

Guest Resident at Great-West Life Assurance Company

200 King Street West, Suite 1400, Toronto, ON M5H

3T4

*Affiliated with the Centre for
Addiction and Mental Health*

Phone: 416 343-5337 or bill.wilkerson@gwl.ca
www.mentalhealthroundtable.ca

Text of Presentation

by

Bill Wilkerson

Co-Founder and CEO

Global Business and Economic Roundtable on Addiction and Mental Health

To

**Canadian International Development Agency (CIDA)
Africa and Middle East Branch**

**Four Points Sheraton, Notre-Dame Room
35 Laurier Street
Gatineau, QC**

January 31, 2005

Text of Presentation

by
Bill Wilkerson
Co-Founder and CEO
Global Business and Economic Roundtable on Addiction and Mental Health
To
Canadian International Development Agency (CIDA)
Africa and Middle East Branch

Four Points Sheraton, Notre-Dame Room
35 Laurier Street
Gatineau, QC
January 31, 2005

Urgent Necessity.

In 1996, the Harvard School of Public Health found that disability, not life expectancy, was the top health issue of our times – and that depression is the leading source of disability which makes it a business issue.

In fact, depression and heart disease are emerging as the leading sources of work years lost in the global economy. Beyond their economic impact, these conditions are medically and physically linked.

To rein in these trends, business can build on substantial progress that has been made in the past 20 years in physical health and safety at the workplace.

Unmanaged Costs of Short-Term Employee Absence

Many Canadian employers neglect the costs or causes of short-term absences among employees. As a result, all too often, they neither identify nor deal with the underlying reasons for the employee's absence from work such as illness or stress-induced downtime.

Less than a third describe their return-to-work and case management programs as effective.

Only one-in-five communicate with their employees about disability management.

Most resist “innovative approaches” and settle for mediocre return-to-work results.

In this light, employers are well-advised to re-examine their approach to the management of mental disabilities.

The Stress of Work and Life

Workplace stress is a hot topic. It is important to have a clear picture of the distinctions between stress which motivates us to positive action and stress which saps our energy and produces dysfunction – even ill health.

Stress is not a state. It is more like a process, a set of variables associated with how we react to circumstances at work or in life. It is very much an individual experience.

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 invade our well-being.

The 21st century workplace is the product of the frantic 90s where and when the struggle to juggle time and obligations – at work and home – became the defining challenge of our times.

There is evidence that the distinction between disruptive stress and constructive stress is the presence or absence of hope. There seem to be several workplace sources of this kind of stress:

Where and when the skills of the individual and the expectations they face are not aligned with the demands of the job or the resources available to do it.

Where and when workplace policies and practices conflict with the individual's sense of fairness.

Where and when workplace stress intensifies at the margin of the work day and is taken home. According to the Institute of Health and Work, this poses a greater risk to the cardiac health of people than smoking.

Where and when the “struggle to juggle” home and work duties never lets up. Job and home stress are synergistic.

Chronic Stress

When it becomes chronic, stress can override our natural defenses 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.

All human beings have a built-in stress alert system. When that system kicks-in, a lot of things start to happen.

The brain orders our adrenal glands to release hormones. These boost our heart rate, blood pressure, breathing and blood flow to our muscles. This is OK from time to time. And for limited periods.

But as a continuous diet, stress creates conditions where bacteria, viruses and tumors flourish, where blood clotting is more likely. Chronic stress stimulates the excessive release of hormones in our system and this promotes the accumulation of abdominal fat.

Stress is a risk to the health of employees and can cause accidents on the job which is why energy companies and nuclear producers are turning to the subject. Stress and depression fuel/feed off sleep deprivation and lost concentration.

The Roundtable has also identified 10 faces of problem stress among middle-managers.

Growing irritability and impatience, “no end in sight” reactions to even routine requests for information.

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.

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.

Treating the concerns of others about workload and deadlines with contempt and “join the club” sarcasm.

Displaying frustration with one’s own boss in the presence of others and leaving angry voicemails after regular business hours.

Stretching the workday at both ends, calling in sick a lot, persistently late for meetings.

“Working at home” to avoid the negative energy of the office;

Limiting eye contact with others except to “react,” finding it painful to smile openly, your cheeks heavy, a fuzzy feeling behind your eyes.

Finding small talk hateful. Tuning-out what others say. Missing deadlines, losing faith in yourself and others, resenting and even alienating customers.

Eventually, physical symptoms of pain and burning, breathing troubles, back

problems. Burn-out may migrate to a diagnosable and dangerous medical condition.

