Psychiatric impairment and disability assessment — proposals to improve current inadequacies

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Impairment and disability assessment on psychiatric grounds has always been subjective, controversial and at best, a difficult task.

The South African Society of Psychiatrists (SASOP) needs to be congratulated, firstly on being instrumental in the publication of the first 'Guidelines to the Management of Disability Claims on Psychiatric Grounds'[1] in 1996, and secondly on following this up with an improved and revised version in May 2002.[2]

These guidelines have gone a long way towards improving the standards of report writing, increasing objectivity in the assessment process, and improving fairness and reasonableness of the outcomes.

However, it is apparent that certain areas still need to be brought to the attention of many psychiatrists. These are discussed below.

Adequate and appropriate treatment

Most of the bigger employers and insurers have trained and well-informed medical advisors doing their disability assessments. Many of these advisors have expressed major concern about the extent of under-treatment of psychiatric conditions before application for permanent disability (Dr Andre Botha (ESCOM), Dr Denys Schorn (Liberty Life), Dr Louis Boshoff (Momentum Life), Dr Chris Snyman (Telkom), Dr Chris de Beer (ISCOR), Dr Peter Bond (Old Mutual) — personal communication). This aspect has also been questioned in clinical psychiatry.[3]

It seems that the main focus of the treating psychiatrist has shifted from treating the patient with the aim of returning him or her to normal functioning, to conforming to published guidelines with the aim of assisting the patient to get a disability claim admitted.

This does not reflect well on the integrity, ethical conduct and professionalism of any psychiatrist. Psychiatry has become a play ball which is abused by clever employers and legal firms as an easy back door through which staff numbers can be reduced or reconstituted. A testimony to this is the steady rise in the proportion of disability claims admitted for psychiatric conditions, which increased to 34% of all claims in 2001 compared with 19.6% in 1997 (unpublished data: presentation by P Coetzer at psychiatric seminar, April 2000, Durbanville, title 'Business and health: on preventing psychiatric disability in the workplace').

An area of particular concern is the (lack of) treatment of major depressive episodes. Whereas clinical trials report very successful outcomes on modern-day antidepressant therapy[4-6] quite the opposite is seen in the disability arena (unpublished data: presentation by P Coetzer at psychiatric seminar, April 2000, Durbanville, title 'Business and health: on preventing psychiatric disability in teh workplace').

Very often patients are recommended for boarding by their treating psychiatrists after having been on monodrug antidepressant therapy at initiating dosages for 2 years. No attempts have been made to increase dosages, change to a different class of antidepressant, use a combination of drugs, or use augmentation therapy, lithium or other options. Yet these treatment guidelines are well known and accepted internationally.[2]

The same applies to many other psychiatric conditions.

The time has now come when risk carriers and employers who are concerned about absenteeism and the long-term wellbeing of their employees, are going to decline sick leave benefits as well as temporary and permanent disability benefits to patients who are continuously treated inadequately and suboptimally by psychiatrists.

As it would be fairly easy in such cases for the patient to prove that the psychiatrist did not act in his/her best interests, this may have significant medico-legal and financial implications for these psychiatrists. These clinicians will have to take responsibility for their (lack of) action.

It should be mentioned that access to treatment is taken into account in each case. In cases where patients have no medical aid and cannot afford the expensive modern classes of therapy, the different treatment options available at local governmental level will be considered. This will generally, however, still allow for increase in dosages and prescription of several types of drugs.

Lack of collateral information

The vast majority of psychiatric reports are based on patient self-report. This is virtually never substantiated by the evaluating psychiatrist by obtaining collateral information.

One would assume that a person incapacitated by psychiatric illness such that s/he will never be able to work productively again, would leave a trail of supporting collateral evidence.

It would therefore be prudent once again to emphasise the importance of telephonic discussion with the spouse, employer, family, neighbours and other social contacts of the patient in this regard. This task could be made much easier if a list of names and contact numbers is obtained from every patient before consultation.

