



Shaping
Organizational
Excellence



[Home](#) > [Knowledge Centre](#) >

Ten Tips for Returning Workers with Depression

✦ Written by: Cindy Moser

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.

Originally published in: Back To Work, Vol. 8, No. 4, April 2004 (Business Information Group, Toronto, Ont.)

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 . 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.



Back To Work provides the latest news, best practices and leading-edge developments to those responsible for rehabilitating and returning employees who are off work due to occupational or non-occupational injuries and illnesses. Visit www.ohscanada.com or contact c.moser@sympatico.ca

RELATED LINKS

- ✦ [The Duty to Prevent Emotional Harm at Work](#)

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](http://www.cpa-apc.org), 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, benzo-diazepines — 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 work-place

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.

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.

Cindy Moser is the editor of Back To Work newsletter, as well as the editor of Human Resources Management in Canada and Canadian Employer, and a researcher for the Canadian Employment Law Factbook.

 PRINT THIS PAGE