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*An Agenda for Progress*  
*Global Business and Economic Roundtable on Mental Health*

**2006 BUSINESS AND ECONOMIC PLAN FOR  
MENTAL HEALTH AND PRODUCTIVITY**

**Featuring**

**“Employers Getting Started”**

**Dedicated to His Excellency Michael H. Wilson  
Canadian Ambassador to the United States of America  
Roundtable Senior Chairman 2000-2006**

*This Plan was developed with the input and advice of hundreds of experts, business people and individuals living with mental illnesses.  
We are universally grateful.*

*We also wish to acknowledge the contribution of the  
National Quality Institute (NQI)  
and  
B.C. Business and Economic Roundtable on Mental Health*

**Sole responsibility for the contents of this Plan is that of  
Bill Wilkerson, Global Roundtable Co-Founder and CEO**

*“I endorse this Plan. It brings us closer to the dream of preventing the cost and suffering of mental disabilities among men and women who produce the goods and services we depend upon for our national prosperity and well-being.”*

**Edgardo Perez, MD  
CEO and Chief of Staff  
Homewood Health Centre**

*“Employers Getting Started provides good advice, valuable information and sound guidance to employers who wish to make the journey to a healthy workplace.”*

**John Perry  
Senior Advisor & SVP  
National Quality Institute**

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## THE ROUNDTABLE WEBSITE – 2006

### Welcome

Since start-up, this site has grown in reach around the world.

Our friend Dr. Gaston Harnois at The World Health Organization Centre at McGill University tells us this site is the most frequently-visited among those dedicated to mental health in the workplace. We feel the responsibility of that.

As recent as January, 2006, we received a request from Australia for our Year 2000 Business Plan to Defeat Depression, forerunner to this comprehensive plan. This demonstrates the appetite for information on this subject.

### 2005: A Big Year

Momentum has gripped mental health in the workplace.

- In 2005, Watson Wyatt Worldwide declared the business case for mental health “case made”. In its prestigious “Staying@Work” survey, 58% of employers (300,000 employees) said mental health claims were their top workplace concern.

2005 was the year that:

- The National Quality Institute put mental health into its definitive healthy workplace criteria.
- Medisys Health Group launched a national Health and Productivity Council, the first of its kind in Canada.
- The BC Business and Economic Roundtable on Mental Health brought health, business, government and insurance people together and found that, yes, we can reduce short-term disabilities due to mental illnesses.

2005 was a year when:

- The Conservative and Liberals both put mental health into their plans to govern the country.
- The Parliament of Canada unanimously passed a resolution establishing mental health as one of three national disease management priorities. The other two are cancer and heart disease. Depression is linked to both.
- The Canadian Institutes for Health Research launched a long-term research initiative focused squarely on mental health in the workplace. This is unprecedented.
- The Government of Canada announced the creation of the Canadian National Mental Health Commission. The first such agency in Canadian history.

- Our Senior Chairman, Honourable Michael Wilson, was named special adviser on mental health in the federal workplace.
- The federal and provincial ministers of labour put mental health on the agenda of their intergovernmental conference in Toronto.
- The World Health Organization produced a comprehensive review of mental health policies and programs in the workplace. Dr. Gaston Harnois was the author and authenticated mental health as an international workplace concern.
- The Ontario Chamber of Commerce held the first Economic Summit on Mental Health and Productivity and distributed RT information to 57,000 employers.
- McGill University's business school – the Faculty of Management – introduced a compulsory course on mental health and productivity for its MBA students.

### Website Line-up

This website now corrals the theme of Mental Health and Productivity. It includes:

- The 2006 Business and Economic Plan, the most comprehensive and frank exposition of this complicated subject.
- A roster of “*Employers in Action*” (*EIA*) to promote collaboration and idea-testing among employee organizations.
- An information and tool kit inside the Business and Economic Plan called “*Employers Getting Started (EGS)*” – a detailed and user-friendly account of what needs to be done to arrest mental disabilities in the work force.

The Roundtable's on-line website also includes:

- A summary of Watson Wyatt Worldwide 2005 “Staying@Work Survey.
- The National Quality Institute “Healthy Workplace Award” criteria including mental health.
- The Roundtable's “Publishers for Mental Health Statement” released in 2005.
- Verbatim transcripts of our unprecedented 2002-03-04 chief and senior executive roundtables.
- Our 2004 Roadmap for Mental Disability Management, 2003 CEO Survey on Mental Health, 2003 Charter for Mental Health in the Global Economy and 2000 Business Plan to Defeat Depression which has attracted interest across Canada and outside the country since its release in Toronto and Geneva.

We draw visitors attention to a terrific “tool for managers” called “***All You Need to Know About Mental Health***” produced by IBM Canada and the Conference Board of Canada based on input from Canadian HR executives.

### **Eight Years Later**

Since 1998, Canada has been home to the development of a business and economic strategy to promote mental health and reduce the disabling effects of depression, anxiety disorders and substance abuse.

This strategy has articulated new concepts to ground mental health in business and economic terms.

- ***Sustainable performance in a brain-based economy***

Today’s economy puts a premium on innovation. Most of the new jobs coming on stream require cerebral not manual skills. We are seeing the advent of a brain-based economy.

- ***Brain-based disorders as leading source of worker disability***

We are witness to convergence of the brain-based economy with the advent of brain-based disorders significantly concentrated among men and women in the labour force.

- ***The physical properties of mental illnesses attack the myth that such conditions are a function of imagination or character***

The website discusses these facts of mental illness:

- Life experience and genetics affect the onset of mental disorders.
- Psycho-social influences including management practices, workplace environments and economic loss do the same.
- The workplace is a venue for mental health research, early detection and intervention.
- The lack of access to adequate mental health care in the publicly-funded healthcare system, present Canadians with historic conundrums.
- Productivity losses: “Depression is draining productivity from our economy like an unseen leak in a ship at sea,” says Senior Chairman Michael Wilson. The productivity losses of mental illness are heavier than the cost of treatment.



## Introduction

### WHAT THE PLAN IS

The *2006 Business and Economic Plan for Mental Health and Productivity* is a history. It is also a map for directing us how to implement a plan for dealing with mental illness when it manifests itself in the workplace.

It is the story of how literally hundreds of experts, business people, government people and individuals, who are concerned about mental illnesses in the workplace, have shared their knowledge and expertise to develop a persuasive conversation about what must be accomplished in changing the way we deal with mental illness in the workplace.

As a result, this paper explores rationale and ethical and corporate responsibilities. It also sets out a framework for defining the problem and the principled systems for action. What remains is to continue to implement these creative solutions and to evaluate and refine their implication so that the effects of workplace mental illnesses are mitigated.

Since 1998, Canada has been home to the development of a business and economic strategy to promote mental health and reduce the disabling effects of depression, anxiety disorders and substance abuse.

Canada has the knowledge and tools to significantly improve our prevention, recognition, treatment and reintegration strategies in relation to employees with psychiatric disabilities.

Therefore, this document defines, in depth, the problems and solutions associated with mental illness as well as comorbid conditions in a knowledge-based economy.

This document travels from general facts to specific interventions. It calls for a re-shaping of workplace practices in a brain-based economy so that employees are treated like the assets that they are.

This information is a compilation of the work that has been accomplished, since its inception, by the Global Business and Economic Roundtable on Addiction and Mental Health. It includes the facts and rationale for intervention in the problem of dealing with workplace mental health and illness.

After the introductions of the subject, the paper is divided into four parts that will help you decide which section might interest you.

Part I is concerned with the rationale for dealing with the issue, Part II defines the problem and Part III explores a model for action.

Part IV is action central. There are 11 modules. The modules are really roadmaps delineating strategies at each level of an organization. They point out the necessity of board level knowledge regarding corporate responsibility, personal and cost impacts, and productivity implications. They aim at the necessity of CEO commitment and leadership regarding implementation of the plan.

Management policies are framed to deal with education and training regarding awareness and stigma and workplace hazards, the complexities of disability management, and ultimately with the successful reintegration of the employee to the workplace.

A model for articulation between workplace, employee and health care is also offered and the legal implications, human rights and mental health are discussed with real precision.

Finally, links are made to the National Quality Institute Healthy Workplace Strategy and although much progress has been made, much is left to be done. Therefore, the Plan identifies further issues for study and resolution.

## **OVERVIEW**

### **1. THE STAKES**

Mental illnesses are big news touching tens of millions of lives and costing tens of billions of dollars in Canada alone.

Conservatively, we estimate that 7.5 million Canadians – each year, every year – actually suffer depression, anxiety, substance abuse or another mental disorder.

That's one in four. When you extend that number to family members, friends and co-workers, virtually no Canadian is excluded from the effects of mental disorders.

Yet, we continue to struggle to engage governments, other institutions and many, many individuals in the belief that the subject merits our serious attention. That said, we are making good progress.

For employers, economists, public policymakers and hard-working bread-winners, mental illnesses have an especially important characteristic. These conditions are concentrated among men and women in their prime working years.

When untreated mental disorders rise to the threshold of disability, they rob Canada of productivity and buying power – depressive disorders especially so.

For example, families with disabilities at home see their purchasing power drop by an estimated 60%. Depression and anxiety disorders take people off the job more than any other medical condition.

The demographic of greatest vulnerability for mental illnesses are kids and young adults – 15 to 24 years of age. These are our tomorrows.

The costs of mental illnesses in Canada are born mostly by employers and employees in organizations of every stripe and kind – this, in the form of insurance premiums, fees, out-of-pocket expense and lost economic activity.

This cost burden falls to employers and employees on top of their tax contributions to the publicly funded health care system which fails, in large measure, to meet their “medically-necessary” needs as promised by the Canada Health Act.

By one account, Health Canada, Canada spends \$6B/yr. to treat depression and something they call “distress.” The economic costs are \$8B/yr. (*See the Info Appendices for the Roundtable’s comprehensive cost summary.*)

## 2. SUPPLY AND DEMAND

Unhealthy work climates generate some demand for mental health care services. By and large, the publicly-funded system doesn’t meet that demand.

This is true to the extent that physicians at one large corporation expressed frustration about raising awareness of mental health in the workplace and then having such difficulty referring employees for “medically-necessary” care.

There are several reasons for this:

- The familiar waiting list crunch, lack of timely access to psychiatrists – the specialty care for mental health problems.
- Problems in adequate diagnosis and treatment in the primary care system. In daily practice, family physicians simply don’t have the 30 minutes for one patient – time needed to diagnose depression.

*One family doctor was challenged by Ontario health officials when he billed that much time for one single patient for precisely this reason.*

- The symptoms of mental illnesses – say, pain or fatigue – may get treated but the underlying condition is neither diagnosed nor treated – creating a cost multiplier in health care.

*Canadians with untreated mental illnesses are found to use the health care system 4x more than other Canadians. The result is a health care system feeding on itself, creating adding layers of avoidable costs.*

### 3. PLAN HIGHLIGHTS

The Plan is organized in four parts with a series of practical modules in Part IV dubbed “*Employers Getting Started.*”

The organization of the Plan is straightforward and its writing style fairly easy to read. The Plan has clear, subject-specific access points which foreclose the need to go front-to-back. There is no need to tackle this at one sitting.

The subject is a complicated matrix, touching tough questions of management, personal bias, privacy, human rights, job performance and workplace policies. There’s no getting around this. And there is urgency.

The Plan contains information for many different groups, parties and individuals – researchers, students, managers, families. Find what interests you.

The Plan consists of practical, savvy and new information and pivots on two major themes:

- The implications of a brain-based economy (cerebral skills in demand) converging with the onset of brain-based disorders as the leading source of employer disability.
- The “Wilson Principle” extending physical health and safety to mental health and safety. A credible and persuasive point of reference for mental health policies and programs in the workplace.

The Plan gives voice to:

- The need for tax and financial incentives to stimulate investment in healthy workplaces and employee health and well-being. We call this the Human Capitalization of the Economy.
- Putting human capital on an equal footing with financial capital for tax and accounting purposes. The Plan specifies:

***New ways to describe and measure productivity in a brain-based economy --***

Time and volume-based measures quantifying output may be obsolete. We need new thinking. The Roundtable will consult experts in the field.

***How investments in everyday brain-based skills can be lost --***

85% of new jobs require cerebral skill sets which can be compromised by brain-based disorders, the leading source of employee disability today.

***The significance of human capital to competitive and economic success --***

Brain-based or cerebral skills are relevant to sustaining the operational efficiency and productive capacity of the contemporary workplace.

***The building blocks of productive capacity in a brain-based economy --***

These are different than brick and mortar but just as concrete in giving organizations a foundation upon which to compete in a transformed and transforming environment.

***Tax incentives for investing in the source of innovation: human capital --***

In a brain-based economy, investing in human capital is necessary to promote and embed innovation which is now widely accepted as key to Canada's competitive position and prosperity.

*“Of all the problems presented to me which reflects the greatest public concern is mental health” – Jurist Emmett Hall, the future of health care 40 years ago.*

#### **4. NEXT STEPS**

##### **Employers Agenda for Progress**

It will be the Roundtable's intention to bring employers and their health advisers – including insurers – together to explore ways and means of creating and implementing a practical mental health and productivity Agenda for Progress.

The over-arching objective is to define and implement a *Workplace Mental Health System* which both supports and draws on the publicly-funded primary care system for progress in the early and effective treatment of mental disorders.

There are several dimensions to this:

##### **Leadership Agenda**

This will be based on the World Economic Forum model, new alignment between corporate citizenship and healthy workplace goals.

##### **Applied Research Agenda**

The CIHR has embarked on a long-term initiative focused on mental health in the workplace. The Roundtable is working to bring the Harvard Medical School Depression and Work Performance study to Canada.

##### **Mental Health and Productivity Agenda**

This will relate to investments relating in human capital including employee health and productive capacity.

##### **Prevention Agenda**

This will concentrate on management practice reforms, employee self-help and timely workplace referrals for mental health care to prevent the disabling affects of depression et al.

**New Generation Agenda**

We will build on the McGill University agenda and the engagement of students and young executives in the advancement of mental health and productivity in a brain-based economy.

**Refer:**

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## The 2006 Business and Economic Plan for Mental Health and Productivity

### PART I

#### BUILDING PRODUCTIVE CAPACITY IN A BRAIN-BASED ECONOMY

*“Of all the problems presented to me which reflects the greatest public concern is mental health.” – Jurist Emmett Hall, on the future of health care in Canada 40 years ago.*

#### Highlights

A brain-based economy is an economy that:

- Puts a premium on innovation. Most of the new jobs will call less for manual skills and more for cerebral skills, cognitive capacity and sensory health.
- Achieves productivity gains not through the blind efficiencies or speed of machines but by people being innovative, analytical, resilient, team-oriented and dedicated to customer service.
- Defines the competitive edge of companies by differences that cannot easily be replicated. Specifically, the skills and productive capacity of their people.
- Demands creative “human thought content” for products and services as a condition for marketplace success, replaces mass production with mass customization, puts more microchips than sparkplugs into modern cars.
- Re-shapes the skills profile of so-called “old economy” industries like steel manufacturing. Dofasco CEO Don Pether says his company is going from “backs to minds” as source of output and skills.
- Re-defines workplace work hazards. Xerox (US) found their employees living with “constant interruptions, not enough time to get their work done and a sense of crisis even getting routine things done” – mental distress.
- Re-scripts the attitude of managers toward the time of workers. At Xerox Corporation, managers were re-trained and re-tuned to the time constraints of their direct reports to relieve the workplace of stress impediments.

In a brain-based economy:

- Investors are more likely to buy into companies that are able to attract and retain good people and top talent. This calls for healthier workplaces, an intelligent, compassionate, informed response to employee health concerns.

- The surest way to profits is treating employees as assets, the premise for this Plan’s concept of “human capitalization.”
- There are measurable returns on investments in occupational health services for employees with mental distress and disorders and testimony from several Fortune 500 companies named in this Plan says why:
  1. Employee attitudes and well-being are linked to financial results.
  2. Re-shaping corporate culture is as important as monitoring \$ results.
  3. Best-run firms promote emotional ties and well-being.
  4. Compelling place to invest is a compelling place to work.
  5. Employees who feel they count predict financial results.
- The building blocks of productive capacity in a brain-based economy are not the building blocks of factories and offices. They are different and specific.

### **The Wilson Principle**

Honourable Michael Wilson, Roundtable Senior Chairman articulates the core principle of this Business and Economic Plan for Mental Health and Productivity.

*“We have seen tremendous progress in preventing physical injuries and illnesses at work. The safety records of companies I am associated with are a source of great pride to them.*

*“It would be a shame to un-do 30 years of great progress in physical health and safety as a result of massive losses of productive capacity due to untreated mental illness in the workplace.”*

### **British Petroleum Health Savings**

At British Petroleum, efforts are underway to twin employee health with well-established plant safety. The Wilson Principle in action. BP’s vice-president for health, Dr. Chris Roythorne, says why:

*“At the company’s Texas plant, proactive case management programs encouraged employees to seek medical attention when they needed it. The result: \$5 million in savings due to reduced absenteeism.”*

Dr. Roythorne says in a media interview that the company may *“be losing \$14,000 per employee per year in health-related productivity losses and if you reduced that by even \$1,000 per year, the company would save \$10 million per year.”*



### **MINDSETS: Mental Health – The Ultimate Productivity Weapon (1998)**

Roundtable CEO Bill Wilkerson and Dr. Edgardo Perez, CEO and Chief of Staff of the Homewood Health Centre, co-authored the first comprehensive examination of the business and economic effects of mental health in a 350-page book lauded by the American Psychiatric Association and World Federation for Mental Health.

This set the stage for the Roundtable's start-up and the advent of mental health in the workplace as a Canadian economic, health and social issue.

### **Business Plan to Defeat Depression – 2000**

On the heels of MINDSETS, the Roundtable introduced a business plan focused on the medical and non-medical aspects of fighting depression in the workforce.

Released in news conferences in Toronto, Canada and Geneva, Switzerland, this 12-point initiative attracted substantial interest from many parts of the world which continues today.

Three themes characterized the 2000 plan and remain relevant today:

- One, the importance of CEO leadership in reducing the costs and effects of mental disorders in the workplace.
- Two, the necessity of hard financial targets to stimulate action. Health related costs – as a percentage of pay roll – is one indicator.
- Three, the need to modify and, if necessary, re-vamp workplace practices which are known to create environments where employee health is compromised.

We proposed in 2000 – and repeat now – steps to relieve employees of the pressures driven by an email-only culture of communications. Employers are awakening to this.

***“Mindsets Grow Businesses”***  
**Roger Enrico, former CEO, Pepsico**

The 2006 Business and Economic Plan link mental health and productivity in workplaces of a brain-based economy. This discourse follows next.

For 12-15 years (at least), we have been witness to mass downsizings in economies around the world. Michael Wilson says *“mass lay-offs have become the first not last alternative to handle downturns.”*

In Canada, as productivity lagged the number of hours that employees worked, even profitable companies cut jobs to dance the haunting rhythm of shareholder value. We entered an investor-driven economy.

It appears, however, that downsizings on a large scale proved to be more fool's gold than money in the bank – to wit:

- The compound annual growth rate in the market value of companies that achieved higher than average (bottom-line) growth but lower revenue growth compared to their industry average was half that of competitors who had both higher profits and higher revenues. (William Mercer and Company)

This suggests top-to-bottom line growth is healthier for shareholders than cuts-to-bottom-line growth.

Fortune Magazine: “Without doubt it is easier to get a dollar of profit by cutting costs than by raising revenues. But investors, the final arbiters of value, know that these two dollars are very unlike in terms of the future they presage.”

A survey by the American Management Association finds that fewer than half of the companies that downsized since 1990 – fewer than half – went on to report higher operating profits in the years following the lay-off's and even fewer saw improved productivity.

Research by the U.S. consulting firm, Monitor, found that nine out of ten firms that outperformed their industry over a 10-year period had stable structures with no more than one reorganization and no change in the CEO.

### **Human Indicators of Corporate Success**

The milestone study by Sears Roebuck says this: “A compelling place to work is a compelling place to shop and a compelling place to invest.” The study links employee attitudes to customer satisfaction and ultimately financial results.

It shows, in fact, that a five point improvement in employee satisfaction drives a 1.3% improvement in customer satisfaction and nearly .05% in revenue growth. Metrics finally catch up to common sense.

PricewaterhouseCoopers in the U.S. and Europe reports that CEOs now spend as much or more time on “people issues” as financial matters. Half say re-shaping culture and employee behaviour both rank with setting and monitoring financial results.

The best-run firms put an emphasis on best practices which promote emotional ties and well-being. As a result, over 10 years, investing \$1,000 in the Fortune 100 Best Run Companies produced a return of \$8,000, twice that of companies not on the list.

The Gallup organization surveyed 55,000 workers to match attitudes and financial results and found that four attitudes in particular that, taken together, strongly correlate with higher profits – employees:

1. Feeling they are being given an opportunity to do their best every day.
2. Believing their opinions count.
3. Sensing their company is committed to quality.
4. Seeing a direct connection between their efforts and the company's mission.

Consulting giant Ernst and Young says investors are now more likely to buy stock based on a company's ability to attract and keep talented people. CEOs in a Roundtable survey said promoting mental health is an attribute that will attract good people.

According to a study for the U.S. Commerce Department by the Wharton School and Harvard Business School, "a company's surest way to profits is to treat their employees as assets."

Based on its global experience, General Electric – one of the toughest and most competitive corporations in the world – affirms that it has seen a positive return on its investment in occupational health services for its employees worldwide.

Other major corporations with household names report their findings:

**3M Company** – with 74,000 employes – introduced a human capital measurement tool that integrates employee health and productivity; the company used this tool to drive down abuse of prescription drugs, adverse work climates, troubled workplace relationships and management practices that undermine the emotional state of employees.

**Pepsico** employed a balanced scorecard which focused on four specific measures: employee enthusiasm, financial performance, customer experience and consumer perceptions of the company. Pepsico's former CEO Roger Enrico said "mindsets grow businesses."

Studies by **Johnson&Johnson, Chase Manhattan Bank, Motorola, Marriott Hotels and Merck Corporation** says employers that help employees resolve time conflicts attract more qualified people. The study defined a "health-based competitive advantage."

**J&J** found in 1993 that employees with supportive supervisors and access to support programs in managing work/life conflicts were the most productive.

**First Tennessee Bank** found 71% of its employees' productivity was negatively influenced by time conflicts and moved to provide support for these employees. The company saw a 6x improvement in productivity which added \$1.5M to its bottom line.

**Texas Instruments** found that individual performance is the result of health and well-being at two levels – mental and physical health. Both were influenced by a sense the company was headed in the right direction.

**Fortune Magazine** surveyed 200,000 companies and found that 74% of star employees were looking for trust, relationships and job fulfilment.

**The Canadian Armed Forces** created a national peer support network. This network consists of CAF members who are trained to assist peers one-on-one, and to provide support for families.

Returning to **Xerox Corporation**: the productive workplace of the future will require management groups to attain a greater understanding of what it takes to make people want to come to work.

The question is attitude – that of the organization, its leaders and employees. In its study, Xerox:

1. Saw a direct link between the climate of a hospitable workforce and employee motivation. This, in turn, was traced to customer satisfaction.
2. Found motivation was stimulated by the underlying qualities of the work environment.

Meanwhile:

**Telus**, the telecommunications giant reports \$3M in averted WCB claims as a result of its wellness strategy.

**Hewlett Packard** recorded “soaring morale” in the U.S. as a result of efforts to reduce “burn-out.”

**McDonnell Douglas** found that for every dollar invested in employee mental health, the company realized a four-dollar return through improved absenteeism rates, fewer medical claims and sharply reduced turn-over.

**Honeywell** reported \$2.80 for every dollar spent on providing its employees with information on chronic health problems.

**First National Bank of Chicago** – now Bank One – found depression rates up 20% in the 90s and met the issue head-on through education, manager training and early detection. The result: 32% drop in mental health-related insurance claims.

**Champion**, the battery company, enacted policies recognizing the impact of mental health problems and, among other things, introduced multi-lingual education materials.

**Canada Post** introduced measures to compensate its employees for exhibiting the right behaviours – and this goes beyond cost savings or customer service improvements. Profitability improved, customers saw the difference.

**Dofasco**, the steel maker, moved from what its president calls a “strong back” to a “strong mind” model, the intellectual side of employee capacity. Success is based on the innovation of employees. Without strong minds, we aren’t going to be successful.

The CEO of a small chain of supermarkets in **Mexico** put a label on every meat package saying “Depression, do you want to know about it? Ask the cashier for information.” The cashier gave customers a small brochure and a phone number.

### **The Guts of a Successful Company**

Economists have assumed that people focus solely on outcomes and according to the Harvard Business Review, “that assumption has migrated into much of management theory and practice.”

As such, it has become “embedded in the tools that managers use traditionally to control and motivate employees all the way from incentive systems to organizational structure.”

This is the “bottom line” syndrome (to use a phrase) – the source of “get to the point” angst – which compresses “listening” to a bare minimum.

People care about outcomes and process and it is in that context that fairness – a sense of fairness – materializes in the workplace – to wit:

- Employees want a process through which they have the opportunity to express their point of view, to know that what is happening in the company is intelligible, fair and reliable.
- Managers who believe the rules of the workplace are more likely to trust their employer.
- When fair process is present, managers and employees alike tend to hoard ideas and drag their feet.

Three principles guide fairness to trust:

**Engagement:** involving individuals in decisions and allowing them to debate the merits and assumptions behind those decisions.

**Explanation:** this means making sure everyone is given a chance to understand why the decision was taken, its necessity and implications.

**Clarity:** employees want to know precisely what is expected of them and to know upfront how they will be judged, and the goals they will be expected to support.

### **Companies Tuning-In**

**Pepsico** surveyed its workers to determine their feelings about managerial style and work environment and, in doing so, discovered a correlation between job satisfaction and accident rates.

At **Boeing**, researchers found that employees who said they “hardly ever” liked their job, were 2.5X more likely to report back problems.

**Texas Instruments** introduced a team to promote health excellence in its 43,000 person workforce.

### **Employees as Assets**

According to a study for the U.S. Department of Labor conducted by the Harvard Business School and Wharton School of Business, “a company’s surest way to profits is to treat their employees as assets.”

A survey by the American Management Association finds that fewer than half the organizations that downsized since 1990 went on to report higher operating profits in the years following the lay-offs and even fewer saw improved productivity.

One in every five employees who lost their job during the decades of downsizing was line supervisors – the synapses within the company’s institutional brain. Excessive firings and downsizing depleted human capital.

Current depressants on productivity stem in large part from a lack of critical mid-level leadership or effective coordination of efforts across companies.

There is insufficient evidence that executives recognize or promote the value of knowledge and experience among middle managers – until after they leave. As a result, these ex-employees often return as consultants or sub-contractors.

### **Value: A Big Word**

One way to create value is to manage financial capital properly using an equation of net operating profit after tax minus the cost of capital.

In the economy of mental performance, this is incomplete. A measure to capture the return on investment in human capital is called for. Human capital may be more important than financial capital in sustaining shareholder value.

