

***EMPLOYERS GETTING STARTED***  
***On the Road to Mental Health and Productivity***

**MODULE SEVEN**

**MEDICAL AFFIRMATION PROCESS (MAP)  
TEAMWORK TO MANAGE MENTAL DISABILITY**

**Highlights**

**Module Seven Introduces a Medical Affirmation Process (MAP) to Manage the Front End of Mental Disability More Effectively.**

MAP identifies critical transitions for employees in the onset and recovery/return to work from mental disorders:

- Onset of symptoms, work decline
- Time on and off work without appropriate care
- Onset of disability and disability leave
- Absence from work and isolation at home
- Recovery and clearance to return to work
- Process of actually getting back on the job

*Each transition is problematic – and each should be managed as a distinctive phase of the employee’s departure, recovery and return to work.*

MAP describes the steps that treating and consulting physicians should take in creating the collaborative process needed to make gains at the front end of the disability period.

**Special Report: Specialized Disability Management for Complex Cases**

This special report was prepared especially for this Business and Economic Plan for Mental Health and Productivity by –

- Dr. Stanley Dermer, Occupational Psychiatric Consultant
- Dr. Sarah VanderBerg, Lead Medical Director, RBC Insurance
- Diane Westcott, Director of Wellness, Ontario Power Generation

The approach described in this Special Report stipulates an employee-centred approach in complex cases which may represent 15-20% of all short-term disability but 80% of disability management.

A mental health consultation/liaison team would serve as a vehicle for improving outcomes. The model is exciting in concept and merits evaluation.

“MAP” is a concept which tries to “aggregate” the various features of teamwork to produce better results at the front end of the disability management process. MAP is an expression of Shared Care.

#### MAP Objectives:

1. To improve the capacity of primary physicians to diagnose and treat mental disorders.
2. To improve substantially the prospects of employee-patients recovering and returning to work sooner.
3. On the merits, to reduce the need for costly independent medical evaluations in the process of managing mental disabilities at work.
4. To not offend the administration of the Canada Health Act.

#### Issues

***Only one in five Canadians receives adequate care for mental disorders.***

- Canada will never have enough psychiatrists. Primary care physicians are key.

*Family practitioners are not adequately trained to diagnose and treat mental illness and typically the referral time to see psychiatrists is months not weeks. Conditions corrode.*

- The shared care model of supporting family physicians is an opportunity-in-waiting to deal with this conundrum.

*Employee-patients navigate four critical transitions in the onset and recovery from mental disability:*

- Onset of symptoms, declining work performance; time on and off work without appropriate care; disability leave, recovery and return-to-work.

*Each transition is problematic.*

- One, coping with symptoms, not getting help; two, loss of self-confidence, relationships suffer; three, isolation, delay and confusion and four, uncertain performance period up to six months.

#### MAP: Fresh Take on a Thorny Old Problem

MAP offers the family physician the support of shared care from a workplace base – funded by employer at the front-end of managing the disabling effects of mental disorders – specifically, depression and anxiety.

MAP entails:

- Physician-to-physician consultations between the treating family physician (whose services are publicly-insured) and consulting occupational physician/psychiatrists (whose services are paid by employers).

Through MAP, the treating and consulting physicians:

- Review and affirm the diagnosis and treatment plan prescribed by the treating physician.
- Inform employers and insurers of this fact – that the diagnosis and treatment plan are correct and will be monitored appropriately.

In this manner, the parties – employers, insurers and employees – are unified by good information at the front-end of the disability leave.

The consulting physician:

- Like the treating physician, is bound – as a physician – to the recovery interests of the employee-patient and, within that stricture, keeps employers and insurers duly informed.
- Advises the treating physician on the occupational aspects of recovery and consults the treating physician on restrictions and timing for the return to work.

MAP is a new take on an existing idea – that is, third party payers and consulting physicians as in the practice of commissioning independent medical evaluations.

