Navigating Workplace Disability Insurance

Helping People with Mental Illness Find the Way

CANADIAN MENTAL HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE
BC DIVISION

Navigating Workplace Insurance: Helping People with Mental Illness Find the Way

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Navigating Workplace Disability Insurance: Helping People with Mental Illness Find the Way

Background and Introduction

This report looks at the issue of workplace disability insurance for people with mental illness. The overall purpose of the report is to make a complex system more understandable for employees with mental illness and for their employers. Another goal is to identify some areas of difficulty and start to create a constructive dialogue for change among all the players involved with this most challenging topic.

Workplace disability insurance coverage related to mental illness is an area of growing concern for employers, employees, and disability service providers alike. Mental illness has been identified as one of the leading causes of disability in the workplace, with a recent 2003 study noting that "mental and nervous conditions – from depression to post-traumatic stress disorder and psychotic conditions such as schizophrenia – now make up about 30% of the reasons for long-term disability."

At the same time, recognition is growing that mental illness can go undetected for long periods of time in the workplace. In these situations, what appear to be workplace performance problems may instead be illness-related disability, which if identified correctly, could be dealt with effectively. The potential benefits of effective early intervention to the employer – in terms of productivity, reduced disability costs and the health of its human resources – would therefore be significant indeed. Even when the illness is detected after some delay, the benefits of an effective rehabilitation and return-to-work strategy can be significant.

Of course, workplace disability issues are also significant to the employees who are in the midst of accessing coverage and benefits, while at the same time managing a mental illness. When the process of accessing workplace disability benefits goes awry, from the personal perspective, the costs can be quite considerable, in terms of vocational aspirations, relationships, the individual's mental health, and in extreme cases, even their personal safety.

The present project is part of a larger study relating to the factors that contributed to the death of Donald James Mayer, investigated in a Coroner's Jury in the fall of 2000. Mr. Mayer died in 1999 from a gunshot wound during an altercation with the police in the Emergency Department of Langley Memorial Hospital, in BC. A separate report, also conducted by CMHA BC, looks into the issue of the increasingly frequent interactions between police and people with mental illness.

The connection of this incident to the present project stems from the fact that one of the main reasons behind Mr. Mayer's distress that day was the rejection of his disability insurance claim by his workplace insurance provider, after he had gone through a drawn-out application and appeal process for both coverage through a private insurer, as well as through the Workers' Compensation Board (WCB).

At the subsequent Coroner's Inquest, at which CMHA BC Division had intervenor status, the Jury recommended to the Canadian Life and Health Insurance Association that the organization and others take steps to make the claim process more "efficient, accurate, and timely," so as to help avoid similar situations in the future. The jury also made a recommendation to WCB about the need to consider "apparent work stress claims" more carefully so that "larger problems, such as clinical depression and anxiety" can be either ruled out or identified as having been "triggered by a work-stress event."

The present report is in two parts. Through a series of case study descriptions, the first part, 'Mapping the Terrain,' looks at experience of people with mental illness in trying to access either the long-term disability (LTD) and WCB systems. The case studies are based on interviews done with people who responded to an ad requesting stories relating to workplace insurance difficulties. The second part of the report, 'Charting a Course,' provides an analysis of each system, looking at the issues of gaining coverage, comprehensiveness of benefits, and opportunities for dispute resolution. It is based on a key informant survey of individuals who are involved in the insurance industry either directly or indirectly (e.g., on regulatory bodies) for both LTD and WCB.

The two reports together provide a complementary picture of the issues that need to be dealt with in order to make disability insurance as equitable and productive as possible for people with mental illness and for all of the players involved. Towards this end, both reports identify issues for consideration or reform that are relevant to potential claimants, employers, and the insurance industry itself.

A final note about the first part of this report: In part One, we attempt to give voice to experiences that have often been difficult and extremely emotional. Readers who look at Part One from the employer perspective should be mindful of the fact that in giving voice to these difficult experiences, we by no means intend to be critical of employers who deal in good faith with these issues, in the way they best know how. Our ultimate purpose is not to blame, but to foster dialogue and change where this is needed; and more immediately, to offer some constructive advice that both employees and employers can use when they make decisions surrounding disability insurance. (Readers who wish to start here are encouraged to go directly to our resource guide at the back of the report on page 43.)

Part One: Mapping the Terrain

Introduction

Part One of this report represents an effort to collect the stories of people with mental health issues and their experiences trying to access workplace-related disability insurance coverage. The issue, when stated in these terms, seems a dry and obscure subject; ideally, it would be. However, the process of making a claim or seeking coverage can be a demoralizing experience and – at its worst – explosive.

On December 17, 1999, Donald James Mayer, upset over the denial of his workplace insurance claim, went to Langley Memorial Hospital for psychiatric assessment. While being processed for admittance to the psychiatric wing, he became increasingly agitated and the police were called. When the police arrived, the situation deteriorated, and Mr. Mayer was fatally shot.

Clearly this case is atypical, but managing a personal disability claim is a potentially difficult undertaking for everyone involved: claimants and their families, caregivers, and employers. The premise behind this project is that understanding people's actual experience with the process is a first step to achieving a full understanding of what needs to change.

As the stories will illustrate, there are a variety of complex factors that need to be navigated when a person makes, appeals, or maintains either a workplace disability claim, or a WCB claim. Besides the role of claimants and insurers themselves, employers and mental health professionals also have a critical role to play in the success or failure of the different aspects of the claim and coverage process. With so many actors involved, the potential for disagreement can spiral, and the process often becomes emotionally charged.

The psychological difficulty of the claim process for a person with mental illness cannot be denied, and it is a thread of experience that runs through many of the stories. This difficulty – combined with the shame, stigma, and even low self-esteem associated with having a mental illness – can make the claim process seem impossible, or even peripheral to dealing with the illness itself. Too often, the end result is that the person's mental health deteriorates even more, and their value as an employee is sidelined.

Through this report, we hope to make the process more productive for people with mental illness, and for all parties concerned. By illustrating some of the common experiences of people with mental illness in relation to the claim process, we hope to:

- Reveal the obstacles faced by people throughout the claim process, including accessing initial coverage, comprehensive benefits, and maintaining coverage over time
- Identify policies and practices that should be reformed
- Identify positive practices that should be more widely disseminated and practiced
- Help others in similar circumstances to both cope with and gain perspective on the processing of their own claims
- Help employers and mental health professionals understand how they can play a positive role in their employees/clients accessing adequate insurance coverage

In addition to detailing the experiences of individuals who have made claims for disability coverage, this collection of case studies also includes the story of a consumer (someone who utilizes mental health services) who tried to purchase a life insurance policy at work, illustrating some of the barriers that exist in that situation.

As a final note, it is important to recognize that all of the personal experiences recorded in this report utilize pseudonyms for participants and insurers in order to protect privacy and to prevent any potential legal liability in connection with what is discussed here. As one person said: "These are not just 'stories', these are our lives."

We would like to thank all the people who participated; without your contributions this project would have been impossible. Telling your story involved no small amount of bravery.

Max

Max Danvers has a Master's degree in 'Jack of all Trades.' Throughout his life he has had many successes in careers as diverse as inventing and teaching, and has centred much of his time around either building a career or building a business. Five years ago, Max found himself on short-term disability due to extreme symptoms of anxiety and depression. After the three months of coverage expired, he was unable to undertake the back-to-work transition. Max's subsequent request for long-term disability access was refused. When Max appealed with the help of a lawyer, the result was a prolonged struggle to secure coverage, a struggle marked by the experience of some questionable tactics through his insurance provider.

Now a proud father of three children, Max has had to cope with a serious mental illness since he was a teenager. His problem was not recognized until he was diagnosed and treated for clinical depression and anxiety in his late twenties. Two years later, Max found a promising job at an industrial waste firm called Braxis. His start at Braxis did not go smoothly, however, and soon after starting work at the plant, Max had to be hospitalized for depression. Despite this initial setback, Max soon returned to work and the following six and a half years at Braxis passed without another crisis.

Max excelled at Braxis and his responsibilities grew as a result. He established an exceptional reputation with his co-workers, taught courses, and was rapidly promoted to the highest post possible for a union member. He was also appointed to the post of Shop Steward, the union's representative in the factory. Together, he and his wife had managed to save a sizeable down payment and were preparing to buy a home together.

Unfortunately, after almost seven years at Braxis, Max was beginning to feel uncomfortable with the growing pressure of his many responsibilities. Max found that his mental health was beginning to deteriorate as symptoms of his illness returned. To add to these difficulties, tension at the site had dramatically increased when a new management team was brought in.

Max was familiar with the warning signs of an impending psychiatric crisis, and he tried to avert the danger by giving up his post as Shop Steward late in 1995. But this action was not enough to halt his rapidly-escalating symptoms of anxiety and depression, and Max was forced to leave work in February 1996.

Fortunately, Braxis had a reasonable short-term disability insurance plan for its employees. With the support of his psychiatrist and his general practitioner (GP), Max received full wages and benefits for three months. It gave Max vital financial support.

After these three months lapsed, Max returned to work with the agreement of his psychiatrist and doctor. His return did not go well. Two hours into his first duty shift in almost four months, Max found himself in a heated argument about proper procedure. Shaking and upset, Max informed the Facility Environmental Health and Safety Manager of his dilemma. Seeing his distress, the manager agreed that Max should return home.

"For Max and his lawyer, the most daunting task would be proving that Max's disability was absolute."

Max's recuperation had suffered a significant setback. Now, aside from coping with pronounced anxiety and depression, there was the new dilemma brought about by the unwelcome realization that his return to work would take longer than he had expected. Max's plans for the future would have to be put on hold as recovery necessarily became a priority in his life.

With his short-term disability access exhausted, Max filed an application for long-term disability benefits with his insurer, Dooley. It took six weeks for him to gather the necessary documentation of his condition, and it was another three weeks before a reply from Dooley came, denying his request for coverage. It was their decision, after examining doctor's letters and the testimonials of his supervisors, that Max's inability to work resulted from stress associated with his workplace – not his illness – and was therefore not insurable.

This reasoning seemed strange to Max, since having debilitating reactions to stress were part and parcel of his illness. To him, the ruling seemed to be an attempt to absolve Dooley of its responsibility by claiming that if a disability was connected in any way to normal workplace conditions, it was not insurable.

Max had no option but to pursue the matter. Hampered as he was, he still had to find some means of supporting his family, as his wife couldn't manage as the sole income provider. His psychiatrist and GP were both supportive of his claim, and with their help and the aid of a lawyer on retainer, Max appealed the Dooley decision.

As Max's lawyer pointed out, one of the central questions of Max's claim surrounded the details of the Dooley insurance policy he had signed up for almost ten years ago. Probably the most important detail of this contracted coverage was its very restrictive definition of disability: it claimed that disability did not exist where *any* abilities associated with the position were retained. For Max and his lawyer, the most daunting task would be proving that Max's disability was absolute.

The trauma that resulted from this decision to appeal remains fresh in Max's mind today. The outcome of this decision was a drawn-out and painful association with his insurer, as Dooley responded to his appeal with a complex series of legal and procedural tactics.

> " It was their decision, after examining doctor's letters and the testimonials of his supervisors, that Max's inability to work resulted from stress associated with his workplace – not his illness – and was therefore not insurable. "

As the appeal progressed, Max and his lawyer encountered increasingly frustrating procedural difficulties in their dealings with Dooley. Routine requests and communications with Dooley were complicated by the fact that the caseworkers assigned to Max's case were constantly being reassigned. New caseworkers unfamiliar with Max's case would require time to learn its details, and this would delay the processing of even the most routine of requests. Procedural difficulties like these were most apparent when one caseworker decided that the doctors' summations Max had submitted were not a sufficient description of Max's condition. The caseworker subsequently made a request for the doctors' case notes. At the time (October 1996), Max remembers asking this caseworker if she would not prefer to wait for the notes to be transcribed, but the caseworker declined. However, six weeks later, a new caseworker issued a request for transcripts of the doctors' notes.

The appeal process was slow. These delays served to heighten Max's apprehension about his future. For Dooley, there were no legal incentives – such as time requirements for decision-making – to speed up the process. Meanwhile, Max put in an illness claim with Employment Insurance, and he received fifteen weeks of retroactive coverage at 65% of his wages.

Max's recovery was undoubtedly being hampered by his claim with Dooley. On one occasion in March of 1997, he noticed a blue van parked across the street from his house and promptly forgot about it until the van followed him to and from the Skytrain where he had dropped off his wife. When the van again resumed its place across the street, Max could not restrain himself and approached the van, urging the driver to come out. When Max gave up and walked away, the van left. Later, the insurer admitted to having requested this surveillance. Such surveillance for a psychiatric claim begs the question of what behaviour would be consistent with physical indicators of depression. Today, Max can at least joke about it: "Am I supposed to sit on the front lawn looking sad?"

> " The trauma that resulted from this decision to appeal remains fresh in Max's mind today. "

With his Employment Insurance settlement exhausted, Max found himself financially overextended. After he and his wife used up the down payment they had saved, they were forced to fall further behind in their rent. They had no option but to borrow from family and friends on the assumption that the disability settlement would come through. Feeling the pinch, Max's wife Stephanie also wrote a highly personal appeal on Max's behalf to a Dooley Vice President – Mr. Brackendale – describing the financial stress the family was under. Not unmoved, Mr. Brackendale subsequently authorized the disbursment of six months of disability benefits to Max.

This disbursement undoubtedly aided Max and his family, but accessing it had required a level of confidentiality and openness more suited to a psychiatrist's office than regular business correspondence. Despite the temporary financial respite, Max was still unable to resume work. The disbursement went to old debts, and not much could be applied to future, or even current financial obligations.

The claim process was depleting inner resources that Max did not have, and as a result he withdrew from the world, "closed up shop," and hid in his house, refusing to answer the phone or the door. His personal business of building trailers and installing computer anti-theft devices suffered from lack of attention and effort, and his relationships deteriorated as he became consumed by depression. Haranguing creditors left progressively ruder messages on his answering machine when he refused to answer calls. The pressure to get his family out of the financial mess they were in consumed Max while his ability to conceive of any constructive action was hampered by the skewed perceptions of a deep depression. He couldn't see any way out. Psychiatric care itself seemed pointless to Max: it would not provide a cure for reality.

This pressure drove Max to consider what he believed was the only escape: suicide. Powerlessness and anger turned inward had become self-loathing, but he reserved a special contempt for Dooley. Max found himself perversely fantasizing about making Dooley's practices public the only way he could conceive of: by suiciding with a sign around his neck thanking Dooley.

While Max was fighting this life and death struggle, his legal challenge progressed slowly. Max and his lawyer were hearing alarming news about Dooley's plans for what was to become a courtroom challenge. Max and his lawyer were told of Dooley's plans to fly in two 'high calibre' witnesses: one of the many Vice Presidents of Dooley as well as one of Max's former managers, now living in North Carolina. The announcement was intimidating. Dooley's resources in presenting their case were vast compared to Max's.

Nevertheless, Max and his lawyer methodically built their case, trying to prepare themselves for any eventuality, while remaining uncertain of Dooley's ultimate courtroom strategy in refuting Max's case for disability.

On the more personal side, it had become clear that Max's former manager in North Carolina was being brought forward in order to undermine Max's credibility. In his written testimonial, this manager admitted he had not known Max for very long, but this did not prevent him from suggesting that Max's real reason for leaving work centred on union disputes. He then proceeded to describe Max as 'devious', saying that Max would 'hide' his eyes behind his sunglasses. However, the manager could only make vague allegations. In the end, he was forced to concede that he had been unable to find anything negative in the work record about Max's job performance.

Max also had some unexpected support from Dooley's psychiatrist. In his report, this psychiatrist wrote the observation that had Max's claim been settled sooner, he would likely have already returned to work.

It had been almost two years since Max had filed his claim, and he was looking forward to his day in court, what he saw as his opportunity to have his say in a public forum about what he had been put through.

But Max did not get to testify. The day before the court date, a settlement offer was tabled by Dooley; Max's lawyer counselled him to accept.

Max experienced the entire claim process as a series of delays and stonewalls. He was left with an enduring sense of having been intimidated and maligned. The impact was predictable. Max became distraught and attempted suicide twice, and his family's financial troubles continue to this day. Max and his family remain several months behind in their rent, and Revenue Canada is pursuing them for half of the remaining two thirds (minus the lawyer's commission) of the hard-won financial settlement. Max has also lost good friends over money that he borrowed with honourable intentions to repay from the pending financial settlement from Dooley. Three and a half years later, the settlement is gone and creditor calls keep coming. And they get progressively more insulting. Max continually tries to put his psychiatric health on the back shelf of his life, but its presence permeates his daily life, tending to make the simple, complex and the routine, arduous.

"Powerlessness and anger turned inward had become self-loathing, but he reserved a special contempt for Dooley."

Upset and suicidal, Max recently had to be hospitalized after a particularly insulting phone call from a creditor. The situation became critical and his wife was forced to call the police. When the police responded to the call, Max attempted to force them into shooting him.

The turmoil that resulted from Max's protracted long-term disability claim five years ago has not ended. There remains a clear connection between Max's current emotional and financial difficulties and the grueling claim process.

Max feels that the settlement he fought so hard for was not commensurate with his work record and term of employment. It did little to alleviate his debt and next to nothing to repair the damage that the claim process had done to himself and his family. Even with the moral support of his family, his caregivers, and his lawyer; Max found the process unnecessarily traumatic and upsetting. His encounter with Dooley left a knot in Max's life that he is still labouring to unravel.

Sue

Sue Bradley's experience in the workplace will resonate for many other consumers of mental health services. Her ongoing campaign to secure disability coverage has impacted her and her young family in a very personal way. The issue at hand – as posed by her insurer – is whether or not Sue's depression was a pre-existing condition. Having exhausted more informal routes to contesting this decision, Sue's only remaining option in pursuing her claim requires legal representation. However her case draws little attention from prospective lawyers not only because of the meagre size of any potential settlement, but also due to the difficulties involved in going against an insurer ruling. To further complicate matters, the viability of Sue's case for coverage has also been hindered by the fact that she never developed a constructive relationship with her first psychiatrist.

Sue's experience with depression in the workplace was both sudden and dramatic. She had been working intensively on a publication for her employer – a major insurance company – for half a year. Although the initial response to her publication was positive, a week later she found herself demoted to the switchboard in a very public manner. The strain she had been under for the past six months together with the excessive and unexpected actions taken by her supervisors were too much for her: Sue had run into a wall. Two weeks later, she went on leave from her position, suffering from pronounced depression and anxiety.

Once Sue's leave commenced, she was covered at 100% of her wages on a short-term disability claim from Skylar Insurance. Accessing the program was not a problem for Sue, but this young mother of two was now on an indeterminate leave and suffering from depression. She knew she needed help and asked her family doctor to refer her to a psychiatrist. He referred her to a Dr. Green.

Dr. Green initially supported Sue in seeking long-term disability benefits, helping Sue with a claim that she filed as her short-term disability coverage began to run out. Despite Dr. Green's support, the long-term disability insurer, Blakely, denied Sue her long-term disability claim. The company's decision was that Sue's depression had been a pre-existing condition, citing as evidence a single visit to her doctor the previous year about the stress she was under at the time.

Just prior to starting work at her new workplace almost a year previously, Sue had seen her family doctor about the stress she was experiencing: the stress of starting a new job and looking after her family. The doctor responded to this complaint by prescribing a non-therapeutic dose of an antidepressant. Unfortunately, her GP had cited depression in his notes as the reason behind his prescription, and since this also occurred prior to her start at her new job, Blakely denied the claim. Sue was considered disabled for short-term disability but was not considered disabled for her long-term claim. Ironically, having a pre-existing condition disqualified her from receiving long-term disability, despite the fact that her previous experience with treatment had no negative effect on her acceptance for short-term coverage.

