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***For Discussion  
VISION 2020 REPORT***

***Boardroom Series #2,  
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***A. THE CONTEXT***

This is a global issue shaped, in part, by four great trends:

- Shift in global burden of disease from infectious to non-communicable disorders and disability as premiere public health concerns.
- Shift to a global economy of mental performance, information, and product/service thought content where innovation, a cerebral function, is king. This clarifies the asset value of mindsets in the labor force and helps to position mental health as the ultimate productivity weapon.
- Dawning of the software civilization, the e-mail society and “the commercialization of existence” in the telling portrayal by two Canadian physicians of distinction – Paul Garfinkel and David Goldbloom.
- Expanding knowledge of the brain and the genome – and the advent of the era of privacy and ethics.

***B. THE PICTURE EMERGING***

Addiction and mental health issues, meanwhile, have congealed into a spaghetti-like maze of “causes and effects” which, overall, produce both a conundrum and exquisite opportunity for breakthrough change.

For discussion, the strands are traced here:

1. Heightened profile for chronic and brain-based health problems.
2. Disabilities overtaking life expectancy as focus of public health.
3. Economic impact of mental disorders better known.
4. Connection between depression and heart disease established.
5. New premium on prevention of disability.
6. Economic and production losses driven by lost work hours and partial days.
7. Impact greatest on younger adults in prime working years.
8. Eggregiously low rates of detection, diagnosis and effective treatment.
9. Emerging generation of working wounded.
10. Embedded cost syndrome.
11. Mental ill health has physical properties.
12. Dichotomy in the experience of men and women.
13. Disability claims experience rising.
14. No universality in mental health. A no-tier system.
15. Dual conditions crisis.
16. Co-morbid chronic physical disorders and mental ill health insidious.
17. Possible 30-40 per cent redundancy in health care spending.
18. Dollar costs are six per cent of national debt, 3 per cent of total economy.
19. Business incentives to act are pure bread and butter.
20. Capacity /demand/need disconnect.

### *C. THE ACTION PLAN*

In this context, we see several groupings of opportunity and prospective action which is proposed here as the guts for an intensive 12-month period of analysis, case-making, education and activity.

In the first instance, this Action Plan would flow from the Charter for Addiction and Mental Health in the Global Economy and, in time – through the efforts of the Roundtable as catalyst – would be customized and adapted by individual organizations in Canada and beyond.

For discussion, therefore:

- 1. The Charter Year for Addiction and Mental Health**
  - Targeting disability prevention
- 2. The Business Year for Addiction and Mental Health**
  - A period to do our homework, get our act together, take action.
  - 2020 Vision international alliance of employers for mental health– business, government, NGO’s and MUSH sector. Roundtable teams as catalyst, developing standards and test pilot programs to implement the Charter.

- Establish a Roundtable “Delivery System” of information and value-added support services to assist individual employers and managers.

### **3. CEO Mandates for Mental Health and Safety**

- A construct to arm leaders with information with which to mandate action plans consistent with the Charter’s core objectives.

CEO Mandates, among other things, would challenge the organization to design --

- A measurable reduction of partial and full day absenteeism.
- A measurable reduction of top ten sources of work place stress.
- A contribution strategy governing employee drug utilization
- In this context – creation of composite group health/community and medical services/disability insurance/EAP/wellness model fixed on –
  1. early intervention
  2. disability prevention.
- Specific financial objectives to drive the prevention agenda.
- A plan to root out the embedded operating costs associated with mental ill health.
- Behavioral management and oral communications skills training for managers.
- The prevention role of each party to the disability insurance contract.
- Corporate care maps to facilitate early detection/treatment.\*
- A product and service quality objective for the prevention agenda.
- An organizational, mental and cardiovascular health promotion.
- Define clear standards and best practices for the protection and promotion of mental energy and resilience at work.

### **4. Three-year business and economic mental health research agenda.**

- CEO qualitative surveys; work and mental health; the Kessler Study

### **5. Public and work place education**

- The CAMH model. Major stigma reduction tool; the “how to” of promoting mental health at work; original mind/heart advertising.

### **6. Customized prevention, education and treatment services for SME’s.**

- Design of community-based group mental health services; funding and delivery through financial institutions and business associations.

