

EMPLOYERS GETTING STARTED
On the Road to Mental Health and Productivity

MODULE THREE

GUIDELINES FOR MENTAL DISABILITY MANAGEMENT

Dr. Sol Sax, Global Medical Director, Dupont Inc.

The cost burden from short and long-term disability is about \$3,000 an employee at Dupont and this means mental disorders cost about half that.

Primary prevention is eliminating the root cause. In the workplace, the key thing is workplace stress. What can we do in terms of the behaviour and actions of front-line leadership?

Secondary prevention is early detection and intervention. I have promoted the idea of depression screening. But our doctors and nurses say we have enough trouble getting people who are already diagnosed for treatment within six months. The treatment resources just aren't there. Which leaves us with band-aid solutions.

Tertiary prevention is basically prompt treatment, the prevention of complications. Here again, we have the same conundrum.

Highlights

Module Three:

- Deals comprehensively with line manager involvement in the complexities of disability management, job accommodations, return to work and questions which dog this experience.
- Advises managers what questions to ask in order to become safely accountable for the results of disability management in their organizations.
- Spells out what line managers need to know about the organization's current policies, practices and experience in the disability management field.
- Says line managers must become familiar with the concept of case management and how it is practiced in their organization. (*The Module introduces the Green Chart as a case management tool.*)

- Briefs line managers on signs and symptoms of mental distress, and potential mental illness in employees, how these mingle with job performance, how to understand, separate and manage them.
- Informs line managers on the ironic difficulties of employees returning to work after they have been medically cleared to do so.
- Introduces a new concept called the Rule out Rule (1) and (2) to:
 1. Approach employees with performance problems and signs of distress.
 2. Assess work climates which may deter an employee's early RTW.
(*The Plan has phrasing ideas for talking to employees on such matters.*)

This Module:

- Sets out “rule of thumb” costs and timelines for recovery and return from mental disabilities. Recovery and return to work are two sides of the same coin, interdependent, should be managed as such.
- Underlines the compounding effect of mental disorders co-occurring with other chronic disorders including heart disease and diabetes – disability, time off and recovery times are all compounded.

This Module describes in detail:

- The roles of employees, employers, physicians, and unions in making proper job accommodations for employees returning to work from mental disability.
- The tough issues all of the parties face in this process – ranging from the difficulty of obtaining a proper diagnosis and employee non-compliance with treatment plans to relationship problems at work, home issues and delay.
- The best approach to handling these issues – from treating physician as part of the case management team to employee input into the job accommodation planning process.
- The customization of job accommodations: supervisors and employees working together to adjust space and time at work, using physical fitness programs as part of the recovery and return to work process.
- Planning job accommodations in advance: manager and employee talking to each other during the disability leave period, when the employee is cleared to come back to work (but before the actual date) and on the return date.

A major report on **Depression and Work Function** by an outstanding team supported by The Health Care Benefit Trust in Vancouver, University of British Columbia and Great-West Life, is a formidable work and its conclusions notable:

- The workplace response to depressive disorders among employees is generally uninformed, disorganized and often ineffectual. Therefore, a comprehensive and coordinated strategy for managing depression in the workplace is called for.

Employers Getting Started combined with the Roundtable Business Plan to Defeat Depression and our 2004 Roadmap to Mental Disability Management are instruments to do that.

- A chasm has opened between the public healthcare system and the workplace ... different cultures, poor communications and lack of coordination in the treatment and management of mental health problems.

The Roundtable adds: relations between physicians and employer case or claims managers, however, is faulty, tense and often counter-productive.

- Depression in the workplace has a significant effect on productivity and profitability of corporate employers whose employees suffer this condition. Continuum of risk reduction, health promotion and early intervention is needed.

Fundamental Goal: Reduce Disability Rates

B.C. Roundtable Chairman Lloyd Craig convened two substantive discussions of insurers, employers and health professionals to tackle the question of mental disability.

A powerful consensus was reached and it forms the backbone of *EMPLOYERS GETTING STARTED* – that is, yes, we can substantially reduce the incidence of short-term disabilities due to mental illness.

From this flows a second emphatic conclusion: if STD rates are reduced, a natural effect will be the significant reduction of the incidence of long-term disability involving mental illnesses as a primary disorder.

Meanwhile, a focus on the impact of depression as a secondary diagnosis in LTD cases merits attention given the links between the disorder and physical pain and other chronic health problems including heart disease and low back pain.

Therefore, the underlying objective of EGS is the reduction of short and long-term disabilities due to mental illness as a percentage of the total disability experience and payroll costs.

On this basis, it is plausible to:

1. Stabilize disability claims due to mental illness as a percentage of all disability insurance claims with ongoing annual shrinkage of new claims on a year-to-year basis.
2. Achieve 95% success rate in the return to work of employees on disability leave due to mental disorders for a period of not less than one year taking into account the possibility of relapse inside the first six months and the likelihood of re-occurrence in the future (like any chronic illness).

