



330 University Avenue, Suite 400, Toronto, Ontario M5G 1R8
Phone: 416 552-5937 or bill.wilkerson@gwl.ca
www.mentalhealthroundtable.ca

**Keynote Address by
Bill Wilkerson, Co-founder, Chairman and CEO
Global Business and Economic Roundtable on Addiction and Mental Health
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*This text is accompanied by appendices which provide detail on proposals herein.
(This speech was delivered to a capacity audience of 1,100 people.)*

Wilkerson is General Chairman of the US/Canada Forum on Mental Health and Productivity. In 2007, he was named Founding Fellow of the University of British Columbia Institute for Mental Health and Special Adviser (Neuroeconomics) to the Scientific Director, Douglas Institute for Mental Health (McGill University)

I am here to talk about mental health and productivity in the workplace of the 21st century. Pretty lofty sounding speech title. Why should you listen? Why should you care?

The answers to these questions won't be found in the workplace. More likely, you will find the reason for caring about this issue in the schools, playgrounds, malls and hockey rinks. The places kids are. Because our children are the reason we should care.

Unless we understand the issues associated with mental health and mental illness as they affect us – adults – co-workers- husbands and wives – how can we protect and promote the mental health of our kids?

I want you to understand this. The average age of onset of anxiety, depression and substance abuse is age 12, age 21 and age 18. Children, adolescents, young adults. These are the tomorrows of Canada. And this is the stake we have in the topic at hand.

Mental illnesses reach across the lifespan of Canadians.

For hundreds of years – for decades through the 20th century – and now in the early hours of the 21st century – mental illnesses have been passed from one generation to the next, from childhood to our adult years – mostly unchecked, mostly a source of shame.

Today, we see the effects of chronic stress flowing like dusty wind from home to work, from work into the community, across cyberspace and into the perceptions and perspectives we have of life and work.

Chronic stress can make people unhealthy between the ears and inside our chest. The functions of our brain and heart are connected, both influenced by chronic stress.

Kids are surrounded by adult stress. They see and sense it at school where the rates of disabling depression among teachers are higher than the national average. The workplace of teachers is so toxic it is virtually uninsurable.

Kids see and sense stress at home. Parents struggle to juggle. In over-organizing our kids, are we not trying to liberate ourselves? Spontaneity leaks from our life like the hole in a ship at sea because ‘time certainty’ in our personal lives like “cost certainty” at work are what we seek but never find.

It is said the advent of disease reflects the nature of our times. Perhaps the surge of chronic stress, the intensification of life, the commercialization of everything and breakdown of the family (Garfinkel and Goldbloom) help explain the advent of depression as a defining characteristic of the late 20th Century and early 21st.

If so, the price we’re paying for that is borne mostly by kids. The demographic of greatest vulnerability is 15-24 years of age.

The Government of Canada has proclaimed knee and hip replacements a national priority for health spending, but kids between 11 and 14 are killing themselves with tragic frequency. Is that not a national priority? Absurdly, it is not.

While we preen over the majesty of our universal health care system, it takes a lifetime for a six month old baby to see the infant psychiatrist at the famed Hospital for Sick Children in Toronto.

When employers and unions sedate their sense of responsibility with the bromides of workplace wellness, we draw a veil across the reality that in sheer numbers, mental illnesses are concentrated among men and women in their prime working years.

When executives and union leaders stay aloof from the facts of how much mental illness affect their own workplace and their own families, they ignore the economic costs of mental disorders which now exceed \$50B a year not including the costs of prescription drugs to treat these conditions outside hospitals.

One year ago this month, Prime Minister Harper became the first PM in Canadian history to stand up on behalf of those Canadians who live with mental illness. I credit him for doing that.

It's funny, though, how this kind of thing is perceived. Most people would agree that Mr. Harper deserves a lot of credit for launching the Mental Health Commission of Canada. But the ones I talk also are mystified why he would do so.

