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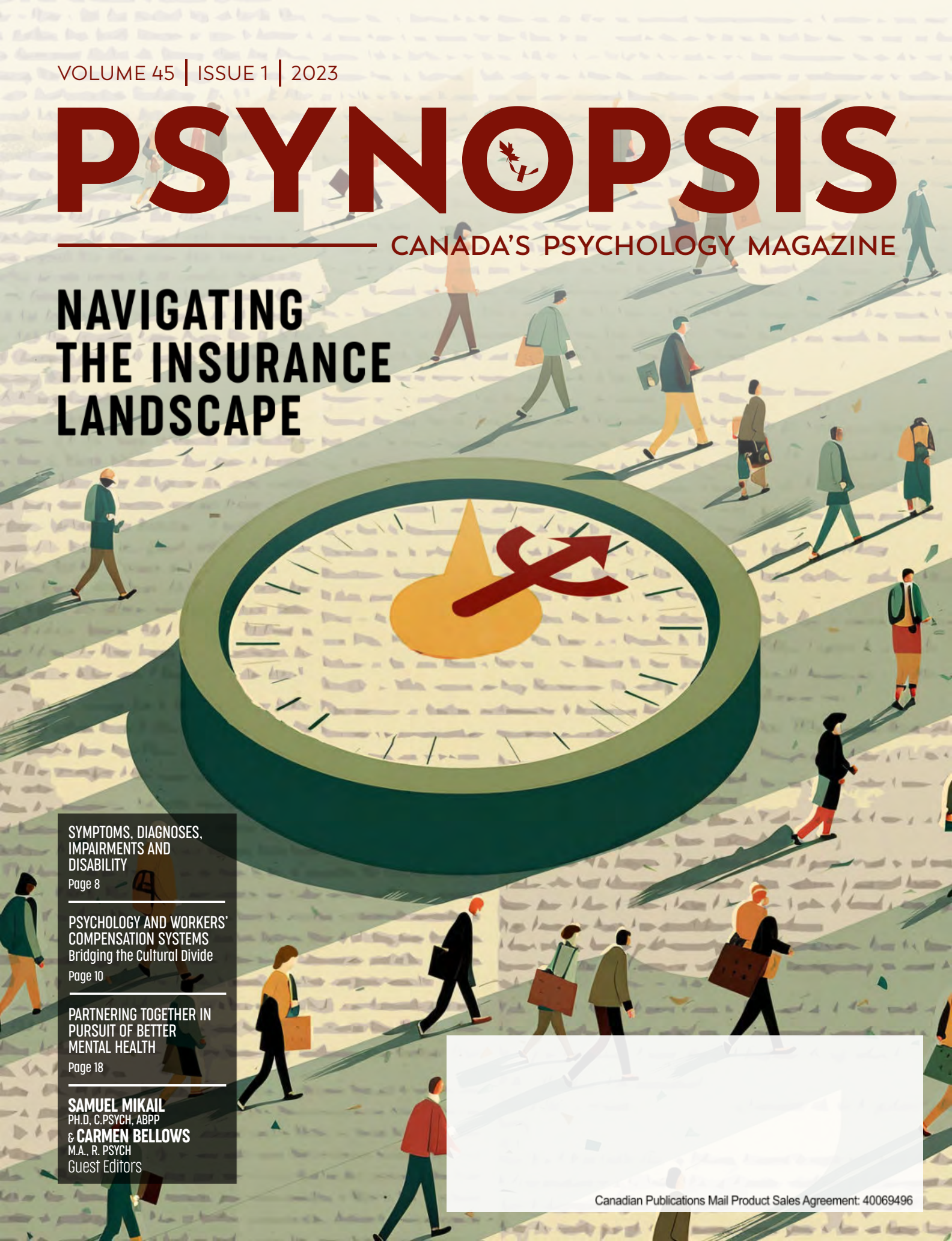
PSYNOPSIS

CANADA'S PSYCHOLOGY MAGAZINE

NAVIGATING THE INSURANCE LANDSCAPE



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THE OFFICIAL MAGAZINE OF THE CANADIAN PSYCHOLOGICAL ASSOCIATION

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MESSAGE FROM THE GUEST EDITORS

Navigating the Insurance Landscape

Over the past two decades psychological services have become part of the mainstream within the health care ecosystem. What was once accessible to a select few able to afford the services of private-practice psychologists has become more widely available to a broad cross section of Canadians. Numerous developments have made this possible, some of which include:

- The artificial divide between physical and psychological health has become increasingly blurred with recognition that these are overlapping dimensions of one's functioning.
- Both family physicians and pediatricians have made repeated calls to government for the integration of psychological services into primary care.
- Psychological associations like the CPA have helped to shape health system change through advocacy with government, funders and other mental health stakeholders[i]
- Initiatives such as Mental Health Month, World Suicide Prevention Day, Psychology Month, and other public service messaging have contributed to stigma reduction.
- Workplace harassment and bullying are recognized as compensable within legislation governing worker's compensation schemes.
- The World Health Organization legitimized burnout as a source of mental distress that can disable employees.
- The development of standards for Psychological Health and Safety in the Workplace by the Mental Health Commission of Canada.
- Several of Canada's large employers have increased their coverage for psychological services through extended health benefits plans for their employees[ii]

Despite these developments, Canada's public health care "system" has yet to evolve in a manner that meets the mental health needs of its citizens. The resulting gap has been filled largely by private insurers. This occurs within several contexts including employer-sponsored extended health care plans, private health care plans purchased individually or through alumni associations and Chamber of Commerce groups, disability insurance, and auto insurance. CPA has dedicated a significant amount of advocacy with organizations who represent insurers, trying to ensure that the coverage provided in the private sector covers an evidence-based amount of psychological service.[iii] Unfortunately, psychology training programs place little to no emphasis on how clinicians can best navigate these systems to meet the needs of their clients.

As a first step in responding to this knowledge gap, the Canadian Psychological Association collaborated with the Canadian Life and Health Insurance Association to create a set of resources for clinicians who provide health care in the extended health benefit environment (see CLHIA - Resources for healthcare providers). This special issue of *Psynopsis* was born out of the expressed needs of psychologists who have continued to experience frustration and confusion in their dealings with private insurers. As an example, the 2020-2021 annual report of the College of Psychologists of Ontario lists "Insurance or Other Benefits Assessment" as the second highest source of complaints to the College (25% of total complaints in that year). Even though the majority of these complaints did not result in disciplinary action against the clinician, the complaints process itself is a significant source of stress and disruption for the affected practitioner.

It is our hope that the articles that follow will advance the reader's understanding of critical contextual factors relevant to working effectively with insurers. Optimizing clinical outcomes is best achieved by the skillful application of evidence-based treatment, a positive therapeutic alliance, and effective and ongoing collaboration between all parties involved in a client's care. The article by Jeremy Frank makes the distinction between diagnosis and impairment. Dr. Frank explains that a diagnosis of a mental disorder does not always meet the definition of disability. Dr. Renee-Louise Franche expands on this point but noting that a determination of disability also requires consideration of work demands and worker beliefs. Dr. Franche underscores the importance of early intervention in the rehabilitation process and the inclusion of multiple partners when preparing an individual for the return- to-work (RTW) phase of treatment. Ron and Faith Kaplan untangle the complexities of working within the auto-insurance system using Ontario's system as an illustrative example. Central to their thesis is the importance of multidisciplinary collaboration and communication if we are to achieve positive outcomes for our patients. In many cases, successful RTW requires gradual re-entry coupled with appropriate accommodations. An article by Dr. Monique Gagnac considers the need to apply a biopsychosocial lens to workplace accommodations. Dr. Gagnac's recent research at the Institute of Work and Health has centred on developing a work accommodation tool for use by clinicians and employers. Finally, an issue on working effectively with insurers would be incomplete without insight from the vantage point of an insurer. To that end Mr. Dave Jones, President of Sun Life Health, provides an overview of the insurance landscape including the definition of disability as determined by insurers and employers. Mr. Jones concludes his article by offering six recommendations intended to forge greater collaboration between insurers and psychologists.

