

## Managing depression-related occupational disability: a pragmatic approach

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### Abstract

**Objective:** To identify the crucial issues that arise for psychiatrists and other physicians when dealing with occupational disability of their depressed patients and to suggest practical strategies for responding more effectively to the challenges of this aspect of patient function.

**Method:** Fundamental concepts in the occupational disability domain are identified and crucial distinctions are drawn. The wider context for occupational disability is articulated, involving the workplace environment and the disability insurance industry. Research with direct relevance to clinical decision-making in this area is highlighted. Pragmatic suggestions are made for effective management of occupational disability in depressed patients .

**Results:** To successfully manage issues of occupational disability, psychiatrists and other physicians must understand the distinction between impairment and disability. In order to make this decision fairly and accurately, the adjudicator requires particular types of information from the physician, with requirements varying across short term or long term disability claims-failing to provide relevant information may cause substantial stress or financial harm to the patient. Balanced and collaborative decision-making regarding whether and for how long to take work absence will greatly facilitate maintenance of occupational function in the long term. Realistic expectations and support of the patient's sense of personal competence foster recovery of occupational function.

**Conclusion:** Management of depression-related disability is challenging. Thoughtful evaluation of the patient's functional status, careful response to the requirements of disability determination and focus on functional recovery yield substantial benefits.

**Keywords:** work disability, occupational function, recovery

### Clinical Implications:

1. An increased focus by physicians on evaluation and management of occupational disability will significantly benefit depressed patients.
2. Understanding the perspective of disability insurance adjudicators will better enable physicians to respond to their patients' needs.
3. An emphasis on supporting the patient's sense of personal competence will foster functional recovery.

### Limitations:

1. The research literature concerning optimal strategies for managing depression-related disability is sparse.
2. The disability criteria discussed here are not true of all insurance plans and may well change over time.
3. The complexity of interactions between patient, workplace and insurance carrier means that only broad guidelines can be formulated.

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Mental disorders are increasingly recognized as major contributors to occupational disability and absence. This is particularly true for depression: the rate of depression-related disability in the workforce appears to be increasing and it is projected by the World Health Organization to become, by 2020, the second leading cause of disability in the developed world. (1) Depression is already the primary source of disability in many occupational sectors and raises the risk for secondary physical and psychiatric illness, as well as injuries and accidents. Lessons learned from appropriate management of depression-related disability are relevant for other psychiatric disorders.

Much of the burden related to managing mental health-related occupational disability will fall on the shoulders of primary care physicians: many depressed patients receive their care from general practitioners. Psychiatrists are, however, typically involved when cases are more severe and prolonged; in fact, many longer-term disability insurance benefits require assessment or treatment by a psychiatrist.

Physicians are often confronted with issues concerning occupational function in patients they are assessing or treating. But physicians are in an awkward position -- trained to evaluate and alleviate symptoms and distress rather than occupational function. The increasing demand to deal with issues of occupational function can be daunting and may also be seen as tangential to the primary focus of clinical intervention. Furthermore, physicians often feel they are caught between the interests of their patients and the requirements of employers and insurers.

Nevertheless, proper medical assessment and management of occupational disability is essential to the patient's care and quality of life. We will examine some basic issues in the pragmatic management of depression-related occupational disability and make suggestions for more effective practice.

## Impairment and disability

A crucial distinction is that between *impairment* and *disability*. Psychiatrists have expertise in assessing and documenting the former, while the latter is largely an insurer/employment/contractual issue.