*\*Mensante Corporation*

### **7. Information pooling/web-site networking.**

### ***D. THE WAY AHEAD***

#### Actions today:

- Endorse the Charter
- Endorse the Year
- Endorse the working alliance concept –

### ***E. DISCUSSION***

#### The Business and Economic Challenge

Based on the Roundtable's three-year, 8,000 page review of existing medical, academic and business research reports and published commentaries plus hundreds of interviews inside and outside Canada with leaders in the field, we profile the addiction and mental health challenge facing NAFTA and the European Community as follows.

We then offer a national and international response to that challenge in the form of a macro and "very micro" series of inquiries, investments and activities to rally scientific, economic and medical forces in a new strategic framework to turn the tide on what Harvard calls "the unheralded crisis" of mental health.

This proposition advocates enlightened self-interest and aims to unify business, government, labor and the non-profit community as employers with common interests as employers.

Therefore, we will emphasize community over politics, work place over institutional hierarchies, investment and market place over taxation and give-away funding.

World transition on two specific levels:

1. The shift in the global burden of disease from infectious to non-communicable disorders. An ironic twist in the shadows of SARS and AIDS.
2. The shift from an industrial to a knowledge or information economy which we coin as the "economy of mental performance" which RBC's CEO Gordon Nixon announced for us in January, 2002.

In this economy, the brains of workers do the heavy lifting for employers. Strong backs are becoming obsolete.

The picture which emerges something like this:

**One**, a heightened profile for chronic and brain-based health problems.

**Two**, disabilities have overtaken life expectancy concerns as a global public health priority.

**Three**, the economic impact of mental disorders is better known.

**Four**, the documented connection between and among, depression, anxiety, substance abuse, heart disease and other physical chronic is center-stage as the leading source(s) of disability and premature death.

**Five**, as a result, disability and premature death will increasingly influence the economic and health service costs and encourage us to put a premium upon prevention, dual diagnostic excellence, work-centred mental health care, addiction, neuro-scientific and business management research and education.

**Six**, business and economic production losses associated with mental ill health is mostly a function of lost work days through disability and premature death.

**Seven**, these effects are concentrated among younger adults in their prime working years. New “age of onset” and lifetime prevalence figures for Canada and six other countries produced by the famed Ron Kessler at the Harvard Medical School counter the “aging society” image.

**Eight**, new assumptions about the emboldened impact of egregiously low rates of detection and effective treatment of depression, anxiety and substance abuse.

**Nine**, an emerging generation of the “working wounded.” Depression et al is invading the productive capacity of the labour force class like a virus.

**Ten**, production losses and capacity impairment are taking place in the public and private sector hour-by-hour and half-day increments. Presenteeism, CAMH tells us is more expensive than absenteeism.

**Eleven**, mental ill health has physical properties. A broken back has emotional ones. In the majority of cases, depression is “comorbid” with anxiety, work-related stress, alcohol problems and, notably physical chronic health problems.

**Twelve**, there is a dichotomy of unknown origin between the experience of men and women in this matter. More depression among women, more suicides among men. Workplace health thinks managers need to be aware of this.

**Thirteen**, there is effectively no mental health care system in Canada or the United States – emphasis on the word *systems*.

The public pays the bulk of the costs of mental ill health through payrolls, private insurance premiums, unemployment job impairments and prices.

**Fourteen**, Canadians right now, have a no-tier mental health care system.

**Fifteen**, less than 10 per cent of the estimated number of cases of depression go untreated. This wounds maybe as much as a third to a half of the labor force.

Prevalence rates of depression et al have been calculated without reference to the embedding of mental ill health in chronic physical disorders and vice-versa, such as heart, respiratory and thyroid disease as well as diabetes.

**Sixteen**, mental ill health and physical ill health are insidious, unheralded and literally unchecked as a defined source of economic loss disability and early death. Consider this:

- Toxic stress is like a virus. Deadlier, in fact, than SARS.
- Boss bullying is a public health problem. We need to face up to that without blaming each other.
- Gridlock is a public health issue.
- Bad management makes people sick.

**Seventeen**, as a result of the low to no rates of detection and effective treatment, mental ill health may be creating a 30-40 per cent redundancy in health care spending. Which, if corrected, could produce a windfall and dramatic prevention-based reinvestment opportunities for taxpayers and private payers alike.

Consider:

- More than 70 per cent of health care spending in the U.S. – one of the least efficient health care systems in the world – pays for preventable behavioral health problems.
- Excessive utilization rates of health care services among those suffering mental ill health is anywhere from 30 to 50 per cent greater than persons not suffering these conditions due to delayed, improper or no treatment.
- Downtime at work as well as time away from work is 300-400 per cent higher among suffering mental illness. The same reasons apply.
- When proper treatment is applied, employees with mental illness also recover their productivity. This is a powerful case for re-channeling private and public sector investments to this end.

