BACK TO WORK

Strategies for managing rehabilitation and return to work in Canada

MENTAL HEALTH ROUNDTABLE TO PUBLISH RTW PROTOCOLS

Return-to-work protocols for physicians and human resources professionals who are dealing with employees disabled by mental illness are to be released later this spring by the Global Business and Economic Roundtable on Addiction and Mental Health.

These tools are among the initiatives being pursued by the Roundtable as part of its strategy to engage Canada's corporate leaders in addressing mental health issues. "The generations of government, mainly, and society as a whole ignoring, stigmatizing and fearing mental health problems are now coming home to roost," says Roundtable CEO Bill Wilkerson. "We're going to pay the piper for this age-old ignorance through increasing rates of disability, increasing insurance costs, increasing drug costs and, I think eventually, civil suits."

The return-to-work guidelines are being put together by a working group that includes Dr. William Gnam of the Toronto-based Centre for Addiction and Mental Health (for more on his research into depression and return to work, see page 5). Explaining the rationale for the RTW guidelines, Wilkerson says the Roundtable is "trying to help people navigate processes right now that are just alien to everybody involved in them."

The guideline for physicians will concentrate on the manner in which they communicate with employers. According to Wilkerson, doctors "often dictatorially set out what the employee can and cannot do, and the tone and level of that communication are alienating to the employer. This puts the employee in the middle of a very stressful situation." As for the guideline for human resources directors, it will address the fact that the workplace return-to-work systems that companies have implemented tend to "break down within 12 seconds when they involve someone who has been off for a year with depression," he says.

Guideline also developed for BoDs

Efforts to get business leaders to pay closer attention to workplace stress and employee mental health received a boost in mid-February when the chairs and CEOs of some of Canada's top companies endorsed the Roundtable's "Board of Directors Guideline on Mental Health and Safety." These industry leaders, spearheaded by Dr. John Evans, chair of the board of Torstar Corporation, called on corporate boards of directors to put the subject of employee mental health on their agenda as a matter of good governance.

The guideline, which is being circulated to the boards of all publicly traded companies in Canada, advises corporate directors to put the topic of mental health on all future agendas of their boards and relevant committees. It also advises them to report this action to shareholders and to support senior management efforts to implement a strategic action plan to promote mental health as a business asset. "In my judgement, any board that doesn't insist on having environment, safety and health — with a special emphasis on mental health — on its agenda is not discharging its governance responsibilities," Dr. Evans says.

According to 16 corporate leaders who took part in a Roundtable survey, the results of which were released on March 22, mental health and stress problems in the workplace are bigger today than they were five years ago, with middle managers being the most vulnerable employee group. These executives also say that "CEOs themselves should assume responsibility for reducing stress at work and eliminating the stigma of mental illness in the workplace."

Other guidelines are also forthcoming from the Roundtable. One will be addressed to institutional investors to

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encourage them to become informed about the health status of employees in those companies in which they want to invest. "This should be a matter of routine due diligence when it comes to assessing the quality of management and the standards of asset risk management employed by those firms," says Wilkerson.

Another guideline will be designed for working parents who may have concerns about their own mental health or that of a family member. This guideline will focus specifically on what working parents can do when faced with a mental health crisis among adolescent children, Wilkerson says.

Insurance data being analyzed

The Roundtable is involved in a number of other initiatives of particular interest to workplace disability managers. One is the Roundtable's Research and Return on Investment Task Force, which is being headed up by Dr. Gnam and Watson Wyatt's Joseph Ricciuti, the director of the national group and health care practice in Canada.

The task force is analyzing disability data provided by insurance companies in an attempt to get practical answers to two questions: (1) Why do mental health short-term disability claims migrate to long-term disability claims as frequently as they do? (2) What does and doesn't work when people are returning to their jobs?

The Roundtable is also helping to introduce an on-line early detection and referral module called "Feeling Better Now." The on-line system is the creation of occupational psychiatry expert Dr. Sam Ozersky, a senior consultant at the Toronto Hospital Mood Disorders Clinic and president of Mensante, who is working with other top psychiatrists in Canada and the U.S. in developing the tool.