*Impairment.* Impairment has been defined in various ways; the World Health Organization defines it as "any loss or abnormality of psychological, physiological or anatomical structure or function." The job of the psychiatrist is to delineate a patient's impairment. In addition to a statement of *diagnosis*, generally using the DSM-IV TR system, and delineation of *symptomatology*, it is critical that the practitioner specify *functional impairments* arising from the condition as well. These might include reduction in: sustained ability to read, learning capacity, independent decision-making, effective social interaction or tolerance for unexpected stress. The American Medical Association's Guides to the Evaluation of Permanent Impairment (5th Ed.) provides a framework for evaluating

functional deficits.(2) In this framework, psychiatric impairment is determined via assessment of four areas: *activities of daily living; social functioning; concentration, persistence, and pace;* and *deterioration or decompensation in complex or worklike settings.*

The Global Assessment of Functioning (GAF) index is often used by psychiatrists and the insurance industry. Although this measure has poor reliability and validity,(3) it remains a standard index of functional status. Careful determination of the GAF score can pay dividends to patients with regard to insurance eligibility; an insurer may lack confidence in a psychiatrist's opinion whose patient's listed symptoms and apparent functional limitations are inconsistent with the stated GAF.

A useful approach for psychiatrists or occupational physicians carrying out disability assessments is to precisely describe how an individual typically spends his days: the time he goes to bed, how long he needs to fall asleep, number of nocturnal awakenings, timing and contents of meals, activities, how often he leaves the house, how often he drives and for how long, number and duration of social contacts, what sort of material he reads, how long it takes to read the paper, etc. Realistically looking at Activities of Daily Living is key to assessing a patient's functioning.

The psychiatrist needs to be aware of appropriate language for describing functional deficits. For example, it is not meaningful to state "Robert cannot concentrate" and "Can't sleep"; it is most unlikely that Robert is so depressed that he is entirely unable to concentrate or sleep to any extent for any period of time. It is more appropriate to describe some degree of impairment, whether in terms of reduced capacity, time limits of sustained concentration or specific difficulty with concentrating on several tasks at the same time.

*Disability.* There are legal and nosological components to the definition of disability, but the most practically relevant definition may be that of the insurance industry. After all, psychiatrists often encounter the occupational disability issue when they are asked to complete claims forms. If a psychiatrist does not understand the perspective of the employer and insurance carrier, results for the patient can be unnecessarily dire.

The insurance carrier is typically represented by a case manager, also known as an *adjudicator* or *claims analyst*, who is bound by the terms of the existing contract with the patient (whether as an individual or a member of a larger entity such as a union or professional group). Such contracts define the criteria that must be satisfied in order to qualify an individual as disabled. The terms of such contracts vary considerably with respect to the disability criteria, qualifying period or whether the coverage applies only to the patient's 'own occupation' or to 'any occupation', even on a part-time basis or lower rate of salary. Decisions about disability criteria are not personal, and are not ultimately the responsibility of the psychiatrist. Failing to meet these criteria does not deny a patient's illness, impairment, or suffering.

The case manager compares the information provided by the physician with the criteria of the relevant contract and the nature of the workplace. This involves a comparison of the diagnosis, prominent symptoms and degree of functional impairment with the particular position, essential and nonessential job requirements and possibilities for flexibility or accommodation. The case manager usually has access to an experienced occupational psychiatrist on the insurer's Medical Board: but note that it is the manager, not the Medical Board consultant, who is charged with formally determining the presence of a compensable disability.

The psychiatrist's written assessment must be directly responsive to an insurance carrier's disability criteria. Simply writing that a patient cannot work due to their medical condition is no guarantee that they will receive financial support during work absence. For example, if the medical assessment fails to show that Jennifer's condition meets the criteria for coverage, her claim will likely be declined. Furthermore, if there is delayed or miscommunication between psychiatrist and insurer, she may not discover her lack of coverage until she has been off work for months. This not only results in undue financial hardship, but also may rupture a therapeutic relationship or lead to an entrenched conflict with the insurer.

### Sick time, short term disability (STD) and long term disability (LTD)

Physicians will encounter patients at various stages of disability. The requirements with regard to evaluating the patient at each of these stages are somewhat different.

