



*Affiliated with the Centre for
Addiction and Mental Health*

Text of Keynote Speech By
Roundtable Co-Founder and CEO Bill Wilkerson
To The Ontario Medical Association Annual Meeting
Toronto, Ontario, Canada
April 30, 2004

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I am pleased to be here this morning. My particular thanks to Dr. Michael Ross not only for his introduction, but for his interest in and support of the Roundtable's activities over the past several years.

The work of Michael and his colleagues on the Committee on Work and Health and the guidelines you recently published on mental health issues are most welcome.

Over the next few minutes, I will discuss the work of the Roundtable particularly within the context of a broad initiative we have undertaken bearing the title "corporate leadership in mental health."

Over the past several years, we have worked hard to raise the awareness of business leaders as to their stake in the mental health of their employees. The time has come to move from there to concrete action.

In that light, the Roundtable has pegged the years 2004-05 the Business Years for Mental Health – thus giving employers, employees, breadwinners and their families a point of reference in turning their attention to this subject.

In doing so, we have learned a fair bit about the issues linking mental health and work. Before getting into the guts of my speech, I'd like to single one out.

It is important for laypersons such as myself to understand the distinction between job performance, per se, and medical conditions, per se.

Indeed, medical conditions can affect the capacity of a person to function and thus perform their job. But let's not allow ourselves – as business people – in our zeal to become aware of mental health problems, to slip into the habit of "medicalizing" real, live job performance issues.

We must retain this distinction in order to appropriately deal with both questions – and the links between ill health and job function – as circumstances merit.

I wanted to make this point up front and ask you to be patient with me if anything I say this morning seems to suggest a different view. I do not intend that to be the case.

In the mid-90s, I led a comprehensive review of the workers compensation systems across this country – we called our report “Unfolding Change” (the OMA was very helpful) – and in the course of that work, I became familiar with the difficult “gatekeeper” role imposed upon family physicians by the nature of WCB process.

Many physicians expressed to me their discomfort with that role and as we discuss the whole question of mental disability management, we must be alert to such concerns in this context as well.

Through that same period, I also became acutely aware of the importance of primary care reform and, specifically the role of occupational medicine and that view will be reflected in my remarks this morning.

On Wednesday of this week, the Roundtable’s Senior Chairman, the Honorable Michael Wilson made a seminal speech to a workshop put on by the Canadian Institutes for Health Research.

In that speech, Mr. Wilson outlined his vision for a new partnership between business and science in dealing with the rising rates of mental illness and mental disability in the labor force – most particularly among men and women in their prime working years.

It was a powerful speech – articulating a brand new role for business and science as partners in the funding and strategic direction of medical and health research into mental health, work and the workplace.

Michael Wilson began his remarks yesterday this way: “The economy and mental health: I firmly believe,” he said, “that we are bearing witness to an issue whose time has come.”

And no wonder, he said. The disabling impact of mental ill health on men and women in the prime of their working life is enormous.

On top of that – the horribly low rates of detection and treatment of mental conditions afflicting a quarter of our population is scandalous and the dollar costs are huge.

In lost production alone, mental ill health costs corporations \$33 billion a year. That’s about three per cent of the whole economy.

Obviously, from a business perspective, the matter merits our attention.

I mentioned that mental disorders are concentrated among men and women in their prime working years. This is well-documented. But there are three specific implications of this I wish to mention.

One, it appears that a significant portion of young adults who are diagnosed with depression have likely suffered the disorder since their adolescence and, in some form, since childhood.

As a result, it has become apparent that large numbers of new entrants to the workforce come into the job market already bearing this particular health burden.

Second, the early age of onset of mental ill health – from childhood to early adulthood and into mid-life – has real consequence for the country's capacity to anticipate its productivity potential over the next decade or more.

A study done for the World Health Organization by the Harvard Medical School compared the onset experience in Canada with that of six other countries and found that mental illness is striking younger people in Canada at higher rates than certain of our trading partners.