Productivity and human health are self-reinforcing in an economy of mental performance.

As we move deeper into the 21<sup>st</sup> century, inspiration will have to catch up to perspiration – which means:

- Technology by itself will not produce innovation or improved costs; technology no longer differentiates one competitor from another.
- “Embedding a capacity for innovation” means building workplaces where people can be creative, match their skills with their job and consume the real nutrient of a productive workplace: job fulfillment.

This defines the emergence of a brain-based economy where:

- As McKinsey and Company reports – that 85 per cent of all the new jobs coming on stream require cerebral skills.
- As RBC Financial CEO Gordon Nixon says – employers expect their people to be innovative, to think. Mr. Nixon calls this an “economy of mental performance.”
- The productive capacity of employees is found in their brains and where brain functioning is affected by work environments and work experiences.
- As a result of globalization – according to distinguished economist Sylvia Ostry – fostering the productive capacity of the human resources of organizations becomes all-important.
- The World Bank says, human capital is more important than financial capital to economic development in a world of interdependent economies.
- Harvard’s Michael Porter points out that a company will outperform its rivals only if it can establish a difference it can preserve. That difference, says Ontario Power Generation Executive Vice-President John Murphy, is skilled people.
- Productivity gains will be led not by the blind efficiencies or blind speed of machines – these are relevant but replicable tools – but by people being innovative, analytical and dedicated to service.
- Companies who build the most “thought content” into their products will be the most successful. The thought content built by car company employees is to the vehicles that come off their lines is worth more commercially than the metals or plastic which bind its body and frame.

### **Cognitive Capacity Tested**

A brain-based economy is where work hazards put our cognitive capacity and emotional well-being at risk. These are functions of the brain.

Xerox – famous for re-inventing itself – in a seminal 1990s study – found that the reactionary day-to-day nature of its managers created a sense of crisis and disorganization that undermined employee performance.

These *work hazards* ranged from constant interruptions and not enough time to get their work done to a general imbalance as to how their work contributed either to their company or their family. The company delivered remedies:

- Managers were made more aware of the time constraints that their direct reports functioned under.
- Parts of the workday were re-scheduled to permit employees to work without interruption.
- Steps were taken to give employees working on special projects freedom from random requests which took them away from their project as deadlines closed-in.

The company found that when managers do not value the time of their direct reports, the workplace becomes harried and less respectful generally. The study teaches us this:

- Good management is more than squeezing more output from fewer hours worked or fewer people working. Good management means sustaining the performance of people and the organization as two-sides of the same coin.

### **Value-Added Comes From Where?**

In this investor economy – this brain-based economy – we need to remind ourselves that it is the *workplace* and the *workforce* which produce value-added in goods and services not investors and stock markets.

Human capital is the stream of output from *workplaces* and *workforces* with market value.

In an economy of mental performance, human capital is formed by the workings of the minds of employees. This kind of economy is where job fulfillment and fairness are as important as a pay cheque – in some ways, anyway.



### **The Building Blocks of Productive Capacity in a Brain-Based Economy**

Ten building blocks of human productive capacity must be in place to achieve acceptable productivity standards in a brain-based economy.

1. Skills properly matched with the job they do.
2. Objectives and expectations well-understood by employees and their boss.
3. Discretion given employees to carry out their jobs.
4. Permission accorded employees to ask for help, inquire about priorities, raise concerns about workload, and clarify ambiguities in their work.
5. Constructive feedback and appropriate recognition of employees as a continuing procedure and value of the company.
6. Training of employees to help them cope with change.
7. Commitments to fostering job fulfilment as part of the employment contract.
8. Corporate values which are lived not just preached and seen that way.
9. Employee understanding of the big picture and their part in it.
10. Policies which put work/life balance high on the priority list.

### **Postscript**

Harvard School of Public Health concluded in 1996 that disability and premature death – not life expectancy – were the principal health issues of the 21<sup>st</sup> century. Mental illnesses, they found, were the leading cause of disability.

Disability, by definition, is a business issue because it is concentrated in the labour force. As a result, so are mental disorders. Which is, by definition, a business issue.

This takes us to Part II of this Plan – the distribution and demographics of mental illnesses.

## PART II

### THE DEMOGRAPHICS AND DISTRIBUTION OF MENTAL ILLNESS: MOSTLY A BUSINESS, ECONOMIC AND LABOUR COST *Health Care Costs Less than Productivity Loss*

*Despite the attention we pay to the “aging society,” it is men and women in their prime working years that are most at risk for mental disorders which disable more Canadian employees than any other health problem.*

#### Highlights

##### Cost Burden

- The health care costs of mental illness are less than the cost of lost productivity and the fees and premiums of workplace health programs.
- Privately-funded prescription drug insurance coverage – a key weapon in the management of mental illnesses – exceeds public spending in this area. Anti-depressants: one of five categories most in demand.

##### Concentration of Disorders

- *The workforce:* the bulk of mental disorders – mostly depression, anxiety and substance abuse – are concentrated in the workforce – among men and women in their prime earning years. Depression disability top category.
- *Prevalence:* by far, most mental illnesses take the form of depressive and anxiety disorders, accounting for probably 90% of all actual/projected cases of mental illnesses. (See *Prevalence Summary in Info Appendix.*)
- *Demographic of vulnerability:* those Canadians most likely to suffer mental disorders in a given year are 15-24 years of age. Employers have a basic stake in these younger people.

##### Health and Productivity

- Watson Wyatt Worldwide: “This is a crucial issue for the success of organizations today and one which forward-looking leaders will recognize because it makes good business sense.”
- Medisys Health Care Group has launched a Health and Productivity Council to help its own customers better understand and respond to the issues embraced by this complex concept.

- These major trends hyphenate health and productivity:
  1. High proportion of productivity costs associated with the rising rates of mental disorders in the workforce.
  2. The concentration of these conditions in the workplace and workforce impairing output as well as both productive and consumptive capacity in the economy.
  3. The scale of mental health risks facing younger Canadians and the carry-over of specific depression and anxiety from childhood and adolescence to adulthood.
  4. Continuing shortages of “medically-necessary” physician care for mental illnesses.
  5. The growth and importance of case management in workplace disability programs but no standards of governance.
  6. Co-occurrence of mental illnesses and other chronic illnesses, compounding the disability and costs of each disorder.
  7. Onset of depression raises the risk of a sudden fatal heart attack 4x-5x among recovering heart patients.

### **Concentration in the Workforce**

*The concentration of mental disorders in the workforce impairs the concentration of the workforce on a rather large scale.*

Productivity is essential to sharpening Canada’s competitive edge. Innovation – a cognitive function – is key to this.

Therefore, the prevalence of mental disorders in the labour force constitutes a strategic cost and challenge. From this emerges a “demographic of vulnerability.”

- Mental disorders are concentrated among men and women in their prime working years and long-term employees with upwards of 10-12 years of continuous service with the same employer appear to be the biggest users of anti-depressants.
- According to Statistics Canada, young people 15-24 are most likely to experience a mental disorder and that is most likely to be depression and/or anxiety.
- Depression is the leading cause of disability in the labour force and, with heart disease, is on track to become the 21<sup>st</sup> century’s leading source of work years lost through disability and premature death.

Employers have a basic stake in this demographic of vulnerability as a source of talent for their workforce and buying power for their products and services. Both are diminished by current prevalence rates and Canada's sluggish record of treatment rates.

### **Health and Productivity**

Watson Wyatt Worldwide says: *“Health and productivity is a crucial issue for the success of organizations today and one which forward looking leaders will recognize. It makes good . . . business sense.”*

Medisys Health Care Group, one of the most prominent publicly-traded providers in the private health sector, has launched a *Health and Productivity Council* to help its own customers better understand and respond to the issues. The Roundtable is participating.

Five major trends merit the attention of these and other leaders:

1. The increasing prevalence and productivity costs of depression and anxiety in the labour force and a sharp rise of disability due to these conditions.
2. The heavy concentration of depression and anxiety among men and women in their prime working years – the “demographic of vulnerability” just noted.
3. The risks facing young Canadians in the 15-24 years range. This is the future of the country's labour pool and consuming population. Consumption represents about two-thirds of our economy.
4. Continuing shortages of medical care for mental illnesses in the primary health care system and waiting lists for psychiatric care in the community.
5. The lack of certified practices, qualifications and standards governing the prevention and management of employee disabilities in the workforce – complicated by paucity of standard and effective intervention practices.

### **The Costs of Mental Disorders**

We know mental disorders in the labour force cost Canadians billions of dollars. (See the Cost Summary) We also know they affect millions of people (See the Prevalence Summary).

But we have not done enough work in detailing exactly where those costs land inside organizations and how proactive investments by employers can reduce those costs and when.

Certainly wage replacement costs and payroll redundancies are significant. Other costs may take this form:

- Employee benefit and disability costs
- Liability exposures (tax, legal, pension, severances)
- Unfunded (unplanned) downtime and lost capacity
- Intransigent service problems
- Sluggish receivable collections
- Team management problems
- Spending inconsistencies
- High turn-over

And, more particularly:

- Absence/disability costs which exceed 3% of payroll.

How do your absence rates stack up? Employers may wish to draw a comparison with the national average.

1. Illness accounts for more than 7 of the 9 total days of absence per employee per year in Canada; mental conditions, in turn, account for about half of those illness days – 3.5 days per employee per year or total days absent from work.
2. In the full-time workforce – estimated to be 10 million Canadians – the workdays lost due to mental conditions amounts to 35 million workdays (10x 3.5). This equates to 49% of the work time lost due to illness among full-time working Canadians.

### Compounding Costs

U.S. and Canadian studies demonstrate that:

- Disability associated with liver problems, arthritis, asthma, even heart disease is less than depression alone but when depression co-occurs with these conditions, the length of disability is compounded 2x-3x.
- A person suffering two mental disorders concurrently – depression and anxiety, for example – may use the health care system 4x-5x more frequently.
- Persons dealing with an episode of depression spend 50 per cent more money for medical purposes than they did previously. The re-hospitalization costs of heart patients with depression have been recorded at 4x higher than other heart patients.

(U.S.) figures show that medical costs among employees with depression were 70% higher than employees without this condition, another sign of the multiplier effect.

This tells us that individuals living and working with undiagnosed depression may seek medical attention for physical symptoms such as unspecified pain, fatigue or headaches or develop more serious illnesses with psychosocial antecedents such as heart disease.

The cost picture expands further. Studies tell us that a family of four with one member living with a disability spends 60% less on goods and services.

This reminds us that an assessment of the non-medical costs of mental disorders is a function of lost earnings and lost purchasing power.

Further:

- Employees working under what researchers called “uncontrolled stress” had health costs 46% higher than other employees.
- On the flip side, alcoholics receiving proper treatment saw their health care costs (or their demands on the system) drop by 24% in one study.

According to Health Canada three years ago:

- Canada spends \$6 billion per year treating depression and “distress.” This is less than 6% of all public health care spending in this country. Even productivity costs were higher, \$8 billion per year.

### **Company Costs Documented**

Some major Canadian companies have documented the costs of mental disorders in their workforce:

- Dupont Canada reports that costs associated with both short and long-term disability are approximately \$1,500 per employee – about half the total.
- Dofasco concludes that short-term disability costs associated with mental disabilities – including prescription drugs and productivity losses – are \$25-\$30 million per year.
- At CIBC, mental disorders produced absences averaging 95 days compared to 40 days for other illnesses, prompting the bank to introduce a health and well-being strategy, recognizing their number one health problem was mental illness.
- Great-West Life Assurance Company estimate that 30% of disability insurance claims relate to mental illnesses and in 75 per cent of the long-term files, depression is a secondary diagnosis.

A study by Atlantic Blue Cross tells us:

- Casual absence from work represents about 2-4% of payroll but STD and LTD consume between three and six per cent. As a result, absence plus disability represents up to 10% of payroll in Canada, more than WCB costs.

The costs of mental disorders in the labour force in Canada fall mostly to employers and employees through operational, payroll, premiums and out-of-pocket expenses.

Dr. Ron Kessler of Harvard Medical School – chair of the Roundtable’s Scientific Advisory Committee – estimates that upwards of 50% - 98% of the costs of depression treatment could be offset by resulting gains in productivity.

### **Depression: Efficient Target and Higher Payback**

Poor access to care, misdiagnosis and inappropriate treatment of mental disorders not only increase the cost of health care but compound it. This is a regressive form of funding other health services.

The fact is – from a cost perspective – the treatment of depression is an attractive intervention compared to other chronic disorders.

The disorder is common, the age of onset is much earlier and involves higher medical services for seemingly unrelated symptoms. In short, the payback is greater.

It also points to a major opportunity for Canada. An investment approach improving mental health care would produce a return in the form of savings that, in turn, justify new expenditures in the public health system.

Reducing the higher incidence of mental disorders among those living with other chronic disorders such as heart disease would be one such return, the dollar savings predictably substantial.

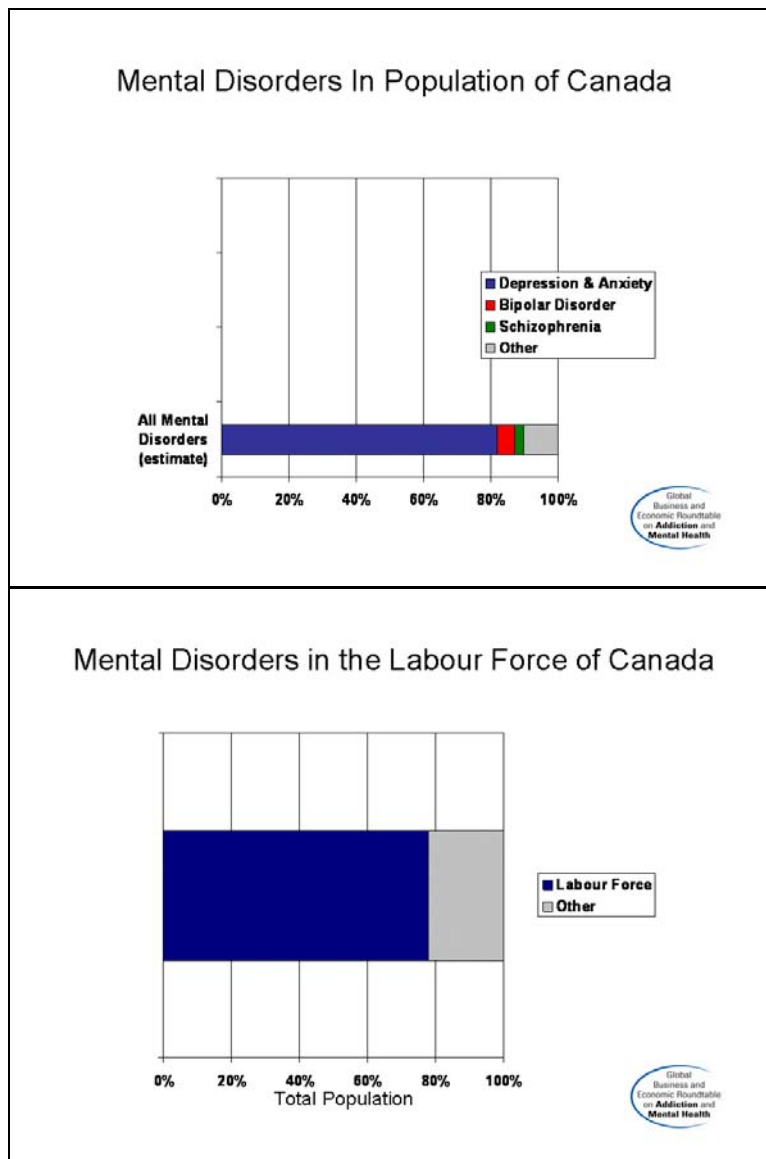
This is theory. And it needs work. But the prospects of savings in the health care system combined with reduced disability and less production impairment in the workplace will produce significant cost benefits for Canada. That’s what’s important to understand.

### **The Distribution and Stigma of Mental Illness in Canada**

We can no longer tip-toe around mental health in the workplace, act hesitantly and wait for new studies or best practices – although we need both. We must do now what we know now.

For example, we know depression, anxiety disorders and substance abuse constitute the most common serious disorders and are concentrated in the labour force.

The Roundtable's illustration follows:



### The Stigma of Mental Illness

**John Hunkin, President and CEO, CIBC**  
**November 12, 2003**

*“The stress of modern life is catching up with us. The fall-out, in terms of individual suffering, is immense and the cost to society at large has yet to be counted.*”

*Mental illness and mental health are critical important economic and social issues. But most people keep their problems to themselves, not wishing to risk negative reactions from colleagues and employers.*



*But their suffering soon manifests in other ways, and all too often gives rise to addiction, depression, even suicide. Therefore, the bigger challenge we face is the culture of silence that surrounds depression and other mental disorders.*

*As CEOs, I believe we need to create an environment where people don't feel they need to hide their illness, corporate cultures where people dealing with stress and mental illness will be accepted, respected as participating team members.*

*It's time we tackle this issue head-on."*

Suicide – mostly due to depression – kills more Canadians and Americans each year than murders. Stigma contributes to the desperation of mental illness. It is a matrix of sources and effects.

<b>MATRIX</b>		
<b>The Stigma of Mental Illness</b>		
<u><b>Inward Perceptions</b></u> <i>(Seeing ourselves)</i>		<u><b>Outward Perceptions</b></u> <i>(Others seeing us)</i>
Personal shame		Damaged goods at work
Fear of discovery		Loss of respect and abilities
Useless		Can't contribute
Isolated		Unapproachable
	<u><b>Media Portrayal</b></u>	
	Violent	
	Strange	
	Weak	
	Failed	
 <i>Reviewed for the Roundtable by Dr. Heather Stuart Department of Community Health and Epidemiology Queen's University</i>		

The myths of mental ill health persist alleging such conditions are an expression of moral weakness or character. Which is nonsense. Education is the mightiest weapon we have in fighting this imagery.

The Roundtable's mission is to wield that weapon and to open a new front in the old war against mental illness – that new front being the workplace and commercial marketplace.

## PART III

### WORLD ECONOMIC FORUM Model for Corporate Citizenship

#### *Goals and Principles for Mental Health in the Global Economy*

#### Highlights

#### Corporate Citizenship Model for Mental Health

Part III strengthens the argument for investments in mental health on grounds advanced by the World Economic Forum statement on corporate responsibility and global health which drew the support of CEOs the world over.

The World Economic Forum created a corporate social responsibility framework which CEOs, boards of directors and executive management teams can use to develop a strategy for managing their impact on society.

CEOs and corporations supporting this framework included McDonald's Corporation, Merck and Co., the Coca Cola Company, UBS, RIO Tinto and many others.

The World Economic Forum, through its advisers, is currently examining the concept of a "psychologically healthy" organization and the Roundtable has been consulted on this.

Meanwhile, the President and CEO of Hewlett-Packard (Canada) Co., Paul Tsaparis, links corporate social responsibility (CSR) to "solid financial performance."

Mr. Tsaparis says CSR delivers competitive advantage and quotes in surveys which say that 79% of global chief executives agree that social responsibility is vital to profitability. In fact, he says, goodwill accounts for 71% of total market value.

The Hewlett-Packard CEO says these facts are driving socially-responsible investments and ethical indices such as the Dow Jones Sustainability Group index.

"Given the new level of convergence of personal, business and societal values, there is clearly a new imperative to act," Mr. Tsaparis said, quoting the founder of his company, David Packard: "HP exists to improve the welfare of humanity."

The World Economic Forum Framework for Action spells out these steps for developing a social responsibility program. It applies to breaking new ground elsewhere – including mental health and productivity:

Based on the Forum's model, the Roundtable proposes the following "***steps to corporate citizenship, mental health and productivity in the global economy.***"

Step One:

Provide leadership, set strategic direction, articulate purpose, promote the business case internally, and use this Business and Economic Plan as a tool.

Step Two:

Define what it means to your company, define the issues, agree on how your company can make a difference to your employees and the wider community, and use this Business and Economic Plan as a source.

Step Three:

Establish policies and procedures, engage in dialogue internally, let your customers and suppliers know about your commitment in this area, use this Business and Economic Plan as a source.

Step Four:

Be transparent, build confidence in your commitment to corporate citizenship and mental health by talking about the subject, encourage your employees to talk about it, engage your unions and other stakeholders, use this Plan as a source.

Step Five:

Agree what and how to measure, develop a reporting system for tracking progress, be realistic, and use this Plan as a source.

Please note:

- Each of these five steps can be fleshed-out as action plans drawing on the substantive content of this Plan and the recommendations (especially) in Part IV.
- Further, the Roundtable will pursue the idea of bringing the World Economic Forum to Canada in 2007 to explore mental health and productivity as a 21<sup>st</sup> century economic construct.
- There is plenty of international research and data from sources such as the World Bank, World Health Organization, International Labor Organization, Harvard Medical School and others to suggest this has considerable merit.

Concrete Business Objectives

The Corporate Citizenship model spells out the leadership role of CEOs in advancing quality of life on earth and draws links to eight concrete business objectives also identified in the Roundtable's CEO Survey on Mental Health:

1. Reputation management
2. Risk management
3. Access to human capital (recruitment, retention of talent)
4. Access to financial capital (investor relations)

5. Learning and innovation (market realities)
6. Competitiveness
7. Operational efficiencies
8. Licence to operate

### *Principles of Action*

Using the World Economic Forum model, the Roundtable has isolated five principles to guide advancement of mental health and productivity as a new 21<sup>st</sup> century economic construct. These are:

#### *The principle of leadership*

- CEO engagement.

#### *The principle of enlightened self-interest*

- CEOs linking mental health and productivity to legitimate corporate and economic interests and opportunities.

#### *The principle of transparency*

- CEOs fostering open discourse on mental health and productivity issues.

#### *The principle of action*

- CEOs sponsoring policies and practices to reduce the risks of unproductive and unhealthy workplaces.

#### *The principle of research and inquiry*

- CEOs supporting mental health in the workplace research initiatives and under the leadership of the Canadian Health Research Institute – with the Roundtable’s support – Canada has already broken ground on this.

These principles are discussed in detail in the Plan.

### **Business Education and Mental Health – (*Aspen Teaching Innovation Program*)**

Through the leadership of Roundtable Vice-Chair, Maria Gonzalez, the Roundtable participated in a special education initiative in 2005 which sets the stage for a “new generation” approach to mental health and productivity.

A member of the Aspen Institute’s “Teaching Innovation Program,” the McGill University Faculty of Management introduced an MBA program called “Mental Health and Productivity: Sustainable Performance in a Brain-Based Economy.”

Compulsory for its first year MBA students, the session drew a full house of 2<sup>nd</sup> and 3<sup>rd</sup> year MBA and PhD students and put mental health into McGill’s business curriculum.

Meanwhile, the Aspen Institute received a presentation on the Roundtable's mission and new possibilities emerged: building mental health into an international discourse on the economy, education and social progress.

The topic deserves a place on that agenda on its merits, and that it is now receiving the attention of leaders in these fields generates new momentum for mental health in the workplace.

The NQI healthy workplace movement combined with Aspen's Teaching Innovation Program creates a strong platform upon which to put mental health and productivity securely into these agendas for the future.

The Roundtable draws upon the World Economic Forum's ground-breaking statement of corporate citizenship endorsed by top CEOs in 2002.

In an economy of mental performance, human capital is not a narrow economic construct; it is a form of capital that companies need in order to drive innovation into every sector of the economy.

The World Economic Forum's Global Corporate Citizenship Statement serves as a useful framework for corporate unity and action to promote mental health and productivity.

In preparation for the World Economic Forum's 2003 annual meeting, CEOs were polled worldwide on the role of corporate citizenship in world affairs and these themes emerged:

- The powerful role played by CEOs as a champion of corporate values and builder of consensus is more central and critical than ever.
- The strong link between corporate citizenship and corporate governance and the importance of monitoring the company's wider social, economic and environmental performance.
- Collaboration among CEOs and companies on such matters.

### **Mental Health Goals**

The Roundtable's Charter for Mental Health in the Global Economy was signed by several business leaders in 2003. Its goals inform this Business and Economic Plan.

1. Prevent the disabling effects of depression, anxiety and substance abuse in the labour force through improved early and effective treatment of these disorders and an integrated model of disability and performance management.
2. Reduce production losses associated with employee absence and on-the-job downtime due to unchecked or advanced mental disorders especially among employees with longer terms of continuous service.

3. Promote greater awareness and vigilance among managers, employees and health professionals of the heightened risks of disability and death among employees with chronic disorders including heart disease.
4. Support efforts to create a national strategy for suicide prevention by the Canadian Association for Suicide Prevention.

### **Research: Mental Health in the Workplace**

Michael Schwartz, Senior Vice-President, Group Benefits  
Great-West Life Assurance Company, articulates a model for the  
management of mental health in the workplace

#### POLICY FOCUS

Management accountability

#### LEADERSHIP

CEO, senior management

#### EDUCATION / TRAINING

Managers/employees

#### POLICY SPONSORSHIP

Management/union

The Roundtable supports the Canadian Institutes of Health Research long-term research agenda for mental health in the workplace.

To anchor the Principle of Research and Inquiry, we present here employer priorities for this unprecedented national initiative.

- Demonstrate how absenteeism and productivity losses due to diagnosable mental illnesses and sub-threshold conditions such as burn-out can be continuously reduced through workplace and clinical measures.
- Identify those common elements in workplaces that contribute to chronic job stress as a health risk.
- Document those changes in management practices most likely to reduce harmful stress in the workplace.
- Produce a cost/benefit analysis of positive “wellness” changes in the workplace that will promote employee mental health in the normal course of operations.

- Identify disability management procedures that are customized around mental illnesses.
- Document how employees lose work time due to the progression of untreated mental illnesses and identify workplace interventions that will help arrest and halt this progression.
- In particular, develop an early intervention standard and methodology for use by non-medical personnel or lay managers in the workplace as a step toward early detection and referral.
- Design an integrated prevention, detection, diagnostic, treatment, recovery and return to work system suitable for the management of mental health in the workplace. *(In this context, employers and insurers need a frank appraisal of what it will require to improve access to qualified care.)*
- Develop recovery and return to work timelines to guide treating physicians and disability case managers in the management of employee disability.
- Identify how to avoid relapse once an employee has successfully returned to work from disability leave – assuming appropriate job accommodations are in place.
- Develop a workable hypothesis to demonstrate how employer investments in group drug plans may reduce short-term disability due to depression.

**CIHR Priorities Include:**

- Focus on the prevention and treatment of mental illnesses, promotion of mental health, evaluation of clinical best practices, disability management, research relating to specific population segments, strategies to address stigma and –
- Development/evaluation of measurement tools for each of the areas noted above both at the level of organizations and society.
- Identify the impact of government and corporate policies on short and long-term disability rates and outcomes.
- Identify the effects of organizational practices on mental health and related workplace risks and positive/protective workplace factors.
- Clarification of medical illness (“diagnostic entities”), sub-threshold conditions (stress and burn-out) and physical/mental co-morbidities including bio- psychosocial risk and protective factors.

