



*Affiliated with the Centre for
Addiction and Mental Health*

Guest Resident at Great-West Life Assurance Company
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SUMMER DRAFT

Roadmap to Mental Health and Excellence
At Work in Canada

*Presented To The
Ontario Chamber of Commerce
Economic Summit on Mental Health and Productivity in Ontario
A Pilot for Canada*

Sutton Place Hotel,
Toronto, Ontario Canada
June 8, 2005

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This Roadmap was built with the invaluable input of scores of Canadians with specialized knowledge in the relevant subject areas.

The content was also drawn from the real-time experience of actual employees who navigated the choppy waters of returning to work from months on disability leave from work due to mental illness.

It is the Roundtable's view that no single employer, union, professional group or member of society shoulders singular blame for Canada's disgraceful history of mismanaging, ignoring, stereotyping, stigmatizing and confounding human experience in this area.

"We found in the world an almost impenetrable maze of causes and effects, vicious spirals of mental illness and social pathology, self-perpetuating and producing human suffering on a mass scale." Harvard School of Public Health Researchers: 1996 Global Burden of Disease, World Bank and World Health Organization.

That said, it is also the Roundtable's view that the jury is in – not out – as to whether we must now, as a nation, set history aside and fruitfully act as a matter of conscience and common sense. We can do now what we know now. And research more to do more.

What we can't do is wait. Not if we believe what we ourselves say, as Canadians, that universal health care is a unique Canadian value and legacy for future generations. Mental health has been largely left out of that legacy.

“Of all the problems presented to me which reflects the greatest public concern is mental health.” – Jurist Emmett Hall on the future of health care in Canada.

Bill Wilkerson, Roundtable Co-Founder and CEO

APPRECIATION

*Ronald C. Kessler, Ph.D., Professor
Department of Health Care Policy, Harvard Medical School, Boston, MA*

Dr. Kessler's contributions to the world's knowledge of mental health and work have largely inspired the Roundtable's efforts to produce a practical instrument for change and progress in the prevention and management of mental disability.

Beyond Dr. Kessler's remarkable contribution to new progress in the field under discussion in this Roadmap, we appreciate the dedication of Dr. William Gnam and Dr. Alain Lesage, leader and co-leaders of our Harvard Medical School Depression and Work Performance Study in Canada.

We salute the fabulous leadership of the Canadian Institutes for Health Research and specifically Dr. Jean-Yves Savoie, Dr. Remi Quirion and Dr. Lesage for bringing a long-term national research agenda on workplace mental health in Canada to reality.

We acknowledge the work of Dr. Sidney Kennedy, Dr. Raymond Lam and Dr. Roger McIntyre for their critical work in developing guidelines for the treatment of depression. We drew on these heavily for this Summer Draft.

And we salute the practitioners in front line and specialist card – physicians, nurses, psychologists, occupational therapists, pharmacists – yes, pharmacists, often overlooked despite their unique touch in our daily lives.

We take our hats off in real appreciation for those community service leaders and providers – the Roundtable sees you playing a valuable future role in delivering key services to the workplace. More on that in the fall.

MORE APPRECIATION

The Centre for Addiction and Mental Health

Special Place and Special Purposes

It goes without saying that the Roundtable continues to draw a large measure of its strength and momentum from our affiliation with the Centre for Addiction and Mental Health, a distinguished WHO collaborating centre and affiliate with the University of Toronto.

To Board Chair Jamie Anderson, CEO Paul Garfinkel and Research VP Dr. Shitij Kapur, Dr. David Goldbloom and the terribly productive team at CAMH Foundation – we express our sincerest appreciation.

Our appreciation not only for your association with the Roundtable, but for your leadership in the field of addictions and mental health, for the lives you save, the hope you give and the futures you re-assure among so many members of our Canadian community.

Torys LLP

Present at the Creation

There are unsung heroes in almost every endeavour, and in the Roundtable's evolution, the distinguish law firm of Torys, LLP, is certainly that. Torys is the Roundtable's corporate counsel – pro bono. The firm was key to our attaining corporate status in 2004 as a federal non-profit corporation.

This gives the Roundtable a stable platform from which to continue its service to the wider community and for that – and much, much more – we say thank you.

DEDICATION

The Roundtable is dedicated to the hundreds – yes, hundreds – of men and women who emailed and phoned the Roundtable to share their experiences with mental illness and work as a constructive to listen for and to them.

SPECIAL MENTION

NQI

The Year for Mental Health and Excellence at Work in Canada

In 2005, the Roundtable is enjoying a special relationship with the National Quality Institute – one of those institutions in Canadian life that if we didn't already have it, we would have to invent it. The highest form of praise.

NQI – thanks to the leadership of its former CEO Dan Corbett – wrote a bit of history this year by deciding to incorporate mental health into the criteria of its prestigious healthy workplace award. This is a wonderful breakthrough.

NQI also dedicated its 2005 Chairman's Dinner to the Roundtable and the theme "Mental Health and Excellence at Work in Canada." More than 400 guests gave the evening a very special quality.

The Roundtable wishes to thank the board and staff of NQI for all this and to say that we take great pride in traveling such an important journey with you this year.

Chambers of Commerce and Mental Health in the Workplace

The Ontario Chamber of Commerce has aligning itself with mental health in the workplace this year and, as a result, is giving the Roundtable such incredible support through this Summit and a platform at its 2005 Annual General Meeting.

In fact, chambers of commerce have been present and accounted for in this issue for some time. Proudly, the Roundtable received the endorsement of Canadian Chamber of Commerce President and CEO Nancy Hughes Anthony in 2001

Ms. Hughes Anthony was the keynote speaker in 2002 to the Roundtable's first in a series of four CEO special roundtables and was an original signator to the Roundtable's original Charter for Mental Health in the Global Economy a year later.

In British Columbia, the BC Chamber is active with the BC Business and Economic Roundtable, the Calgary Chamber gave us our first important business audience in 2000, the Halifax Chamber has sponsored events, and other local chambers are participating in workplace mental health initiatives.

For mental health in the workplace, chambers of commerce are a column of strength. The Roundtable thanks them for that.

Watson Wyatt Worldwide
Mental Health and Productivity

In 2005, Watson Wyatt Worldwide – under the leadership of its National Practice Leaders for Canada, Joseph Ricciuti – gave mental health in the workplace significant new authenticity as a business and economic issue.

Mr. Ricciuti, actively supporting the Roundtable on a personal/professional level as Co-Leader (Recruitment) of our Harvard Medical School depression and work research initiative in Canada, is striving to put real metrics behind mental health and productivity.

As part of this, WWW recognized mental health in its annual Staying@Work survey, briefed a special meeting of the Roundtable on those findings and, by taking this step, sowed the seeds of this topic even deeper into the employer landscape and the Roundtable salutes the resolve behind that.

Medisys
Modern Mental Disability Management

Through its Vice-President Glenn Carman, Medisys – a success story in the field of disability management – is helping the Roundtable to develop a comprehensive standard – and centre-piece process – for a responsive mental disability management system founded on the twin principles of early access to care and return to work.

The company is an innovator in this field and the Summer Draft of the Roadmap was designed with Mr. Carman's assistance and that of his colleagues. They will be instrumental to us in making the final draft this fall, an enduring tool for managers and health professionals alike. We thank them for that.

ATF Canada
Among the Best and Brightest

Doug Smeall is vice-president of ATF Canada and he served as a key adviser in the development of this roadmap giving its author(s) real insight into the dynamics of a complex area of concern which touches lives throughout our economy and across the country.

Mr. Smeall fashioned for us a remarkable "rights and responsibilities" Charter that, while not discussed in this Summer Draft, will certainly help anchor the final draft in the fall and serve as a real "check list" of how to reach a higher ground in managing the disabilities, recovery and return to work from mental illness. Our thanks to him.

FGI Worldwide

Sponsor and Adviser

A sponsor of the Economic Summit on Mental Health and Productivity in Ontario, FGI also served as a valued adviser to the Roundtable in the development of this Summer Draft of the Roadmap. CEO Allon Bross and his colleagues deserve our appreciation and certainly have it in abundance.

Employee Assistance Society of North America

Through the distinguished firm Warren Shepell, EAP Professionals, and the firm's CEO Rod Phillips – vice-chair of the Roundtable – the Roundtable has enjoyed access to and support from the EAP community for several years.

We wish to extend our special thanks to the Employee Assistance Society of North America – its board and president, Canadian Louise Hartley, vice-president at Family Services, an excellent provider – for their assistance in exploring and shaping our view of the EAP role in mental health in the workplace.

While the subject is not discussed in depth in the Summer Draft of the Roadmap, we will examine it more fully in the final draft this fall. Our thanks to EASNA for their help and continued leadership in the pursuit of EAP excellence in the United States and Canada.

RECOGNITION

Many people contributed to this Roadmap. We thank them most sincerely including those who have agreed to serve on the Roundtable's advisory panels.

We thank the continuing support of the Roundtable's sponsors – CIBC, Great-West Life Assurance Company, Scotiabank, TD Bank Financial Group and Torys LLP, our corporate counsel.

We pay special tribute to the National Quality Institute. You embraced Mental Health and Excellence at Work in Canada and gave mental health a permanent place in your prestigious healthy work place award.

NQI will help us transform this Roadmap into a user-friendly workplace tool and the Roundtable is proud it will become part of the NQI portfolio.

For their commitment to the Roundtable's efforts, we thank Medisys, Watson Wyatt Worldwide, ATF Canada, Warren Shepell and FGI. And to Chris Keen, our On-Line Communications designer and advisor and Diane Rogalski, a children services worker in Simcoe County, Ontario.

We thank Lloyd Craig at the BC Roundtable for a critical employer-insurer strategy session last February which produced the “Yes Report” – a powerful consensus that, yes, Canada can reduce mental disability in its workplace.

This finding influenced the directions in this Roadmap.

The Employee Assistance Society of North America and its president Louise Hartley, gave us valuable advice and we thank her and the EASNA board for their insight.

We will call upon these and other friends again as the Roadmap proceeds from Summer Draft to Final Draft this fall. At that time, each contributor will be more appropriately cited – and saluted.

Global Business and Economic Roundtable on Addiction and Mental Health

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SIGN POSTS FOR THE ROADMAP

“Four HR practices have a profound impact on disability rates: Degree of employee involvement/participation in work decisions extent of conflict resolution and grievance instruments. Workforce stabilization and continuity policies disability management which emphasizes early supportive assistance” **The Columbia School of Business in a study for UNUM Insurance in the US.**

“Everybody is aware, everybody is concerned, and everybody is totally sold on the business case.” **Elisabetta Bigsby, EVP- Human Resources, RBC Financial Group**

“That men in general should work better when they are ill fed than when they are well fed, when they are disheartened than when they are in good spirits, when they are frequently sick than when they are in good health seems not very probable. Years of dearth among people are years of sickness and mortality which cannot fail to diminish the produce of the industry.” **Adam Smith, Wealth of Nations, 1776**

“I notice, I see, I’m concerned, how can I help.” **Guidelines for Managers, Canadian Mental Health Association**

“Our government is committed to ensuring that mental health continues to be given the priority it deserves. Breaking down the stigma of mental health in the workplace is the next frontier.” **Honourable Brenda Lake, Minister of Mental Health, Government of British Columbia**

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ROUNDTABLE ADVISORS

Harvard Depression and Work Performance Study in Canada
Scientific Advisory Committee and Study Leaders

- Dr. Ron Kessler (Harvard Medical School), Chairman
- Dr. Philip Wang (Harvard Medical School)
- Dr. Roger Bland (University of Alberta)
- Dr. Gaston Harnois (WHO Collaborating Centre, McGill University)
- Dr. John Millman (Medical Adviser, Canadian General Electric and Toronto Police)
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- Study Leader: Dr. William Gnam (Centre for Addiction and Mental Health)
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- Study Co-Leader (Employer Recruitment): Joseph Ricciuti, National Practice Leader, Watson Wyatt Worldwide (Canada)

Panel of Advisers:

- Dr. Larry Myette (University of British Columbia) – Special Adviser, Occupational Medicine, Mental Health in the Workplace
- Glenn Carmen (Medisys) – Special Adviser, Operational Solutions, Mental Health in the Workplace.
- Douglas Smeall – (ATF Canada) – Special Adviser, Disability Management, Mental Health in the Workplace
- Mary Ann Baynton – (Mental Health Works) Consultant and Adviser, Workplace Relations, Mental Health in the Workplace
- Chris Keen – (Indigo Books & Music) Consultant and Adviser, On-Line Communications

Statement by
PUBLISHERS FOR MENTAL HEALTH

There are times in the life of a nation when a generation is defined by the challenges it stands up to. For this generation, terrorism is one such challenge. The integrity of our public institutions is a second. And, mental illness is a third.