The study also found that the lifetime prevalence rate of depression, anxiety and substance abuse in Canada is 37.8 per cent compared to the annual prevalence rate of 20 to 25 per cent and the spot prevalence of 10 per cent or so.

These findings also told us this: the average age of onset for anxiety disorders in this country is age 12; substance abuse, age 18; and depression, age 21.

This drives home another point.

The challenges of promoting and protecting the mental health of the labor force is incomplete if we focus on today's generation of workers, managers and executives alone.

The children of working parents are at risk – and, in fact, the parental burden borne by parents with kids exhibiting undiagnosed symptoms of mental illness is an undocumented feature of the mental health burden in the labor force.

The issue of children's mental health is important to the physician community as well. I don't think you would contest the notion that adolescent children – including those with suicidal ideation or behavior – have been overlooked by the healthcare system itself.

The third implication of the high rates of mental ill health among working men and women relates to specific jobs which seem to carry special risks.

One example of that is the nursing profession. Another is doctors. A third is lawyers. A fourth is truck drivers. A fifth is office administration staff. A sixth is call centre operators. And a seventh is school teachers.

The experience of school teachers has real resonance with me because – for kids – it completes the circle of adult stress surrounding them among their rushed and stressed-out parents at home – and their rushed and depressed teachers at school.

When we are asked why business should pay attention to mental health issues now – why not last week, last year, five years ago or five years from now – our response is this.

Today – unlike ten years ago – we live in an economy of mental performance where mental health has tangible, functional value to business. A point Mr. Wilson made so powerfully in his speech to scientists on Wednesday.

The economy of mental performance is one where we ask people – as part of their everyday work – to be routinely creative, to routinely use their head, to be innovative, to develop and sustain good relationships at work, to put an emphasis on customer service.

A human function.

In fact, Gordon Nixon, the President and CEO of the Royal Bank Financial Group, says these attributes are “vital to the ability of companies to compete.”

The business case for mental health was propelled by the 1995 revelation by the Harvard School of Public Health that disability – not life expectancy – is the premiere public health concern of the 21st century.

By definition, worker disability is a business issue. And as the principal cause of disability today, mental ill health is – by definition – a business issue. In fact, despair – which may characterize depression as the leading source of disability – costs business more money than strikes, work stoppages or product recalls.

Consider this: 85 per cent of all the new jobs coming on-stream in this economy require cerebral not manual skills.

Last year, the Roundtable sought and got business support for what we call the Charter for Mental Health in the Global Economy. The Charter set out four concrete and achievable goals. These are:

1. To prevent the disabling and deadly effects of depression, anxiety and addictions through early detection and effective treatment.
2. To eliminate those toxic management practices and sources of problem stress which precipitate or aggravate mental health conditions in the workforce.
3. To promote the dual diagnosis and treatment of mental and chronic physical disorders including depression and heart disease. As a risk factor, problem stress is common to both.
4. Once and for all, to eradicate stigma.

These goals are the moorings for a master plan on mental disability management which the Roundtable will bring forward next year and which Mr. Wilson announced earlier this week.

There will be two dimensions to that master plan. The health issues of the individual. The health issues of the organization itself.

On the latter front, we now have good information singling out the principal management and business practices which drive problem stress at work and which are most likely to aggravate, trigger and complicate mental health problems in the labor force. These include:

- Imposing no end in sight deadlines on employees day in and day out. This is plain bad management.
- Withholding information from employees which is material to them doing the job they've been asked to do. This is plain bad management.
- Holding back from employees the discretion they need to function effectively hour-to-hour and day-to-day. This is plain bad management.
- Changing priorities too swiftly and without apparent reason. This is plain bad management.
- Feeding an employee treadmill effect at work. In fact, the struggle to juggle work and home responsibilities is a major health and management issue of our time.

The intensification of the workplace – and the free market economy – has dulled some of our most basic business senses.

For instance, we, as business people, have become all-too-accustomed to pervasive work place stress as an accepted condition of doing business in a competitive, global market economy.