**Postscript: Medical Mental Health Care for Canadians**

The question of “what works, what doesn’t work and do we know the difference” in terms of the diagnosis and treatment of mental illness represents a perplexing ambiguity for employers.

The scientific and medical professionals need to help employers and insurers understand what constitutes the “diagnosis” of mental illness and how subjective self-reporting of patients is balanced with objective criteria guiding diagnosis, treatment and recovery determinations including return to work clearance.

Employers are concerned that positive strides in the workplace will not have the desired effect if access to qualified primary medical care and specialist care – that is, psychiatrists – is provably limited.



## **PART IV**

### ***EMPLOYERS GETTING STARTED (EGS) On the Road to Mental Health and Productivity***

#### **MODULE ONE**

#### **GOVERNANCE AND MENTAL HEALTH IN THE WORKPLACE**

*All the players with a vested interest in the success of employer organizations have a role to play in advancing workplaces along the road to mental health and productivity. The following are guidelines for investors and members of boards of directors.*

#### **Highlights**

Part IV moves into the workplace and sets out a specific slate of goals which guide this Business and Economic Plan for Mental Health and Productivity. They are:

- a. To develop a standard and strategy for mental health in the workplace that is based on sound principles not exigencies. These principles are spelled out in this Plan.
- b. To forge a Workplace Mental Health System to create a new frontline in both the primary and secondary prevention of mental disorders and disabilities. This is discussed in detail in this Plan.
- c. To define and promote the means to prevent the disabling effects of depression, anxiety and effective treatment of these disorders including an integrated model of disability and performance management as a powerful instrument for this purpose.
- d. To define and promote the means to reduce the production losses associated with employee absence and on-the-job downtime due to advanced mental disorders especially among employees with longer-term continuous service.
- e. To promote heightened awareness and vigilance among physicians, managers and employees of the risks of depression co-occurring with heart disease. This Plan contains a dedicated section on this.
- f. To support efforts to defeat stigma and discrimination and to create a national strategy for suicide prevention.

**PREVENTING THE PREVENTABLE**  
**Suicide in Canada: The Business of Business**

The Roundtable supports the *Canadian Suicide Blueprint for a Canadian National Suicide Prevention Strategy* being advanced by the Canadian Association for Suicide Prevention (CASP).

There are more suicides in Canada than murders – 4,000 a year and aside from the sheer humanity of preventing this, there are pragmatic implications for employers. Those who die by suicide are mostly younger people in the prime or their earning, spending or growing years – otherwise productive parents, employees, consumers and future employees – lost forever.

Mostly, these are the fatalities caused by depression. The economic costs are significant in the workplace and marketplace alike. There are also legal liability concerns for employers if an employee signals intent but nothing is done.

In 2006, the Roundtable will work with employers, EAP professionals and CASP itself to do four things:

1. Develop response guidelines to help executives, managers and co-workers respond properly if an employee mopes or talks to them about taking his or her own life. What do you do first? What do you do, period?
2. Develop the elements of training for co-worker, colleague or direct reports to support an employee who receives news of suicide in their family.
3. Distribute the Roundtable's "*Guidelines for Working Parents to Protect the Mental Health of their Children*" to employees. These focus on teen suicide.
4. Bring an Employer Delegation to CASP's annual meeting in Toronto to help launch suicide prevention in the workplaces of Canada.

The Roundtable believes this: Canadians need a bold but measurable goal to motivate passion and support for the flesh and blood of a national suicide prevention strategy.

We believe that a goal to save 3,000 lives from suicide over the next 10 years is realistic and called for given the "treat-ability" of depression, the leading cause of suicide.

Let that trumpet our intent to prevent the preventable – suicide in Canada.

## Investor Guidelines for Mental Health and Productivity

### Discussion

Module One contains the first known slate of guidelines for institutional investors and boards of directors to mandate/support management policies to protect shareholder value against:

1. Unfunded costs of unmanaged absence due to unchecked mental health problems in the workforce.
2. Inherent instability of business plans which fail to recognize the underlying challenge mental disorders poses to productive capacity in the organization.
3. Chronic job stress on a large scale, raising questions about the quality of management of companies which tolerate and feed it.

### Investors

**OMERS President and CEO Paul Haggis:** *“Employee health and productivity are fundamental aspects of good management and appropriate measures for institutional investors to use in assessing the quality of management of companies in which they invest.”*

### Governance

**Torstar Chairman John Evans, MD:** *“The case for the importance and severity of mental disability is incontrovertible and any board of directors that doesn’t insist on having environment, safety and health on its agenda – with a special emphasis on mental health – is not discharging its governance responsibility.”*

### Leadership

**Gordon Nixon, President and CEO, Royal Bank Financial Group:** *“Today’s economy puts a premium on information and innovation. This is an economy of mental performance where the capacity of employees to think, be creative and be innovative is key to the competitiveness of all business – including my own.”*

Following are “Mental Health and Productivity” guidelines for institutional investors and boards of directors.

### European Investors

There is evidence that European investors are beginning to worry about the impact of job stress on their investment. A worry well placed.

Meanwhile, in accounting and management terms, human resources are inadequately defined in terms of their asset value to companies competing in a brain-based economy where there is such a high premium on innovation as a key to productivity.

Yet:

- Between 1982 and 1998, the percentage of market value attributable to intangible assets grew from 38% to 85%.
- Studies find that about 85% of the new jobs coming on stream in the U.S. require cerebral not manual skills.
- Study after study shows financials are a “rear view mirror” of performance, a lagging indicator. The attitudes of people – morale, perspective, outlook, health – are leading indicators.
- At the same time, Watson Wyatt Worldwide tells us most employers don’t keep track of employee absenteeism on any given day.
- The leading source of disability in today’s work environment is depression often co-morbid with other chronic illnesses – compounding the disablement and time off work.
- These matters touch upon basic aspects of management:
  - Quantifying, managing and reducing risk
  - Protecting valued assets and those investments in them.
  - Tracking carefully the return on investments, assets and resources

By absorbing unfunded costs due to unmanaged employee absences including those due to mental illnesses, employers – including publicly-traded corporations – are, in effect, taxing themselves.

- First, by not addressing those cost factors within their control including workplace chronic stress impugning the asset value of employees who represent the largest single investment employers have.
- Second, by not pressing other parties for corrective action on other cost factors including, in the case of government, poor access and less than adequate care and treatment available to employees through publicly-funded health care.
- Third, by not doing the homework necessary to be able to see direct spending on human resources as an investment or opportunity cost with returns and benefits if we found a way properly to calculate them.

## **Action**

Institutional investors are advised to use employer health issues as another way to evaluate the quality of management of the companies in which they currently invest or may do so in the future:

1. Inquire and determine whether corporate directors and the management team grasp the operational and cost impact of employee absence due to mental disorders.
2. Sharpen this inquiry by asking for specific data on the company's:
  - Disability, group health and absence pay-outs as a % of payroll
  - Experience with employment law or human rights complaints
  - Operational, not just HR costs associated with employee disability.
3. Determine if the costs and incidence of absence and disability are clearly known to the company's management and whether these costs are adequately funded.
4. Probe how many employees of more than 10 years continuous service are among those on long-term or short-term disability and what management is doing to re-capture their asset value. This is a bell-weather.

### **Board of Directors Guideline on Mental Health and Productivity**

*(This Guideline was endorsed by the business leaders named at the end)*

## **Discussion**

The costs of mental illness in the Canadian labour force exceed \$33 billion per year. Depression is the leading cause of disability in the workforce.

The greatest concentration of mental illness occurs among men and women in their prime working years with ten or more years of service with their current employer.

The prevalence of mental illness across such a wide track of the working population affects a range of corporate policy and strategic issues – among them:

- The recruitment and retention of skills employees who want balance between their working, personal, or family lives.
- The viability of business plans in an economy which puts a premium on innovation and productivity as the pathway to national prosperity and international competitiveness for Canada.

- Employee productive capacity for innovation, service and workplace team relationships are necessary for companies to sustain performance. People are leading indicators of performance. Financials are lagging indicators.

It is widely known, among employers, that depression and anxiety in the workforce – the most common and often serious forms of mental illness – are a leading source of employee absence and disability – and productivity impairment.

Unchecked, the absence or downtime of employees arguably poses material risks to the realization of business planning objectives and optimal shareholder value and, as such, may constitute a form of unfunded liability among public companies.

### **Action**

Corporate directors are advised to:

- Place the topic of environment, health and safety with an emphasis on mental health on the agenda of board and board committee meetings.
- Report this action to shareholders in the normal course as a matter of appropriate disclosure and governance given the recent attention given to these topics and the conscionable merits of reporting and acting on them.
- Express your explicit support and/or wishes to senior management for a comprehensive assessment of the prevalence/costs of mental disorders in the workforce.
- Consider the *Investor Guidelines for Mental Health and Productivity* to focus board and management attention on these matters through the lens of shareholder value.

This Guideline was endorsed on February 17, 2004 by:

John Evans, MD, Chairman Emeritus, Torstar Ltd.

John Hunkin, former President and CEO, CIBC

Gordon Nixon, President and CEO, RBC Financial Group

Guy Saint-Pierre, Chairman Emeritus, Royal Bank of Canada

Honourable Michael Wilson, Chairman, UBS Canada

### Further Discussion

**Arnie Cader, Roundtable Director, President, The Delphi Corporation:** *“Good Governance has been taken to a whole new level in Canadian companies. Boards are reconsidering how they examine the companies that they’re running and how they look at management. One of those factors should be what companies have in place for the mental health of its employees.”*

**Paul Haggis, President and CEO, OMERS:** *“Investing in companies means investing in people. So, in a word, absolutely, yes, investors must pay attention to these considerations.”*

**John Hunkin, Former President and CEO, CIBC:** *“If you are a CEO in today’s world, one of the things you learn is that, in fact, the majority of our shareholders have a very short-term view of the world. That’s reality. But, creating a great corporation suggests sustainability of performance over time.*

*And I don’t think you can have sustainability unless you have good practices around human resources. And clearly, mental health issues are some of the very most important.*

*Management practices relating to mental health are good business practices that not only warrant the attention of management, but also should be very much on the mind of the board of directors.”*

**Rod Phillips, Roundtable Vice President and President and CEO, WarrenShepell, the EAP Professionals:** *“There is a fantastic return on investment with increased utilization of EAP services. That can be demonstrated in productivity costs, employee turnover costs, management time dealing with a troubled employee, and prevention of cases going from short-to long-term disability. So the key message is that promoting mental health in the workplace is a cost-effective effort that can be demonstrated over and over and over again. It makes absolutely good business sense and good people sense.”*

### Postscript

These governance guides aim to produce incentives and support for CEOs and their management teams to build mental health into their vision of a healthy workplace. For this, we proceed to Module Two of “Employers Getting Started” (EGS).

***EMPLOYER S GETTING STARTED***  
***On the Road to Mental Health and Productivity***

**MODULE TWO**

**CEOs AND MANAGING MENTAL HEALTH IN THE WORKPLACE**

**Highlights**

This Module contains the first slate of Guidelines to help CEOs fashion an informed leadership role in the advancement of mental health in the workplace.

The CEO Guidelines for Mental Health and Productivity advises leaders and senior decision-makers of organizations to:

Start by:

- Making your employees and unions partners in the development of policy, practices or programs relating to mental health in the workplace. These issues touch job performance and workplace concerns directly.

In doing so:

- Encourage flexible, creative thinking among managers and employees alike; say clearly – in these very words – it is OK to discuss mental health in the open.
- Send a clear, plain message that your organization will become an “employer in action for mental health and productivity” and join the Roundtable’s growing roster of employers who are doing so.
- Make it clear you will become an employer-in-action not because your organization has all the problems or all the answers. But that you want to identify your share of the first and find the requisite number of the second.

Further, the Guidelines advise CEOs to:

***Audit your organization’s disability experience with respect to mental disorders. The Plan specifies the areas to look for including existing disability rates, why some cases have lingered, patterns of return to work, the incidence of long-term disability.***

***Evaluate existing Return to Work policies and procedures.***

The purpose:

- To determine if there are systemic or attitudinal barriers to the return to work of employees on disability leave due to mental disorders.



***Create management accountability for getting employees on disability leave back to work on sound medical and management grounds.***

The purpose:

- To establish the means of integrating disability and performance management which the Plan suggests is an essential step.
- To ensure the development of well-crafted policy to reduce chronic job stress and management practices which represent a health risk for employees and therefore a cost to the organization.
- To engage unions in the design and implementation of relevant policies.

*Model of Joint Leadership*

*As an example of management-union joint leadership in this area, the Plan cites a collective bargaining agreement between the Canadian Union of Public Employees and Ontario Workers' Insurance and Safety Board.*

*This CBA spells out very specific goals and conditions regarding employee well-being, work/life balance and the shared responsibilities of the employer and the union to make these happen.*

***Create a principles-based policy for mental health in the workplace.***

Purpose:

- To use policy as a tool to:
  1. Foster and sustain a non-discriminating and caring environment which protects all employees against stigma and discrimination. Systemic forms of this can seep through an organization like water.
  2. Guarantee that job access, promotion and security will not be influenced by health status alone. The Plan sets out specific steps needed for this.

***Ensure mental health is vested in the competence and commitment of human resources staff and establish concrete targets to reduce the incidence of mental disorders. The Plan suggests what those targets can be.***

**“In Their Own Words”**

*The following quotations were spoken by CEOs and senior corporate executives at events staged by the Roundtable in 2002-05. Use these quotes as emphasis to help make your case to senior managers in your workplace.*

*“Most companies now recognize mental health as one of the most important workplace issues today. It’s an issue that’s only going to get bigger as business and life become more complex and fast-paced.*

*“How a company’s leadership deals with it will determine whether the workplace becomes a healthy environment or a place that makes people sicker. One of the main challenges will be to help remove the stigma of mental illness –*

*“To get to the point where mental illness is treated and accepted in the workplace in the same way as a physical disability – that is, without stigma or blame.”* **Rob MacLellan, EVP and Chief Investment Officer, TD Bank Financial Group and Chairman, TD Asset Management Inc.**

*“Changes in the physical environment to improve productivity are limited. The opportunity to better engage employees is to ‘de-stigmatize’ mental illness.”* **John Murphy, EVP, Ethics Officer, Human Resources, Ontario Power Generation (now Executive Vice President, Hydro)**

*“The case for the importance and severity of mental disability is incontrovertible and any board of directors that doesn’t insist on having environment, safety and health on its agenda – with a special emphasis on mental health – is not discharging its governance responsibility.”* **John Evans, Chairman Emeritus of the Board, Torstar Ltd.**

*“Mental health and workplace stress must be counted as one of the top business issues for all of us who claim that our people are our most important asset and the basis of our success or failure.”* **John Hunkin, former President and CEO, Canadian Imperial Bank of Commerce**

*“We understand how we treat people in the workplace, is at the very heart of sustaining business performance over the long-term.”* **David Wilson, Vice-Chairman, Scotiabank (now Chairman of the Ontario Securities Commission)**

*“Today’s economy puts a premium on information and innovation. This is an economy of mental performance where the capacity of employees to think, be creative and be innovative is key to the competitiveness of all business – including my own.”* **Gordon Nixon, President and CEO, Royal Bank Financial Group**

*“Business must have a mental health agenda.”* **Paul Godfrey, President and CEO, Toronto Blue Jays**

*“We simply must get our arms around this issue for sound business reasons.”*

**Tim Price, Roundtable’s Co-Founder and Chairman**

*“Business, definitely, has a strategic interest in the mental health of the labour force.”*

**Nancy Hughes-Anthony, President and CEO, Canadian Chamber of Commerce**

*“When the Roundtable was formed, many of us were from Missouri. We had to be convinced that mental health issues deserved to have a distinctive place on the corporate agenda. For one, I don’t need more convincing.”* **Colum Bastable, President & CEO, Royal LePage Ltd.**

*“The pay-off of investing in the mental health of our people will be huge.”* **Don Tapscott, Co-founder, Digital 4Sight and President, New Paradigm**

*“We endorse the goal of preventing disability associated with depression, anxiety and substance abuse. We believe in early intervention.”* **David Henry, Managing-Director, Toronto, Great-West Life Assurance Company**

*“The cornerstone of what we have done in our organization is to establish mental health as a priority – that is, to understand the problem and provide our staff with the necessary tools and support to address it.”* **Don Pether, President and CEO, Dofasco Inc.**

*“The issues that we’re addressing in workplace mental health are questions of good management and that’s key criteria for assessing financial performance or the future performance of any institution.”* **Paul Haggis, President and CEO, Ontario Municipal Employees Retirement Savings (OMERS)**

*“Just as every physical injury carries with it identifiable, unwanted and, to my mind, fully preventable business costs, and if compassion isn’t enough, we have a self-interest in restoring productivity to its highest possible level if it is being constrained by a mental illness.”* **Former Syncrude CEO, Eric Newell**

**(See the Roundtable’s CEO Survey on Mental Health which is posted on the Roundtable website.)**

## CEO Survey on Mental Health

In 2003, the Roundtable published the results of the first-ever CEO Survey on Mental Health and the findings represent a useful context for these CEO Guidelines.

### **Maintaining a Productive Work**

*Employees who exhibit symptoms of poor mental health have a direct impact on co-workers' ability to function in workplace teams.*

### **Recruiting and Retaining the Best Talent**

*Companies must build a reputation for providing employees with the support and assistance they require in meeting their responsibilities at home and at work.*

- “Organizations which have a reputation for not respecting employees or responding to mental health concerns will be unlikely to attract talented recruits.”

### **Remaining Competitive and Protecting Customer Service**

*The emphasis in both areas is placed on the capacity of employees to sustain productive relationships and to provide service. Both are impaired by unchecked mental disorders.*

## Prototype CEO Fact Sheet

This fact sheet is based on an actual briefing note prepared for senior executives at Dupont Canada.

### ***Prevalence and concentration of mental disorders in working population***

- high (20%+/yr)
- men/women in prime working/earning years
- adolescent and entry-level age groups

### ***Rates of detection/early treatment***

- low/no treatment for four out of five via public health system
- workplace referrals stymied

### ***Costs***

- \$33B/yr (estimate) (*see Info Appendix: Cost Summary*)
- embedded/unfunded operating costs
- company estimates (*i.e., Dofasco: \$25-\$30 million per year*)

### ***Disability experience of major employers***

- mental disorders dominate claims
- on-job downtime is outgrowth of low-no early detection/treatment
- unnecessary migration from short to long-term disability

## **CEO Guidelines for Mental Health and Productivity**

### **Phase One**

Chief Executive Officers and their equivalents are advised to:

- Impart a clear message to their direct reports that mental health is a legitimate topic and it will be the policy of the organization to encourage open and informed discussion among employees.
- Order up a comprehensive briefing for yourself. This will galvanize the organization and allow you to ready your senior management group to play a leadership role. *The Roundtable is ready to help. This Plan is a start.*

### **Phase Two**

CEOs are advised to make seven commitments to the organization – that is, you will:

1. Champion mental health and not drift away from that role.
2. Deploy the Wilson Principle and build on your organization's success and commitment to plant safety in creating a similar commitment to mental health and safety.
3. Give all your employees every opportunity to learn about mental health and mental illnesses through information, training and "tolerance tutorials."
4. Articulate and enforce a policy of zero tolerance toward stigma and discrimination systemic or episodic in nature.
5. You will embrace a vision of a healthy workplace for your organization and ensure mental health is part of that.
6. Engage your employees and unions in the process of learning about mental health issues.
7. Do everything you can to say it's OK to discuss the topic openly.

### **Phase Three**

CEOs are advised to:

- Audit existing disability rates and disability management procedures and isolate the reasons why some files have lingered.

- Probe each and every long-term disability file not in terms of forcing employees to justify their predicament but the systemic reasons for it.
- Evaluate:
  1. The expertise and track record of external service providers, insurers and ASO contractors in managing mental health issues and disabilities. Don't assume anything.
  2. Existing policies and procedures, if any, for proactively designing appropriate job accommodations and work modifications for employees returning from mental disability.
  3. Tools and policies for functional assessments of employees in recovery from mental disorders and cleared to return to work.

#### **Phase Four**

Create management accountability for workplace mental health and, in doing so, a number of priorities stand out:

- Require each of your senior people to review and understand their responsibilities under the law for the recognition and preservation of human rights in your workplace. Discrimination against mental illnesses is unlawful.
- Ensure that a practical and well-enunciated policy on workplace stress is crafted and deployed. Management practices that can trigger stress-related health risks must be modified.
- Make your line managers accountable for managing risks which threaten your investment in your human assets in the same way you assign accountability for protection of inanimate assets. This is needed to:
  1. Protect productive capacity in the organization.
  2. Reduce the management-related risks to mental health in the organization.
  3. Ensure mental health is incorporated into the organization's vision of a healthy workplace.
  4. Build and observe a policy of zero tolerance.
  5. Engage unions in the design and implementation of policies and procedures in this area. Unions share management's duty to accommodate.

### **Phase Five**

Create a policy framework for mental health as part of a healthy workplace embracing the following principles:

- Fostering and sustaining a non-discriminating and caring environment which protects all employees against stigma and discrimination based on their experience with mental illnesses.
- Fostering and sustaining an integrated model of performance and disability management anchored by clear accountability for line managers which:
  1. Guarantees that job access, status, promotion, security and training will not be influenced merely by health status.
  2. Stipulates that executives and managers have a responsibility to be actively supportive of employees encountering health problems which interferes with their productive capacity and ability to perform their job.
  3. Acknowledges and recognizes the desire and ability of employees who are on disability leave due to mental illness to return to their job and productive engagement at work.
  4. Commits needed case management support to that employee to plan and facilitate a safe return to work; and, further, promises that the employee will receive independent advice on his or her human rights governing this process.
  5. Ensures the employer will do everything possible to make the necessary job accommodations to facilitate those employees returning to work and to do so in a spirit of cooperation, understanding and openness.

### **Phase Six**

Develop five policy objectives to support an integrated approach to mental disability management – that is, an integration of performance, disability, treatment and return to work factors:

**Portfolio Approach:** Incorporate and monitor existing investments in employee health into a single, integrated portfolio of expenditures and outcomes. For example, the costs of group health – and particularly prescription drugs – may help to hold disability premiums down. Employers need to evaluate this return on this investment.

**Education and Training:** Give employees every opportunity to learn about mental health and train executives and front-line managers to recognize and respond properly to co-workers (and direct reports) in distress. Tap into the expertise of those veterans of mental healthcare – “consumers/survivors” – who have valuable lessons to share.

**Primary Prevention:** Identify workplace practices which pose material risks to the health of both the employees and the organization and make needed changes through positive, not punitive, incentives.

**Secondary Prevention:** Put into place early detection, referral, and access-to-treatment protocols as a means of promoting early intervention. This is easier said than done.

**Gradual Return-to-Work:** Apply this concept universally to all forms of employee disability including those involving mental health problems.

### **Phase Seven**

Ensure mental health is vested in the competence and commitment of HR staff. Without it, CEOs will be frustrated by a “mysterious” lack of progress – and to this end:

- HR managers and HR support staff should be assessed annually for attitudes, aptitudes, hard skills and pre-conceived notions about mental illnesses and how to manage mental disabilities with knowledge, compassion and timelines.
- HR managers should receive training on three levels – that is, to:
  1. Provide informed support of line managers in their defined responsibilities.
  2. Serve as the chief ethics officer of the disability management process and exercise appropriate independence.
  3. Assume the same kind of fiduciary role as a CFO might to meet the requirements of human rights law, industry standards and core values.
- HR managers must also receive the necessary budget, staff and high-level support against adversarial managers in order to carry out these responsibilities.

### **Phase Eight**

Aim to protect those areas of functional responsibility, talent and impact most likely to be compromised by unchecked mental disorders and chronic job stress. The performance qualities of employees most likely to be compromised by mental disorders are:

#### **Employees’ Customer Orientation**

Mental illnesses compromise the capacity of employees to exhibit an outward and helpful way of thinking. These conditions draw them inward.



### **Communication**

Mental illnesses compromise employees' way of perceiving information, its relevance, their capacity to listen attentively as a consequence of losing the capacity to concentrate well, relationships suffer, the employee becomes isolated.

### **Teamwork**

Mental illnesses cause employees' motivation to slump and along with it, their desire and capacity to cooperate with others, answer phone calls, meet deadlines for written material, irritability develops, burn-out deepens.

### **Managing People**

Mental illnesses compromises the capacity of employees – in this case, managers – to display empathy and interest in the problems of others, impatience and a tendency to over-generalize problems cause friction.

### **Taking Criticism**

Mental illnesses make it difficult for people to take constructive criticism openly and well. Their self-esteem is already badgered by their illness and criticism of any nature becomes an attack to which the person may respond defensively and disproportionately.

### **Showing Persistence**

Mental illnesses compromise the capacity of employees to “stay with” the task, they become easily discouraged and turned off even by modest set-backs which make them feel the job is hopeless.

### **Phase Nine**

Establish concrete targets to reduce the incidence of disability due to mental disorders – and aim to:

- See a moderation of mental disability rates as a percentage of your total disability experience inside 24 months – say, the present 30-40% of the total to 10% inside five years.
- Aim to achieve a 20 per cent reduction of mental disability as a percentage of all disability inside five years based on sound, medical and management criteria. Stifling eligibility criteria is not what we have in mind.
- Forge a long-term disability prevention strategy to reduce the LTD option – on sound medical grounds – to a bare minimum inside five years. This is plausible.

### **Phase Ten**

Establish line manager accountability for the effectiveness of the firm's disability management and prevention initiatives embracing financial incentives / disincentives.

1. A “mental health bonus” system would be appropriate to vest managers’ compensation into disability management success strategies as defined by successful return to work for one-year minimum.

### **Postscript**

These Guidelines are detailed and precise to help CEOs give clear direction and get results. Management Guidelines, in response, constitute Module Three of Employers Getting Started.

***EMPLOYERS GETTING STARTED***  
***On the Road to Mental Health and Productivity***

**MODULE THREE**

**GUIDELINES FOR MENTAL DISABILITY MANAGEMENT**

**Dr. Sol Sax, Global Medical Director, Dupont Inc.**

The cost burden from short and long-term disability is about \$3,000 an employee at Dupont and this means mental disorders cost about half that.

*Primary prevention* is eliminating the root cause. In the workplace, the key thing is workplace stress. What can we do in terms of the behaviour and actions of front-line leadership?

*Secondary prevention* is early detection and intervention. I have promoted the idea of depression screening. But our doctors and nurses say we have enough trouble getting people who are already diagnosed for treatment within six months. The treatment resources just aren't there. Which leaves us with band-aid solutions.

*Tertiary prevention* is basically prompt treatment, the prevention of complications. Here again, we have the same conundrum.