**Eighteen**, the intricacies of depression et al at work must be understood to be acted upon. Consider the following:

- The costs of mental ill health, in the estimate of the Roundtable’s Scientific Advisory Committee are running at about \$33 billion a year in Canada.
- This is more or less equivalent to six per cent of this country’s national debt, three per cent of the economy itself and, in 2000 dollars, about 14 per cent of the income generated by Canadian companies as a whole.
- On a per-company basis, this means –
  - For one oil company, 11 million barrels of lost production or \$275 million of lost revenue a year;
  - One manufacturer – an estimated \$50 million a year;
  - For a financial services company, an estimated \$20 million a year.
- About 30 per cent of the total disability insurance and self-insurance claims experience in Canada relate to “mental and nervous” conditions. The Canada Pension Plan estimates its pay-out for these conditions is nearing one-in-four.
- That said, the impact of mental and stress-related disabilities are characterized more by their duration and dollar cost than volume. This is characteristic of mental disability.
- The longer employees are off the job for any reason, the more likely there is a mental health component to their disability.

**Nineteen**, this much seems clear. Depression, anxiety and substance abuse constitute a frontal attack on the productive human resources of this country. We have yet to fight back and --

- The business reasons for doing so are pure bread and butter if not heart and soul, starting in the office or on plant floor. There we find the top ten sources of toxic work place stress. These must be stopped. (List attached.)
- Statistics Canada cites an imbalance: through the 90s, employees worked longer and harder. We entered the software civilization. And we realized meager growth in productivity.
- The 90s “cuts culture” and the rapid infusion of information technology – mainly e-mail and voice-mail – has rendered the labor force hurried, worried and rattled by change.

- The personal health of federal public servants is deteriorating. Senior mandarins have less discretion, less latitude, more responsibility and more work. The affairs of the nation are rigidly centralized in the PMO. Claustrophobic work environments ensued.
- Federal civil servants are conflicted by standing orders to ring the risk out of every public policy initiative, further layering the bureaucratic culture.
- Toxic stress in the federal work place – including Parliament – is intense. Politicians, in a word, are bad employers if health and well-being of their staff is a measure
- On a parallel course, the shadow of depression is lengthening
- Both depression and anxiety have a very early average age of onset (23 and 12) and psychiatric crisis is concentrated among adults in their prime working years.
- At the same time that business pays good money for the thought content of product and services through innovation (a form of mental energy), it is precisely this asset that is under attack.
- Mental ill health in the labour force may well represent an unfunded business liability. Costs are embedded in operations.

Consider this:

- Those suffering a chronic physical disorder live with a 42 per cent higher risk of having a mental disorder – most likely depression, anxiety or substance abuse.

And this:

- Lost work days is one measure of the impact of depression and anxiety on the productivity of the labor force. It is only the “tip of the ice-berg.” Partial lost work days and the downtime associated with “extra effort days” tell a fuller story.

Further:

- Taking a “sick day” for a mental disorder occurs much later than in the case of a physical health problem. This compounds the risk of late diagnosis and treatment.
- Combined, chronic physical illness and mental disorders – in one study of three companies – exploded the monthly average of disability days by 600 per cent.
- A recent study of Fortune 500 manufacturers in the US showed that two-thirds of employees treated for major depression went on disability.



- CAMH researchers found nearly half of those being treated for depression claimed for short-term disability.
- In both Canada and the U.S., employers bear more than one-half of all costs – probably closer to two-thirds – associated with depression through increased absenteeism and lost production and service.

For example:

- In the U.S., depression accounts for more than 440 million lost work days in the U.S., more than both hypertension and heart disease combined.

Meanwhile, we note that:

- The average absence from work produced by depression is 40 days (U.S.) -- longer than that cardiac disease. This is unnecessary. Effective treatments are available which would dramatically reduce and even prevent mental disability.
- The functional limitations posed by mental ill health often persist even after the medical symptoms subside. This “lag effect” has important implications for disability managers. It should guide return-to-work strategies.
- In one study of three companies, employees who claim benefits for depression were off work 95 days compared to 65 days for other mental conditions.

There’s good news behind that last bullet.

