# BACK TO WORK

Disability management and return-to-work strategies in Canada


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# HOSPITAL'S USE OF THIRD-PARTY PROVIDER DOES NOT VIOLATE COLLECTIVE AGREEMENT

Hamilton Health Sciences (HHS) is not violating the collective agreement or any relevant statutes by using a third-party provider to adjudicate short-term disability benefits, an Ontario arbitrator has ruled. And although the consent section on a medical certificate needs to be reworded, the return-to-work practices used by the third-party provider are, by and large, intact.

The arbitrator, Paula Knopf, released her decision on July 10 in response to a number of policy grievances filed by Local 4800 of the Canadian Union of Public Employees (CUPE). Local 4800 represents more than 3,000 employees — such as lab technicians, diagnostic equipment operators, janitors, food service employees and other clerical and clinical workers — at HHS, a family of five hospitals and a cancer centre located in Hamilton, Ont.

The union, in large part because of fears about confidentiality of employee medical information, challenged the 2005 decision of HHS to use a third party, Cowan Benefits Consulting, to adjudicate and recommend eligibility for short-term disability benefits under the Hospitals of Ontario Disability Income Plan (HOODIP). The union also questioned some of the forms and procedures being used by Cowan for this purpose. CUPE's grievances echo those of Local 70 of the Ontario Nurses' Association, which launched its own policy grievance about HHS's use of the same third-party provider (see *Back To Work*, February 2007).

The arbitrator dealt with CUPE's issues in turn:

**The propriety of using a third party to adjudicate claims and recommend eligibility for short-term disability benefits under the collective agreement:** Knopf "conclude[d] and declare[d] that the retention of Cowan … does not violate the collective agreement or any relevant statutes." She arrived at this decision because:

•Cowan and its employees are bound by all applicable privacy legislation and are also governed by their professional obligations under the *Regulated Health Professionals Act;*

• the hospital's contractual relationship with Cowan does not override or undermine its ultimate responsibility to determine questions of eligibility under the collective agreement; and

•any recommendation made by Cowan concerning an employee's entitlement to benefits is subject to grievance.

**The text and content of Cowan's "Medical Certificate of Disability":** Many of the union's concerns with respect to this issue were valid, Knopf said, "particularly regarding the scope of the consent that was required." She ordered that the wording in the section in which employees give their consent to attending physicians to release infor-

# MANAGING EMPLOYEES WITH DEPRESSION: SOME SUGGESTIONS FOR IMPROVEMENT

We have not yet developed best practices for helping employees with depression recover and remain at, or return to, work. But we have developed some good practices. Now we just need to use them.

**By Merv Gilbert, Ph.D., R. Psych., Joti Samra, Ph.D., R. Psych., and Dan Bilsker, Ph.D., R. Psych.**

Mental health disorders, particularly depression, are rapidly becoming the leading cause of disability in the workplace. Depression frequently has an initial onset in late adolescence or early adulthood, and as such it affects individuals during their prime working years. In addition to raising the risk for physical injuries and illnesses, mental health difficulties can complicate recovery and rehabilitation. It is estimated that depression costs the Canadian economy $25 billion per year; the social and personal costs are immeasurable.

The existing approach to dealing with emotional and behavioural problems in the workplace may best be described as denial and desperation. A typical course for an individual with an emerging depression typically begins with performance problems at work that manifest as some combination of absenteeism, illness, conflict/withdrawal and/or loss of efficiency. A concerned manager or supervisor may notice the change and intervene in an appropriate manner, by noting the relevant workplace behaviours and suggesting the employee seek assistance.

Employee assistance or employee health programs may be available, but these are typically time-limited and have a limited mandate. The employee may seek medical assistance from his or her family physician and may receive an appropriate diagnosis. The normative treatment is pharmacotherapy, which the patient may comply with. Little consideration is given to situational determinants of the depression or to specific strategies that would help an employee manage difficult workplace factors.

Should symptoms not subside, it is common that a physician may recommend and support a leave from work for an indeterminate period of time. Limited attention is given to specific activities that will facilitate recovery during this period. Efforts to return to work are frequently hampered by a lack of communication among the concerned parties and the absence of appropriate accommodations or planning that can address residual decrements in functioning and ongoing workplace risks. If the individual does successfully return to work, little attention is given to ensuring a sustained work return or to preventing a relapse.