**Highlights**

**Module Three:**

- Deals comprehensively with line manager involvement in the complexities of disability management, job accommodations, return to work and questions which dog this experience.
- Advises managers what questions to ask in order to become safely accountable for the results of disability management in their organizations.
- Spells out what line managers need to know about the organization's current policies, practices and experience in the disability management field.
- Says line managers must become familiar with the concept of case management and how it is practiced in their organization. (*The Module introduces the Green Chart as a case management tool.*)

- Briefs line managers on signs and symptoms of mental distress, and potential mental illness in employees, how these mingle with job performance, how to understand, separate and manage them.
- Informs line managers on the ironic difficulties of employees returning to work after they have been medically cleared to do so.
- Introduces a new concept called the Rule out Rule (1) and (2) to:
  1. Approach employees with performance problems and signs of distress.
  2. Assess work climates which may deter an employee's early RTW.  
(*The Plan has phrasing ideas for talking to employees on such matters.*)

This Module:

- Sets out “rule of thumb” costs and timelines for recovery and return from mental disabilities. Recovery and return to work are two sides of the same coin, interdependent, should be managed as such.
- Underlines the compounding effect of mental disorders co-occurring with other chronic disorders including heart disease and diabetes – disability, time off and recovery times are all compounded.

This Module describes in detail:

- The roles of employees, employers, physicians, and unions in making proper job accommodations for employees returning to work from mental disability.
- The tough issues all of the parties face in this process – ranging from the difficulty of obtaining a proper diagnosis and employee non-compliance with treatment plans to relationship problems at work, home issues and delay.
- The best approach to handling these issues – from treating physician as part of the case management team to employee input into the job accommodation planning process.
- The customization of job accommodations: supervisors and employees working together to adjust space and time at work, using physical fitness programs as part of the recovery and return to work process.
- Planning job accommodations in advance: manager and employee talking to each other during the disability leave period, when the employee is cleared to come back to work (but before the actual date) and on the return date.

A major report on **Depression and Work Function** by an outstanding team supported by The Health Care Benefit Trust in Vancouver, University of British Columbia and Great-West Life, is a formidable work and its conclusions notable:

- The workplace response to depressive disorders among employees is generally uninformed, disorganized and often ineffectual. Therefore, a comprehensive and coordinated strategy for managing depression in the workplace is called for.

*Employers Getting Started* combined with the Roundtable Business Plan to Defeat Depression and our 2004 Roadmap to Mental Disability Management are instruments to do that.

- A chasm has opened between the public healthcare system and the workplace ... different cultures, poor communications and lack of coordination in the treatment and management of mental health problems.

*The Roundtable adds: relations between physicians and employer case or claims managers, however, is faulty, tense and often counter-productive.*

- Depression in the workplace has a significant effect on productivity and profitability of corporate employers whose employees suffer this condition. Continuum of risk reduction, health promotion and early intervention is needed.

### **Fundamental Goal: Reduce Disability Rates**

B.C. Roundtable Chairman Lloyd Craig convened two substantive discussions of insurers, employers and health professionals to tackle the question of mental disability.

A powerful consensus was reached and it forms the backbone of *EMPLOYERS GETTING STARTED* – that is, yes, we can substantially reduce the incidence of short-term disabilities due to mental illness.

From this flows a second emphatic conclusion: if STD rates are reduced, a natural effect will be the significant reduction of the incidence of long-term disability involving mental illnesses as a primary disorder.

Meanwhile, a focus on the impact of depression as a secondary diagnosis in LTD cases merits attention given the links between the disorder and physical pain and other chronic health problems including heart disease and low back pain.

Therefore, the underlying objective of EGS is the reduction of short and long-term disabilities due to mental illness as a percentage of the total disability experience and payroll costs.

On this basis, it is plausible to:

1. Stabilize disability claims due to mental illness as a percentage of all disability insurance claims with ongoing annual shrinkage of new claims on a year-to-year basis.
2. Achieve 95% success rate in the return to work of employees on disability leave due to mental disorders for a period of not less than one year taking into account the possibility of relapse inside the first six months and the likelihood of re-occurrence in the future (like any chronic illness).

The development of plan-solid, clearly-stated objectives in workplace mental health is important to employer credibility and employee acceptance of such an initiative. Two diverse employers make the point.

#### Ontario Power Generation

First, we turn to the efforts of the Wellness Division (under Diane Westcott) at Ontario Power Generation, one of the worlds largest hydroelectric and nuclear energy producers.

An OPG policy states:

*“Mental health will be a wellness priority for 2005 – partnership with our unions regarding this matter is essential ... tripartite committees will make recommendations and monitor progress.”*

OPG’s mental health strategy aims, first and foremost, to *“mitigate the impact of mental illness through early and effective intervention and prevention ... three pillars – prevention, organizational effectiveness and disability management.”*

#### Prevention at OPG

This centres on education including a *“broad range of topics that go beyond the conventional definition of mental health but are vitally important to a healthy work environment and individual well-being”* – with initiatives including:

- Wellness website
- Lunch and learn sessions
- Supervisory training
- And videos

### Organizational Effectiveness at OPG

This centres on creating “*a high energy environment in which work stress is positive and motivating – not demeaning, demanding or demoralizing.*” OPG compares the two types:

#### **Healthy**

Fairness  
Respect  
Recognition  
Appreciation job clarity  
Reasonable demands  
Involvement  
Control over work  
Common purpose

#### **Unhealthy**

Frustration  
Distrust  
Anxiety  
Fear  
Tension  
Low morale  
Low commitment  
Bad stress

### **Disability Management at OPG**

The firm is piloting a mental health case management initiative “*based on the premise that early intervention/treatment is vital to recovery from mental illnesses. This will identify sick leave cases where mental health is an issue.*”

The OPG mental health policy includes:

- Identification and resolution of workplace issues which may complicate or confound an employee’s successful re-entry.
- A monthly report to keep a close watch on cases that require follow-up and intensified attention. This is an important way to prevent the gradual migration of short-term cases to the threshold of long-term disability.
- A simple but telling provision: supervisors and co-workers are reminded to welcome the returning employee back to work and, in this same spirit, identifying workplace problems.

#### Another important OPG policy measure tied to early intervention:

- Employees off work must be contacted by a nurse care coordinator within five days to discuss a return to work plan. This will take combined questions and information in a supportive, non-judgmental form.

### **B.C. Provincial Health Services Authority**

The authority delivers health services in British Columbia – including mental health care. That said, the executive leaders of this remarkable public agency have made mental health in their own workplace a priority.

Special adviser Peter Coleridge outlines the approach:

- The health authority has embarked on a mental health strategy which aims to achieve a range of results but none more important than this: improved patient care through improved employee health.
- Seven key principles embraced by the strategy:
  1. Evidence-based planning
  2. Quality management
  3. Executive accountability
  4. Problem-solving, participative approach
  5. Culture change to create a supportive work environment
  6. Treatment compliance rates in excess of 905
  7. Interest/accountability of employees for their own recovery
- Six practical components of the strategy:
  1. A health profile for the organization. This is compass for the future.
  2. Resilience training to optimize prevention/management of depression
  3. Depression screening for high risk employees
  4. Periodic health monitoring for high risk health groups
  5. Depression self-care material
  6. Depression return to work process

### **Accountability of Managers for Results of Disability Management**

Managers are encouraged to ask questions to learn what the disability burden of their organization or department is.

Managers are encouraged to focus on certain hot spots and look for:

- a) Evidence that “out of sight out of mind” prevails in your organization or department as to the status of employees who may be on disability leave. This is a warning sign.
- b) Evidence that lines of communications have not been opened with employees early in the disability period.
- c) Patterns of delay in returning employees to work even after medical clearance is received.
- d) No established process to define accommodations needed to facilitate the employee’s return to work gradually.



- e) No involvement at all with the employee's direct boss in the process; signs that the job of the person on disability has been permanently re-assigned.

These indicators suggest that the disability management process in your organization is inadequate. A more comprehensive audit of current and recent disability cases is called for.

In both current and recent files, managers need to know:

- Are there inexplicable gaps between when an employee is cleared by his or her physician to return to work and when they actually come back?
- Are appropriate functional assessments done with respect to the design and implementation of proper accommodation strategies?
- Do your employees on disability leave hear from their supervisors or co-workers while on leave? Do they receive regular communications about work activities? An isolated employee faces a steeper hill to climb.
- Why are employees on LTD? Was their STD mismanaged, was the treatment ineffective, was the case put on the back burner?
- Does the management of STD or LTD cases reflect a lack of due diligence, knowledge and understanding? If so, this suggests:
  1. Systemic problems in the management of disabilities in the organization.
  2. Prejudicial atmosphere or behaviour in the case of mental disability.

### **Incentives**

Ultimate accountability for the success of the RTW process must be vested in line and staff managers responsible for that individual's performance on-the job guided by the case manager.

The line manager and human resources personnel should receive financial incentives to bring about a successful RTW wherein the employee comes back full-time gradually and remains successfully on the job.

### **Case Management**

The quarterback of the disability management process is called a case manager – and case management, while not formally certified in Canada, is nonetheless an accepted and valuable part of disability management.

One of the first steps the case manager takes is meeting with the employee and then contacting the employee's physician and discussing the nature of the condition and the outlook for that employee's return to work.

The case manager's job is to unify all the parties who have a stake in this employee's health and work status. He or she helps the physician, employee and line manager sort out job issues for purposes of a return to work.

### **The Green Chart**

The **Green Chart** becomes the case manager's blue print. This device houses a written return to work plan but does not contain confidential medical information.

A tool to assist physicians and case managers to track and recover and RTW information is next.

## Physician's – Tracking Recovery – Green Chart

In the space provided explain and/or list specific accommodations that can be made by the employer to ease the Return to Work process

	<b>1</b> At this time, the task is impossible for the employee to perform	<b>2</b> The employee can perform some aspects of this task with accommodations	<b>3</b> The employee can perform this task with accommodations	<b>4</b> The employee performs this task well although some accommodations are still necessary	<b>5</b> The employee can easily perform this task with little or no special assistance
<i>General Work Skills</i>					
Understanding and following instructions					
Performing simple and repetitive tasks					
Maintaining a work pace appropriate to the work load					
Relating to other people beyond giving and receiving instructions					
Influencing others, accepting instructions, planning					
<i>Specific Job Functions or Requirements (not covered above, as outlined by the case manager)</i>					
<b>Information Required by the Physician</b>					
Character of the workplace – pace, dynamics and history					
Patterns of absence or downtime in the last 30 days					

**Reviewed by Sr. Sol Sax and Dr. Bruce Rowat**

<b>Case Manager – Tracking Recovery – Green Chart</b>				
Employee:				
Case Manager:				
Date:		Date of Next Case Meeting:		
	<b>Physician's Rating 1 to 5</b>	<b>Physician Recommendations</b>	<i>Plan of Action</i>	<b>Desired Outcome</b>
<i>General Work Skills</i>				
Understanding and following instructions				
Performing simple and repetitive tasks				
Maintaining a work pace appropriate to the work load				
Relating to other people beyond giving and receiving instructions				
Influencing others, accepting instructions, planning				
<i>Specific Job Functions or Requirements (not covered above, as outlined by the case manager)</i>				
<b>Additional Tasks for Case Manager</b>		<b>Date</b>	<b>Comments</b>	
Re-entry interview scheduled				
Employee invited to bring friend, family member or physician to re-entry interview				
Employee assured his/her job is waiting for him/her				
Employee formally welcomed back by employer				
Re-entry plan established and reviewed; a realistic timeline implemented				

## **Symptoms of Mental Disease and Job Performance**

*“Individual and organizational risk factors contribute to depression and it is important to consider both in developing an intervention.”* – Depression and Work Function Study sponsored in B.C. by UBC, Great-West Life and Health Care Benefit Trust.

The crossover between unrecognized symptoms of a mental disease is one of the most complicated features of mental disability management.

Symptoms of mental conditions can be mistaken for a “negative attitude” on the job. This never happens, of course, when an employee has a physical injury such as a broken arm. In that case, it becomes self-evident he or she cannot function 100 per cent. But with depression and anxiety, nothing is self-evident to managers or co-workers.

Nonetheless, like other injuries and illnesses, depression affects the performance of the individual employee – but the reasons usually go undetected and unrecognized.

Researchers have found that employees with depression tend to “play through their injury” (to use a sports phrase) and trudge to work each day not recognizing they have a medical condition. Downtime ensues. Part of the workday gets lost.

These random absences represent a bigger cost to business than disability leaves. This is one complication in managing mental disability. There is another.

Many managers today do not deal with performance issues effectively, defer HR problems, avoid them or wait for a downsizing solution. Also, formal job descriptions frequently do not describe the actual responsibilities of the employee.

On the other hand, performance management is an important tool in the early identification of job stress, distress and developing medical conditions. For example:

- The observance of sound performance management practices combined with empathetic two-way communication between the “direct report” (employee) and his or her boss, will ultimately smoke out symptoms of depression and anxiety.
- But when performance concerns do not get discussed or dealt with in a timely way, important conversations do not happen.
- Further, the build-up of performance problems often parallels the decline of working relationships, thus creating a residue which becomes a trap waiting to snare the employee when he/she returns to work from sick leave.

### Re-Entry Interview

As a result, ironically, the most telling and risky milestone in the RTW process may be the point at which the employee is cleared by his/her physician to return to work.

The employee is likely still in recovery mode and – like anyone coming back from any illness – uncertain, even brittle. This is natural. There are certain protocols, planning, and sensitivities, therefore, the employer must observe:

- The employer must welcome the employee back, first and foremost, and affirm its duty and desire to accommodate a smooth re-entry.
- Make it clear that the employee's job is waiting for him/her. The assumption behind this: the employer has not filled the job permanently in the employee's absence.
- Do not make the "residue of issues" which developed in the immediate pre-leave period the order of first business. These matters can and should be addressed later in the process.

### Signs and Symptoms

A co-worker, manager or supervisor can recognize the signs of distress in others by recognizing changes in the way their colleague or direct report conducts themselves.

- For example, an even-tempered person becomes routinely irritable, down in the dumps a lot, obviously struggling to participate in meetings, looking sluggish, uneasy and tired much of the time.
- The co-worker or direct report may also begin to show signs of being unable to concentrate, being late on deadlines and for meetings when they were punctual before.
- Inside themselves, that person may feel like they aren't pulling their weight, and feel guilty about it while becoming defensive and sharp with anyone who innocently inquires if they need or want help with a particular task.
- At the same time, even a person who was usually optimistic is not always optimistic about how things might turn out begins to doubt that anything will work out OK, they come to expect problems.
- And when those problems occur – as they often do foreseen or unforeseen – the person in distress feels both darkly satisfied (I told you so) and deeply frustrated (nothing works anymore so nothing matters anymore).

- In terms of what a co-worker or boss can do in response to seeing these signs fairly consistently over a period of time – say, 2-3 weeks – there are three assumptions to make before taking action of any kind:
  1. Unless the person in distress wants to talk about what’s bothering them, unless he or she decides they should seek professional help, then neither friend nor boss can force them to do either.
  2. A co-worker may reach out to this person privately and sympathetically as a friend if that friendship – and trust that goes along with it – pre-exists that point-in-time.
  3. A boss, on the other hand, should reach out privately, with compassion and empathy. But the supervisor’s job, at that point, is to manage the person’s job performance not their health.

We should note the following:

- *The co-worker supports a person who is a friend (sympathy), and the boss engages a person who is an employee (empathy). Both are appropriate. Both are anchored by compassion. But the purposes differ:*
- *The friend helps the person; the boss helps the person continue to be a productive employee. Both for reasons which are appropriate and can be mutually reinforcing.*

### **Performance Problems and Medical Symptoms -- “Rule out Rule (1)”**

The Roundtable offers the “Rule out Rule (1) (2) as a tool to distinguish between developing medical symptoms and garden variety performance and relationship problems, on the one hand, and organizational health risks, on the other.

The “rule out rule” gives managers and employees a way to discuss sensitive matters fruitfully and clearly – taking into account:

- The employee’s right to personal privacy and –
- The manager’s accountability for that individual’s presence-in-the-job and performance of it.

The “rule out rule” is called for given the high prevalence rates of mental disorders and mental disability insurance claims in the workforce. By using it, the manager makes no assumptions or inquiry about the health of the employee.

The “rule out rule” revolves around gradual or marked change in an employee’s performance, relationships, affect, energy and other visible signs. It involves a trainable, learnable and non-judgmental construct of oral communications and empathetic observation:

### Manager to Employee

- *“Jack, we value you here but we need to discuss some aspects of your performance lately. But I’d like you to consider something first.*
- *“I’ve noticed, Jack, that you seem to be under a lot of pressure. We all go through that from time to time; and sometimes, it takes a toll. Would you care to take a bit of time to talk to our EAP people? I would certainly support you doing that and we can talk about the job later.”*

### Body Language

- Sit don’t stand; avoid a desk between you
- Manager makes eye contact
- But don’t stare or glare
- Look away easily from time to time
- Then return
- Don’t lean back in your chair; stay in a relaxed neutral position or lean forward a bit just to make the conversation seem more personal.

### Delivery

- Get to the point quickly, no big lead-up
- The construct is a series of brief, short sentences and transitional phrases
- This allows you to pause and yet complete the message in a single thought.

### Tone

- Balance genuine concern, empathy and clarity

### Listen

- Patience breeds listening and listening breeds patience; take an interest in the employee’s viewpoint – feelings – give him/her the gift of listening.

### Next Steps

- Don’t end the conversation in a fog
- If need be, adjourn and make an appointment to talk again
- Give the employee time to think about things
- But don’t end the meeting on a vague basis. Establish, exactly, the next step.

### Onus

- Rule-out-rule is not a means to escape one’s obligation as an employer and manager. It is a tool to exercise those obligations.



- Human rights findings run against an employer who takes disciplinary action against an employee even if the employee resists offers to help.

### Preps

- Pre-planning this conversation is key.
- Get up-to-speed on employer services available to the employee; EAPs are a good starting-point.
- Also, make a deal with your own boss: you intend to invoke the “rule out rule,” express support for the employee, and you need to make sure you and your boss are on the same page.

### Also, be clear:

- If the employee exercises this option and learns he/she is suffering a mental condition which merits medical attention, this could produce sick leave or even short-term disability leave.
- When the employee recovers and returns to work, his/her right in this regard is established in law. The deferred “performance discussion” cannot, then, be activated on a condition for the employee’s return to work.
- In fact, in complex cases, performance discussions of this nature are best cancelled and make a fresh start to the employee’s job performance opportunities and obligations.

### **Organizational and Individual Health -- “Rule Out Rule (2)”**

Ruling in or ruling out the health concerns of the individual is only one part of the strategy to prevent the disabling effects of mental disorders. The other part is ruling in or ruling out the possible contributory symptoms of the organization itself.

Is the workplace sick – and is it making the people working there sick?

Data demonstrates certain management practices and workplace practices can precipitate or aggravate mental health problems. Do these practices show up in the departing employee’s department, office or work area?

As a matter of due diligence, therefore, employers are advised to deploy “Rule out Rule (2)” to determine whether such factors may be in play:

- Seek out signs – those common stress traps which frequently snare employees and using the principle of the “exit interview” among current employees, evaluate whether these hazards are routinely in play.

- Survey employees now off work on sick or disability leave to determine their experience, what worries them about returning to work.
- Survey managers and supervisors and consult executives to ascertain if a preponderance of employee absence – noted through common observation if not formally monitored – is collecting in any given part of the organization.
- Interview the employee-on-leave’s direct supervisor to affirm the individual’s understanding of their role in facilitating a successful return to work process and, in turn, inquire as to workplace factors which may impede the employee’s safe return to work.
- Over and above the case manager or union rep., the employee should have the option of being accompanied at the re-entry interview by a family member, personal friend, trusted co-worker, or his/her physician.
- It is critical that as the gradual return to work proceeds, the employee is not isolated for weeks after the re-entry interview. This can be destructive to his/her health. Being alone at this point is both unnecessary and unhelpful to the return to work process.

### **Recovery and RTW**

The longer the period of recovery, the more likely the time off work will compound disproportionately.

Greenberg et al estimate the average length of an episode of depression is 12 weeks for those who receive adequate treatment and within those 12 weeks, the employee may accrue 33 days of lost work compared to 60 days over an 18-week period.

Also untreated sufferers of depression spend twice as many days home in bed than treated sufferers spend in hospital – when that is called for – 32 vs. 16 days. This means helping employees at home to get “out and about” and stay connected to the workplace.

In a study by Carolyn Dewa at the Centre for Addiction and Mental Health, employees on disability using recommended first line anti-depressant medication in recommended doses were significantly more likely to return to work rather than to claim LTD benefits.

“These results are congruent with the hypothesis that anti-depressants can play an important part in the ability of employees to resume work,” the study finds.

Further, “early intervention was associated, shortens disability by three weeks among employees who receive appropriate anti-depressant medication.”

Based on the average wage of the sector (financial services), this represented a per-employee saving of about \$3500 in productivity terms and total savings of up to \$875,000 to employers with a combined workforce of 63,000.

Depressed and highly stressed individuals may seek medical attention for physical conditions such as unspecified pain, fatigue or headaches or develop more serious illnesses with psychosocial antecedents such as heart disease; also, people with serious illness become depressed as a result.

Therefore, aggressive outreach to provide treatment and facilitate maintenance therapy to prevent relapse might have positive workplace effects and the costs could be amortized over a longer pay back period than costs of other chronic disorders

Maintenance therapies can dramatically reduce episode recurrence. This must be considered as seriously as treatment.

### **Days Lost Compounded**

Certain data from one major U.S. study gives us insight into the numbers of days lost when mental disorders are in play. This can be used to develop and track timelines on a “rule of thumb” basis, a compass of sorts, given the absence of formally approved timelines for recovery and return to work.

#### Average work loss associated with depression et al: (Kessler et al)

1. 6 complete days per month per 100 workers
2. 31 downtime days per month per 100 workers  
*\*2 denotes presenteeism impact, greater (5-1) than previously projected*

#### Average work loss associated with co-morbid disorders (depression plus) (Kessler et al)

1. 49 complete days per month per 100 workers
2. 346 downtime days per employee per 100 workers  
*\*employee w/no health problems average 2 complete and 11 downtime days*

Analysis shows that role impairments among four of the most common chronic disorders is almost exclusively limited to those with co-morbid mental disorders which represented 20 – 50 per cent of the total number of employees with co-morbid conditions.

There is compelling evidence that co-morbid mental health problems and addictions have considerable fall-out across a range of other conditions and produce disability and work performance problems on a large scale. Individuals with a chronic illness have 41 per cent greater risk of depression.

Employers should act on three fronts concurrently:

1. Equip managers to understand their role in managing employee performance within the context of a healthy workplace model.

2. Determine how much expertise their health service providers have in the area of mental health.
3. Learn what is driving their long-term and short-term disability experience – who is on LTD and why – why did STD migrate to LTD – why didn't treatment work – and if it did work, why isn't the employee back to work.

### **Employees' Questions**

Employees on disability leave need this information:

- Are there provisions in your disability arrangement for your physician to be informed about the nature and specific duties of your job? This is important to later decisions concerning return to work.
- Will your physician be required to fill out reports and will this be onerous and cause you delays in the process? Are you expected to pay the physician for this?

Both employers and employees are advised to become familiar with the predictors of disability. Across a wide range of large U.S. companies, researchers found that the major predictors of the length of disability leave were:

- The emotional and cognitive variables – mood, locus of control, self-esteem and these were more important in the case of recovery from survey in these studies than financial/income worries.
- Severity of depression in back patients was the strongest predictor with respect to return to work and this, in turn, was closely correlated to locus of control at work (“what am I going back to?”)

### **Drug Plans as Part Case Management**

Pharmacists should be engaged by employers and insurers as part of the Case Management team. This, to ensure the efficacy and effectiveness of prescription medication prescribed and paid for under group drug plans.

In their normal role, pharmacists implement drug treatment protocols through the process of overseeing the dispensation of prescription drugs in Canada. This is their natural role.

#### **Reduce Drug Costs**

1. The way to reduce rising drug costs is through effective management. For drug therapies to treat major depressive disorders and anxiety, this begins with an evaluation of the patient's drug therapy record (drug profile) to ensure the prescribed therapy is safe.

2. Pharmacists also monitor patient compliance with the prescribed regimen. This heads off the risk of patients stop taking their medication prematurely. On-going management of the treatment plan is critical.

*(The Ontario Pharmacists Association reports say patient non-compliance with treatment regimens costs about \$7B a year in Canada. “This is disturbing because well-controlled pharma-economic studies point to the significant cost-effectiveness of drug therapy.”)*

The role of pharmacists can/should be incorporated into the disability management to:

- Help physicians manage the change from one medication to the other in the face of limited or no improvement in the patient’s depressive symptoms. Psychiatrists advise an aggressive change strategy – different drug, increased dosage or both.
- Advise patients and physicians on the use of non-prescription drugs especially during the use of prescription medication for depressive or anxiety disorders.

*(Sleeplessness and pain may be symptoms of the depression itself and the patient may not understand this and seek out over the counter meds.)*

*(This can be important in the case of those with a history of chronic illnesses such as cardiac disease, or diabetes. Depression can co-occur with these conditions and may be signalled by symptoms that seem unrelated to mental health.)*

- Counsel patients on the purpose of the medication, how to take it; what the effects should be, what side-effects may occur, interactions with food and other drugs and, as noted above, the absolute necessity of adhering to the prescription.

*(If patients or physicians do not see results in a specific timeframe, the pharmacist can advise both on alternative drug strategies in terms of drug choice and dosage. This promotes evidence-based treatment.)*

- Make generic substitutions of prescribed medications as a cost reduction measure; manage the “therapeutic switch” of one drug to another within a specific class to select the most cost-effective drug with equal benefit.
- Advise clients to consult their family physician or workplace health adviser. Pharmacists are often the first person the patient sees when health problems begin to materialize.
- Pharmacists charge a dispensing fee. If additional charges are incurred in the case of the management of medication for mental disorders, this should be negotiated among the parties. It is a relatively small investment with big potential returns.

*(On the other hand, pharmacies or regional or national chains could offer these services as value-added and attract group plan business with employers on a contracted or “preferred provider” basis.)*

Drug utilization is a big issue today. Anti-depressants are among the top five prescribed “meds” and drugs, overall, representing 16 per cent of all health care costs. Which is second only to hospitals and 25 per cent higher than physician’s charges.

Also, private drug expenditures have now overtaken publicly funded drug use. Further, in 2002, professional fees on prescription drugs rose 14 per cent and ingredients were up 42 per cent.

More particularly, a “shared care” strategy engaging pharmacists would also support the advancement of effective outcomes, early interventions and responsible cost reductions.

### **Rights and Requirements of Each Participant In Disability Management Process**

It is natural and understandable for individual employees and managers to want to know precisely what the job accommodation and return to work process entails – especially, if they are accountable for the result.

Common sense is always a valuable tool. In the case of human rights, there are clear end-game obligations but no pat set of instructions how to get there. Please refer to the Human Rights Module for more on this.

There are a range of questions that develop in the RTW process that we need to consider.