The IME has inherent weaknesses as a means of enhancing the recovery and return to work prospects of employee-patients:

- First, it is downstream, after-the-fact and does nothing to produce actual treatment capacity in the health care system.
- Second, it can be redundant and adversarial, forcing rebuttals by treating physicians and leaving the insurers or employers in the position of sorting out the deadlock.
- Third, IME's are over-used and often without rhyme or reason. When an employee is cleared to return to work by a treating physician, IMEs are not called for unless there is a concrete conflict of professionally-informed opinion at hand.

IMEs are valid when 1) the recovery of the employee-patient is lagging; 2) the treatment plan isn't working; 3) or the employee is resisting the doctor's advice to return to work.

Each transition is problematic.

- One, coping with symptoms, not getting help; two, loss of self-confidence, relationships suffer; three; isolation, delay and confusion; four, possible relapse and re-RTW.

Specifically what functions the employee performs, patterns of absence or downtime, say, over the past 30 days, and the pace, dynamics and history of the work environment in which the employee routinely functions.

The amount of interpersonal exchange, planning skills, attention to critical detail and the pace of work which characterizes the employee's duties.

This helps the physician make a judgment – in the face of the employee's illness – as to what considerations or accommodations might be necessary to assist in bringing that employee back to work.

In California, for example, psychiatrists are expected to address the employee's ability in areas such as:

- Understanding and following instructions.
- Performing simple and repetitive tasks.
- Maintaining a work pace appropriate to the word load.
- Relating to other people beyond giving and receiving instructions.
- Influencing others, accepting instructions, planning.

### **Proposed Workplace Mental Health Model Based on Shared Care Principles**

Shared care is not a new idea. It is designed to improve the capacity of family physicians in the primary care system to provide effective diagnosis and treatment of mental illnesses.

The assumption behind this: will have a better chance to reduce waiting lists for mental health care by turning to the primary care system to treat serious but common conditions including depression, anxiety disorders and substance abuse.

#### ***Dr. David Goldbloom, Centre for Addiction and Mental Health***

*“The access issue is not simply producing hundreds more psychiatrists. The problem stems from primary care and how we reorganize this to ensure people with mental illness get the same treatment as people with physical illnesses.*

*“Psychiatrists are an important component in a larger system of mental health care but system reform at the primary level is called for – from community agencies, hospitals, multi-disciplinary primary care as well as specialty care.”*

Dr. Goldbloom's thinking is reflected in the concept of shared or collaborative care which has gained traction in both Canada and the United States.

Therefore, the Roundtable proposes discussions with government, insurers, employers and physicians to explore the concept of a workplace mental health system based on shared care principles.

### **Part One: Supporting Public Primary Care**

This model would bring together:

- Family (primary care) physicians whose fees are paid by the public health insurance system (Medicare) in each province consistent with the Canada Health Act; these physicians treat employees and their families.
- Consulting psychiatrists and occupational physicians whose fees would be paid by employers to make this expertise available to family physicians in the diagnosis, treatment and maintenance care of employees with depression et al.

### **Part Two: Promoting Dual Diagnosis and Treatment**

The prevalence of depressive disorders among people being treated for other things in the primary care system is nearly twice that of the population at large.  
(*Canadian Psychiatric Association Bulletin, 2002*)

International studies say that 25% of heart patients also have depression. Among those with a recent heart attack, it is 20%. Depression is now an independent risk factor for sudden death from a heart attack.

The reasons for this are not known. There are strong suggestions now that depression causes a physical response which is detrimental to the heart, blood vessels and platelets.

There is also increased risk of blood clotting and reduced heart rate variability. The heart of a depressed person seldom sleeps.

Studies indicate about 25% of cancer patients develop clinical depression and this can impede recovery. Cancer patients with depression have an increased risk of suicide.

About half of those with Parkinson's disease, in one study, were found to suffer depression and this impairs memory, language and motor functions.

About half of depressive episodes in patients with medical illness are not accurately diagnosed and, in one estimate, a third of all patients in Ontario hospitals have untreated addiction problems.

Canada is a leader in cardiac psychiatry and psychiatric cardiology. The importance of diagnosing and treating concurrent disorders is obvious.

But it is not done as a rule and the subject is absent from the wellness, group health and disability management regimes among most if not all employers.

