Disability Management, Return to Work and Treatment

DISCUSSION PAPER

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ABSTRACT

Individuals with severely disabling mental illness receive more benefit from supported employment initiatives than from other vocational services, but these initiatives show variable job tenure and low implementation by governments. For those with less severely disabling mental illnesses, such as depression, evidence-based treatment results in substantial restoration of job function, and restored work function occurs in synchrony with reduced symptomatology. However, there is a substantial degree of residual impairment despite receiving standard treatment. Major research trends include an increasing focus on occupational recovery in less severe forms of mental illness and potential application of integrated disability management models to occupational recovery from disabling mental disorders. Promising research directions include effectiveness of standard mental healthcare in restoring work function; effectiveness of actively managing co-morbid mental health problems for disabling physical disorders; population factors affecting return to work in those with disabling mental disorders; identification of policies fostering occupational recovery for disabling mental disorders; effectiveness of innovative mental healthcare focused on occupational recovery; and organizational interventions to foster occupational recovery in employees with disabling mental disorders.

Introduction

The purpose of this paper is to discuss research issues related to disability management, return to work and treatment as they relate to people with mental health problems and mental illness in the workplace. The current report is one of a series of discussion papers being developed by a Working Group mandated by the Institute of Population and Public Health (IPPH) and the Institute of Neurosciences, Mental Health and Addiction (INHMA) of the Canadian Institutes of Health Research (CIHR) for the purpose of advancing research and increasing available evidence in the area of workplace mental health.

The paper has three main objectives:

(1) to report on the state of knowledge in the area
(2) to identify major trends in research
(3) to identify significant gaps in knowledge with suggestions for promising research directions

In order to achieve these objectives, a review of the scientific and "grey" literature was undertaken and a small group of researchers who have studied occupational disability in people with mental illness were interviewed.

Current State of Knowledge

Knowledge Related to Physical Health Problems

There has been significant research activity on workplace health that has considered disability management, return to work and treatment. For the most part, however, such research has not directly addressed mental health problems or mental illness but have been focused upon various physical health problems encountered in the workplace (e.g., back injury and other musculoskeletal problems, brain injury, cardiac illness and chronic rheumatic diseases). Although the findings do not tend to address mental health problems

directly, they may provide valuable information about mental health and may be useful for future research concerned directly with mental health and mental illness. Some of the relevant research findings are highlighted in this section.

Consistent across a number of health problems in the workplace has been the finding that the likelihood of an individual returning to former employment after an absence from work is determined by a number of factors other than the nature and severity of the health problem (Brewin et al. 1983; Kenny 1994; Shaw et al. 2001).

Predictors of a more rapid recovery and return to work include socio-demographic characteristics, job satisfaction and referral to appropriate rehabilitation services (Brewin et al. 1983; Kenny 1994). In a study of disability and return to work following occupational low back pain, a systematic review examined 361 studies and selected 22 that met specific inclusion criteria (Shaw et al. 2001). The factors associated with protracted disability included low workplace support, personal stress, shorter job tenure, prior episodes, heavier occupations with no modified duty, delayed reporting, greater severity of pain, more significant functional impact and extreme symptom reports. On the basis of the evidence gathered in the study, the following measures were recommended to help physicians improve disability management: the use of standardized questionnaires, improved communication with patients and employers, provision of recommendations for specific return to work accommodations, early intervention and use of behavioural approaches to pain and disability.

A review of scientific literature related to workplace disability management for musculoskeletal disorders (Williams and Westmorland 2002) found employer participation, a supportive work climate and cooperation between labour and management to be crucial factors facilitating return to work.

A systematic review undertaken to determine the effect on time lost from work of physical conditioning programs for workers with back and neck pain (Schonstein et al. 2003) found that physical conditioning programs that included a cognitive-behavioural component could produce a clinically worthwhile reduction in the number of sick days taken at 12 months (average of 45 days; 95% confidence interval [3, 88]), compared to general practitioner care or advice for workers with chronic back pain. There was little evidence of an effect on time lost from work of specific exercise programs that did not include a cognitive-behavioural component.

