BACK TO WORK

Disability management and return-to-work strategies in Canada

NEW DM ASSOCIATION PROMOTES PROFESSIONAL CERTIFICATION

Canada has a new association for disability management professionals. Officially launched on February 24, the Canadian Society of Professionals in Disability Management (CSPDM) is an association for practitioners who have achieved their Certified Disability Management Professional (CDMP) or Certified Return to Work Co-ordinator (CRTWC) designation in Canada. The mandate of the Society is to promote the acceptance of the disability management profession nationally, as well as to assure the quality standards of the profession and to promote innovation within it.

"With the launch of CSPDM, Canada is once again taking a leadership role in the effort to minimize the socio-economic impact of disabling injuries and illnesses on employees and employers," says Abdou Saouab, chair of the new Society and the manager for disability research and knowledge development in the Office for Disability Issues within Human Resources and Social Development Canada. "The development of this new organization, with its focus on quality standards, must be seen in the same context of providing quality assurance as in other health and public policy fields, where maintenance of professional knowledge, skills and competency standards are critical for society at large." Indeed, he hopes that within 10 years, the CDMP and CRTWC disability management designations are as recognized as the CA, CGA and CMA accountant designations.

The new association has its roots in the International Disability Management Standards Council. The Council was established in 2003 to oversee the global certification process for the two professional designations and the global administration of the Consensus Based Disability Management Audit (all of which Canada had a big hand in developing through the National Institute of Disability Management and Research).

As of December 2005, the Council included representatives from Australia, Austria, Canada, Germany, Ireland, Singapore, Switzerland and the United Kingdom. These countries agreed that each would create its own national society responsible for developing the disability management profession within its borders. The process for establishing the Canadian society began late last year, culminating in the official launch this month.

Society includes 100 members

All disability management practitioners certified in Canada automatically become active members of the Society. Following the most recent certification examinations held last May, about 70 people now have their CDMP designation and another 30 their CRTWC designation. The Society also includes student members who are currently enrolled in a recognized formal disability management education program, honourary members who may be appointed from time to time and retired professional members.

The Society promises to raise the profile of the profession, ensure and improve professional standards, provide educational opportunities, offer opportunities for networking and sharing ideas, act as a national advocate for disability management and return to work, and collaborate nationally and internationally to share best practices and the latest research. Members get access to the Members Only section of the CSPDM website (which includes a discussion board, a membership contact list and access to the latest research and publications), discounts on Society-sponsored education events, current information on continuing education units and an e-newsletter.

In the meantime, the Canadian Association of Disability Management Co-ordinators (CADMC), which could be affected by the creation of a disability

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management organization with similar aims, is not saying much. According to CADMC president Clive Walton, the Association, which worked with NIDMAR on the development of the two professional designations, "will continue to support NIDMAR and all organizations that support consensus-based disability management." The CADMC differs most notably from the new organization in that its membership is open to all parties who practice disability management and abide by the Association's code of ethics, not just those with CDMP and CRTWC designations.

For more information on the new Society, visit www.cspdm.ca or contact Nancy Lee at nancy@cspdm.ca. •

RETIREMENT CHANGES WILL AFFECT DM AND ACCOMMODATION

Come December 12, 2006, mandatory retirement in Ontario will be prohibited and, in most situations, employers will not be legally allowed to compel an employee to retire at age 65. That may have implications for disability managers, whose role as the go-to person when it comes to accommodating functional impairments related to disabilities will expand to include accommodating functional impairments related to age – and they are not necessarily the same.

Ontario's Bill 211, the *Ending Mandatory Retirement Statute Law Amendment Act, 2005*, received Royal Assent on December 12, 2005. The bill includes a one-year delay before coming into effect in order to give employers time to adjust their workplace policies and practices. The bill essentially amends the definition of "age" in the province's *Human Rights Code* so that the prohibition against age-related discrimination in matters of employment, currently limited to those who are 18 to 64 years old, is extended to everyone 18 years and older.

Although employees will still be able to choose to retire at 65 and employers will still be able to offer early retirement incentive packages, employers will not be able to force employees to retire at age 65, as they are currently allowed to do. The only exception is if the employer can show an age-related rule is a *bona fide* occupational requirement. Of course, employers will still be able to dismiss older employees for the same reasons they can dismiss any employee: for cause or without cause upon giving notice or pay in lieu of notice.

