

# Able-Minded

Return To Work and Accommodations for  
Workers on Disability Leave for Mental Disorders

Human Solutions™ Report | 2010





Winter 2010

Human Solutions™ is pleased to present this year's annual report ***Able Minded: Return to Work and Accommodations for Workers on Disability Leave for Mental Disorders.***

We offer this report to our customers and other key stakeholders in an effort to bring the most current and empirically validated perspectives to this very important issue. As discussed in the report, mental disability is the fastest growing health-related disability in Canada, and has claimed this title for over 20 years. These cases can be complex but typically respond well to appropriate treatment, coordinated stakeholder actions, and employer and organization support. **Our hope is that this report will assist you by illuminating the many advances in this area in recent years, and help you be proactive and/or respond effectively when the need arises.**

As a valued customer whose opinions are important to us, your feedback is welcome. Please feel free to provide me or your Account Manager with any ideas that you think would be worthy of future consideration so that we can help you meet your needs.

Regards,

A handwritten signature in blue ink that reads "Craig" followed by a stylized flourish.

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*Loss of work capacity for any reason is a life crisis, but especially so when the loss is due to a mental health disability.*

–Partnership for Workplace Mental Health  
American Psychiatric Association Foundation (2006, p. 2)<sup>1</sup>

## Introduction

It used to be that mental health disability was somewhat mysterious. It only happened to a small number of employees and detailed information about it was scarce. Actual data on such cases was held in confidential human resources files and stashed in the private databases of the disability insurance companies. In many regards, when an employee left the workplace on a disability leave for depression, trauma, or substance abuse, it was likely that the “out-of-sight; out-of-mind” concept would apply to the situation. As mental disorders are not well understood by most people, supervisors and others in the workplace often did not know how to respond to these kinds of disability events.

This scenario is now changing. Due to the dramatic rise in the number of cases of mental health disability, and the associated rise in disability-related costs, mental disability is receiving the attention of business, government and science. For example, in Canada, recent years have witnessed the formation of an active national commission on mental health, a call to action by leaders in the business community, and a wealth of new scientific findings. According to a 2009 review, disability management was the second of 11 areas identified as the top trends in research.<sup>2</sup>

Indeed, there are now many evidence-based reports on the nature of mental health disability, its impact, its treatment, and what helps get people back to work and to stay at work after their return.

The report is divided into five sections:

**The Challenge: Mental Health Disability.** The prevalence and nature of mental health disability.

**Individual Response: Treatment.** Research on disability and clinical treatment options.

**Employer Response: Making Accommodations.** Key employer actions for the initial phase of disability and commonly used accommodations.

**Organizational Response: Prevention.** Prevention of disability through risk screening, organizational factors, reducing stigma, and employer benchmarking.

**Toolkit: Resources for Employers.** Employer guides, reports, organizations, and employer case studies.

**Note: Table 2 contains important definitions and terminology.**

It is clear from all of the sources available that **disability due to mental disorders is a rising and serious concern for business, insurers, and government.**

**TABLE 1: KEY FINDINGS FROM THE REPORT\***

## Section 1: The Challenge

**Mental Health Disability**

- The prevalence and cost of mental health disorders and related disability is increasing dramatically in Canada and other countries.
- Mental health disability is often clinically complex and difficult to manage.
- Employers have legal responsibilities to employees relating to mental health disabilities.

## Section 2: Individual Response

**Treatment**

- Conceptual approaches for treatment of mental health disability emphasize multiple interrelated factors.
- Psychotherapy and medication have been proven clinically effective for treatment of most mental health problems.
- Treatment has some limits on how much it can improve work performance and how soon the worker can return from disability leave.
- Innovations in treatment address physician skills, collaborative care, and work-focused approaches.
- Early return to work while undergoing treatment is popular but also controversial.

## Section 3: Employer Response

**Making Accommodations**

- Employer actions for the initial phase of disability include assessing the employee's work limitations, conducting a psychological job analysis, assessing workplace risks, and making plans for work return.
- Many different kinds of workplace accommodations for mental health disability are possible. The most common accommodation practices are described.
- There is a need to identify and engage multiple stakeholders to make the accommodations for return to work a success.
- The cost-benefit of these kinds of programs is widely accepted but has not been thoroughly researched.

## Section 4: Organizational Response

**Prevention**

- Prevention of mental health disability is important to controlling this growing problem.
- Risk screening is one tool for prevention at the individual level.
- Creating a psychologically healthy workplace is a form of prevention at the organizational level.
- Reducing stigma and promoting accurate understanding of mental health disorders is a key component of successful Return To Work initiatives.
- Despite progress by some employers, employer benchmarking studies reveal that most organizations are not yet embracing mental health prevention and Return To Work accommodation best practices for mental health disability.
- Employer case studies from Canada and the US showcase innovative practices for supporting mental health disability and their results.

## Section 5: Toolkit

**Resources for Employers**

- Several employer guides for mental health disability management are available from Canadian and US sources.
- Practical resource reports on workplace aspects of mental health disability and information about support organizations are listed.

\* The source of these findings can be found in the corresponding section of the report.

**TABLE 2: KEY TERMS**

<b>Mental Disorder</b>	Mental disorders are not diseases to be likened to physical illness (unless there is an organic component to the mental disorder, e.g., schizophrenia). We maintain that mental disorder is first and foremost a disorder of behaviour and/or thinking, and a failure of an individual's internal (e.g., psychological) mechanisms to counteract the stresses to which the individual is subject. Additionally, the term "disorder" is consistent with most international clinical documents and classification systems, and suggests a psychological (versus medical) approach to treatment.
<b>Disability</b>	A disability is a physical or mental condition that is both (a) permanent, ongoing, episodic or of some persistence, and (b) a substantial or significant limit on that person's ability to carry out some of life's important functions or activities, such as employment. Disabilities include both visible disabilities (e.g., the need for wheelchairs) and invisible disabilities (e.g., cognitive, behavioural or learning disabilities resulting from mental health disorders).
<b>Return to Work (RTW)</b>	Return To Work (RTW) is a process that assists employees with a health condition or disability to go back to work after a disability leave. By working closely with employers (including line managers and where appropriate human resource or occupational health staff) the RTW service provides guidance and support to overcome barriers to returning to the workplace and then maintaining employment afterwards. By focusing on early intervention and putting in place the correct support mechanisms it enables employers to retain the skills, knowledge and benefits of a productive workforce.
<b>Work Accommodations</b>	Work accommodations are employer-sponsored modifications and strategies used to adapt the job and work environment for an employee who is expected to return to work after a disability leave. Some of the kinds of work accommodations include: reduced hours, different work schedules, modified or reduced tasks, changing the function or job, a reduced pace of work, transferring the employee to another department, and modification of the workstation or workplace (e.g., furniture, equipment, special lighting, or private office space).
<b>Work Rehabilitation</b>	Work rehabilitation (also called occupational rehabilitation or vocational rehabilitation) concerns efforts to increase the chance to obtain and sustain employment for people whose mental disorders <i>should</i> be manageable such that they can eventually return to work.

**Mental disorders are considered one of the "Top 3" leading sources of STD and LTD claims** by 78% and 67% of Canadian employers (respectively).<sup>14</sup>

*Psychological disorders are often referred to as 'invisible'; however, [their] impact is anything but invisible.*

*Psychological disorders are associated with significant impacts on the workplace, including conflict, turnover, accidents and injuries.*

–Joti Samra, Ph.D. & Merv Gilbert, Ph.D.,

Visions: BC's Mental Health and Addictions Journal (2009, p. 22)<sup>3</sup>

## SECTION 1: THE CHALLENGE

# About Mental Health Disability

Mental disorders contribute heavily to disability and their influence cannot be ignored. For example, the World Health Organization recognizes mental disorders as significant contributors to the global burden of disease with depression being the fourth leading cause of the disease burden and the leading cause of disability worldwide.<sup>4</sup>

## 1.1 Mental Health Disability in Canada

Each year in Canada, about 12% of the adult population has a diagnosable (i.e., clinically significant) mental disorder with major depression being the most common.<sup>5,6,7</sup> Other mental disorders include bipolar disorder (or manic depression), social anxiety, phobias, panic disorder, schizophrenia, and suicide.

Mental health disability affects between one and two percent of Canadian working adults each year and is the fastest growing health-related disability in Canada over the past 20 years.<sup>5,8,9,10</sup> For example, the incidence of long-term disability (LTD) claims related to mental health problems more than doubled between 1991 and 2003 at one insurer (Standard Life).<sup>11</sup>

Mental health disorders comprise a large share of all disability claims. Consider:

- Leading disability insurance companies in Canada serving the private sector (i.e., Desjardins, Great-West, Manulife, Standard Life, Sun Life Financial) all report that mental health diagnoses account for between one-third to one-half of short-term disability (STD) claims and LTD claims combined.<sup>12,13</sup>
- Mental disorders are considered one of the “Top 3” leading sources of STD and LTD claims by 78% and 67% of Canadian employers (respectively).<sup>14</sup>

- Forty-four percent of all LTD claims are for mental disorders (primarily depression) according to a joint national council of insurers that covers over one million employees in Canada through 18 labour organizations and five employer members.<sup>15</sup>
- Canadian Disability Pension Plan data from 2007 indicates that mental disorders and substance abuse combined account for almost half (46%) of all STD and LTD claims.<sup>15</sup>

## 1.2 The Difficult Nature of Mental Health Disability

Having a mental health disability is often more difficult to manage than other health conditions for a variety of reasons.