The rising rates of mental ill health among Canadians and populations the world over have been described as an “unheralded crisis” – unheralded, but also unanswered. As such, it is also a crisis of conscience.

Only one in five Canadians who need mental health care in this country actually get it – many, children, teenagers and young adults.

Statistics Canada says young people between 15 and 24 are uniquely vulnerable to mental illness. The average age of onset for anxiety disorders in Canada is age 12. Depression is age 21. Canada has the third worst teenage suicide rate in the world.

Mental illness – most of its undiagnosed and untreated – has a hefty price tag costing Canada an estimated \$33 billion in lost industrial production annually. Depression is the leading source of disability among Canadian workers.

This is not just a health care problem, a funding problem or a government problem. Although it is all of those. This is societal problem and demands a response from society as a whole – including employers.

2005 has been designated the “Year for Mental Health and Excellence at Work in Canada.” Now is the time and this is the generation to arrest the mental health crisis confronting Canadians. Several million of our fellow citizens are counting on that.

PUBLISHERS FOR MENTAL HEALTH in association with the Global Business and Economic Roundtable on Addiction and Mental Health

April, 2005

Neil Fowler, Publisher and CEO, Toronto Sun
Michael Goldbloom, Publisher and CEO, Toronto Star
Jim Orban, Publisher, Ottawa Citizen
Les Pyette, Publisher, National Post

EXECUTIVE SUMMARY

The Roadmap aims to engage many stakeholders:

- Investors to measure the quality of management of companies they invest in
- Corporate directors to exercise a particular expression of their fiduciary duty
- CEOs to provide the necessary leadership in defence of performance standards and shareholder value
- Executives and line managers to accept accountability for workplace conditions which promote employee mental health
- Insurers – with employers – to forge a generation of standards and best practices to reverse current trends in the rise of the incidence and costs of mental disability in the workplace
- Physicians in the spheres of primary care, occupational medicine and specialist care to help improve the capacity of family practitioners to diagnose and treat mental disorders effectively
- Clinical psychologists to articulate their role in efforts to bring about a dramatic improvement in the diagnosis and treatment of depression and anxiety among men and women in the labour force
- Employees to develop and act on a sense of personal responsibility for their own mental health

Employers and employees in high-risk jobs such as police, fire, emergency services, children's services, the military – working together to –

- Fashion strategies to tackle the bureaucratic, administrative and political hassles which represent a greater risk of stress injury and subsequent health problems than the risks these brave people face on the job day-to-day.

Health professionals in other disciplines – occupational therapists, nurses, practitioners, specialists in community care, others – to make their voice heard and to contribute capacity to a new Canadian model of disability management and vocational rehab.

SUMMARY CHARTS

This summary gives users at-a-glance access to several components of the Roadmap.

Recapping the Summary Charts here:

CEO Leadership Chart

- Serving business objectives

Architecture of the Wilson Principle

- Unifying mental and physical health and safety

Architecture of Shared Responsibility

- Unifying the parties behind recovery and return to work from mental illness

The Green Chart

- Physician's Roadmap
- Case Manager's Roadmap

Getting the Facts

- Information for all employees

Recognizing Depression and Anxiety

- Individual effects
- Signs of group stress
- 10 distinct faces of problem job stress among middle managers

Pathways to Burnout

- 10 high risk management practices

Managing Mental Health in the Workplace

- Illness and attitude

Rule out Rule

- Return to work: two objectives

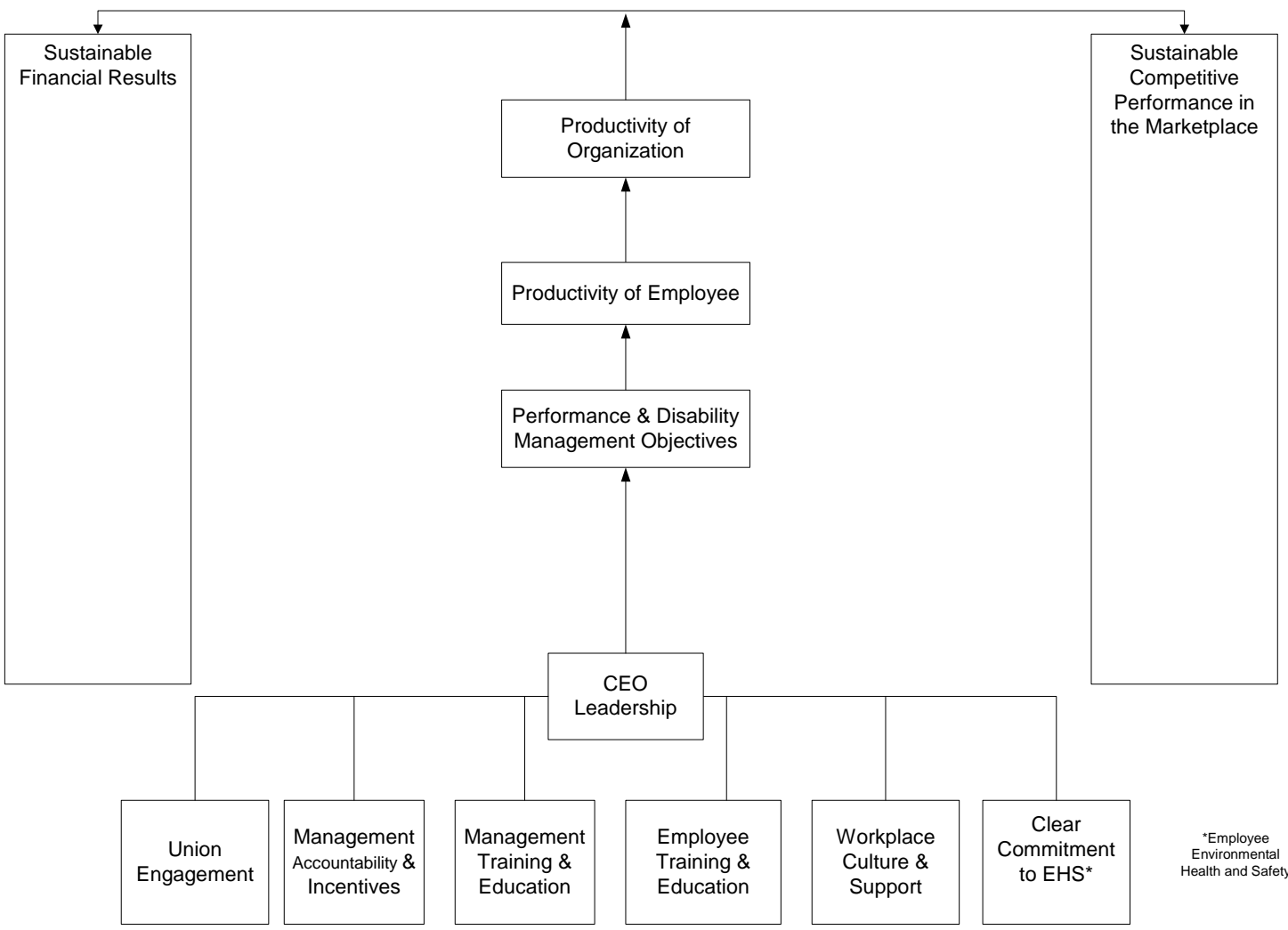
It's a Matter of Law

- Union responsibilities

Peel Region Pilot

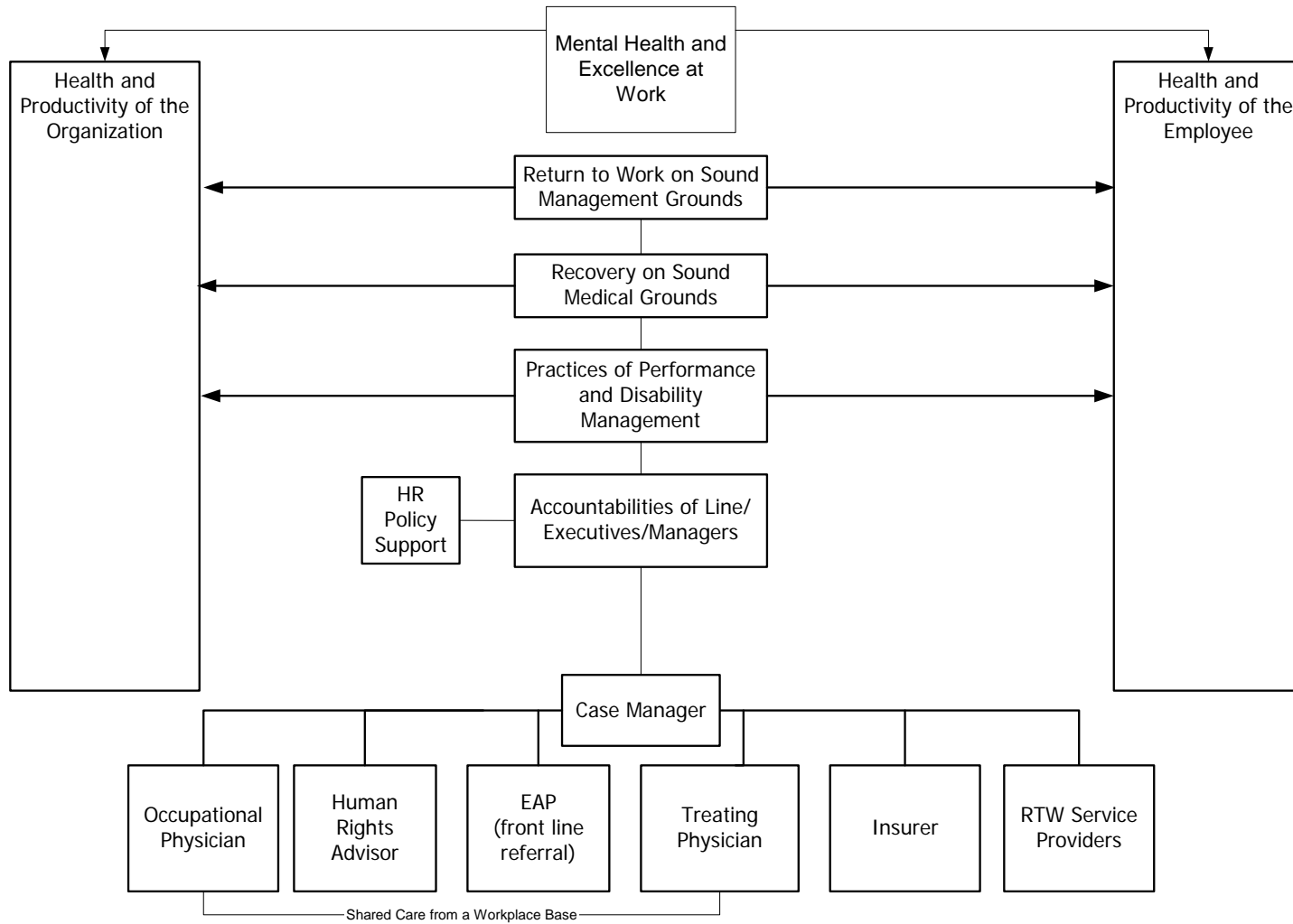
- Alleviating symptoms of depression through physical fitness

Summary Chart CEO Leadership



*Employee Environmental Health and Safety

Architecture: Recovery/Return to Work and Shared Responsibility



Case Manager's Roadmap to Recovery – Green Chart

Employee:

