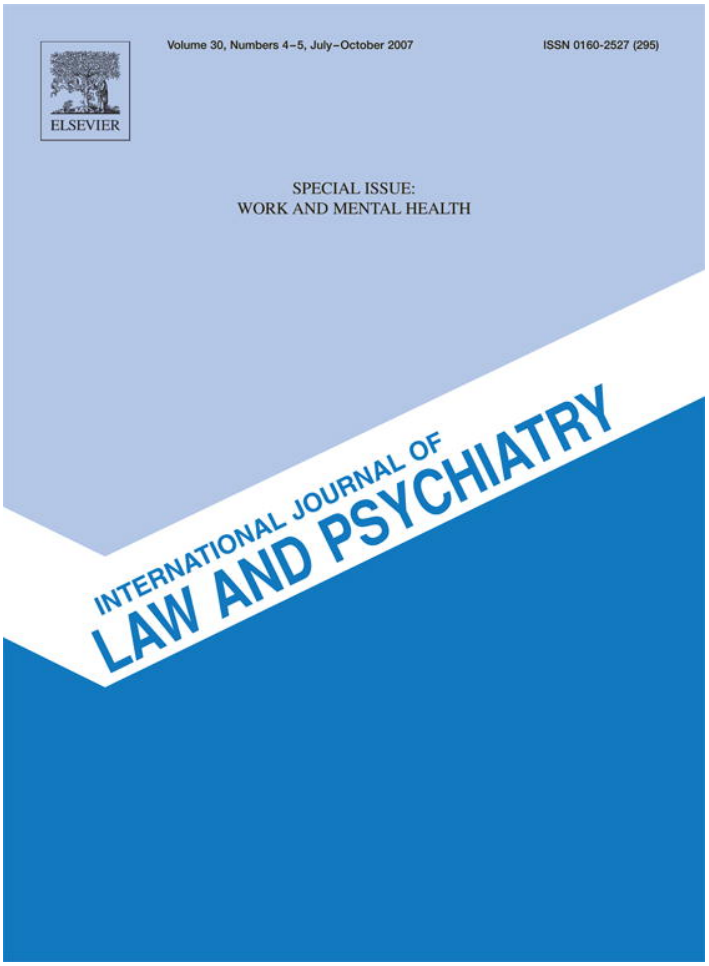

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Knocking at the wrong door: Insured workers' inadequate psychiatric care and workers' compensation claims

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Abstract

Objective: To describe the prevalence of inadequately evaluated and treated psychopathology among insured workers making workers' compensation claims for psychiatric disability whose cases were reviewed by one forensic psychiatrist. To assess the relationship of inadequate evaluation and treatment to the outcomes of these workers' compensation claims.
Methods: Records of a series of 185 workers' compensation cases reviewed in 1998 and 1999 by a California forensic psychiatrist were abstracted. Patient factors (gender, Axis II pathology, psychosocial circumstances, substance abuse), case factors (psychiatric injury secondary to physical injury, or secondary to psychological stresses), type of provider (mental health, or other), adequacy of evaluation and treatment, forensic psychiatrist's recommendation, and claim outcome were categorized. The relationships between case characteristics, adequacy of care, and claim outcome were described.
Results: 22% of cases had adequate evaluation, 48% superficial, and 30% had no evaluation. 11% had adequate treatment, 67% superficial, and 22% had no treatment. Compared to claims for psychiatric disability related to a physical injury, claims related to psychosocial stresses more often had superficial diagnostic evaluations and treatments. Those with superficial treatment were less likely to have their claim granted (19.3%) than those with no treatment (47.5%) or those with adequate treatment (36.8%). Success of claim was not related to provider type.
Conclusions: The majority of the studied workers with employer-provided health insurance who sought workers' compensation for disability due to mental illness did so inappropriately, in that the workplace did not cause the psychopathology. Their seeking workers' compensation was plausibly due to the observed inadequate evaluation and treatment available through their employer-provided health insurance. The adequacy of their care influenced the likelihood their claim would be granted. The relations observed here merit further research to establish their generality and to determine their causes.

Keywords: Workers compensation; Psychiatric injury; Workplace; Psychiatric evaluation; Mental health parity; Health insurance; Managed care; Disability

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1. Introduction

There have recently been informal reports of an increase in the number of workers seeking to have their mental health care paid for by their workers' compensation insurance (e.g., Bursztajn, Paul, Reiss, & Hamm, 2003; Ellen, 2002). These two (disguised) case descriptions drawn from the consulting forensic psychiatry practice of one of the authors illustrate the situation.

Case 1. A 44 year old female has been on disability for eight months from her job as a teacher's aide for disabled children, due to becoming depressed after having to report two cases of possible neglect/abuse of students. She herself was abused as a child, raped as an adult, admitted abusing her own son, and was hospitalized for two days a few years ago for fear that she would physically attack her acting out step-daughter. Treatment being received: prescriptions for Prozac and Trazadone, no counseling or psychotherapeutic intervention.

