



Mental Health Problems as Secondary Conditions to Work Injury Including Traumatic Mental Stress



By: Gary Majesky, *WSIB Consultant & Executive Board Member*

An important debate is taking place at our 353 union meetings regarding the need to adopt a Canadian Standards Association policy on Psychological Health and Safety in the Workplace. It's a motherhood and apple pie issue, but I really have some concerns regarding the lack of core competencies among the workplace parties to deal with these matters.

In my practice I deal with a lot of mental health issues, which incidentally, can be work related either as secondary consequence injury or due to traumatic mental stress i.e., witnessed/experienced a horrific life threatening event or act of violence. In my experience there is a lack of sophistication in many construction workplaces even though many of us have personal experiences with mental health in our own families, communities and among friends. Whether it is depression, anxiety, or myriad other issues such as addiction, which includes drugs, alcohol, as well as sexual disorders, you begin to see the enormity of the issue.

This month I wish to bring into focus Mental and Behavioural Disorders because the WSIB has long recognized that an injury can take place to the mind as well as the body. The problem areas arise in cases in which there is a claim for a psychological reaction to an accident, a psychological reaction to non-physically injuring events at work, or the real or perceived pain resulting from a physical injury. These cases deal with highly subjective areas that are not susceptible to exact, reproducible scientific standards.

In dealing with psychological disabilities, the standard classification system used to adjudicate mental health is derived from the American Psychiatric Association publication, Diagnostic and Statistical Manual of

Mental Disorders, 4th edition, (DSM-IV).

Psychotraumatic Disability

The WSIB has developed policies regarding entitlement for what is referred to as "psychotraumatic" disability. It is unclear why the WSIB used this phrase in referring to mental disorders that result from a compensable accident or the sequelae of accidents. The phrase itself is not defined and it seems to imply the requirement of a traumatic incident as a causative force. As can be seen in the Board policy, this is clearly not the case. Where a mental disorder results from the sequelae of an accident, it will be compensated even though it is quite unlikely that any part of the accident/injury is "traumatic" in the normal sense of the word. However, it is not unusual to see a claim denied, particularly at the initial levels, on the grounds that the accident was not "traumatic".

Although the word "Psychotraumatic" is undefined, the Board policy outlines clinical entities that are not consistent with terminology used in the DSM-IV, which is odd because the WSIB requires a DSM-IV diagnosis to consider psychological entitlement. The most prevalent diagnoses are anxiety disorder, depressive disorder, conversion disorder, psychogenic pain disorder, obsessive compulsive disorder, simple phobia, hypochondriasis, post-traumatic stress disorder, and psychological factors affecting physical condition. But this list is not exhaustive.

Of course, establishing that one of the above-mentioned mental disorders is present is not sufficient for entitlement to be granted. The question of causation must first be addressed. Indeed, if any other

mental disorder, with the obvious exception of malingering, can be shown to be causally related to the accident or its sequelae, there does not appear to be any reason why entitlement would not be granted.

It is commonly accepted that some people do not react as well as "normal" people would to various life events. However, when determining whether an accident or its sequelae (i.e., consequence) caused a mental disorder it is important to look at the question of causation in the individual case.

WSIB Policy Psychotraumatic Disability

The current WSIB policy has changed very little since a major revision in 1982. The policy now outlines the general entitlement criteria for a Psychotraumatic disability if the disability "is attributable to a work-related injury or a condition resulting from a work-related injury...providing the Psychotraumatic disability became manifest within 5 years of the injury, or within 5 years of the last surgical procedure."

The policy specifies Psychotraumatic disability may be established when the following circumstances exist or develop:

- Organic brain injury secondary to:
 - Traumatic head injury
 - Toxic chemicals includes gases
 - Hypotoxic condition, or
 - Conditions related to decompression sickness
- As an indirect result of a physical injury:
 - Emotional reaction to the accident or injury
 - Severe physical disability, or



- Reaction to the treatment process
- The Psychotraumatic disability is shown to be related to extended disablement and to non-medical, socio-economic factors, the majority of which can be directly and clearly related to the work related injury.

In every WSIB or third party private insurance claim, a mental health diagnosis must be provided by either a psychiatrist or psychologist in order for the claim to be adjudicated and accepted. Even though your family doctor may diagnose depression or anxiety and prescribe psychotropic medication, unless they are certified mental health care professionals, their diagnosis will not be sufficient to allow a claim.

This is frustrating because Psychiatrist

services are covered and paid for under OHIP, but good luck finding one when you need one. The waiting lists are horrendous, and the maladaptive mental health episode may have worsened or abated by the time you see a psychiatrist. That leaves workers and the public reliant on psychologists, whose services are not covered by OHIP, but are more readily accessible. So how does an ill or injured worker suffering wage loss self-fund the cost of mental health care services when incapacitated, including the cost of preparing medical reports, which insurers frequently request, but don't pay? It is a complex issue that I deal with frequently, and fortunately, our union leadership has funded my requests for supportive psychiatric reports, when needed.

Looking to the future, if we want to make

our workplaces psychologically healthier, we need to ensure our drug program covers most commonly prescribed drugs used in treatment, including a mechanism that links members with accessible, affordable and timely psychological services. More importantly, we need to be pragmatic and focus on the basics while dispelling mental health stereotypes' and the tendency for premature psychiatric labeling. The worst of these systemic behaviours, particularly among insurers, is that mental health problems are illnesses of convenience, because the disorder cannot be imaged on diagnostics, such as an MRI

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