The Canada Labour Code generally protects employees during work absence due to illness or injury for up to twelve weeks. This maintains the security of their position and benefits, but does not guarantee salary continuance. If the employee does have salary continuance, the amount and duration will depend on their employment contract, accrued 'sick time' and nature of the illness or injury. An employer may require a note from a physician if an employee has been absent, or is expected to be absent, for an extended period of time. If they have used up their sick time and their regular weekly income has been reduced by more than forty per cent, qualifying employees may be obliged to apply for Employment Insurance. In order to receive Employment Insurance, the employee's physician is required to submit a medical certificate. The medical practitioner is asked to confirm that the individual is currently incapable of working and to provide an estimated date of recovery; a diagnosis or specific disability is not usually required.

STD coverage will pay benefits to the worker up to a specified time period: contracts vary in their maximum STD coverage, but often set the maximum at 3-6 months. For an STD claim, the type of information required varies from plan to plan: most require a specific diagnosis and a clear description of current symptomatology, as well as an estimate of when the individual will be recovered sufficiently to return to work. If you think that your patient has a diagnosable disorder, it is preferable to state this fact, rather than simply identifying "stress" or workplace problems as the reason for the claim. Employers and Insurers will not accept the "stress" explanation as an appropriate basis for a disability

claim; an inability to cope with family issues or changing workplace demands is not a disabling illness. In general, making a diagnosis such as "Adjustment Disorder", accompanied by appropriate supporting evidence regarding symptoms and functional deficits, is more effective than simply referring to stressors in the patient's life or workplace.

LTD coverage will pay financial support to your patient for a variable length of time and at a proportion of their prior income, depending on the contract. Most Canadian plans will pay until age 65, if disability criteria continue to be met. More detailed information is typically required for an LTD claim, including diagnosis, symptoms, clearly-specified functional deficits and description of current treatments. Furthermore, there is typically a requirement to re-evaluate the patient's diagnostic, functional, and treatment status at regular intervals. A red flag 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 dose of medication and seeing his or her psychiatrist every two months for non-specific supportive therapy.

## Form-filling

*Filling out forms* is a notable requirement of disability assessment by psychiatrists. It can place psychiatrists in the awkward role of invoicing patients for this task if the pertinent disability contract makes no provision for reimbursement by the insurer. Rather than berating the insurance carrier, practitioners should inform themselves about items not covered by the carrier and, if necessary, arrange with the patient an acceptable plan for payment. While acknowledging the frustration of extra paperwork, we must emphasize that disability evaluation forms are the primary way for insurance case managers to obtain the information needed to perform their job effectively.

Here is a typical disability evaluation form, along with some explanatory comments.

<i>Kumquat Insurance Corp.</i>	
<u>Disability Evaluation Report: Physician</u>	
Name: _____	Date of birth: _____
Date at which disability commenced: _____	
DSM-IV Diagnosis: _____	①
Symptoms: _____	②
Current Treatment: _____	③
GAF rating: ____	④

① The diagnosis must be as specific and credible as possible. For example, "stress" is not a psychiatric diagnosis. Post Traumatic Stress Disorder has a number of complex diagnostic items and specific criteria which need to clearly be identified and supported; it is also not generally diagnosable in the face of workplace stress, conflict or even harassment from boss or co-workers etc. Generalized Anxiety Disorder is usually chronic, and although unpleasant, is rarely disabling on its own. Even "Depression" is not a specific diagnosis, and may not itself speak to whether an individual can work or not.

② Symptoms should be specific and in keeping with the given diagnosis. The more detail provided here, the better the chance of the claim being accepted by the insurer. Details about daily functioning, if not requested elsewhere, can usefully be included here: what exactly do the symptoms prevent your patient from being able to do?

③ Current treatment should reflect the diagnosis and symptomatology, and also the fact that you are claiming that your patient is ill enough that he or she cannot work. Particularly in long term disability cases, passive or infrequent treatment when a patient is apparently highly impaired on an ongoing basis will understandably trigger questions: why hasn't the dose been raised, the medicine augmented or changed, group therapy or individual CBT sought, or more frequent contact made with the patient?