Case 2. A 46 year old male teacher in a correctional facility was placed on disability for one month after multiple arguments with his supervisor. Reports being upset and angry, but describes no symptoms of psychiatric illness other than mild insomnia. His general practitioner prescribed Paxil and supported his being placed on disability. No counseling or psychotherapeutic intervention has been provided.

These patients sought workers' compensation for psychiatric disability. Their need for psychotherapeutic care is clear. Yet it is not clear that their suffering and impairment is the result of injury at the workplace, a requirement for workers' compensation. Besides these selected cases, how common is it that the patients with employer-provided health insurance benefits who claim they have a work-caused psychological impairment are actually experiencing the effects of inadequate psychotherapeutic care for suffering and impairment not caused by work conditions? We report here the results of an exploratory study that analyzed a series of workers' compensation cases evaluated by a consulting forensic psychiatrist in the late 1990s in California, in an era when health insurance was dominated by the managed care philosophy. Though time has brought changes in California's Workers' Compensation laws (Institute of Governmental Studies, 2005) and industry's approach to health and disability insurance (Clemens, 2006), the issue continues to be central to a comprehensive view of the effects of the mental health care financing system in the U.S.

1.1. Workers' compensation: appropriate and inappropriate recourse

Workers' compensation systems are designed to provide a mechanism for treatment or compensation for injuries at work while avoiding legal proceedings. In the late 1990's, for a workers' compensation claim about a mental health problem to be justified, the worker must have had a diagnosable disorder that required a medical (psychiatric) intervention and interfered with the ability to work, and the disorder must have been objectively caused by the work or workplace events or conditions (Bohm, 2006; Institute of Governmental Studies, 2005). Thus, it is obvious that not all workers whose work performance was impaired due to mental illness would have claim to recompense from the workers' compensation system. Yet if a worker suffering from mental illness could not get adequate treatment through the employer-provided health insurance, it may have seemed reasonable to seek relief through the workers' compensation system (Bursztajn, 1999). Additionally, and probably more commonly, inadequate treatment may lead to a continuation of symptomatology and impairment which, when they become manifest in the workplace, can be projected onto workplace events and lead to the claim of an industrial injury, when objectively the workplace events were not the cause of the pathology.

1.2. Evaluation of workers' compensation claims for psychiatric disability

The California workers' compensation system includes a process for arbitrating claims about workplace-caused psychiatric disability outside the courtroom. A claims examiner or attorney overseeing the arbitration process for the workers' compensation insurance carrier refers the claim to a forensic psychiatrist, who interviews the patient and reviews the record of previous treatment. The forensic psychiatrist then makes a judgment as to whether the claim should be compensated as an industrially-related psychiatric injury, and if so recommends what type of treatment the patient should receive and for how long. This recommendation is returned to the claims examiner or attorney who then makes a decision about compensation, based upon the medical opinion received as well as other legal or administrative considerations. If the insurance company accepts the claim, it is required to provide treatment in concordance with the forensic psychiatrist's judgment. In the late 1990's, the disability insurance company was not required to pay for

treatment until the decision to accept the claim had been made.[1] If the claims examiner decided against the claim, there would be no compensation and no insurance coverage for treatment, and the patient would be expected to work adequately or have his or her employment terminated. The patient's last recourse within the Workers' Compensation system would be to take the claim to the Appeals Board. Some workers also have private disability insurance, and most qualify for the lesser benefits of the state disability system and, after a year of disability, for federal social security benefits.

1.3. Description of the psychiatrist's role reviewing workers' compensation cases in California

The forensic psychiatrist whose cases we studied (D.R.) receives claims of industrially-related psychiatric injury from a number of disability insurance companies, attorneys, employers, and governmental agencies within California. He reviews a wide variety of claims, including city and county employees (including police, fire, and sheriff's offices), state employees (including corrections), agricultural workers, school system employees, bank personnel (particularly robbery victims), and employees of various health providers (hospitals, HMOs, etc.) in south and central California.

Cases are referred to the forensic psychiatrist by attorneys representing either party, or by claims examiners employed by the insurance company. Even if the case obviously does not meet the criteria established by current Workers' Compensation Law, the claims examiner does not have the authority to deny the claim without a medical evaluation. Cases that involve a claim of stress or psychiatric injury due to the workplace are assigned to a forensic psychiatrist, possibly one of several such consultants on an approved list.[2] Referrals from attorneys always have an element of dispute regarding causation, the extent of disability, or the adequacy of the treatment provided.