A three-year follow up study evaluated a randomized intervention for low back pain in which the intervention group received early intervention through a clinic, which provided information, reassurance and encouragement to engage in physical activity (Molde Hagen et al. 2003). The intervention group had significantly fewer days of sickness compensation (average 125.7 days per person) than the control group (169.6 days per person), whose members received usual care through their own physicians. This difference was primarily due to more rapid return to work during the first year. Economic returns of the intervention were calculated in terms of increases in the net present value of production for the society because of the reduction in number of days on sick leave. Net benefits accumulated over three years of treating the 237 patients in the intervention group amounted to approximately $2,822 per person.

A number of studies have investigated potential difficulties in physician approaches to disability management and have report mixed results (Anema et al. 2002; Dasinger et al. 2001; Guzman et al. 2002; Mahmud et al. 2000). Most have found that physicians' actions related to disability management are inconsistent with recommended clinical practice guidelines and policies, such as those set out by the Canadian Medical Association (Kazimirski 1997). Mahmud and colleagues (2000) found disability to be significantly associated with increased utilization of specialty referrals, use of specialized diagnostic tests and prescription of opioids. They found that patients with low back pain whose treatment course did not involve extended opioid use and early diagnostic testing were 3.78 times more likely (95% confidence interval [1.6, 8.9]) to have gone off disability status by the end of their study. Dasinger and co-investigators (2001) found positive recommendations by physicians to be associated with a 60% greater rate of return to work in "sub acute and chronic disability" (i.e. >30 days of disability) following back injury. However the association between positive recommendations by physicians and return to work for patients "acutely disabled" (i.e. <30 days) was found to disappear when injury and workload characteristics were taken into account.

Knowledge Related to Mental Health and Mental Illness

Research on vocational rehabilitation related to mental health has primarily involved people with severely disabling mental illness. In trying to understand better the work integration processes of people with severe mental problems, detailed descriptions of the different vocational services/programs have been undertaken (Cochrane et al. 1991). Trochim et al. (1994) tried to describe them along a continuum of services, with sheltered work as a first step, transitional work as a second step and supported employment as a subsequent step. Of all these vocational services, supported employment, which appears to have been studied the most, has yielded significantly higher work integration results than other vocational services (Crowther et al. 2001).

Although supported employment has been found to be more successful than other programs directed toward people with severe mental illness, it still encounters difficulties, such as variability in achieving successful job tenure. It has also seen relatively minimal adoption by governments and administrations (Bond et al. 2001). In recent years, many studies of the work integration of people with severe mental disorders have been published; they have investigated vocational outcomes in relation to clinical and economic correlates (McGurk and Meltzer 2000; Latimer 2001; Rogers et al. 1997), to psychosocial individual variables (Midgley 1990) or to specific work-related variables (Macias et al. 2001; Mueser et al. 2001). There have also been promising interventions using psychosocial approaches to improve occupational function in people experiencing severe mental illness as a result of schizophrenia (Liberman et al. 1998; Reker and Eikelmann 1997) and bipolar affective disorder (Craighead and Miklowitz 2000).

Fewer research studies have examined disability management or return to work in relation to people with less severe mental health problems or disorders. Those that have done so, however, have

found that, despite policies to the contrary in the United States, few accommodations are made by employers for mental health disability (MacDonald-Wilson et al. 2002; Zwerling et al. 2003). A retrospective cohort study of the quality of rehabilitation provided to workers with adjustment disorders in the Netherlands found that four of the ten performance indicators measured were adequate in less than 50% of the time, when measured against clinical guidelines (Nieuwenhuijsen et al. 2003). Overall, optimal care was found to have been received by only 10% of the cohort.

Evidence-based treatments for major depression have been shown to yield corresponding improvement in occupational function, and employees with substantial improvement in depressive symptoms after receiving appropriate treatment rate themselves as much more able to function effectively in the work environment (Berndt et al. 1998; Coulehan et al. 1997; Ormel et al. 1993). Furthermore, improvement in major depression appears to be associated with greater likelihood of remaining employed and less work absence due to depressive symptoms (Claxton et al. 1999; Mintz et al. 1992; Simon et al. 2000; Wells et al. 2000). However, two studies did not find a relationship between improvement in depression and in self-reported work function (Simon et al. 2002; Simon et al. 1998).

