

MENTAL HEALTH DISABILITY CLAIMS: CASELAW AND DEVELOPMENTS

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INTRODUCTION:

- **Mental Health** is an ideal we all strive for. It is a balance of mental, emotional, physical and spiritual health. Caring relationships, a place to call home, a supportive community, and work and leisure all contribute to mental health. However, no one's life is perfect, so mental health is also learning the coping skills to deal with life's ups and downs the best we can.

*(Source: Quick Facts: Mental Illness and addiction in Canada
3rd Edition – Mood Disorders Society of Canada)*

- **Mental Health** “is a feeling of well-being in which the individual realizes his or her own abilities, can cope with the normal stressors of life, can work productively and fruitfully, and is able to make a contribution to his or her own community.”

(World Health Organization:

http://www.who.int/features/factfiles/mental_health/en/)

FACTS ON MENTAL HEALTH - WORLD HEALTH ORGANIZATION:

- Mental and substance use disorders are the leading cause of disability worldwide.
- Around 20% of the world's children and adolescents have mental disorders or problems;
- About 800,000 people worldwide commit suicide each year and suicide is the second leading cause of death in 15 – 29 year olds.
- Mental disorders increase the risk of getting ill from other diseases such as HIV, cardiovascular disease, diabetes and vice-versa.

http://www.who.int/features/factfiles/mental_health/mental_health_facts/en/

WORLDWIDE FACTS ON MENTAL HEALTH:

- Leading cause of years lived with disability in the world: Depression.
- Fourth leading cause of disability and premature death in the world: Depression.
- The year it is predicted that depression will become the second leading cause of disability (next to heart disease): 2020
- Most common cause of violent death in the world: Suicide at 49.1% with homicides at 31.3%
- The impact of mental and neurological disorders on levels of disability: 5 of the 10 leading causes of disability worldwide are mental or nervous disorders.

WORLDWIDE FACTS ON MENTAL HEALTH (continued):

- Number of people worldwide with mental or neurological disorders: 450 million.
- Percentage of all those with mental illness in the world who never receive any treatment at all: 75%.
- The group of illnesses that contributes more to global burden of disease than all cancers combined: mental disorders.

*(Source: Quick Facts: Mental Illness and Addiction in Canada
3rd Edition – Mood Disorders Society of Canada)*

MENTAL HEALTH STATISTICS IN CANADA:

- In any given year, one in five Canadians experience a mental health problem or illness, with a cost to the economy in excess of \$50 billion.
- Of the 4,000 Canadians who die every year as a result of suicide, most were confronting a mental health problem or illness.
- Mental health problems and illnesses are rated in the top three drivers of both short- and long-term disability claims by more than 80% of Canadian Employers.
- Mental illnesses account for approximately 30% of short- and long-term disability claims.

MENTAL HEALTH STATISTICS IN CANADA (continued):

- 21.4% of the working-age population (20-64) was living with a mental health problem or illness in 2011.
- Percentage of Canadians who will experience a major depression in their lifetime: 8%
- Percentage of Canadians who will experience bipolar disorder in their lifetime: 1%
- Percentage of Canadians who will experience an anxiety disorder in their lifetime: 12%

MENTAL HEALTH STATISTICS IN CANADA

(continued):

- Mental health illnesses hit early in people's lives. More than 28% of people aged 20 – 29 experience a mental illness in a given year. By the time people reach 40, 1 in 2 people in Canada will have had or have a mental illness.

Source: Making the Case for Investing in Mental Health in Canada – Mental Health Commission of Canada

<http://www.mentalhealthcommission.ca>

MENTAL HEALTH STATISTICS IN CANADA – DEPRESSION:

- Prevalence rates of depression (as shown through research) associated with other medical diagnoses:
 - Cardiac Disease: 17 – 27%
 - Stroke: 14 – 19%
 - Epilepsy: 20 – 55%
 - Diabetes: 26%
 - Cancer: 22 – 29%
 - Chronic Pain: 30 – 54%.