In the workplace, some employees are especially vulnerable to the health risks of chronic stress – among them:

Working women who are pregnant;

Employees returning to work from heart attack and stroke;

Employees living with chronic conditions such as asthma and diabetes.

In the frantic 90s, stress management is more than individual lifestyle, more than eating habits, exercise and meditation – it is also creating conditions and environments of work which inherently promote and protect human health.

The sustainable performance of organizations and the individuals working there is the goal that binds employer and employee in common cause. It is the proposition that underlies employee, health and safety.

Stress is a serious variable in achieving that objective and in light of that, CIBC CEO John Hunkin says job stress is the number one problem facing business today. If it is problem one, it must be job one.

Problem job stress can double, even triple the risks of worker disability associated with depression, anxiety, substance abuse, back pain, on-the-job injuries and infections.

The Roundtable estimates that:

Mental health problems are the primary and secondary issue in 60-65 per cent of disability insurance claims in Canada.

Statistics Canada reports that:

Healthcare costs are nearly 50 per cent greater for employees who report high stress and the Canadian Policy Research Networks estimates that stress-related absences cost employers nearly \$4.0 billion a year.

Leaders' Goals

The Roundtable's principal theme this year and next is corporate leadership in mental health. Chief and senior executives who participate in the Roundtable have pronounced "leadership" as the key element in preventing mental disability and promoting mental health in the labour force.

In this light, the Roadmap guides employers to four strategic business goals recently articulated by participants in the Roundtable's first-ever CEO Survey on Mental Health.

These goals are:

- Maintaining a productive workforce
- Recruiting and retaining the most talented personnel
- Maintaining high standards of customer service
- Remaining competitive and profitable in the long-term

Business executives are speaking out on this subject. Please consult "*In Their Own Words*" which appears as an attachment to this Roadmap.

Policy Aims

Like any road, this one will be more navigable with curbs and directional signs. To that end, we recommend a slate of five policy objectives which support the CEO's goals noted above. These fit nicely within a unified EHS strategy.

Portfolio approach: Incorporate 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. Consult the Roundtable's top ten list later in the Roadmap.

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 and a Roundtable Roadmap to Prevention will be developed as part of this series.

Gradual Return-to-work: Apply this concept universally to all forms of employee disability including those involving mental health problems. In doing so:

Employers do not need to know the nature of the diagnosis of the disabling illness that is involved in any given case. This information is private and confidential.

Employers do need to understand, support, and participate in a return-to-work plan which will inevitably involve customized adjustments in the content of the employee's job or hours of work in order to make the transition go smoothly.

Employers need to know that while the employee is coming back, he/she is not 100 per cent and gradual RTW is necessary to help the individual catch-up with things, get up to speed and build tolerance and endurance.

Facts

Facts are the foundation of effective disability management, especially so in the case of mental disability where a sticky residue of mythology and misinformation remains.

Get these facts about mental illness to your employees, executives, managers and supervisors and give them every opportunity – and the incentives – to use this information to the benefit of their families and themselves.

The numbers:

In one day, 10 to 15 per cent of Canadians experience a mental disorder.

In one year, the number is 20 to 25 per cent.

In one generation, 37 to 40 per cent.

Fewer than 20 per cent of those who need treatment actually get it.

And 70 per cent of these people are in the labor force.

The physical properties:

Depression and anxiety – by far the most common mental disorders – are not functions of character or weakness. These are physical conditions centred in the brain but affecting the whole body.

A U.S. court has ruled, for example, that bipolar disorder can be categorized a “physical condition” (Perez).

Depression is linked to other common chronic physical disorders such as diabetes,

hypertension, asthma, heart disease, or stroke.

Depression is linked to heart disease:

About 20 per cent of people who suffer heart attacks exhibit signs of clinical depression at the time. In fact, depression can dispose individuals with damaged hearts to arrhythmia, a cause of heart attack.

The Montreal Heart Institute found that depression quadruples the risk of cardiac death among patients admitted to their care for unstable angina and the U.S. National Center for Health Statistics reports “there is evidence to suggest that depression may cause stroke or other cardiovascular events.”

Cardiac patients suffering depression experience what experts call “decreased heart rate variability.” Which means the heart of a depressed person never sleeps.

Depression may increase blood clotting. In turn, this can impair the supply of blood and oxygen to the heart. A cause of heart attack.

The U.S. National Center for Health Statistics reports that “there is evidence to suggest that depression may cause stroke or other cardiovascular events.”

Chronic connections:

Those living with diabetes, epilepsy, thyroid problems, cardiovascular disease, digestive issues, liver disease, asthma are believed to be more vulnerable to depression.