A study of short-term disability based on a nationwide Canadian sample of employees of three large financial and insurance companies (representing 12% of their sector) found that most employees absent on depression-related disability were in fact receiving appropriate pharmacological treatment and that prompt initiation of pharmacological treatment shortened disability absence (Dewa et al. 2003b). They also found the receipt of pharmacological treatment did not predict earlier work return when compared to those depressed employees who did not receive such treatment. However, those employees on depression-related disability who were not receiving antidepressants also reported relatively fewer symptoms related to depression as compared to those who were receiving antidepressants (Dewa et al. 2003a), a finding that suggests that the severity of depression may have differed across the two groups. It is also interesting to note that the researchers observed an association between complexity, or resistance to antidepressant treatment, and return to work. That is, employees with complex patterns of use (i.e., those who switched antidepressants or augmented their antidepressant use) had relatively longer episodes of disability (Dewa et al. 2003b). Several studies produced data suggesting that cognitive behavioural therapy (CBT) has a beneficial effect on work function above and beyond the impact of antidepressant medication (Hirschfeld et al. 2002; Mynors-Wallis et al. 1997; Sherbourne et al. 2001). Hirschfeld and colleagues (2002) 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."

One important question is that of "synchrony": does change in work ability occur in tandem with change in depression symptomatology? An early review paper suggested that improvement of work ability might occur well after resolution of depressive symptomatology, i.e., that there might

be a delay in the impact of antidepressant treatment on work function (Mintz et al. 1992). However, subsequent research has not supported this idea. It has been determined that change in work ability is, for the most part, simultaneous with change in depressive symptomatology – as depression resolves, work function is restored. (Berndt et al. 1998; Judd et al. 2000; Kocsis et al. 2002; Miller et al. 1998; Sherbourne et al. 2001). Most of the improvement in depression symptoms or work function is evident in a few months following initiation of treatment. There is some indication that adverse effects of antidepressants may be of concern for recovery of work function: a recent study found that some employees experienced antidepressant side effects that interfered with work performance, including sleep disturbance, poor concentration, lack of motivation and a "numbing down of feelings and responses" (Haslam et al. 2003).

Despite substantial effectiveness of standard treatments for depression with regard to recovery of work function, it has also been demonstrated that there is a significant degree of residual impairment in function after treatment. A study of depression treatment in primary care provides detailed information concerning the relationship between depression treatment and recovery of work function (Simon et al. 2000). After 12 months of appropriate treatment with antidepressant medication, 41% of patients with major depression were no longer depressed (i.e., they were in full remission) and had six days of depression-related job absence in the year; 47% were improved but still had significant depressive symptoms (i.e., were in partial remission), with 11 days of depression-related job absence; 12% remained persistently depressed (had no remission) and had 17 days of depression-related job absence. Furthermore, one study found that even in those who have fully recovered from major depression according to clinical criteria, some degree of reduced work capacity is evident, and it concluded that this subset of patients might benefit from specific psychosocial interventions designed to foster more complete rehabilitation (Kocsis et al. 2002).

There is some emerging evidence that a disability management approach, similar to that applied to recovery from musculoskeletal injury, may yield significantly improved work recovery for depression-related work impairment (Burton and Conti 2000; McCulloch et al. 2001).

Several studies have examined the impact of depression on work disability associated with other health problems. In a sample of 114 physically injured persons who were receiving workers' compensation benefits and vocational rehabilitation, Ash and Goldstein (1995) found that subjects with moderate or severe depression were significantly less likely to return to work than patients with less severe depression. Similarly, a Swedish study (Soderman et al. 2003) of 198 employed patients who had recently experienced an acute myocardial infarction or had been treated with coronary by-pass surgery or coronary angioplasty found that clinical depression before intervention exerted a great influence on work resumption. Chronic pain conditions constitute a substantial proportion of long-term disability cases in many workplaces (Faucett and McCarthy 2003), and there is evidence that depression is a substantial predictor of long-term disability in employees with chronic pain (Ericsson et al. 2002). Similarly, fibromyalgia is a frequent cause of disability that has been found to have a significant relationship to mental health (Wolfe et al. 1995).

Major Trends in Research

With an increasing realization of the importance of disability management and the need for successful approaches to assist people in their return to work, there has been intensified interest and activity in these areas of research. New models and methods have been developed and recommended recently, and, although these may not have been designed specifically to address mental health problems, they may be applicable in future studies of this population.