*(Source: Quick Facts: Mental Illness and Addiction in Canada
3rd Edition – Mood Disorders Society of Canada)*

MENTAL HEALTH STATISTICS IN CANADA – DEPRESSION (continued):

- Heightened risk of medical illness for people with depression:
 - Stroke: 2.6 times the rate for the general population
 - Epilepsy: 4 to 6 times the rate for the general population
 - Alzheimer Disease: 1.71 to 2.67 times the rate for the general population
 - Cancer: 1.35 to 1.88 times the rate for the general population

*(Source: Quick Facts: Mental Illness and Addiction in Canada
3rd Edition – Mood Disorders Society of Canada)*

MENTAL HEALTH STATISTICS IN CANADA – DEPRESSION (continued):

- Likelihood of suffering depression if you are diabetic: 2 times that of the general population
- A risk factor for developing breast cancer: depression
- Strongest predictor of physician visits and hospitalization: depression and psychological stress among people with a physical illness
- Likelihood of people who are depressed suffering a heart attack: 4 times more likely
- Percentage of women with depression at risk for heart disease: 70%

*(Source: Quick Facts: Mental Illness and Addiction in Canada
3rd Edition – Mood Disorders Society of Canada)*

MENTAL HEALTH STATISTICS IN CANADA – DEPRESSION (continued):

- The 4th most common diagnosis for Canadians in 2008: Depression. Accounted for 8529 visits to doctors' offices (32% men, 68% women). 82% of these visits resulted in a prescription for medication.
- The 5th most common diagnosis for Canadians in 2008: Anxiety. (33% men, 67% women). 57% of these visits resulted in a prescription for medication.

*(Source: Quick Facts: Mental Illness and Addiction in Canada
3rd Edition – Mood Disorders Society of Canada)*

MENTAL HEALTH STATISTICS IN CANADA – MOOD DISORDERS:

- According to Statistics Canada, the following shows the increase in numbers of people in Canada who have reported being diagnosed with a mood disorder each year:

	2010	2011	2012	2013
	number			
Canada	1,882,731	2,041,587	2,105,882	2,264,640
Males	699,288	707,388	776,500	899,995
Females	1,183,443	1,334,198	1,329,381	1,364,645

MENTAL HEALTH DISABILITY CLAIMS IN PRACTICE:

- Mental health disability claims fall within the “subjective” or “invisible condition” category;
- Common reasons for denial:
 - No “objective” medical evidence supporting the reported restrictions and limitations;
 - Not under the regular care of a physician as required by the policy;
 - Not under the regular care of a psychiatrist;
 - Not following recommended treatment (i.e. cognitive behavioural therapy or psychotherapy);
 - Not being treated optimally (i.e. the anti-depressant medication is at a minimal dose where one would have expected it to be at a higher dosage considering the reported restrictions and limitations);
 - The medicals provided in support of the claim do not provide a clear diagnosis and do not clearly outline what prevents the insured from performing his / her work duties and are therefore “insufficient”.

Cruise v Wal-Mart Canada Corp. 2013 ONSC 5630

- Employee experienced significant anxiety and chronic depression due to ongoing harassment by her former fiancé, a fellow employee.
- Employer did not provide assistance despite numerous requests from the Plaintiff to remedy the situation.
- She applied for LTD from Manulife, a co-defendant. ML brought application to dismiss the action on the basis that she was off work not due to any medical disability but because of harassment, which had nothing to do with ML.
- The Plaintiff submitted she was TD because the harassment caused her psychiatric and psychological problems., however, when her ex was not there, she was capable of working.
- Psychiatrist: a return to work would cause an exacerbation of her symptoms (“objective” evidence suggested she was Td despite her statements otherwise).

Cruise (continued)

- Held: motion dismissed. The plaintiff's issues cannot be viewed in isolation and her claims against the two defendants arose out of the same factual matrix.
- *“There is a nexus between the two (workplace relationship and the cause of her psychiatric and psychological conditions) and very much in issue is the nature and extent to which her dysfunctional workplace relationship with G.C. has caused her disability to perform her job.”*

Andreychuk v. RBC Life Insurance Co.
2008 BCCA 492

- The insured, a construction litigation lawyer submitted a claim for total disability benefits for major depression and anxiety.
- Policy required the insured to be under the regular and personal care of a physician.
- Insured had received benefits up to June 30, 2002. Action was commenced March 10, 2005. Rolling limitation period barred claim prior to March 10, 2004.
- The policy expired on February 13, 2005.
- On May 4, 2004, the treating psychiatrist reported that “things have reached the point where she has been free of any depressive symptoms for a prolonged period.”
- The insured moved to a new town and in March 2006 consulted a physician for the first time for depression and anxiety.
- For the period of March 10, 2004 up to the time the policy lapsed on February 13, 2005, the Trial Judge found that the insured was not under the regular care of a physician and was therefore not entitled to disability benefits under the policy.