The development of plan-solid, clearly-stated objectives in workplace mental health is important to employer credibility and employee acceptance of such an initiative. Two diverse employers make the point.

Ontario Power Generation

First, we turn to the efforts of the Wellness Division (under Diane Westcott) at Ontario Power Generation, one of the worlds largest hydroelectric and nuclear energy producers.

An OPG policy states:

“Mental health will be a wellness priority for 2005 – partnership with our unions regarding this matter is essential ... tripartite committees will make recommendations and monitor progress.”

OPG’s mental health strategy aims, first and foremost, to *“mitigate the impact of mental illness through early and effective intervention and prevention ... three pillars – prevention, organizational effectiveness and disability management.”*

Prevention at OPG

This centres on education including a *“broad range of topics that go beyond the conventional definition of mental health but are vitally important to a healthy work environment and individual well-being”* – with initiatives including:

- Wellness website
- Lunch and learn sessions
- Supervisory training
- And videos

Organizational Effectiveness at OPG

This centres on creating “*a high energy environment in which work stress is positive and motivating – not demeaning, demanding or demoralizing.*” OPG compares the two types:

Healthy

Fairness
Respect
Recognition
Appreciation job clarity
Reasonable demands
Involvement
Control over work
Common purpose

Unhealthy

Frustration
Distrust
Anxiety
Fear
Tension
Low morale
Low commitment
Bad stress

Disability Management at OPG

The firm is piloting a mental health case management initiative “*based on the premise that early intervention/treatment is vital to recovery from mental illnesses. This will identify sick leave cases where mental health is an issue.*”

The OPG mental health policy includes:

- Identification and resolution of workplace issues which may complicate or confound an employee’s successful re-entry.
- A monthly report to keep a close watch on cases that require follow-up and intensified attention. This is an important way to prevent the gradual migration of short-term cases to the threshold of long-term disability.
- A simple but telling provision: supervisors and co-workers are reminded to welcome the returning employee back to work and, in this same spirit, identifying workplace problems.

Another important OPG policy measure tied to early intervention:

- Employees off work must be contacted by a nurse care coordinator within five days to discuss a return to work plan. This will take combined questions and information in a supportive, non-judgmental form.

B.C. Provincial Health Services Authority

The authority delivers health services in British Columbia – including mental health care. That said, the executive leaders of this remarkable public agency have made mental health in their own workplace a priority.

Special adviser Peter Coleridge outlines the approach:

- The health authority has embarked on a mental health strategy which aims to achieve a range of results but none more important than this: improved patient care through improved employee health.
- Seven key principles embraced by the strategy:
 1. Evidence-based planning
 2. Quality management
 3. Executive accountability
 4. Problem-solving, participative approach
 5. Culture change to create a supportive work environment
 6. Treatment compliance rates in excess of 905
 7. Interest/accountability of employees for their own recovery
- Six practical components of the strategy:
 1. A health profile for the organization. This is compass for the future.
 2. Resilience training to optimize prevention/management of depression
 3. Depression screening for high risk employees
 4. Periodic health monitoring for high risk health groups
 5. Depression self-care material
 6. Depression return to work process

Accountability of Managers for Results of Disability Management

Managers are encouraged to ask questions to learn what the disability burden of their organization or department is.

Managers are encouraged to focus on certain hot spots and look for:

- a) Evidence that “out of sight out of mind” prevails in your organization or department as to the status of employees who may be on disability leave. This is a warning sign.
- b) Evidence that lines of communications have not been opened with employees early in the disability period.
- c) Patterns of delay in returning employees to work even after medical clearance is received.
- d) No established process to define accommodations needed to facilitate the employee’s return to work gradually.

- e) No involvement at all with the employee's direct boss in the process; signs that the job of the person on disability has been permanently re-assigned.

These indicators suggest that the disability management process in your organization is inadequate. A more comprehensive audit of current and recent disability cases is called for.

In both current and recent files, managers need to know:

- Are there inexplicable gaps between when an employee is cleared by his or her physician to return to work and when they actually come back?
- Are appropriate functional assessments done with respect to the design and implementation of proper accommodation strategies?
- Do your employees on disability leave hear from their supervisors or co-workers while on leave? Do they receive regular communications about work activities? An isolated employee faces a steeper hill to climb.
- Why are employees on LTD? Was their STD mismanaged, was the treatment ineffective, was the case put on the back burner?
- Does the management of STD or LTD cases reflect a lack of due diligence, knowledge and understanding? If so, this suggests:
 1. Systemic problems in the management of disabilities in the organization.
 2. Prejudicial atmosphere or behaviour in the case of mental disability.

Incentives

Ultimate accountability for the success of the RTW process must be vested in line and staff managers responsible for that individual's performance on-the job guided by the case manager.