While acknowledging the subjective nature of such collateral information in many instances, it may in addition be helpful to list part-time activities, club membership, sport participation, etc. Details of such social interactions should form an integral part of holistic case evaluation.

Evidence of consultation dates, prescriptions provided (contents and frequency) and compliance with psychotherapy will also be very useful.

It is important to realise that every effort should be made to obtain supporting information from any source other than the patient himself/herself.

Rating patient credibility and compliance

Whenever compensation becomes an issue, the credibility of the patient's description in terms of the severity of symptoms, efficacy of treatment, side-effect profile and impact on activities of daily life may be questionable.

Similarly, very often compliance with psychotherapy sessions, follow-up consultations and regular medication prescriptions may be suboptimal.

It would therefore be valuable to obtain feedback on both these aspects from the evaluating psychiatrist. Ideally, comments on patient compliance, co-operation and credibility should be part of any independent opinion report.

Different models utilising scoring systems to assess these aspects exist in medical literature. Alan Colledge *et al.*[7] have commented extensively on one such model, the Performance APGAR model. In this model Acceptance, Pain, Gut (intuition), Acting and Reimbursement are rated on a point system to arrive at a credibility score. This model could easily be adapted to suit psychiatric circumstances.

Duty for workplace accommodation

South African employment law with regard to managing impairment/disability in the workplace has developed extensively over the last decade. Legislature has in fact developed a holistic approach in order to ensure fair and equitable management of impairment in the workplace. Testimony to this is found in the following statutes.

Employment Equity Act (EEA) 55 of 1998[8]

This classifies people with disabilities as employees who had previously been disadvantaged, and who need to be advanced using the concept of affirmative action (section 1).

The Draft Code of Good Practice On Key Aspects Of Disability In The Workplace attempts to define people with disabilities and provide the employer with guidelines regarding the accommodation of such employees in the workplace.

Labour Relations Act (LRA) 66 of 1995

Schedule 8, Code of Good Practice — Dismissal deals with employees who have become incapacitated as a result of an injury or illness. The code determines that in the first instance an

employer has to consider the accommodation of an employee's impairment in the workplace (either through adapting the job outputs, working environment or by providing alternative work), and only if it is not possible can the employer terminate such an employee's services.

Basic Conditions of Employment Act (BCEA) 75 of 1997

In terms of the abovementioned statutes the employer needs to consider the nature and duration of the employee's impairment/disability before the employer decides on an appropriate response.

The nature of the impairment/disability needs to be expressed on a continuum ranging from partial to total. This refers to the employee's inability to perform the job outputs of his current occupation or of any alternative outputs. Total impairment would therefore mean that the employee is totally incapable of performing any job outputs, while partial would imply that the employee is capable of performing accommodated job outputs.

The duration of the impairment/disability refers to the period over which the impairment/disability would resolve. It is therefore expressed on a continuum ranging from temporary to permanent.

Not all psychiatric disorders/illnesses are totally disabling and those that only partially limit the capabilities of an employee should be accommodated in the workplace.

Unfortunately many employers opt for termination of the employee's contract of employment (through boarding, disability benefits or incapacity management) rather than accommodating an employee in the workplace. Such employers would of course use whatever assistance they can get and even manipulate the medical profession in assisting them with attaining their goal, namely the termination of the employee's contract of employment.

The only way in which this problem can be addressed would be for the psychiatrist to classify the patient's illness correctly, according to the four quadrants in Fig.1, and to advise the employer appropriately on reasonable workplace accommodation to assist the employee's productive return to work.

