

Pre-1990 Claims Unit Study
Final Report To the Workplace Safety and Insurance Board

By

Peri Ballantyne, PhD
Faculty of Pharmacy and
Department of Public Health Science, Faculty of Medicine
University of Toronto;
Adjunct Scientist, Institute for Work & Health

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Workplace Safety and Insurance Board Pre-1990s Claims Unit Study

Executive Summary

This report is based on the findings of the Workplace Safety and Insurance Board Pre-1990s Claims Unit Study. This study was undertaken at the request of the Board and carried out by the Institute for Work & Health (IWH). Peri Ballantyne, IWH Adjunct Scientist, was the Principal Investigator.

The purpose of the study was to gain an in-depth understanding of the lives of WSIB permanently partially impaired clients from the Pre-1990s Claims Unit, to identify their needs, and to identify the ways the WSIB can better meet those needs. Ultimately, the goal is to improve quality of life and return to work possibilities of injured workers in this claims unit, and to consider what might be done to prevent chronicity and complexity of these claims as well as more recent claims. The project was one of several initiated by the Board in early 2000 to better understand the Pre-1990s Claims Unit clients and their experiences with services provided to them.

Methodology:

The study involved in-depth qualitative interviews with 40 injured workers. The sample was stratified by region (Greater Toronto, Ottawa, Windsor and Sudbury), and active/inactive status. Within these stratified groups, individuals were selected at random. Additionally, focus groups with WSIB managers, adjudicators and nurse case managers were conducted. These involved staff responses to the preliminary findings from the injured worker study, and their reflections on the WSIB as an organization.

Findings from the interview study were focused on the pre-injury status of workers, their point of injury experiences, return-to-work, employment and non-employment experiences after the injury, the trajectory of injuries, the injured workers' social, family and marital status, as well as other effects on workers' lives, post injury, and workers' discussions of their relationship with the WSIB. Findings from the focus group study were based on WSIB staff's reflections on the issues of concern to workers, and managers', nurse case managers, and adjudicators' own discussions of the Board, and their roles in it.

Injured workers' injury and return-to-work experiences were examined in the context of their pre-injury employment and social status. The workers in this study had stable employment histories, were committed to their work, recognized the difficulties, and in some cases, the danger and risks involved in their work, and they described the benefits of their work, related to income and financial security, and a favourable standard of living.

Discussions with Workers:

The workers' discussions of the injury-episodes indicated that in many cases, the injury was not immediately recognized, that in some workplaces, routine experiences involving heavy and painful work prevented them from recognizing that a significant injury had occurred.

Workplaces varied to the extent that there were formalized procedures for reporting an injury. Some injuries occurred abruptly and were indisputable, others occurred incrementally; others that were the result of a discrete event were sometimes misinterpreted by a worker or challenged by an employer.

Post injury employment was varied in this injured worker group, but most workers had chronic employment instability following the injury through to the point of interviews (which occurred, on average 17 years after the initial injuries occurred). The options for post-injury employment varied by the level of security of occupational positions in which the workers were injured. Less than half of the injured workers had secure employment at the time of injuries, that is employment in larger sized firms or companies, or in unionized shops, firms or companies. Post-injury stable employment occurred only for those who had been injured while in secure jobs. However, access to a secure job did not necessarily determine that workers were able to retain their pre-injury employment. Further, being a member of a union at the time of workplace injury did not necessarily ensure that a worker's position was protected by that union.

Workers from insecure workplace/occupations were, by far, the majority in this study. These workers had more limited or marginal opportunities for work after injury and were likely to experience under-employment or unemployment. Over time, many workers in this study became retired well before the "normal" age of retirement; only two did so voluntarily.

Some workers had successful rehabilitation, retraining and return-to-work experiences. However, many workers who returned to work after injury discussed the risks of injury reoccurrence and deterioration and re-injury. Many felt their workplaces did not fully protect them, and in some cases, exacerbated their injuries and hastened their physical degeneration.

The trajectory of injuries was a central focus on workers' discussions of their post-injury quality of life. Most experienced reoccurrence and deterioration, or "injury cascade"; many experienced new injuries, and several also experienced additional co-morbid illnesses and conditions that complicated the management of their disabilities and negotiations over return-to-work. Many workers reported that they lived with chronic pain, and over time, as their conditions deteriorated, many expressed concern about what they perceived as additional risk to their health caused by long term use of medications to control pain.

Injured workers described the ways in which their health and ability status post-injury led to a declining standard of living, both for themselves and their families. Many struggled over losses related to the inability to support their families and several described family breakdown. The financial consequences of the loss of employment following injury were of great consequence for injured workers. Related to this was the loss of benefits associated with employment, such as extended health benefits, life insurance, retirement pension contributions, etc.

Injured workers' discussions of their relationship with the Workplace Safety and Insurance Board took all of the above into consideration. Many workers described the difficulty they had in feeling they were treated as legitimately injured and [in cases of being unemployed] legitimately unable to work. At the same time, many injured workers in this study described what they saw as

a great challenge for adjudicators, related to weeding out “cheaters” in the system. With regard to their own claims, workers felt mixed about their relationship with the WSIB. Some had primarily positive experiences with the Board, and many noted that interaction and communication with adjudicators was improving. Others spoke specifically about the nurse case managers, and applauded the Board for this new initiative.

Many, however, described having long histories of contentious interaction with the Board. Difficulties were related to lack of clear rules about how a case would proceed and lack of a written policy; adjudicator turnover leading to repetition, redundancy and general disorder in processing a case over time; poor access to staff resulting in poor management of files and information coming into the offices through mail or fax; a perception of a negative attitude toward the worker by the adjudicator, and related to this, uneven application of rules and seemingly, arbitrary decision-making, unclear processes and timelines for appeals, and lack of control by the worker over the case. Workers also had little understanding of how disabilities were measured and pensions were determined. They were frustrated over the apparent discretion of Board physicians and their lack of accountability for their decisions. Workers’ own family physicians and/or specialists were not given due regard with respect to their own medical judgments about a worker’s case.

Workers also felt their pensions in no way replaced the financial losses they incurred as a result of workplace injury. Workers felt they had little choice regarding the negotiation of rehabilitation programs, or return-to-work or retraining programs sponsored by the Board, and some felt pressure to return-to-work prematurely. This, it was suggested, lead to relapses, reoccurrences and re-injury that were preventable through better planning. Finally, some workers felt they were not treated with dignity and compassion by Board staff.

Discussions with Board Staff:

Managers, adjudicators and nurse case managers had the opportunity to respond to the workers’ points of view about the Board, in focus groups. In general, there was a fair amount of agreement over the significance of issues identified by workers, and a fair amount of agreement between the three groups of Board staff. All identified with the complexities of dealing with the Board as an organization, particularly related to legislative and operational changes that have been undertaken while these injured workers were clients of the Board. The staff groups also recognized that discretion around the processing of a claim, built into an adjudicators’ role, created inconsistent and unequal outcomes for workers. While staff agreed that this flexibility is important to deal individually with each case, it also made adjudicators’ role very difficult and stressful.

Recent changes in operational practice related to the commitment to the “whole person” approach currently espoused by the Board has had the effect of both reducing the caseload of an adjudicator, but increasing the demands on an adjudicator to address all needs of the worker. However, both workers and staff agreed that it was important to recognize the broad effect an injury had on a worker’ life, and thus saw this as important change by the Board.

The nurse case manager role was seen as very important, both by workers and by staff. In particular, the philosophical approach of nursing—of treating the whole person in their environment—was seen as consistent with the direction that the adjudicators’ role had taken, and thus was seen as potentially supportive of that role. A fair degree of tension related to the differing decision-making powers of nurses and adjudicators was described by all staff groups, but all agreed that eventually, their working as a team on behalf of injured workers would advance the goals of the Board to improve services to clients.

Board staff did not agree with all accounts of workers’ lives, post-injury. For example, they addressed the difficulty of determining worker capacity to return-to-work or to attending retraining, and described situations where it could be interpreted that workers’ lacked motivation. They also differed with respect to the weight put on pain management; while workers suggested that chronic pain often led to their inability to work, managers and adjudicators were more apt to see workers as exaggerating the extent to which pain prevents their physical abilities.

These views were inconsistent with workers’ descriptions of the profound effect of the losses associated with inability to work, extreme reductions in their standard of living, and their [involuntary] role changes in families, related to declining ability to maintain independent function and reciprocity in relationships.

Recommendations Arising from the Study:

The above issues culminated in a broad set of recommendations to the Board, regarding the types of issues workers’ identified as important for the continued development of Board services to injured workers. These included:

- improved communication/compassion for workers
- improved processes, improved forms, timely processing of a case
- accountability for decisions rendered
- increased human resources/better training and ongoing support for adjudicators
- reduced adjudicator turnover
- better use of/integration of family and specialist medical practitioners already treating injured workers
- pensions that reflect cost of living as well as (in)availability of additional sources of income for a worker
- financial payment options/flexibility
- continuation of pre-injury work-related benefits
- spousal benefits
- individual and family support
- non-compensable resources information service
- rehabilitation and retraining options and flexibility
- continued monitoring of workplace safety

The WSIB Responds to the Issues:

The findings of this study, and others commissioned by the Board, have led to increased understanding of the experiences and needs of the Pre-1990s Claims Unit clients. According to the WSIB, the information gathered has led to improvements in the handling of these claims and to changes to enhance the clients' quality of life and return to work possibilities.

The unit has introduced a new service delivery model that facilitates a single rather than multiple adjudicators following the case of an injured worker over time. A series of outreach initiatives were introduced to improve client satisfaction and meet their needs. These include a dedicated online information on the WSIB web site and an ongoing process to receive feedback from clients and ensure continuous quality improvement. A recent evaluation of the changes has suggested clients are more satisfied with their interactions with the Unit and view the changes as positive. (See Appendix C of this report for a more detailed outline from the WSIB regarding its actions to address the concerns and issues raised in this study.)

Background, purpose and justification

The Workplace Safety and Insurance Board (WSIB) has an interest in better understanding its clients' needs and preferences, and in modifying its services to better meet them. An area of specific interest for the WSIB is the well-being of their long-term clients, that is, clients who, prior to 1990, were deemed to have permanent partial impairment and therefore, entitled to receive permanent WSIB pensions. In 1997, in an effort to centralize services to this group of clients, the WSIB inaugurated the Pre-1990s Claims Unit.

In February 2000, the WSIB initiated research to determine whether there was a perception of improved service delivery among these clients since the creation of the centralized service unit. Recommendations from the initial study focused on the WSIB-client relationship and the need for improved communication and services to pre-1990s claimants. The WSIB Board of Directors remains interested in improving programs for these clients, in order to enhance quality of life and return to work possibilities. They would also like to consider what might be done to prevent the type of chronicity and complexity that characterizes pre-1990 claims, from occurring in more recent claims.

The following report is based on the results of one research project that the Board has sponsored to address these concerns. The purpose of the project was to gain an in-depth understanding of the lives of WSIB permanently partially impaired clients (the "pre-1990 claimants"). The main method of data collection was in-depth personal interviews with a sample of pre-1990s claimants. The interviews focused on the broad social experiences of injured workers from the point of their initial workplace injury to the present, including clients' post-injury employment, family status and changes and their assessments of both their need for services and their relationship with and expectations of the WSIB. Injured workers' experiences were discussed in relation to their pre-injury social and occupational/employment status. In addition, focus groups with WSIB managers, nurse case-managers and adjudicators were conducted. The format of these focus groups involved presentation of the preliminary findings of the interview study to WSIB staff, group discussions of some of the major issues raised by clients, and staff reactions to and perceptions of those issues.

Research procedures.

The research addresses two general questions:

1. What are the self-declared needs of injured workers who have been designated permanently partially disabled (pre-1990s claimants).
2. How can these clients' relationship to the WSIB be strengthened or organized in a way to maximize the resolution of their needs?

To access the meaning attached to their experiences, in-depth face-to-face interviews were conducted with a sample of pre-1990s claimants. In interviews, clients were asked about:

1. their current health and ability/disability status
2. the extent of change in health/ability status and employment capacity since the episode leading to WSIB services
3. other changes following the relevant injury/episode (social, economic, psychological)
4. a client's relationship with the WSIB
5. a client's evaluation of WSIB services, and suggestions for change/improvement.

A total of 40 pre-1990 claimants were recruited for the interview study. This sample size is appropriate for qualitative studies that seek to explore and discover new ideas and to develop theory about a phenomenon and its outcomes from the perspective of those who have experienced the phenomenon (Creswell, 1998). Study participants were drawn from 4 WSIB regions (Ottawa, representing eastern Ontario; GTA representing central Ontario; Windsor, representing south-western Ontario; and Sudbury, representing northern Ontario). Within each region, seven "active" and three "inactive" cases were drawn at random¹.

The interviews took place between November 2000 and January 2001². Participants completed one face-to-face interview with an experienced interviewer who had been trained for this study. Interviews were approximately 90 minutes in length, and were tape-recorded.

All interviews were transcribed verbatim, and transcripts were audited for accuracy. A coding framework and full code-book was developed incrementally by the three researchers involved in the study (and who also completed the interviews). This involved independent coding of 2 interviews, and several meetings to examine agreement on themes, codes and code descriptions for these interviews, and to assess codebook content and its development, based on the interviewers' independent experiences and perceptions of the interviews each had completed. Full coding of the interviews proceeded. The Ethnograph program for text based coding and data

¹ "Active" clients are those who have had significant interaction with the WSIB in the past year, related to negotiation over access to programs and benefits in addition to their disability pension. "Inactive" clients receive disability pensions, but have not had other significant interaction with the WSIB in the past year.

² Weather conditions in Ottawa led to three "make-ups" in March 2001.

management was used (Qualis, 1998).

Preliminary results of the interview study, reporting on clients' pre-injury, injury and injury trajectories, pre- and post-injury employment and return-to-work experiences, other impacts on workers' social lives after an injury, and clients' perceptions of and experiences with the WSIB, were presented to selected WSIB staff in focus groups. The purpose of the focus groups was to seek staff feedback on major issues identified in the client-study. Separate focus groups for nurse case-managers, adjudicators and managers were conducted in May and June 2001. Focus groups were audio-recorded and transcribed verbatim. In the analysis of the focus group data, the level of agreement or discordance between staff and clients, and between the separate staff groups (adjudicators, nurse case-managers and managers) with respect to perceptions of the WSIB organization, perceptions of clients' needs, and views of how the organization (WSIB) might respond to client needs was assessed.

Findings

A qualitative study requires a small sample to allow for in-depth analysis of issues defined as important by study participants. Due to the small sample size, the characteristics of a population may not be fully reproduced in the sample drawn for a qualitative study. It is useful then, to identify and compare the characteristics of a sample and population and to consider possible biases in qualitative study findings. A comparison of selected characteristics of the full pre-1990s claims unit population, the sample (study participants), and refusals is shown in Table 1.

In the population (full pre-1990s claims unit of approximately 160,000), the proportion of active and inactive claimants is not known. The sample was stratified to include 70% active and 30% inactive claimants in order to give greater voice to active claimants, seen as more complex cases within the Board. "Active" clients are those who have had significant interaction with the WSIB in the past year, related to negotiation over access to programs and benefits in addition to their disability pension. "Inactive" clients receive disability pensions, but have not had other significant interaction with the WSIB in the past year.

Information on the distribution of the population by the four regions selected for this study was not available when this report was prepared. In the sample, the regions were equally weighted in order to give equal attention to potential regional issues related to types of injuries, differences in return-to-work opportunities, and differences in injured workers' experiences with the WSIB. In the analysis that follows, regional differences are addressed.

Comparing the population and sample, females are under-represented and males are over-represented in the study sample. Females are over-represented in the category of refusals. That is, of men who were asked, 81% (34/42) agreed to participate in the interview study (34/42), while of women who were asked to participate, only 40% (6/15) agreed to do so. Study findings should be read with this gender bias in mind, both in terms of who was asked, and who was willing to discuss their injury and Board experiences.

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In terms of age distribution, the study sample does not include pre-1990s claimants who are very young (25-34) or very old (75-84 or 85+), thus our analysis and discussion may not be applicable to these groups.

**Table 1
Selected Characteristics of Population, Sample and Refusals**

	Population	Sample	Refusals
WSIB Status			
Active	Not available	70% (28)	67% (12)*
Inactive		30 (12)	33% (6)
unknown			2
Region			
GTA	Not available	25% (10)	50% (10)
Ottawa		25%	15 (3)
Windsor		25%	20 (4)
Sudbury		25%	15 (3)
Gender			
Female	21.6%	15% (6)	53% (9)*
Male	78.4%	85 (34)	47 (8)
unknown	-----	-----	(3)
Age Group			
25-34	.7%	-----	-----
35-44	9.9	30% (12)	31% (4)
45-54	22.2	25 (10)	38 (5)
55-64	27.0	35 (14)	23 (3)
65-74	27.5	10 (4)	8 (1)
75-84	11.5	-----	-----
85+	1.3	-----	-----
Back Injured	30.1%	65% (26/40)	Unknown
N	155,000	40	20

Ns are presented in () in the cells;
% in cells represent column percentages;
*percentage excludes unknowns.

In the pre-1990s claims unit population, about 30% of claimants have a back injuries (including neck) as the main injury leading to WSIB permanent pensions. A larger proportion of participants in the study indicated that the injury leading to a WSIB partial pension was a back

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injury (26 of 40 participants or 65%). The study findings, therefore, may over-represent back-injured workers.

Table 2 highlights some important facts about the injured workers who participated in this study, and illustrates some differences between regions included in the study.

**Table 2
Sample Characteristics**

	Total	GTA	Ottawa	Windsor	Sudbury
Age (mean) at interview	51	46	60	46	53
Age at injury (mean)	35	32	41	29	35
Years since injury (mean)	17	15	19	16	17
Number with back injury	26/40	7/10	6/10	7/10	6/10
Other injury Types		-& legs -rotator cuff (shoulder) -elbow -head	-elbow -knee -knee -multiple (MVA)	-& knee -& shoulder -knee -arm/wrist (carpel tunnel) -hand (amputee)	-& knee -knees/shoul -hip/knee -neck, feet & wrist
Unemployed/invol retired at interview	24/40	6/10	6/10	6/10	6/10
N	40	10	10	10	10

These workers suffered injuries at relatively young ages ($X=35$ years), and had been living with the consequences of their injuries for a considerable length of time at the point of participation in the study ($X=17$ yrs). The average age at injury varied across the four regions, with the oldest average age found in the Ottawa region ($X=41$) and the youngest average age in the Windsor region ($X=29$). Age at injury and the duration of time spent in (or seeking) post-injury employment is very likely an important determinant of each injured worker's quality of life. To highlight this notion, we revisit the theme of time/aging at various points in this report.

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As highlighted above, a large number of participants in the study indicated that the injury leading to a WSIB partial pension was a back injury. Back injuries are prominent across regions, ages, and occupations/circumstances of injury, and the effects of back injury were described in similar ways by this diverse group of workers. For back-injured workers, the themes of time, injury degeneration and reoccurrence, and pain are common.

Discussions of the impact of the duration of living with the effects of an injury, and the nature of specific injuries, particularly in the context of post-injury employment opportunities and/or involuntary retirement and unemployment are developed more fully in the report.

Findings are presented in six theme areas. Each of these themes was presented as a topic for discussion by the interviewer, as outlined in the interview guideline (Appendix A). The content in each theme area is a summation of the (range of) qualitative issues that participants chose to elaborate on during their interviews. While references may be made to the frequency of a type of response or experience in the sample, the open-ended nature of the text (data) prohibits any generalization, based on quantity or frequency of a response, to the broader pre-1990s claims unit population. In terms of the quality of responses, based on the open-ended method of data collection, we are confident that the results outlined in this report provide a comprehensive perspective on the life experiences and needs of injured workers in the pre-1990s claims unit, and in particular, the experiences of men and back injured workers. Findings should be read with a caution that women clients of the WSIB pre-1990s claims unit were somewhat under-represented in this study.

Theme areas:

1. Pre-injury status
2. Point of Injury Experiences
3. Employment post injury (RTW and details of employment (in)stability following injury)
4. Injury trajectory
5. Social, family, marital status post-injury and other post-injury effects (psychological, financial)
6. On the relationship with the WSIB/recommendations to WSIB

1. Pre-injury status (employment and quality of occupation, social and health)

The majority of occupations held by individuals prior to and at the time of their main injuries were labourer occupations (skilled, semi-skilled and unskilled labour). In these occupations, a worker's skills are often based on experience and (for some) apprenticeship rather than on specific pre-employment training or education. In this study, examples include miners, construction-workers of various types, other industrial and assembly line (manufacturing) workers, drivers of various types, and workers from across the services sector. With the exception of mining in the Sudbury region³, there was nothing distinctive about the regions, or among active/inactive cases in terms of the occupational distribution. Three individuals in the sample were in professionals/managerial positions--one of these was a senior level nurse.

In terms of work histories, most individuals in the study reported having had *stable employment* prior to and at the time of their injuries. However, many did not have *secure employment*, that is, having secure positions with larger sized firms or companies, or in unionized shops/firms or companies. For example, in the Greater Toronto Area (GTA), Ottawa, Sudbury and Windsor, 7/10 7/10, 4/10 and 8/10 individuals did not have secure employment. Related to the lack of secure work was the problem of lack of control over the work. Several participants indicated they were not engaged in the work they were trained or hired to do at the time of their injuries, some were temporary or seasonal workers who put in extended hours of work when it was available, and others worked in unpredictable environments, where worker safety could not be guaranteed.

Among those who had not been in stable and/or secure occupations or workplaces at the time of their injuries, there was evidence, nonetheless, of their having a sense of security in employment, generally related to their capacity to work, and strong work ethic. Many individuals had accumulated experience and developed skills within specific workplaces or with specific employers, and others had been able to rely on their own physical capacity to work in manual labour across their working lives, up to the point of their injuries.

The following excerpt illustrates a trucker's confidence in his capacity to find work and to maintain employment, even though he was not protected by having union membership, or seniority within one company:

R: *I quit school, I went to work, I been working ever since. Up 'til the day I got my accident, I worked. When I wanted to go take a vacation, I took a vacation.*

I: *Um-hm, um-hm.*

R: *I didn't care, I knew I'd get another job.*

³ Our random selection in the Sudbury region resulted in 5 miners being included in the sample.

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Others expressed pride in the quality of work, or recognition of the value of being self-reliant and independent because of one's own efforts, even in work that was tedious and difficult, or dangerous.

R: *Ah, I had a couple of other motor accidents, motor vehicle accidents. My back and...and legs again. Ahm, some other ones where fighting with individuals, you know you're . . . I mean broken fingers and whatnot. Ahm, I guess we call it routine stuff but part of--*

I: *You kind of expect that when you go into that . . .*

R: *(overlapping) Part of the territory. Sure. (police officer)*

Individuals spoke about the work in terms of its value to them, and described their high level of commitment to their work/occupations at the time of the injury. For example, some had reaped the benefit of advancement built into their places of employment; others spoke of such opportunities, and their planned trajectories within their places of work. Others expressed pride in the capacity they had had to deal with the many facets of their jobs, such as in mining, where many and diverse skills were often developed by the long-term employee; some expressed having a sense of being indispensable, or uniquely valued by their employer:

R: *Like, you have to be able to run the place, to drill, to drill, to blast, to bolt, to muck, do everything--aspects of the job. You had around ten aspects, and you had to be trained by (company) through the government on all these jobs. And that's what I was doing when I got hurt.*

R: *I enjoyed getting up in the morning and going to work. I liked it because I knew what I was doing good, and I was good at it. (miner)*

Another responded to the interviewer's questions about the work:

I: *And what did..exactly did you do? Did you set--*

R: *Oh, I would do the, like you know, we'd clean the holes, get ready, and then, uh, load all the explosives, I was strictly with explosives, him-- the two of us. We'd load a ton of explosives everyday. The whole ton. Two thousand pounds of explosives in there everyday, and we'd blast every evening...before, like when we...when you go home...If you had twenty holes or twenty-five, you'd go from one to twenty-five. And that's how you do it. You know, you work with explosives all day. Cleaning the place up first. 'Cause every blast you loosen some concussion or loosen up the rock. So, you had to clean the place every morning. Wash it down.... and uh, we didn't uh, like, my partner and I, we never took lunch. We were just--well, some people didn't care for the two of us.....We were a little bit haywire, but you know. That's what they called us. We never took lunch....well, the bonus system the way it worked...so many tons*

per day if you could do that, you get incentive pay. So our wages, say they were twenty dollars, instead of making twenty dollars, we'd probably be making fifty dollars. Thirty dollars an hour extra...if you work. If you were a free loader, like some...people that work there (laughs) you know, they uh, you know, you would get twenty dollars an hour, whatever the case may be. But you don't make any extra. But we're making thirty dollars an hour extra. So, at the end of that month, every month, what they call incentive bonus, on top of my wages, I'd be making maybe five thousand dollars extra. (miner)

Discussions about the value of one's employment were often made with specific reference to the capacity to earn income---as in the case above, individuals described making very high incomes because of their personal work commitment. Others described the opportunities to earn overtime income, and some indicated that their incomes were well over what others earned, or what they might have expected to earn, given their educational levels. Some suggested that their incomes were based on the relative risks (long hours, dangerous tasks) involved in their jobs. Many worked in physically demanding jobs, and the workers reflected on the risks of injury; some spoke matter-of-factly, of risk and injury as integral to the job.

The injured workers also reflected on the benefits of their work over the long term. These benefits included care of their family, as breadwinners; the purchase of homes and responsibility for mortgages, the capacity to plan for their children's post-secondary education, or to provide a high quality standard of living to their children/families---a desired lifestyle that allowed recreation and leisure, travel and vacations, and for some, hopes of a secure (for some, early) retirement.

Retrospective accounts can produce biased, "rose coloured" evaluations. However, among injured workers we spoke to, many were involved in jobs that involved heavy manual labour, and monotonous, physically taxing work, intense time lines and schedules, pressures related to running small businesses, or pressures related to keeping one's reputation as a reliable worker. During interviews, injured workers also described these negative or challenging qualities of their work, as well as the benefits of the work.

In summary, the injured workers in this study discussed the practical aspects of their pre-injury employment that helped to account for its value to them; and they recognized the relative losses that had been incurred because of workplace injury. They described having a tremendous commitment to work; that work/employment, the employer—mentioned explicitly in some cases—and the incomes attached to that work were highly valued. This brings to mind the idea of work as an important component of one's identity; and the corollary that loss of work is a blow to one's very sense of self.

2. Point of Injury Experiences

Injuries were of various types. Back injuries were the main injury of 26/40 individuals. Of these 26, 5 included back+other injury (nose, head, knee, shoulder, legs). Among the six women in the study, 3 had back injuries; among men, 23/34 had back injuries. Among 11 inactive claimants, 5 were back injured; among active claimants, 21/29 were back injured.

Other injuries included shoulder/rotator cuff, tennis elbow, elbow, head injury, knee or knees, hip, neck, wrist, feet, multiple (total body) and in one case the injury involved a severed hand. Ten cases involved more than one initial injury location; all but one of these cases was male.

In a few cases in this sample, an incident and injury to a worker was immediately recognized, with no contention over its definition as a workplace injury. Examples include motor vehicle accidents, accidents resulting in an unconscious worker where it was clear that hospitalization was necessary, or where crushed limbs occurred. However, the nature of most injuries described by our study participants was such that recognition of them was not always immediate. For example, the injury may have developed incrementally, and was not the result of a discrete incident:

I: *At the point when this initially happened, how long was it from the point when you went to your doctor to having to go off work?*

R: *It was about a month and a half.*

I: *From your first visit to him.*

R: *Yeah.*

I: *So it must have just—it would flare...*

R: *It continually got worse and worse and worse and I wasn't getting anywhere with getting different type of, you know, job or going to therapy after working hours and coming in to work and trying to do it, nothing was being...you know, done. So I thought- - the doctor just got fed up and said "That's it" and basically that's.. that's how it all... (office worker)*

In some cases, the worker experienced an incident that was only later recognized as a significant injury. The following excerpts illustrate this point:

R: *At the (hospital). I was just making my rounds, ahm, nursing rounds; I was like the Head Nurse on evenings, so it was my responsibility to make sure that all the children were settled properly and everything and I was making my rounds, and of course, unfortunately this one bed was left up by the nursing... registered nursing*

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assistant at that time had left up and I saw a little boy coming over the edge. He had leg Perthes' Disease with a heavy brace on him, in those days they had braces in '73. And a boot, and he would have hit the cement floor but I ran in and threw both my arms underneath him and tipped him back in to the bed. It was in the up position with the rails up. And ah, he rolled back in. I just heard a (makes tapping sound) in my back and I thought that's a very strange sound, but I never thought much about it until about fifteen minutes later when I felt my legs going numb on me, semi-numb. You know, I could feel there was a big difference in them and I couldn't feel them quite as good as I did before. (Clears throat). So I came home and I, ah, when I left my shift that night at eleven-thirty, I came home and the next morning the legs were even worse so I called the doctor and I had the appointment and I reported the injury to the Health nurse. (nurse)

R: Well, when I had the accident, March the 14th, 19xx I believe it was, I was working in a bathroom in one of the units and I slipped, fell backwards up against the, ah, inner wall of the tub, and I slid down and hit the rim of the tub, and ah, I was in a lot of pain but I was in more anger than pain because the bar that I was putting up, the curtain rod bar, it fell and it broke a tile. So I had to pull the tile out and put a new one in, and I was very angry about that because it was a beautiful job. I hate doing patch work when the job was complete. And then, ah, I finished off by putting the, ah, rod in and finished all that bathroom. And then I had another bathroom for that afternoon, so I went and did it. Then I came home around four-thirty, and everyone was going out when I got home, so I laid out in the living –room on the chesterfield. When I went to get up I couldn't move, so I rolled off and I crawled up and ah, I knew my back was bad. So I went to the hospital, they took x-rays, sure enough they showed me, they said, "Here is the problem". Anyways, ah, they said that I had fractured some vertebrae, two vertebrae. Oh yeah, and I did another bathroom, all the tiles, yeah. But I know once I got up off that chesterfield, I was in bad shape. (self employed contractor)

R: So in those...those days it was a little bit slow so they give--palm off other small jobs on you to do right?

