DECISION OF THE WORKERS' COMPENSATION APPEAL TRIBUNAL

Introduction

[1] The worker has appealed the September 28, 2015 decision (*Review Decision #R0191118*) of the Review Division of the Workers' Compensation Board (Board)[1] to the Workers' Compensation Appeal Tribunal (WCAT). The review officer varied the February 2, 2015 decision by a disability awards officer to grant the worker a permanent partial disability award of 15% of total disability for her permanent condition of a Major Depressive Disorder (MDD), effective August 1, 2012. The review officer increased the worker's permanent partial disability award to 25% of total disability.

[2] The worker is represented by a lawyer. By notice of appeal dated October 27, 2015, the worker requested that her appeal be heard in writing. The worker provided a submission on February 4, 2016, which enclosed a report by Dr. Rami Nader, a registered psychologist, concerning his psychological assessment of the worker on January 11, 2016.

[3] The employer, represented by a consultant, provided a submission on February 15, 2016. The worker provided a rebuttal on March 3, 2016. On March 9, 2016, a WCAT appeal coordinator advised that submissions were considered complete.

[4] The worker's appeal requires consideration of expert evidence regarding the assessment of her psychological disability and does not involve any significant issue of credibility. I find that the worker's appeal can be properly considered on the basis of the written evidence and submissions without an oral hearing.

Issue(s)

[5] Was the worker's permanent psychological disability due to her MDD correctly assessed at 25% of total disability, effective August 1, 2012?

Jurisdiction

[6] The Review Division decision has been appealed to WCAT under section 239(1) of the *Workers Compensation Act* (Act). WCAT may consider all questions of fact, law, and discretion arising in an appeal, but is not bound by legal precedent (sections 250(1) and 254 of the Act). WCAT must make its decision based on the merits and justice of the case, but in so doing must apply a published policy of the board of directors of the Board that is applicable (sections 250(2) and 251 of the Act).

[1] operating as WorkSafeBC

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[7] WCAT has jurisdiction to consider new evidence, and to substitute its own decision for the decision under appeal. If the evidence supporting different findings is evenly weighted on an issue respecting the compensation of a worker, WCAT must resolve that issue in a manner that favours the worker (section 250(4) of the Act).

Background and Evidence

[8] The worker, a custodian performing janitorial services, submitted an application for compensation on December 29, 2011. She advised she was suffering from depression due to years of verbal abuse and bullying by her immediate supervisor. Her last day of work was October 3, 2011.

[9] By report dated September 23, 2008, Dr. P. Thillainadarajah diagnosed the worker as probably suffering from a chronic adjustment disorder with anxious mood and paranoia.

[10] By report dated January 20, 2012, Dr. T. Catona, a psychiatrist, noted the worker reported depression and anxiety, with onset at least four or five years earlier, which the worker attributed to harassment at work. Dr. Catona diagnosed major depression, chronic, severe, treatment resistant, without psychosis or suicidality. In a subsequent report based on the worker's last visit on March 1, 2012, Dr. Catona noted that the worker was calmer, depressed – moderate, and anxious – moderate.

[11] In a report dated June 4, 2012, Dr. H. Mallavarapu, a psychiatrist, diagnosed the worker with MDD and post-traumatic stress disorder (PTSD), due to harassment by her supervisor.

[12] On December 20 and 23, 2013, the worker was assessed by Dr. A. S. Shergill, a registered psychologist. In a report dated January 14, 2014, Dr. Shergill diagnosed the worker with MDD, Single Episode, with anxious distress, moderate severity (with no significant indicator of any personality disorder). Dr. Shergill did not consider that the worker presented with PTSD or an independent anxiety disorder. Dr. Shergill found that the worker's MDD likely developed as a direct result of her workplace stress related to the harassment by her supervisor.

[13] Dr. Shergill advised:

> **3. Describe psychological restriction or limitations the client may have regarding work and or daily activity as a result of diagnosed psychological condition(s).**
>
> i. Restrictions (activities to be avoided)
>
> There are no psychological restrictions associated with [the worker's] Major Depressive Disorder.
>
> ii. Limitations (inabilities or difficulties)
>
> a) [The worker] is likely to have moderate difficulties engaging in tasks requiring sustained concentration, tasks with low error threshold, and multitasking.

b) [The worker's] productivity is likely to be moderately compromised due to her low energy, fatigue, and sleep disruption. She is unlikely to be able to complete a full workday initially and is likely to require a gradual return to work upon completion of her psychological treatment.
c) [The worker] is likely to have significant difficulty managing workplace stress and conflict, respond constructively to criticism and feedback, and is likely to require ongoing psychosocial support.
d) [The worker] reported pre-existing, but undiagnosed, learning disabilities and dyslexia which are likely to be a barrier with respect to vocational training process.

[all quotations reproduced as written, except as noted]

[14] Dr. Shergill further advised:

7. Description of worker's functioning in the following spheres:

i. Activities of daily living

[The worker] seems to be independent with respect to her activities of daily living, self-care, personal hygiene, communication, ambulation, and driving. However, she reported significant difficulties with respect to her sleep maintenance, most household tasks, child rearing, and social and recreational activities due to fatigue, low energy, and vegetative depressive symptoms. She also reported an absence of libido.

ii. Social functioning

[The worker] seems to be leading a rather sedentary lifestyle confined to her home and being socially isolated and withdrawn due to depression and anxiety. She reported some improvement in her irritability and anger, but it still seems to be an ongoing stressors in her life.

iii. Concentration, persistence and pace

As per restrictions and limits noted previously.

iv. Deterioration or decompensation in complex or work-like settings

As per restrictions and limits noted previously.