The assumption being there's no political gain in taking this kind of stand. I beg to disagree. If I asked for a show of hands in this room as to how many of us are living with mental illness, have had a family experience, know a co-worker – every hand would go up.

In this room alone, that's a lot of hands to mark an X beside the name of a politician who would stand up and speak out – honestly – in the name of hope and support for those living with mental illness.

Canada's Health Minister Tony Clement spoke out forcefully for mental health at a Roundtable event last November.

Ontario's Minister of Health, I'm told, wants to make mental health a priority. In British Columbia, the Premier of that province matched a private research gift of \$10M dollar-for-dollar to launch the UBC Institute for Mental Health.

The Federal Deputy Minister of Health is a member of the board of directors of the Mental Health Commission of Canada and I recently recorded consensus among senior deputies that it is time for the Canadian Government to deal with mental health in its own workforce and workplace. I am very hopeful about this.

Just as I am about the awakening to this issue among other major employers and Canada's top insurance companies – for example –

Canada Post Corporation has made mental health its charitable cause of choice by a vote of its employees. President and CEO Moya Greene is a major advocate for mental health.

Financial Service companies are taking mental health initiatives and special recognition of this was accorded Coast Capital Savings of Vancouver in Boston last November by the world's leading private mental health research funding charity, NARSAD.

Energy and real estate companies, manufacturing firms, steel makers, government agencies and, in a grassroots efforts, federal employees are promoting mental health in the workplace.

Meanwhile, Great-West Life Assurance Company has demonstrated remarkable leadership – creating the Great West Life Centre for Mental Health in the Workplace – funding research and critical knowledge transfers.

The Great-West Life Innovation Fund is supporting clinical innovations to improve mental health care in communities across Canada – this, in partnership with the Canadian Psychiatric Association. A wonderful and needed initiative.

At the same time, the Roundtable benefits greatly from GWL's commitment to mental health – both financially and with office space in Toronto. And with no strings attached.

About one in four Canadians who need mental health care actually get it and only 24% of those receive evidence-based, guideline-concordant medically necessary (physician) care, according to the past president of the Canadian Psychiatric Association, Dr. Don Milliken of Vancouver.

Canada is, of course, not alone in dealing with the rising rates of disability linked to mental health problems and depression in particular. In this country, and in the US, these conditions represent upwards of 30-40% of all disability insurance claims.

In the United Kingdom, there are now more people –one million – drawing incapacity benefits due to mental illness than there are unemployed (900,000). This means mental health and mental illness are social problem Number One in Great Britain.

In Europe, mental health costs now represent about 4% of the total gross domestic product of the European Community. A major strategy focussed on mental health in the work place of Europe has just been published. I am reviewing it.

Last year, the Roundtable launched the US/Canada Forum on Mental Health and Productivity to stimulate greater cooperation and leadership among our corporate and research leaders to accelerate breakthrough research in mental health.

Three of four of these events have been held with the active support of our respective Ambassadors and Consuls-General as well as the participation of the top scientific figures and senior business executives from both countries.

One outcome is most unique. The firm of Cushman & Wakefield LePage Inc. has agreed to test among its own employees in Canada and the United States an information package to help working parents become more vigilant about the mental health of their children.

This brings me back to my earlier point.

The Roundtable's own guidelines for working parents to prevent teenage suicide start by urging parents to disabuse ourselves of the mythology, fear and ignorance which often surrounds this issue.

We warn parents – bluntly and factually – that if we wallow in ignorance, incompetence or cynicism about mental health and mental illness – because that's how we've grown up and that's how it's been – our kids' lives may be endangered.

And, when the facts are so vividly different, how could we be so clueless as to entertain the notion that mental illness is invisible, that it is a function of weak character, and that it is fixed by picking up our boot straps.

I serve on a committee for peer support of those members of the Canadian Forces who suffer 'operational stress injuries' – PTSD – and depression. At our committee meetings, around the table are decorated war and peacekeeping veterans trained in peer support.

They have much in common. Being wounded and injured in action. Loving their comrades and putting their lives on the line for country and duty. A pretty good package. But they also suffer mental illness.