I: Yes.

R: And it's not a union place so..... And ah, I was piling--it was long boxes that were used for...for pipe and for rods...

I: Right.

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R: And they're about twenty feet long and they're made out of wood. They're not heavy, but when you put them all together they get to be heavy. And I was piling them into ah...ah...racks that they had, and as I piled them up, you had to go up a stepladder and slide them in. And when I was –they were getting all piled up and the racks collapsed and fell in and it landed on my shoulder and knocked me off the top of the ladder and I went down to the bottom. And I got up and I was okay. I felt fine.

I: Right. Now from the way you were gesturing it sounds like everything was piling above your head; is that right?

R: Yeah. And it's up here and it came down, like I'd slide the box in this way..

R: and it came down on my shoulder. And I guess what it must have done, it must have popped my disk at the lower back out, and I didn't realize this at all at the time, because I wasn't – I didn't feel anything. I fixed the rack, fixed everything; worked the rest of the day. The next morning when I tried to get up out of the bed I couldn't get out of bed. I was in a water-bed and I couldn't get out of it. I was trapped. I couldn't believe it. I couldn't move out; couldn't get out of the bed. (industrial worker)

In other cases, the worker recognized they had had an injury, but continued to work following the incident.

I: Tell me about the work at (company). That accident happened in 19xx?

R; 19xx, yeah. And ah, I went home that night, my..my hand was swollen. And I was in pain. My arm, my hand and everything but when you work in that kinda work it's like working in construction; most people will come home.. you're in actual...heavy physical pain. You know? And so a few days later and then on a weekend, well Monday you're just hurting a bit and you go back to work. So I thought it was normal. Then it got worse and worse. (industrial worker)

Another individual had had a previous experience with an injury that influenced their interpretation of the new incident's seriousness:

R: But then I hurt my back, I had hurt it the first time, and the doctor had said, "Well, you can go back to work", he said it was just a muscle strain, and then I went back to work, and a week later, it happened again. (delivery truck driver)

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In the following examples, injuries had occurred but were not viewed as serious at the time. The following individual had experienced an injury but didn't consider it to be serious, and did not intend to report it at the time of the incident

I: So you hurt your knee that day and you kind of ignored it, is that...?

R: well I was going to ignore it, but then.. then it was sore as hell at first, and then ah, I was just gonna say wait, you know, and see how it was like in a week's time or so, and (another employer) said well no. And uh...she convinced me that I should ah, she was gonna report it and .. and I went to-o-o the doctor to get checked out, I guess it was the next day. (manager)

Another worker teased his shift boss about an incident that was later determined to be a severe knee injury:

R: I really didn't think anything of it when I did it. It hurt like a son-of-a-gun when I did it, but I got up, walked around, I looked at my knee and all I did was bark up a little bit of skin. But our shift boss was a real stickler for guys getting hurt. So I teased him. M.M. was his name. I said, "M.,M., I got an injury for you". "Oh no" he says. "no, L, no" he says, "we're going good". I said, "Ah, I'm just kidding, M., I just barked up a little bit of skin". I said, "But put it down in your report anyway". "Alright", he says, "well we'll hold it off for a couple of days" and he wrote it in his book. I woke up the next morning, my leg looked like that stove pipe. About as big around and about the same colour. My wife screamed when she saw it when I thr—when I threw my leg outa bed in the morning and she looked at my leg ,she screamed! I was black and blue, like just black, just the darkest purple you've ever seen! Right from the crotch to the instep. And I went to work and I got in with the –in the van with the guys and I went to work and I showed it to my general foreman and he told me, he says, "L., get the hell out of here and go see the doctor", he said, "because you got something drastically wrong in there". (miner)

And another experienced a significant delay between the point of incurring an accident, and the experience of debilitation and serious loss of function:

R: You know, like smaller shops. And ah, I was working a real heavy machine there and I was doing real heavy work. I slipped and fell, because I was quite high, maybe about as high as that table, that was my table at work. And I was standing on it and I slipped and I fell on the floor. Well that's when it started, my back, you know, because I fell right on my...

I: Right on your tail bone?

R: Yeah. (Chuckle) like, boom! And it hurt for a little bit and I think I took two weeks off because it was sore, then it was okay, it felt pretty good. I went back to work and I forget how long I worked, and ahm, I bent down and I couldn't get up. That's when it really started. And I couldn't move; I couldn't even pick up my feet that much off the floor. (industrial worker)

These examples illustrate the ways in which a worker's interpretation of an incident and outcome as serious and legitimate was complicated and inexact, often *because of* the nature of the work being done. Interpreting the extent of harm to backs and knees, and the extent of pain resulting from such injuries was particularly complicated. The examples also provide insight into the type of work or activity in which workers incurred injuries, and the varying types of responses to an incident. Recognition that an injury had occurred, and responses to it varied widely. Not infrequently, workers initially under-estimated the seriousness of an injury. Cues such as pain and numbness did not necessarily over-ride the worker's intent to continue their work activities. In settings where physical pain was a "normal" experience, these cues were not necessarily meaningful. In these settings, injury status at the point of injury was open to interpretation.

The above examples also indicate the importance of there being an institutional role for surveillance and reporting of worker injuries in the workplace. In two cases described above, workplace representatives responsible for reporting injuries and following a new "case" were identified. Such an institutional role, with formalized procedures for follow up of even minor incidents were more common in larger companies or unionized workplaces. However, in some cases, workers had to persuade their employer that an injury had occurred, and that it was caused by activity in the workplace. Some injured workers described experiencing overt conflict with an employer over an accident or injury:

...and I don't--I know that the, ah, the guy in the office that ran the..the-the show, he lied when it got to Compensation. And I was really upset about that because he witnessed my accident. And..and the warehouse manager witnessed my accident. They were together. The warehouse manager said--stated yes he saw that, and when they asked the, ah, Mr. R., his name is, he said no, he didn't see anything. And I thought to myself, 'well there you go right away'. (industrial worker)

Another case illustrates a similar point:

I: *Could you talk about...just how the injury happened?*

R: *Okay. We were working up in XXXXX, it was November 28th; there was a lot of snow on the ground. There was about a forty-five per cent grade of decline from the side of the road into an embankment and we were installing underground piping. So I was putting out delineators along the highway so the traffic would swerve away from the construction, and the backhoe operator was digging the trench. The machine itself started to slide down the grade, and in order to stabilize the machine from toppling*

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over, he swung the bucket far to his right, and dropped--tried to dig it into the ground. In the meantime, he hit me in the head, and knocked me into the middle of the highway.

I: *Now, you didn't have to have--were you wearing a helmet?*

R: *Yeah, I was wearing a helmet. It just flew. I don't know where that ended up. I didn't even see that helmet ever again. Ahm, I didn't know what happened. I woke up in the middle of the highway, two other workers came out in the middle of the highway, got me, and said, "Come on, we have to get you to the hospital", and then they put me in the car and they drove me to the XXXXX hospital. There the doctor made me look in the mirror to see what had happened, and ahm, then he started to stitch me up...I was off work for two weeks while the stitches and everything were being removed. And ah, a Workers' Compensation form was filled out and completed, signed by the superintendent, signed by myself, and it was never submitted to the Workers' Compensation Act. So what happened was I went back to work the following Spring, and worked approximately through the Summer into the Fall...*

I: *Now wait; you said first though, you said you were off two weeks and then--*

R: *Two weeks and I think I went for a couple o' weeks....and ahm, then was laid off for the Winter and called back in the Spring.*

I: *Oh okay. Because of the season, right?*

R: *That's right, that's right. And then what happened was, ahm, I started getting headaches and that; the more physical work I was doing, the more it was bothering me and I was losing sleep. I started receiving really bad headaches and spasms in the side of my face. So I ex--I explained that to the superintendent and ah, told him that I was gonna go and seek medical attention and I did, and then I star--I went to the Workers' Compensation office and the claim--made sure that the claim was ongoing. Apparently Workers' Compensation hadn't heard anything about it. So for a year nobody even knew that I was injured. (construction labourer)*

Among self-employed persons, stopping work to respond to an injury had immediate financial consequences, and, at times was avoided until the worker simply could not function. The costs of either a worker's or an employer's efforts to avoid or ignore an injury should be the focus of systematic investigation: avoidance of a quick response to an injury is likely to increase the damage initially incurred and to create greater negative long-term consequences for the worker, such as is described in some cases included in this study.

3. Post-injury Employment

A variety of outcomes related to post-injury capacity to work, and return-to-work experiences were discussed by participants in this study. Due to the lengthy times between the occurrence of injuries and their participation in the study interviews, workers also discussed their employment trajectories, that is, the pathways from the point of injury to the point of the interview. Employment outcomes at the time of the study included full employment, under-employment, “employment leaves” (for unionized workers unable to work, but whose seniority is protected through union membership), unemployment and/or involuntary retirement, and voluntary retirement. Employment, leaves of absence, under-employment, and unemployment among the injured workers were of variable duration; but for the majority of workers in this study, *chronic employment instability* followed their initial injuries. Involuntary retirement, distinguished from unemployment on the basis of an individual having given up looking for work and/or being unable to work, far outweighs voluntary retirement in this sample. Among those who were involuntarily retired at the time of interviews, most had experienced years of intermittent, unstable employment and unemployment, usually due to injury relapses/reoccurrences that culminated in the permanent leave from paid employment. Outcomes illustrating employment status at the time of the interviews are summarized in Table 3, and post-injury employment pathways are discussed at length, in the remainder of this section.

Table 3
Post Injury Work-related Outcomes at Interview

GTA	Ottawa	Windsor	Sudbury
-no work interruption (1) -accommodated; modified work, same workplace (2) -WSIB sponsored retraining (1) involuntary retirement (6) *12 yrs after injury *13 yrs after injury *11 yrs after injury *15 yrs after injury *< 1 yr after injury *5 yrs after injury	-continuous employment (modified when required) (1) -unemployed (3) -voluntary retirement (2) *at age 65 *7 yrs after injury at age 54 -WSIB re-training (1) -involuntary retired (3) *28 yrs after injury *24 yrs after injury *16 yrs after injury	-continuous employ- ment, same comp and same job (1) -new occupation after rehabilitation (1) -chronic underemployment (1) -WSIB re-training (1) -union-medical leave (1) -involuntary retired (5) *11 yrs after injury *9 yrs after injury *15 yrs after injury *9 yrs after injury *20 yrs after injury	-union medical leave (1) -underemployed (1) -WSIB re-training (2) -involuntary retired (6) *< 1 yr after injury *18 yrs after injury *at time of injury *12 yrs after injury *1 yr after injury *24 yrs after injury
χ Yrs Since Inj: 15	χ Yrs Since Inj: 19	χ Yrs Since Inj: 16	χ Yrs Since Inj: 17

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The place of work at the time of injury appears to determine, to a great extent, how well one will do after it--how accommodated the injured worker will be following an injury. In this study, of 40 participants 14 had secure jobs to return to after an injury. Their workplaces had instituted accommodations for injured workers, and 13/14 were unionized (the 14th was a senior manager who was hired by a competitor shortly after incurring a serious injury). Injured workers from these types of workplaces experienced less alienation from the workplace than other injured workers who were in more tenuous occupations or employed in workplaces that did not follow formalized procedures for dealing with injured workers.

Importantly, *access to a secure job did not necessarily determine that workers were able to retain their pre-injury employment*. Only 5 of the above 13 were employed at the time they were interviewed for this study. For most injured workers who participated in this study, injury deterioration, new injuries and/or co-morbidities continued to limit their capacity to work following their injuries. Some stopped working after they continued to deteriorate to the point of being extremely limited or unable to function at the workplace. Some of these 14 took company-sponsored disability pensions, union-supported medical leaves, or were able to receive early- or full-retirement pensions.

Further, *being a member of a union at the time of a workplace injury did not necessarily ensure that a worker's position was protected* by the union. Several workers were unionized at the time of their injuries, but were unable to retain their employment positions or union membership (they had low seniority, were seasonally employed thus discharged at the end of a season, or were unable to continue working even in modified settings following their injuries. One individual mentioned explicitly that he was fired by his employer, but was able to re-gain his position when the union supported him.

R: *You hear of these equal opportunity and all this stuff and that, yeah, okay, that's just for a good image. It's never, you know. Unless you're actually hurt in some phenomenal company like Chrysler, you're not gonna be doing well. Chrysler's or Ford's or GM, they'll keep their injured workers, you know. They got the union to back them up and fight them and stuff like that. The smaller companies even with unions, they don't have any backup. You know, you're a nuisance to them after that.*

R: *You're a pain in the ass. You're an eyesore.*

I: *How long were you off work?*

R: *Ah, not long. I was--went to the hospital on a Friday, was back out on the following Friday, and I think, I believe back to work within four to six months. Yeah, yeah. The only reason I ah, took me so long to get back to work is they fired me when I had the injury.*

I: *They fired you?*

R: *Yeah.*

I: *On what grounds?*

R: *I don't really remember. But the union fought to get me back in. They fired me four or five times after that, the union fought, got me back in, fought, got me back in and then finally I just, you know, it's time to move on.*

While serious disability and deterioration sometimes determined that the worker could not sustain work, some workers described having experienced explicit discrimination as an injured worker (and more explicitly as a WCB claimant) because they were seen as a risk for a company:

R: *... people look at you, you're on Workers' Compensation, either you're pulling a scam, and I know a couple guys that are pulling scams, but they look at you, it's either you're lazy or ahm... unreliable, you know.*

I: *Right.*

R: *And it's just that, you know, it's that instability that makes everybody uneasy and unsure, right? (labourer)*

Another stated:

R: *Yeah. Well now I'm ready to go back and work; do whatever work I can find or whatever I want to do, right? Now, I went out and I applied to certain places. They asked, "You have ever Comp?" You can't lie to these people because they check if they, you know. And I'd say yes, and they'd ask what back problem. Garbage. Those--I never got a call back from anybody that I put that I had Comp and I had a back problem. Not one of those companies ever called me back. The only ones that did was the ones I didn't write on--that on. So they don't want you. You see, you're broken, they don't want that. They don't want back problems, it's the worst thing. (industrial worker)*

In cases of deterioration and inability to work, workplace-, WSIB- and/or CPP-disability pensions might be negotiable, but these took time to negotiate—sometimes years, as some of our study participants described---and workers were often stranded with long periods of unemployment, without incomes or with extremely inadequate incomes.

It is notable that most “inactive” clients were employed in unionized positions at the time of their injuries (8/11). One might be inclined to expect then, that these inactive claimants had more acceptable accommodations following their injuries that led to fewer demands of and negotiations with the WSIB following their injuries. However, at the time of interviews, among

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inactive claimants, 3 had retired involuntarily and 2 were unemployed. Another 3 were employed, one was voluntarily retired “on time” at age 65 and two retired early with company benefits. It cannot be assumed, then, that inactive status with WSIB implies lack of need for employment, retraining, income or other benefits.

It is perhaps not surprising that of 6 women participants, only 2 were in unionized positions at the time of their injuries; one continued to be employed by the same company (with delayed responses to her need for accommodating office work). The other (a registered nurse) reported that she was fired from her job, charged with taking too much sick time. She was unable to continue in her professional occupation, and never retained full and adequate employment again.

This woman had serious symptoms following the injury episode, but because they were not completely debilitating, she continued to work, and may have exacerbated the initial injury. Another woman worker reflected that while the workplace provided her with work after the injury, it didn’t provide a modified work site to accommodate her physical status following the injury. She has continued to experience frequent reoccurrences and flare-ups that have worsened her condition. She felt that much of her post-injury deterioration and relapse could have been avoided with a more appropriate response by her employer (related to ergonomic assessment that occurred two years after her RTW):

R: *I was off for that long time, I had a cast on the arm again, good old cast. This was in the summer time. I was on my holidays up north and with this big cast on. Pain in the butt but anyway I did it. Ahm, after the cast was off I was told return back to work. I came back to work. My...my area was exactly the way I left it. No modifications were done to it, nothing.*

I: *Now was this the the different job?*

R: *Yeah. The new...the new job that I got into. It was supposed to have an ergonomics come down, I came back on a Monday, the ergonomics came down on a Tuesday to do my assessment on my jo--my desk and that, I was there, I finally got my assessment and my ergonomic thing done this year of July. (two years later) It took them THAT LONG to have the ergonomic assessment. (office worker)*

For this woman and other injured workers, the injury became an integral part of their selves, and its management a part of their daily routine. In the above case, the workplace was a major source of risk for reoccurrence.

For some, co-workers created or contributed to a workplace attitude that demands that you “pull your weight” even in the case of an injury and prolonged rehabilitation. Then, the injured worker, like other persons with disabilities, faced the contradictory pressures of managing their bodies/pain at the same time as participating in a job they value; and of managing the stress involved in knowing the work might cause re-occurrence or compound the injury.

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Thus, even with a “good job”, the injury and frequent reoccurrence of some types of injuries limited a worker’s ability to continue in their occupational positions, to seek and gain promotions⁴, and to feel a sense of financial security following their injuries.

Workers in “insecure” workplaces/occupations were by far the majority in this study. These workers (for example waitresses, non-unionized factory/shop/construction workers/truck drivers) had more limited or marginal opportunities for work after injury, and were more likely to experience under-employment and unemployment. Injured workers in small, non-unionized companies faced immediate risk of losing their jobs because smaller shops did not accommodate extended leaves, modified work programs, and other accommodations to the injured. For several, early return to work was an immediate risk to their well-being. Indeed, the culture of some workplaces and some types of work/employment appears to compel early return to full or partial duties, and several participants in the study remarked that they had returned to work too early to have recovered from their injuries. Some also noted that they were encouraged to return to work prematurely by their company or by WSIB staff. Some described serious physical deterioration that they viewed as a result of early return to work:

R: *I did my upgrading up to Grade ten I think it was, and then they come in, they told me "Okay, you're done school, go back driving".*

R: *So, that's what happened back then, and I went back driving, and I kept driving until I couldn't walk. Yeah...I kept..I kept driving transport and ah, until I couldn't walk no more, then I had to get off. (truck driver)*

Another stated:

R: *I was stuck in there, literally stuck in there, and so that was my job; I had to do that.*

I: *You had to go back to it?*

R: *I had to go back to it. And I asked them to get me outa there, and they wouldn't move me out.*

I: *Now what did the union say? Like when you go—*

R: *Ah, they..they gave me some long story and I ended up, I had to go back. And I said, I'm going to hurt myself again because I just know with all this twisting and that, that is not going to work. But they wouldn't--none of them would listen to me. (hospital worker)*

⁴ Three individuals in this study did earn promotions that were available to them through their workplaces (a police officer; a city-employed middle-level manager; and a private sector senior manager who was fully accommodated in several workplaces despite his injury, physical deterioration and injury-related leaves from work).

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And another:

R: *Well I..I was originally injured in ah...I guess it was '82 I think it was, give or take a month or two here, ahm, I injured myself, and I never completely let myself get healed. The doctors would always say, "Well, you can go back to work."and ah, but a lot of times I was sent back to work, and I wasn't ready. I knew physically I wasn't ready. My back ached. Ah, you know, if I bent one way or...but ah...*

I: *Did you ever question it? That it--*

R: *Well I questioned it, but I never got any ah, answers that were...you know.*

I: *Did you ever resist and say, 'I don't think I'm ready to go back.'?*

R: *I did. ...But the thing is-is you ah, they send you back to see a doctor. ...ah, in my-- when I was there in (town) I'm sure that the companies and ah, anybody else that was hurt will tell you the same thing, that they were pressured by the companies to send the men back to work. (miner).*

In many cases, the small workplace wasn't able to support an injured worker, such as by providing long-term modified duties. In the following example, an injured trucker's company tried to support her, but she was unable to sustain the work:

R: *I went back in September, off and on I'd say. Like when I was really bad I'd just tell my employer "I can't, you know..." so he put me in the office. I'd do the odd load, and I did a lot of office work. So probably...oh god...we're talking eleven years ago then.*

I: *Hard to remember all the details.*

R: *Maybe...maybe a year and a half. And then next I went in the office and then did the odd load and..because I...can't just quit that, you know, like completely, you know, something you love to do. But then it got to the point where the business was starting to go down and he couldn't afford to put somebody with me to go, and you know, if you can't do the whole job... So I had to get out. (truck driver)*

Another example of the tenuous nature of small business operations is illustrated below:

I: *You said you owned your own company...*

R: *Yeah. And no, I didn't own it after that, ah, what happened.*

I: *What happened?*

R: *When I was in the hospital, the lad that I had looking after my business robbed me blind. He got rich and I got poor....he had to pay for the material and everything, so he had access to my bank account which he depleted in no time at all. And there was a substantial amount in that bank account. And then my ah, the money that he got for jobs seemed to disappear as well. I, ah, I got a call from the bank one day stating that I had an overdraft and could I come in and settle it up. And I said well how could I have an overdraft? I had a lot of money in there. Well, there's been money taken out gradually and consistently, and it's depleted!*

I: *And over how long a period did that happen?*

R: *About six months. You know, you build an additional home back then, you're looking... you know, maybe \$80,000, and half of that would have been material, and half of the other half would have been labour. So....my..my net profit on a job of eighty thousand would be about twenty thousand dollars. And ah, that's managing it very closely and that's why I was on the job constantly. I never left a job alone for somebody else to run until I injured my back.*

I: *So it was just you and one other guy working? Or...*

R: *Oh no, I had ah, four or five guys working for me sometimes, three some other times and ah, at this particular time there was this fellow that was looking after the company and three; a carpenter and two other labourers, so there were three extras. But ah, I don't know if it was just poor management on his part or just ah, greed, you know. He saw things that maybe he shouldn't have seen and figured well, here's a way I can get my... some money.*

I: *How do you mean?*

R: *Well he just took extra money out of the account to pay for bills which weren't there, and then he'd buy extra material and ah, return it, get credit for it and ah, take the cash.*

I: *So did you confront him about this?*

R: *Oh yeah. He said "Well you told me to look after it so that's what I did". He said, "I can't help it, it's not my fault. Wasn't my company, it was yours". So I said, okay. (contractor).*

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Another individual attempted to development his own business, and spoke of the benefits of self-employment for coping with his low back injury. Eventually reoccurrence prevented his continued employment:

R: *So what I did, I did some part-time things here and there and then I started my own little business, and which went pretty good. And ah...*

I: *What kind of business did you start?*

R: *Well I started--I started networking computers.*

I: *Okay.*

R: *And I started working with ah, a couple other people first, and they understood my back problem. ...I had a deal with them that I would sorta make my own appointments.....and go and if I couldn't go, I wouldn't go. You know what I mean?*

I: *Right.*

R: *They were good about it, so I..I did well and...eventually I owned part of the business and it went pretty good. And it was just two of us and sometimes we brought in some people to help us, right? And I'd live with money I was earning, and I--and I did alright. And...I had some problems where I had to shut it down. I got into a car accident and it was just a fender- bender, somebody bumped in behind. I was the second car, and I got hurt--my back was so bad, it took me six MONTHS! I mean, nobody else would have even felt it. Took me SIX MONTHS to recover. I had to shut everything down. You know how many jobs I lost and stuff - right?*

I: *Oh dear.*

R: *...now I had problems off and on, and sometimes my back would flare up and I'd be out for a month. But I would always recover. I....I would just rest and I would put my ice on and, you know, and during all that time I went to see chiropractors and massage therapy and always kept up, tried to keep myself--capable of going, right. And this went on until two years ago, when I hurt my back and I couldn't recover. I was putting, ah, making the bed, and I was stretching over and I was, you know, making the bed. And my back went out and I was down. And I had to lie down in the half-made bed and I'd lie there for hours, I couldn't move. I was in absolute agony. Eventually I-I--you know, that was--that was before, what was that...around October, November of ninety-eight. And I couldn't recover. I..I tried, I rested and I--then I'd start feeling a little bit better, I'd try to do something, I'm back to where I was, back to bed. I couldn't do--like I couldn't sit here with you, couldn't sit down for more than ten minutes. And as ah, coming close to Christmas around December, I had another attack where I--I was on the floor and I couldn't move....and I was off--I told*

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Compensation and they all--they knew all about it and...February, I think it was around February, I was still hurting, but I had--my business was failing large. I had all kinds of things I had to do, right? And I tried to go back. I went two days and I couldn't walk for a month after I went. Things were done, that was it. I closed the books.

In conclusion, employment outcomes for injured workers from “secure” and “insecure” workplaces were varied. Irrespective of the employment status of injured workers at the time of

**Table 4
Employment Outcomes at Interview Date by Type of Workplace**

	Secure Workplace at Injury	Insecure Workplace At Injury
Employed	T3*, T4*#, T8, O3,	W3#*
Under-employed		W8, S12#
Unemployed		O8, O6*, O4*, T5
WSIB retraining		S11, W6, O7#, S13#
“on leave” (workplace sponsored)	W7, S4, W2	
Voluntarily Retired	O5*	O10,
Involuntarily Retired	O9, S1, S2, S7, S8*, S10*	T1, T2*, T6, T9, T11, O1, O2#, W9*, W10, W4*, W1, W5, S3, T7
N	14	26

* inactive # female

this study, most experienced chronic employment instability following their injuries. Table 4 summarizes employment outcomes at the time study interviews were conducted. Most workers had experienced ongoing complications related to their initial injuries, some experienced new injuries and other developed other illness conditions. Each of these experiences increased the likelihood of unemployment, unstable employment or retirement. Issues related to the trajectory of workplace injuries are the focus of the following section.

4. Injury trajectory

The major themes related to workers' injury trajectories are noted in Tables 5 and 6. Summaries in these tables allow comparison of regional differences in injury outcomes, and differences by active and inactive status.

Table 5
Injury Trajectories and Outcomes

Participant Mentioned...	GTA (N=10)	Ottawa (N=10)	Windsor (N=10)	Sudbury (N=10)
Reoccurrence/ Deterioration	T1*, T3, T4, T5* T6*, T11*	O1*, O3*, O7*, O9 O10*	W1#, W2*, W5*# W6*, W7*, W9* W10*	S1#, S2*#, S3#, S4*, S7#, S8* S10*, S11*, S12*, S13
New Injury	T2*, T4, T7	O5#, O9,	W1#, W4*, W5*# W6*, W7*, W9* W10*	S2*#, S4*, S10* S12*
Continuing Pain	T2*, T1*, T8*, T9* T11*, T5*	O1*, O2*, O3*, O4, O7*, O8* O10*	W2*, W5*#, W6* W7*, W9*, W10*	S1#, S2*#, S3# S4*, S7#, S10* S11*, S12*, S13
Concern about medication use	T1*, T8*, T9*, T11* T5*	O2*	W6*, W7*, W10*	S1#, S3#, S4* S11*, S12*
Co-morbid Conditions	T2*, T8*, T9*	O4	W2*, W3, W9*	S4*, S10*, S13

*back injured
#knee injured

In Sudbury, all 10 injured workers discussed having injury deterioration, 9/10 described having chronic pain, 5/10 described being concerned about their use of medications/drugs for the management of pain and health problems related to their injuries, and 3/10 described having developed co-morbid conditions since the time of their initial injuries. In Toronto, 6/10 participants describe reoccurrence or deterioration, 6/10 described having chronic pain, 5/10 described being concerned about medication/drug use, and three described having developed co-morbidities since their initial injuries. Injury deterioration or reoccurrence and chronic pain is also high in the Windsor sample, and participants in the Windsor sample were more likely than individuals in the other regions to have incurred an additional injury. These summary figures suggest the need for continued research, for example to compare the rates of (illness) morbidities in injured and non-injured workers from different occupational classes, to examine medication

and drug/substance-use as a method of coping in high stress, physically demanding occupations, etc.