A forensic psychiatrist utilizes evidence from all aspects of the claimant's life to assess disability and determine the issue of causation. Past medical records of evaluations and treatments, psychosocial history, personality testing, witness statements, depositions, employment records, and the Workers' Compensation claim forms are evaluated as part of the record review. During the interview with the patient, a history of the present illness, the patient's subjective description of current status, occupational history, past medical and mental health history, legal history, family history, social history, and developmental history are assessed. The forensic psychiatrist assesses the patient's present mental status, and may administer psychological testing. Corroborative data, e.g., job descriptions, affidavits, personnel files, and depositions may be analyzed. Then, the psychiatrist formulates an opinion as to whether the claimant truly has an impaired mental status due to workplace events, and judges how much of the impairment can be attributed to the workplace events and how much of it can be attributed to events outside the workplace. The psychiatrist establishes whether the claim meets the California criteria: first, there must be a preponderance of the evidence that the actual events of employment were a cause of the psychiatric injury. Second, if the events were lawful, nondiscriminatory, good faith personnel actions, there is no basis for a claim. Third, the workplace causes must play a predominant role — greater than 50% (35% if violence is involved).[3]

In sum, the psychiatrist makes diagnoses along Axis I and II (evaluation of other medical conditions is deferred to appropriate specialists), assesses the patient's disability status, determines causation, apportions mental injury causality to industrial and nonindustrial factors, judges whether the patient requires vocational rehabilitation, and suggests treatment options for the future and whether they should be paid for on an industrial or non-industrial basis. Afterwards, the claims are referred back to the claims examiner or attorney and a judgment is made of whether the claim should be granted.

The goal of this article is to present information regarding the occurrence of workers' compensation claims for psychiatric disability that are inappropriate because the disability can not be attributed to the workplace, using the case experience of a forensic psychiatrist who reviews claims for workers' compensation in California. When reviewing the records of patients' treatment prior to his medical–legal evaluation of their claims of industrially related psychiatric injury, he noticed many cases in which the patients' initial complaints of psychiatric symptoms were not evaluated or responded to appropriately by the health care providers whom they were permitted to see by their company-purchased personal health insurance plans.

[1] Subsequent to the period of this study, California Workers' Compensation law changed so that the disability insurance company must provide treatment while the claim is being evaluated; if the claim is denied the treatment is terminated.

[2] Prior to 2005 each party would appoint its own qualified medical examiner; subsequently the worker is required to select from a pool approved by employers and insurers (Institute of Governmental Studies, 2005).

[3] 3208 (b) (1) (2), and (3), California Labor Code, Title 8, California Code of Regulations, 1993.

The analysis of the cases will be organized in terms of the model in Fig. 1, which traces the steps from the patient's gender and the type of injury claimed, through the previously received psychological evaluation and treatment, to the consultant's recommendation and the workers' compensation decision. The model gives a framework for quantifying and understanding the proportion of workers' compensation claims for mental health problems which fit the pattern described above — that these patients have genuine mental health problems and since they are unable to get adequate treatment from their employer-provided health insurance, they turn to workers' compensation, even though they are not eligible since the injury was not caused by their employment.

2. Methods

This was a retrospective case series study of the claims referred to one forensic psychiatrist practicing in California. A forensic psychiatrist who reviews workers' compensation claims has access to the entire history of the evaluation and treatment of the worker's mental health problem. As such, this provides a unique data set for a study of the functioning of the workers' mental health benefits. It is beyond the scope of these data for us to estimate the prevalence of mental illness in the workplace (see Bromet et al., 1990; Claxton, Chawla, & Kennedy, 1999; Druss, Rosenheck, & Sledge, 2000; Kessler et al., 2006), the proportion of workers who receive satisfactory treatment for mental health problems (Goldman et al., 2006; Wang, Berglund, & Kessler, 2000; Wang, Demler, & Kessler, 2002), or the proportion of those not receiving satisfactory treatment who nonetheless do not seek workers' compensation (Biddle, Roberts, Rosenman, & Welch, 1998).

A total of 185 consecutive cases were selected, from two time periods (59 cases between April 30 and August 1, 1998, and 126 cases between January 8 and June 22, 1999). Available information about each case included past medical history from the medical record, as well as the forensic psychiatrist's interview, evaluation, and assessment of whether the claim is justified. The files also included the subsequent decision by the claims examiner or attorney concerning whether to accept or deny the worker's claim for reimbursement or for payment for future treatment. The files do not include information about whether the decision was appealed, nor about whether patients have private disability insurance. The information was abstracted from each case by the forensic psychiatrist (D.R.), using descriptive and evaluative categories.

