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NAVIGATING THE INSURANCE LANDSCAPE

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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. The article by Jeremy Frank addresses 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.
- The World Health Organization legitimized burnout as a mental disorder also requires consideration of work demands and worker beliefs. Dr. Franche underscores 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.
- 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 been involved in 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. Unfortunately, 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 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. 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 skilful 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 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.

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.
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 In 5 Canadians in the workforce 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 area in which we work 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.

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 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.

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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 risk for conditions like heart disease4 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 illness5 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.6 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 inter-ventions; 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-independent, 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 won’t 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.7 The largest category of short- and long-term disability claims is mental illness related.8

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.

FROM THE
PRESIDENT’S DESK

KERRI RITCHIE
Ph.D., C.Psych. [CPA President 2022-2023]
Climical 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 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 the 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-feeding, 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 flashbacks 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 indicate. Often, such beliefs are defended with little regard for whether they are supported or not supported in other areas of functioning. Consider this in the case of ongoing treatment, repeated administration of treatment progress measures and free of bias. And how can this be understood when considering objective psychiatric test results that incorporate measures of response bias?). And proper consideration of base rates of various forms of compensation seeking 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.
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 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) 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 returning to pre-injury function. The 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 adjudication 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 disagreements on the part of psychologists when, for instance, they are faced with limits on what treatments are offered to injured workers (e.g., 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 and culturally competent approach to treatment is needed. A strong recommendation has been made to use brief, well-validated measures to monitor worker treatment progress (Tasca et al., 2019). The approach can facilitate a fair adjudicative approach to treatment 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 to this cultural divide. Having more occupational and work-focused rehabilitations courses during training, along with WCIS-based practicums and internships, would contribute to this cultural divide. Having more occupational and work-focused rehabilitations courses during training, along with WCIS-based practicums and internships, would contribute to this cultural divide. Having more occupational and work-focused rehabilitations courses during training, along with WCIS-based practicums and internships, would contribute to this cultural divide. Having more occupational and work-focused rehabilitations courses during training, along with WCIS-based practicums and internships, would contribute to this cultural divide.

The relationship between psychologists and WCIS is not always harmonious – 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 complementing one-to-one contacts and webinars to 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 opinions, 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. Providing role clarity to psychologists can be immensely helpful in diffusing potential misunderstandings. Psychologists provide diagnoses, treatment, and clinical opinions, 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.

Employers need not 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.

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 and implementing effective psychological services for injured workers. Nevertheless, in these times of technological advancements and remote work, basic foundational blocks to relationships may require increased intentional effort. Educational initiatives complementing one-to-one contacts and webinars to 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.

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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 professionals 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) modified 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 Psychologists (OCP) 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 guidelines). 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”; and
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.

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.

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

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<th>Province</th>
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<td>Quebec</td>
<td>Combination</td>
<td>Public Insurance covers minimum limits for personal bodily injury or injury to others, and liability (property damage) by private insurers.</td>
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<td>Saskatchewan</td>
<td>Combination</td>
<td>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.</td>
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<td>Ontario</td>
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<td></td>
</tr>
<tr>
<td>Newfoundland</td>
<td>Private</td>
<td></td>
</tr>
</tbody>
</table>
| 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.

<table>
<thead>
<tr>
<th>Province</th>
<th>Average Premium</th>
<th>No-Fault</th>
<th>Tort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premier</td>
<td>$1,210</td>
<td>$5,534</td>
<td>$500</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>$1,220</td>
<td>$10,087</td>
<td>$300</td>
</tr>
<tr>
<td>Newfoundland</td>
<td>$1,251</td>
<td>$8,081</td>
<td>$200</td>
</tr>
<tr>
<td>Nova Scotia, New Brunswick, Prince Edward Island</td>
<td>$1095, $1014, $800</td>
<td>$50,000</td>
<td>$24,544</td>
</tr>
</tbody>
</table>

No Fault

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Wage Protection</td>
<td>Up to $24,544 per year.</td>
</tr>
<tr>
<td>Third Party Liability Insurance</td>
<td>$200,000 - $200,000.</td>
</tr>
<tr>
<td>Auto Damage Coverage</td>
<td>Up to $60,000.</td>
</tr>
<tr>
<td>Medical Payments</td>
<td>Up to $213,000 for catastrophic injury.</td>
</tr>
<tr>
<td>Disability Income Benefits</td>
<td>70% of gross wages to maximum $400/week, minimum $158/week for 156 weeks.</td>
</tr>
<tr>
<td>Lump-sum cash settlement</td>
<td>Yes, if injury meets severity test (called “threshold”), and subject to deductible.</td>
</tr>
<tr>
<td>Right to Sue for Economic loss in excess of no-fault</td>
<td>Yes, if injury meets severity test (called “threshold”), and subject to deductible.</td>
</tr>
<tr>
<td>Right to sue for Medical benefits (e.g., pain and suffering) under tort law</td>
<td>Yes, if injury meets severity test (called “threshold”), and subject to deductible.</td>
</tr>
</tbody>
</table>

Tort

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Benefit</td>
<td>Up to $7,250,484.</td>
</tr>
<tr>
<td>Deductible Compulsory</td>
<td>$500/week.</td>
</tr>
<tr>
<td>Deductible Collision</td>
<td>$500/week.</td>
</tr>
<tr>
<td>Right to Sue for Economic loss in excess of no-fault</td>
<td>Yes, if injury meets severity test (called “threshold”), and subject to deductible.</td>
</tr>
<tr>
<td>Right to sue for Medical benefits (e.g., pain and suffering) under tort law</td>
<td>Yes, if injury meets severity test (called “threshold”), and subject to deductible.</td>
</tr>
</tbody>
</table>
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 systems. Workers often prefer to deal one-on-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, 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 task performance 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 the worker or workplace needs. Workers are not necessarily 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 model to address mental health 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 work 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 job 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 workers with mental and physical disabilities. It targets job demands related to physical, cognitive, interpersonal, and working conditions and provides tailored ideas for support 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.
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.

Did you know?

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.

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, we will sign-off with a few thoughts:

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.

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.

• 79% of Sun Life’s employer benefit plans (representing 1.5 million Canadians) offer less than $500 per year in psychology coverage.

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.

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 tells us that a graduated return to work program is a critical component of the recovery process. Being in the workplace serves a dual purpose 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, and other leaders in the insurance space you offer 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.
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 biweekly 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 organizations to discuss national/pan-Canadian licensure in Canada. Some professions, notably medicine, have issued public statements in support of pan Canadian licensure. 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, 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.
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- **Our 190+ Continuing Professional Development courses**
- **Podcasts** on timely topics like Remote Practice, Racial Injustice, Vaccine Disinformation, Supporting Female Mental Health Professionals with Self-Care and The Naomi Osaka Effect
- **Our 20+ grants and awards** including – student conference, research and knowledge mobilization grants, and service member and humanitarian awards
- **Discounts, learning and networking opportunities** that are available to you through our Career Fairs and Annual Convention – the premier psychology conference in Canada
- **Resources and Publications** including a monthly newsletter, quarterly magazine, fact sheets, journals and a discount on PsychNet Gold
- The ability to develop your leadership skills, get published or build your resume
- Our ongoing advocacy work on relevant issues like conversion therapy, tele-health therapy and mental health parity

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