### 1.2.1 Range of Clinical Severity

People receiving STD benefits for mental disorders are a heterogeneous group and range widely in how severely they are impaired—from mild to moderate to very severe.<sup>16,17</sup> This heterogeneity contributes to variations in the complexity of required treatment and the ease (or challenge) of successful return to work after the disability episode.<sup>18</sup>

**Mental health disability  
is the fastest growing  
health-related disability**  
in Canada over  
the past 20 years.<sup>5</sup>

## 1.2.2 Comorbidity

Among people with mental health disorders, many have more than one mental health disorder at the same time or also have an addiction problem with alcohol or other drugs.<sup>19</sup> Approximately 45% of people with a mental health disorder meet the diagnostic criteria for having two or more different kinds of mental health disorders.<sup>20</sup> About one-third of Canadians with a diagnosed mental health disorder also have a substance abuse problem.<sup>21</sup> (Interested readers are directed to the 2009 Human Solutions™ annual report *Hidden Hazards* which features an in-depth review of how alcohol, drugs, medication, gambling and other addictions affect workers and the workplace.<sup>22</sup>)

There is also a high rate of overlap between mental health disorders and other chronic and serious medical conditions. Depression and other mental disorders can interact with physical illness to amplify the problems of the worker on a disability leave.<sup>23</sup> Depression, in particular, has been found to have a major negative impact on functional capacity of individuals with a variety of other illnesses, including: asthma,<sup>24</sup> arthritis/rheumatic diseases,<sup>25</sup> back pain,<sup>26</sup> cardiovascular disease,<sup>27</sup> diabetes,<sup>28</sup> hypertension,<sup>29</sup> migraine headache,<sup>30</sup> pain,<sup>31</sup> and ulcers.<sup>32</sup>

This comorbidity effect appears to drive up total costs for care for those with disability claims. Insurance industry experts estimate that in the employer-paid disability market in the US, 20–40% of all claims involve comorbid or secondary mental health problems that contribute directly to disability or impede rehabilitation and return to work.<sup>1</sup>

In most cases **it is realistic to expect substantial recovery** from uncomplicated mental disorders of moderate severity and a return to work **within 6 to 8 weeks after treatment.** <sup>50</sup>

## 1.2.3 Duration

Mental disorders that are serious enough to warrant absence from work often require longer periods of treatment to yield effective recovery than do physical illnesses.<sup>33,34</sup> For example, the duration of STD claims related to mental disorders averaged 72 and 95 days as reported by one Quebec-based insurer and a Canadian employer, respectively.<sup>35,36</sup> And the length of absence related to depression is often twice as long as that of other illnesses.<sup>37</sup>

## 1.2.4 Precipitating Life Events

Mental disorders often become more severe when the individual experiences certain negative events, work disruptions, or personal setbacks. A study of Canadian workers on mental health disability leave identified factors that contributed to health problems and inability to work, including: Stressful life events outside of work (e.g., death of a loved one, conjugal violence, difficult divorce, financial problems, assuming responsibility for a sick parent or child) and problems related to the work environment itself.<sup>38</sup>

## 1.2.5 Stigma and Discrimination

Stigma can be defined as negative, disrespectful and untrue judgments based on what people think they know about someone and their situation. When the person believes these negative opinions that others express towards them as true, this is called ‘self-stigma’. In contrast, discrimination involves negative and disrespectful actions against another person.<sup>39</sup>

Because of widespread stigma, self-stigma, and discrimination associated with mental disorders, a disability leave for a mental disorder is usually more socially complicated than it is for a leave due to physical illness. For example, social psychological research documents how co-workers, employers, family members and even some health professionals consider certain causes of work absence (e.g., physical illness) to be more valid than other causes (e.g., mental disorder).<sup>40</sup> This results in added stress and pressure on workers with a mental disorder because they feel a need to justify the authenticity and impact of their symptoms.<sup>38</sup> Ultimately, this may influence the individual’s decision to seek treatment and to take any necessary time away from work. It may also delay or complicate their re-entry into the workplace.

## 1.2.6 Relapse After the Return To Work

Employees with mental disorders tend to have a higher rate of recurrence or relapse of disability episodes relative to those employees with a physical illness. Specifically, about 1 in 8 workers who have been on disability leave related to a mental disorder will subsequently have another leave from work.<sup>33</sup> A case study of a large Canadian employer in the late 1990s found that over three-fourths (76%) of employees with a STD claim for depression returned to work, whereas only 8% did not and converted to LTD status. The remaining 16% ended their employment.<sup>36</sup>

**TABLE 3: MENTAL HEALTH DISABILITY FACTS AND FIGURES\*****20–40%**Percentage of employer-paid STD claims that involve comorbid or secondary mental health problems (data from the US market).<sup>1</sup>**246%**Increase in total expenses relating to work-related injuries linked to psychological factors from 1995 to 2004 in Quebec.<sup>44</sup>**700%**Increase in the number of court-awarded settlements due to mental injury in the workplace since 2004 in Canada.<sup>49</sup>**> \$100 million**Amount in benefits paid to employees with LTD claims specifically related to mental disorders for a consortium of employers in Canada.<sup>15</sup>**> \$18 billion**Estimated productivity losses in Canada relating to mental disorders in the workplace in year 2003.<sup>45</sup>

\*Numbers are rounded to the closest percentage point.

### 1.3 The Cost of Mental Health Disability

The economic burden related to mental disorders has made it a prime concern for Canada and many other industrialized countries.<sup>41</sup> It is clear from all of the sources available that disability due to mental disorders is a rising and a serious concern for business, insurers, and government.

One of the first Canadian studies to put a price tag on disability costs for mental disorders was conducted more than a decade ago. This analysis estimated that productivity losses in 1998 due to depression, or to depression and mental distress combined, were \$2.6 billion (STD) and \$8 billion (LTD) respectively.<sup>42</sup> This figure was on par with that for musculoskeletal injuries in Canada during the same period (\$7.5 billion).<sup>43</sup>

In Quebec, the Commission de la Santé et de la Sécurité du Travail [Health and Workplace Security Commission] has seen its total expenses for work-related injuries linked to stress, psychological burnout, and other psychological factors increase from \$5.8 million in 1995 to \$14.3 million in 2004.<sup>44</sup>

More recently, estimates of productivity losses in Canada related to mental disorders total approximately \$18 billion a year.<sup>45</sup> For example, the Joint National Council's most recent data from 2008 demonstrates that just over \$100 million dollars in benefits were paid out to employees with LTD claims specifically related to mental disorders.<sup>15</sup>

### 1.4 The Legal Context for Disability

Apart from humanitarian concerns and financial incentives there are labour and human rights statutes protecting workers with mental health conditions in Canada in each of the different provinces. Thus, protection and accommodation is a legal responsibility as well. Employers *and* employees both have rights and responsibilities in this area.

**The Canadian Human Rights Act.** For workplaces under federal jurisdiction (e.g., federal departments, agencies and Crown corporations, chartered banks, airlines, interprovincial communications and telephone companies, interprovincial transportation companies, among others) the *Canadian Human Rights Act* (the Act) prohibits discrimination in employment on a number of grounds, including disability.<sup>46</sup> The Act considers both mental disorder and drug and

alcohol dependence as disabilities. Under the Act, employers have two main responsibilities toward employees and people who apply for employment. First, employers must not discriminate on the basis of a disability or a perceived disability. Second, the Act requires that employers do everything they can to accommodate an employee with a disability. Just as someone with a physical disability might need physical aids or structural changes in the workplace, someone with a mental disorder might need social or organizational accommodations.

**Provincial Court Rulings.** Several provincial court rulings have held employers accountable for the psychological health of their staff. Recent examples of such cases have occurred in Saskatchewan in 2007 and Quebec in 2009.<sup>47,48</sup> Implications of these rulings have placed increasing responsibility on businesses to appropriately accommodate their employees who have mental disorders.

**Liability for Mental Injury.** The *Mental Health Commission of Canada* has recently begun exploring the legal principles governing liability for mental injury at work. Martin Shain, SJD, led the development of a major report published in 2009 for the commission on this topic.<sup>49</sup> This report summarized several key facts, including:

- The number of court awarded settlements due to mental injury in Canadian workplaces is now seven times greater than 5 years ago;
- The largest sum awarded so far in Canada for employer negligent injury to mental health was one million dollars;
- According to recent Canadian law rulings, there appears to be emerging “a superordinate duty of care that requires employers to provide a mentally or psychologically safe system of work”; And,
- There is also the legal risk to the organization for damages.

## KEY MESSAGES

- About 1–2% of workers have a mental health disability each year in Canada.
- Over the last 20 years, there has been a rapid rise in the number of employees who have short-term and long-term disability claims for mental health causes.
- Employees with mental disabilities (particularly depression) form a large portion of all STD and LTD cases.
- Mental disabilities are often more difficult to treat and to successfully return to work because of a variety of clinical and social factors that complicate the problem.
- Along with greater complexity comes greater costs associated with these kinds of disability claims.
- There are legal requirements for employers to accommodate employees with mental disabilities.

Labour and human rights statutes protecting workers with mental health conditions in Canada make it **a legal responsibility to accommodate employees with disability for mental disorders.**

*Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.*

– Canadian Charter of Rights and Freedoms  
(2004, Section 15)<sup>46</sup>

## SECTION 2: INDIVIDUAL RESPONSE

# Treatment and Return To Work

The first priority for employees on disability for mental disorders is obtaining treatment to assist with recovery. For most mental disorders there is a range of effective (evidence-based) psychological treatments. For example, clinical practice guidelines for the treatment of depression and most other mental health disorders recommend psychotherapy (e.g., cognitive behaviour therapy in the case of most types of depression and anxiety disorders, sometimes in combination with pharmacotherapy). In the instance where there is an organic basis to the mental disorder (e.g., schizophrenia) pharmacotherapy is usually indicated and often combined with psychotherapy for assisting with management of the behavioural sequelae of the disorder.<sup>51,52</sup>

Although treatment is often effective at reducing clinical and subjective symptoms, it doesn't always improve work-related outcomes. To answer the question why treatment effects do not necessarily generalize to the workplace, we need to look towards current models of Return To Work and understand the patient-focused framework that often guides independent clinicians in the specifics of their treatment choices.