*The following line-up was developed with the valued assistance and guidance of Douglas Smeall, VP, Marketing and Sales, ATF Canada, a Roundtable adviser and outstanding executive and specialist in the field of disability management.*

### **THE EMPLOYEE**

#### **Rights:**

- Gradual return to work. (linked to severity of illness and safety aspects of the job)
- Meaningful work and reasonable hours
- Proper supervision (in terms of workload, oversight, support)
- Privacy
- Proper professional support
- Training to update skills as required
- Equitable severance including career counselling if things don’t turn out

### Requirements:

- Meet the employer half-way in working out job accommodations.
- Not seek the “perfect” or “only” solution to such arrangements.
- Comply with medical instructions and treatment plan during both the pre-return and post return to work recovery phase.
- Be vigilant in self-managing stress so as to not induce relapse. This is part of one’s own responsibility for one’s own health.
- Ask for help as may be necessary. Be proactive in asking your manager how this will work before you begin the return process.
- Not use personal relationship problems as an excuse not to come back to work when the physician has cleared the employee to do so.

### **THE EMPLOYER**

#### Rights and Requirements:

- Help get the employee back to work and full-time status as soon as possible on sound medical grounds.
- This includes having the employee work shift work if that is what the employee did before disability leave.
- The employee participating in rehabilitation activities and complying with appropriate treatment.
- Set and monitor reasonable, objective standards of performance. Common sense says the manager is smart to work these out with the returning employee.
- Offer fair and equitable severance with career counselling when and if the employees’ performance does not meet the requirements of the job.
- Provide the employee with appropriate support services to facilitate the return to work phase of the recovery process.
- Meet its duty to accommodation and to understand the human rights obligations vested in employers by provincial and federal statute. Ensure managers understand and comply with in good faith and goodwill.

## **THE PHYSICIAN**

### **Must and should:**

- Provide Guideline-concordant diagnosis and treatment and use of DSM-IV criteria to assess patients. (*“Stress” is not adequately-precis as a diagnosis for disability management purposes and should be questioned if it appears as such.*)
- Be willing to act as a partner with the case management team and for this purpose the treating physician:
  - Should be paid his/her fees by the employer – or insurer – if required to fill out forms/attend meetings as a team member.
  - Otherwise, these charges fall to the employee or the treating physician receives no compensation for these additional duties. Which is counter-productive.
- In the course of treatment, help maintain the employee focus on a return to work and incorporate RTW into the concept of recovery and vice-versa.
- Help the employee realize gains in his or her functionality and not just symptom relief; support cognitive therapy initiatives when called for and physical activation.
- Make it his or her business to find out about the nature of the employee’s job and set return to work conditions that make sense. A “new boss” or a “new job” is not helpful advice from physicians to employers.

## **THE UNION**

### **Must and should:**

- Enable the part-time, gradual return to work of employees.
- Assist with identifying alternative or modified duties of work.
- Support the employee to receive appropriate medical treatment and support.
- Support the employers’ right to shift work for employees who did this before they went on leave.
- Promote re-training efforts
- Ensure life and health care benefits are continued on disability leave.



- Support EAP support.
- Support early identification and wellness initiatives.
- Avoid turning the employee's disability case into a subject of grievance or legal due process except as a last resort. Working with the employer and the case management team is a much more desirable approach.
- An employee becoming embroiled into a drawn-out contractual dispute is not good for his or her health.
- Like employers, become informed on human rights obligations that are relevant to the process of job accommodation in a unionized environment.

*The question is: do you assume that under all circumstances, the collective bargaining agreement is supreme. That assumption is wrong.*

### **TOUGH ISSUES FOR ALL CONCERNED**

- Getting a proper diagnosis and effective treatment plan for mental disorders.
- Getting treating physicians to become engaged in the case management process in an informed and balanced way.
- Employee non-compliance with drug therapies and other forms of appropriate treatment.
- The effects of certain combinations:
  1. Depression and chronic physical disorders including heart attack.
  2. Anxiety disorders, depression and personality disorders. This adds great complexity to effective case management and medical success.
- Reluctance on the part of managers and employees to make adjustments to their relationship.
- Employees drift from short to long-term disability and the implications of that in terms of employee's chances of returning to work and employer getting a return on their investment in that individual.
- Home issues: employees who are hospitalized or treated on an out-patient or doctor's office basis may report a chaotic home life in the early stages of the disability period.

*(Case managers must explore this with the employee and recommend home care, daycare or family support as may be called for or helpful.)*

- Employees' developing of a disability mindset combined with the "disincentives" of rich benefit packages for some employees to return to full-time work.
- Physicians who reinforce negative outlook of employees, provide sub-optimal treatment including the lack of treatment maintenance or relapse-prevention oversight.

### **BEST APPROACH FOR ALL CONCERNED**

- Proper diagnosis and enlightened case management approach with the physician serving as a compensated member of that team. This will increase the odds of earlier RTW, continuance of a health monitoring system during this period.
- Upfront identification of the workplace factors that will have a bearing on the success of the return to work process, honest appraisals of relationship issues and a plan to resolve them.
- Proper use of cognitive therapy, physical fitness and activation programs to get the employee out of the house; use of communications (art) therapies customized to the individual to keep their thought processes tuned-up.
- Active involvement of a supportive, interested, informed manager with accountability for that employee's successful return to work or an appropriate outcome that involves other measures.
- Well-planned job accommodation with the employee's own input and understanding how her or his performance will be judged.
- Clear expectations all-round with regard to the pace and timing of the return to work and understanding that relapse is a possible nature and not necessarily a permanent or serious setback.
- Union support of the employee, a proactive and fully-engaged way. Union members should be part of the case management team.
- Vocational assessments used prudently; independent medical evaluations used in a non-adversarial, collaborative manner to assess the treating plan in concert with the treating physician.

## Customizing Job Accommodation

### CIBC Model

*Ron Lalonde, Chief Administrative Officer, CIBC*

*“CIBC’s disability management program starts with meetings between employee, his or her manager and a facilitator.*

*“The whole focus is on the abilities of the individual, what he or she feels she can or can’t do and what CIBC can do to accommodate that person and help them get back to work.”*

*“Accommodation can mean gradual return to work, flexible hours, more frequently work breaks, different ways to communicate and none of these are really expensive but can make a world of difference to people and it had amazing results for us.*

*“Typical short-term leave for psychiatric reasons is now 40% shorter than it was in 1999 and our employees on LTD are coming back almost 50% faster than other companies in our insurers’ book of business.*

*“But we all know there’s more to do – lurking just beneath the surface are intangible barriers to our success, the attitudes and beliefs in the workplace and in society at large that undermine people who are coping with mental illness.*

*“People with mental illness put up with a lot more than their disorder. Stigma from family, friends, co-workers and health professionals contributes yet another major stress; it keeps people from coming back to work following a crisis.*

*“We have to create corporate environments where people living with psychiatric disabilities will be accepted and respected as participating members of the team – and society.”*

**Case managers and physicians are the key advisers to determine what workplace accommodations are needed by employers to facilitate the employee’s gradual RTW.**

These two specialists, therefore, need to develop a clear picture of the demands of the job in order to translate this information into “functional” terms – including, for example, difficulties the returning employee may yet have in –

- Concentrating for any length of time
- Dealing with noise and distractions
- Managing emotions and time
- Maintaining stamina during the workday

These concerns can be resolved by –

- Flexible and part-time scheduling
- Longer or more frequent work breaks
- Self-paced workloads
- Minor changes to the work setting such as –
  - Moving the employee closer to natural light.
  - Reducing noise levels – a common EHS practice to preserve employee hearing.
  - Make it easy to get water, tea, soft drinks or crushed ice to counter the effects of some medications. Dehydration can produce fatigue.

**Supervisors and employees returning to work can work together to ensure that these kinds of accommodations are workable and easy. Some tips from the experience of others:**

- Make daily ‘to-do’ lists and check items off as they are completed.
- Remind each other of important deadlines. Give and get extra feedback.
- Divide large assignments into smaller tasks and goals.
- Look for opportunities to provide positive reinforcement.
- Use written job instructions to the extent that this is helpful.
- Ask the employee what is the best time of day for them. For some, it is the morning, for others, the afternoon.
- Possibly avoid working Mondays which are “crazy days” in most places of work.
- Agree to open communication – devise discrete one-on-one hand signals, if necessary, to indicate that unwelcome stress is building up and it is time for a time-out.
- Make sure the employee is treated as a member of the team and not excluded from social events, business meetings or other activities relevant to the job.
- Do not be excessively protective.

## One Person's Action Plan – The Return to Work from Bipolar Disorder

Steps reported to the Roundtable by one young mother and wife as she prepares to return to work full-time.

1. Take my medication as directed.
2. Get at least 7 hours of sleep.
3. Exercise at least 30 minutes per day at least five times per week.
4. Eat sensibly; avoid over-eating and use of food supplements.
5. Take time to read daily (this is time for relaxation).
6. Do not over-extend or over-schedule self.
7. Keep meals and clean-up during the week simple. Spend time with family.

### Physical Fitness

Fitness workouts – 30 minutes/day, five days a week – hold out great promise for the relief of symptoms of depression. Studies found that depression was well-tolerated by participants. As a public health measure, physical exercise has two major impacts: helping with the treatment of depression and fighting obesity.

Study by the Universities of Texas and Colorado, found “exercise may be a viable treatment because of it and recommended for most individuals.”

It has not yet met efficacy standards although in a 12 week randomized study, high probability of remission in the 12<sup>th</sup> week. The study found that the public health dose of exercise is effective for mild to moderate depression. Exercise less than half this amount was not effective.

### Planning Accommodations in Advance

Employers are encouraged to be explicit, as a matter of policy, about this: when an employee is on disability leave, you are replacing that employee on a **temporary** not **permanent** basis.

There is considerable value to plan the accommodation of an employee's return to work well in advance of the actual return date. Certainly:

- It is advisable to plan the accommodation process well in advance of the point at which the employee is cleared by his/her physician to return to work gradually.
- The RTW work plan must include the act of giving immediate co-workers enough information – cleared by the affected employee on leave in advance – to help them understand three things:
  1. How the employee's absence will affect their work if at all.
  2. Their role and responsibilities in making job accommodations work in line with the employer's responsibility to provide this kind of transitional support.

3. Their own behaviour and attitude – even if they don't have supervisory duties or management rank – can implicate an employer in a human rights complaint if it contravenes the returning co-worker's rights under law.

It is the duty of the line manager to think about and raise questions which come to mind and take them up with human resources people or their own direct boss.

***EMPLOYERS GETTING STARTED***  
***On the Road to Mental Health and Productivity***

**MODULE FOUR**

**QUESTIONS TO WHICH MANAGERS AND EMPLOYEES NEED ANSWERS**

**Highlights**

This Module is a very detailed look at the challenges of disability management through the eyes of the:

- Individual line manager who is being asked to assume accountability for the disability management and return to work policy and process.
- Individual employee who must navigate these waters while he or she is still feeling shaky, uncertain, probably fearful about what's going to happen.

Following is a sample of the questions that are explained, deepened and answered in this Module:

**The Manager**

- Does our disability management system work?
- Does the organization have a clear return to work policy?
- What kind of support will I get from my boss?
- Am I supported to become an amateur “shrink?”

**The Employee**

- What's going to happen to me?
- How will I get up to speed when I go back?
- What happens if I relapse?
- Am I damaged goods?
- Can I handle the pressure?

**If they are expected to be accountable for the results of managing disabilities in the workplace, here are questions line managers need answers to in order to protect and equip themselves for these responsibilities.**

- **Does the organization have a clear return to work policy – or one at all?**

*Make sure that this question is answered by HR in writing and a copy given to both you and your boss. Do not accept simply verbal assurances. Ask to see this policy.*

*The policy should specify what the company will do and is expected to do in accommodating the return to work of employees on disability leave.*

*Also, as a matter of personal self-protection, ask for the company's guidelines on human rights as it will govern your own behaviour. If none exists, insist that you receive appropriate advice and instructions anyway.*

- **What kind of support can the manager expect from higher-up?**

*If employers expect line managers to be accountable for the results of disability management including return to work provisions – and they should – they must make sure managers have support from senior management to:*

1. *Observe company policies and human rights and/or employment law. If you think this is the business of the experts only – HR or legal – think again.*
2. *Act according to principles of common decency and the stated values of the organization.*

- **Is the manager supposed to become an “amateur shrink?”**

*Obviously not. But ask the question anyway. The idea is to get a clear understanding with your own boss and HR what exactly is expected of you in these matters? What are the limits?*

*Managers should be clear on **this**: at no time should your employer ask you to accept responsibility for managing an employee's health. Your focus is performance in line with the spirit and letter of the law, common decency and corporate values.*

*It is in this context, as noted elsewhere in EGS, you must ask for the training and coaching needed to manage employee behaviour and distress as a broadened expression of your performance management responsibilities.*

*Disability management, in fact, must and can be seen as an extension of performance management and it is only then that the role of the manager becomes clear.*

- **What kind of job accommodations will I be expected to agree to – how far should I go?**

*As a rule, it is simply common sense and humanly decent, as a manager, to work with the employee who is coming back – in partnership, no doubt, with a case manager – to figure out how he or she can perform the essential functions of the job or some aspect thereof.*

*Can the employee perform those functions, if so, under what accommodations will be helpful to make this happen?*



*It is important for the line and case manager to give the employee encouragement but also to ensure the employee has a clear perception of his or her own strengths and the need to talk openly about job stress.*

*In all of this, focus on function and performance not symptoms. Emphasize this to the employee when you talk about returning to work and coming up with a suitable way to accommodate the return to work process.*

*Also, be clear: when an employee comes back to work, he or she is likely not fully-recovered from her/his illness. In fact, returning to work is part of the recovery process. That is true for almost every disabling illness or injury.*

- **Will co-workers see job accommodation as special treatment for the employee return to work? What if they have to do more work as a result?**

*This is always possible if co-workers are kept in the dark about the process of accommodation, what those accommodations will be and how the return to work of the employee will affect them.*

*It is not necessary to talk about diagnosis (what the employee “has”). You are dealing with prognosis – which is the forward movement toward full recovery.*

*That means you should talk to co-workers about what needs to happen – flexible hours, extra feedback, one task at a time – not the medical reasons for these modifications.*

*Help them understand their role – and they have one, be clear on that – in the return to work and job accommodations process.*

- **Why is this your job? You’re no expert in this. Isn’t this the job of the experts?**

*You are responsible for the performance of all the employees who report to you whether they are on the job or off the job due to illness or injury including employees who are still on salary (continuance).*

*As noted earlier, your focus is performance. Your job is to manage the performance of certain people. Their output is part of the asset base and capital of the organization. Returning to work means recapturing that output and the value of that asset.*

*No one will expect you to become an expert or to do things you are not qualified or prepared to do in dealing with employee health concerns. You must have professional support and, as noted above, a clear picture of the limits of your responsibilities.*

- **What happens after the absent employee comes back to work and goes off the deep end? What am I supposed to do then?**

*This isn't likely if, by deep end, we mean some form of aberrant behaviour. On the other hand, relapse happens and that is a natural part of the recovery process. Just like someone who walks too soon on a broken ankle. The swelling returns.*

*Guide your thinking with these facts:*

*First, depression and anxiety disorders can be chronic, recurring from time to time.*

*Second, if a relapse during an episode of depression happens, it should be handled as a not surprising development. Don't see it as a big setback. Or that the employee has failed a test of some sort.*

*Third, in the course of chronic illness, we should see a difference between relapse within an episode of illness and a re-occurrence of the illness itself after a period of remission. In both cases, these things happen.*

*With 25% of the population experiencing mental disorders annually, we can't write off that many Canadians simply because there is the inconvenience, pain and disquiet associated with the "return" of an illness. Chronicity continues. Remission happens.*

- **When he or she is back, how will I know she's coping with the job?**

*Common sense and simple observation will help. Human distress at work is not invisible. It manifests in breathing, watery eyes, complexion (pale), changes in body language, fatigue response and reaction. These are all visible.*

*But you can also have an arrangement where an employee will come to you or give you the "high sign" that stress is beginning to take its toll. This means the employee should take a break, go home, talk about what may be causing stress and how the two of you can change or tweak the routine.*

*Finally, information. Depression and anxiety disorders – during the recovery process, when the employee is feeling better but not 100% -- do not produce dangerous, violent or crazy behaviour. Distress may build. You can spot it. And you will not be contaminated by it.*

**Naturally and inevitably, the employee who is returning to work will have questions and concerns.**

*Managers should anticipate specific concerns going through the minds of employees coming back from disability leave and answer them, even if the employee does not voice them?*

*Don't be surprised. Be patient. Don't interpret employee questions as insolence or lack of gratitude or negativism.*

- ***What's going to happen to me? Will my job be still there?***

*This kind of apprehension is to be expected. The key thing for managers to remember is 1) the person's job is still there; 2) the first step is to agree on how the employee will be accommodated to perform that job; and 3) stay focused on performance.*

- ***How will I get back up to speed when I come back?***

*Research by scientists at the Centre for Addiction and Mental Health demonstrates that high percentages of individuals returning to work from mental disability do so successfully:*

*"History of mental disorders is not necessarily associated with unproductive workdays and, in the absence of current symptoms, workplace functioning should be unaffected."*

*"(Employees) with mental health problems ... are far more likely to show up for work but require greater effort to function up to par."*

*Managers can usefully give the returning employee explicit encouragement to believe that the accommodation process will improve the odds of a successful return to work and by using the CAMH data, managers can factually demonstrate this.*

- ***Do I really want to go back to work to that boss and that job?***

*The challenge posed by this question is to confront the reality of the honest-to-goodness facts of the relationship between the employee and the boss. If this relationship is bad, the employee's return to work can be blocked. This is unlawful.*

*If the employee is a poor performer, the most practical way to handle the situation – as noted in the "re-entry advice provided earlier – is to treat the return to work as a new chapter. The past should be deferred for a time.*

*A poor performer who knowingly takes refuge in their symptoms as a means of avoiding coming back to work is not living up to their end of the employment contract.*

*A poor performer who returns to work and performs poorly even under modified circumstances can still be held accountable for that poor performance.*

*A **good** performer coming back to work will also likely return to their former selves if the accommodation process runs its course properly.*

*A reluctant supervisor or negative boss – or even a management style which runs counter to the kind of support envisaged by an accommodation – must not be allowed to stand as a barrier to that employee's return to work.*

- If I go back, what happens if I have a relapse?
- Who else knows what's happening to me, what's wrong with me?
- Will people think I'm crazy, or damaged goods; will look at a chance to fire me?
- How will I ever handle the pressure of the job again?

*These questions flow from a central concern about one's acceptance. It is the most fundamental kind of concern in the context of return to work. It is also basic to everyone's ability to perform well even when we're healthy. Acceptance is fuel.*

**Managers should consider communicating certain information to their returning direct report in anticipation of these concerns or in response to them:**

- *Remind the employee that you understand that while he or she is back to work, it will take time to get back to 100% and to feel like your old self.*
- *(It is good policy, in fact, for the manager to call the employee at home before they come into work for the first time since their leave began and break the ice a bit about what's ahead.)*
- *Acknowledge the possibility the employee may be distracted from time to time and there's no crime in that.*
- *Let the employee know that working only a few hours a day for a while may be the best approach but don't start dictating the exact details of the accommodation plan. The employee must have input and feel like it.*
- *Work on performance criteria together that will apply for the accommodation and return to work period which could be as long as six months. Sound flexible and be flexible. Do performance reviews in 2 or 3 week increments, then 3 and 4 weeks. Over-communicate in between. But not excessively.*
- *Give the employee extra feedback focused mostly on progress. You are not a shoulder to cry on. You are a boss trying to recapture the output value of an employee.*
- *With the employee, build-in discrete ways to communicate with each other about how things are going and do not dwell on the past – past problems at work, for example.*
- *Keep this clearly in mind. Recovery and return to work must be defined by forward motion which is re-gained even after a relapse.*

- *Make a particular effort to keep an eye on whether the employee has the time and resources to do the job asked of him or her especially if that employee is working directly for/with other people.*
- *Assumptions:*
  1. *There will be fatigue problems early on so vary tasks during the day; the employee's own judgment when he/she needs a break is a good barometer.*
  2. *There will be concentration problems. Accommodations might include keeping interruptions down, play soothing music, break tasks into smaller units, use daily to-do lists, and give instruction in plain writing.*
  3. *But do not assume "no news is good news" if you are not hearing from the employee. He/she will try to cope. Stay in touch.*

### **Morale vs. Mental Health**

In all of this, it is important not to confuse mental health concerns with morale concerns. The former can mimic the latter. But they are different.

Morale has been described as the emotional foundation for one's enthusiasm, commitment, engagement and confidence born usually from a bond of trust, honesty and recognition for one's effort and how it contributes to the organization's overall goals.

Morale does not necessarily bloom only in fair weather. One rule of thumb is this: morale is shaken less by the nature of bad news than by the manner in which managers communicate that information.

### **Postscript**

Treatment works. And two-thirds of the capacity to return to work occurs in the first 4-12 weeks of treatment. This means employers have a real stake in early intervention and efficient treatment. One important pathway to improved mental health is a comprehensive stress policy. We turn to that in Module Five.

***EMPLOYERS GETTING STARTED***  
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**MODULE FIVE**

**COMPREHENSIVE STRESS POLICY**

**Highlights**

**Module Five:**

- Spells out a detailed approach to the management and reduction of chronic job stress in the workplace – and provides a clear, factual description of what good stress and bad stress are and are not.
- Warns about common stress traps which employees routinely fall into and links healthy stress and conditions of performance in the form of a “STRESS AND PERFORMANCE MATCH-UP.”
- Describes the “ten faces of stress” and notes the special vulnerability of working women who are pregnant, employees returning to work after a heart attack, stroke or depression, employees with chronic illnesses.
- Organizes stress policy into two major categories – information (the facts) and prevention (management practices) – and with respect to prevention:
  1. Specifies which managements need to be modified to reduce the triggers of unhealthy job stress.
  2. Identifies questions employees can ask themselves to take personal responsibility for their own health by seeing if they are “stressed out” and what the sources of the stress are.
  3. Sets out – in precise detail – the pathways to burn-out in a descriptive chart.

This module gives you the ingredients of a well-defined policy on chronic stress. This is an essential part of prudent and effective management of mental health issues in today’s intensified workplace.

Stress policy must be developed with employee in-put and it can be measured by periodic surveys which have the credibility of honest intent by the employers.

Meanwhile, unions and employers must work closely on this.

The Roundtable cautions both parties about contesting the definition of stress as a medical condition in its own right. It is not. But, day-to-day, it can be a serious health risk which is the next best/worst thing.

## **THE FACTS**

### What Stress Is

- Stress is not all bad, or all good. Some keeps us on our toes. Too little makes us disinterested. Too much – even of a good thing – can upset our well-being.
- Stress is not a state. It is a process, a set of variables, with how we react to circumstances at work or in life, an individual experience.

### Physical Basis

- There is a relationship between stress, the nervous system and brain regulation of the cardiovascular system. This demonstrates the physical basis of stress-related problems including depressive disorders.

### Two Kinds

- There are two concepts: disruptive stress and constructive stress. Otherwise stated, anxiety stress and motivation stress.
- Human beings have a protective mechanism which alerts us to withdraw when the anxiety form of stress faces us. Uncertainty is one source of this kind of stress.

## **Stress Traps**

Stress can become dysfunctional over time when:

- The skills of the individual and expectations of their boss and the demands of the job and resources available to do it are not aligned.
- Workplace practices seem routinely unfair or illogical.
- The “struggle to juggle” obligations at home and work never let up. Job and home stress are synergistic.
- Workplace stress intensifies near the close of the workday and is taken home. According to the Institute for Work and Health, this poses a greater risk to the cardiac health of people than smoking.

- When job stress becomes chronic, it can:
  - Override our natural defences to ward off infection and viruses, escalate the production of inflammatory hormones that drive heart disease, obesity and diabetes, spark flare-ups of rheumatoid arthritis, trigger depression.
  - Escalate hormonal release which boosts our heart rate, blood pressure, breathing and blood flow to our muscles. This is OK from time to time and for limited periods. But not continuously.
  - Cause accidents on the job. Stress, a trigger for depression, fuels and feeds off sleep deprivation and lost concentration.

### **Ten Faces of Stress**

A “Stress Policy” should help employees (including executives) to recognize what unhealthy stress looks like. It has a face – in fact, 10 faces:

1. Growing irritability and impatience, “no end in sight” reactions to even routine requests for information.
2. Inability to stay focused, finishing other people’s sentences to “save time,” wincing at new ideas (who needs another new idea), being unable to sit still, looking distracted and far away.
3. Staying out of sight, keeping the world at bay, being testy about casual interruptions such as a phone ringing, not looking up when talking to others.
4. Treating the concerns of others about workload and deadlines with contempt and “join the club” sarcasm.
5. Displaying frustration with one’s own boss in the presence of others and leaving angry voicemails after regular business hours.
6. Stretching the workday at both ends, calling in sick a lot, persistently late for meetings.
7. “Working at home” to avoid the negative energy of the office.
8. Limiting eye contact with others except to “react,” finding it painful to smile openly, your cheeks heavy, a fuzzy feeling behind your eyes.
9. Finding small talk hateful. Tuning-out what others say. Missing deadlines, losing faith in yourself and others, resenting and even alienating customers.



10. Eventually, physical symptoms of pain and burning, breathing troubles, back problems. Burn-out may migrate to a diagnosable and dangerous medical condition.

### **Special Vulnerability**

Employees especially vulnerable to the health risks of chronic stress:

- Working women who are pregnant.
- Employees returning to work from heart attack, stroke and depression or anxiety.
- Employees with chronic conditions such as asthma, depression or diabetes.

### **PREVENTION**

In the workplace, it is important to align goals and expectations to create realistic possibilities. This model links healthy stress and conditions of performance.

#### **STRESS AND PERFORMANCE MATCH-UP**

Healthy person/healthy work environment

Goals/expectations/output

plus

Values recognized/values lived

Incentives offered/rewards given

Life balance/ workplace stability

Skills/ jobs/standards

### **Management Practices**

Certain management practices should be modified to reduce the triggers of unhealthy job stress by:

1. Continuous imposition of unreasonable demands on subordinates and withholding information that is materially important to them to carry out their jobs.
2. Refusal to give employees reasonable discretion over the day-to-day means and methods of their own work and failing to credit or acknowledge success.
3. Rejecting “out of hand” employee workload and deadline concerns and creating a treadmill effect in the allocation of work and priorities.
4. Pushing unnecessarily tight deadlines as a force-feeding technique and talking personally to direct reports only when there’s a problem and, in doing so, creating an email-only culture.

5. Changing priorities without notice or reason, tolerating ambiguities in work assignments, expectations and outcomes. Meaningful job descriptions and annual performance reviews are an anachronism in this environment.
6. The treadmill effect at work – one deadline morphing into another and draining the work experience of its essential “job fulfillment” quota.