This has inspired me – allowed me – to make this point wherever I go. Mental illness, clearly, is not a condition of the weak. It is a condition of the brave.

Research tells us time and again that those who suffer mental illness in the workforce try to work through it – year after year – not knowing what they have – afraid to tell anybody – including their spouse – 70% of them bearing this burden since childhood –

And, on top of that, most of those employees using anti-depressant medication have upwards of 12 years of continuous service with the same employer.

Clearly, mental illness is not a condition of the self-indulged. It is a condition of the hard-working and working wounded.

Mental illnesses. Zillions of them, right? Well, maybe lots of different brands and labels but for benefit managers and trustees, here's the scoop. Let me refer to my virtual chart.

BILL'S CHART

Blue bar represents 95% of the mental illnesses that are diagnosed in this country every year – that's depression (including bipolar disorder), anxiety and substance abuse.

Red bar represents the other 5% -- prominently schizophrenia. Each of these affects less than 2% of the population.

Yellow bar shows depression as the most common form of mental illness in the workforce and Green bar shows the other one, anxiety. These often go together.

Purple bar demonstrates that employees using antidepressant medication through group drug plans concurrently take medications for pain, hypertension and stomach ailments anywhere from 70 to 500% more than the plan average.

Black bar shows that mental disorders represent 49% of all the workdays that full-time workers in Canada take off due to illness.

By 2020, mental disorders will account for 15% of the entire global burden of disease and depression will disable more people than AIDS, war and traffic accidents combined.

These conditions are chronic. But also, treatable and beatable in most cases. Treatment is simply not available in nearly enough cases. One reason is a lot of us don't really understand what these illnesses are and are not. Let me give you my 'take.'

Mental illness is essentially not mental at all. It has physical properties.

Mental illness is not just a mood disorder like depression – it is a heart problem like depression. Mental illness is not just an anxiety problem, it is a breathing problem, a blood problem, it suppresses our immune system and amplifies chronic pain.

That's a lot more than a bad mood, or worrying too much. We trivialize depression when we call it a mood disorder and that term is commonly accepted in medical circles. That's like saying a heart attack is just a chest pain.

In fact, depression and heart disease are linked and there is evidence that those suffering cardiovascular disease can benefit from routine screenings for depression and this is an opportunity for benefit plan managers to push for this practice.

Among those Canadians recovering from one heart attack, depression increases by 500% the risks of a second heart attack inside six months of the first that proves fatal.

Studies have shown that anywhere from 20% to 50% of the population with cardiovascular disease suffer from depression. Not only is depression coincident with heart disease, it contributes independently to the worsening of that condition.

The heart of a depressed person never sleeps. Heart rate variability over the course of 24 hours is reduced. The heart is abnormally stimulated, it works harder, longer and becomes more vulnerable to ventricular arrhythmias, the leading cause of heart attack.

In 75% of the LTD cases of one of Canada's largest insurance companies, depression stands out as a secondary diagnosis regardless of the original disabling injury or illness. The implications of this are significant.

For one thing, as a secondary diagnosis, depression may well be the primary reason that your LTD client is not getting back to work – for reasons which seem to elude the medical or case management team.

In my estimate, screening for depression during the course of disability leave – whatever the primary cause – a burn, a heart attack – should become standard procedure. There is powerful clinical and scientific evidence for this.

A study conducted by Dr. Ron Kessler of Harvard University – routine screening for depression among all employees – like a flu shot – can be a preventative measure with a real financial upside for employers, insurers and benefit trusts alike.

Earlier, I said mental illnesses reach across the lifespan. The World Health Organization estimates that 40% of Canadians suffer mental illness in their lifetime, 25% in any given year, 10% on any given day, and five per cent any given moment.

The face of mental illness is mostly young. Depression is present in 90% of suicides. And suicide is now the leading cause of violent death in the world. But depression is deadly in other ways.

In Canada, depression is the fastest growing source of workplace disability and antidepressant medication is leading the charts in group drug use.