Therefore, it is appropriate and timely to raise the profile of concurrent disorders in the workplace and to take steps to promote their recognition, diagnosis and treatment.

To that end, this Workplace Mental Health Model extends the Shared Care concept to the dual diagnosis of co-occurring disorders:

- Family physicians with assistance, as required, to secure the advice of physicians with specialized knowledge in the field of co-morbidity – that is, co-occurring conditions such as depression and heart disease.
- This additional expertise would become available in the normal course of a patient referral – however – if this was not possible due to waiting lists:
- The specialist physician would be retained by employers as part of the workplace model to offer advice to the treating physician on the diagnosis and treatment of these especially complex and dangerous cases.

*BC family physician Dr. Anthony Ocana has proposed special training for family physicians to handle concurrent disorders. This has great merit.*

### **Part Three: Guarding Against Migration from STD to LTD**

At a BC Roundtable meeting, Dr. Ocana also proposed setting up a special provision to protect mental health patients on short-term disability from gravitating into long-term disability by default of inadequate care.

The Roundtable endorses this and as part three of the proposed Workplace Mental Health Model, we visualize:

- Designation of a “risks safety zone” for cases after six months off work – before STD benefits are discontinued or LTD entry process begins. This would set into motion specific, extraordinary measures to avoid LTD.

These measures to include:

- STD benefits are continued. The LTD process, frozen – pending:
- Complete re-assessment of the complex case including the employee’s medical condition, the current and past treatment plan, the employee’s compliance record, home and workplace issues.

In effect, when the disability leave passes six months, the employee would enter what we might call a “risk safety zone” which, in turn, would run up to three months before any of the parties could trigger LTD proceedings.

This would have the benefit of heading off LTD and creating a shared responsibility on the part of all concerned to achieve this end:

- Re-energize the recovery and return to work process within the bounds of medical possibility and integrity and –
- Best case, prevent cases from being dragged into LTD by inadequate care and/or patient motivation and –
- Worst case, create a less adversarial way to determine whether equitable severance is preferable to LTD for both the employee and employer
- And more lead time to build a better LTD plan if this is necessary after all.

We note that:

- The development and acceptance of this extraordinary pre-LTD measure would require leadership from a handful of large employers in partnership with the insurance industry and physician community – leading to:
- Formation of a study, design and implementation team drawn from these areas to figure out how the extraordinary pre-LTD process would work. Some questions are obvious:
  1. Is it necessary in the first place? The Roundtable believes so and certainly the process of asking and answering that question will be enlightening for all concerned. There is value in that.
  2. What qualifications are needed by the individual who will conduct the extraordinary pre-LTD experience? Will the process be a natural extension of well-established case management? Case managers certainly share the goal.
  3. Consultation with government is necessary to ensure the concept is understood and consistent with CHA.

#### **Part Four: Shared Responsibility**

The principle of shared responsibility centres on the employer, employee, health professional, insurer and government – the last in providing publicly-funded “medically” necessary services. Each party has a role to play in preventing and managing mental disabilities.

Let us remind ourselves of these facts:

- The comparative costs of treating depression et al are less than the costs of production losses which unchecked mental disorders cause. Therefore, there are economic grounds for shared investments and shared returns.
- Key to a successful return to work process is the understanding that the reduction of work impairments – “I’m feeling OK to go back” – lag the actual reduction of symptoms – “I may have gone back too soon.”
- Therefore, relapse planning should take into account these risks and, on top of that, ensure that the return to work is gradual, well-planned and sensitively-managed. A shared duty.

*“Good health,” former Health Minister Marc Lalonde told us 30 years ago, “is the bedrock on which societal progress is built. A population of healthy people can do things that make life worthwhile.”*

*And he said: “The health care system is only one way of maintaining and improving health. Of greater importance is raising the general standard of living and advances in medical science.”*

### **Part Five: Proposed Course of Study for Employers, Employees and Insurers:** **The Physics of Mental Health**

Understanding mental health for what it is/isn’t will help us tap into the productivity capacity and energy of the workforce which, as Mr. Lalonde prescribes, has more to do with health than health care.