It has been suggested that the optimal approach to managing depression-related disability is to apply models that have been demonstrated to be effective in managing physical disabilities, in particular musculoskeletal injuries. There is certainly merit in adhering to similar underlying principles, including early intervention, an emphasis on functional activation, and collaboration in planning the work return and accommodations.

However, several aspects of depression-related disability are distinctive and complicate both rehabilitation and return to work.

- First, unlike physical injuries, the **onset of depression is typically very gradual.** The average duration between the onset of a depressive episode and consultation with a health professional is estimated to be nine months, with many never receiving evidence-based diagnosis or treatment.
- Second, **considerable stigma is attached to psychiatric conditions** such as depression. As a result, employees may be reluctant to inform employers and colleagues of their circumstances, thus hampering collaborative problem solving. Similarly, coworkers and employers may be ill-informed, fearful or judgmental with respect to mental health disorders, and thus hinder successful work returns.
- Finally, it is estimated that **depression recurs for approximately 50 per cent** of individuals. Such individuals may manage to stay at, or successfully return to, work after a depressive episode only to relapse and require treatment and rehabilitation once again.

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No best practice guidelines exist for managing depression-related disability. Therefore, disability managers and providers need to be particularly attentive and creative to be successful in these circumstances. What follows are some recommendations for improving our responses to supporting employees with depression.

## 1 Assess impairment and functioning

Although disability requires the presence of significant impairment in the ability to perform daily activities, including occupational activities, impairment alone does not determine disability. Factors such as age, general health, social supports, motivation, satisfaction with job and relationship with supervisor/manager are important determinants. Functional deficits may occur in four areas for depression:

- activities of daily living (e.g., patterns of eating and sleep, activities outside the home);
- social functioning;
- concentration, persistence and pace; and
- deterioration or decompensation in complex or work-like settings (e.g., how an employee's symptoms might cause problems in work function).

It is important to remain cognizant of appropriate language for describing functional deficits. For example, it is not meaningful for a psychiatrist or health care provider to state that an employee/client "can't concentrate" and "can't sleep" because it is most unlikely that the employee is, for example, so depressed that he or she is entirely unable to concentrate or sleep to any extent for any period of time. It is more appropriate to describe some degree of impairment, whether in terms of reduced capacity, time limits of sustained concentration, or specific difficulty with concentrating on several tasks at the same time.

It is worth remembering that impairment does not necessitate disability. An employee may be able to remain at work with significant impairments, *if* appropriate accommodations are provided by the employer.

## 2 Communicate effectively with the employer and employee

A multi-pronged, integrated approach is necessary. Addressing mental health issues in the workplace requires cooperation among a range of key stakeholders, including the employer, health care and disability providers, and the employee. The question to keep in mind is who needs what information at what point in time.

Employees need to know that they are able to access timely and appropriate treatment and rehabilitation, that their position is secure, and that they are valued by their workplace. Employers need to know that workers are collaborating in care and that care providers have an appropriate appreciation for the nature of the employee's job and work context.

Health care providers need to offer care that focuses on functional recovery as well as symptom relief, and to be specific and realistic when communicating with employers and employees. With provision of appropriate consent, the information that is of value to treatment and rehabilitation providers is the nature of the disability condition, the treatment plan and expected prognosis for the disabling condition, identification of relevant workplace or situational stressors, and a description of specific suggestions for optimal recovery or work return.

## 3 Collaborate with the employee on decision-making around accommodation and work absence

As noted above, it is critical to encourage employees/clients to be actively involved in decision-making with respect to their care, rehabilitation and work plan (e.g., decisions around modifying duties at work, taking leave from work and returning to work). Failure to do so may encourage hopelessness and helplessness, which can impede compliance and recovery. It is helpful to elicit information on the employee's/client's expectations for recovery. Collaboratively consider the advantages and disadvantages of work absence

### WORK ABSENCE

#### Benefits versus costs

**BENEFITS**

- Employee removed from occupational stresses, allowing stabilization in a protected environment
- Less risk of work incidents, especially in safety-sensitive positions
- Employee has more time for activities conducive to recovery, such as psychotherapy or exercise programs

**COSTS**

- Employee may become inactive and socially isolated, a behavioural pattern likely to worsen depression and reinforce anxiety
- Employee may develop a secondary anxiety pattern after extended work absence in which he or she becomes more apprehensive about work return
- Prolonged absence from work is a negative prognostic factor with regard to whether an individual ever returns to work

(see box on page 7). If absence from work is appropriate, it should be integrated into the treatment plan, with specific recommendations and goals in mind for the time away from work.

