

BACK TO WORK

Disability management and return-to-work strategies in Canada

COMPANY SUING FAMILY DOC FOR ALLEGED FALSE SICK NOTE

A major Canadian corporation is suing a family physician for negligence for providing a note that the company says falsely verified an employee's sick leave claim.

The company's lawyer, Howard Levitt, a senior counsel in the Labour and Employment Law Group at Lang Michener in Toronto, filed the suit in mid-August. "We're taking a stand," says Levitt. "We're sending a message to family physicians that they better take this stuff seriously. If doctors are asking us to pay money on behalf of employees on the basis that they are sick, the doctors better make sure they [the employees] are sick. And if they're not sure, they better say they're not sure."

The allegations of the case, as stated by Levitt, go like this: An employee of the corporation asked for a few days off work to visit a dying friend in Ottawa. The company agreed to accommodate the employee's need to visit the friend, but denied her the specific days off she requested. Instead, the company offered to let her take some earlier days off to go to Ottawa.

This, according to Levitt, caused the employee to say that she was so stressed by the decision that she was unable to work. She filed a claim for disability benefits. This claim was initially denied, but the employee's doctor wrote a series of letters saying that the employee deserved disability benefits because she was very distressed, was suffering severe depression and

couldn't work. As a result, the employee's disability claim was accepted, and she ended up on benefits for months.

Levitt says he got involved when the employee went to the Canadian Human Rights Commission with a complaint. He started doing some digging around and learned that, instead of going to Ottawa to visit a dying friend on the days the employee requested off, she went on a shopping trip to New York City. "She wanted those particular days off because those dates were booked," Levitt claims.

Lawyer questions qualifications

So Levitt turned his attention to the doctor's letters, which he claims — in light of what he had learned — must have been wrong. Via letter, he questioned the doctor: What tests did you do? What qualifications do you have to diagnose stress and depression? Do you have psychiatric training? What do you know about the jobs at the company? What discussions of accommodation did you have? "I got a letter back from her lawyer refusing to comment," Levitt says.

The company decided to sue the employee for fraud and the doctor for negligence. Because it is only trying to recoup the money it says was wrongfully paid out in disability benefits, the company is suing in small claims court. As Levitt explains, it would not be worth the tens of thousands in legal fees to sue in superior court. Besides, the company is not suing because of

the money; it's suing because it's a matter of principle, he adds.

If Levitt wins the case on behalf of his client, it will "send a bit of a shock through the medical profession," he admits. "Family physicians will learn that they just can't send medical reports to help out their patients without knowing whether or not their patients are actually disabled." It's time for doctors, he adds, "to start telling the truth and not be misleading."

The case has already sent some waves throughout the medical community. Levitt, who is the Workplace Law columnist for the *National Post*, told readers in his June 1, 2005, column that he had been instructed to sue the doctor for rendering a false opinion. In the same column, he also wrote:

"False sick leave claims have become the most intractable human re-

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source problem facing Canadian employers. The correct question, in deciding whether to permit medical absences, is not whether the employee is stressed, has a headache or isn't feeling well, but whether the condition is sufficiently crippling to render the employee entirely disabled from performing their particular job. ... As long as some doctors are prepared to provide medical certificates without the requisite competence or adequate investigation, employers must take a vigorous approach to determining who is entitled to absences and disability benefits."

That column led to a brief discussion on the U.S.-based Work Fitness and Disability Roundtable about letting employers sue doctors for false disability opinions. The column also prompted a letter to Levitt from a doctor in Canada who says he has changed his practices with respect to employee notes. According to Levitt, this doctor now writes letters to employers that simply say something to this effect: "The employee says he's sick. I believe him. Why don't you?"

Vigorous defence expected

Levitt is not expecting an easy ride with this case. First, he assumes that the Canadian Medical Protective Association will vigorously defend the doctor. "It's a horrible precedent for the CMPA if I win," Levitt explains. (The CMPA is a mutual defence organization for physicians who practise in Canada. It provides legal defence, indemnification, risk management and advice to physicians.)

Second, because the case is being heard in small claims court, there is no "discovery" — that is, no sharing of evidence beforehand. "The CMPA may call a hundred witnesses saying that what this doctor did was fine, and because it's small claims court, I won't know what the doctor did until I get there."

Third, Levitt suspects he is going to have a "very hard time" finding a doctor who will say that what the doctor in this case did was not acceptable. "Doctors don't want to go against their own professional body," he says. "What doctor in Ontario is going to want to testify and say the CMPA is wrong and the doctor was negligent? I already spoke to one psychiatrist about testifying, and the response was 'Are you kidding? I want them [CMPA] to protect me if I'm ever sued.'"

For more information, e-mail Levitt at hlevitt@langmichener.ca.