## 2.1 Models of Return To Work

There is no single theoretical framework for conceptualizing return to work and accommodations for mental health disability. However, there are a number of principles and processes that are applicable from the field of disability in general. This literature points to the need to adopt a multi-causal perspective that includes some combination of individual, psychosocial, and work factors.<sup>53</sup>

### 2.1.1 Process Models

Clinicians and researchers increasingly recognize that return to work is not a discrete, all-or-nothing event. Instead, it is likely a process that involves preparing to return to work, attempts at re-engaging in the workplace, and efforts to stay

at work.<sup>54,55,56</sup> One such process approach is being examined by researchers in Quebec.<sup>57</sup> These researchers are seeking to describe the various interactions and dynamic influences that act upon a worker over time as he or she recovers from a mental health disability. These influences are:

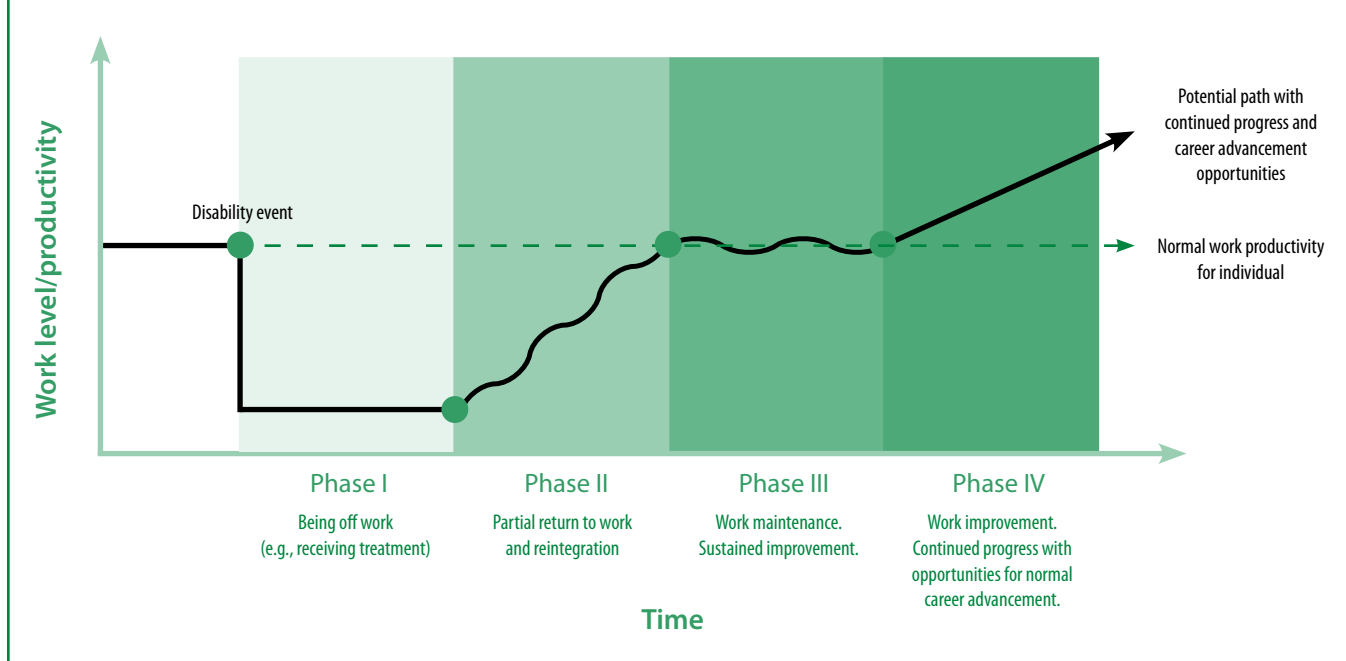
1. **Individual characteristics of the affected worker.** These include age, sex and personal dimensions linked to physical and mental health, particularly the person's psychiatric history.
2. **Psychosocial environment at work.** This integrates the *structural dimensions* of work (i.e., "what to do", "how to do it" and "how much to do" in a given time) and the *human dimensions* of work (i.e., communication between superiors, subordinates, and colleagues). And,
3. **Life events outside of work.** This refers to social factors that can affect mental health and capacity to work (e.g., support from those close to the person, family context, etc.).

### 2.1.2 Phase Models

Historically, many disability accommodations have derived from conceptualizing return to work as a single event. However, follow-up data on workers with persistent or recurrent mental health problems shows that they are liable to experience further absences due to the nature of their clinical conditions.<sup>54</sup>

By introducing time into the equation, phase models extend the time frame of return to work to include factors that help workers stay at work once they have returned from a disability-related absence. One influential model (a 2007 revision by the Quebec team of their 2005 model) encompasses four phases, see Figure 1.<sup>55</sup> These four phases include:

1. Being off work (and receiving treatment);
2. Work reintegration (coming back into the workplace);

**FIGURE 1: RETURNING TO WORK: FOUR PHASE MODEL<sup>55</sup>**

3. Work maintenance (avoiding a relapse); And,
4. Work improvement and career advancement.

Particularly important is the inclusion of phase 4, which increases chances that the employee will have continued success and eventual normal progression for career advancement (just as for any employee). If there is indeed a higher level of career advancement in the future after coming back from disability, it means that the person did not fall victim to prejudice and discrimination. A knowledge of which factors contribute to the worker's ability to sustain and increase their work performance success after return to work from a disability leave can then also be applied to developing tactics to prevent disability as well and potentially improve other work-related outcomes.

## 2.2 Work Outcomes

Reviews of treatment outcomes for patients with severe mental disorder symptoms have concluded that restoration of the ability to regain high levels of work performance often lags behind the restoration of clinical function (or shows immediate improvement, but only slightly).<sup>59,60</sup> For example, one study found that approximately 60% of individuals with medication-only treatment for major depression continued to show impaired work functioning at follow-up one year later.<sup>61</sup>

How do we explain these findings? One contributing factor is that medication-only treatments for mental disorders target symptom relief but leave psychosocial and other factors that may have contributed to the mental disorder unexamined. Thus, treatment may not have had any impact

on behavioural functioning, adaptability, or resilience, particularly as this functioning relates to the workplace. Complicating matters further, some medication side effects can interfere with the ability to perform work duties (e.g., disturbed sleep, impaired concentration).<sup>62</sup>

Another important factor that may explain the lack of positive work outcomes following successful treatment stems from the clinical framework that guides independent clinicians in the specifics of their treatment choices. Independent clinicians often focus their therapeutic efforts on reducing symptoms and improving functioning in the absence of understanding and acknowledging the relationship that binds the client to their employer. If, instead, the employer-employee relationship is operationalized and threaded through the treatment process, it is reasonable to conclude that work readiness will be improved and greater work outcomes achieved (see section 2.3.3 later in this report).

**The shadow of stigma follows many people who have recovered from a mental disorder but are not trusted by others in the workplace for advancement.**

## 2.3 Innovations in Clinical Treatment

The good news is that although an explicit work focus is not always emphasized in typical clinical treatment, there is evidence from recent studies that when depression, anxiety and other mental disorders of moderate severity are treated appropriately (i.e., the proper, evidence-based treatment is used) work performance does improve, and absences from work are reduced.<sup>63,64</sup>

There are now promising innovations in clinical treatments for workers on disability for mental health disorders. These innovations focus primarily on three areas:

1. Improving the identification and treatment skills of primary care physicians.
2. Collaborative care models that encourage joint participation of physicians and mental health professionals in the assessment and treatment of disability cases.
3. Emphasizing the individual's ability to perform their work as a component of the clinical treatment process.

### 2.3.1 Improving Physician Skills

Primary care physicians are often the first point of therapeutic contact for an individual seeking help for a mental disorder.<sup>6,36,37</sup> But there is concern that physicians often do not understand the functions that an individual regularly performs for their job.<sup>50,63</sup> Thus, improving the specificity of the kinds of clinical care provided by physicians and providing better training to help these physicians to detect, assess, and treat common mental disorders, may help advance the success of mental health treatments for workers on (or contemplating) a disability leave.

**Example.** In the Netherlands, primary care doctors were trained on methods of assessment and on how to use cognitive behavioural therapy (CBT) techniques for adults on work disability leave for mental health reasons.<sup>65</sup> The intervention consisted of training on five aspects of the occupational rehabilitation process. After one year, 84% of the employees partially returned to their jobs and 73% had completely returned to work.

**Example.** In another example from the Netherlands, a two-group experiment was conducted with employees on sickness work leave because of a mental disorder.<sup>66</sup> The study compared CBT (assisting the individual in developing an inventory of stressors and problem-solving strategies, practice in applying new coping skills) with “treatment as usual” (empathic counselling and lifestyle advice without work-focused coping skills training). The study results were very positive in favour of the CBT plus work focus group. In comparison with the control (treatment as usual) group, the CBT group participants returned to part-time and full-time work sooner, and the total duration of their sickness

leave was significantly shorter. The results were used to develop a set of clinical practice guidelines for use with general primary care doctors.<sup>67</sup>

### 2.3.2 Collaborative Care Models

A second innovation in treatment brings trained mental health clinicians into primary care practices to work collaboratively with physicians.