Workplace disability managers should note some important exceptions to the application of Bill 211.

- The status quo with respect to **disability plans, life insurance plans** and **health benefit plans** will be maintained; that is, the provision of these benefits to workers aged 65 and older will continue to be at the employer's discretion. However, Marcel Théroux of Mercer Human Resource Consulting makes an interesting point. Writing in the firm's December 2005 *Communiqué*, Théroux comments that, "in the absence of adequate notice that [the employer will not be providing non-pension benefits to older employees], a failure to provide these benefits may be viewed as constructive dismissal of older employees."
- Similarly, the status quo with respect to **workers' compensation benefits** will be maintained. That is, workers aged 63 or more at the time of injury will continue to be entitled to receive up to two years of loss-of-earning benefits, while the benefits of workers under the age of 63 at the time of injury will still end at the age of 65. As well, as is provided for in the *Workplace Safety and Insurance Act*, an employer's obligation to re-employ will continue to end at age 65 because the Act is exempt from the Code's prohibition against age discrimination. Again, however, Théroux comments that the restrictions on workers' compensation benefits for older workers may mean "accidents suffered by older employees on the job will raise difficult legal issues."

Jason Mandlowitz, vice-president of consulting at the law firm *Hicks Morley*, says the application of the mandatory retirement legislation will "create challenges at a practical level," likely resulting in some "very interesting" legal outcomes. He suggests that companies take a close look at their performance management, attendance management and absence/disability management programs, all of which "will have to be reviewed and tweaked in the

context of the special needs of older workers," with an emphasis on ensuring consistency in their application and flexibility in their approach.

In its January 2006 *Client Update*, Hicks Morley says "employers can expect a significant increase in the number of requests for accommodation of special needs related to age and age-related disability." These requests will be increasingly complex, "involving conditions which are not reversible or curable and which will involve ongoing deterioration over time." (For tips on this subject, see "How to address the needs of the aging workforce," *Back To Work*, September 2004.)

For more information, visit www.labour.gov.on.ca, www.mercerhr.ca or www.hicksmorley.com. •

MANITOBA RESEARCH PROMISES TO DELIVER PRACTICAL DM TOOLS

A number of practical disability management tools should be available to employers and labour representatives in Manitoba as a result of the most recent research projects to be funded by the province's Workers Compensation Board.

The WCB announced its 2005 funding recipients on January 30, 2006. Among the 11 groups sharing nearly $1-million in 2005 research dollars are:

- the Canadian Auto Workers ($110,930), which will be providing educational sessions on disability management and return to work to all interested Manitoba workplaces, as well as developing a disability management manual tailored to Manitoba workplaces;
- the Manitoba Federation of Labour's Occupational Health Centre ($85,000), which will be determining the quality of life of workers with musculoskeletal injuries in return-to-work programs in order to help employers develop suitable modified work programs, culminating in workplace training and advice and a best practices resource guide that will be available in print, on CD and via the Internet; and
- National Disability & Resource Management Inc. ($165,150), which will be working with the WCB to help about 50 high-risk employers develop and implement return-to-work, disability management and injury prevention programs and, based upon the results, writing a report to help employers lower injury rates, return workers to employment and reduce overall costs.

For information on the funded projects or on 2006 funding priorities — and the deadline for the first stage of the 2006 application process is April 14, 2006 — visit www.wcb.mb.ca/whats_new/wcb_funds_prevention_projects_2006_priorities.html. •

HEADS UP: RTW CONSTRUCTION REGS COMING IN ONTARIO

Draft regulations setting out return-to-work and re-employment requirements for the construction sector under Ontario's *Workplace Safety and Insurance Act* are currently before the Minister of Labour for review and approval.

The draft regulations were developed by the Workplace Safety and Insurance Board after "extensive discussions" over several years with employer and labour representatives in the construction industry, says a Board spokesperson. The draft regulations have already been approved by the WSIB's board of directors

According to the spokesperson, the proposed regulations include different requirements than those set out in the Act for most other employers in the province, based "on the unique characteristics of the construction sector." If and when the regulations are approved — and a Ministry spokesperson could offer no timelines — the WSIB will engage employer and labour groups in developing the operational policies needed to administer the regulations.