FIRMS STRUGGLE WITH TRACKING ABSENCES, SURVEY SHOWS

Many companies are struggling with tracking absences due to both work- and non-work-related injuries and illnesses. According to a new survey from the human resources consulting firm Hewitt Associates, 81 per cent of employer respondents said they would have difficulty producing five

years of data related to disability absences. And these are not small companies: the average size of the workforce among the 77 organizations responding to the survey was 2,600 employees.

Hewitt's Disability Absence Index Survey, released this month, shows that 38 per cent of the organizations attribute their inability to track absences to a lack of resources; namely, a lack of technology, people and/or data. This creates "something of a vicious circle," says Rochelle Morandini, Hewitt's senior organizational health consultant. Many Canadian organizations say they want proof that wellness and disability management programs work before investing in the required technology and people to run them — the very things needed to gather the proof.

Even where there are the people resources to track absences, Hewitt suggests in its survey report that the wrong people are being charged with this task. It notes that, when conducting organizational health needs assessments, the consulting firm often finds that those people who are responsible for disabili-

RETURN-TO-WORK RESPONSIBILITY

How much responsibility does each of the following have in the day-to-day facilitation and monitoring of your RTW program?

	Considerable	Some	Limited	None	N/A
Internal					
Managers/supervisors	55%	32%	13%	0%	0%
Disability management co-ordinators	33%	18%	4%	7%	37%
Health and safety representatives	16%	19%	16%	27%	21%
Human resources generalists	36%	25%	23%	12%	4%
Benefit administrators	31%	19%	16%	16%	18%
Occupational health nurse	9%	3%	8%	17%	64%
Occupational therapist	3%	5%	8%	21%	63%
External					
Pre-LTD insurance provider	24%	24%	10%	6%	36%
LTD insurance provider	53%	27%	16%	1%	3%
Workers' compensation agency	30%	27%	24%	7%	12%
Contracted third party*	13%	17%	21%	16%	33%

* Includes EAP provider or rehabilitation/case/claims management company

Source: Hewitt Associates: Disability Absence Index Survey 2005

ty management are performing the key tasks related to both managing absences and managing administrative matters.

“For example, we have seen many worksites where highly skilled resources, such as occupational health nurses, occupational therapists or disability management specialists, have limited to no administrative support,” the report says. “The required paperwork and statistics gathering may prevent these key personnel from focusing on the proactive, direct disability management activities that would truly have an impact on an organization’s disability experience.”

Strategy lies with human resources

Hewitt conducted its Disability Absence Index Survey (DAIS) for the first time in the spring of 2005. Its aims were:

- to establish a database of benchmark data for future cross-comparisons between companies and industries;
- to gain an understanding of the types of information companies are tracking and able to produce;
- to determine who has primary responsibility for managing disabilities (both internally and externally); and
- to create a tool that companies can use to evaluate their programs annually.

Among the survey respondents, the estimated average direct cost per employee for all disability-related absences per year is \$1,933 for union employees and \$1,579 for non-union employees. With an average workforce of 2,000, the potential lost revenue as a result of absenteeism could exceed \$3-million a year, the survey concludes.

“Some organizations estimate these figures could double if indirect costs such as administrative and replacement costs were included,” says Morandini. “These numbers also don’t account for absence days that are often missed or are simply not tracked, or for lost productivity time when people remain at work while coping with injury or ill-

ness. Absenteeism clearly impacts a company’s bottom line, but without the necessary data, an organization can’t truly know how big that impact can be.”

As for absence management, the overall strategic responsibility for overseeing the disability management program lies with the human resources department in the vast majority (92%) of responding workplaces, the survey shows. The chart on page 2 shows the groups responsible both internally and externally for return to work.

To order the 100-page report (which costs \$150), call (416) 225-5001 or e-mail infocan@hewitt.com. •

QUEBEC REPORTS ON PSYCHOLOGICAL HARASSMENT CLAIMS

Quebec’s Commission des normes du travail (CNT) received 2,500 psychological harassment complaints during the first year that the province’s prohibition against psychological harassment in the workplace was in effect. Of these, 1,200 have been dealt with — including 36 that were sent on to the Commission des relations travail for a further hearing.

Since June 1, 2004, Quebec employees have been entitled to a workplace free from psychological harassment under *An Act respecting labour standards*. A report released to mark the first anniversary of the legislation — the first such legislation in North America — included these findings:

- 93 per cent of complaints involved repetitive and ongoing incidents of psychological harassment and only seven per cent involved a single incident of psychological harassment;
- 62 per cent of complainants were female, although females represent only 49 per cent of the working population; and
- 81 per cent of complaints cited a

manager as the alleged perpetrator of the psychological harassment.

The CNT is promising to step up its educational campaign this year to help workplaces prevent and deal with psychological harassment. For more information, visit www.cnt.gouv.qc.ca.