Psychologists bring a unique set of skills to the assessment and management of disability. As scientist/scholar-practitioners we are trained to draw on an extensive empirical literature and objective psychometric measures to guide our work. As noted by Mr. Jones, disability is defined contractually. As such, the role of the psychologist is to assess, document, and treat an individual's impairments. It does not include stating whether an individual is disabled. Assuming the role of patient advocate risks eroding the perception of a clinician's objectivity and potential credibility. ■

NAVIGATING THE INSURANCE LANDSCAPE

PSYNOPSIS
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Psynopsis is the official magazine of the Canadian Psychological Association. Its purpose is to bring the practice, study and science of psychology to bear upon topics of concern and interest to the Canadian public. Each issue is themed and most often guest edited by a psychologist member of CPA with expertise in the issue's theme. The magazine's goal isn't so much the transfer of knowledge from one psychologist to another, but the mobilization of psychological knowledge to partners, stakeholders, funders, decision-makers and the public at large, all of whom have interest in the topical focus of the issue. Psychology is the study, practice and science of how people think, feel and behave. Be it human rights, health care innovation, climate change, or medical assistance in dying, how people think, feel and behave is directly relevant to almost any issue, policy, funding decision, or regulation facing individuals, families, workplaces and society. Through *Psynopsis*, our hope is to inform discussion, decisions and policies that affect the people of Canada. Each issue is shared openly with the public and specifically with government departments, funders, partners and decision-makers whose work and interests, in a particular issue's focus, might be informed by psychologists' work. CPA's organizational vision is a society where understanding of diverse human needs, behaviours and aspirations drive legislation, policies and programs for individuals, organizations and communities. *Psynopsis* is one important way that the CPA endeavours to realize this vision.

CANADIAN PSYCHOLOGICAL ASSOCIATION
SOCIÉTÉ CANADIENNE DE PSYCHOLOGIE

FROM THE PRESIDENT'S DESK

KERRI RITCHIE Ph.D., C. Psych. (CPA President 2022-2023)

In 2018 the rates of people reporting a need for mental health services in the previous year was approximated at 5.3 million in Canada.[1] 1in 5 Canadians in the work force indicated living with a mental health problem or illness.[2] The disease burden of mental ill health & substance was found to be 1.5 times higher than all cancers combined.[3] These numbers are staggering. That all of this research was conducted before the COVID-19 pandemic, in which the cost of living continues to increase, and we have seen an increase in mental ill health is deeply concerning. Our discipline often speaks in terms of statistics, at the same time, we understand that we are speaking to what is happening within our families, neighbourhoods, communities, and for ourselves.

In this issue of Psynopsis, the authors systematically explain the difference between living with a mental illness and experiencing mental ill health. The need for expertise in assessing how mental ill health may or may not intersect with the various job tasks and demands for individuals could not be clearer. However, even senior health practitioners can go through their training and can be decades into their careers with little formal training or experience in understanding how mental health, mental ill health, and mental illness can intersect with occupational demands, accommodations, and disability. As with many busy professionals, we keep up with what we know, we teach and supervise in our areas of expertise, while too few of us have developed this expertise.

The CPA's partnerships with the Mental Health Commission of Canada on understanding the role of extended health benefits (Extended Mental Health Benefits in Canadian Workplaces) and with the Canadian Life and Health Insurance Association for clinician resources (CLHIA - Resources for healthcare providers) can help us close this gap. Irrespective of the area in which we work and our particular expertise, this issue of Psynopsis, provides a needed perspective on the inevitable health challenges all of us will face across our personal and professional lives.

FOR A COMPLETE LIST OF REFERENCES, PLEASE GO TO CPA.CA/PSYNOPSIS

SUPPORTING WELLNESS, NO MATTER OUR STATE OF HEALTH

K.R. COHEN
Ph.D., C. Psych.
CEO, CPA

While many stakeholders turn to the CPA and psychology for our expertise in the area of mental illness, there is increasing recognition of the important role that psychological health and well being plays in physical illness. Psychological factors can be risks for conditions like heart disease[i] and are commonly recognized as comorbid with chronic health conditions and critical to how successfully those conditions are managed.

Further, wellness is not categorical – it is not only for the well. Over the course of a lifetime, all of us live in various states of health. To extend Corey Keyes views on flourishing and languishing along the continuum of mental health and illness, it is possible to live well with illness[ii] and poorly in health. Treatments, service and supports across biopsychosocial dimensions can support health, no matter where we sit on the continuum.

Models of disability that focus on function rather than diagnosis take into account the many factors that determine disability, some of which are less related to the individual and their diagnosis than to a society that through its services and programs, fails to accommodate them. Some of these are not related to health interventions or the public and private insurance systems which cover their costs at all. Function can depend on curb cuts, audio signals for traffic lights, and ramps. Function can depend on the policies and programs in place to support diverse people participating fully in work and family life. The tax measures that Canada offers to individuals living with disability are a good example.[iii] They endeavour to compensate people (by reducing their tax burden) for the extraordinary costs of living with disability in a society where their needs are not otherwise accommodated.

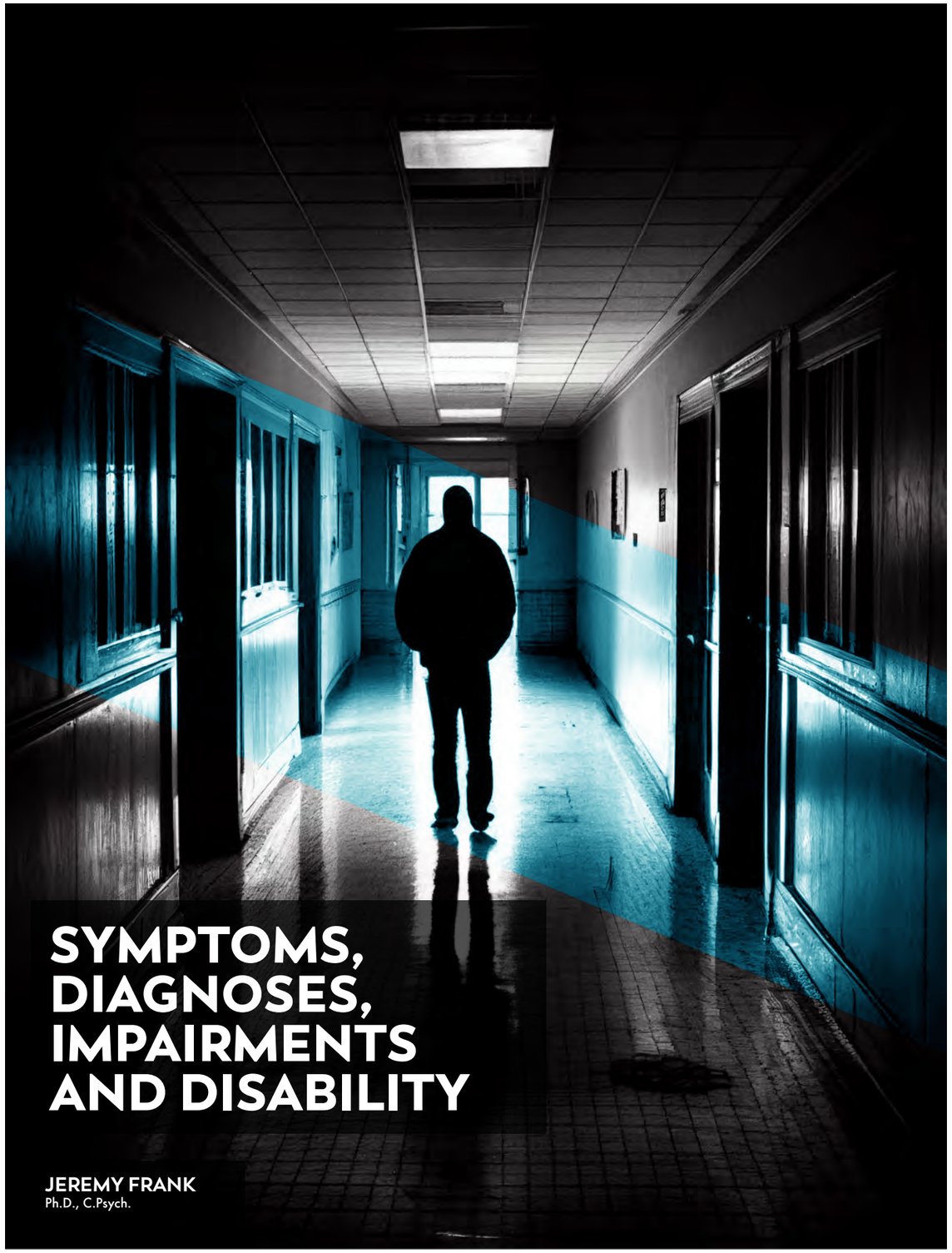
Any health condition, like disabilities, which are managed rather than cured will be impacted by what we think, feel and how we behave. Whether we adhere to food plans, maintain exercise, follow through on recommended treatments depend in large measure on psychological factors; factors that may need more attention than the brief mental well-being check-ups possible in the office of a busy primary health care practitioner. For some health conditions, notably mental disorders, biological treatments (i.e. medication) are more often palliative than curative.