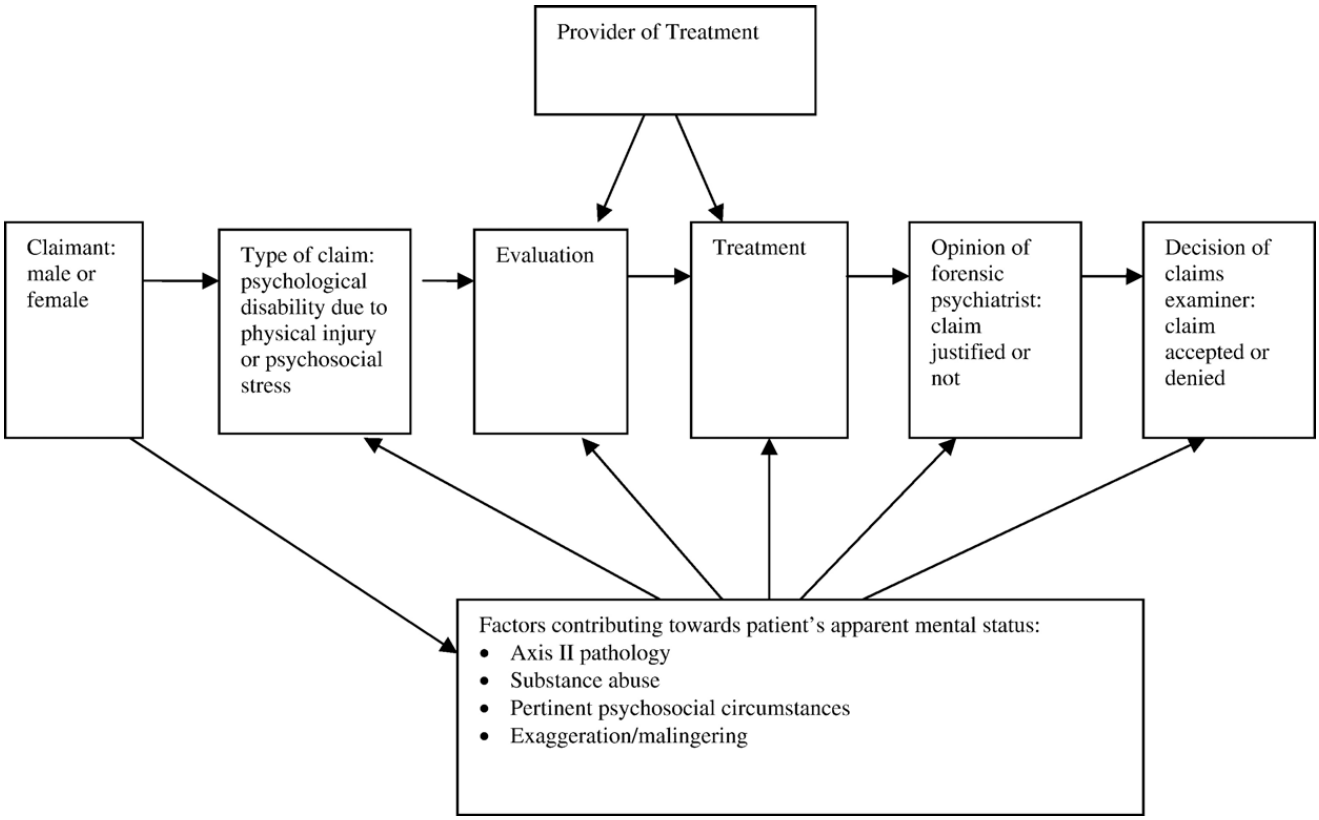

Fig. 1. Model depicting influences in the sequence of steps encountered by patients in the workers' compensation claim process.

Patient information extracted from the case included: patient gender, the presence of Axis II pathology (i.e., a personality disorder), the presence of exaggeration or malingering, the presence of a substance abuse problem, and whether psychosocial circumstances affecting the patient's mental status had been considered in the earlier evaluation or treatment of the patient. Information about the type of claim indicated whether the psychiatric injury was associated with physical injury or was due to psychosocial stresses (including harassment and exposure to violence). Information about the previous treatment included whether there had been a provider and whether that provider had been from a mental health or non-mental-health specialty. Each of these case characteristics was coded as a dichotomous variable.

The diagnostic evaluation the patient had previously received was categorized as "comprehensive," "adequate," "superficial," or "none." A "comprehensive" evaluation would attempt to identify all possible problematic areas, with a full evaluation of past and present history, developmental factors, psychosocial factors, medical history, substance abuse history, and psychodynamics. An "adequate" evaluation reasonably explored the patient's current problems, describing symptoms and contributing factors, with enough longitudinal historical context to be able to effectively address those problems, but without delving into other issues which may have revealed additional problem areas which could also be addressed within the treatment. A superficial, inadequate evaluation elicited little information beyond the chief complaint and manifest symptoms, with no attempt to understand the nature or etiology of the disorder present. The final category included patients who did not receive any mental health evaluation. Little interpolation was required interpreting the data about the evaluation the patient had received, because the case file included an evaluation form which indicated whether a complete history was documented, whether there was a case formulation, and whether there was a discussion of the rationale for the treatment recommendations.