In the meantime, the Employers' Advocacy Council is holding workshops across the province on claims management and return to work for construction employers that includes a review of the construction regulations. For information on the sessions, go to www.EACforEmployers.org. •

ONTARIO WSIB NAMES NEW LMR PROVIDERS

A new roster of labour market re-entry (LMR) providers has been named by Ontario's Workplace Safety and Insurance Board. The providers were the successful applicants following a request for proposals (RFP) issued by the Board last August. The RFP resulted in the total number of providers being reduced by about one-third. Effective February 27, the LMR providers include:

- Acclaim Ability Management (www.acclaimability.com);
- Cascade Disability Management (www.cascadedisability.com);
- Crawford Healthcare Management (www.crawfordandcompany.com/ca_home.html);
- NRCS (www.nrcs.ca);
- Ontario March of Dimes (www.dimes.on.ca);
- Rehabilitation Network Canada (rehabnetwork@on.aibn.com); and
- Sibley & Associates (www.sibley.ca).

LMR providers are called upon to help injured workers who, for various reasons, are unable to return to work with their injury employer. The LMR providers work with the injured workers to develop a plan for their return to the workforce. •

SUPERVISOR'S HARASSMENT ENDS IN MILLION-DOLLAR AWARD

A female RCMP officer who was sworn at, belittled and intimidated by her detachment commander has been awarded $950,000 to compensate for the harm and lost wages she suffered due to her resulting depression. **By Cindy Moser**

A former female member of the Royal Canadian Mounted Police (RCMP) has been awarded almost $1-million in damages because of her supervisor's "negligent infliction of mental suffering." The British Columbia Supreme Court found that her supervisor harassed her to such a degree that she became clinically depressed and felt compelled to accept a medical discharge from the RCMP.

In 1988, Nancy Sulz began working for the RCMP detachment in Merritt, B.C., as a general duty police officer. Her first six years there were largely uneventful. Under two different commanding officers, she received excellent evaluations. She was generally happy and well-adjusted.

That all changed in 1994 when Donald Smith became the new detachment commander. The details of the treatment to which Sulz was subjected are too much to include here, but, in brief, Sulz described events such as:

- being told to "open [her] fucking eyes and look at the book" after seeking help from Smith with respect to a light-duty auditing assignment she was given while pregnant;
- being told by one of Smith's subordinate supervisors that she had done something "stupid" and would have to "pay the price" after she went shopping in the U.S. without Smith's permission while on medical leave due to complications with her pregnancy;
- hearing rumours that Smith and his subordinate supervisors had made derogatory remarks about the trip in front of other staff members;
- getting a message from a detachment clerk shortly after the birth of her second baby to the effect that Smith said she better "get [her] ass down to the detachment" and sign the necessary forms if she wanted her paycheques;
- hearing that Smith did not like her because she could not "cut the mustard" and had no place in the RCMP; and

> "It is obvious that he did little to curb his temper or prevent the rumours that were circulating about [Sulz], even though he ought to have known … that he was causing serious emotional problems for [Sulz] at a time when she was facing significant personal pressures due to her pregnancies."

- learning that the auxiliary constables working at the detachment had been instructed not to ride with her because she was manipulative, afraid of the dark and needed to learn to stand on her own two feet.

In mid-1995, Sulz's physical and mental health had deteriorated so badly — she was 20 pounds underweight, unable to sleep and constantly on the verge of tears — that her attending physician advised her to go on sick leave, which she did. She then consulted a psychologist under contract with the RCMP who suggested she return to work on a part-time basis. Because she wanted to normalize her work situation, Sulz decided to go back full-time.

The return was not a pleasant experience for Sulz. She felt completely ostracized by Smith and others in the detachment. In February 1996, her doctor diagnosed her as having a major depressive disorder. As a result of tests routinely done before anti-depressants are prescribed, Sulz was shocked to learn she was pregnant again (due to a failed vasectomy). She went on maternity leave in September and did not return.