As a result of these trends, the workplace has become an appropriate and necessary venue in which to concentrate our efforts in the promotion and protection of the mental health of the labor force.

The workplace has become an appropriate and necessary venue in which to educate individuals about mental illness, to research and promote good mental health practices, to develop and test tools for the early recognition and identification of mental health problems.

But to do these things, we must see and feel the influence of occupational medicine and draw down on the decades' old contribution occupational medicine has made to work place health and safety.

I say to those occupational physicians within reach of my voice, let mental illness be your next challenge. There is urgency and compelling need for this.

Recovery from mental illness and return-to-work are linked, go hand-in-hand. Business must understand this connection and work with it. You can help us learn how.

Meanwhile, as part of our corporate leadership effort, the Roundtable is introducing a three-part research initiative aimed at validating the return on employers' investments in employee mental health.

One, the Roundtable is joining the Harvard Health and Work Performances project. This work will help business understand the return on investing in the early detection, referral and treatment of depression.

The second is an analysis of insurance drug-claims data, coupled with data on lost time at work, short-term disability and long-term disability.

This will help us really understand more clearly what the effect of more appropriate and closer-to-optimal drug treatment might be on return-to-work and the ability to stop the progression from short-term disability to long-term disability.

The third is a survey of companies in Canada and the U.S. for anecdotal information about success in managing mental disability and the return-to-work of distressed employees. Lessons taught. Lessons learned. Shared among businesses.

We are publishing a series of guidelines for employers and employees – among them guidelines for returning the mentally disabled to work –

And for working parents – guidelines to manage the suicidal behavior of their children. An issue of urgency beyond what I imagined even weeks ago.

In these matters, questions often confront reason. For one thing, longer-serving and hard-working employees with 12-14 years of service with their current employer have a higher use of anti-depressant medication in Canada, according to one study (CAMH).

Mental illness is a disorder of the hard-working. Only 10 to 15 per cent of all mental disability insurance claims involve malingering.

Decorated war heroes have a high incidence of post-traumatic stress and depression. Mental illness is a disorder of the brave.

Men and women in their prime working years are most vulnerable to depression and anxiety if they have a concurrent or preceding chronic physical disorders and any ensuing disability absence is compounded by a factor of two. Three or four.

What is our response to that – as business people and as physicians?

Meanwhile, while disability insurance claims for physical injury or illness have moderated over the past 10 years, claims for disability relating to mental illness have exploded – now representing more than 30 per cent of all disability insurance claims being recorded by some of our largest insurers and largest employers.

This includes teachers.

Studies done for the Ontario Teachers' Insurance Plan paint a sobering picture. Mental disorders are the leading source of long-term disability and prescription drug use among teachers in this Province.

When you weigh that data with other findings across other job functions, we note that like other employees in other fields, teachers suffering depression have a particular health risk – and vulnerability – if they also live with conditions such as cardiovascular disease, digestive disease, infectious disorders, thyroid conditions, blood disease and muscle, joint and bone problems.

Clinical studies – as you already know and we in business are just learning – tell us the disabling effects of depression and heart disease combined are greater than that spawned by either condition alone. In other words, a sum greater than its parts.

The taxpayers of Ontario – when you consider the education and healthcare systems combined – is experiencing a terrific multiple of costs on two levels:

One, in our school system. The cost of teacher mental ill health – at high rates – is adding to the education cost burden;

And two, in healthcare. Estimates in the United States – relevant here – tell us that persons living with untreated mental illness use other healthcare services four to five times more frequently. This is a staggering cost redundancy in the publicly-funded mental health system.

In both cases, these costs could be returned to the public treasury as windfall revenue if our identification and treatment of mental disorders – both generally in the population and specifically among teachers – were even marginally improved.

Individual health and organizational health are linked. Bad management can make people sick. Good management helps keep them well.

Back to teachers. The costs of mental disability in their ranks are equivalent to more than 50 teaching positions in one education district alone. Province-wide, the dollar costs of untreated mental disorders represents hundreds and thousands of teacher positions.

Which poses this intriguing proposition.

