Disabled and dumbfounded?

Making a difference in a mental health patient's functionality and keeping them at work

Divulgation des conflits d'intérêts

Conseil consultatif ou comité analogue	
Essais cliniques ou études	
Honoraires ou autres revenus	Valeant, BMS, Otsuka, Eli Lilly, Lundbeck, Janssen, Shire
Subventions de recherche	

objectives

- Work with patients suffering from mental health problems to:
  - First: promote full function
  - Stay at work
  - Know how to properly fill insurance documents with a psychiatric slant
  - Return to work

Filling out insurance disability documents for mental health patients

One. Be as precise as you can be. If a patient has difficulties at work, interpersonal problems, financial difficulties, or other social stressors that are causing symptoms of disability, make sure to write that there is an adjustment reaction component to the problem. It is easy to write depression as a diagnosis in most of these cases, but that is not entirely accurate. Furthermore, it lends a certain long-term flavor to the problem, which might prolong disability as well. If these adjustment reaction problems persist for more than a couple of weeks, are very debilitating, and have strong suicidal features, then one might write that there are both adjustment reaction and depressive problems concurrent in this case.

Two. Use the disability document as your own personal therapist. If you have any concerns, difficulty in understanding discrepancies, or are not progressing with the client, right this diplomatically in the insurance document so that the level of difficulty is understood by the insurance company, and the appropriate resources are mobilized for the patient. In this way, there can be a therapeutic element for the professional in filling out the insurance document.

Three. Do not ask what you can do for the insurance company, but what the insurance company can do for you. Getting more or supplementary sessions of psychotherapy, the involvement of reintegration specialists, an occupational therapist, or specialty evaluations, can be procured for our patients if we write them in our insurance documents that are periodically filled throughout treatment.

Four. Talk to the insurance company doctor. The insurer will get a better picture of your difficulties in treating the patient, and are more likely to supply support, when they speak to the treating doctor directly. These physicians are generally very open to feedback, and helpful in terms of establishing supplementary services or return to work.

Five. Use the DSM-IV five axis classification system. The DSM-V is nifty, but the five axis system is truly good at describing the total picture of what the patient suffers from. Like a college exam, a GAF score of 60 or below means the patient fails from work, and should not be working. The best of us, in the best of health, and in the best of times, only have a GAF score of about 80.

Six. If the client is to be worked disabled, then it should be documented in the insurance forms that you have recommended that he absolutely engage in certain activities while out of the workplace. The goal of being out of the workplace is to condition oneself to return into employment as quickly as possible. Clients who stay out of the workplace for a year or more have less than a 12% probability of ever returning to any workplace whatsoever. The consequences of this for families, socialization, and mental illness is devastating.

As such, clients must engage in regular exercise while off on disability. They should adopt the Mediterranean whole foods diet. They must keep in touch with their friends at work to know what is going on, and what the gossip is. Early on in the treatment of their depression, they must not be in an overly strenuous or introspective psychotherapy, since this might worsen the emotional and anxious features of axis one disorders. Supportive psychotherapy, with a slant towards healthy living, healthy

relationships, and an attitude that work must be engaged with, is absolutely necessary. Please write all of these endeavors and interventions into your treatment plan included with the disability forms.

Six. Charge the patients for any and all forms are disability letters that you write for them. Even for our poorest patients, billing five dollars is absolutely necessary. The money and the earnings are completely unimportant, it is the client proactively having to pay for disability, and participating in the process, that is most important. There is no free lunch, and our patients must understand that this ability comes with a price.

Seven. Attached is a list of clinical symptoms and signs that are translated into cognitive and functional terms that employers and insurance companies understand. For example rather than stating that a patient is highly irritable, or has cognitive dysfunction, we should write on our forms that the patient will have difficulties with interactions due to an argumentative nature, and that the ability for the employee to organize himself to be efficient and quick in doing tasks is compromised. This makes a big difference in the company's assessment of the situation.

Eight. Use the antidepressant skills workbook text, a truly remarkable work of cognitive-behavioral therapy developed for free by a group of psychologists at the University of British Columbia, and available free online, to help patients reassess their work capacity and what can be done in the workplace to facilitate their future reorientation and integration. Putting this into your insurance form plan tells the company that you have implemented true biopsychosocial treatment, and, if the patient is not following through with these measures, will give everyone a better idea as to the motivation for change and have future treatment is developed.