Now Sue was out of work and out of coverage. She went through her savings, maximized her credit, borrowed from family and friends and got extensions on her rent. The uncertainty of her financial situation, the questionable ruling from the insurance company, and her symptoms of depression were beginning to take their toll. But as a single mother, Sue had no option but to put the bravest face she could muster on her difficulties. She could not afford to take any 'time out.'

Then, through someone she had known at work, she found out that she might be entitled to a retroactive settlement from the federally administered Employment Insurance program. She appropriately released all the supporting documentation for an EI claim and a month later, got a settlement from the office. The settlement covered her for the first fifteen weeks of unemployment at 65% of her demoted wages. Sue was facing a very uncertain future, but she did not yet feel capable of returning to work and this, along with financial strain, contributed to her growing apprehension.

Sue decided to appeal the denial of long-term benefits by Blakely. She was still considered an employee of her company and was still a member of the Office and Professional Employee's International Union, so Sue enlisted the help of her union representative with her claim who advised Sue not to seek a lawyer's counsel.

Unfortunately, at this point Dr. Green was no longer willing to support Sue's claim that she could no longer work, and he submitted a letter to this union representative contradicting Sue's claim that her depression still affected her, and he maintained that Sue was able to return to work. Sue's appeal for disability coverage was subsequently denied in February 2001.

When Dr. Green informed Sue of the action he had taken, she was understandably distressed but decided that what he said must be some version of 'tough love' and that he must be right: she could return to work; indeed, she saw no alternative. But as the date approached when she had to return to work, her anxiety increased. Her Return-to-work Officer was also urging her to return to work but was making some unpleasant stipulations; the most humiliating of these was a clause restricting Sue's ability to accept promotion. This clause stated that should Sue be offered a promotion in the future, she would need a doctor's note approving her acceptance of the position. This stigmatizing and embarrassing condition naturally fed into Sue's distress about returning to work.

This anxiety led to a frustrating and increasingly intense phone campaign by Sue and her friend, Todd, to get Dr. Green

to either see Sue before her next session, or change his opinion about her ability to return to work. The tension escalated as Dr. Green refused to take these phone calls, and Sue, feeling insulted, decided she needed a different psychiatrist. Distraught, she went to Dr. Green's office to pick up some personal journals of hers, leading to an uncomfortable and hostile encounter in his office.

Sue was now cut off from psychiatric care and was facing what seemed to her an impossible return to work: she felt trapped in an unbearable situation. Sue could not conceive of going back to work, but she seemed to have little choice in the matter. Both the pressure of her circumstances and her depression overwhelmed Sue, and the day after her final visit to Dr. Green, she attempted suicide.

Sue's friend, Todd, discovered her in time and took her to Royal Columbian where she was first treated in Emergency and then admitted to the psychiatric ward for a total of four days. Sue does not remember much about her stay there, but dimly remembers being hastily discharged. She then made sure her children were being taken care of, and thoroughly disoriented, she then made a second attempt at suicide. Because she was at Todd's house this time, she was not admitted to Royal Columbian but to Surrey Memorial where she was kept overnight.

Abruptly released from the hospital to cope on her own, Sue's problems must have seemed insurmountable. She was unable to go back to work by the date her Return-to-work Officer had set, but she still had no income and was now without a psychiatrist. It was an impossible situation. To add to these difficulties, she did not feel comfortable with the counselling offered at her mental health centre. However, Sue knew she needed assistance, and she got a referral to another psychiatrist.

Fortunately, this new psychiatrist, Dr. Wilder, was more supportive of Sue with both her depression and her financial difficulties. First, Dr. Wilder realized that Sue needed a rest and arranged for her to stay in an informal psychiatric care facility in order to get her medication adjusted. He then resolved himself to try and undo the damage that had been already done to Sue's case for disability. He wrote letters attesting to the fact that Sue had not been suffering from depression when her GP had first prescribed her the antidepressants, and that the clinical depression Sue was currently suffering had emerged after she had started work.

While Dr. Wilder is currently helping Sue overcome depression, Sue's case for disability coverage from Blakely is still up in the air, despite this support. Although she had engaged a lawyer through the Legal Aid office to advocate her long-term disability claim against the insurance company, this support was subsequently withdrawn. This left Sue with few other options, as she came to the uncomfortable realization that she "was not making enough to lure a lawyer."

To offset the extreme financial pressure on her and her family, she has managed to get Disability Benefits II (now referred to as the Persons with Disabilities designation) from the provincial government. This, combined with child support, means that she and her family are managing, barely. Her David-and-Goliath battle against Blakely may not offer a solution to her problems, but could offer the support she needs to get back on track and perhaps back into the workforce. As it is, her outrage about this situation – that has in the past sent her writing letters protesting aspects of her case and her care – has been blunted by resignation and gnawing worry.

It seems ironic to Sue that the reason that her claim was denied, on the basis that it was pre-existing, was a direct result of what she had been led to believe was a wise precaution: seeing the doctor about the stress she was under at the time. She has earned a wary attitude towards the 'fine print,' and has come away with some uncomfortable insights into psychiatric care. She intends to continue to pursue the matter of her claim.

Meanwhile, Sue's collection of unpaid bills continues to pile up, and she is now undergoing bankruptcy proceedings. Sue traces many of her problems to Dr. Green's lack of support for her disability claim and wonders: "How can you ever get over depression when they are having to deal with all that comes as a result of it?"

The central assertion by Blakely, that Sue's condition was pre-existing, seems problematic. According to this line of reasoning, Sue was disabled while working full time for over half a year.

Not only has her medical history been used against her, Sue has been penalized for seeking help. Complicating matters, the effect of Dr. Green's letter was profoundly traumatic, and led to a situation that culminated in Sue's conviction that the only way out of an impossible situation was to kill herself.

Another persistent question raised by Sue Bradley's case centres on the discretion of psychiatric care providers in providing evidence to insurers, and surrounds the issue of evidence or standards of objectivity regarding an individual's readiness for return to work. In such a seemingly grey area, should a doctor's assertions be accepted without question?

A related issue is the question of whether the individual with a disability has any recourse in situations where the evidence offered by the physician doesn't appear valid. The College of Physicians and Surgeon's policy manual spells out the potential liability to insurers should doctors not properly consider their support of a patient's disability claim, but does not identify any analagous liability to patients in situations where questionable evidence harms the well-being of the individual in question. Adopting such a provision does not seem unreasonable.

Also of note here is how insurance companies routinely use medical and psychiatric case files and doctor's notes to determine client eligibility for benefits and/or coverage. Sue's case suggests just how vulnerable people with mental illness can be in situations where objective standards for making determinations (in this case about "readiness to return to work") are lacking.

It also raises the question of what constitutes a pre-existing condition, and whether other Sue Bradleys will be reluctant to seek help, for fear of being disqualified from insurance coverage in the future.

Peter

Interpretation of mental illness and its diagnosis is subjective and often open to argument. What caused the illness onset? How long has the individual been suffering from this illness? What is the diagnosis? All of these questions can potentially have several different answers depending on who interprets the data. The irony is that not only do the answers affect treatment, they also have legal repercussions that affect the obligations of insurers and employers. This can lead to lively academic debate between insurance representatives and psychiatric professionals, but ultimately the policy holder's financial (and mental) health can suffer while the question of coverage is disputed on the basis of rather murky and even philosophical issues about the origin of illness. What is distressing is how financial and legal objectives can overshadow recuperative ones, as happened with disability claimant Peter Schwartz as a sufferer of post-traumatic stress disorder (PTSD).

As a paramedic and a union member, Peter had access to three forms of coverage. As do all employees in BC, he had coverage from the Workers' Compensation Board for a portion of earnings for the duration of disability as well as six-month, full salary protection through his employer's Short Term Illness and Injury Plan (STIIP), and under the insurer New Life, he was covered for long-term disability (after this six-month period) at 75% of earnings.

> "What is distressing is how financial and legal objectives can overshadow recuperative ones, as happened with disability claimant Peter Schwartz as a sufferer of Post-Traumatic Stress Disorder."

In his career, Peter has been a valuable member of a team of professionals that represent the first stage of medical crisis care. As a profession, the demands of being a paramedic are known to be extremely stressful, and the potential for burnout is generally accepted as being a risk in this career. It wasn't until his fourteenth year working as a paramedic that this risk became a reality for Peter.

Throughout 1999 and early 2000, Peter found that his ability to 'bounce back' from particularly bad calls was in decline. What was particularly wearing was the fact that an unusually high proportion of his co-workers needed crisis care themselves. Crisis calls are difficult to manage with strangers, but the pressure to perform is even higher when the victim is familiar. In addition, Peter was finding that cases involving children were particularly hard to recover from.

As time wore on, Peter became more anxious and more irate, constantly complaining about everything from dispatch to police response. Had Peter known more about post-traumatic stress disorder (PTSD), he would have recognized these very typical symptoms. Perhaps he might then have acted early to avert his own impending crisis.

The cause of Peter's PTSD was not so much a single catastrophe as it was an accumulation of different stressors. What sticks in his mind was a busy day when he and his partner were responding to a difficult call and it was announced over the radio that a paramedic – Peter's friend, Ted – was being attacked by a dog. Dispatch would not clear Peter and his partner to respond to the call and instead kept them on route to the scene of a domestic disturbance which turned out to be a terrible call. Peter's partner ended up being trapped by an angry husband and so they were both prevented from leaving a very volatile situation, a situation they were not trained to cope with. Contributing to the stress of the situation, Peter was simultaneously hearing a play-by-play account of Ted's attack over the radio.

During the week that followed, Peter found he could not relax. He was taking sleeping pills, but remained unable to get the sleep he needed. He knew something had changed, but did not understand what it was that was different. A week later, early March 2000, Peter found himself unable to continue working. His resulting absence from work was to last a year and a half.

It was not until Peter stopped going to work that his new counsellor suggested that he had post-traumatic stress disorder. With her help, he was able to access the STIIP (Short Term Illness and Injury Plan), for the first six months off work. Later, when it became apparent that Peter's ongoing symptoms would not permit him to return to work before the six months of coverage lapsed, he filed two claims: one with New Life for disability and another with the WCB for disability and damages.

New Life was incredibly supportive, and Peter's claim went smoothly as they quickly agreed to disburse disability for a period of two years. Unfortunately, Peter's claim with WCB did not go as smoothly. At first, when Peter filed his claim, a WCB intake worker had assured him that his case certainly seemed to be a clear case of psychiatric illness arising from his work. It was the worker's opinion that, barring any psychiatric history, the claim would be straightforward. However, this assessment was premature, and WCB subsequently would not acknowledge that Peter's PTSD had resulted from what had happened in his work as a paramedic.

Initially, Peter confided different aspects of his illness to this intake worker, his impression at the time being that she was a professional counsellor. He didn't find out until afterwards that she was not a psychologist. Unfortunately, this misunderstanding meant that Peter's claim status would later be negatively affected by his confidences to this worker. Peter had told this worker that he was experiencing flashbacks related to calls involving children. This confession and the

notes the intake worker took were to fit in well with the later claims from the WCB staff doctor that Peter's psychiatric condition was related to childhood rather than work.

Subsequently, there were difficulties with Peter's claim for WCB coverage. The first step in the claim process was a visit to a WCB therapist, a visit that pre-dated Peter's first visit with his own psychiatrist. After a single appointment, this counsellor made the assertion that Peter did not suffer from PTSD, but rather anxiety adjustment disorder. It was his opinion that this was not a work-related trauma, and therefore not covered by WCB.

But Peter was a persistent advocate for himself. His own psychiatrist supported the conclusion that Peter was suffering from PTSD and that it was work-related. "Psychiatrically, your cup is full," his doctor concluded. Peter started making phone calls to WCB asking for reconsideration, telling his claim adjudicators about how he had been initially reassured that his claim was straightforward by the WCB intake worker and also that his psychiatrist did not agree with the diagnosis of anxiety adjustment disorder. Peter's persistent self-advocacy resulted in a meeting between Peter, his union representative and two managers from WCB.

During this meeting, the WCB managers justified their denial of Peter's claim by quoting the opinion of their desk doctor who had evaluated Peter's file though he never met Peter. It was this doctor's opinion Peter's illness had been caused by childhood trauma rather than workplace trauma. Peter and his union representative presented their argument that Peter's condition was a direct result of work. Both sides were at an impasse, but by the end of the meeting, everyone had agreed to a compromise. Peter would make an appointment with a forensic psychiatrist to determine whether or not his illness was related to childhood events. If *this* psychiatrist's observations supported Peter's claim that his illness was work-related, his claim would be approved.

The forensic psychiatrist had been apprised of his role in adjudicating the claim before Peter met with him. But this WCB-appointed psychiatrist felt strongly that the issue to be decided was ethically inappropriate; that it violated Peter's rights to privacy and confidentiality. The psychiatrist summarily decided in Peter's favour.

Despite this support, Peter's WCB claim still did not get approved. Peter's union representative had attended the meeting with WCB management, but would not support Peter's interpretation of the bargain made there, so Peter dismissed him. Now WCB's officials had changed the basis of their denial of the claim. It was now their position that PTSD had to stem from a single incident, that there was no delayed onset to PTSD, despite the fact that the psychiatric community generally accepted the phenomenon as fact.

Meanwhile, New Life and their experts (indeed, with his own doctor's agreement) insisted that Peter needed to change fields, as the nature of his work as a paramedic did not allow for a smooth recovery from PTSD. They subsequently agreed to pay for a rehabilitation program that would fund an education regimen for a comparable career. Peter and the rehabilitation counsellor decided together that his new career would be in computer programming. However, New Life's approved rehabilitation plan specified home-based self-study rather than courses at a local college.

Meanwhile, Peter's path to recovery was not smooth. He and his wife became separated, then divorced, and his wife took their four children with her. Peter's condition began to deteriorate and he started to contemplate suicide. It had become apparent that Peter was not receiving the care he needed. Fortunately, his employers perceived this problem and agreed to pay for him to receive therapy in the hope of helping Peter towards both a better state of mind and a return to work. It was a valuable concession, and this counselling support became crucial to Peter's treatment.

Peter's symptoms were making his life difficult, in addition to experiencing disturbing symptoms like flashbacks and sleep disturbances, Peter was feeling isolated. He was alone and experiencing the strain from a new divorce as well as the financial pressure of child support. Peter was starting to panic as a result. Acting against the advice of both New Life and his caregivers, Peter returned to work with the reluctant approval of his psychiatrist in July 2001.

It was only a month and a half after his return that Peter, not yet settled in to work, read an exposé in the local paper about orphanages. Peter had spent a significant part of his childhood in an orphanage in Calgary, and this story refreshed Peter's memory of the trauma of his years there.

Peter's memories of being in care were not pleasant. When first admitted to the orphanage, new residents were de-loused and had their clothes taken away to be replaced by orphanage clothes. All those kids, Peter remembers, "just wanted to love someone." Peter was frequently punished for disobedience, and he would be sent to the 'Orange Room'. The Orange Room was bare except for a mattress – there were no toilet facilities – and Peter would be left alone in there for hours. As a child, Peter learned to cope by refusing to trust others; to this day, this problem with trust persists.

When Peter read in this feature article of the research conclusions that adult orphans faced persistent problems in adulthood, it really hit home. His flashbacks resumed with a vengeance, only this time they were more acute and related to his childhood experiences in the orphanage. Psychologically 'reeling' from the previously repressed memories, Peter was forced to stop working a week later, in September 2001.

Now Peter barely leaves his home and he finds it impossible to concentrate enough to learn from the computer programming self-study modules. He continues to see a psychiatrist, but his treatment has been negatively affected by the WCB claim. His initial WCB claim is still being processed. Although WCB administrators have fastened on a single negative comment about his conduct at work, their justification for denying Peter coverage is their insistence that

Peter's PTSD is completely unconnected to his job, that his condition arose in connection with childhood experiences. However, both Peter and his doctor are convinced that the reasons behind his first absence from work were directly connected to the work itself. This connection between Peter's work and his disability is crucial to the viability of this claim, and consequently Peter's psychiatrist has advised Peter *not to discuss his childhood* during their sessions. His psychiatrist hopes that this admittedly drastic course of action will protect the integrity of Peter's claim in the event WCB should request to see the notes about their sessions. Peter's ongoing therapy has also been damaged further by his employer's decision to stop paying for the therapy that had proved so invaluable during Peter's initial absence from work.

Peter was denied STIIP this second time off work. Although his New Life claim has been extended, this coverage is not adequate to meet the financial demands of child support as well as Peter's own living expenses. WCB cannot be sued, and the processing of Peter's appeal is completely at WCB's discretion, and it has already been over two years since Peter first filed his claim with WCB.

One of Peter's frustrations is with the discrepancy between WCB's assessment of his condition and that of his own doctor. Another concern is about the contents and privacy of his file contents at WCB. One memo that came into his possession advised WCB personnel to be warned that Peter tended to be histrionic, making him wonder – like others with mental illness making disability-related claims – what information about his illness could be shared.

Listening to Peter Schwartz, one gets the impression that he is still very much in the grip of the nightmares of his life, first as a paramedic and later with a delayed reaction to childhood trauma. While medical experts debate the origin of his PTSD, he is not moving on, and – more importantly – is not getting the treatment he should because of financial and legal concerns. Peter does not have the support or the resources, internal or external, to move beyond the trauma that caused him to stop working, and his ability to face the future is being smothered by his inability to deal with the trauma of today and yesterday.

As Peter himself says: "WCB did not ask for a second opinion when it came to my back injuries, why do they insist on one with psychiatric claims?" The stance toward his case for disability by WCB in particular has, at best, led to dispute rather than mediation and, at worst, financial hardship and an enduring shame.

With his disability claim with New Life expiring in a matter of months, Peter is currently considering a return to work as a paramedic. He is considering a return despite his knowledge of the likelihood that this return will probably aggravate an illness that has not yet subsided. Yet again, the primacy of recovery is subordinated to rising financial pressure.

Greg

All too often people with mental health issues in the workplace can fall through the cracks because they remain undiagnosed. Undiagnosed illness or unresolved questions surrounding diagnosis can not only hamper recovery, but can affect liability issues. But perhaps the most significant factor affecting insurer liability for disability income streams is that symptomatic individuals may not be able to perceive what would be in their own best interest. Where these individuals manage to file a claim in spite of the crisis of illness – and should the claim be denied – that decision often becomes incorporated into the mythology of mental illness, acting as a platform for its flawed logic. Perversely, many individuals can themselves feel that the denial of their own claim is something that was warranted. Whether illness or complacence dictates claimant behaviour, often the demands of self-advocacy prove to be beyond them, despite the importance of this income support. In Greg Ripkin's case, both issues – uncertainty about his diagnosis and the skewed perceptions of his illness – negatively affected the outcome of his case for disability coverage.

Like many consumers, Greg's mental health issues were not readily apparent to others. In high school, Greg was a lifeguard; at university, he was the Student Senate President, and that aura of accomplishment has stuck with him throughout his career. Success always seemed to come easily to Greg, and he always had plenty of options. But this was all just on the surface. It is only in the last five years that Greg has started to get the help he needs for what is tentatively diagnosed as a bipolar disorder with mood-congruent psychosis.

> "Through treatment, Greg has come to the recent realization that he has been alternating between delusional, manic, and depressive behaviour since his teens."

Through treatment, Greg has come to the recent realization that he has been alternating between delusional, manic, and depressive behaviour since his teens. Without psychiatric help, Greg developed his own coping strategies, and some strategies were better than others. Often he simply concealed his thoughts, but – most apparently – he also developed a tendency to abuse alcohol, and for many years he remained an active alcoholic. In addition, throughout much of his life, Greg has also had to deal with the fact that medical practitioners and counsellors often assumed that his mental illness was only a secondary issue – that his problems derived from coming to terms with his homosexuality. Throughout university, Greg's condition would cycle between stability, depression and mania. This was readily apparent in the dramatic highs and lows of his academic performance; he was on the Dean's list in some semesters, and almost failed in other semesters. Sober through much of university, he started to resume drinking as graduation approached in order to deal with an accelerating depression. The strain Greg felt in his final year was incredible, and he barely slept or ate.