B.C. WCB WILL NOT AMEND WORKPLACE VIOLENCE REG

The British Columbia Workers’ Compensation Board announced this month that its board of directors has decided not to amend Part 4 of the province’s Occupational Health and Safety Regulation in response to a coroner’s inquest that looked into the fatal shooting of two government workers in Kamloops by a co-worker.

After a review of legislative and non-legislative practices regarding workplace violence in 22 jurisdictions, the board of directors determined that B.C. already has some of the most comprehensive regulations among the jurisdictions examined. The board has, however, approved increased education for health and safety officers on how to enforce existing regulations and increased education for employers and workers on the regulation’s current worker-to-worker violence provisions.

B.C.’s occupational health and safety regulation contains performance-based requirements for addressing workplace violence. In response to the coroner’s recommendations, the board had been considering expanding the definition of violence to include worker-to-worker incidents and adding new requirements to address “improper conduct” (e.g., intimidation and bullying).

For more information and a copy of the jurisdictional review, go to www.worksafebc.com and click on “Workplace Conduct and Violence in the Workplace.” •

DEALING WITH THE CHALLENGE OF A TRAUMATIC BRAIN INJURY

Workers with brain injuries often present a variety of cognitive, emotional, physical and social barriers to re-employment, making their return one of the most challenging tasks facing a disability manager. **By Garry Corbett***

The National Institute of Disability Management and Research has just published a book for return-to-work practitioners on dealing with challenges in disability management. This excerpt — reprinted and adapted from *Challenges in Disability Management: A Resource Manual for Return to Work Practitioners* with the permission of NIDMAR — looks at traumatic brain injuries. For information on the book, see the box on page 7.

WHAT IS A TRAUMATIC BRAIN INJURY?

Brain injury is often described as either “traumatic brain injury” or “acquired brain injury.” Some use these two terms interchangeably, but in general the term traumatic brain injury includes all incidents where there is direct damage to the brain, usually through some form of accident. Acquired brain injury includes these injuries plus other non-traumatic causes, such as infection, meningitis, hepatic encephalopathy, aneurysm, stroke and tumour.

This [article] looks at the effects of traumatic brain injury (TBI) on the return-to-work process. Many of the principles that apply to individuals with traumatic brain injury also apply to those with acquired brain injury.

It is estimated that over 50,000 indi-

viduals sustain a traumatic brain injury every year in Canada. Of this group, the majority are young men under the age of 34, with the largest group between the ages of 19 and 24.

At one time, the survival rate for a traumatic brain injury was very low, but with advances in medical procedures, approximately 95 per cent now survive. The results of a traumatic brain injury can range from mild physical disability to a pervasive set of physical, behavioural and cognitive deficits that severely affect functioning throughout the individual’s life.

The ongoing effects of a brain injury are dependent upon which part of the brain is damaged.

■ The frontal lobe is located just behind the forehead. It is responsible for such functions as initiation, problem-solving, inhibition of behaviour, organization, mental flexibility, attention and concentration, planning, personality and emotional control.

■ The cerebellum is located at the base of the brain. Its specific functions include balance, co-ordination of voluntary movement and skilled motor activity.

■ The occipital lobe is towards the back of the head. This area controls vision.

■ The parietal lobe is located near the back and top of the head. It has the specific function of controlling the sense of touch, visual perception, manipulation of objects and identification of size, shape and colour.

■ The brain stem is located deep in the brain and leads directly to the spi-

nal cord. The brain stem’s functions include controlling breathing, heart rate, arousal and consciousness, sleep and wake cycles, attention and concentration, blood pressure, digestion, sense of balance and body temperature.

■ The temporal lobe is located at the side of the head above the ears. Its specific functions include memory, hearing, receptive language, organization and sequencing.

In a brain injury, there are primary and secondary processes by which the damage occurs. The primary forces are compression, tension and shear (i.e., twisting). These can combine together to produce both localized and diffuse damage. For example, when a head strikes the windshield of a car, the brain, which is floating in cerebrospinal fluid, smashes into the skull. The compression at the site of impact tears and bruises the nerve fibres. Certain areas of the skull, most notably the base of the frontal and temporal lobes, have bony ridges that increase the likelihood of bruising in this area.

As the compression wave travels throughout the brain, further damage occurs. As the brain is a soft, jelly-like mass, it will often rebound from the force of the initial impact and be driven into the opposite side of the skull. This is referred to as coup/countra-coup phenomenon.

The brain can also be injured when it rotates severely within the skull. The brain is anchored at its base by the spinal cord and cranial nerves. If the head is rotating at the time of the impact, the skull will stop its rotation while the brain inside does not. This can cause significant stretching of the nerve tissue. This twisting action (shearing) is not limited to the base of the brain, but continues upward to higher levels. The billions of thread-like nerves are stretched so severely that they either snap or become temporarily dysfunctional.