Our health insurance plans, both public (medicare) and private (extended health benefits typically available through employment) are challenged most by the health conditions which intervention manages rather than cures, the health conditions that may relapse and remit and those that may not go away at all. While we do a reasonable job in ensuring that biological treatments are covered when needed, we do a much poorer job when it comes to non-biological interventions. This disproportionately impacts the treatment of mental health issues and disorders.

Extended health insurance plans, for example, typically have no caps on the amount of medication coverage they offer but often have caps on psychological interventions; caps that are too low to afford any evidence-based dose of treatment… and this even though psychological treatments can be as, or more effective than medication for many mental disorders. Public health insurance plans (i.e. Medicare) fall short as well – they cover the services of designated health providers (i.e. physicians) and/or services delivered in designated venues (e.g. hospitals), which makes the coverage of psychological services, increasingly delivered in the private sector by psychologists and other non-physicians, uninsured by Medicare.

When it comes to health care insurance, we must stop offering what's available at the expense of what is needed. Just as a band aid won't suffice when stitches are needed, a cap of $500 annually for psychological services wont suffice in treating depression. We must disabuse ourselves of the notion that if we decline the coverage expense now, we won't feel it later. Untreated mental disorders can have far reaching and long-term impacts on individuals, families, workplaces and the economy. Organizations rate mental health as the third highest risk to their businesses.[iv] The largest category of short- and long-term disability claims is mental illness related.[v]

Whether Canada opts to make the non-medical treatment of mental disorders a responsibility of the private or public sector, it must make this responsibility accountable. Services covered must be evidence-based, sufficient, and sustainable. We must support people in living well, no matter their state of health, illness, or disability. Full stop.



SYMPTOMS, DIAGNOSES, IMPAIRMENTS AND DISABILITY

JEREMY FRANK
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NAVIGATING THE INSURANCE LANDSCAPE

Clinical psychologists are routinely asked to support a claim for disability or for accommodations. For instance, such requests come from students requesting academic accommodations, employees claiming an inability to perform essential duties of their occupation, or injured individuals who are unable to engage in their pre-injury social, occupational and daily life activities. Mental health conditions can result in people going on short-term or long term-disability.

Many clinicians make the decision to support or not support such claims rather quickly, and sometimes with little regard for the actual question at hand: Are there psychological impairments that impede the individual's ability to engage reliably and productively in the activity for which they claim they cannot? Psychologists are asked regularly to respond to questions of disability from a psychological perspective either in their role as a solo practitioner or as a member of a multidisciplinary team. All too often clinicians equate symptoms and/or diagnosis with disability. On the one hand, it is true that most DSM-5 conditions include a criterion that the psychological condition is associated with significant distress or impairment in social, occupational or other important areas of functioning. However, we should not arrive at a finding of disability or need for accommodation just because a diagnosis is identified. Disability is contextual, requiring thoughtful consideration of the nature and demands of the activity in question relative to the individual's impairments.

Consider this: Persons A and B are both diagnosed with a Major Depressive Disorder, Single Episode, Moderate in severity, both reporting irritable mood, anhedonia, guilt, disturbed sleep, and impaired concentration. Person A works as a custodian in a high school. Person B works as a real estate agent. It is plausible that Person A will be able to continue working on a full-time basis, as the demands of custodial work could potentially still be met, even with Major Depression. Person B on the other hand would likely struggle as realtors are required to engage with clients with energy and enthusiasm, research and analyze comparable properties in order to properly price a home, negotiate with other realtors, and draw up contracts.

Now consider this: Persons C and D are both diagnosed with a Major Depressive Disorder, Single Episode, Moderate in severity and both work as high school custodians. Person C is able to work reliably and productively whereas Person D cannot. How can this be? Quite simple, individuals with the same diagnosis can present quite differently. The determination of disability needs to be at the level of impairment and not simply diagnosis. Person D might suffer from serious motivational problems and have difficulty getting out of bed while person C is able to get going each day and work a full day, but might struggle with self loathing, guilt, and social withdrawal.

In most instances, clinicians are not required or asked to determine if an individual is disabled. Rather, the clinician's task is to identify the nature and degree of impairment and whether the impairment impedes the individual's ability to perform specific tasks. Sometimes the answer is obvious: a police officer presenting with post-traumatic stress and experiencing flashback triggered by high pressure situations is unlikely to be capable of performing front line police work; a role that requires the ability to regulate affect and make quick decision in the face of high pressure situations. Other times, the answer is not clear cut and requires comprehensive psychological assessment and assessment of the activity demands.

Complicating matters further is the possible impact of primary and/or secondary gains. Some individuals deliberately feign or embellish their impairments in hopes of compensation or some other benefit (e.g., time off work, examination accommodations, etc). Some hold strong enough beliefs about having been wronged (by an individual who injured them or by an insurance company that is denying benefits) that they develop a style of communicating that portrays them as highly wounded and impaired. Some engage in depressogenic or catastrophic thinking patterns that contribute to a view of self as more functionally impaired than objective testing would suggest. In contrast, symptom denial or minimization can be equally problematic when the individual's role is safety sensitive and yet there is a strong motivation/need to return to work. Other factors that may need to be considered include personality traits (e.g., alexithymia), culture, internalized stigma, or active litigation. Finally, one cannot discount the impact of assessor bias. For instance, in the sphere of personal injury assessment, it is not uncommon for assessors to work on "one side" of the system (e.g., accepting referrals only from insurance companies or only from personal injury lawyers) and such assessors are at higher risk of developing a narrowed perspective due to confirmation bias. It is incumbent upon all assessors to regularly question their attitudes, beliefs, assumptions and methodologies in order to proffer opinions and recommendations that are objective and free of bias.