Nine. If patients appear to not be taking their medication, exaggerating or falsifying symptoms, are not seeing you regularly, come in only to get their insurance forms filled every two months, or have contradictory clinical findings, it is not up to us to say that they are malingering, but we may state clearly in the insurance forms that the client's progression is erratic, idiosyncratic, and perhaps requires a psychological or psychiatric evaluation. While it is up to us to note contradictions in the patient's behaviors, we are not policeman.

Ten. Whenever possible, try to keep patients in the workplace. This may require part-time work, altered duties, a lighter load, and the more strict definition of what the patient should be doing in the workplace. We often see disabled workers who have several bosses at a time, who cover for less competent employees in the workplace, who work long hours, and to seem to hold workplace productivity together. If we wish to keep certain of our patients in the workplace, noting this in the insurance documents, and getting that situation investigated, can be very useful. Again, use the disability papers as your friend.

Work is a basic function of life

"What we do affects how we feel just as much as how we feel affects what we do." (Vaillant, 1982)

Disability claims …

- *For depression have gone up by 30% in recent years*
- *Why?*
  - *More social complexity & strife in the workplace*
  - *More emotional & time investment in the workplace*
  - *Better insurance plans and more mental health conscious consumers*
  - *Advocacy and recognition of emotional abuse in the workplace*

Risk Factors for disability (non axis-1)

- Job strain is a form of psychosocial stress that occurs in the workplace. One of the most common forms of stress, it is characterized by a combination of low salaries, high demands, poor job definitions, and low levels of control along with raises and paid time off regarding one's job
- High Risk jobs for disability (Number 1 is…)
- Pareto principle: 20 % do 80%
- The borderline quandry: 70%
- Clash of the personality disorder titans
- The Disability Trap: Use it if you have it
- Disability causing disability and depression

Disability assessments are not reliable

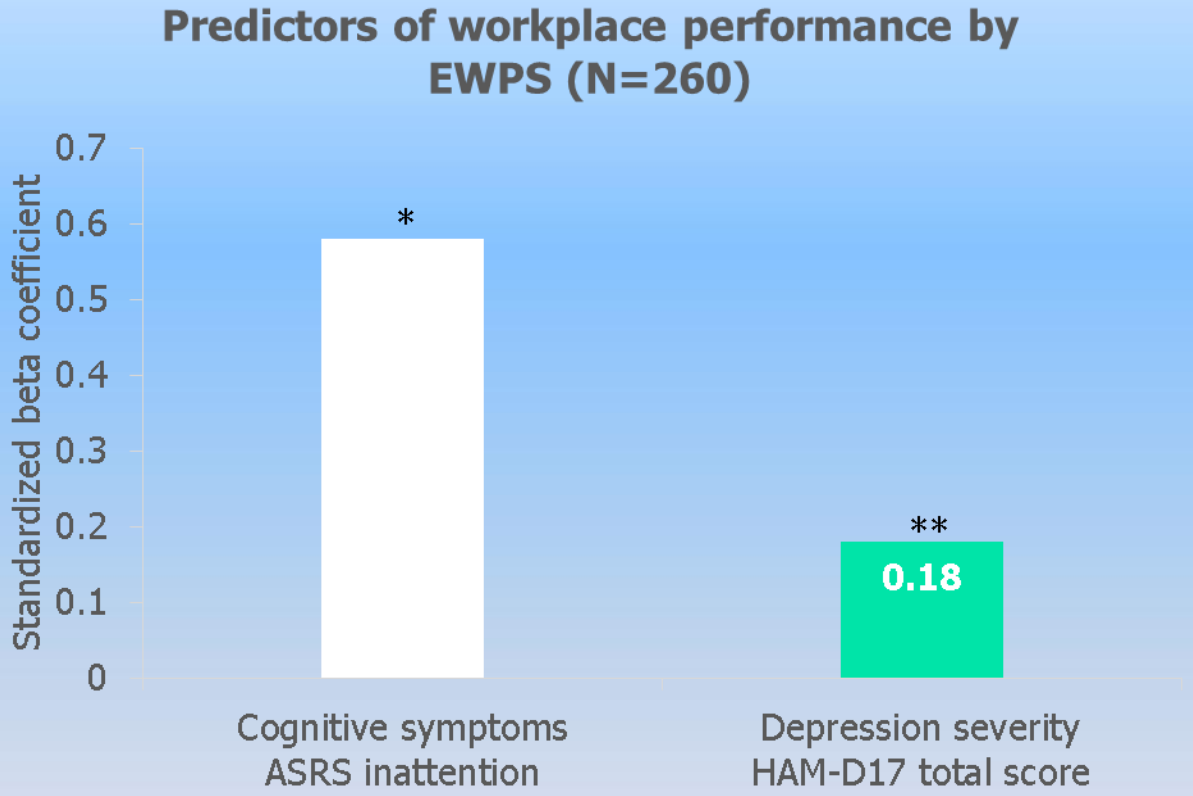
- Even clinicians given the same strict course training have poor inter-rater reliability (2019)
- Reasons: personal and psychological philosophy on disability, medical-legal fears, patient pressure, the requirements of the employer, the type of mental health disability

