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Remarks by Bill Wilkerson
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To
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"Helping Students at Risk"
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My very first public speaking assignment was to a Niagara Regional conference of the OSSTF when I was an education reporter for the local newspaper. That was nearly 40 years ago.

Well, I'm back. And delighted to be here.

My hometown roots are shared by Chris Malkiewich. We grew up in Niagara Falls, attended rival high schools, I was a regular at his father's restaurant – the late, great Rapids Tavern – and there's every chance I ate "chicken in the basket" that Chris himself cooked in the kitchen.

So I'm quite at home with you this morning.

I accepted the kind invitation to join you on fairly short notice because I believe that the mission you have embarked upon – protecting "students at risk" – has great significance for our schools, society – and to business.

My focus this morning will be on questions concerning the mental health of young people and, in particular, how adult job stress may be affecting the well-being of our kids at home and school.

As context for this, I will describe the state of the mental health of Canadians and then dial in to the education workplace – our schools – and the challenges of mental health which face our teachers and your students. I will then propose a course of action.

The fact is this: we face a mental health crisis in Ontario, in Canada and in the world due to

the rising rates and staggering costs of mental disability – compounded by –

One, egregiously low rates of access to treatment and care and –

Two, the continuing effects of stigma and discrimination against those who suffer mental illness.

Let me begin by describing the global picture of mental health and in doing so I want to make one thing especially clear.

The statistics and trends I am about to tell you about are tough to take and we can either steel ourselves against the trends and statistics I am about to communicate or we can use them as a wake-up call to action.

In deciding which course to take, I ask you to hear **this** if you hear nothing else I say this morning:

The most common and often most serious forms of mental illness can be treated, can be defeated, can be resolved, can be remitted and those who suffer them can both protect and re-capture their productive lives.

Study after study affirms that 20 per cent of our population suffers a mental disorder each year – but only one in five seeks and gets the medical help they need.

The lack of access to primary or specialized health care for those suffering mental illness in this province – and this country – is a fact. And a disgrace.

For all practical purposes, the cherished principles of the Canada Health Act – universality, comprehensiveness, portability to name three – elude those who suffer mental illness.

Perhaps the most distressing expression of this default is the lack of psychiatric care that is available for children.

The Provincial Centre for Excellence for Child and Youth Mental Health reports that 15 -25% of children and young people in Ontario alone experience a psychiatric disorder each year.

But, in 2003, only one in eight of those kids accessed the mental health services they needed. Before then, the ratio was one in six. So we are headed in the wrong direction.

I will come back to this in a moment.

Meanwhile, across our entire population, depression is the most common and disabling

form of mental illness in the labor force – accounting for upwards of 30 to 40 per cent of the disability insurance claims registered among our largest employers.

The Supreme Court of Canada ruled in 1996 that in designing disability insurance policies, drawing distinctions between mental and physical disability violates human rights law. Surely, this reasoning applies more broadly.

At the heart of distinctions which separate physical and mental conditions is a suspicion that mental illness is not really an authentic source of disability, cannot be measured or managed in a defined way. That it is a subjective ailment, maybe even an imaginary one.

Depression, a form of mental illness, has physical properties. It is a physical disorder involving the biology and chemistry of the human brain and, in time, the entire body. A court in the U.S., for example, has ruled that bipolar disorder is a physical illness.

Additional evidence of the concrete, physical nature of mental illness is the links between depression and cardiovascular disease – and other familiar physical, chronic conditions.

Mental illness is a physical experience with psychological implications and pain much like other illnesses and injury such as cancer, diabetes or hypertension.

Given the influence that our living and working environments and experience have on the mental health of our population, a condition like depression might be seen more like an injury than an illness.

Along the same lines, the isolation caused by other forms of disability can, in time, trigger mental health problems. In this light, mental illness is a health complication born of the disabling effects of other injuries or illness.

Mental illness – in the form of depression, bipolar disorders and anxiety – has close ties with a number of familiar so-called physical chronic illnesses. Consider these facts:

> About 20 per cent of those who suffer heart attacks show signs of major depression at the time.
>
> Heart attack victims who suffer depression have a five-fold higher risk of sudden death within six months of the first heart attack.
>
> The Montreal Heart Institute tells us that evidence is building to say that symptoms of depression among heart patients may pre-date eventual heart attacks by years.
>
> Aside from the links to our heart, disorders of the brain – like depression – run higher among those who live with thyroid disease, arthritis, asthma, liver problems

and stomach conditions.