In May of the following year, a psychiatrist hired by the RCMP corroborated the depression diagnosis of Sulz's physician. At about the same time, the RCMP initiated an internal investigation into Sulz's allegations, which ultimately substantiated that she had been harassed by Smith. Although the report gave Sulz some sense of vindication, she remained depressed and on medical leave. No action was taken against Smith because he retired from the force in April 1998. In early 1999, still off work, Sulz agreed to a medical discharge, which came through in March 2000.

Province vicariously liable

Sulz successfully sued the province of B.C. for the "negligent infliction of mental suffering" on the grounds that it was vicariously liable for Smith's actions. Smith, as Sulz's commanding officer, owed her a duty of care, which included ensuring her a work environment free from harassment, as required by various RCMP policies.

There is no question that Smith breached this duty, the B.C. Supreme Court ruled. He should have known his intemperate and, at times, unreasonable behaviour would have negative consequences for Sulz.

"It is obvious that he did little to curb his temper or prevent the rumours that were circulating about [Sulz], even

though he ought to have known … that he was causing serious emotional problems for [Sulz] at a time when she was facing significant personal pressures due to her pregnancies," the court said. "His frequent outbursts and cutting comments were major causes of [Sulz's] troubled work environment."

Smith's actions definitely caused harm to Sulz. "Although there are many stresses in [Sulz's] life, and although she may tend to personalize incidents that others might not, the evidence as a whole shows that the harassment which she experienced in 1994 and 1995 was the proximate cause of her depression, which, in turn, ended her career in the RCMP," the court said.

The court awarded Sulz general damages of $125,000 because of the severe impact of her depression on her ability to work and enjoy life as a family and community member. It then added $225,000 for the wages lost from the time of her medical discharge until the time of the trial and another $600,000 for loss of future income, for a total award of $950,000.

It is worth noting that Sulz's claim of "intentional infliction of mental suffering" was unsuccessful. "Although [Smith's] manner was abrupt, demanding and unfeeling, his actions were consistent with his experience of the paramilitary command structure of the RCMP," the court said. "It is clear, especially in light of the establishment and dissemination of a specific harassment policy, that this command style was no longer appropriate in the modern RCMP. … [He] should have been more sensitive and aware of the negative effects of his actions. However, his conduct does not demonstrate wilful or reckless disregard for [Sulz's] mental health."

Source: *Sulz v. Canada (Attorney General)*, British Columbia Supreme Court, January 19, 2006. •

EMPLOYEE'S IME REFUSAL DOES NOT WARRANT DISCIPLINE

An employee was unjustly disciplined for twice refusing to attend an independent medical exam with a physician chosen by the employer. **By Susan Stanton**

An employer that thought it was okay to order a stressed employee to undergo an independent medical examination (IME) — and to apply discipline when he refused — has been set straight by a federal adjudicator under the *Public Service Staff Relations Act*.

In 1996, Dr. Chandler Grover, a physicist specializing in the field of optics, was appointed a section director at the National Research Council of Canada (NRC). The appointment was part of an out-of-court settlement of a human rights complaint.

During the years 2003 and 2004, Grover was in open conflict with a new supervisor who was trying to implement changes to the management structure. He had even initiated a harassment investigation against the president of the NRC, whom he believed had appointed the new supervisor "to deal with" him.

In January 2004, Grover obtained a medical certificate from his doctor prescribing "stress leave for four weeks, spread over eight weeks as required," followed by identical certificates in March and June. While the supervisor had accepted the first two medical certificates, he balked at the third. He was concerned about its validity and about the fact that there had been no improvements in Grover's health.

However, the supervisor did not discuss his concerns about Grover's health with him. Instead, he requested that Grover undergo an IME by an NRC-chosen physician. Until that happened, Grover was to remain off work. A letter explained that the IME was needed to "determine the validity of the current medical situation and [Grover's] medical capacity to resume his duties and responsibilities." NRC based its request on an occupational health and safety policy that allowed the employer to request an IME if enough evidence suggests an employee cannot perform his or her job without presenting a safety risk to himself, herself or others.