### Personal Responsibility

A series of questions will help employees evaluate the kind of stress they are experiencing at work – for example:

- Does the job at hand call upon the skills, time and resources I actually possess?
- Conversely, do I feel responsibilities piling on and resources disappearing?
- Does my job right now create the opportunity for fulfillment of some sort?
- Do I feel I can contribute – or is this just a treadmill I’m on?
- Do I realistically think the job I’m doing right now will add up to something?
- Do I realistically think the job I’ve been given to do under deadline can be successfully completed and recognized as such?
- Does the task at hand flow from a job that is meaningful?

### U.K. Stress Code - 2003

Bill Callaghan, Chairman of U.K. Health and Safety Commission: *“There is a difference between the buzz people get from doing a busy and challenging job, and an unreasonable pressure which can harm health, lead to absence and put additional strain on people trying to cope in an already pressurized environment.”*

Based on Whitehall Studies, the Code is supported by six guidelines:

- 85% of employees must say they can cope with the demands of the job
- 85% must say they have adequate say over how they do their work
- 85% say they receive adequate support from co-workers and bosses
- 65% say they are not subjected to bullying
- 65% say they understand their roles and responsibilities
- 65% say they are allowed to be involved in organizational change

## PATHWAYS TO BURNOUT

*A first step toward international standards governing the return to work from mental illness  
Eliminating the stigma of mental health problems in the work place*

### PATHWAYS TO BURNOUT

*As a matter of good business and good health, remedies are called for to eliminate and reduce the effects of poor management practices in the 21<sup>st</sup> century workforce*

- A **bad match** between the demands of an on-going job and the individual's resources and skills to handle those demands
- Taking serious responsibility without authority, recognition or appreciation
- **Losing or lacking control** over the things that need to get done
- Work and role **overload**
- **Unclear functional goals** as a steady diet
- **Constant fire-fighting** which seems useless or unnecessary
- **Losing private time**, all the time

*Depression predictors vary by occupation:*

#### **Factory Workers**

- Minimal control over workload and excessive environmental noise

#### **White Collar Employees**

- Role ambiguity, lack of control over their work, lack of support from co-workers

#### **Teachers, Physicians, Healthcare Workers, "Caring Professionals"**

- Job strain

*10 High-Risk Management Practices*

1. Imposing **unreasonable demands** on subordinates and withholding information materially important to them in carrying out their jobs.
2. Refusing to give employees reasonable discretion over the day-to-day means and methods of their work.
3. **Failing to credit or acknowledge** their contributions and achievements.
4. Creating a **treadmill** at work – too much to do, all at once, all the time.
5. Creating **perpetual doubt**, employees never sure of what's happening around them.
6. Allowing **mistrust** to take root. Vicious office politics disrupt positive behaviour.
7. Tolerating, even fostering **unclear company direction** and policies, job ambiguity and unclear expectations.
8. **Sub-par performance management practices** – specifically employee performance reviews – even good ones – which fail to establish the employee's role in the company's near or mid-term future.
9. **Lack of two-way communication** up and down the organization.
10. Managers rejecting, out of hand, an employee's concerns about workload

**JOB STRESS AND HOME STRESS HAVE A SYNERGISTIC EFFECT**

*As a result, the line between is blurred between health conditions that are or are not work-related*

***EMPLOYERS GETTING STARTED***  
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**MODULE SIX**

**ROADMAP FOR COGNITIVE AND SENSORY DISABILITY MANAGEMENT**

**Highlights**

Module Six:

- Contains an original roadmap by Watson Wyatt Worldwide to guide managers in the return to work of employees with disabilities affecting cognitive and sensory capacities.
- Draws on Watson Wyatt’s four pillars of engagement for this purpose:
  - Alignment (employee knows what to do)
  - Capability (skill requirements and modified work)
  - Resources ( tools to do the job)
  - Motivation (employee encouraged/supported to succeed)
- Provides managers with a play-by-play description of what they must do to oversee and, in some aspects, hands-on management of the return to work process:
  - Make sure that once back on the job, the employee is not stretched too far.
  - Are expectations of the employee clear to him/her and you?
  - Noticed changes in behaviour.
  - How to handle relapse.
  - Talking to co-workers about the job modifications needed.
  - The process of interviewing the employee who is returning to work.
  - Create a “clean slate” performance record. This is smart and appropriate.

**Roadmap for Cognitive and Sensory Disability Management**  
***(Watson Wyatt Worldwide Model)***

Further to the “Quarterbacking” Module, we introduce this specific roadmap to the “return to work” phase of mental disability management.

“*Cognitive*” refers to brain capacity for thought and understanding which can be impaired by brain-based disorders including depression and anxiety disorders.

We wish to express our sincerest appreciation to Colleen McKinnell, Senior Consultant, Watson Wyatt Group Benefits and Health Care Practice, and colleagues for this design and continued efforts to make mental health an integral part of corporate business and health policies.

### **Four Pillars**

The Cognitive and Sensory Model is based on Watson Wyatt's "Productive Engagement Model" and specifies questions that should be considered when an employee returns to work from mental disability.

#### ***Alignment*** (returning employees know what to do)

- Have goals and expectations for the modified role been developed and communicated to the employee and to co-workers?

#### ***Capability*** (returning employees will meet the skill requirements of the modified work they are returning to)

- Has the pre-leave job been assessed against the medical restrictions the employee must observe?
- Have appropriate modified duties been developed (for the pre-leave job or another job)?
- Has a plan been established to review periodically those modified duties? Should they continue or be further re-worked?
- Are the goals set for the returning employee realistic?

#### ***Resources*** (the returning employee has the tools needed to do the job)

- Are special tools required for individuals to be successful? If so, are they in place?
- Is workload manageable in relation to the individual's restrictions and capabilities?
- Has a support system been put into place? A buddy system is a good idea.

#### ***Motivation*** (the returning employee is encouraged, supported and wants to do a good job)

- Has the returning employee been shown empathy, concern and support?

- Have milestones for the return to work been established, understood and activated?
- Has an arrangement been made for frequent feedback?
- Have pre-leave performance issues been “wiped clean”?

### **Managerial Responsibility**

#### **Lower job stress in the work environment:**

- Determine if employees are stretched too far.
- Determine if roles and expectations are unclear to them.
- Determine what tools to do the job of the returning employee are needed or lacking. (This includes information, budgets, technical and people resources)
- Provide constructive feedback and (when the opportunity presents itself) – recognition.

#### **Be aware of your (returning) employee’s wellbeing. Notice changes in behaviour and attitudes. HR Managers: educate your leaders and managers along these lines:**

- Responsibilities under human rights.
- Obligations of performance management.
- Awareness of mental disorders and what chronic stress is and is not.
- Information on behavioural changes and signs – how to respect.

#### **How to handle relapse (notification of extended absence)**

- Express empathy and concern.
- Has the individual seen a doctor; how long does the doctor say the additional time away will be?
- Advise that you will be sending paperwork the physician will need to fill out.

#### **Managers managing the return to work process itself:**

- Conduct team meeting and brief co-workers on the employee’s return.
- Do not talk about limitations. Talk about “the job” and getting back in the saddle.

- Brief co-workers (briefly) on the modified duties and make it clear this job accommodation process is both smart and necessary.
- Ensure no single person or group bears the lion's share of the work transfer necessitated by the job accommodation process.
- Interview the returning employee:
  - Welcome back
  - Update on the company
  - Review the job/modified duties
  - Invite the case manager to come in
  - Discuss accommodation requirements
  - Set dates and times for reviewing progress and problems
  - Make a two-way "feedback understanding." This is absolutely key.
- Express personal support and also, in that context, establish the clear principle that the objective – the necessity – is that employee's return to full-time employment.
- Create a "clean slate" performance record. This is smart and appropriate.

Proceed to the Watson Wyatt Worldwide Job Analysis Work sheet at  
[www.mentalhealthroundtable.ca](http://www.mentalhealthroundtable.ca)



***EMPLOYERS GETTING STARTED***  
***On the Road to Mental Health and Productivity***

**MODULE SEVEN**

**MEDICAL AFFIRMATION PROCESS (MAP)  
TEAMWORK TO MANAGE MENTAL DISABILITY**

**Highlights**

**Module Seven Introduces a Medical Affirmation Process (MAP) to Manage the Front End of Mental Disability More Effectively.**

MAP identifies critical transitions for employees in the onset and recovery/return to work from mental disorders:

- Onset of symptoms, work decline
- Time on and off work without appropriate care
- Onset of disability and disability leave
- Absence from work and isolation at home
- Recovery and clearance to return to work
- Process of actually getting back on the job

*Each transition is problematic – and each should be managed as a distinctive phase of the employee’s departure, recovery and return to work.*

MAP describes the steps that treating and consulting physicians should take in creating the collaborative process needed to make gains at the front end of the disability period.

**Special Report: Specialized Disability Management for Complex Cases**

This special report was prepared especially for this Business and Economic Plan for Mental Health and Productivity by –

- Dr. Stanley Dermer, Occupational Psychiatric Consultant
- Dr. Sarah VanderBerg, Lead Medical Director, RBC Insurance
- Diane Westcott, Director of Wellness, Ontario Power Generation

The approach described in this Special Report stipulates an employee-centred approach in complex cases which may represent 15-20% of all short-term disability but 80% of disability management.

A mental health consultation/liaison team would serve as a vehicle for improving outcomes. The model is exciting in concept and merits evaluation.

“MAP” is a concept which tries to “aggregate” the various features of teamwork to produce better results at the front end of the disability management process. MAP is an expression of Shared Care.

#### MAP Objectives:

1. To improve the capacity of primary physicians to diagnose and treat mental disorders.
2. To improve substantially the prospects of employee-patients recovering and returning to work sooner.
3. On the merits, to reduce the need for costly independent medical evaluations in the process of managing mental disabilities at work.
4. To not offend the administration of the Canada Health Act.

#### Issues

***Only one in five Canadians receives adequate care for mental disorders.***

- Canada will never have enough psychiatrists. Primary care physicians are key.

*Family practitioners are not adequately trained to diagnose and treat mental illness and typically the referral time to see psychiatrists is months not weeks. Conditions corrode.*

- The shared care model of supporting family physicians is an opportunity-in-waiting to deal with this conundrum.

*Employee-patients navigate four critical transitions in the onset and recovery from mental disability:*

- Onset of symptoms, declining work performance; time on and off work without appropriate care; disability leave, recovery and return-to-work.

*Each transition is problematic.*

- One, coping with symptoms, not getting help; two, loss of self-confidence, relationships suffer; three, isolation, delay and confusion and four, uncertain performance period up to six months.

#### MAP: Fresh Take on a Thorny Old Problem

MAP offers the family physician the support of shared care from a workplace base – funded by employer at the front-end of managing the disabling effects of mental disorders – specifically, depression and anxiety.

MAP entails:

- Physician-to-physician consultations between the treating family physician (whose services are publicly-insured) and consulting occupational physician/psychiatrists (whose services are paid by employers).

Through MAP, the treating and consulting physicians:

- Review and affirm the diagnosis and treatment plan prescribed by the treating physician.
- Inform employers and insurers of this fact – that the diagnosis and treatment plan are correct and will be monitored appropriately.

In this manner, the parties – employers, insurers and employees – are unified by good information at the front-end of the disability leave.

The consulting physician:

- Like the treating physician, is bound – as a physician – to the recovery interests of the employee-patient and, within that stricture, keeps employers and insurers duly informed.
- Advises the treating physician on the occupational aspects of recovery and consults the treating physician on restrictions and timing for the return to work.

MAP is a new take on an existing idea – that is, third party payers and consulting physicians as in the practice of commissioning independent medical evaluations.

The IME has inherent weaknesses as a means of enhancing the recovery and return to work prospects of employee-patients:

- First, it is downstream, after-the-fact and does nothing to produce actual treatment capacity in the health care system.
- Second, it can be redundant and adversarial, forcing rebuttals by treating physicians and leaving the insurers or employers in the position of sorting out the deadlock.
- Third, IME's are over-used and often without rhyme or reason. When an employee is cleared to return to work by a treating physician, IMEs are not called for unless there is a concrete conflict of professionally-informed opinion at hand.

IMEs are valid when 1) the recovery of the employee-patient is lagging; 2) the treatment plan isn't working; 3) or the employee is resisting the doctor's advice to return to work.

Each transition is problematic.

- One, coping with symptoms, not getting help; two, loss of self-confidence, relationships suffer; three; isolation, delay and confusion; four, possible relapse and re-RTW.

Specifically what functions the employee performs, patterns of absence or downtime, say, over the past 30 days, and the pace, dynamics and history of the work environment in which the employee routinely functions.

The amount of interpersonal exchange, planning skills, attention to critical detail and the pace of work which characterizes the employee's duties.

This helps the physician make a judgment – in the face of the employee's illness – as to what considerations or accommodations might be necessary to assist in bringing that employee back to work.

In California, for example, psychiatrists are expected to address the employee's ability in areas such as:

- Understanding and following instructions.
- Performing simple and repetitive tasks.
- Maintaining a work pace appropriate to the word load.
- Relating to other people beyond giving and receiving instructions.
- Influencing others, accepting instructions, planning.

### **Proposed Workplace Mental Health Model Based on Shared Care Principles**

Shared care is not a new idea. It is designed to improve the capacity of family physicians in the primary care system to provide effective diagnosis and treatment of mental illnesses.

The assumption behind this: will have a better chance to reduce waiting lists for mental health care by turning to the primary care system to treat serious but common conditions including depression, anxiety disorders and substance abuse.

#### ***Dr. David Goldbloom, Centre for Addiction and Mental Health***

*“The access issue is not simply producing hundreds more psychiatrists. The problem stems from primary care and how we reorganize this to ensure people with mental illness get the same treatment as people with physical illnesses.*

*“Psychiatrists are an important component in a larger system of mental health care but system reform at the primary level is called for – from community agencies, hospitals, multi-disciplinary primary care as well as specialty care.”*

Dr. Goldbloom's thinking is reflected in the concept of shared or collaborative care which has gained traction in both Canada and the United States.

Therefore, the Roundtable proposes discussions with government, insurers, employers and physicians to explore the concept of a workplace mental health system based on shared care principles.

### **Part One: Supporting Public Primary Care**

This model would bring together:

- Family (primary care) physicians whose fees are paid by the public health insurance system (Medicare) in each province consistent with the Canada Health Act; these physicians treat employees and their families.
- Consulting psychiatrists and occupational physicians whose fees would be paid by employers to make this expertise available to family physicians in the diagnosis, treatment and maintenance care of employees with depression et al.

### **Part Two: Promoting Dual Diagnosis and Treatment**

The prevalence of depressive disorders among people being treated for other things in the primary care system is nearly twice that of the population at large.  
(*Canadian Psychiatric Association Bulletin, 2002*)

International studies say that 25% of heart patients also have depression. Among those with a recent heart attack, it is 20%. Depression is now an independent risk factor for sudden death from a heart attack.

The reasons for this are not known. There are strong suggestions now that depression causes a physical response which is detrimental to the heart, blood vessels and platelets.

There is also increased risk of blood clotting and reduced heart rate variability. The heart of a depressed person seldom sleeps.

Studies indicate about 25% of cancer patients develop clinical depression and this can impede recovery. Cancer patients with depression have an increased risk of suicide.

About half of those with Parkinson's disease, in one study, were found to suffer depression and this impairs memory, language and motor functions.

About half of depressive episodes in patients with medical illness are not accurately diagnosed and, in one estimate, a third of all patients in Ontario hospitals have untreated addiction problems.

Canada is a leader in cardiac psychiatry and psychiatric cardiology. The importance of diagnosing and treating concurrent disorders is obvious.

But it is not done as a rule and the subject is absent from the wellness, group health and disability management regimes among most if not all employers.

Therefore, it is appropriate and timely to raise the profile of concurrent disorders in the workplace and to take steps to promote their recognition, diagnosis and treatment.

To that end, this Workplace Mental Health Model extends the Shared Care concept to the dual diagnosis of co-occurring disorders:

- Family physicians with assistance, as required, to secure the advice of physicians with specialized knowledge in the field of co-morbidity – that is, co-occurring conditions such as depression and heart disease.
- This additional expertise would become available in the normal course of a patient referral – however – if this was not possible due to waiting lists:
- The specialist physician would be retained by employers as part of the workplace model to offer advice to the treating physician on the diagnosis and treatment of these especially complex and dangerous cases.

*BC family physician Dr. Anthony Ocana has proposed special training for family physicians to handle concurrent disorders. This has great merit.*

### **Part Three: Guarding Against Migration from STD to LTD**

At a BC Roundtable meeting, Dr. Ocana also proposed setting up a special provision to protect mental health patients on short-term disability from gravitating into long-term disability by default of inadequate care.

The Roundtable endorses this and as part three of the proposed Workplace Mental Health Model, we visualize:

- Designation of a “risks safety zone” for cases after six months off work – before STD benefits are discontinued or LTD entry process begins. This would set into motion specific, extraordinary measures to avoid LTD.

These measures to include:

- STD benefits are continued. The LTD process, frozen – pending:
- Complete re-assessment of the complex case including the employee’s medical condition, the current and past treatment plan, the employee’s compliance record, home and workplace issues.

In effect, when the disability leave passes six months, the employee would enter what we might call a “risk safety zone” which, in turn, would run up to three months before any of the parties could trigger LTD proceedings.

This would have the benefit of heading off LTD and creating a shared responsibility on the part of all concerned to achieve this end:

- Re-energize the recovery and return to work process within the bounds of medical possibility and integrity and –
- Best case, prevent cases from being dragged into LTD by inadequate care and/or patient motivation and –
- Worst case, create a less adversarial way to determine whether equitable severance is preferable to LTD for both the employee and employer
- And more lead time to build a better LTD plan if this is necessary after all.

We note that:

- The development and acceptance of this extraordinary pre-LTD measure would require leadership from a handful of large employers in partnership with the insurance industry and physician community – leading to:
- Formation of a study, design and implementation team drawn from these areas to figure out how the extraordinary pre-LTD process would work. Some questions are obvious:
  1. Is it necessary in the first place? The Roundtable believes so and certainly the process of asking and answering that question will be enlightening for all concerned. There is value in that.
  2. What qualifications are needed by the individual who will conduct the extraordinary pre-LTD experience? Will the process be a natural extension of well-established case management? Case managers certainly share the goal.
  3. Consultation with government is necessary to ensure the concept is understood and consistent with CHA.

#### **Part Four: Shared Responsibility**

The principle of shared responsibility centres on the employer, employee, health professional, insurer and government – the last in providing publicly-funded “medically” necessary services. Each party has a role to play in preventing and managing mental disabilities.

Let us remind ourselves of these facts:

- The comparative costs of treating depression et al are less than the costs of production losses which unchecked mental disorders cause. Therefore, there are economic grounds for shared investments and shared returns.
- Key to a successful return to work process is the understanding that the reduction of work impairments – “I’m feeling OK to go back” – lag the actual reduction of symptoms – “I may have gone back too soon.”
- Therefore, relapse planning should take into account these risks and, on top of that, ensure that the return to work is gradual, well-planned and sensitively-managed. A shared duty.

*“Good health,” former Health Minister Marc Lalonde told us 30 years ago, “is the bedrock on which societal progress is built. A population of healthy people can do things that make life worthwhile.”*

*And he said: “The health care system is only one way of maintaining and improving health. Of greater importance is raising the general standard of living and advances in medical science.”*

### **Part Five: Proposed Course of Study for Employers, Employees and Insurers:** **The Physics of Mental Health**

Understanding mental health for what it is/isn’t will help us tap into the productivity capacity and energy of the workforce which, as Mr. Lalonde prescribes, has more to do with health than health care.

This also means being honest with ourselves.

The impact of persistently late and poor diagnosis is, in part, a function of deeply-rooted scepticism among managers and co-workers whose stigmatizing view of mental illnesses may prevent employees from reaching out.

One of the myths of mental illnesses is that it is invisible, not concrete, not physical, not real. Employers, employees, insurers, physicians and health professionals share a responsibility to get past these notions and in doing so:

- Promote earlier detection, more effective treatments and a more routine acceptance that mental illnesses are part of being human.

The following “physics course” on mental health is simply to help us understand that the reality of mental illnesses has physical properties and consequences, that it is about brain function. So, let’s get physical – about mental health.



***Back pain: yes, it's all in your head – that's where your brain is.***

In 2003, Statistics Canada reported that half of the people who met the criteria for depression reported physical symptoms. In fact, physical pain is the ancient unwritten, common language – the lingua franca – for distress in our society.

As long as the stigma of mental illnesses abounds, people will go to their family physicians with belly aches, back pain, chronic headaches and a variety of other physical markers that act as screens for mental illnesses.

Is the pain imagined? It is not. Pain is mediated by the brain. Those who are isolated at home, away from work and friends – and even family – develop greater sensitivity to their physical discomforts. The brain's filtering-out process is reduced.

Someone injured in a car accident may develop secondary depression which can amplify their physical pain. In reverse, depression going untreated or even undiagnosed for three months can spill over into physical symptoms.

### **Part Six: Employers, Insurers and Case Managers Understanding the Objective Scientific and Clinical Nature of Diagnosing Mental Illnesses**

Some think that the diagnosis of mental disorders is a subjective exercise by doctors.

This view is held by some in the insurance sector, among some HR managers. It implies the condition is based solely on what the employee tells the physician who “takes the order” and writes the script.

**CAMH's Dr. David Goldbloom:** *“All diagnosis in medicine is based on pattern recognition and the pattern of depression is as reliable as would be the pattern for most physical diseases throughout medicine.”*

Even the authors of the diagnostic bible – DSM-IV – concede the confusion between physical and mental disorders. In its preamble, the standards manual says:

*“The term “mental disorders” unfortunately implies a distinction between mental disorders and physical disorders. When, in fact, there is compelling evidence that there is much that is physical in mental disorders and much that is mental in physical disorders.”*

A judge in the U.S. agreed that bipolar disorder could be classified as a physical disease. And if that is true, then diagnosing mental illnesses, as Dr. Goldbloom says, is like diagnosing physical disorders.

There is another distinction to observe between what is subjective and what is objective.

### Physician is Objective

Physicians should and can make objective diagnoses based on the recognition of patterns – as Dr. Goldbloom noted – as well as scientific and clinical evidence.

Studies tell us that clinical judgments also involve value judgments and “rules of thumb,” just like any other decision-making process led by human beings.

It is said therapeutic treatment involves an assessment of risk through which physicians specify the target. In treating depression, “return to work” is appropriately a desired outcome of treatment and thus part of the recovery process.

Dr. Walter Rosser, ex-chairman of Family Medicine at the University of Toronto, says “evidence-based medicine requires clinical knowledge, communication skills, patience and commitment to help patients make informed choices.”

The diagnosis of mental disorders, like physical disorders, involves science, judgment and knowledge. Depression is visible on brain-imaging screens, so we know its there. That said, there is no blood test.

### Employees Can Be Subjective

Meanwhile, the employee’s view of his or her condition or desire to return to work is subjective. Which is natural. We are all human beings. Subjective creatures.

Recovery and return to work can be influenced by many factors outside the realm of diagnosis and treatment – workplace relationships being one. This can delay or deter getting back to work.

That said, the information which employees (patients) give physicians – in the office or in surveys – has proven to be reliable as a basis for diagnosis and treatment even compared to so-called “objective” criteria.

### Managers Can Be Subjective

That said, subjective thinking has another source and influence – the perceptions and attitudes of managers and it is important for all of us to get beyond the notion that mental illnesses are invisible and that diagnosis is guesswork.

### **Postscript**

We need new thinking. And to that end, the Roundtable received the benefit of a Mental Health Collaborative Team Model which may effectively meet the needs of employers and employees reflected in the foregoing text.

## SPECIAL REPORT

### **Employee Centered Mental Health Consultation – Liaison Specialized Disability Management for Complex Cases**

Prepared for the Roundtable  
by

S. W. Dermer, MD, FRCP(C), Occupational Psychiatric Consultant <sup>(1)</sup>  
Diane Westcott, Director of Wellness Division, Ontario Power Generation <sup>(2)</sup>  
Sarah VanderBurgh, Lead Medical Director, RBC Insurance <sup>(3)</sup>

*Complex cases (often entailing a mental health diagnosis) are said to represent 15 – 20% of cases on short term disability, yet take 80% of the disability management time.*

*A specialized approach employing a Mental Health Consultation – Liaison Team is a means of obtaining improved outcomes.*

*Characteristic employee profiles warranting the label ‘complex case’ may include:*

- *Repeated and progressively longer major absences*
- *Prolonged absence, no evidence of sufficient impairment to warrant total disability, often a diagnosis of “stress leave”*
- *Multiple medical and psychiatric diagnostic co-morbidity*
- *No identifiable proactive health practitioner and/or lack of adequate clinical treatment and/or progress*
- *A history of work performance issues and/or conflict with peers/supervisors*
- *Poor employee work satisfaction or “doing pensionable time”*
- *Previously unknown longstanding psychosocial difficulties prior to being hired*
- *Lack of clarity as to the extent to which the underlying problems are health related or symptomatic of work issues*

*Conditions driving the need for a specialized team approach consist of:*

1. *The lack of timely access to psychiatric resources in the community*
2. *Incomplete assessment of presenting problems*
3. *Poor coordination and monitoring of the required interventions*

*This collaborative Consultation – Liaison Team approach can provide any one or all of these services:*

1. *Review of files (group discussion or paper review)*
2. *Liaison with stakeholders (family physician; other health professionals; union representatives; supervisors; human resources; labour relations)*
3. *Gathering of information and implementation of a path forward*
4. *Interviewing<sup>1</sup> of employee and, if necessary, significant others*
5. *Monitoring/reassessment of path forward to maximum medical recovery, including provision of support and direction to the attending family physician*

*To obtain resolution of these cases, the following tasks need to be completed on an intensive basis.*

*① Comprehensive data must be gathered regarding the employee's illness, performance and treatments received, etc.*

*This data must be ② analyzed in a bio-psychosocial context.*

*③ A path forward to maximum medical recovery needs to be implemented which leads to a return to work or access to an entitlement (LTD).*

*As these tasks are labour intensive and require a bio-psychosocial orientation, a multidisciplinary team is recommended. This entails the employer securing the services of a consulting psychiatrist, who, along with a nurse with mental health experience, will consult and advise the occupational physician or the employer's disability management coordinator.*

*The necessary condition for successful application of this model is collaboration, as opposed to an adversarial approach.*

*The latter is available under conventional disability management conditions using Independent Medical Evaluations (IMEs).*

*To receive assistance, employees must be willing to be transparent, including provision of authorized access to caregivers.*

*As well, cooperation amongst all stakeholders will be essential with an emphasis on facilitation of assessment and treatment, rather than exclusively on disability.*

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<sup>1</sup> In person or via video conferencing with employees who are geographically distant from the psychiatrist.