* Garry Corbett, PhD, CCRC, CRTWC, is the principal of his own consulting firm — Dr. Garry Corbett Inc. — in Winnipeg. He is also the current president of the Canadian Association of Rehabilitation Professionals.

In addition to these primary forces, commonly occurring secondary processes can result in additional damage. When the brain receives an assault, there is often bruising (haemorrhaging); the pooled mass of blood compresses and displaces nerve fibres. Increased intracranial pressure may result as the brain swells and there is a retention of the blood flow. This increase in pressure can cause damage to parts of the brain, well away from the initial trauma. Prompt and appropriate monitoring and control of intracranial pressure during prehospital stabilization and transportation and during critical care treatment can decrease secondary injury and improve outcomes.

It is possible to make a general determination of the severity of the brain injury soon after the initial insult. The Glasgow Coma Scale (GCS) is often used to label the severity of a TBI. The GCS is an objective measure that rates the injured person based on eye opening, verbal abilities and motor abilities. With scores ranging from 3 to 15, a Glasgow score of 8 or below indicates the individual is in a true coma (for an example of the Glasgow Coma Scale, go to www.trauma.org/scores/gcs.html).

WHAT IS THE TYPICAL COURSE OF RECOVERY FOR AN INDIVIDUAL WITH A BRAIN INJURY?

The course of recovery for an individual who has experienced a brain injury is dependent upon severity.

Mild injury: Persons experiencing no or, at most, a brief (i.e., less than 20 minutes) loss of consciousness are said to have a mild brain injury. This category of brain injury is by far the most common that will occur at a worksite or in a sporting accident. Neurological examinations are normal and, even though some nausea, headaches and dizziness may be present, it has typically been assumed that no permanent

damage to the brain has occurred.

If an individual participates in very physical sports (e.g., football or rugby) or works in a dangerous environment, he or she could experience the cumula-

tive effect of a number of mild brain injuries. The individual may experience either no or a brief period of unconsciousness, thus the incident may look like a mild brain injury. However, due

INJURY AFTERMATH

What are the effects of a brain injury?

No two brain injuries are alike; they are as unique to the individual as a fingerprint. Whatever abilities an individual possesses are at risk of being disrupted by the effects of a brain injury.

[The information below] looks at the relatively common deficits resulting from a moderate or severe brain injury. While the deficits resulting from a mild brain injury are not specifically discussed, it is understood that many of these deficits may be present in a less intrusive form and be overlooked or misunderstood. Deficits may be physical, cognitive, executive function or psychosocial.

Physical deficits are a very common result of brain injury. The individual may experience:

- weakness or paralysis to one side of the body (hemiparesis or hemiplegia);
- unco-ordinated muscle control (ataxia);
- fine or gross motor control difficulties;
- balance problems;
- difficulties with endurance;
- motor difficulties in the speech apparatus, commonly called dysarthria (i.e., difficulty in the articulation of speech sounds due to injury in the motor speech nerves) and apraxia (an impairment of the programming of the cortex);
- deficits in sensory and tactile sensation (taste, smell, pain, temperature and texture).

For an individual with a brain injury, **cognitive deficits** usually present a greater barrier to reintegration back into the workplace than do the person's physical injuries. There are numerous cognitive problems the person may encounter, including:

- arousal problems (difficulty maintaining any consistent degree of alertness);
- diminished attention and concentration;
- easily distracted;

- poor memory (short- and long-term);
- problems with concept-formation and problem-solving;
- problems with visual-motor co-ordination and spatial relations;
- aphasia (disruption of linguistic competence and performance);
- expressive aphasia (difficulty expressing thoughts in writing or orally);
- receptive aphasia (difficulty understanding written or oral communication);
- dysnomia/anomia (difficulty with or total loss of word-finding ability); and
- dysgraphia (impairment of writing ability).

Executive function deficits result when the functions associated with the frontal lobes are affected by a brain injury. Problems in this area can occur even in mild brain injury cases. Individuals are unable to self-direct and self-initiate. Workers who have deficits in their executive functions find it very difficult to return to work and often encounter significant problems.

Psychosocial deficits can arise from damage to the brain structure that generates and modulates the emotions (i.e., the frontal lobe) or from impaired perception and understanding of environmental cues. They may also be caused by feelings of anxiety and fear about one's situation. Often, right after the injury, the individual may exhibit disorientation, agitation, violent behaviour, delirium, hallucinations, unpredictability and impulsive behaviours. These symptoms often subside over time. Some of the more persistent problems include:

- irritability;
- impatience;
- impulsiveness;
- poor frustration tolerance;
- denial; and
- anxiety, depression and anger.

to previous mild brain injuries, the symptoms may be similar to those found in a moderate brain injury.

