Disability Evaluation and Treatment for Patients With Psychiatric Disorders

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Abstract

Primary care physicians (PCPs) are often asked to perform disability evaluations for patients with psychiatric disorders, which are now a leading cause of disability worldwide. After acknowledging the limitations of disability assessments for all conditions, this review aims to provide PCPs with practical knowledge to inform their assessments and interventions with a focus on patients with depression. After the disability definitions and programs in the United States are reviewed, a pragmatic approach to assessing function and discussing return to work is offered. Individualized assessment is key, and functional recovery rather than symptom relief should be prioritized. Finally, evidence-based interventions for enhancing the likelihood of return to work are considered. We believe the principles of functional assessment and recovery lend themselves to ready adaptation for use in other psychiatric conditions and chronic somatic syndromes, including chronic pain. The key principles of this approach are as follows: 1) a patient is not categorically disabled, but has specific limitations in specific contexts; 2) graded, work-oriented rehabilitation with tailored problem-solving strategies are essential; 3) involving a multidisciplinary team in coordinated care optimizes functional recovery; 4) return to work is an iterative process aimed at restoring meaningful function in a...
stepwise fashion; and 5) the relationship between symptoms and function is bidirectional. PCPs can use these principles to plan optimal recovery paths for psychiatrically ill patients presenting with a wide array of biopsychosocial realities.

In 2001, the World Health Organization named major depressive disorder as the leading cause of global disability among the 15- to 44-year-old age group. The responsibility for disability evaluations in these patients often rests with primary care physicians (PCPs). Given the biopsychosocial nature of depression, the traditional focus on physical impairments alone (eg, difficulty lifting, standing, and pivoting) is insufficient. PCPs must be prepared to assess cognitive, affective, and interpersonal abilities in addition to physical limitations.

A recent position statement by the American College of Occupational and Environmental Medicine (ACOEM) acknowledges there is generally little scientific literature to inform work restrictions. Indeed, a review of assessments for patients with a mix of disabling mental and musculoskeletal disorders concluded that current disability evaluations are limited by variable methodologies, low inter-rater reliability, and findings that generalize poorly to the workplace. Despite this empirical uncertainty, a consensus is growing about helpful and harmful approaches to patients with potentially disabling mental illness and chronic somatic conditions, specifically chronic pain. This review will primarily focus on a practical approach for the assessment and treatment of depressed patients presenting with disability.

If patients are employed and the impairments prevent them from performing the essential functions of their job, the Family and Medical Leave Act (FMLA) protects them from being fired for up to 12 weeks. Independent of FMLA, short- and long-term disability (STD and LTD) insurance plans protect the employee’s pay. Employees work with their human resource department to appropriately sequence FMLA, STD, and LTD in order to protect their job and income while out of work. The ADA also encourages employers to provide reasonable accommodations, which modify the requirements of the position enough to allow the individual to continue to perform their job.

If the patient is unemployed or unable to return to work (RTW) after 12 weeks, the Social Security Act determines eligibility for Social Security Benefits (SSB). If the condition 1) prevents them from doing their normal job, 2) is expected to last at least 12 continuous months or result in death, and 3) the patient cannot perform substantial gainful activity (SGA) doing other work, then (s)he qualifies for SSB.

Patients with untreated psychiatric disorders are more likely to progress to requiring SSB. To reduce the overall duration of disability and potentially avoid the need for SSB, it is important for these patients to receive mental health care as soon as possible. It is also important to note that most psychiatric patients receiving SSB express a desire to work; however, they report that the fear of losing benefits most often prevents them from attempting RTW. This fear stems from a historic reality, but the Ticket to Work program now protects SSB, while providing employment networks and vocational rehabilitation agencies for patients with disabilities attempting to RTW.

Specific guidance on the assessment and treatment of depression-related disability is...
not widely known. This article attempts to address this deficit with a practical approach for such patients. The Figure summarizes the approach to a patient requesting a disability assessment. It is important to first clarify what the patient’s employer requests. The following steps as outlined in the Figure also serve as a guide to the step-by-step approach described in the following sections.