The line manager and human resources personnel should receive financial incentives to bring about a successful RTW wherein the employee comes back full-time gradually and remains successfully on the job.

Case Management

The quarterback of the disability management process is called a case manager – and case management, while not formally certified in Canada, is nonetheless an accepted and valuable part of disability management.

One of the first steps the case manager takes is meeting with the employee and then contacting the employee's physician and discussing the nature of the condition and the outlook for that employee's return to work.

The case manager's job is to unify all the parties who have a stake in this employee's health and work status. He or she helps the physician, employee and line manager sort out job issues for purposes of a return to work.

The Green Chart

The **Green Chart** becomes the case manager's blue print. This device houses a written return to work plan but does not contain confidential medical information.

A tool to assist physicians and case managers to track and recover and RTW information is next.

Physician's – Tracking Recovery – Green Chart

In the space provided explain and/or list specific accommodations that can be made by the employer to ease the Return to Work process

	1 At this time, the task is impossible for the employee to perform	2 The employee can perform some aspects of this task with accommodations	3 The employee can perform this task with accommodations	4 The employee performs this task well although some accommodations are still necessary	5 The employee can easily perform this task with little or no special assistance
<i>General Work Skills</i>					
Understanding and following instructions					
Performing simple and repetitive tasks					
Maintaining a work pace appropriate to the work load					
Relating to other people beyond giving and receiving instructions					
Influencing others, accepting instructions, planning					
<i>Specific Job Functions or Requirements (not covered above, as outlined by the case manager)</i>					
Information Required by the Physician					
Character of the workplace – pace, dynamics and history					
Patterns of absence or downtime in the last 30 days					

Reviewed by Sr. Sol Sax and Dr. Bruce Rowat

Case Manager – Tracking Recovery – Green Chart				
Employee:				
Case Manager:				
Date:		Date of Next Case Meeting:		
	Physician's Rating 1 to 5	Physician Recommendations	<i>Plan of Action</i>	Desired Outcome
<i>General Work Skills</i>				
Understanding and following instructions				
Performing simple and repetitive tasks				
Maintaining a work pace appropriate to the work load				
Relating to other people beyond giving and receiving instructions				
Influencing others, accepting instructions, planning				
<i>Specific Job Functions or Requirements (not covered above, as outlined by the case manager)</i>				
Additional Tasks for Case Manager		Date	Comments	
Re-entry interview scheduled				
Employee invited to bring friend, family member or physician to re-entry interview				
Employee assured his/her job is waiting for him/her				
Employee formally welcomed back by employer				
Re-entry plan established and reviewed; a realistic timeline implemented				

Symptoms of Mental Disease and Job Performance

“Individual and organizational risk factors contribute to depression and it is important to consider both in developing an intervention.” – Depression and Work Function Study sponsored in B.C. by UBC, Great-West Life and Health Care Benefit Trust.

The crossover between unrecognized symptoms of a mental disease is one of the most complicated features of mental disability management.

Symptoms of mental conditions can be mistaken for a “negative attitude” on the job. This never happens, of course, when an employee has a physical injury such as a broken arm. In that case, it becomes self-evident he or she cannot function 100 per cent. But with depression and anxiety, nothing is self-evident to managers or co-workers.

Nonetheless, like other injuries and illnesses, depression affects the performance of the individual employee – but the reasons usually go undetected and unrecognized.

Researchers have found that employees with depression tend to “play through their injury” (to use a sports phrase) and trudge to work each day not recognizing they have a medical condition. Downtime ensues. Part of the workday gets lost.

These random absences represent a bigger cost to business than disability leaves. This is one complication in managing mental disability. There is another.

Many managers today do not deal with performance issues effectively, defer HR problems, avoid them or wait for a downsizing solution. Also, formal job descriptions frequently do not describe the actual responsibilities of the employee.

On the other hand, performance management is an important tool in the early identification of job stress, distress and developing medical conditions. For example:

- The observance of sound performance management practices combined with empathetic two-way communication between the “direct report” (employee) and his or her boss, will ultimately smoke out symptoms of depression and anxiety.
- But when performance concerns do not get discussed or dealt with in a timely way, important conversations do not happen.
- Further, the build-up of performance problems often parallels the decline of working relationships, thus creating a residue which becomes a trap waiting to snare the employee when he/she returns to work from sick leave.

Re-Entry Interview

As a result, ironically, the most telling and risky milestone in the RTW process may be the point at which the employee is cleared by his/her physician to return to work.

The employee is likely still in recovery mode and – like anyone coming back from any illness – uncertain, even brittle. This is natural. There are certain protocols, planning, and sensitivities, therefore, the employer must observe:

- The employer must welcome the employee back, first and foremost, and affirm its duty and desire to accommodate a smooth re-entry.
- Make it clear that the employee's job is waiting for him/her. The assumption behind this: the employer has not filled the job permanently in the employee's absence.
- Do not make the "residue of issues" which developed in the immediate pre-leave period the order of first business. These matters can and should be addressed later in the process.