The treatment the patient had previously received was judged as "comprehensive," "adequate," "superficial," or "none." A "comprehensive" plan was one that laid out a case formulation that described all problematic areas, and then devised a treatment strategy that covered each. Axis I, Axis II, and psychosocial factors were considered in developing a comprehensive treatment plan. An "adequate" plan would be based upon a reasonably full understanding of the presenting problem and its etiology, including understanding the psychodynamics involved, but not attempting to address the full spectrum of difficulties present. Also considered "adequate" were cases handled with an acute problem oriented approach, that attempted to understand the current problem, but without reference to the patient's psychodynamics, Axis II pathology, or psychosocial circumstances. "Superficial" treatment was based only on presenting symptomatology, with no attempt to understand etiology or other circumstances. An example would be to prescribe anti-anxiety medication, perhaps with some very general "support", but without discussing issues such as how to deal with supervisors more effectively. The treatment records available were at times brief and poorly written. The forensic psychiatrist had to determine from the notes what areas were being discussed in the sessions, and this required some interpretation.

Data analysis. The analysis sought to identify associations – plausibly causal relationships although the retrospective case series methodology does not establish causality – among the entities included in the model in Fig. 1 (above): patient characteristics, provider characteristics, the adequacy and quality of the evaluation the patient received, the adequacy and quality of the patient's treatment, the judgment of the forensic psychiatrist, and the decision of the claims examiner. These connections were sought not only between adjacent elements of the model, but between early elements and elements several steps later in the process.

Analysis was done using the Statistix for Windows program (Version 2.0, Analytical Software, P.O. Box 12185, Tallahassee, FL, 32317) and the Microsoft Excel spreadsheet program. Comparisons between pairs of categorical variables (such as associations among patient features, and causal relations between variables) were tested with the Odds Ratio and its confidence interval (when both variables had 2 categories) or the χ^2 statistic (for more than 2 categories). Multiple logistic regression was used to determine the effects of multiple variables upon the judgment of the forensic psychiatrist and the decision of the claims examiner, as well as to explain the influences on each element in Fig. 1. Similarly, multiple logistic regression was used to explore whether any variables predicted the cases in which the claims examiner disagreed with the forensic psychiatrist. When data were missing, the case was dropped from an analysis.

3. Results

The forensic psychiatrist abstracted the data from the case files of 185 patients, 69.2% female. Of the 184 cases for whom the type of claim could be determined, 77.2% involved a claim of psychiatric injury secondary to psychosocial

stresses, 22.3% claimed emotional trauma associated with physical injury, and one case claimed both. Although it was not an explicit coding category, over 90% of patients had an Axis I diagnosis. Additional diagnoses, explicitly coded, include fourteen patients judged to possess some element of Axis II pathology (personality disorder), 22 judged to have issues of substance abuse, 9 who raised suspicions of exaggerating or malingering, and 16 who had psychosocial circumstances which were pertinent to their mental status. Receipt of these diagnostic characteristics was associated with the type of claim the worker filed. Workers who made psychosocial stress claims were significantly less likely to have a record indicating consideration of Axis II pathology ($\chi^2=3.04$, $p=0.037$), substance abuse issues ($\chi^2=10.02$, $p=0.0006$), or exaggeration ($\chi^2=4.15$, $p=.014$). Additional details are available at http://www.fammed.ouhsc.edu/robhamm/mancal/tables.htm.

Because patients rarely received "comprehensive" evaluation and treatment, according to the criteria stated above, these cases were combined with "adequate" for all analyses. Of 161 patients for whom the adequacy of the diagnostic evaluation prior to the psychiatrist's review could be determined, only 35 (21.7%) had an adequate diagnostic evaluation, while 77 (47.8%) had a superficial diagnostic evaluation and 49 (30.4%) had none at all. Of 181 patients for whom the adequacy of treatment could be determined, only 19 (10.5%) had adequate treatment of their mental health problems, while 122 (67.4%) had superficial treatment, and 40 (22.1%) had none. 130 patients (70.7%) had treatment from a mental health provider, 31 (16.8%) from a non-mental health provider, and 23 (12.5%) had no provider. The forensic psychiatrist considered only 46 of the patients (25.0% of 184 patients for whom information was available; see Table 1) to have a justified workers' compensation claim (patient mentally ill, and illness caused by work). However, the claims examiners actually accepted 51 workers' claims (27.7%). The claims examiner accepted the forensic psychiatrist's judgment (justified, undecided, or unjustified) in 171 of 184 cases (92.9%).