**EVALUATING DISABILITY IN PATIENTS WITH MENTAL ILLNESS**

Patients can qualify for SSB with any psychiatric diagnosis in the Diagnostic and Statistical Manual (except substance use disorders) if the symptoms are persistent and result in occupational impairment. Without objective laboratory or imaging findings, clinicians must correlate the patient’s reported depressive symptoms and associated functional impairments with the mental status exam findings. Currently, the physician’s assessment of how patients’ cognitive, affective, and interpersonal deficits affect their work is the gold standard of evaluating disability.

A realistic framework for evaluating disabling mental illness is a “capacity-context interaction model.” In this model, individuals are not categorically disabled, but have specific or dimensional functional limitations in specific environments. Severe depression can produce cognitive, affective, and interpersonal difficulties that interfere with any number of activities of daily living (ADLs) and job-specific tasks at their place of employment. Table 2 summarizes examples of reported symptoms, associated signs on exam, and functions that may be impaired.

For a practical approach, the physician can ask the patient about a typical day in chronological fashion, starting with awakening, serially asking, “What do you do next?” and ending with bedtime. This reveals the patient’s abilities before depression, including ADLs and social roles, and how their symptoms limit current functioning. For specific workplace concerns, a performance appraisal from a supervisor or specific concerns noted from human resources could be helpful. Collateral information from family and friends offers a more complete picture. Additionally, referrals to an occupational and/or physical therapist, neuropsychologist, psychiatrist, and/or an occupational physician may more accurately delineate impairments. These complementary data sources are especially important for patients whose mental status findings do not match the reported symptoms. Ideally, an RTW program (eg, “Progressive Goals Attainment Programs” in Table 1) simulate the work environment, and generate assessment data about more complex, job-specific functions while simultaneously initiating rehabilitation.

In keeping with the capacity-context model, physicians must consider that impairments may not be consistent across settings. For example, a patient not displaying interpersonal difficulties with a trusted physician or family member may regress when interacting with customers, colleagues, or supervisors. Patients with severe depression typically manifest symptoms and limitations that generalize to more than one setting. Importantly, ACOEM warns clinicians against “medicalizing” nonmedical issues such as workplace conflict, job dissatisfaction, or family strife. For example, when a patient has panic symptoms triggered only by stressful interactions with a supervisor or coworker, the physician can encourage them to approach their human resources department about workplace conflicts. In such situations, prolonged medical leave hinders adaptive coping through avoidance.

Psychosocial elements of the patient’s history (age, dependents, educational and occupational history, sources of financial support, etc) are critical in discussing the patient’s problem and treatment plan, but they are not components of the US definition of a disability. This is important for patients to know, as a clinician’s dimensional assessment informs, but does not determine the categorical outcome of a disability application. Furthermore, physicians should consider how the delivery of their findings will affect patients. For example, telling patients they are disabled may translate to a fixed, core belief that they will never work or contribute to society again in any capacity.
or context. Additionally, recommending accommodations that employers find unreasonable may result in termination. As such, we will turn our attention to expectation setting and treatment planning.

### SETTING EXPECTATIONS: SYMPTOMS AND RECOVERY

A qualitative study of clinicians evaluating and treating depressed patients on sick leave found that treating symptoms, assessing function, and attempting to collaborate with key stakeholders (ie, other health care professionals, employers, and insurers) were common components of best practices. The main differences between practices were: 1) whether the practitioner incorporated RTW as a goal from the beginning of treatment, and 2) if interventions included the workplace. The failure to involve the workplace in treatment planning may be driven by a common misconception that symptom remission must precede functional recovery.