It must be understood that…

- *For clinicians & therapists an objective evaluation of disability is difficult:*
  - *There is no standard for measuring stress or ability to function in the workplace*
  - *The patient's mental status can vary in and out of the examining room*
  - *We are put in a conflict of interest as treators*
  - *We have nowhere to turn for help*
  - *We want to care and "take the pain away"*
  - *So…time off work may be the only tool available to the clinician, even if it is inappropriate*

Potential consequences of disability:interlocked negative cycles

Cognitive Symptoms of MDD Predict Workplace Productivity and Performance



Cognitive symptoms account for more variability in workplace functioning than total depression severity

*p<0.001.
**p=0.00.

ASRS, Adult ADHD Self-Report Scale; EWPS, Endicott Workplace Productivity Scale; HAM-D17, 17-item Hamilton Rating Scale for Depression.
McIntyre RS, et al. Compr Psychiatry 2015;56:279-82.

Medical Insurance Reports

Stated goal;

- *justify time off work: not just to wait for an antidepressant to work; i.e. psychotherapy planning; initiation of workplace facilitation; crisis management*
- *provide services to aid productive work reintegration and encourage health*
- *record progress and course of treatment*

Our additional Goals….

- *above, plus…*
- *long term amelioration*
- *improved quality of life*
- *Provision of services not otherwise affordable/available*
- *Getting aid in psychological, pharmacologic evaluation*