## 4 Maximize recovery of occupational function

Although it was previously believed that restoration of occupational function lags behind symptomatic recovery in depression, current research indicates that symptom remission and recovery of function are typically synchronous. Bear in mind that with proper psychological and pharmacological care, symptomatic and functional recovery should be evident within the first few months of treatment. Failure to observe some improvement within a reasonable period indicates the need for a change in treatment strategy and/or the involvement of other mental health providers.

Although pharmacologic treatment for depression and anxiety disorders can lead to significant improvement in function, it still leaves a significant gap in functional recovery for many individuals. Medication can be augmented with cognitive behavioural therapy, which has been shown to have specific benefit in promoting functional recovery. The combination of pharmacotherapy and cognitive behavioural therapy may be optimal for both symptom relief and functional improvement in cases of severe depression.

A critical component of maximizing recovery is to assess capacity for activity and to encourage early, graduated functional activation. It is important to take an active role in encouraging self-management efforts, focused on helping employees/clients understand their diagnosis and ways to manage their symptoms.

One way to augment standard treatment to support individual coping and promote functional recovery is to disseminate self-care material, such as the *Antidepressant Skills at Work: Dealing with Mood Problems in the Workplace* (see below). If appropriate, the employee/client should be encouraged to investigate opportunities for ongoing assistance through the employer, for example employee and family assistance programs or extended health coverage for care by a psychologist. Early intervention efforts targeted at

RESOURCE

### Free on-line guide recommends step-by-step approach

An important new Canadian guide for employees with low mood or depression focuses on anti-depressant skills instead of anti-depressant pills.

*Antidepressant Skills at Work: Dealing with Mood Problems in the Workplace,* is written by Vancouver psychologists Dr. Dan Bilsker, Dr. Merv Gilbert, and Dr. Joti Samra — the authors of the article above. The guide has been developed by the Simon Fraser University Faculty of Health Science's Centre for Applied Research in Mental Health and Addiction (CARMHA), with funding from B.C. Mental Health & Addiction Services (BCMHAS), an agency of the B.C. Provincial Health Services Authority.

*Antidepressant Skills at Work: Dealing with Mood Problems in the Workplace* is intended for:

- working people with low mood, who may be at risk for developing depression;
- working people who have developed a mild or major depression;
- individuals who have been off work for a period of time and are re-entering the workplace;
- partners, family members, friends or workplace colleagues who want to help an individual suffering from low mood or depression;
- employers, disability providers, supervisors or managers concerned about employee well-being; and
- treatment providers who would like a tool to use as an adjunct to their clinical treatment, including facilitating return to work.

The workbook is based on research about strategies that are effective in managing depressed mood. It focuses on ways to:

- deal with workplace problems so they are less likely to cause depressed mood or lead to depression;
- reduce the effects of depression and depressed mood on work satisfaction and performance; and
- complement pharmacological, psychological and rehabilitation interventions.

*Antidepressant Skills in the Workplace* was developed in consultation with a range of stakeholders concerned with depression in the workplace. These include workers who have experienced mood problems, employers, union representatives, physicians, occupational health professionals, disability management personnel, and employee and family assistance counsellors.

The manual can be downloaded — for free — from the website of the Centre for Applied Research in Mental Health and Addiction at www.carmha.ca, under Publications. Print versions of the manual are also available, for an at-cost price. For more information, contact Dr. Joti Samra at jsamra@sfu.ca.

assisting workers to regain functioning are effective in recovery, decreasing subsequent disability and reducing secondary illness reinforcers (e.g., reduced personal responsibility, avoidance of personal or work stressors, dependency).

## 5 Focus on relapse prevention/response strategies

Given the high recurrence rate of depression, it is important to have a targeted and planned strategy to provide early and effective response to possible relapse. This requires ongoing communication and follow-up with employees for a period of three to six months, even following a successful return to work. Relapse response strategies include collaborating with the employee to identify triggers for relapse, behaviours that might suggest relapse or current situations that may be particularly challenging.

In addition, it is important to ensure that there is ongoing supportive dialogue between the employer and employee during the work-return period. There needs to be opportunity for ongoing access to rehabilitation as well as mental health care, as needed. Finally, it is important to develop a specific plan to address actual recurrence of symptoms so that functional decline or "return to disability" is minimized.

We have yet to develop best practices for assisting employees with depression. We have some good practices; we just need to use them. •

**Further reading …**


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