After graduation, Greg got a job with his university, travelling around BC. On the road all the time, he was isolated and this kept others from realizing that he was suffering from a mental illness.

After some years in this position, Greg made a move to Ontario, but his sense of isolation persisted despite his new position at a consulting firm. Again, his career demanded a lot of travelling to meet various clients and when Greg was manic, his behaviour was perceived by them as dedication. Other times, his depression threatened to swamp him. Those days when he was meant to be in the office, he would often not go in at all or he would be unable to show up before 10:30 in the morning. However, these habits received few complaints from co-workers as he was successful in his work.

In the years that followed, Greg changed jobs and companies, always feeling that something was not quite right. He found himself floundering in inexplicable bouts of sadness but did not connect this to mental illness. Instead, he developed an excessive fondness for video games and a terror of 'doing anything.' Despite the gloom of his state of mind, Greg managed to attain a prominent job as fundraiser at a post-secondary institution in the Lower Mainland. It was a career-making position with a promising future.

In spite of the potential of this new opportunity and the prospect of a fresh start in British Columbia, Greg experienced new as well as ongoing problems. Driving to work every day became so debilitating that Greg had to move on to the campus grounds, a move that meant he could sell his car and walk to work. As he no longer had to worry about car payments, he had more money to spend on alcohol.

His work performance was not unaffected. Untreated symptoms of mania translated into a larger-than-life persona that negatively affected his relationships with others. At one point, a co-worker complained: "You act like you are the president of the university!" Given the soured workplace politics and his as-yet untreated condition, Greg started to become more and more delusional. Chance comments would precipitate an avalanche of wild supposition and bizarre conclusions. Greg became convinced that listening devices were everywhere and that surveillance was being conducted on him. But he never acted out these delusions, he just became more and more intense as the mania developed. His smoking, coffee intake, and drinking spiralled out of control.

Finally, Greg decided to ask for help and utilized the Employee Assistance Program (EAP), a free counselling ser-

vice available as an employee benefit to staff of the college in times of duress. However, the counsellor who saw him only recognized the fact that Greg was in the grip of alcohol addiction; what the counsellor misconstrued as pride was the mania that was a part of Greg's bipolar condition. The counsellor subsequently recommended an alcohol treatment program. However, with his credit maxed out and a wariness of attending group therapy, Greg never followed up on this advice. The counsellor did not recommend psychiatric care, and the only result of this session was paid therapy with an addiction specialist who also failed to detect Greg's mental illness.

Greg had barely undertaken EAP counselling when his supervisor at work advised him to "go home and get better." Greg, realizing that his supervisor was right, took six weeks off from work, in order to recuperate. But his return after this six-week absence was brief; and he only managed to remain one more month. It was a difficult month. While sober, Greg's paranoia was overwhelming, and working proved to be extremely unpleasant and stressful. Again, Greg went on extended leave, and he never returned to work at the institution.

The mental illness and addiction that had begun in early adolescence had finally crushed Greg's ability to participate in society. Upon leaving work, Greg found he could no longer support himself financially. After leaving work in May 1998, Greg began the spiral into a poverty that would deepen and prolong his suffering from mental illness.

There was no short-term disability program at Greg's workplace. The only financial support immediately available to Greg after his leave commenced was Employment Insurance. Greg duly filed a medical claim on the basis of his alcohol addiction and received 15 weeks of coverage. Greg informed his roommate that he could no longer afford his share of the rent and prepared to move out.

Meanwhile, unapparent to those who knew him, Greg was full of despair, and he had made a decision to kill himself once his money ran out. The outward signs of his inner struggle were difficult to perceive, made doubly so by Greg's decision not to inform anyone of his new address when he moved to a friend's home, cutting himself off from acquaintances. Greg was to spend close to two years living with this friend, sleeping on his couch. It was a very bleak period in his life, but Greg admits that if it had not been for his friend, he would have ended up on the street. As for finances, Greg managed to scrape by for those first six months with the maximum allowable fifteen weeks of Employment Insurance benefits and by cashing in his RSPs, RSPs that had been bought with a loan.

Financial pressures were forced into the backseat as Greg slid into a depression so severe that a GP would later describe him as catatonic. In December, alone in the apartment, Greg decided to commit suicide and, leaving his returning roommate a note, went to follow through on his plan. His roommate was very upset, but his anxiety became relief when he managed to track Greg down, alive but profoundly depressed. However drastic Greg's actions were, they had served one useful purpose: now there was finally concrete evidence that Greg was battling mental illness. With the support of his roommate, Greg talked openly with his GP about his depression and he was prescribed some antidepressants. But this diagnosis of depression captured only a portion of Greg's difficulties, and Greg's delusions remained his own secret.

At this point, a letter from his insurer, Skylar, was eventually forwarded from his old address informing Greg that he may be eligible for their Income Replacement Plan, that is, long-term disability benefits. In addition to asking him for the required documentation, Skylar also advised Greg to apply for Canada Pension Plan's (CPP) disability plan. Skylar even supplied the toll-free number for applying for CPP, which would, they explained, reduce their own potential liabilities for income replacement.

> "While his insurer's ruling may seem peripheral to Greg's illness, it contributed to Greg's feelings of persecution and paranoia."

The news that Greg could be eligible for benefits was a double-edged sword. The paperwork required would be intimidating to most, let alone to someone struggling with as-yet untreated delusions, and Greg's paranoia peaked upon receipt of the letter. He was convinced that his employer did not really want him back, and that there was no point applying for the Income Replacement Plan because his application would be denied. Despite his forebodings, Greg did manage to send in the application with his GP's description of a depression-induced disability and alcohol abuse. Ashamed of the fact that he did little more than eat, sleep, and wander the streets at night, Greg lied on his application, claiming he routinely performed household chores.

As for his mental health, Greg's diagnosis was not yet accurate. Treating Greg for depression, his new psychiatrist gave him high doses of antidepressants. This regimen only seemed to heighten Greg's mania and psychosis, so he decided to discontinue his treatment regimen. Symptoms had become particularly frightening when he started to experience raging blackouts. It was due to one of these rages that Greg found he could no longer show up for an outpatient depression program that his GP had arranged for him to attend. Hearing about the incident, his psychiatrist prescribed Greg antipsychotics. It had now become plainly apparent to the people who knew him that there was a lot more than they were aware of going on underneath the surface.

Meanwhile, Greg's financial resources were becoming exhausted. Greg was forced to confront his financial need by

formally declaring bankruptcy and going on the provincial government's income assistance program for people with disabilities (known at the time as DBII). Around this same time, a letter came from Skylar denying Greg disability benefits. The letter had come almost a year after Greg initially left work in distress. The basis of their denial was that Greg, with a then-current dual diagnosis of depression and secondary alcoholism, did not fit their definition of "total disability." Greg's confusion and disappointment at this news increased when he received conflicting advice from caregivers. His occupational therapist believed that Greg was not disabled enough for disability coverage, and, although he had the support of his doctor for pursuing the issue, Greg decided not to appeal Skylar's decision.

At this point, Greg may have appeared rational, but what this calmness concealed was how the denial of benefits fit with his delusion that Skylar had never meant to give him access to disability. The Skylar decision was incorporated into the new version of reality that Greg was busily constructing in his mind: a world where street noises came in patterns that only Greg could recognize and where Greg's phone was being monitored. Everyday events in Greg's life had assumed a new and frightening significance.

It was only after a hospitalization, when Greg made the decision to change psychiatrists, that his new doctor realized what no one else had yet noticed: Greg was suffering from full-blown psychosis, and his psychiatric care took on a new urgency as a result. Finally someone had perceived how Greg's delusions, along with the pressure of paranoia and the extreme fear it engendered, were impinging on Greg's ability to recognize and deal with reality. Since this psychiatrist recognized Greg's illness for what it was, other events in his life, such as the Skylar decision, have been forgotten as Greg and his psychiatrist now work together to establish some vital equilibrium to his state of mind.

Today, Greg's struggle with mental illness is far from over as managing his bipolar condition is proving itself difficult. Since his first visit to a psychiatrist, Greg has been hospitalized twice, despite additional attempts to be admitted for care. Just over a year ago, he abruptly cut himself off from family and friends to drive to Calgary, planning all along to commit suicide outside a hotel.

It has not been easy, but with the help of doctors, friends, and support services, Greg has made quite a comeback. Vocational Rehabilitation Services marked his first step back towards financial independence, and was soon followed by a volunteering position at a local consumer organization where he eventually got a full-time job. After two years of living on DBII, Greg officially terminated his employment at his old workplace and got access to his severance package. He never pursued the matter of Skylar's ruling.

> "He found himself floundering in inexplicable bouts of sadness but did not connect this to mental illness."

While his insurer's ruling may seem peripheral to Greg's illness, it contributed to Greg's feelings of persecution and paranoia. Central to the insurer decision was their assessment that he did not fit the definition of "total disability," but in Greg's case, this threshold would have been almost impossible to meet, for a number of reasons. His diagnosis at the time of his application (depression) didn't reflect the true seriousness of his condition. Even if it had reflected his psychosis, Greg was in no position to make the case for himself, since simply dealing with his illness took up most of his resources, and he was ashamed to disclose just how disabled he was when he did fill out the application.

Had Greg's self-esteem not been so low, and had he not been so ill, he might have actually contested the decision, rather than scraping by on his savings and what he managed to borrow. Ironically, the fact is that the decision *not* to appeal probably did more for improving his mental health than the often taxing process of appealing would have. But despite this silver lining, Greg deserved the benefits, which would undoubtedly have brought a certain invaluable sense of stability and security to Greg's life after leaving work.

Karen

Some people do manage to collect disability coverage from their workplace insurance providers despite initial rejection. Managing to secure benefits can in itself be significant, but qualifying for benefits is only half the story; the formalities necessary to maintain these benefits can also be complicated. Disability payments can be erratic and even cancelled without warning. As each payment date draws closer, client anxiety about claim status accelerates and can significantly feed into symptoms. Necessity dictates that claim status assumes a central role in a recipient's life, and the negotiations necessary to secure ongoing coverage can consume inner resources when they are already at a low. One of the most enduring problems in maintaining coverage in the case of a long-term condition is the random but almost insurmountable two-year barrier to continued coverage. Insurance companies often redefine disability status after a policyholder has collected for two years, or limit disbursements to this timeframe using other means such as difficult reassessment protocols. Thus, maintaining benefits can be a gruelling process as reflected in Karen Gerard's long-term disability claim.

Easygoing and engaging, Karen Gerard is a success of the most important kind, someone who has rescued herself from a crippling depression while refusing to become embittered by the experience. She loves her home of the past seven years in Vancouver, loving it for all the reasons it differs from her former home where she worked as a government employee.

Karen went to work with the government immediately after high school. It was a position with a lot of potential and she managed to keep working on a part-time basis while majoring in an Honours program of Sociology. After Karen completed her degree, she stayed on at her job, working full-time. Her position was a demanding one, and her duties ran from talking to irate clients on the phone to the management of politically sensitive projects. The demands made of Karen in her position grew steadily, and towards the end of her eight-year tenure, her job had become a veritable pressure cooker. Faced with hostile co-workers and a sixteen-hour workday, Karen was steadily being pushed towards the boundaries of her ability to cope. As Karen describes it: "I was the last person to get information, the first person to put it together, and the first person everyone went to with questions and demands." If Karen went for lunch, or even to the bathroom, co-workers would go looking for her to bring her back into the action.

Her seventh year at the job found Karen facing especially unrealistic deadlines on a very high-profile project. In what remained of her private life, she had no appetite and had virtually ceased eating and sleeping. Colleagues and friends may have noticed something was wrong, but did not mention anything. When Karen went to her doctor, he helped her recognize what she already knew: that she had difficulty setting limits to the expectations put on her. Her doctor also perceived that Karen was at a dangerous threshold, that she needed to get away from a career that was escalating a severe depression. Karen resisted his advice – she had an ingrained resistance to the idea of stopping work – until the physical and psychological stress escalated to a point where Karen could no longer ignore the crippling effect it was having on her life. One particular day she finally gave notice to her supervisor and went on leave.

Karen now faced the more difficult task of overcoming a severe and incapacitating depression. Her GP, who was also a psychotherapist, was incredibly supportive and with three sessions a week, they both set about administering some psychiatric first aid. It was to prove a difficult period as Karen and her doctor sought out an appropriate medication regimen. Ironically, Karen suffered severe reactions to the medications with reputations for few side effects. But with the support of her doctor, Karen was not discouraged by her treatment; she was, in her own words, "tired of dying."

In spite of these difficulties, both Karen and her doctor expected her absence from the workforce to be a brief one. Instead, it was to last five years.

While her treatment got under way, Karen went about securing an income to support herself during her absence from work. She did have access to insurance through Gaiman, but only for long-term disability. This would only kick in after a 13-week elimination period when her only access to income support would be the federal income scheme, Employment Insurance. Getting EI with her doctor's support was easy enough, but before the process could be initiated, Karen was first required to apply for income assistance at a provincial office. She would only be able to apply for EI after presenting EI with a rejection note from income assistance. It seemed to Karen that the system was already failing her.

As for her job, Karen received no news. Despite an eight-year term of employment, Karen was considered a temporary employee; she had remained employed by a series of six-month contracts. It was only through Gaiman that Karen was to find out later that her employment contract had been dropped three months after her leave commenced, and she was no longer an employee of the ministry she worked for. Despite efforts to keep her employers informed about her status over the preceding months, no manager at her workplace had made a discernable effort to either see how Karen was doing, or even to keep her informed of the recent change in her employment status. In the grips of a severe clinical depression, Karen did not have the fortitude to contest her treatment, while her union representative was also curiously silent.

As for her income concerns, after thirteen weeks of EI

coverage, Karen submitted her claim for long-term disability with Gaiman. Fortunately, the fact that she had been dismissed from her position would not affect her claim, because the disability had originated before her contract was terminated. For Karen, filing her claim was to mark the beginning of an acrimonious, and even nasty relationship with her insurance company.

Karen's claim with Gaiman was immediately declined. They maintained that she was not sick enough to be considered disabled. Fortunately, Karen's GP stepped in and handled the appeal process, adamant in his assertion to Gaiman that Karen was indeed disabled.

Karen won the appeal and started receiving disability coverage. Gaiman, however, insisted on a back-to-work deadline, and throughout the period that her claim was viable, Karen was to be haunted by these back-to-work dates. Back-to-work dates would find Karen still in the grip of a debilitating depression, when, without advance notification, benefits would suddenly stop. These compulsory deadlines presented Karen and her psychiatrist with a persistent problem; her doctor was required to set these dates within the insurer's established cutoffs despite his own opinion that Karen's disability could last longer. Karen relied heavily on her disability coverage, but she was often faced with the knowledge that her next disbursement would not arrive. She and her doctor were unable to act to prevent this impasse as they could only alter back-to-work dates *after* they had expired and the payments had ceased. Month to month, uncertainty about her benefits left Karen feeling like she was being held hostage by her insurer, that she was always a hair's breadth away from complete insolvency. Every few months, this tedious ritual would have to be repeated and re-repeated in order for Karen to maintain her coverage.

Karen's mental health was far from being re-established, and, newly unemployed, she was feeling claustrophobic about life in her hometown. Her doctor advised her to find a new direction in her career, and Karen decided to become a chef by enrolling in a course at her favourite cooking school in Vancouver. Armed with a referral to a new doctor, Karen packed her two cats and all her belongings into her compact and set off to drive to Vancouver, a decision she has never regretted.

Karen was perhaps overly optimistic when, soon after her arrival in Vancouver, she quickly registered for training in her newly chosen career as a chef. This was despite the advice of Gaiman's vocational rehabilitation counsellor who had closed her file, concluding that Karen was not yet ready for retraining or employment. This counsellor was to be proven correct, and, halfway through her first semester, Karen's teachers at the institute realized that Karen was pushing herself too hard. Karen may have been reliable in terms of attendance, but she was exhausted and unable to concentrate during class. Talking with Karen, they reached the decision that she should finish the semester and return only once she was better.

With her new GP's help, Karen had finally found a medication regimen that did not leave her physically ill or exhausted, but she was still severely depressed. Her memory is cloudy about the ensuing period. What does remain is the memory of how the uncertainty of her disability benefits lent a great deal of trepidation and anxiety to her life. What she found was especially crucial to her survival was a new network of friends who were supportive and understanding about her circumstances.

At this point, Karen faced a new problem. After twenty-four months of disability, Gaiman's disability plans were subject to re-evaluation. Through the semantics of contract law, this effectively established a two-year shelf life to the extent of disability, as at the two-year mark claimants would face another onerous process of proving their disability all over again. Of particular relevance was Gaiman's definition of disability: to be considered a disability, a condition must prevent one from performing each and every duty of *any* employment position, *whether or not such a position exists at that point of time.* It is difficult to believe that anyone could continue to qualify for disability beyond this two-year mark, using this test of disability.

As intended, the wording of this policy proved difficult, effectively establishing a significant obstacle to the endurance of the disability claim. Karen was aware of the impending challenge but – despite still being not well enough to return to work – could do little as the time came to deal with this more stringent definition of disability.

Despite her knowledge of the barrier she would face at the two-year mark, both Karen and her doctor *were* surprised when Gaiman cut off payments without performing any reassessment. Now a familiar ritual, Karen called the claim centre to enquire as to why her disability coverage had been discontinued. She was informed that in order to remain qualified for disability coverage, she would have to see a doctor for a reassessment of her condition. An independent expert chosen and paid for by Gaiman would then conduct an objective assessment of Karen's psychiatric health.

Karen had met with patronizing psychiatrists like the one appointed by Gaiman before, and she found the assessment interview difficult, almost traumatic. Throughout the interview, she had the distinct impression that the psychiatrist was only seeking to make the facts fit an opinion that he had already formed about Karen's condition. Not surprisingly, Karen subsequently lost disability status because of this evaluation.

Faced with the possibility of no longer having access to benefits, Karen went over her policy booklet with a fine-toothed comb, and realized that she shouldn't have been cut off prior to being reassessed. Subsequently, she was able to have the payments reinstated because of this error, and because she was also able to argue that they could not stop her

benefits without any warning, when she had no other source of income. The extended payments lasted for two months to cover the period until the insurance company psychiatrist finally did the reassessment.

Before the critical appointment with Gaiman's independent specialist, Karen had been required to apply for the Canada Pension Plan's (CPP) disability benefit. Gaiman wanted the federal program to assume responsibility for Karen's disability status, leaving their company free of any enduring contractual obligation.

CPP did not send any acknowledgement of Karen's application, and she was forced to repeatedly call CPP's claim centre, seeking information on the status of her application. For weeks, no one could answer her questions, claiming that her application was 'under medical review.' One day, her patience frayed, Karen got angry with the representative she was talking to, and was finally informed that she did not qualify for CPP disability. The medical opinion was that her disability only 'commenced' two years *after* she was laid off, so CPP – being a workplace disability insurance scheme – was not responsible for her current disability as it was their opinion that it did not originate in the workplace.

This convoluted decision only made Karen angry, and she channeled her frustration into action, presenting CPP representatives with meticulous notes describing who had said what and when during her previous calls to their 1-800 number. Confronted with the ambivalent operators at the call centre, Karen would insist on answers; finally, she managed to get a representative to arrange an appointment to talk to the doctor responsible for the refusal of her benefits. When Karen put her case to this doctor and described her situation, the doctor changed her mind about Karen's case and approved Karen for the $658 monthly CPP disability benefit.

Although for a few months Karen would be covered by two disability schemes, she was still in a difficult position. After Gaiman's coverage for a rehabilitation plan lapsed, she would be facing the prospect of only receiving $650 dollars a month. To cope with this new development, Karen had to move in with her boyfriend; it was either that or "move into Stanley Park."