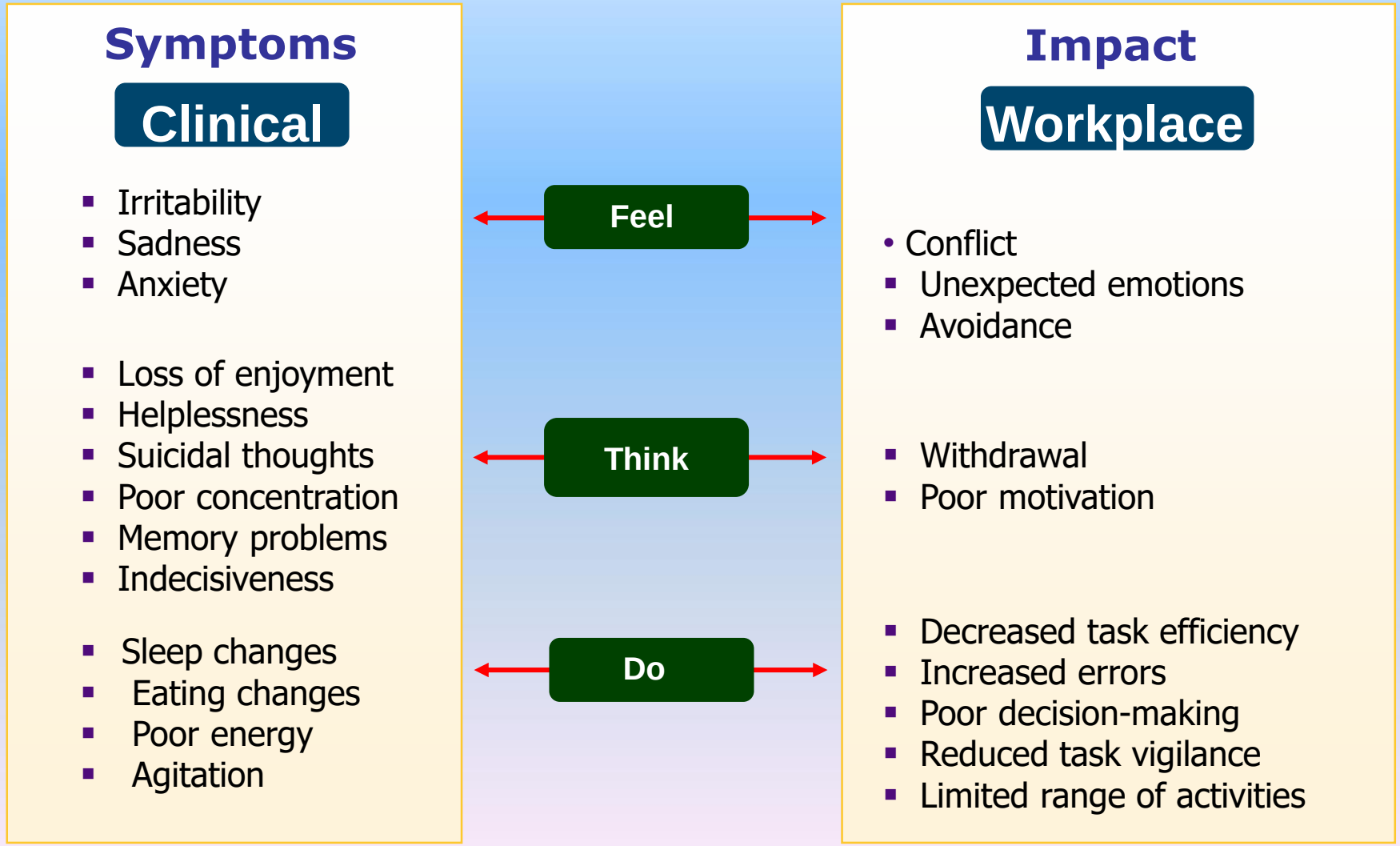
Prevent long term dependency/disabililty

Treatment planning

Your mantra:

Ask not what you can do for the insurance company, but what it can do for you.

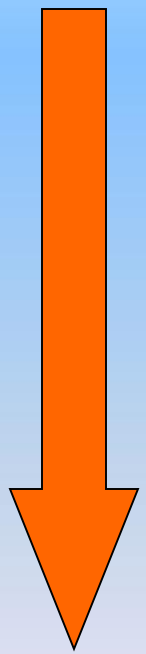
How might depressive symptoms translate into functional impairment?



Adapted from Bender A. *Can J Diagnosis* 2011;28(1):13-20.

Early Intervention is critical

Increasing costs



- *Recognition and early intervention*
- *Optimization for remission*
- *Monitoring progress*
- *Work rehabilitation and other Rx modalities*
- *Work reintegration*
- *Re-evaluation and long term disability*
- *Poor prognosis for reinsertion*