Impairment determination requires comprehensive psychological assessment that includes: 1) the examinee's subjective report of symptoms and functioning in various areas of life, 2) psychometric testing suited to the question and individual being assessed, 3) established measures of effort or malingering norms, 4) a review of available documentation such as family physician's clinical notes or past psychological or psychiatric reports, 5) behavioural observations over the course of the assessment, 6) collateral information when possible, 7) consistency and discrepancy analysis between all data points (e.g., how do behavioural observations line up with subjective reports during the interview and how can this be understood when considering objective psychometric test results that incorporate measures of response bias?), and 8) proper consideration of base rates of various forms of impression management given the applicable population (e.g., compensation seeking populations exhibit much higher levels of negative response bias than do victims of violent crimes, for instance). In the case of ongoing treatment, repeated administration of treatment progress measures is critical.

Comprehensive psychological assessment, when performed systematically, thoughtfully, and sensitively to the examinee's cultural background, with proper attention to various forms of bias, can be an effective and powerful means of helping individuals achieve a state of wellness.

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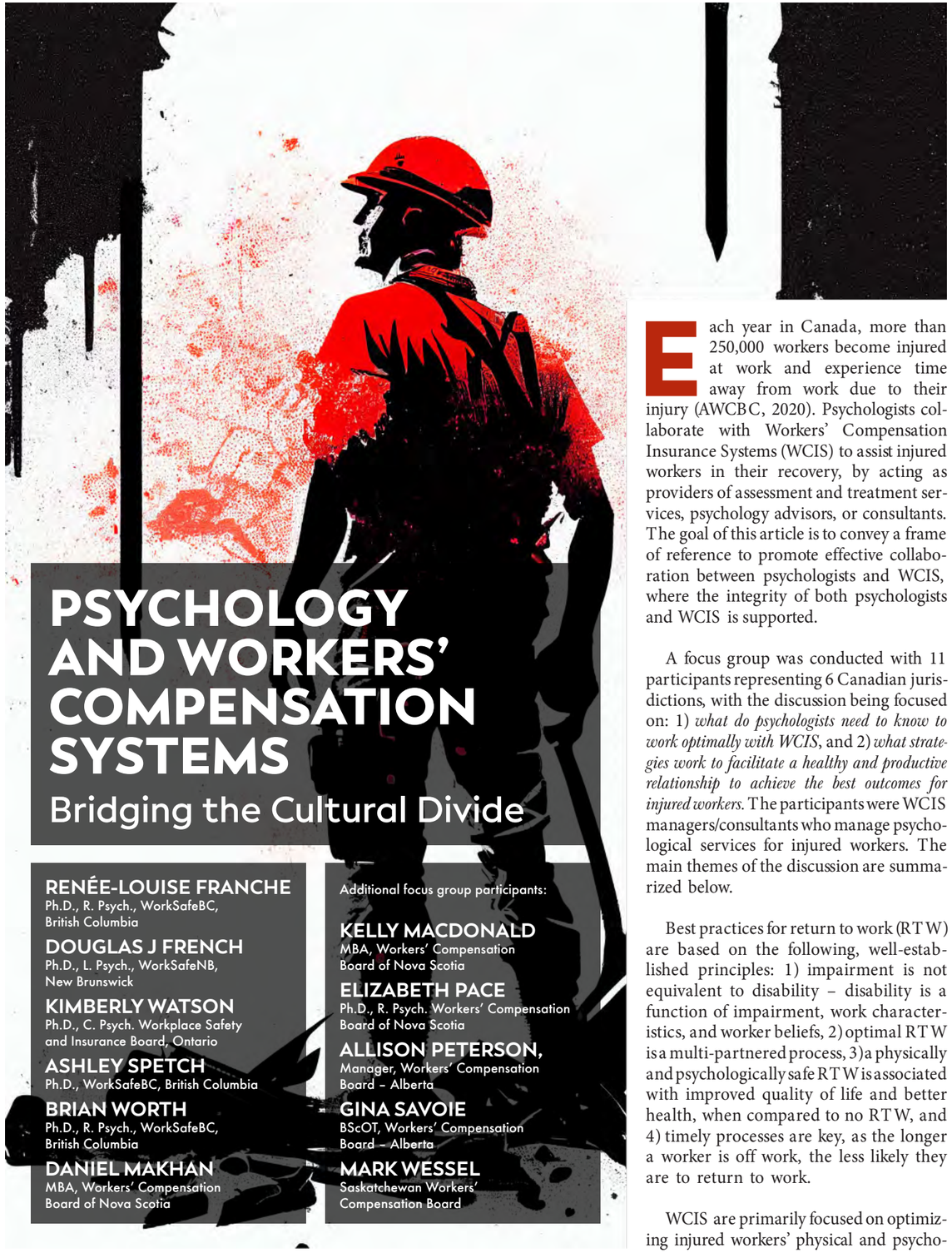

PSYCHOLOGY AND WORKERS' COMPENSATION SYSTEMS

Bridging the Cultural Divide

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Each year in Canada, more than 250,000 workers become injured at work and experience time away from work due to their injury (AWCBC, 2020). Psychologists collaborate with Workers' Compensation Insurance Systems (WCIS) to assist injured workers in their recovery, by acting as providers of assessment and treatment services, psychology advisors, or consultants. The goal of this article is to convey a frame of reference to promote effective collaboration between psychologists and WCIS, where the integrity of both psychologists and WCIS is supported.

A focus group was conducted with 11 participants representing 6 Canadian jurisdictions, with the discussion being focused on: 1) *what do psychologists need to know to work optimally with WCIS*, and 2) *what strategies work to facilitate a healthy and productive relationship to achieve the best outcomes for injured workers.* The participants were WCIS managers/consultants who manage psychological services for injured workers. The main themes of the discussion are summarized below.

Best practices for return to work (RTW) are based on the following, well-established principles: 1) impairment is not equivalent to disability – disability is a function of impairment, work characteristics, and worker beliefs, 2) optimal RTW is a multi-partnered process, 3)a physically and psychologically safe RTW is associated with improved quality of life and better health, when compared to no RTW, and 4) timely processes are key, as the longer a worker is off work, the less likely they are to return to work.

WCIS are primarily focused on optimizing injured workers' physical and psychological function, with the ultimate goal of a safe, sustainable, and healthy RTW, and return to pre-injury function. Less emphasis is placed on symptoms and pathology, and more on rehabilitation to improve function. Although accurate diagnosis remains essential to determine compensability of conditions and entitlement to benefits, efforts are made to de-medicalize the RTW process. To inform adjudicative processes, WCIS expect psychologists to provide evidence-based and objective information using a comprehensive biopsychosocial approach to psychological assessments and treatment.

The relationship between psychologists and WCIS does not come without challenges as psychologists often interface with at least two parties, the worker and WCIS. A cultural divide can exist between psychologists' best intentions and the realities of WCIS. It can be challenging for psychologists to fully appreciate how the clinical information they provide is being utilized within the adjudicative and policy-driven context of WCIS. This can lead to disappointments on the part of psychologists when, for instance, they are faced with limits on what treatments are offered to injured workers (eg. only compensable conditions are treated, typically for a limited duration). The WCIS' focus on RTW and function, and how it can be supported by psychologists, is not always fully understood by psychologists. To achieve optimal RTW outcomes, a comprehensive assessment of biopsychosocial factors is critical, including personal, family, social, occupational, and trauma history factors. These factors are all pertinent to RTW prognosis, to understanding the causal relationship of the condition to the workplace event, and to guiding RTW-focused interventions. In that regard, WCIS can at times encounter challenges due to absence of assessment of relevant RTW factors by psychologists, and absence of attention to those RTW factors in treatment.