Signs and Symptoms

A co-worker, manager or supervisor can recognize the signs of distress in others by recognizing changes in the way their colleague or direct report conducts themselves.

- For example, an even-tempered person becomes routinely irritable, down in the dumps a lot, obviously struggling to participate in meetings, looking sluggish, uneasy and tired much of the time.
- The co-worker or direct report may also begin to show signs of being unable to concentrate, being late on deadlines and for meetings when they were punctual before.
- Inside themselves, that person may feel like they aren't pulling their weight, and feel guilty about it while becoming defensive and sharp with anyone who innocently inquires if they need or want help with a particular task.
- At the same time, even a person who was usually optimistic is not always optimistic about how things might turn out begins to doubt that anything will work out OK, they come to expect problems.
- And when those problems occur – as they often do foreseen or unforeseen – the person in distress feels both darkly satisfied (I told you so) and deeply frustrated (nothing works anymore so nothing matters anymore).

- In terms of what a co-worker or boss can do in response to seeing these signs fairly consistently over a period of time – say, 2-3 weeks – there are three assumptions to make before taking action of any kind:
 1. Unless the person in distress wants to talk about what’s bothering them, unless he or she decides they should seek professional help, then neither friend nor boss can force them to do either.
 2. A co-worker may reach out to this person privately and sympathetically as a friend if that friendship – and trust that goes along with it – pre-exists that point-in-time.
 3. A boss, on the other hand, should reach out privately, with compassion and empathy. But the supervisor’s job, at that point, is to manage the person’s job performance not their health.

We should note the following:

- *The co-worker supports a person who is a friend (sympathy), and the boss engages a person who is an employee (empathy). Both are appropriate. Both are anchored by compassion. But the purposes differ:*
- *The friend helps the person; the boss helps the person continue to be a productive employee. Both for reasons which are appropriate and can be mutually reinforcing.*

Performance Problems and Medical Symptoms -- “Rule out Rule (1)”

The Roundtable offers the “Rule out Rule (1) (2) as a tool to distinguish between developing medical symptoms and garden variety performance and relationship problems, on the one hand, and organizational health risks, on the other.

The “rule out rule” gives managers and employees a way to discuss sensitive matters fruitfully and clearly – taking into account:

- The employee’s right to personal privacy and –
- The manager’s accountability for that individual’s presence-in-the-job and performance of it.

The “rule out rule” is called for given the high prevalence rates of mental disorders and mental disability insurance claims in the workforce. By using it, the manager makes no assumptions or inquiry about the health of the employee.

The “rule out rule” revolves around gradual or marked change in an employee’s performance, relationships, affect, energy and other visible signs. It involves a trainable, learnable and non-judgmental construct of oral communications and empathetic observation:

Manager to Employee

- *“Jack, we value you here but we need to discuss some aspects of your performance lately. But I’d like you to consider something first.*
- *“I’ve noticed, Jack, that you seem to be under a lot of pressure. We all go through that from time to time; and sometimes, it takes a toll. Would you care to take a bit of time to talk to our EAP people? I would certainly support you doing that and we can talk about the job later.”*

Body Language

- Sit don’t stand; avoid a desk between you
- Manager makes eye contact
- But don’t stare or glare
- Look away easily from time to time
- Then return
- Don’t lean back in your chair; stay in a relaxed neutral position or lean forward a bit just to make the conversation seem more personal.

Delivery

- Get to the point quickly, no big lead-up
- The construct is a series of brief, short sentences and transitional phrases
- This allows you to pause and yet complete the message in a single thought.

Tone

- Balance genuine concern, empathy and clarity

Listen

- Patience breeds listening and listening breeds patience; take an interest in the employee’s viewpoint – feelings – give him/her the gift of listening.

Next Steps

- Don’t end the conversation in a fog
- If need be, adjourn and make an appointment to talk again
- Give the employee time to think about things
- But don’t end the meeting on a vague basis. Establish, exactly, the next step.

Onus

- Rule-out-rule is not a means to escape one’s obligation as an employer and manager. It is a tool to exercise those obligations.

- Human rights findings run against an employer who takes disciplinary action against an employee even if the employee resists offers to help.

Preps

- Pre-planning this conversation is key.
- Get up-to-speed on employer services available to the employee; EAPs are a good starting-point.
- Also, make a deal with your own boss: you intend to invoke the “rule out rule,” express support for the employee, and you need to make sure you and your boss are on the same page.

Also, be clear:

- If the employee exercises this option and learns he/she is suffering a mental condition which merits medical attention, this could produce sick leave or even short-term disability leave.
- When the employee recovers and returns to work, his/her right in this regard is established in law. The deferred “performance discussion” cannot, then, be activated on a condition for the employee’s return to work.
- In fact, in complex cases, performance discussions of this nature are best cancelled and make a fresh start to the employee’s job performance opportunities and obligations.