Meanwhile, studies in Europe tells us that a condition known as vital exhaustion may pre-date heart attacks by many months – driven by a combination of fatigue, irritability and poor morale.

The Canadian Community Health Survey released yesterday found that people with bipolar disorder had a "strikingly high" incidence of asthma and migraine.

The links between mental illness and chronic conditions of this nature have major workplace implications. For instance, we now know that most of the work impairment recorded among young and middle-aged people suffering physical health problems can be traced to co-occurring mental health problems.

The dual nature of these conditions compounds the disability rates and days significantly. Unhealthy job stress stimulates these trends and is common to the onset of depression, cardiovascular problems and many of the chronic conditions we mentioned.

And while job stress can predict depression in the work force, the conditions of work which produce the greatest risk for disease and injury tend to vary among occupations.

For example, factory workers are especially vulnerable to excessive environmental noise.

For office workers, role ambiguity, no control over workload and no support from co-workers takes its toll.

For teachers, pervasive uncertainty, the piling-on of expectations, too many bosses but not enough leadership can graduate into health risks overtime.

Across most occupations, isolation and rumination (seething) in the work force can predict depression. Weak management and unclear policy directions sow the seeds of worker distress and downtime.

Let me pause here.

The lesson I had to learn from my studies of mental health over the past six years is a lesson I wish I learned much earlier in my professional life. It is this:

Disease and disorder do not routinely emerge from some extraneous force which fate controls.

Yes, the random assembly of our genetic profile seems to be a matter of chance and that certainly affects our propensity or vulnerability to certain conditions which affect our health

and well-being.

But much or most risks to our health emerge from within human behavior unto ourselves and one unto another. The Centre for Disease Prevention and Control in Atlanta, Georgia, for example, estimates that 75% of the disease and injury burden in the United States can be traced to human behaviour.

The axis of human health swings from our relationships and how we treat each other. It swings from parent-to-child – abuse begets abuse from one generation to the next.

It swings from the group-to-the individual – isolation from our friends, co-workers, our job, the expectations of our boss are forms of isolation which, if perpetuated, can undermine our emotional health.

The axis of health swings from boss-to-direct reports, executives-to-employees, school boards or principals-to-teachers and the Roundtable has identified ten management practices most likely to trigger or aggravate mental health problems among employees.

> Imposing unreasonable demands on subordinates day in and day out.
>
> Withholding the information and resources that employees need to get their job done hour to hour.
>
> Refusing to give employees reasonable discretion in the conduct of their responsibilities. Rules which wipe out the opportunity to exercise judgment.
>
> Failing to acknowledge the daily contributions and achievements of employees.
>
> Creating the sensation of a treadmill at work.
>
> Creating perpetuated uncertainty in the work place.
>
> Creating mistrust and allowing it to take root.
>
> Office politics on a large scale.
>
> Sub-par meaningful communications top to bottom and side to side across the organization. The rumour mill as the chief source of information.
>
> Rejecting out of hand employee concerns about workload.

The fact is this: bad management in the workplace – any workplace – contributes to employee illness-based absence and disability.

All in all, the world of work that parents and teachers of our young people navigate each day of the week is a hurried and worried place where the struggle to juggle our responsibilities at home and at work defines the times in which we live.

In growing numbers all day long, all night long, kids are in the hands of stressed-out adults grappling with conflicts of time compression, space limitations, fairness gaps, too much to do all the time, it seems, at home and work.

For teachers, depression is the principal cause of disability among 40% of those on disability leave this year. This is higher than the national average.

One might speculate this is a telling consequence of the tension and stress that has invaded your workplace.

In this light, it is important that school boards and school principals give teachers every opportunity to learn as much as they can about these disorders and how to respond to them – among themselves, among others.

Co-worker support is critical to early detection. Isolating teachers in a classroom might seem efficient and logical but what other workplace keeps its key people out of touch with each other as a matter of policy.

It seems logical to conclude that untreated mental disability is adding to Ontario's education bill – the equivalent, I am told, of some 50 teaching positions in one school district alone. Which poses this intriguing proposition.

Investing in the prevention of mental disability and promotion of mental health among teachers might well produce substantial cash savings and help fund education priorities such as smaller class sizes.

Let me turn to the especially heart-breaking face of mental illness among our young – and the toll which adult job stress may be exacting on them at home and school.

We hear a lot about the dangers of smoking.

Well, it seems to me that the swirl of adult job stress among parents and teachers alike exposes our children to a kind of second-hand smoke which may be just as dangerously inhaled as that generated by cigarettes.