Franche and Krause (2002) at the University of Toronto's Institute of Work and Health have proposed a new "Readiness for Return-to-Work Model" that focuses upon the interpersonal context of the work-disabled employee. In this model, employee interactions with the workplace, the healthcare system and the insurance system are considered as they affect the three defining dimensions of change – decisional balance, self-efficacy and change processes. The model was designed to account for individual variation in optimal stage-specific timing of interventions based on an individual's readiness to return to work. Thus, interventions to assist return to work may be applied at the time most appropriate for the individual, thereby faciliting improved outcomes.

Following a review of the literature on the design, conduct and evaluation of occupational injury interventions, one group of investigators found randomized controlled trials to be rare and noted that quasi-experimental studies had often used the weakest designs (Zwerling et al. 1997). They recommended a hierarchical approach to evaluating occupational injury interventions, beginning with qualitative studies, following up with simple quasi-experimental designs using historical controls, continuing with more elaborate quasi-experimental designs comparing different firms' experience, and, when necessary, conducting randomized controlled trials.

Fisher (2003) utilized a survey tool, the "Return to Work Perception Survey," to examine the perception of various supervisors and front-line workers of factors related to return to work, including company policies and procedures, job satisfaction, worker relationships and work environment. Significant differences were found in the responses of supervisors and front-line workers.

Researchers in the Department of Community Health Sciences at the Université de Sherbrooke have developed the Work Disability Diagnosis Interview (WDDI) to assist in the detection of prognostic factors for disability in patients with sub-acute or chronic musculoskeletal pain (Durand et al. 2002). The WDDI, which was developed through systematic methodology, is composed of open-ended questions about physical, psychosocial, occupational and administrative factors that have been collated into an interview form used at the first encounter with a disabled worker. Initial applications have demonstrated a high prevalence of socio-demographic, work-related, and psychosocial factors that may contribute to prolonged work absence and have enabled clinicians to develop appropriate rehabilitation plans.

Mustard and colleagues (2003) at the University of Toronto's Institute of Work and Health utilized surveillance data to investigate trends in the incidence of work-related morbidity and disability in Ontario. Time series estimates of workplace injuries and work-related disability based on two panel surveys for the period

1993-1998 were compared with rates of work-related injury and illness compensation claims during the same period. The investigators found that, over the six-year period, lost-time compensation claims declined by 28.8%, self-reported work-related injury declined by 28.2% and the self-reported incidence of work absence for work-related causes declined by 32.2%. Thus, three independent data sources indicated reductions in work-related morbidity during the period of observation. The researchers interpreted these findings to mean that there has been an important reduction in injury risk in Ontario workplaces over the past decade.

Some recent studies have applied qualitative methods to study disability management and return to work. In a study undertaken at the University of Toronto's Joint Centre for Bioethics, the authors examined how people living with HIV/AIDS perceive, attach meaning to and approach the experience of returning to work (Nixon and Renwick 2003). They found that participants were influenced by, and wrestled with, both the dominant societal perspective that "people should return to work," and the opposite perspective that people with HIV/AIDS "should not return to work." A theoretical understanding of the results was developed through the use of the concepts of the "sick role" and the "hierarchy of identities."

In another qualitative study, researchers in three Canadian provinces explored the perceptions of many different actors involved in return-to-work programs for injured workers, studying their views on successful strategies, barriers and facilitators of the return to work process (Baril et al. 2003). The investigators, who analyzed the underlying dynamics of their different experiences, found that roles and mandates of the different groups of actors (injured workers, other workplace actors and actors outside the workplace), while sometimes complementary, could also differ, leading to tension and conflict. Human resources managers and healthcare professionals tended to attribute workers' motivation to their individual characteristics, whereas injured workers, worker representatives and health and safety managers described workplace culture and the degree to which workers' well-being was considered as having a strong influence on workers' motivation. Non-workplace issues included confusion stemming from the compensation system itself, communication difficulties with some treating physicians and role conflict on the part of physicians wishing to advocate for patients whose problems were non-compensable. Several common themes emerged from the experiences related by the wide range of actors, including the importance of trust, respect, communication and labour relations in the failure or success of return-to-work programs for injured workers.