"It's really a tremendous concept," says Wilkerson. "It is, in effect, a care map through which individuals can confidentially answer questions on-line. This allows them to take a hard copy of the results of that questionnaire, based on DSM-IV diagnostic criteria, to their family doctor." (For more information on "Feeling Better Now," check out www.mensante.com.)

The Roundtable continues to urge CEOs across the country to join the growing number of top execs who have already endorsed its Charter for Mental Health in the Global Workforce. The Charter names 2004 to 2006 as the Business Years for Mental Health, during which participating companies are asked to turn awareness of mental health problems into actions to address them (see box at left).

For more information, contact Bill Wilkerson at (416) 598-5790 or at bill.wilkerson@gpcinternational.com, or visit www.mentalhealthroundtable.ca. •

QUICK TIPS

Addressing mental health issues in the workplace

Speaking at the second annual Connex/IHPM Canadian/U.S. Employer Forum on employee health and productivity, held in Toronto in early February, Bill Wilkerson offered ideas on what companies can do to address mental health issues:

- Create information centres in the workplace to give executives, managers and employees the opportunity to become familiar with the facts about the avoidance, early detection and successful management of depression, anxiety and substance abuse.

- Train executives, managers and workers in what might be called "mental health first aid" — that is, in knowing how to observe, understand and appropriately respond to the signs of mental distress among co-workers.

- Ensure group health, disability, employee assistance and wellness programs have the capacity to help break the vicious cycle of stress, burnout, depression and anxiety and to take into account the very particular characteristics of recovery from depression.

- Take steps to remove the "awful burden" of secrecy and apprehension among working people who struggle with mental illness and don't know where to turn or who to trust for fear of keeping their job. Foster an internal culture in which employees are permitted, encouraged and helped to talk about this subject openly.

- Establish policies that target the elimination of problem job stress in the workplace as part of a firm's performance management policy.

- Take steps to eliminate the sources of workplace stress that have been proven to be injurious to the health of employees: having too much or too little to do, with no control over the situation; lack of two-way communication; being unappreciated; inconsistent performance management processes; career and job ambiguity; unclear company direction and policies; mistrust; doubt about where things are headed; random interruptions; and work overload (i.e., too much to do at once, leading to a "24-hour" workday).

- Take steps to eliminate the four specific management practices that are most likely to precipitate or aggravate mental ill health in the workforce: imposing unreasonable demands on subordinates; withholding information that is materially important to subordinates in carrying out their jobs; refusing to give employees reasonable discretion over the day-to-day means and methods of doing their own work; and failing to credit or acknowledge the contributions and achievements of employees.

WORKER HEALTH DEMANDS STRATEGIC CHANGE, EXPERT SAYS

Healthy workplaces will not come about simply because of "superficial" changes such as the introduction of fitness, stop-smoking or flextime programs that focus on individual health behaviours. To be successful, these stand-alone programs must be an integral part of a larger "transformational" strategy that seeks to reduce employee health risks through job redesign, workplace culture, organizational systems and management practices.

This is one of the key messages of organizational health researcher and consultant Graham Lowe, in a report he prepared for Health Canada called *Healthy Workplace Strategies: Creating Change and Achieving Results*. In the report, released in early March, Lowe admits that this type of organizational change is time-consuming: it can easily take three to five years. What's more, if the lessons learned from past organizational change experiences are ignored, it's prone to failure: organizational change success rates hover between 25 to 33 per cent.

Yet Lowe, based in Kelowna, B.C., is undaunted. The evidence showing that healthy workplaces benefit employees, employers, customers, shareholders, citizens and society as a whole is too compelling to ignore. And, interestingly, he essentially puts the responsibility for taking the first steps on occupational health and wellness teams.

"My emphasis on the need for strategic thinking about the change process must be taken seriously by practitioners in workplace health promotion and occupational health and safety," Lowe says in his report. "I am challenging them to redefine their roles in the organization, from providing support programs to contributing far more directly to business goals."

When asked where disability managers, workplace wellness advocates, and occupational health and safety professionals should start, he offers this advice. First, they should team up with the organization's human resources staff and any other potential collaborators in the workplace, such as people in the organizational development department or the training department, if they exist. Together, they should create an interdisciplinary team to start discussing organizational health issues.