There are medical treatment guidelines for major mental illnesses but most physicians don't consult them. There is no coherent mental health care system in Canada or the United States. Transformational efforts are underway in both countries.

As health benefit trustees, you have a fiduciary responsibility to defend interests of your clients. I encourage you to defend them against the effects of publicly-funded medical care that fails them egregiously.

I do not suggest we privatize publicly-funded mental health care services. I do believe that your industry must challenge the provinces to deliver better care – better by a long shot.

For employers – whatever one's mandate, purpose, product or service – mental health in the workforce is a complex economic, moral and basic operating issue with financial meaning and operational implications.

Employers of every stripe and type have an obligation to support proactively the mental health of their own employees.

No single factor can be cited as the stand-alone cause of the symptoms of mental illness. There are genetic and environmental influences, and life's experience has an effect. But in combination, or alone, none of these explains why these conditions happen.

That said, there is a consensus that the kind of slow-building, long-lasting job stress evident in the workplace - otherwise known as chronic job stress – is a risk factor for pre-medical conditions such as burn-out and the medical condition known as depression.

Chronic stress is part of the environment and while we hear much about climate change – the kind Al Gore talks about – there are other kinds we should consider as well: social climate change that intensifies life, creates greater densities of distraction and pressure at home and work.

This kind of climate change – social climate change – won't melt the polar ice cap, but it can melt human resilience, compromise our immune system, increase the risk of depression which increases the risk of heart attack and stroke.

Researchers at Johns Hopkins University earlier this year concluded that by treating depression, we may be preventing stroke.

Social climate change is not the drama – and thunder – of a collapsing ice berg – it is the drip, drip, drip of everyday stress at work and home – perpetuated uncertainty and tension, job ambiguity and insecurity.

A decade ago, the late Peter Drucker forecast an extended transition from the industrial to a knowledge economy. He said it would take 20 years. It's taken half that.

The acceleration was provided by Moore's Law, personal computers giving way to wireless methods of computing, communicating and living with information. The pace of everything at work, home and in-between accelerated.

The struggle to juggle home and work obligations became the anthem of our times and we found ourselves landing in a new world where emails proliferated.

And the Blackberry was born and, you know, if Adam had picked this blackberry before that apple, he might not even have noticed Eve and Original Sin would never have happened.

For ten years I have been calling for our liberation from email enslavement. Now I say we need a blackberry ceasefire. (*Applause, pause*)

Just as we need relief from a cluster of workplace practices cultivated by managers influenced by the email culture.

With apologies to David Letterman, let me give you my top ten list of management practices now driving us crazy:

1. Treadmill effect. Got that done, get this done.
2. Lots of responsibility, not much discretion
3. Too much work, not enough resources? Join the club.

4. Got something to say? Email me.
5. What's the priority? Everything.
6. Not sure what's expected of you? So what's your point.
7. Job fulfillment? What's that? Besides, be glad you even have a job.
8. Skills and job don't match-up? Not what you were hired to do? Too bad.
9. That's not fair, doesn't make sense? Is it supposed to?
10. Turned your cell phone off? Who told you to do that?

Job and home stress become synergistic when workplace stress intensifies near the close of the workday and is taken home. This poses a greater risk to the cardiac health of people than smoking (IWH). 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 arthritis and trigger depression.
- Boosts our heart rate, blood pressure, breathing and blood flow to our muscles. OK for limited periods. But not continuously.
- Cause accidents on the job. Chronic stress fuels and feeds off sleep deprivation and lost concentration.

Unhealthy stress has many faces – we see them everyday – growing irritability and impatience, reacting as if there was ‘no end in sight’ even to routine requests for information, wincing at new ideas. (Who needs another idea?)

Since the Roundtable first started in 1997-98, we have argued for investments in the mental health of the workforce on sound business and economic grounds. We make this case nose to nose not heart to heart.

In both Canada and the United States, benefit plans bear the bulk of the costs of treating mental disorders in the work force through drug and talk therapies, case management and salary continuance programs.