Organizational and Individual Health -- “Rule Out Rule (2)”

Ruling in or ruling out the health concerns of the individual is only one part of the strategy to prevent the disabling effects of mental disorders. The other part is ruling in or ruling out the possible contributory symptoms of the organization itself.

Is the workplace sick – and is it making the people working there sick?

Data demonstrates certain management practices and workplace practices can precipitate or aggravate mental health problems. Do these practices show up in the departing employee’s department, office or work area?

As a matter of due diligence, therefore, employers are advised to deploy “Rule out Rule (2)” to determine whether such factors may be in play:

- Seek out signs – those common stress traps which frequently snare employees and using the principle of the “exit interview” among current employees, evaluate whether these hazards are routinely in play.

- Survey employees now off work on sick or disability leave to determine their experience, what worries them about returning to work.
- Survey managers and supervisors and consult executives to ascertain if a preponderance of employee absence – noted through common observation if not formally monitored – is collecting in any given part of the organization.
- Interview the employee-on-leave’s direct supervisor to affirm the individual’s understanding of their role in facilitating a successful return to work process and, in turn, inquire as to workplace factors which may impede the employee’s safe return to work.
- Over and above the case manager or union rep., the employee should have the option of being accompanied at the re-entry interview by a family member, personal friend, trusted co-worker, or his/her physician.
- It is critical that as the gradual return to work proceeds, the employee is not isolated for weeks after the re-entry interview. This can be destructive to his/her health. Being alone at this point is both unnecessary and unhelpful to the return to work process.

Recovery and RTW

The longer the period of recovery, the more likely the time off work will compound disproportionately.

Greenberg et al estimate the average length of an episode of depression is 12 weeks for those who receive adequate treatment and within those 12 weeks, the employee may accrue 33 days of lost work compared to 60 days over an 18-week period.

Also untreated sufferers of depression spend twice as many days home in bed than treated sufferers spend in hospital – when that is called for – 32 vs. 16 days. This means helping employees at home to get “out and about” and stay connected to the workplace.

In a study by Carolyn Dewa at the Centre for Addiction and Mental Health, employees on disability using recommended first line anti-depressant medication in recommended doses were significantly more likely to return to work rather than to claim LTD benefits.

“These results are congruent with the hypothesis that anti-depressants can play an important part in the ability of employees to resume work,” the study finds.

Further, “early intervention was associated, shortens disability by three weeks among employees who receive appropriate anti-depressant medication.”

Based on the average wage of the sector (financial services), this represented a per-employee saving of about \$3500 in productivity terms and total savings of up to \$875,000 to employers with a combined workforce of 63,000.

Depressed and highly stressed individuals may seek medical attention for physical conditions such as unspecified pain, fatigue or headaches or develop more serious illnesses with psychosocial antecedents such as heart disease; also, people with serious illness become depressed as a result.

Therefore, aggressive outreach to provide treatment and facilitate maintenance therapy to prevent relapse might have positive workplace effects and the costs could be amortized over a longer pay back period than costs of other chronic disorders

Maintenance therapies can dramatically reduce episode recurrence. This must be considered as seriously as treatment.

Days Lost Compounded

Certain data from one major U.S. study gives us insight into the numbers of days lost when mental disorders are in play. This can be used to develop and track timelines on a “rule of thumb” basis, a compass of sorts, given the absence of formally approved timelines for recovery and return to work.

Average work loss associated with depression et al: (Kessler et al)

1. 6 complete days per month per 100 workers
2. 31 downtime days per month per 100 workers
**2 denotes presenteeism impact, greater (5-1) than previously projected*

Average work loss associated with co-morbid disorders (depression plus) (Kessler et al)

1. 49 complete days per month per 100 workers
2. 346 downtime days per employee per 100 workers
**employee w/no health problems average 2 complete and 11 downtime days*

Analysis shows that role impairments among four of the most common chronic disorders is almost exclusively limited to those with co-morbid mental disorders which represented 20 – 50 per cent of the total number of employees with co-morbid conditions.

There is compelling evidence that co-morbid mental health problems and addictions have considerable fall-out across a range of other conditions and produce disability and work performance problems on a large scale. Individuals with a chronic illness have 41 per cent greater risk of depression.

Employers should act on three fronts concurrently:

1. Equip managers to understand their role in managing employee performance within the context of a healthy workplace model.

2. Determine how much expertise their health service providers have in the area of mental health.
3. Learn what is driving their long-term and short-term disability experience – who is on LTD and why – why did STD migrate to LTD – why didn't treatment work – and if it did work, why isn't the employee back to work.

Employees' Questions

Employees on disability leave need this information:

- Are there provisions in your disability arrangement for your physician to be informed about the nature and specific duties of your job? This is important to later decisions concerning return to work.
- Will your physician be required to fill out reports and will this be onerous and cause you delays in the process? Are you expected to pay the physician for this?