When Grover refused to attend the first appointment with the NRC doctor, NRC called his refusal "insubordination" and suspended him without pay for three days. It then scheduled another appointment, warning Grover that a second refusal would not only be viewed as a further act of insubordination, but also make him subject to a "no work, no pay" policy. In other words, he would be required to remain off work without pay until the medical assessment was complete.

Grover did not attend the second appointment, explaining by letter that he had not been provided with enough information to understand the reason for the IME or to determine whether the physician chosen by NRC was independent. Although he was given a copy of the relevant oh&s policy, he didn't understand how it related to him since his work was in no way safety-related. He offered to see a physician approved by both him and NRC. NRC responded by suspending him without pay for a further five days. Grover grieved his discipline.

The adjudicator hearing the grievance did not agree with NRC that its IME request was motivated by concerns about Grover's health and that the suspensions and "no work, no pay" penalty were an administrative, not a

disciplinary, consequence of Grover's failure to attend the medical assessment. The adjudicator noted that NRC used the words "insubordination" and "disciplinary action" in much of its correspondence with Grover. Moreover, it never mentioned its concerns about Grover's health to him.

The employer's reasons for making the IME request, said the adjudicator, were in fact contradictory, questioning Grover's illness and medical certificate on the one hand and suspecting his health was so deficient that he might harm himself or others on the other. In any case, both reasons were insufficient.

Even if NRC had doubts about the validity of Grover's medical certificate, it did not have the right to ask for an IME, noted the adjudicator. Its actions were limited to requesting more information from the employee and his or her physician, or coming to an agreement with the employee on the choice of a third-party physician.

And even if NRC had the right to request an IME to determine fitness to work in the "exceptional and clear circumstances" set out in the oh&s policy, these circumstances were not present in this case, said the adjudicator. The nature of Grover's illness and job responsibilities did not warrant such a measure, as might be the case of "an employee with suspected back problems who is expected to lift heavy equipment regularly."

As for the discipline, the adjudicator found it was unwarranted. Grover was not provided with reasonable justification for the IME request and, therefore, had the right to refuse it. The adjudicator ordered that Grover be reinstated and be paid 14 months' salary and benefits retroactive to July 21, 2004.

Source: *Grover v. National Research Council of Canada*, Canadian Public Service Labour Relations Board, October 3, 2005. •

WORKING WITH PSYCHIATRISTS TO PREVENT WORK DISABILITY

The most recent issue of the Canadian Psychiatric Association's monthly journal focuses on mental disorders in the workplace — and it advises psychiatrists to take an active role in preventing work disability. **By Cindy Moser**

Now is the time to change the way that the mental health care system and the workplace collaborate to manage workplace depression. So says Dr. Dan Bilsker, a consulting psychologist in the Psychiatric Assessment Unit of the Vancouver General Hospital, in a guest editorial in the February issue of *The Canadian Journal of Psychiatry*. "We need to establish a bridge between mental health care and the workplace," he writes.

Published by the Canadian Psychiatric Association, the most recent issue of the journal focuses on mental health disorders in the workplace and includes an article for psychiatrists and primary care physicians on their role in the management of workplace disability issues. "My overall impression is that management of occupational disability is fairly low on the priority list for clinical psychiatrists," Bilsker, a co-author of the paper, told *Back To Work*. "Several factors contribute to this. First, it is not a significant part of psychiatry residency training. Second, clinical psychiatrists generally have their hands full treating disorders with regard to ameliorating symptoms and distress. Third, communication with insurance or employer representatives, in particular form completion, is often perceived as an intrusion on 'real' clinical work."

Nonetheless, disability managers in the workplace and in the insurance industry will be heartened by Bilsker's article, entitled "Managing depression-related occupational disability: A pragmatic approach." It suggests practical guidelines for psychiatrists and other physicians for working with their patients to ensure their optimal recovery, with particular emphasis on the interaction between the psychiatrist and the insurance carrier. Indeed, any bias aside, Bilsker says it would be a good idea for workplace disability managers to send a copy of his article to the psychiatrists and family physicians who are treating their employees with depression. They might also recommend the sessions being given by Bilsker and co-author Dr. Stephen Wiseman, a consulting psychiatrist at St. Paul's Hospital in Vancouver, who have also been giving presentations to psychiatrists in support of the article.