There is considerable controversy in the medical community regarding the validity of mild brain injury. Some professionals in the field of brain injury believe that there is no such thing as a mild brain injury, and that any ongoing effects should be termed “post-concussive syndrome.” In their view, any residual effects of post-concussive syndrome should totally abate within six months of the injury.

Others in the brain injury professional community believe that mild brain injury is a valid diagnosis and can have ongoing effects for the individual. These professionals feel that, even though organic damage may not appear on an MRI or a CT scan, damage to the brain can occur at the cellular level.

With a diagnosis of mild brain injury or post-concussive syndrome, most individuals will return to work in just a few days with no residual effects. However, it has been found that a significant number of these individuals are unable to maintain their preinjury performance.

Ongoing symptoms of a mild brain injury can include dizziness, impaired concentration, fatigue, depression, irritability, headache, insomnia, poor memory and restlessness. In most cases, these residual effects diminish within six months of the accident. Many who experience a mild brain injury do not understand what is happening to them. These mild impairments can often lead to feelings of frustration and incompetence. It is not uncommon for these individuals to return to work, fail to perform adequately and then be fired.

Moderate injury: Moderate brain injury is characterized by a period of unconsciousness ranging from one to 24 hours. Usually, the individual is hospitalized for some period of time

before being transferred to a rehabilitation centre. Where there is wide variability in the degree of physical, cognitive, emotional and social disability resulting from the injury, it is usually six months to a year before return to work is achieved.

Physical disabilities could include spasticity, tremors, weakness, paralysis, lack of co-ordination and seizures. Cognitive impairments could include problems in language, learning, memo-

The return-to-work practitioner needs to be aware that, after a brain injury, the worker may display atypical behaviours.

ry, perception, planning and judgement. Up to two-thirds of individuals who experience a moderate brain injury are unable to return to work even a year or more after injury.

Severe injury: These individuals are in a coma lasting more than one day. Such individuals tend to have more severe physical deficits because of the damage to the brain stem. Acute care may be followed by a considerable length of time in rehabilitation. Involvement in post-acute rehabilitation programming may not begin for a year to two years post-injury and may last for years. Individuals with a severe brain injury may not return to work for a number of years and, if they do, may return in a much reduced capacity. Many individuals in this category will need ongoing professional assistance to maintain any type of employment.

The greatest predictor of an individual experiencing brain injury is a previous brain injury. Persons who have had even a mild brain injury previously are more likely to experience a second when compared to the rest of the population.

The relatively common deficits — physical, cognitive, executive function and psychosocial — of moderate and severe brain injuries are discussed in the box on page 5.

HOW CAN THE RETURN-TO-WORK PRACTITIONER ASSIST A WORKER WITH A BRAIN INJURY?

For a worker with a brain injury, it is very important to follow the accepted protocol for the return-to-work process. Early contact with the worker is probably more important for this type of injury than any other illness or injury. The worker will probably be confused, anxious and in a state of despair about what is happening. Early contact by the return-to-work practitioner provides workers with a sense of attachment to their preinjury lives. It can also give them a feeling of hope for their future rehabilitation and recovery.

The return-to-work practitioner needs to be aware that, after a brain injury, the worker may display atypical behaviours. Anger and loss of emotional control often accompany this type of injury. The return-to-work practitioner must remember that the worker has no control over these emotions and they are not intended to be directed at the practitioner.

Denial of the severity of the injury is also very common (e.g., “I’ll be back at work next week...”). The worker may have a very significant brain injury that may require months or years of rehabilitation before the worker can consider any type of employment. However, he or she may feel that there is nothing wrong with them and that they should be able to return to work right away. The return-to-work practitioner needs to recognize that this is a “normal” course for this type of injury. Trying to convince the worker otherwise is futile.

Depending on the severity of the brain injury, it could be a few days to

two or more years before a return-to-work plan can be developed. Due to the complexity of this type of injury, the return-to-work practitioner will need to work closely with the professionals involved. Two of the key players in this process will be the neuropsychologist and the occupational therapist.

A neuropsychologist is a psychologist who has been trained in the field of brain function and disability. Typically, an individual with a brain injury will have a neuropsychological assessment within two to three months following his or her injury [to provide] information regarding the individual's cognitive, emotional and psychological functioning. Throughout the rehabilitation process, the individual may have two or more neuropsychological assessments to assist in determining the speed and level of recovery.

For most return-to-work practitioners, trying to understand a neuropsychological assessment is a daunting task. Direct contact should be made with the neuropsychologist to ask specific questions regarding the worker's limitations and the best course of action for the return-to-work process.

