DEPRESSION IN THE WORKPLACE: *Shared costs and responsibilities*[1]

By Dr. Merv Gilbert and Dr. Larry Myette

Approximately eight per cent of Canadians will experience a major depression during their lifetime. Depression frequently coexists along with other mental health conditions, such as anxiety, or physical conditions, such as chronic pain. It is increasingly being linked to other illnesses such as cardiovascular disease. Typically, depression first occurs during the late teens or early adulthood , thus impacting individuals as they are preparing for or entering the period when they are contributing members of society. Fifty per cent of such individuals are likely to have recurrent episodes. The exact cause of depression remains unknown, however, it is likely initiated and maintained by a combination of biological and psychological factors.

Depression and other mental health conditions create massive problems in the workplace and cost the Canadian economy 7.3 billion dollars a year. While one-third of this cost is in direct health care costs, the other two thirds are due to indirect costs such as absences, disability payments and lost productivity. For those who remain at work impaired functioning or “presenteeism” can be particularly insidious as depression frequently affects an individual’s concentration, energy level, confidence and judgment.

Mental health problems, particularly depression, are the most rapidly rising source of disability and are expected to exceed 50 per cent of administered

[1] This article appeared in People Talk Magazine in 2003

claims within the next five years. The workplace can be a source of structure, support and solace for the depressed individual. Alternatively, work may initiate or exacerbate depression as a source of stigma, stress and alienation.

As striking as these figures are they cannot reflect the human side of depression and its effect on individuals, family members and community involvement. Depression can also impact on morale and team functioning in the workplace as well as contributing to recruitment and retention, risk management and human rights concerns. This is particularly tragic as there are increasingly effective treatments for depression, ideally involving some combination of medication and therapy, which can minimize the functional impairment and absenteeism. Unfortunately, less than one in four individuals with depression is correctly diagnosed and, of those, only one in four receive treatment consistent with best practice guidelines. These low figures point to factors including the stigma about seeking help for mental health problems; ignorance about depression on the part of supervisors, co-workers or management; naivety amongst health care providers about the workplace, and the general lack of knowledge of mental health disability prevention and management strategies.

CASE STUDY

Janet is a 47-year-old nurse working in a community hospital. Lately, she has become increasingly fatigued, sad and uncertain about the future. Her colleagues note that she has become irritable, distractible and lacking her usual enthusiasm about her job. They attributed this to increased workload demands on her unit, a

new manager who is also responsible for several other areas, and her need to care for her aging mother with Alzheimer's.

She did visit her employee assistance program and received some suggestions for stress management as well as some information on community resources for eldercare, but her distress persisted. Her family physician said she sounded burnt out and depressed and prescribed an antidepressant and suggested that she take a couple of weeks off work to rest.

After a while, Janet was starting to feel some improvement in mood and energy, however, when she returned to work she quickly became overwhelmed. She also had a sense that her colleagues resented her absence but was unsure if this was true or simply a reflection of her depressed state. She took more time off but felt her self-assurance declining and was increasingly isolated..

Eventually she went on long-term disability and was assigned to a disability management co-ordinator who set her up with a counselor who talked with Janet about her relationship with her mother. While this was informative, it did little to change her situation or mood. Without notifying her physician, she discontinued her medication because of the side effects. While a return to work plan was developed, it lacked clarification of appropriate expectations with respect to the cognitive, interpersonal and emotional requirements of her position. Neither Janet nor her work team was given any assistance to facilitate her return and it failed. After three years Janet is now considered permanently disabled. Her position remains vacant.

This example is not intended to cast blame; there is no villain and no one is winning. There are many barriers to effective recognition, diagnosis, treatment and rehabilitation. There is, however, an enormous problem, which can only be expected to increase, based on present trends, an aging workforce and the predominantly psychosocial, rather than physical, expectations of the current job market. Keep in mind that the absence of blame does not mean an absence of responsibility. All involved can make a difference. A collaborative effort between employers, insurers, health care and service providers and affected individuals is what is needed.