Andreychuk (continued)

- Issue: was the insured entitled to benefits for any period after March 10, 2004?
- The insured relied on an Ontario Court of Appeal authority that stands for the proposition that “where permanent disability is established and no useful purpose would be served by regular attendance on a physician, the law will not compel the performance of futile acts.” (*Kirkness v. Imperial Life*)
- The Trial Judge found that the insured’s depression was treatable and when she recovered from her depression and anxiety, continuing frequent visits to the physician were no longer required.
- The insured appealed and attempted to differentiate between depression and anxiety. She asserted that she may have been free of “depressive symptoms”, but she suffered from an undiagnosed and non-treated anxiety disorder. She contended this made her condition untreatable and rendered nugatory the contractual provision requiring her to be under the care of a physician.
- Held: The medical evidence did not support a distinction, and even if it did, she would not prevail. It was clear on the evidence that the insured was at risk of becoming severely depressed if she were to return to a construction litigation practice. In that sense, it might be said that she remained ill and disabled, but she was not under the care of a physician for this illness, which was a condition of coverage.

Dodgson v. Great West Life Assurance Co.
2014 ONSC 389

- The insured, a married 37-year old senior personal banking officer, mother of two, filed a claim for disability benefits as result of depression, agoraphobia and panic and anxiety disorders.
- She had been employed by the Bank since 2005. Various people close to her passed away (a colleague at the bank in 2007, a close friend in an accident in 2008, followed by the suicide of another friend 6 weeks later).
- She worked closely with the public. The financial crisis of 2008 caused customers to lose money. The plaintiff would become tense and uptight dealing with these customers. She experienced panic attacks and would avoid customers and colleagues by hiding under her desk, in the bathroom or file room.
- Her work performance suffered. She had to meet targets and meet with clients on a regular basis. She could not reach her targets and started to inflate and misrepresent her sales and statistics. Her superiors became aware of these misrepresentations.

Dodgson (continued)

- The plaintiff developed an ulcer and ground her teeth at night to the extent that she dislocated her jaw.
- In the Spring of 2009, the plaintiff had a meeting with her supervisors. After that meeting, she went directly to the crisis centre at the hospital. She sent an e-mail to her manager advising that she needed help and needed some time to get her head “screwed on straight.” She advised that she would file a claim for short term disability benefits.
- The plaintiff’s family physician submitted an Attending Physician’s Statement (“APS”) in support of her claim, providing a diagnosis of panic disorder and anxiety / depression. The treatment plan included medications and psychotherapy. He stated the plaintiff was unable to work.
- Great West Life (“GWL”), in an administrative capacity, was retained. The case manager (“CM”) wrote a letter to the plaintiff in May 2009, advising that she would assist in the plaintiff’s active treatment plan, her return to work, and any work-related accommodation. She also advised that the plaintiff’s claim for short term disability benefits was denied.

Dodgson (continued)

- The letter went on to state that the APS was deficient: it did not indicate the plaintiff was unable to perform her duties at the bank, it did not describe the extent and severity of the diagnosis and how her ability was limited, and did not provide the objective medical information or clinical findings to support the diagnosis. The letter also noted that clinical records requested had not been received. The appeal procedure was described.
- The plaintiff's doctor provided a second APS, again providing the diagnosis and the treatment plan of counselling and medication. He again stated the plaintiff was unable to work and returning to work was not in her best interests. GWL maintained the denial. No benefits were forthcoming and the plaintiff was unsure as to why not.
- The plaintiff attempted to return to work and remained at work for one week. She was unable to perform her duties; her panic attacks were more frequent and lasted longer. She was written up for recording inflated results. She requested part time work or a demotion with less stress and responsibility. Nothing came of her request. She requested an unpaid leave of absence.