- These people can and do recover, they can and do regain their capacity for productive work.
- One professional firm, employees who received proper treatment for depression returned to work and achieved the same or better productivity levels as co-workers.
- In A U.S. study of chronically depressed individuals, absenteeism from work decreased a mighty 82 per cent from an average of 12 to two hours a week among those who received proper treatment.

In a CAMH study, the same theme emerged:

- Seventy five per cent of those who got the treatment they needed successfully returned to work. But this requires emphasis.
- An opposite pattern has been observed elsewhere. Large percentages of employees lacking proper treatment migrate from long to short-term disability, even to job termination, especially, sadly, young people.

An interesting insight:

- Across a breadth of studies, we find that that the short-term disability claimants tend to be employees in their tenth and eleventh years of service. These are not disgruntled employees but productive people who can be again.

This is instructive.

- Among these longer-term employees, mental illness is plainly not a cloak for disgruntlement or revealing a flaw of character – it is an authentic and common medical disorder as physical as a broken back and as emotional as breast cancer.

For public policymakers, here is gripping testimony for measures to improve early detection, treatment and recovery rates is this:

- Many studies have shown that nearly half of all patients with a major depression are heavy users of the health care system for other reasons.
- Depression is associated with increased prevalence and worse prognosis of medical conditions such as hypertension, diabetes and ischemic heart disease.
- Therefore, treating depression effectively could reduce the health care utilization costs attributed to these other well-defined medical conditions.
- Among several U.S. control groups in cross-sectional studies in the U.S., researchers found among depressed patients 50-75 per cent increases in direct health care costs.
- Total medical expenditures for those with a single mental disorder are about 4.5 times larger than those with no mental disorder.
- Moreover, total medical expenditures by those with mental health co-morbidities represent ten times those without mental illness.
- The employees of one U.S. insurance company, who were living with anxiety and depression had medical expenditures ran three times those of employees with no mental disorder.
- This pattern stems from late diagnosis and treatment, the complexities of mental ill health co-existing with the physical disorders and diagnostic and drug compliance problems.

Meanwhile, a study by the Yale School of Medicine says:

- That, among patients exhibiting early symptoms of depression, problems in getting appropriate health care predicts a 1) 34 per cent increase in the likelihood of persistent depression and 2) 66 per cent increase in the likelihood of problems with work productivity two years later.

**Twenty**, the connection between serious depression and cardiovascular disease simply must be widely appreciated.

Consider:

- About 20 percent of the people who suffer heart attacks show signs of a major depression at the time.
- Heart victims who suffer depression do not have the same chance of surviving a heart attack after one year as those without depression.
- Women who are in hospital with a heart problem are twice as likely to have a major depression compared to men. But once depression sets in, men and women face about the same risk of experiencing a fatal heart attack.
- There is some evidence in Canadian studies which says that the rate of depression among women in specific coronary units runs at about 52 per cent. More than double the average in the general population of women. Research is needed to learn why.
- Heart research has been handicapped by limited understanding of gender issues.
- Women are more likely to die from their first heart attack than men.
- Three-quarters of women don't know heart disease and stroke are the disorders most likely to kill them.
- The risk of heart disease for women soars in the post-menopausal years.
- Depression may predispose patients with damaged hearts to arrhythmia and sudden death. In turn, arrhythmias make up an estimated 25 per cent of all heart problems and it is believed five per cent of the population develops an arrhythmia at some point in their lives.

Further:

- Studies suggest that depression may increase blood clotting – which, in turn, can impair the supply of blood and oxygen to the heart. A cause of heart attack.

- Researchers at the famed Montreal Heart Institute say that symptoms of depression among heart patients may predate eventual heart attacks by many years.
- Among 222 post-heart attack patients studied by the Montreal Heart Institute, in the 18 months after hospitalization, the risk of death from cardiac causes for those with depression was 14 per cent higher than those in the study group not suffering depression.
- By the end of one year after a heart attack, the mortality rate of those who are depressed is three times higher than those heart victims who are not depressed.
- Studies in the Netherlands point to a condition called “vital exhaustion” which involves a combination of fatigue, irritability and poor morale predating the heart attack by several months.
- Depression, studies show, may predict cardiovascular disease – separate and apart from cardiac function itself. Thus, depression may increase the odds of a heart attack.
- The Montreal Heart Institute has documented the negative impact of depression on the recovery outlook of patients admitted for unstable angina.
- Studies found that depression following hospitalization for unstable angina quadrupled the risk of cardiac-related death or non-fatal heart attack.