[15] Dr. Shergill considered that the worker would benefit from a referral to a registered psychologist with ongoing pharmacological interventions. He also suggested that the worker be referred to some form of reactivation program, in consultation with her psychologist, likely in about two months after commencing her psychological treatment. Dr. Shergill explained that psychological interventions, in the absence of behavioural activation, were unlikely to be sufficient by themselves.

[16] By decision dated March 31, 2014 (*Review Decision #R0155958*), a review officer found that the worker's psychological condition was predominantly caused by the bullying and harassment that occurred in the workplace.
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[17] An independent evaluation of the worker was performed by Dr. J. N. Russell, a psychiatrist, on May 26, 2014. Dr. Russell noted the worker was being prescribed a high dosage of an antipsychotic medication (asenapine) that, in his opinion, was not clinically indicated and was probably contributing to her complaints of being so sedated, fatigued, and cognitively impaired that she could not function in her household or workplace.

[18] By memorandum dated July 30, 2014, Dr. D. Eveleigh, a registered psychologist and Board senior psychology advisor, commented:

> In summary, there are uninterrupted references to significant psychological symptoms in the currently available file documents since May, 2011. [The worker's] symptoms appear to have changed very little over the past three years, despite having been treated with psychotherapy and numerous psychotropic medications. In January, 2012, Dr. Catona referred to the worker's condition as being "treatment resistant." In September, 2013, Dr. Strovski noted that there had been "no progress for a long time." In May, 2014, Dr. Russell suggested ECT [electroconvulsive therapy] due to the fact that several years of medications had led to no real improvement in the worker's symptoms. Given these comments, it appears that [the worker] has reached clinical plateau in her recovery. Additional treatment is not expected to significantly improve her symptoms.
>
> File records suggest the onset of [the worker's] depression occurred around May of 2011. By the following January, Dr. Catona was noting that the condition was not responding to treatment. Current medical reports suggest that the condition still has not responded to treatment. Using a generous estimate, it appears that the diagnosed Major Depression reached plateau approximately 12 – 14 months after onset (i.e., May – July, 2012).

[19] Wage loss benefits were paid from October 3, 2011 until July 31, 2012. By decision dated August 13, 2014, the case manager found the worker's condition had plateaued. The worker's MDD was accepted as a permanent condition. The case manager found the worker had no medical restriction due to her MDD. The case manager accepted the following limitation as preventing the worker from performing her pre-injury job:

> - Limited in your physical tolerance and productivity due to low energy level and fatigue

[20] The case manager further noted:

> WorkSafeBC medical advisor's opinion is that you are unable to return to your pre-injury job due to ongoing symptoms consistent with Major Depressive Disorder. WorkSafeBC psychology advisor and Medical advisor have concluded from medical evidence on file that your condition has not responded to treatment in a long time . **You stated that you are satisfied with your current treatment**

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> **from Dr. Mallavarapu and are not considering other treatments as suggested by Dr. Russell. As such further improvement is not anticipated and no further treatment is recommended at present.**
>
> [emphasis added]

[21] By report dated October 28, 2014, Dr. S. Strovski, the worker's attending physician, advised that the worker had been attending his office every two weeks since 2011. He advised that the worker had recently completed a questionnaire in which she reported that on a daily basis she suffered from:

- Little interest or pleasure in doing things
- Feeling down, depressed or hopeless
- Trouble falling / staying asleep or sleeping too much
- Feeling tired or having little energy
- Have poor appetite or overeating
- Feeling bad about herself – or that she is a failure or has let herself or her family down
- Trouble concentrating on things, such as reading the newspaper or watching television
- Feeling restless

[22] Dr. Strovski advised that these symptoms had been present over the last three years. The worker had seen psychiatrists over the years and tried different medications but these had very limited effect on her condition. Dr. Strovski advised that it was his opinion that the worker was unable to return to work, even on a part-time basis.

[23] The worker underwent a one-day Functional Capacity Evaluation, on July 22, 2015. By report dated July 28, 2015, Ms. K. Chan, consultant occupational therapist, advised that it was her opinion that the worker was not able to complete the full scope of the duties associated with the occupation of janitors, caretakers and building superintendents, for the following reasons:

- Significant tearfulness that impacted test progression was observed during review of her pre-injury work duties and position (e.g., janitorial duties).
- Difficulty coordinating job duties with other janitors assigned to the same facility.
- Difficulty to effectively interact with staff and public.
- Difficulty with prolonged sustained attention when operating powered cleaning equipment to ensure safety.

[24] Ms. Chan advised that the worker was not suitable for part-time employment in the occupation of janitors, caretakers and building superintendents. She advised that, based on the worker's demonstrated functional abilities, it would be reasonable for the worker to pursue gainful part-time employment, on a gradual basis, with the following considerations:

- Work duties are primarily completed independently with minimal interactions with co-workers and no requirement to interact with the general public

- Instructions should be provided using verbal description and accompanied by rehearsal opportunities to ensure accuracy.
- No requirement for intensive or significant attention demands (e.g., prolonged sustained attention, auditory selective attention, auditory-verbal working memory, attentional switching, cognitive flexibility, and divided attention).

[25] Ms. Chan advised that the worker provided mostly accurate estimates of her physical capabilities. However, objective measurements, at times, revealed discrepancies between her disability reports and her demonstrated functioning. Testing revealed lesser levels of restriction than her self-reporting suggested. Ms. Chan noted that this did not imply intent. She recommended that guidelines regarding the worker's physical capacity to perform work incorporate objective findings, and that some degree of caution be utilized when interpreting the worker's subjective reports.