These financial problems and the resulting battles for coverage had accelerated Karen's symptoms of depression. The only good news was that CPP's monthly coverage was reliable compared with the erratic monthly disbursements of Gaiman. There were no mandatory back-to-work dates or abrupt cutoffs to her benefits.

The coverage 'overlap' afforded Karen the opportunity to embark on a more pragmatic, less reckless approach to her rehabilitation than her previous attempt at cooking school. Gaiman and CPP were both cooperating to work with Karen and establish a plan geared toward recovery. Representatives of both groups agreed that Karen was not ready for an immediate return to the workforce; indeed their opinion was that she might never be ready. Their recommendation was that, as a resident of Vancouver, she could benefit from access to provincial programs in vocational rehabilitation at Gastown Vocational Services, Coast Foundation, and THEO.

That was two years ago, and Karen has not looked back since. These programs were incredibly helpful, and combined with her doctor's stubborn insistence that she could advocate for herself, recuperation from a crushing depression became first a possibility, and then a reality. Today, she has embarked on an educational regimen paid by CPP that will steer her into a career based in research, while she also works part-time in an associate position at a Vancouver consumer group.

Karen retains lingering concerns about insurance. She feels that the insistence on return-to-work dates in cases of mental health disability are unrealistic, that insurers have sought to artificially graft the standard practices concerning physical disability status to that of mental health disability. These two forms of disability are vastly different, and should not be forced into the same administrative category; doing so can prolong mental health disability rather than foster recovery. An additional concern of Karen's centres on the dubious assertion of 'independent' status by an expert who is being paid by the insurer.

Karen also credits her success to access to rehabilitation programs, and she realizes that these programs can be crucial to recovery but, private or governmental, they need to be more visible and accessible. She also came away from her experience with the knowledge that the moral support of people who care about you can be invaluable to recovery.

Alex

As many people who have experience with psychosis know, it is not an inconspicuous phenomenon. Usually, it is only through the manifestation of extreme, drastic behaviour that others realize there might be something wrong and help is sought out. Subsequently, sufferers not only have to recover their mental health, they often also have to recover from the wounds to their pride brought about by their behaviour when they were ill. The resulting difficulty they feel upon the return to the workplace after 'involuntary disclosure' can be a serious hazard to recovery. To ignore this factor and other associated demands of recovery is to face the likelihood of relapse. Despite this, people often get tired of what can be perceived as the tedious and enforced idleness of recovery and will be overly anxious to oblige employers anxious for their return to work. This approach, an early return-to-work plan, replaces a slower but more considered rehabilitative process with the expedience of work. Such an approach can be very expensive in the long term in both financial and psychiatric terms, as it was with Alex Smythe at his workplace.

Alex Smythe's personality exhibits seemingly contradictory elements. He is soft-spoken and candid, yet he possesses characteristics that have enabled him to thrive in the often cut-throat world of business. It is no accident that Alex ended up in business. As someone with a bipolar condition, he thrived on the pressure to perform. Character attributes like radical behaviour and risk-taking (indicative of a bipolar condition in Alex's case) that would get people in other careers into serious trouble are instead rewarded. Although symptoms of his bipolar condition remained manageable for an extended period of time, eventually Alex's illness cycled out of control when he became delusional in his mid-thirties. At this point, the illness that had kept him on the fast track since adolescence brought his life to a crushing halt.

"the illness that had kept him on the fast track since adolescence brought his life to a crushing halt."

Since his psychiatric crisis, Alex has sifted through his past with the help of his doctor for clues to his bipolar condition. He has had to acknowledge that much of his success can be said to be a by-product of his bipolar condition, specifically a condition known as hypomania. Hypomania is characterized by racing thoughts and often-frenetic goal-oriented behaviour; those affected seem to function at a higher speed than is the norm.

Alex was in Grade 10 when he got his first job at Safeway. Throughout the rest of his high school education, he managed to excel academically while working a gruelling thirty-five hours a week. Always pressed for time during high school, Alex not only managed to save most of his earnings; he also played the stock market. He proved to have quite a flair for trading, and by the time he finished high school, he had accumulated a sizeable $100 000 portfolio.

After graduating high school, Alex got into SFU without any problems. Within two years he had transferred to UBC's Commerce Faculty program in Portfolio Management while continuing to work full-time at Safeway where his managerial duties had been expanded. At the time of his graduation from UBC in the late eighties, he was profiled in the Financial Post as one of the five "Canniest Investors" in Canada. Alex remembers much of this period as a time of almost excessive euphoria, symptomatic of his prolonged hypomania.

Just out of university, Alex worked steadily to establish a reputation for himself in the financial sector, first as a trader and then as an investment advisor; working his way up in smaller firms. Flushed with early success, he made a smooth transition to a larger firm, Manford, in the early nineties. Meanwhile, in his personal life, he married and became a father. Everything seemed to be falling into place for him.

Things started to change imperceptibly after Alex's move to Manford in 1995. His bipolar condition began to cycle from the more controllable hypomania into mania for the first time. He became euphoric, expansive and grandiose, and he also became sexually reckless. He had started giving away his money in late 1997, and for this and other reasons, he became concerned enough to see his doctor. His doctor concluded that Alex suffered from pronounced depression and anxiety and prescribed Paxil.

A few months later, in early 1998, Alex abruptly decided he didn't need the medication and stopped taking it. The results are a textbook example of uncontrolled mania. Not only was his behaviour becoming ostentatious, his judgement started to slip. One day in April 1998, it became apparent to his co-workers that he was not well when he started to act out what had become delusions in front of two major stakeholders during negotiations for a takeover of Alex's firm. When the dust cleared, it became apparent that in the months leading up to this incident Alex had run up debt in clients' accounts to a total of $1 million. As Alex puts it: "It's like the loss of judgement those with gambling addictions suffer, except the odds are better."

Driving home after this episode at work, Alex suffered from the delusion that he was seeing the real world for the first time. It was as if he had passed the initiation into a secret club, and all the covert members of this club of brilliant people were welcoming him into their ranks. It seemed to him that people were smiling at him inappropriately, winking at him, or sending him secret signals. Confused and unnerved, Alex drove to his parents' home instead of his own.

Alex checked himself into the hospital for psychiatric care. He was to remain there for two months, two months he

has trouble recollecting. When released, he returned home dazed and depressed. However, before he could emotionally reconcile himself to the turbulence of his life in the past year, Alex's employer began to urge him to return to work. The bad debt that Alex had accumulated during the past year had been absorbed by Manford, and the negotiated takeover was going forward. Management had smoothed over the 'blip' caused by Alex's flamboyant departure, but now the takeover firm, Trabick, was anxious to know where the star performer of their new acquisition had gone. Trabick had not been informed of Alex's illness, and Manford wanted Alex to seal the takeover deal. Bored with recuperation, Alex agreed to return to work and to attend the celebration of the takeover of Manford by Trabick, where he was asked to smile a lot and only pretend to drink.

"They knew I had bipolar illness and covered it up, putting their interests ahead of their clients' and myself," is how Alex describes what happened. Compliance officers responsible for monitoring the activities of investment firms remained unaware of Alex's manipulation of client accounts, thanks to a coverup by Trabick's senior management. Only a few months out of hospital, Alex knew enough to emphasize to his managers and co-workers that he needed supervision and *he could not be allowed to carry debt.* Despite these warnings, when Alex returned to work, nothing had changed in terms of supervision or controls.

Alex had not yet adjusted to life with a bipolar condition, and early the following year, he again had to be hospitalized. He had not recovered from his previous break, and returning to a fast-paced work environment had done little to break the rhythm of his mania. The bill of his spending spree at work – this time as part of the new, merged Trabick – was doubled to $2 million.

> "Despite these warnings, when Alex returned to work nothing had changed in terms of supervision or controls."

It was clear Alex was not doing well. Not only was his grip on reality slippery, his marriage was in trouble. The only thing that seemed reliable to Alex was Trabick's desire to get him back to work. After being discharged from the hospital, Alex's financial indiscretions were again swept under the rug and his employers were urging him to return to the office once again. Alex, still in the grip of life-long hypomania at best, mania at worst, was again anxious to get back to work. His financial pressures had mounted as he had his obligations; during his last manic cycle, he had moved his family into a new, more lavish home. In addition to financial stress, his relations at home were strained as his in-laws had also recently moved in. Alex welcomed the opportunity to bury himself in work, performing the financial wizardry that he was so at home with, and he returned to work two weeks after checking out of the hospital.

No clairvoyant skill is necessary to foretell what was bound to happen again, sooner or later. Alex returned to work and within 14 months ran up another $4 million of debt in client accounts. When he was again forced to leave work – delusional – early in 2001, the managers at Trabick were undecided about how to proceed. Would they again absorb the debt loss and cover up these violations or opt for more formal and punitive measures? While they debated, Alex found himself hospitalized for the third time in as many years. In addition to the symptoms of his bipolar illness, he was also dealing with another blow; he and his wife were now separated and she was taking their two children with her.

In spite of Alex's disability, financial obligations mounted. Alex had to sort out his insurance coverage. On paper, he was well covered. He was entitled to salary protection by his employer for his first three months off work, but Trabick laid claim to these three months of insurance protection and put it toward Alex's debt. Alex, mollified by this debt at the firm, did not complain about the seizure, but promptly filed for long-term disability coverage as these three months of coverage lapsed. Within a month of filing for long-term disability, his employer formally fired him. "I know what you are doing," a senior manager claimed, "You are going to blame your illness for this mismanagement." Management at Trabick seemed unwilling to accept any responsibility for its own role in urging Alex back to work without supervision or controls after two previous – and expensive – incidents of illness, incidents that they had hidden from clients and other members of the firm. Now his supervisors at Trabick had decided not to protect Alex any longer and they abandoned him to the formal consequences of trading, unauthorized trading they had not acted to prevent.

As a result of Alex's third psychotic break and the loss of the valuable support of the management at Trabick, Alex faced the possibility of being barred from the Investor Dealers' Association (IDA) and punitive fines that could be as much as $250 000 because of his mismanagement of client funds. In addition, one of his past clients instigated legal proceedings and personally sued Alex for damages, seizing tax returns and any of Alex's accessible assets in the firm. Revenue Canada wanted $47 000 in back taxes, and his employer seized any capital of Alex's that remained: not only his 90-day salary continuance, but all the company stock that Alex had been holding in his RRSP. In terms of personal income support, Alex's only available financial support was fifteen weeks of Employment Insurance coverage (through a medical claim) and his own savings, and every bit was needed to cover not only his own expenses but also the demands of child support and a divorce settlement. He was forced to liquidate his possessions, and had to sell his new house at a loss in equity of almost $500 000. Alex now found himself in the unlikely position of living with his parents.

Alex's financial situation was not good. His lawyer main-

tains that the top priority should be negotiating with the IDA for lenience before contesting the legality of the asset confiscation by Trabick. It was a costly but inevitable delay as Alex could only afford one legal battle at this point.

Meanwhile, Alex tried to sort out the problems of his disability claim. Having paid premiums for top-up income insurance coverage of $10 000/month minimum up to 65 years of age, Crenum's apparent liability to Alex was heavy. But there were political aspects to this liability as well: an ongoing dispute between Crenum and his employer. Trabick's change in insurance carriers from New Life to Crenum was a recent one. As a result, there remained lingering questions about whether or not Trabick had at the time of transfer disclosed that an employee, Alex, suffered from a debilitating mental illness. Crenum's position is that Trabick should have revealed details of Alex's illness before Crenum became Trabick's insurer.

Perhaps because of this potential dispute between Trabick and Crenum, Trabick first denied that Alex had any access to Crenum coverage. His ex-employer's position was that he had filed his claim *after* he was fired and was therefore not covered. Crenum since denied this was the case, yet did not subsequently authorize disbursement of disability benefits. Since being forced to acknowledge their error, Trabick delayed this claim wherever possible, postponing the release of vital paperwork and policy information. So, while Crenum and Alex's former employers bickered over the legality of the transaction that established Crenum as Trabick's insurance carrier, Alex had yet to receive any disability coverage. He has been forced to use his savings and fifteen weeks of EI to carry him through a divorce, legal disputes, and seven necessary months worth of recovery.

The management at Trabick had been happy to ride along with Alex when the hypomania of his mental illness brought clients to their door and a lucrative buy-out, but they would not acknowledge their own responsibility: that they had brought Alex back too soon, without sufficient understanding of the nature of his bipolar condition; they had also failed to adopt accommodations and safeguards to protect client funds from mismanagement, despite Alex's requests.

Without having demonstrated due consideration to Alex's recovery and rehabilitation, or even suitable management of his financial decision-making, his employers are facing the possibility of censure or even legal liability. At every point in the processing of Alex's application for disability coverage, Trabick stalled in order to delay or discourage Alex from the claim process. Trabick's position was difficult. Not only did their lack of understanding undoubtedly contribute both to the cycle of illness and to the deterioration of Alex's mental health; by refusing to see the downside to a mental illness that had often worked to their advantage on their balance sheet, they ultimately damaged themselves – and their clients – financially.

At least at this point, Alex is feeling more at peace with himself. After his last hospitalization and subsequent notice of dismissal, Alex took seven months off for a long-overdue recuperation that he spent resting, exercising, reading and visiting with his children. Now Alex is finally learning how to cope with his bipolar condition with the help of intensive therapy and lessons in illness management.

In early 2002, Alex secured himself a modest position in a small firm with the help of a friend. Sharing a small office takes a bit of getting used to, but he feels this is just what he needs. He no longer has the authority to spend client funds, therefore he no longer faces the potential of losing those funds as his illness cycles. It will take some adjustment for Alex as this new career is without the drama of trading in capital markets, but the likelihood that hypomania will magnify into mania seems significantly less with this change of pace.

Since 2002, the impasse between Alex's insurer and his old employer was resolved, and Alex is now receiving monthly disability benefit disbursals. It seems that the questions surrounding the legal ramifications of both Alex's illness and managerial response negatively impacted Alex's access to disability. In the end, the settlement favoured Alex, highlighting the pivotal role that employer/insurer interactions can have in affecting access to benefits for claimants.

Jody

One of the central questions surrounding workplace insurance and mental health issues is the issue of coverage. Employers negotiate a contract for a benefits package with private workplace insurance providers for employee coverage with or without the consultation of employees or the unions that represent them. Ideal coverage is difficult to define, but it seems that the lack of any short-term disability coverage would be considered a limitation of a workplace insurance package. Jody Lee was to face this problem when she was forced to go on leave from the long-term care facility where she continues to work as a nurse.

> "Ideal coverage is difficult to define, but it seems that the lack of any short-term disability coverage would be considered a limitation of a workplace insurance package."

The insurance package at Jody's workplace does not contain short-term disability provisions. For illness that lasts longer than the annually allowable 21-day leaves of absence, but less than six months, there is simply no coverage available. For those employees who suffer from not-quite-six-months of illness, they have to make do with government-funded income protection programs, and face at least a portion of their disability without any income support. Unfortunately, the most immediate form of these government programs, Employment Insurance, is a somewhat inadequate stopgap, providing a maximum coverage of only fifteen weeks for a medically-based employment absence at 65% of earnings. Such practices engender significant financial pressure to return to work.

In the months before her leave commenced in February 1999, Jody gradually became overcome with what was diagnosed as a major clinical depression. She first noticed that she was suffering from a growing exhaustion, and throughout the day she would be periodically overwhelmed by inexplicable bouts of weeping. At this point, it became apparent to Jody that she could not simultaneously cope with work and what she and her doctor realized was depression, so she went on leave.

After her leave started, Jody was forced to use up the rest of her annually allowable 21 L.O.A. days (leaves of absence) for the year, only to subsequently find herself without an income. Already dealing with a consuming depression, she started the process of securing coverage from the federal Employment Insurance program for medical reasons. If Jody's depression proved to be incapacitating in the long term, the fifteen weeks of Employment Insurance coverage would be the only private or public salary protection Jody was entitled to, until the six-month waiting period for long-term disability had elapsed.

> "Returning to work was not easy, and Jody experienced ongoing fatigue and feelings of awkwardness, but it was a success."

Jody did manage to qualify for this sick leave under Employment Insurance with the help of her doctor, and started a necessary process of recovery. Fortunately, her time away from work was brief, and she was off work for only six weeks when she felt capable of attempting a return to work.

But when Jody returned to work, she was informed that she actually owed money for unpaid benefit payments that had accrued while she was sick. There was more bad news: Jody also was to lose out on her wage and vacation increments for the following year. In other words, not only was she *not* entitled to disability benefits, she had been financially penalized as a result of her illness.

When Jody expressed her frustration at having been financially penalized as a result of her illness, her benefits officer suggested she write some letters. So Jody wrote some letters, which is how the Canadian Mental Health Association learned of her dilemma.

What comes through in these letters is her impatience and disappointment with the entire process, particularly the financial penalties to which she was subjected. Jody highlights the difference between her treatment as someone suffering from an unexpected illness and the treatment of someone who *plans* an absence from work for maternity or paternity purposes. The policy differences seemed discriminatory and punitive towards people with disabilities. Mothers on maternity are able to access extensive EI benefits for a longer period than fifteen weeks and they are not subjected to financial penalties when they do return to work. This is in stark contrast to Jody's treatment at her workplace.

Jody was also forced into a very personal struggle with the lack of public awareness about mental illness. Although she decided to disclose her illness at work to supervisors and co-workers, she has since formed reservations about disclosing so openly. Disclosure brought her valuable accommodations for her return to work, but even among the medical professionals who were her co-workers, misinformation resulted in a lack of understanding about mental illness. Popular misconceptions such as the one that identifies mental illness with a personal 'lack of character' were difficult to face when the issue was so personal. Jody had to confront this prejudice on a daily basis with little guidance and support, and she grew uncomfortable with the fact that everyone she worked with knew of her illness.

In addition, Jody had to deal with the lack of support and resources in a small community. Although her workplace offered a free counselling service through an Employee Assistance Program, the counsellor was located an hour away

and only offered a maximum of six sessions of therapy. Jody went once and chose not to go to the counselling services again. It didn't seem worthwhile, due to the limited amount of counselling that she qualified for and the distance she had to travel. Access to her workplace Employee Assistance Program did little to alleviate her depression.

Despite the fiscally punitive stance of her employer and the lack of support from her union on the issue, Jody remains positive about many aspects of how her employer helped her overcome her crisis. She describes her employer as incredibly supportive, collaborating with Jody's doctor in order to work out accommodations for her return to work. The result was a schedule of short shifts that gradually increased in length until Jody was once again working full-time hours. Her supervisors were also remarkably sympathetic and understanding of her illness.

Returning to work was not easy, and Jody experienced ongoing fatigue and feelings of awkwardness, but it was a success. Today she credits her successful return to work to the compassion of her employers. Of course, this success could not have occurred had it not been for Jody's own bravery and endurance when faced with significant internal and external adversity.

Tanya

Sometimes it is not just the symptomology of mental illness that leads to a perception that one is being persecuted. Just as debilitating can be very real problems at work. Problems with workplace relationships can be intensified by both mental illness and the resulting stigma surrounding it.

Up until twenty-three, Tanya's life was relatively normal. She was a solid performer in school and joined the swim team, but never excelled at any one thing. There was a lot she could take for granted: the ability to go to university, to maintain a social life, and to work: holding as many as three jobs at once. In Tanya's third year at university, her professor urged her to apply for a scholarship to study history in the United States. She applied, and her application was successful; she received a generous endowment to study in Atlanta for a year.

At first, everything in Atlanta was exciting and new. Tanya was an enthusiastic and industrious student, and she found the classes engaging. But after about six months, her state of mind started to decline. She found the intense social scene brought about by living on campus difficult to deal with and she started to withdraw, no longer attending classes and only rarely venturing out of her room. The breaking point for her mental health was a friend's tragic suicide off his dormitory balcony. First, she began to imagine she was being watched and then she became convinced that everyone she met was urging her to commit suicide as well. Predictably, a psychiatric crisis ensued and she found herself first hospitalized and then flown back home to Canada, where she was driven straight to a local hospital from the airport.

