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## FMLA and mental health: Don't let depression get you down

by Presley Reed, M.D.

Mental health issues present unique challenges to individuals charged with managing disabilities and the administration and tracking of FMLA absences. Diagnostic criteria are available for the treating healthcare provider to use in establishing a mental health diagnosis, and treatment protocols are broadly used among mental health professionals. Still, mental health issues have been known to create discomfort for the individuals, often not medically trained, who are responsible for approving and denying leaves.

While FMLA regulations do not permit employers to directly ask an employee's healthcare provider for specific diagnostic information about that employee, the employer may already be aware of the employee's mental health condition because of concurrent management of a medical disability case. In addition, the employee's condition may become known anecdotally. With that in mind, this article provides general information on depression as excerpted from *The Medical Disability Advisor*, Fourth Edition.

### Types of depression

Depression is a serious medical illness that negatively affects how an individual feels, thinks, and acts. Everyone experiences depressed moods as a result of a change, either in the form of a setback or a loss, or as Freud said, "everyday misery." The sadness and depressed feelings that accompany the changes and losses of life are usually appropriate, necessary, transitory, and can present an opportunity for personal growth. However, depression that persists and results in serious dysfunction in daily life could be an indication of a depressive disorder that may need to be treated as a medical problem. Severity, duration, and presence of other symptoms are factors that distinguish normal sadness from a depressive disorder.

The three primary subtypes are major depression, chronic depression (dysthymia), and atypical depression. Major depression is severe depression in which the individual experiences a decline in general level of functioning. Dysthymia is a mild, chronic depression that lasts two years or longer. Atypical depression is characterized by increased appetite and sleeping more than usual.

Major depression is characterized by a general slowing down of physical and mental activity, including a lowering of mood. This may manifest as irritability, sadness, dejection, tearfulness, and a sense of hopelessness, anguish, and despair. Psychosomatic symptoms such as fatigue, loss of appetite, weight loss, sleep disturbance, and multiple forms of bodily discomfort may be present. Feelings of self-reproach, worthlessness, and guilt may be extreme.

Thought processes may also be affected, with impaired memory and diminished ability to think, concentrate, or make decisions. Other symptoms may include extreme agitation, diminished interest or pleasure in day-to-day activities (anhedonia), and ruminations on death or suicide.

Major depression can afflict anyone, regardless of age, race, class, or gender. In the United States, about 17 million Americans are estimated to develop depression each year. Major risk factors are female gender, age, family history, bereavement, and brain injury. Women suffer from the disorder at least twice as often as men in societies around the world. The peak age at onset is between 20 and 25 and then 40 and 45 years. In the U.S., lifetime risk is 10 percent to 25 percent for women, and 5 percent to 12 percent for men.

The chances in a lifetime of experiencing a bout with major depression are about 17 percent, but only a third of depressed individuals receive proper treatment. One explanation for the low percentage of treatment of depressed individuals is that society has stigmatized mental illness for so long that people with depression, and sometimes their families, feel too ashamed to acknowledge the disease and to seek treatment.

## **Accurate diagnosis**

One of the difficulties in accurately diagnosing depression is distinguishing the normal sadness following a major disappointment or loss from clinical depression. All humans experience sadness periodically. And following episodes of loss or extreme stress, individuals may develop some symptoms of depression, yet still not be considered as suffering from a clinical depression that may qualify as a serious health condition.

According to the Fourth Edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), depression is diagnosed when an individual experiences persistent feelings of sadness or anxiety, with loss of interest or pleasure in usual activities (anhedonia). In addition, five or more of the following symptoms must be present for at least two consecutive weeks: changes in appetite that result in weight losses or gains not related to dieting; insomnia or oversleeping; loss of energy or increased fatigue; restlessness or irritability; feelings of worthlessness or inappropriate guilt; difficulty thinking, concentrating, or making decisions; and thoughts of death or suicide, or attempts at suicide.

Depression is diagnosed only if the above symptoms are not the result of any other psychiatric conditions (such as bipolar disorder), medical conditions (such as neurological or hormonal problems), or physical illnesses (such as cancer or heart attack). Symptoms must not be the result of unexpected side effects of medications or substance abuse.

The healthcare provider should take a thorough patient history including an account of current and previous symptoms; questions about mood, memory, and changes in relationships; and corroborative history from friends, family members, or employers. It is important to determine whether there is a family history of depression or of suicides. A careful, nonjudgmental inventory of substance abuse should be made in every case, as this requires specific treatment measures of its own.

A general history of psychological problems could predispose an individual to depression. Because physical conditions have been associated with depression, a thorough history should include an account of diseases such as neurologic disorders (stroke, Parkinson's and Alzheimer's diseases, multiple sclerosis, epilepsy, encephalitis, and brain tumors); endocrine disorders (diabetes mellitus, hypothyroidism, and hyperparathyroidism); and other disorders (coronary artery disease, cancer, and chronic-fatigue syndrome). Conversely, individuals with major depression may see a medical doctor for physical complaints of headache, abdominal pain, body aches, low energy, feeling poorly, or problems with sexual function.

It is also important to obtain a complete history of medications the individual is taking because major depression has been shown to be a side effect of some medications.