Individuals with mental disorders who receive care in primary care settings often do not receive adequate treatment for various reasons, including limited face-to-face contact and less experience on the part of the treating physician with effective mental disorder treatments.<sup>68</sup> The collaborative care model seeks to improve accessibility to mental health-specific resources in primary care settings, increase case-specific communication between different providers seeing the same patient, and promote greater treatment continuity and follow-up care.<sup>69</sup>

When measured in terms of symptom reduction, collaborative care models are a success.<sup>70,71</sup> Additionally, some studies have shown reduced costs of care and improved return to work outcomes. For example, in one demonstration project, an integrated care practice model was developed that involved a network of psychiatrists in Ontario and employees who were on STD leave with major depressive disorder or adjustment disorder.<sup>72</sup> The results showed the following four Return To Work outcomes:

1. A significantly higher proportion of the cases in the collaborative care treatment group returned to work than in the comparison group (85% vs. 63%, respectively).
2. The average number of days on short-term disability leave was significantly shorter for cases in the collaborative care treatment group than in the comparison group (62 days vs. 76 days, respectively).
3. A lower proportion of the collaborative care cases transitioned from short-term to long-term disability leave than in the comparison group (7% vs. 31%, respectively). And,
4. The employer-paid portion of the costs of providing treatment services for return to work support was approximately \$500 less per case in the collaborative care treatment group than in the “care as usual” control group.

The *Canadian Collaborative Mental Health Initiative* lists the following three tactics as being effective in the collaborative practice model:<sup>69</sup>

1. Physicians and mental health clinicians should be located in the same clinic facility;
2. Treatment guidelines and protocols should be formulated and closely followed; and,
3. Follow-up should be provided to all patients.

### 2.3.3 Emphasizing Work Focus During Treatment

Adding a work focus to therapeutic efforts for the treatment of employee disability is advocated by leading clinical researchers in many countries, including Australia,<sup>73</sup> Canada,<sup>50</sup> Ireland,<sup>74</sup> the Netherlands,<sup>75</sup> the UK,<sup>76</sup> and the US.<sup>77</sup>

Examples of work-focused interventions include:

1. Collaborative disability case management.
2. Early contact with the absent worker from the supervisor.
3. Ongoing communication between the absent employee and other people at work. And,
4. An agreed-upon rehabilitation plan including work tasks, and flexibility in creating work accommodations and return to work arrangements.<sup>78</sup>

The results from studies of these intervention innovations are very encouraging, as noted in the examples below.

A recent study from the Netherlands compared the rates of return to work for employees on disability with work-related psychological complaints (anxiety, depression, and job burnout). Half of these employees received a CBT treatment that focused on individual issues and the other half received a CBT treatment delivered by labour experts that focused on work issues *in addition to* individual health issues.<sup>79</sup> While both groups later had improvements in mental health, the group with the work-focused treatment had significantly better return to work outcomes. Follow-up at 10 months revealed that the work-focused group was able to return to partial work status one month (30 days) sooner and to return to work full-time more than six months (200 days) sooner.

A similar study in which treatment incorporated a work focus in an effort to more actively manage mental health disability claims resulted in a 23% reduction in the duration of short-term disability (the equivalent of 17.1 work days).<sup>80</sup>

Similar efforts are being tested in Canada although it is too soon to draw conclusions. One example is a pilot project in Ontario involving insurer-based referrals of employees on STD leave. Employees on disability leave receive dedicated outpatient and inpatient care that emphasizes functional recovery and return to work. As well, medical doctors and mental health clinicians are collaborating on the provision of care to these individuals.<sup>81</sup>

At the time of writing this report, a Canadian effort in progress concerns determining the clinical best practices managing workers' mental health disability. The research team is led by Dr. William Gnam and is sponsored by the Institute for Work and Health. The project goals are to evaluate the impact of an innovative disability case management program for workers with a disabling mental

disorder and to generate benchmarking data on work disability due to mental disorders.

It is too early to draw conclusions from this project. Interested readers are encouraged to follow-up with the project lead.

## 2.4 Early Return To Work

Participation in a partial work experience while still involved with clinical treatment is called "early return to work." Early return to work presumes that staying at or returning to work is beneficial to employees on (or considering) a disability leave unless there is evidence in the individual case to the contrary.

Early return to work is not a broad brush approach and all proponents agree that this approach calls for consideration on a case-by-case basis. Indeed, practice guidance documents from disability insurance, workers compensation, safety, and occupational medicine organizations in Canada,<sup>82</sup> Australia,<sup>83</sup> and the US,<sup>84</sup> all emphasize the harmful effects of prolonged sickness absence and recognize the benefits of staying at work. For example, the *Practice Guidelines of the American College of Occupational and Environmental Medicine*, recommends "the earliest possible safe return to work" (page 10).<sup>85</sup>

**Proponents of early return to work** argue that creating conditions that support employees to remain actively involved in their work can have profound effects. For example, some studies show that the majority (e.g., 90%) of individuals experiencing severe and persistent mental health disorders express a strong desire to go back to work or obtain new work.<sup>86</sup>

**Critics of early return to work** argue that most of the literature on this approach addresses its effectiveness in relation to cost outcomes and duration of time from work without consideration of its impact on worker quality of life and without treating each case singularly (i.e., on a case by case basis).<sup>53,87</sup> These critics point to the risks of working while recovering from a mental disorder.<sup>50</sup> Some of these risks include:

- Exposing the worker to the stresses and conflicts that may have contributed to their distress;
- Placing workers and coworkers at increased risk of injury or accident (e.g., workers returning to safety sensitive positions while experiencing side effects from medication);
- Some workers may agree to return to work before they are mentally capable of doing so to maintain their employment status (and thus begin to recover some of their lost income) or to convey their commitment to being good workers.

## KEY MESSAGES

- A wide range of individual and workplace factors seem to interact with general medical and psychiatric components to predict return to work outcomes.
- New conceptual approaches take into account different influences and place the return to work experience into a dynamic longitudinal model with several phases.
- This extended time frame includes the ability to productively stay at work after a leave (sustained return to work). Also examined are the factors that encourage or impede the longer-term career success for those with a history of disability from a mental disorder.
- The two most widely used types of clinical treatments for mental disorders are psychotherapy and pharmacotherapy approaches, often with a combination of both.
- These treatment approaches have substantial research support for being able to improve the health and clinical symptoms of most patients.
- Some innovations in clinical treatment have been effective in overcoming some of the limits of routine care. Skills training for medical doctors concerning mental disorders, adding mental health professionals to the clinical care team at medical settings, and including more work-focused assessments and treatments all have shown potential for improving clinical care.
- In order to foster a more rapid and more lasting return to work outcome in patients with mental disorders, a focus on work function and work readiness is essential regardless of who is providing the treatment.
- The practice of using a partial or early return to work for mental disability cases has both advocates and critics.

Clearly **there remains significant debate about the role of working while in recovery from mental health-related disability and the use of early return to work practices** as a therapeutic strategy. This is an area that requires more research.

*Employers can and should play an important role in the prevention, management, and rehabilitation of employees with disability due to mental health problems.*

– Larry Myette, M.D., M.P.H.,  
Journal of Occupational and Environmental Medicine,  
(2008, p. 496)<sup>88</sup>

## SECTION 3: EMPLOYER RESPONSE

# Making Accommodations

Many of the advances in this area have been pioneered by very large employer organizations, largely due to their greater cost impact and the ability to hire specialized personnel to assist in addressing the problem. By contrast, smaller size companies have an advantage in having fewer administrative and regulatory regulations (e.g., less red tape) and can bring innovative responses to action more quickly. Smaller companies also can more readily change the tone and culture of their workplace, especially when those in leadership take an interest and get personally involved.

## 3.1 Getting Started

It is no simple task for an employer to effectively manage an employee with a disability for mental health reasons. One experienced corporate medical director suggests the following four-step process should be considered at the initial phase of supporting an employee disability episode:<sup>88</sup>

1. Work with health professionals to assess the employee's clinical status and functional capacity from a medical and psychological perspective.
2. Describe the essential task or work demands of the employee's current job and compare these with health care requirements and functional capacity (i.e., conduct a psychological job analysis).
3. Identify problematic physical and psychosocial environmental factors or work practices that can be adjusted to accommodate an early, safe and sustainable return to work. And,
4. Develop and support a set of coordinated therapeutic, self-management, return to work, and relapse prevention plans.

### 3.1.1 Assess the Employee's Work Limitations

The employer should strive to communicate with the employee, the disability case manager, and relevant health care professionals to learn the nature and severity of the employee's disability as it pertains to the ability to work. The employer needs to know how the employee's psychological health affects or limits their work in order to support the employee. In this process, it is acceptable for an employer to ask the employee to provide supporting documentation from a health care provider or other pertinent information so that the employer can develop the best accommodation options.

### 3.1.2 Conduct a Psychological Job Analysis

A psychological job analysis may be useful for developing on-site transitional work and guidance on how to modify work duty options to accommodate workers who are attempting to return to work. The employer can undertake a formal and disciplined psychological job analysis to determine how various components of an employee's work involve different mental functions.<sup>89</sup>

If required, a simplified version of the psychological job analysis can be done. This could involve a thorough and logical review of all of the employee's major tasks and duties in light of whether or not these tasks and duties potentially impact or influence the employee's mental health condition. At minimum, this analysis requires input from the supervisor, a health professional, and the employee.

### 3.1.3 Assess Risks in the Workplace

The employer should also conduct interviews with the employee, their supervisor, and relevant coworkers to identify if there are problematic aspects of the physical and psychosocial work environment that have contributed to the mental disability. Available work records and reports

should also be reviewed. This kind of information can then be used to try to make the accommodations necessary to change these factors or create new work practices that do not negatively affect the employee.

### 3.1.4 Make Plans for Managing the Return To Work

The development of plans to prevent a relapse once the employee returns to work are needed. Some of these accommodations and changes can be carried out in advance of the proposed date when the employee comes back to work, either part-time or full-time.

## 3.2 Making Workplace Accommodations

A major component of the return to work plan is to formulate the specific actions and behaviours that accommodate the disability of the returning employee. Accommodations are usually customized on a case-by-case basis to match the individual needs of employees as well as the resources available to the employer. In most cases, the accommodations are inexpensive and involve workplace flexibility rather than capital expenditures.