Had the Government of Ontario – or the Boards of Education across this province – acted with foresight and invested in the prevention of mental disability – and the promotion of mental health – among its teachers, they would have realized cash savings which – if reinvested – could have contributed to financing government’s major priorities in education – such as smaller class sizes.

It is speculation on my part – but fair speculation – that the isolation of individual teachers caused by restricting their time with other teachers in the course of their workday is a material factor in the accumulation of depression disability days.

As you know – and as I have learned from the Roundtable’s work – one’s isolation from ideas, from the community, your colleagues, your friends, your family – one’s isolation from hopefulness and some sense of job security – can evolve into mental illness – and specifically serious depression.

It is more than possible that the pervasive job stress produced by the education wars have incited a mental health crisis among teachers.

It is more than possible that the employers of teachers – be they technically the boards of education or really the Government of Ontario – abetted by confrontational teacher representatives – have poisoned the workplace of teachers so as to produce a major public health crisis in the classrooms of our schools.

Emotional work hazards are stockpiled in our education system like plant floor clutter inside an unsafe factory. Whatever we have learned in raising the bar of physical health and safety in the workplace, we obviously have un-learned – or have yet to learn – in the very arena where the special cargo is our children.

Where does all this leave our kids? Their parents bring job stress home. Their teachers bring it to the classroom – the workplace of kids.

Kids get job stress too – too much homework, peer pressures, programmed living and now, they are encircled at both ends of their day by the propounded job stress of the key adults in their lives.

If the school environment is such that teachers are taking voluntary retirement in record numbers, then how could children not sense that, not pick up on that, not notice that, not interpret and absorb it?

It also stands to reason that teachers are on the receiving end of the job stress parents encounter and bring to parent-teacher consultations which I am told by those closest to the scene are tougher and generally more negative.

The OTIP data illuminates the growing influence of social isolation teachers experience in their own workplace, the loss of control over their work while expectations increase nonetheless.

These are symptoms of an organization that is unhealthy, management practices that are unhealthy and that occupy the Roundtable's own list of the top ten sources of problem job stress at work right across the economy.

This work experience among teachers tells me that the teachers' workday – for them – feels relentless, not shorter.

Teachers are conflicted by their innate desire to be with the kids during regular school hours and in extra-curricular activity after that, but the school wars have shut down their exercise of this instinct.

Scientists tell us that rumination is a predictor of depression – and rumination – seething – among working people flows from a protracted sense of frustration and perceived illogic and unfairness – even injustice – in the affairs and leadership of the organization by which they are employed.

This is a picture of teachers at work.

The employee disability rates of corporations can be predicted by the degree to which employees approve of the values by which those companies are led.

This is a picture of teachers at work.

The OTIP data tells me that – in significant numbers – teachers love their work and hate their workplace.

The OTIP data also tells me that teachers' loss of control over their daily duties has become, for them, a very real health and disability issue.

Low control, high expectations and low reward is the classic chemistry for deleterious workplace stress – and, over time, a predictor of depression disability.

The OTIP data tells me that for many teachers – far too many – the joy of teaching has been sucked out of the classroom.

Yes, they still love to teach but their respect for their employer understandably wanes when some of them pay for basic classroom supplies out of their own pocket.

Many teachers – far too many – feel like a political football being kicked from one end of the field – or political spectrum – to the other.

In my judgment, the depression rates among teachers will rise above 50 per cent of the total number of teachers on disability leave unless school boards and governments –

1. Give everyday teachers relief from the education wars. Minister Kennedy seems to have had a calming influence already. I applaud him for that.
2. Specifically undertake a teachers' health management strategy and get to the root cause of these disability rates. I can tell you that the causes are complex but singularly, the teachers' work environment is a significant factor.
3. Introduce mental health promotion training and education initiatives for teachers and remember, their stress experience – unless checked – becomes the stress experience of our kids.

Originally, I reported these numbers in a speech I made to a Teachers' Conference last fall. The speech was not publicized and I preferred a behind the scenes effort to draw this information to the attention of the new Ontario government.