Increase as the illness burden

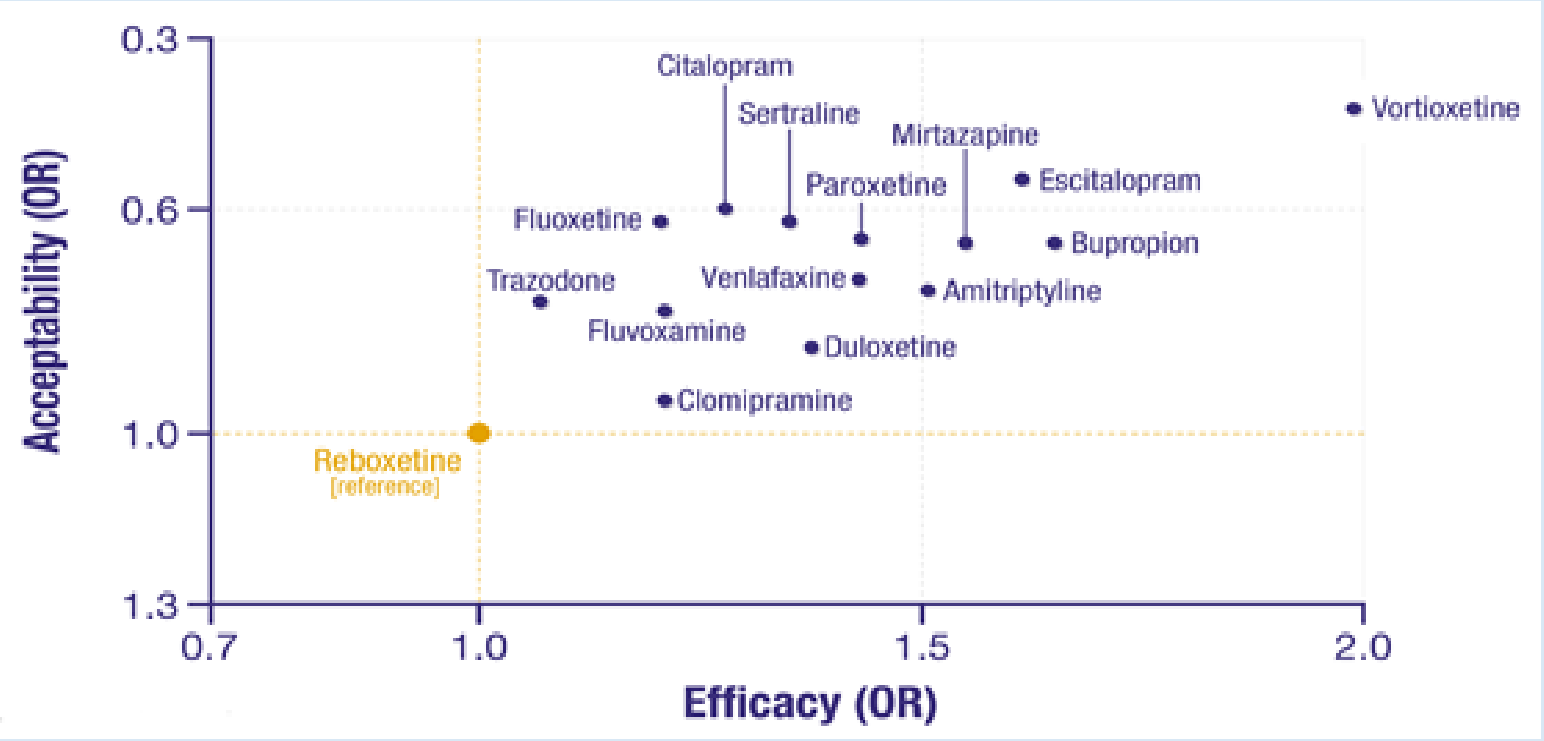
How to short circuit depression resistance

- **Apply scales, labs, and good history to rule out other treatable morbidity:**
  - Borderline personality +/- dependent, narcissistic
  - Workplace and adjustment dynamics: work role, stress, strain, interpersonal, secondary gain
  - Hypothyroidism and metabolic imbalances, sleep apnea
  - Bipolar depression: see criteria
  - Comorbid anxiety +/- insomnia: careful use of benzos
  - Substance overuse or abuse: even low grade alcohol, THC, hard drugs, benzos
- **Do not wait: start pharmacotherapy +/- atypicals and go to next steps quickly:**
  - Rapid dose optimization with new generation drugs: easily dosed, effective, minimal SFX
  - Knowledge of effective boosting strategies and their doses
  - Use scale score guided depression treatment (PHQ (and others)
  - Optimize cognition quickly
  - Weight gain early: switch; check for sleep, anxiety, sexual side effects: antidotes
  - Comorbid "atypical" boosters: vitamins, light therapy, ketamine(?)
- **Use adjunctive behavioral and cognitive strategies from the start, even if book or internet based:**
  - Behavioral activation framework
  - Antidepressant skills workbook: slant towards employment and staying employed
  - Exercise daily
  - Whole foods diet/ Mediterranean: Viva L'Italia!!!