Psychosocial strategies considered

As for the clinical management of mental health disorders — and given the fact that most working people being treated for common mental disorders such as depression and anxiety continue to work, albeit often with a lower level of effectiveness — Bilsker and his colleagues emphasize the importance of "approaching occupational function as a target of clinical intervention" (see box on next page). They also look at psychosocial strategies aimed at augmenting the patient's sense of competence and goal-directedness.

In the meantime, Bilsker believes there is an opportunity for the insurance industry and employer groups to work in partnership with government agencies and research groups to develop effective and efficient protocols or modules for psychiatrists and primary care physicians to use in assessing and

managing mental-health-related occupational disabilities. "The payoff in improved information, faster response and more effective clinical management would be more than worth it," he says. "Previous experience with improved intervention programs for back injury and pain conditions should give us hope that we can design intervention and rehabilitation strategies for depression and anxiety that will offer substantial benefits with regard to promoting remain at work and return to work, as well as preventing a return to disability."

The issue can be accessed at www.cpa-apc.org/Publications/CJP/current/feb2006.asp. For information, e-mail Dr. Bilsker at dan.bilsker@vch.ca. •

ADVICE TO PSYCHIATRISTS AND PHYSICIANS

Managing work disability related to depression

The article written by Bilsker and his colleagues Dr. Stephen Wiseman and Dr. Merv Gilbert in the February issue of *The Canadian Journal of Psychiatry* offers advice to psychiatrists and primary care physicians on the management of depression and work disability. Some of that advice is summarized here.

- A "crucial distinction" must be made between impairment and disability. Psychiatrists are the experts in assessing and documenting the former, while insurers and employers are largely responsible for the latter.
- Employers and insurers will not accept "stress" or "workplace problems" as the appropriate basis for a disability claim. An inability to cope with family issues or changing workplace demands is not a disabling illness.
- More detailed information is typically required for a long-term disability claim, including diagnosis, symptoms, clearly specified functional limitations and a description of current treatments. As well, regularly re-evaluating a patient's status is also typically required: "A warning sign to an insurer is apparent lack of clinical progress in the context of passive treatment; for example, an individual apparently too sick to work remaining for six months on the same type and dosage of medication and seeing his or her psychiatrist every two months for non-specific supportive therapy."
- The decision as to whether or not a person must take time away from work deserves careful consideration. A psychiatrist typically recommends time off work because the patient is determined to be unable to handle the demands or responsibilities of the job due to his or her mental illness. In this case, the psychiatrist may base a recommended duration of absence on the projected time required to resolve symptoms and recover function (and, current research has made it clear that functional recovery in patients with major depressive disorder does not lag behind symptom improvement). In most cases, it is realistic to expect substantial recovery from uncomplicated treated depression within six to eight weeks. Failure to achieve functional recovery within several months of treatment suggests the need for a change in treatment or rehabilitation strategy.
- There are advantages and disadvantages to remaining in the workplace while recovering from depression. However, participating in the workforce is often itself "a potent and positive therapeutic factor," providing structure, meaning, an opportunity for social interaction and an income: "We encourage a problem-solving approach, in which all concerned parties collaboratively look at the advantages and disadvantages of work absence: whether to go off work, specifically why, and for how long. It should never be assumed that a patient diagnosed with major depression, for example, needs to take several months of work absence to recover."
- Solid research indicates that standard psychopharmacological treatment for major depressive disorder leaves a significant gap in functional recovery. According to one study, about 60 per cent of people who were treated with antidepressants only continued to show moderate impairment in work function one year later. Thus, other interventions may also be needed. Cognitive behavioural therapy (CBT) may be of particular benefit: "For now, psychiatrists should consider recommending non-pharmacologic interventions such as CBT where standard pharmacologic treatment has not effectively achieved adequate recovery of occupational function."
- Fostering the patient's role in recovery through a "self-management approach" is another intervention worth exploring. Although this approach is "perhaps idealistic" given the time constraints and other realities of the typical clinical practice, "a collaborative approach that emphasizes self-management seems most likely to reinforce the patient's sense of competence, autonomous decision-making and goal-setting," which are crucial factors in enhancing functional recovery and supporting a return to productive work (see inset).