The relation of each of the case features to the ultimate outcome of the claim was inspected. The factor that is most strongly related to the forensic psychiatrist's recommendation and the claims examiner's decision about the claim is the type of claim (see Table 2). Those claims where the mental health problem had its root in a physical injury were granted 59% of the time, while those based on a claim of psychiatric injury due to psychosocial stress (e.g., harassment) were granted only 19% of the time (OR=6.14, CI=4.18–9.01). The degree and quality of care the worker had received for his or her problem was related to the ultimate outcome of the claim. Those who had previously had a treatment provider were less likely (24%) to have their claim granted than those who had not had a provider (57%; OR=0.24, CI=0.15–0.39). This may be related to the fact that more patients with claims of psychiatric injury secondary to psychosocial stress (91.5%) than with claims of psychiatric injury due to physical injury (73.2%) had a treatment provider ($\chi^2=9.65$, $p=.0019$). Among those who had a treatment provider, whether the provider was a specialist in mental health care (psychiatrist, psychologist, or other) or not (orthopedic physician, primary care physician) did not influence the outcome of the claim (OR=1.74, CI=0.62–4.91). The outcome of the patient's claim was related to the adequacy of the provider's diagnostic evaluation ($\chi^2=7.98$, $df=2$, p=0.019). Specifically, those whose provider had done no evaluation were more likely to have their claim granted (38.8%) than those with any evaluation (OR=2.13, CI=1.03–4.41). Among those with any evaluation, those with an adequate evaluation were more likely to have their claim granted (35.3%) than those with a superficial evaluation (17.3%; OR=2.60, CI=1.03–6.55). The claim's outcome was also related to the adequacy of the treatment provided ($\chi^2=12.83$, $df=2$, $p=0.0016$), again with the lowest success rate among those who had received superficial care. The adequacy of the evaluations and treatments was highly related (114 of 159 had the same adequacy rating; for the 3×3 table (not shown), $\chi^2=92.08$, $df=4$, $p<.0001$).

The upper part of Table 3 below shows the proportion of patients receiving no, superficial, or adequate treatment, for the claims of psychiatric injury secondary to physical injury and to psychosocial stress separately. Nearly half of the physical injury related claims received no mental health treatment, while three quarters of the psychosocial stress

Table 1
Comparison between the forensic psychiatrist's judgment and the claims examiner's decision. ($N=184$)

Forensic–psychiatrist's judgment	Claims examiner's decision			
	Justified	Undecided	Unjustified	Total
Justified	43 (93.5%)	0 (0.0%)	3 (6.5%)	46 (25.0%)
Undecided	1 (33.3%)	1 (33.3%)	1 (33.3%)	3 (1.6%)
Unjustified	7 (5.2%)	1 (0.7%)	127 (94.1%)	135 (73.3%)
Total	51 (27.7%)	2 (1.0%)	131 (71.1%)	184 (100%)

Note: Percents refer to the row, except in the "Total" column where the percents refer to the full table.

Table 2
Factors related to the claims examiner's decision

Factor	Outcomes of claim: disability insurance company decision following forensic psychiatrist's review		Odds ratio (95% confidence interval)
	Granted	Denied	
Claim of psychiatric injury secondary to: (N=180)			
Physical injury	24 (58.5%)	17 (41.5%)	OR=6.14
Psychosocial stresses	26 (18.7%)	113 (81.3%)	(CI=2.89–13.04)
Whether has treatment provider (N=181)			
Has treatment provider	38 (24.1%)	120 (75.9%)	OR=0.24
No treatment provider	13 (56.5%)	10 (43.5%)	(CI=0.10–0.60)
Specialty of treatment provider (N=158)			
Mental health specialty	33 (25.8%)	95 (74.2%)	OR=1.74
Non-mental health specialty	5 (16.7%)	25 (83.3%)	(CI=0.62–4.91))
Factor	Outcomes of claim: insurance company decision following forensic psychiatrist's review		
	Granted	Denied	
Adequacy of diagnostic evaluation (N=158)			
No evaluation	19 (38.8%)	30 (61.2%)	χ^2=7.98
Superficial diagnostic evaluation	13 (17.3%)	62 (82.7%)	(df=2, p=0.019)
Adequate diagnostic evaluation	12 (35.3%)	22 (64.7%)	
Adequacy of treatment (N=178)			
No treatment	19 (47.5%)	21 (52.5%)	χ^2=12.83
Superficial treatment	23 (19.3%)	96 (80.7%)	(df=2, p=0.0016)
Adequate treatment	7 (36.8%)	12 (63.2%)	

related claims received superficial treatment. The majority of the patients were in just one of the six cells, psychosocial stress related claims that received superficial treatment. The lower part of the table shows the proportion in each of the cells of the upper part whose claims were granted. Generally, those with physical injury related claims had an absolute 30% advantage over those with psychosocial stress related claims. Those with superficial treatment were less likely to have their claim granted, for both physical injury and psychosocial stress claims.

When multiple logistic regression analysis was used to predict each of the elements in Fig. 1 from all the previous elements, the results usually revealed only one or two statistically significant predictors. This may be due to the inter-correlations among the various patient characteristics and measures of the adequacy of treatment. Thus, the only significant predictors of the adequacy of the diagnostic evaluation were having an Axis II pathology considered and having a provider of treatment. The only significant predictors of the adequacy of the treatment were having a psychosocial stress type claim and the adequacy of the diagnostic evaluation. The significant predictors of the forensic psychiatrist's judgment regarding the claim were having a psychosocial stress type claim and having a provider of treatment. The only significant predictor of

Table 3
Relationship between type of claim, adequacy of previous treatment, and outcome of workers' compensation claim (N=179)