There are many possible workplace accommodations for an employee that is returning to work from a disability leave for a mental disorder. According to a national survey of Canadians in 2001-2002, the most common kinds of work accommodations provided by employers for workers with disability of all kinds were modified or reduced work hours (23%), job redesign including modified or different duties (22%), workstation modifications (7%), an accessible parking space or washroom, elevator, ramps, transportation, or technical aids (all 5% or less).<sup>8</sup>

**Table 4** presents some of the most common accommodations for employees on leave for mental disorders.

## 3.3 Multiple Stakeholders

Creating successful work accommodations for employees with mental disorders requires an integrated and coordinated process that engages a variety of stakeholders, including but not limited to:<sup>87,92</sup>

- Employee;
- Union representatives;
- Supervisors;
- Coworkers;
- Occupational health personnel;
- Treating professional;
- Disability case managers; And,
- Employee and family assistance program professionals.

### 3.3.1 Responsibility of the Employee

The employee's first responsibility is to actively participate in the course of medical and psychological care deemed most appropriate to improving their mental health condition. The employee on disability leave should also be encouraged to maintain open lines of communication with the workplace. Similarly, communication between the employee and their insurance company case manager should be encouraged regarding ongoing status of their claim.<sup>50</sup>

### 3.3.2 Union Groups

According to the Canadian Mental Health Association, unions are required to actively participate in the work accommodation process on behalf of employees who are union members.<sup>93</sup> Union stewards or representatives can work with the employee and management to create effective work accommodations. Often the union can encourage employer responsibility for accommodation, monitor the employee's treatment progress during recovery, and review

### ABOUT PRIVACY AND CONFIDENTIALITY

When collaborating with health care professionals and the employee to develop accommodations, there are some important privacy considerations that employers should heed.<sup>90</sup> Privacy is paramount and employees do not have to disclose information about their diagnosis, history of the disorder, or specifics of their treatment.<sup>91</sup> Only information relevant to the work situation needs to be shared and all health care information shared between the employee and employer is private and must be kept confidential.

If an employee is uncomfortable sharing information with his or her supervisor, it may be useful to involve a third party such as a person from the Human Resources department or from the Employee and Family Assistance Program. All communications need to be consistent with legal requirements and any other relevant privacy and confidentiality guidelines.

**Note:** Any and all communications pertaining to the employee's disability need to respect and protect confidentiality and privacy.

**TABLE 4: SAMPLE WORK ACCOMMODATION PRACTICES****ISSUE****ACCOMMODATIONS/EXAMPLES****EMPLOYEE-SUPERVISOR RELATIONSHIP**

A combination of stigma and misinformation about mental health disorders can create uncomfortable social situations and strained work relationships for an employee returning from a mental disability leave.

It is important for the employee and the supervisor to maintain a good working relationship. This modeling of normal interpersonal relations will be seen by others in the workplace and will make it much easier for coworkers and colleagues to feel comfortable with the employee. Without adequate social support, a return to work becomes very difficult.

**SUPERVISION STYLE**

Often the nature of the supervisory process must be adjusted to accommodate aspects of the employee's disability.

This can involve modifying the way instructions and feedback are given to the employee. For example, putting task instructions in writing may help the employee focus on tasks. Regularly scheduled meetings help the supervisor check on the employee's progress and discuss any changes needed to the accommodation plan.

**WORK SCHEDULING**

Effects of medication, or flexibility to attend treatment appointments, may require changes to work scheduling.

One of the most widely used accommodation practices is to offer a graduated return to work to the employee on sick leave. The employee can work part-time or in split shifts. More frequent breaks during the work shift may be offered. The timing of work periods can be more flexible with changes to start and end of work hours.

**JOB DUTIES**

Modification of job duties may be required, particularly any tasks that provoke recurrence or exacerbation of symptoms.

It can be helpful to reassign minor but symptom-provoking tasks to other employees. As task reassignment adds more work to others, look for a way to exchange small tasks with other employees that maintain a fair balance of work while capitalizing on the strengths of each worker. For example, one employee can take on more of the telephone calls while another does more written correspondence.

**MEETING DEADLINES**

Some employees returning to work may need help managing deadlines for work tasks.

Employees can be encouraged to make a daily "to-do" list or use electronic computer-based calendar tools. Supervisors can provide regular reminders of deadlines. There should be clear expectations for when work is due, defined measures for assessing work performance, regular meetings to discuss work performance, and defined consequences if expectations are not met.

**TABLE 4: SAMPLE WORK ACCOMMODATION PRACTICES (CONT'D)****ISSUE****ACCOMMODATIONS/EXAMPLES****STAMINA**

When recovering from mental health issues, the individual tires more easily and may thus have difficulty maintaining physical and mental stamina.

Allow for a self-paced workload, and access to supportive employment services or a work coach can also be useful to help build work pacing skills. Other options include allowing the employee to do some or all of their work from home and/or job-share.

**CONCENTRATION LIMITS**

Some aspects of depression, anxiety or psychological distress can make it difficult to maintain a normal level of concentration on tasks.

Reduce distractions in the work area. Provide privacy enclosures, encourage protected time without interruptions, allow breaks when concentration is waning, or streamline complex tasks to remove all but the most essential aspects. Exposure to natural light in the work area may also boost concentration.

**EMOTIONAL RESPONSE**

It is common for workers recovering from mental health conditions to experience fluctuations in mood, which can then affect their reactions to work situations and interactions with others at work.

Outline clear expectations about the need to manage emotional expression at work. The supervisor and coworkers can provide frequent praise and reinforcement to keep the employee's mood more positive and reduce worry. The employee can be encouraged to get support from an EFAP counsellor.

**TRAINING NEEDS**

Re-training may be necessary to bring the employee "up to speed" on aspects of their job that may have changed during their absence. This re-training, and any new training, may need to be done slightly differently for an employee who is coping with a mental disorder.

Training should allow extra time for the employee to learn new tasks or information. The employee should be allowed to attend trainings that are individualized and self-paced.

**COMMUNICATION**

Communications with the employee can be difficult to manage when the employee is not at work as much as other full-time staff.

Supervisors need to define what constitutes good communication at work. This should include the ability to ask for open and honest feedback in a prompt manner. It is recommended to have regular meetings between employee and supervisor to discuss organizational changes and work-related issues.

**Note:** Once these accommodations have been provided, the employee then has a responsibility to meet all of the essential job requirements and standards of their position or modified position. Often some of the accommodations will need to be modified or discontinued as the health of the employee improves.

work performance expectations during the return to work.<sup>94</sup> The union can also meet with the employee's supervisor and co-workers while the employee is on disability leave.

Most unions have the resources to litigate a broad spectrum of disability accommodation issues. They also have the duty to follow-up on the performance of employer responsibilities related to making effective work accommodations for the employee. If needed, labour arbitrators also have the remedial power to order the reinstatement of inappropriately terminated employees. In this regard, labour arbitration has functioned as an important forum for advancing disability accommodation principles and protecting the rights of employees.

### 3.3.3 The Supervisor

Supervisors play a critical role in the return to work process.<sup>95</sup> Supervisors can create supportive links with employees by communicating information about the return to work accommodations. Supervisors should find out what they can do that is considered supportive by the employee and what they can avoid doing that may (inadvertently) make the employee's symptoms worse. The supervisor can also model appropriate behaviours for coworkers. For example, the supervisor should treat the employee with respect, use non-discriminatory language when discussing accommodations, and provide support for the employee with a mental disorder just as they would provide support for an employee with any other kind of health challenge.

The *Global Business and Economic Roundtable on Mental Health and Addictions* recommends that employers should hold supervisors accountable for the success of the reintegration of employees who have a mental health disability leave. This might mean that supervisors need additional skills training and education, and/or incentives (e.g., financial) to ensure they are able to maximally support the return to work process.<sup>81</sup>

### 3.3.4 Coworkers

At an organizational level, shared knowledge is essential for understanding, accepting and knowing how and when to support an employee who suffers from a mental disorder. Coworkers who interact regularly with the employee can play a key part in the return to work process. Some employees returning from a mental disability leave report being ignored and shut out socially by their coworkers. As well, some of their tasks and duties may need to be shared or transferred to coworkers who could potentially harbour resentment at the extra workload.

Coworkers should be educated about their role in the return to work process and encouraged to treat the employee with respect and support, just as they would for any kind of medical problem or injury. Some tasks and job duties may also need to be shared or transferred between the returning

employee and their coworkers. It is therefore necessary to ask for cooperation in these changes (respecting privacy considerations).

One study found that employees who were absent for mental health-related reasons anticipated their return to work positively when they felt supported by colleagues and superiors.<sup>38</sup> Interestingly, co-workers of these employees also experience positive benefits when given the opportunity to meet regularly with the employee suffering from the mental disorder.<sup>96</sup> Employers can thus encourage the formation of employee-led peer support groups.

### 3.3.5 Disability Benefit Case Managers

Several studies have shown that disability management programs are critical for effectively responding to complex situations involving mental disorders.<sup>87,97,98</sup> Proactive case management can facilitate access to a wide variety of services that are needed in the process, including medical care, rehabilitation services, self-help and counselling supports, family care-givers, and benefits. A case manager can also assist with paperwork related to insurance benefits.

To be effective, case managers should demonstrate competence in at least six domains, as determined by analysis of competency measures predictive of successful return to work outcomes in 22 different research studies:<sup>99</sup>

1. Ability to conduct ergonomic and workplace assessment;
2. Clinical interviewing skills;
3. Sensitivity for social problem solving;
4. Familiarity with workplace mediation tactics;
5. Knowledge of business and legal aspects of return to work and disability management; And,
6. Knowledge of physical health and mental health conditions.

Another difficulty facing the case manager is that employers typically have resources for health care benefits in separate areas of delivery and administrative control. Often the expertise, resources, or data residing in one organizational silo are unavailable to other departments, thus preventing the development of integrated programs. To empower the case manager, it is recommended that the disability management benefit be formally aligned or integrated with other allied health and welfare benefit programs offered by the employer. In addition to the medical health care benefit program, these other areas can include wellness, occupational health, the EFAP and others.