Research indicates:

- Those who are depressed are less capable of defending themselves against germs and viruses. The immune system is compromised.
- In that respect, people who cope poorly in today’s stressful way of life experience a substantial outpouring of hormones, particularly steroids, which suppress the body’s basic defence against disease.
- Depression may increase blood clotting by affecting the regulation of platelets in the blood, a serious risk for heart patients.
- Middle-aged men who feel hopeless or think of themselves as failures may develop narrowing of the arteries faster.
- Conversely, the mind (our beliefs) can process hope and foster wellbeing.

Depression and heart disease are a “lethal mix”. Their links are becoming better known. The reasons behind this dynamic are still not well-understood scientifically.

Nonetheless, it is well established that a person’s emotional and psychological state can impair or uplift the functioning of the human heart. Treating depression may well be one way of preventing a fatal heart attack or a stroke.

Meanwhile:

- Medical scientists are also looking at the effects that prolonged and chronic negative emotions have on recovery from heart disease – such as hostility, extreme competitiveness, attempts to dominate other people, pessimism, hopelessness and a depressed mood.
- The Rand Corporation in the United States and the UCLA Neuropsychiatric Institute found that depressed patients frequently had health problems that went beyond the symptoms of the depression. The study found that functional limitations were “significantly worse” for those suffering both depression and an advanced heart condition.
- Depression is often masked by physical symptoms and can mimic chronic physical conditions.
- Researchers say “it is amply clear that depression is strongly associated with more frequent and more malignant cardiovascular disease”. They say, “it is likely that depression’s effect is not limited to cardiovascular disease but involves all vascular disease including stroke.”
- Researchers at the U.S. National Center for Health Statistics report that a high level of depression increases the risk of first-time stroke for men by 56 per cent and women by 95 per cent.
- The Yale Cardiovascular Centre in New Haven, Connecticut says there is evidence “to support the idea that depression may cause a stroke or other cardiovascular events. By treating depression, physicians may be able to lower the incidence of stroke.”
- Studies in the U.S. points to depression as being a major contributor to the course and severity of heart disease and that, later in life, the two conditions may well be synergistic.
- When depression and medical illnesses co-exist in one person, hospitalization is longer and the patient is twice as likely to be readmitted compared to medical patients not suffering depression.

- Researchers in Finland found that men without a prior history of heart attacks but with elevated levels of depression were more likely to have a first heart attack even after biological and behavioural risks were accounted for. Depression was seen as an independent risk factor in cardiac trauma.
- More research is needed to harmonize the treatment of depression with cardiac considerations where the two diseases co-exist.
- According to the Montreal Heart Institute, depression is an independent factor in the risk of death six months after heart attack.

There are depression and cardiac health risks associated with isolation and rumination at work. More research is needed into the interaction among human relations, job issues and social factors as an influence on depression and the outcome of treating cardiac disorders.

The way the heart of a depressed person may work, to wit –

- a) Depressed cardiac patients experience what the experts call “decreased heart rate variability” over a 24-hour period.
- b) Translated, the heart’s rhythm is abnormal. The depressed person’s heart, in effect, never sleeps.
- c) There is also evidence that such fluctuations in the nervous system can cause problems in the ventricular system of the heart.
- d) According to Columbia University, “the direction of those changes is such that one would anticipate an increase in sudden death” and this could easily explain a good part of the increased mortality associated with depression following (a heart attack),” the Columbia research team concluded.

Other studies suggest alterations in the metabolism of depressed patients may increase the risk of vascular disease. According to some studies, the degeneration and hardening of the arteries and valves of the heart – could be a cause both for depression and heart disease.

In fact, there is some evidence that late-onset depression may be one outcome of arteriosclerotic disease in the brain.

So far, however, the bottom line is that science does not know conclusively why cardiac patients with depression are more likely to die.

That said, studies from the Netherlands indicate that a condition known as “vital exhaustion” – involving a combination of fatigue, irritability and poor morale – frequently exists for several months before the heart attack.

The Montreal Heart Institute concludes, therefore, it is possible that, in addition to increasing the risk of becoming depressed after a heart attack, a prior episode of depression may impact the cardiac recovery process.

A 1996 study found that among 35 patients who met the diagnostic criteria of depression in-hospital, only nine both survived the cardiac threat and eventually threw off the depression.

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