Type of claim	No treatment	Superficial treatment	Adequate treatment	χ^2	p-value
Injury	19 (47.5%)	16 (40.0%)	5 (12.5%)	20.69	<0.0001
Psychosocial stress	21 (15.1%)	105 (75.5%)	13 (9.4%)		
Total	40 (22.7%)	118 (67.0%)	18 (10.2%)		
Proportion of the above patients whose claims were granted					
Injury	63.2%	50.0%	60.0%		
Psychosocial stress	33.3%	13.7%	30.8%		
Total	47.5%	18.6%	38.9%		

the claims examiner's decision was the forensic psychiatrist's judgment. No factors predicted which patients the forensic psychiatrist and claims examiner agreed on, or disagreed on. Notably, gender had no effect in any of these analyses. More details about these multiple logistic regression results are available at the website cited above.

4. Discussion

In this exploratory study, a case series from a California forensic psychiatrist's practice in the late 1990's, less than a third of workers' compensation claims for psychiatric injury were granted. Only 28% were ultimately given the benefits sought — disability payments and treatment. For the other 72%, the denial of the claim brought an end to their disability leave or sick leave from the company, and they had to return to regular work and use their own resources to get mental health care.[4]

The employer is compelled by workers' compensation law to provide mental health care and compensation only if employment caused the psychiatric injury. When workers' compensation was denied, it was because the psychiatric suffering and impairment could not be attributed to the work place. That the worker needed psychiatric care was seldom questioned: for only 9 of the 185 patients was malingering recorded as a possibility.

Workers have a basis, other than workers' compensation insurance, for expecting help from the employer in providing resources for treatment for mental health problems. Since the 1950's their employment benefits have included health care or health insurance (Klein, 2003), and workers expect mental health benefits as part of their insurance package (Danis, Biddle, & Goold, 2002). The substantial advances of the last half century in the evaluation and treatment of mental illness, well reported in the popular press, have also raised workers' expectations of effective treatment for psychological problems. These expectations have been systematically undermined by managed care (Stone, 1995) and other aspects of the modern health care and insurance industries, as well as employers' global competitive environment in which third world manufacturers have no health or disability insurance burden.

The study suggests that the mental health care provided by the workers' health insurance is insufficient. Our review of the records of previous treatment for the psychiatric suffering and impairment that was the basis of the workers' compensation claim showed that only 22% of the patients had had an adequate diagnostic evaluation of their mental health problems, and only 11% had had adequate treatment. These proportions are similar to those in The National Comorbidity Survey, a representative household survey, where only 15.3% of seriously mentally ill respondents reported minimally adequate treatment (Wang et al., 2002). However, unlike the general US population, all the patients in this study were employed and most had employer-provided health insurance.

The outcome of the workers' compensation claims was related to the quality of care the worker had previously received. Although the majority of the claims were denied, claims were more likely to be granted if the worker had not yet received any mental health care: claims were granted for 39% of those who had received no evaluation, and for 48% of those who had received no treatment. There was a close relationship, of course, between receiving adequate evaluation and adequate treatment. Among those who had previously received any care, the probability that the claim would be granted was higher for those who had had adequate care than for those with superficial care. The claim was granted for 35% of those with adequate diagnostic evaluation, but for only 17% of those with superficial evaluation. The relationship with treatment adequacy was similar.

Care adequacy in turn was a function of the type of workers' compensation claim. While most patients with claims of psychiatric injury secondary to physical injury either had received an adequate evaluation, or none at all, most patients (55%) with claims of psychiatric injury secondary to psychosocial stresses had received a superficial evaluation. Similarly, most patients (75%) with stress related claims received superficial treatment, while fewer patients with physical injury claims did. In sum, within the framework of Fig. 1, the success of the claim was related to the patient's personal characteristics, the nature of the psychiatric injury, and the adequacy of previous care; and these predictive factors were related to each other in a complicated fashion.

But in a larger sense, the model of the determinants of denial of workers' compensation disability claims does not address the key problem — why is it that these workers were not getting adequate evaluation and treatment of their mental health problems through their regular health care insurance? In the absence of a cause attributable to the workplace, why did these insured workers feel the need to seek workers' compensation? We suggest this is an example of insurer restrictions on mental health care (Goldman, McCulloch, & Sturm, 1998), resulting in cost shifting to other

[4] In our experience, appeals prolong the situation for a few months, though the worker seldom wins.

systems (Stone, 1995). In the 1990s the proportion of workers whose health benefits were administered by a managed care organization increased (Druss et al., 2000). This impacted the quality of mental health care available to workers, as noted in anecdotal reports of frustration and unmet needs (Ellen, 2002). Inadequately treated psychological disability is likely to persist (Gatchel, Polatin, & Kinney, 1995). When the amount and quality of mental health care provided by health insurance decreases, we may anticipate patients seeking to meet their mental health needs in other systems, just as when a balloon is squeezed it pops out somewhere else (Penrose, 1939). Those with persisting, untreated mental illness are more likely to make a workers' compensation claim. The cases reviewed in this article suggest that the workers' compensation system was experiencing such an additional demand in the late 1990s. It is our impression that this represented an increase over the level of inappropriate demand in earlier years, although this exploratory study did not compare different time periods. And although there have been subsequent changes in the California workers' compensation system (Bohm, 2006; Institute of Governmental Studies, 2005) and in employers' and insurance's recognition of the value of early and ongoing treatment of psychological disability (Busch et al., 2006; Clemens, 2006; Goldman et al., 2006; Langlieb & Kahn, 2005), it is our impression that the level of inappropriate demand remains high today for essentially the same reasons.