Working within the limits of a fragmented delivery system that places healthcare and support services in various community, provincial, and federal jurisdictions also presents significant challenges for case managers.<sup>100</sup>

### 3.3.6 Employee and Family Assistance Programs

An ally for disability case managers can be the Employee and Family Assistance Program (EFAP). For the employee who is on disability leave, the EFAP can provide return to work support services, such as preparing the supervisor and employee for re-entry into the workplace. EFAPs can also assist with psychological job analysis and provide supervisory consultation and educational services on an ongoing basis to assist those at the work site while the employee is away on leave.

Due to the frequent comorbidity of mental disorders with other medical conditions, employers may be well advised to mandate a psychological clinical assessment as part of the requirement of applying for disability benefits (not just those with mental disorder as the primary cause). The EFAP may be able to perform this service or assist with making referrals to others who can provide it.

Collaboration of disability case managers and the EFAP is not a new approach. In the early 1990s the Bank of Chicago demonstrated that using EFAP personnel to manage short-term psychiatric disability cases could reduce the length and cost of these claims.<sup>33</sup> In a more recent example, a 2007 study from The Hartford Group<sup>101</sup> showed that employers with high EFAP services utilization had better outcomes for short-term disability claims. The study examined all companies in the Hartford insurance book of business and compared the companies with the highest levels of overall EFAP use (about 11% annual use rate) with companies that did not have an EFAP. The results showed that disability claims for mental disorders were 17 days shorter at the high EFAP-use companies than at the low or no EFAP-use companies (56 days vs. 73 days, respectively). In addition, the Hartford study found that the individual employees on STD who had used the EFAP were much less likely to become a long-term disability case compared to employees on STD who did not use the EFAP (2% vs. 9%, respectively).

In summary, to manage return to work for mental disorders can involve coordinating the efforts and actions of multiple stakeholders, including the employee, union representatives, the employee's supervisor, coworkers, disability case managers, EFAP staff, and others.

## 3.4 Cost Benefit

Very few studies have examined the cost-benefit or return-on-investment for mental disability management treatment and programs.<sup>72</sup> One reason for this lack of quantitative research is that employers and insurers involved with the financial management side of worker disability benefits are already very familiar with the costs per day for a person on STD or LTD. For example, interviews with executives from leading Canadian disability insurance companies noted that there was a positive impact on the bottom line

from early versions of return to work disability management programs and that the "most conservative estimates foresee a 500% return on investment."<sup>102</sup> Additionally, an estimate from the human resources field of the cost for making accommodations in general in Canada was \$500 or less per case.<sup>103</sup>

Thus, it seems reasonable to deduct that there are significant returns for investing in mental disability management initiatives.

### KEY MESSAGES

- Employers should strive to coordinate communications between the employee, the disability case manager, and relevant health care professionals as it pertains to the nature and severity of the employee's disability.
- Employers can undertake a psychological job analysis to determine how various components of an employee's work involve different mental functions that may be affected by (or affect) their disability.
- Employers should conduct interviews with the employee, their supervisor, and relevant coworkers to identify if there are problematic aspects or risks of the physical and psychosocial work environment that may have contributed to the mental disability.
- As in any health-related matter, all employer communication concerning the disability case should be consistent with legal requirements for privacy of information and any other relevant privacy or confidentiality guidelines.
- There are many possible workplace accommodations that can be developed for an employee that is returning to work from a disability leave for a mental disorder: supervisor-employee relationship, supervision style, flexible work scheduling, job duties, deadlines, concentration, emotions, training, and communication.
- Managing the return to work for mental disability can involve the coordination of multiple stakeholders, including the employee, union representatives, the employee's supervisor, coworkers, disability case managers, EFAP staff, and others.
- Cost savings and return on investment (ROI) for the treatment of disability cases and active disability management is presumed to be positive due to the high costs of care and benefits involved, but few research studies have been done in this area.

*Prevention of the development of mental health problems or the reduction of known risks is done by working to create good workplaces and good jobs, excellent leaders and supportive/competent managers, and by educating people for the job.*

– Royal College of Psychiatrists (2008, p. 21)<sup>59</sup>

## SECTION 4: ORGANIZATIONAL RESPONSE

# Prevention

Prevention of disability asks “How can a supportive work environment reduce the onset, severity, impact and duration of mental disorders and contribute to better outcomes for the accommodation of employees with mental health conditions?”

An example of prevention at an individual level is the use of screening tools to identify mental health risks. Potential screening applications include mental health screening in the entire employee population or targeted screening for high-risk groups (e.g., employees who work in highly stressful situations, employees reporting high stress levels, or employees who demonstrate high levels of unexpected work absence).

## 4.1 Creating a Psychologically Healthy Work Culture

Many studies show that organizational approaches to improving mental and physical health generate more significant and longer-lasting effects than intervention strategies directed at individuals.<sup>104,105,106</sup> Canadian researcher Dr. Julian Barling identified ten organizational elements of a psychologically healthy workplace and the impact that work design factors have on the health and well-being of employees and their work performance.<sup>107</sup>

1. Transformational leadership;
2. Workload and pace;
3. Work schedule;
4. Role clarity;
5. Job future;
6. Autonomy;
7. Workplace justice;
8. Reduced status distinctions;

9. Social environment; And,

10. Extrinsic factors.

Leadership style was the most significant factor in Barling’s review. This was also noted in a review of over 100 studies conducted worldwide that found strong evidence that good leadership at companies predicts job well-being for employees, reduces the risk of sick leave, and reduces the occurrence of early retirement.<sup>108</sup>

For more information on this topic, interested readers are directed to the 2008 Human Solutions™ annual report *A Quiet Crisis* that featured an in-depth review of the kinds of practices that employers can use for creating a psychologically healthy workplace.<sup>109</sup> As well, the *National Mental Health Commission of Canada* recently created a website that addresses the critical role of leaders of companies and organizations in advancement of mental health issues in the workplace (see **Table 8** for a list of websites of various resource organizations).

## 4.2 Reducing Stigma and Discrimination

No one wants to be labelled with a mental health condition. Worse yet is when the label is accompanied by stigma and/or discrimination.

Stigma is a barrier to employees seeking early or appropriate treatment of mental health conditions and it can prevent a smooth return to work. For purposes here, *stigma* is defined as negative, disrespectful and untrue judgments based on what people think they know about an individual and their circumstances. *Discrimination* involves negative and disrespectful actions taken towards another person. Self-stigma occurs when an individual begins to believe the validity of the negative opinions others express towards them.<sup>39</sup>

As a form of corporate and social responsibility, employers need to create (or revise) workplace policies that address stigma and discrimination as it pertains to mental disorders.<sup>110</sup> Companies that engage in efforts to eliminate this stigma serve as model workplaces that promote and support the mental health of their workers.<sup>111</sup>

Some employers may believe that education about mental health and mental disorder is the sole key to reduce stigma. However, research has shown that this approach, in isolation, does not work that well. In fact, education, itself, may have little effect on stigma.

The kinds of anti-stigma campaigns that actually do work use other tactics.<sup>112</sup> For example, repeated exposure to people who are functioning positively despite mental disorders has proven effective at challenging inaccurate beliefs and perceptions (this is called the “contact hypothesis”). Another successful approach is to involve influential people and groups in campaigns to educate others (e.g., policy decision-makers, senior executives, health professionals).

### 4.3 Benchmarking Employer Action

The 2007 Watson Wyatt *Stay at Work Study* of Canadian employers addressed the issue of stigma for mental health issues and found some interesting results.<sup>97</sup> Though most organizations planned to take steps to address stigma, about three-fourths of the employers said they lacked knowledge of how to actually deal with stigma and make changes. In addition, almost two-thirds of the employers (64%) lacked a structured process that supervisors could use in their efforts to support an employee’s return to work after any illness or disability.

In 2006, a study of US-based employers examined policies, practices, and benefit plan coverage for absences due to mental health issues.<sup>1</sup> Similar to the Canadian results, the study revealed a puzzling mix of interest and inaction. Most employers were doing relatively little to address the problem of mental health disability, even though they recognized it as a major source of productivity loss.

A 2008 study by the US-based *Disability Management Employers Coalition* explored the number of mental health disability management-related practices that were in place at their member companies.<sup>113</sup> The results found that specific practices were used by about one-third of the employers: 39% used mental health professionals for mental health disability case management; 34% included a behavioural component in an integrated program; 33% used a mental health expert for telephonic case management; 31% included the EFAP or another mental health professional on the disability case management team; and 30% routinely reviewed all of the STD claims for possible underlying mental health issues.

## TABLE 5: CASE EXAMPLES

### SOUTHERN CALIFORNIA EDISON

A utility company. Developed a collaborative care approach between the disability management program and the EFAP for mental health related cases. The program reduce repeat disability cases from 30% a year to zero.

### H-E-B

A grocery store chain based in Texas. Changed the disability management benefits design to encourage appropriate treatment and prompt return to work. Medical costs for mental disorder-related disability are paid only if care is first accessed through the EFAP and a behavioural health vendor and if an in-network provider is used. H-E-B also added questions on their health risk appraisal (HRA) to identify potential mental or substance abuse disorders and the EFAP uses the results to conduct telephone outreach to those employees at high risk.

### GLAXOSMITHKLINE

A pharmaceutical manufacturer based in Pennsylvania. Added a 2-item depression screening question for all high-risk STD cases (i.e., those with multiple, complex, and/or chronic illnesses). Results show this screening prompts employees to then discuss depression diagnosis and treatment with their physician.

### UNIVERSITY OF TORONTO

Recently began to address the higher incidence of mental disability by focusing a number of coordinated interventions on both the individual and the institution. A multidimensional approach is being used to engage multiple stakeholders and to go beyond the traditional focus on individual cases. The project has resulted in a more effective disability management model for the university.<sup>114</sup> The strategy involved the following initiatives: (1) greater employee access to specialized treatment; (2) early employee contact and support; (3) stakeholder participation and solution focused strategies; (4) skills training to strengthen managers’ capacity to respond; and (5) public education and awareness campaigns linking academic excellence and mental health.