Then, ideally using data generated within the organization itself, the team should develop a case for organizational change to bring forward to senior management. This argument for change should support the strategic priorities of the executive team. "This is an easy connection to make," says Lowe. "A lot of executives are already concerned about recruitment, retention, innovation, etc. Therefore, the health initiative needs to be framed as creating an enabling environment that contributes to these bigger goals."

In his report, Lowe offers an "action model" that the workplace parties can use to guide the implementation of healthy workplace changes. And he concludes with words of encouragement: "Almost every organization has strengths to build on and opportunities to launch change. Building incrementally on these strengths and seizing present opportunities, however small to begin, can start making the vision [of a future healthy workplace] a reality."

The full report can be downloaded on-line from the Graham Lowe Group at www.grahamlowe.ca or from the Canadian Policy Research Network at www.cprn.org (under Work Network). For more information, contact Graham Lowe at (250) 717-7371 or glowe@grahamlowe.ca. •

WSIB CARE PROGRAM TACKLES RTW AND JOB-RELATED ASTHMA

Ensuring the early diagnosis and appropriate care of workers with occupational asthma so they can safely return to work is the aim of the Ontario Workplace Safety and Insurance Board (WSIB)'s most recent "program of care." The Board's Program of Care for the Non-Pharmacological Management of Occupational Asthma is currently being piloted across Ontario for a six-month period.

Based on scientific evidence and best-practice guidelines, the program sets out a step-by-step assessment and treatment plan for health care providers faced with a patient who has been diagnosed with, or is being investigated for, occupational asthma. According to WSIB spokesperson Perry Jensen, occupational asthma was chosen as the next program of care because the illness is on the rise in Ontario. However, only a few centres in the province can diagnose it, and early diagnosis and removal from the sensitizing agent are the keys to effective management.

As for returning to work, the program recommends that this be done as soon as possible. However, "all steps must be taken" to ensure that a worker diagnosed by a specialist as having occupational asthma is not exposed to the sensitizing agent. As well, during the return to the new job or new work area, the worker's "peak expiratory flow rate" should be monitored at least four times a day: before work, mid-shift, at the end of the shift and at bedtime to "assess any additional workplace effects on the worker's asthma." This monitoring should take place during the week before the return and the three weeks after. Depending on the results, workplace adjustments may be needed.

The WSIB is taking a number of steps to ensure doctors are aware of the program of care. In February, it sent information about the pilot to all physicians in the respirology, occupational medicine and clinical immunology/allergy sections of the College of Physicians and Surgeons of Ontario. It also sent information to family physicians who have treated workers with occupational asthma in the past two years. The Board will also notify physicians treating patients with new cases of possible occupational asthma about the program.

The WSIB's first program of care targeted acute low back injuries, and an evaluation of the first year of this program is near completion, Jensen reports. Programs of care for occupational contact dermatitis and noise-induced hearing loss are also expected during the next few months. Programs of care for persistent low back pain, mild traumatic brain injury and upper extremity injuries are in development.

More information is available online at www.wsib.on.ca/wsib/wsibsite.nsf/public/healthpocfoa.

Research centre established

In the meantime, an occupational asthma research centre is being created in Quebec by Montreal's Sacré-Coeur Hospital, University of Montreal and McGill University. The province's Institut de recherche Robert-Sauvé en santé et en sécurité du travail (IRSST) announced in February that it, too, was participating in the creation of the centre to ensure that the centre's research findings are transferred to those who need the information; that is, occupational health and safety communities and public health departments.

For more information, contact the director of the new centre, pneumologist and lead respiratory health researcher at Sacré-Coeur Hospital, Dr. Jean-Luc Malo, at (514) 338-2796. •

Proposed B.C. reg change expands violence definition

Adding treatment provisions to prevent or reduce the likelihood that workers will suffer acute reactions (i.e., mental stress) in the wake of traumatic incidents of workplace violence is one of the regulatory amendments being proposed by the B.C. Workers' Compensation Board as part of its review of the province's Occupational Health and Safety Regulation. Under the proposal, an employer would be required to advise any worker who is subject to violence or who witnesses a violent incident that immediate debriefing is an option. Early intervention would be available through the WCB's Critical Incident Response Program. For more information, visit www.worksafebc.com/law_and_policy/public_hearings/law_40_10.asp#2

B.C. WCB begins return-to-work audits

The first audit under the B.C. Workers' Compensation Board's pilot Disability Management Premium Pricing Initiative was conducted in mid-March at Eurocan Pulp and Paper, a division of West Fraser Timber. The audit was carried out by Diversified Rehab, which has been certified by the National Institute of Disability Management and Research to perform its consensus-based audit. The WCB chose the NIDMAR audit for the pulp-and-paper industry pilot (see *Back To Work*, Jan/Feb 2004).