Dodgson (continued)

- An internal e-mail at the Bank described the plaintiff as having lost control and her moral compass appeared to have gone awry. Termination of her employment was recommended without any comment or consideration of her mental health issues.
- A 60-day leave of absence was approved with no further extensions. A deadline was given at the end of the 60 day period for the plaintiff to return to work. The plaintiff requested an extension which was denied. She then noted that she wanted to apply for LTD benefits. She received a letter in August 2009 that she had 4 weeks in which to supply further medical information to GWL or return to work, failing which it would be deemed that she abandoned her position.
- The plaintiff took this letter to her doctor and was shown a fax from GWL indicating that his clinical records were no longer required and that her file was closed.

Dodgson (continued)

- The plaintiff did not return to work. She received a letter from her employer in September 2009 stating that as the conditions stated in the August letter were not met, her resignation was accepted. She gave evidence that she did not resign nor did she ever want to resign.
- Various witnesses gave evidence at trial. A treating psychiatrist noted that she was seen in January 2008 and was diagnosed with panic disorder with agoraphobia, generalized anxiety disorder and possible underlying secondary depressive illness. He had placed her on medication which she had taken for two years. She also had attended counselling.
- The Plaintiff testified that she smoked marijuana to relax. She smoked a joint, three to four times per day.
- The plaintiff admitted that she would use the computer three to four times per day, that she had an interest in graphic design and liked to take pictures, that on Saturdays the family would go out for dinner and that she had gone to the zoo with the kids. She was questioned about her Facebook account with pictures of her trip to the zoo as well as to the CN Tower. She admitted the family had gone on a 2-day vacation and stayed at a hotel.

Dodgson (continued)

- IME psychiatrist for Plaintiff: addressed Global Assessment of Functioning Scores involving the five axes test. Axis I diagnoses were major depressive disorder, recurrent moderate, panic disorder with agoraphobia, marijuana dependence, alcohol abuse (past). GAF score of 49, suggesting a serious impairment – symptoms suffered would impair function especially in regards to occupation. Prognosis was guarded and it was noted that she would require long term therapy.
- The witness admitted the large subjective component in the report in that it is based on what the plaintiff tells them or how she answers questions. It was noted that the plaintiff's symptoms improved when she was not at work. However, as she was not given an opportunity to learn coping skills, she would relapse if she returned to work. After therapy, the plaintiff could attempt to return to work. The witness noted that between 2009 and 2012, the plaintiff did not receive proper treatment as no one taught her strategies to cope.

Dodgson (continued)

- A psychologist also gave evidence, opining that the plaintiff required the use of medication and cognitive behavioural therapy, which she had yet to undergo. She noted that chronic use of marijuana could exacerbate the plaintiff's anxiety.
- The psychologist noted that she was not surprised that the plaintiff had gone up the CN tower or made a trip to the zoo (considering her agoraphobia), as some days would be easier and she made the trips with people whom she felt safe with.
- She believed the plaintiff would have benefited from therapy, but believed it was beyond the plaintiff's financial means. If she had undergone such therapy, it could reasonably have been expected that she could have returned to work on a graduated basis with built-in supports.

Dodgson (continued)

- Psychiatrist (Defence IME): Diagnosis: generalized anxiety disorder (chronic) and panic disorder with agoraphobia (chronic) with a GAF of 70 to 80.
- The plaintiff did not suffer from major depression.
- The plaintiff had an adjustment disorder which is not a permanent condition. If the stressors are removed, the symptoms can resolve if certain modifications are made or if the patient has learned coping mechanisms.
- The witness testified that the plaintiff was able to go to restaurants, stores and shops, and was able to socialize with friends and family. She was able to drive and had an interest in photography.
- He noted that there was no reason the plaintiff could not have returned to work, and that his review of the records did not reveal disabling symptoms from April to September 2009.
- He did agree that the plaintiff was unlikely to return to work in April 2009, but thought she could have returned in the summer of 2009.