The conclusions of these various benchmarking studies and surveys are encouraging. Approximately 1 in 3 employers is following the directions set by research findings on the need to implement various kinds of return to work and accommodation practices for mental health issues in general and for disability in particular. Some examples of these efforts are presented in **Table 5**.

On the flip side, these same benchmarking studies also reveal that the majority of employers in Canada and the US are not embracing these changes. However, there are some encouraging signs that this is beginning to change:

1. Regional consortiums of employers in Canada (Vancouver) and in the US (Kansas City) are collaborating on community-wide initiatives addressing depression in the workplace.
2. At the national level, business groups are focusing on workplace mental health issues (e.g., in Canada, there is the *Global Economic Roundtable on Addictions and Mental Health*; in the US, there is the *National Business Group on Health*).
3. There are significant advances in national government policy (e.g., in Canada, it is the *National Mental Health Commission*; in the US, it is the President's *New Freedom Commission on Mental Health* and the recently enacted federal law requiring parity in healthcare benefits for mental health disorders and addictions). See **Table 8** for website addresses of these organizations.
4. Some employers and organizations in North America are leading the way in the management of mental disability. The *Partnership for Workplace Mental Health*, a program of American Psychiatric Foundation, maintains a feature of their website called "Employer Innovations" ([www.workplacentalhealth.org](http://www.workplacentalhealth.org)). It is an online database of employer case studies related to a wide variety of workplace mental health issues. There are 17 different employers profiled who have initiatives for disability management for mental health disorders. Most of these employers are very large size employers with 10,000 or more staff. Many of the initiatives involved greater use of the EFAP, collaborative care models that integrate health services (particularly return to work, disability and EFAP) and employee screening for mental health. Several of these efforts are profiled in **Table 5**.

## KEY MESSAGES

- Prevention of disability addresses how a supportive work environment can reduce the onset, severity, impact and duration of mental health disorders and contribute to better outcomes for the accommodation of employees affected by these disorders.
- Preventive efforts can include periodic mental health screening for depression, anxiety and substance abuse (as examples) and also ongoing monitoring for mental health disorders among high-risk groups.
- Research has identified organizational factors that foster a psychologically healthy workplace. Company leadership and other work design factors have an effect on the health of employees and their work performance.
- Companies may need to create or revise their workplace policies concerning stigma, discrimination and develop methods to better educate employees, supervisors, and leadership about mental disorders. Increasing contact between employees and those successfully coping with mental health disorders is one effective means of reducing stigma.
- Employer benchmarking studies reveal that the majority of employers in Canada and the US are not embracing mental disorder prevention and return to work accommodation best practices for mental disability. However, there is progress being made at some organizations and signs of hope as many positive steps are being taken at national levels.
- Profiles of leading edge employers offer some practical examples of how companies can better address mental disorders and disability.

*A core pillar to an effective health and productivity program is a focus on keeping healthy people healthy.*

– Watson Wyatt/National Business Group on Health  
(2009, p. 27)<sup>14</sup>

## SECTION 5: TOOLKIT

# Resources for Employers

## 5.1 Employer Guides

Several guides that provide practical tips and management advice on return to work and accommodation practices for employees with mental health disabilities are available to employers. In this section we describe the best of these evidence-based guides. **Table 6** contains details on how to obtain these guides (information is accurate at the time of the printing of this report).

### 5.1.1 Canada

Four guides from Canadian sources are reviewed below.

**Canadian Mental Health Association.** A comprehensive employer guide from Mental Health Works of the Canadian Mental Health Association was published in 2007. The 59-page report is called *Workplace Resource: Complex Issues. Clear Solutions*. The guide has chapters on workplace accommodations, management of return to work, and employer strategies. It also reviews training and other relevant services for workplace mental health issues.

**Canadian Human Rights Commission.** In 2008, the commission released the 24-page report *Policy and Procedures on Accommodation of Mental Illness*. It is the actual internal policy of the Canadian Human Rights Commission on this topic and is offered to other organizations and employers as a model they can adapt for their own use. The document contains examples of how to describe the policy, how to address workplace aspects of mental health disability claims and return to work, and information about specific roles and responsibilities of leadership, supervisors, unions, and employees.

**Canadian Psychiatric Research Foundation.** In 2007, the Canadian Psychiatric Research Foundation published *When Something's Wrong: Strategies for the Workplace*. This 181-page guide has chapters on managing disability leave and return to work, providing workplace accommodations, and accessing and evaluating services for these areas.

**Institute for Work & Health.** In 2009, the Toronto-based Institute for Work & Health published the report *Red Flags/Green Lights: A Guide to Identifying and Solving Return-to-Work Problems*. Although the report covers a variety of medical problems it includes a section devoted to depression and other mental disorders. It describes several “Red Flags” or warning signs that a worker might not be recovering or progressing through the Return To Work process as expected. These flags include employee fatigue, mental distress, and problems at home. It also presents “Green Lights” or suggestions for practices to improve a worker’s recovery, including:

- Acknowledging the difficulties the employee is experiencing;
- Making referrals to supportive services;
- Providing information about accommodations to the employee and coworkers; And,
- Encouraging others to offer support to the employee.

### 5.1.2 United States

Three guides from American sources are reviewed below.

**Job Accommodation Network.** The Job Accommodation Network is a university-based service of the Office of Disability Employment Policy of the US Department of Labor. Released in 2008 as part their Accommodation and Compliance Series, *Employees with Mental Health Impairments* is a 15-page report. After first defining various mental health impairments, the report lists many practical examples for employers that focus on how to accommodate employees with these issues.

**National Business Group on Health/Center for Prevention and Health Services.** The 2005 *Employer's Guide to Behavioral Health Services* is a major resource for businesses in the United States that was created from a blue-ribbon panel of experts and based on interviews with

industry sources and review of the research literature. Many different topics are examined in the 100-page report related to mental health disorders, substance abuse disorders, their interaction with other health problems and their use and cost patterns in health care benefits in the US. It also contains a section that specifically offers some recommendations to employers on how to improve the management of mental disorders that qualify for disability benefits.

**Partnership for Workplace Mental Health.** In 2005, the *Partnership* convened a panel of experts from a variety of psychiatric treatment, research, benefits, government and employer sectors to develop a comprehensive psychiatric disability prevention, management, and return to work program. The results of the group's work is the 29-page report *Assessing and Treating Psychiatric Occupational Disability: New Behavioral Health Functional Tools Facilitate Return to Work*.<sup>1</sup> The report makes recommendations for major phases of the disability course: pre-disability, active disability, recovery and return to work, and training and education.

## 5.2 Resource Reports and Organizations

In addition to the employer guides there are many other kinds of resources for employers on return to work and accommodation practices for employees with mental disabilities. **Table 7** lists a selection of reports written for business leaders. Almost all of these reports are available at no cost online from the website listed for each report. Many of the featured reports are supported by organizations that are devoted to mental disability and to workplace mental health in general and thus many other resources are also available at their websites.

Finally, **Table 8** provides a list of some of the leading organizations from Canada and the US that offer information, resources, and in some cases, services for employers and organizations.

### TABLE 6: EMPLOYER GUIDES

#### CANADA

*Complex Issues. Clear Solutions. A Comprehensive Resource Guide for Managing the Productivity and Performance of Employees Returning to Work from a Mental Disability Leave.* Mental Health Works. Canadian Mental Health Association. <http://cprf.ca/publication/order.html>

*Policy and Procedures on Accommodation of Mental Illness.* Canadian Human Rights Commission. [www.chrc-ccdp.ca/pdf/policy\\_mental\\_illness\\_en.pdf](http://www.chrc-ccdp.ca/pdf/policy_mental_illness_en.pdf)

*Red Flags/Green Lights: A Guide to Identifying and Solving Return to Work Problems.* Institute for Work & Health. [www.iwh.on.ca/rtw-problems-guide](http://www.iwh.on.ca/rtw-problems-guide)

*When Something's Wrong: Strategies for the Workplace.* Canadian Psychiatric Research Foundation. [www.cprf.ca](http://www.cprf.ca)

#### UNITED STATES

*An Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating, Designing and Implementing Behavioral Health Services.* National Business Group on Health/Center for Prevention and Health Services. [www.businessgrouphealth.org/publications/index.cfm](http://www.businessgrouphealth.org/publications/index.cfm)

*Assessing and Treating Psychiatric Occupational Disability: New Behavioral Health Functional Tools Facilitate Return to Work.* American Psychiatric Association/Partnership for Workplace Mental Health. [www.workplacementalhealth.org/employer\\_resources/index.aspx](http://www.workplacementalhealth.org/employer_resources/index.aspx)

*Employees with Mental Health Impairments.* Job Accommodation Network/US Department of Labor's Office of Disability Employment Policy. [www.jan.wvu.edu/media/Psychiatric.html](http://www.jan.wvu.edu/media/Psychiatric.html)

**TABLE 7: RESOURCE REPORTS****CANADA**

*Depression and Work Function: Bridging the Gap between Mental Health Care and the Workplace.* Depression in the Workplace Collaborative.

[www.carmha.ca/publications/index.cfm](http://www.carmha.ca/publications/index.cfm)

*Duty to Accommodate: Frequently Asked Questions.* Canada Human Rights Commission.

[www.chrc-ccdp.ca/pdf/dta\\_faq\\_en.pdf](http://www.chrc-ccdp.ca/pdf/dta_faq_en.pdf)

*Employment: Making It Work.* CrossCurrents: The Journal of Addiction and Mental Health, 2009, Volume 13, Issue 1. [Special Issue]. [www.camh.net/Publications/Cross\\_Currents](http://www.camh.net/Publications/Cross_Currents)

*Environmental Scan on Workplace Health in Canada.* Health Canada.