Case Manager:

Date:

Date of Next Case Meeting:

	Physician's Rating 1 to 5	Physician Recommendations	Plan of Action	Desired Outcome
<i>General Work Skills</i>				
Understanding and following instructions				
Performing simple and repetitive tasks				
Maintaining a work pace appropriate to the work load				
Relating to other people beyond giving and receiving instructions				
Influencing others, accepting instructions, planning				
<i>Specific Job Functions or Requirements (not covered above, as outlined by the case manager)</i>				
<i>Additional Tasks for Case Manager</i>		<i>Date</i>	<i>Comments</i>	
Re-entry interview scheduled				
Employee invited to bring friend, family member or physician to re-entry interview				
Employee assured his/her job is waiting for him/her				
Employee formally welcomed back by employer				
Re-entry plan established and reviewed; a realistic timeline implemented				

Physician's Roadmap to Recovery – Green Chart					
In the space provided explain and/or list specific accommodations that can be made by the employer to ease the Return to Work process					
	1 At this time, the task is impossible for the employee to perform	2 The employee can perform some aspects of this task with accommodations	3 The employee can perform this task with accommodations	4 The employee performs this task well although some accommodations are still necessary	5 The employee can easily perform this task with little or no special assistance
<i>General Work Skills</i>					
Understanding and following instructions					
Performing simple and repetitive tasks					
Maintaining a work pace appropriate to the work load					
Relating to other people beyond giving and receiving instructions					
Influencing others, accepting instructions, planning					
<i>Specific Job Functions or Requirements (not covered above, as outlined by the case manager)</i>					
<i>Information Required by the Physician</i>					
Character of the workplace – pace, dynamics and history					
Patterns of absence or downtime in the last 30 days					
Any other relevant information					

ROADMAP TO MENTAL DISABILITY MANAGEMENT

*A first step toward international standards governing the return to work from mental illness
Eliminating the stigma of mental health problems in the work place*

GETTING THE FACTS...

Demographics and facts to help define “target audiences” for early education and intervention

*Number of Canadians
experiencing a mental disorder
in...*

1 day	10 – 15%
1 year	20 – 25%
1 generation	37 – 40%

- Fewer than 20% of those who need treatment actually get it
- 70% of those people are in the labour force
- Individuals in their prime working years and valued employees with 10 to 15 years of service are uniquely vulnerable
- Bipolar disorder can be categorized as a “physical condition” according to a U.S. court
- Depression is linked to diabetes, hypertension, asthma, heart disease or stroke
- 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. *Researchers at the Centre for Addiction and Mental Health find that 75% of those who get the treatment they need, do successfully return to work.*

Depression and Heart Disease

- 20% of people who suffer heart attacks exhibit signs of clinical depression at the time
- Depression can dispose individuals with damaged hearts to arrhythmia
- Depression quadrupled the risk of cardiac death among patients admitted to the Montreal Heart Institute for unstable angina
- The U.S. National Centre for Health Statistics reports "there is evidence to suggest that depression may cause stroke or other cardiovascular events."
- Cardiac patients suffering depression experience "decreased heart rate variability," which means the heart of a depressed person never sleeps
- Depression may increase blood clotting which can impair the supply of blood and oxygen to the heart, a cause of heart attack

ROADMAP TO MENTAL DISABILITY MANAGEMENT

*A first step toward international standards governing the return to work from mental illness
Eliminating the stigma of mental health problems in the work place*

RECOGNIZING DEPRESSION & ANXIETY

Depression and anxiety have major physiological implications affecting perspective, sleep and concentration; handling time pressures, feedback, multi-tasking and change.

Individual Effects:

- 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

Signs of Group Stress:

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

10 distinct faces of problem job stress among middle managers

1. Growing **irritability and impatience**, “no end in sight reactions to even routine requests for information.
2. **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.
3. **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.
4. Treating the concerns of others about workload and deadlines with contempt **and sarcasm**.
5. **Displaying frustration** with one’s own boss in the presence of others and leaving angry voicemails after regular business hours.
6. **Stretching the workday** at both ends, **calling in sick** a lot, **persistently late** for meetings.
7. **“Working at home”** to avoid the negative energy of the office.
8. **Limiting eye contact with others** except to “react,” finding it painful to smile openly, your cheeks have a heavy, a fuzzy feeling behind your eyes
9. **Finding small talk hateful. Tuning out** what others say. **Missing deadlines, losing faith** in yourself and others, resenting and even alienating customers.
10. Eventually, **physical symptoms** of pain and burning, breathing troubles, back problems. Burnout may migrate to a diagnosable and dangerous medical condition.

ROADMAP TO MENTAL DISABILITY MANAGEMENT

*A first step toward international standards governing the return to work from mental illness
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PATHWAYS TO BURNOUT

As a matter of good business and good health, remedies are called for to eliminate and reduce the effects of poor management practices in the 21st century workforce

- 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

Depression predictors vary by occupation:

Factory Workers

- Minimal control over workload and excessive environmental noise

White Collar Employees

- Role ambiguity, lack of control over their work, lack of support from co-workers

Teachers, Physicians, Healthcare Workers, "Caring Professionals"

- Job strain

10 High-Risk Management Practices

1. Imposing **unreasonable demands** on subordinates and withholding information materially important to them in carrying out their jobs.
2. Refusing to give employees reasonable discretion over the day-to-day means and methods of their work.
3. **Failing to credit or acknowledge** their contributions and achievements.
4. Creating a **treadmill** at work – too much to do, all at once, all the time.
5. Creating **perpetual doubt**, employees never sure of what's happening around them.
6. Allowing **mistrust** to take root. Vicious office politics disrupt positive behaviour.
7. Tolerating, even fostering **unclear company direction** and policies, job ambiguity and unclear expectations.
8. **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.
9. **Lack of two-way communication** up and down the organization.
10. Managers rejecting, out of hand, an employee's concerns about workload

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

ROADMAP TO MENTAL DISABILITY MANAGEMENT
A first step toward international standards governing the return to work from mental illness
Eliminating the stigma of mental health problems in the work place

MANAGING MENTAL HEALTH IN THE WORKPLACE
A person suffering depression may exhibit behaviours that mimic bad or negative attitudes.
It may be a symptom, not an attitude.

The failure to draw a distinction between **illness** and **attitude** can cost an employee their job and the company an otherwise valuable asset.

It is difficult to tell the difference when work relationships are strained by an individual's failure to meet their obligations at work, proneness to anger, inability to concentrate or communicate appropriately

Rule Out Rule

<p>A three step process to “rule out” OR “rule in” health problems as the source of an employee’s performance deterioration.</p>	<ol style="list-style-type: none"> 1. Train supervisors, managers and executives to ask questions of an employee which both respect their privacy and help them to consider whether a health consultation is worth doing <u>before</u> the performance issues are reviewed in more conventional terms. 2. Encourage the employee to consult his/her family physician or another health professional including the company’s EAP provider if one is available. 3. Defer the “performance discussion” until this health review is complete. Once it is, the employee has information – confidential and private – with which to make a decision about next steps in consultation with his/her boss or the employer’s confidential staff
--	---

Return to Work – RTW
A process where recovery and a gradual return to work are mutually reinforcing

- | | |
|--|---|
| <p>Two Objectives:</p> <ul style="list-style-type: none"> • Keep the lines of communication | <p>Two Precautions:</p> <ul style="list-style-type: none"> • Like other chronic illnesses, coming back to work too soon can impede |
|--|---|

open between the employee and the work place. Isolation predicts and deepens depression. It prolongs disability.

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

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% return**

1 year – 10%

2 years – 2%

Employers can bridge recovery and return-to-work by carefully tracking, 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.

ROADMAP TO MENTAL DISABILITY MANAGEMENT

A first step toward international standards governing the return to work from mental illness

Eliminating the stigma of mental health problems in the work place

IT'S A MATTER OF LAW

Mental illness is explicitly protected against in human rights legislation.

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.

- Courts have ruled that impairment due to disability is unique to the individual. Job accommodations must – and can – be the same.
- 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.

<i>Union Responsibilities</i>	
<ol style="list-style-type: none"> 1. Unions have a responsibility to accommodate and cannot escape this duty through any provision of a collective bargaining agreement. 2. Unions and co-workers of the RTW employee must participate in the search for an accommodation – and cannot flatly refuse on the basis of seniority or job posting rights. 3. Neither can the employer ask the union and co-workers to waive seniority rights unless “no other reasonable alternative resolution exists.” 4. Unions have a duty to represent their members “at the higher end of the scale” in matters concerning a disabled employee. This is particularly true when an employee is mentally disabled and the issue is termination. 	<p>In one case ...</p> <p><i>The union was “held to have violated its duty of fair representation to the employee” by failing to seek arbitration in the case of an employee disabled by depression who was fired for not following orders and getting along with fellow employees.</i></p> <p>The Saskatchewan Labour Relations Board held that “the union failed to take sufficient account of the mental disability experience by the employee and it therefore discriminated against him in handling the grievance.”</p>

Business Leaders Speak Out on Mental Health

“In Their Own Words”

These are the verbatim accounts of statements made by senior business people in speeches and four of Roundtable meetings hosted by the leaders of TD Financial Group, Scotiabank and CIBC in their Boardrooms in 2002, 2003 and 2005

*“The case for the importance and severity of mental disability is incontrovertible and any board of directors that doesn’t insist on having environment, safety and health on its agenda – with a special emphasis on mental health – is not discharging its governance responsibility.” **John Evans, Chairman of the Board, Torstar Ltd.***

*“Mental health and work place stress must be counted as one of the top business issues for all of us who claim that our people are our most important asset and the basis of our success or failure.” **John Hunkin, President and CEO, Canadian Imperial Bank of Commerce***

*“How we treat people in the workplace is at the heart of sustaining business performance over the long-term. This is a big agenda and a critical one.” **David Wilson, Vice-Chairman, Scotiabank and CEO, ScotiaMcLeod***

*“Today’s economy puts a premium on information and innovation. This is an economy of mental performance where the capacity of employees to think, be creative and be innovative is key to the competitiveness of all business – including my own.” **Gordon Nixon, President and CEO, Royal Bank Financial Group***

*“Business must have a mental health agenda.” **Paul Godfrey, President and CEO, Toronto Blue Jays***

*“We simply must get our arms around this issue for sound business reasons.” **Tim Price, Chairman, Brascan Financial Corporation and the Roundtable’s Co-Founder and Chairman***

*“Business, definitely, has a strategic interest in the mental health of the labor force.” **Nancy Hughes-Anthony, President and CEO, Canadian Chamber of Commerce***

*“A case can readily be made – with lots of data to back it up – that investing in the mental health of our workforce isn’t a leap of faith, it is a reasonable and prudent thing to do.” **Jamie Anderson, Deputy Chairman, RBC Capital Markets and Chairman, Centre for Addiction and Mental Health***

“When the Roundtable was formed, many of us were from Missouri. We had to be convinced that mental health issues deserved to have a distinctive place on the corporate agenda. For one, I don’t need more convincing.” **Colum Bastable, President and CEO, Royal LePage Ltd.**

“The pay-off of investing in the mental health of our people will be huge.” **Don Tapscott, Co-founder, Digital 4Sight and President, New Paradigm**

“We endorse the goal of preventing disability associated with depression, anxiety and substance abuse. We believe in early intervention.” **David Henry, Managing-Director, Toronto, Great-West Assurance Company**

“The cornerstone of what we have done in our organization is to establish mental health as a priority – that is, to understand the problem and provide our staff with the necessary tools and support to address it.” **Don Pether, President and CEO, Dofasco Inc.**

“Leadership in this area must come from the top. HR departments must be empowered.” **Lynton J. Wilson, Chairman Emeritus of the Board, Nortel Networks Corp.**

“The issues that we’re addressing in workplace mental health are questions of good management and that’s key criteria for assessing financial performance or the future performance of any institution.” **Paul Haggis, President and CEO, Ontario Municipal Employees Retirement Savings (OMERS)**

“Just as every physical injury carries with it identifiable, unwanted and, to my mind, fully preventable business costs, and if compassion isn’t enough, we have a self-interest in restoring productivity to its highest possible level if it is being constrained by a mental illness.” **Former Syncrude CEO, Eric Newell**

CEO Perspectives on Mental Health in the Workplace

The Roadmap flows from:

- 22 CEOs who took part in an extensive CEO Survey on Mental Health sponsored by BMO Financial Group for the Roundtable

Their principal goals for mental health in the workplace:

1. *Maintaining a productive work force:*
 - Employees who exhibit symptoms of poor mental health have a direct impact on the ability of co-workers to function, especially in workplace teams.
2. *Recruiting and retaining the most talented personnel:*

- To recruit the best people, companies must build a reputation for providing employees with the support and assistance they need to avoid or successfully manage stress-related health problems.
- CEOs say CEOs:
 - Must champion good mental health themselves and they would benefit from coaching and support to get comfortable talking about the subject in an open and frank way.
 - Must champion good mental health not only in their own company but among other CEOs who are customers, competitors, both or neither.
 - Should share best practices and personal experiences in dealing with mental health issues on-the-job and in the community.
 - State both the desire and commitment to promote and maintain good mental health among employees in their organizations.
 - Must be accountable for reducing stigma and promoting mental health in the workplace and should ensure that:
 - Managers and supervisors in their companies receive the training and the tools they need both to identify symptoms of mental distress among employees help co-workers and direct reports access treatment.
- Make funding and time available for managers and supervisors to attend courses and access written materials that will help them become more knowledgeable about employee mental health issues.
- Encourage employees to educate themselves about mental health in the workplace.