Dodgson (continued)

- Alice Jones (GWL CM): registered nurse. Two weeks classroom training and two weeks training with GWL.
- Initial telephone interview with the plaintiff (April 21, 2009): symptoms were panic attacks 3 -4 times per day, sweating, palpitations, poor concentration, forgetfulness, shaking (triggered by a friend's suicide).
- May 4, 2009, further call to the plaintiff: advised APS was deficient as symptoms were lacking to support diagnosis.
- May 11, 2009: fax sent to physician to request clinical records.
- May 13: letter sent to plaintiff advising her STD claim was denied.
- May 21: CM received call from the plaintiff, where it was noted she was crying. CM advised to get more medical data and that a second form was sent to the physician.
- May 26: CM spoke with the Bank and was advised of the plaintiff's performance issues. The file was to close if no further medical information was received by May 29.

Dodgson (continued)

- June 1: telephone discussion with plaintiff when she noted panic attacks when at work. June 1 entry ends with “file will be closed.”
- June 4: enquiry by physician whether his entire file is needed. The note then reads: “No further action. File closed.” The request for records was rescinded earlier.
- The CM testified that she had some experience with anxiety issues and her only experience with agoraphobia was during training. She had no history dealing with panic attacks.
- The CM admitted there was some pressure from the Bank to close the files quickly.
- On May 13, the claim was rejected as there were no clinical findings to support the diagnosis. The CM agreed that the APS dated April 22 had a diagnosis of panic and anxiety disorders, **as well as a GAF score**. She admitted therefore that it was incorrect for her to say there was no supporting data.
- The clinical records would have been useful if they reflected symptoms, severity, frequency and duration. She felt the APS was deficient and did tell the plaintiff she had requested the records.

Dodgson (continued)

- The CM agreed that she could have called the physician with respect to her concerns about the deficiency in regards to the APS. She testified she did this all the time. The more distraught the claimant, the more help he or she would need to get the necessary information together. The CM acknowledged that someone like the plaintiff would need help from someone like her and the plaintiff did not get that help.
- The CM admitted that she had nothing to contradict the physician's conclusion that the plaintiff was unable to work. The plaintiff was not told what was needed but was told that she could appeal.
- She admitted that two of the four points of denial (no diagnosis and no support) were false, as a diagnosis was given as well as a GAF score. She then advised the doctor that his clinical notes were no longer needed.
- The CM admitted finally that the only block to granting the STD claim was the lack of clinical notes and records, which request she herself had cancelled after she closed the file.

Dodgson (continued)

- Plaintiff's argument: she was TD within the meaning of the policy; she was under the regular care of a physician and followed recommended treatment; she did not fail to mitigate by not completing therapy as she did not have any source of income to attend therapy (\$200 per session); she attempted to return to work and took reasonable steps to get better; and the Bank's benefit plan is not an insurance plan – it is part of the employment contract and creates an obligation on the Bank. The attempted return to work was an effort to mitigate.

Dodgson (continued)

- Defendant's argument: a. things came to a head in April 2009, not because of mental health issues, but because of the plaintiff's work performance issues; b. If she were so disabled, why did her doctors not implement more aggressive treatment; c. the plaintiff's witnesses relied on the plaintiff's subjective reports to base their opinions on and did no objective testing; d. the plaintiff is able to use her computer and Photoshop program, behaviours which require cognitive focus and concentration; e. the plaintiff could have learned some coping skills to return to work; f. the plaintiff had credibility issues (her panic attacks were not as regular as she suggested, she was able to go on trips to the zoo and the CN tower in contradiction to her reports of agoraphobia and panic attacks); g. the plaintiff failed to follow an active treatment plan (counselling); and h. the exclusion clause with regards to substance abuse was triggered due to the plaintiff's marijuana use.

Dodgson (continued)

- Court's analysis: The Court accepted the plaintiff's evidence with respect to her symptoms (as corroborated by her family and friends). The CM admitted that she would have approved the STD claim had she received the physician's notes. The Court held that the Plaintiff was TD within the meaning of the Plan: she was under the regular care of a physician, was following the recommended treatment plan and was taking prescribed medications and her physicians opined that she was so disabled.
- The Court held that "however we define the plaintiff's illness, she will suffer from it indefinitely and will likely always exhibit symptoms of the illness. The symptoms will vary in duration and intensity depending on the triggers and the plaintiff's ability to manage and cope with the symptoms."
- With respect to the plaintiff's improvement during the time she was off work, the Court rejected the Defendant Psychiatrist's opinion and noted "it is too simple a conclusion to suggest that, because the plaintiff's symptoms had improved by the summer of 2009, the plaintiff was no longer disabled...Such a conclusion does not address the likely complications of the plaintiff returning to work...There is no evidence that (she) was prescribed any type of behavioural therapy which would teach her coping strategies."