Table 6
Active/inactive Status by Injury Trajectory

Participant Mentioned...	Active (N=29)	Inactive (N=11)
*Reoccurrence/ Deterioration	T1, T5, T6, T11, O1, O3, O7, O9, O10, W1, W2, W5, W6, W7, W10, S1, S2, S3, S4, S7, S11, S12, S13	T3, T4, W9, S8, S10
*New Injury	T7, O9, W1, W5, W6, W7, W10, S2, S4, S12	T2, T4, O5, W4, W9, S10
*Continuing Pain	T1, T8, T9, T11, T5, O1, O2, O3, O7, O8, O10, W2, W5, W6, W7, W10, S1, S2, S3, S4, S7, S11, S12, S13	T2, O4, W9, S10
*Concern about medication use	T1, T8, T9, T11, T5, O2, W6, W7, W10, S1, S3, S4, S11, S12	
*Co-morbid conditions	T8, T9, W2, S4, S13	T2, O4, W3, W9, S10

*multiple response categories

Regarding active and inactive status, “active” cases are more likely than “inactive” cases to have experienced reoccurrence and deterioration, chronic pain, and concern about the use of medications. This may explain their greater involvement with the Board. On the other hand, “inactive” cases were more likely to have reported experiencing a new injury. While potentially, a new injury may lead to re-newed negotiations with the Board, it may also be negotiations outside the Pre-1990s Claims Unit. Detailed analysis of these new injuries and their outcomes are not examined in this report.

Among injured workers in this study, many had experienced *reoccurrence and deterioration* of their physical status related to the initial injuries, especially those who had back and knee injuries. For several individuals, enduring chronic pain was an outcome that affected both capacity to work as well as emotional/mental well-being and general lifestyle, as is explored in the following section.

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Several workers experienced deterioration related to the continued physicality of their work, where risk of injury is integral to the job (police, mining, office work). Others returned to work environments that failed to fully provide protection to workers, and workers had to weigh a concern for their health and safety with the need for employment. The following example describes one injured worker's first return-to-work experience:

I: *Did you ever go back and work for (company)?*

R: *Yeah I went back because I had to go back and try see what was going to happen, how my arm was gonna be, eh, after and I went back and I went back and the job they put me on was ah, running a big shear; it's cutting, you know, cutting machine for cutting the metal, everything from thin things up to five-inch plate steel. That day--now, it's a hydraulic machine, eh, you have a pedal that pumps hydraulic fluid to make the, ah, blade come down and cut. That hydraulic pedal had been leaking ah, for at least a year, all the time that I'd worked there that was leaking. And ah, when I came back to work I went to--(unclear) give me a..an order to get done and I took it over (water running) and I had set that up and was going to do, ah, was cutting a bunch of aluminum siding stuff ... just like on, ah, aluminum siding like ahm, ah, houses, you know....So I --I walked over, I looked down and there's a puddle of hydraulic fluid right where I've got to lean in and press the pedal.After about two hours I said to myself, I said, 'am I insane? What am I doing this for?'...you know, because the slightest slip I could lose my arm, both arms right up to the elbow. You know, there I was working, coming back from an injury that shoulda never happened, was preventable because they knew they never should have used this tool to do that, you know, for that long.*

I: *Yeah.*

R: *So, now I come back and I'm trying out and I'm working on the machine, even if you turn it on it shouldn't even be running because of the hydraulic leak right where you gotta stand. You know, you had to. So around eleven o'clock that morning I said, I just...said this is crazy. I stood up and I said, 'that's it, I can't work any more, my arm's sore and I'm going home'. Because is was sore, but I was trying to work with it anyway. But then I said this is crazy. And, there was other things that happened there... (industrial worker)*

Risk of re-injury was also related to the compromised physical state of the individual, as illustrated in the following examples:

R: *after the surgery about ah, about six weeks ago while I was recovering I was like having baths and stuff like that and I was getting into the bath and I slipped and fell right where they took the bone out of my hip...and I was back in really bad pain again. It was...then I thought, what will happen. Completely undone everything that's happened. And it really scared the heck right out of me. (food service worker)*

R: *What happened was, uh...oh, I guess I was at work and uh, I was lifting on a generator, and something snapped in the back again. And that's—from then on I went off work, and I never did go back then....I was off from September to February when I retired...about seven months I guess with it. Man, it was getting so bad, I couldn't breathe, it was takin' the wind out of me, and I couldn't stand up right. Oh, it was getting worse all the time, so finally...like my doctor said, and even the Board, they got together...with the company and they said 'lookit...you're gonna end up in a wheelchair if you keep it up'. Cause I'd been working crippled for...I guess I was on night duty for about 10 years after my knee surgery and stuff like that...but I'd kept goin' to work. I'd...I'd go off periodically you know. Something would go wrong and then I'd go off, but then I'd go back all the time. ...and they...they were pretty good to me at (company). (miner).*

There are, in most cases reviewed to date, health consequences of the injury, or at least heightened awareness of one's vulnerability to injury both in and outside the workplace. We use the term “*injury cascade*” to describe some workers' experience of physical effects of the initial injury and consequential stresses on (other parts of) the body used to compensate for the injury. An example is where a knee injury causes the body to compensate for the injury/favour that injury site, by relying on the opposite leg and hip, with the physical imbalance to the spine, legs, hips eventually resulting in new damage, as was experienced by more than one worker in this study.

R: *I got bad news again because it was...it was, ah, I had a cracked bone in there, I don't know how I done it, but like my legs been letting go. And meanwhile, in the past fourteen years I've been putting my weight all on one leg. I've screwed up my knee and Compensation is saying it has nothing to do—they don't understand like I've had doctor reports sent to them that it was from the injury because I put all my---and I need a new knee. Now they're giving me a rough time and saying it has nothing to do with my knee...and it does...like I'm a heavy man, I weigh two hundred and sixty pounds, and I had all my weight on one leg and ah, screwed up my other leg. (following motor vehicle accident 14 yrs earlier)*

R: *But a lot of other things are starting to fade like my bladder. ...I've no control over it at times.*

I: *Is that related to your back?*

R: *I think so.*

I: *Hm. And what do they say about that?*

R: *Nothing. Get Depends (chuckles). Yeah. That's what they tell me, wear Depends. There's nothing that can be done about the bladder. It's just that there's no feelings, eh? I guess with the injury to the spine, the bladder when it's ...when it's filled to capacity and it needs to be relieved, there's no triggering system to the nerves that says, let me know that the bladder has to go.* (initially injured 11 years earlier)

R: *But now, since my back started acting up, the knee now is starting to pop again. Not...not as bad yet, but I fear that because of the , uh, corrective movement that I've been trying to do to alleviate the pain in the back well, its putting a lot of pressure on the knees.* (first injured in low back 21 yrs ago)

The cascading effect of an injury can also be the result of the complex and frequent medical procedures experienced by many injured workers. In this study, several injured workers had experienced numerous surgeries, not infrequently leading to extended recovery and rehabilitation periods, and in some cases uncertain or worsened condition:

R: *The first—the first surgery really completely uh me...screw my whole life up.*

I: *Did the second one help?*

R: *When I went back for my second one I think things was already too late.*

I: *You continued to have pain and problems?*

R: *Pain and I lost my sex drive...the first surgery I had, like I had pain in my leg before, and ah, well I had shooting pains. After the first surgery my leg is numb, you can just take a knife from one side to the other, I don't feel it. ...completely numb...half of my penis is numb. A-a-and the pain is...sometimes it knocks you right down... (initially injured 18 years earlier)*

Many workers experienced *chronic pain*, and pain management became a central focus of their daily routines, both for those who returned to work, and for those who didn't. For several injured workers in this study, the management of chronic pain and disability following their workplace injuries became, with time, the central focus of their lives.

R: *heck, I guess it took a good two to three years before my back really didn't hurt after the...after I quit work. That is, I say, I've never been without pain, but it didn't hurt as bad. You know, you could do things and not—there was for the time I lay on heating pads and ahm...I couldn't sit--you'd sit up for a little while and your back would start to ache, so you'd lay down; lay on the heating pad seemed to help. Ahm, you didn't do anything; you stayed put (chuckles).* (retired truck driver)

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I: *Now does your knee give you pain or...*

R: *Oh yeah. I think it's like a toothache the damn thing. But, like I've learned to live with that! But now it's gettin' to a point where it's bone on bone, and that's what he's been saying, now there's nothing more. Cause every—I'd go every year to Toronto, and they'd do an athroscopy and clean it out and inject it. And that would last a year and that. But the last couple of times it didn't do any good. Like he said, there's nothing now. It's just bone on bone. So he said, "You're gonna have to..." you know, "either a get knee replacement or quit walkin'." (retired miner)*

I: *Do you live with pain?*

R: *Yeah. I live with pain. Sitting right here now it's painful. I live with pain all the time.*

I: *Do you take medication for it?*

R: *Yeah. I take it, but I don't--I'm not a person that will plop pills every day, every day. I don't pop pills unless it's really, really bad.*

I: *So it sounds like then you take pain killers, is that right?*

R: *Yeah. I take the anti-inflammatories or Tylenol, whatever I could have and that sometimes. But ah, no, I don't pop them all the time because I feel like once you get on that track, you know, you get to..to live with it, and that's what I do, I live with it. (employed office worker)*

I: *Now, after the first surgery did you experience an improvement within in your back?*

R: *Not really. No.*

I: *Have you been living with discomfort or pain?*

R: *I've been livin' with pain now for...yeah, fifteen years.The fact, ah, it was only, um, couple a weeks ago that I went off painkillers for two weeks and that was the longest I've ever went without painkillers but I'm back on them this week again, to be honest (chuckles). (initially injured 16 years).*

Several workers expressed concern about their use of medications used to cope with chronic pain.

R: *I got addicted to drugs at a point, and my family doctor got a hold of me, he-he straightened me out pretty fast, like you know. I was taking them for a reason not to..to joy full of drugs but I had no pain...for a while. No pain. I could--*

I: *And how--so your family doctor got a hold of you and what did he do?*

R: *(Overlapping) And I told him when I went back for..for the drug XXX, that's a substitute for heroin, I went back and I asked for more and he said "no!".*
(retired miner)

I: *What was it like going back to work then, at that time.*

R: *Oh, (chuckles) that was--I hurt. I hurt really bad. And I had to watch at work because I'd do heavy machinery and I couldn't take a lot of medication because I, you know, like oh-h-h, some of the stuff will knock you out. And I didn't want to hurt myself again because that was (chuckling - unclear) too bad, you know. So I had to be really careful. (retired labourer)*

R: *So I says well, I says--he says, "Well what would help you?" I said, "Well, put me on morphine, a morphine drip every day". I could turn it on when I need it, turn it off when I don't. But then I'm drugged up. I said, "I don't want to be dependent on nobody but myself". So when I'm in a lot of pain there's different things I do. I go and work in my workshop or get bitchy, watch TV, I leave, you know, I don't bring it on to my family. (retired miner)*

I: *How do you feel about taking that amount of medication?*

R: *Well, nothing--no type o' medication is good on a permanent basis because what is it doing? In this case it gives me headaches, there's a side effect of headaches, it's a side effect of the depletion of the blood corpuscles, but it's--the-the..the article also says it's like one in a thousand, but just like how I got chose to do this survey, I could be chosen to get a low blood count with this pill.*

I: *Yes.*

R: *So, I don't like taking any medication. Long-term medication means destruction of kidneys. Long-term medication means probably low blood cell count. It means, uh, destruction some things being destroyed in the..in the stomach area...*
(retired salesperson)

R: *Now, the medication they gave me, I can't take Tylenol 3. Even last week when I received the other twenty-five stitches, doctor said Tylenol 3. Well no, I can't take them, because to me it's like having about eight or nine beers. You know, it's like getting really drunk, that's how it affects me, eh? Ahm, so I steer clear. I take Advil but I refused the amitriptyline. I was only taking five milligrams. Doctor said that's like a very small amount. I told him how it was affecting me. So I seem to not have a very high tolerance for any kind of pharmaceutical drugs, whether it's Tylenol 3, codeine, or amitriptyline. All these affect me adversely where I become really sluggish and un, you know, just feel like it's not myself.*

I: *Okay.*

R: *Ahm I drink an awful lot of beer--not an awful lot, I drink an awful lot of beer now; I never did before, but I am now, it becomes a habit, it's kind of snowballed.*
(unemployed construction worker)

Other co-morbid conditions that develop over time, or that existed at the time of the injury compound the problems associated with the injury-related disability. Several workers in this study also experienced serious *co-morbid conditions* (such as heart attack, heart disease, Parkinson's disease, carpal tunnel syndrome, Hepatitis C, arthritis as well as new injuries that were unrelated to the first.

Additionally, several injured workers had indicated that over time since their initial injuries, they had struggled in terms of their mental and emotional health; some experienced depression:

R: *well...some guys would say "I don't care and I can live this life, you know, just staying at home and having Comp pay or having this" - I can't do that. I still ah, I mean, I'm proud of our house, I'm proud of where we live, you know, want to keep things up and ah, I'm going nuts; I'm just going crazy right now. So I think a lot of it is the mental part of it. I'm pretty strong mentally, so I'm gonna get through it.*
(employed, on medical leave)

R: *You know, to try to figure out things, you know, and you gotta worry, you know, like make sure my daughter's okay and...I get up in the morning, I have to drive her to school, I fight to drive her to school because there's no bus to pick her up here. And I gotta drive her to high school and ah, like it takes me an hour and a half to get outa bed. I don't sleep at night because of pain and I worry, I worry, I do a lot of worrying. It's stressful. It's a stressful situation I'm in and I don't know what to do. I don't know, I don't have a clue at all at all!* (under-employed industrial worker)

One worker commented that while he was rated as 10% disabled as a result of back injury, he was 100% unemployed. This person had completed education and training that gave him the skills for alternative (to manual labour) employment, but he also commented that without physical accommodation in an office environment, a back injury can easily relapse. He experienced such a relapse and has remained unemployed for many years. Regarding his own lack of success in finding paid work, he notes:

“ you're more than disabled physically; you start becoming disabled mentally. You become very discouraged. Mentally you do, and emotionally...you become very emotional...you want to do things that you can't do, so it hurts you mentally.(unemployed 11 years since injury).

In response to the interviewer's query about his emotional health, another worker commented:

I: *Do you feel depressed ever?*

R: *Yes I do. Yeah. There has been, lots of times. I ended up in the hospital.*

I: *For depression?*

R: *Yeah.*

I: *Do you take an antidepressant?*

R: *No. No. I don't believe in that. You know, I'm sorry about that, but I don't, you know. It's just ah....everything came to a standstill so, and that was it. You know (sigh). It's...yeah, it's hard.* (retired miner)

Some injured workers turned to professional assistance for help with their mental state, clearly a more pro-active response to depression than indicated in the above excerpt:

R: *I went to Compensation Board, that was in seventy-..well, can't be sure right now, but they have the facts on this; it was before seventy--seventy-five it may have been*

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when I went, and I says I gotta have, you know, I think maybe I should see a psychiatric...doctor or something. Me a nurse, should have known that I should get off my bum, you know, and get some help. They're not gonna give it to me. So I told my counsellor at the Compensation Board, Mr. N., I said, I think I'm gonna have to go to a..psychiatrist. Because I say-I say, this...it's been--it was--it's been the biggest shock of my life to lose my career and everything. I told him all this and ah...

I: *Now why did you think you needed to see a counselor?*

R: *Because I felt depressed. I was struggling against odds, people didn't believe me, the doctor didn't believe me, my GP didn't believe me and now it wasn't Dr. B. then, it was Dr. C. then. Even when I went for the initial (deep breath out) appointment they didn't think there was much wrong with me. She just put me on Valium and Tylenol #3. (retired nurse)*

In two interviews, a spouse implied to the interviewer that her (injured) husband was depressed, but refused to seek help for the depression. This is a serious problem for individuals who have reached a point where they feel powerless to help themselves, or when they feel that admitting to depression is akin to admitting to being weak and helpless. The most worrisome cases were those where the injured worker spoke of having been suicidal as a result of their injuries and consequential employment and financial troubles:

R: *Then I, ah-ah, I tried to hang my--ah, I tried to commit suicide. When all this was around the pension problems.*

I: *Why were you feeling that you wanted to kill yourself*

R: *Oh, 'cause you ha--well you had no income, you had no nothing, you--the pain was driving you nuts...and ah--and every time you fought with them...constantly. Everything was..was an argument....so ah, I tried to commit suicide and what happened was I'd just come out--I wasn't out of the hospital too long, because they give you--you had a social worker, and he was keeping in touch with me. And ahm, General Hospital was coming on on television at that particular time (snaps fingers) and that just stopped me from pushing the chair from underneath me. Ah, because the kids will be walking in the door. (retired salesperson)*

It is perhaps notable that the individual who sought out psychiatric treatment was a woman, while the individual who rejected the use of medications for depression was a male injured worker, as was the individual who stated he had been suicidal. To the extent that men are less likely to seek medical care in the first place, and to engage in potentially destructive activities in response to emotional stress, the issue of the emotional health and coping capacity of injured men and women needs to be seriously considered in any negotiations over their entitlement to benefits from the WSIB.

5. Post-injury Family and Social Status

In addition to the issues of the management of injuries and their effects, and employment/return-to-work, participants were asked to discuss the effects of workplace injury on other areas of their lives. Interviews revealed that problems of living that arise following workplace injury and the onset of disability are intricately intertwined, and produce, for some individuals, spiraling social problems that threaten to leave the injured worker isolated and with a diminishing capacity to respond to their predicament in a pro-active or positive way:

R: *....when you have problem like this, it's not just a back problem; it's a social problem, it's a money problem, now it's a money problem, see. Social--I can't go socialize. I missed my aunt's funeral, I missed my best friend's mother's funeral, I missed two weddings, you know, it's unreal, unbelievable.*

Discussions about family and marital status, social and lifestyle changes, and financial status are highlighted in the following section.

Central to the management of the effects of the injury is the quality and stability of relationships available to the worker. Family support and the quality of that support matters. Several injured workers in this study experienced the dissolution of their marriages following an injury, and some individuals attributed their marital breakups to the social havoc and upheaval caused by the injury and loss of work:

R: *....my life is, like I said, it's changed now. It's (pause)...really bad.*

I: *How so?*

R: *Well, like all the stuff I used to do--well I'm divorced now. Like my marriage, after you get hurt it's hard to explain; people would have to be in your shoes.*

I: *Yeah, it's hard to understand, but I*

R: *Like your lifestyle changes. It changed, I mean completely changed. Here you are a person that's go, do everything, you know you got everything....like your whole lifestyle changes. I was never home half of the time, I had--like I had a perfect marriage, I thought I had a perfect marriage, and ah, when you get hurt you're at home, you're in pain, you're miserable, you hate everybody around because you--like I was hurt severely, I was ah, all crippled up there for awhile and...one thing led to another and the first thing you know, I'm.. my wife left me, I lost my house. Like I had a family, I lost everything.*

R: *But like sometimes, I went to psychiatrist, you know...because--no, I didn't know what was happening, you know, because like I said I thought my--was my second relationship, second marriage and I thought was going fairly well, and because of my injury she just--everything just went out the door. So, and ah, but he said "No", he says, "there's nothing wrong with you", he says, "it's just ahm, unfortunate thing". So but sometimes you know, you're not able to do things and that bothers you too*

I: *Yes, yeah. What bothers you most about that?*

R: *Well knowing--it irks me that I have to pay somebody eighty-four dollars an hour to fix my car when I know that I can do it, but I couldn't get through it because of the pain.*

Others spoke about long-term family instability and upheaval in their closest relationships with others. Some had worked through conflict and reached resolutions, while others continued to experience a variety of negative outcomes:

R: *Ah, well it created that my oldest son, he was gonna go to college, and ahm, when it first happened he said "no darn way!" He was going out to work. So, it affected a college education for him.*

I: *He wanted to go out and work at that time and start earning.*

R: *Yeah. Well he was at home too, you see. Ahm, the ahm...the two girls were away from home, but the two boys were both at home. And ahm, he said no, he wasn't going to go to college, he was going out and find work. Ahm, oh it..it didn't help. Takes a while to get over. You know, ahm, you gotta quit work but yet you wanna work. And it... it affects you as much as anything. My wife had a rough time of it, with tempers and whatever for a period till I got straightened away. After ah, spending your life working and then all of a sudden you can't go any more it..it affects--*

I: *How does that affect you? Both you and her, I guess.*

R: *Well, it was my temper I guess, you know. Because you couldn't work, you're...stuck at home, couldn't do what you wanted to do, it was bad for--off and on for two or three years and then you resi.. it's time to quit! (chuckle), smarten up!*

I: *And did you get that message...*

R: *Ah yes. Yes, yes. Ahm, my wife was completely fed up with me. But ah, as I say, it straightened out and we're back where we're supposed to be (laughs) for forty-eight years. Yeah, and ah, of course it...it was hard on the rest of the kids too. They were...in on it, you know.*

I: *How in on it?*

R: *Well, if I was in bad humour my wife would tell the kids and then the kids would be wanting to know what was going on, what was wrong.*

I: *So did you get some help with that or did you just decide to act differently?*

R: *(overlapping) Oh we went for..we went for counselling and so on.*

I: *How have you figured out how to cope with living with pain?*

R: *Believe you me, you have to. If I didn't..if I didn't have somebody like ah, my wife in there and my family who being truthful, they are my strength. They are. If they weren't, I would probably, ah, (chuckle) I may not even have been around times, being truthful. Ah, I mean there was times I had--I was on pills because of my nerves, ah, you know, the walls come in on you. There's no question about that. You can't do things so the walls come in on you, you take it out on your family. I'll be the first one to admit that you do. You take it out on..on my wife, I take it out on my kids ah, but I've been very blessed that way because they know me and they understand me.they probably know me better than I know me. They have to for to be able to put up with..with me.....ah, and for..... The more I've lived all over the years, the more I've learnt with it, and I would say now I cope with it much more easily than I ever had....but no, it's not--it's the two--as a family we've got through it rather than just me alone.*

R: *You know, she's like..... My wife doesn't even see it, you see. She knows, but she's aggravated too because here I am stuck here, right? You know, and she gets upset about things too, and I'm thinking, what are you getting upset about, (chuckles), you know? But I don't push it. I...I can understand the aggravation that just, you know...because you can't socialize is a big, huge part of it. And not knowing where you're going from here is another huge part of it mentally. Where do you go from here? What happens after this? When this is when I'm, you know? You know, IF you get better. Hopefully you do. But even if you have surgery, you know, it's gonna be months and months and months. Could be another year before. I mean by the time I have the surgery and the six months recuperation and everything it takes, it's gonna be another year before I'm...anywhere NEAR being healthy. Then what do you do, right?*

The effects of chronic injury and disability status went beyond the family to include a worker's broader social network. The breadth of social losses associated with the injury and the physical

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decline following an injury were often devastating. One woman stated: *“it’s not only your work that’s affected by an accident, but your lifestyle. It’s your family, it’s everything.”*

Social losses were often tied to the workplace, where individuals often experience camaraderie and a social support network that goes beyond the work and the workplace (such as police work, and mining). Several individuals explicitly mentioned the losses they felt over losing their role as a worker; of *missing* work. Their discussions highlight the important role that work plays in helping individuals feel a sense of place in the world, and an intact and purposeful self:

I: *What is it like not working, not being able to work?*

R: *It is--uh, uh, you got lots o' time, it's very depressing. You miss like ah, the first three years I cried and I took it hard because you're not there meeting the people, your friends, you know, your coffee breaks, you know, and talking to people, and I covered all of, ah, over across Canada like I said, because I worked for XXXXX... I was all over the place. And I miss that. Like I miss--I'm an outside person, and I really miss it.*

Social losses were also related to the broader lifestyle that is affected by the onset of disability:

I: *How has your life changed...with this*

R: *(chuckle) That's a good question. Ah, lately things--it seems like they're slightly a little bit better. But there was a point that, ah, my marriage was going bye-bye. Because I, ah, they couldn't cope with me, I couldn't cope with them. It's like I'm not the same like I used to be. I mean, ah, I'm thirty-eight years old, I should be like the same as if I was twenty-five. And no, it's like a already I'm fifty, or sixty, whatever, it's...it's not the same thing.*

I: *Do you physically feel like that your body is older than...than it should be...*

R: *Yeah. I can't--because I can't do the things that I used--I used to go hunting. I can show you, my shotguns are rusted. I got four or five guns in there. And they're getting rusted. I used to go for moose, for deer, for ducks, for--I used to walk in fields in the woods, picking up mushrooms and for rabbits and for partridges, I'm not going nowhere. I mean lately I'm not going nowhere. It's been at least two years the last time that I, ah, shot...*

R: *Ah before I had the injury I used to be able to play racket ball. Physical..physical games like that. Baseball. I can't do any of that now. And yes, I've aged. (chuckles) But, even after the injury I couldn't do them. So I mean, those were things I had to*

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give up. Ahm, I enjoyed softball and rag--I really enjoyed racket ball. Particularly the physical aspects of it.

R: But ah, like even the girl I was going out with, after a while, you know, we broke up because I couldn't do anything any more. And ah, she said, "Look, ah, I know you feel uncomfortable and I feel uncomfortable about this so why don't we just separate and go our own ways". I said "I don't mind if that's the way you feel". You know, I'm obliging, so that's what we did. Then my friends ah, slowly pulled away because I wasn't able to go out and party the way they wanted to, you know. We used to go up to, ah, cottages and ah, you know, have weekend parties and just have good times.

R: But this was part of, you know, I couldn't go out and play, right? I played the week before, but then I can't play and maybe I won't be able to play next week. And this has--this has been since...since my back problem. And you know, I go out and then I'd be fine, I'd feel great, and I'd hurt myself from some strange thing. You know, not related to the game itself, but related to my back. If I didn't have a sore back it wouldn't have got hurt, sort of deal...these things put limitations on me and then...and then after a while I had to retire basically, I had to stop playing because I couldn't; I just couldn't function, I couldn't do it, right?

I: Yes. Yeah.

R: And, you know, I'm only--and I got friends who are older than me that are all playing, you know. And I can't play. And I was, you know, I used to organize teams and everything. You know, I did all kinds of things for--in sports but this put limitations on my ah, my own abilities to play.

Some workers, such as is illustrated below, also described having intact and supportive social networks outside their immediate families, but retirement from work and physical limitations that limited mobility and social interaction often left the worker isolated.

I: Do you have support from others outside of your immediate family? Do you have an extended family or social circle here that...?

R: (overlapping) Oh the guys at work...yeah, the guys at work, they come, they're always calling, you know, and keeping me in touch, keepin' me up with investigations that are going on, making sure I'm not---making sure I'm not left out. Ahm, yeah, I

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got a good network of friends....ah, I shouldn't say "I"--my wife and I, we've got a good network of friends that ah, if there's anything we need or if anything they can help with, they're always there. (employed, on medical leave)

Financial consequences (losses) associated with injury, and employment instability were described as being among the most significant outcomes, for workers who previously had expected a full occupational work-life:

I: *What's been the biggest adjustment for you, with life as it is now?*

R: *It's probably trying to get used to living on the money I'm getting. You know, like when I was working, when I was mining...my kids, I never denied them anything. And now it's at particular point where well, if we can't do it, well it's too bad. You know, it's... You know, you hate to do it. You know, you do whatever you can to..to ah, give them what they want. But ah...that's the biggest adjustment, I think.*

I: *Will you have the income potential with this new work that you had with mining?*

R: *I sh-...should be able to. Well they did a..well, it's in here somewhere. This is one of the things that I had to do before, ah, I started school. And they had to try and restore my earnings at twenty-seven dollars an hour. And, with this course I should. You know, it may take a year or two, but I should restore it.*

R: *Like I live from pay to pay. I'm not a rich person; I got nutt'n. I lost everything I had, and I got a hard time surviving with what I got right now and I got a teenager here and like I say, I pay six hundred--I get seven hundred and forty, I get two thousand dollars a month, I gotta pay seven hundred dollars a month rent, plus my phone and buy groceries, I got a daughter staying with me, I got my car for gas and insurance, and I pay six hundred dollars, ah-h-h, a month child support. You know, like and they wanna know why-why-why I'm bitter. Like I was making, ah, I was paying that in income tax what I'm getting now. You know, like I had a good job and I lost it over it because I went to work somewhere. Like ah, and I lost my pension, I lost everything from (company), I lost my job because I shoulda been home staying home, I was getting paid.*

I: *Oh really! You lost your pension because of that?*

R: *Lost my pension and everything. I worked eighteen years, I missed five days for (company). And I lost it. They said that they were cutting back then and they said "There's a good example, we're showing people", and I got--I went I fought it all the way; I spent five thousand dollars with a lawyer and I lost. I lost. I thought I was*

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gonna get a pension out of the deal, I didn't get noth'n'. "Here you go buddy, goodbye, you're just a number and you'll be replaced." (fired from "secure" place of employment after being injured while "moonlighting" on another job; injured 14 years earlier)

I: *Do you have future plans in terms of work or of what you'll do?*

R: *Just to try and make it, you know*

I: *Yes.*

R: *It scares the hell outa me to think what's going to happen when I'm sixty-five. It scares--that's my biggest fear, what's going to happen when I'm sixty-five. I got no benefits, I got no pension plan or anything like that, I don't have enough of an income to create RSP savings or anything like that....you know, a lot of people say, 'oh that's easy, five bucks here, ten bucks here a week, you know. Sometimes five, ten bucks a week is all I got at the end of the week...I mean, it's not all the time times are that tight, but it's most of the times. Most of the times you gotta make up with, for some of the time it's not, you know. You gotta try and catch up*

R: *Financially, I mean...financial they ah, when I first got hurt, the finances were coming in very..very small and the money when I needed it was not there. When I was raising my kids, the two thousand dollars a month was not there. When I got older, it become higher.*

Several injured workers spoke of income inadequacy in the context of what they see as the unnecessary or inappropriate spending of money by the Board:

"... now they waste so much time that it costs them more just processing me than if they paid me."