Manitoba seeks feedback on workers' comp law

Public consultations on Manitoba's Workers Compensation Act are set to begin on April 14. A committee including representatives of business, labour and the public will hold hearings until the end of June and accept written recommendations until June 3, 2004. The public review, the first in almost 20 years, is wide open. Comments on all areas of the Act are being accepted. For information, call (204) 957-0024, e-mail info@wcbactreview.com or visit www.wcbactreview.com.

Disability prevention model a step closer in Ontario

The Round Table Project on Safe & Timely Return to Function & Return to Work is moving forward on its plan to investigate the implementation of an evidence-based disability prevention model in Ontario. It has hired Starfield Consulting to facilitate strategic planning with respect to the model, which is based on Dr. Patrick Loisel's PREVICAP system (see *Back To Work*, September 2003).

Newfoundland claim rates to reflect RTW efforts

The Newfoundland Workplace Health, Safety & Compensation Commission is changing the way it calculates employer premiums so that employers have a financial incentive to prevent workplace accidents and get injured workers back to work. Called PRIME (Prevention, Return to Work and Insurance Management for Employers), the new rate-setting method aims, in part, to change the fact that injured workers in Newfoundland and Labrador miss more work because of their injuries than workers in any other part of Canada.

PRIME will, in the first phase, refund employers up to five per cent of their total assessment rate for meeting legislated criteria with respect to prevention and RTW policies. In the second phase, PRIME will send refunds to employers who significantly reduce their claims costs from one year to the next and levy a penalty on those whose claims costs increase significantly. The WHSCC began consulting with employers about the new rate-setting method in February. •

10 TIPS FOR RETURNING WORKERS WITH DEPRESSION

Research scientist and psychiatrist Dr. William Gnam offers some practical tips for disability managers who face one of the most complex and challenging case management situations: helping workers with depression return to work.

When Dr. William Gnam looks at current practices for managing depression in the workplace, he sees a lot that is going wrong: little or no surveillance for early detection; poor communication between the treating physician and rehabilitation staff; the risk of substandard clinical care; and, often, no clear benchmarks for the treatment, recovery or return to work of employees diagnosed with depression.

Dr. Gnam, a research scientist and health economist at the Centre for Addiction and Mental Health (CAMH), is also a practising psychiatrist at the CAMH's Depression Clinic. His experience as both a scientist and clinician has made him a leading expert in Canada on the return to work of people diagnosed with depression and a key player in the work of the Global Business and Economic Roundtable on Addiction and Mental Health (see page 1).

What follows is some advice from Gnam about how to improve current practices when it comes to returning people with depression to work.

1 Implement early detection protocols in the workplace. Because massive stigma is still attached to mental health problems, getting people to recognize that they might have a problem for which they need to seek help is a slow and incremental process. However, workplaces can help by educating employees and supervisors about the signs of depression and integrating employee assistance programs (EAPs) with a workplace's occupational health services. They can also make available to employees Internet-based health-screening tools that employees can use on an anonymous and confidential basis. These on-line assessments don't replace a psychiatrist or family doctor, but they can help get around the stigma of asking for help.

In the end, however, nothing helps more in the early detection of depression than a supportive workplace. There is no substitute for a culture in which people feel empowered to let their employer know that they are in trouble. Only when employees feel safe communicating their problems, knowing that their information will remain confidential, can disability managers know if treatments are going as planned or if tailor-made RTW programs are needed.

2 Become familiar with what constitutes "guideline treatment" of people with depression. People involved in the vocational rehabilitation and return to work of people suffering from depression should know what constitutes "good treatment" when it comes to depression. That's because they may be called upon to assess the quality of the treatment in the course of their work, especially practitioners who are members of regulated health professions (e.g., nurses, occupational therapists) and have access to this type of confidential information.

