Managing Workplace Mental Health & Occupational Disability: Guidelines for Physicians

Introduction

- Mental health disorders are major contributors to occupational impairment, absence, and disability. This is particularly true for depression, the primary source of disability in many occupational sectors. The World Health Organization projects that, by 2020, depression will be the second leading cause of disability in the developed world. Depression raises the risk for secondary physical and psychiatric illness, as well as for injuries and accidents. Lessons learned from appropriate management of depression-related impairment are often relevant for other psychiatric disorders, including adjustment and anxiety disorders.

- The family physician plays a major role in the clinical management of mental disorders. As in other areas of medicine, the role of the family physician is to restore health; optimize social, psychological, physical, and functional capabilities; and, minimize the negative impact of injury/illness.

- The tasks of the family physician with respect to working patients are to provide a clinical diagnosis; establish appropriate clinical goals; recommend/implement evidence-based treatment, in line with existing standards; and monitor clinical response.

- The family physician can make a significant contribution toward the prevention and mitigation of occupational disability, with support from a psychologist, psychiatrist and/or other mental health professional for more severe or treatment resistant patients.

- Management of workplace mental health issues can be challenging, as the family physician:

    - is trained to focus on symptomatology and diagnosis, rather than functioning (including occupational functioning);

    - may not be informed about the particular job or job requirements held by the patient and the degree to which the individual is able to meet those requirements;

    - is interacting with unfamiliar systems (e.g., employers; insurers); and

    - may feel torn between the concerns of patient/worker, the employer, and the insurer.

Nevertheless, this is a critical issue for the patient and all concerned parties. Failure to provide appropriate, timely and specific information can lead to exacerbation and increased complexity of mental health conditions; increased risk of injury, accident or incident; and/or delayed financial compensation for disabled patients.

There are several key steps for the physician that is caring for patients with workplace mental health issues or occupational disability:

I. Assess impairment and functioning
II. Communicate effectively with the employer and/or insurer
III. Collaborate with patient on decision-making

I. Assess Impairment and Functioning

The role of the physician is to evaluate *Impairment* (diagnosis, symptomatology, functional deficits) rather than *Disability* (patient's incapacity to carry out a particular job, which is determined by the employer or insurance adjudicator).

Impairment is defined by the World Health Organization as "*any loss or abnormality of psychological, physiological or anatomical structure or function"*. Delineation of impairment requires a statement of diagnosis and detailed description of symptomatology.

Family physicians have expertise in assessing and documenting degree of impairment, including:

Diagnosis:

- Be specific as possible, preferably using DSM-IV-TR diagnosis (e.g., "stress" is not a psychiatric diagnosis).
- Include information on expected course and prognosis.
- Include information on evidence-based treatment.

Symptomatology:

- Provide sufficient details, particularly with respect to symptoms that may impact occupational functioning.
- Symptom constellations within a diagnosis vary from patient to patient, therefore it is important to specify a patient's particular symptoms, their severity, and how they impact work performance.
- When describing impairments, provide details such as their frequency, intensity, and duration, as well as any ameliorating factors or supports that may assist the patient in maintaining a greater functional level.

Functional Impairment:
There are four areas in which deficits may occur:

- Activities of daily living (e.g., patterns of eating and sleep, activities outside the home).
- Social functioning.
- Concentration, persistence, and pace.
- Deterioration or decompensation in complex or work like settings (e.g., how a patient's symptoms might cause problems in work function).

The GAF (Global Assessment of Functioning) index has questionable reliability and validity, but nevertheless remains the standard index of functional status.

Careful determination of the GAF with respect to consistency with stated symptomatology and evident functional limitations will greatly assist with determination of a patient's insurance eligibility *(e.g., a claimant separately describing a reasonable family life, some volunteer work, and a relaxing trip to Hawaii, does not have a GAF of 40-45).*

- Provide information on functional impairments specific to a patient's particular occupation. For complex patients, a job analysis may be of value.

- Be cognizant of appropriate language for describing functional deficits (e.g., it is not meaningful to state that a patient "can't concentrate" and "can't sleep"; it is most unlikely that a patient is, for example, so depressed that he is entirely unable to concentrate or sleep to any extent for any period of time). It is more appropriate to describe some degree of impairment, whether in terms of reduced capacity, time limits of sustained concentration, or specific difficulty with concentrating on several tasks at the same time.

- Although **disability** requires the presence of significant impairment in ability to perform daily activities, including occupational activities, impairment alone does not determine disability. Factors such as age, general health, social supports, motivation, satisfaction with job and supervisor/manager are important determinants.

Impairment does not necessitate disability. A patient may be able to remain at work with significant

impairments, if appropriate accommodations can be provided by the employer. Consider the contributing role of factors such as age, general health, social supports, motivation, and job satisfaction.