"... they pay money for stupidity like XXX rehab program, okay? ... For me it was a stupidity, that was a waste of money, and they don't pay me."

“... I had a friend that he has a bad back, they give him--they..they train him to be a tow-motor operator. (Chuckles). How can you be a tow-motor operator with a bad back? And he-a-a-and he's..and he's off now. I mean they make stupid..stupid decisions.”

This is an important issue, also brought up in the nurse case manager focus group in their discussion of finding the most effective way to reduce the costs of managing cases, and to optimize outcomes for injured workers.

The spouse of an injured worker sometimes faced increased and long-term responsibility for the financial status of the family, and if the injured worker was the sole breadwinner in a family, the spouse may have been unable to keep the family in their pre-injury income standard of living:

R: *And ah, then as my income went down (wife) started getting jobs, part-time jobs, but she's at an age now, fifty-five, where she hasn't got the...the ability to function as much as, ah, you know.*

I: *Yeah.*

R: *Because also the fact that all these things going on also tend to...sorta drag down your performance level, you know.*

R: *Yeah, my wife is working. She works at ah, (hospital).....She works at--she runs the cafeteria there.*

I: *Um-hm.*

R: *But she doesn't make all that much either, you know, money...wise. I guess life must go on, you know (chuckles).*

One person mentioned that he and his wife basically reversed roles. Another said that he had gradually come to take on much more work in the home, and as a result, he had become more aware of and sensitive to issues on the home front. One called himself “Mr Mom” and had become a very involved grandparent...a role he could take on because he could manage and control the activity involved. For some injured workers, the injuries prevent them from finding role adaptations, and they have to manage the stress of “being a burden”. For example, one man stated:

“I still have a hard time picking up a load of wash. I can't pick up that much.I was trying to play catch with my son the other day and after a few times I had to give that up because of the twisting. ...even just menial jobs that you have to...you have to watch; like I say, I can't

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vacuum...haven't vacuumed yet. I tried...it's just...it's just painful. As menial as it sounds, or as I guess wimpy as it sounds, here's a two-hundred and thirty pound guy who after two minutes of vacuuming he's gotta sit down because his back hurts."

The examples above illustrate the ways in which both injured workers and other significant people in their lives face major role changes. These changes were described in both negative and positive terms, but all were tempered by the fact that they were *involuntary role changes*---they had been foisted upon the injured worker and his or her family because of a workplace injury.

The stress of an injury or disability, and the abrupt lifestyle changes that they bring about appears to have lasting psychological consequences, especially for those workers dealing with conditions with prolonged/long term and uncertain trajectories. Several individuals mentioned having experienced dramatic changes in self, such as becoming withdrawn, becoming very easily frustrated or impatient, becoming more introverted, or becoming lethargic and depressed:

I: *Has your life changed with these injuries?*

R: *Quite a bit, yes.*

I: *Could you talk a bit about that? What things--what is different about the way it is?*

R: *Well uh, same like uh, I'm more snappy to everybody. First of all, like I don't have the patience like I used to have. Ah, I guess..I guess from the pain or something like that. I'm very snappy.*

R: *Lately I'm not getting on with nobody. I'm just getting so frustrated in my life, I can see no-one, I don't want to talk to no-one.....because it's so much effort. (Voice emotional.) But they don't understand it.*

One man was positive, stating that with time, he has learned to “quiet down” and slow down. However, he noted that his life has become an exercise in waiting for surgeries that may or may not reduce chronic pain or improve his quality of life, more generally, and he described the burden of waiting and uncertainty, and general loss of personal control over his life.

R: *Yeah. And then when I got home, ah, I was laid up in bed for quite a while because of the...the situation with my health. I'd get up, I'd feel good, then, ah, I'd walk around for a while or do some dishes or my clothes and then I'd have to go and lay down again. Like right now I'm in pain. From my knees down is just constant pain. My toes are knotting up, you know, and that's VERY painful. And ah, I just had a re-evaluation with Worker's Comp and they upped it from 15% to 20% disabled. Well 20% to me - \$320 - sure doesn't buy groceries here for a week. And ah, but I don't*

question it, I accept it and that's it. I know I can get a lawyer and go after them, but that costs money and I don't have the money. But as far as my life is concerned, I would say it's completely turned around. Ah, enjoyment of life right now is about 15%, and the other 85 is not enjoyable at all. Like, just because you, ah, you get injured it doesn't mean that your bills go away or, you know, your way of life stops because it doesn't. I used to go to Puerto Vallarta, Mexico every year for two weeks, and that was right in the middle of the winter, you know, like in February, I'd go and it was...it was a nice break because ah, winters were bad, and that was my way of alleviating that...that type of situation for myself because I don't go out in the winter any more, I can't go outside. The minute I go out, everything starts aching. Like from--

I: *What is your injury?*

R: *It's back injury. It's ah, from L1 right down to the tail bone. And ah, I saw the x-ray. In fact I think I got them in my bedroom, but ah, they're slanted; they're compressed vertebrae and discs that look like ah, tires around the vertebrae. So there's pinching in there. And doesn't matter what I do, it's gonna be there. I asked about an operation and I can't see a back surgeon for a year! That's how long it's going to take to get an appointment. And then it could be a year after that before surgery....but as far as life is concerned, I haven't bought a new vehicle since '89 and I used to buy one every second year. You know, I could go out and pay cash for a vehicle. I can't even buy a free hamburger right now.*

Some discussions highlighted the profound effect of uncertainty on an individual's sense of self, of personal, bodily security; of not being able to rely on one's self as an independent being, or as in the illustration below, of the ability to predict one's physical capabilities:

I: *Do you at this point expect your health to--what do you see in the future as far as your health is concerned?*

R: *Well the way sometimes I look at myself, I'm a thirty-seven-year-old in a seventy-year-old woman's body, there's days when it's just horrible. There's days that are good and there's days that are just not good. You know, the pain is there. We become very good weather forecasters (chuckles). In the future, I don't know. The way things are progressing, it's not fast, but it is not getting better. It's getting worse. And I'm hoping that it's not gonna get too much worse. But ah, again the doctor told me that it was gonna be--it's gonna deteriorate with the fractures that I had, it just can't help but deteriorate, I guess. And he made me promise I would never gain weight because my feet wouldn't support me (laughs). So this is great!*

I: *There's a strong incentive for you.*

R: *No kidding, you know. He says, "Make sure you never gain weight". He says, "your feet just won't, ah, won't handle it". So, I could feel it when I gain a bit a.. a few pounds there*

Despite losses that were incurred by most of the injured workers who participated in the study, the capacity to cope-- to take stock and organize effective new strategies for living their lives— was notable. The excerpt below illustrates the extensive planning undertaken to cope with limited income and uncertain future health status, and perhaps more poignantly, the psychological resilience and buoyancy of this individual who worked for 25 years following his injury and was finally forced to retire two years prior to his interview, at age 50:

I: *Yes. Do you figure you're okay financially?*

R: *Ah! Well, I should be. If I don't live to be ninety maybe, but...(laughs) I..I go by my parents and my father-in-law, mother-in-law. My dad, he had six kids I mean, he worked all his life and my Mum never did work. You know, he passed away, he didn't have much money, but he did well while he was on pension. He was on pension for seventeen years, I guess. He retired at 62, he died at 6-- er, 78. Sixteen years. And he was doing well. My mother-in-law, father-in-law, same thing. They had \$5000 in the bank when he retired. And they were living pretty good. So, I gotta say, yeah, her and I think financially for the next 10, 12, 15 years. You know, we put a few bucks away in the in..investments you know. Ahm, unless somethin' dramatic comes up, I think we should do alright. ...is kind why we done this. My daughter rents downstairs and that pays for everything. We don't pay...nothing out of our own pocket up here. Everything is clear to us, and..... I don't take a nickel out of my pension to pay hydro heating, everything's paid with the rent downstairs. I think if we live like that, and we want to sell the house to my daughter, so we don't lose our apartment up here, and then it's an investment for her and her husband. And that way we'll always live up here, and we'll pay them rent. And that'll help them, so... This kinda what we did in this is uh, you know, for our future. We just started doing it a little earlier than what we expected. But again, I think we were smart doing this, uh, seven years ago eh? Yeah, seven years now...we done this...so, it kinda worked our good for us, I think in a way that at least we don't have any payments to pay, you know, and stuff like that. So that..my pension is cleared to me.*

I: *Yes.*

R: *So-so...get a vehicle whenever we need one, I guess, we could do that. Price of 'em now, we could buy a house. (laughs)I think we should be alright, you know. Unless unforeseeable things come up or...and I think, when we go back to our parents, the older you get the less you need anyway. The less you do. You don't go out and buy toys anymore...*

The capacity to cope was greatly affected by worker's experiences with the WSIB, both in terms of the negotiation of benefits, but also in terms of the extent to which they had to negotiate their status as an injured worker, as legitimately entitled to injured worker benefits, and the extent to which they had, over time, positive interactions with Board staff. The following section is focused on the major issues that injured worker's discussed regarding their relationship with the WSIB, and their recommendations to the Board with respect to its future interactions with injured workers.

6. Clients' Relationship with WSIB

Participants in this study were eager to discuss their experiences with the WSIB. In their discussions and criticisms of the Board, many workers (22/40) included comments regarding the magnitude of responsibility Board staff have for weeding out the people who cheat the system, and they reflected on how “cheaters” affected their own legitimacy as a claimant:

- I: *Well is there anything you'd like to add about your experiences with Worker's Compensation or WSIB? I've been asking people for suggestions or recommendations for the WSIB.*
- R: *Ah...there's things you can, but you can't change them, you know, because well--well the perception, the perception and it's political, the perception is that anybody who has anything to do with Workmen's Compensation is a fraud artist.*

These workers had intimate knowledge of how the Board, as a bureaucracy, worked, and frequently, individuals noted that in their own cases, they followed the requirement to be “upfront” with the Board...do what they felt was expected of them (such as attending medical appointments, filing paperwork as required). They assumed that being accommodating to the system would minimize problems with their claims. When they did have problems, especially when they felt they had “done everything right”, they felt powerless, helpless, frustrated, and angry.

To put the discussion of problems with the WSIB into perspective, of 40 participants in the study, 4 described their interactions with the Board as primarily positive. It is notable that among those who had had only positive interactions, all had been almost continuously employed following their initial injuries; three were employed in “secure” workplaces where they suffered no negative consequences of extended leaves for recuperation and rehabilitation (the fourth individual in this group had changed occupations, as a result of the injury she had incurred, and had been satisfied with both the vocational support she had received from the Board, and with the wage subsidy she receives to accommodate the lower income earned in this new occupation). Consequently, none of these four experienced a reduced financial status following an injury. Three of these individuals were “inactive” claimants, while the fourth was an “active” case. This individual was continuing to experience deterioration of his back injury, and he did express concern about his ability to continue full time employment until he became eligible for a full retirement pension. Those who had positive experiences with the Board after their initial injuries were, perhaps, less complicated cases in terms of their support needs following an injury.

Many injured workers had experienced a contentious relationship with the Board at some point in their “careers” as injured workers. As was reviewed earlier, many have had injury reoccurrences and/or new injuries that required renewed or on-going interaction with the Board, either for support during rehabilitation, or for re-evaluation of their partial disability pensions.

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Problems with the Board were related to several major areas:

- 1) lack of clear rules about how a case would proceed; lack of written policy for injured workers that outlined their rights and obligations in the event of an injury; feeling like a number in a bureaucratic structure whose rules are unclear;
- 2) adjudicator turnover; repetition and redundancy and general disorder in trying to process a case; poor access to staff, even to get a phone call through, resulting in poor management of files and information/documents coming in through mail or fax;
- 3) Adversarial relationship with the Board and/or adjudicator...some indicated the need to protect oneself by keeping their own files with all correspondence with the Board; some individuals felt the Board was not reliable with respect to maintaining files;
- 4) Uneven application of rules and the seemingly arbitrary decision-making. (and related to this, for some, unclear processes for appeals, and no control over their process and resolution); lack of any control by the worker over the adjudication of his/her case; no sense of the timeline for the resolution of their case; many injured workers were bitter about the time it took to adjudicate their claims;
- 5) Little understanding of how disabilities were measured and pensions were determined. And anger/frustration where pension values varied for inexplicable reasons (some injured workers were from workplaces where injuries were common so they often had the opportunity to discuss experiences, pension amounts, etc.);
- 6) Apparent discretion of Board physicians and lack of accountability for decisions reached (a couple of individuals said WSIB doctors made decisions about their case without ever having met them, and without any physical exam); and Board doctors can apparently over-ride the opinions of family or general physicians who provide continuous care to the worker, and even 2nd opinions or specialists' opinions; perceptions that their own doctors are disregarded or treated inappropriately;
- 7) Pensions that don't in any way replace financial losses experienced, even after all the struggles to resolve a claim;
- 8) Poor organization of Board-sponsored "rehabilitation"; some mentioned the humiliation of having had no choice but to attend a rehab program to "prove" one is motivated to become re-employed;
- 9) Less than satisfactory WSIB sponsored retraining programs. In the sample, 12/40 individuals described having participated in retraining programs. While several individuals were successful in using retraining opportunities to find new and accommodating work or careers (6/12; 4 of these were women), other workers indicated they had been given no choice about the type of retraining they were provided, that it had

been inappropriate for their physical capacities and or skills, and did not lead to successful employment. Some felt they were pressured to undertake “retraining” when it was in an area that was not appropriate for them. Some suggested they were not trainable, couldn’t be educated, were meant to work with their hands (these were men). Some felt that the expenses of retraining were poorly used for their individual cases, that more “rational” ways of spending that money could have been considered, such as providing retirement pensions, or one-time monies for small business ventures. Others commented that rules for retraining were unclear, ie: that workers were not allowed to contest a decision about retraining made by Board staff; one person had been told “retraining is a one-shot deal”. Without written rules, and having experienced only their personal case with the Board, claimants did not know the rules, including whether or not they had options to appeal decisions about retraining made on their behalf: regarding the type of training, the location of training, the duration of retraining, etc.

10) Pressure to RTW even when risk of relapse is great; lack of innovative options for RTW;

11) Lack of compassion for the situation of the injured worker.

Other representations of difficulties experienced with the Board are illustrated in the excerpts that follow:

“they finally, ahm, agreed with me and agreed with my doctors that it was the accident that caused it. That two..two and a half years was--it was monotonous. The paper work and being denied and denied when, ahm, I can understand if it was my word against theirs and--or if I didn't have any, ah, physical ah, ahm, evidence or anything. But I had, like I said, I had everything from my doctors, from the neurosurgeons, from orthopaedic surgeons, and it was just that two, two and a half years where I had to fight and fight and fight”

“Maybe if some of these people in that office get injured themselves and spend a little bit of time nursing their injuries that, ah, you know, they would feel for the..the next person. But ah...they don't. Some of them are so cold”.

Well, like I said, I've been very fortunate I think, anyway. But uh, it's..life-wise, it changes a person's life a hundred per cent around. It's a complete reversal to what you used to do and what you can do. And this is--the worst part is I guess if you're lazy and you're used to that, it's fine. But if you're used to workin' and you like workin', that's the hard part, is adjusting to that...lack of doing things. And that's the hard part of uh...like, I've put on probably twenty pounds you know, I'm never this high. I mean I weighed 170, usually 172, now I'm 190, so.....

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That doesn't help because lack of activity, can't even walk. Can't go for a walk.....So, that's the part about this is, getting adjusting to that and then if you have to put up with stupidity, it even adds salt to the wound I guess, it makes it that much more difficult, because uh..... Otherwise than that, uh, like I said, once you get over the..the hump of not working hard or, you know, changing your lifestyle.....but then if these people hassle you, well that makes it that much worse than that, so..... I just think they gotta have a better way of communicating with people. My opinion anyway. Like I said, (chuckles) maybe this is what this is all about---is..is learning that these people should get together with people and explain things and, don't make a decision looking at a piece of paper. That to me is (chuckling) just un-godly. It's-it's..it's cruel. When a doctor can say, well 'Yeah, you're doin' this', he hasn't even seen you, and never heard of you, ALL by the paper. And I think this hurts a lot of..they just cause a lot of the problems (unclear). But... I know it's caused me some.

I: "So what else could they be doing?"

R: "Well besides looking for extra work and putting out extra money? I think they should have people, like I say, going out and seeing what's happening to people like myself. Because without them actually knowing what's happening, what can they do for us? Can't do anything. They have to go on the old system of saying "okay, you can't move this way, so you're this much disabled". That's a farce because just because you can't move doesn't mean that, ah, that's your disability. Your disability is in the pain that does not enable you to go out and work. If I didn't have pain I'd be out working, you know?"

Like it was the onus all became on me. It was like..it was like, I don't know how to prove; it's like being charged with something and having to prove that you're innocent. And that went on for years. In the meantime you lose everything; your self-respect, your friends, your property, ah relationships, everything is gone. In the meantime you still have yourself doing battle with them.

One issue discussed by injured workers as well as by staff in the focus groups was that of worker representation. In the sample, almost half of the injured workers (18/40) indicated they had sought representation from a variety of sources (lawyers, union reps, injured worker group, the Office of the Worker Advisor, and MPs or MPPs). Of these, 14 had reported getting positive results to their challenges around their case with the WSIB, and 2 situations were pending at the time of interviews. One outcome was uncertain, and one individual indicated the lawyer who was consulted had told the claimant that he would not take the case. One individual stated they had spoken to a lawyer, but did not move forward with a case against the Board for fear of retaliation: *"I said 'I don't want anything done....because if you do you're gonna, you know, you're gonna piss them off". And who knows what they're gonna do? They're gonna lose my file?'"*

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Workers from each region were as equally likely to have sought representation at some point during their years of interaction with the Board (4/10 in the Greater Toronto area, 5/10 in Ottawa, 4/10 in Windsor and 5/10 in Sudbury region). Only 2/6 women sought representation, and most of the 19 who considered or who following through on a complaint with the Board with representation most were from “insecure” labour markets; 2/4 who were in secure labour markets at the time of their injuries had union representation that worked favourably for them in terms of the resolution of a complaint. Only one injured worker who sought representation for a complaint or case was an inactive claimant.

Several individuals (10/40) stated that their experiences with the Board had improved in recent years, were aware that the former WCB had been changing its services, and attributed the improvements to changes at that level. Some individuals described the ways in which they had been able to work out problems related to their WSIB cases through normal processes involving good communication with their adjudicators, and the use of the appeal process if necessary:

“like I say, that's uh..I think that's why I've never really--can't say I've had a problem with the Board. A couple of complaints; like they cut me off..they put me at half wages there, you know, while I was waitin' for my back surgery, because they said I could do some type of work. Well, I gave 'em a call. I says, "If you can figure I can do some type of work, you find me somethin'. I'll do it." "Well, we'll send a nurse over, do you mind?" I says, "No, send her over anytime." So she came here, just like you. She spent two and a half hours with me. When she left here they called up and they said, "No, we're puttin' you back on full...disability” (this man also had a union rep for support through an appeal with the Board).

Improvements at the Board were related to claimants’ perceptions of increased compassion and concern among adjudicators, and enhanced efforts made by adjudicators and nurse case managers to communicate with workers. Positive comments about the recent availability of nurse case-managers occurred in several interviews, in addition to the one above:

I: *Have you found that the Board, in your interactions with them, that it's changed over the years or... does it just depend on who you get.*

R: *No it's changed, it's changed. They're more concerned...to be, ah, you were more or less just a number, you know. “We can push you out, get rid o' you!” And now there's more concern there I find.They take a bigger interest in it.*

I: *And how does that show itself?*

R: *Oh, ah, well this ah, Mrs. or Miss S., R., she phones periodically to see if you're ahm...how it's going and so on, you know. As I say, they take an interest in it now that wasn't there before...never hear from them, before! You know, you went back to work, “fine, that's okay” and ah, till your next claim come up, but you never hear from the Board.*

R2 (spouse of claimant):

One of the other things we really appreciate, he has a nurse (chuckles)...that if we have a problem, we call the nurse. And if we have a bigger problem, then we call his adjudicator. Personality-wise and compassionate-wise she's an excellent person...an EXCELLENT person. Couldn't ask for better. If you want to compare, ah from now...if you want to compare from 1972 to 1990, it's as different as night and day. You can be comparing apples and oranges.

I: *And since 1990 things have been much better?*

R2: *Not completely since 1990. Actually things have not really improved for J., uh, with WSIB until he had his hip replaced...last September, 1999*

I: *Ah, so things have gotten much better since the hip. You had to go through the hip replacement.*

I: *So has their service changed over the years at all or has it been pretty good?*

R: *It seems to me in the last--in the last years or so it seems to have improved. Well...it didn't matter whether you were hurt or not hurt, they did their best not to pay ya. You know, not to allow you.. To disallow your claim.*

I: *When was that?*

R: *Fifteen years ago, twenty years ago. Now it seems that they're not--I mean, I can't say that they're eager, but they're a little more congenial? They're not so hard to talk to. They're more..more personal people now. You know, easier to get along with*

I: *Um-hm. Just the tone of the communication.*

R: *Yeah. The communi--that's it; the communication has changed completely. (Pause) Back then it was, 'ah well, we don't think you deserve it, na-na-na, no, you're not gonna get it'. Now you go in and you talk to people or you talk to people by phone and you tell em what your problem is, and they're more congenial and they seem to...they almost seem to go to bat for you!*

R: *And she's (adjudicator) gonna do the best she can to help me out, and she has, and same with the nurse. And I mean they've been super. I..I can't say enough this time compared to the last time. The last time was...I don't even know who I had the last time. Even if it was the same person, but I'll tell you, attitude has changed. It has definitely changed. Ahm, just like company and union working together to try to create a better workforce, to try to give the guys something a little more positive to look forward to. It has changed, so maybe Compensation took on this right to think okay, if the companies and unions are starting to do it, let's work with the company and see what we can do to help the worker get back into the workforce so that he can feel better.*

One woman, who had almost continuous employment following her injury, but at time felt penalized because of her chronic injury, had noted that things had improved, but suggested areas for improvement:

The..basic thing that I would like to say is that ahm, the organization (Board) ...is trying their best and that to...to get everybody back to work or to prevent the accidents, totally prevent them. Ahm, but remember that there are accidents that are gonna happen, and people do need their support and their kindness or whatever else you could say to them...

In the following section, the findings from focus groups with nurse case managers, adjudicators and managers are summarized. These findings are based on WSIB staff feedback on preliminary findings from the interview study with injured workers, and thus are focused on similar issues.

Findings from Focus Groups

Preliminary results of the interview study, reporting on clients’ pre-injury, injury and injury trajectories, pre- and post-injury employment and return-to-work experiences, other impacts on workers’ social lives after an injury, and clients’ perceptions of and experiences with the WSIB, were presented to selected WSIB staff in focus groups. The purpose of the focus groups was to seek staff feedback on major issues identified in the client-study. Separate focus groups for nurse case-managers, adjudicators and managers were conducted. In the analysis of the focus group data, the level of agreement or discordance between staff and clients, and between the separate staff groups (adjudicators, nurse case-managers and managers) with respect to perceptions of the WSIB organization, perceptions of clients’ needs, and views of how the organization (WSIB) might respond to client needs was assessed. The major areas of discussion in the focus groups are outlined in Table 8.

**Table 8
Pre-1990s Claims Unit Study Focus Group Themes**

Themes		
WSIB Organization	Clients/Clients Needs	Responding to Clients
WSIB – organization bureaucracy	Injured Workers	Confusion - workers - adjudicators
WSIB – organization bureaucracy	Measuring Disability	
Adjudicators	Pain	Unfairness
Nurse Case Managers	Financial Compensation	
Physicians (Board/general practitioners)	Communication	
	Worker Representatives	

WSIB AS AN ORGANIZATION

WSIB as an organization/Organizational Change

All three groups discussed the issue of unequal legislation and rules for injured workers in Ontario, because these have been changed over time. All recognized that legislative and bureaucratic (operational) changes in the organization have likely been very confusing for the worker in pre-1990s Claims Unit. The adjudicators noted these changes have been confusing for everyone. In the NCM focus group, it was noted that legislation changes from pre-1990s to post-1990s likely has had the effect of setting up claimants to mistrust the system because they may be aware of someone’s case that has been adjudicated under different legislation. Managers noted “there’s no way to justify differences in the legislation to the claimants”, and managers and

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nurses noted the unfairness of pre-1990s legislation relative to the newer legislation, especially around the issue of re-employment rights.

All three groups agreed that ongoing legislative changes and changes in practices have resulted in a lack of clear rules, as was expressed by injured workers in the study. It was noted that the policies are complex, and as they may have changed several times over the course of a worker's claim, this is no doubt very confusing to the worker.

Regarding the worker's involvement with the organization, one adjudicator noted:

“it started off when you just did claims and it was just the initial entitlement. And that was all you concentrated on. Then you went to Pensions, and all you concentrated on that was just the pension portion of that file. So even though it was one worker and one file, you only did a specific role in that file. Ah, payment for health care was done by the Health Care Adjudicator. They took care of the medication, they took care of the therapy, and I had a very limited role, if any, involved in the health care. The same thing for the rehabilitation. That was done by a Rehabilitation Counsellor. Now it's blended. Now you do all of it. There is no more Health Care Adjudicator – you do it.

In the adjudicator group, it was suggested that in the past clients might not have known or been told about services available, because of high case-loads of adjudicators, who were primarily performing an administrative role. While in earlier times, the work was piecemeal and very bureaucratic, it has evolved; all three groups felt this evolution has been primarily positive. Yet, it was noted that there remains the potential of uneven and unequal services to injured workers, based on adjudicator discretion, because, as all three groups noted, adjudicators are encouraged to “work outside the box”—they have much more discretion around interpreting the rules than in the past. Managers had mixed views regarding changes in the role of adjudicators. Adjudicators are now being asked to deal with a whole range of issues other than organic ones, and to try to build rapport with claimants, caseloads are smaller now (ten or fifteen years ago, might have 250 - 500 cases now the average is 65), but now the function of the adjudicator is totally different. While previously it was all done on paper - forms, assessments by Pensions etc.--with little time for anything but the paper shuffle--current attempts to understand the impact of injuries on workers' lives may lead to confusion and feelings of powerlessness. How to you ask the right questions, and how to deal with the information you get (“You get all this sort of “life” thrown at you from the client ”; examples given - accidents, divorces, depressions, drugs) is less clear.

Adjudicators also had mixed views of organizational changes. They were positive about reduced caseloads, but their role in managing a case is much broader and more complex. They are in contact with the claimant now, they sometimes go out and visit injured workers, But while caseloads are smaller, but you're always still running. “You're doing LMR, health care, outreach - you're doing so much more in the file. There's no way to quantify caseloads right now. Or their complexity... while previously [the attitude] was just ‘Get it done. Get it paid and be done with it!’, now if we don't know the answer we find out, take the time to talk to them, be

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pleasant with them”. The adjudicators indicated that they are encouraged to “think outside the box”;, where previously they “did it on paper” and it was more cut and dried. “We allow a lot more than we did in the past. For example, if the worker’s working and more physio may keep him at work, we’ll allow another month of physio. In the past it was ‘You’ve had your 12 weeks. That’s it!’ Now we’re encouraged to use our common sense, e.g., not spend thousands of dollars upholding the policy of not granting a \$12 cane.”

Another issue brought up by adjudicators was the lack of adequate training following changes in legislation, and the difficulty of the adjudicator’s job, as it evolves too. They felt that training often is inadequate to prepare them enough for the challenges that they have faced. They noted that someone new to the position would no longer progress gradually through posts dealing with distinct types of adjudication decisions. Now they have 6 months training, and are expected to deal with the whole range of issues/adjudication decisions:

“Six months training and then “Boom!” You’re on a desk and you open a claim that, you know, 10 years old now, with every possible conceivable issue that could come up in a file.”