This also means being honest with ourselves.

The impact of persistently late and poor diagnosis is, in part, a function of deeply-rooted scepticism among managers and co-workers whose stigmatizing view of mental illnesses may prevent employees from reaching out.

One of the myths of mental illnesses is that it is invisible, not concrete, not physical, not real. Employers, employees, insurers, physicians and health professionals share a responsibility to get past these notions and in doing so:

- Promote earlier detection, more effective treatments and a more routine acceptance that mental illnesses are part of being human.

The following “physics course” on mental health is simply to help us understand that the reality of mental illnesses has physical properties and consequences, that it is about brain function. So, let’s get physical – about mental health.



***Back pain: yes, it's all in your head – that's where your brain is.***

In 2003, Statistics Canada reported that half of the people who met the criteria for depression reported physical symptoms. In fact, physical pain is the ancient unwritten, common language – the lingua franca – for distress in our society.

As long as the stigma of mental illnesses abounds, people will go to their family physicians with belly aches, back pain, chronic headaches and a variety of other physical markers that act as screens for mental illnesses.

Is the pain imagined? It is not. Pain is mediated by the brain. Those who are isolated at home, away from work and friends – and even family – develop greater sensitivity to their physical discomforts. The brain's filtering-out process is reduced.

Someone injured in a car accident may develop secondary depression which can amplify their physical pain. In reverse, depression going untreated or even undiagnosed for three months can spill over into physical symptoms.

### **Part Six: Employers, Insurers and Case Managers Understanding the Objective Scientific and Clinical Nature of Diagnosing Mental Illnesses**

Some think that the diagnosis of mental disorders is a subjective exercise by doctors.

This view is held by some in the insurance sector, among some HR managers. It implies the condition is based solely on what the employee tells the physician who “takes the order” and writes the script.

**CAMH's Dr. David Goldbloom:** *“All diagnosis in medicine is based on pattern recognition and the pattern of depression is as reliable as would be the pattern for most physical diseases throughout medicine.”*

Even the authors of the diagnostic bible – DSM-IV – concede the confusion between physical and mental disorders. In its preamble, the standards manual says:

*“The term “mental disorders” unfortunately implies a distinction between mental disorders and physical disorders. When, in fact, there is compelling evidence that there is much that is physical in mental disorders and much that is mental in physical disorders.”*

A judge in the U.S. agreed that bipolar disorder could be classified as a physical disease. And if that is true, then diagnosing mental illnesses, as Dr. Goldbloom says, is like diagnosing physical disorders.

There is another distinction to observe between what is subjective and what is objective.

### Physician is Objective

Physicians should and can make objective diagnoses based on the recognition of patterns – as Dr. Goldbloom noted – as well as scientific and clinical evidence.

Studies tell us that clinical judgments also involve value judgments and “rules of thumb,” just like any other decision-making process led by human beings.

It is said therapeutic treatment involves an assessment of risk through which physicians specify the target. In treating depression, “return to work” is appropriately a desired outcome of treatment and thus part of the recovery process.

Dr. Walter Rosser, ex-chairman of Family Medicine at the University of Toronto, says “evidence-based medicine requires clinical knowledge, communication skills, patience and commitment to help patients make informed choices.”

The diagnosis of mental disorders, like physical disorders, involves science, judgment and knowledge. Depression is visible on brain-imaging screens, so we know its there. That said, there is no blood test.

### Employees Can Be Subjective

Meanwhile, the employee’s view of his or her condition or desire to return to work is subjective. Which is natural. We are all human beings. Subjective creatures.

Recovery and return to work can be influenced by many factors outside the realm of diagnosis and treatment – workplace relationships being one. This can delay or deter getting back to work.

That said, the information which employees (patients) give physicians – in the office or in surveys – has proven to be reliable as a basis for diagnosis and treatment even compared to so-called “objective” criteria.

### Managers Can Be Subjective

That said, subjective thinking has another source and influence – the perceptions and attitudes of managers and it is important for all of us to get beyond the notion that mental illnesses are invisible and that diagnosis is guesswork.