A number of studies have used mixed methods in studies of disability management and return to work. A Finnish study evaluated outcomes of the "Pathway-to-Work Project," which aimed at tailoring return-to-work plans for 140 middle-aged, long-term unemployed participants with various disabilities and getting half of them into work or training (Juvonen-Posti et al. 2002). The research design comprised three parts: a quantitative quasi-experimental component with a matched control group, a register follow-up and the collection of qualitative data. The main variables used to evaluate the outcomes were (1) changes in the labour market situation during the two-year

register follow-up, (2) changes in distress, perceived competence and sense of coherence during the intervention and (3) description of the process in the project. After two-year follow-up, 14% of the participants were at work and 59% unemployed, whereas 9% of the control group were at work and 86% unemployed. The participants' distress level decreased remarkably, and their perceived competence increased, but their sense of coherence did not change. The investigators concluded that even carefully tailored client work enables only some of the long-term unemployed people with disabilities to cross the job threshold and that other kinds of policy, strategy and intervention are needed to link the return-to-work interventions more closely with work, work places and enterprises.

Becker and colleagues (2000) have described methods for their work in progress, which will evaluate four workplace prevention and/or early intervention programs designed to change occupational norms and reduce substance abuse at a major US transportation company. The four programs are an employee assistance program, random drug testing, managed behavioural healthcare and a peer-led intervention program. An elaborate mixed-methods evaluation is planned, combining data collection and analysis techniques from several traditions. A process improvement evaluation focuses on the peer-led component to describe its evolution, document the implementation process for those interested in replicating it and provide information for program improvement. An outcome assessment evaluation examines the impacts of the four programs on job performance measures (e.g., absenteeism, turnover, injury and disability rates) and includes a cost-offset and employer cost-savings analysis. Issues related to using archival data, combining qualitative and quantitative designs, and working in a corporate environment are discussed.

In a study of 108 supervisors who were provided with a 1.5-hour training session to reinforce a proactive and supportive response to work-related musculoskeletal symptoms and injuries, results showed improvements in supervisor confidence to investigate and modify job factors contributing to injury, to get medical advice and to answer employees' questions related to injury and treatment (McLellan et al. 2001). More supervisors reported decreases (38.5%) than increases (9.6%) in lost work time in their departments.

Significant Gaps in Knowledge

Canadian representation and sponsorship were included in an international research project on job retention and return-to-work strategies for disabled workers undertaken by the International Labour Office and GLADNET (the Global Applied Disability Research and Information Network on Employment and Training). A code of practice for managing disability in the workplace has been published by the International Labour Office (ILO 2002). However, research into the utility and uptake of the code has not yet been developed.

Researchers have begun to study questions that can improve disability policies and practices, but such research has not yet been developed significantly in Canada. In the United States, Sim (1999), using research by experts on return-to-work practices in Germany and Sweden, examined the following three approaches that have been suggested for improving the rate of rehabilitation of disabled

workers: (1) intervening as soon as possible after a disabling event to promote and facilitate return to work, (2) identifying and providing necessary return-to-work assistance and managing cases to achieve return-to-work goals and (3) structuring cash and health benefits to encourage people with disabilities to return to work. Potential benefits and limitations were discussed in the application of these approaches in the US environment. Another study assessed the impact of US federal programs, such as Social Security Disability Insurance, vocational rehabilitation, medical insurance and psychiatric services, upon employment, by conducting a qualitative study of 16 employed and 16 unemployed individuals with psychiatric disabilities (O'Day and Killeen 2002). All participants had disabilities severe enough to qualify them for Social Security Disability benefits. However, they reported that the federal policies and practices encouraged employment and integration of only a few participants in a particular stage of their recovery and placed significant barriers in the employment path of others. Studies of policies and their influence on disability management and return to work are needed in Canada.

There is a need to study disability management and return-to-work factors related to anxiety disorders, such as social phobia and panic disorder, given their prevalence and the low availability of appropriate treatment resources (Lepine 2002; Wittchen and Fehm 2001). In workplaces where there is a high risk of traumatic events, evidence-based approaches to disability management and return to work are needed in order to support individuals with post-traumatic stress disorder and work-related injuries (Asmundson et al. 1998).

Similarly, disability management and return-to-work factors related to problem substance use requires study (Becker et al. 2000). The high prevalence of substance use disorders and their co-existence with other mental health problems are important reasons to address this significant gap in the research literature.

Although some important research studies of disability management for depression have been done, there has been only limited study of the impact of depression on work disability associated with other health problems. In a sample of 114 physically injured persons who were receiving workers' compensation benefits and vocational rehabilitation, Ash and Goldstein (1995) found that subjects with moderate or severe depression, defined as having a score greater than 16 on the Beck Depression Inventory (BDI), were significantly less likely to return to work than patients with less severe depression (for back-injured patients, odds ratio (OR = 31, 95% CI [8.8, 108]). BDI scores correctly classified 84% of the back-injury and 86% of the other-injury groups with respect to their return to work. The level of workers' compensation benefit was the only variable that added (marginally) to the predictive power of the BDI.