WCIS draw on multiple strategies to bridge this cultural divide. The first one, which appears deceptively simple, is for WCIS to have one-on-one quality conversations with psychology providers, to explain the context and expectations of WCIS. Communication and building relationships are key – this will not be new for psychologists! Nevertheless, in these times of technological advancements and remote work, basic foundational blocks to relationships may require increased intentional effort. Educational initiatives complement one-to-one contacts; webinars and workshops focus on explaining the implications of legislation/policy/adjudication, the rationale for WCIS' focus on rehabilitation and function, and the practicalities of assessing and promoting function. Structured guidance in the form of assessment and treatment report templates is useful to further convey RTW principles. As well, structured reports can be more easily interpreted by case managers than traditional narrative reports.

Providing role clarity to psychologists can be immensely helpful in diffusing potential misunderstandings. Psychologists provide diagnoses, treatment, and clinical information which inform the decisional process of WCIS. Although their psychological reports, treatment progress reports, and clinical opinions are given weight in WCIS decisional processes, psychologists do not have the final say in various decisions which have important impacts on injured workers and their care. Understanding how the WCIS team functions, and who makes which decision based on what information, can be very helpful to psychology providers.

Objectivity and critical analysis are part of a robust psychological assessment, and treatment progress reporting. This can be supported by core required psychological tests, inclusion of validity scales, and a measurement-based approach to treatment. A strong recommendation has been made to use brief, well-validated measures to monitor treatment progress (Tasca et al., 2019). This approach can facilitate fair adjudicative decisions about treatment planning. It can also inform treatment providers, workers, and WCIS about the nature and magnitude of clinical change, and have therapeutic benefits for workers.

The relative absence of occupational focus during the graduate training of future psychologists is a possible root cause contributing to the cultural divide. Having more occupational and work-focused rehabilitation courses during training, along with WCIS-based practicums and internships, would contribute immensely to broadening the vision of future psychology providers and orienting them to the WCIS context. Likewise, with respect to WCIS case management staff, providing education and guidance to them is part of a coordinated approach to support optimal uptake of psychological services. The complexity of claims involving mental health issues translates into a need for promoting mental health literacy in case management teams. In addition to the involvement of psychology advisors, other mental health specialists have been useful to offer case managers decisional support and targeted mental health information. Such involvement can include providing education about how to read psychological reports in the most effective and time-efficient way, how to use measurement-based treatment reports, how to deliver decisions effectively, and how to identify optimal points in the life of a claim to have check-in conversations with injured workers or hold multidisciplinary team meetings.

Workers' voices of course need to be heard in all steps of their recovery. Their input and reactions are critical in developing successful return-to-work and treatment plans. Their inclusion is part of a fair and respectful process.

Employers can not be forgotten either, in reaching successful health outcomes for all workers. We are becoming increasingly aware of the immense impact of employer-based responses and workplace culture not only for injured workers, but for all workers. Employers, WCIS, and psychologists need to gain a deeper understanding of how important it is to improve perceived employer-based justice, cultivate a psychologically healthy and safe workplace, respond appropriately to bullying and harassment, and develop a trauma-informed approach to work life, among various other topics. Psychologists can play an important role in bridging the gap between primary prevention and RTW.

Last, but not least, it is important for WCIS to develop a clear and well-articulated, evidence-based mental health strategy to guide the above initiatives. This will ensure that initiatives are coordinated in terms of content, audiences, and timing. Psychologists will continue to be crucial participants in this multi-partnered approach and contribute to developing a shared culture, focused on optimizing function and mental health of injured workers.

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TOWARDS A WORKING RELATIONSHIP BETWEEN AUTO INSURERS AND PSYCHOLOGISTS

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Multiple and complex Auto insurance systems exist in Canada that include private and public systems as well as tort settlements and no-fault benefits. Each auto insurance system in nested in a unique Provincial health and welfare system which provides widely divergent access to mental health and rehabilitation services.

Canadian auto insurance, health care and rehabilitation systems face issues of access and cost. In 33 years of working in the Ontario auto insurance system, which integrates no fault accident benefits and tort compensation through law suits against an at fault party, change has been a constant.

Unfortunately, the increased awareness of and concern about provision of mental health care post incident has not reduced the many barriers to access auto insurance accident benefits, nor sufficiently overcome skepticism and stigma about mental health disorders. In reality, providing mental health care under accident benefits often requires dealing with administrative complexity and cost which create roadblocks and delays for patients. When it works well, accident benefits allow for psychological treatment and rehabilitation.

Psychologists working in the auto insurance systems must be well versed in psychological assessment, treatment and comprehensive rehabilitation interventions. Psychologists must be ready to interact with others in the system for the benefit of patients including adjusters, lawyers, and other members of the health care team in order to optimize outcomes. Educating lawyers, insurers, government, other health professions and other stakeholders about psychological disorders/impairments and effective psychological care for rehabilitation and restoration is essential for sustained access to psychological services for patients.

The system in Ontario is presented as an illustration of the issues faced by psychologists and their patients. Our present Ontario system was last revised in 2016 and follows a long series of mixed tort and accident benefits legislation and regulations since 1990. Each variation of the Insurance Act has provided 1) limits on the rights to sue at fault drivers in combination with 2) specified accident benefits for treatment, rehabilitation, attendant care and income replacement. The range of treatment and rehabilitation services available under the policy has remained very broad as has the overall goal of returning the injured person to their pre-accident roles within the home, community, family, work place or school.

Within this broad treatment/rehabilitation mandate, members of the Ontario College of Psychology (CPO) can be funded to carry out the full range of psychological services. Ideally, Psychologists can also work with their patients' family, employers, and schools. Referral to and collaboration with health professionals and other service providers is an important feature of services which may be paid by the auto insurer. The opportunity to build an effective collaborative rehabilitation team is a positive of this system. However, funding of any services is dependent upon insurer approval.

Over the decades, the quantum of accident benefits, the duration, and the process to access benefits has changed. Levels of benefits based on impairment criteria have been introduced (e.g., catastrophic level benefits, minor injury guideline). Some benefit changes have created a barrier to provision of psychological assessment, treatment, and rehabilitation, for example:

1) The requirement for prior approval of psychological assessment;

2) A cap on fee payable for an assessment or examination;

3) Minor Injury Guideline where a patient must demonstrate they have a psychological impairment which is not a minor injury or its sequelae;

4) A reduction in duration accident benefits from ten to five years;

5) The quantum of benefits of the basic policy has not increased in spite of significant health care inflation since 1990;

6) The current hourly fee schedule for psychology is lower than it was in the year 2000 resulting in a lack of available psychologists to provide services for some accident victims;

7) Insurers have the ability to deny a benefit application without obtaining a medical opinion and when an Insurer Examination is obtained, there is no required timeline and delays can be lengthy;

8) Denied psychological services must be contested at a Licence Appeal Tribunal hearing, a slow and expensive process, and many applications by psychologists for patient care are never funded;

9) There has been significant reduction of availability of attendant care benefits;

10) Non earner benefits over the past two years have been eliminated;

11) Weekly income replacement is capped at the 1996 level, $400.00 per week;

12) Benefits for the catastrophically impaired have been reduced $2,000,000 to $1,000,000;

13) Accident victims with brain injuries and mental disorders now face an increased and disproportionately high bar to demonstrate catastrophic impairment compared to those with physical injury to establish entitlement;

14) There are significant limits on the right to sue which now include a deductible of $41,500 from monetary awards and a "threshold" requirement that the impairment is "permanent, serious disfigurement, or a permanent serious impairment of an important physical, mental or psychological function";

15) The designation of which health professional can be relied upon to offer opinions in tort and certify Catastrophic Impairments have changed over the years, impacting accident victims' ability to rely solely on a members of the College of Psychologists.