EMPLOYER RESPONSIBILITIES

Employers have a major role to play. Depression awareness programs can help to reduce stigma and promote early detection and intervention which will help prevent the onset and/or reduce the severity of depression. Shaping the work environment can promote a sense of individual control and accomplishment and reduce stressful demands. Job design and review can be revised to include psychological and cognitive demands. Policies and benefits plans can be structured to allow flexibility in workload and scheduling and to permit access to appropriate services. Employee assistance programs can be an invaluable aid but only if they have the knowledge, skills and opportunity to identify and augment the treatment of depression. It is critical that an organization have an early return to work process including creative and aggressive case management to identify potential barriers and optimize functioning.

INSURANCE PROVIDER RESPONSIBILITIES

Insurers and disability co-ordinators can make every effort to become involved early in the process. When possible this may include developing, promoting or participating in programs that will prevent the onset and/or severity of disability. They can work with the individual, the employer and the health care provider in order to establish a balanced and realistic picture of the individual's condition, treatment plan and work situation. This role should be reciprocal, with the insurer providing information about entitlements and responsibilities, specific job demands or extenuating circumstances. If external providers are contracted to provide services, the exact nature and reason for such services should be clarified.

In circumstances where leave is necessary, return to work planning should begin rapidly and specifically address any limitations on job tasks and performance, accommodations that are necessary and realistic, and the need for intervention and information for the employee's supervisors and co-workers. Once a return to work plan is initiated there should be ongoing supports for the employee with respect to pacing and goal setting, interpersonal issues such as disclosure to colleagues about the situation and the management of stress or relapse. Finally, the plan should be monitored, evaluated and adapted as needed.

HEATH CARE PROVIDER RESPONSIBILITIES

Health care providers can play a role by providing assessment, diagnostic and treatment services in line with recommended practice guidelines. Recognizing depression and making the distinction between disability and impairment is needed. It helps to determine how the individual rates their work in relation to their own sense of self-worth and identity. The provider will need to understand what are the current overwhelming stressors, job requirements or circumstances at the individual's place of employment.

Patient care that combines drug treatment with coping, mood and lifestyle management, goal setting and activation will help whether the person is still working or has stopped. If the health care provider is not able to supply these, they may be available through outpatient mental health programs (such as Changeways), private-sector practitioners or psychoeducational sources such as the Self Care Depression Guide http://www.mheccu.ubc.ca/publications/scdp/patientguide.pdf.

THE INDIVIDUAL'S RESPONSIBILITY

Depressed individuals have a responsibility to obtain the best information and services available. This includes being informed of and correctly using employee health, employee assistance or extended benefits options. If there are workplace circumstances which may be causing or contributing to stress and distress, the worker should bring these to the attention of co-workers, supervisors, human resources staff or union stewards. Hopefully, this will include a willingness and opportunity to devise and contribute to possible solutions.

Educating oneself about the signs, impact and treatment of depression is one of the first steps. When interacting with health care providers, individuals should be candid about their experiences and willing to request and question treatment options. Time away from work may be necessary but is unlikely to resolve difficult situations or provide new skills. The individual does have a duty to collaborate with health care providers, insurers and employers in setting realistic plans and options.

COLLABORATION NEEDED

It is clear that depression is a major workplace condition that will not go away. What is needed is the co-operation and innovation of all involved. For employers, paying attention to the emotional and psychological well-being of their workers is not just a benevolent option but a necessity. In a recent Towers Perrin survey of employees' emotional connection to their jobs, it was concluded that the enhancement of this connection with their jobs may be the last remaining source of increased productivity. The gauntlet has been flung.

Dr. Merv Gilbert is a registered psychologist providing clinical and consulting services with Gilbert, Acton and Le Page. Dr. Larry Myette is an occupational physician who is director of Employee and Workplace Health Services with the Healthcare Benefit Trust. Contact: ***mgilbert@interchange.ubc.ca*** *or* ***larrym@hbt.bc.ca****.*

For more information on depression in the workplace:

National Institute of Mental Health, Depression in the Workplace:

http://www.nimh.nih.gov/publicat/workplacemenu.cfm

Canadian Mental Health Association: http://www.cmha.ca/

Psych Direct: Evidence based mental health education and information:

http://www.fhs.mcmaster.ca/direct/