"Flatly, the insurer informed Tanya that they disagreed with her psychiatrist's opinion."

After three weeks in the Canadian hospital, Tanya spent the next three years 'recuperating.' She found herself medicated to such an extent that to this day she retains only fragmented memories from those years. Although she had been financially independent for years, she was now forced to rely entirely on the charity of her family in order to survive. When she finally surfaced from the murk of overmedication at twenty-six, her first priority was to get back to work rather than finish her degree. Finances were her priority as her protracted financial dependence was wearing thin on her sensibilities.

The first job that she was offered was at a big bank as a cash clerk. It was a mundane job processing paperwork and deposits, but it was just what Tanya felt she needed. When she first started at the bank, she was timid and even shell-shocked from recent experiences, but as she learned, Tanya built up her confidence and speed. Unfortunately, there was one problem that would not be ignored: Tanya was convinced that her psychiatric crisis was a one-time-only affair. Tanya 'knew' that her doctors were wrong; she did not suffer from bipolar disorder. She did not disclose her illness to her employer and after almost a year at work, she stopped taking her medication.

Her character underwent drastic changes from quiet to argumentative and even brash. Friends noticed the change, but no one realized that this behaviour was a sign of an impending psychiatric crisis. One day, Tanya went into the supervisor's office and announced she suffered from bipolar disorder. The supervisor met this confession with a blank stare and never made any discernable effort to find out more. As for Tanya, in the week that followed, her illness cycled into full-blown mania and she was hospitalized once again.

Tanya was to spend close to five months recovering, covered at 65% of her wages while she was first treated in the hospital and then stabilized at home. Neither her psychiatric care providers, her employers, nor her insurance representatives discussed the possibility of accommodations at work, or attempted to coach Tanya about how to manage her illness. She received no instruction about how to recognize the warning signs of mania or how to identify triggers. When a disoriented Tanya returned to work, she resumed full-time hours immediately.

By now, Tanya had developed a skepticism about psychiatry that could only do her harm, and – antagonized by what she saw as patronizing caregivers – she placed her own skewed perceptions above those of her doctors. She considered her diagnosis meaningless, and unilaterally decided that the side effects of her medications were more debilitating than her symptoms. Indeed, when she was becoming manic it seemed she could work faster and think more clearly; it was an intoxicating experience, especially compared to the slowed-down world she had to face when medicated. The result of this mindset was predictable, and Tanya had only been back to work for half a year when she had to be hospitalized once more.

This second time, her psychiatrist recommended to the insurance company that Tanya needed four months off. But the insurer disagreed. An insurance representative called one morning and insisted Tanya return to work the next day after only six weeks of the recommended four months had passed. Flatly, the insurer informed Tanya that they disagreed with her psychiatrist's opinion.

This time Tanya returned to work chastened and worried about what others thought of her. Did the other employees know that she had a mental illness? How was her absence explained to her co-workers? Bewildered as she was, Tanya remained uninformed about the possibility of accommodations for mental illness in the workplace.

But Tanya did realize that things were different. Previously-friendly co-workers seemed to go out of their way to

avoid her, and people tended to stop talking when she entered the room. Although she was finally taking her medication, workplace politics had made reality a very unpleasant place for her to be.

One day it was announced that an envelope of cash had disappeared from one of the big depositors. Blame was laid at Tanya's feet. Where co-workers had avoided her before, now they refused to talk to her entirely. It seemed everyone else but Tanya knew what was going to happen next. Indeed, within the month, her supervisor curtly summoned Tanya into her office where she delivered an ultimatum: six months probation or you leave now. Her supervisor had a file two inches thick in front of her that she maintained was full of Tanya's errors. Tanya felt she had fallen into the rabbit hole; this persecution was not a delusion. The perception of mistreatment was reinforced when she asked to see the file and it was full of fax cover sheets, not errors. Unnerved, Tanya decided to leave. Her supervisor did not argue. When she walked out of the office and out through the rest of the bank for the last time, it seemed that everyone's eyes were following her. It would be five years before Tanya was able to return to work.

Tanya's memories of work at the bank remain jumbled, but she has since recognized how her employer refused to acknowledge or accommodate her mental illness. It remains her perception that her illness meant that she was treated like an expensive and unwelcome liability and that they had decided to set about limiting their liability by forcing her out. It seemed that Tanya's employer and/or supervisor made no effort to become informed about her illness, or adopt anything other than a stigmatizing attitude. After being forced to leave, Tanya again had to be hospitalized. When she was released yet again from the hospital, she swung into a major depression and tried to commit suicide several times.

But, despite hardship, finances still needed to be managed. With the financial demands of a car and an apartment, and her savings rapidly being depleted, Tanya needed an income. After leaving work she immediately filed a claim for Employment Insurance, without stipulating that her unemployment could be interpreted as having a medical pretext. Employment Insurance proved difficult to access on these terms, and while she waited for her EI claim to be processed, Tanya was obliged to apply for income assistance. Unfortunately, this request for income assistance was refused because of her pending claim for Employment Insurance.

Tanya was in a quandary, as her initial claim for Employment Insurance had been denied because they claimed she had left her job voluntarily. A prolonged appeal process culminated in a tribunal that Tanya's old supervisor attended, but Tanya herself did not. The entire proceedings were conducted without Tanya because she was informed of the tribunal only after it had been held.

Tanya was financially and emotionally tapped out, so she changed the basis of her EI claim to a medical one, her mental illness. This amended claim submitted with a letter from her psychiatrist was rejected outright. When Tanya called EI, a brusque caseworker challenged Tanya, maintaining that her claim was not valid, implying that Tanya's 'new' medical claim had been fabricated to access coverage. The caseworker's cynicism may have been the result of whatever Tanya's supervisor had said about her at the tribunals. Whatever the reason, Tanya's caseworker was insistent: a letter from a psychiatrist was not sufficient proof of illness, and Tanya would need additional supporting documentation. Since Tanya's EI claim had, by this time, dragged on for five months, Tanya had to give up her car and her apartment and move back in with her parents. Predictably, Tanya was first frustrated and finally angry about the entire process. After talking to this caseworker, Tanya photocopied her entire psychiatric file and forwarded the entire package in response to the caseworker's demand for supporting documentation. Finally, less than a month later, Tanya received a settlement. The caseworker made no further comment. Although effective, this was a drastic measure that succeeded only by undermining Tanya's privacy. It was a gesture that reflected both Tanya's desperation and the fact that she had lost her sense of good judgement.

This victory was small, and the fifteen-week settlement was soon exhausted. Tanya remained overwhelmed by illness, and a perceptive outreach nurse saw the impending financial crush and took a listless Tanya to an advocate who helped her file an application for the provincial assistance program: Disability Benefits, Level II. This support was to become vital to Tanya over the years that followed.

The actions undertaken by Tanya's employer and insurer, as well as her encounter with the Employment Insurance program had damaged Tanya and have demanded their own recovery above and beyond the demands of illness. It would be difficult for anyone to perceive such treatment as anything other than punitive, and the sense of persecution is doubly difficult to overcome for someone with tendencies towards paranoia and delusion. It was to take Tanya another five years before she was ready to attempt another return to work.

To this day, Tanya finds herself plagued by memories of her treatment at the bank. After having the paranoia inherent to her condition – now her diagnosis is schizoaffective disorder – validated in real life, she is finding it difficult to avoid destructive and paranoid thought patterns. Illness management remains only a vaguely understood concept to her, while her fears of workplace politics reverberate to this day. Thanks to the support of the DBII program, she embarked on a more considered and gradual return to work than her first, disastrous attempt.

Now working part-time, Tanya is tentatively optimistic that her state of mind will improve, that she will be able to teach herself how to better manage her symptoms and her fears.

Claire

Buying life insurance is something that becomes necessary for most people, at some point or other. Without it, buying a home, getting a business loan, gaining employment, and/ or providing for loved ones becomes more difficult. Being denied life insurance in one of these situations can have negative repercussions on some important lifestyle milestones. For instance, a person who has been denied life insurance for the sake of protecting family members may find that this decision also affects their eligibility for taking out a business loan, as many bankers expect loan customers to secure life insurance to provide for repayment of funds in any eventuality. While certain progressive banks or credit unions have specialized loan programs for people with disabilities that can override this prerogative, in many institutions, there is no room to maneuvre around the requirement for life insurance coverage. Goals such as home ownership, entrepreneurship, and other dreams may therefore become more difficult to attain for a person with mental illness.

Life insurance policy purchases can also demand detailed medical information from potential policyholders. In the context of workplace life insurance packages this can put people with mental illnesses in a delicate position, due to a sort of 'involuntary disclosure' that can occur when applications for life insurance become part of one's employment record.

As someone with panic disorder, Claire Saunders has had her share of experience in overcoming a potential barrier to success. She has struggled to make this condition marginal to her life by knowing her triggers and avoiding conditions that might lead to an attack. Should an attack occur despite her precautions, she utilizes visualizations and breathing exercises to control her symptoms. Through the exercise of these illness management strategies, Claire has been largely successful in relegating her condition to the back rooms of her life. She has moved on to achieve a large degree of professional success, apparent by her current position as an account executive at an advertising firm.

> "What one may have struggled to keep private abruptly becomes public, injuring a valuable sense of personal dignity and self-esteem."

Like many others, Claire has found the issues surrounding disclosure of mental illness complicated. In the past, she has come face to face with the ignorance common in our society surrounding mental health issues. In one instance, when she made the difficult decision to disclose, the other person started to speak to her in a slow and careful manner, as if she believed that Claire was intellectually impaired. Such behaviour poses a difficult question: how can someone feel comfortable about disclosing when faced with the often-rampant misconceptions of mental illness in society? It is one thing to identify a generalized need for more education, quite another to attempt single-handedly to do so on your own at significant personal risk.

At her previous employer, routine employee insurance coverage required that Claire apply for life insurance coverage. One of the questions on the application required information about current medication, and Claire duly answered that she occasionally used medication to stem the symptoms of her panic disorder. She found her application was denied on the basis of this, what they termed her 'heart condition.' Her supervisor was informed of Claire's rejection for life insurance coverage, and while Claire was never sure what information was passed on, she suspects that her employer learned about her mental illness.

Claire was embarrassed. She didn't know what to tell her boss, and so she avoided discussing the decision. Her supervisor never raised the issue with her either, and Claire maintained a self-conscious silence.

Claire knew that the connection the insurer had made between panic disorder and a heart condition was flawed, not only because of her own experiences with the condition, but because of her own degree in psychology. In spite of an impulse to enlist her doctor's help in refuting their decision or even faxing the insurance company pages from her abnormal psychology text, in the end Claire did nothing to correct the error of the insurer's ruling. As she says: "I definitely felt stigmatized, and it made me feel depressed and unworthy." Dwelling on the issue made her upset, so she pretended it had not happened.

Despite her efforts to ignore the issue, Claire felt its repercussions. When her supervisor remained quiet about the insurer decision, Claire began to believe that she was being treated differently. She perceived that her supervisor became less disposed to treat her kindly and observed in their discussions that her supervisor thought she was uneducated, even unintelligent. Faced with such a difficult situation, it hardly seems surprising that Claire soon decided to seek another position.

In a new position at a new firm, Claire's life insurance application was accepted without a hitch. In addition, or perhaps partially because of this, she felt much more comfortable with her fellow staff. If she could go back and handle the previous situation over again, she would handle the rejection decision differently. She would fight the decision, and demand that the insurer re-examine her application. While she understands the need for disclosure about physical conditions on life insurance applications, she cannot see the relevance of disclosure about mental illness. If such disclosure is to be considered necessary, then equally necessary should be a certain level of education for insurance representatives about mental illness, so, as Claire asserts, "They don't make decisions based on ignorance."

One important issue raised by this story is the seemingly inequitable nature of the criteria being used to deny insurance to a person with mental illness. The issues of confidentiality and privacy are perhaps equally important. Being denied life insurance coverage can attract negative attention from employers, business contacts and co-workers. Why was this person considered too big a risk for life insurance? Are there risks to maintaining a business relationship with this individual that should be taken into account? Supervisors may reconsider decisions to give this person more responsibility, and employers may think twice before giving such an employee a raise or promotion. Disclosing to others at work that one suffers from mental illness is a sensitive undertaking and the involuntary disclosure brought about by rejection for life insurance coverage can negatively impact workplace relations. What one may have struggled to keep private abruptly becomes public, and not on one's own terms, injuring a valuable sense of personal dignity and self-esteem.

The question of disclosure may seem simple to the non-consumer: don't disclose and protect your privacy. But as this story and others in their report show, events can take the decision out of the hands of the person with mental illness. Sometimes symptoms need to be explained or consumers could lose their jobs or damage their prospects. Every disclosure is a risk, a risk that needs to be carefully considered and managed. The reaction from the disclosure can be far from appropriate, considered or informed.

Undoubtedly, disclosing a mental illness can bring valuable accommodations at many workplaces, such as flexible hours or modified work conditions. In turn, these accommodations can be necessary to the success of a return-to-work strategy, representing critical support from an employer when an individual is especially vulnerable to the inherent stress of work. It is a catch-22 situation: by not disclosing, an individual can't gain valuable support; but those who do disclose can face questions that ultimately remain unanswerable. They wonder if their capabilities have been underestimated by supervisors as a result, and they wonder whether or not other co-workers know of their illness.

Summary and Conclusion

The experiences described throughout these stories suggest that people with mental illness who make a claim for disability benefits face a number of obstacles. The initial challenge involves accessing benefits in the first place, followed by the wait for long-term disability coverage to commence should short-term coverage be unavailable.

When private disability coverage proves to be unavailable, employees facing disability in such circumstances must rely on public insurance schemes, provincial or federal, introducing new issues and difficulties in navigating these systems. Once benefits from public systems have been accessed, these can occasionally negatively impact the level of benefits that are eventually received from private disability schemes.

For those who do successfully access private coverage, the next issue to face is the question surrounding the comprehensiveness of the benefits and supports received during the period of disability, and whether these are sufficient to support recovery and an eventual return to work. The actual return to work is the next issue, the first challenge here being making an objective assessment of the individual's readiness to return. The success or failure of the return depends also on the extent of preparation and planning done for the transition process, as well as on the level of ongoing support to be made available. For those individuals who are considered unable to return to work, another obstacle occurs at the two-year mark, when disability status may be reassessed.

A significant issue running throughout this entire process is the difficulty involved in resolving disagreements about coverage – either eligibility or the nature thereof – with the insurer in a situation where a level playing field does not exist, as we'll discuss later.

Access to Coverage

In order to successfully make a claim for coverage, the individual has to present information to insurers clearly demonstrating the existence of a mental illness (in most cases also that the illness does not pre-date the policy) and that the severity of illness prevents work.

Proving Existence of Illness

Proving the existence of a mental illness that can be covered by the policy can be a considerable feat, as a variety of issues often come into play, including the sometimes contentious issue of when the illness started. For instance, some plans dismiss claims where an illness is considered to be pre-existing, as in Sue Bradley's case. In Sue's case, a pre-employment visit to a doctor for stress that had resulted in a temporary prescription of antidepressants, meant she was judged to have a pre-existing condition in her depression-related disability claim several years later. A similar problem for Peter Schwartz required that he prove definitively to WCB that his illness was caused at work, and that it was not related to any past trauma or stress. Another potential problem with coverage is illustrated in Max Danvers' story and relates to situations where workplace stress plays a role in the person's health condition. In Max's case, the severity of his illness was directly linked by his insurer to workplace politics, meaning that it was the insurer's opinion that his symptoms were *primarily* stress-related rather than illness-related, despite the serious and enduring nature of these symptoms.

Proving Severity

The other challenge, proving the severity of the disability, can arise at the outset of a claim and at the two-year mark if a person hasn't yet returned to work. This task proved to be particularly relevant in Greg Ripkin's case, where even though his illness had left him incapacitated, the insurer denied his claim, ruling that his condition was not serious enough to warrant coverage. After initially making a successful appeal with the aid of her GP, Karen Gerard's claim was initially denied with similar reasoning. She then had to face a new test at the two-year mark, a change to the disability definition that meant she had to prove that her disability was so severe that she couldn't perform any job, whether or not such a job existed.

Presenting the Right Information

Presenting the right information in the right way that will allow claimants to overcome these obstacles is a challenge in and of itself. Marshalling adequate information to prove the claim depends on having a mental health professional – GP, psychiatrist, or other mental health professional – who is both sufficiently knowledgeable about the person's illness and can sympathetically present the case in a thorough fashion. This wasn't always the case with the people interviewed. Information from employers may also negatively impact claims, especially in situations like those of Max Danvers and Tanya Thomas, where illness symptoms had resulted in a soured employee/employer relationship. This is particularly the case where the employer does not have enough knowledge to attribute these difficulties to the existence of an illness, rather than to the character of the individual in question.

Waiting Periods

Another complicating factor in disability coverage is the necessity of waiting extended periods of time, often up to six months, before long-term disability coverage kicks in. Individuals without short-term disability benefits, or without adequate sick leave coverage, like Jody Lee, can be left with the quandary of dealing with a serious illness while negotiating other income assistance systems – usually medical leave coverage from Employment Insurance, but sometimes pro-

vincial income assistance – each with a differing series of barriers to negotiate.

A further complicating factor can arise when the individual (e.g. Greg) has difficulty admitting to the extent of disability, due to the associated stigma of the process or a relative lack of insight and understanding of their condition. Claimants are also required to document information that is very personal in nature, including daily activities, habits, and character in order to highlight disability; such candour is not easy to achieve, especially in the case of an appeal, where this process becomes adversarial. Feeding into these difficulties, in some instances, individuals may not even receive a diagnosis or achieve an understanding of illness until months or even years after it has jeopardized quality of life and career prospects. Such claimants are then confronted with the near impossibility of trying to fight a claim in retrospect, after deadlines have passed, often without a clear memory of what happened.

Comprehensiveness of Coverage

Should a claimant achieve success in accessing disability benefits, monthly disbursements represent a very crucial but only partial portion of the range of supports that are part of a comprehensive disability support plan. The issues of counselling, vocational rehabilitation and a sound return-to-work strategy, despite their importance to a person's recovery and successful return to work, were often missing aspects of the benefits available.

Counselling

Access to counselling services can be an important means of recovery. This counselling is not a substitute for psychiatric support, but can complement its success. Workplace benefit schemes sometimes include counselling services administered through Employee Assistance Programs. Such programs are usually easy to access and confidential, however necessity dictates that the focus is often one of short-term mental health goals, which can exclude long-term therapeutic goals. In smaller communities, as for Jody Lee, access to such programs can be limited by significant commutes.

Vocational Rehabilitation

Without the support of vocational rehabilitation programs, the term of disability can lengthen. Careers previously chosen by consumers may no longer be appropriate to the ramifications of life with particular mental illnesses, and in such cases, a return to a previous position may be disruptive to illness management, and/or expensive to the employer as marked by diminished performance. Peter Schwartz's case is a good example. As someone with PTSD, a return to work as a paramedic was not necessarily appropriate; while the strategy of training for a comparable career in computer programming certainly seemed a reasonable one, its success was likely undermined by the choice of a correspondence curriculum rather than a classroom one.

Return to Work and Disclosure

All disability supports discussed here in combination with a return-to-work strategy can be important parts of what has been termed *disability case management*, as coordinated through the insurer. As demonstrated in almost all the experiences discussed here, even the idea of embarking on a return-to-work strategy can introduce significant stress to the lives of people who are already struggling to manage mental health symptoms. In many of these stories, pressure for an early return – due to pressure from the insurer, mental health professionals, or self-imposed in nature – negatively affected the recovery process. Accommodation strategies, disclosure management, and employer involvement can be especially helpful at gradually building up the confidence and mental resilience of employees, as well as providing vital moral support. All of these strategies combined with a carefully considered return-to-work decision, can significantly improve the chances of a successful return.