The misconception likely stems from the traditional approach to transient physical disabilities, such as broken bones, and from initial studies assessing the effect of traditional depression treatments (medications and psychotherapy) on work-related functioning. Such studies have reported that symptom

**TABLE 1. Disability Definitions and Programs in the United States**

<table>
<thead>
<tr>
<th>Disability</th>
<th>Information</th>
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<tbody>
<tr>
<td>Family and Medical Leave Act (FMLA)</td>
<td>Requires entities employing at least 15 workers to provide up to 12 weeks of unpaid, job-protected leave per year. Employees are eligible for FMLA if they have a serious health condition preventing them from performing the essential functions of his or her job, or if they must care for a child, spouse, or parent.</td>
</tr>
<tr>
<td>Short-Term and Long-Term Disability (STD and LTD)</td>
<td>STD and LTD are private insurance plans. STD covers a portion of the patient’s pay after sick leave runs out, and spans a period of 9 to 52 weeks depending on the policy. LTD takes over after STD ends. LTD terms and length of coverage vary, and not all LTD policies include coverage for occupation specific disability.</td>
</tr>
<tr>
<td>Reasonable Accommodations</td>
<td>The ADA requires employers to provide “reasonable accommodations” for individuals with a disability, unless to do so would cause undue hardship on the employer. Reasonable accommodations typically entail modifications to the work environment or position to help the individual perform the essential functions of their job.</td>
</tr>
<tr>
<td>Social Security Benefits</td>
<td>Under the Social Security Act, individuals are eligible for Social Security Benefits if they 1) have a disability expected to last at least 12 continuous months or result in death, and 2) are unable to obtain substantial gainful activity (SGA) doing some other work.</td>
</tr>
<tr>
<td>Substantial Gainful Activity (SGA)</td>
<td>SGA is a minimum monthly income, which was set at $1220 in 2018. Patients receiving SSI have minimal to no work experience and are insured by Medicaid. SSI paid $750 per month in 2018.</td>
</tr>
<tr>
<td>Supplemental Security Income (SSI)</td>
<td>Patients with SSDI have worked a substantial amount and are insured by Medicare. SSDI monthly payments are based on the patient’s historical average earnings.</td>
</tr>
<tr>
<td>Social Security Disability Insurance (SSDI)</td>
<td>Patients with SSDI have worked a substantial amount and are insured by Medicare. SSDI monthly payments are based on the patient’s historical average earnings.</td>
</tr>
<tr>
<td>Ticket to Work</td>
<td>US government (Social Security Administration) provides employment networks and vocational rehabilitation agencies for patients with disabilities who wish to return to work. This program also addresses myths related to working and continuing to receive disability benefits, such as losing insurance coverage, provoking a medical review or having to reapply for benefits all over again.</td>
</tr>
<tr>
<td>Job Accommodation Network (JAN)</td>
<td>The Job Accommodation Network is the leading source of free, expert, and confidential guidance on workplace accommodations and disability employment issues.</td>
</tr>
<tr>
<td>Progressive Goals Attainment Programs (PGAP)</td>
<td>A standardized intervention delivered by occupational and physical therapists trained specifically in this approach. The approach is designed to help injured workers struggling with a wide range of medical and mental health conditions. The goal is to incrementally increase patient activity to help recover function in multiple life roles.</td>
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remission precedes work recovery in most depressed patients\(^7\) by up to 1 year,\(^8\) and that residual symptoms increase the risk of functional impairments and relapse.\(^9\) These studies send an important message about the severe morbidity associated with depression, the need for aggressive treatment, and the difficulty in treating residual cognitive symptoms of depression. However, they likely understate the bidirectional relationship between symptoms and function. Recent studies highlighting the importance of work-related interventions have shown that reducing depressive symptoms alone is not enough to reduce work absence.\(^10,11\)

The ACOEM urges clinicians to set an early expectation for RTW as the goal of treatment, and to target work-oriented interventions from the outset. Patients can be counseled that they will likely still have some symptoms when returning to work, and that working will help to alleviate these residual symptoms.\(^12\) Some patients will need reassurance that resting at home, at the expense of activity at work, is not beneficial to their recovery, and many will need guidance about how to restore optimal home and work functioning in a graded fashion.