And I submit to you that drug benefit plans are inherently compromised when big gaps exist in the access to and calibre of care provided by medical doctors who anchor the treatment and recovery process.

Certainly a “systems” approach is called for and we propose the design of a national workplace mental health system which unifies but does not structurally integrate publicly-funded physician services and privately funded supplementary health services.

The Roundtable's comprehensive Business and Economic Plan for Mental Health and Productivity, sets out the elements of such a system which also embodies executive leadership and sound managerial practices in the workplace. We have developed guidelines to facilitate this at four levels:

First, CEO (or equivalent) leadership to ‘galvanize’ the organization around the principles of openness and inclusion in discussing and understanding mental illness and their effect on all of us.

Second, human resource management practices to sort out what and where the barriers are in the workplace which confound the return to work by employees on sick leave due to mental illness.

Third, a CFO framework for mental health and productivity based on the premise that CEO leadership is severely handicapped without CFO engagement and informed participation in the benefits and disability management process.

Driving need for CFO engagement is:

- The frequency and cost of depression / anxiety / relate claims among their employees is increasing.
- Over 10% of general drug plan costs are for mental illness drugs and over 21% of all drug claims are to treat mental illness.
- When medical conditions co-occur with mental illness, specifically depression, total pharmacy costs related to mental illness increase by a factor of three.
- The number of mental illness-related pharmacy claims increased 5.4% from 2004 to 2005, as compared to a total pharmacy claims increase of 3.8%.

Mental illness can be linked to financial measures and other corporate costs, including:

- Decreased revenues – caused by lost productivity, absenteeism, presenteeism
- Increased expenses – caused by higher benefit costs, temporary labour, and greater need for recruitment and training.
- Long-term impact on customer / supplier / co-worker relationships – Interpersonal problems due to mental illness, including poor working relationships, withdrawal, communication conflicts.
- Unfunded liabilities – corporations that do not track or manage mental health issues in their workplace may have unfunded or under-funded liabilities, a sensitive exposure for publicly-traded companies.

In today’s environment, a CFO is responsible for profitability, reporting, risk and internal controls, performance management and resource allocation. Mental health issues affect each of these.

Fourth, we propose a workplace model of shared care and so let's consider why a system of this nature is called for:

1. The labour force constitutes the demographic of greatest vulnerability to the most common and frequently most serious forms of mental illness – major and moderate depression and the various forms of anxiety including generalized anxiety disorder, panic attacks and PTSD.
2. The workplace is where most adults spend most of their waking hours. As such, the workplace becomes a uniquely-fertile ground for the prevention of the disabling effects of these conditions.
3. The bulk of the costs for treating these conditions are borne not by the public treasury through physician and hospital services, but through employer benefit plans – prescription drugs, case management, other ‘non-insured’ (from a public perspective) services including psychologists and lost productivity.

We propose a ‘Workplace Model of Shared Care’ to provide for 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).

This consultation would create an organized, front-end method for ‘colleagues’ to:

- Review and affirm the diagnosis and treatment plan prescribed by the treating physician.
- Inform employers and insurers of prognosis without disclosing diagnostic data. (Prognosis yes – diagnosis no)
- Provide expert on-going management of the medical portion of the employee’s overall recovery plan.

The consulting physician will have specialist knowledge in psychiatry and occupational health and will be bound – as a physician – to the recovery interests of the employee-patient.

It is possible that my suggestion to co-fund physician services through public and private insurance to provide adequate medical mental health care for employees will raise the spectre of ‘privatizing’ our universal health care system.

What I am proposing is permissible under the Canada Health Act. Beyond that, the legitimate self-interest of employers, employees and benefit trusts demand that action be taken to improve the access and quality of “medically necessary” physician services to treat mental illnesses.

It's fair to worry about the advent of two-tier health care in this country, but that kind of concern is a luxury when we talk about mental health. Right now, we have a **no-tier** system of mental health care in this country.

With respect to employer costs in funding consulting services, in my judgment, this will save money in the short and long-term alike.