I promised the teachers I would write the Premier on the matter and did so on November 13, 2003. I sent a copy to his Ministers of Education, Health and Children Services. Eventually, I received very polite replies from each of them. I am discussing this matter publicly because the time has come to do so.

I gave the Premier and his Ministers my best assessment of what these disability insurance numbers told us about the state of the education workplace. Which is this.

The school teachers of Ontario face a significant public health crisis.

- Depression is the principal source of disability leave and the principal reason for prescription drug use among school teachers in Ontario.
- Depression is the leading cost of disability costs among teachers in this province.
- The mental disability rate – depression – among teachers was at least a third higher than the insurance industry average. This merits his attention.
- Depression appears to be causing disabilities among younger teachers.
- The LTD claims processed by OTIP have doubled since 1993.
- The duration of disability insurance claims among teachers is increasing while the incidence – or volume – goes down. This suggests a preponderance of chronic health issues, consistent with the high prevalence of depression.

The dollar costs of mental disability among teachers represent an avoidable and significant redundancy in the cost structure of Ontario's education system.

Teachers' workplace is unsafe. As a result, teachers are nearly uninsurable in the open insurance market for disability purposes. It is well they have their own insurance plan.

I recommended to the Premier that his government deal with these matters on compassionate grounds in accordance with the principles of good management and good government. I remain hopeful they will.

The alternative, in my view, is a continued depletion of the human capital of the education system. Which would be tragic.

I recommended to the Premier that his Ministers put into place a comprehensive mental health assessment, recovery and protection plan for teachers in Ontario.

I repeat that recommendation today – suggesting that this measure, if for no other reason, be taken on behalf of the parents and children of this province who have the greatest stake in a humanly healthy school system. The Roundtable is prepared to help.

Government in this country – not just Ontario – has a blind spot on mental illness. Bill 8 in Ontario demonstrates this.

The government's intent to outlaw payments by employers to physicians for occupational medical services is crazy and worse uninformed. I endorse your petition to the Government seeking changes in this measure. I understand an interim word amendment has been installed.

From a mental health perspective, Bill 8 has an ironic twist.

The failure of the public healthcare system to provide those living with mental illness adequate services and support is well-documented. Nonetheless, by way of this Bill, the government threatens to cut off one of the few sources of access working people with mental illness have to specialized diagnosis on a timely basis.

I refer, of course, to occupational mental health services provided – at the employers' expense – by occupational physicians including psychiatrists – through independent medical evaluations and consults.

These services are essential to the process of recovery and return-to-work and this Bill will outlaw them in its original form. In doing so, the government proposes to send physicians to jail or fine you large sums of money.

If we are going to jail doctors, maybe we should jail patients who try to jump the cue in their desperate search for help – or maybe we should jail politicians when they ask doctors – which they do regularly – to let a member of their family, or a constituent or friend jump the cue as a favor to them.

Better yet, maybe the Government will simply amend Bill 8 to avoid this unintended consequence and if they do not, I recommend that the OMA advise its members to report each and every politician – this day forward – who asks for special “cue jumping” favors and post those names on your web-site.

Senator Michael Kirby’s Senate inquiry may yet demonstrate that the mentally ill are systematically excluded from the ‘medically necessary’ standard of the Canada Health Act by the sheer weight of the system’s failure to serve the needs of the mentally ill.

On practical grounds, it could be argued that government does not recognize mental illness as medically necessary – and yet, on the turn of a dime, through Bill 8, this Government is about to slam shut one of the very few doors open to those experiencing mental illness to receive a proper diagnosis and the hope for appropriate treatment.

The preamble of Bill 8 says the primary system is the cornerstone of a responsive health care system. Then, if that’s true, let the system be responsive to some not all.

Let business and medicine unify ourselves in common purpose to make this happen. I am ready to stand with you if you will have me.

Together, let us do what we can not to dismantle medicare, but to strengthen it—for those living with the despair of mental illness and the hope of mental health.

Thank you.

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