II. Communicate Effectively With the Employer and/or Insurer

- A unique aspect of management of workplace mental health issues is the need to communicate with unfamiliar systems, such as employers and/or insurers.
- Employers may require clinical information from the family physician to make necessary accommodations in the workplace; similarly, the family physician may need information from the employer to address the impact of symptoms on occupational function.
- Insurers require information from the family physician on clinical diagnosis, functional impairments, prognosis, recommended treatment, and duration of treatment to (a) adjudicate claims for eligibility for benefits and (b) ensure the patient has access to appropriate treatment. It is important to complete forms in a timely and thorough manner. Although extra paperwork can be frustrating, disability evaluation forms are the primary way for insurance case managers to obtain the information needed to perform their job effectively.
- Obtain specific consent to communicate with the insurer and/or employer, including informing patients of what information will be released.

In complex patients (e.g., those that are treatment-refractory or require workplace accommodation) **it may be helpful to directly communicate with the employer or insurer** (as well as other treatment providers).

III. Collaborate with Patient on Decision-making around Accommodation and Work Absence

- Encourage patients to be actively involved in decision-making with respect to their care, rehabilitation and work plan (e.g., decisions around modifying duties at work, taking leave from work, and returning to work). Failure to do so may encourage hopelessness and helplessness, which can impede compliance and recovery. It is helpful to elicit information on the patient's expectations for recovery.

Prolonged absence from one's usual roles – including prolonged absence from work – has negative impact on individual's mental, social and physical well-being and health.

Accommodation

- Consider appropriateness of accommodation in the workplace, as an alternative to complete work absence.
- In cases where accommodation in the workplace is being considered, encourage the patient to communicate with the employer.

Work Absence

- Collaboratively consider the advantages and disadvantages of work absence. If an absence from work is suggested, it should be a part of an overall treatment plan with specific recommendations and goals in mind for the time away from work.

Develop a definable treatment plan, including a plan for treatment if a work absence is recommended. Do not put an open-ended return to work date.

- Set a definite duration for the work absence. In recommending leave duration, consider norms of treatment response (e.g., it is realistic to expect substantial recovery from uncomplicated treated depression and anxiety disorders in 6-8 weeks).

Benefits and Costs of Absence from Work

Benefits	Costs
Patient removed from occupational stresses, allowing stabilization in a protected environment.	**Patient may become inactive and socially isolated, a behavioural pattern likely to worsen depression and reinforce anxiety.**
Less risk of work incidents, especially in safety-sensitive positions.	**Patient may develop a secondary anxiety pattern after extended work absence in which they become more apprehensive about work return.**
Patient has more time for activities conducive to recovery such as psychotherapy or exercise programs.	**Prolonged absence from work is a negative prognostic factor with regard to whether an individual ever returns to work.**

IV. Maximize Recovery of Occupational Function

- Although it was previously believed that restoration of occupational function lags behind symptomatic recovery in depression, current research indicates that symptom remission and recovery of function are typically synchronous.

Symptomatic and functional recovery should be evident within the first few months of treatment. Failure to achieve functional recovery within 6 – 8 weeks for common mental health disorders, such as depression and anxiety disorders, indicates the need for a change in treatment strategy or involve of other mental health treatment providers.

- Pharmacologic treatment for depression and anxiety disorders can lead to significant improvement in function, but still leaves a significant gap in functional recovery for many individuals. Psychopharmacology can be augmented with referral for cognitive behavioural therapy, which has been shown to have specific benefit in promoting functional recovery.
- Assess capacity for activity. Encourage early, graduated functional activation. Consider prescription of activity.
- Take an active role in encouraging self-management efforts, focused on helping patients understand their diagnosis and ways to manage their symptoms. One way to augment standard treatment to support individual coping and promote functional recovery is dissemination of Self-Care material, for example the **Antidepressant Skills at Work (AS@W): Dealing with Mood Problems in the Workplace** manual.
- If appropriate, the patient should be encouraged to investigate opportunities for assistance through the employer, for example Employee and Family Assistance Programs or extended health coverage for care by a psychologist.
- For severe and persistent mental disorders such as schizophrenia, referral to rehabilitation/supported employment program should be considered.

Early intervention efforts targeted at assisting patients to regain function are effective in decreasing subsequent disability, and in reducing secondary illness reinforcers (e.g., reduction of responsibility, avoidance of work and personal stressors, family sympathy).

References

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About AS@W

How was *Antidepressant Skills at Work* developed?

The guide was developed by British Columbia Mental Health and Addiction Services (BCMHAS), an agency of the Provincial Health Services Authority. The guide and accompanying materials have been authored by **Dr. Dan Bilsker**, **Dr. Merv Gilbert**, and **Dr. Joti Samra** – registered psychologists and scientist-practitioners with expertise in issues relating to workplace mental health. These psychologists are with the Centre for Applied Research in Mental Health and Addiction (CARMHA), Faculty of Health Sciences, Simon Fraser University. The guide was written on the basis of a review of the scientific literature; consultation with employers, unions, mental health providers and employee groups; and adaptation of existing self-care depression programs.

How can the manual be accessed?

The manual is available for viewing and free download at http://www.carmha.ca/selfcare or from www.bcmhas.ca/research. Individuals or organizations are free to print and make multiple copies of the guide, with permission from CARMHA. Print copies and audio CDs are available at a low cost from our ordering page at www.carmha.ca/ordering/

For further information about AS@W and associated resources and materials, please visit www.carmha.ca/selfcare . This information will be updated on a regular basis.