Besides, employers are already spending considerable sums on the services of consulting physicians for regressive purposes. In this I refer to the practice of independent medical evaluations as (essentially) a dispute resolution instrument.

The costs of independent medical evaluations and employee replacement savings can be re-routed to this combined or unified system of "shared care" in the workplace.

Benefit providers should 'kick-in' financial incentives through premium reductions or administrative discounts to help sustain the viability of the new system.

The IME concept is obsolete anyway.

- First, it is downstream, after-the-fact and does nothing to produce actual treatment capacity in the health care system.
- Second, IME are adversarial, in nature, forcing rebuttals by treating physicians and leaving insurers or employers to sort out the deadlock.
- Most important, the practice poses an ethical dilemma stemmed from the medical examination of a Canadian for the purposes of a 3rd party.

Renditions of such as this unified system are already being practiced in isolated but encouraging scenarios. A network of psychiatrists operating under the name of Medaca and led by Dr. Richard Guscott of Hamilton, Ontario, is a case in point.

Dr. Guscott is having extraordinary results in preventing migration of employees from short to long-term disability and accelerating recovery and return to work. This, among cases referred by insurance companies represented in this room.

Also, a pilot project in Guelph, Ontario, west of Toronto, at the Homewood Health Centre involves insurer referrals. Employees on disability leave receive dedicated outpatient and inpatient care aimed squarely at functional recovery and return to work.

My own vision for this new approach is to render the workplace to a venue of prevention:

- Prevention of the disabling effects of depression –
- Prevention of symptom migration from short to long-term –
- Prevention of relapse and excessive work days lost and, eventually –
- Prevention of work days lost altogether. This is a plausible goal, and
- Prevention of unnecessary and unproductive employer costs.

In support of such a vision, we propose these plausible goals:

1. Stabilizing and reducing the incidence of disabilities linked to depression from the current 35-40% of the total claims experience to 15-20% in three to five years.
2. Achieving 90+% success rates in the referral, diagnosis and treatment of depression and anxiety inside the average 40-day duration of an episode of depression and reducing that duration period to 27 days.

The Medaca experience can give us a baseline for this purpose.

3. Preventing the onset of depression as a secondary diagnosis among employees off work more than six months as result of ‘unrelated’ illnesses and injuries. *Depression appears as a secondary diagnosis in 75% of the LTD cases of one major insurer.*
4. Rendering LTD virtually obsolete in the treatment of depression and anxiety disorders. Higher success rates in the diagnosis and treatment of these conditions will have this effect.

Through these goals we will:

- Promote heightened awareness of the risks of depression when it co-occurs with other chronic illnesses including heart disease.
- Develop, test and disseminate mental health guidelines among working parents. We began this process at the Roundtable’s 3rd US/Canada Forum on Mental Health and Productivity in Boston on May 29th.
- Prevent ‘relapse’ as a deal-breaker in the return to work process. This is critical.

The System I am proposing today will recognize that while no one risk factor – genetics, chronic stress, biology – is a stand-alone cause of mental illness, a simple truth prevails: toxic work environments are bad, and healthy work environments are good.

This proposed Workplace Mental Health System will specifically help employers, employees, including unions as employers in their own right to manage effectively six critical transitions in the development and onset of disabling mental disorders:

1. Performance decline
2. Time on and off work without appropriate care
3. Onset of disability and disability leave
4. Absence from work and isolation at home
5. Recovery and clearance to return to work
6. Process of actually getting back on the job

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

In summary, the concept of a workplace mental health system based on shared care principles will:

One: support primary care physicians to improve the diagnosis, treatment and management of mental illnesses in the workforce.

Two: promote early diagnosis and access to care in those cases of depression co-occurring with other chronic illnesses including cardiovascular disease.

Three: prevent the migration of burn-out-to depression and depression from short-to-long-term disability, re-energizing the recovery and return to work process as needed during the STD period.

Four: reduce the incidence and the risk of depression as a secondary diagnosis among cases of disability due to other causes including injuries and illness.