When discussing expectations about RTW, the role of an individual’s psychosocial factors become clearer. These factors, while not included in the US government’s definition of disability, influence RTW and staying on SSB.\(^13\) In addition to lower depression severity

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**FIGURE.** Flowchart depicting the approach to disability evaluations in patients with psychiatric disorders.
and fewer comorbidities (psychiatric or medical), patient factors that correlate with earlier RTW include no prior sickness absence, positive expectations about and motivation for RTW, and conscientiousness. Work-related issues, including high job stress and demand, low autonomy at work, injury at work, and delayed RTW also negatively affect RTW. The significance of age, the number of dependents, level of education, and occupation are less clear.

Encouraging an open discussion about how these factors affect an individual’s RTW can help explore ambivalence, barriers, and disincentives to recovery. As expectations are set and psychosocial contexts are clarified, an individualized, work-oriented treatment plan can be formed.

NEGO T IATING A RETURN TO WORK DATE
The idiosyncratic characteristics of psychiatric illness and the diverse factors associated with RTW suggest that RTW dates may be moving targets. Indeed, the ACOEM acknowledges that predicting RTW in psychiatric patients is an inexact science; large Scandinavian studies have illuminated a wide range of possible RTW trajectories. One study of depressed patients reported a median sick leave duration of 34 days, but it took 7 years before 89% of patients achieved RTW. Another study reported that 43% of depressed patients RTW after 4 months, and another 22% RTW after 9 months. The remaining one-third of patients achieved transient periods of RTW interspersed with sick leave.

Taken together, these studies suggest that many patients RTW in a matter of weeks or months. An RTW date can be given as a range (e.g., 4 to 8 weeks), and the initial estimate subject to revision as treatment progresses. This acknowledges that RTW is an iterative process and encourages stakeholder communication as well as timely follow-up. As treatment planning and RTW dates are negotiated, the role of patient’s psychosocial factors continues to be clarified to further inform the next steps in treatment.

EFFECTIVE RTW INTERVENTIONS
Clinicians are advised to shift out of the “disabled or not” paradigm as soon as possible. In other words, what patients are able to do becomes the focus, rather than their symptoms or what they cannot do. Drawing on the patient’s abilities as well as sources of resilience and values, clinicians can work collaboratively with their patients towards a gradual RTW strategy informed by evidence-based interventions, even when symptoms have not entirely abated.

Two recent reviews summarize evidence for RTW interventions in patients with a broad array of somatic and psychiatric difficulties.

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**TABLE 2. Clinical Assessment of Disability for Psychiatric Disorders**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Symptom</th>
<th>Sign</th>
<th>Impairment</th>
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<tbody>
<tr>
<td>Cognitive</td>
<td>Inattention</td>
<td>Difficulty attending to the interview, lack of linear thought</td>
<td>Basic activities of daily living</td>
</tr>
<tr>
<td></td>
<td>Forgetfulness</td>
<td>Inability to register new information or recall recent and remote events</td>
<td>Feeding, toileting, grooming, bathing, mobility, dressing</td>
</tr>
<tr>
<td></td>
<td>Difficulty organizing, prioritizing, and making decisions</td>
<td>Disorganized thoughts, difficulty prioritizing and planning treatment</td>
<td></td>
</tr>
<tr>
<td>Affective</td>
<td>Depression, anxiety, and fatigue</td>
<td>Psychomotor slowing (little spontaneous movement) or restlessness</td>
<td>Instrumental activities of daily living</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Affective constriction or lability</td>
<td>Telephone use, public transportation, shopping, meal preparation, driving, housework, medication management, financial management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Speech slowed or rushed</td>
<td></td>
</tr>
<tr>
<td>Interpersonal</td>
<td>Difficulty engaging and working with others</td>
<td>Difficulty interacting with interviewer, too little or too much eye contact, slowed or hurried speech</td>
<td>Occupational functioning</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Maintaining pace and persistence with specific work tasks, and interacting with customers, coworkers, and supervisors</td>
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including depression. As one review reported findings for patients with common mental disorders, stress-related difficulties, and personality and somatoform disorders, and the second review focused on musculoskeletal, pain-related, and mental health conditions. 21,22 Effective approaches for all conditions were comprised of multicomponent treatment plans that incorporate traditional health care, service coordination, communication with the workplace, and work-oriented interventions. Work-oriented interventions that improved RTW for all conditions included “graded” (achievable, sustainable, and increasingly challenging) work-related activities and work accommodations. PCPs can help guide the patients’ efforts in remastering ADLs and social roles in a gradual fashion that progressively incorporates simulated work challenges. These endeavors can inform which accommodations may aid RTW. The Job Accommodation Network provides online resources to inform reasonable accommodations for individuals with mental illnesses attempting RTW. IPS included team-based, coordinated care with comprehensive insurance coverage for clinical and vocational services, and gave patients a choice of competitive employment opportunities. IPS helped 60% of patients RTW as compared with 40% in the treatment-as-usual group. 23 A history of prior employment, fewer years on disability, and fewer physical health problems were predictive of successful employment following IPS. Notably, participants who had not worked for more than 2 years benefitted even more than those with more recent work experience. 24 A meta-analysis reported that IPS leads to return to competitive employment 2.3 times more often than other vocational rehabilitation services. 25 One randomized controlled trial showed IPS was more effective when augmented by worked-focused cognitive behavioral therapy; again, patients with longer periods of unemployment benefited most. Importantly, the intervention reduced depression and anxiety symptoms, in addition to increasing health-related quality of life as compared with usual care. 26