The other professional who is often involved with a brain-injured worker is the occupational therapist. The occupational therapist usually conducts a thorough functional capacity evaluation that delineates the worker's physical abilities. These reports are usually straightforward and relatively easy to understand. A protocol for an occupational therapy work skills assessment has been developed and tested in British Columbia. This protocol is intended to give a more accurate assessment of the functional capacities of a worker with head injuries (see Chappell I., Higham J., McLean A, "An occupational therapy work skills assessment for individuals with head injury," *Canadian Journal of Occupational Therapy*,

70(3): 163-169). In assisting a brain-injured worker back to work, it is advisable to work closely with the occupational therapist when setting up the plan.

WHAT ACCOMMODATIONS CAN BE USED TO ASSIST A WORKER WITH A BRAIN INJURY?

Accommodating the worker with a brain injury is a challenging task for any return-to-work practitioner. A worker with this type of injury can present a vast array of residual effects.

RESOURCES

NIDMAR guide tackles RTW challenges

Challenges in Disability Management: A Resource Manual for Return to Work Practitioners was released this month by the National Institute of Disability Management and Research. The 106-page handbook is designed to help RTW practitioners manage some of the more difficult return-to-work situations.

The first part of the guide looks at the issues surrounding particular disabling conditions. These include:

- chronic illnesses and diseases, including cancer, cardiovascular disease and multiple sclerosis;
- chronic pain, including low back pain;
- mental health issues, including stress, depression and anxiety disorders;
- alcoholism; and
- traumatic brain injury.

The second part looks at the issues surrounding problematic practice areas in disability management. They include the duty to accommodate, the phases of adaptation to serious illness or injury, the role of various professionals in the RTW process, and disability management in small firms.

For more information or to order the book, which costs \$42, go to www.nidmar.ca and click on "Products" and then "Publications," call (250) 386-4388, or e-mail nidmar@nidmar.ca.

The first step in assisting this worker back to the jobsite is to have a clear understanding of his or her restrictions. This information is usually found in reports and discussions with the professionals involved in the case. During this process, the return-to-work practitioner needs to work very closely with these professionals in the development, implementation and monitoring of the plan. (For specific accommodation ideas, see the insert with this issue.)

WHAT CAN BE DONE TO ASSIST SUPERVISORS AND CO-WORKERS?

For many individuals, working with someone with a brain injury is a frightening experience. Workers may look just the way they did prior to their accident, but they are now completely different people. Education is the key to assisting supervisors and co-workers in making the return-to-work process as easy as possible for all involved. The return-to-work practitioner should educate the supervisor (or other key stakeholders) in the following principles:

- Do not take the behaviour personally.
- Do not base an opinion of the worker's behaviour by usual standards.
- Remember a brain injury heals very slowly. It may be months or years before the worker returns to preinjury capabilities. In some cases, workers may never regain past capabilities.
- Do not have overly optimistic or unrealistic expectations.
- Set up frequent times to go over the worker's production, quality of work and interaction with others.
- Never openly compare the worker's post-accident quality/quantity of work to what was achieved before the accident.
- Set small realistic goals for the worker with a brain injury.
- Attempt to give important directions in writing, not just verbally.
- Be sure to give positive feedback. •

OMA offers guidance on RTW of physicians

The Ontario Medical Association has published a guideline for physicians who are treating fellow physicians with mental illnesses. The guideline includes advice for developing return-to-work plans for physician patients. This advice includes strategies such as:

- use an individualized approach;
- consider clinical stability so that

the stress of work does not cause relapse or a worsening of symptoms;

- be familiar with the work setting and demands;
- advise returning to work in stages;
- be specific (because general advice such as “work part time” might mean 40 hours a week to some doctors);
- be flexible and re-evaluate often; and
- consider formal monitoring.

The full guideline is available at www.oma.org/pcomm/omr/jul/05physhealth.htm.

BOARD UPDATE

New advisor, new title

Henry Harder has joined *Back To Work's* board of expert advisors. Harder is a registered psychologist specializing in rehabilitation and family psychology. He holds a doctorate in counselling psychology from the University of British Columbia.

Harder has been in the field of vocational rehabilitation and disability management for approximately 18 years. He is currently an associate professor at the University of Northern British Columbia, where he is also chair of the Disability Management Program and Psychology Program. Immediately prior to this, he was in private practice in Vancouver and Delta, B.C. He is also the past training director for the National Institute of Disability Management and Research, as well as the former director of the Vocational Rehabilitation Services Department at the Workers' Compensation Board of B.C. You can reach Harder at harderh@unbc.ca.

Back To Work expert advisor **Gene Shematek** recently left her job as the Occupational Health and Safety Practice Leader with TELUS Sourcing Solutions Inc. in Calgary to set up her own consulting company. Still based in Calgary, the company is called GMS & Associates Ltd. and focuses on strategic occupational health and safety services, program/management systems auditing and problem-solving. You can reach her at (403) 547-5591 or at shematek@gmsassociates.ca.