Reasonable accommodation

The aim of workplace accommodation is to reduce the impact of an employee's impairment on the employee's functional capacity and to enable the employee to fulfil the essential physical and

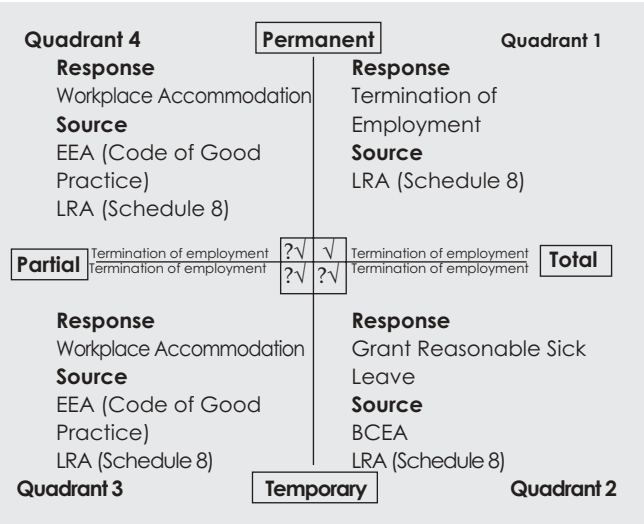

Fig. 1. Managing impairment integrated model — employer's response to impairment/disability

mental outputs of a specific job.[8]

Accommodation is to be considered in the following categories: (*i*) making facilities accessible; (*ii*) job restructuring; (*iii*) part-time or modified work schedules; (*iv*) reassignment to a vacant position; (*v*) providing support staff; (*vi*) special equipment or devices; and (*vii*) administrative adjustments.

Reasonable accommodation means to assist in enabling the employee to perform the essential functions of his/her job.

The employer has a duty to accommodate the impairment/ disability of an employee when:[8] (*i*) the employee voluntarily discloses a need for a disability to be accommodated, or such a need is reasonably self-evident to the employer; (*ii*) an employee's work environment or his work change, and the need for accommodation becomes apparent; and (*iii*) the employee's impairment varies to the extent that it affects the employee's ability to perform the essential functions of the job.

When accommodating an employee the employer may adopt the most cost-effective means. The employer need not accommodate an employee if it would impose unjustified hardship on the employer's business.[8]

Unjustified hardship would mean that in accommodating the employee the employer would encounter significant or considerable difficulty or expenses which would substantially harm the viability of the enterprise.[8]

The reasonableness of accommodatory measures will be influenced by the following factors: (*i*) the nature and cost of the

accommodation; and (*ii*) the overall financial resources of the employer.

However, the key is to be creative/innovative and to remember that each individual is unique.

Areas where the employer can accommodate employees are in the: (*i*) work environment; (*ii*) workflow (adjusted work outputs and alternative work); (*iii*) evaluation of work and compensation; and (*iv*) benefits and privileges of employment.

It is important that when contemplating the accommodation of an employee's impairment the employer should consult the employee and where practical, technical experts. This may include medical specialists, occupational therapists, etc. The aim would be to establish the most appropriate and feasible mechanisms to accommodate the employee's impairment.

The nature of the accommodation will depend on the individual's needs, the impairment and its effects on the employee's ability to perform work, and the nature of the employee's job and work environment.

Reasonable accommodation of psychological illnesses

As a first step it is important to determine the basic cause of the illness and to address it positively. This may imply any of the following: (*i*) poor worker/occupation compatibility; (*ii*) lack of control over his/her workplace; (*iii*) lack of social support; (*iv*) unpleasant work conditions; (*v*) monotonous work; (*vi*) shift work; (*vii*) over- and under-load of work; (*viii*) unexplained workplace change; and (*ix*) difficulties in handling peers/colleagues.

Accommodation of the psychologically impaired employee is by nature a complex matter. Fig. 2 provides a holistic model for the accommodation of employees suffering from psychological illnesses.

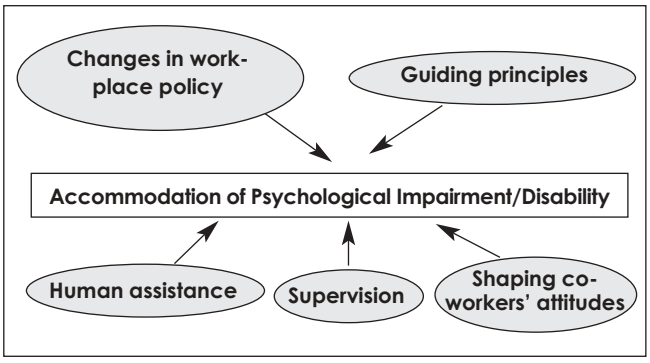

Fig. 2. Holistic model for accommodation of psychologically impaired employees.