Like these other physical conditions, depression and anxiety have major psychological implications and can affect perspective, concentration and sleep; handling time pressures, feedback, multiple-tasks and change.

Prime Working Years

A clear demographic is emerging. Men and women in their prime working years and valued employees with 10 to 15 years of service are uniquely vulnerable.

These demographics and the links of depression to chronic illnesses help employers and employees define priorities or ‘target audiences’ for education information about the risks of mental illness and the rewards of doing something about it early.

The functional effects of depression:

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.

The signs of group stress:

Disputes and disaffection.
Increased staff turnover.
Increased grievances and complaints.

The breeding ground of burn-out – a potential pathway to depression:

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.

It becomes clear that mental disability management involves more than treating a medical illness. It is – to a significant degree – a bread'n'butter management challenge.

In this light, the Roundtable has identified 10 management practices – or, in some cases, behaviours – which appear most likely to precipitate or aggravate mental health problems in the workforce.

Imposing unreasonable demands on subordinates and withholding information materially important to them in carrying out their jobs.

Refusing to give employees reasonable discretion over the day-to-day means and methods of their work.

Failing to credit or acknowledge their contributions and achievements.

Creating a treadmill at work – too much to do all at once all the time.

Creating perpetuated doubt, employees never sure what's happening around them.

Allowing mistrust to take root. Vicious office politics disrupt positive behavior.

Tolerating, even fostering unclear company direction and policies, job ambiguity and unclear expectations.

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.

Lack of two-way communication up and down the organization.

Managers rejecting, out of hand, an employee's concerns about workload.

This leads us to this conclusion:

Remedies are called for to eliminate and reduce the effects of these practices in the 21st century work force as a matter of good business and good health.

Return-to-Work (RTW) From Mental Illness

Once an employee is off work, a pro-active return to work process is essential and two immediate objectives stand-out:

Keep the lines of communication open between the employee and the work place. Isolation predicts and deepens depression. It prolongs disability.

Returning this employee to work full-time. This is the employee's wish and legal right. The employer's natural advantage and legal obligation.

Two precautions:

Like other chronic illnesses, coming back to work too soon, too fast, can impede the recovery from depressive disorders;

At the same time, the longer an employee is away from work – for any reason – the greater the risk of them never coming back. For example, after 12 weeks, 75 per cent return; after one year, 10 per cent; after two years, two per cent.

The purpose of mental disability management:

Make recovery and a gradual return to work mutually reinforcing.

In turn:

Employers can bridge these vital determinants by tracking, carefully – in cooperation with the employee and his or her physician – the pace and timing of the employee regaining his or her capacity to perform the functions of the job.

This is called return-to-function or functionality and, for the physician, one means of measuring the reduction of symptoms.

The disability management challenge:

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 and researchers at the Centre for Addiction and Mental Health find that seventy-five per cent of those who get the treatment they need do, in fact, successfully return to work.

But:

About 80 per cent of the estimated numbers of Canadians who experience mental ill health each year do not get the treatment they need when they need it.

As a result, high percentages of employees migrate from long to short-term disability, even lose their job – especially – sadly – young people.

Job-to-Job:

The predictors of depressive symptoms may vary among occupations;

Among factory workers, the predictors of depressive symptoms include minimal control over workload and excessive environmental noise.

Among white collar employees, the predictors are role ambiguity, lack of control over their work and a lack of support from co-workers.

Among teachers and the “caring professions” (including physicians and healthcare workers) job strain is a predictor of depressive symptoms.

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.

The Green Chart

The RTW from mental illness may involve well-established procedures used in other forms of disability – among them low back pain. But common to each is this tested edict: plan ahead.

A return-to-work process begins when the employee’s disability claim is approved and the leave period begins. At that time:

Open what we might call a Green Chart headlined by the stated goal of that employee returning-to-work fulltime – gradually – and anchored by the unification principles governing recovery, return-to-function and return-to-work.

The Green Chart will house key information that the employee’s physician needs in order to develop a clear picture of the implications of the disorder on the individual’s capacity to work. The physician needs to know:

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.

The Green Chart will also house information the employer needs to support the employee's recovery and return-to-work including –

Guided work-to-home and home-to-work communication between the employee and his or her supervisor and co-workers. This is absolutely vital.

And, information the employee needs to know in order to understand the RTW plan, to participate in building and believing in it.

Quarterback System

The concept of case management is a quarterbacked system already well-established in business in the form of workplace teams and process management. This concept is the key to a successful RTW process.