Both employers and employees are advised to become familiar with the predictors of disability. Across a wide range of large U.S. companies, researchers found that the major predictors of the length of disability leave were:

- The emotional and cognitive variables – mood, locus of control, self-esteem and these were more important in the case of recovery from survey in these studies than financial/income worries.
- Severity of depression in back patients was the strongest predictor with respect to return to work and this, in turn, was closely correlated to locus of control at work (“what am I going back to?”)

Drug Plans as Part Case Management

Pharmacists should be engaged by employers and insurers as part of the Case Management team. This, to ensure the efficacy and effectiveness of prescription medication prescribed and paid for under group drug plans.

In their normal role, pharmacists implement drug treatment protocols through the process of overseeing the dispensation of prescription drugs in Canada. This is their natural role.

Reduce Drug Costs

1. The way to reduce rising drug costs is through effective management. For drug therapies to treat major depressive disorders and anxiety, this begins with an evaluation of the patient's drug therapy record (drug profile) to ensure the prescribed therapy is safe.

2. Pharmacists also monitor patient compliance with the prescribed regimen. This heads off the risk of patients stop taking their medication prematurely. On-going management of the treatment plan is critical.

(The Ontario Pharmacists Association reports say patient non-compliance with treatment regimens costs about \$7B a year in Canada. “This is disturbing because well-controlled pharma-economic studies point to the significant cost-effectiveness of drug therapy.”)

The role of pharmacists can/should be incorporated into the disability management to:

- Help physicians manage the change from one medication to the other in the face of limited or no improvement in the patient’s depressive symptoms. Psychiatrists advise an aggressive change strategy – different drug, increased dosage or both.
- Advise patients and physicians on the use of non-prescription drugs especially during the use of prescription medication for depressive or anxiety disorders.

(Sleeplessness and pain may be symptoms of the depression itself and the patient may not understand this and seek out over the counter meds.)

(This can be important in the case of those with a history of chronic illnesses such as cardiac disease, or diabetes. Depression can co-occur with these conditions and may be signalled by symptoms that seem unrelated to mental health.)

- Counsel patients on the purpose of the medication, how to take it; what the effects should be, what side-effects may occur, interactions with food and other drugs and, as noted above, the absolute necessity of adhering to the prescription.

(If patients or physicians do not see results in a specific timeframe, the pharmacist can advise both on alternative drug strategies in terms of drug choice and dosage. This promotes evidence-based treatment.)

- Make generic substitutions of prescribed medications as a cost reduction measure; manage the “therapeutic switch” of one drug to another within a specific class to select the most cost-effective drug with equal benefit.
- Advise clients to consult their family physician or workplace health adviser. Pharmacists are often the first person the patient sees when health problems begin to materialize.
- Pharmacists charge a dispensing fee. If additional charges are incurred in the case of the management of medication for mental disorders, this should be negotiated among the parties. It is a relatively small investment with big potential returns.

(On the other hand, pharmacies or regional or national chains could offer these services as value-added and attract group plan business with employers on a contracted or “preferred provider” basis.)

Drug utilization is a big issue today. Anti-depressants are among the top five prescribed “meds” and drugs, overall, representing 16 per cent of all health care costs. Which is second only to hospitals and 25 per cent higher than physician’s charges.

Also, private drug expenditures have now overtaken publicly funded drug use. Further, in 2002, professional fees on prescription drugs rose 14 per cent and ingredients were up 42 per cent.

More particularly, a “shared care” strategy engaging pharmacists would also support the advancement of effective outcomes, early interventions and responsible cost reductions.

Rights and Requirements of Each Participant In Disability Management Process

It is natural and understandable for individual employees and managers to want to know precisely what the job accommodation and return to work process entails – especially, if they are accountable for the result.

Common sense is always a valuable tool. In the case of human rights, there are clear end-game obligations but no pat set of instructions how to get there. Please refer to the Human Rights Module for more on this.

There are a range of questions that develop in the RTW process that we need to consider.

The following line-up was developed with the valued assistance and guidance of Douglas Smeall, VP, Marketing and Sales, ATF Canada, a Roundtable adviser and outstanding executive and specialist in the field of disability management.

THE EMPLOYEE

Rights:

- Gradual return to work. (linked to severity of illness and safety aspects of the job)
- Meaningful work and reasonable hours
- Proper supervision (in terms of workload, oversight, support)
- Privacy
- Proper professional support
- Training to update skills as required
- Equitable severance including career counselling if things don’t turn out

Requirements:

- Meet the employer half-way in working out job accommodations.
- Not seek the “perfect” or “only” solution to such arrangements.
- Comply with medical instructions and treatment plan during both the pre-return and post return to work recovery phase.
- Be vigilant in self-managing stress so as to not induce relapse. This is part of one’s own responsibility for one’s own health.
- Ask for help as may be necessary. Be proactive in asking your manager how this will work before you begin the return process.
- Not use personal relationship problems as an excuse not to come back to work when the physician has cleared the employee to do so.