Dodgson (continued)

- The Court accepted that the plaintiff's ability to socialize varied and depended on the day she was having.
- The Court noted that all the witnesses agreed that the plaintiff would benefit from cognitive behavioural therapy: *"I find that to return to her substantial employment duties, the plaintiff would first need cognitive behavioural therapy. Without such therapy, she remained disabled in regards to the substantial duties of her employment. No such therapy was made available to the plaintiff nor was it financially viable."* (par. 20)
- However, in response to the defendant's argument that the plaintiff failed to mitigate, the Court noted: *"The defendants cannot set up the plaintiff to fail in her claim by denying the plaintiff the financial benefits which would provide income for the plaintiff to afford such therapy. Nor did the Bank provide any rehabilitation supports which may have included such therapy, via the Workassist Program."*

Dodgson (continued)

- The Court as such rejected the defendants' argument that the plaintiff failed to mitigate by not undergoing CBT. In regards to mitigation generally, she attempted to return to work, took her medications and underwent some counselling.
- The Court held that the CM failed in any duty which she may have owed the plaintiff. The Court found it most troubling that the CM rescinded the request for clinical records in light of a policy, as expressed by the CM, that GWL would review new medical information even after the closure of a file.
- The Court accepted that the plaintiff had the ability to work on a computer for periods of time and that she has an interest in photography and editing. This did not equate to function in the workplace.

Dodgson (continued)

- The Court's analysis concludes as follows (par. 370):

“Had the Bank approved the plaintiff’s disability claim initially and even if she was still disabled from her employment with the Bank, the plaintiff, at this point in time, may very well not have been disabled from occupations based on her skills and experience.”

Conclusion:

- Mental health disability claims are by their very nature fact specific, and require a case by case approach as to what evidence is really required to assess the alleged disability, as opposed to an approach leading to a generic denial based on the absence of “objective” medical evidence;
- Although in some instances treatment providers are labelled advocates for their patients, their opinions in many other instances will carry weight (and will carry the day) due to the proximity of the patient-doctor relationship and the opportunity to formulate an opinion based on first hand accounts and experiences and frequency of visits (as opposed to the opinions of health partners who did not have the benefit of a clinical interview and who only performed a records review).
- Case managers should assist vulnerable claimants (especially those suffering from mental health illnesses) by guiding them through the process and clearly defining what further medical information would be of assistance when a claim has been denied due to a lack of supporting medical evidence.

Conclusion (continued):

- In the Dodgson-case, the Court noted on various occasions that support for the diagnosis and symptoms were found in the GAF score. The CM herself admitted as much. The DSM V, which replaced the DSM IV, no longer has the multi-axial measurement system for mental disorders, which means that the GAF grading scale has been removed.
- The GAF scale called for clinicians to consider psychological, social, and occupational functioning on a hypothetical continuum of mental health illness, which excluded impairments due to physical limitations. The GAF was widely used as an indicator of the severity of an alleged mental health disability by various parties, including insurers, lawyers and triers of fact in litigated matters.
- The DSM V now suggests the use of the WHODAS 2.0 (World Health Organization Disability Assessment Schedule) as a measure of disability. The WHODAS 2.0 is a 36-item tool to measure impairments due to both mental and physical limitations. It assesses function across 6 areas, namely understanding and communicating, getting around, self-care, getting along with people, life activities and participation in society.

Changes in the BC workers compensation legislation with regards to mental stress claims:

- Most disability policies have language pertaining to offsets with respect to disability benefits received through workers compensation legislation.
- In BC, prior to 2002, it was possible to receive workers compensation due to psychological harm caused in the workplace (workplace bullying and harassment) which resulted in a psychological disorder.
- Section 5.1 of the *Workers Compensation Act* was introduced on June 30, 2002, which limited compensation for mental stress claims to instances where the mental stress was an acute reaction to a sudden and unexpected traumatic event arising out of and in the course of the worker's employment and was diagnosed by a physician or a psychologist as a mental or physical condition described in the most recent DSM. Claims for gradual onset stress were not accepted by WorkSafe BC under this provision.