④ The GAF is imperfect, but can be useful when looking at consistency. A claimant separately describing a reasonable family life, some volunteer work, and a relaxing trip to Hawaii, does not have a GAF of 40-45.

Thoughtful attention to completion of required documentation will reduce the likelihood you will be asked for further information. When you have been asked for copies of your clinical office notes, this is indicative of a concern that the information provided so far is inadequate for determining a patient's disability. For example, the case manager may be seeking confirmation that the patient was, in your estimation, symptomatic and impaired when they actually began their work absence. If you are confident that your patient is very ill and that the issue revolves around information transmission to the insurer, consider telephoning the case manager to explain this and give the requisite details (with appropriate patient consent). Most psychiatrists are not comfortable directly providing their notes under the generic consent given to the insurer by their patients; the Canadian Psychiatric Association clearly supports this stance for obvious reasons of confidentiality and therapeutic alliance. Getting further direct guidance from your patient or taking a few minutes to black out "personal" issues in the notes and then getting patient approval for distribution may be other ways to address this. Likewise, a narrative letter outlining your patient's condition and impairments, along with detail concerning onset and duration of illness, may suffice. That said, a letter providing nonspecific assurances that the patient is under the physician's care and will be unable to work for a protracted period of time is unlikely to be considered sufficient by the insurance company.

## Recommending work absence

The decision as to whether a particular individual must take time away from the workplace has important consequences for the patient and deserves careful consideration. Typically, a psychiatrist will recommend disability leave from the workplace because an individual is judged to be incapable, due to illness, of handling the demands and responsibilities of their job. The psychiatrist may base recommendation for duration of absence upon projected time required for resolution of symptomatology and recovery of function. For example, it is realistic to expect substantial recovery from uncomplicated treated depression, in most cases, within six to eight weeks.

In estimating the likely duration of absence, consider whether this patient has had previous episodes of mental health-related disability absences. Such episodes may significantly extend the expected length of absence. This will be especially true if there have been one or several failed courses of treatment or failed work returns -- worsening the prognosis and raising the length of absence expected. It is, of course, this type of patient who is most likely to be under the care of a psychiatrist, rather than exclusively a primary care physician.

Direct illness issues aside, estimated or recommended duration of absence is also influenced by the perceived costs and benefits of work absence.

*Benefits* of work absence, from the perspective of recovery, include:

- the patient will be removed from occupational stresses or conflicts, allowing them to stabilize and reintegrate in a protected environment.
- the patient will have more time and opportunity to engage in activities conducive to recovery such as psychotherapy, exercise programs, rebuilding of disrupted connections to friends and family, etc.
- the patient will be at less risk of involvement in a work-related injury or incident. This is particularly germane to those individuals working in 'safety sensitive' positions where such an occurrence could result in significant threat to their own health or the health of their colleagues or the public.

*Costs* of work absence include:

- the patient may become inactive, retreating to bed or couch, a behavioural pattern likely to worsen depression.
- the patient may become isolated lacking the usual social contacts afforded by the workplace, once again a factor likely to worsen mood problems.
- the patient may develop a secondary anxiety pattern after extended work absence in which they become more apprehensive about work return, doubting their own competence and fearing that coworkers will respond with resentment or pity when they do return -- in effect, a kind of workplace phobia.

- there is research data indicating that prolonged absence from work is a negative prognostic factor with regard to whether an individual ever returns to work -- the longer one is absent on a disability leave, the less likely that one will ever return to gainful employment.(4)

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 taken as a given that a patient diagnosed with Major Depression, for example, needs to take several months of work absence to recover. There are pros and cons to remaining in the workplace while recovering from a disorder (with therapeutic support) vs. staying at home to await recovery. Furthermore, participation in the workforce is often itself a potent and positive therapeutic factor. As Marie Jahoda, a pioneer of the positive mental health movement, pointed out, work provides structure, meaning, and an opportunity for social interaction.(5) Work also provides an income, which is good for one's mental health.