THE EMPLOYER

Rights and Requirements:

- Help get the employee back to work and full-time status as soon as possible on sound medical grounds.
- This includes having the employee work shift work if that is what the employee did before disability leave.
- The employee participating in rehabilitation activities and complying with appropriate treatment.
- Set and monitor reasonable, objective standards of performance. Common sense says the manager is smart to work these out with the returning employee.
- Offer fair and equitable severance with career counselling when and if the employees’ performance does not meet the requirements of the job.
- Provide the employee with appropriate support services to facilitate the return to work phase of the recovery process.
- Meet its duty to accommodation and to understand the human rights obligations vested in employers by provincial and federal statute. Ensure managers understand and comply with in good faith and goodwill.

THE PHYSICIAN

Must and should:

- Provide Guideline-concordant diagnosis and treatment and use of DSM-IV criteria to assess patients. (*“Stress” is not adequately-precis as a diagnosis for disability management purposes and should be questioned if it appears as such.*)
- Be willing to act as a partner with the case management team and for this purpose the treating physician:
 - Should be paid his/her fees by the employer – or insurer – if required to fill out forms/attend meetings as a team member.
 - Otherwise, these charges fall to the employee or the treating physician receives no compensation for these additional duties. Which is counter-productive.
- In the course of treatment, help maintain the employee focus on a return to work and incorporate RTW into the concept of recovery and vice-versa.
- Help the employee realize gains in his or her functionality and not just symptom relief; support cognitive therapy initiatives when called for and physical activation.
- Make it his or her business to find out about the nature of the employee’s job and set return to work conditions that make sense. A “new boss” or a “new job” is not helpful advice from physicians to employers.

THE UNION

Must and should:

- Enable the part-time, gradual return to work of employees.
- Assist with identifying alternative or modified duties of work.
- Support the employee to receive appropriate medical treatment and support.
- Support the employers’ right to shift work for employees who did this before they went on leave.
- Promote re-training efforts
- Ensure life and health care benefits are continued on disability leave.

- Support EAP support.
- Support early identification and wellness initiatives.
- Avoid turning the employee's disability case into a subject of grievance or legal due process except as a last resort. Working with the employer and the case management team is a much more desirable approach.
- An employee becoming embroiled into a drawn-out contractual dispute is not good for his or her health.
- Like employers, become informed on human rights obligations that are relevant to the process of job accommodation in a unionized environment.

The question is: do you assume that under all circumstances, the collective bargaining agreement is supreme. That assumption is wrong.

TOUGH ISSUES FOR ALL CONCERNED

- Getting a proper diagnosis and effective treatment plan for mental disorders.
- Getting treating physicians to become engaged in the case management process in an informed and balanced way.
- Employee non-compliance with drug therapies and other forms of appropriate treatment.
- The effects of certain combinations:
 1. Depression and chronic physical disorders including heart attack.
 2. Anxiety disorders, depression and personality disorders. This adds great complexity to effective case management and medical success.
- Reluctance on the part of managers and employees to make adjustments to their relationship.
- Employees drift from short to long-term disability and the implications of that in terms of employee's chances of returning to work and employer getting a return on their investment in that individual.
- Home issues: employees who are hospitalized or treated on an out-patient or doctor's office basis may report a chaotic home life in the early stages of the disability period.

(Case managers must explore this with the employee and recommend home care, daycare or family support as may be called for or helpful.)

- Employees' developing of a disability mindset combined with the "disincentives" of rich benefit packages for some employees to return to full-time work.
- Physicians who reinforce negative outlook of employees, provide sub-optimal treatment including the lack of treatment maintenance or relapse-prevention oversight.

BEST APPROACH FOR ALL CONCERNED

- Proper diagnosis and enlightened case management approach with the physician serving as a compensated member of that team. This will increase the odds of earlier RTW, continuance of a health monitoring system during this period.
- Upfront identification of the workplace factors that will have a bearing on the success of the return to work process, honest appraisals of relationship issues and a plan to resolve them.
- Proper use of cognitive therapy, physical fitness and activation programs to get the employee out of the house; use of communications (art) therapies customized to the individual to keep their thought processes tuned-up.
- Active involvement of a supportive, interested, informed manager with accountability for that employee's successful return to work or an appropriate outcome that involves other measures.
- Well-planned job accommodation with the employee's own input and understanding how her or his performance will be judged.
- Clear expectations all-round with regard to the pace and timing of the return to work and understanding that relapse is a possible nature and not necessarily a permanent or serious setback.
- Union support of the employee, a proactive and fully-engaged way. Union members should be part of the case management team.
- Vocational assessments used prudently; independent medical evaluations used in a non-adversarial, collaborative manner to assess the treating plan in concert with the treating physician.