Canadian society is increasingly aware of the harms caused by lack of access to treatment of mental and behavioral disorders and the effectiveness of psychological treatment. At the same time, our survey of the changes in auto insurance across Canada over 33 years reveals that cost pressures not only lead to cuts in a wide range of necessary services but also numerous additional barriers to patient access and limitation on the authority and role of Psychologists. Advocating for psychological services and providing education regarding the needs of individual patients as well as for easier access to available services, is a continuing responsibility of our profession.

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The following tables provide comparative information regarding various auto insurance systems in Canada.

This first table illustrates which Provinces rely on Public Insurance, Private Insurance, or a Combination.

Province	Insurer Type
Quebec	Combination: Public insurance covers minimum limits for personal bodily injury or injury to others; civil liability (property damage) by private insurers.
Saskatchewan	Combination: Public insurance covers minimum limits for bodily injury or injury to others, as well as property damage, though many limitations; can buy additional coverage through private insurance for both bodily injury and property damage.
Manitoba	Public
British Columbia	Public
Alberta	Private
Ontario	Private
Newfoundland	Private
Nova Scotia, New Brunswick, Prince Edward Island	Private

This table compares the average premium paid and the various coverages included in the Canadian provinces that rely on Private Insurance.

		Private			
		Ontario	Saskatchewan (Combination Public/Private)	Newfoundland	Nova Scotia, New Brunswick, Prince Edward Island
Average Paid Premium		$1,655	$1,230	$1,251	$1066, $1014, $860
No Fault	*Maximum Wage Protection*	$400 pw	Up to $24,544 per year.	None	$250 pw
	Third Party Liability Insurance	$200,000	$200,000	$200,000	$500k, $200k, $200k
	Auto Damage Coverage	Yes	Yes	No	Yes
	Medical Payments	Up to $65,000.	Up to $213,090 for catastrophic injury.	Up to $25,000.	Up to $50,000.
	Funeral Expense Benefits	$6,000	$7,103	$1,000	$2,500
	Disability Income Benefits	70% of gross wages to maximum $400/week, minimum $185/week for 104 weeks.	$458/week for total disability (lifetime if unable to return to any job); $229/week for partial disability.	Maximum $140/week; 104 weeks for partial disability, lifetime for total disability; must be disabled for at least seven days to qualify.	80% of gross weekly income (less any payments for loss of income).
	Impairment Benefits	N/A	Up to $14,206/person for non-catastrophic injury, up to $184,678 for catastrophic injury.	N/A	N/A
	Medical Benefit	$65,000 Max. $1M (if catastrophic).	N/A	None	$50,000 (Max. 4 years).
	Deductible Comprehensive	$500	$200	$500	$500
	Deductible Collision	$500	$200	$500	$500
	Lump-sum cash settlement	Yes	No	No	No
Tort	*Right to Sue for Economic loss in excess of no-fault*	Yes	Yes.	Yes	Yes
	Right to sue for medical benefits (e.g., pain and suffering) under tort law	Yes, if injury meets severity test (called "threshold"), and subject to deductible.	Yes, subject to deductible of $5,000.	Yes. Awards are subject to deductible of $5,000.	Yes. If injury is deemed "minor" under provincial legislation.

This table compares the average premium paid and the various coverages included in the Canadian provinces that rely on Public Insurance.

		Public				
		Quebec	Saskatchewan (Combination Public/Private)	Manitoba	Alberta	British Columbia
Average Paid Premium		$857	$1,230	$1,140	$1,514	$1,830
No-Fault	*Maximum Wage Protection*	$1,324 pw	$1,700 pw	$1,750 pw	$400 pw	$740 pw
	Third Party Liability Insurance	$50,000	$200,000	$500,000	$200,000	$200,000
	Auto Damage Coverage	Yes	Yes	Yes	No	No
	Medical Payments	No time or amount limit; includes rehabilitation.	Up to $7,259,646.	No time or amount limit.	Up to $50,000.	No time or amount limit.
	Funeral Expense Benefits	$5,534	$10,887	$8,951	$6,150	$9,310
	Disability Income Benefits	90% of net wages based on gross annual income of maximum $83,000/year.	90% of net wages based on actual gross annual income that is less than $102,673/year	90% of net wages based on gross annual income of maximum, up to a maximum $103,500/year.	80% of gross weekly wages to maximum $600/week; up to 104 weeks for total disability (nothing payable for the first seven days of disability).	90% of net wages based on actual gross annual income that is less than $100,000
	Impairment Benefits	Up to $258,947.	Up to $208,037/person for non-catastrophic injury, up to $254,087 for catastrophic injury.	Minimum $770/week up to $154,261 for noncatastrophic; up to 243, 580 for catastrophic injury.	N/A	Up to $167,465/ person for non-catastrophic injury, up to $264,430 for catastrophic injury.
Tort	*Medical Benefit*	No time or amount limit; includes rehabilitation.	$7.5M Indexed Lifetime.	Unlimited Lifetime.	$50k Max. 2 yrs .	No Limit.
	Deductible Comprehensive	$500	$200	$200	$500	$300
	Deductible Collision	$500	$200	$200	$500	$300
	Lump-sum cash settlement	No	No	Yes (if not recovering within specified timeframe).	Yes	No
	Right to Sue for Economic loss in excess of no-fault	No	Yes	No	Yes	No.
	Right to sue for medical benefits (e.g., pain and suffering) under tort law	No	No	No	Yes. If injury is deemed "minor" under provincial legislation, maximum award is $5,365.	No. However, claims can be made for pain and suffering with a maximum settlement amount of $5,627 for accidents.

DISABILITY, EMPLOYMENT, AND ACCOMMODATIONS

The workplace perspective

MONIQUE A. M. GIGNAC
Ph.D.

Paid employment is a valued role, providing financial resources and contributing to one's identity, self-worth, and social inclusion. When considering the disability process at work, it is important to remember that a disability is not an attribute or characteristic of a person but is an interaction between a health condition and personal, social, and environmental factors that can make tasks and activities challenging. It includes not only difficulties with job demands, but also barriers to working related to negative attitudes and behaviours like stigma and discrimination, lack of access to education and training, and physical and environmental barriers in a workplace. This makes managing a mental health condition at work or as part of a return-to-work process complex.

The workplace context

A challenge in many workplaces is who becomes involved in the accommodation process and how the process unfolds. Workers experiencing a mental health condition are often unaware of organizational policies related to disability and may be ill-equipped during a mental health episode to navigate the organizational and insurance system. Workers often prefer to deal one-to-one with a supervisor or manager. However, this may not be possible, and others may be involved depending on the level of accommodation needs and changes that might be required to job demands or schedules. Supervisors, human resource professionals and even disability managers may not understand the needs of workers with mental health conditions. Psychologists may lack awareness and understanding of organizational policies and practices, workplace needs and expectations, and a worker's particular job demands. All the parties involved may have limited experience and understanding of working with insurers. Added to this, workplace parties often have misgivings about one another – human resources and disability managers may not trust supervisors to have the skills needed to manage disability issues; unions may focus on the needs of many and may not be well prepared to advocate for an individual worker living with a mental health condition; and supervisors can find themselves caught between wanting to help a worker, meet the productivity needs of their work unit, satisfy other workers on the team, and comply with organizational demands.

Not infrequently, mental health disability in the workplace is initially cast as a performance problem. In the absence of other information, difficulties with work tasks and challenges interacting with others is viewed as a lack of motivation, an attendance problem, and as reflecting inadequate job performance or poor interpersonal skills. This can be exacerbated if a worker is confronted about job difficulties and denies there is a problem, either because they are concerned about disclosing personal health needs or because they are not fully aware of changes in their behaviours and cognitions brought about by their condition. In these situations, trust and confidence in the accommodation process is easily eroded, interactions can become adversarial, and in occasional instances, disability management evolves into a disciplinary issue.