For kids – like adults – home stress and work stress are synergistic – the effects compounded like an emotional interest rate – the root causes assimilated.

The rising rates of mental illness among our children, adolescents and young adults merit our urgent attention. Consider this:

> 37 per cent of deaths in the U.S. are attributable to mood disorders among 25 to 44 year olds. The heart and soul of our workforce.
>
> The average age of onset for anxiety is age 12; depression, early 20's; substance abuse, late teens.
>
> *UNICEF tells us that Canada has the third worst record in the world for suicides among adolescents in the 15-19 age range. This is about 10 per cent of all suicides in Canada.
>
> A third of Canadian suicides happen in Ontario – and nearly one in three occur among children and young people ten years and up (into early adulthood).
>
> Canadians kids – 18 and 19 years old – kill themselves at a higher rate than U.S. kids.
>
> US studies tell us that gay youth are two to three times more likely to attempt suicide than "straight" teens – and 30 % of teens who complete suicide are gay or lesbian.

Meanwhile, suicide among children in aboriginal communities is five to six times higher than the national experience. This fact was tabled at the recent first minister's healthcare summit.

Suicide rates among young people have increased all over the world and it seems we may have reached some sort of tipping point

A cynic might say suicide is a risk of growing up. Well, this much is clear on this planet: in any given year, adolescent suicide kills more kids than smoking, AIDS, homicides, wars or obesity combined.

This much is also clear: suicide is preventable, depression is treatable and yet both continue to put students at risk on a scale that is both bewildering and unnecessary.

Schools and teachers, by definition, are a first line of defense against the preponderance of teenage self-destruction – but can an environment obviously so stressful for its adult inhabitants suitably host the vigilance it takes to promote and protect the emotional health of our kids?

I ask not this question to point a finger at anyone. I ask it to beg a response.

In short, are schools today duly equipped to play a constructive role in arresting the trends of self-destruction and depression emerging among our kids?

The Ontario Suicide Prevention Network thinks not and cites a chronic lack of training for teachers, support staff and school board personnel – saying this:

"Today any number and type of school board staff including school administrators, special educators, guidance teachers, classroom teachers, chaplains, social workers or school psychologists manage suicidal behaviors in schools but lack sufficient training to do so."

School boards who ask or expect teachers to intervene in student crises of this nature presume adherence to a fiduciary duty and therefore must provide adequate training of teachers and other staff in suicide prevention or run the risk of serious liability if a tragedy ensues.

For kids, like adults, work – school – is not just the job we go to, it is the community we belong to. Kids, like adults, have an individual variable in their make-up – that is, a sense of belonging that translates into a sense of worth.

If we lose one, we can lose the other. This is the variable – tilted one way – which may trigger destructive behaviour.

It is well that you can focus on the issues of early childhood development.

Experience early in life can alter the size of a child's brain and his or her perception of violence and violence. A child born to a mother with depression has a higher chance of acquiring the disorder by age 19.

There is a revolution happening in the social environment in which kids function.

The Internet has lifted their traditional moorings and produced new risks of isolation at home away from their friends.

Studies in the U.S. show kids spend less time with adults – the manifestation of the time squeeze and adult distractions.

So where do we go, what do we do with this information.

First, let's recognize the challenge and decide to meet it. Lives are at stake. It's that simple. That clear.

Second, let's recognize our stake and our role in meeting that challenge.

Putting my business hat on, I submit the mental health of children belongs on the agenda for business for two reasons at least:

Working parents will work better if their off-spring are healthy and alive.

New labour entrants – kids – are going to work in large numbers with undetected and unresolved mental health problems which means they are producing a high yield of lost work time.

Your stake in this is self-evident and I urge you to express that by forging a "Partnership in Health" to unify school boards, teachers and parents in pursuit of three broad goals.

Measurably, to arrest and reduce the rising rates and staggering costs of mental ill health among teachers in this province.

Measurably, to promote the mental health of kids at school and to protect them against the risks of suicide facing their generation.

Measurably – and creatively – to break the circle of adult job stress surrounding kids at home and school.

I urge you to make a solid commitment to reach out and return to the classroom those teachers now on long or short-term disability – and, in doing so, educate yourselves on the facts of mental illness and undertake, vigorously, to explode six myths which harass the capacity of teachers to return to work from mental illness and the capacity of school boards and unions to welcome them back.