Changes in workplace policy

In order to create effective workplace policies dealing with reasonable accommodation it is important to allow flexibility in enforcing such policies.[9] Policies should further support relatively inexpensive accommodatory measures such as:[9] (*i*) permitting contact with friends and other supportive individuals during work hours; (*ii*) if possible and practical, allowing such employees to work from home; (*iii*) providing enclosed offices for individuals who lose concentration and accuracy amid distractions; (*iv*) allowing employees to adapt work hours in order to attend medical appointments; (*v*) creating a job-sharing policy that will provide backup for the period that the employee is absent from work; and (*vi*) permitting the employee to self-determine the workload and pace at which the work is performed.

Guiding principles

The following overall guiding principles are suggested:[9]

1. Reasonable accommodation should be instituted in a manner that will empower the affected employee and that is non- stigmatising. In order to do so it is important to recognise the individual strengths of the affected employee and thereby recognise the potential contribution the employee may make to the overall goals of the organisation.

2. The employer should be willing to engage in joint problem solving with the affected employee. This would entail the involvement of the affected employee in decision making related to job restructuring and reasonable accommodatory measures.

3. The employer should create a culture/climate where the affected employee is able to accept reasonable accommodatory measures voluntarily. The employer should further provide an environment in which disclosure is not stigmatised but where the employee has certainty that confidentiality will be respected with regard to his or her illness.

Human assistance

Depending on the nature of the employee's impairment, the following strategies may be considered:

1. The appointment of a job coach to assist the impaired employee with the application of his or her skills while performing the required job outputs.

2. Individualised training for impaired employees. This could imply the designation of a co-worker to serve as a peer and/or

support for the employee, or the pairing of workers with mentors who could guide the impaired employee.

Supervision

Supervision is probably the single most important aspect in accommodating an employee who is psychologically impaired.

Supervisory accommodations could include the following:[9]

1. The employer should appoint a supervisor who is supportive and has good listening skills to supervise such employees, and provide training to supervisory staff in order to: (*i*) improve their ability to provide clear direction and constructive feedback; and (*ii*) offer praise and positive reinforcement appropriately.

2. Supervisors should further be clear with employees regarding job duties, responsibilities and expectations, and agree with the employee on short-term performance indicators so as to create certainty for the employee.

Shaping co-workers' attitudes

Employers should further educate co-workers on the subject of psychological impairment by providing sensitivity training, thereby dispelling myths with regard to mental illnesses.

Conclusion

It is important to realise that permanent medical boarding on psychiatric grounds is usually not in the best interests of either the patient or the economy of our country. Any recommendation in this regard should be carefully considered and objectively evaluated.

However, before permanent boarding, a few very important aspects need to be considered: (*i*) a *Diagnostic and Statistical Manual IV* (*DSM-IV*) diagnosis; (*ii*) adequate treatment supplied in terms of internationally accepted treatment guidelines;[2,4-6] (*iii*) assessment of functional impairment, substantiated by collateral information; (*iv*) classification of impairment as either total or partial, temporary or permanent (Fig.1); (*v*) recommendation on reasonable workplace accommodation by the employer, which may include any of the aspects mentioned in Fig. 2; (*vi*) failing the above, recommendation on any other type of work environment other than the present one, where useful functioning may continue in the absence of specific psychological triggers; and (*vii*) in cases of temporary impairment, recommendation on the period required for review.

Psychiatry is at best very subjective, and therefore subject to abuse and misuse. The above measures may go a long way towards restoring credibility to this medical specialty. The better the buy-in into these concepts, the better for all parties involved in the disability assessment arena.

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