Moving forward

We can improve workplace accommodation processes with attention to two areas. First, efforts are needed to address the frequent tension between a worker's expectations for privacy with the need to communicate and validate support needs so that organizations can provide reasonable support and accommodations. Providing a mental health diagnosis and symptoms typically does not serve either worker or workplace needs. Workers are concerned about stigma, gossip, and loss of career opportunities if others become aware of their mental health condition. It is not uncommon for workers to delay sharing workplace needs until the impact of their condition on their jobs is significant. As noted, this frequently leads others to interpret difficulties as performance problems.

Organizations vary in responding to privacy and communication needs. Some workplaces adopt a biomedical approach to disability. Validation of a mental health condition is deemed critical, and a diagnosis may be requested despite laws protecting privacy and the disclosure of health information. Challenges with a biomedical model arise if wait times for psychological assessment result in workplaces delaying accommodations. It can also mean that workplaces over-emphasize worker responsibility for health and wellness and de-emphasize workplace barriers, negative attitudes, and environments that contribute to disability. More recently, some organizations have adopted a biopsychosocial model to mental health disability at work, recognizing the role of the workplace in contributing to or ameliorating disability. Psychologists remain important members of the disability team but sharing a diagnosis or specific symptoms is not necessary. Instead, the emphasis is on job demands and removing barriers to foster work participation.

This gives rise to a second area in need of attention. Psychologists may be asked to provide input on workplace accommodations but may not be confident that they understand the job activities of their clients or the supports available within an organization. Traditional functional and cognitive demands assessments may have low ecological validity and don't identify interpersonal working challenges or working conditions that can be problematic. More work needs to be done, but research is making inroads. An example is the Job Demands and Accommodation Planning Tool (JDAPT). The JDAPT is an online tool developed with input from researchers, organizations, and people living with mental and physical disabilities. It targets job demands related to physical, cognitive, interpersonal, and working conditions and provides tailored ideas for support or accommodations that may be useful in addressing disability. Supports may not work for all jobs, but they provide a starting point for accommodation planning (https://aced.iwh.on.ca/jdapt/worker-en/access).

Addressing communication-support processes using worker and organizational perspectives is essential to tackle mental health disability at work. In this context, psychologists play a key role in focusing the conversation away from a diagnosis and toward identifying and addressing job demands and broader social and environmental workplace barriers that create disability.

FOR A COMPLETE LIST OF REFERENCES, PLEASE GO TO CPA.CA/PSYNOPSIS

PARTNERING TOGETHER IN PURSUIT OF BETTER MENTAL HEALTH

DAVE JONES
SVP and President, Sun Life Health

Two psychologists and other mental health industry professionals, insurance companies are often perceived as "one of the bad guys". In reality, insurers recognize that timely payment of claims is critical to helping claimants regain a state of wellbeing. Establishing and maintaining a collaborative relationship with health care practitioners is essential to helping patients/clients live healthier lives.

Both insurance companies and health care practitioners share a common goal—to improve the health and wellbeing of Canadians. To that end, we must partner to achieve the best patient outcomes and a seamless coverage experience for our clients. What follows are some of the ways insurers and psychologists can work together to achieve this goal.

First, it is important to understand how insurance contracts work. There are multiple types of benefits offered by insurance companies that are typically structured into two categories:

1. **Extended Health Coverage**
   Offered through employer benefit plans, extended health coverage (EHC) is designed to support the cost of various health services and offer protection from catastrophic events.

2. **Disability**
   Offered through employer benefit plans or self-insured by the employer, disability is an income replacement benefit for individuals who are away from work due to disability.

Extended Health Coverage

Benefits, contracts and coverage vary by employer based on affordability, philosophy on employee benefits, advice from advisors, and the insurance company underwriting the coverage. These differences can include:

- Amount of coverage (e.g., annual dollar maximums, shared maximums across health care providers and services)
- Percentage coverage (e.g., 100% coverage or less)
- Deductibles
- Maximum amount covered per session

For example, employer benefit plans have varying levels of mental health coverage with an annual limit that can range from $0 to $12,000.[i]

Did You Know?

- The Canadian Psychological Association recommends mental health coverage of $3,500 to $4,000 (15-20 sessions). This is the number of sessions required to achieve a therapeutic outcome for people suffering from depression or anxiety[ii]
- 79% of Sun Life's employer benefit plans (representing 1.5 million Canadians) offer less than $500 per year in psychology coverage

The good news is that enlightened HR leaders are starting to increase coverage. Leading employers like Apotex, Sun Life and others now provide more than $10,000 in annual mental health coverage to their employees. This is a great start, but we acknowledge there is still a long way to go to get others on board.

Disability

Disability is an income replacement benefit (not treatment coverage like EHC). Disability benefits cover a portion of an individual's earnings while they are deemed incapable of performing the essential duties of their occupation. The definition of disability is articulated in the employer contract and can vary but typically includes some element of:

- A condition that impairs an individual from performing the essential duties of their work.

However, the definition of "work" can differ across employers:

- "Work" can be defined as "job" or "occupation" (e.g., a lawyer who is unable to perform their current "job" vs. a lawyer who is unable to perform the duties typically performed by a lawyer).

There are generally two types of disability coverage:

3. **Short-term disability**
   Typically, the "first line of defense", can be offered as salary continuation or insured short-term disability, ranging from 12 to 52 weeks (on average, 26 weeks) from the time that an individual is approved for disability. Average income replacement percentages are 50-75%. Often this coverage is provided directly by the employer, but insurance companies also offer this through their employer benefit plans.

4. **Long-term disability**
   Typically kicks in at the end of the short-term disability period. Average income replacement percentages vary from ~50-75%, and usually this is a component of an employer benefit plan. Generally, long-term disability coverage under an employer's definition of disability will last for 2 years. After 2 years, the definition may change to encompass whether the disabled individual can do any job that is commensurate with their level of income and education.

Once we are actively working on a patient's disability case, our goal is to support return to work when it's optimal for the individual's health. During this time, the individual is expected to seek the treatment and care that will help restore their wellbeing and resume their usual role in their community and place of employment.

Did you know?

- Working-aged Canadians with Major Depressive Episode experience significant earnings loss that persists for at least a decade[iii]
- For men, this loss represents 115,000 CAD and for women it represents 71,000 CAD (variance is driven by pay inequity)[iv]
- Sun Life pays more than 90% of long-term disability and 95% or short-term disability claims.

We want to help disabled individuals regain a sense of health and wellbeing. We view wellness as encompassing physical, psychological, and financial health, recognizing that it can vary over the course of the individual's life.

Given the common alignment between insurers and psychologists to help Canadians live healthier lives, I will sign-off with a few thoughts:

1. It's important to remember that our goal is to help patients return to work

As insurers, we are focused on a patient's health and ability to perform their role. Studies suggest that having a job in a safe, encouraging, and supportive environment is beneficial to a person's overall health.[v] We want to help them return to work when it is optimal to do so.

2. Effective disability management requires a team effort to help patients safely and efficaciously return to work

Insurers, practitioners, employers, and patients must coordinate and work together throughout a patient's disability journey. It is important to understand and support one another in our respective roles to help drive the best outcome for patients.

Insurers are required to provide evidence to the patient's employer to support the work absence. It is tremendously helpful if clinicians use objective measures to track an individuals' response to treatment to help us understand the trajectory to resolution of the person's disability. This also helps employers manage the vacancy.