[www.hc-sc.gc.ca/ewh-semt/pubs/occup-travail/env\\_scan-balayage\\_eco/index-eng.php](http://www.hc-sc.gc.ca/ewh-semt/pubs/occup-travail/env_scan-balayage_eco/index-eng.php)

*Interacting with Persons Who Have a Disability: Tips on Interacting with People in a Manner that Best Accommodates Their Disability.* ARCH Disability Law Centre. [www.archdisabilitylaw.ca](http://www.archdisabilitylaw.ca)

*Navigating Workplace Disability Insurance: Helping People with Mental Illness Find the Way.* Canadian Mental Health Association. [www.cmha.bc.ca/files/wi-report.pdf](http://www.cmha.bc.ca/files/wi-report.pdf)

*Return to Work Plans.* Workplace Safety and Insurance Board Ontario.

[www.wsib.on.ca/wsib/wsibsite.nsf/Public/employersrtwplans](http://www.wsib.on.ca/wsib/wsibsite.nsf/Public/employersrtwplans)

*Stigma Research and Anti-Stigma Programs: From the Point of View of the People Who Live with Stigma and Discrimination Every Day.* Mood Disorders Society of Canada.

[www.mooddisorderscanada.ca](http://www.mooddisorderscanada.ca)

*Stress at Work, Mental Injury and the Law in Canada: A Discussion Paper for the Mental Health Commission of Canada.* Mental Health Commission of Canada.

[www.mentalhealthcommission.ca](http://www.mentalhealthcommission.ca)

*Ten Tips for Returning Workers With Depression.* Back to Work/Occupational Health Services Canada.

[www.machc.org/documents/13-Ten%20tips.pdf](http://www.machc.org/documents/13-Ten%20tips.pdf)

*The Road Ahead: Employment, The Economy and Workplace Mental Health.* Network (Canadian Mental Health Association), 2009, Spring, Volume 25, Issue 1. [Special Issue].

[www.ontario.cmha.ca/admin\\_ver2/maps/network\\_25-1\\_spring\\_2009.pdf](http://www.ontario.cmha.ca/admin_ver2/maps/network_25-1_spring_2009.pdf)

*Workplaces.* Visions: BC's Mental Health and Addictions Journal, 2009, Volume 5, Issue 3. [Special Issue].

[www.cmha.bc.ca/resources/visions/workplaces](http://www.cmha.bc.ca/resources/visions/workplaces)

**UNITED STATES**

*AAPL Practice Guideline for the Forensic Evaluation of Psychiatric Disability.* Journal of the American Academy of Psychiatry Law, 2009, 36 (4 Suppl), S3-S50.

[http://peterash.com/pdf/AAPL\\_competence\\_guideline.pdf](http://peterash.com/pdf/AAPL_competence_guideline.pdf)

*Assessment of Employees with Mental Health Disabilities for Workplace Accommodations: Case Reports.* Professional Psychology: Research and Practice, 2001, 32(4), 380-385.

<http://psycnet.apa.org/index.cfm?fa=browsePA.volumes&jcode=pro>

*Preventing Needless Work Disability by Helping People Stay Employed: ACOEM Guide to Return to Work.* American College of Occupational and Environmental Medicine.

[www.webility.md/pdfs/ACOEM-SAW-RTW-Guideline-2007-06-19.pdf](http://www.webility.md/pdfs/ACOEM-SAW-RTW-Guideline-2007-06-19.pdf)

*Psychiatric Disabilities and the ADA.* Equal Employment Opportunities Commission (EEOC).

[www.eeoc.gov/policy/docs/psych.html](http://www.eeoc.gov/policy/docs/psych.html)

*The Management of Workplace Mental Health Issues and Appropriate Disability Prevention Strategies.* Work Loss Data Institute. [www.worklossdata.com](http://www.worklossdata.com)

*What Accommodations Work On The Job?* Boston University Center for Psychiatric Rehabilitation.

[www.bu.edu/cpr/reasaccom/employ-accom.html](http://www.bu.edu/cpr/reasaccom/employ-accom.html)

**TABLE 8: RESOURCE ORGANIZATIONS****CANADA**

ARCH Disability Law: [www.archdisabilitylaw.ca](http://www.archdisabilitylaw.ca)  
 BC Business and Economic Roundtable on Mental Health (Vancouver): [www.bcmentalhealthworks.ca](http://www.bcmentalhealthworks.ca)  
 Canadian Alliance for Mental Health and Mental Illness: [www.camimh.ca](http://www.camimh.ca)  
 Canadian Centre for Occupational Health and Safety: [www.ccohs.ca](http://www.ccohs.ca)  
 Canadian Council on Rehabilitation and Work: [www.ccrw.org](http://www.ccrw.org)  
 Canadian Human Rights Commission: [www.chrc-ccdp.ca](http://www.chrc-ccdp.ca)  
 Center for Applied Research in Mental Health and Addiction: [www.carmha.ca](http://www.carmha.ca)  
 Consortium for Organizational Mental Healthcare: [www.comh.ca](http://www.comh.ca)  
 Disability-Related Policy in Canada: [www.disabilitypolicy.ca](http://www.disabilitypolicy.ca)  
 Guarding Minds @ Work: [www.guardingmindsatwork.ca](http://www.guardingmindsatwork.ca)  
 Global and Business Economic Roundtable on Addictions and Mental Health: [www.mentalhealthroundtable.ca](http://www.mentalhealthroundtable.ca)  
 Mental Health Commission of Canada: [www.mentalhealthcommission.ca](http://www.mentalhealthcommission.ca)  
 Mental Health Works: [www.mentalhealthworks.ca](http://www.mentalhealthworks.ca)  
 Mood Disorders Society of Canada: [www.mooddisorderscanada.ca](http://www.mooddisorderscanada.ca)  
 National Institute of Disability Management and Research: [www.nidmar.ca](http://www.nidmar.ca)

**UNITED STATES / UNITED KINGDOM**

Center of International Rehabilitation: [www.cirrie.buffalo.edu](http://www.cirrie.buffalo.edu)  
 Centre for Psychiatric Rehabilitation: [www.bu.edu/cpr/](http://www.bu.edu/cpr/)  
 Dartmouth Psychiatric Research Center: <http://dms.dartmouth.edu/prc/>  
 Disability Management Employers Coalition: [www.dmec.org](http://www.dmec.org)  
 Employers' Forum on Disability (UK): [www.employers-forum.co.uk](http://www.employers-forum.co.uk)  
 Employment and Disability Institute (Cornell University): [www.ilr.cornell.edu/edi](http://www.ilr.cornell.edu/edi)  
 Global Applied Disability Research and Information Network on Employment and Training (GLADNET): [www.gladnet.org](http://www.gladnet.org)  
 Harvard Law School Project on Disability: [www.hpod.org](http://www.hpod.org)  
 Health Safety Executive (UK): [www.hse.gov.uk/sicknessabsence/index.htm](http://www.hse.gov.uk/sicknessabsence/index.htm)  
 Job Accommodation Network: [www.jan.wvu.edu](http://www.jan.wvu.edu)  
 Mid-America Coalition on Healthcare (Kansas City Community Initiative on Depression): [www.machc.org](http://www.machc.org)  
 President's New Freedom Commission on Mental Health: [www.mentalhealthcommission.gov](http://www.mentalhealthcommission.gov)  
 Sainsbury Center: [www.scmh.org.uk/employment](http://www.scmh.org.uk/employment)  
 Scottish Development Center for Mental Health: [www.sdcmh.org.uk](http://www.sdcmh.org.uk)

*Many people living with mental health problems and illnesses will need specialized services, treatments, or supports to help them to achieve a better quality of life; but, at the core, when it comes to mental health and well-being, we are all the same—whether we are currently experiencing a mental health problem or illness or not. There is no us and them.*

– Mental Health Commission of Canada  
(2009, p. 13)<sup>15</sup>

## Final Statement

As mental disability claims continue to rise, it is increasingly recognized that most of these cases can be helped back to work. However, successful Return To Work is typically dependent on the coordinated action of stakeholders, appropriate psychological (and sometimes medical) treatment, reasonable accommodation practices, and supportive workplace practices free of stigma and discrimination. Additionally, mental disability presents unique challenges for different industries, different kinds of positions, and different sizes of organization.

When considering the research findings and case study experiences from the past decade, valuable lessons have been learned that can guide employers to respond more effectively to employees on disability leave for mental disorders. Some recommended action steps for employers include:

1. Employers should establish ways for identifying at-risk employees and encouraging early treatment while they are still at work;
2. Employers should intervene early in an employee's disability absence and maintain regular, caring contact with the employee;
3. Mental health should be a consideration in all cases of disability, not just those explicitly labeled as resulting from a mental disorder cause;
4. Employers should arrange the benefits design to support a requirement of the use of a mental healthcare specialist for evaluation and/or treatment. This specialist should be cognizant of the employer-employee relationship as it pertains to understanding the presenting problem(s) and establishing treatment goals;

5. Employers should require a comprehensive treatment plan be established for all employees with a mental disability. The treatment plan should address the preservation or improvement of work function and include repeated use of clinical tools that provide an objective assessment of the scope, range, and severity of the functional impairment.
6. Employers should use a team-based approach for managing return to work. Teams can be formal or informal and should include the employee and treating physician(s), employer, EFAP, and health and disability plan representatives;
7. If EFAP services are available, employers should define their policies so that employees on disability for a mental disorder are referred for individual and family support and assistance with return to work accommodations; And,
8. Employers should develop a more proactive and integrated approach for managing mental disability that emphasizes opportunities for prevention.

In the end, it is important to **keep the focus on the person—not the disability**. Workplace accommodation is about increasing the ability of a person suffering from a mental disorder to get back to work and contribute again to the workplace and to the community.

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