In the majority of the stories discussed here, a return to the previous workplace represented an unwelcome vocational goal to both claimants and employers. In the majority of cases, the initial onset of symptomatic behaviour at work harmed relationships and created an unhealthy workplace environment. Disability case management can serve to smooth over the politics of such a return, aiding the employee, co-workers and the employers in successfully overcoming what can often represent an awkward and difficult transition. It is important to note, however, that these common-sense benefits can be undermined if such an approach is perceived as adversarial rather than collaborative.

Carefully considered disclosure of one's illness provides another opportunity for such support. When returning to work after an encounter with mental illness, individuals occasionally still need to decide whether or not to reveal mental illness. Stigma and even discrimination in connection with such disclosures remain very real concerns in the majority of workplaces, and a careful weighing of risks and benefits is crucial to this decision. For Claire Saunders, her application for life insurance demanded disclosure but led to a perceived, if unconfirmed, change in her status at the organization, a subtle yet persistent perception of discrimination and a loss of privacy.

Equitability Issues in Psychiatric Disability Claims

It is the tendency for many insurance providers to transfer the established techniques for the management of physical disability claims to those of psychiatric disabilities. In the opinion of many of the people we interviewed, there was need for a different kind of approach for people with mental health related claims. Pre-arranged back-to-work dates, for example, are perhaps more relevant to broken legs and bad backs than to mental illness, and an insistence on such a procedure can introduce an element of anxiety to claim status that amplifies symptoms, as occurred in Karen's case. Another compelling illustration of the need for a unique ap-

proach to mental illness is illustrated by the use of surveillance. As with the case of Max Danvers, surveillance can feed into a sense of persecution and/or paranoia, making symptoms more persistent and difficult to overcome.

Another problematic issue is associated with the definition of disability adopted by insurers. For instance, the notion of 'total disability' does not usually apply to mental illness-related disability, which may be episodic in nature and not permanent in the same sense as many physical disabilities. A final related issue is that the ability to attribute direct causality in connection with physical disability may not transfer well to psychiatric disabilities, especially in the case of Peter and WCB, where the illness must be shown to have a clear cause in the workplace.

Negotiating Disputes: The Playing Field

Disputes about coverage were related to all the issues identified above, and all the people with mental illness we talked to were faced with the situation of resolving disputes in a very difficult situation. As noted above, these people were often in the throes of illness, which meant the ability to debate difficult coverage issues was seriously compromised, if not completely lost. In attempting redress, such claimants would encounter a situation where it appeared that few rules applied. A lack of procedural clarity worked in the favour of the insurer rather than the claimant who was faced with the dilemma of limited financial resources and the crisis of illness while having little information to go on about what the process for making an appeal was, what the timelines were, and what resources might exist to aid or facilitate an appeal.

This lack of procedural clarity can be apparent in many aspects of the claim process. For Max Danvers, it seemed that caseworkers tended to delay the processing of any request, large or small; caseworkers were frequently reassigned, and new caseworkers would need time to become familiarized with the file. For Karen Gerard, simply accessing accurate information about the status of her claim often proved problematic. In many of these situations, the individual had to rely on personal financial resources (if any), borrowing, ingenuity, and/or sheer persistence. When faced with these difficulties, the support of mental health professionals and/or employers seemed to facilitate claim success, but such support did not always prove to be readily available or appropriate.

A sense of hopelessness is a distressing, if understandable, response, and this hopelessness was a common reaction among the people we interviewed about the claim process. Indeed, the commonplace nature of suicidal tendencies and ideation among claimants is unsettling.

In such situations, there is a tremendous need for the assistance of an advocate, that is, for the intervention of a knowledgeable, dispassionate individual with the expertise to help a claimant work their way through the various aspects of the claim or appeal process. Such support has the potential to protect claimants from the often drawn-out, emotional nature of the process. In some cases, a mental health professional may informally play this role; in others it may be a union representative, employer, or family member. The problem is one of reliable access to qualified advocates or other helpful resources that may exist. Mental health professionals or union representatives, while sometimes helpful, possess no specific mandate to intervene on the behalf of the financial interests of claimants or union members. Access to legal action itself is limited by the expense of soliciting a lawyer. Funded advocacy services for the purposes of mediating disability claims with *private* as opposed to public insurers are either rare or simply non-existent.

The decision to pursue a claim despite very real difficulties can often become a more psychologically demanding role than employment itself. An increasing sense of outrage can easily become unmanageable, protracting financial difficulties and profoundly hampering recovery. The process of making a psychiatric disability claim can ironically become worse than the illness itself. Given this fact, it is not surprising that deserving people, like many of those we talked to, felt compelled to walk away from the process despite actual need and forgo the painful process of securing coverage.

Part Two: Charting A Course

Introduction and Background

In the first part of this report, we had a look at the experience of people who had difficulties accessing workplace disability insurance. To put it concisely, what the stories as a whole illustrate, is the challenge of navigating the complexities of the insurance process, while at the same time dealing with a mental illness. What the case studies point towards is the need for some form of advocacy to support people going through this process, in particular, to help individuals help understand the process for gaining coverage and making an appeal in the event of a dispute.

The next part of this report is an analysis of the various aspects of the insurance claim process based on interviews with industry personnel. While the focus is on the identification of issues that need to be addressed, it is hoped that this analysis can also serve an immediate advocacy function in that it can help claimants with mental illness navigate their way through the disability insurance system. It can do this, first of all, by helping potential claimants and those who support them – employers, mental health professionals, family members – understand various complexities surrounding coverage, benefits and dispute resolution and in doing so, make the claim process easier to navigate for all concerned. Secondly, the report identifies actual resources that can help people understand and work through the claim process.

Outline: Charting a Course

Like the case studies in the previous section, this section looks at the issues faced by people with mental illness who attempt to access long-term disability insurance (LTD), and/or Workers' Compensation (WCB) coverage when they are unable to work because of their disability. Rather than being experientially based, the present analysis is based on a survey of key informants working in areas related to the insurance industry or its oversight, as well as a review of industry documentation.

The first section to follow explains the similarities and differences between LTD and WCB coverage, and outlines some considerations for individuals attempting to access either system. The current analysis looks specifically at LTD, including the claims process, coverage and return-to-work issues, as well as dispute resolution alternatives, followed by a similar exploration of these issues as they apply to WCB. The final section makes recommendations for individuals attempting to access either system.

As noted, the report is a companion piece to a preceding study that interviewed individuals about their experiences trying to access either LTD or WCB. Both reports were motivated by the experience of Donald Mayer, a man with mental illness who died in an altercation with police at Langley Memorial Hospital, in BC. As a Coroner's investigation showed, difficulty accessing disability insurance – both LTD and WCB – was a significant contributor to Mr. Mayer's distress when he attempted to receive treatment at Langley Memorial. The purpose of both pieces – the insurance industry survey and interviews with people with mental illness – is to both identify barriers and potential solutions, so that similar situations can be avoided in the future.

Workers' Compensation Board and Long-Term Disability: Similarities and Differences

When a person is injured at work, they are usually covered by Workers' Compensation. If they become ill or injured and the injury is not caused by their work, they may also have disability insurance through their employer. There are some important differences between these two types of coverage and there are also several things they have in common. In order to understand the claims process for either system, it is important to understand which program is relevant in what situation and to understand the similarities and differences in the way they operate.

One major similarity between the two types of insurance is that they both use quasi-legal processes that are adversarial and require extensive proof and documentation. However, proof and documentation are not sufficient for a successful claim if one does not have a good understanding of the limitations of the coverage – and all insurance policies have limits. If it is WCB coverage, those limits are delineated in legislation and policy; if it is long-term disability insurance, the policy states what is and is not covered. If a particular illness or injury is excluded from coverage, no amount of documentation or proof will lead to a successful claim.

Another similarity is that with both types of insurance, the employer has contractual or legislated agreements with an insurer. With Workers' Compensation, the agreement is between the WCB and the employer; with long-term disability insurance, the contract is with the employer and the insurance company. This situation leads to implications that differ from situations where the insurance is between the individual and the insurance company. The result is that the employer has certain entitlements, responsibilities, and access to information that they would not have if coverage was solely between the insurance company and the individual.

One major difference between WCB and long-term disability insurance is that the legislation requires that employers provide WCB coverage, and this legislation defines the type and extent of coverage, so coverage is uniform for all

employers and employees under WCB. This is not the case with disability insurance.

With long-term disability insurance, because employers are not required to provide disability coverage, it also means that the terms and extent of coverage vary considerably from employer to employer. It also means that the employer can also serve as the insurer, and can hire the insurance agency to serve only as an administrator of the policy. This type of disability insurance is called an *administrative services only* (ASO) agreement. With an ASO, provincial insurance laws and regulations do not apply, and the employer has more flexibility in the services they provide and the requirements they must meet. Contract law alone governs these contracts. If an employer hires an insurance company to provide the insurance, contract law and provincial insurance laws govern the contracts. Whatever the type of agreement, the most important implication is that the amount and the extent of coverage varies widely between employers, and there is no minimum amount or type of insurance that must be provided.

Regardless of the type of coverage, whether WCB, insurer provided, or ASO provided, extensive and complex rules, regulations and bureaucracies guide practices. Because WCB is legislated, WCB has a much more transparent process than that for disability claims with private insurers. WCB also provides more appeal mechanisms, and the government provides an independent source of advice for claimants. No such service exists for those dealing with disability insurance; therefore, appeals can be quite costly because of the complexity of the process and the limited number of appeal mechanisms that are available. The appeal mechanisms available through WCB are free, although they can require considerable investment of time and effort.

With both WCB and disability insurance, it is easier to access assistance if the disability is temporary. It is very difficult to make a permanent disability claim, particularly for a psychiatric disability. With long-term disability insurance, generally the standard of proof becomes higher and the requirements more stringent after a person has been disabled for a period of two years. In both systems, the burden of proof is on the person with the disability, and a diagnosis alone is not considered to be sufficient for a claim. The person also has to prove that their illness or injury prevents them from working permanently. The challenges of proving this are daunting in both systems unless the evidence is indisputable.

We'll now go on to look at each system in more detail.

Disability Insurance

The following section is based on a survey of insurance industry key informants and a review of disability insurance websites. It discusses issues that may create barriers for people with psychiatric disabilities as they attempt to negotiate the various aspects of the long-term disability process, including making a claim and having their disability assessed (the claims process), understanding what is covered and what is not (coverage and exclusions), and returning to work.

While insurance companies are different, so too is each individual contract between the employer and the insurance company. It is also conceivable for employers to provide different contracts for different groups of employees within the same organization. For example, executives may have a richer benefit package than other workers. Different unions within an organization may also have different benefit packages. So if you have to make a disability claim, it is extremely important to know your contract or to be able to access someone who does. Possible sources of information are the human resources department, the union if you are represented by one, and the insurance company.

Despite these differences, the following section highlights some of the similarities and differences among insurance policies and highlights issues that individuals or employers should be aware of as they purchase or attempt to access insurance coverage, respectively.

The Claims Process

The disability industry does a good job of advertising their services to employers, because their customers are employers – not employees. Because it is a competitive industry, it is more difficult to acquire information for how the industry operates and makes decisions. This situation is exacerbated by the myriad different policies that exist. There is no standard disability policy and within each policy, every claim is weighed on its own merits.

While it is easy to acquire general information, specific information about claims management is hard to acquire. It is not easy to determine how claims are assessed, what procedures are used to assess them, and what statistics are collected within the industry about disability claims. The only exceptions are those matters where government regulators provide oversight. For the most part, it appears that very few statistics about psychiatric disability claims are kept, and most companies will not release information to the public about their own records.

While the claims evaluation process is not clear, there is some information about the submission process. Usually the claimant and their physician provide information to the insurance company where it is assessed by the company. Insurance companies have staff who make assessments, and it appears that most have physicians on staff who provide advice. Most appear to have access to psychiatrists, and some appear to make use of psychologists as consultants to the claim process. In addition, most companies seem to provide some type of rehabilitation services, although psychiatric rehabilitation appears to be rare.

In speaking with regulators in BC and Ontario and with an industry representative, two general statistics kept recurring in relation to disability insurance. The first is that claims

for psychiatric disabilities are increasing more than any other disability as a result of increasing stress in the workplace. The second is that the most common complaint made to the insurance industry and to government insurance regulators is the denial of long-term disability (LTD) claims for all illnesses.

Frequent reasons for denials:

- claimant's misunderstood the terms of their contract and made a claim for something that the contract did not cover
- insufficient evidence was provided about the nature and severity of the disability to prove, for the purposes of the claim process, a coverable disability existed

As discussed earlier, this is where it is critical to have an understanding of what is covered by the insurance as well as an understanding of what evidence is required to justify the claim. While employees are usually provided with a description of coverage, these descriptions often have legal definitions and implications that are not always apparent. Most people would have difficulty understanding the subtleties of policy wording. The other part of the problem is that providing evidence of disability, particularly psychiatric disability, is hard to do.

Assessing the extent of the disability is complicated because a psychiatric disability is invisible, and evaluation is not clear-cut. In speaking with regulators and insurance representatives, quadriplegia was sometimes used as an example of a permanent disability that is easy to prove. In the example of quadriplegia, it is fairly easy to demonstrate that quadriplegia exists, and that the person cannot perform their previous job functions, or many other job functions. With other physical injuries, rehabilitation consultants often measure observable indicators like range of motion. However, even with some physical injuries, while there may be agreement on the diagnosis, there is not always agreement on the level of disability. The existence and degree of pain, for example, is difficult to prove. There are no reliable, observable instruments that can measure the level of pain that a person experiences; one has to rely on the self-reports of the individual. Similarly, with psychiatric disabilities, there are no indisputable tools like blood tests to measure the reliability of the diagnosis, so sometimes disagreements about diagnosis exist.

It is even more difficult to determine the level of impairment or disability, and to prove that the symptoms interfere with the person's capacity to work. The insurance systems generally rely on physicians to provide opinions about the illness and the symptoms. They may also rely on physicians to assess either the person's ability to return to work or to do the functions of their job. Physicians, however, may not be the best suited to provide this kind of evidence, as compared to mental health professionals such as occupational therapists or others who specialize in psychiatric rehabilitation. In addition, the insurance industry does not appear to have industry standards for guiding assessments.

Companies do appear to have mental health professionals on contract, often psychiatrists or psychologists, who specialize in insurance claims and who provide opinions and evaluate claims that are in dispute. However, it must be remembered that these professionals are on contract to the insurance companies and hence not independent. While mental health consumers may have access to independent mental health professionals who have a good understanding of their condition, these professionals usually do not have experience in dealing with the requirements and intricacies of the insurance systems, and hence would probably not understand the implications of the wording and the terms of the individual insurance contracts. This can be a distinct disadvantage for the claimant because the onus is on the individual to prove the claim, and companies generally do not have a process whereby the client can obtain an independent evaluation if they do not agree with the insurance company's conclusions.

Given the increasing pressures on insurance companies because of psychiatric disability claims, the need to improve their processes, to develop standards, and to make the process more transparent is even more important. Industry standards and regulations are required not just for the claims adjustment process but also for the disability assessment process, to ensure that the process is objective. At the same time, a mechanism for providing independent assessments must be developed, otherwise the process will always be suspect.

Some companies have attempted to develop objective assessment tools and processes. The Cooperators is an example of one company that has implemented a process called Fair Assessment Claims Technique. This service was developed in 1997 in consultation with a psychologist from a firm specializing in psychiatric disability claims management. Following development, the Cooperator's staff were provided with extensive training. The tool they use was designed to assess the severity of the illness and the person's motivation levels. It is used in combination with an analysis of the job description to identify mental demands and level of difficulty. As part of their process, the adjusters gather information from the claimant, the employer and the physician and focus on objective measures to determine how the person's symptoms affect their ability to do their job. Adjusters have access to psychiatric and psychological consultants and rehabilitation professionals if they have questions about whether the treatment provided is appropriate to an individual's condition, or if they want advice about how to assist individuals to return to work. In many cases, they negotiate with the employer to modify the job and to remove barriers to returning to work.

The Cooperators' process sounds like a good system for evaluating claims. However, it is difficult to actually assess how well this process works for employees making claims, as no information is publicly available. It may work very well or not well at all. Effectiveness would depend on a number of factors such as the quality of the assessment instrument, the quality of the adjusters' training, whether there is ongoing training and

updates for employees, and the choice of objective measures.

The information we have from the Cooperators only describes how this one insurance company responds. It appears that each insurance company has developed its own independent process and procedures, so that it is difficult to know how the Cooperators' process compares to the processes used by other companies. The writer of this report looked at information provided by other organizations and was unable to find any information about the claims process for assessing psychiatric disability within any of the information that was examined and found it difficult to locate individuals from other organizations who were willing to discuss their process. This suggests that they may not have a specific process. Most of the available comparison data on the insurance industry only looks at the number of total complaints and the total costs of disability claims, without referencing claims for psychiatric disabilities or data from specific companies.

Coverage and Exclusions

Throughout this study, one issue that kept surfacing was the uniqueness of each contract. As stated earlier, the insurance contract is not between the worker and the insurer, but between the employer and the insurer. It is the employer that decides how much they will spend on their insurance services, and what kind of coverage they will provide. As a result, employees are not a party to all the terms of the contract, yet some of these terms can have a significant impact on their coverage. Examples of information not usually available to employees include global limitations on disability payments, or whether rehabilitation is provided to employees who are disabled. So, if the employer has a limit on the total amount of coverage that will be provided to employees over any given year, or if there are limitations on the kind and extent of rehabilitation covered, it would not necessarily be apparent to employees. Yet, these kinds of limitations could be a factor in the denial of the employee's claim.

The policies themselves also vary tremendously, and as mentioned, the benefits and services depend on what the employer is willing and able to pay. Because each policy is different, the claimant has to try to make themselves as familiar as possible with the employer's specific disability policy. For example, some policies have time restrictions, that is, you may be required to make your claim within a certain number of days after becoming ill or you cannot make a claim, no matter how valid your claim is. Your policy may also indicate what options you have for appeal, and these would have to be followed. Those appeal options may also have time limits associated with them. On the other hand, the insurer may or may not have any time limits imposed on them.

Another issue to consider is whether the policy provides rehabilitation for psychiatric disabilities. Employers do not usually provide this benefit. Another difference between policies is that some provide payments only if you are completely disabled, in those cases, only providing coverage if you are unable to perform the functions of *any* job. Some policies do provide coverage if you are partially disabled. Usually with partial disability coverage, the policy specifies a percentage, such as inability to perform 60% of job duties. So in this example, in order to successfully file a claim, you would have to demonstrate that you were only able to perform 40% or less of your job duties.

Another significant benefit that may be available in a disability policy is coverage for pre-existing conditions. Insurance contracts usually have exclusions for pre-existing conditions. However, as stated earlier there is no standard clause, and contracts vary widely. As an example, in the usual contract with this exclusion, if the diagnosis was depression and depression had existed at some time previous, the person would not be covered. Even if the person had taken antidepressants without being diagnosed as having depression, the person would probably not be covered. A person would also probably not be covered in a situation where the condition had been stable prior to employment, and then became ill some time after employment. For someone with a mental illness, this kind of clause can have very serious consequences because of the cyclical nature of mental illness.

On the other hand, there are some contracts that do allow for coverage if the condition was stable prior to employment. These policies usually specify an amount of time that would indicate stability, such as being free from the illness for a period of ninety days prior to starting work.

Another variation is that most policies have qualifying periods. Some have qualifying periods at the beginning, such as you having to be working for six months prior to being covered. Most also have qualifying periods before you can make a claim, such as you having to be ill for six months before you can make a claim. These requirements can impose a severe financial hardship on anyone who does not have the financial resources to carry them through the qualifying periods, especially for individuals who do not have the benefit of short-term disability coverage.

