Reporting of validity concerns

When validity concerns are detected through psychometric testing or significant inconsistencies in a WorkSafeBC claimant's presentation, this information should be reported in detail in the assessment or treatment report. In addition, the reporting professional should outline the limitations on the validity and reliability of the claimant's presentation and information, as well as the limitations this imposes on their diagnoses, opinions and conclusions. (Please see CPBC Code of Conduct, 3.17, General Standards for Competency, Limitations on Opinions).

Conclusion

Assessing validity of a claimant's presentation and information in a compensation context can be very difficult and complex. Those professionals who simply accept a claimant at face value, who do not assess for possible sources of bias (especially when significant impairment is reported), or who disregard/de-emphasize important information about invalidity and inconsistency, will have little weight given to their reports by WorkSafeBC staff. In contrast, those providers utilizing the systematic approach outlined above - the "gold standard" in psychology - will provide WorkSafeBC with an accurate and unbiased report which will ultimately be the most useful in providing injured workers with the assistance they are entitled to.

10.0 Appendices

WorkSafeBC Website

<http://www.WorkSafeBC.com>

The WorkSafeBC 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

Psychologist Policy and Practice

http://www.worksafebc.com/health_care_providers/health_care_practitioners/psychologists/policy_and_practice/default.asp

WorkSafeBC Standards of Conduct

http://www.worksafebc.com/contact_us/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_WorkSafeBC/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 Exposure

<http://www.WorkSafeBC.com/forms/assets/PDF/7.pdf>

Form 8/11: Physician's Report

http://www.worksafebc.com/forms/assets/PDF/8_11.pdf