Accommodation conference coming to Vancouver

The Canadian Information Exchange is holding its “Update 2005: Accommodation to the Point of Undue Hardship” conference on September 14-15 in Vancouver. The conference explores the expanding scope of “disability” and how to accommodate both physical and psychological disabilities. For information, visit www.informationexchange.ca, e-mail info@informationexchange.ca or call 1-866-516-7833.

EAC offers RTW workshops

The Employers' Advocacy Council is presenting half-day workshops on return to work and claims management in 14 Ontario cities this fall. From September 21 to December 1, the Council is presenting “A Workplace Guide to WSIB Claims Management and Return to Work.”

The afternoon workshop is devoted to return to work. It looks at RTW programming, disability theory, the duty to accommodate, RTW placement and RTW work plans. For more information, visit www.EACforEmployers.org or call (519) 748-5771 or 1-888-663-4929.

Advice now in book form

A book of collected disability management advice columns is now available from the U.S. Disability Management

Employer Coalition. Called *Disability Prevention and Management: The Collected Columns of Dr. J*, the book brings together the question-and-answer columns written by Dr. Jennifer Christian over the last several years for DMEC's monthly bulletin.

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BACK TO WORK

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ACCOMMODATING WORKERS WITH A TRAUMATIC BRAIN INJURY*

* Reprinted and adapted, with permission, from *Challenges in Disability Management: A Resource Manual for Return to Work Practitioners* (2004, 106 pp., \$42, ISBN 0-9687859-3-X), which was published in August 2005 by the National Institute of Disability Management and Research. For information or to order, go to www.nidmar.ca and click on "Products" and then "Publications," call (250) 386-4388, or e-mail nidmar@nidmar.ca. Because of the wide array of residual effects, only those physical, cognitive and emotional/behavioural deficits that cause the most difficulties at the worksite are discussed below. The return-to-work practitioner needs to consider these deficits and potential accommodations in developing a return-to-work plan for a worker with a brain injury.

PHYSICAL DEFICITS

Nature of deficit

Fatigue: Almost all individuals with a traumatic brain injury experience fatigue. Even though they may appear to be physically healthy, they may need many more hours of sleep than those without a brain injury. It is not uncommon for an individual with a brain injury to sleep 10 to 12 hours every night and require naps during waking hours.

Examples of deficit

- Arriving at work every morning looking tired and sleepy
- Functioning well for the first two hours at work, but then experiencing fatigue
- Requiring a nap after only a short period of work

Potential accommodations

- Some individuals with a brain injury can function well in the morning; others work better in the afternoon. Try to schedule the worker during those times when he or she is at peak efficiency.
- Allow time and space for naps during the morning or afternoon.
- Allow a longer lunch break to permit the individual to take a nap.
- Provide a timer or some other alarm system to remind the worker to take a break after a set period of time.

Diminishment of muscle control: This could include loss or diminishment of fine or gross motor control, hemiplegia, hemiparesis, ataxia or balance problems. The return-to-work practitioner should recognize that these difficulties are not related to body mechanics but to upper pathways.

- Unsteady gait
- Inability to use one side of the body
- Slurred speech
- Frequent trips or falls

- Have workers perform their work at ground level and not on ladders or elevated platforms from which they could fall.
- Provide supportive computer technology (e.g., speak/write word processing program).
- Remove tasks that require the individual to have fine motor control.
- Allow more time for workers to move from one area of the worksite to another.

Loss of sense of taste/smell: A common residual effect that is sometimes not recognized in the rehabilitation setting is the worker's loss of sense of taste or smell. Remember that the loss of taste and/or smell may go undetected for some time. The return-to-work practitioner should ask the returning worker about these senses.

- Complaining that food doesn't have any taste
- An inability to smell noxious odours that everyone else can identify
- Using an excessive amount of salt or pepper on food

- Place the worker in an environment where safety and performance is not compromised by a loss in the sense of smell (e.g., leaking gas) or taste.

COGNITIVE DEFICITS

Nature of deficit

Memory difficulties: Nearly 40 per cent of individuals with a brain injury will experience some memory loss. Memory loss may affect a worker's ability to recall information such as a phone number found in the directory long enough to dial it (short-term memory) or to recall events that happened at an earlier time (long-term memory).

Examples of deficit

- Appearing at appointments on the wrong day or at the wrong time
- Forgetting where tools were left at the end of a previous task
- Forgetting co-workers' or customers' names
- Asking numerous times for an answer to the same question

Potential accommodations

- Encourage individuals with memory difficulties to use compensatory devices such as journals, notebooks, calendars and tape recorders.
- Give the worker directions or information in writing, as well as verbally.
- Provide as many environmental aids as possible (e.g., labels on items, signs on bulletin boards, checklists).

Problem-solving deficits: Minor problems include not being able to make a decision in a timely manner or having difficulties with complex business decisions. Severe deficits can result in an inability to complete even the simplest tasks that require problem-solving. In some cases, these difficulties can put the individual in danger at the worksite. The return-to-work practitioner and the direct supervisor must be aware, for safety reasons, of any difficulties the worker has with problem-solving.