*The team will actively engage and provide support/direction by direct contact with the employee, if necessary, and any or all of the stakeholders, both within the company and in the community.*

*Videoconferencing can be utilized for employees who are geographically distant from the psychiatrist, to ensure timely access.*

*Implicit in this model is early intervention, (based on identification of “red flags”), to help ensure better outcomes. Over time, one can also expect that the Mental Health Consultation – Liaison Team can be made available to assist with the assessment and re-entry of employees returning from LTD, as well as being made available to employees at work suffering from presenteeism.*

*Health promotion and training of supervisors lie also in the scope of the potential service available from members of the Consultation – Liaison Team.*

*Although this model has yet to be rigorously evaluated, anecdotal experience would suggest a strong business case, with outcomes, such as, a reduced need for adversarial costs associated with use of IMEs or avoidable arbitrations.*

*Most importantly, employee health, morale and loyalty is enhanced when innocent absenteeism is addressed by the employer with a proactive approach, geared to enhancing facilitation of care and interventions.*

***EMPLOYERS GETTING STARTED***  
***On the Road to Mental Health and Productivity***

**MODULE EIGHT**

**HEART DISEASE AND DEPRESSION**  
***Urgent Information for Employees and Their Families***

**Highlights**

This module is information that people need. The Roundtable asks employers to distribute this Module among employees so as to help them inform themselves and their families.

The data linking depression and heart disease is stunning in its implications and in its portrayal of depression, a common mental illness, as a physical condition with physical properties.

This Module says:

- 20% of people who suffer a heart attack show signs of depression at the time and they do not have the same chance of survival.
- Depression may increase blood clotting which impairs the supply of blood and oxygen to the heart. This is the cause of heart attack.
- There is evidence that depression may cause stroke; by treating depression, physicians may be preventing stroke.
- Employees with family members recovering from heart disease, or with a history of it, are encouraged to be screened for depression as a regular feature of managing the health of their heart.

*Knowing the facts and findings contained in this Module could save your life. In one case in 1998, it probably did. In another case in 2004, it did not.*

*It is critical for employers, employees, families, mothers and fathers to become familiar with the links between mental illnesses and major chronic conditions including heart disease and stroke.*

We ask employers to share this information with colleagues, co-workers and family members especially those recovering from heart disease, heart attack or surgery.

**Dr. Wm. Gnam, the Centre for Addiction and Mental Health:** *“The presence of a chronic medical condition (such as chronic pain or physical disability) increases the risk of developing a mental disorder, especially a depressive or anxiety disorder.”*

The risk of developing a mental disorder increases with the severity of other chronic medical conditions. The famous National Co-morbidity Study by Dr. Ron Kessler found that:

- Mental disorders – anxiety and depression – are at least twice as prevalent among those people with these chronic (physical) disorders versus those without.
- The combination which predicts the highest level of role impairment is depression/anxiety and heart disease, ulcers, arthritis and asthma.

### **Depression and Heart Attack**

About 20 percent of the people who suffer heart attacks show signs of a major depression at the time. Heart victims who suffer depression do not have the same chance of surviving a heart attack:

- Depression may predispose patients with damaged hearts to arrhythmia and sudden death.
- Studies suggest that depression may increase blood clotting – which, in turn, can impair the supply of blood and oxygen to the heart. A cause of heart attack.
- Researchers at the famed Montreal Heart Institute say that symptoms of depression among heart patients may predate eventual heart attacks by many years.
- By the end of one year after a heart attack, the mortality rate of those who are depressed is three times higher than those heart victims who are not depressed.
- A condition called “vital exhaustion” – fatigue, irritability and poor morale – predate heart attack(s) by several months.
- Study at Columbia University says “it is amply clear that depression is strongly associated with more frequent and more malignant cardiovascular disease. It is likely that depression’s effect involves all vascular disease including stroke.”
- Researchers at the U.S. National Center for Health Statistics report that a high level of depression increases the risk of first-time stroke for men by 56 per cent and women by 95 per cent.

- The Yale Cardiovascular Centre says:
  1. There is evidence “to support the idea that depression may cause a stroke or other cardiovascular events. By treating depression, physicians may be able to lower the incidence of stroke.”
  2. Evidence from medical outcomes studies suggests that later in life, depression and heart disease may be synergistic.

### **Functional Limitations**

- In one study, functional limitations were “significantly worse” for those suffering both depression and an advanced heart condition. A Rand Corporation study concludes that depression can mimic chronic medical conditions.
- Research in the U.S. says that individuals with conditions such as cardiac disease, cancer and stroke face a greater risk of depression.
- Those suffering one or more chronic medical disorders have a four-in-ten chance of having suffered a recent psychiatric disorder, about twice the population average.

### **What Kills**

Researchers in Finland found that men – without a prior history of heart attack – but with elevated levels of depression – were more likely to have a first heart attack.

This was taken to mean, depression is an independent risk factor in cardiac trauma and according to the Montreal Heart Institute depression is an independent factor in the risk of death six months after heart attack.

### **Depression and Behaviour**

What factors produce a fatal event? What are the “biological mechanisms” that swing into action? One is behaviour: the patient’s failure to do the things necessary to contain the risk of further cardiac trauma, such as diet, smoking, drinking, and stress.

Medical scientists are looking at the effects that prolonged and chronic negative emotions have on recovery from heart disease – hostility, extreme competitiveness, attempts to dominate, pessimism, hopelessness.

### **Depression and Heart Function**

Other implications:



- Depressed cardiac patients experience what the experts call “decreased heart rate variability” over a 24-hour period. Translated, the heart’s rhythm is abnormal. The depressed person’s heart, in effect, never sleeps.
- Stress interrupts the interplay among the brain, endocrine system (glands), and organs that produce and release hormones and the immune system releasing compounds that cause inflammation.
- Increased blood pressure narrows blood vessels and causes blood to become sticky and more likely to clot, increasing the risk of heart disease and stroke.
- A layman might think depression is a blood disorder when he or she learns that it can increase the risk of blood clotting and exacerbate the risk of heart attack.
- According to Columbia University, “the direction of these changes is such that one would anticipate an increase in sudden death. This could explain a good part of the increased mortality associated with depression following (a heart attack).”
- Other studies suggest alterations in the metabolism of depressed patients may increase the risk of vascular disease.
- It is conceivable, according to some studies, that atherosclerosis – the degeneration and hardening of the arteries and valves of the heart – could be a cause both for depression and heart disease.

### **Depression and Infections**

Research indicates:

- Our immune and nervous systems talk to each other. Emotional stress, among some of us, will suppress our capacity to ward off physical infection. Depression has links to thyroid disease.
- Fluctuations or changes in the nervous system are considered an integral part of serious depression. There is also evidence that such fluctuations can cause problems in the ventricular system of the heart.
- Those who are depressed are less capable of defending themselves against germs and viruses.
- Middle-aged men who feel hopeless or think of themselves as failures may develop narrowing of the arteries faster.
- Conversely, the mind (our beliefs) can process hope and foster well-being. It is well established that a person’s emotional and psychological state can impair or uplift the functioning of the human heart.

**Based on this information, the reader is advised to:**

- Ask your family doctor about the advisability of screening a family member for depression who is recovering from heart problems but the “blues” have persisted for weeks or months. It could represent the onset of a depressive episode.
- Inquire about compatibility of medications for depression and heart disease if and when they are prescribed concurrently.
- Sources of information on the links between heart disease and depression are the Montreal Heart Institute, Ottawa Heart Institute, Toronto General Hospital and St. Michael’s Hospital in Toronto.

***EMPLOYERS GETTING STARTED***  
***On the Road to Mental Health and Productivity***

**MODULE NINE**

**HUMAN RIGHTS AND MENTAL ILLNESSES**  
**“A Matter of Law”**

**Highlights**

This module is **“required reading”** for those who wish to become well-informed on the legal obligations, duties and imperatives associated with the human rights of employees experiencing mental disorders.

Given the sensitivity of the subject, the thoroughness with which it is discussed in this Module, and the reader-friendly style in which the information is organized and written, we will not summarize these contents here.

We commend this Module to all concerned and wish to emphasize that this Module – or this Plan – does not take the place of qualified legal advice in individual human rights complaints.

This Module is “required reading” at a time when mental disability insurance claims dominate in today’s workplace.

All employers must accommodate employees with mental disabilities according to their individual needs. Accommodation does not include offering an employee a lesser job at lesser pay.

*The Supreme Court of Canada: “Work is one of the most fundamental aspects in a person’s life, providing an individual with the means of financial support and, as importantly, a contributory role in society. Work is an essential component of his or her identity, self-worth and emotional well-being.”*

Alberta Human Rights Act defines mental disability as “any mental disorder, developmental disorder or learning disorder regardless of cause or duration.”

*Not all mental impairments give rise to functional limitations and where such limitations do exist, they may be minor.* WORKink (Michael Lynk)

Impairment refers to the medical documentation and quantification of reduction of function. Disability is a social/legal determination defining task specific limitations in performance.

Mental illness is explicitly protected against discrimination in human rights legislation. Courts have ruled that impairment due to disability is unique to the individual. Job accommodations must – and can – be the same.

Disability is defined as the gap between what a person can do and needs or wants to do while mental disability refers to the effects of any mental disorder regardless of cause.

**Differential treatment as a result of drawing a distinction, exclusion or preference. This can be either the behavior of a terrible manager or a biased one, or both.**

- *Organization remains responsible for the outcome of managing the signs of distress and agitation and where changes have occurred in the person's performance of their job.*
- Exclusion can come via attitude. (Banks include mental illness in diversity training).

***Imposing a burden or withholding benefit.***

- Q for managers is whether they are treating this person differently because they are put off by what they see and/or have decided to ignore it – thus handicapping that person's access to help or chances for rehab.
- This would include not only unfair treatment but also neutral factors which have a negative impact – such as doing nothing.

***Offending human dignity encompasses individual self-respect and self-worth.***

- This is concerned with physical and psychological integrity and empowerment such as when individuals are marginalized which, in the workplace, can mean being ignored or excluded.

***Human rights and performance management are inconsistent***

- Privacy and confidentiality includes stopping rumours about any one individual.
- Essence of accommodating people with disabilities is individualization. Law says accommodation must be done on an individual basis.

***The presence of untended systemic barriers to integration***

- Conclusion about inability to perform essential duties should not be reached without testing.
- Leaving someone to twist in the wind is the same as not testing. Calculated indifference. A form of abuse.

- Right to return to work exists when the individual can return to work and do the essential tasks with accommodation – without undue hardship to the employer.

***Individual human rights are not limitless. But employer duties are clear***

- Employer must accept the employee's request for accommodation in good faith.
- Get expert advice when needed, take active role in accommodation, maintain confidentiality.
- Grant accommodation requests in a timely manner, bear the cost of medical information.
- When an employee is clearly unwell or distressed, the employer should attempt to assist that employee although employers are not expected to diagnose or second guess the health status of an employee.
- When an employer sees performance problems and signs of distress, the employer must exercise progressive performance management or violate the code.
- Before an employer may terminate an employee for unacceptable behaviour, the employer must determine if it is caused by a disability.
- Severe changes in behaviour could signal to an employer that the situation merits further investigation or attention. This may be linked to mental illness and this is explicit.
- Prudent employers offer employees assistance and support employees before imposing sanctions.
- Some mental illnesses may render an employee incapable of identifying his or her needs. Mental illness engages the protection of the code. Once disability-related needs are known, the onus shifts to the employer.

The duty to accommodate an employee's return to work from mental illness falls squarely on the employer and – in a bargaining unit – the union – up to the point of undue hardship.

depression must be accommodated with modified work through changes in their existing job or through alternative positions.

The employer may assume the union's voice in RTW matters is, by definition, the voice of the employee. For RTW purposes, the employee should make that choice.

Unions, and employers, in fact, should recruit independent human rights experts to advise all parties including the employee on whether his/her rights are being observed and protected.

In a five-point analysis by lawyer William J. Johnson of McGown, Johnson in Calgary, we learn that:

1. Unions have a responsibility to accommodate and cannot escape this duty through any provision of a collective bargaining agreement.
2. Unions and co-workers of the RTW employee must participate in the search for an accommodation – and cannot flatly refuse on the basis of seniority or job posting rights.
3. Neither can the employer ask the union and co-workers to waive seniority rights unless “no other reasonable alternative resolution exists.”
4. Unions have a duty to represent their members “at the higher end of the scale” in matters concerning a disabled employee. This is particularly true when an employee is mentally disabled and the issue is termination.
5. In one case –
  - The union was “held to have violated its duty of fair representation to the employee” by failing to seek arbitration in the case of an employee disabled by depression who was fired for not following orders and getting along with fellow employees.
  - The Saskatchewan Labour Relations Board held that “the union failed to take sufficient account of the mental disability experience by the employee and it therefore discriminated against him in handling the grievance.”

### **Unionized Workplace**

In the unionized workplace, collective agreement provisions are to be respected in the course of fulfilling an employer’s duty to accommodate. But these may have to be waived if they unreasonably block a viable option.

**Supreme Court of Canada – Madam Justice McLachlin recognized in 1999 the need to be proactive and sensitive to the individual in designing workplace requirements:**

- “Employers designing workplace standards owe an obligation to be aware of both the differences between individuals and differences that characterize groups of individuals. They must build conceptions of equality into workplace standards.

- “To the extent that a standard unnecessarily fails to reflect the differences among individuals, it runs afoul of the prohibitions contained in the various human rights statutes . . .”
- “The employer is required to provide for individual accommodation if reasonably possible.
- A viable accommodation can override the provisions of a collective agreement unless the proposed accommodation would “significantly” interfere with the rights of other employees such as causing the loss of another employee’s job or granting super-seniority to an accommodated employee.

### **What’s a Disability?**

- More generally, a disability is the consequence of a disease, injury or condition that impairs one or more facets of a person’s ability to perform the daily functions of life. (Source: Michael Lynk)
- The Human Rights Commission advises that disability should be interpreted in broad terms including past and present conditions as well as a subjective component based on perception, myths and stereotypes.
- Certain disabilities might be non-evident (pain, chronic fatigue, episodic conditions).
- Regardless of whether it is evident or non-evident, certain social constructs and stigma define features of discrimination.
- The Supreme Court of Canada has recognized the distinct disadvantage and negative stereotyping faced by persons with mental disabilities and has held that discrimination against individuals with mental disabilities is unlawful.
- Discrimination may also take place where a term or condition of employment requires enrolment in a group insurance contract and the applicant does not qualify for the insurance plan because of disability. The term or condition of employment would be seen as a violation of the human rights code.

In 1982, the Supreme Court of Canada wrote: “Discrimination may be described as a distinction, intentional or not, based on grounds relating to personal characteristics of the individual or group.”

In 2000, Court wrote that:

- “Unlike gender or ethnicity which usually stamps a member with of the class with a singular characteristic, disabilities vary in type, intensity, and duration across the full range of personal physical or mental characteristics that present an individual from working. Disability means vastly different things.”
- “An individual may suffer severe impairments that do not prevent him or her from earning a living. Beethoven was deaf when he composed some of his most enduring works. Franklin Roosevelt, limited to a wheelchair, was elected president of the U.S. four times. Terry Fox inspired Canadians coast to coast.”
- “The concept of disability must therefore accommodate a multiplicity of impairments, both physical and mental, overlaid on a range of functional limitations, real or perceived, interwoven with recognition that in many important aspects of life, the so-called “disabled” may not be limited in any way at all.”
- “The principal objective ... is the elimination of discrimination by the attribution of untrue characteristics based on stereotypical attitudes. Exclusion from the mainstream of society results from ... (construction) of a society based solely on mainstream attributes.”

### **No Set Formula**

There is no set formula for accommodating people with disabilities. The goal of employers should be to create an “environment where a person with a disability may access their environment and face the same duties and requirements as everyone else with dignity and without impediment.”

Employees cannot expect a perfect solution, but the human rights code guarantees equal treatment to all persons capable of performing the essential duties or requirements of the job or service.

No one can be declared incapable of performing those duties until efforts have been made to accommodate the individual up to the point of undue hardship which (Corry) should be determined with “common sense and flexibility”.

The duty to accommodate may require employers to consider modifying performance standards and productivity targets, referring broadly to qualitative or quantitative standards on some or all aspects of the work. Productivity relates specifically to output.

“The task of determining how to accommodate individual differences may place burdens on the employer and union. (Sopinka)

Duty to accommodate requires more than simply looking to see if there is an existing job that might be suitable for a returning employee.



Questions to ask:

- Can the employee perform his/her existing job
- If not, can he/she perform it with some of the duties modified
- If not, is there another job in the company in its existing form
- If not, is there another job in a modified form?

### **Defining Undue Hardship**

The employer must accommodate up to the point of undue hardship; and while there is no single definition in law as to what constitutes undue hardship, the employer must demonstrate that its efforts were serious, conscientious and genuine.

The duty to accommodate rests on three sets of shoulders, according to the Supreme Court of Canada:

1. Primary responsibility rests with the employer
2. The union must cooperate with the accommodation process and not unreasonably block a viable option.
3. The employee is expected to participate in the process also and cannot refuse a reasonable offer of accommodation.

### **Standard Life's "Return to Work Guide" offers this:**

"Overall, an employer has a moral and in some circumstances, a legal duty to accommodate to the point of undue hardship." The following steps are recommended by the company:

- Welcome the request (to accommodate) in good faith, treat all requests as confidential and clarify what is needed to accommodate (prognosis).
- Avoid asking the employee to fill out forms in the early days off disability leave. This task is tough for anyone but especially so for someone having a difficult time concentrating.
- Don't badger the employee, don't ask for a lot of information and limit your requests to those reasonably related to the nature of his/her limitations or restrictions. Do not breach privacy requirements.
- Obtain expert advice and opinions, respond in a timely manner.

### **Critical Features of Human Rights Concerning Mental Illness:**

- When an employee's capacity for rational judgment is impaired by mental disability, human rights place a higher onus on both employers and unions to accommodating the employee.
- The fact the employee does not disclose the mental illness when he or she was hired, or did not provide the employer with a diagnosis in the throes of the illness is not disentitled to accommodation for these reasons.
- When an employee returns, part-time, the employer cannot terminate their employment unilaterally. The employer must demo the genuine effort before claiming undue hardship.
- The duty to accommodate applies to part-time and probationary employees.

### **Human Rights and Human Resources**

#### **QUESTIONS / ANSWERS**

**Question:** *Briefly, what are the laws in place to deal with discrimination in the workplace?*

**Answer:**

- There are several: employment law, the Canadian Charter of Rights and Freedoms and the Provincial and Federal Human Rights Codes. The obligations under all three are very similar.

**Question:** *What does the law say about job accommodations?*

**Answer:**

- Employers have a duty to accommodate employees with disabilities if the accommodation will allow them to perform the requirements of the job.
- Accommodation can include providing a quiet office for a person who is easily distracted, or permitting a person to take an extra break if they are required to eat when taking medication.
- Employers are only obligated to accommodate a person to the point of undue hardship. The Ontario Human Rights Code and the Canadian Human Rights Code restrict what constitutes undue hardship.

**Question:** *Can I ask someone whether they have a mental illness when they are interviewed for a job?*

**Answer:**

- A person can be asked whether they can perform the essential functions of the job. But the interviewer should not ask the applicant if they have an illness or whether they require accommodation until they hire the person.

*Question: An employee has requested an accommodation but has not disclosed detailed information about the disability. What information can I request?*

**Answer:**

- The employee is required to provide the employer enough information to enable the employer to provide the accommodation but not disclose the specific diagnosis or even the category of disability.
- Information about a diagnosis provided for the purposes of disability insurance, should not be disclosed to an employee's manager without their consent, even if an accommodation is requested.
- Employees may be afraid to disclose a diagnosis of mental illness because of concern about the reaction of their co-workers or managers. This must be respected.
- Longer term, the best solution is creating a workplace in which harassment or negative comments about mental illness are not tolerated.

*Question: An employee's performance has deteriorated over the past year. Can I ask them if anything is wrong? What if they say that there is no problem?*

**Answer:**

- An employer may, as part of a discussion about performance, ask an employee whether there are any problems, including health problems, which are interfering with their work. This must be done in a way that reassures the employee that disclosing this information will not jeopardize their employment.

If the employee replies that there are no problems, the employer is allowed to follow normal disciplinary process if there is no disclosure.

*Question: An employee has returned to work after an extended disability leave. They are fine while taking their medication, but have behavioural problems when they stop taking it. Can I require an employee to take their medication?*

**Answer:**

- It is difficult to find any legal basis for an employer requiring an employee to take or continue a particular treatment, even as part of a return to work program.

- However, the employer can make it clear when the person returns, that there are certain performance expectations. If these are not met, then the return to work will be reviewed and a determination made about whether the person can carry out the requirements of the job.

***Question:** Does an employee with a mental health problem pose a safety risk? Can I refuse to hire the person on that basis?*

**Answer:**

Safety is one of the criteria which can be used to refuse to hire someone on the basis of a disability provided that it is directly related to a bona fide occupational requirement and there is clear evidence that the individual cannot do the job in a safe manner, even with accommodation. Basing the decision on stereotypes would be considered discriminatory.

*\*Our appreciation to Patricia Bregman, a lawyer, for guidance in preparing this Q/A.*

***EMPLOYERS GETTING STARTED***  
***On the Road to Mental Health and Productivity***

**MODULE TEN**

**SMALL AND RURAL BUSINESS**  
**Mental Health and Productivity Model**

**Highlights**

There are a number of assumptions that can be reasonably made as to how small and rural businesses can address mental health issues in their places of work – firstly, they do not have the same resources as big employers.

This Module contains a strategy chart which:

- Affirms the business goal of mental health policies in smaller enterprises as protecting cash flow and employee availability.
- Establishes critical aims through primary prevention (workplace environment) and secondary prevention (timely access to services)
- Proposes a system through which small and rural businesses can get access to customized information through on-line website links, retail channels such as banks and pharmacies.

The Roundtable aims to work with chambers of commerce and other small or rural business associations to flesh out this strategy.

The Roundtable will work with chambers of commerce to develop a small business model for mental health and productivity. Meanwhile, some initial thinking is set out here.

There are a number of assumptions that can be reasonably made as to what might constitute an employee health model customized around the requirements and inherent characteristic of small or rural businesses.

One is that small and rural businesses lack the financial resources to build an infrastructure of employee health services such as employee and family assistance plans and, in some cases, adequate group health or disability (income protection) insurance.

That said, the economic impact of chronic health problems among Canadians employed by small and rural businesses is significant and, conversely, the economic stake we have in the small/rural business sector is very substantial.

In Roundtable meetings, the CEOs of the Canadian Chamber of Commerce and IBM Canada have both voiced strong views that a business and economic strategy promoting and protecting the mental health of the labour force must attend to the specific needs of small business.

The five policy aims set out in the CEO Guidelines can be adapted to small and rural business.

For example:

#### The ROI of Employee Health

- Small/rural business owners and managers should – for planning and operational purposes – recast the costs of employee health as an investment and, in doing so adopt the “portfolio approach” recommended in EGS. This will help them track return-on-investment and avoid the trap of one-off expenses.

#### Education and Training

- Information customized for small business can be made available on-line but the key is in knowing what owners and managers – and their employees – will find useful. We need to consult.

#### Primary Prevention

- A known roster of everyday managerial practices can aggravate or even precipitate chronic health problems in the small/rural workplace – triggered in part by the social, psychological and work environments in which we function.

#### Secondary Prevention

- The voice of small and rural business must be heard by federal and provincial governments on the matter of access to primary and specialized medical care for mental health problems among men and women in their prime working years.

#### Return to Work

- The return to work from scheduled sick leave: a complicated topic. The duty-to-accommodate employees’ return to work falls to larger and smaller employers alike provided this does not inflict undue hardship on the business. This needs to be understood.

A Chart is attached to capture the elements of a small business model.

**5-Step Strategy Chart**

***Small and Rural Business Employee Health Model***

***Affirm the Business Goal***

Protect income and cash-flow of small and rural businesses

***Establish Critical Aims***

ROI

Primary prevention (workplace environment)

Secondary prevention (timely access to services)

RTW

***Access to Customized Information***

Linked Websites

Retail distribution channels (banks, pharmacies)

On-line (email)

Chambers of Commerce  
(website and email services)

***Network of Customized Services and Preferred Providers***

Community services (family clinics)

Medical care (publicly-funded)

Occupational/vocational/transitional services

Family caregivers

***Affordable Insurance***

Geographically pooled risks

Small employer products: income protection (disability)

Group and family health plan (Rx)

Chamber of Commerce “umbrella contracts”

***EMPLOYERS GETTING STARTED***  
***On the Road to Mental Health and Productivity***

**MODULE ELEVEN**

**LINKS TO NATIONAL QUALITY INSTITUTE HEALTHY  
WORKPLACE STRATEGY**

**Highlights**

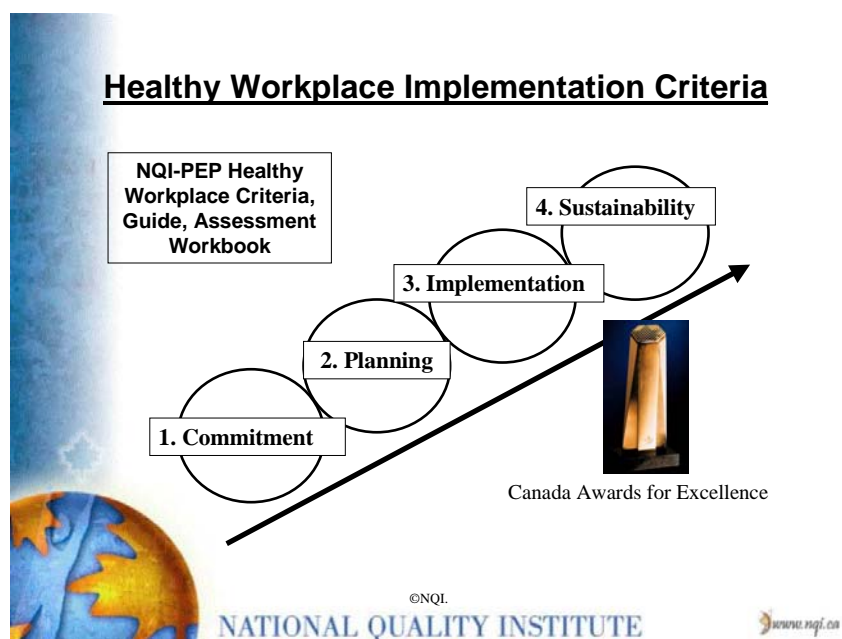
In 2005, the National Quality Institute incorporated mental health into its healthy workplace criteria and, this year, mental health is present in the criteria for NQI's prestigious Healthy Workplace Award.

This authenticates and substantiates the relevance of mental health to workplace performance in a very major way and the Roundtable is delighted.

In 2006, in partnership with the Homewood Centre of Organizational Health, the Roundtable and NQI will develop a training program for employers to build mental health into their vision of a healthy workplace.

Meanwhile, the Roundtable will be a friendly adviser to employers who may wish to assess the status of mental health in their workplace in their efforts to progress up the NQI performance ladder.

Module Eleven contains a description of the four levels of the NQI healthy workplace process: commitment, planning, implementation and sustainability.