THE WILSON PRINCIPLE

This principle is advocated by Roundtable Senior Chairman, Honourable Michael Wilson, Chairman of UBS Canada and it:

- Incorporates mental health into broader environmental, health and safety policies.
- Links this enhanced form of EHS to performance management.

- Represents an opportunity for employers to extend the substantial progress made in reducing physical accidents and injuries in the workplace to mental health and safety and “stress injuries” (Canadian Labor Congress and Canadian Armed Forces).

Refer to the Architecture Chart

EHS FIRST THE ALCAN MODEL

Good practices in the workplace begin with good policy. Alcan’s *EHS FIRST* policy is predicated on a vision “to be a recognized leader of environment, health and safety in everything we do and everywhere we operate.”

The policy describes EHS excellence as a “journey of continuous improvement not a destination” – it is about “developing a mindset or attitude where each of us makes *EHS First* a priority at all times.”

“In concrete terms, we all have the right to return home safely at the end of the day ...and a key component (of the EHS policy) is to transform all employees into EHS champions and believers at home, at work and in their communities.”

EHS First cites specific occupational health objectives such as “hearing conservation.” Notably, noise controls – as a health and safety measure – would also apply to conserving “concentration” – a skill set attacked by depression.

Alcan’s Chairman of the Board, the distinguished Canadian, Yves Fortier, formally endorsed the Roundtable’s Board of Directors Guideline for Mental Health and Safety last year.

DEFINITIONS AND TERMS USED IN THE ROADMAP

Reading the signposts is necessary to using the Roadmap:

This is a roadmap to the meanings, distinctions and implications of words both commonly and infrequently used in reference to the mental health in the labour force.

MENTAL HEALTH: the successful performance of a mental function resulting in productive activities, fulfilling relationships with other people and the ability to adapt to change. It is the springboard for thinking and communications skills, learning, emotional growth, resilience and self-esteem.

MENTAL ILLNESS: this refers collectively to all mental disorders which, in turn, are health conditions characterized by alterations in thinking, mood or behavior associated (in some combination) with distress, impaired functioning and disability.

MENTAL HEALTH PROBLEMS: these are less serious, though distressing to the person at the time they occur. If recognized, these problems can be alleviated by family and social support and professional interventions. Work and life need not be too adversely affected if the appropriate help is obtained early.

BURN-OUT: this has three dimensions: exhaustion, cynicism and a loss of professional or occupational efficacy. This is a dangerous condition and can spread in the work place – producing the high levels of employee disengagement recorded by Gallup and others. It is a pathway to depression.

MENTAL STRAIN: this refers to psychological stress that is common to most people at varying degrees and different times. It need not suggest illness.

STRESS: this is a non-specific response of the body to any demand made upon which it results in symptoms such as the rise in blood pressure, release of hormones, quickness of breathe, perspiration, tightening of muscles, and increased cardiac activity.

Stress is not always necessarily negative. Some forms keep us alert and motivated. Too little can have the opposite effect and represent a problem in its own right. Too much stress, though, triggers both mental and physical health problems particularly over a prolonged period of time.

JOB STRESS: This is a harmful physical and emotional response when the requirements of the job do not match the capabilities, resources or needs of the worker.

Job stress leads to poor health and even to injury – and may contribute to a number of serious, debilitating disorders including depression, cardiovascular disease and cancer.

In the 1990s, the most highly-ranked stressors are job loss, technological innovation (or invasion), change and ineffective top management.

At the work unit level, the primary causes of job stress include work overload, poor supervision, and inadequate training.

In the context of job stress, the following terms merit attention:

Job insecurity: Persistent uncertainty about whether individual employee will keep his or her job.

Work design: In inordinate workloads, relentless deadlines, long hours, shift work, routine tasks that are routinely urgent, hectic or chaotic to get done; work that fails to use the skills of the individual.

Management practices: These can promote or impair the health of employees as a source of job stress

STIGMA: Cluster of negative attitudes and beliefs motivating the public to fear, reject, avoid and discriminate against people with mental illness;

RECOVERY: Process in which people are able to live work, learn and participate fully in their communities For some, recovery means the ability to live a fulfilling and productive life despite a disability; for others, it means the reduction or complete remission of symptoms.

RESILIENCE: The personal qualities that enable us to rebound from adversity; change, trauma or tragedy – to go on with life with a sense of competence and hope. The President Commission says hope plays an integral role in the recovery process.

EARLY DETECTION: Scientific and clinical research studies – one after the other – have emphasized the importance of early detection and proper treatment as the cornerstone of effective mental health care.

The workplace has emerged as an appropriate setting in which to promote:

- One, the prevention through early detection.
- Two, the early referral of cases to appropriate professionals.
- Three, support for follow-up phase of treatment including return-to-work. This is the hope phase.
- Four, augmenting the critical role of the primary care physician in this process.
- Five, promoting the role of hope – and a return to productive work – as part of the recovery process.

LONG-TERM DISABILITY (LTD): programs that partially replace income for long periods of illness or injury (typically until recovery or retirement).

SHORT-TERM DISABILITY (STD): programs that replace all or part of an employee's income during disability up to a maximum period that is seldom longer than one year.

COSTS OF MENTAL DISORDERS: many sources quote many other sources to assign economic costs to these conditions. To clarify:

\$33B/yr in lost industrial production (Roundtable - 2002)

- Medically-treated burn-out and stress-related conditions cost 2x medically-diagnosed depression and anxiety.

\$14B/yr at a minimum for depression and distress both treated and untreated (Health Canada – 2001)

- \$6.3B/yr for medical treatment; \$8.1B/yr for lost productivity

\$44B/yr for depression in the US (MIT/others 1990)

- \$23.8B/yr in absence and lost productivity
- \$12.4B/yr in treatment costs
- \$ 7.5B/yr in mortality (premature death) costs.

(* *These numbers do not equate to a single sum*)

HUMAN CAPITAL: this concept sees people producing a stream of output that is valued at market earnings. Mental disability can reduce output by causing people to lose time and effectiveness at work.

- The results can be forcing them out of the labor force or causing them to die prematurely through (for example) suicide or heart attack.

MORTALITY COSTS: present value of lifetime earnings lost by all those active in the labour force who died in one given year due to mental disorders – combining the number of deaths with the expected value of future earnings.

- Depression and heart disease are the leading indicators of work years lost due to disability and premature death.
- This combination of disability and premature death traced to two common and interacting chronic, episodic conditions defines the new workplace-public health challenge.

MORBIDITY COSTS: the value of goods and services not produced as a result of mental disorders in the labor force. Losing even small share of labor output is expensive.

- 15 minutes of downtime = 100% impairment of 3% of an employee's available work time over an 8-hour day.

MUTIPLIER EFFECT ON COSTS: In the workplace, wage replacements for employee downtime or disability produces a significant redundancy in wage costs. Unchecked or mismanaged mental disorders have the same effect in the health care system.

- Absenteeism costs employers 2.0-2.5X their normal payroll costs.
- Problem drinkers, generally, use the medical system 8x more often.
- In Ontario, 30% of hospital beds believed to be filled with untreated alcoholics.
- In NY, people w/unchecked depression see primary care doctors 16x more often.
- Medical spending on those with more than one mental health disorders 5X higher.
- Cases of untreated depression can produce 50-75% increase in health care costs.

ROADMAP GOALS AND OBJECTIVES

The Roadmap has links to four strategic business goals:

- Maintaining a productive work force
- Recruiting and retaining the best people
- Sustaining customer service excellence
- Remaining competitive

The Roadmap drives toward five concrete objectives:

- Prevent the disabling and deadly effects of mental disorders and addictions in the labour force.
- Identify and remedy the effects of those management practices most likely to precipitate or aggravate stress-induced mental disorders in the workforce.
- Promote and advocate for the dual diagnosis of mental and physical health conditions including depression and heart disease. Chronic stress is a risk factor in both.
- Create a policy of zero tolerance for discrimination against employees with mental illness and defeat stigma as a barrier to care and treatment.
- Foster workplace cultures which permit open and informed communication on these subjects among all parties in the workplace.

The Roadmap is built on 10 specific facts:

1. Mental disorders are driving the incidence of employee disability today. Acute psychiatric conditions are the leading primary and secondary drivers of the incidence of long-term disability (Great-West Life).
2. Anti-depressant medications are the principal drug of necessity for employees between 25 and 44 years of age.
3. Depression is the leading source of worker disability in Canada and the world and with heart disease, emerging as the leading source of work years lost through disability and premature death.
4. Depression multiplies the risk of sudden death among convalescing heart attack victims and may contribute to the onset of stroke.

5. Depression is clinically linked to a number of chronic physical disorders including diabetes, arthritis, digestive problems, asthma and thyroid disease.
6. Where these conditions co-occur, the minimal impairment of one is overpowered by the disabling effects of the other and the result is a compounded rate of disability and absence from work.
7. Depression, on average, takes an employee off the job for 40 days. Early detection and treatment are key to reducing this.
8. Long-term disability is often the end result of mental conditions which go unrecognized, untreated or treated improperly.
9. The longer employees are off work for any reason, the more likely a mental health problem will become a secondary diagnosis and the less likely they will return to work at all. After 12 weeks, U.S. studies show, 75% return to work. After one year, it's 2%.
10. Mental disorders cost industry \$33B a year in lost production. In one oil company, the number was \$275 million a year. In one steel maker, \$60 million a year.

INVESTORS ROADMAP

Discussion

In accounting and management terms, human resources are adequately defined as an intangible or tangible asset. This must change as an incentive for employers to build, protect and invest human capital just as they build, protect and invest financial capital.

This assumes a certain urgency when one considers that –

- Between 1982 and 1998, the percentage of market value attributable to intangible assets – as defined – grew from 38% to 85%.
- Upwards of 85% of new jobs coming stream (US) require cerebral not manual skills. In a phrase, the minds of employees now do the (competitive) heavy lifting of business.
- The return on financial capital expended (ROCE) is an inadequate measure of how well organizations perform on a going forward basis. In fact, study after study proves that financial markers are a “rear view mirror” perspective of performance.

- Time and again, studies find that employee perspectives, morale and presence/absence on the job are advance predictors of future success and valid indicators of the quality of management now-in-place.
- The one force more than any other which detracts from the return on human capital investment – and the availability of employees on the job – is the downtime and absence triggered by mental health problems and full-blown mental illness.
- Chronic job stress is a major factor in the onset of these conditions and can be traced to a specific slate of management practices that – by definition – offend the principle of good management separate and apart from their impact on employee health and capacity.