Five: create a greater critical mass of success in the treatment of mental disorders on the basis of unifying the medical model and on-going case management.

Let me return to earlier themes:

- Mental illness is a burden of the brave, the young and the hardworking.
- Mental illness is a physical disease with psychological implications and effects. Just as a heart attack is more than a chest pain, depression is more than a mood disorder.
- To rein-in rising rates of mental disabilities, we need the medical model to work right, we need adequate social and peer support for employees recovering at home and on the job alike.

And final thoughts.

Happiness is not the opposite of despair. Hope is.

Mental health is not the opposite of mental illness. Hope is.

Like George Bernard Shaw, let us dare to see the world not as it is – only to ask why – but to see the world as it might one day be and say why not.

Why not a world where mental illness is part of the human experience and is recognized as such?

Why not a world where it is unthinkable that a young child would shut her eyes today because she has lot hope in tomorrow.

Why not a world where mental illness happens, but never at the cost of human dignity.

Why not a world where love and care for those who live with mental illness are routine not rare and where suffering alone is rare not routine.

Why not a world like that.

God Bless You

ATTACHMENT 1
The Rights and Requirements of the Various Players in the Prevention and Management of Disabilities Associated with Mental Illness

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.

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:

- Use Guideline-concordant and DSM-IV criteria for the diagnosis and treatment of patients. (*'Stress' is not adequately-precise as a diagnosis for disability management or medical purposes.*)
- 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 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.
- 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

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.

ATTACHMENT 2 CFO Framework for Mental Health and Productivity

Corporate Canada continues to under invest in mental health. **The single most important issue is the lack of adequate measurement of the costs of mental illness by individual companies.**

The Roundtable's CFO Framework for Mental Health and Productivity has been introduced by the Roundtable to build a microeconomic, CFO-proofed business case for investing in mental health and measuring that investment.

Chief executives believe that their own leadership is essential to addressing mental health in the workplace, according to the Roundtable's CEO's survey. The CFO Framework is based on the premise that without CFO buy-in, the chances of CEO leadership are less.

Reporting risk – risks associated with inadequately mental health programs and the impact of poor mental health on customer / supplier / co-worker

Finance is no longer just transactional reporting. As a result, finance executives bring a discipline to data collection and analysis and are able to measure progress toward achieving strategic and business plans, including the impact on ROI. To reduce the rate of mental disabilities and their associated costs requires proper measurement of programs aimed at promoting mental health. The framework – while simple in design – embraces a range of complexity that cannot be downplayed for the sake of recruiting adherents.

The framework sets out specific steps to tackle these cost issues.

Step One: Establish Baseline Costs of Mental Health

Measure the following metrics:

- Extended / Group Health Care Costs
 - Drug claims by major drug category per active employee
 - Mental illness-related drug claims as a percentage of total drug claims per covered active employee
 - Number of mental illness-related drug claims + those where a second drug is also being claimed for another ailment (co-morbidity)
- Employee Assistance Costs
 - Number of employees using the program for mental illness-related disorders
 - Utilization as a percentage of total program users
 - Number of cases referred to community-based treatment programs
 - Number of high risk mental illness cases

Further:

- absenteeism Costs
 - Lost workdays (paid and unpaid) per active employee
 - Lost workdays (paid and unpaid) for mental illness-related disorders
 - As a percentage of total lost workdays per active employee
 - Absenteeism rates by type of ailment / disorder

- Average duration of absenteeism
- Replacement Worker Costs
 - Total cost of replacement workers
 - As a percentage of total active payroll costs
 - Number of replacement workers (fulltime equivalent) used per reporting period
 - Employee turnover rates relating to mental health disorders
- Short and Long Term Disability Costs
 - Number of short term disability claims related to mental health disorders
 - As a percentage of total short term disability claims
 - Number of long term disability claims related to mental health disorders
 - As a percentage of total long term disability claims
 - Average duration of short / long term disability claims relating to mental health disorders
 - Cost per claim of short and long term mental health related disorders
- Presenteeism Costs
 - Actual output per worker as a percentage of targeted output per worker
 - Quality of output (e.g. defect rates, customer feedback, etc.)
 - Actual vs. targeted worker output percentage times the total active payroll cost
- Other Useful Financial Metrics
 - Health related costs as a percentage of payroll
 - Productive capacity measures