Changes in the WorkSafe BC legislation (continued):

- BC introduced legislation which put it in line with other jurisdictions like Alberta and Saskatchewan that do not have legislation limiting compensation for gradual onset claims.
- Bill14, the Workers Compensation Amendment Act, 2011, amended the 2002 Act as follows (effective July 1, 2012):
 - The references to mental stress are replaced with mental disorder;
 - The references to physician are replaced with psychiatrist;
 - The scope of entitlement for mental disorders are broadened to cases where the mental disorder is caused by a reaction to one or more traumatic events arising out of and in the course of the worker's employment or in cases where the mental disorder is **predominantly** caused by a significant work-related stressor, **including bullying and harassment**, or a cumulative series of significant work-related stressors, arising out of and in the course of the worker's employment.

Changes in the WorkSafe BC legislation (continued):

- Under this new legislation, the policy now requires that a worker's mental disorder be diagnosed by a psychiatrist or a psychologist as a condition that is described (in the new DSM V) at the time of diagnosis.
- The policy in place requires that a work-related stressor be "significant", which means it must exceed the intensity and / or duration expected from the normal pressures or tensions of the worker's employment (workplace bullying / harassment).
- With respect to claims filed for bullying and workplace harassment, an investigation is often launched where employers and colleagues are interviewed to establish whether there was a significant stressor(s) that exceeded the normal interpersonal conflicts in the workplace and whether the stressor or series of stressors was / were the predominant cause of the mental disorder.

Changes in the WorkSafe BC legislation (continued):

- The questions to be considered by an adjudicator in terms of the revised Policy when dealing with mental Disorders claims in terms of Section 5.1 are now as follows:
 - Does the worker have a DSM diagnosed mental health disorder?
 - Was there one or more events, or a stressor, or a cumulative series of stressors? (these must be identifiable)
 - Was the event “traumatic” or the work-related stressor “significant”? (an emotionally shocking event, which is generally unusual and distinct from the duties and interpersonal relations of a worker’s employment)
 - Significant: did the conflict result in behaviour that is considered threatening or abusive?
 - Causation: Was the mental disorder predominantly caused by one or more traumatic events / significant stressors arising out of and in the course of the worker’s employment?

Changes in the WorkSafe BC legislation (continued):

- A cursory review of recent WCAT decisions reveal that the majority of claims for compensation due to mental health disorders (including bullying and harassment claims) that were appealed were unsuccessful.

Changes in the WorkSafe BC legislation (continued):

- Case study: WCAT-2014-03626
- First Nations worker filed a claim for compensation due to a mental health disorder caused by workplace bullying and harassment. Her claim was initially dismissed by the Board.
- Incidents:
 - She agreed to facilitate a First Nations Beyond Trauma women's group. The executive director told the director "your program just got richer"
 - She was encouraged to say a First Nations prayer at the beginning and end of the sessions, even though it made her uncomfortable.
 - When the director reported to the executive director that she had done a good job, he responded: "Good! I need a token Indian for Rebuilding Lives (another program)"
 - Comments about her weight and her ability to navigate the stairs
 - Comments in front of colleagues about needing "a couple of Indians" to facilitate groups.

Changes in the WorkSafe BC legislation (continued):

- The Board initially denied her claim: while the use of terms “Indian” and “token Indian” and the discussion of the worker’s weight with other employees were inappropriate, they were not meant to harm, humiliate, threaten or abuse the worker.
- The worker’s evidence was that she felt embarrassed and humiliated, and broke down crying. She underwent counselling and was diagnosed with a stressor related disorder by a psychologist.
- With respect to bullying and harassment claims, the policy directive states that conduct that is intended to, or should reasonably have been known would, intimidate, humiliate, or degrade an individual, would qualify as such.
- WCAT found that the cumulative effects of the executive director’s comments were abusive (extremely offensive and insulting) and therefore met the threshold to constitute harassment. The worker was successful with her appeal and qualified for compensation for a mental health disorder.