OMERS President and CEO Paul Haggis: *“Employee health and productivity are fundamental aspects of good management and appropriate measures for institutional investors to use in assessing the quality of management of companies in which they invest.”*

Action

Institutional investors can use these matters – employee health and productivity – as a channel for new insight into the quality, prudence and common sense of the management in place among companies in which investors have a material stake.

To this end, the Roadmap suggests that investors:

- Inquire and determine whether corporate directors and management have quantified and therefore grasp the impacts of employee absence, disability and downtime on 1) current performance and more important, 2) future performance.
- Inquire and determine where boards and managements have acted on such information if they have it and what specific measures have been put into place specific to management practices known to deplete performance capacity among employees.
- Sharpen the point of your inquiry by focusing it annual short and long-term disability rates among employees and wage replacement costs.
- Inquire and determine the degree to which management has identified the productivity (production loss, downtime, quality impairments) costs of these matters and what steps have been taken to fund, manage and reduce them longer-term.

BOARD OF DIRECTORS ROADMAP

Discussion

Four specific management practices are most likely to precipitate or aggravate conditions such as depression and anxiety at work and these are:

- Imposing unrealistic deadlines
- Withholding information and resources that employees really need to do their jobs
- Depriving employees of reasonable discretion over their means and methods of work
- Chronic failure to acknowledge or credit employee contributions in the workplace.

The damaging effects of these conditions – according to legal experts and case law – are foreseeable in law. From this, therefore, emerges a duty of care also recognized in the law of torts and various branches of human rights, labor law and employment standards (Shain).

In turn (Shain), the duty of care evokes “the judicial principle of fairness and reasonableness in employment relationships and extends the principle of due diligence in occupational health and safety law to psychosocial as well as physical work hazards.

Meanwhile, employers in Quebec are now operating under a law prohibiting psychological harassment and a “stress code” has been enacted in the United Kingdom.

Torstar Chairman John Evans, MD: *“The case for the importance and severity of mental disability is incontrovertible and any board of directors that doesn’t insist on having environment, safety and health on its agenda – with a special emphasis on mental health – is not discharging its governance responsibility.”*

Action

Boards of Directors are advised to review the Investors Roadmap and anticipate inquiries which may be forthcoming from some. More particularly, the Roadmap advises Boards to:

- Place the topic of environment, health and safety – with a special emphasis on mental health – on all agendas of boards and board committees. The Torstar model.
- Report this action to shareholders.

- Evaluate merits and potential impact of the “duty of care” as described here and measure the status of management practices which may or may not adequately reflect this principle.
- Request management to examine these matters and, in the same light, to report on those steps taken to protect the interests of shareholders, customers and employees against the effects of unduly high rates of mental disability in the work force.
- Consult the CEO and Managers Roadmaps to sharpen the focus of your inquiry as you deem appropriate.

CEO ROADMAP

Discussion

Mental disorders are concentrated among employee in their prime working years. The Roadmap draws your attention to the (vastly) most common forms of this: depression, anxiety disorders and related forms of substance abuse and addiction.

Currently, 35-40% of disability insurance claims in your work force relate to mental disorders; among long-term claims, mental disorders are a primary or secondary disorder in 40-50% of the cases.

Disability costs in your company, overall, are driven by the duration of the claims not their frequency or volume. This reflects of the onset of chronic health problems in the current generation – principally depression and anxiety.

The workplace costs of mental disorders tend to spread laterally across operations – there is a bleeding and migratory effect – reflecting the insidious pattern of chronic stress, burn-out and depression as it invades the working lives of employees.

Middle managers are especially vulnerable.

The result –

- Elevated levels of cost redundancy through wage replacement costs – taking into account that disabled employees are on salary continuance.
- Pressing need to fund, contain and reduce these costs on sound ethical, business and (in the case of employees on disability) medical grounds.

Other considerations:

- The disabling effects of mental disorders are preventable but these conditions are unduly disabling. Depression is treatable. But only one in five get treatment.
- The low rates of diagnosis and care mean employees suffer these conditions unchecked sometimes for years. This produces excessive and elusive on-the-job downtime.
- This is called “presenteeism” – employees on the job but not fully-functioning and it costs employers 2x-3x more than absenteeism.

To be clear:

- Presenteeism is not about malingering, faking it; the phenomenon refers to productivity losses (Harvard Business Review) stemming from real productivity problems.
- The assumption behind presenteeism (Harvard Business Review) – based on extensive study – is that employees need to work, and do not take their responsibilities lightly.
- That is, they “hang in there because they’re afraid to lose their jobs.”

Meanwhile:

- The American Productivity Audit found that presenteeism in the US costs employers \$150M/yr – more than what they spend on prescriptions drugs through employee group health plans.
- Mental disorders attack men and women in their prime years. The most vulnerable demographic overall: young people 15-24.
- Nearly half of the days all full-time working Canadians are off the health reasons can be traced specifically to mental health.

Action:

- Make clear your commitment to mental health and excellence at work and to do this, the Roadmap advises CEOs to:
- Incorporate mental health into existing environment, health and safety systems.
- Articulate a plain-spoken policy that mental health and excellence at work will be part of your company’s vision of a healthy workplace.

- Establish a team of executives/top managers to evaluate the status of employee mental health in the organization with reference to those risk factors indigenous to the work place itself. Specifically:

One, audit existing disability management procedures and select short and long-term files that have lingered.

Two, evaluate your experience with the disability insurance adjudication experience over the past three years, looking for anomalies and cost-pushing trends.

Three, evaluate the mental health expertise and savvy among outside providers and contractors

Four, review in detail your employees' return-to-work experience specifically with respect to the time between the employee's clearance to return to work and actual return to work on an agreed/accommodated basis.

Five, evaluate what tools are used to perform cognitive functional assessments of employees and the knowledge and awareness of your line and professional staff as to the existence of such tools.

Six, evaluate your policies and process for designing job accommodations based on the key principles of "flexibility" and "customization."

Seven, establish that line managers will be accountable for the effectiveness of the firm's disability management and prevention initiatives including the design of incentives for this purpose.

Eight, ask – explicitly – for an account of return to work "horror stories" and solicit explanations, lessons learned and corrective steps taken.

Nine, make a clear commitment to employee education and information in the area of mental health and root this commitment in a determined effort to reduce stigma and in a zero tolerance policy of discrimination against mental illness in the workplace.

Ten, build this fact-finding into a concrete "going forward" strategy aimed squarely at reducing the cost and incidence of short-term disability associated with mental disorders, making long-term disability claims obsolete on sound medical grounds and injecting mental health into the company's vision of a healthy workplace.

MANAGERS ROADMAP

Discussion

Key measures of employee mental health status

1. Absence rates
2. Injury rates on shift work
3. Drug plan utilization rates
4. On-the-job downtime
5. Visible functional effects (slumping performance)
6. Signs of group stress (disputes, turn-over, increased grievances and complaints)

Breeding ground for burn-out – potential pathway to depression

1. Chronic bad match between the job and the employee's skills
2. More authority, fewer resources
3. Losing, lacking control over what obviously needs to get done
4. Work and role overload
5. Unclear functional goals as a steady diet
6. Constant fire-fighting even of routine times

Compounded effects of mental disorders

1. Depression doubles absence due to sickness days
2. Depression, though, is treatable; substantial cost-benefits
3. Job satisfaction predicts good health/early return from sick leave

Impact of mental disorders on job performance

1. Unduly disabling
2. Excessive on-the-job downtime
3. Tough productivity issues

Major upsides

1. Disabling effects are preventable
2. Can reduce incidence of disability and costs

Early onset

- Mental disorders are concentrated among younger adults

National absence rates

- Canadian are off work, on average, 7 days per full-time employee per year for healthy reasons alone; just short of half those days can be traced to mental disorders.

Action

Develop five policy objectives to support the CEO’s goal of an environment, health and safety system that is linked to performance management and includes mental health. Develop five policy objectives that support the CEO’s goals:

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.

Target the Common Management Stress Traps that Snare Employees to Protect Productivity Levels

Ten stand out:

1. Creating treadmills at work via unreasonable deadlines to drive results.
2. Creating dysfunctional stress through haphazardly transient work priorities.
3. Trivializing employee workload concerns.
4. Rewarding office politics.
5. Micro-managing employees as a habit.
6. Not giving employees the information and resources needed to do their job.
7. Routinely mismatching the skills of employees & the job they're asked to do.
8. Seldom saying thank you or otherwise acknowledging good effort.
9. Isolating managers and employees in a culture of emails.
10. Allowing uncertainty in the workplace to go unabated.

Create hard targets for EHS System Incorporating Mental Health

1. Reduce disability rates year-to-year beginning three years out and ensuing over the succeeding five years.
2. Eliminate absolutely the top sources of stress; develop benchmarks to guide this process.
3. Train supervisors, managers and executives to communicate with employees on these matters:
 - One, give managers and executives techniques, appropriate phrasing and relevant oral communications skills, including listening and appropriate use of body language to reach out to co-workers and direct reports in an appropriate way.
 - Two, quell honest concerns or apprehension about crossing the line of privacy which may cause the manager or executive to do nothing when, in fact, reaching out is the right course of action as a matter of good management and simple human compassion.
 - Three, ensure the organization observes the letter and spirit of human rights law governing the accommodation of employees returning to work from mental illness which is specifically protected by statute.

Consult the NQI Criteria for a Healthy Workplace as a Framework for Mental Health and Excellence at Work

Guide managers and employees with a series of questions to help them evaluate the kind of stress they are experiencing at work – for example:

- Does the job at hand call upon the skills, time and resources I actually possess?
- Conversely, do I feel responsibilities piling on and resources disappearing?
- Does my job right now create the opportunity for fulfillment of some sort?
- Do I feel I am – or can – contribute – or is this just a treadmill I’m on?
- Do I realistically think the job I’m doing right now will add up to something?
- Do I realistically think the job I’ve been given to do under deadline can be successfully completed and recognized as such?
- Does the task at hand flow from a job that is meaningful?

Learn, yourself, how to recognize what unhealthy stress looks like.

It has a face – in fact, there are 10 faces of stress for working parents in middle management. Do you see these in yourself?

1. Growing irritability and impatience, “no end in sight” reactions to even routine requests for information.
2. 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.
3. 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.
4. Treating the concerns of others about workload and deadlines with contempt and “join the club” sarcasm.
5. Displaying frustration with one’s own boss in the presence of others and leaving angry voicemails after regular business hours.
6. Stretching the workday at both ends, calling in sick a lot, persistently late for meetings.
7. “Working at home” to avoid the negative energy of the office.
8. Limiting eye contact with others except to “react,” finding it painful to smile openly, your cheeks heavy, a fuzzy feeling behind your eyes.

9. Finding small talk hateful. Tuning-out what others say. Missing deadlines, losing faith in yourself and others, resenting and even alienating customers.
10. Eventually, physical symptoms of pain and burning, breathing troubles, back problems. Burn-out may migrate to a diagnosable and dangerous medical condition.

Employees especially vulnerable to the health risks of chronic stress:

- Working women who are pregnant;
- Employees returning to work from heart attack, stroke and depression;
- Employees with chronic conditions such as asthma, depression or diabetes.

Mental Disability Management – 2005 -06

ROADMAP TO SHARED CARE AND SHARED RESPONSIBILITY

“Can we substantially reduce the incidence of short-term disability due to mental illness?”

Discussion

In work sites large and small, the return-to-work from weeks or months of mental disability leave due to mental illness can be a punishing and even punitive experience for employees recovering from mental disorders.

It is apparent that managers lack the knowledge and training to distinguish normal performance issues from potential mental health symptoms – which is natural.

Yet some managers and co-workers instinctively tend to hide behind “privacy” concerns as a reason not to reach out to employees in obvious distress.

As a result, there is a need for managers and employees to have a clear understanding of the boundaries of privacy and thus facilitate reaching out to coworkers or direct reports.

Policies and standards are needed to define and designate:

- The specific nature of managerial accountability in the management of mental disability in the workplace including the kind of incentives (and disincentives) needed to animate this concept in practical, meaningful terms.
- The procedural and operational links between the performance and disability management systems of organizations where such systems now exist.