Another indicator of the quality of a policy is whether it will reduce monthly payments by any amount the employee **is** ***eligible*** to receive from government, such as CPP. In other words, if you become ill, with this kind of policy you would have to apply for CPP. If you were deemed eligible to receive a LTD payment, it would be for the amount to which you were entitled, minus the CPP payment. CPP payments can take some time to process. If the determination was that you were eligible for LTD, and payments began before CPP kicked in, you would need to refund that difference to the insurer when you received your CPP.

Return to Work

Because the assumption is that the employee will return to work, most disability policies assume that there will be a treatment plan and a foreseeable recovery. In other words, the person has to be receiving treatment (where treatment is appropriate) and cooperating with a treatment plan. If the insurer feels that the client is not complying with treatment, they can refuse to make

disability payments. Given that unpalatable treatments have at times been forced on people with psychiatric disabilities, this requirement could easily victimize the claimant, further exacerbate their illness, and leave them without an income.

Furthermore, insurers seem to assume that you can work while experiencing psychiatric symptoms. Some people *can* work effectively while experiencing psychiatric symptoms, but others may have difficulty doing this, and for various reasons may return to work too early. Some people work while ill because of the fear of stigma and fear over job security and access to future promotions. In addition, an employee may be encouraged to return to work before they are ready. The general disability literature suggests that an early return to work makes it less likely an employee will require permanent disability payments. The implications for the person with a serious mental illness may be just the opposite, and this possibility needs to be researched and further explored.

Insurers are not obligated to provide a person with employment, so if a person is well enough to work but a job is no longer available with their employer, they are generally not eligible for payments and are expected to secure another job. It becomes even more complicated if a policy has a clause like "the person is unable to perform the duties of any occupation for which he is fitted." This clause means that if the employee can no longer do their original work, they would not be eligible for disability payments if they could do some other type of work, even if the employee is unable to secure a job doing that work. If they have to accept a job at a lower level and a lower income following their illness, their coverage would not provide any supplement. This type of clause usually comes into effect between one and three years after the claim is first made, although some contracts do not have this kind of clause at all.

The insurer also would not pay if there is another job that the claimant can do, even if the person is unaware of that possibility. This is particularly troubling. In Ontario, regulators found that insurance companies often failed to tell the claimant what kind of job that the claimant might be capable of doing. In that province, the regulators usually require the insurance companies to provide this information. However, insurers are not required to share their records and findings with the employee, so the employee may not know that they have been assessed as being capable of a particular job, and would be denied the disability benefit, without knowing that the reason for the denial was that other employment options might be open to them, or knowing what those other jobs might be.

At the same time, even if the employee has this information, it does not help them if they are unable to secure the other kind of employment. They would still be ineligible to receive disability payments. Clearly, insurers can make it standard practice to advise claimants about jobs they have been assessed as being capable of performing. At the same time, employees need to be aware of the limitations of their disability coverage and lobby their employers to make improvements when these kinds of clauses are in force.

Access to Dispute Resolution

Access to dispute resolution depends upon whether your employer serves as the insurer and uses the insurance company for administration only – in which case the insurer is described as ASO: Administrative Services Only – or whether the insurance company provides the insurance directly. As described below, the claimant has more options if the policy is not ASO. Regardless of which type of policy is in place, a complicating factor one must deal with is that insurers are not obligated to share their records on the claim. Without knowing what is on the file, negotiation is more difficult and achieving quick and informal resolutions more challenging meaning that dispute resolution becomes more time-consuming, costly and stressful.

The first steps in trying to resolve a claim is to seek assistance from your employer's Human Resources Department. If you are a member of a union, you can also request the assistance of a Labour Relations Officer. If these options are unsuccessful and if your company's contract is *not* an ASO, there are three other potential lower-cost options available, as well as two other expensive options.

1. Non-Administrative Services Only Situations: Options for Recourse

Recently, the federal government announced the creation of a National Financial Sector Ombudservice, which will provide an independent ombudsman service in situations where complaints are not resolved to the claimant's satisfaction by their insurance provider. In addition, under the new initiative, each company will put an ombudsman into place, and many have done so already. The role of the ombudsmen is to determine if the adjudicators adhered to the company' s procedures, and if they were reasonable and fair. They do not make decisions about the outcome of claims. Please see the resource guide on page 45 for information on how to contact this service.

You can also call the consumer line of the Canadian Life and Health Insurance Association (CLHIA), a national body that represents insurance companies. This organization will answer general questions about insurance and will intervene with an insurance company to have a case reviewed. This agency also houses the national Ombudservice. The Ombudservice has the capacity to produce a report with recommendations, including, in some cases, restitution or compensation. However, the recommendations are not binding on the insurer.

You can also make a complaint to the provincial regulator, the BC Government's Financial Institution Commission. If the insurer has violated the terms of the contract, if they have violated the Insurance Act, or if they have engaged in unethical business practices, the Commission can take action. Determining if a company has violated the legislation is not easy, as the legislation in BC is quite complex. Disability insurance can be included either in the section of the legislation under life insurance or under the health insurance section. What section governs the policy depends on the terms of the disabil-

ity policy itself. Once the section of legislation has been clarified, the relevant law determines what rules apply and what options for appeal might be available, if any, under the legislated provisions.

If the Financial Institute Commission intervenes, the company may also decide to release their records to the claimant, but they are not obligated to do so. Since the commission can prevent an insurance company from operating in BC, they can be quite persuasive. However, preventing a company from operating is a very serious penalty, and a violation would usually have to be extreme and repetitive to result in this kind of action. Therefore, it is not an action that is frequently pursued. In Ontario, the provincial government operates an Insurance Ombudsman service, with the authority to resolve complaints, and to make recommendations to the Superintendent if it appears that the company has engaged in unlawful practices. That service is also in the process of developing standards that insurance companies must meet when complaints are received. Unfortunately, BC does not provide this service.

If all of the above avenues are not successful, your only recourse is to try to pursue arbitration through a private arbitration service specializing in insurance complaints, or to sue the insurer. Both of these options incur costs. Suing is an extremely expensive and slow process. The only advantage of suing the insurance company is that the courts will usually force the company to release their records of the claim. However, with both of these two options, success is not guaranteed, and these choices would have to be balanced against the costs and stresses of taking legal action.

2. Administrative Services Only Situations: Options for Recourse

The ASO leaves an employee with even fewer options for resolution if a claim is denied. As mentioned, if the disability contract is an ASO – that is, the employer is the insurer – the employee may be able to get assistance from their HR department or their union if they have one. If not, the BC Financial Institution Commission may choose to assist, although they usually do not in ASO situations. Even though they do not have the same authority to intervene when this is the case, employees may still want to contact them to see if they can assist. The CLHIA and the insurance organization's ombudsman service is also not an option, and arbitration would only be available if the employer agreed. The only remaining alternative is take legal action against the employer. Clearly, this is not an action to be taken lightly.

Finally, when there is sufficient evidence to prove systemic discrimination, several employees together can launch a class action suit, whether the disability contract is an ASO or not. In the United States, insurers in the past capped long term-disability payments for mental illness after 24 months, but paid for claims for physical disabilities up to age 65. This policy was challenged and changed. This is an example of a discriminatory practice, and if it existed in Canada, would be an example of systemic discrimination. With systemic discrimination cases, significant research would be required in order to identify and prove discrimination. A class action suit is the longest, most involved and most expensive option available and would not provide a short-term remedy.

Issues and Concerns

The biggest issues with disability claims from an employee's standpoint are the lack of standard policies. Because each policy is unique and insurance claims management is a quasi-judicial process, it is difficult for individuals to have a good understanding of what coverage they have and how to use it. The limited information available about the process of making a claim and adjudicating claims makes it even more confusing.

The individual's lack of access to their own personal information also makes it difficult for individuals to understand a number of issues: how to file, why claims are rejected, and how to appeal. In addition, because there are no apparent standards for assessing psychiatric claims, it is hard for employees to determine what kind of evidence they need to provide. It would also not be obvious to most lay people how to find a mental health professional who could adequately relate their symptoms or illness to their ability to perform their job in a manner that would meet the requirements of their insurance contract. When a person has a serious mental illness, this lack of information and clarity makes it even more difficult to access the services to which they may be entitled.

Preparing a Claim

As the preceding section makes clear, disability insurance issues are very complex, so if you have to make a claim, having someone who can explain the terms of the coverage at the beginning is a must. If you can afford to hire a lawyer who can explain your policy, do so. Regardless, try to access someone who will agree to serve as an advocate and a support person, such as a family member or friend, a mental health professional, a human resources professional, a union representative, or an individual attached to an advocacy agency. There are numerous complicated rules, regulations, policies and practices that you have to comply with in order to successfully make a claim. Having one or more persistent support persons who can help you collect and keep records of the necessary information is critical, especially if you are not well enough to do so.

Workers' Compensation Board (WCB)

WCB covers any injury that is work-related. The overwhelming majority of claims to WCB are for physical injuries, and psychiatric disabilities claims are relatively uncommon. The largest proportion of WCB claims are resolved with the person returning to work within a month, as most injuries are relatively minor. The most common psychiatric claims that are accepted at WCB are post-traumatic stress disorder (PTSD), adjustment disorder, chronic pain disorder, and depression related to physical injury.

Making a claim under WCB is a more transparent and consistent process than making a long-term disability claim. WCB has a website at www.worksafebc.com which provides a great deal of information. This website includes suggestions for how to be safe at work, and it offers a range of information about the claims process. It includes the Workers' Compensation Act which governs coverage, information on what to expect if you are making a claim, tips for making claims, a description of the appeal process, and downloadable forms that health care providers and others are asked to complete. It also has links to Ministry of Labour publications on how to get information and make appeals. You can also access a range of related publications.

Mental Illness and the WCB

- the WCB does not recognize psychological disabilities such as clinical depression, substance abuse and anxiety disorders as occupational diseases, nor does it list them in its schedules for determining awards
- long-term disability claims for psychological illness alone are extremely rare; such cases fall under non-scheduled awards, which are based on whether the disability is deemed to prevent the employee from returning to work
- most long-term disability claims for psychological illnesses are for post-traumatic stress disorder, which involves a sense of re-experiencing a traumatic event for months and sometimes years after the incident
- claims for post-traumatic stress disorder must be linked to a specific incident, for example, a police officer who has shot an individual during the course of duty and is unable to return to work because of ongoing emotional trauma
- claims for post-traumatic stress disorder have nearly doubled over the past decade: an average of 250 short-term and long-term disability claims for post-traumatic stress were accepted each year between 1992 and 1996 versus an average of 485 such claims each year between 1997 and 2001.
- post-traumatic stress disorder accounted for for less than 1% of the total number of accepted claims from 1997 to 2001
- accepted claims for post-traumatic stress disorder cost an average of about $4.7 million per year, excluding health care and rehabilitation costs
- WCB: www.worksafebc.com

Source: Statistical Services, Workers Compensation Board of BC

The Claims Process

When a claim is being made for a psychiatric disability, the employer files an incident report, and the worker's physician completes an assessment. A WCB psychologist or a psychiatrist would then assess the employee, taking into account the person's functioning level prior to the incident. They would explore the causative factors related to the individual's current functioning and would examine the role of pre-existing conditions and work.

If the initial assessment shows that there was some incident at work that played a significant causative role in the injury, a claim would be adjudicated. There are a number of possible outcomes. The claim, if accepted, could be accepted as a temporary claim, meaning that the individual would be eligible for support while they recuperate and may be provided with supports to assist them to return to work. Alternatively, it could be accepted as a permanent claim, meaning that the individual would not be expected to return to work at their pre-existing levels.

Once a diagnosis is made by the WCB professional, that individual provides their opinions to the adjudicators. The psychologists or psychiatrists do not make the decision about accepting or rejecting the claim, but provide opinions to the adjudicators, who make their determinations based on legislation, policy and any other information that they have available to them. Once a claim is accepted, then a plan would be developed to bring the person back to pre-existing levels of functioning, if it was determined that the condition was exacerbated by work. The claimant can then apply to the WCB for rehabilitation options, such as supported work.

When adjudicators refuse claims, they may accept the diagnosis but decide against the claim if there is evidence inconsistent with psychologist's opinion about whether there is an illness and, if so, whether it was caused by work. The adjudicators may conclude that stress in the work environment was the cause – as opposed to a specific incident or series of events – or they may conclude that the claim was not consistent with legislation and policy.

Coverage and Exclusions

There is a long list of requirements that claims must meet in order to qualify. For example, the minimum standard is that the person needs to be employed at the time of injury, that is, if the person was doing volunteer work, they would not qualify.

Despite the transparency of the system, it is often diffi-

cult to make claims for a psychiatric disability because the psychiatric disability has to be related to an 'injury' at work and you have to be able to prove that some incident or incidents at work caused the condition. Because the relationship between work and the illness is not often obvious, and the disability is invisible, making a claim for a psychiatric disability can be very difficult. Proving that an apparently work-related mental disorder was not a pre-existing condition can also be difficult.

Bipolar disorder is an example of a diagnosis that is typically not seen as work related. However, if an event at work *can* be shown to precipitate an episode, it would likely be accepted as a claim if the bipolar disorder were assessed as *not* existing previously. Another psychiatric injury that might be covered is PTSD. So for instance, if you get robbed at knifepoint at your work site and suffer PTSD, you will be covered for the period that you are disabled from working until you function at your pre-injury level. If you were unable to return to work, you would be provided with rehabilitation to allow you to work at a job at a comparable rate of pay.

Exclusions

Each case at WCB is evaluated on its own merits; however, there are certain rules and regulations that apply in determining what would not be covered. Pre-existing conditions are generally not covered by WCB. Physical and emotional exhaustion are not accepted as claims, and a claim that the workplace is stressful or unhealthy would also lead to a rejected claim. It is assumed that stress at work is inevitable, and would not be a problem unless the person had a pre-existing condition. The only exception occurs when the person has been involved in a traumatic event at their workplace. However, this is a grey area and it seems to depend upon the occupation. For example in certain emergency health professions, stress is common but serious traumatic events may also be part of the working environment from time to time. Examples of controversial cases of this type which have received media attention include both a nurse and a paramedic, who apparently developed depression and PTSD respectively, after responding to a number of health emergencies which were unusually serious, and which occurred with unusual frequency.

The exclusion of emotionally unhealthy workplaces appears to be a discriminatory exclusion and a serious deficiency. WCB does cover workplaces that are physically hazardous, and covering workplaces that are emotionally hazardous should also be part of their mandate by definition. The literature does provide substantial evidence for emotionally unhealthy work environments that cause illness, and has identified practices that lead to improvements in health. Employers should be expected to follow practices that address and rectify emotional hazards. Currently, if an employee is unionized, their union may negotiate language in a way intended to help provide this protection. Employers may also initiate such practices independently because there are some major demonstrated cost savings that arise from creating mental healthy environments. However, these steps are not required under the WCB Act and do not appear to be commonplace.

Access to Dispute Resolution

Once a claim is rejected, there are – or were at time of writing – five options for appeal. Currently, a person can make an appeal to the WCB Review Board, the WCB Appeal Division, a medical review panel, or the WCB Ombudsman. The BC Ministry of Skills Development and Labour funds workers' advisors to assist workers in appealing claims. The Ministry also provides information for claimants and will assist a worker to make an initial claim if they are unable to because of a psychiatric disability. If the employee is a member of a union, their union will also be able to provide advice and assistance regarding their claim, and some unions also provide additional financial supports to employees who are on WCB.

In addition to these mechanisms, if any additional information comes to light at any time, it can be submitted and the claim will be considered. There are no time limits on making claims. However, there are time limits if a claim has been made and rejected, and the person wants to file an appeal. If a decision is being appealed, the first step is to go to the WCB Review Board, and if not successful to the WCB Appeal Division. The WCB Ombudsman's office intervenes when there is an issue related to fairness. Claims are sent to the medical review panel when there is a dispute about the diagnosis or the prognosis. At that level, an independent medical panel will review the evidence and make a final decision.

Issues and Concerns

While there are several clear-cut avenues for appeal, the process of appealing can be stressful, demanding and time-consuming. One advantage of this system, however, is that if you win an appeal, benefits would be paid retroactively. Another is that the WCB rarely launches appeals of Review Board findings, and is prevented by legislation from appealing findings of the Appeals Board. Still, someone with a serious psychiatric disorder would probably find the appeal process to be difficult to manage while they were ill, if his or her claim were not initially accepted.

An issue of concern is the release of information. Typically claims for psychiatric disabilities fail because not all the relevant information is provided. Dr. G. Meloshe, the Director of Psychological Services for WCB indicated that the one thing critical to adjudication is complete information. He suggested that more information is better than less, and indicated that his staff try to acquire and use all relevant information that they have in making their assessments. He noted that there are times when people are reluctant to provide complete details. Providing complete information, however, can create a dilemma for the claimant.

The reluctance to provide information can be well founded. Claim files become accessible to employers if an

employer decides to appeal a decision. When employers appeal, the entire WCB file including all of the employee's medical information goes to the employer. This is further complicated by the practice of some physicians to provide the entire medical file to WCB, not just the relevant records.

There are safeguards for how the information can be used under the WCB Act and employers can be held accountable for maintaining confidentiality. The Freedom of Information and Privacy Act obligates the WCB to provide only relevant medical information to employers. Still, there clearly are some risks for the employee, if the employer receives more information than they are entitled to, or if they do not maintain confidentiality with respect to the relevant information.

This concern, though serious, does not seem to often come into play as employers do not commonly launch appeals and when they do, they are usually not disputing the claim but their assessed costs. Still, the release of information does put the employee in potential jeopardy, and there are no clear penalties or processes available to claimants if the employer does not respect the confidentiality of their employee's medical records. The only appeal processes if this happens are through Human Rights and the Labour Relations Board. Again these are lengthy, stressful and challenging processes particularly for someone who is suffering from a mental illness.

Preparing for a Claim

In preparing for a claim, the claimant should contact their union representative or their human resources office. If these options do not meet their needs, they may also contact a worker's advisor at the Ministry of Skills Development and Labour. They can assist you in preparing and appealing if you need to. They can also provide you with materials to explain the process as you go through it. The WCB website at www.worksafebc.com is also a very good resource with helpful information.

Overall Recommendations

Because of stress in the workplace, psychiatric disabilities are increasing disability costs, increasing absenteeism, and increasing productivity losses. Employers can incur several thousand dollars to replace one lost worker, and up to a million dollars to replace a lost executive. Employers can address these costs effectively by creating healthier workplaces. Individuals can better protect themselves by learning strategies for coping with their illness at work. Boston University's Center for Psychiatric Rehabilitation provides examples of work problems that a person with a psychiatric illness may experience, and suggestions for how to manage them. See www.bu.edu/cpr

However, the bottom line is that when a person suffers illness as a result of their work they should be entitled to WCB. If they become ill or disabled while working they should be able to access long-term disability insurance if they require it. Because WCB and disability insurance processes are quite different, recommendations for each will be discussed separately.

Long-Term Disability

Both claimants and the insurance industry would benefit from a more transparent process that would make it easier for claimants to understand the process of making claims and of appealing claims. They could do this by providing more information about entitlements, exclusions, and the reasons for the outcome of an individual's particular claim. They can also clarify and set standards for the process of assessing claims involving psychiatric disabilities.

In speaking with regulators, it appears that one of the problems is that general practitioners and psychiatrists (or other mental health professionals) do not often make the right connections between claimants' symptoms, their disabilities, and their job requirements. The medical community needs to ensure that physicians' reports meet the needs of claimants. The insurance industry needs to ensure that they have a process in place to adequately assess the disability in relation to the person's ability to perform their job.

The insurance industry also needs to make use of a wide range of mental health professionals such as psychologists and occupational therapists. Both of these disciplines have specialties in rehabilitation and mental illness that can effectively assess the connection between the person's symptoms and their job performance.