[26] By memorandum dated January 29, 2015, the Board's Psychological Disability Awards Committee (PDAC) met to review the level of the worker's functional psychological impairment. In a preamble to its report, the PDAC cited the policy set out in the Permanent Disability Evaluation Schedule regarding the assessment of psychology disability (contained in Appendix 4 to the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II)). The PDAC also cited its own Section 23(1) practice guidelines. The PDAC referred to the policy as "an administrative tool and not a clinical rating scale." The PDAC commented:

> The Psychological Permanent Disability Evaluation Schedule is based on, but not identical to, the categories outlined in the American Medical Association Guides to the Evaluation of Permanent Impairment. These category descriptors were elaborated on during the development of the Board's Psychological Permanent Disability Schedule.
>
> **While some of the language in the Schedule refers to the severity of symptoms, the focus of the rating is on functional impairment. Symptoms represent a person's subjective experience and are useful in establishing a diagnosis; however, they do not correlate directly with impaired functioning.** In reviewing the material, the person's symptoms and subjective complaints are considered within the context of clinician observations and psychometric test results to arrive at a balanced estimate of functional impairment.
>
> **The use of the terms mild, moderate, marked-extreme in the Schedule do not correlate directly with clinical terminology. The permanent functional impairment ratings in the Schedule relate to the calculation of the award and should not be taken as a rating of the degree of psychological impairment.** These terms are used with reference to the internal structure of the Psychological Disability schedule, and for the sole purpose of determining the permanent psychological functional impairment rating. For example, a rating of 20% relates to the calculation of the permanent functional award and does not indicate 20% impairment in psychological functioning.

> **Another challenge in the use of terminology is that subject matter experts also use terms such as "mild", "moderate", and "severe" to describe many different aspects of the clinical picture. To ensure a proper understanding of the available documentation, it is important to distinguish between the severity of the symptoms, the severity of the diagnosed condition and the severity of the functional impairments.**
>
> **The PDAC award is specifically concerned with the level of psychological impairment, and not the level of psychological symptoms. Psychological symptoms represent a person's subjective experience and do not correspond directly to psychological functional impairment.** For example, an individual may feel sad all day every day, but still be able to perform most daily activities with little or no difficulty. For this reason, the overall level of severity of psychological symptoms is not a good measure of the overall level of psychological impairment arising from those symptoms.
>
> Similarly, the use of the term "significant" can be used in multiple ways. This term does not typically relate to a clinical rating scale, but most often is used by clinicians to mean "clinically or diagnostically meaningful" in order to distinguish it from normal fluctuations in functioning.
>
> Because of these language issues, when PDAC reviews clinical reports consideration is given to the meaning of the report as a whole, rather than on single word descriptors or categorical statements.
>
> The situation may arise in which the Board provides an adjudicative decision that a worker's condition is "at plateau" at the same time, a clinician provides an opinion that the worker has some possible chance of improvement with time and or therapy and is therefore "not at plateau." While the Board's decision is informed by clinical expertise, it is important to note that one is based on adjudicative criteria and the other on clinical criteria.
>
> In weighing the clinical evidence, PDAC recommendations are informed by all of the evidence on file taken within the broad context of the work injury claim. Individual pieces of evidence are weighed and considered with other evidence to arrive at an integrated view of the worker's psychological functioning.
>
> [emphasis added]

[27] The PDAC addressed the worker's psychological restrictions and limitations as follows:

> A limitation is an inability or reduced capacity for a specific activity. Limitations reflect both capacity and tolerance and can often be mitigated by appropriate environmental accommodations.
>
> A restriction is a clinical proscription to avoiding a particular activity because of immediate risk of harm to self or others, or because of the likelihood that

Workers' Compensation Appeal Tribunal

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engaging in the activity will significantly increase the Injured Worker's permanent impairment.

The psychological restriction(s) accepted on claim are:

- None.

The psychological restriction(s) identified in the psychological assessment report are:

- None.

In comparing the accepted restrictions to those identified in the psychological assessment, the committee finds them to be equivalent for the purposes of determining the worker's psychological permanent functional impairment.

The psychological limitation(s) accepted on claim are:

- **Limited in physical tolerance and productivity due to low energy level and fatigue.**

The psychological limitation(s) identified in the psychological assessment are:

- **[The worker] is likely to have moderate difficulties engaging in tasks requiring sustained concentration, tasks with low error threshold, and multitasking**
- **[The worker's] productivity is likely to be moderately compromised due to her low energy, fatigue, and sleep disruption; she is unlikely to be able to complete a full work day initially and is likely to require a gradual return to work upon completion of her psychological treatment**
- **[The worker] is likely to have significant difficulty managing workplace stress and conflict, responds constructively to criticism and feedback, and is likely to require ongoing psychosocial support.**

In comparing the accepted limitations to those identified in the psychological assessment, the committee finds them to be that the limitations suggested by Dr. Shergill appear relevant and therefore were used for the purposes of determining the worker's psychological permanent functional impairment.

Restrictions and limitations not considered in this rating are:

- [The worker] reports pre-existing, but undiagnosed, learning disabilities and dyslexia, which are likely to be a barrier with respect to vocational training process.