Those who design industrial health insurance systems consider the benefits of mental health care to be uncertain, while its costs are highly variable and unpredictable. Managed care introduced a variety of techniques to control the costs of health care (Sanchez & Turner, 2003) by erecting administrative barriers to care (Kemper, Tu, Reschovsky, & Schaefer, 2002) that continue to be used today. These include guidelines based on evidence of treatment efficacy that include demands for specific research evidence for the efficacy of any proposed treatment, policies that restrict the amount of treatment available for particular diagnoses, and subcontracts to provide all the care that will be available for particular classes of problem through a separate limited bureaucracy. The net effect of years of managed care competition for market share can be that it is difficult for insured individuals to get their insurance to cover adequate care for mental illness (Bursztajn, 1999; Bursztajn & Brodsky, 1999; Bursztajn & Brodsky, 2002), although one study observed no effect on the number of mental health visits (Fiscella, Franks, Doescher, & Saver, 2003).

For example, primary care physicians have learned through repeated experience that patients rarely follow up on referrals to psychiatrists or psychologists, in part because their insurance won't cover it or the physician does not understand how to work with the case management systems (Gask, 2005; Sommers, Hacker, Schneider, Pugno, & Garrett, 2001) which differ for each insurance company and are reinvented annually with different names and different administrative procedures. Consequently, the only evaluation and treatment many insured patients receive happens at the end of their 15-minute visit with the primary care physician (Robinson & Roter, 1999). Often the physicians prescribe a potent psychoactive drug without a thorough workup (Horn, 1997). It may be tempting to simultaneously offer hope to the patient, and to relieve one's own burden, by suggesting the use of other institutions upon which he or she may have a legitimate claim, such as the workers' compensation system. It is a complex system with many actors, each with multiple interests and strategies. We could analyze the contributions of the worker, the employer, the insurer, the therapist, or the lawyer, in the same way we have described the primary care physician, and find a similar degree of responsibility for the inadequacy of the care typically received by the psychiatrically disabled worker and for the doomed approaches to the workers' compensation system.

4.1. Limitations

The study's conclusions about the prevalence of inappropriate workers' compensation claims due to health insurance limitations on mental health care are based on a series of California workers' compensation cases reviewed in 1998 and 1999 by a single forensic psychiatrist. Reliance on one psychiatrist's cases may limit the study's generality, due to the particular mix of industries that he consults for, as well as the insurance companies' choice to refer these cases to him due to their interpretation of his past decisions. The cases date from one 2-year period, and thus cannot establish that there had been an increased number of such cases correlated with the managed care era, nor rule out the possibility of a recent improvement.

In this exploratory study, the expert reviewed his own case abstracts. This has a tremendous advantage because he could categorize the cases accurately due to the depth of his understanding. However, his summaries, in particular his interpretation of the adequacy of the patient's previous evaluation and treatment, may be biased due to his training or perspective. Additionally, there is the potential that associations between case characteristics and case outcome may have been introduced by the abstractor, who knew the outcome of the case.

The coder did not record the main diagnostic category, and consequently cannot support with data his impression that virtually all had an Axis I diagnosis. The study reviewed the therapy received by workers who had filed workers' compensation claims, but did not observe the therapy experiences of those workers who had mental health problems but never sought workers' compensation. Therefore it is a possibility that a much higher proportion of workers in the latter category may have received adequate mental health care. This topic needs to be researched. Finally, the study cannot speak directly to the patient's motives for applying for workers' compensation because information was not collected about alternative disability options available nor about the patient's subjective goals.

5. Conclusions

This exploratory study provided evidence confirming the anecdotal impression that many health-insured workers do not get adequate psychiatric care and seek help through workers' compensation. The high proportion of workers seeking workers' compensation for psychiatric injury who did so inappropriately, in that the work place was not the cause, and the marked inadequacy of the care they had had for their psychiatric complaints, identify a clear failure of the U.S. health care financing system to provide sufficient resources for mental illness.

Though California Workers' Compensation law has been changed (Institute of Governmental Studies, 2005) and industry, insurance, and psychiatry are collaborating to design improved responses to mental illness in the work place (Clemens, 2006), we believe the phenomena described here continue to be common today. We encourage research to document changes over time in the relation between the aspects of psychiatric care and disability claims that were identified in this exploratory study.

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