The quarterback is called a case manager. It is well-established that physicians prefer not to be the sole gate-keeper in the RTW process. Additional expertise is called for – ranging from the management of job and workplace pressures to occupational health.

One of the first steps the case manager takes is this: meeting with the employee and then contacting the employee's physician and discussing the nature of the medical imperatives governing the individual's recovery. This does not suggest the case manager garners access to the employee's medical file. Not at all.

The quarterback – or case manager – keeps the unification principles in sight throughout in order to ensure the recovery process is fully-protected – flowing gradually into an assessment of the employee's return to function and, gradually, return to work – full time.

The quarterback – or case manager – helps the physician, employer and employee identify those job issues that will influence the pace and timing of the “return” elements.

The Green Chart becomes the case manager's blueprint. A water color effect.

As such – green or blue – this device houses a written RTW plan. The Green Chart does not contain confidential medical information.

Let us emphasize this:

The RTW plan deals with returning-to-work full-time gradually without reference to diagnosis but with clear reference to modifications of job content or hours of work that may

be required to accommodate this.

And this:

The employer's duty to accommodate is clear. Managers and co-workers are the face of the employer in this matter. They implement this duty and represent the employer in doing so.

As a result, managers and co-workers must perform a constructive role in the RTW process and not doing so – whatever the employer's declared intent or policy – could expose the employer to a human rights violation.

Making Reasonable Accommodations

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 –

Like 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 RTW employees 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 which 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 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.

Re-Entry Interview

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 her or him. The assumption behind this: the employer has not filled the job permanently.

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.

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 RTW process.

The Duty of Unions

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.

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.

This is a matter of law.

Employees returning to work after an absence due to a mental disability such as 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.

Accountability and Incentives

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 co-workers – immediately aligned with the disabled employee – enough information – cleared by that employee in advance to understand how their action will affect the process of accommodation under law.

Further:

Accountability for the success of the RTW process should be vested – in significant measure – in the 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 for six months and counting.

Unilateral terminations (without cause) or downsizing of RTW employees within six months of their return can be viewed suspiciously.

Symptoms and Job Performance

The crossover between unrecognized symptoms of a mental disease and emerging performance and relationship problems on-the-job 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.

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.

In 2000, the Roundtable developed a 12-step business plan to defeat depression and anxiety

at work.

This will be updated this year in the form of a workplace Roadmap to Mental Health and Excellence in Canada.

We, in fact, with National Quality Institute, have designated 2005 “The Year for Mental Health and Excellence at Work.”

I will give you a preview.

Step One: CEO Briefing on Depression

Comprehensive briefing for the Deputy Ministers, department head or Chief Executive, et al on the impact of depression at work.

Galvanize the organization’s executives and managers to “get on top” of depression, et al.

Empower the CEO and his/her leadership team with information to set detection and financial targets associated with reducing the effects of depression inside the organization.

Step Two: Target Depression Financially

Annual targets to reduce the effects of depression at work through early detection, specifically: 35 to 50 per cent annual improvement in the combined rates of detection, diagnoses and proper treatment of current employees known to suffer this disease compared to the current rates of 6.25 per cent.

Target per employee annual savings of \$10,000 through prescription drug and wage replacement costs. Additional gains would be realized through productivity improvements, probably well in excess of the savings noted here.

Step Three: EAP and Group Health Plan Reforms

The Roundtable calls for:

Management training for managers/executives at all levels to play a fundamental role in the early identification of a troubled employee.

Written policies to support managers in this role to overcome the sensitivities of dealing with such matters, recognizing the very real concerns of privacy and personal department involved.

The redesign of present day EAP (employee assistance plans) and group health plans to target and reduce the effects of depression (and its comorbid partners, i.e., heart disease) at work.

Dramatic improvements on current low rates of employee utilization of EAPs (7 – 10 per cent) to 25-35 per cent, in order to help achieve the detection rate targets noted earlier.

Arming EAP professionals and medical directors with state of the art information on depression at work, et al.

Employee education and screening modules to increase early access through the workplace to appropriate care for depression.

Education and internal communication initiatives aimed specifically at awareness-building among managers to help them recognize and act on signs of depression in others. (We are not asking managers to diagnose medical conditions but to recognize the signs that something may be wrong.)

Specific education initiatives customized to top management. Their leadership is essential.

Establishing benchmarks for current depression rates in the company to found the detection improvement process. The findings can be stunning. For example:

Depression recently accounted for 40 per cent of all EAP referrals at one company in one year.

30 per cent of employees on one company survey indicated symptoms of depression.

And in a third case, a company found the running rate of depression at 17 per cent among women and nine per cent among men in one year.