[emphasis added]

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[28] The PDAC evaluated the level of the worker's psychological impairment as follows:

> [The worker] has a number of ongoing symptoms of lowered mood and heightened anxiety. These symptoms include feelings of emptiness, emotional numbness, loss of appetite, sleep disturbance, heightened anxiety, heightened tiredness, and an absence of libido. As a result of these symptoms, she has a number of impairments in her every day and anticipated future work life. These impairments include reduced sleep functioning, reduced sexual functioning, and reduced social functioning due both to her social withdrawal and heightened irritability. Such impairments are consistent with minor residual impairment with some increased risk of decompensation under stressful situations. This would place her at an overall mild Permanent Functional Impairment range at a level of 15%. Note that this 15% reflects only the level of her psychological impairments and not directly the severity of the psychological symptomatology underlying those impairments.
>
> Although [the worker] has been determined to have pre-existing psychological issues, there is no evidence that these psychological issues impaired her from work nor would have affected her earning capacity and likely did not meet minimal criteria for consideration of a formal psychological impairment. As such, it is considered that her pre-existing impairment was at 0%. (Although there is description from Dr. Thillainadarajah of psychological impairment from September 2008, this assessment occurred two years after [the worker] would have first been subjected to workplace bullying and so therefore is not evidence of pre-existing impairment.)
>
> ...
>
> In this specific case, the PDAC has determined that the compensable condition(s) is rated at 15% of total. The non-compensable factors are considered to have had no measurable impact on disability. In other words, the total disability of 15% in this case is attributed entirely to the compensable factors.
>
> Therefore, PDAC recommends a psychological permanent functional impairment award in the Mild range of 15% to reflect the impact of the compensable conditions on the worker's psychological functioning.

[29] By decision dated February 2, 2015, a disability awards officer granted the worker a permanent partial disability award of 15% of total disability, for her permanent condition of MDD. The disability awards officer noted that her decision was based on the psychological assessment performed by Dr. Shergill on December 20, 2013. The award was calculated on the basis that the worker would have retired at age 65.

[30] The worker requested a review of the February 2, 2015 decision. The review officer concluded that the worker's impairment rating in respect of her accepted permanent MDD condition was 25% of total disability. The review officer found that the worker's impairment level was in the mild rather than the moderate range:

> In general, I agree with PDAC's characterization of the worker's impairment level as mild and that her residual symptoms are compatible with most useful functioning. While the worker's solicitor submitted that the worker's impairment was in the moderate range, the evidence does not support this and I note that there is no medical or psychological opinion before me directly contradicting PDAC's conclusions on this point.

[31] However, the review officer found that an increase in the worker's award was warranted. The review officer reasoned, with reference to Dr. Shergill's January 14, 2014 report:

> In my view, the worker's impairment falls in the upper range of the mild psychological impairments rather than the mid-range. Specifically, I note that in her Psychology Assessment Report, Dr. S noted that the worker would "likely have significant difficulty managing workplace stress and conflict, [and] respond[ing] constructively to criticism and feedback." I interpret this as supporting that the worker was at a moderate risk of decompensation under stressful situations. Dr. S also noted that the worker would "likely require ongoing psychosocial support". I interpret this as supporting that the worker will likely require ongoing treatment and support. In my view, these factors support an award in the 20 to 25% range.
>
> Dr. S noted that the worker's productivity was moderately compromised and that she has moderate difficulties with tasks requiring concentration, accuracy and with multi-tasking. This suggests that the worker will require accommodation in order to return to work. I note that a subsequent Functional Capacity Evaluation determined that the worker was capable of only part-time work. However, Dr. S's report does not, in my view, support that the worker was at an increased risk of decompensation under moderate stress or that she had an inadequate adaptation to impairment even with accommodation which are elements of impairment rating in the 30 to 35% range. Further, Dr. S did not indicate that the worker was incapable of returning to work, only that she would require accommodation. A lack of significant competitive vocational capacity would be required to support an award in the 50 to 60% range.
>
> As such I conclude that an award in the upper range of mild psychological impairments is warranted. Having regard to the evidence before me, including Dr. S's Psychology Assessment Report, the other psychological and psychiatric evaluations on the file and the submissions made by the worker's solicitor and the employer, I conclude that the worker's impairment rating in respect of her accepted permanent MDD condition is 25% of total disability.

[32] The worker has appealed the September 28, 2015 Review Division decision to WCAT.

Workers' Compensation Appeal Tribunal

150, 4600 Jacombs Road, Richmond, B.C. V6V 3B1
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[33] By decision dated December 9, 2015, a case manager, Special Care Services, found that a light duty cleaner position and part-time schedule of 20 hours per week offered by the employer were reasonable and within the worker's accepted limitations. The Board officer found that the worker was not entitled to a loss of earnings pension assessment.

[34] The worker requested a review of the December 9, 2015 decision. In support of her request for review, she submitted the report dated January 13, 2016 by Dr. Nader (the same report provided in support of this appeal). Dr. Nader's report was based on an assessment of the worker on January 11, 2016. By decision dated April 4, 2016 (*Review Decision #R0200818*), a review officer found the modified job offered by the employer was not suitable for the worker, and that the worker was eligible for a loss of earnings assessment. The review officer reasoned:

> The Board concluded that the modified position was suitable for the worker on a part-time basis given that the only compensable limitation accepted on her claim is limited physical tolerance and productivity due to low energy level and fatigue. In order to truly appreciate the extent of the worker's limitations, I reviewed a psychological assessment report dated January 14, 2014 written by Dr. S, another registered psychologist. Dr. S conducted a comprehensive two day assessment of the worker with psychological testing. Dr. S's observations with respect to the worker's presentation were similar to Dr. N's observations. Furthermore, Dr. S specifically addressed the nature of the worker's psychological limitations. Therefore, I have given his opinion significant weight.
>
> Based on his assessment of the worker, Dr. S concluded that the worker had the following limitations as a result of her MDD:
>
> - The worker is likely to have moderate difficulties engaging in tasks requiring sustained concentration, tasks with low error threshold, and multitasking.
>
> - The worker's productivity is likely to be moderately compromised due to her low energy, fatigue, and sleep disruption. She is unlikely to be able to complete a full workday initially and is likely to require a gradual return to work upon completion of her psychological treatment.
>
> - The worker is likely to have significant difficulty managing workplace stress and conflict, responding constructively to criticism and feedback, and is likely to require ongoing psychosocial support.
>
> For the reasons noted above, I agree that this is an accurate list of the worker's compensable limitations. Furthermore, Dr. S's observations of the worker during the assessment and his information regarding the worker's self reports is also consistent with Dr. N's conclusions and the FCE [functional capacity evaluation] report's recommendations. For example, Dr. S noted that the worker had significant difficulties with basic tasks such as child rearing and house cleaning due to fatigue, low energy, and vegetative depressive symptoms. Dr. S also noted the worker's significant tearfulness and anger issues as did Dr. N.

> Given Dr. S's observations and conclusions with respect to the worker's limitations and her depressive presentation/symptoms, Dr. N's observations and conclusions with respect to the worker's ability to perform the modified position, and the FCE results, I find that the modified job offered by the pre-injury employer is not suitable for the worker. In a memorandum dated September 10, 2015, the VRC [vocational rehabilitation consultant] noted that he was unable to identify any other alternate part-time employment for the worker. Therefore, in the absence of any other alternative occupation for the worker, I find that she is eligible for a loss of earnings assessment.

[35] By decision dated May 26, 2016, a case manager, Special Care Services, advised the worker that she would refer the worker's claim back to the vocational rehabilitation consultant to determine alternative occupations. Once this assessment was complete, the case manager would give further consideration to a loss of earnings award. The case manager noted:

> Briefly, the Review Decision decided that:
>
> - Additional limitations needed to be considered in order to accurately assess you[r] entitlement to a loss of earnings award. I have accepted the following new limitations as permanent:
>
>   1. The worker is likely to have significant difficulty managing workplace stress and conflict, responding constructively to criticism and feedback.
>
>   2. Productivity is likely to be moderately compromised due to her low energy, fatigue, and sleep disruption.
>
>   3. The worker is likely to have moderate difficulties engaging in tasks requiring sustained concentration, tasks with low error threshold, and multitasking.
>
> The following existing limitation remains unchanged:
>
> - Limited in ability to tolerate full-time or part-time work in her pre-incident position as a Building Worker due to low energy level and fatigue.

[36] In his report of January 13, 2016, Dr. Nader provided an opinion that the worker's permanent functional impairment related to her MDD would be 50%, based on the PDAC Section 23(1) Guidelines. Dr. Nader advised:

> With regards to the severity of residual symptoms, it is my opinion that [the worker's] current depressive symptoms are [in the] moderate to severe range. Dr. Catona's January 2012 report noted that [the worker's] depression was severe, while Dr. Shergill's January 2014 report concluded that her depression was in the moderate range. The records consistently note that [the worker] demonstrated little to no improvement in her symptoms over the years. Based on

> the current assessment, I would place [the worker's] depression into the moderate to severe range, specifically highlighting her high levels of fatigue, social isolation/withdrawal, extremely low levels of motivation or interest in activities, and irritability/anger. Therefore, I would disagree with the Review Officer's position that [the worker] is experiencing only mild residual symptoms (PFI [permanent functional impairment] range of 25%).

[37] Dr. Nader expressed the opinion that the worker was at relatively high risk of decompensation under normal stress conditions. He noted:

> … Her limited capacity to manage stress was noted on a number of occasions throughout the clinical records and reports. She was unable to describe any adaptive methods for managing stress, noting that her primary coping mechanism for dealing with stressful situations is to go to bed. She was so dysregulated by being five minutes late to an appointment (what many would consider a relatively minor stressor) that she was unable to work her cell phone and broke into tears at the start of the assessment.

[38] Dr. Nader expressed the opinion that the worker demonstrated notable difficulties in executive functioning. He noted:

> … She demonstrates difficulties with planning, initiating and completing goal directed activities, as demonstrated by her lack of participation in activities, or following through with her psychiatrist's recommendations (e.g. regular walking). It is important to note that executive dysfunction is commonly seen in Major Depressive Disorder.
>
> [footnote deleted]

[39] Dr. Nader did not consider that the worker was currently able to return to work, even on a part-time basis, due to her current depressive symptoms. He advised:

> … Her current energy level appears to be barely keeping up with the minimal demands she has in her life, such as grocery shopping or taking her daughter to school. Such seemingly mild activities exhaust [the worker] and she spends much of her day lying down or in bed. As demonstrated in her behavior during the assessment, she easily lost focus when responding to questions and appeared spent after a two hour and fifteen minute assessment. During the assessment, she had difficulty regulating her emotions and demonstrated notable displays of emotional distress and anger/irritability, with relatively little in the way of provocation. I cannot imagine how it would be expected that [the worker] could regularly attend work on a day to day basis, being expected to be productive for four hour shifts, given that taking her daughter to school exhausts her.

[40] Dr. Nader did not believe the worker would be able to manage or cope with the inevitable stressors and challenges that would be present even in a "low stress" work environment. With respect to the functional capacity evaluation, Dr. Nader noted that this primarily focused on the worker's physical and cognitive abilities, with little attention to her psychological functioning

during the functional capacity evaluation and how that would impact her ability to work. From a psychological perspective, he did not believe the functional capacity evaluation demonstrated that the worker was capable of managing and regulating her emotional responses in a manner that would be appropriate in a work setting.