Clinical best practices are not hard to understand, and they make it possible for educated readers to make judgements about the quality of care someone is getting. People who get and follow guideline-level care have the highest probability of recovering from their symptoms and of returning to work. Unfortunately, the latest figures show that only 20 per cent of people diagnosed with depression are getting "guideline" care.

People are more likely to get guideline-level care when they are treated by a specialist (e.g., psychiatrist). Specialist care is more expensive, but the additional costs are usually offset by earlier work returns. However, specialists are often hard to access, especially in remote areas, leaving family physicians as the front-line health care providers. This makes it all the more important that disability managers be aware of guideline care.

The Canadian Psychiatric Association released "Clinical Guidelines for the Treatment of Depressive Disorders" in June 2001. You can download the guidelines from the CPA Web site at www.cpa-apc.org/Publications/Clinical_Guidelines/depression/clinicalGuidelinesDepression.asp, or by calling (613) 234-2815 or e-mailing cpa@cpa-apc.org.

3 Be aware of a number of "red flags" that may indicate employees with depression are not getting the proper care. Signs of non-guideline treatment include:

- *Wrong dosage or type of medication:* If the drug prescribed is not an antidepressant, that is certainly an indication the person is not getting guideline-level care. For example, benzodiazepines — or tranquillizers — are not the proper medication for treating depression.

As well, even if a person is prescribed an antidepressant, it might not be at the right dose or the right type. If someone has been on the same dose of a particular antidepressant for six weeks without evidence of any benefit

to the patient, then something is amiss. Six weeks is long enough to figure out if a dose is adequate. The leading problem is that antidepressant dosages are persistently below the minimum suggested by guidelines.

If someone is getting the right dose of a particular antidepressant and there is still no evidence of improvement after 12 weeks (unless the drug is being given in combination with another), then it is not working. Therefore, if you get a report four months later that says a person is not getting better, and you notice they're getting the same treatment now as they were four months ago, something needs to change.

- *Improper duration.* Not keeping patients on their medication long enough is the most prevalent problem in treating people with depression. According to clinical best-practice guidelines, people suffering from depression for the first time should be treated for one year, people for the second or third time should be treated for two years, and people for the fourth time or more should be treated for their lifetime.
- *Fuzzy or non-conventional diagnosis.* If you see a diagnosis like "stress disorder" or "burnout," then it's an indication of "imprecise thinking." Even family doctors should know how to diagnose depression.
- *Wrong type of psychotherapy.* Certain types of psychotherapy have been shown to work well for major depression, but these are not the types that doctors and psychiatrists typically prescribe. Only cognitive-behavioural and interpersonal psychotherapy have been proven effective. Getting the wrong type of psychotherapy is especially problematic if psychotherapy is the only treatment (i.e., not in combination with medication) because the probability of return to work is much lower.

A family physician or psychiatrist might very well respond coldly to any kind of suggestion from an occupational health nurse or disability manager that his or her treatment is not what it should be. One way to get around this barrier is to ask for a specialist consultation. Specialist expert opinion is hard to ignore by most doctors.

4 Consult with a specialist after a defined period of work absence. Specialty treatment should be recommended as soon as possible for those workers with concurrent depressive disorders, with substance abuse problems or with repeated absences. For all other cases of depression, consultation with a specialist (such as a psychiatrist) should occur, at the very latest, within four months of being absent from work. As the next step, a workplace should consider consulting a third-party clinical specialist (an independent psychiatric evaluator), particularly if there are concerns about the standard of care.

5 Don't be too hasty in concluding that an employee is unmotivated to return to work. A depressed employee can seem very unmotivated about his or her career or the prospect of returning to work. But a person's motivation should not be judged when he or she is ill: it's part of the illness.

6 Initiate a graduated return-to-work protocol once recovery begins. It used to be believed that a depressed person's functional recovery lagged behind his or her symptomatic recovery by about four to eight weeks. As a result, it was recommended that, even though a person's symptoms of depression might have lifted, he or she might need another month or two before being able to adequately function at work. *But the thinking on this front is changing*.