### **Postscript**

We need new thinking. And to that end, the Roundtable received the benefit of a Mental Health Collaborative Team Model which may effectively meet the needs of employers and employees reflected in the foregoing text.

## SPECIAL REPORT

### **Employee Centered Mental Health Consultation – Liaison Specialized Disability Management for Complex Cases**

Prepared for the Roundtable  
by

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*Complex cases (often entailing a mental health diagnosis) are said to represent 15 – 20% of cases on short term disability, yet take 80% of the disability management time.*

*A specialized approach employing a Mental Health Consultation – Liaison Team is a means of obtaining improved outcomes.*

*Characteristic employee profiles warranting the label ‘complex case’ may include:*

- *Repeated and progressively longer major absences*
- *Prolonged absence, no evidence of sufficient impairment to warrant total disability, often a diagnosis of “stress leave”*
- *Multiple medical and psychiatric diagnostic co-morbidity*
- *No identifiable proactive health practitioner and/or lack of adequate clinical treatment and/or progress*
- *A history of work performance issues and/or conflict with peers/supervisors*
- *Poor employee work satisfaction or “doing pensionable time”*
- *Previously unknown longstanding psychosocial difficulties prior to being hired*
- *Lack of clarity as to the extent to which the underlying problems are health related or symptomatic of work issues*

*Conditions driving the need for a specialized team approach consist of:*

1. *The lack of timely access to psychiatric resources in the community*
2. *Incomplete assessment of presenting problems*
3. *Poor coordination and monitoring of the required interventions*

*This collaborative Consultation – Liaison Team approach can provide any one or all of these services:*

1. *Review of files (group discussion or paper review)*
2. *Liaison with stakeholders (family physician; other health professionals; union representatives; supervisors; human resources; labour relations)*
3. *Gathering of information and implementation of a path forward*
4. *Interviewing<sup>1</sup> of employee and, if necessary, significant others*
5. *Monitoring/reassessment of path forward to maximum medical recovery, including provision of support and direction to the attending family physician*

*To obtain resolution of these cases, the following tasks need to be completed on an intensive basis.*

*① Comprehensive data must be gathered regarding the employee's illness, performance and treatments received, etc.*

*This data must be ② analyzed in a bio-psychosocial context.*

*③ A path forward to maximum medical recovery needs to be implemented which leads to a return to work or access to an entitlement (LTD).*

*As these tasks are labour intensive and require a bio-psychosocial orientation, a multidisciplinary team is recommended. This entails the employer securing the services of a consulting psychiatrist, who, along with a nurse with mental health experience, will consult and advise the occupational physician or the employer's disability management coordinator.*

*The necessary condition for successful application of this model is collaboration, as opposed to an adversarial approach.*

*The latter is available under conventional disability management conditions using Independent Medical Evaluations (IMEs).*

*To receive assistance, employees must be willing to be transparent, including provision of authorized access to caregivers.*

*As well, cooperation amongst all stakeholders will be essential with an emphasis on facilitation of assessment and treatment, rather than exclusively on disability.*

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<sup>1</sup> In person or via video conferencing with employees who are geographically distant from the psychiatrist.

*The team will actively engage and provide support/direction by direct contact with the employee, if necessary, and any or all of the stakeholders, both within the company and in the community.*

*Videoconferencing can be utilized for employees who are geographically distant from the psychiatrist, to ensure timely access.*

*Implicit in this model is early intervention, (based on identification of “red flags”), to help ensure better outcomes. Over time, one can also expect that the Mental Health Consultation – Liaison Team can be made available to assist with the assessment and re-entry of employees returning from LTD, as well as being made available to employees at work suffering from presenteeism.*

*Health promotion and training of supervisors lie also in the scope of the potential service available from members of the Consultation – Liaison Team.*

*Although this model has yet to be rigorously evaluated, anecdotal experience would suggest a strong business case, with outcomes, such as, a reduced need for adversarial costs associated with use of IMEs or avoidable arbitrations.*

*Most importantly, employee health, morale and loyalty is enhanced when innocent absenteeism is addressed by the employer with a proactive approach, geared to enhancing facilitation of care and interventions.*