Similarly, a Swedish study (Soderman et al. 2003) of 198 employed patients who had recently experienced an acute myocardial infarction (AMI, n = 85) or had been treated with coronary by-pass surgery (CABG, n = 73) or coronary angioplasty (PTCA, n = 40) found that clinical depression before intervention (≥16 as measured by the Beck Depression Inventory) exerted a great influence on work resumption both at full time (OR = 9.43, 95% CI [3.15, 28.21]) and at reduced working-hours (OR = 5.44, 95% CI [1.60,18.53]).

Mild depression (BDI 10-15) influenced only work resumption at full time (J88 = 2.89, 95% CI [1.08,7.70]). More research is needed in order to elaborate the degree to which treatment of depression enhances work resumption rates for a variety of health problems.

Chronic pain conditions constitute a substantial proportion of long-term disability cases in many workplaces (Faucett and McCarthy 2003), and there is evidence that depression is a substantial predictor of long-term disability in employees with chronic pain (Ericsson et al. 2002). Similarly, fibromyalgia is a frequent cause of disability that has been found to have a significant relationship to mental health (Wolfe et al. 1995). Research in disability management and return-to-work factors related to these conditions is needed.

In the multicultural environment of Canada, cultural factors related to disability management require research study. Yip and Ng (2002) have described Chinese cultural dynamics of unemployability of male adults with psychiatric disabilities. Further research on issues that affect various populations is needed.

Summary and Promising Research Directions

In an article in 1993, Rachel Jenkins asked why mental health at work was so under-researched (1993). More than a decade later, the same question remains relevant. There are many gaps in knowledge to be filled. Little is known regarding best practices in managing the disability associated with the most prevalent mental disorders (i.e., depression, anxiety disorders and substance use disorders). Although some information is available to assist people with severe mental disorders in obtaining employment, knowledge to help people maintain employment is lacking. Additionally, knowledge regarding systemic factors that influence disability management and return to work (e.g., employee assistance programs and disability insurance regulations) relevant to people with mental disorders is yet unavailable.

There are several promising directions for research:

(1) *Application of disability management principles to a variety of psychiatric disorders*. Until recently, the focus of disability management has been on physical disabilities, particularly musculoskeletal injuries. Disability management models have not been applied systematically to a variety of psychiatric disorders: research is needed in this area.

(2) *Understanding the impact of disability management for mental health problems in relation to various physical health problems*. Disability management and return to work following physical conditions such as musculoskeletal injury, coronary heart disease, chronic pain syndromes and fibromyalgia require study in relationship to mental health and mental illness.

(3) *The relationship of population factors in disability management and return to work*. It is likely that a variety of approaches to disability management and return to work may be applicable to specific populations. Issues related to culture, gender, age and environment should be accounted for in future research.

(4) *Policies and guidelines relevant to occupational disability*. Existing guidelines for the assessment and treatment of mental illness

have neglected workplace functioning. There is a need for the development and evaluation of protocols to guide practitioners in interventions to enhance or restore work function. Furthermore, there are important questions regarding the optimal role of different health practitioners in working collaboratively to foster work return of psychiatrically-disordered individuals: e.g., which health provider should act as the main referral agent for work entry programs, what skills should family physicians have in order to evaluate depression-related work disability, etc.

(5) *Effectiveness of standard mental healthcare in restoring work function*. The outcomes of standard healthcare for psychiatric disorders *vis à vis* recovery of work function have not been well established. How effective is the existing Canadian mental health system at fostering employability and employment of individuals with severe psychiatric disorders? How effective is this system at fostering work return in depression and anxiety disorders?

(6) *Innovative approaches to mental healthcare*. Controlled outcome research is needed on innovative approaches to the delivery of mental healthcare that could lead to improved outcomes for recovery of previously adequate work function; shortening of disability absence related to psychiatric disorder; and enhancement of functional level for those who have not been successfully employed.

(7) *Organizational interventions to foster recovery of work function in individuals with disability related to mental health problems*. Examples of organizational interventions might include changes in employee assistance programs or in the structure of health benefits to increase access to evidence-based health services.

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