Use modern medications

- Whenever insurance coverage allows, modern medications are
  - easy and quick to dose adequately
  - much better with the side effects that inhibit function
  - Less likely to cause “asthenia” (esp. cymbalta, abilify)
  - If using benzos, low dose them regularly, no prns , and taper as improvement happens

Efficacy and Acceptability: Simplified Version of Head-to-head Trials



Confidence intervals have been removed for visual clarity.

Reboxetine, the reference drug for the meta-analyses, is not available in Canada.
OR, odds ratio.
Adapted by Kennedy SH, et al. from Cipriani A, et al. Lancet. 2018;391(10128):1357-66.

Treatment Recommendations for Cognitive Dysfunction in MDD

CANMAT recommendation		Notes
Pharmacotherapy	Vortioxetine (Level 1) Bupropion (Level 2) Duloxetine (Level 2) SSRIs (Level 2)* Moclobemide (Level 3)	Limited data available on cognitive effects of other antidepressants and on comparative differences in efficacy
Non-pharmacological	No specific recommendations	

***Criteria for Level of Evidence**:*

Level 1: Meta-analysis with narrow confidence intervals and/or two or more randomized controlled trials (RCTs) with adequate sample size, preferably placebo controlled

Level 2: Meta-analysis with wide confidence intervals and/or one or more RCTs with adequate sample size

Level 3: Small-sample RCTs or nonrandomized, controlled prospective studies or case series or high-quality retrospective studies

Level 4: Expert opinion/consensus

**Comparisons only with placebo.*

CANMAT, Canadian Network for Mood and Anxiety Treatments; SSRI, selective serotonin reuptake inhibitor.
Kennedy SH, et al; CANMAT Depression Work Group. Can J Psychiatry 2016;61(9):540-60.

Global assessment of function; (GAF)

- *In psychiatric illness:*
- *Score of 40 = hospitalization cut off*
- *Most of us: 70-80 under optimal conditions*
- *Do not include*
  - *Physical or medical handicap*
  - *Inability to function due to environmental stressors or impediment unless it carries over to all life circumstances*

Travail et dépression : optimisation du rétablissement fonctionnel et professionnel

Questionnaire sur la santé du patient (PHQ-9)

Nom du patient	

Visite (encerclez)	VI	V2	V3	V4
Date				

Questionnaire PHQ-9

1. Au cours des 2 dernières semaines, à quelle fréquence avez-vous été importuné par l'un ou l'autre des problèmes suivants? (Encerclez votre réponse.)

POINTAGE

Jamais	0
Plusieurs jours	1
Plus de la moitié du temps	2
Presque chaque jour	3

	VISITE DU PATIENT			
ITEM	V1	V2	V3	V4
a. Je tire peu d'intérêt ou de plaisir à faire des choses	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
b. Je me sens triste, déprimé ou désespéré	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
c. J'ai du mal à m'endormir ou à rester endormi, ou je dors sans fin	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
d. Je me sens fatigué ou je manque d'énergie	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
e. Je manque d'appétit ou je mange avec excès	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
f. J'ai une mauvaise image de moi ou j'ai l'impression d'avoir raté ma vie ou d'avoir laissé tomber les miens	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
g. J'ai du mal à me concentrer, par exemple pour lire le journal ou regarder la télévision	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
h. Je bouge ou je parle tellement lentement que ça se voit. Ou, au contraire, je suis agité ou nerveux au point de bouger beaucoup plus que d'habitude	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
i. Je vois la mort comme quelque chose de souhaitable ou j'ai envie de me mutiler d'une façon quelconque	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
SOMME DES COLONNES / SCORE TOTAL				

2. Si vous vous êtes heurté à *n'importe lequel* de ces problèmes, avez-vous éprouvé des *difficultés* à accomplir votre travail ou vos tâches ménagères ou dans vos relations avec les autres?