Recent systematic reviews of the research evidence have concluded, in fact, that recovery in functioning closely parallels symptomatic recovery. Therefore, it is reasonable to initiate a graduated return-to-work protocol once a person with depression has achieved a partial improvement in symptoms.

7 Recognize that a partial return before all symptoms have abated is possible and, often, advisable. An early offer of accommodation can help when dealing with people with depression. The isolation that can come from feeling disconnected from the working world can perpetuate depression. Indeed, it has been said that the chances of a successful return are 50 per cent for an absence of less than six months, 20 per cent for an absence of a year, 10 per cent for an absence of two years and zero per cent for an absence of over two years,

A respectful workplace culture and the willingness to offer flexible workplace accommodations are crucial to successful work-returns. So, too, is early contact with the treating medical provider. A company should consider customized workplace accommodations for those workers suffering from a combination of depression and anxiety, especially if the workplace triggers the anxiety.

8 Institute a progressive return-to-work model. A phased return to work, from part-time to full-time hours, should arguably be the standard for depression, and be stated in the company's disability management policies as standard practice. People with depression have dysfunctional thoughts about their ability and do not believe in their ability to succeed at work.

A phased RTW allows people to have successes, and encouraging people to take small steps to ensure they experience successes is one of the principles of cognitive therapy. A phased-in

return to work is the easiest way to create successes. Phased-in hours allow for the correction of cognitive distortions associated with depression.

In terms of standards for phasing in work, none exist (although the Roundtable is developing such standards). At present, the recommendation is to start a worker at no more than 50 per cent of his or her regular job hours if all symptoms have disappeared — and at no more than 25 per cent if they have not — gradually phasing in hours up to full-time over at least four weeks, and more likely eight.

9 Be very aware of the potential for relapse. Relapse following the remission of symptoms is a big problem with depression. Indeed, it is estimated that 85 per cent of people who recover from depression will experience a recurrence within 15 years. Some people who show a good early response to treatment suffer a rapid relapse.

10 Expect some failures. Although the proper clinical treatment can lead to a marked improvement among many workers with depression, about 20 per cent of people, for reasons not yet known, don't respond even to guideline-level treatment. The workplace parties and insurers must guard against having unrealistic standards or expectations of recovery.

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Gnam says research still has plenty of questions to answer about managing depression in the workplace. In the meantime, knowing what we do know at this point, he advocates for depression disability management that is characterized by early detection, work accommodation, early specialist consultation and incremental return to work. For more information, e-mail Dr. Gnam at william_gnam@camh.net. •

Quebec publication tackles workplace mental health

A publication on preventing psychological health problems in the workplace is now available from the Institut de recherche Robert Sauvé en santé et en sécurité du travail (IRSST). Released in February, the publication — entitled *La santé psychologique au travail … de la définition du problème aux solutions* — was produced under the direction of Jean-Pierre Brun, the University of Laval's Chair in Occupational Health and Safety Management. The three-part publication talks about the prevalence, sources and prevention of occupational stress. Available in French only, the free publication can be found at www.irsst.qc.ca.

Graduate program trains work disability researchers

The University of Sherbrooke is hoping to develop a cadre of high-quality researchers specifically trained to answer the difficult questions that arise in the field of work disability prevention. The second session of this new program, called the Work Disability Prevention CIHR Strategic Training Program, gets underway this month.

Developed with the support of the Canadian Institutes of Health Research (CIHR), the three-year program recognizes that current research in the field of work disability prevention rarely addresses all of the factors that influence this complex and multidimensional problem. The program hopes to fill this gap by developing transdisciplinary knowledge among students interested in work disability research.

Designed for PhD students and postdoctoral fellows, the program involves 24 key "mentors" from nine different Canadian universities — and the list of names reads like a "who's who" of people currently doing research work in the field of work disability prevention. The program's director is Dr. Patrick Loisel, a professor in the university's Faculty of Medicine, and the driving force behind the PREVICAP disability prevention model.

For more information, visit www.usherbrooke.ca/wdp/eng, or contact the program's co-ordinator at virginie.benjamin@usherbrooke.ca or (450) 463-1835, ext. 1799.