Because coordinated, multicomponent RTW interventions are not always available, the PCP may need to guide the patient to pursue each component in a sequenced fashion. Additionally, those patients who presently cannot RTW would still benefit from rehabilitation, such as volunteering and participating in community activities. These activities can also be gradually intensified, permitting eventual RTW efforts.

**CONCLUSION**

Despite the challenges of disability assessments in patients with psychiatric conditions, PCPs can conduct practical disability assessments by 1) assessing function at home and the workplace, 2) collaborating with consulting services

### TABLE 3. Key Principles of Functional Assessment and Recovery

<table>
<thead>
<tr>
<th>Principle</th>
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<tr>
<td>A patient is not categorically disabled</td>
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<tr>
<td>A patient on disability has dimensional functional limitations in specific environments (i.e., disability is context specific)</td>
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<tr>
<td>Graded, work-oriented rehabilitation with individualized problem-solving strategies are essential</td>
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<tr>
<td>Involving a multidisciplinary team in coordinated care optimizes functional recovery</td>
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<tr>
<td>Return to work is an iterative process aimed at restoring meaningful function in a stepwise fashion</td>
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<tr>
<td>Symptom remission does not necessarily precede functional recovery</td>
</tr>
<tr>
<td>Accommodations not found to be reasonable by the patient’s employer could result in termination</td>
</tr>
<tr>
<td>Functional recovery can improve symptoms and quality of life</td>
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</table>
and stakeholders, and 3) setting functional recovery and RTW as an early goal of treatment. As functional limitations and psychosocial context become clearer through data synthesis and close follow-up, the goals of care, RTW date, and treatment can be revised to better fit the patient’s needs. PCPs can encourage gradual functional improvement by targeting interventions to fit the workplace and educating the patient about the bidirectional relationship between symptoms and function. We believe these principles of functional assessment and recovery (Table 3) apply broadly to other psychiatric conditions and chronic somatic syndromes, specifically chronic pain.

A patient collaborating with a multidisciplinary team led by their PCP can pursue an individualized, coordinated, and work-oriented treatment plan. Symptom reduction alone is not sufficient to help patients return to work. Clinicians play a pivotal role in reframing a gradual RTW as a key component of good medical treatment with full symptom remission often lagging behind functional recovery. This article is intended to provide clinicians with practical evidence-based knowledge to inform their management of patients with depression who are transiently or more persistently disabled. Ultimately, PCPs know their patients best and can use their insights to help them navigate the disability system while fostering the fullest possible recovery.

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