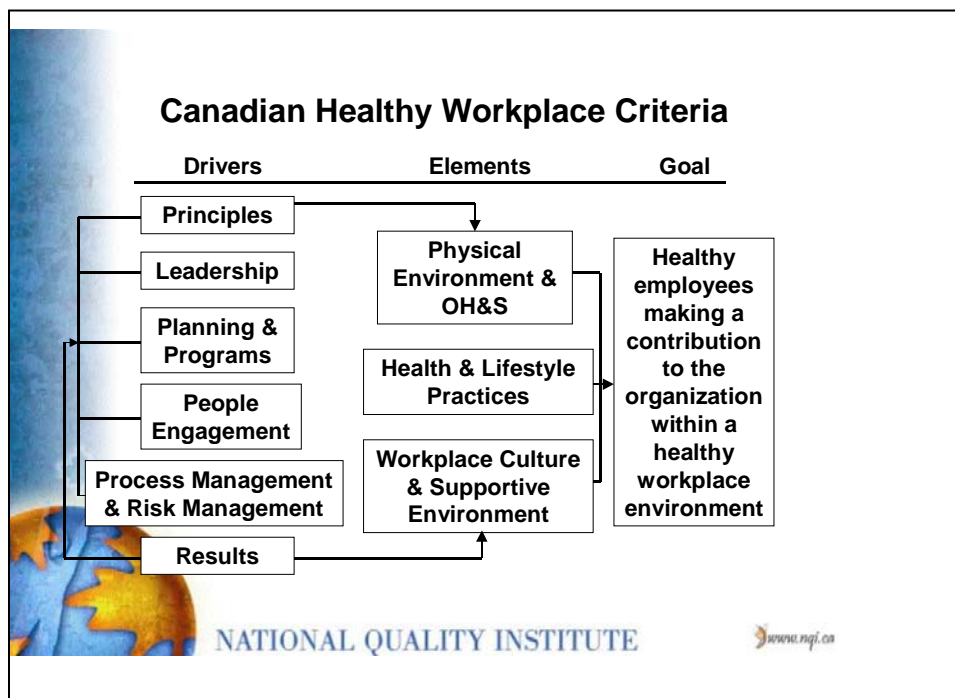


If organizations wish to develop, implement and sustain a healthy workplace culture, then THE Business and Economic Plan on Mental Health and Productivity (*Employers Getting Started –EGS*) – linked to NQI-PEP Healthy Workplace Criteria – will help in a practical manner.

Organizations that move through the implementation pipeline of NQI Certification (at all levels) can achieve role model status by winning Canada’s national healthy workplace award (Canada Awards for Excellence).

### Key linkages – Mental Health as Part of Healthy Workplace Development

- EGS provides guidance, education and effective practices/tools to assist organizations in managing and handling mental health issues in the workplace.
- Mental health is interwoven within the elements of the Canadian Healthy Workplace Criteria (revised version: October 2005), and the implementation model (NQI-PEP®).
- The following outlines the key focus of the four levels of the implementation model. For clarification, key elements from the Mental Health and Productivity Roadmap applicable to Levels One and Two are noted.
- The key consideration is that implementation elements of the Canadian Mental Health and Productivity Plan can be used to ensure a solid foundation of commitment and planning on mental health issues.
- This approach breaks implementation down to a practical and manageable method that will get desired outcomes for all.



## NQI-PEP® Level One – Commitment

The key focus of Level One:

- Leadership support (and application) for:

### An integrated management approach

- A comprehensive healthy workplace focus and policy provides context for consistent direction of an integrated framework of policies, programs and initiatives linked to a stakeholder-driven planning system supporting the wellness and well-being of staff throughout the organization.

### A primary focus on needs

- People need varied programs and levels of programming because everyone has different needs and preferences. Relevant to everyone, however, is the impact of chronic job stress across most if not all organizations.
- Chronic job stress can lead to specific medical conditions and a general lessening of a sense of well-being in the workplace. This needs to be addressed within the context of workplace culture and dedicated programming.
- Health programs and services must be adaptable to the unique features of the workplace. While workplaces exhibit distinctive characteristics, there is a common theme that merits attention – the need to meet demands for cognitive skill sets at all levels.
- The job demands that flow from a stronger emphasis on cerebral functioning than on manual skills place a higher premium on mental capacity and resilience, both key factors for achieving innovation in the workplace.
- Health programs should address issues concerning work environment and employee health status that pertain to mental health and stress-related concerns.
- In order to go beyond band-aid approaches, the organization must address root causes when developing approaches to meet employee needs. The organization's strategy must look at more than just programs targeting lifestyle behaviours, as root causes are often found in systemic factors, such as the negative impact of management practices that aggravate or precipitate mental health problems.

### Recognition that health is determined by many interdependent factors

- Policies and programs that affect the mental health of the workforce are considered an integral part of the healthy workplace focus.

- The interdependent elements of a healthy workplace are Physical Environment and Occupational Health and Safety, Health and Lifestyle Practices, and Workplace Culture and Supportive Environment, which specifically recognize the need to reduce chronic job stress and the incidence of employee disability.

#### Employer and employee joint responsibility

- Leadership and employees of an organization acknowledge joint responsibility to develop and sustain a healthy workplace, and to take personal responsibility for managing their health effectively.

#### Assessment, evaluation and continual Improvement

- Progress toward achieving goals is assessed on a scheduled basis and, when necessary, corrective action is taken. Healthy programs and services are evaluated through a system of program, process and economic evaluation.
  - A healthy workplace policy that includes reference to the reinforcement and promotion of mental health
  - Responsibility, accountability and resources
  - Health issues in the decision-making process
  - Respect for diversity
  - Compliance with employment rights and responsibilities legislation as well as with occupational health and safety legislation
  - From the Mental Health and Productivity Roadmap:
    - Guidelines for Board of Directors
    - Guidelines for CEOs (notably commitment factors, policy and senior management reinforcement)
    - Chronic Stress Policy (as part of overall health workplace policy)

### **NQI-PEP® Level Two – Planning**

Key focus of Level two:

- Quantification of current state of health and productivity indicators
- Healthy workplace plan
- Evaluation of employee needs and provision of healthy workplace programs
- Programs span continuum of care, such as prevention, screening and disease management

- Key priorities in workplace health issues linked to operating plans and integrated into other related human resource practices
- Planning of financial and other resources for a healthy workplace strategy
- From the Mental Health and Productivity Roadmap:
  - Guidelines for CEOs (notably evaluation of current state and implementation/operating issues)
  - Management Guidelines
  - Mental Disability management – Return to Work Process

### **NQI-PEP® Level Three – Implementation**

The key focus of NQI-PEP Level Three:

#### Progress and program outcome evaluation

- Assurance on levels of understanding of goals and policies
- Ease of participation (programs and job issues) and input on decisions
- Work process assessment, documentation and stability
- Training and development effectiveness
- Measures of work satisfaction and well-being
- Recognition of employee achievement
- Continuous improvement of interpersonal skills (positive impacts on organizational culture)

### **NQI-PEP® Level Four – Sustainability**

The key focus of NQI-PEP Level Four:

- Evaluation of program effectiveness and impacts
- Information system for evaluation of healthy workplace focus
- Results: Levels and trends:
  - Goals
  - Work satisfaction/morale/retention
  - Customer satisfaction

## INFO APPENDIX I

### **DEFINITIVE PREVALENCE RATES OF MENTAL ILLNESS SUMMARY (Prepared by the Global Business and Economic Roundtable on Mental Health)**

Prevalence defines the estimated number of people in a given population who suffer a form of mental illness over a given span of time. There are several milestones of measurement:

- Spot prevalence rates
- 30-day/six month/ one-year prevalence rates
- Lifetime prevalence rates

Also, note:

1. Prevalence rates are an epidemiological calculation.
2. Rule of thumb: the closer the time horizon, the lower the number.

The layman's difference between prevalence and incidence:

1. Prevalence defines a population.
2. Incidence defines a caseload.

The Roundtable has examined prevalence data for six years and counting. From this, we have done extrapolative analysis and developed our strategic and statistical arguments (the business case) and narrative themes for speeches and reports.

It became necessary to do this to rationalize the statistical variances, inclusions / exclusions of certain disorders from one study to the next and the rank of confusion.

Harvard and the World Bank describe an “unheralded crisis in world mental health” – a crisis characterized by –

1. Concentrations among younger segments of the population and the labour force.
2. Low rates of care and treatment.
3. High rates or incidence of disability in working population due to depression.
4. Compounded effect on duration of disability/risk of death due to heart attack.
5. Current/projected impact on work years lost due to premature death and disability.

These trends:

- Display depression/anxiety high on both the prevalence and incidence plain.
- Constitute an “unheralded world mental health crisis.”

For these reasons, the Roundtable targets:

- Depression, anxiety and substance abuse in the workforce and workplace.
- Treatment capacity issues including dual diagnosis.
- Job stress at source.
- Stigma as a barrier to care and treatment.

### Summary of Prevalence – (Sources and Findings)

#### 1. United States Surgeon General Report on Mental Health (2000)

##### **1-year prevalence rates:**

Any anxiety disorder	16.4% of US population
Any mood disorder (depression incl. bipolar I and II)	11.1% of US population
* Any mental disorder	21.0% of US population

- 16.4% and 11.1% include co-morbidity experience. Therefore, the overall prevalence rate (21%) is not an arithmetical sum of the individual categories above or below and includes the following:

Schizophrenia	1.3%
Non-affective	0.2%
Somatization	0.2%
ASP	2.1%
Anorexia Nervosa	0.1%
Severe cognitive	1.2%

#### 2. World Health Organization Report on Mental Health (2001)

##### **1-year prevalence rates – depression/anxiety/alcohol dependence – by major city:**

• Bangalore, India	22.4%
• Groningen, Netherlands	23.9%
• Mainz, Germany	23.6%
• Manchester, UK	24.8%
• Paris, France	26.3%
• Rio de Janeiro, Brazil	35.5%
• Santiago, Chile	52.5%
• <b>TOTAL PREVALENCE</b>	<b>24.0%</b>

##### **WHO:**

“(In 2000) about 450 million people were estimated to be suffering from ... unipolar depressive disorders, bipolar, schizophrenia, epilepsy, alcohol and selected drug use disorders, Alzheimer’s (+other dementias) and anxiety disorders (PTSD, OCD, panic disorder) and primary insomnia.”

### 3. Bulletin 2000 of the World Health Organization

(University of Sao Paulo, Mexican Institute of Psychiatry, University of Michigan, Netherlands Institute of Mental Health and Addiction, Harvard Medical School (Kessler et al); Chedoke-McMaster Hospital (Offord); WHO-Geneva.)

<b>Prevalence rates:</b>	<b>Lifetime</b>	<b>12-month</b>	<b>30-day</b>
<b>Canada</b>			
Any anxiety	21.3%	12.4%	6.2%
Any mood	10.2%	4.9%	2.6%
Any substance abuse	19.7%	7.9%	3.8%
Any study disorder	37.5%	19.9%	10.4%
<b>US</b>			
Any anxiety	25.0%	17.0%	10.3%
Any mood	19.4%	10.7%	5.1%
Any substance	28.2%	11.5%	5.7%
Any study disorder	48.6%	29.1%	17.1%
<b>Germany</b>			
Any anxiety	9.8 %	7.1%	2.7%
Any mood	17.1%	9.6%	3.6%
Any substance	21.5%	13.2%	6.2%
Any study disorder	38.4%	24.4%	10.9%

(Brazil, Mexico, Netherlands and Turkey also studied on a comparative basis)

<b>Average Age of Onset: Anxiety</b>	<b>Mood</b>	<b>Substance abuse</b>
All countries (7) age 15	age 26	age 21
Canada age 12	age 23	age 18

- WHO: “Surgeon-General of the US says the world faces a crisis in children’s mental health.”
  - Prevalence rates: US – 21% Switzerland - 22% Spain - 21% \*Canada - 15-25%
  - Treatment rates US – one in five \*Canada - one in six
- \* Source: The Provincial Centre for Excellence for Child and Youth Mental Health, Ottawa

### 4. Statistics Canada –Canadian Community Health Survey – Mental Health (2003)

(N.B. StatsCan surveyed for only five conditions omitting dysthymia (form of depression) and generalized anxiety disorder (GAD).

#### **1-year prevalence rates**

- Any mood disorder 5.9%
- Any anxiety disorder 5.8%
- Substance dependence 1.6%
- Total “any measured” disorder or substance dependent 11.1% (ex. conditions noted)

“Although mental disorders are present throughout all stages of life, results show differences according to age groups. Teenagers and young adults between 15 and 24 were most likely to report suffering from surveyed mental disorders or two substance dependencies.

- Age 15-24                    18%
- Age 25-44                   12%
- Age 45-64                   8%
- Age 65+                     3%

## **5. Canadian Alliance for Mental Illness and Mental Health (CAMIMH)**

### **One-Year Prevalence Rates**

- Anxiety Disorders        12.2%
- Mood Disorders            8.3%
- Schizophrenia            0.3%
- Eating Disorders          2.5%

### **Suicide**

- 12.2% per 100,000 (1995)
- 2% of all deaths
- 24% of all death among 15 to 24 years
- 16% of deaths among 25 to 44 years

### **Hospitalizations**

- 38% of total

## **6. “Treating Depression Effectively: Applying Clinical Guidelines” (Dr. Sid Kennedy et al)**

### **Six-month prevalence of Major Depressive Disorder (MDD) In Different Countries**

- Canada                    6.0%
- US                         10.3%
- UK                         9.9%
- France                    9.1%

## **7. Mental Health and Work: International Labor Organization and WHO**

### **Key facts:**

- Harvard: five of ten leading causes of disability are psychiatric disorders
- British Confed. of Industry: 15-30% working life prevalence rates in UK labor force
- The European Union: 20% spot prevalence rate in adult working population of Europe
- International Labor Organization (UN): 40 million Americans have mental illness



## **8. World Health Organization Report on Mental Health (2001)**

### **Co-Morbidity (Kessler)**

- 79% of those with mental illness worldwide have co-morbid physical conditions.
- Physical health problems co-exist with depression; can predict onset and persistence.
- 50% of depression/anxiety sufferers experience both conditions at the same time.
- 60%+ of those (receiving) alcohol and drug treatment have a dual disorder.

## **9. Harvard School of Public Health (WHO and World Bank)**

(The Harvard Burden of Disease study is a milestone and introduced a new international measurement called Disability-Adjusted Life Years (DALYS) to give the international community the means of measuring and comparing the burden of disease experience.)

Depressive disorders = 4<sup>th</sup> leading cause of DALYS (disability and premature death ('96).  
 = 1<sup>st</sup> leading cause of Years Lost through Disability (YLDs) ('96).  
 = projected to be 2<sup>nd</sup> leading cause of DALYS by 2020 in all countries.  
 = projected to be 1<sup>st</sup> leading cause of DALYS by 2020 in devel'd countries.  
 = projected to rank just behind/ahead of ischemic heart disease re above.

## **10. Great-West Life Assurance Company**

- Acute psychiatric disorders are leading primary and secondary driver of incidence of LTD. Anti-depressant medications are principal drug prescribed for employees 25-44 years.

## **11. Extrapolating the Preceding Spectrum of Prevalence Data for Canada:**

- Spot prevalence 10% of population
- Year 20+%
- Lifetime 37+%
- Most vulnerable segment of population 15-24 years
- Concentration of depression/anxiety – the labour force (prime working years)
- Depression/anxiety dominant source(s) of prevalence/incidence among all forms of mental illness:
- Average age of onset (anxiety disorders) in Canada: age 12
- Average age of onset (depression) in Canada: age 21
- Average age of onset (substance abuse) in Canada: age 18

This suggests that Canada's prevalence rates are under-estimated. The Health Canada study referenced here concedes that.

## INFO APPENDEIX II

### GLOSSARY OF TERMS

*We offer the following glossary to help clarify what frequently used terms used on our website mean and don't mean. This is drawn from various sources including the World Health Organization. We encourage readers to scan this:*

**MENTAL HEALTH** is the successful performance of mental functions leading to productive activities, fulfilling relationships, ability to adapt. It is the springboard for thinking, communicating, learning, emotional growth, resilience and self-esteem.

**MENTAL ILLNESSES** are medical conditions which have physical properties and physical origins and may be characterized by alterations in thinking and mood. These illnesses have links to chronic conditions such as heart disease.

*The Roundtable's focus is primarily on those conditions which are most serious, common and concentrated in the labour force.*

**DEPRESSION AND BIPOLAR DISORDER** -- A person with depression feels "very low." Symptoms may include: feelings of sadness or hopelessness, changes in eating patterns, disturbed sleep, constant tiredness, an inability to have fun, and thoughts of death or suicide.

A person with bipolar has periods of depression and periods of feeling unusually "high" or elated. The highs get out of hand, and the manic person can behave in a reckless manner, sometimes to the point of financial ruin or getting in trouble with the law.

**ANXIETY DISORDERS** include generalized anxiety, post-traumatic stress disorder (PTSD), phobias (fear of objects, animals or situations) and panic disorder (a condition where the person has repeated intense episodes of intense, sudden fear and physical symptoms such as difficulty breathing). Another anxiety disorder is obsessive-compulsive disorder, in which a person is unable to control the repetition of unwanted thoughts or actions. \*Combined, these conditions affect 22-25 per cent of the population.

**SUBSTANCE ABUSE** -- For purposes of *Employers Getting Started*, substance abuse should be taken to mean excessive consumption of legal or illegal substances which impair a person's capacity to meet the family and job responsibilities. The term also includes addictions and addictive behaviours. Substance abuse is commonly associated with mental distress and mental disorders and addictions are a diagnosable disease in its own right.

**CO-MORBIDITY** means two different medical conditions co-occurring simultaneously. In the case of depression and heart disease, for example, the risks and effects of both conditions are magnified by the presence of the other.

***MENTAL HEALTH PROBLEMS*** are conditions which may not reach the threshold of an illness which meets the criteria for a specific medical diagnosis but may require medical attention and include:

***STRESS:*** is a non-specific response of the body to any demand made upon it. It is not necessarily negative and some forms alert and motivate us to positive action. On the other hand, too much good stress, or bad stress may be a threat to one's health.

***CHRONICS STRESS:*** harmful physical and emotional response to job requirements that do not match the capabilities, resources or needs of the worker. The most stressful jobs are characterized by a combination of high demand and low reward.

***CHRONIC JOB STRESS*** is not a distinct clinical or medical diagnosis. It can be a health risk. In fact, the term "stress" has multiple meanings and can be used to denote either the nature of the stressor or the individual's reaction to it. In this respect:

***BURN-OUT:*** exhaustion, cynicism, loss of professional or occupational efficacy, creates high levels of employee disengagement and is a pathway to depression.

***STIGMA*** is a cluster of negative attitudes and beliefs motivating the public to fear, reject, avoid and discriminate against people with mental illness.

***RECOVERY*** from mental illness is a process in which people regain the capacity to work and participate fully in their communities. *For some, recovery means the ability to live a fulfilling and productive life despite a disability; for others, it means the reduction or complete remission of symptoms.*

***RESILIENCE*** enables us to rebound from adversity; change, trauma or tragedy – to go on with life with a sense of competence and hope.

***LONG-TERM DISABILITY (LTD):*** programs that partially replace income for long periods of illness or injury (typically until recovery or retirement).

***SHORT-TERM DISABILITY (STD):*** programs that replace all or part of an employee's income during disability up to a maximum period that is seldom longer than one year.

***PRESENTEEISM*** is not about malingering, faking it; the phenomenon refers to productivity losses (Harvard Business Review) stemming from real productivity problems. *The assumption behind presenteeism (Harvard Business Review) is that employees need to work, do not take their responsibilities lightly and "hang in there."*

## INFO APPENDIX III

### EMPLOYEE FACT SHEETS

These fact sheets are basic information and can be downloaded for distribution in your workplace.

#### Employee Fact Sheet (1)

##### GETTING THE FACTS

*A first step toward international standards governing the return to work from mental illness  
Eliminating the stigma of mental health problems in the work place*

##### GETTING THE FACTS

*Demographics and facts to help define “target audiences” for early education and intervention*

*Number of Canadians experiencing a  
mental disorder in...*

1 day	10 – 15%
1 year	20 – 25%
1 generation	37 – 40%

- Fewer than 20% of those who need treatment actually get it
- 70% of those people are in the labour force
- Individuals in their prime working years and valued employees with 10 to 15 years of service are uniquely vulnerable
- Bipolar disorder can be categorized as a “physical condition” according to a U.S. court
- Depression is linked to diabetes, hypertension, asthma, heart disease or stroke
- On average, an episode of serious depression can take an employee off the job for an estimated 40 days. Which is longer than cardiac disease.

*Effective treatments of depression – better accessed – can change this picture. Researchers at the Centre for Addiction and Mental Health find that 75% of those who get the treatment they need, do successfully return to work.*

#### Depression and Heart Disease

- 20% of people who suffer heart attacks exhibit signs of clinical depression at the time
- Depression can dispose individuals with damaged hearts to arrhythmia
- Depression quadrupled the risk of cardiac death among patients admitted to the Montreal Heart Institute for unstable angina
- The U.S. National Centre for Health Statistics reports “there is evidence to suggest that depression may cause stroke or other cardiovascular events.”
- Cardiac patients suffering depression experience “decreased heart rate variability,” which means the heart of a depressed person never sleeps
- Depression may increase blood clotting which can impair the supply of blood and oxygen to the heart, a cause of heart attack

## Employee Fact Sheet (2)

### RECOGNIZING DEPRESSION & ANXIETY

#### *RECOGNIZING DEPRESSION & ANXIETY*

*Depression and anxiety have major physiological implications affecting perspective, sleep and concentration; handling time pressures, feedback, multi-tasking and change.*

#### *Individual Effects:*

- Slumping performance at work
- Poor timekeeping
- Increased consumption of alcohol, tobacco or caffeine
- Frequent headaches or backaches
- Withdrawal from social contact
- Poor judgment/indecisiveness
- Constant tiredness or low energy
- Unusual displays of emotion, e.g. Frequent irritability or tearfulness

#### *Signs of Group Stress:*

- Disputes and disaffection
- Increased staff turnover
- Increased grievances and complaints

*10 distinct faces of problem job stress among middle managers*

1. Growing **irritability and impatience**, “no end in sight reactions to even routine requests for information.
2. **Inability to stay focused**, finishing other people’s sentences to “save time,” wincing at new ideas (who needs another new idea), being unable to sit still, looking distracted and far away.
3. **Staying out of sight**, keeping the world at bay, being testy about casual interruptions such as a phone ringing, not looking up when talking to others.
4. Treating the concerns of others about workload and deadlines with contempt **and sarcasm**.
5. **Displaying frustration** with one’s own boss in the presence of others and leaving angry voicemails after regular business hours.
6. **Stretching the workday** at both ends, **calling in sick** a lot, **persistently late** for meetings.
7. **“Working at home”** to avoid the negative energy of the office.
8. **Limiting eye contact with others** except to “react,” finding it painful to smile openly, your cheeks have a heavy, a fuzzy feeling behind your eyes
9. **Finding small talk hateful**. **Tuning out** what others say. **Missing deadlines, losing faith** in yourself and others, resenting and even alienating customers.
10. Eventually, **physical symptoms** of pain and burning, breathing troubles, back problems. Burnout may migrate to a diagnosable and dangerous medical condition.

## INFO APPENDIX IV

### ROUNDTABLE SUMMARY OF THE COSTS OF MENTAL DISORDERS

Canada spends \$142 billion per year on healthcare, \$43 billion per year in private care, nearly half of that in prescription drugs, the fastest growing cost in healthcare.

In this context, the Roundtable's estimates of the costs of mental disorders in Canadian workplaces – and on industrial production in this country – stem from a report compiled for the Roundtable by a scientific advisory committee led by Dr. Martin Shain.

The report was tabled at a special roundtable hosted by the TD Bank Financial Group on November 14, 2002. Committee members are acknowledged below.

Key extracts from this report:

- A conservative estimate of the net impact of depression, anxiety and substance abuse on productivity losses alone is around \$11.1B/yr based on 1993 data and (only) on disorders that would qualify under criteria established by the American Psychiatric Association.
- If this estimate were expanded to include sub-clinical syndromes such as burn-out, demoralization, disengagement and excessive substance abuse, the losses could be three times this conservative estimate – or \$33B/yr.
- This \$33B estimate does not include costs related to health care or social service systems, costs transferred from the workplace to these systems or employer costs originating from medical conditions triggered by factors outside the workplace.
- *These estimates were produced by a committee composed of Ash Bender, MD, Jane Brenneman Gibson, William Gnam, MD, Martin Shain, S.J.D. (chair), Maurice Siu, MD and Helen Suurvali BA., November 14, 2002.*

#### **Health Canada**

The Population and Public Health Branch of Health Canada produced a report called “The Economic Burden of Mental Health Problems in Canada” – 2001. This report covered only “depression and distress.”

#### **Principal findings:**

- Costs of treatment of diagnosed depression and distress \$ 6.3B/yr
- Costs of lost productivity due to depression and distress \$ 8.1B/yr
- **Total** **\$14.4B/yr**



<b>Within the treatment number:</b>	<b>\$B/yr</b>
• Medications	.6
• Physicians	.9
• Hospitals	3.9
• Other institutions	.9
• Non-publicly insured mental health services	.3
• <b>Total</b>	<b>6.3</b>

<b>Within the productivity number:</b>	
• Short-term disability costs of	6.0
• Long-term disability costs of	1.7
• Costs of early death	.4
• <b>Total productivity costs</b>	<b>8.1</b>

**The Health Canada study excluded and the Roundtable study included:**

- Sub-threshold numbers such as burn-out
- Substance abuse
- Anxiety disorders

**The Health Canada report says that:**

- “The upshot of all these limitations is that the estimates presented in this paper are quite conservative.
- “We can thus conclude with confidence that the economic burden of mental health problems – both medically-treated and not – is \$14.4B annually – at a minimum.”

**Comparing these reports:**

Productivity losses due to clinically-recognizable medical conditions:

- Roundtable estimate - \$11.1B/yr (depression, anxiety disorders, substance abuse)
- Health Canada estimate - \$ 8.1B/yr (depression, distress)

Treatment costs:

- Roundtable estimate n/a
- Health Canada estimate \$6.3B/yr

Presenteeism costs

- Roundtable estimate \$22B/yr (\$11.1+\$22B=\$33.1B)
- Health Canada n/a

## **EPILOGUE**

The challenge of bearing a beatable foe means creating a world where the acceptance and treatment of mental illnesses are routine not rare, a world where the incidence of mental disability is rare not routine.

A world that feels less worried and hurried because it is. A world where the struggle to juggle seems manageable, where we have enough time and space to do routine things routinely.

A world where suicide is less common, where the eyes of a despairing child never – but never – close on tomorrow because she has lost hope today.

A world where 12 year old kids are not medically anxious but appropriately care-free, where the “second hand smoke” of toxic stress in the adult workplace is reduced at source.

A world where mental illness happens – as surely it will – but never at the cost of human dignity. This is a world that can happen if we are brave enough and wise enough to see things as they might be.

Ask why not – why not a world like that?