Managers and adjudicators agreed, in response to workers’ plea for written policies for injured workers, that the Board couldn’t have a written policy for an injured worker, even now, because there could be 4 or 5 different legislations that decisions have been made under, for an individual worker. However, “no clear rules” also exhausts the adjudicator, because the appeal process allows a decision to be considered and re-considered over and over again. Also, the absence of a clear policy for injured workers, (ie: no general information package to orient workers to the organization, their rights within it, and the processes they should expect to be involved in), leaves that responsibility to the adjudicator, and to adjudicator discretion in how well oriented the worker might be. The adjudicators also noted that the pre-1990s claims are particularly complex, because many of these are aging clientele who need a lot more time with the adjudicator (they may have less social support, they may be developing memory deficiencies). Problems with the disability ratings, using the previous rating system (1973 rating schedule), and recognition that compensation was not based on the occupation and age of the claimant as well as the type of injury and future earnings potential was also noted. Adjudicators/managers noted that in the pre-1990s claims unit, they are governing by the Act that was in effect when the worker had the injury. In sum, the changes and reorganizations within the Board has made work for adjudicators difficult. (this topic is revisited below).

However, all three groups were generally positive about changes in the organization. Managers applauded the increased personal contact with claimants, and the hiring of NCM; and the move away from a rigid, bureaucratic system; however, managers noted that they, and adjudicators find the new rules are confusing because it is hard to have equal rules when considering a case subjectively, so managers and adjudicators are struggling with that. And they note the rules could change again . In terms of interaction with clients, one manger noted: we’re attempting to cut the red tape...”let them know up front what’s needed, that way the expectations are there...

whenever I talk with people, especially if they're going to appeals, I let them know what that step and time frame involves”.

All three groups (as well as workers themselves) viewed the NCM role as an important new addition to the Board. While nurses noted that they had to work with people who've been dealing with the Board for years, and sometimes seen their having an adversarial relationship with adjudicators, they recognize, and the Board recognizes that their advocacy services are important for claimants. Managers noted the importance of nurses' identifying non-compensible conditions, and directing injured workers to other places to get help if the condition isn't compensible. Managers also noted that the Board is attempting to change the involvement of worker's physicians “and are trying to bring in the physician, using physician's instructions “as much as we can” in processing claims.

The fact that the Nurse Case Manager role involves more personal contact with and concern for workers than was seen in the system in the past is improving people's experience with WSIB. “When we go out on visits, people are really appreciative of that - it's given a different light to the Board.” The nurses were concerned that the very positive changes brought about by their work in the organization is not easily amenable to evaluation. There are no outcome measures of impact of qualitative changes, and the nurses indicated they are threatened, because of the Board's need to demonstrate efficiency and effective outcomes.

The Adjudicator's Role

This section details comments made by adjudicators, nurse case managers and managers about the role of the adjudicator within the Board. The major issue raised by all three groups was the complexity of cases that adjudicators face, and the broad discrepancy available for adjudicating the case. This puts the adjudicator in an extremely difficult position, particularly as their role has moved from a bureaucratic one, involving rigid application of rules, to a one involving “one stop shopping” for injured workers, where adjudicators are encouraged to use their broad discretion in managing a case. All groups noted that this leads to inconsistency among different adjudicators' practice. The inconsistency exists between individual adjudicators, and also may differ regionally.

To the extent that injured workers described long and complicated case histories with the Board, adjudicators inherit those files when appeals or second entitlements come up:

“You open a file that's 10 years old, read through it and find a lot of decisions that they don't agree with. “So, like, do you open up that can of worms?”

Adjudicators feel that their job involves making a lot of difficult decisions:

“You've got to weigh this, make a decision based on that. But I mean it can be pretty frustrating at times!”

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“Contrary to the way they are perceived as the “bad guys”, the policy they follow (and have over time) is “When in doubt - allow!”

Adjudicators get opinions from the medical consultants at the board, but are not obliged to go by them. It’s taken as a recommendation only, not the decision. On the other hand, some felt that they were in a difficult position if someone challenged their decision:

“how do I legitimize the decisions I make - somebody will come back and say “what do you know - you don’t have a medical degree!” ...but it depends on what the issue is - if it’s strictly a medical opinion regarding the relationships of two conditions - that’s a MEDICAL decision, and you would take the doctor’s opinion. But other instances are administrative decisions, so those you could change”.

One adjudicator spoke of the burden of their having to make important decisions about a worker’s future after s/he has completed an LMR program. If LMR provider offers three possible jobs, and it’s up to the adjudicator to decide:

“This man’s livelihood - I feel like it sits in my hands, what this man’s going to do. And I find that really intimidating, and really overwhelming for me to have to make those kinds of decisions” (33)

The content of the nurse case manager focus group suggested there was a fairly high degree of tension between the adjudicators and the nurse case managers – perhaps due to the relative newness of the latter’s role at WSIB. This did vary between the different participants, with some noting positive and constructive team interactions in the settings where they worked. However, more frequently, it appeared that there were difficulties in the relationship between the two groups. The idea of professionalism, and the impression that this was lacking in adjudicators, could be inferred from one nurse’s comments about shortcomings in adjudicators’ knowledge and training:

“Adjudicators, for the most part, at the board, started in word processing, typing, started doing something and just – they’ve been there forever. And they have no real education around who, what makes up a person on the five dimensions, you know? “

When asked how the adjudicators were trained, another said :

“They prepare them with ‘these are the laws’. But they don’t have the ability to critically think out that injury.”

Some nurses felt that some adjudicators didn’t buy into the idea of nurse case managers, and so were reluctant to refer cases to them:

“We never get some of the files that we should be getting.” “We get them by chance... or we just never get them.” “They may give you the file to say ‘Is he allowed this Tylenol?’

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But when you open it, there's more than the Tylenol in it!" "Because they still believe that they can adjudicate this all without a nurse's involvement: "'cause they look in terms of money, you know?"

Some of the nurses seemed unhappy with the fact that adjudicators wield decision-making power that supercedes that of the medical consultants (whose word, in turn, had more weight than theirs [the nurse case managers'] did. They felt that this was not understood by others outside the board, who felt the doctors made the final call. While some suggested that adjudicators exploited their decision-making power, others suggested that their experience with adjudicators was that they valued physicians' and nurses' input. There seemed to be differences in personality style, and perhaps regional differences.

As had been suggested by one of the participants in the Managers' Focus Group, there was the suggestion that the presence of the nurse case managers was having a positive effect on the way adjudicators saw things, but it appeared that this was a slow process. "There's a lot of work, trying to move into a trusting relationship and try and allow them to understand that advocacy is important for this worker.

Although it was felt that some adjudicators lacked training, and were very rigid in their roles, the nurses acknowledged that the adjudicator's role had different demands than theirs did, and had to work within the rules they had been taught:

"In fairness to them, though, they are.. they have to have clear guidelines as to entitlement or no entitlement.. so their perspective comes from that point! they're used to the rules, and now we're saying 'let's break them' and they've been used to being slapped down if they break the rules!"

It was also acknowledged that it was part of the adjudicators' responsibility to consider employer rights and expectations. Participants noted that adjudicators have to balance things out, and ensure that the worker is entitled to the various benefits:

"Adjudicators are very accountable to the dollars to this – they have to be very careful."

Participants in the managers' focus group appreciated the difficulties experienced by the adjudicators in their jobs. For example, the fact that it's those cases where the workers who complain a lot, or who go to doctors a lot, where it's easier to grant entitlement, because there's something on the file:

"..that's what we look at, we establish continuity through complaints. Through people that go to doctors or not. So if you got hurt 20 years ago, and you know, you see your doctor on a regular basis, sometimes the doctor will say 'you know, I never really found much but he did come in' That's enough!"

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On the other hand, they knew that adjudicators had to deal with many difficult cases that did not fall into the complainer category:

“It’s a huge struggle to – you’ve got the stoic who does not complain, and now is at a point in his life where he cannot move because of ongoing deterioration... how do we build that picture? And how do we do it in a way that’s sensitive and understanding? How do we communicate it so that.. even if we give them everything we can, it’s still not enough to restore his earnings!”

Participants had lived through the changes in the adjudicator’s role, from a time when they had a case load of 275 or more, and had to make quick decisions with very little information:

“When you look back, you were – 15 years ago, what we had and what we were basing our decisions on, in hindsight, very little information. You know, where you’re doing it from one medical report, or a real quick conversation that’s maybe three lines on a file. And we had to make a decision. A really tough decision the adjudicator has to make is ‘pay benefits or not, and how much’ then to on to the next one”

One manager emphasized that there are many ways in which an injured worker can claim further benefits – based on severity, whether the person is Temporarily Totally Disabled, whether they’re entitled to bi-weekly benefits, whether they’ve slowly deteriorated and looking for a pension (an increase in their pension) etc. Whether the worker had a vertebral fracture, and no on-going complaints, but has now got arthritis in that location. As one manager said:

“That’s why adjudication is not something monkeys do – it’s something that, you know, adjudicators do... determining ongoing benefits depends on a range of what happened then, what’s happened in the meantime and what’s happening now.” P. 5

It was noted that workers are, in some cases, highly aware of and sensitive to the power of the adjudicator in making decisions regarding their case (and their lives). Notably, one manager commented:

We found in the (previous) focus groups that a lot of clients were reluctant to go to the manager for fear of retribution by the adjudicator.

Adjudicators also noted in their discussion of the heavy caseloads carried by adjudicators in the past, that clients may not make or keep contact with their adjudicator because of fear, because of the attitude they had before [toward the Board to its adjudicators]...”so we lost track of them, they lost track of us”.

As alluded to in a couple of excerpts included from the worker interviews, it was clear that some claimants still had this fear based on an adjudicator’s power; and their flexibility in interpreting the rules.

The Nurse Case Manager

There was unanimity among all parties who participated in this study regarding the positive role NCM played in the management of injured worker cases. The nurse's role was developed around the new organizational philosophy promoting care of the whole person, increased contact with the client etc. Managers noted that, as a result, all staff are getting a better picture of what something was like [for an injured worker], and clients are getting a whole different view of the Board. One manager stated:

...recently I went out with one of my nurse case managers to a client's home and was just amazed by the perception of the client's and the impact the nurse case managers had. And it's been quite interesting for me personally because when this role was introduced to the Board, I thought nurse case managers will really have an impact in the post 90 world, where people have just had injuries and the nurse case manager can get involved and they can assist in that whole return to work piece. But, they'll have very little success with our clients because these people are entrenched in their pain behaviour and, you know, really realistically what is it going to do? In fact, the exact opposite, in my perception, has happened. The nurse case managers that are working in pre-90 are having a tremendous impact on the clients, because it's the first time for a lot of these people that they have been heard....Since the NCM, what I've found is that the NCM can call somebody and it is not limited to the compensable injury, the discussion....they take, and they talk to them about everything in their life. And then can immediately direct them where to go.

Another manager noted:

I've been with the Board 15 years and I never ever heard about the Trillium program until the nurses came on Board....I knew the government had some kind of program in place but to actually know it was called Trillium and how it actually worked, I didn't know that until the nurse came on board, to be honest with you. The adjudicators, that's not something they know.p, 26.

The notion of their being tension between adjudicators and nurse case manager that has eased up as different staff groups came to know and work with one another, is noted in the following excerpt:

Nurse case managers when they first came on board, um, in my opinion would need to feel like they walked on water. And I mean to the point, Mordecai would (unclear) , we had one who saw it everyday. We had one who thought, (laughter) who thought that whatever she said somebody could have, who the Board would pay for, you know, assistive devices for non-compensable problems (unclear). You know, well why wouldn't we, we, cause that's supposed to deal with them wholistically. Like we sort of evened that out, and in two years, the two years that we've had them, we've sort of, they've sort of

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come down to earth, we've come up to realize how important they are. They've come down to realize that, you know what the Board does have limitations on what we can and cannot give. P. 30 managers.

Another discussion between two managers indicated the same idea:

R2: And I still think also that there is a struggle in some areas between the adjudicators and the nurse case managers. I think there's still definitely a power struggle going on there.

R7: I don't think necessarily that it's in mo-, a power struggle in most cases though. I think that a lot of it concerns personality, like some, some people work better together than others...I think that in most of that sort of nurse-adjudicator conflict consists of a specific nurse and a specific adjudicator and what their individual perceptions are.

In the adjudicator focus group, the same idea was reiterated:

I think with, um, having the nurse case managers – I don't know – I know some adjudicators don't like them to get involved, but I know on our team, we use them a lot. J And they've been great. Because they know all the medical aspects of what a worker may need. I don't really know? So, I work really closely with my nurse case manager, and it's been great. Like, we do outreaches together, and if a worker calls me on, you know, treatment or medication, I just you know – sometimes we even do a conference call, and it really helps. And, I think, the worker – like, it's a different relationship with a nurse? Cause, you know, the adjudicator is the decision-maker, so you're the bad person. Whereas the nurse – they have the different kind of empathy for the worker? So I think it makes a big difference.... I think they've really opened it up, as far as the way we look at a worker? We're looking at the emotional aspect of the accident or the lost time from work, versus just the physical. And I feel that it's of benefit to the way we are approaching our clients when they are calling now. Or coming into the office, or when we go out to meet them in their homes. P. 3a

Another comments were:

And I think that's made it, um, a lot easier to deal with the workers. I know that some of these adjudicators, from listening to the way the nurse case managers talk, or approach the workers, have taken on that approach.(manager)

it's a brand new role, it's a brand new position to the Board and there wasn't really a clear understanding on anybody's part, what would the function of that nurse is to be. And they were coming at it in, in fairness to them "we're nursing; we give patients care". (manager)

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We, we found that the nurses that came from patient care versus the nurses that came from insurance companies for example, had very different perspective ... on that role. Because the ones who came from the insurance, they understood this to be an administrative position. I think it was sold to a lot of nurse case managers when they came for interviews that this was very patient focused, you're going to be a client advocate, you're going to be out there, you know, in the community, in the patients' homes, blah, blah, blah. And that wasn't realistic. It wasn't realistic. And then what ended up happening is, is there became a little bit of a struggle, if you will, between the nurse case manager, the professional practice branch, the operations managers because it was like "well who's actually dictating here what's happening? who's the one that's accountable for this nurse case manager in what he or she is doing?" (manager)

Nurses agreed that their role was to promote the wholistic approach to client management, including meeting psycho-social needs and providing positive and empathetic interaction with the clients:

So where they can't provide anything more than 10 per cent, knowing our knowledge and our expertise what might be available to a system with the other 85 or 90 % of what they need that we can't provide them. And that's what we've been doing, is giving them other resources. Or educating them about other things that might be available and who can provide that for them. Just because we can't, that doesn't mean somebody else won't, available to them (talking and coughing)

Given their innovative role that is new to the Board, the nurses feel they are overworked and in short supply:

And we could look at every file, and every one is messed up....if you d-, the Board can't provide it because, look for other community resources" And that's a big job. Cause some workers, they're so down, they're so depressed. You almost have to do some of the, a lot of the (talking over) work yourself. And uh, the resources aren't there. And you gotta fish them out and you, see, but you don't have time to do that. ...and you often do a lot of the counseling yourself.

Nurses recognized their role as distinct from adjudicators, who have the authority to final decisions on a case, whereas they can only make recommendations:

We come from different schools of thought, though that's what makes it so different. Cause we can recommend something and know that it's in the best interest of the worker, but the ultimate decision lies with the adjudicator.

The nurses were entrenched in a philosophy of practice that they viewed as distinct within the organization, and ultimately, as superior to previous practice philosophies:

Well, we're looking from a wholistic perspec, perspective, and we're not just looking at, I mean we're looking at the whole person. How this knee injury has affected this person's life on every level. Whereas the adjudicator is looking at that number and basically putting him in a very tight box. But we're saying, well okay this happened to this worker, however, economically he's suffering or his family relations are suffering, he has some psych component and although it's not really, i- indirectly related to the injury. He doesn't have an entitlement, let's set him up with this, this, this and this. We don't have to pay for it, but we're advocating for the client in that we're ensuring that his needs are being met on every level. Whereas some adjudicator will say "no it's not related. (talking over)...because they've been stuck on this policy and we've come in with our school of thought and implemented others, other um, advocacy services and whatever. And it kind of makes our job a little bit harder in that we have people dealing with the Board for years that have, have not had positive feelings with the Board and then we're coming in and it's kind of making our job a little bit harder. And then you're kind of stuck in the middle in that you know what the Board policy is. Like you know what your, your training is, so you're kind of put in the middle?

The Role of Physicians

All three focus groups included a discussion of the role of Board physicians and the relationship between the Board and community physicians. This topic was also of major concern to several injured workers in the study, primarily due to the perceptions that Board physicians had too much authority--making significant decisions made of behalf of claimants, while having no or little interaction with claimants--whereas workers' own general practitioners or specialists had no authority.

Adjudicators' and managers' views were that the role of both Board and private physicians were evolving. Adjudicators did acknowledge that there is some confusion among workers regarding the role Board physicians play. Both nurses and adjudicator groups noted that currently, Board doctors have only an administrative role; they were not there to treat, but to make pension assessments or re-assessments, using available medical reports. It was recognized that workers' confusion may stem from the fact that Board doctors did physical exams in the past (likely experienced by some of the workers in the study). One adjudicator noted that physicians had "pretty well formed an idea in their mind if this worker's below or above pension level. Um, all he does when he goes in to see the worker, is just basically confirm uh, his suspicions. It's not an actual examination. He already has the information."

None of the groups expressed any empathy for the position of workers who feel exploited by the process, especially when they have positive and well-developed relationships with their general- or family physicians or with specialists, who workers see as having the greatest professional authority to make a decision on their behalf. There was no apparent recognition that the bureaucratic role of the Board physician is contrary to recent changes made in Board operations, notably the philosophy of treating the whole person. And, no one challenged the assumptions

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made about the family or specialist physician—who were viewed as biased and, by some Board staff, as unable to make objective (professional) decisions about their patients’ needs.

Regarding workers’ family physicians, both adjudicators and nurse case managers noted that family doctors acted as advocates for their patients, often in a way that set up an adversarial situation with the board. For example, they might make recommendations that they know the board is unlikely to accommodate, and thus create inappropriate hopes and expectations in the worker. Thus, the Board became the “bad guys” by saying “no”. It was the perception of some that family doctors went along with anything that their patients thought they should have, were intimidated by the prospect of telling the worker that they should go back to work, as it might have repercussions on their practice which was in essence a business. In some cases, the perception was that the family doctor was considering the worker’s situation in a more holistic light than the adjudicator had the latitude to do, seeing for example that “the worker’s wife was stressed out”, and thus that it would be preferable for the worker to be home. One adjudicator expressed some distress at this practice, explaining that it was *“really putting the Board in a very difficult position when we have to make these hard decisions, and it’s - it’s reflecting on the way the um, clients feel about us.”*

Others felt that physicians in the community lacked an adequate knowledge of the guidelines under which Board decisions are legislated, workers’ job demands, ergonomics, and things that could be done to promote successful return to work.

On the other hand, one manager noted that the Board is trying to improve their relations with community physicians, and bring them in as a more active participant in the worker’s cases. It was noted that the way continuity was established on a worker’s case was through his/her visits to the family doctor, which made adjudication more clear-cut. One manager commented that one of the nurse case manager’s roles could be to communicate with the treating physician about non-compensable problems, and suggest sources of assistance for these.

Generally, the problems with Board/family physicians articulated by injured workers in this study do not appear resolvable without changes in the attitudes of Board staff, as well as changes in the practice involving more interaction with family physicians. Adjudicators appear to have the authority to over-ride medical decisions, and to the extent they feel family physicians do not realistically assess their patients’ needs or return-to-work capabilities, it is unlikely that they view the family physician/specialist as a member of the “team”. To the extent that physicians may not wish to become involved in WSIB cases—because it requires them to have to deal with the Board as a bureaucracy, as some injured workers suggested, the Board is likely facing a long and difficult process if it wishes to change it’s current practices. Perhaps, as one manager suggested, NCM can facilitate more productive interaction and involvement of injured workers medical practitioners.

INJURED WORKERS

Perception of Injured Workers

Adjudicators' and managers' views of injured workers were mixed, perhaps reflecting both the complexity of many cases and the injured worker population, and also the complexity of adjudicating cases within shifting boundaries (legislation, practice philosophies). As was noted in earlier discussions based on the analysis of interviews with injured workers, workers themselves recognized the complexity of adjudicators' jobs, and indicated that this must be an extremely stressful job. A large number of workers commented on the difficulties they faced in gaining legitimacy with the Board and their adjudicator because they assumed that many people submitted false claims, or exaggerated the extent of their injuries. In most cases, the injured workers also noted that weeding out the legitimate cases from illegitimate ones must be a major source of stress for adjudicators, and would lead them to mistrust and challenge all claims.

The tone in the following excerpt illustrates an adjudicator's mixed views about managing injured worker's cases:

A lot of times, too, I find that everything, like, a lot of workers, their claim is their life. They play that role, like, "My job is an injured worker. I am an injured worker!" And that encompasses everything. So when they do start to develop other non-compensable problems, they still relate it to their original injury, even though if – and they may only be getting a 10% back or something – but everything else is exacerbated by that 10% back! Or it exacerbates everything else in their life! And its hard for them to understand why we're only giving them this 10% . And why we're not looking at you know, all their other areas that are non-compensible. And its frustrating for them.

Adjudicators noted that the nature of the cases they're dealing with makes for potential animosity from claimants, and makes their relationship with claimants one that has to be carefully managed:

... "you have to watch on how personal you are with the workers"

Noting the their own limitations in managing a case, based on prevailing legislation and available services, adjudicators expressed the expectation that workers' take responsibility for responding to their situations, whatever the circumstances—the inability to do so may stem as much from the nature of the person as from the circumstances of the injury:

R4: But if they're, like my theory is, if you're 30 years old and you have a 10% back, (all talk at once), you, they're

R: There's something you can do (? hard to hear, talking at same time)

R2: There's something you can do.

R7: *A lot of workers who are unable to move on or be assisted high up in an LMR or whatever, lack coping skills, which were, which they always lacked. And it was before the injury, and it's an unfortunate situation. We do what we can to assist them in developing some skills, but ...*

I: *Are there services that you would refer them to for psychological counselling or life skills ??, things like that, is that a benefit that could that be provided to people like that? I'm sure you meet (R: Mm-hm) people who would benefit greatly from services like that.*

R7: *But those have to be dealt with, if you get them right at the beginning. Because the claims that we deal with, they've developed a pattern. These claims are old and the longer they stay off, the less likely that they're going to go back to work. So those, .. they do have a lot more available now in terms of rehabilitation for the newer accidents. But we dealt with what we had at the time.*

R7: *And basically, it comes down to with how they cope with their accident.*

R7: *I hate this, I don't want to sound callous but, those that want to work, will work.*

R3: *But it, I was saying, but I think it's also Board legislation. Back then, if you had an injury and the employer thought "well you know what, you're not going to pull your weight" and I think you use that term "well, you know, that's it, you're finished". But today, it's different. We demand that the employer accommodate, we, we demand that they be returned to work in a timely fashion. So it's different. I mean, and how are those people to be blamed from the time they have their injury and the type of legislation, they can't be. And neither can we. I mean that's, like you said, that we did the best based on what we had to work with then.*

R6: *When I explain a person's pension to them. I don't tell them that this is legislation, there was at the time... no I say to them, "look, you've got a 10% permanent disability. That means you can't do 10% of all the things you used to be able to do before. But you can still do the 90%". Like you focus on that "90% you can do".*

R3: *But I found the one that had, were like, a quarter inch thick, had the most significant accidents, they just went back to work. Their injury, they did not let their injury rule their life. And these are people, like I had to phone them to find out if they were working or not. They're back at gas stations, they're back digging, in construction, I mean and we never saw these files here at head office, they never contacted us. They never called for anything. The more significant the accident, the less contact they had with the file.*

These comments illustrate the complexities and contradictions that adjudicators face on an everyday basis, in carrying out their work with the Board. They also point out that adjudicators' powers of discretion, in the face of complex (or invisible) injuries and uncertain information, may result in the restriction of services because of the expectations the adjudicator makes about a worker. For example, one of the above comments suggests that whereas adjudicators agree that decisions about how to measure the severity of an injury or disability related to it are inexact (see below), the *age* of a claimant influences the expectations an adjudicator has of that individual. The comment above implies that in cases of 10% disability, the injured worker *has a choice* about how to carry on. The assumption of choice contradicts the view of several injured workers in this study, particularly cases of severe pain, caused by deterioration of back injuries.

Managers made similar assumptions--that to some extent, injured workers are responsible for their outcomes. The following explanation from a couple of managers in the focus group suggests explicitly that in some manner, workers choose whether they will return to work:

R5: they've done studies before and, and, ... the Board Compensation versus non-Comp injuries, and injuries have less of a significant bearing when there's no money involved. The problem that we have at the Board is that there's always money involved. The longer the person will be off work, number one, it's work and compensation, then it's insurance, and then if it's no, E.I. basically, and they're right back to work, eh...there has been a full study on that....

R4: ...the guy said, might say, is a 70, 70 per cent success rate when there's no money involved and a 30% success rate where there was money, either their insurance companies or compensation. The other thing is, the high wage earners, like, um, like boiler makers, what are they, they're the highest paid trade in Canada. Those guys get hurt and never stay off work. Because they, they can't afford to stay on compensation.

Managers noted there is an attempt to educate workers more, for example about dealing with pain, encouraging activity, but they also commented on the increased use of lawyers or other representatives by workers who perceive their adjudication to be quasi-legal.

Adjudicators' and managers' may seek out ways of finding order amidst their claims work, by pegging workers into categories ranked along need and legitimacy. Some of the language above suggests that variability in success rates for return-to-work is understood to be due to characteristics of workers (such as coping style), or types of workers (based on occupational or income rankings). Adjudicators also commented that worker motivation and their outcomes with the Board also varied by ethnic groups and gender, age, and educational status:

R6: um, another comment is, and I'm not being prejudiced, but you, you mention the psychological factor. I think a lot of it has to do with ethnic backgrounds too. So I don't think it's just, um, the work ethic, I think it's, you know, who the person is and where they come from. And I've seen that in a lot of my clients. So I think the psychological factor really lays heavy on who it's coming from.

R7: *I see that too, especially with the women. Because if they're new Canadians, and their country before, where they came from, they do not work, and they weren't expected to work, except look after the family, and then they come here. And the family needs income from them. So in many cases, they're the ones that I see because I do deal with the food sector. In some of the plants, the people are here, and they do not speak English. But they're all the same ethnic background. And when they're hurt, they're hurt that much more in their mind, which will relieve them from working. So they ...*

R4: *Or middle-aged women.*

R7: *Right.*

R4: *I mean, we're all close to that (short laugh). You know it's .. no it's just a different time in the person's life or where they come from. I find it's different.*

R7: *Yeah, they didn't have to work in their own country. And now that they're in, in their own country here, they do have to work to keep up their standard of living. Well, or to obtain a standard of living cause some of them, they're just new.*

R5: *Or they had been very educated in their own country, and didn't have to do manual work.*

R7: *Oh yes.*

R5: *And come here and have to do manual work, and they're just not accustomed to it physically. (general murmurs/comments, "that's right", "yeah")*

R2: *Now just talking about women, um, I'm finding too, cause the people we're dealing with are a lot older now, and I'm coming across lots of situations, women in their mid 50's and so the job's not available for them anymore. They have been with a company that perhaps accommodated them and because now the company is downsizing those jobs aren't available, and then they get me telling them "well okay, let's take a look at your skills, let's take a look at your education, and let's take a look at retraining you and getting you out there in a new job approximating the other one." You can hear the panic and the fear in these people in their voice.*

R2: *And I feel really awful. Because I know for myself if anyone was to come to me and say that to me now? I would react in the very same way. And I feel very ill-equipped to deal with these people and best um, how to comfort them or how to walk them through that or how to help them get over that or get past that?*

One manager made a similar comment:

R3: *There's a 'known' population of workers in their mind, in my mind, and I'm sure in everyone here who are adjudicators ... who you knew, well not, who you knew were very difficult to return to work. And they'll tell you who they were. They were Italian, older women who had kids at home. Who said "I'm now injured. It's easier for me to stay at home, so I can cook for my husband, clean for my husband, watch the kids, and not have to return to work". And you knew they were difficult to return to work. Not because there was anything more dif-, more in their, uh, uh, health wise, than someone else. It was just one big (unclear) to get them back to work. And when you did it*

I: *What kind of injury would that person have?*

R3: *Usually a back. Usually a back.....*

In the context of this conversation, the managers observed that the relationship between ethnic minority status or immigration status and (low) occupational class is important for understanding the successes and failures of rehabilitation, retraining and return-to-work efforts made by Board staff:

R2: *the population that, that I found most difficult to rehabilitate were the, usually um, uh, immigrants who had just arrived, who had literally worked themselves to the bone, like to just sheer exhaustion, taking the heaviest, filthiest jobs from the day they got here until they were in their forties or early fifties, literally worked, like, all day, every day, in their minds, very hardworking people, in reality, very hardworking people, would sustain that first injury that for the first time debilitated them and made it, made them unable to go to work. And then, everything just fell apart. They just, they couldn't get beyond, get over that shock of not being able to work. And I think sheer exhaustion sets in. And that's the population that to, to me in my experience is most likely to develop the chronic pain disability that we couldn't get over, the soft tissue would apparently have, have healed, but their experience of pain would continue to worsen. And that was the most difficult population to get, to be able to communicate to because they were so entrenched in the, their true self value of "I am a hard working person"and then to accept that, they really did need a rest after 30 years of working themselves almost to death. I didn't actually find any one particular ethnic group stood out over any other. Just, but just that experience of being, you know, that immigrant, "I'm here to work to build a better future for my kids."*

R5: *The thing that I'll add to that though is that I agree with that, but I also agree with what ... in addition what I would add, I would add in the, the money again where the most difficult ones were the, the, the ladies or men who were able to stay home and virtually after you took away the cost of driving to work, or commuting to work, their income was virtually the same to stay home. Plus we give them, you know, cost of living raise every mo-, every October, some of those people who have remained off for ten years from the sweat shops are making more money now at home... .. than the people working in the sweatshops.*

R2: *My answer would be subjective to my experience in xxxxx region... bricklayers really came to mind for me, I've had a lot of experience in structural bricklayers who were um, Portugese or um, um, Italian, and just sort of Mediterranean brickworkers, uh, who would come over with, you know, and English as a second language and they would have achieved grade 6 or whatever that equivalent would have been in Europe, and, and then sustained a back injury. But soft tissue, not, not, um, disk related, no nerve damage kind of deal, and would just never, never be able to get back to it even though it was sort of iffy about whether or not they'd done enough damage to completely put them uh, from that, from that work. And for women, um, they would be doing like the heavy cleaning jobs, and uh, factory jobs, like dirty factory jobs, and chicken eviserators, no one wants to go back and pulling bits out of chickens and ...*

These comments were important both for articulating the complexity of claims and highlighting the difficulty of verifying the severity of certain types of injuries (such as back injuries, also focused on by injured workers). They also illustrate what may be a significant type of problem for some injured workers--that is, class/age/gender and language and other ethnic/cultural differences between injured workers and their adjudicators. This difference may be a significant barrier to communication and constructive interaction between a claimant and the Board staff, and makes the adjudication process all the more complex. These issues might be addressed by the provision of ongoing support programs—for injured workers, to provide information and services in an appropriate format; but also for field staff--to provide ongoing education and information support services, and sensitivity training, especially in regions with particular worker-classes and sociocultural groups. When asked about training around sensitivity issues, managers suggested there has been some interest in such a service to Board staff, stating that “it is an area that really hasn’t been formally addressed” and “there is such variation...”. While cultural/ethnic/immigration status was not addressed in client interviews (either by interviewers or claimants), it is likely that there is regional variation in the cultural/ethnic make-up of workers from the pre-1990s claims unit.