The industry also needs to carefully examine the assumption that early return to work results in better outcomes for people who are experiencing psychiatric symptoms. The writer's experience suggests that there are numerous factors that would affect the ability to return to work such as diagnosis, severity, and psychosocial stresses and supports. In some instances, an early return to work would result in a worse outcome. Early return to work may be a particular problem when rehabilitation is not part of the insurance coverage package. Regardless, processes need to be in place to guard against sending an employee back to work before they are ready.

Employers can ensure that they are providing adequate coverage for their employees, and that their materials clearly spell out the extent and limits of coverage so that employees can make well-informed personal and financial plans in the event that they do become disabled.

Workers' Compensation Board

There are three areas that should be addressed by the WCB system. The area of greatest concern is the issue of protection of confidential employee medical records from abuse by employers. Physicians and WCB need to ensure that only relevant medical

files are transferred. WCB needs to ensure that employers don't abuse the information that is transferred to them and that there are clear penalties for using records inappropriately.

The second concern relates to the policy deeming psychiatric disability due to stress as not compensated. There is sufficient evidence to demonstrate that some workplaces are psychologically toxic, and that they do lead to increases in illness and injury. Employers should be held accountable for creating such environments, and workers should be able to access compensation when an employer creates that kind of situation.

There is also a particular concern involving individuals who work in occupations (such as emergency health workers) where traumatic events are more common. WCB should develop more equitable policies that address this 'grey area' and compensate individuals who develop stress-related disorders such as PTSD and depression which are triggered by unusually traumatic events of unusual frequency.

While every occupation does involve some stress, employers can do a great deal to alleviate or mediate stress just as they can increase the stress that employees experience. Employers are expected to put physical safety procedures into place; they should be required to put emotional safety procedures into place as well.

The last concern relates to the assumptions that stress at work is inevitable, and that it would not be a problem for a person unless that person had a pre-existing condition. While the assumption that stress at work is inevitable is indisputable, the assumption that it would not be a problem for a person unless that person had a pre-existing condition can be argued. All of us have a pre-disposition to some types of illness because of our particular genetics and experiences. As far as the writer can determine, WCB does not refuse claims for a physical injury because an employee had a pre-disposition to develop that injury, if the injury was a result of a precipitating event in the workplace. At the same time, WCB appears to deem a person as having a pre-disposition to a mental illness because they develop one in a stressful work environment. These claims then get refused even though the work environment may have created or contributed to the illness. This seems to be a discriminatory practice that should be addressed.

Conclusion

For a person who is experiencing psychiatric symptoms, the complexities of understanding and gaining disability insurance coverage can be challenging indeed. The complex quasi-legal system involved in dispute resolution is an additional major obstacle, especially for LTD. When a person is suffering from psychiatric symptoms, one would expect that their ability to manage these kinds of requirements would be diminished. Whether that capacity was diminished or not, the stress of meeting these requirements would likely exacerbate the symptoms.

Because these are time-consuming processes, it can potentially take months or even years to access benefits. This often means that the claimant can be without income for those periods when they are making and appealing claims. The strain on finances can cause a further deterioration in health.

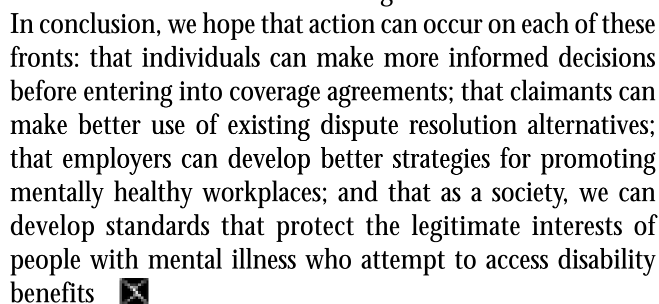
Having a strategy in place so that others can step in to provide assistance and support in the event that one needs to make a claim could potentially help to avoid or lessen these impacts. If you also have the means to create a financial plan that takes into account the potential financial hardship should you become disabled, it can also help to prevent the personal and fiscal catastrophe that can result from being ill and without income.

It is ironic that the process that is supposed to protect people from financial hardship can be one of the contributors of hardship. The reality is that proving that a person has a psychiatric disability that prevents them from working is difficult to do because of the invisibility of the illness, the lack of objective standards for assessing psychiatric disability, and the difficulty of providing information to meet the definition of disability as defined in the insurance policy contract.

Information is power, and therefore the authors of these reports hope that the information and resources provided throughout will make it easier for people with mental illness to understand how to, first of all, find a policy that meets their needs, and then, if necessary, how to navigate the workplace insurance claim or dispute resolution process.

Throughout the report, we've identified a number of issues that individuals and employers should consider before they sign on to a benefit package. These have been consolidated in Part One of the ensuing resource guide, which provides a checklist of questions to consider, from the employee and employer perspective, when considering entering into an LTD coverage agreement. In order to make a successful claim in either LTD or WCB, there are a number of strategies that should be understood and considered by the claimant, his or her advocate, or employer. Again, this report has identified some of these throughout, and Part Two of the resource guide provides a concise list of issues and strategies to consider when making a claim. Part Three of the resource guide provides a further list of helpful resources and websites.

Ultimately, however, the insurance coverage process cannot reasonably serve the needs of people with mental illness until some fundamental issues are addressed, including:



- the lack of insurance industry requirements to divulge information about their decisions around LTD coverage or around the process for LTD dispute resolution
- the lack of knowledge around mental illness in the workplace, leading to misidentification of mental illness and subsequently, the need for individuals with mental illness to access coverage after the fact

In conclusion, we hope that action can occur on each of these fronts: that individuals can make more informed decisions before entering into coverage agreements; that claimants can make better use of existing dispute resolution alternatives; that employers can develop better strategies for promoting mentally healthy workplaces; and that as a society, we can develop standards that protect the legitimate interests of people with mental illness who attempt to access disability benefits

Resource Guide

Part One: Making Informed Decisions about Disability Coverage for Mental Illness: A Checklist of Questions to Consider for Employees and Employers

As employers or employees, investigate your disability insurance coverage before entering into an agreement. Below is a checklist of questions to consider from both standpoints.

1 Considerations for an Employer:

As an employer, if you do not provide a disability insurance package, evaluate the potential value of such a strategy. Comprehensive, appropriate disability insurance coverage at the workplace can make sense from a human resources and economic standpoint. If coverage is available or if you are considering entering into an agreement about coverage, here are some questions and issues to consider about whether the policy would meet the needs of people with mental illness:

- ☐ Does the insurer's definition of disability specify that claimants have 'total disability' or be 100% disabled for any job, whether or not such a position is appropriate to the claimant's training and background? Such a policy would probably be inaccessible to a person with mental illness, given the episodic nature of many mental illnesses.
- ☐ Often, claimants who are granted access to their workplace insurer's disability coverage face a new series of qualifying criteria after two years accessing the plan. In such cases, how do these criteria change, and do they use the 'total disability' criterion here?
- ☐ Does the insurer have a return-to-work strategy in connection with disability coverage for people with mental illness?
- ☐ Does insurer disability coverage encompass funding for a vocational rehabilitation strategy in the event that the claimant cannot return to his/her previous position?
- ☐ Do employees have the opportunity to access short-term and long-term coverage? Short-term insurance coverage can span periods of disability that last 3-6 months, and ideally at that point, long-term disability becomes accessible. Intermittent coverage through the disability insurance provider can exaggerate the stress of mental health issues and delay rehabilitation and/or recovery.

2 Systemic workplace mental health issues

- ☐ Develop a policy for dealing with mental health issues in the workplace. Stress is the reality at most workplaces, but can be improved by sound strategies governing how management addresses the problem of mental illness.
- ☐ Develop consistent, reasonable strategies for dealing with employee mental health issues. Ensure that management does not adopt punitive stances towards those employees with self-confessed mental health issues.
- ☐ Ensure that management and co-workers have an adequate understanding of mental illness and the stigma surrounding it and the need for dialogue.
- ☐ Provide support and follow up to those employees on leave or considered disabled. Returning to work can be facilitated by a show of interest or concern on the part of the employer.
- ☐ Help employees understand and access different aspects of insurance policies and coverage.
- ☐ Adopt a return-to-work strategy with the cooperation of the employee and the insurer to facilitate rehabilitation and recovery.

The benefits of considered policy choices are manifold. Workplace profitability, employees, and even society stand to benefit both from a carefully selected disability insurance package and a comprehensive workplace mental health policy. Disability is not planned; it is best that employees and employers put some thought into coverage issues before just such an eventuality occurs.

3 Considerations for an Employee:

- ☐ Employees can shop around for disability insurance coverage and do not necessarily have to purchase into the plan that is offered through their employer.
- ☐ An insurance broker may be a helpful resource when considering available coverage options independently.
- ☐ When considering whether to accept an existing employer benefit package, examine whether the policy:
  - ☐ Excludes pre-existing illnesses (where, by the definition of the contract, even without a diagnosis, a past prescription of psychiatric medication may constitute a pre-existing illness)
  - ☐ In the event of a pre-existing illness, provides coverage for the re-occurrence of an illness that was demonstrated to be under control (e.g. where there have been no episodes over a certain period of time)

Resource Guide
Part Two: Tips for Making a Claim

For the employee, when considering or making a claim, it is important to:

- ☐ understand exactly what the insurance policy does and does not cover
- ☐ read the insurer's policy booklet and know about claimant entitlements and the process of securing them
- ☐ have a physician and/or another health care provider – this could be a psychologist or an occupational therapist or other rehabilitation professional, such as your mental health caseworker, if you have one – who are supportive and have a good understanding of the reporting requirements needed to justify a claim. These usually include demonstrating proof of the disability and documenting the relationship between the symptoms of the disability and the ability to perform the specific functions of the job
- ☐ when putting forward evidence for your claim, be careful about mentioning office politics and workplace stress in the application for disability; these elements of the workplace are endemic and not considered sufficient in order to qualify for disability coverage. Describe symptoms, not factors in the workplace environment, unless they relate directly to illness-related behaviour or symptoms
- ☐ keep a thorough record of your illness symptoms, as well as notes on conversations with health care professionals and adjusters
- ☐ follow up phone calls to your insurance representative with a letter that describes your understanding of the main points of the conversation, of what had been agreed to and why, and what issues remain to be resolved. Consider asking for a similar letter from the person you spoke to
- ☐ be prepared for claims representatives and adjusters who will require extensive documentation and who may treat you in an adversarial manner. Be assertive yourself, but try not to become angry or aggressive
- ☐ if you're not satisfied with the response from your customer representative or case manager, contact the Claims Manager or even someone at a higher level, such as the Vice President responsible for disability claims, and try to resolve the issue at that level. If this is not successful, find out if the company has an internal Ombudsman whom you can contact. If you have exhausted all opportunities for resolving the dispute internally, see the options described below, and see Part Three on page 46 for more advice or resources related to making or disputing a claim
- ☐ assume that WCB and private insurers will expect you, as the employee, to return to work at the same job or another job. WCB explicitly states this as a goal. This point must be emphasized since many people expect that long-term disability and WCB insurance will be provided if a person cannot work. In reality, it is extremely difficult to prove a permanent inability to work if one has a psychiatric disability.
- ☐ in the event of a disagreement over coverage that cannot be resolved internally, or for general questions about coverage, understand and make use of available resources listed below and others (See Part Three for relevant websites and contact information). These include:
  - ☐ Human Resources personnel
  - ☐ Labour Relations Officers, if in a unionized environment; and in a non-ASO policy, include:
    - ☐ Canadian Life and Health Insurance Association (CHLIA) Consumer Line: for information about policies and procedures
    - ☐ Financial Sector Ombudservices: the federal body that can investigate whether policies were followed, and make recommendations for resolution
    - ☐ BC Financial Insurance Commission: can investigate whether practices were unethical, if they violated the Insurance Act, or if the terms of the insurance contract were violated

Resource Guide

Part Three: Some Useful Resources

Accommodation, Disclosure and Return to Work

- **www.mentalhealthworks.ca**
  This is a CMHA Ontario Division site that provides employer and employee-relevant information about mental health and work issues. Includes discussions that range from support for disclosure decisions to accommodation strategies.
- **www.cmha-bc.org/inventory**
  A CMHA BC Division database of employment and education service providers across BC. The focus of the database is employment and education issues for people with mental illnesses, however the database contains information on a variety of programs, generic or specialized, that may be helpful to vocational planning for consumers.
- **www.janweb.icdi.wvu.edu/media/Psychiatric.html**
  This is an interesting factsheet about accommodations for people with psychiatric illnesses in the workplace from a US-based disability group called the Job Accommodation Network.
- **www.bu.edu/cpr/reasaccom/employ-func.html**
  An interesting article from the Boston Centre for Psychiatric Rehabilitation on the need for accommodations and reasonable strategies for doing so.
- **www.benefitscanada.com/content/legacy/Content/2000/12-00/a16.html**
  An article detailing the personal and professional experiences of a prominent Toronto executive who has a serious mental illness.
- **janweb.icdi.wvu.edu/soar**
  A searchable online resource of disability accommodations. This is a resource available through the US national Job Accommodation Network.
- **www.publiclegaled.bc.ca/working**
  A plain language version of the Employment Standards Act for British Columbians, detailing employee rights and entitlements. Also available at this site in French, Punjabi, Spanish and Chinese.

Accessing Disability Insurance

Please note: most disability insurance companies also maintain their own websites, although most provide limited information for claimants.

- **www.worksafebc.com**
  Contains useful information about the Workers' Compensation Board of BC (WCB), including information on worker safety as well as procedural forms, the WCB Act, how to make claims, how to appeal and related publications.
- **www.insurance-canada.ca/consinfodisability/l25.php**
  A must-see article by Insurance Canada for anyone shopping for disability insurance coverage.
- **www.about-disability-insurance.com**
  An informational resource for people seeking to purchase disability insurance coverage or to understand existing coverage. This site is oriented to a US market, but much of the information is also relevant to Canadian plans.
- **www.insurance-canada.ca**
  Informational resource for Canadian employers, providers, and consumers of insurance services. Consumer disability issues are explored through various online articles and shopping advice.
- **www.insurance-canada.ca/consinfogeneral/whencomplaint.php**
  Article from the website of Insurance Canada, a website providing information to insurance professionals and consumers. The article details what a policyholder should do in the event of a dispute about disability coverage.
- **www.disabilityinsuranceforums.com**
  This is a US-based disability discussion board forum on a variety of disability claim issues. Canadian clients can request information as well. A search for specific disability issues can be made by registered users through a variety of forums directed at consumers, employers and providers.
- **www.mhr.gov.bc.ca/PUBLICAT/bcea/pwd.htm**
  Online brochure outlining BC Employment and Assistance Policy for Persons with Disabilities, the provincial assistance program for people with disabilities.
- **www.hrdc-drhc.gc.ca/isp/cpp/disabi_e.shtml**
  Information on accessing Canada Pension Plan disability coverage.

Resolving Disputes

In addition to the resources listed here, some workplaces also staff an Ombudsperson to assist in case of dispute between staff members and insurance carriers.

- **www.cfson-crcsf.ca** or call 1-866-538-3766/ 1-866-668-7273 (for services in French)
  The Financial Services OmbudsNetwork (CFSON), in order to use this service, you must first have tried to resolve your complaint at the company level. If you have done so and are still not satisfied, the Centre will refer you to one of the three industry-level ombudservices, including the Canadian Life and Health Insurance OmbudService (CLHIO), for life- and health-related insurance complaints, at www.clhia.ca

- **www.fic.gov.bc.ca**
  Information about the BC Financial Institute Commission and its oversight role of financial institutions, including insurance companies, in BC.

Policy Issues

- **www.cmha-bc.org/bottomline**
  Bottom Line Conference: A one-day annual conference arranged through the Canadian Mental Health Association in downtown Vancouver addressing the issue of mental health in the workplace from the employer's perspective.
- **www.mentalhealthaddictions.bc.ca**
  The Primer: BC Partners for Mental Health and Addictions Information fact sheets on mental health and addictions issues, including overviews on the impact of mental health issues on the economy.
- **www.mentalhealthroundtable.ca**
  Global Business and Economic Roundtable on Addiction and Mental Health: This Canadian Initiative is focused on generating momentum among the business community to deal with the economic and health-oriented issues surrounding mental health and work.
- **www.wsib.on.ca/wsib/wsibsite.nsf/Public/HealthPhysiciansGuideRTW**
  Physician's Guide to Return to Work: This is a guide produced in Ontario for the purposes of facilitating physician communication with stakeholders in the process of negotiating disability claim status.
- **www.wsib.on.ca/wsib/wsibsite.nsf/LookupFiles/DownloadableFilePhysiciansRTWGuide/$File/RTWGP.pdf**
  Injury/Illness and Return to Work/Function: A comprehensive guide for physicians and psychiatrists in how to communicate effectively with insurance providers.
- **www.ontarioinsurance.com**
  Describes the insurance regulatory process in Ontario, which could be considered a model for other provincial disability regulatory policy.
- **www.ibc.ca**
  Insurance Bureau of Canada: This is a site dedicated to advocating insurer issues in Canada. It is a useful source for determining current regulatory issues in the industry.
- **www.cmha-bc.org/content/resources/research/reports/fed_income.pdf**
  Position Paper on Federal Income Security Programs: CMHA National paper by Wendy Steinberg outlining the implications of federal supports to people with mental illnesses. Finishes by outlining CMHA National's position on key policy issues.
- **www.gvbln.ca**
  The Greater Vancouver Business Leadership Network: Group promoting the hiring and retaining of employees with disabilities among businesses in the Lower Mainland of BC.

Appendix 1: Individuals Interviewed for Issues Paper on WCB and Long-Term Disability Insurance

Long-term disability insurance

Rob Mayhew
Financial Institute Commission, Province of BC

Terry James
Financial Institute Commission, Province of BC

Joanne Fortin
Insurance Commission of Ontario

Mary Bowles
Manager, Consumer Assistance Centre,
Canadian Life and Health Insurance Association

Chuck Wilson
Ombudsman,
The Cooperators Insurance

WCB

Barb McAloney
Worker's Advisor's Office,
Ministry of Skills Development and Labour

Peter Hopkins
WCB Ombudsman

Dr. Greg Meloshe
Director of Psychological Services, WCB

Dr. Elsie Cheung
Psychologist, WCB

CANADIAN MENTAL HEALTH ASSOCIATION

L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

Addendum

Page 38 of this report discusses the Workers' Compensation Board (WCB) claims process, in relation to people with mental illness. Since this report was written, certain changes have come into place.

- Under the new legislation which governs WCB, claims can be accepted for "mental stress", (post traumatic stress disorder and related disorders) where the condition results directly from a workplace injury or occupational disease (as it was under the old legislation), but also if "it is an acute reaction to a sudden and unexpected traumatic event arising out of and in the course of a worker's employment". The term "acute reaction" means that is sudden and extreme, but may not be immediate, and may occur up to two weeks after the traumatic event is experienced.

- The way in which pre-existing conditions are evaluated has changed somewhat. According to WCB: "WCB's number one mandate is to prevent accidents. But following a workplace accident, our mandate expands to provide treatment for workplace injuries to return the worker to their "pre-injury" level of functioning. In the situation where the worker has a pre-existing disorder, WCB must determine what portion of the current difficulty is related to pre-existing conditions and what portion is related to a work injury. Treatment is limited to the work-injury condition and is not supported after a return to the pre-injury level of functioning. As with any kind of injury, if treatment does not return the worker to his/her pre-injury level of functioning, he/she may be eligible for a permanent functional impairment award based on the remaining degree of disability attributable to the work injury."

- Some changes have been made to the appeal process. The changes reduce the levels of review and appeal of WCB decisions from three to two, create a new internal review function in an attempt to improve the quality of initial decision-making and establish a new, independent appeal tribunal as the final level of appeal for workers' compensation matters. For a description of the new appeal process, see www.labour.gov.bc.ca/wab