Myth one: Employees suffering depression are damaged goods and can't recover or come back. Wrong on every count. They can, they do and with management support, they will.

> The evidence to support this is hot off the press. Yesterday, the Community Health Survey reported that 69 per cent of Canadians 25 – 64 years of age suffering bipolar disorder <u>are employed</u>.
>
> And hear this: that is only <u>nine</u> per cent below the corresponding proportion of people without the disorder. Key to this promising statistic: support from friends, family and co-workers.

Myth two: Employees suffering depression and anxiety pose a risk to their co-workers. This is nonsense.

Myth three: Employees suffering mental health problems are unreliable employees. Wrong big-time.

Myth four: most mental health disability insurance claims are fake. Wrong. About 20 per cent involve malingering.

Myth five: mental health problems give employees an excuse for taking time off work. Wrong.

> In fact, employees most frequently diagnosed with depression tend to be in the 10^{th} to 12^{th} year of service with the same employer. Most work through their health problems until they crash.

Myth six: depression reflects a weaker disposition. This is wrong. Big-time athletes are treated for depression – in their case, a disorder of the strong.

War heroes suffer depression – rescue pilots – who put their lives in danger every day – suffer depression – in their case, it is a condition of the brave.

Anchor your partnership in health to a slate of clear principles of mental disability management and prevention. Halt the migration from short-term disability to long-term disability, among teachers suffering depression. STD should be a period of recovery. LTD should become obsolete – a thing of the past.

School administrations and health professionals in the education system must develop the capacity to track the progress of those teachers off work and on disability. Create a systematic way to reach out to your colleagues on disability leave.

Today, tomorrow, this week, contact your colleagues at home, get a reading from them on their perception of their recovery and the adequacy – in their mind – of the treatment and support they are receiving.

Contact and communication between the workplace and the employee through the disability period is key. Isolation deepens depression.

Consult the Roundtable's Roadmap to Mental Disability Management and consider this:

The crossover between unrecognized symptoms of a mental disease and performance/ 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

doesn't happen when an employee has a physical injury such as a broken arm. It is self-evident he or she cannot function 100 per cent.

But with depression and anxiety, nothing is self-evident to managers or co-workers – and while depression, like other injuries and illnesses, affects the performance of the individual employee, the reasons usually go undetected and unrecognized.

Study after study shows that employees returning to work from mental illness do so successfully when they receive proper treatment, support and the benefit of a fair return to work process.

The return to work from mental illness need not impose unreasonable demands on the employer or prove onerous to either the employer or employee. And in the course of the employee's recovery and return to work:

> 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 tune with the employee's job and hours of work.
>
> Employers do 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.

And let's remember this. Teachers who achieve recovery from depression are still teachers who belong in the classroom.

And be clear on this: unions and employers share equally the duty to accommodate this gradual return to full-time work. In some cases, the human rights of the individual trumps the collective bargaining agreement.

Use your Partnership in Health to build the architecture of a system of stress reduction without prejudice and without politics.

Schools, uniquely, are a community in their own right – a community where adults and kids live and work together, where family and public interests converge appropriately.

Parents and teachers have much to share in promoting and protecting the mental health of

"students at risk".

The children of baby boomers are coming into the workforce and they're different. Many of the differences are positive – uniquely knowledgeable, energized and equipped with a fluency in the new technology.

Because time on television is now spent on the internet, the experience of youth is different and these kids think differently than their boomer parents.

But they are also a generation under huge pressure, facing an uncertain, competitive and dangerous world.

Two MIT parents whose daughter killed herself, sued the university charging that it was complicit in their daughters death.

If parents could sue a university for failing to protect the mental health of their daughter, or if a company can be sued for causing workplace hazards for their employees, could a corporation be sued for complicity in the mental illness or suicide of an employee?

In a transparent world, companies and school boards will increasingly do well by doing good. Everyone will find out what kind of company and what kind of employer you are. This begins with how you treat your people. How we treat each other.

Let this be the first paragraph in your new Partnership for Health. Let this be the first step in reducing unhealthy job stress. Let this be the first thought driving a suicide prevention strategy for students at risk.

I am delighted to know the Ontario Teachers' Federation has decided to put mental health front and centre in its "Healthy Schools – Healthy Minds" strategy. This is most encouraging.

In this light, let us – all of us – stand up and step out on a crusade to promote and protect the lives, potential and promise of our kids and those who love them, who raise them, and who teach them.

Parents, teachers, children. The mental health of all. Isn't that a goal worth shooting for?

Thank you.

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