Perhaps reflecting their short tenure with the Board or their greater one-on-one interaction with claimants, Nurse Case Managers’ assessments of clients were quite different from adjudicators and managers. One spoke of workers who never asked for anything and the conflict the nurse faced when they knew the worker would be entitled to services. One spoke of the costs to the worker of “falling through the cracks:

“Someone such as someone injured as a teenager on minimum wage earnings, and there out there and they’re lost...the system is lost to them, and by the time you catch it, it’s heartbreaking...alcoholism, drug problems, this and that... That’s the reality. A lot of the workers either become totally detached where they don’t show what’s happening to themself to their family. They go and maybe go in the room, I’ve had men crying on the phone with me saying, “I go to my room and shut the door and uh, I sit there and I might have a cry because I can’t cope anymore. The pain is so bad.” We have other people that

are not able, they don't have the internal resources to even do that, they just fall apart all the time. And everyone stays away from them."

Nurses noted that they advise workers to use the services of the office of the worker advisor, and they spoke of innovations used to accommodate the alienated injured worker:

R2: *And then they, it's a cycle, right.*

R4: *Yeah.*

R2: *Because they slide more, and people reject them more, and they isolate more, and it just continues going on and on.*

R7: *Snowballs.*

"What I'm seeing lately is we're being more creative around "how can we help this guy catch that window to get back to the employer?" So if the employer's kind of saying "well I don't have a responsibility" with which they don't, to bring him back. But um, what we'll do sometimes is we'll keep him on benefits and we'll pay him and put him in a transitional return to work. And say like "we'll put you in there. It'll be a work trial, but we'll, we'll get you going" and, and the workers are really grateful. They, they say "thank you, you got me back in the door. I'm not getting back out". But you have to be very creative. And you, it takes time, you have to meet with the employers, the unions, the workers, and get everybody on board."

They spoke with great compassion about the injured worker:

R4: *I think this return to work piece is important too. We need to look at how to help people with that and make options because to lose your sense of occupation at a young age is devastating....for whether or not we move to volunteer options, even where you're not being paid, for paid work, but you need to have productivity.*

Measuring Disability

Adjudicators were both sympathetic to workers and critical of their expectations of compensation from the disability pensions. Adjudicators felt that workers have a misconception of the role of the partial disability pension, or designation of it as a pension (they feel workers equate this to the CPP), and it was noted that the partial disability pension was not meant to replace income earnings but to supplement earnings that may be reduced by a partial disability. However, both adjudicators and NCM felt that there is implicit inequality built into the system, because new legislation is more generous to the worker. It was noted that disability is rated differently for workers injured prior to 1990. Before, "a knee was a knee", based on allowances in the 1973 Rating Schedule (the "meat chart" principle), wages at the time of injury, and the location of the

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injury. A post-1990s injured worker has both age and type of employment taken into consideration. Workers getting injured now may get trained, or they may get a FEL (Future Economic Loss) award. Also, with newer injuries, legislation requires that employers accommodate injured workers; that's not the case with pre-1990s claimants, so the adjudicators recognize that pre-1990s claimants are greatly disadvantaged. One adjudicator noted:

“the legislation wasn't fair or just” It's a difficult job for an adjudicator, but they are responsible for enforcing the legislation”.

The nurses had a discussion of the major differences between someone designated 100% disabled and someone else who is only a few points from that designation who receives far fewer services but may have as great a need for them. They recognize that the 1973 rating does not account for soft tissue injuries, pain or psychological effects that have a great impact on ability to RTW and for recovery. And they feel that if workers even at a 10% disability don't have all aspects of their injury addressed, they'll just deteriorate, often without re-evaluations. The 10% designation is applied to the physical state and no consideration is given to pain, psychological problems, the effects of living in poverty, as time goes on and they remain unemployed. The nurses also commented that deterioration is not assumed to be likely, but one nurse stated:

“I've never seen a back get better as time goes on, even with surgery”

The inorganic side of injuries has not been addressed for these workers, and greatly limits the types of services they may be entitled to or that may be useful for helping the worker reach a more healthy and productive state.

Pain

The topic of pain was addressed by workers, as well as managers and adjudicators. Pain associated with an injury was a point of contention and confusion for all involved, because of the difficulty of measuring it, and of really understanding its effects on a worker's life; for workers, pain could severely restrict their activity in all aspects of their life, and as described above, severe chronic pain had significant effects on an individual's psychological status as well.

One adjudicator acknowledged that in more recent times, pain was brought up in interviews with clients, and saw this as part of the evolution of their role within the Board:

R3: Yeah. I was going to make a comment on that. I mean you, you look at our, our client from recent, the average a-, age, the time since injury is 17 years. You know, in the 70's they brought in psychological (unclear). In the 80's chronic pain. Before that, it was just a back, you know, broken bones, or backs or knees. So the adjudicators now had to ask a whole host of issues related to personal and social, uh, especially with chronic pain, so the, this client population is seeing us from a different light also, I mean, now with the nurse case managers, there's a little more sensitivity around asking questions and, even

if we don't compensate for it, we are now listening and asking because we're getting a better picture of what something was like.

However, others saw this as a process of bringing more uncertainty and difficulty (and more work) into the adjudicator's job:

I: *Can I just ask around the pain legislation that was introduced in the '80s is that, does that give a claimant the right to expect to be evaluated for uh, pension for pain?*

R6: *That's probably pain policy when it came out. And actually when it came out it was only supposed to affect these very, very small number of workers, and it, the flood gates opened up and that's ...*

R5: *That's a huge error.*

R6: *Like you have an injury, there's pain associated, that pain, chronic pain means "pain for life" really, right? And, and, but we have a policy on chronic pain disability that is totally different than chronic pain. And for the most part, that's the way I explain to people normally, it's like "Yeah you've got a permanent injury, there's going to be chronic pain involved, but chronic pain disability is a separate and (unclear word) issue on it's own. And usually it's pain that's, like the proportion is often, or that the thing is the act is out of proportion to the type of injury, you know, it's (talking at once) ...*

R4: *... or you'd look, you know, somebody says he's had 5 knee surgeries and a knee replacement and is, obvious arthritis, he says "my knee hurts all the time". And we get, I get calls says "well they're not giving me the chronic pain award" I say "that's different, they know what's wrong with your knee, they just can't fix it".*

R6: *It's organic. The chronic pain disability that we're talking about is where literally somebody with a low back injury, they could never find out why they're having such significant problems...well it's everywhere. I mean a person hits, hits their elbow, and then they have chronic pain. You know, they get ...*

R7: *And it usually it, it goes, it's just like travelling pain. It might start as a low back sub-tissue but now their entire body hurts.*

This was an issue whose resolution evaded all who addressed it:

R4: *Pain's very subjective. I mean, everyone's tolerance of pain is different. Like you know, I know I have a high pain tolerance. Someone may have a low pain tolerance. In that particular case, if his injury is back, why would he be retrained in a sitting job. Like, and that's a problem with the LMR's sometimes, they put these workers in these LMR programmes that aren't suitable for their disability. And at the end of the programmes,*

they fail at it. You know, or, I mean, I have one guy who's going in for technical engineer, and I know at the end of it he's not going to be a success, because he doesn't want to, he doesn't want to work. And he's very bright. And I mean how many people get the opportunity to get retrained in something like that when you were a labourer-type person? You know, so, pain's very subjective. Like I mean, I don't, I, I don't how the, I don't know, I don't know how you would determine, you know, the quality of pain.

R6: You talk about painwe're, we're educating them more, we're talking to them more about ... pain ten years ago, we would never have heard, uh, well, pain is not harmful, that's a restricted motion, you can still do something. Ten years ago, they would have just complained about pain and ... they do now, we talk to them about that pain. We try to overcome that aspect of pain, "I can't do anything". "Yes, you still can, it's not going to hurt you". Whereas you didn't hear that 10 years ago.

Again, mixed statements came out of managers and adjudicators' remarks about pain: "it's subjective", "it's not harmful", "you can still [function with pain]...*it won't hurt you*". Thus, while pain is recognized and discussed as an outcome of injury, it is not easily managed, either by the worker who lives with it, as suggested in the interviews, or by the adjudicator who cannot experience another's pain, and may feel powerless to deal with it. One outcome of this may be to minimize or deny the significance of pain in particularly difficult cases.

Financial Compensation

Managers' views of the issue of injured workers' finances seemed somewhat more distant or removed from individual workers than was the case for adjudicators or nurse case managers, as perhaps might be expected given their position (i.e., not on the front lines). In general, their comments about financial compensation were mixed. On the one hand, it was suggested that some workers are over-compensated: several managers spoke of the fact that workers who were injured between 1985 and 1998 were compensated on the basis of their earnings on the day of their injury, and the fact that this amount often was not a true representation of what the person was making in the longer term. Examples included construction workers, or workers who had only been working for a week. One manager disagreed with the person who had said this had "a huge impact" on the system, saying that for most workers it was not an issue. No examples where this system might under-represent a worker's real earning history were mentioned. On the other hand, one manager spoke of the "huge paradox" stemming from the fact that "there's no science to get inside their life and find out the effects of the injury." He acknowledged that for Pre-1990 clients, "it's not a lot of money that we give away. I don't know if I could live on it." One manager spoke of how high wage earners' income may drop very drastically, for example "Some of those guys go from 2 to 3 thousand dollars a week to five hundred dollars a week on compensation." Another spoke of the fact that there is a statutory maximum that is paid out.. "so people who were earning a hundred grand plus are never going to be compensated to the level that they were."

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Adjudicators acknowledged that workers injured pre-1990 did not get much money from their claim “No, 10% or 20% isn’t an income, and you have to explain that to people.” They had various strategies for dealing with this. One involved putting the worker in an LMR program, in which case s/he got a supplementary benefit on top of their pension allowance. Another looked in the longer term, and said she encouraged people to go back to work, which means they’ll contribute to Canada Pension. Because “when they retire and they’re not getting that Canada Pension, that’s another form of loss of income!” However, one adjudicator spoke of the workers who get income from various sources:

“Well, not to be callous or, you know, I’m very empathetic towards the workers, but a lot of them are getting a lot more than what you think they’re getting. They’re getting their pension from us, they’re getting Canada Pension, they’re also getting a pension from their employer, so I think a small portion, or maybe half of them, are the affected ones that aren’t getting other benefits...”

The nurse case managers spoke of WSIB’s spending of money on injured workers’ cases. One felt that if WSIB were more willing to supply workers with aids (such as a sit-stand chair) without multiple assessments, appeals, etc., might be a cost-saving measure in the longer-term. This in spite of an attitude on the part of some that “*you give them a grab bar, and they’re going to want - oh, they’ll want ‘this!’ You’ll open the floodgates!*” One participant commented on the fact that in the previous presentation on injured workers’ suggestions, they didn’t ask for more money but instead for more information, education etc. Another commented, however, that if you know the system and how to work it (like any system) - you’re better off. You do get more. Like if you can have a representative or a lawyer speaking on your behalf, you do get a lot more!” One nurse case manager mentioned that she might advise the worker to go the Office of the Worker Advisor if she felt that they had not had a fair decision, and that this service was free. Participants in the other groups also said that the OWA provided workers with a good service, and knew the system and the legislation well (but were, as one Manager noted, overworked).

Injured Worker Representatives

Our discussion of workers’ practices of using representatives in their dealings with the board suggests that, in fact, workers benefit greatly when they engage a representative. Adjudicators and managers had a different view of worker-representatives, focusing the redundancy of the work they do, on the financial costs to the worker, and on the additional work it causes them.

Adjudicators and managers both noted the growing presence of independent worker representatives, who can readily set themselves up in business, have no legislating body, may be poorly informed about WSIB, may overcharge workers and misrepresent them. One manager felt that workers were “very highly represented” by strong unions, and other representatives. Adjudicators, on the other hand, seemed to feel that not many people had representatives, and that this varied geographically.

Managers and adjudicators had the view that workers were being exploited by companies that offered this service to injured workers. One manager commented:

R2: And we also have representatives that we have to put into the mix here because these populations very highly recommend it. Got a lot of very strong unions and got a lot of strong representation, and companies, I mean, that's their business, is representing clients against the Board. And you know it's like, oh, you know, come to me, pay me and I'll get more. I mean this springing up with independent representatives, I think is, is a phenomenon that's sort of occurred in the last 10 to 15 years more so than what it was. The unions were always there, but this, the fact that, I mean, we're actually supporting another entire industry now in representation. And that's because the system is so complicated and people feel that it's quasi-legal and they can't do it alone. They prefer it because talking to a lay person and talking to somebody who is well versed in Board's policies and procedures, it's night and day.

I: Yeah, they're not on equal footing, that's for sure. Now, you said this is quasi-legal. From their perspective is it legal? And or should it be, or, I mean I think what they're suggesting is that they feel they sometimes have rights they're not getting looked after.

R2: I find someone's not satisfied with the answer the adjudicator's given and called me, and I'm giving him the same information I frequently get, well I guess it's time to get a lawyer. And I never encourage them to get lawyers, cause generally-speaking, lawyers are not particularly well versed in our act and the office of the worker advisor is, is free. I mean, they're overworked, but they're free and they know what they're doing. And there's a lot of shady representatives out there that will take these clients for vast amounts of money when their chances of winning are not good, you know, some stuff is pretty black and white, some of it's greyer, and the judge will call it and they, well win at another level, but there's some stuff you know, you're not going to win. And if they go to a private representative they're going to have to pay up front and they're going to see further behind, not, not further ahead.

The adjudicators also discussed worker representatives:

R4: I feel bad for workers because a lot of them are paying a lot of money and are, are misrepresented. Because a lot of these representatives have no idea what WSIB is all about. And all they have to do ... all they have to do is call the adjudicator and you could guide the worker better than the representative.

I2: And what representatives?

R4: Independent representatives.

R2: Anybody, anybody can hang up ..

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R4: *But the office of the worker advisor, they know the legislation, they know how we operate. So they're probably the most well-versed in WSIB.*

Adjudicators commented on the increased workload when they are dealing both with a claimant and their representative, and they expressed concern for the cost to the worker:

R4: *And the workers are paying a lot of money for them (general agreement "yeah"), and they're paying for work that we would normally do. Like we're here to give them what they're entitled to, basically.*

One nurse case manager suggested that representation may advantage workers, that if you know the system and how to work it (like any system) - you're better off. Another nurse case manager mentioned that she might advise the worker to go the Office of the Worker Advisor if she felt that they had not had a fair decision, and that this service was free. Participants in the other groups also said that the OWA provided workers with a good service, and knew the system and the legislation well (but were, as one Manager noted, overworked).

Communication

Communication was another area of discussion in client interviews as well as focus groups. It was noted in all focus groups that historically, communication with injured workers in the pre-1990s Claims Unit has not been good, but it was also noted that efforts are being made to improve contact and communication with the client.

Commenting specifically on the presentation given on the preliminary findings from the interview study, one manager remarked:

"A lot of what's happening and a lot of the problems that are specific in this report come down to communication. And I, I think it's a lot more widespread now than what it was and by that I mean that I think the communication is improving at all levels now. And you have to feel for people that are, you know, told to go in the doctor, okay, you know, you're saying that your back is deterior-, go to your doctor and send us in the medical reports. So they do that, they send us in the medical report. "Oh I see that you had an x-ray, here's the waiver, sign the waiver so I can get the x-rays." So they go off and they do that. Then they come back and it was always the game. You know, not intentional, but now, you know, we've changed that process, so that we're giving all of this information to the people up front. Give them a copy of their last pension medical exam. We tell them exactly what it is that we need in order to consider this. So we're giving them the rules ahead of time, as opposed to saying "Okay, run off and get me this information." They get it for you. "Okay, well that's not enough. Now I want you to go and get this information." Incredibly frustrating".

The nurses commented:

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R: *I think the biggest problem is that they haven't had communication. I think the communication has been ... so horrific.*

R4: *Bad, bad history.*

R8: *Like I, I took for example, so I called someone, just left a message. And um, I'll never forget the first time this happened. I was, I was just touched by, touched, I was like moved by it, and it just broke my heart. Someone said I was the first person who returned a call in 10 years. And it was, he broke right down, and I said, and I said "excuse me?" He said "you're the first person". I said "well this is unfortunate" we had ... (p. 25).*

One adjudicator, these changes also may not be well communicated to the worker:

R2: *And we've moved into sectors. And so um, I do automotive, and so perhaps someone else had automotive, but now it's designated to me, so the file gets transferred. Not the adjudicator, but the file gets transferred from one adjudicator to another.*

R2: *And now it's my responsibility, we've had a lot of that, our reorganization that's gone on in the last couple of years.*

I: *And how is that communicated to the worker, the client?*

R2: *As far as I know, the only thing happened, a letter would go out to say "you have a new adjudicator. This is their name. This is their phone number".*

I: *And is there any explanation given that would help the, the client understand what's happening?*

R6: *It's a standard form letter.*

Workers also commented on how poor communication has alienated them from the whole system. One major source of frustration related to poor communication was the issue of adjudicator turnover. It is notable that adjudicators attributed turnover in their group to the opportunities that exist for job changes in a large organization like the WSIB (such as promotions, secondment) and organizational changes leading to adjudicator transfer, and not to adjudicator burnout, such as was speculated by workers. Workers in the interview study did comment on improvements in communication with the Board, particularly regarding improved interaction with the adjudicators and the outreach work by nurse case managers.

Confusion and Unfairness

Confusion—of workers and adjudicators working under changing legislation and operational procedures—was touched upon at different times throughout the focus group discussions. For workers, confusion stems from the fact that legislation differs for Pre-1990 claims. One manager noted:

“They’re playing the game and it’s almost a game, and everybody keeps changing the rules, as you go through the game. I: Yeah. R4: And of course it’s very frustrating for them. It’s frustrating for us as well. Cause what we say today may not apply in two years from now.”

There are various ways in which injured workers are likely to become confused about their interaction with the Board. It was mentioned that they may talk to other (more recently-injured) workers, and get confused and mistrustful when their experiences differ. Workers may also not realize that inequities in their pensions (compared to those of others) is due to pre-injury earnings, and doesn’t depend on how big your problems are. Confusion may also result from discretion available to adjudicators in making decisions about a case. The NCM pointed out specifically that there is a lack of clear rules regarding the recognition of chronic pain, or award for a psychological component. And the worker may be confused by the different levels of decision-making power of adjudicators and NCM, so while nurses may agree that a worker has specific (non-compensable) needs, the worker isn’t necessarily supported by the adjudicator in terms of benefits awarded. It was also noted that workers’ doctors may be confused, too, by the fact that Pre-1990 workers’ impairment was rated by the 1973 Ontario schedule, whereas those with more recent injuries are rated using the American schedule. The ratings schemes, in themselves, create different outcomes for workers with the same injuries. Taking into account doctors’ differing interpretations of their patients’ injuries, additional diversity of outcomes is possible.

The adjudicators were the group who spoke most about the issue of confusion around claims and compensability, and the workers’ perceived need for a “written policy”. It may be that this confusion is most relevant to the adjudicators’ role. Also, it is the adjudicators’ responsibility to sift through an array of information, which is often less than 100% clear, and make a decision which will affect the worker’s livelihood, and which may be appealed at a higher level within WSIB. The adjudicators noted that the rules around how they themselves made decisions about workers’ entitlement kept changing. Adjudicators are now encouraged to “think outside the box”, and whereas adjudication used to be cut and dried, at present there are many “grey areas” in their everyday decision-making with regard to claims. It was recognized that there may be differences in practice depending on region, the adjudicator’s personality, level of experience, and the culture of practice encouraged in his/her location. For example, one adjudicator spoke of the new “merits and justice” policy, i.e. to look at claims on an individual merit basis, noting that this “allows us to allow giving a worker a little something, not extra, but what they deserve, as opposed to say someone else.” Others in the group, working in different locations, had never heard of this new policy. There also appeared to be significant difference in how the newer

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adjudicators and those with long experience have learned the job. The more experienced adjudicators began working in a system in which they made decisions concerning one specific area of the claim (for example, health care entitlement), and when they had become thoroughly familiar with that area, moved on to another area. Eventually, as a senior adjudicator, they had experience and expertise in the full range of issues involved in a claim. As participants described the system as it is set up now, however, it was very different. A new adjudicator undergoes training lasting several months, and then handles the full range of issues involved in a claim, albeit for a substantially smaller caseload. This can lead to great uncertainty about how to deal with cases.

“You get six months training, and then - ‘Boom!’ You’re on a desk and you open a claim that, you know, ten years old now... With every possible conceivable issue that could come up in the file... That’s frustrating as an adjudicator and people don’t see that! Yes, there’s one person handling everything, but there’s no way that your brain could absorb all that.”

Overall, the confusion was seen as a result of the fact that job of adjudication was not black and white, but “very grey”:

“you could have went this way, and you could have went that way, and when that line is not black and white, it’s very difficult. And you think you’re making the best decision... but certainly there’s a lot of external factors that some of us really don’t have a lot of control over.”

In a similar view, another adjudicator said:

“You’re saying that the injured workers want us to clarify rules and procedures. But I mean as an adjudicator (and I’ve been here for a lot of years) I don’t even know how to clarify it for me! It’s really, really difficult. An as, of course, that there is, it’s a lot of grey. A lot of grey. And you can talk to six different people and get a different opinion from each one of them.”

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Recommendations to the Board

The final section of this report is focused on injured workers recommendations for improving services to injured workers, and some discussion of the recommendations that takes into account the WSIB staff's discussion of the issues. Table 7 highlights the range of recommendations for the WSIB made by injured workers. The full text describing these issues/recommendations in injured workers' own words are presented in Appendix B.

**Table 7
Injured Workers' Recommendations to WSIB by Region**

	GTA	Ottawa	Sudbury	Windsor
Worker Interaction with the Board				
Consideration	T5, T6, T9, T2*, T4*	O1, O2, O3, O7, O8, O9, O4*	S1, S12, S2, S3, S10*	W1, W5
Communication	T1, T1, T6, T6	O1, O2, O3, O8, O6*	S1, S11, S2, S3, S3	W10, W2
Improve Process	T1, T1, T6, T6			
Improve Forms	T1, T1		S4	W7
Timely processing	T5, T6, T7	O3		W10, W5, W4*
Accountability	T6		S1, S4	
Staffing at Board				
Increased Human Resources	T5, T7	O3, O9	S3	W1
WSIB Staff Training / Qualifications.	T6		S1, S3	
Less WSIB Staff Turnover			S11, S2	W6
Family Doctors as Resource	T1, T6		S3	
Benefits to Injured Worker				
Standard of Living Requirements				W8
Financial Payment Options		O7	S3	
Continued Health/Pension Benefits	T6, T7, T9, T2*		S3, S4	W8
Spousal Benefits	T6			
Ind/Family Support	T7, T9			W5
Information Service		O8		
Flexible Options for Return to Work				
Retraining Options	T6, T7		S1	W8
Workplace Safety	T7, T4*	O4*		

* = non active

The recommendations are separated by region, providing some insight into the importance of these in each region. It is important to review these recommendations with an understanding that they are highly interrelated, and not necessarily discussed as discrete issues by workers.

Recommendations fall into several areas:

A. Worker Interaction with the Board

Consideration/Communication/Improved Processes/Improved Forms/Timely Processing of a Case/Accountability. These refer to the quality of interaction between the worker and WSIB staff—usually the adjudicator. Injured workers are concerned about being respected, as being seen as legitimate, and as in need of compassion from WSIB staff who they view as having a great deal of control over their lives after a workplace injury. Many workers feel that adjudicators and physicians have too little interaction with them—in particular, personal interaction—to realistically understand what their needs and capabilities are. Furthermore, injured workers feel controlled by a system over which they have little control, often because of poor processes for communicating procedures to the claimant. And they feel that the result is an adversarial relationship with the Board. Some feel this is due to the fact that much of the work done by staff around a case is done in secrecy, or behind closed doors. Several injured workers, for example, described events where they went to their Board office and asked to see their own files and were denied. Managers, adjudicators and nurse case managers all agreed that this was an area for improvement, and all groups, including workers, agreed that the Board has made some progress in improving communication to injured workers. However, many workers remain alienated from the processing of their own claims, and many continue to feel their interaction with the Board is poor.

Recommendations:

- *more humane and respectful interaction with claimants;
- *better communication with claimants
- *improved processes (including forms) within the Board to enhance interaction with claimants;
- *more timely processing of claims
- *accountability to the public and to workers

B. Staffing at the Board

Increased Human Resources at Board/Better Training for Adjudicators/Reduce Adjudicator Turnover/Better Use of Available Resources (using general or family practitioners). Injured workers assumed that adjudicators carry very heavy caseloads so they are not able to process legitimate cases appropriately/efficiently. Some also questioned the qualifications of adjudicators, given the responsibility of this position. Furthermore, many workers described their frustrating experiences of adjudicator turnover, which resulted in either repeating their case history and progress with the new adjudicator and/or failing to develop a

relationship with a new adjudicator: both of these outcomes are unacceptable to injured workers. Related to adjudicator turnover is the fact expressed by several workers that they often did not know they were re-assigned a new adjudicator, or they received a form letter that reported the change, with no explanation for it. This was very alienating for anyone who felt they had established some level of rapport with their adjudicator. It epitomizes poor communication and lack of respect for the worker. Furthermore, better training of adjudicators was recommended, to improve adjudicator's ability to do their jobs effectively. Adjudicators and managers agreed that their heavy caseloads and (broadening case work) is a problem. They also agreed that turnover is an issue, but this was due to the organizational requirements, rather than to adjudicators "burning out". A major difference to be overcome is the difference orientations of adjudicators/managers and injured workers. The former view their work as case management, while for the worker, the adjudicator's involvement in their case is much more personal, and in many ways, the worker's well-being is tied to there being a positive and personable relationship with the adjudicator. In the least it is inefficient for the worker to have to "orient" many different adjudicators to their workplace injury and the history of their file. Workers' also saw this as "inhumane".

Workers feel there is too much of a waiting list for seeing Board doctors. Also mentioned in interviews and focus groups, workers have a problem about the fact that adjudicators do not necessarily take medical recommendations from their own physicians/specialists. This was viewed an inefficient use of medical resources that the workers' themselves usually select and trust, and who are already involved in workers' cases due to the requirement that the worker provide forms and reports completed by the family doctor. Further, given that medical doctors are morally and legally entrusted with making medical decisions on behalf of their patients, it seems a contradiction that their medical recommendations on behalf of a patient who is a client of the Board may be over-ruled.