Policy and Practice

[41] Section 23(2) of the Act provides:

> The Board may compile a rating schedule of percentages of impairment of earning capacity for specified injuries or mutilations which may be used as a guide in determining the compensation payable in permanent disability cases.

[42] The Permanent Disability Evaluation Schedule is contained in Appendix 4 to the RSCM II. It constitutes policy of the board of directors of the Board. The schedule provides:

XX. Psychological Disability

> Due to overlapping symptoms across diagnoses and their potential interactions, psychological disability awards are not made per diagnosis. All accepted psychological diagnoses are combined and rated as a whole.

A. Aphasia and Communication Disturbances

	Percentage
Mild - minimal disturbance in comprehension and production of language symbols of daily living	0 – 25
Moderate - moderate disturbance in comprehension and production of language symbols of daily living	30 – 70
Marked - inability to comprehend language symbols. Production of unintelligible or inappropriate language for daily activities	75 – 95
Extreme - complete inability to communicate or comprehend language symbols	100

B. Disturbances of Mental Status and Integrative Functioning

	Percentage
Mild - some impairment but ability remains to satisfactorily perform most activities of daily living	0 – 25
Moderate - impairment necessitates direction and supervision of daily living activities	30 – 70
Marked - impairment necessitates directed care under continued supervision and confinement in home or other facility	75 – 95
Extreme - individual is unable without supervision to care for self and be safe in any situation	100

Workers' Compensation Appeal Tribunal

150, 4600 Jacombs Road, Richmond, B.C. V6V 3B1
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C. Emotional (Mental) and Behavioural Disturbances

The impairment levels below relate to activities of daily living, social functioning, concentration and adaptation.

	Percentage
Mild - impairment levels are compatible with most useful functioning	0 – 25
Moderate - impairment levels are compatible with some but not all useful functioning	30 – 70
Marked - impairment levels significantly impede useful functioning	75 – 95
Extreme - impairment levels preclude most useful functioning	100

Disability ratings greater than 0% are made in 5% increments.

[43] The July 19, 2004 Permanent Psychological Impairment Guidelines are not policy. They represent Board practice, and commence by stating:

> Item # 39.01 of the Rehabilitation and Claims services manual requires that an interdisciplinary committee make determinations regarding the extent of permanent psychological impairment. Given the nature of psychological impairments there will always be a larger degree of subjective judgement and interpretation in awarding percentages for these conditions. For that reason, the schedule was approved with the requirement that awards be reviewed and granted by the Committee. This is an expansion of previous Board policy that required the Senior Psychologist to review all awards. This provides a more concentrated experience base and consistency of decision making across claims.
>
> In an ongoing effort to provide consistency of adjudication, the Psychological Disability Awards Committee (PDAC) have been developing and refining guidelines within the approved schedule of psychological impairments published in the RS&CM.
>
> An example of the challenges PDAC faces is reconciling comments and opinions from subject matter experts where terms such as mild, moderate and severe are used in the absence of common definitions. The PDAC awards are based on, but not identical to, the categories outlined in the American Medical Association Guides to the Evaluation of Permanent Impairment. These categories were modified during development of the Board's Psychological Disability Schedule. In addition, psychological disorders are typically diagnosed based on the Diagnostic and Statistical Manual of Mental Disorders, which also uses the terms mild, moderate and severe, but once again with different definitions.
>
> PDAC have developed a set of guidelines that outline the behavioural descriptors and anchors on which the schedule was developed. These guidelines are under

Workers' Compensation Appeal Tribunal

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continuing development, so care should be taken to reference the current version posted on this site.

One drawback to the Committee structure is a lack of experience and understanding amongst stakeholders as to how decisions are reached. The current guidelines are attached for your information in an effort to provide additional clarity. It should remembered that these are functional awards, and as such are based on the nature and degree of the injury as it impacts vocational capacity, and not the client's actual or presumed employment or employability.

[44] The Guidelines provide:

In order to be eligible for consideration of an award, the following minimal criteria must be met:

- psychological diagnosis is related to the work incident
- if there is a pre-existing condition, at least a portion of the current psychological impairment arises from the work incident
- psychological impairment is affecting or has the potential to affect earning capacity

Criteria	**PFI Range**
• does not meet minimal criteria for consideration of award • may be minor indicators of impairment but not likely to affect current or future earning capacity • Chronic Pain/Pain Disorder Diagnosis with some depressive/anxiety symptoms not out of keeping with same (apply Chronic Pain Policy)	0%
MILD IMPAIRMENT LEVELS ARE COMPATIBLE WITH MOST USEFUL FUNCTIONING	
• minor residual symptoms • no, or little significant increased risk of decompensation • accommodation or different job would likely attenuate psychological impairments	5%
• minor residual symptoms • some increased risk of decompensation under stressful situations • accommodation or different job would not likely completely attenuate psychological impairments • only sporadic continuing treatment likely	10-15%

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• mild residual symptoms • moderate increased risk of decompensation under stressful situations • accommodation or different job would not significantly attenuate psychological impairments • continuing treatment and support likely	20-25%
MODERATE IMPAIRMENT LEVELS ARE COMPATIBLE WITH SOME, BUT NOT ALL USEFUL FUNCTIONING	
• moderate residual symptoms • capable of competitive work • inadequate adaptation to impairment with or without accommodation • • moderate increased risk of decompensation under normal stress	30-35%
• moderate residual symptoms • capable of competitive work if provided significant support • inadequate adaptation to impairment • significant accommodation required • high increased risk of decompensation under normal stress	40-45%
• no significant competitive vocational capacity • competitive vocational capacity only in exceptional circumstances • may be capable of sheltered work • none to mild ADL problems or executive dysfunction	50-60%
• no significant competitive vocational capacity • may be capable of sheltered work if provided significant support • moderate ADL or executive dysfunction • supervision/monitoring required for some complex tasks	65-70%
MARKED-EXTREME IMPAIRMENT LEVLES PRECLUDE MOST USEFUL FUNCTIONING	
• significant ADL problems or executive dysfunction	75-90%