Customizing Job Accommodation

CIBC Model

Ron Lalonde, Chief Administrative Officer, CIBC

“CIBC’s disability management program starts with meetings between employee, his or her manager and a facilitator.

“The whole focus is on the abilities of the individual, what he or she feels she can or can’t do and what CIBC can do to accommodate that person and help them get back to work.”

“Accommodation can mean gradual return to work, flexible hours, more frequently work breaks, different ways to communicate and none of these are really expensive but can make a world of difference to people and it had amazing results for us.

“Typical short-term leave for psychiatric reasons is now 40% shorter than it was in 1999 and our employees on LTD are coming back almost 50% faster than other companies in our insurers’ book of business.

“But we all know there’s more to do – lurking just beneath the surface are intangible barriers to our success, the attitudes and beliefs in the workplace and in society at large that undermine people who are coping with mental illness.

“People with mental illness put up with a lot more than their disorder. Stigma from family, friends, co-workers and health professionals contributes yet another major stress; it keeps people from coming back to work following a crisis.

“We have to create corporate environments where people living with psychiatric disabilities will be accepted and respected as participating members of the team – and society.”

Case managers and physicians are the key advisers to determine what workplace accommodations are needed by employers to facilitate the employee’s gradual RTW.

These two specialists, therefore, need to develop a clear picture of the demands of the job in order to translate this information into “functional” terms – including, for example, difficulties the returning employee may yet have in –

- Concentrating for any length of time
- Dealing with noise and distractions
- Managing emotions and time
- Maintaining stamina during the workday

These concerns can be resolved by –

- Flexible and part-time scheduling
- Longer or more frequent work breaks
- Self-paced workloads
- Minor changes to the work setting such as –
 - Moving the employee closer to natural light.
 - Reducing noise levels – a common EHS practice to preserve employee hearing.
 - Make it easy to get water, tea, soft drinks or crushed ice to counter the effects of some medications. Dehydration can produce fatigue.

Supervisors and employees returning to work can work together to ensure that these kinds of accommodations are workable and easy. Some tips from the experience of others:

- Make daily ‘to-do’ lists and check items off as they are completed.
- Remind each other of important deadlines. Give and get extra feedback.
- Divide large assignments into smaller tasks and goals.
- Look for opportunities to provide positive reinforcement.
- Use written job instructions to the extent that this is helpful.
- Ask the employee what is the best time of day for them. For some, it is the morning, for others, the afternoon.
- Possibly avoid working Mondays which are “crazy days” in most places of work.
- Agree to open communication – devise discrete one-on-one hand signals, if necessary, to indicate that unwelcome stress is building up and it is time for a time-out.
- Make sure the employee is treated as a member of the team and not excluded from social events, business meetings or other activities relevant to the job.
- Do not be excessively protective.

One Person's Action Plan – The Return to Work from Bipolar Disorder

Steps reported to the Roundtable by one young mother and wife as she prepares to return to work full-time.

1. Take my medication as directed.
2. Get at least 7 hours of sleep.
3. Exercise at least 30 minutes per day at least five times per week.
4. Eat sensibly; avoid over-eating and use of food supplements.
5. Take time to read daily (this is time for relaxation).
6. Do not over-extend or over-schedule self.
7. Keep meals and clean-up during the week simple. Spend time with family.

Physical Fitness

Fitness workouts – 30 minutes/day, five days a week – hold out great promise for the relief of symptoms of depression. Studies found that depression was well-tolerated by participants. As a public health measure, physical exercise has two major impacts: helping with the treatment of depression and fighting obesity.

Study by the Universities of Texas and Colorado, found “exercise may be a viable treatment because of it and recommended for most individuals.”

It has not yet met efficacy standards although in a 12 week randomized study, high probability of remission in the 12th week. The study found that the public health dose of exercise is effective for mild to moderate depression. Exercise less than half this amount was not effective.

Planning Accommodations in Advance

Employers are encouraged to be explicit, as a matter of policy, about this: when an employee is on disability leave, you are replacing that employee on a **temporary** not **permanent** basis.

There is considerable value to plan the accommodation of an employee's return to work well in advance of the actual return date. Certainly:

- It is advisable to plan the accommodation process well in advance of the point at which the employee is cleared by his/her physician to return to work gradually.
- The RTW work plan must include the act of giving immediate co-workers enough information – cleared by the affected employee on leave in advance – to help them understand three things:
 1. How the employee's absence will affect their work if at all.
 2. Their role and responsibilities in making job accommodations work in line with the employer's responsibility to provide this kind of transitional support.

3. Their own behaviour and attitude – even if they don't have supervisory duties or management rank – can implicate an employer in a human rights complaint if it contravenes the returning co-worker's rights under law.

It is the duty of the line manager to think about and raise questions which come to mind and take them up with human resources people or their own direct boss.