Recommendations:

*more and highly qualified staff

*better training/ongoing training for adjudicators

*better use of external medical resources; considered re-evaluation of external medical professions' role in workers' cases.

C. Benefits to the Injured Worker

Consideration of Standard of Living Requirements/Financial Payment Options/Continuation of Extended Health Benefits or Pension Contributions/Spousal Benefits/Individual and Family Support/ Non-compensible Resources Information Service

Many recommendations are related to the topic of injured worker benefits. Regarding direct financial compensation, workers noted that benefits rarely led them to retain their pre-injury standard of living, and many workers received no other source of support, or they received inconsistent additional support such as intermittent employment. Permanent support, such as through the CPP disability pension or retirement pension often took long periods of time, or had age-eligibility. Addressing the issue of uncertainty in the outcome of their initial claim with the board, or of an appeal or re-assessment, workers asserted that there is a need for flexibility and

choice of how support is to be provided them. For example, an initial lump sum paid to an injured worker would provide a means of subsistence during the time their claim is being adjudicated. As one worker pointed out, if it was determined later than this claimant was a fraud, then appropriate charges should be laid. This is an important issue for those workers who are not able to return-to-work after their injury or a reoccurrence, and for those who have no job to return to because they are fired, laid off or otherwise unemployed following their injuries—situations that were described by several workers in this study.

Aside from the need for higher pension benefits and easier access to wage subsidies or wage replacement, workers expressed a concern for their lack of extended health benefits, particularly when these were provided in the workplace where the individual was injured. They also noted the long-term effects of their injuries on their families, and pointed out the need for spousal and family benefits (extended health/medical and retirement contributions).

In terms of non-monetary support, workers also suggested that both workers and their families are often in need of supportive services (family counselling, psychological or psychiatric counselling, vocational counselling, financial counselling, recreational therapy, etc). To this end, it was suggested that the Board would be providing a valuable service if it was able to offer an information service that would assist the injured worker in identifying and accessing these types of services. It was mentioned in the focus groups that the nurse case managers were often serving this role in providing “non-compensible” benefits, and their services (as well as their positive communication and hands-on, “outreach services”) were highly valued by injured workers who had experienced them.

Recommendations

- *pensions should meet a basic standard of living needs of injured workers (net of other support sources if they are permanently available)
- *financial support should be made available at the time employment earnings (or EI) cease, even if the adjudication is in progress
- *continuation of extended health benefits or pension contributions that were available to a worker prior to their injury
- *spousal benefits that were available pre-injury should be continued, and supported by the Board
- *individual and family considered in determining both financial and non-monetary benefits to the worker
- *non-compensible resources information service

D. Flexible Options for Return to Work

Retraining Options and Workplace Safety As was described in above, while several individuals were very satisfied with retraining opportunities provided by the Board, several others were not, and men were much less likely to be satisfied than women. Men commented that money spent on retraining that was not going to lead to re-employment was poorly spent, and

that better options could be considered. Some individuals felt that participation in a retraining program was demanded of them (as for some, participation in rehabilitation programs) to “prove” they are motivated, and they feared adjudicators had the power to assign retraining program at their own discretion, without consideration of the worker’s opinions or expectations. Some workers described being humiliated and embarrassed at being forced to attend retraining/rehabilitation programs that exposed their personal limitations and set them up for failure. Workers also spoke at length about their frustrations regarding the failure of some workplaces to provide safe working environments, and some saw this is the root of re-injury and re-occurrence and the source of huge public expenses.

Recommendations:

- *more consideration and flexibility in designing appropriate retraining plans, or other innovative options in place of retraining, as appropriate for individual cases;
- *flexible return-to-work options including graduated return-to-work, partial return-to-work with wage subsidies and home-working options for those who live in permanent pain and need to manage it on an ongoing, daily basis;
- *more monitoring of workplace safety and clear consequences for workplaces that fail to comply

Additional Considerations

Implicit in the above set of recommendations is the suggestion that there is a need for more humane and compassionate treatment of injured workers, and the right, despite all parties’ acknowledgement that fraud may occur in some cases, for all injured workers to receive the benefit of the doubt, unless their lack of legitimacy is otherwise proven. As one worker stated, becoming a client of the WSIB amounted to being punished for becoming injured.

While some regional differences can be examined (see, for example, the tables on injury trajectory and post-injury employment), and while an effort has been made to highlight differences in outcomes by gender, and by active/inactive status, the general conclusion is that injury severity is varied and individual, and the nature of the injury itself determines to a great extent, whether deterioration is likely to occur. The trajectory of a case then, *should be planned* where deterioration and degeneration and cascading physical effects are likely -- increased service needs and re-entitlement appeals *should be anticipated*, as the sample herein suggests.

Injury appears to be related to the labour markets that these workers are in at the time—in particular, workers from skilled, semi- and unskilled “pink collar” and “blue collar” labour markets face risk and harm that is inherent in the work performed. It is notable that the individual worker in this study who had the *least* difficulty as a claimant with the Board had the occupation of *highest status* (as a white collar senior manager in the private sector). This individual came to the Board with greater personal and financial resources, a strong commitment by the companies that continued to employ him--even as a partially disabled worker who continued to experience significant deterioration to the extent that he later, like other workers, required significant

surgeries—and this individual also described having an exceptionally positive relationship with the Board.

Given the complexities of cases, described both by workers and by WSIB staff—managers, adjudicators and nurse case managers, the active/inactive designation may not be meaningful. In fact, adjudicators suggested that inactive files could take far more time and work than inactive files; and nurse case managers suggested that inactive cases may be inactive because no one has followed up on the case, to determine what needs that worker might actually have. Nurses suggested that complexity of “active” or “inactive” cases could be minimized by early and effective intervention, even if that meant the outlay of expenditures—costs could be saved, they suggested, by spending money on pensions and services that might reduce the injury degeneration *at the outset of a case*, rather than later. Having medical backgrounds and training, nurses were perhaps better oriented to considering the disability and health aspects of a case in the first place, while adjudicators, as arbiters of the public monies used to support injured workers, are oriented first, to the financial considerations of a particular case.

Workers recognized that many of their specific concerns were being addressed by organizational and operational changes within the WSIB. For some, this heightened the sense of the injustices of the past, related to their cases with the Board. In particular, workers’ were extremely (positively) affected by the recent addition of NCM to their cases.

In identifying major responses of WSIB staff, the complexity and diversity of cases—related to the diverse population and occupational backgrounds of workers in the pre-1990s claims unit, but also to the shifting boundaries within the Board, related to organizational philosophy as well as to legislation and operations--was recognized. There was little explicit disagreement of major issues between the workers and WSIB, but the views of some of those issues varied widely. For example, managers/adjudicators’ views of pain suggested that pain is something a worker has to work around, implying choice to manage it, whereas many workers described pain as responsible for their finally being unable to work. Workers in this study described primarily successes associated with the use of representatives, while staff felt workers were often exploited by such representatives. Workers saw medical decision-making about their case the legitimate realm of their physicians who were often of their own choosing, whereas WSIB staff saw physician input as potentially increasing difficulties in enhancing RTW opportunities.

Understanding workers’ work ethic and motivation to work will continue to be more difficult where there are large differences between the status (occupational class, cultural or ethnic identification, immigration status, gender, age) of adjudicators and that of workers. Without greater sensitivity to the unique problems and needs of the most marginal labour markets, or by social groups that are marginalized in society in other ways (ie: ethnic minority status)—who may also be most likely to work in and face risk of injury at work—the efforts to improve communication to injured workers may be thwarted. If so, this will result in continued uneven and inconsistent outcomes for injured workers. Continued training for adjudicators was applauded by adjudicators and managers, who recognized the diversity of workers with whom they have had interaction.

Finally, it is notable that all parties to this study became involved in it in good faith: the workers were anxious to tell their stories, not because they felt their own problems would be rectified—as some stated explicitly, but because they were committed to the idea the Workplace Safety and Insurance Board was in existence for the protection of injured workers. They recognized, in principle, the difficulties and complexities of the Board’s mandate to injured workers, and as well as the Board’s efforts to improve services to them. In a similar vein, managers, adjudicators and nurse case managers were similarly motivated to participate in focus groups, and were forthcoming in their discussions of the Board and of their experiences with injured workers. The commitment of all is evident in the content of this report.

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Appendix A
WSIB Pre-1990 Claims Unit Study
Interview Guideline

1. Current social, health and ability status: age, medical status (other health problems, receiving treatment, for what, sources of treatment, insurance coverage, etc.), marital status, living arrangements, employment status/main occupation, or current main activity, expressed level of disability or impairment.

2. Background: (previous health, employment, marital and living arrangements)
-**employment history** (include occupation, type of work prior to disability, injuries, problems, concerns about safety, meaning of work and work loss)
-**health history** prior to episode
-**marital and family history** and previous living arrangements

3. Details of Injury or Workplace Episode

4. Details of life changes in response to injury (changes since injury; and recent episodes of improvement, decline, etc.

- probe changes in health/mental health and ability status including periods of improvement, decline or deterioration (probe re: presence of pain, dysfunction, use of and duration of prescription, over-the-counter, alternative drug/products, alcohol, illicit drugs and financial/social costs/consequences)
- changes in employment status/capacity to work, income security changes;
- changes in social-relationship/leisure/living arrangements;
- also note stability since injury episode (ie: maintained household living arrangements, social ties)

5. Informal network: What are *current daily routines and interactions*; and describe negotiation of major daily roles and activities (how dependent is individual is carrying out daily roles and activities). Who does one live one's life with on a daily basis; and *probe specific exploration of community and neighbourhood resources and/network*)

Probe: Who is in informal network; Ages of network members; (spouse, family, friends); what kind of support provided; outcomes of support provided; reciprocity in exchange, and what does it involve? Issues of control, negotiation, conflict in support network (who defines terms of "supportive" interaction). Does or has conflict emerged because of acute situations and how managed?

6. Formal resources currently available and used (institutional help and assistance); who has been identified as potential carers and have these sources been pursued? Is treatment available when needed (waiting period)? NB...what formal resources are available, accessed and frequency of access, in addition to WSIB; what is extent of respondent's knowledge of formal

social resources and options for seeking assistance for a problem/life situation (medical/psychological, social, legal, financial).

7. What about the future:

Probe: future expectations re: health, employment, family and social network and support.

-does client expect current **health status** to improve, be stable or deteriorate?

-re: **employment status**does *the injured worker envision taking any form of work, part time or otherwise...do you ever see yourself working again; what would it take)*

-*what would returning to work mean for you?*

-*would you be able to do your old job?(do you have enough seniority to expect to return to that job?)*

-*do you have a job to return to?*

-*have you thought about retraining? Any transferable skills*

-*meaning of work and work loss...*

-re: **income security**: current and expected sources of future income; is pension adequate (*if not, does this influence client's views on return to work?*); do you have benefit coverage with your pension; is it adequate?

-re: **family and social network and informal support**: does client expect improvements, stability/status quo, or deterioration, and why...discuss...

-what does client expect re: future relations with WSIB? (move to specifics on WSIB)

8. Ask client to describe their past and current relationship to the WSIB.

-probe details of WSIB interactions, contacts, dependencies, conflicts....

9. Ask client to evaluate WSIB services (past and current).

10. Ask client for suggestions for improvement in WSIB services

Appendix B

Suggestions for the Board as quoted by Injured Workers

WORKER INTERACTION WITH THE BOARD

Consideration:

I: Is there anything you could suggest that might improve those services from the Board?

R2: Somebody who could care. Take one person and give somebody that cares.

I: Okay.

R2: You get the feeling nobody cares there.

I: Yes.

R2: You get the feeling that no matter how much you're suffering that it's coming out of their pockets and they're trying to save as much as they can save.

R: ...you know, because they're a terrible thing, labels. And I'd like to see that done with the Compensation Board. Forget the labels, try and see the person. ... They have to look at the patient as a whole person. They have to look, well is this person going to lose their career? What do they REALLY think of their career? Do they like it? You know, or could they shift to other careers without any problems? What career do they want to shift to? Ah, I don't know how they do it...because it was a big decision for me to go out there.

I: ... Are there things you thought about that would improve--that could be done to improve the service they've given you? Or lack of service?

R: Yeah, there probably--I think definitely there could be things done, ah, not just for me probably. Other people might ah, I think they should look at the individual person.

I: So, if you were to make some suggestions about how they could improve their services, what would you say?

R: I'd say per--more personal contact. For sure. That way the workers get to really know the person that they're talking to on the phone. They would get to--

I: Like face to face.

R: Face to face, or having the person coming in. I have never denied anytime they've ever asked me to come. Okay? I've made it to there. And most people would, I believe. Okay? If they were asked. Now I understand that some of these workers are probably scared of the worker that they're dealing with. And that's fine. And then

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you have somebody else with them. I think the--that way--you really to get to know the person. You can understand then what they're going through. Ahm, like, most people look at me and they go, "I really realize you're in pain right now". And they'll go, "But how come you can sit there, and you can still smile?" Well, I've had the--people say that to me. Well, what's the point of me putting my sadness onto you, or my pain onto you? No. No point. And most people with absolute injuries are that way. When they have an injury, they'll say that. And--but I think it's really the necessary of having personal contact. I'm not saying you have to do it every six months or anything.

R: Yeah. Yeah. See the one thing I don't understand about Worker's Comp is they make a decision on your disability, but what do they base it on? Is it just because I can't move so far or I can't bend my body a certain way? Well if that's the case, that's...that doesn't represent what a person really goes through, you know? If they could come and live with me for a month, I'd feed them; I'd even feed them and you know, give them a place to sleep because there's enough beds around here. x number of weeks and saw what they went through, they would have a better understanding as to what goes on with people.

R2: That's what they call it, swinging the lead. [meaning faking it] There's nothing wrong with you, so they put everybody in the same category, and where individual injuries should have individual cases, individual cases should have precedence over everything else.

R: And the biggest thing I want to see their attitude change.

I: To what?

R: If we were not disabled, they wouldn't be working.

I: Right.

R: That's what. You know? We're all here to help each other, so let's do it. I am not a burden to WCB. (Company) pays WCB. I worked at (company). They pay a lot of money. They're paying most of my earnings to WCB. They have to pay an insurance. So why should I feel..feel degraded or feel bad when I go for an interview that some lady sits there, with her nose in the air and just writes down everything you say, and when you go to question her, interview's over! That's what I'd like to see changed!

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R: And I think that they should have a little, these people, be trained that way to understand that you cannot treat ALL of sick people the same. Because we are all different.

I: Right.

R: It's not that they have to pamper us, you know, just work for--that- that's..that would be crazy, no. But is just when they deal with us, just to see who they dealing with.

I just think they gotta have a better way of communicating with people. My opinion anyway. Like I said, (chuckles) maybe this is what this is all about--is..is learning that these people should get together with people and explain things and, don't make a decision looking at a piece of paper. That to me is (chuckling) just un-godly. It's-it's..it's cruel. When a doctor can say, well 'Yeah, you're doin' this', he hasn't even seen you, and never heard of you, ALL by the paper. And I think this hurts a lot of..they just cause a lot of the problems (unclear). But... I know it's caused me some. So I can imagine some people that are in bad shape or not in good grace with the board, I guess. Because they get awful tough with them (chuckles), you know.

I: Yes. Okay. Any other suggestions about how the Board could do things better?

R: They gotta get somebody in there that knows...I think they gotta hire people that's been in an accident, that's been hurt to talk to these people. You know, like uh, like somebody that's been through what they've been through. You know, like because I think ninety per cent of them people in there are not people that were in accident.

I: Somebody told me that they are hiring a few...

R: They gotta hire somebody that can talk to people, you know, like not be rude with them and it's people that are understands...

I: Yeah.

R: ...that understands.

R: Before you'd call and they were more friendlier, now it's just like you're..you're a number.

R: Like they take all your digni..dig..how you say that word? Dig..

I: Dignity.

R: Yeah, away from you. Like you're--they-they seem like they--you're a piece o' sh..shit and that's it, and "you do what we tell you". Like they take your pride away from you, they take everything away from you. You got no..you got no more moral, you know, like you're..you don't feel like, you know, you're nobody.

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I: Anything else that you can think of that they could do to make life easier so that you didn't need to get a representative, um?

R: Well get on the case right away.

I: Yeah.

R: Get on the case right away. And not that you have my file in front of you, ah, and you go on vacation. I call, she's on vacation, she's gonna be back in two weeks, there's somebody else that can help you, no, I want to talk to her...

I: Right.

R: ...or to him, whatever.

I: Yes. So some consistency in terms of--

R: Well some consideration at least.

The service provided --the service provided...(unclear) by the WSIB is clearly not intend to help injured workers, but frustrate and cause anxiety because that's what I've gone through, right? And to intimidate workers to the point where they will give up. The WSIB will n--will do what is necessary, that's what they did, what was necessary to rehabilitate me. But the aim is obviously to close the case and ignore the worker who must then suffer consequences for the rest of their lives. They will do the minim--the minimal for that injured worker, just this. They paid, like let's say they paid for the operation, they paid for the physiotherapy, they paid for rehabil--you should be, that is it, we are gone. Don't talk to us any more. And that should change.

R: But you don't treat everybody as being a bad claim. ... and come nasty on the phone.

R: Ah, the only thing I can say, if they--to improve things they should start taking a little cla.. a little closer look at each indi--instead of going by a whole programme, each individual case 'cause one case could be similar to the other one, but it'll ... a little bit different. And I think what they do now, they take the whole thing as a whole, and judge everybody the same instead of taking each case individual and going that route ...

I think they should evaluate each situation on its own, and take into consideration, you know, what the past history was like.

I: Yeah. Okay. Well is there anything you'd like to add about your experiences with Worker's Comp or WSIB? I've been asking people for suggestions or recommendations for the WSIB.

R: Ah...there's things you can, but you can't change them, you know, because well--

I: What would they be if you could? I want to take to them a--

R: Well the perception, the perception and it's political, the perception is that anybody who has anything to do with Workmen's Compensation is a fraud artist.

I just had a few people there I didn't agree with, the way they treated me. I mean, you know, the only thing is sometimes I thought I should be treated same as anybody else.

I don't know what they set up since they changed the Board director or whatever happened there, what kinda rules they changing, the rules which were letting you know what is happening, or they're just there to look after the companies' interest and never mind the rest.

R: ... people do need their support and their kindness or whatever else you could say to them, because you feel just as bad that this happened to you as they, you know, at their organization. Because it's not only your work that is affected by an accident, but your lifestyle. It's your family, it's everything is affected by..... It's not just work, everything. So a little bit more - what's the word - not sympathy, ah...

I: Empathy?

R: ...empathy. Like a little bit more empathy or ah, like ah, we know, we understand what you're going through, we know it's just not work, like it comes across here sometimes, it's just that they worry about their work. Forget about everything outside, it's work only. We don't care how you cope with the outside world. You gotta cope with it here first.

Communication:

I: Have you thought of things that would make it better in terms of service from the Board?

R: You know like, sometimes you just give up because you just can't talk to anybody. You know, like that's what I mean.

I: Would it make it--

R: If they...if they were to come out and say what, you know, what..what.. what they think of--what is the uh, what the general thing, what they want from you, you know, like that's uh, but they won't come out; they just go hedging and hedging or they just ignore you completely. Somebody like (unclear) you know, sit down and say well okay, we got your case and you gonna talk about it and this and that but they never do.

R: But I'd like to see the counsellors in the Compensation Board listen more and not be so...I felt it was superstitious--superficial situation when I go in for counselling. That if I didn't come in and say positive things about things, that...I was going to be blackballed, you know. ... But anyway that's--and I'd like to see them just pay a little more attention to the--to the client. Listen to them, investigate what they say. ... Rather than just writing it down on paper.

R: Ah, when they see a person, i.e., like myself who's had two, three back operations, maybe they should pull them in and have an interview to find out exactly, you know, what he has or what he hasn't. Okay, I could turn around and say, 'well I can do this job in my work, I know I can do this job'.

I: Right.

R: 'But I have problems doing it on a full-time basis'.

R: Well they should be actually going into the homes like you're doing.

I: Yeah.

R: They should have a division of people that have so many people to look after just to go in and spend one day with them to see how they're doing, what they're doing, how they're coping, you know. It's sad to say, but that's what's lacking. Maybe they don't have enough people. Maybe they're not--their budget's not big enough, I don't know. You know, if the provincial government has anything to do with them, then the provincial government should be funding this. It should be part of the funding. And

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then the provincial government should be looking at ways to utilise the people like myself in creating job fairs, you know, make work projects.

I: Right.

R: Because there's lots of things that we can do.

R: To help somebody else like you know, to..to have better communication. You are talking with people, you're not talking with animals. You're talking with injured people that have a little bit more troubles than yourselves, and have..have sympathy for them. You know, can't put yourself in their place, but think about them. That's what they don't do, and that's what they should do. I think when they're--when I meet a counsellor that's courteous, who-who is kind and nice, it makes me feel better.

I: Are there things that you can think of that would improve the service...to clients?

R: ... Ahm...yes, but I don't think I got time right now to (chuckles) go through it all.

Ahm...like when you go downtown to the Sudbury office, I mean you go to the desk, and ah, there's a..somebody sitting at the front desk. You have to show--almost show I.D., who you are, you want to speak to somebody. Ahm, and beyond that everything is locked. All the doors are locked. And to get the attention of an adjudicator or somebody, sometimes you have to sit there for hours.

I: So you can--you can walk in, but they'll--

R: You can walk in, but you could be sitting there all day waiting to see that person.

And ah...I think probably they're getting better in some respects. But ah...like when you talk to them, and you, you know, their files, I mean, a lot of times, I swear to God, that your file is on their desk when you talk to them and they can't find it. And ah, you know, if they'd just be truthful with, ah, the injured worker. ... Maybe if some of these people in that office get injured themselves and spend a little bit of time nursing their injuries that, ah, you know, they would feel for the..the next person. But ah...they don't. Some of them are so cold.

I think the Board is boggled down with calls and I mean just for people to explain what's going on. If they would send out a letter saying, "Here's what...", itemize things, say "here's what it's for..." Away you go! You..at least you know what you're lookin' at. Right now you don't. So you have to get on the phone or write 'em, sayin' you know, 'Why did you do this? Why'd you only send me that?' Then it's a process they gotta re-write you again (chuckles) It's..it's a snowball thing, it's..it's stupid as far as I'm concerned.

Like get a bunch o' people together and ah, have one of them come and talk and explain to people a lot better what the situation and what their system is and all that. Like nobody knows Compensation system. But I, like I said, at Compensation I don't--like ah, I wish they'd change the system; and how to change the system is they gotta start explaining themselves more and try to help the people that are--have more people in there like people like, uh, the guy went through what I went through.

And another beef I got with Compensation is their goddamn phone system. Every time you call there you got an answering machine. You know, like you can call and leave message and they're two three days before they get back to you. Like their system, ah, stinks

I: But they don't answer?

R: They don't answer their phones. I've been dealing with them for fourteen years, and I think once someone actually answered the phone when I phoned.

I: You think it's deliberate?

R: Sure. I mean they're screening their calls. They're calling you back when they want to call you back, you know. And it's, you know, it's an obvious thing right there, and that's aggravating. Some of them call you right back, some of them don't. I called Miss H.B. this morning at quarter after nine. We'll see when she calls back. Probably Monday. But, ah, she might call this afternoon. Um, thing is...that-that's just by--that's--it's a small point but it would make it a lot nicer if people would answer their phones when they're around, you know.

But they have to give you this guidance. And the thing is, is so--people don't know what to do. People are lost, they don't know what to do. When you get a problem like this what do you do? And your energy and the way you think it changes. Some people have more difficulty with it. That's what you need; a little bit of guidance, you know. And..and if they did give you that guidance, I think they would catch out the people that aren't sincere.

But I also I wanted to mention, ahm, apart from having my injury in 1987, and they didn't tell me that it could get worse, I think they should tell people if the WSIB finds a case where the injury is gonna get worse, they should advise that worker in writing.

That's something that...I think all injured workers would be happy of.

13. This is a part of the Compensation Board that HAS to be changed. Telephone conversation between adjudicators and client should be recorded for quality and accuracy because an adjudicator has the power to place any comment they choose in a worker's file and which should--which can be used to discredit that worker.

It would be nice if the Board would sit down with you and say, 'okay, Mr. X, this is what you were before, now this is the way you are, you know; now you can do this, this and this and this'. They don't..they don't tell you anything.

I: So if you were to make some suggestions for them overall to improve their service, what would they be?

R: Ah, maybe keep..keep an open line of communication. I know I've learned through the years that contact with the people and keeping open communication helps .. helps alleviate a lot of the problems.

R: ...that ah..ah, you gotta either registered mail it or something. I says, "this is not right" okay? "If the paper is so important it should have been registered to me." okay? Like letters from Compensation Board, something important should either be registered mail where the mail man comes to the door, he hands it to you by hand, you know. Just uh, when they send you a letter, make sure it's registered, you know. Don't have some other poor guy out there that maybe don't have a brother to lend him some money to pay the rent.

I guess if they inform people more...because people didn't--some people didn't know you're allowed to get reimbursed from your parking and ...

Improve Process

R: Anyway, they--I think from their point of view, even to make it easier for themselves, they should have a programme that they should set up for themselves that this is the steps we do. The steps they do now are ludicrous. You go see your family doctor, you're off work and you can't work and you've determined that your doc says oh you can't work. I can't even play. See I can't do anything. So, you know, this is the whole thing. I-I..I can't go out, I can't drive, I can't...you know. So anyway, what I think they should do is they should have something where they should bring you in there, see their doctor, they have doctors, determine if you need to go see a specialist to have something done like an MRI or CAT scan; CAT scans are pretty useless on backs. They never determined anything.

I: Right.

R: MRI determines it. Because they can see it. They should..they should do it. Because then they would have less time, less hassle--less shuffling of papers, and I think they'd be... wasting--now they waste so much time that it costs them more just processing me than if they paid me.

I: Yes.

R: I don't understand that. It's total waste. It's a bureaucracy that's beyond belief. You know, and...if they had some way of doing that, telling you here's--this is your doctor's report, and even saying to the doctor at this level, at this point, he should go see a specialist. An orthopaedic surgeon or whatever; rheumatoid, whatever, to determine if it's disease or if it's a disk problem or what it is. Because regular doctors can't do it. It's a hard thing, backs.

I: Yes.

R: And ah, if they did that, you know, I would have had this whole process done. And it takes months to get an appointment with an orthopaedic surgeon.

R: What I--I had this conversation with my doctor, right? I have a good--the family doctor, he brought me into this world so I've known him a long time. And he said that he thinks the best way to deal with Compensation is to shut them down and give the job to insurance companies that know what they're doing. He said if he had--they had a group of insurance companies that the government said okay, this is..this is the deal; you guys got to deal with this and let the professional insurance companies deal with it, it would be dealt with, dealt with properly. He says you never have this problem with insurance companies when you have car--different levels of-of, ah, you know, of how well they work, he says different insurance companies do different things. But he says he thinks that would be the only way you could really solve it. Because they are professionals and they care about their business. These people they don't care about the actual business of the WSIB.

You should be careful, we should--you should go through programmes, you should do this every year, you should probably come in every two years for an MRI to see where it's at. We should not allow an injured worker to have this same re-occurrence again, never. You've gone through enough. Having an injury is.. is serious matter in our lives. We want to work. I'm not sitting here telling you that I want to work; I DO want to work. I DO want to go out and make a living for myself.

Ahm, the next one is we should, and this is VERY important, should have liaison, liaison should be encouraged between injured workers, management at WSIB, and injured workers' support group in order to ensure that the service provided by the WSIB meet the needs of injured workers, not only in providing benefit but also in ensuring that workers is rehabilitated and able to face the future without doubts and fear, which is the big problem that we have right now. You meet--there is no liaison. There is nothing like that.

Improve Forms

R: The only thing I don't like about the Board, is to fill in those forms..progress report forms every second month just to get the medication. ... And the medication has been ongoing for years and years. You know, I understand if I went in to see the doctor and I had a change of medication. Now, I can understand filling out a form for that. Uh, I can understand filling out a form if I was gonna go see my doctor for my--for a specific injury, something like that.

I: Right.

R: But if I'm just going to go see him for medication, why should I fill a progress report, just for medication?

R: And when you go in there and you got a small easy form and the doctor will just fill boom-boom-boom. Boom, couple minutes, it's done. But they don't even have a form for this. Their forms are...are very strange. If you want to improve Compensation, they should have a set...forms for doctors to fill out. Easy, right? And what the problem is, is they keep asking for the same information over and over and over again. They don't check their files. The information's in the file. I don't understand it. And if they're asking for faxes of things, they should be there to get--receive those faxes right away. It shouldn't be fax the office, I'll find them later. You know, could you imagine how many faxes are going in to..to that place every day?

I: Do you know if your doctor's ever had his receptionist follow up and phone them?

R: Oh yeah. Well yeah! Eventually they did get them. You know, we had to go and do it all over again.