☐ Aucune difficulté ☐ Quelques difficultés ☐ Grandes difficultés ☐ Difficultés extrêmes

RÉFÉRENCE : PHQ-9 est une adaptation de PRIME MD TODAY, conçu par les Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke et al., grâce à une subvention à l'éducation accordée par Pfizer Inc.

Questionnaire PHQ-9

(Patient Health Questionnaire)

- *Auto-évaluation de la dépression*
- *Conçu expressément pour la médecine de premier recours*
- *Très sensible et destiné précisément au diagnostic de la dépression*

RÉFÉRENCE : PHQ-9 est une adaptation de PRIME MD TODAY, élaborée par les Drs Robert L. Spitzer, Kurt Kroenke, et Janet B.W. Williams.

Promote health whenever possible

- Explain the insurance process from the start and why it should be short term
- Use “adjustment reaction” diagnoses when appropriate, avoid depression diagnoses in acute stressor situations
- Only write 2 week disability periods on the forms wherever possible
- Use a psychologist’s services early when possible, even if the patient has a limited number of paid sessions
- Charge for the forms whenever possible

Health whenever possible….contd.

- Part-time, modified work
- Communicate/socialize with friends from the workplace when possible
- Exercise is a **must**
- Do not assume a stereotyped depressed role: Behavior activation needed!
  - Do not avoid situations because of anxiety or disappointment
  - Schedule pleasureful rewarding activities everyday from a list of favorites

Focus on function

- Use the PHQ-9 and SDS disability scale to get a measure of the severity of symptoms, even when the diagnosis is not yet depression
- On the disability forms, describe the functional deficits that prevent a return to work using the following table:

Use work as part of the solution…

- Write the patient's concerns on the disability forms when appropriate
- Resources you can ask for to ease the passage back to some work:
  - Reintegration specialist
  - Part time work
  - Modified work responsibilities
  - Ongoing psychology sessions; ask insuror to increase number of sessions that are covered

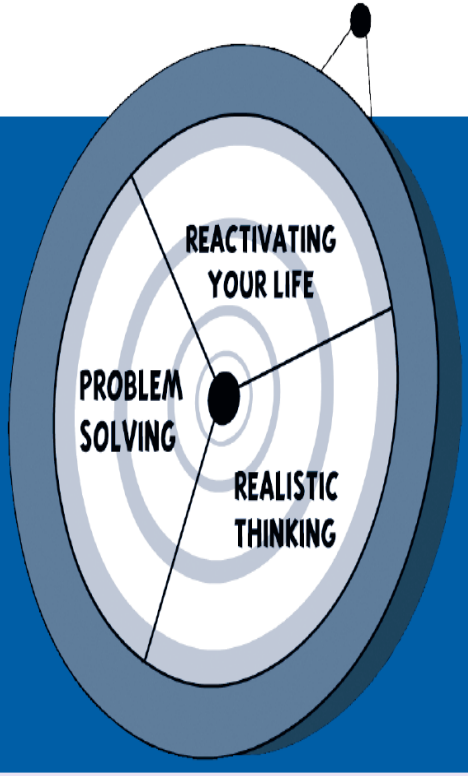
SELF-CARE DEPRESSION PROGRAM

2ND EDITION

ANTIDEPRESSANT SKILLS WORKBOOK

ANTIDEPRESSANT SKILLS AT WORK:

Dealing with Mood Problems in the Workplace



Learn when to stop

- It is not up to us to play police officer at this point
- By this time, the insuror generally asks for an expertise, which usually endorses a return to work.
- “The patient does not believe herself capable of a return to work at this time, despite prior improvement.”

Exceptions to the rule: when patients can be off work

- *A "tragedy" adjustment reaction*
- *Psychosis, mania, active (not passive) suicidality or severe melancholic sx related to depression (not personality)*
- *Documented ongoing physical or sexual abuse in the workplace*
- *Inebriation that is during the work day (unlikely to receive benefits, however)*
- *Threshold is lower for high risk jobs*

Summary:

- Disability management is crucial in getting clients needed resources and preventing chronic loss of functionality
- Psychotherapy, reintegration specialists, and further evaluations can be provided through insurers
- Modified work, contact with the workplace, exercise, and social activities are key
- Using questionnaires standardly, and providing WILD with manualized CBT very useful