- Where such resources and systems do not exist, the employer obligations persist. For instance, small business employers are equally bound by human rights and employment law in this area even if they lack specialized in-house resources to match those of larger employers.

Deep Skepticism

The impact of persistently late and poor diagnosis and treatment of mental health problems among men and women in the labour force is compounded by deeply-rooted skepticism among some many managers as to the authenticity of these conditions.

Such resistance may stem from ignorance, instinctual fear or just a lack of information – but such beliefs can hamper the early access to care, the early return to work and the productive performance of the organization itself due to the effects of both disability and on-the-job downtime produced by untreated mental conditions.

The discriminatory beliefs also diverge with these basic facts:

- Successful recovery from mental disorders happens;
- Successful return to work from mental disorders happens;
- An effective mental disability management system enjoins these two facts into a single principle of action.

The Dangers of Isolation

Reducing the incidence of short-term has important implications beyond the obvious. The longer an employee is off work for any reason, the more likely he or she will experience a mental health problem and, in fact, never return to work. The isolation of disability can predict depression.

Lack of Data

The widespread lack of current absenteeism and short-term disability data among employers mean, in effect, many or most employers are “flying blind” with respect to dollar costs, productivity losses and rates of daily absence. This is a serious gap at the front-end of forging new approaches to workplace mental health.

Principles for Action

Employers and insurers agree* that yes, we can reduce that burden – but it will take time and all the players in the workplace coming together to surmount systemic barriers. To do this, the BC Roundtable shaped a 14-part “Framework for Making YES Happen.”

**Special Roundtable, Vancouver, British Columbia: “The YES REPORT”.*

1. A strong alliance between business and science – including insurers – to develop and implement standards and guidelines governing the process of managing mental disabilities and returning employees to full-time work on a gradual basis.
2. This alliance supported by the principle of shared responsibility and shared care among employers, physicians, other health service providers, insurers and unions.
3. This alliance supported by “ownership” in one’s own health among employees.
4. This alliance supported by performance and disability management systems aligned the workplace to operationalize early detection of and intervention in mental disorders.
5. Recovery and return-to-work construed as a single entity for purposes of planning and implementing an integrated strategy of care, treatment and return-to-function and work among employers on disability leave.
6. CEO leadership must to reform management practices which most likely will precipitate and aggravate mental health problems in the work place.
7. Line managers held accountable for the successful return to work of employees on disability leave on sound management and medical grounds.
8. Mental and physical health integrated into a single construct for occupational health and safety in the workplace.
9. Functional assessments and depression screenings for employees deployed in the workplace to head off the disabling effects of mental conditions through early referral for care and treatment and pre-disability modification of job duties.
10. Customizing disability prevention and management practices around specific work sites and individual need. Flexibility in the design modified job duties is called for.
11. Program customization of disability prevention and management practices is a key
12. Meeting stigma head-on, through “tough love” policies of zero tolerance of discriminatory behavior toward mental disability at work.
13. Clear targets to reduce the disabling effects of mental illness in the labor force through primary (reducing job stress at source), secondary (early detection and referral) and tertiary (better access to proper care) means of prevention. A fourth column: relapse prevention.

14. Peer group training – even among executives – to assist individual employees – navigate the early hours of disability leave and, later, the return to work experience.

Course of Action

Enunciate a clear and descriptive policy on chronic job stress

“Job stress is the number one issue facing business today.”
John Hunkin, Chief Executive Officer, CIBC

This policy has three components:

Information – what chronic job stress is/is not;

Prevention – on-going efforts to pro-actively eliminate workplace sources of chronic job stress as a simple matter of good management.

Remediation – correcting workplace conditions or behaviors to facilitate the successful return to work of employees on disability leave. This is part of the disability management process.

- The return to work, it must be understood, is part of the recovery process. Coming back to a toxic environment does not predict success.

Facts Guiding this Policy:

Stress is not a state. It is a process, a set of variables, with how we react to circumstances at work or in life, 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 upset our well-being.

Disruptive job stress and constructive job stress is defined, simply, by the presence or absence of hope. For example, stress becomes dysfunctional over time when:

- The skills of the individual and expectations of their boss are not aligned with the demands of the job or the resources available to do it.
- Workplace policies, practices and behaviors seem routinely unfair or illogical.
- Workplace stress – probably related to the perception of fairness – intensifies near the close 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.

- The “struggle to juggle” the obligations of home and work duties never lets up. Job and home stress are synergistic.
- Job stress becomes chronic and, in fact, 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.
 - Escalate hormonal releases which 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 not continuously.
- Cause accidents on the job. Stress, a trigger for depression, fuels and feeds off sleep deprivation and lost concentration.
- Learn how to recognize what unhealthy stress looks like. It has a face – in fact, there are 10 faces of stress for working parents in middle management. Do you see these in yourself?
- 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.

Introduce the “Rule out Rule (1)” to Link Performance and Disability Management

The “rule out rule” helps distinguish between developing medical symptoms and garden variety performance and relationship problems.

The “rule out rule” gives managers and employees a new tool to discuss sensitive matters fruitfully and clearly – taking into account:

- The employees’ right to personal privacy and –
- The manager’s accountability for that individual’s presence-in-the-job and performance of it.

The “rule out rule” is called for given the high prevalence rates of mental disorders and mental disability insurance claims in the workforce. By using it, the manager makes no assumptions or inquiry about the health of the employee.

The “rule out rule” revolves around gradual or marked change in an employees’ performance, relationships, affect, energy and other visible signs.

The “rule out rule” involves a trainable, learnable and straightforward construct of oral communications and empathetic observation:

Manager to Employee:

- *“Jack, we value you here and we have some questions to discuss your performance lately. But I’d like you to consider something first.*
- “I’ve noticed, Jack, that you seem to under a lot of pressure. We all go through that from time to time; and sometimes, it takes a toll;
- *“So, before we begin this conversation, I have a suggestion ...”*
- “Would you care to take a bit of time to find out if there are any health issues getting in the way right now and, if you decided to do that, I would be supportive and we would put this conversation on hold until then.

- *“Now, you find out is your private information -- but if a health issue does show up, then that’s priority one for both of us.”*

Body Language

- sit don’t stand; avoid a desk between you;
- manager makes eye contact
- but don’t stare or glare
- look away easily from time to time
- then return.
- Don’t lean back in your chair; stay in a relaxed neutral position or lean forward a bit just to make the conversation seem more personal.

Delivery

- get to the point quickly, no big lead-up
- the construct is a series of brief, short sentences and transitional phrases
- this allows you to pause and yet complete the message in a single thought.

Tone

- balance genuine concern, empathy and clarity.

Listen

- patience breeds listening and listening breeds patience; take an interest in the employees’ viewpoint – feelings – give him/her the gift of listening.

Next Steps

- Don’t end the conversation in a fog;
- If need be, adjourn and make an appointment to talk again
- Give the employee time to think about things
- But don’t end the meeting on a vague basis. Establish, exactly, the next step.

Onus

Rule-out-rule is not a means to escape one obligation as an employer and manager. It is a tool to exercise those obligations.

Human rights findings run against an employer who takes disciplinary action against an employee even if the employee resists offers to help.

Preps

- Pre-planning this conversation is key.
- Get up-to-speed on employer services available to the employee; EAPs are a good starting-point.
- Also, make a deal with your own boss: you intend to invoke the “rule out rule,” express support for the employee and you need to make sure you and your boss are on the same page.

Also, be clear:

- If the employee exercises this option and learns he/she is suffering a mental condition which merits medical attention, this could produce sick leave or even short-term disability leave;
- When the employee recovers and returns to work, his/her right in this regard is established in law. The deferred “performance discussion” cannot, then, be activated on a condition for the employee’s return to work.
- In fact, in complex cases, performance discussions of this nature are best cancelled and make a fresh start to the employee’s job performance opportunities and obligations.

Introduce “Rule Out Rule (2) To Link Organizational and Individual Health

Ruling in or ruling out the health concerns of the individual is only part of the strategy to prevent the disabling effects of mental disorders. The other part is ruling or ruling out the symptoms of the organization itself.

Is the workplace sick – and is it making the people working there sick?

The Roadmap to Shared Responsibility:

- Provides for an assessment or inventory of physical work hazards and practices of the nature companies routinely do in the face of physical accident or injury.

That said, no assumptions can or need be made that an employee’s mental disorder is attributable in whole or part by the workplace environment. But the question merits attention.

Data demonstrates certain management practices and workplace practices can precipitate or aggravate mental health problems. Do these practices show up in the departing employees' department, office or work area?

As a matter of due diligence, therefore, employers are advised to deploy "Rule out Rule (2)" to determine whether such factors may be in play:

Line of Inquiry

Consult the CEO Roadmap and Managers Roadmap" for context and focus for using "Rule out Rule (2).

- Seek out signs those common stress traps which frequently snare employees and using the principle of the "exit interview" among current employees, evaluate whether these hazards are routinely in play;
- Survey employees now off work on sick or disability leave to determine their experience, what worries them about returning to work;
- Survey managers and supervisors and consult executives to ascertain if a preponderance of employee absence – noted through common observation if not formally monitored – is collecting in any given part of the organization.
- Interview the employee-on-leave's direct supervisor to affirm that individual's understanding of their role in facilitating a successful return-to-work process and, in turn, inquire as to workplace factors which may impede the employees' safe return to work.
- Organize this input into an honest appraisal of the health of the work environment and take steps needed to remove any "toxic substances" (behaviors or practices) in advance of the employees' return to work –
- This, to guard against unsuccessful re-entry one the one hand and, on the other, to protect the employer against management practices which would compromise a faithful appraisal of the employees' performance on the job going forward.

Continue "Rule out Rule(s)" during the leave period:

Has the direct-report manager stayed in contact with direct-report employees on sick or disability leave?

Has the manager provided for the employees' gradual return to full-time work by pre-planning the necessary modifications to his/her existing job according tom information and advice provided by professional staff?

Does the manager monitor the progress in the employees return to work before re-entry but after medical clearance – this, to ensure –

The employee is being well-prepared for returning to work in terms of job accommodation planning and answering concerns and questions;

The employees' phone calls are being answered promptly by professional or insurance staff to prevent frustration and fear;

The employee is back to work within 14 working days from the point of medical clearance;

The employee's previous "performance issues" are set aside and a policy of "fresh start" in place – focusing on current and "going forward" performance reviews customized around 1) the recovery and return to work process and 2) the return to full-time status.

The employee's co-workers are adequately briefed on their role in the return to work process – making it clear job accommodations are not "applying favorites" or "cow-towing" but are a practical response to a formal strategic and legal requirements.

Doctrine of Shared Responsibility

Reducing the Disabling Effects of Depression/Anxiety Disorders in the Work Force

The most crucial time to arrest the disabling potential of these mental conditions is the first two weeks of the actual or suspected onset of symptoms which may or may not be coincident with employees' continuing absence from work.

The most effective form of early-intervention, therefore, takes hold in that period of time or as close to it as possible. That said, barriers exist and overcoming them means overcoming some history. A first step:

Re-thinking the concept of disability management. The term mental disability management suffers from the widely-held perception that the individual is "damaged goods" and probably permanently so. Which is inaccurate.

For a new approach – and new terminology – we turn to the concept of recovery at three levels:

1. Recovery of the individual through sound medical means
2. Recovery of the organization from the loss of the individual through sound management means
3. Recovery of the functional capacity of both.

Point 3 means twinning employee health and organizational health to form a complete perspective on what it will take to reduce the disabling effects of mental disorders. Some management practices and behaviors impair the health of individuals in the work place.

In fact, symptoms of mental disorders or other forms of illness complicated or triggered by the toxic stress associated with bad management practices may also serve as symptoms of an unhealthy organization.

Therefore, a unified approach to disability management is called for to be known as “*The Health and Function Recovery System.(HFRS)*” supporting the recovery of the health and productive capacity of the individual and the organization – both concurrently and interdependently.