- Taking unnecessary risks in order to get the job done
- Being unable to "think on one's feet"
- Missing deadlines or having to work late because work is not done in a timely manner

- If possible, remove time constraints from job-related tasks.
- Consider whether a change in job responsibilities may be necessary.

COGNITIVE DEFICITS (CONTINUED)

Nature of deficit

Lack of initiative: A worker with a brain injury may have difficulties starting or staying at a particular task. This is often labelled as “lack of motivation” or laziness. Workers who display lack of initiative may become “talkers” in order to avoid the difficulties they encounter in getting involved in starting a task.

Cognitive inflexibility: This area probably causes more difficulty at the worksite than any other deficit. Cognitive inflexibility means the individual is unable to use divergent thinking skills. The worker may make up his or her mind regarding a certain course of action and be unable to think of or consider alternatives. When working with others, this can lead to the worker becoming short-tempered and argumentative.

Lack of concentration: A significant difficulty for many individuals who have had a brain injury is the inability to concentrate or “stay on task.” A worker with this problem may have difficulties filtering out things that are going on around them. Co-workers may complain that the worker is listening in on their conversations or constantly trying to find out what they are doing.

Examples of deficit

- Failing to get started on a task, despite knowing all the steps that are needed
- Chatting to anyone that comes by rather than staying on task
- Playing games on the computer rather than working

- Criticizing the supervisor and co-workers as to how they are doing the job
- Inability to switch from one task to another
- Inability to complete tasks when a variable is changed
- Becoming involved in heated arguments over the “right” way to complete tasks

- Stopping work to watch and listen to others
- Becoming so distracted by activity that the simplest of tasks are not completed
- Inability to read or operate a computer due to the ambient noise

Potential accommodations

- Establish a timeline for the completion of a task.
- Give the worker a series of small tasks rather than one large assignment.
- Make job expectations clear at the beginning of a task and reinforce these expectations as needed.

- Ensure that the return-to-work practitioner and supervisor define the worker’s roles and responsibilities both verbally and in writing when the worker first returns to the workplace. It should be clear to the worker who is to be consulted if there is a problem concerning the work being done.
- If possible, structure the job so that there is a series of related tasks rather than a number of divergent tasks.
- Attempt to have the worker steer clear of potential confrontational situations.

- Ensure that the worker’s work area is as uncluttered as possible.
- If possible, isolate the worker from visual and auditory distractions.
- Place visual cues in the workplace to assist the worker in “staying on task.”

EMOTIONAL/BEHAVIOURAL DEFICITS

Nature of deficit

Agitation: An individual who has experienced a traumatic brain injury is often very agitated when coming out of the coma. This may last from a few hours to a few months. Usually, some degree of agitation remains and can be seen in restless, unfocused activity. This can occur on either an episodic basis or continuously. There is very little that the return-to-work practitioner can do about this other than try to diminish its effects on other workers.

Verbal outbursts: It is very common for an individual with a brain injury to blurt out the first thought that emerges from confused thinking. A person who has never uttered a curse word before the injury may “swear a blue streak” on a regular basis.

Physical outbursts: Although somewhat rare, physical outbursts are an extreme challenge for the workplace. Physical outbursts may occur after a verbal exchange or when the individual is feeling insecure. Usually, these outbursts are directed against inanimate objects, but occasionally may be against another person.

Examples of deficit

- Continuously tapping a pencil during a meeting
- Finger drumming, pacing, foot-tapping or any other repetitive behaviour occurring during periods of inactivity
- Shuffling papers purposelessly

- Having difficulties undertaking a task that could easily be completed preinjury
- Making a point if the worker believes he or she is not being heard
- Experiencing any stressful situation

- Punching a wall or other object when frustrated
- Taking out frustration on tools or equipment
- Getting into an altercation with a co-worker over a seemingly trivial matter

Potential accommodations

- Keep any waiting periods as short as possible for the worker.
- If possible, excuse the worker from meetings requiring sitting for extended periods of time.
- Arrange for the worker to have frequent short breaks rather than three scheduled breaks during the day.
- Allow time for exercise and relaxation techniques.
- If all else fails, place the worker in an area where he or she is not a distraction to others.

- Have worker return to work in a systematic manner, leaving the more difficult tasks until later when he or she is feeling more comfortable coming back to work.
- Avoid confrontation with the worker unless absolutely necessary.
- Educate the supervisor and co-workers not to take the verbal outbursts personally.

- If the physical outburst is directed against an inanimate object, ignore the situation whenever possible.
- Educate all involved not to take the outbursts personally.
- Discuss with the worker the effects the physical outbursts have on others.
- Whenever possible, remove the worker from confrontational situations.