Step Two: Evaluate, Construct and Strengthen Programs

- Evaluate Programs for:
 - Employee access to:
 - Mental health information
 - Adequately trained clinicians
 - Workplace screening for depression
 - Other Useful Financial Metrics
 - Benefits related to mental health
 - Integration of mental health programs with other programs, including EAP, disease management and disability provider
 - Benefits consultant
 - Determine if up to date on latest mental health data
 - Determine how consultant evaluates the mental health services of various vendors
- Construct Your Program
 - Conduct an employee awareness program about depression, anxiety and substance abuse

- Educate managers about mental illnesses
- Offer mental health screening
- Strengthen Your Program
 - Integrate all healthcare services
 - Collaborate with other employers and stakeholders; adopt a proactive approach
 - Retain employee assistance program (EAP) if your company does not have one

Step Three: Establish Accountability

- Include specific mental health-related goals / objectives in the annual strategic planning and budget process for each department
 - Reduce short term disability duration with a focus on co-morbid depression and physical illness
 - Reduce mental disability rates as a percentage of total disability experience inside 24 months
 - Reduce by 20% the ratio of mental illness as a percentage of all disability inside five years
 - Forge a long term disability prevention strategy to reduce the use / need for LTD
- Using surveys, evaluate qualitative measures of productive capacity
 - Employee engagement and performance outcomes
 - Customer satisfaction and improved relationships

Step Four: Set Performance Initiatives and Reward Appropriately

- Establish positive, not punitive, incentives
 - For employees to actively address workplace issues that contribute to stress and mental health issues
 - Achievement of metrics must depend on participation by all departments so success of the improved metrics benefits the entire organization
 - Include metrics in the determination of salary reviews and bonus calculations

Step Five: Benchmark and Report

- Benchmark annual costs and benefits of initiatives addressing mental health issues
 - Compare against the baseline costs and benefits
 - Compare, where possible, against external benchmarks
- Report results to the board

Case Study

The benefits of an aggressive measurement and treatment program for mental illness, in this case depression, are evidenced by one outstanding case study.

JP Morgan Chase benchmarked depression in the workplace, introduced strategies to address workplace mental health and saw impressive results:

The company discovered:

- Of the 60% of employees covered by the company's pharmacy plan, antidepressants currently rank third in spending (behind antihypertensive and antihyperlipidemic medications)
- 24% of participants in the corporate health risk assessment program had scores indicating the need for mental health follow-up
- Since 1995, 6% compound annual growth rate in psychiatric disability (v. 1% per year growth in medical-surgical disability)
- Mental health cases comprise 10-12% of all disability cases if only primary diagnoses are considered

The company implemented a number of strategies:

- Established a dialogue with all treating professionals in the corporate medical plan
- When a psychiatrist is not available, primary care physicians work in concert with a mental health provider
- EAP plays an integrated role in disability management by facilitating return-to-work interventions with employees and management
 - Helps separate true disability issues from workplace issues
- Established program allowing returning-to-work employees to work part-time
- Introduced training for managers
 - to recognize depression and anxiety disorders
 - how to refer employee to EAP
- Increased compliance of anti-depressant medication

Results:

- Reduced recidivism rate to 9% in 2003 from 17% in 1989
- Short term disability reduced by 1 full week for employees in part-time work program
- Target savings of \$1M for future improved adherence to antidepressants

In my judgment, the growing acceptance and advancement of mental health in the military and police communities will contribute significantly to de-stigmatizing mental illness in civilian Canada.

The development of national systems of integrated care for mental health problems by these public institutions is an example for civilian Canada to follow.

Refer: bill.wilkerson@gwl.ca or 416 552-5937