3. Early intervention can improve recovery and health outcomes

We should encourage patients to reach out early to their insurance company and understand their coverage levels. This will help insurers minimize wait times on disability claims approvals and in turn expedite other areas of the recovery process. Early intervention has been shown to expedite recovery and leads to better outcomes.

4. Reentry to the workplace can be stressful

Practitioners have a critical role to play in preparing their patients to reenter the workplace. Practitioners can help ease return-to-work anxiety as part of the treatment process. Research is clear that a graduated return to work program is a critical component of the recovery process. Being in the workplace serves a vital normalizing function by providing structure to a person's schedule. The treating clinician can play a vital role in defining the graduated return to work schedule and educating the client about the benefits of returning to work.

Let's work to together to improve the health and wellbeing of Canadians. To doctors, psychologists, other mental health professionals, I and other leaders in the insurance space offer you our partnership. If we all perform our roles in good faith and with an emphasis on collaboration, we can get more Canadians on the road to recovery.

POUR CONSULTER LA LISTE COMPLÈTE DES RÉFÉRENCES, VEUILLEZ VOUS RENDRE À L'ADRESSE CPA.CA/FR/PSYNOPSIS

CPA HIGHLIGHTS

CPA HIGHLIGHTS

A list of our top activities since the last issue of Psynopsis.

Be sure to contact membership@cpa.ca to sign up for our monthly CPA News e-newsletter to stay abreast of all the things we are doing for you!

1.NEW CPA PRESIDENT-ELECT

Eleanor Gittens, Ph.D., has been elected by the CPA board as President for 2023-2024. Dr. Gittens will serve as President-Elect between now and the Annual General Meeting, at which point she will replace current president Dr. Kerri Ritchie. Says Dr. Gittens, "I am eager to pick up and lead the charge in an effort to maintain some momentum as we continue to grow as an organization in our pursuit to promote equity, diversity and inclusion in all we do."

2. FORMAT CHANGE TO THE CPA PODCAST *MIND FULL*

Mind Full, the official podcast of the CPA, has switched to a bi-weekly format. New episodes will be published every second Thursday throughout the year. Find Mind Full wherever you get your podcasts, and take on some of our most recent content – 'Intimate Racism' with Dr. Maya Yampolsky, or 'Nobody Chooses Addiction' with Dr. Andrew Kim and Dr. Nassim Tabri.

3. MEETING TO DISCUSS NATIONAL LICENSURE

The CPA hosted a meeting of nine national health organization to discuss national/pan-Canadian licensure in Canada. Some professions, notably medicine, have issued public statements in support of pan Canadian licensure https://www.cma.ca/news-releases-and-statements/canadian-physicians-support-national-licensure-and-increased-use The purpose of the meeting was to learn where each profession is with respect to the issue of national licensure and to discuss whether there is interest and opportunity to address it collaboratively.

4. 3RD ANNUAL CAREER FAIR ANOTHER SUCCESS!

On January 12th, the CPA, in collaboration with the Canadian Society for Brain, Behaviour and Cognitive Science, held its third annual virtual career fair. Over 60 registrants had the opportunity to hear from and connect with seven mentors about career paths outside of academia and health services. Thank you to all the mentors for sharing of their time and insights, and to all the delegates for participating!

5. MENTAL HEALTH REPORT CARD

The CPA, working with the Canadian Alliance on Mental Health and Mental Illness (CAMIMH) will be releasing a Mental Health Report Card in late February. This is the first national survey we are aware of that asks Canadians who have recently accessed mental health care to rate the performance of their provincial mental health system.

6. CPA POLICIES DEVELOPED AND IN DEVELOPMENT 2022/23

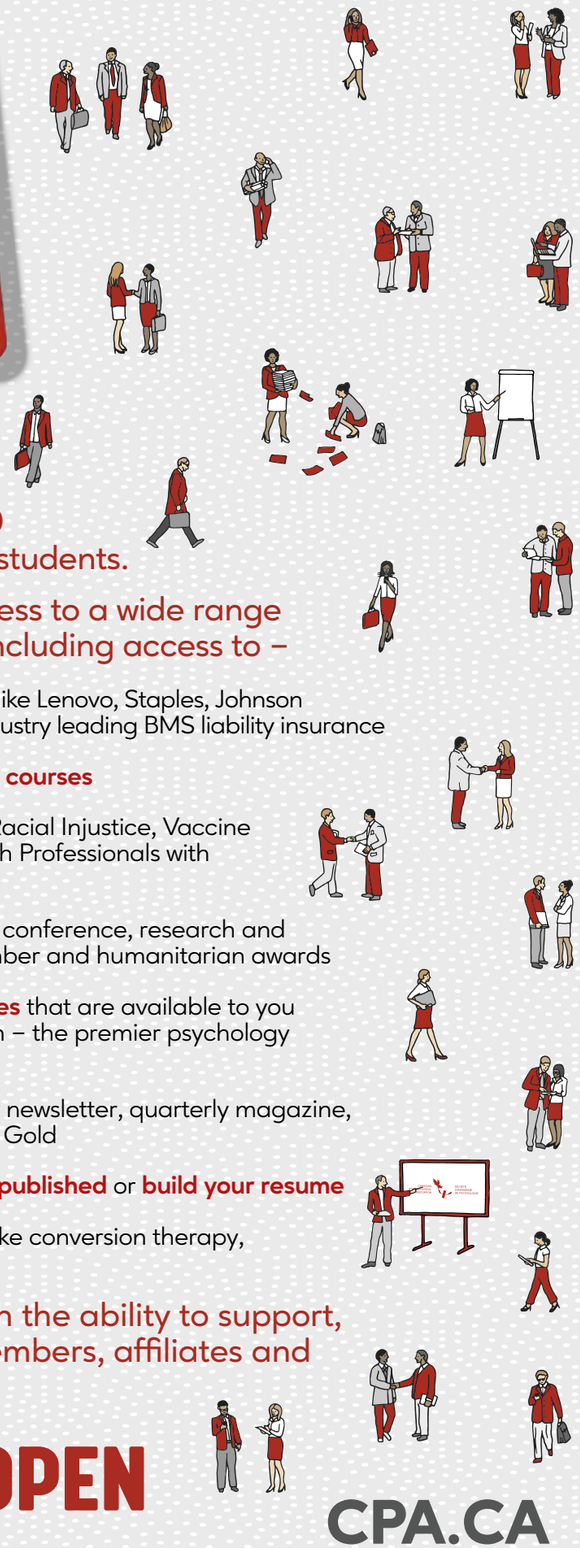
- Mental health care for Canadian children and youth https://cpa.ca/docs/File/Position/Mental%20Health%20Care%20for%20Canadian%20Children%20and%20Youth%20-%20FINAL%20EN.pdf

- Revised policies on gender diversity and gender-based violence – to be released in 2023

7. CANADIAN CONSORTIUM FOR RESEARCH ANNUAL BREAKFAST WITH THE FUNDERS

On January 19th, the Canadian Consortium for Research (CCR), for which the CPA's Deputy CEO is Chair, held its Annual Breakfast with the Funders. The Breakfast allows CCR members, who represent researchers and students in the health, natural, and social sciences and humanities, to discuss both the state of research in Canada and issues facing researchers, students and early career scholars, and research labs and facilities. The CCR extends its thanks to Dr. Ted Hewitt (President, Social Sciences and Humanities Research Council), Dr. Marc Fortin (Vice-President, Vice-President, Research Grants and Scholarships Directorate, Natural Sciences and Engineering Research Council of Canada), Rhonda Kropp (Vice-President, Research – Strategy, Canadian Institutes for Health Research), and Dr. Roseann O'Reilly Runte (President and CEO, Canada Foundation for Innovation) for taking the time to share their insights with the members.

MEMBERSHIP HAS ITS PRIVILEGES!



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