New consumer magazine focuses on mood disorders

A quarterly consumer magazine called Moods— the first of its kind in Canada — hit the newsstands in January. Focused on mood disorders and related illnesses, the magazine discusses current research, workplace issues, treatment options, pharmaceuticals, lifestyle and more. Bulk subscription rates are available for organizations that want to offer the magazine through their wellness programs. For information, visit www.moodsmag.com, e-mail info@moodsmag.com or call (905) 897-2558.

Workers' comp group creates research database

The Association of Workers' Compensation Boards of Canada (AWCBC) has created a Web-based research inventory to make it easier for people to find out about research funded by workers' compensation boards across the country. The inventory currently contains about 170 summaries of current research projects organized according to five priority areas — including one headed "Compensation, Disability Management and Return to Work." It is available at www.awcbc.org.

Annual report discusses workplace benefit trends

U.S. employers who encourage workers to take more responsibility for their individual health care decisions — by significantly increasing employee pre-

CONTINUING ED

Upcoming conferences

The annual conferences of a number of associations representing professionals instrumental in disability management are just around the corner:

- The annual conference of the **Canadian Association of Rehabilitation Professionals** (CARP) takes place May 13-14 in Victoria. Call (604) 681-0295 or visit www.carpbc.org.
- The **Canadian Physiotherapy Association**'s national congress is being held in Quebec City on May 27-30. Call (416) 932-1888 or visit www.physiotherapy.ca/2004.
- June 9-11 are the dates for the annual conference of the **Ontario Occupational Health Nurses Association**, taking place in Hamilton, Ont. Call (416) 239-6462 or visit www.oohna.on.ca.
- The **Canadian Association of Occupational Therapists** is holding its annual conference in Charlottetown, P.E.I., on June 24-26. Call 1-800-434-2768 or visit www.caot.ca.

The Canadian Institute is holding its second annual conference on **Managing and Litigating Depression Disability Claims** on June 3-4 in Toronto. Call (416) 927-7936 or visit www.canadianinstitute.com.

Return to work is the focus of the B.C. Workers' Compensation Board's **1st Annual Health Care Provider Conference**, taking place June 4 in Vancouver. Call (604) 276-3329 or visit www.worksafebc.com.

Looking for a good reason to travel out of country?

- The ninth annual **National Disability and Absence Management Conference**, hosted by the Disability Management Employer Coalition, takes place in San Francisco on July 18-21. E-mail assoc.dir@ dmec.org or visit www.dmec.org.
- The second **International Forum on Disability Management** is being held in Amsterdam September 13-15 — the first forum having been held here in Canada. E-mail info@ifdm.nl or visit www.ifdm.nl.

miums and point-of-care cost sharing and by providing them with tools to help make better health care purchasing decisions — are doing better at keeping health care costs in check.

This is a key finding in the ninth annual report on U.S. health care benefits trends published by the National Business Group on Health (formerly the Washington Business Group on Health) and Watson Wyatt. You can access the report at www.wbgh.com or www.watsonwyatt.com.

U.S. insurance study links health care and RTW

CIGNA, a U.S. insurer, released a study in mid-March that, although tied to the American health care system, included some interesting findings. For example, it found that the length of time on short-term disability — as well as how quickly a disabled person returns to work full-time — is better for those individuals with an integrated disability and health care program. (This finding was so strong, in fact, that CIGNA lowered the cost of disability benefits for U.S. employers who also purchase CIGNA medical coverage.)

The study also found that almost half (45%) of the expense of treating depression stems from people who suffer from other disabilities such as low back pain or heart disease, not from people seeking treatment for the mental health condition itself. The full study, *The Disability and Health Care Connection: How Strong is the Link?,* is available free, upon request, by e-mailing gloria.barone@cigna.com.

Disability management group offers free on-line seminars

The U.S.-based Disability Management Employer Coalition (DMEC), in conjunction with Unum Provident, is once again offering free "virtual education forums" on disability, absence and productivity management. Still to come this year are one-hour on-line sessions on the impact of the corporate work-health culture on lost time, health care costs and productivity (May 25), the prevalence and management of incidental absences (September 21); and best practices on building a business case to sell ideas to upper management (November 11). For information, visit www.dmec.org and click on 2004 Virtual Education Forum. •

BACK TO WORK

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