Complete physical examination and medical work-up are indicated to rule out medical causes. Illnesses that frequently cause depression include hyperthyroidism and other glandular disturbances, cancer, stroke, and heart attack.

## **Treatment**

Treatment choice depends on the outcome of the evaluation (history, physical exam, and tests). Treatment usually consists of psychotherapy, medications, or both. Today, there are a number of effective antidepressant medications that work by correcting imbalances in the levels of brain chemicals (neurotransmitters). About two-thirds of individuals treated will respond to one or more medications. Generally, these medications take full effect three to six weeks after treatment has begun. Psychiatrists usually recommend that individuals continue to take the medication for five or more months after symptoms have improved.

Treatment of depression consists of three phases. Acute treatment, lasting 6 to 12 weeks, is aimed at remission of symptoms. Continuation treatment, lasting 4 to 9 months, is aimed at preventing relapse. During this phase, medication should be continued at full dosage. Psychotherapy may also be helpful. Maintenance treatment is aimed at preventing new episodes (recurrence) in individuals with prior episodes. Although only maintenance medication can prevent recurrence, maintenance psychotherapy may delay the next episode. Individuals and their families should be educated before treatment about the diagnosis, likely outcome, treatment options, costs, and side effects.

## **FMLA leave and depression**

Employees diagnosed with mild to moderate forms of depression may qualify for FMLA leave. Depending on the health provider's treatment plan, a "reduced leave" schedule, or one of "intermittent leave" may be most practical for employee and employer alike during the treatment period in order to accommodate and

encourage compliance with prescribed therapies. Intermittent leave is ideally planned in advance, but does not conform to a predictable schedule. Reduced leave schedule, by its name, implies an established agreement that the hours worked by an employee will be reduced on a daily or weekly basis. In either case, it is incumbent on the employer to remain vigilant within the limits of the legislation to ensure that the certification and the treatment remain current. In order to qualify as a serious health condition under the FMLA, the depression must take a form that is to some degree debilitating.

Administration and tracking of FMLA “intermittent leave” is one of the more unwieldy aspects of the legislation, and in practice can cost companies time and money, sometimes unnecessarily. It taxes the workflow and available personnel, and because it can be taken in increments of one hour or less, it adds a heavy administrative burden to absence management.

Not only is intermittent leave costly to companies, it can also enable employees to compromise their own well-being in a way that a scheduled reduced leave prevents. From a therapeutic viewpoint, the individual will often benefit from a reduced schedule—predictable reduction of stress. If the depression warrants the label of “serious health condition,” it merits a serious regimen of treatment and consistent care of the individual.

### **Compliance with the FMLA**

In compliance with the FMLA, the employer is limited in the information that he or she asks either the healthcare provider or the employee about the employee’s medical condition. The employer, however, is fully entitled to scrutinize and clarify the information provided on the medical form that certifies an employee as having a serious health condition under the FMLA.

The form will either be U.S. Department of Labor Form WH 380 or a form that captures the same information. Form WH 380 requires the health provider to stipulate the kind of leave that an employee should have, as well as the duration of leave:

*Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in Item 6 below)?*

*If yes, give the probable duration:*

The medical responses to questions such as these are very important. Any vagueness in the health provider’s wording or any apparent deviation from the certification on the part of the employee should be noted and clarified.

If anything in Form WH 380 is unclear, the employer should verify the intended meaning, either through questioning the employee or the healthcare provider. Being the only map to follow, Form WH 380 (or its equivalent) must be very clear about durations of leave and types of therapy, so that the employer is confident that the leave is being used for the employee’s welfare.

Therapists generally support a reduced leave schedule, with the result that the psychiatric problem that motivates the leave is fully recognized, both in the work schedule and in the required therapy. The employee is offered lower stress without a false sense of freedom.

### **Recertification**

Assuming that both the employee and the employer have followed due procedure, and the employee is granted intermittent leave or reduced leave schedule for depression, what’s next? Should the employer resign himself to, at the worst, yearly intermittent, short-term notice absences occurring for up to a total of 12 weeks per year? Or, similarly, if the employee is placed on a restricted leave schedule, must that schedule be maintained until all the potential hours (480) are lost? Not at all.

It is the employer’s right to ask for recertification every 30 days, with a few exceptions. For example, if the original certification recommends a 60-day treatment, the employer must wait until that period has passed before requesting recertification (if the employee still asks for leave). But, in general, recertification is good practice, because it allows employers to periodically clarify and/or adjust the type and duration of leave specified in the first certification. The regulation states the legitimate reasons for recertification this way:

- 1) The employee requests an extension of leave;

- 2) Circumstances described by the previous certification have changed significantly (e.g., the duration of the illness, the nature of the illness, complications); or
  - 3) The employer receives information that casts doubt upon the continuing validity of the certification.
- (29 CFR 825.308)

Recertification provides a formal and perfunctory way for the employer to verify any apparent discrepancies between the employee's apparent condition and the need for leave.

Inasmuch as a reduced leave schedule involves routine treatment for the employee, there is very little inconvenience, if any, for the employee to obtain recertification. After all, the employee should generally be in frequent contact with the healthcare provider, and that provider should have a current diagnosis and treatment plan on file. It is incumbent on the employee and the provider to see that the employee's treatment is meeting the criteria for FMLA leave. To this end, both the employer and the employee benefit from the recertification process.

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