RESOURCE

A manual to enhance the self-management of depression, called the *Antidepressant Skills Workbook*, has been developed by the Mental Health Evaluation & Community Consultation Unit at the University of British Columbia. It can be downloaded from www.mheccu.ubc.ca/publications, under Self-Care. It is available in English, French, Chinese and Punjabi.

"I know of one occupational physician dealing with a very large employee group who sends out a copy of this manual to all claimants suffering depression-related disability," says Bilsker. "This is a good idea, with minimal cost."

Bilsker notes that the same group has just been given funding to develop a version of this self-care manual that specifically focuses on the workplace. Called *Antidepressant Skills at Work,* it should be available for free dissemination in the fall of this year.

NIDMAR book offers global overview of DM

Two quite different case studies of global companies that exemplify what it takes to implement an effective disability management program — and how this investment can pay off — are included in a new book from the National Institute of Disability Management and Research. Called *Disability Management Success: A Global Corporate Perspective*, the 80-page book offers a global overview of disability management and puts into context the need to implement workplace-based programs in order to compete in the global economy. To order (ISBN 0-9738181-0-7, $36.00), go to www.nidmar.ca and click on Publications under Products.

International DM forum taking place in Australia

It's not too early to start planning for the third biannual International Forum on Disability Management, which is taking place this year from October 8 to 10 in Brisbane, Australia. The forum follows up on previous conferences held in Vancouver in 2002 and in the Netherlands in 2004. For information about attending or presenting, e-mail IFDM2006@somc.uq.edu.au or visit www.ifdm.com.au.

OMA offers advice on preparing for avian flu

An article in the December issue of *Ontario Medical Review*, the monthly magazine of the Ontario Medical Association (OMA), offers advice to occupational health nurses and physicians on ways to prepare for an avian flu pandemic. Prepared by Dr. Sidney Siu, former chair of the OMA's Section on Occupational and Environmental Medicine, the article includes a number of recommendations with respect to business continuity programming, prophylaxis readiness, personal protective equipment planning and travel to avian flu areas.

The paper, "Readiness for the avian flu pandemic: An occupational health perspective," can be downloaded from www.oma.org/pcomm/OMR/dec/05maintoc.htm.

DMEC opens registration for virtual seminars

Registration is now open for a number of web-based educational sessions on disability, health and productivity management. Sponsored by the Disability Management Employers Coalition and the insurer UnumProvident, upcoming sessions in the 2006 Virtual Education Forum include the following:

- March 14 — "On the front lines of lost-time management";
- April 11 — "Managing the impact of cancer on the health and productivity of a workforce";
- September 12 — "Managing chronic pain and arthritis in the workplace";
- October 10 — "Managing lost time in a call centre operation"; and
- November 14 — "The changing role of employer-based occupational health programs."

Registration is free, participation is limited and registration closes three days before each session date. For more information, go to www.dmec.org.

Insurance company offers on-line supervisor's toolkit

CIGNA Group Insurance has developed a web-based resource for managers that is designed to help them deal with absent employees — from the time they call in to the time they return to work. Recognizing that supervisors play "a crucial role" in the management of an employee's disability-related absence, the step-by-step program, called the Manager's Disability Toolkit, offers advice on dealing with the initial absence, the ongoing absence, employee assistance, claim decisions, behavioural health issues and return to work.

Although targeted to CIGNA clients and American employers — the FMLA (or *Family Medical Leave Act*) is referred to from time to time — the site may prove to be a useful reminder to supervisors of the key steps to be taken when dealing with an absent employee. You will find the toolkit at www.cigna.com/group/toolkit/mdt/home.htm. •

BACK TO WORK

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PUBLICATION INFORMATION

Subscriptions: $269/12 issues
Call toll-free: 1-800-268-7742

Back To Work is published 12 times a year by:
Business Information Group
12 Concorde Place, Suite 800
North York, ON M3C 4J2
Fax: (416) 510-5140

• Business Information Group is a division of Hollinger Canadian Newspapers L.P., a leading Canadian information company with interests in daily and community newspapers and business-to-business information services.

ISSN 1206-6826
Publications Mail Registration No. 08603
Canadian Publications Mail Products Sales
Agreement 1118676