Step Four: Dollar Value of Healthy Work Climates

Establish organizational and employee health as “twin priorities” among managers in business.

Survey employees to identify stress which threatens individual health.

Interrupt the treadmill effect plaguing employees with too many priorities and

too much to do at once.

Combat distrust, disrespect, autocratic management styles and too-repetitive tasks – all contribute to stress-related health problems.

Step Five: Email Enslavement

New protocols to reduce the “overload” frustration and aggravation associated with the exaggerated and random use of e-mails.

Studies to nail down the efficiencies of both emails and voice-mails in their current use.

Maximum use of e-mail filters.

“Restricted delivery” rules for e-mail, limiting messages to business-only purposes and in certain hours no access at all in order to reduce the overload crisis.

E-mail and voice mail culture training to reduce stress and overuse of this technology at the expense of human contact.

Step Six: Depression, Anxiety and Return-To-Work Strategies

Create disability management and return to work strategies which address the recovery issues associated with depression et al.

Introduce formal protocols into employee health programs setting out the specific rules for return-to-work planning around depression.

Establish modified work programs to facilitate the re-entry of employees recovering depression-based disability absence.

Step Seven: Knowing About the Physics of Depression

Education of managers, HR executives and health professionals on connections between depression and heart disease, stroke, immune system problems and other chronic physical disorders.

Step Eight: Inventory of Emotional Work Hazards

Create inventory of emotional work hazards which put the employee and

organizational health at risk. Develop an organizational action plan.

Confront and eliminate the practice of office politics. This malignant behavior as a predictor of absenteeism and mental distress among those subjected to it.

Train managers to stop wasting the time of their direct reports because of unclear expectations and confused priorities. It causes enormous stress.

Step Nine: Work / Life Strategies

Work / life imbalances depress the productivity of more than a third of the employee population in the U.S. Similar proportions exist in Canada.

Create policies to protect work/life balance among employees. The incentive: absences due to employee eldercare obligations run into the hundreds of millions of dollars a year.

Enact specific policies, including flexible work hours, home care services, workplace daycare and eldercare services.

Aim, via these policies to:

Reduce absenteeism

Attract / keep most talented people.

Step Ten: “Rule Out Rule”

A person suffering depression – often a top performer, loyal employee and good friend among job peers and supervisors alike – may exhibit behaviors that mimic bad or negative attitudes. But it is the symptoms of their disease and not their attitude toward the job which is confronting their co-workers and even customers.

Our failure to draw a distinction between illness and attitude (for want of a better phrase) can cost an employee their job and the company an otherwise valuable asset in which it has a significant investment.

But how can we tell the difference when work relationships are strained by that individual's failure to meet their obligations, proneness to anger, or inability to concentrate or communicate appropriately?

We recommend a new concept being introduced by the Roundtable called the “Rule Out Rule” in order to unmask the effects of depression in those cases where it mimics plain work failure.

In effect, we are suggesting:

When an employee is performing badly, especially where this contradicts past

performance, introduce the “Rule Out Rule” to rule out (or, as the case may be, rule in) health problems as the source of performance deterioration.

This process will be defined and published by the Roundtable in detail, but generally, it involves:

Training of supervisors, managers and executives to ask questions of an employee which respect their privacy while helping them to consider a health consultation before performance issues are reviewed in more conventional terms.

Creating mechanisms for referrals to internal professional staff or external health professionals in order to screen the individual for symptoms of depression, anxiety or other conditions.

Deferring the “performance review” process until this health review is complete.

Preserving the confidentiality of the matter at all costs.

Setting into place a process to receive the health-review report from the employee (orally or otherwise, as they may wish), and should a health concern emerge, accommodating that concern by way of work schedule and other arrangements.

In effect, this is an asset protection program. And it meets head-on one of the most significant business costs of them all – employee turnover – as well as offsetting the productivity costs which, by then, will already begin to accumulate.

Step Eleven: Health-Based Productivity

Shift from pure volume/quantitative measures of productivity to “Quality of Life” measures and forge a blended standard of productivity which reflects both. Special opportunity for public service.

Step Twelve: Transformation Policies – Defeating Stress and Depression

Aim to reduce disability rates by 15 – 25 per cent a year by targeting mental health issues.

Aim to dramatically improve EAP usage by employees, reflecting current-need in stress and depression.

Eliminate the leading sources of stress.

Reduce burnout rates through job and work climate strategies.

Refer:

Bill Wilkerson
416-343-5337

bill.wilkerson@gwl.ca

PAGE

PAGE 22