## Establishing realistic expectations

The psychiatrist will often be asked by patient or case manager to indicate the expected time for recovery of work function. This task can be frustrating, since there is more evidence available concerning reduction of psychiatric symptomatology than recovery of occupational function.

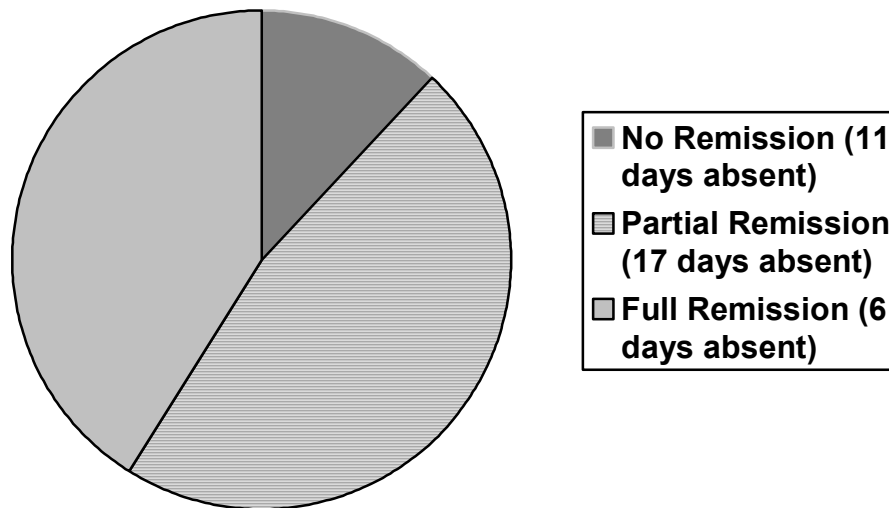
The relationship between symptom reduction and functional recovery is a complex one. An early review concluded that functional recovery is a delayed impact of treatment, continuing to improve long after maximum symptom reduction.(6) This implies that one should continue standard depression treatment well after symptom resolution in order to obtain functional recovery. The physician could confidently inform the patient and case manager that substantially more functional recovery could be expected after symptom improvement by continuing with the same treatment approach.

However, subsequent and more sophisticated research has made it clear that functional recovery in Major Depressive Disorder does not lag behind symptom improvement. (7-10) On the contrary, changes in symptoms and function are synchronized and reach their peak within the first few months of treatment.(11) The psychiatrist can no longer be quite so confident in providing assurance that functional recovery will eventually occur; it may be that "what you see is what you're going to get". Based on current evidence, failure to achieve functional recovery within several months of treatment for depressive illness suggests a change in treatment or rehabilitation strategy.

Furthermore, well-designed research indicates that standard psychopharmacological treatment for Major Depressive Disorder leaves a significant gap with regard to functional recovery. For example, the figure below shows outcomes in terms of work absence related

to Major Depression in the year after a standard course of appropriate pharmacological treatment. (12)

**Depression treatment outcomes (average days of work absence over both years)**



Standard treatments for Major Depression can have limitations with regard to recovery of occupational function, and other types of intervention may be needed to augment them. One response to the need for augmented intervention has been the addition of other psychopharmacological treatment such as antipsychotic, mood stabilizing or stimulant medications. However, the scientific evidence base supporting these pharmacological augmentation strategies for job-related functional improvement is still rudimentary. The bottom line is that we do not yet know consistently effective means of enhancing the impact on functional recovery of standard treatments for Major Depression.