A principle of shared responsibility is necessary to the effective deployment of the HFRS engaging each of the following on a unit or team basis:

The employer as defined by the executive or manager responsible for the work of affected employee;

The union is defined by the local, provincial and national leaderships of the bargaining unit involved, if any;

The health professional defined three ways:

1. By the qualified treating physician - funded by the provincial government according to the Canada Health Act – whose sole responsibility is the medical safety and health interests of the employee/patient;
2. By the consulting physician(s) – funded by the employer – who does three things:
 - Advises the qualified treating physician as a member of his/her peer group on work environment and job demands which may influence the employee/patient’s health status, recovery and return to work;
 - In that context, reviews and advises the responsible manager and treating physician on the pace, prospects and timing of the employees’ return to work.
 - Provides actual care when the employee cannot get access to a qualified treating physician.
3. By the professional case manager – funded by the employer – to coordinate all aspects of the HFRP.

By the insurer which performs two key roles:

- Adjudicating the employee's claim for salary continuance during an extended absence from the job, thus determining the nature and severity of the illness;
- Providing "disability management" services aimed at early diagnosis, effective treatment and timely return to work.

The employee who –

- Participates in design of the HFRP.
- Receives employer support and information so as to understand and meet his/her treatment compliance obligations;
- Is not confined to his or her home by the recovery plan but is encouraged to remain active in the community including the work place;
- Receives independent employment and human rights advice from experts made available by the employer or the employer and the union on a joint-basis.

Pitfalls of Self Insurance

The Health and Function Recovery System will require a number of innovations and improvements to existing disability management programs.

Employers who self-insure their short-term salary continuance program must exercise greater vigilance in reporting the absence in monitoring the sustained absence of employees and report their absence to their plan administrator.

One unintended consequence of self-insurance for these purposes is a greater delay in the process of employee claims for salary continuance. The employer simply reports this to the plan administrator further into the absence period.

This, in turn, increases the probability that the employee is receiving appropriate care and support in the critical early days and weeks of the onset of a mental disorder.

The insurance industry as a whole is advised to review the tremendous variations in the "forms" used to garner medical information. This imposes a hardship on individual physicians, frustrates the opportunity for any kind of best practice standardization and perpetuates a fragmented understanding of mental conditions specifically.

In this respect, the industry is well-advised to modernize its use of certain terms including "mental and nervous" which is both obsolete and descriptively inaccurate.

The health assessment process needs modernization as well. Carried out on a sequential basis by health providers operating in isolated silos, the process is both more expensive and less efficient than it should be.

A “fast track” system of medical assessments is needed prior to the adjudication of so-called disability claims and this, in turn, leads to the concept of the Workplace Health Network.

On this same plain, the HFRS contemplates a process not only to arrive at a diagnosis, but - given the high rate of misdiagnosis among mental disorders – an independent means of confirming that diagnosis as a matter of routine and standard procedure in the work place.

This would extend the IME concept beyond its current deployment as a dispute resolution measure and use it strategically to improve front end care and the systematic management of mental disorders.

All medical diagnoses take into account the pattern of symptoms, the descriptions and observations of the individual and the medical standards.

In the case of depression and anxiety – as bona fide medical conditions – the perception exists that the diagnosis is a subjective one. This is incorrect.

The medical diagnosis is objective. The employee’s view of returning to work may not be. The two need not be confused.

In fact, subjective views of the employer are just as likely to delay and deter employees from getting back to work even after their physician has cleared them to do so.

Stress is not a medical condition. It is not an illness. It is a health risk factor and when “stress” is used interchangeably with, say, depression, the distinctions between depression (as a specific medical condition) and stress (as not one) are confused.

When insurers and physicians use “stress” in questionnaires or reports as a category or condition, they fuel the false notion that stress unto itself is a medical condition unto itself.

The lack of generally-accepted recovery timelines for depression and anxiety hampers all parties to remain alert to the lack of progress in the care and treatment of the employee.

The focus, therefore, might be shifted to generally-accepted return to work timeliness based on experience and an innovative points system which anticipates the eventuality of relapse without punishing the employee.

Such a system, however, must be anchored by the fact that salary continuance during “disability leave” is not a social service or entitlement. It is part of the employment contract which, by definition, has limits.

When employers permit employees to accumulate take sick leave and use it as a form of vacation, they undermine the understanding of illness and wellness as serious work place concerns.

MODEL

1000 Points: The Achievement of Recovery - 1000 Points

Phase 1 performing 25% of the job satisfactorily for 2 weeks = 50pts
 Phase 2 performing 50% of the job satisfactorily for 3 weeks = 75pts
 Phase 3 performing 75% of the job satisfactorily for 2 weeks = 150pts

Relapse: two weeks off; accumulative points remain

Phase 4 performing 50% of the job satisfactorily for 2 weeks = 100 pts
 Phase 5 performing 75% of the job satisfactorily for 4 weeks = 300pts

Relapse: one week off; accumulative points remain

Phase 6 performing 50% of the job satisfactorily for 3 weeks = 150pts
 Phase 7 performing 75% of the job satisfactorily for 4 weeks = 300 pts

1,125 points in 22 weeks: celebrates the achievement of recovery

Within this 1,000 point system:

- The importance of early intervention is established. When treatment is started within four weeks of onset (Kennedy), the beneficial effects kick in twice as fast – say, 10 days instead of 3 weeks. Half recover in 6 months.
- The employee never loses points. Always building points. Always going forward.
- Recovery Feedback Cycle for the manager/employee is built into the process.
- Relapse is recognized as a natural occurrence in the course of treating depression. (BC study) Some 60% of individuals with MDD show at least moderate impairment a year later.
- This system neutralizes relapse fear. Employee continuously eligible for salary continuance.
- STD and LTD are not mentioned; replaced by HFRS.
- Completing/building specified key tasks and relationships define success.

- Responsible manager receive credits for successful outcome.
- Peer support for both manager and employee to achieve recovery.
- Return to work is explicitly recognized in policy as part of the recovery process.
- In this respect, relapse is not a failure, it too is part of the fluid recovery process.
- Functional and health risk assessments flow into the system set out here.

Employee engagement and the pattern of disability claims are leading indicators of the organizational health of the company. Claims costs, absence rates and turn-over are lagging indicators.

Studies found that physical conditioning combined with a CBT component produced clinically worthwhile result for low back pain.

Standardized Insurance Practices for Employers

The industry can usefully consider the customer/client benefits of standardizing certain practices and terms to assist employers and employee navigate these waters on a more informed and less confusing basis.

Recognizing insurance carriers – while regulated – are also very competitive, this concept of standard should stop well short of intruding upon competitive variables and values.

Focus for Standardization

- Guideline treatment of mental disorders and return-to-work procedures go hand-in-hand; as a standard for the industry, this would stabilize employer understanding and acceptance of the strategic connection between recovery and return to work plus the job accommodations needed to facilitate both.
- Stress is not a diagnosis or medical condition; it is a symptom or trigger. A clear articulation of this, industry-wide, is important.
- The term is often used opposite depression (“depression and stress”). This practice should be eliminated unless more explicitly defined as a health risk or disease trigger.
- Insurers are looking for an actual diagnosis and a treatment plan. Industry-wide language saying this to physicians is called for.

- Industry-wide, STD and LTD policy requirements vary company-to-company and standardization is needed to give disability leave a commonly-accepted base definition.
- The question of whether an employee is “cleared to return to their specific job” is one issue, whether they are “employable” overall is another. Is the insurance industry consistent on this?
- Industry LTD forms should be standardized around specific terms and definitions concerning mental disorders. For example:
- The term “mental and nervous” is archaic and obsolete and, by and large, not factually accurate in terms of the specific nature of the medical conditions under review.
- Industry supplementary (disease-specific) paper forms relating to mental health issues should be reviewed by an industry-wide committee to ensure the entries are well-informed, technically accurate, precise and – in context - factually correct taking into account – for example – the question of co-morbidity linking depression to other chronic illnesses.
- An industry-wide standard introducing the benefits and needs for dual diagnosis when assessing claims involving mental illness – specifically depression – would be a valuable innovation.
- The term “complex claims” needs standard definitions to assist employers understand the purpose of the attendant disability management or claims adjudication process. This also touches upon the need for a “dual diagnosis”
- capacity in the medical planning process.
- As a service to employers, the industry could usefully articulate how it assess risks in adjudicating claims, the application of “anti-selection” and preceding illness especially where and when employers may contract with different carriers for their short and long-term disability administration or coverage.

For example:

When an employee is granted STD benefit by one carrier, fails to recover and then applies for LTD benefits from the second carrier, is there an industry standard which guides the insurers – and employers – in determining if and when the STD experience is judged to be evidence of “prior condition” for purposes of adjudicating the LTD claim.

Accommodation guidelines for employers – and observed by the industry – would improve the management of disabilities associated with chronic illness and particularly depression et al.

Chronic Illness

Employers and the industry are advised to consult on the future direction of employee health benefits taking into account the particular features of managing chronic illness – mainly mental illness among younger employees and other illnesses among old employees such as diabetes and arthritis.

Chronic disorders habitually carry relapse risk, symptoms recede and may re-appear suddenly. These do not define a chronically ill person, they define the dynamics of chronic illness. In this context, relapse should not render employees ineligible to return to disability benefits as if re-recovery from a temporary relapse of mobile symptoms was somehow indicative of inherent malfunction.

- Employers and insurers are advised to consult on the future direction of recognizing, understanding and managing chronic pain, somatic conditions and the implications on job performance. This issue is a harbinger of the future.
- Standard language for collective bargaining units and non-union employee benefit packages. For example:

Job modification means:

- Modifying goals and expectations;
- Doing meaningful work nonetheless

Return to work means:

- Assuming that pre-leave performance issues were related to symptoms;
- Thus, to be set aside; fresh start doctrine.

At time of RTW

Review with the employee what you will and will not say about the absence; ask the employee if she/he wishes to talk about her diagnosis with co-workers and if so in what terms. (Whether disclosed or not, this information cannot be used to determine the employee's' future employability at the company.)

Before the employee returns:

- Conduct team meeting (without employee present)

Doctrine of Shared Care

Diagnosis and Recovery (Objective vs. Subjective)

The medical diagnosis of mental disorders – like other chronic conditions – involves the observation of patterns of symptoms by physicians or psychologists. Conclusions are based on international diagnostic standards. Therefore the diagnosis is objective.

On the other hand, timelines for recovery and return to work can be influenced by a number of facts and feelings facing the employee and employer both:

- The nature of the work that the employee will be returning to; the kind of work environment;
- The temperament – supportive, indifferent, bullying – of the supervisor;
- Performance or relationship issues that have developed in the period leading up to the disability.

For example, does the employee really want to come back to that job, that workplace, that boss and does the employer really want the employee back?

This distinction is an important one and counters the notion that many employers and insurers hold – that the diagnosis of mental disorders is a subjective exercise and therefore less reliable. This idea has been repeated and unchallenged for a long time.

The dynamics between objective and subjective influences—facts, findings, feelings, fears and perceptions – make it even that more important that objective decision-making by the physician is correct, reliable on one hand, and accepted as such generally.

Recovery patterns are also influenced by other factors.

The resilience of the individual – a characteristic preceding the onset of the medical condition. The way a person responds to serious injury or illness, adjusts to the circumstances – helps shape recovery timelines.

In fact, emotional resilience is not just a factor but a determinant of physical and mental well-being and the kind of work environment we create, it is a strong predictor of absence and disability rates and in determining recovery timelines.

The nature of depression:

The individual living with major depression cannot work or do normal activities, on average, for five weeks a year (Kessler) which makes depression the leading cause of workdays lost compared to the average of 15 days lost to diabetes or hypertension.

The diagnosis of mental disorders is based on objective medical observations and conclusions by a trained physician. The recovery timelines are affected by the feelings of the individual toward the job and the employer – subjecting considerations.

Medical Affirmation Process (MAP)
Fresh Take on Managing the Front End of Mental Disability

Map Objectives:

1. To improve the capacity of primary physicians to diagnose and treat mental disorders;
2. To improve substantially the prospects of employee-patients recovering and returning to work sooner;
3. On the merits, to reduce the need for costly independent medical evaluations in the process of managing mental disabilities at work..
4. To not offend the administration of the Canada Health Act.