Submissions

[45] The worker submits that it would be reasonable to grant her a permanent partial disability award of at least 50% of total disability. The worker relies on Dr. Nader's opinion, noting that his report was the first formal psychological assessment specifically focusing on the worker's post-plateau permanent functional impairment and vocational capacity. The worker submits that the prior

formal psychological assessment by Dr. Shergill focused on causation. Dr. Nader's opinion took into consideration the relevant variables as set out in the PDAC guidelines, including the severity of residual symptoms, capability of competitive work, level of adaptation to impairment, level of accommodation required, risk of decompensation under normal stress, and presence of executive dysfunction.

[46] The employer questions the objectivity of Dr. Nader's report, noting that the worker's representative reported regularly using Dr. Nader's expertise in order to assist workers in receiving increased benefits from the Board. The employer submits that Dr. Shergill's report is objective and neutral. Based on the conflicting opinions, the employer requests that WCAT refer the worker to an independent health professional under section 249 of the Act. Alternatively, the Review Division decision should be confirmed.

[47] The worker submits that any allegation of bias is without foundation. Dr. Nader's formal assessment is impartial, and he has provided a high-quality expert report. The worker's representative states that he has obtained reports from Dr. Nader on three prior occasions, and that Dr. Nader derives only a small percentage of his income from the worker's representative or his small firm. The reports of Dr. Shergill and Dr. Nader are reasonably consistent. Differences in aspects of their opinions are explained by the fact Dr. Shergill assumed, in January 2014, that the worker would make future improvement to the point of a gradual return to work (following a period of active psychological, pharmacological and behavioural intervention in combination), whereas Dr. Nader recognized (as did the Board) that the worker had not improved since the plateau date. Dr. Nader explored the issues of permanent disability in further depth, and more directly, than Dr. Shergill was in a position to do. The worker notes that while WCAT could refer the worker for further assessment, the recent assessment by Dr. Nader is impartial, reliable, expert evidence.

Reasons and Findings

[48] As a preliminary matter, I note that Dr. Nader's report expressly states that he was aware of his duty to assist in an impartial manner and to not be an advocate for any party, and that his report was prepared in conformity with his duty. I find no basis has been established for impugning the impartiality of his report.

[49] I do not consider it necessary to obtain a further opinion from an independent health professional under section 249 of the Act. Expert evidence concerning the assessment of the worker's psychological impairment has been provided by Dr. Shergill and Dr. Nader, which I consider provides a sufficient basis on which to make a decision on the worker's appeal.

[50] In addressing the worker's appeal, WCAT must apply an applicable policy of the board of directors of the Board. This means that WCAT must apply the policy concerning the assessment of psychological disability set out in the Permanent Disability Evaluation Schedule (contained in Appendix 4 to the RSCM II), as amended effective January 1, 2015. The PDAC Guidelines constitute Board practice. Board practice documents do not constitute policy and are not binding but may provide useful guidance in promoting consistency in decision-making. Policy takes precedence over practice guidance.

[51] The assessment of the worker's permanent partial disability is concerned with her condition as it existed when the worker's condition plateaued effective August 1, 2012. Dr. Shergill's assessment of the worker was performed in December 2013, prior to the acceptance of the worker's claim. A central issue in Dr. Shergill's opinion concerned the cause of the worker's psychological condition. The assessment of the worker's impairment was addressed as a secondary issue. As such, it contained less detailed reasoning regarding the level of the worker's impairment.

[52] Dr. Shergill diagnosed the worker's MDD as being of moderate severity. Dr. Nader expressed the opinion that the worker's current depressive symptoms are in the moderate to severe range. However, one of the reasons given by Dr. Nader for finding that the worker's symptoms extended to the severe range was that Dr. Catona's January 2012 report noted that the worker's depression was severe. That report was provided prior to the stabilization of the worker's condition on August 1, 2012. As well, Dr. Catona's subsequent report of March 1, 2012 indicated the worker's depression was moderate. As such, I do not consider that Dr. Catona's January 2012 report provides support for a conclusion that the worker's permanent symptoms due to depression were severe in nature.

[53] With respect to the application of the policy in the Permanent Disability Evaluation Schedule concerning the assessment of psychological disability, I do not consider the worker's disability was one involving "Aphasia and Communication Disturbances" (the first heading in the Schedule). With respect to the second heading, "Disturbances of Mental Status and Integrative Functioning," I do not consider that the worker's impairment was such as to necessitate direction and supervision of daily living activities. Accordingly, the worker's impairment under this second heading would be assessed as being mild, rather than moderate, with a maximum rating of 25% of total disability.

[54] The third heading in the policy concerns "Emotional (Mental) and Behavioural Disturbances." This heading concerns the assessment of impairment in relation to activities of daily living, social functioning, concentration and adaptation. A mild rating (0 to 25%) would apply if impairment levels are compatible with most useful functioning, and a moderate rating (30 to 70%) would apply if impairment levels are compatible with some but not all useful functioning. The PDAC Guidelines provide further assistance in evaluating impairment levels, given the broad ranges in the Schedule.