R: Yeah. Well they do have some forms. But the...they..they give you these forms, you fill out the forms and then they ask you for the same information over and over again. Why do they make it so difficult? They don't have to. Some standardized forms that they actually look at, would be a start. They..they ask for my doctor's notes, they should have a...every so often they should call the doctor and say, 'we'd like Mr. So & So's new notes'. Simple. 'Fax us now please, we'll receive them'. Okay, we'll call you back with that, be there and they're there. But they don't do that. They don't make it simple. State what your clinical findings are and we'll list them for you. That can be part of the form. Clinical findings, they can put a bi-i-g heading and they can say, 'this is the list of all the things that we want to see. Does he have this? Does he have sciatic pain, does he have this kind of pain, that kind of pain? Has he got a pelvic tilt? How many degrees is it?' They got it all on his things anyway, but they can ask these questions. Does he, you know, can he bend over, right? How far can--is his flexion and all these things, they can..they can ask these specific questions on a form instead of just asking, diagnosis. But they won't give them the specifics that

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they're looking for. They want these things, but the doctor, you know, if he's got it in front of him he'll check them off.

R: when you fill out an S&A form, you have to pay for them notes. It cost you twenty dollars every time you get one filled out. So if your doctor is not a very...how would I say it, very generous doctor, he would make you come in once every week, two weeks to get these filled out. Comp doesn't pay that back. They just pay the money that they gave you.

Timely Processing of Claim

R: Ahm, regarding the claim itself, like when you..when you go off I certainly think they should (unclear) upgrade. In today's society about--I think, you know, they got computers, they've got everything, ah, e-mail, stuff like that that you can't tell me it takes them ten weeks to sort that out. I don't buy that, not one bit.

R: And then not only that; when, ah, then ah, whatever, oh I didn't receive the report or I didn't receive this; even the doctors they..they're pissed. Because you know, they push and they push and push that they want a report. Finally they send the report and then it's gonna take six months? They been pushing me, ah, that they want reports left and right. Now ah, psychiatrist send the report, the psychologist they send the report, ahm, my representative letters here and there and the fax, whatever. My doctor send a report, the specialist send a report, now it's been what, six months that I've been waiting for this, ah, increase of pension. Then finally somebody comes along, okay, ah, questions left and right, okay fine, I answer everything up. Now what? I gotta wait another six months? (Chuckle). I could use that money. Very badly.

I feel that if an injured worker has a re-occurrence, the file should be looked at immediately and it should be taken care of immediately, not three months. A person could die in three months of starvation if he doesn't have resources.

.....

... if they're going to investigate a claim, they should be paying the worker and if it's a phony claim, charge him with fraud, but don't leave the guy destitute, you know, adding insult to injury Pay the guy from the initiation of the investigation, from the initiation of the claim, and then deny him benefits if it's found to be false; and then have HIM charged. You know, there's nothing wrong with charging people with fraud if they're committing fraud. Ahm, but denying people access to.. to benefits is basically making them destitute and you could probably lose all the guys fall through the cracks or become homeless or ah, drunkards because they can't...live, they can't survive. You know what I mean? It's like you go from being a healthy working individual working fifty-five to seventy-five hours a week, to someone that's actually looking for a handout somewhere, and that's what it feels like, you know. don't deny people benefits when they've been injured or they say they've been injured. They're going to investigate, investigate, but in the meantime don't allow these people to fall by the wayside because I've lost everything twice due to the way Workers' Compensation has handled their claims, you know.

... waiting for your money, you know, like ah, if you go back on it again on the same claim, you'll wait. They'll make you wait... maybe six to eight weeks. Well that's--that shouldn't be. You should get your money right away. This is, you know, legitimate claim. Maybe they think everybody's a phony, you know, I don't know how--what their thinking is here.

R: ... Some of the cases that are of real value and they know for a fact that they are, they could do it out of compassion. And if they--I would--

I: And what would they do?

R: You know, like give them a financial settlement out of compassion. And ah, then that goes back to the work--ah, to the employer. But ah, and then again if they think that somebody is fraudulent, they should be in ah, they should be able to have somebody...ah-hm, survey 'em; do a surveillance of them and ah, if they are fraudulent, then deal with it.

I think it's wrong if they're holding people's money or if they're not gonna give them money like they're spending all their means and then get nothing, and then all of a sudden, a turned decision that they do get their money but if you had an eight thousand cheque here and you had bills to pay here, would you cash that cheque to pay those bills or would you cash that cheque to pay those people back that helped you out, like and...that's a tough call.

Accountability

R: --I'd like to see..I like to see Compensation be accountable for their...adjudicators and like don't run people around. Like 'I made the mistake, sir, well let's fix it'. No, don't push the buck. That's what--I..I hate that. I always taught my kids, "you do it, you stand up for it." And I would like to see people at WCB be accountable for what they do. ... that. They changed that, you know. ... But in the long run, I would like to see WCB be accountable for what they do and not treat...their clients as they call us, as retards. We are people who are maybe some of us are more educated than others, but they treat you on a..a level base. And they'll tell you what they want--they tell you what you want to know--no, they'll tell you what they know and that's all, and you can't ask nothing about it. You--it's a know-to-need basis.

I: Sorry?

R: Need-to-know basis. WCB is like a spy, it's need to know. If you enquire, well you're in trouble. If you go down there and stand there and pound on the desk, say 'where's my cheque? I've got two kids at home starving', you'll be arrested.

R: If I submit a form at the desk, the girl at the reception and at the desk should make sure that the individual receives it promptly. But...the individual who takes the forms to the back for filing, should file them, per se, at the Naprosyn. Not, 'oh jeez. I forgot this one.' You know.

I: Right.

R: If you forgot it five minutes ago, another two minutes to put this file away and go do it ain't gonna make a difference. You know. So...you're gonna take something that needs to be filed, file it. That's it. they had it set up, if they don't contact an individual within a certain time frame they get a letter from their computer. 'Contact so-and-so within the next number of hours, or else your file is closed.' You know. That I don't like. You know. If...like she said, she tried to called me about for or five times. She couldn't get a hold of me. I says to her, I says, "Why?" I said, "I gave you the phone number where I'm at now." I says, "I even gave you my cell number." And I said, "You have my wife's number in Toronto. You're gonna tell me that you couldn't get a hold of me through those three phone numbers?" I said, you know, I find that hard to believe. So anyways, I checked the front desk, and sure enough, the front desk has a proper mailing address, but nobody had bothered to change the phone.

R: Well first of all, ahm, I think..I think the Board, ah, the thing that the Board ought to be doing, really - let me show you this - I say the things the Board ought to be doing

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is adjudicators and medical consultants, what--in this case, I didn't in my case, I have observed that they did not use medical information to make their decisions, and I am saying they should therefore be, any adjudicators or a medical consultant that does not do that, they should be held accountable for an injured worker and their family where damages have been caused.

STAFFING AT BOARD

Increased Human Resources

R: What I see there is one simple thing, and it's the same I guess, with any company, it's called manpower. You now, they have cutback, ah, Mike Harris has probably cut them back the-the..the rock bottom, uh, just the same as our company done the same, and our company has discovered it didn't work. So they're having to hire like crazy. And maybe Mike Harris should see the same thing, you know, that it's not working there. Ah, there are genuine people out there who are not out to...screw the government or anything like that. They do have problems, you know.

I: Yeah. So is it--it sounds like, then, you're saying that--or are you saying that their attitude is negative toward people?

R: Well, be it truthful, what I see from the..the people like ah, their handling me, I probably see them they're just frustrated. Because they're probably having pressures in there, have a, ahm, (unclear) on the case load and they know they're pushing above ahm, instead of like, ah, one person is maybe doing about twenty people when in actual fact maybe they should be doing ten. And I know where it's coming from. I know where they're getting it from. Ah, I don't think you need to be a...like a mathematician or anything to figure that out. Ah, I think that's where they need to sort it out. Being truthful, it's just plain manpower that these people can take time for the people who...who need it.

R2: Well, I think maybe one of the problems, that's my opinion only, is maybe she has too big a load. But you can't expect her to handle two people. You know, she has her job to do as well. I have no faults against her whatsoever.

I: This is the nurse you're talking about or the adjudicator?

R2: No, the adjudicator.

R: Well that's the way I feel with Compensation, like right now. Since they changed their name it seems like ah, and I find they don't hire enough men. now like when you call it seems like everybody's mad An they don't explain to you, ah, as good as what they used to.

R: I think what they could do is when an injured worker opened ah, reopened his claim, I think they should ah, ah, put somebody in charge to..to start digging and see what they can do for that injured worker, and not to make him suffer, 'we don't pay you' or they don't pay for months and months and months. See what the hell you can do for that guy to help him out. Not that you just 'oh, we don't pay you' or make him suffer. Ah, unless I have a lawyer I can't get my money. I don't have money to pay a lawyer so, you know, it's gone, I don't see it. What is this? You know, put somebody in charge. Not that ah, y-you got an adjudicator that has twenty, thirty files, and ah, whatever information she gets, she gets. But nobody goes there and start digging. You understand?

R: And the Workers' Compensation doesn't seem to have any referral doctors. Like it takes years to get in to see their own doctors. I think they should actually have more doctors on staff, so that they can have their own, you know, immediately get somebody in to say 'okay, let's look at the situation, how is this person'.

Like I say, they just take each--I know it would take a lot of...extra manpower or something to check these things out if they done it each individual, but they gotta consider like I say, they gotta consider each one different than the other instead of taking all of injured as, ahm, that has the same injury as a whole thing and say, 'well you all should be the same'.

WSIB Staff Training / Qualifications

R: I figure..I figure it's--they need a house cleaning. They need to train their people. It's better to have five trained people than ten people shooting their mouth not knowing what they're saying, you know. You don't get things done, I find that--

R2: Well they're dealing only with the injured person and really it affects the whole family.

R: If they could hear--they built a new building in Toronto, a big office building a while back; if they would take their money that they get from different companies buying insurance and train the people well, or even still, take five disabled people, take one adjudicator, put him in a room for a day and a half, two days, and see how they live, then go back and judge 'em ...

R: And I think, uh, between me and you, like right now, I think some of their people should go for an anger management course or get some, ah, they should train people better, like I say, to deal with people.

Ahm, another thing is their qualifications. I think that that has to change. If a injured worker ask for the adjudicator's qualifications it should be given. Because I believe to deal with an injured worker, the trauma of an injury already puts stress on that person, already. How is that person gonna feel if they don't have an adjudicator who understands even that. I think a person who's doing this type of job should be qualified to do the job adjudicators should be trained to handle situation on a human level with sensitivity.

R: ... you know what they turn around, "we don't hire injured people."

I: Oh.

R: "We do not hire any of our injured people." I said, "You--well, you're the first one that should be hiring them".

Less WSIB Staff Turnover

Well, I would think that it ah...to leave the adjudicators in place. You know, don't change them around so often. And I mean ah, I've heard this from a lot of people. And ah, that's probably one of my biggest beefs.

Again I mean, that's why I think there's so much turnover over there, it's just ridiculous.

... there's no one person the same. we're supposed to get just the one counsellor. From the time I start Workmen's Comp down there, then I dealt with them, I don't think I had the same counsellor more than six months. The only one I think there was one, was a man, think his name was So and So, they transferred him somewhere else or he's not around here no more.

Family Doctors as Resource

- I: So what could they do better? I mean you've made some suggestions. Do you have some more suggestions?
- R: Well I think they should spend more, I don't know. It's hard to say. I-I've a lot of ah--I think they should start listening to like why do they give the people so much rough time with their doctor? Is it because they don't trust their doctors? Our family doc--like our specialist, like I (unclear) this specialist from Toronto; he's not my family doctor, he didn't know me till I went there. Like when he sends a report in, what's wrong with that report?
- I: They don't accept it.
- R: They don't accept it. No, and our--the doctors to the point, they don't want to be bothered, right, any more because they don't want to have nutt'n to say, it's a waste of time with Compensation. Like they as soon as they know you're a Compensation case, they don't even want to deal with you...for some reason and I don't know why, they just said they--we don't want to work.

- R: How much do you want the guy to write, you know. Time is money. He's gonna just write a short little description of my back problem. He's having spasms, you know. But if they put what the clinical findings are, a little list of, you know, I could even make up a list for them, okay? And then you can check them off. This degree of this, this much of that, and then they'll have their clinical findings. At least they'll have somewhere to go from. Okay, this is what we got on your--you go see your doctor, you got the forms, your doctor fills them out, you get them back, these are what he finds, then in a month or two you send another form. Same form, maybe two or three months. Give time for the back to heal. They can do whatever they like. They say three months. There goes the form, the doctor fills it out, is he better or is he worse? And he fills out the things, he's worse here, worse here, worse here, better here, better here, whatever.

- R: The next..the next thing, ahm, I got here ah, medical uh, WSIB adjudicators should not make medical decisions regarding worker ambition unless the personal physician approves the decision. Because I think that your personal doctor sees you every day or every month. They know exactly what's going on in your life. Now I think they should, if adjudicator is making a decision they should talk to your doctor. I don't think it's happening now. I think the WSIB has such a bad (chuckle) it has such a bad name out there, even the doctors don't like them. You know. Doctors would say, you know, I write a letter to them, yeah, but they never write a letter and then you ask them why, "Well, they're not gonna pay me", they're not--they don't..they don't care about nobody, you know. They only care about themselves. So

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I think an adjudicator should, and this should be a criteria, SHOULD talk to your personal physician before decisions are made in the file.

BENEFITS TO INJURED WORKERS

Standard of Living Requirements

R: Ah...supply more to my pension to bring me up to the standard of living that I would make now if I was fitting I would, ah, like I said, I'd like my pension to be based on what a person--either base it on what a person's making now that I was doing back then...

Financial Payment Options

R: but one thing I wished that I could have been able to do which would have made things a LOT easier for me, ahm, I probably would feel a lot more comfortable having the guys here - is if I had been able to ahm...ahm, get an advanced payment, and they had said no to me on it.

I: An advance payment?

R: Ahm, Compensation has something where you can take and get your payments all at once to, ahm, what do they call that... ah, you can get a..a lump sum, lump sum. ... Lump sum payment. And for some reason, they said no to me, and–

I: So you would get the same amount that you would get over a number of years?

R: Yeah. And what I say is, like, “Okay, if you could give me, ah, let's say twenty years as a lump sum, then I could basically take an - put a big down payment on the house, and then it would make things a lot easier for me.” Because then I could of bought a little bungalow which would be a lot better for me than to have these stairs. But at the time this the only thing that I could afford. And they said, "No, your back is going to get worse". Their idea was your back's going to get worse, so we can't really pay it out, because we don't know how far--how bad your back's going to get. And I'm thinking, 'well you're paying me now, just pay me that, if my back gets worse, then– it's an add-on afterwards.' But I'm hoping not--my back not to get any worse, though I know it is getting worse.

R: You know, like I, ah, one day here I was financially hurting and I asked them “Give me a little advance on my ah, Compensation pension, and take it off” and they'll do that; but “No, you don't qualify”. But yet, another guy applied the same time as me, he gets it. He qualifies.

I: And what was the difference?

R: There was no difference. It was just--he just said, “I can get money any time I want to from Compensation”, I said “Yeah, well prove it”.

I: And how did he explain that?

R: He says he could get an advance any time he wants to. And he says, “You try.” And

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I tried and I got turned down and I needed the money, I needed--I was financially hurting here, and I had to sell my, ah, some of my stuff so I could, uh, survive or else I would have, ah, you know, like I had boat motor here and I didn't wanna sell it, I was gonna give it to my son and I had to sell it...to make come--due to my payments because they cut me off here all of a sudden, they cut me off...

Continued Health / Pension Benefits

And like I said, what my beef too is-is medication. If like uh, if a person had drug and plan and all that when he got hurt, where is it now? Where is my drug plan, my private room that I was entitled to? Like here I am, I had drug plan, I got uh, uh, hospital coverage for private room or semi-private, I had, uh, dental plan, eye pl.. thing and every--I'm so poor right now, I'm ruining my eyes because I gotta buy my glasses at K-Mart because the, uh, uh, not K-Mart but Wal-Mart because they're.. I can't afford to buy prescription glasses so I could read. My eyesight was good before I got hurt, but it goes with ages too, but still you know...

R: So, I got hurt at the company...and the way I look at it is, if I'm on compensation because of an injury at the company, my benefits should be carried on no matter how long I a--or up to the age of six--or, well in my case it's thirty-five years, would have been sixty-one. Okay. The minimum requirement of thirty-five years. So if I had seven years to go for thirty-five years, and I was on compensation the whole time, my benefits should be paid by the company up to that point. That's the way I look at it. And it's not being done that way. I'd like to find some way whether it be through the company and WCB jointly, or even between the company, WCB and the union jointly, is that an individual is off work hurt, should not lose any benefits whatsoever. Should be awarded the...full coverage whatsoever in benefits that he's entitled to while he's at work.

I: Including eye, den--

R: The whole shot.

I: --anything you need.

R: Glasses, dental, prescription medication, uh...a wheelchair and whatever. You know. They should be entitled to full benefits, not just partial benefits. If he's off because of an injury, he should still have the life insurance coverage. That shouldn't be taken away.

But if a person get injured, I think the Board should pay for all his benefits too, because it's a..it's a job that you were doing.

R: No dental plan, no ah, health plan, yeah, you lose all of that as well. Ah, maybe dental..dental benefits, you know.

I: Are not covered.

R: Not covered. They should, you know, they're part of your job, you receive a percentage, you don't receive four hundred per cent. Mind you, Workers' Compensation is tax free; but you don't receive the benefits.

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... changes I would love to see happen would be that, ahm, your benefits are carried on for you, like some form of a life insurance policy. (sigh) like..well one would be to try to make some kind of arrangements to carry on the benefits that you've had at your job. Ahm, where..where it wouldn't be a burden onto everybody else. And you know, it's a...the person is limit--is hurt to a point, he shouldn't have to suffer financial ... loss.

R: ...and ah, give me my benefits.

I: Okay. Like dental, medic--

R: Yeah, the stuff I had when I was there; dental, medical, eyeglasses, prescription.

... why don't they just give it to a private insurance company and then you get a policy and then you know where you stand. If your husband die you know that you don't get covered or you get a (unclear) you don't get covered and that's it.

Spousal Benefits

- The Board need to change their policy on if a husband dies If a husband dies, the, uh, your wife should have the widow's pen--it should be considered widow pension. It should not be stopped at that time when he dies because the Board saves money, millions of dollars like that. Why don't they give it to the spouse until, as they were planning to give it, to the person at sixty-five? Sixty-five it stops.
- I: And so the situation you're faced with is that your wife...
- R: Doesn't get anything.
- I: ...she'll only have whatever...
- R: And if an injured worker cannot ever go back to work, he can't contribute to CPP. So that's a pension lost. Those are things that need to be considered very much by the Board. And that is very true, because what happens if a woman wasn't working all her life and her husband got an accident, and then he dies at say... say forty-five, fifty. He was getting thousand dollars from the Board, shouldn't that automatically be a wife pension? Because he was the supporter of his family, and she should get it until he's sixty-five, because she can't get any other monies until SHE is sixty-five herself.

Individual / Family Support

... they should have psychiatrists there to ask--to help them through or some kinda group therapy because, you know, people are injured, you want to talk about it, and nobody wants to hear about it. My sisters or brothers don't want to hear about it. My mother and father - well my father passed away seven years ago - doesn't want to hear about it. They don't want to hear about why you're not working. You know, so if there was some kind of a...support group for people that are injured, because I know that these guys, I know this one guy particularly that lost his arm in a printing accident, ahm, he's become a drug addict, and they keep handing him money. They gave him enough money to buy a house and he lost the house. Because he's not dealt with..he'd not dealt with the loss of his arm. You know, and I don't think there's enough support there for people with serious injuries. And I think that would be really beneficial.

R: Ahm...and there, ahm...there should be some kind of help for your, ahm, your kids. Because they suffer a lot when you're..when you're hurt. They suffer a lot more than they, ahm, these people realise.

I: Yeah. In what way? Can you speak to that?

R: Well, you're seeing your Dad stoned on drugs or in pain and, ahm, nasty or swearing and, ahm, because you get very short fused, you get very nasty, ahm...your whole-your whole life changes, your whole life changes. Even-even your friends change because, ahm, you're sitting there in pain and stuff or you can't do things or you, ahm, you're either--well I know people who's been hurt and they're stoned all the time. Ahm, I've been hurt and I've been nasty quite often; very short fused. Ahm...

I: Yeah. Did they provide any benefits to your children, financial or other compensations like counselling for children about what happened to their Dad?

R: No. Financially, I mean...financial they ah, when I first got hurt, the finances were coming in very..very small and the money when I needed it was not there. When I was raising my kids, the two thousand dollars a month was not there. When I got older, it become higher.

... they don't compensate you for your mental anguish. And I think that they should.

Information Service

R: See that's something Worker's Comp should have, a list of places you can go and contact. We don't have that information. I don't have it. And when you start asking for it, "well, ah, we don't have it but ah, try such and such a place" you know? Well you can be calling around all day long.

FLEXIBLE OPTIONS FOR RETURN TO WORK

Retraining Options

I: So you're saying they need to spend their money more wisely.

R: Right.

R2: Yeah, I think so.

R: On-on things that would benefit. Okay, tell me what benefited me for going to school? For two and a half years.

R2: (Overlapping) That's what I'm saying. Now if that guy gets hurt, you're gonna turn around and send him to school? Maybe he can benefit some other way than going there and being in embarrassed, frustrated even more.

R: (overlapping) At college, you know, what it was? It was-it was funny. Myself I just-- I didn't care, I went. But it was funny. Everybody, ah, looked on to Compensation, people who go back to school for upgrading, as retards! We were a handout from the government. We were there to help the college grow.

But changes has to be made because you can have your own business and work very well...if the Board help you do it. I-I think so. Like you say, you've got to identify the person who is...gonna be able to do a business. So, Workmen's Compensation need to stop taking people in their direction only. What they need to do is look at ideas, identify people who can go in other directions with their help.

R: As well, I think Social Assistance puts them through. I mean Social Assistance guys that are lazy or have it better than what I do because you don't have to fight to get retrained or anything like that, they just go in and say, 'listen, you know, do you have anything available for me, I can't find a job, do you have a programme?' There's lots of people on social assistance. Up at the college they're turning three-year programmes into five-year and six-year programmes. If they feel it doesn't matter, they'll put them in another programme. People are changing their programmes up at the college left, right and centre. I've talked to a couple professors about it. But Workers' Compensation you fail, that's it, done

I: They simply will not help you then, again, is that right?

R: That's what it appears to be, yeah.

I: Yeah. yeah. What happens if you can't, for whatever reason, get a job at the end of this training programme--retraining programme?

R: Then we're put on disability benefit or my--I'll receive my pension.

I: You go back to that again.

I felt if I was counselled more about my options, what I could do and what, you know, stuff like that rather than pushed, then maybe I coulda made a decision. With a little bit of help and counselling like I was expecting from these people, then maybe I would have been able to lead a path or choose a path to take. But I wasn't given that opportunity.

Workplace Safety

R: Oh, what would improve their service. Ahm, I guess stiffer penalties for companies that deny accidents that actually happen ...

R: Best thing is be a...there should be more policing of, like as for as Workmen's Compensation, there should be more policing, and I don't know if it's changed, but I doubt it, policing of the ah, the work environment to monitor the...safeties. We're not gonna be taking off things and..and ah..... You could put a million signs around in a factory that say don't do this, wear your hard hat and everything, but the only time it's enforced is when there's an..inspector on the job. What good is it? Because you take--you're told to do something on a job, it's not only the pressure from employers and the pressure from...(unclear) workplace too, you know. Like if something is dangerous. Now, if you got peer pressure to whether you gonna do it or not and pressure from your employer too so it's, you know, it's part of--we bring it on ourselves too sometimes.

R: The only thing I recommend that the Board does, if somebody gets injured, don't..don't wait till they're ready to come back the day of the return to work. Bring them back maybe a day ahead of time or a couple of days to see if their work station needs to be fixed up somehow before they come back and then you gotta wait longer or whatever to modify their work station like, you know. Like, bring them back like a day early. Like just say 'come in, you know, we need you here for a couple of hours and you could have whatever' and do it that way. (Coughs) but waiting for the...person to come back in and then have to modify everything is like, well, here we go again. Like I mean, you know, like you're flaring up the injury if it's not done properly the first time. if they know that you're coming back on your job, they should be more involved with the people to make sure everything is right for you. Not wait till you get back and then expect you to sit or stand or whatever your job is that may have caused the problem already. Like it should be fixed. You know, they should be more involved in that aspect of the...the, ah, fixing of the stuff ...

Appendix C

Addressing the Needs of Pre-1990s Claims Unit Clients Next Steps for the Workplace Safety & Insurance Board of Ontario

Background:

In November 1997, the Workplace Safety & Insurance Board (WSIB) of Ontario established the Pre-1990 Claims Unit to focus on the specific needs, well-being and priorities of its long-term clients. These clients were injured prior to January 2, 1990 and were deemed to have permanent partial impairments. As a result, they are entitled to receive permanent WSIB pensions. The new centralized unit received full resourcing in the fall of 1999.

Rationale for research:

In February 2000, the Pre-1990 Claims Unit undertook to: expand and validate its knowledge of clients' needs, perceptions and preferences; identify opportunities to improve services; and measure improvements in meeting client needs, quality of life and return to work potential. As well, the Board wished to determine best approaches to decrease chronicity among recent claimants where possible. The study undertaken by the Institute for Work & Health (IWH) is one of the research projects that the Board sponsored in order to address these issues. The IWH study has contributed significantly to expanding the Board's knowledge of the needs of this client group.

How has the WSIB responded to the research findings to date?

As a result of the continuing efforts to increase understanding and the information gathered in the IWH study, the WSIB has been able to make improvements in the care and handling of the Pre-1990 Claims Unit clients. Other improvements continue to be developed and implemented.

The changes made to date include:

- ***A new service delivery model.*** Based on the premise of “one stop shopping” the model has consolidated the adjudication process and has reduced the number of individuals with whom the Pre-1990 claimants must communicate.
- ***One Client One Adjudicator protocol.*** Established in 2001, this protocol ensures that one adjudicator is assigned to and follows clients who have multiple Pre-1990 claims.
- ***Improved staff training.*** Staff training and development, at both the individual and group level, is planned and implemented annually. Based on the results of an internal audit in 2001, in addition to feedback through focus groups and in letters, the training has led to a higher quality of work.

- **Quality service standards.** Ongoing monitoring by managers and regular audits ensures these standards are being met.
- **Continuous quality improvement measures.** Measures have been implemented which have resulted in more timely and more informed handling of claims. Through activities such as better communication, unit staff has increased knowledge and understanding of client issues, resulting in improved client service.
- **On-line information.** An area of the WSIB web site has been dedicated to the needs of Pre-1990 clients. The section aims to better inform clients of their rights and provide information on how to obtain benefits and services. The direct URL for the information on the web site is: <http://www.wsib.on.ca/wsib/wsibsite.nsf/public/Pre1990Benefits>.
- **Outreach activities.** These initiatives have facilitated open dialogue between the WSIB and its injured clients in a neutral environment or in their own environment. They provide an opportunity for face-to-face discussion, information sharing and issue resolution.
- **Client interviews.** The Unit now incorporates interviews with individual clients following a permanent disability assessment, to share results with clients and to allow for an exchange of information regarding their present and future entitlements.
- **Case management model.** A new model was adopted that permits a holistic client-centred approach, in which the client is a member of the team. This allows the client the opportunity to participate in the development of their case plan and helps ensure that it is responsive to his or her needs.
- **Proactive approach.** In the past, injured workers' issues were dealt with individually, using WSIB policy criteria and legislation. Now the issues and needs of the workers are reviewed for WSIB entitlement. Where no entitlements exist, referral information is provided for alternate assistance. Adjudicators and nurse case managers are aware of community resources for health, social services and other supports for injured workers.
- **Advisory Committee.** This committee is being pilot tested in Windsor with the Claims Unit staff in that city. The committee comprises injured workers, employers, service providers and claims unit staff. It aims to further improve understanding of client needs and provide input to support changes that are responsive to those needs. The pilot has been successful and the concept will roll out to all the Pre-1990 Claims Unit locations in 2003.

Evaluating the Changes:

In the fall of 2001, focus groups were conducted across Ontario with workers injured prior to January 2, 1990 to provide feedback on the changes that have been made. The focus group participants confirmed the changes are improvements. In addition to the focus groups, letters and phone calls to the WSIB also indicate increased satisfaction among pre-1990 clients in their more recent interactions with the Board. They especially noted the adjudicators and nurse case managers' desire to gain a full understanding of the injured workers' needs and their commitment to work towards a resolution.

WSIB Pre-1990 Claims Unit Study Final Report – P. Ballantyne

In the coming years the Board and the Pre-1990s Claims Unit will continue to meet the needs of injured workers through the provision and improvement of services within the mandate and resources of the WSIB.