Some evidence suggests that Cognitive Behavioural Therapy has particular benefit with regard to functional recovery. First, two studies indicate that CBT has a beneficial effect on work function above and beyond the impact of antidepressant medication, when these treatments are given in tandem.(13, 14) Another study found that CBT showed a specific advantage over antidepressant medication with regard to reduction of disability and work absence, even though the treatments were equivalent in reducing depressive symptomatology.(15) One researcher suggested that "[CBT] psychotherapy has a direct effect on psychosocial functioning through therapeutic work on issues that have relevance to psychosocial functioning, such as the building of social skills."(16) In many disability cases, even after impressive symptom reduction, a patient may retain: loss of confidence; expectation of condescension or criticism by colleagues; worry about competency in a changing workplace; or concern as to how to again handle a difficult co-worker or

supervisor. The addition of CBT in such circumstances might well have a clinical benefit in helping this patient back to work successfully. The focus of CBT is on active goal-setting, problem solving and re-engagement, all of which are characteristic of successful rehabilitation programs.

Further research will be required in order to determine the optimal approach to enhancing occupational recovery in Major Depression. For now, the psychiatrist should consider recommending nonpharmacological interventions such as CBT where standard pharmacological treatment has not been effective in achieving adequate recovery of occupational function. Note that case managers or insurers' Medical Coordinators may be able to fund such additional treatment in cases where occupational recovery has been elusive; direct contact with the insurer by the psychiatrist is often helpful in this regard. In addition, employees may continue to have access to some degree of coverage for psychological services through their extended health benefit plans.

### Fostering the patient's role in recovery

Self-management of chronic or recurrent disorders has received increasing emphasis in research literature and clinical guidelines over the past decade. It refers to involving the patient in collaborative care of the disorder:

Effective self-management support means more than telling patients what to do. It means giving patients a central role in determining their care, one that fosters a sense of responsibility for their own health... Using a collaborative approach, providers and patients work together to define problems, set priorities, establish goals, create treatment plans and solve problems along the way.(17)

This approach is perhaps idealistic given the time constraints and other realities of usual clinical practice. Nonetheless, a collaborative approach that emphasizes self-management seems most likely to reinforce the patient's sense of competence, autonomous decision-making and goal setting. These are crucial factors in enhancing functional recovery and supporting return to productive work. Assisting the patient toward some degree of self-management of the disabling disorder may be a useful intervention.

First, it is useful to encourage the patient in active coping with difficulties in the work situation. Major Depression is often triggered or strongly influenced by workplace situations involving changes in occupational demand, perceived lack of support or interpersonal conflict.(18,19) Thus, encouraging the patient to identify workplace issues associated with the onset of depressive symptoms and adopt a problem-solving approach are likely to be helpful interventions.

Second, the patient on disability leave may be encouraged to maintain lines of communication with the workplace, rather than avoiding all contact out of shame at being unable to function. This provides the patient with potential sources of support (e.g.

supervisor, co-workers, human resources or occupational health staff in the workplace) and increases the sense of continued relationship with the workplace. Similarly, communication with the insurance company case manager regarding ongoing status is to be encouraged.

Third, collaborative decision-making concerning the appropriate duration of disability leave will maximize the patient's sense of personal effectiveness. The psychiatrist can provide a helpful framework for work return by emphasizing the balance between reducing workplace exposure to assist symptom recovery and protecting the patient from work "deconditioning" and demoralization. The goal of returning the patient to work should ideally be presented and discussed as a key component of treatment and symptomatic recovery. Monitoring this, and not allowing occupational functioning to be stripped or sidelined from the overall therapeutic process, allows for a more active and efficacious approach to the situation.

Fourth, a number of research studies have shown that dissemination of self-management material to individuals suffering mildly to moderately severe clinical depression is associated with high rates of compliance and significant symptom reduction.(20) It is worth noting that more workers suffer mild than severe depression and that mild depression is nonetheless associated with significant impairment of work function.(21) A manual to enhance self-management of depression has been developed by the Mental Health Evaluation & Community Consultation Unit at the University of B.C., and is available for free download from the Internet.(22)

## Conclusion

The management of depression-related disability is challenging for all participants, although the one with most at stake is the patient. Thoughtful evaluation of the patient's functional status, careful response to the requirements of disability determination and focus on functional recovery yield substantial benefits.

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