[55] Dr. Nader considered the worker was at relatively high risk of decompensation under normal stress conditions. Under the PDAC Guidelines, the evidence on this factor would be suggestive of an impairment in the range of 40 to 45%. He did not believe the worker would be able to manage or cope with the inevitable stressors and challenges that would be present even in a "low stress" work environment.

[56] Dr. Shergill advised that the worker was likely to have moderate difficulties engaging in tasks requiring sustained concentration, tasks with low error threshold, and multitasking. Dr. Shergill considered that the worker was likely to have significant difficulty managing workplace stress and conflict and responding constructively to criticism and feedback, and was likely to require ongoing psychosocial support. However, Dr. Shergill did not indicate the worker would be unable to cope in a low-stress work environment.

[57] Dr. Shergill's report was based on an assessment of the worker in December 2013, closer to the time when the worker's condition plateaued on August 1, 2012 than Dr. Nader's assessment of the worker on January 11, 2016. However, Dr .Nader does not indicate that there had been a deterioration in the worker's condition.

[58] The sub-ranges in the PDAC Guidelines make reference to whether the worker is capable of competitive work (30 to 35%), capable of competitive work if provided significant support (40 to 45%), or has no significant competitive vocational capacity or competitive vocational capacity only in exceptional circumstances (50 to 60%).

[59] Dr. Shergill considered that the worker's productivity was likely to be moderately compromised due to her low energy, fatigue, and sleep disruption, that she was unlikely to be able to complete a full workday initially and would likely require a gradual return to work upon completion of her psychological treatment, and would likely have significant difficulty managing workplace stress and conflict, or responding constructively to criticism and feedback.

[60] Dr. Nader did not consider that the worker was currently able to return to work, even on a part-time basis, due to her current depressive symptoms. He noted that the worker's current energy level appeared to be barely keeping up with the minimal demands that she had in her life, such as grocery shopping or taking her daughter to school. Dr. Nader pointed to the worker's lack of participation in activities, or following through with her psychiatrist's recommendations (e.g., regular walking), as evidence of executive dysfunction. Dr. Nader did not address, in this regard, the question as to whether some form of reactivation program, as recommended by Dr. Shergill, would likely be beneficial.

[61] In terms of the worker's adaptation to her impairment, Dr. Nader noted that the worker was unable to describe any adaptive methods for managing stress. Her primary coping mechanism for dealing with stressful situations was to go to bed. This evidence supports a conclusion that there was inadequate adaptation by the worker to her impairment.

[62] Dr. Shergill did not identify a risk of deterioration or decompensation in complex or work-like settings apart from the specific limitations he set out in his report (such as the worker having significant difficulty managing workplace stress and conflict). Dr. Nader expressed the opinion that the worker was at relatively high risk of decompensation under normal stress conditions.

[63] Taking into account the opinions of Dr. Shergill and Dr. Nader, and the other evidence on file including the functional capacity evaluation, I consider that the evidence as a whole supports a conclusion that the worker's impairment due to her MDD is moderate, and that the worker is capable of competitive work if provided significant support. I accept Dr. Nader's opinion that the worker is subject to a high increased risk of decompensation under normal stress, and that there was inadequate adaptation to her impairment. Accordingly, significant accommodation would be required. The degree of permanent impairment suggested by the PDAC Guidelines in relation to these factors is 40 to 45% of total disability. I am not persuaded that the worker has no significant competitive vocational capacity, that she has competitive vocational capacity only in exceptional circumstances, or that she may only be capable of sheltered work. I consider that the worker's depressive symptoms are in the moderate range, rather than the moderate to severe range. Weighing the evidence as a whole, I find that the worker is entitled to an award of 45% of total disability for her MDD. I allow the worker's appeal in part.

Expenses

[64] By decision dated April 4, 2016, a review officer granted reimbursement of the cost of obtaining Dr. Nader's January 13, 2016 report in an amount consistent with the Board's fee schedule. The invoiced amount was $3,084.38, calculated at a rate of $250.00 an hour for 11.75 hours, for the following steps in preparing his medical-legal report:

	Hours	Description		Amount
	4.0	File review		$1,000.00
	1.0	File Review and assessment preparation		250.00
	2.25	Assessment interview		562.50
	1.5	File review summary		375.00
	3.0	Report writing		750.00
Total:	11.75			$2,937.50
			5% Tax:	146.88
			Total:	**$3,084.38**

[65] Reimbursement was granted by the Board in the amount of $2,310.00. The worker requests reimbursement of the full amount of Dr. Nader's invoice, based on Dr. Nader's rate of $250.00 per hour rather than the $180.00 rate in the Board's Psychologist Fee Schedule in effect from June 2012 to November 2016. MRPP item #16.1.3.1 provides that WCAT will usually order reimbursement of expert opinions at the rate established by the Board for the same or similar expenses. The balance is the responsibility of the party who obtained the report. A WCAT panel has the discretion to award reimbursement of an expert opinion in an amount greater than the fee schedule, but will do so only in limited circumstances.

[66] The worker's representative advised that he chose to obtain an opinion from Dr. Nader because of the high quality of his reports, his familiarity with WCB assessment guidelines, and the thoroughness of his analysis. For similar reasons, I accept that a departure from the Board's guidelines is warranted in the circumstances of this case, and direct the Board to provide reimbursement to the worker of the unpaid portion of the cost of Dr. Nader's report (as originally invoiced).

Conclusion

[67] I allow the worker's appeal in part, and vary the Review Division decision. I find that the worker has a permanent psychological disability due to her MDD amounting to 45% of total disability.

Herb Morton
Vice Chair

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