Issues

Only one in five Canadians receives adequate care for mental disorders.

- Canada will never have enough psychiatrists. Primary care physicians are key.

Family practitioners are not adequately trained to diagnose and treat mental illness and typically the referral time to see psychiatrists is months not weeks. Conditions corrode.

- The shared care model of supporting family physicians is an opportunity-in-waiting to deal with this conundrum.

Employee-patients navigate four critical transitions in the onset and recovery from mental disability:

- One, onset of symptoms, declining work performance; two, time on and off work without appropriate care; three, disability leave, recovery and return-to-work.

Each transition is problematic.

- One, coping with symptoms, not getting help; two, loss of self-confidence, relationships suffer; three, isolation, delay and confusion and four, uncertain performance period up to six months.

MAP: Fresh Take on a Thorny Old Problem

MAP offers the family physician the support of shared care from a workplace base -- funded by employer at the front-end of managing the disabling effects of mental disorders – specifically, depression and anxiety.

MAP entails:

- Physician-to-physician consultations between the treating family physician (whose services are publicly-insured) and consulting occupational physician/psychiatrists (whose services are paid by employers)

Through Map, the treating and consulting physicians:

- Review and affirm the diagnosis and treatment plan prescribed by the treating physician.
- Inform employers and insurers of this fact – that the diagnosis and treatment plan are correct and will be monitored appropriately.

In this manner, the parties – employers, insurers and employees – are unified by good information at the front-end of the disability leave.

The consulting physician:

- Like the treating physician, is bound – as a physician – to the recovery interests of the employee-patient and, within that stricture, keeps employers and insurers duly informed.
- Advises the treating physician on the occupational aspects of recovery and consults the treating physician on restrictions and timing for the return to work.

MAP is a new take on an existing idea – that is, third party payers and consulting physicians as in the practice of commissioning independent medical evaluations.

The IME has inherent weaknesses as a means of enhancing the recovery and return to work prospects of employee-patients:

- First, it is downstream, after-the-fact and does nothing to produce actual treatment capacity in the healthcare system;
- Second, it can be redundant and adversarial, forcing rebuttals by treating physicians and leaving the insurers or employers in the position of sorting out the deadlock.
- Third, IME's are over-used and often without rhyme or reason. When an employee is cleared to return to work by a treating physician, IMEs are not called for unless there is a concrete conflict of professionally-informed opinion at hand.

IMEs are valid when 1) the recovery of the employee-patient is lagging; 2) the treatment plan isn't working; 3) or the employee is resisting the doctor's advice to return to work.

Each transition is problematic.

- One, coping with symptoms, not getting help; two, loss of self-confidence, relationships suffer; three; isolation, delay and confusion; four, possible relapse and re-RTW.

Signs of Sub-Standard Treatment:

- Greater than six weeks on the same dosage of antidepressant drug without evidence of significant benefit and accepting minimal improvements without changing the drug or dosage.

Best Model of treatment:

- Trials using the Sherbrooke model of back pain management showed depressed return to work two and half times faster than “treatment as usual” when they received both occupational rehabilitation and proper clinical treatment involving :
 - Multi-disciplinary interventions 6, 8 and 12 weeks
 - Supervisors and union representatives in a progressive RTW plan.

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 work 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.

Quarterbacking Mental Disability Management

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.

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 –
 1. Like moving the employee closer to natural light.
 2. Reducing noise levels – a common EHS practice to preserve employee hearing.
 3. 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.

One Person's Action Plan
The Return-to-Work from Bipolar Disorder

Steps reported to the Roundtable by one young mother and wife as she prepares to return-to-work full-time.

1. Take my medication as directed.
2. Get at least 7 hours of sleep.
3. Exercise at least 30 minutes per day at least five times per week.
4. Eat sensibly, avoid overeating and use food supplements.
5. Take time to read daily (this is time for relaxation).
6. Do not overextend or over-schedule self.
7. Keep meals and clean-up during the week simple. Spend time with family.
8. Understand that a job task doesn't have to be done perfectly to be done properly.
9. Keep involved in mental health advocacy and volunteering.
10. Say "no" to extra work or obligations if I feel overwhelmed.
11. Schedule major activities flexibly to incorporate unexpected events.
12. Stop pressuring myself to get work done right away. Learn when to take a break.
13. I need an outlet for goal oriented activity when I feel manic. Last time I experienced hypomania, I was extremely productive and read three books in five days.
14. I will do majority of housework on Saturday. I will delegate some to my daughters.
15. I must work at maintaining focus on what I am doing. It's OK to multi-task – but I must make sure that I do not stray too far away from the main task at hand.

Let us emphasize this:

- Reasonable accommodations for the return-to-work from mental illness are not costly and can happen informally, within the nature of the job, without fanfare and no disruption of others.
- As the Action Plan shows, an employee can make her own accommodations in other facets of her life which enhance the return to work experience for both employer and employee.

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.

In a five-point analysis by lawyer William J. Johnson of McGown, Johnson in Calgary, we learn that:

1. Unions have a responsibility to accommodate and cannot escape this duty through any provision of a collective bargaining agreement.
2. Unions and co-workers of the RTW employee must participate in the search for an accommodation – and cannot flatly refuse on the basis of seniority or job posting rights.
3. Neither can the employer ask the union and co-workers to waive seniority rights unless “no other reasonable alternative resolution exists.”
4. Unions have a duty to represent their members “at the higher end of the scale” in matters concerning a disabled employee. This is particularly true when an employee is mentally disabled and the issue is termination.
5. In one case –
 - The union was “held to have violated its duty of fair representation to the employee” by failing to seek arbitration in the case of an employee disabled by depression who was fired for not following orders and getting along with fellow employees.
 - The Saskatchewan Labour Relations Board held that “the union failed to take sufficient account of the mental disability experience by the employee and it therefore discriminated against him in handling the grievance.”

Accountability and Incentives

Employers are bound to make temporary not permanent work arrangements during the employee's absence. That being so:

- 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.

In that case, it becomes self-evident he or she cannot function 100 per cent. But with depression and anxiety, nothing is self-evident to managers or co-workers.

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.
- Further, the build-up of performance problems often parallels the decline of working relationships, thus creating a residue which becomes a trap waiting to snare the employee when he or she returns to work from sick leave.

MODELS AND APPROACHES TO MENTAL DISABILITY MANAGEMENT

THE FGI APPROACH

Purpose

- To minimize impact and cost
- To encourage return to work

Needed Elements

- Deals with both mental and physical health issues
- Facilitates/coordinates communication
- Maintains confidentiality
- Ensures employers, employees, health professionals are informed
- Resolves barriers
- Support employee to capture health and function

WATSON WYATT WORLDWIDE MODEL
The Four Pillars of Productive Engagement

Alignment (employees know what to do)

- Have goals, expectations for a modified role been developed/communicated

Capability (employees have the knowledge and skills)

- Has pre-leave job been assessed against employee's limitations
- Have appropriate modified duties been developed (pre-leave job, new job)
- Has plan been develop to periodically these duties
- Have goals been established and are they realistic
- Has plan been established to review employees' changing capabilities

Resources (employees have the tools)

- Are special tools required to make the employee successful
- Is workload manageable in relation to the employees limitations
- Has a "buddy" been assigned or support network put into place to ease RTW

Motivation (employees want to do a good job)

- Has the employee been shown empathy, team support
- Have milestones for achievement been established.
- Frequent feedback plan in place
- Have any pre-leave performance issues been wiped clean?

Canadian Armed Forces Model

- Commanding officer's heavy involvement
- Active role of the individual member (employee)
- The "human dimension factor"
- Trained peer support group
- Integrated medical care
- Family support measures
- Pre/post deployment assessments

Guscott-Anderson Model
New Depression Intervention Framework

- This is a stair-stepped model which replaces the conventional IME with an IMC concept to advance the concept of shared care, accelerate the employees' access to accurate diagnosis and appropriate treatment.

- This model establishes week-to-week monitoring and updates and reduces the care/recovery time from months to weeks. This model will be available at www.mentalhealthroundtable.ca.

LEGAL ROADMAP

(From Patti Bregman, legal specialist of matters of human rights)

Workplace Health and Safety Laws

- Statues prohibiting discrimination against persons with disabilities in employment:
- The Canadian Charter of Rights and Freedoms applies to government action and legislation
- The Provincial and Federal Human Rights Codes
- Although there are two different human rights codes, one provincial, the other federal, and the Charter of Rights, the obligations under all three are very similar.
- On the question of accommodations:
 - Employers have a duty to accommodate employees with disabilities if the accommodation will allow them to perform the requirements of the job.
 - Accommodation can include providing a quiet office for a person who is easily distracted, or permitting a person to take an extra break if they are required to eat when taking medication.
 - Employers are only obligated to accommodate a person to the point of undue hardship. The Ontario Human Rights Code and the Canadian Human Rights Code restrict the factors that can be considered in determining what constitutes undue hardship to cost, health and safety requirements, if any.

Ms. Bregman asks and answers frequently asked questions related to mental illness in the workplace:

Q. Can I ask someone whether they have a mental illness when they are interviewed for a job?

- A person can be asked whether they can perform the essential functions of the job. That might require them to disclose that they have a disability that would require accommodation or mean that they could not do the job.

- Interviewees should not be asked whether they require accommodation until after they have been hired.
- Suggested practice: Creating an environment in which people feel comfortable disclosing their disability benefits the employee and the company. Advising applicants that the company has an accommodation policy, providing them with a copy of the policy and inviting them to request accommodation may increase the comfort level of the applicant.

Q. An employee has requested an accommodation but has not disclosed detailed information about the disability. What information can I request?

- The employee is required to provide the employer enough information to enable the employer to provide the accommodation but not disclose the specific diagnosis or even the category of disability.
- Information about a diagnosis provided for the purposes of disability insurance, should not be disclosed to an employee's manager without their consent, even if an accommodation is requested.
- Employees may be afraid to disclose a diagnosis of mental illness because of concern about the reaction of their co-workers or managers. This must be respected. Longer term, the best solution is creating a workplace in which harassment or negative comments about mental illness are not tolerated may encourage employees to be more open.

Q. An employee's performance has deteriorated over the past year. Can I ask them if anything is wrong? What if they say that there is no problem?

- An employer may, as part of a discussion about performance, ask an employee whether there are any problems, including health problems, which are interfering with their work. Provided that this is done in a way that reassures the employee that disclosing this information will not jeopardize their employment, nor leave them open to harassment or teasing by staff, an employer may follow normal disciplinary process if there is no disclosure. The employee may choose to seek outside help. (Roundtable recommends the rule-out-rule.)
- General approach: Provide information about mental health problems in the workplace at all times so that there will be no association with a particular individual. Encourage employees to seek outside help if they are experiencing problems.

Q. An employee has returned to work after an extended disability leave. They are fine while taking their medication, but have behavioral problems when they stop taking it. Can I require an employee to take their medication?

- It is difficult to find any legal basis for an employer requiring an employee to take or continue a particular treatment, even as part of a return to work program. However, the employer can make it clear when the person returns, that the expectation is that there are certain performance expectations. If these are not being met, then the return to work will be reviewed and a determination made about whether the person can carry out the requirements of the job.

Q. Does an employee with a mental health problem pose a safety risk? Can I refuse to hire the person on that basis?

- Safety is one of the criteria which can be used to refuse to hire someone on the basis of a disability provided that it is directly related to a bona fide occupational requirement and there is clear evidence that the individual cannot do the job in a safe manner, even with accommodation. Basing the decision on stereotypes would be considered discriminatory.
- Avoidance of harm from the toxic management practices listed above has been an article of sound business practice for time immemorial, although the expression of this ethic has differed from one era to another. That said, this ethic has never been the norm and even today tends to be more prevalent in companies that are voted “best run” or “best to work for.”

The Proposed Standard

The duty of care to avoid reasonably foreseeable harm from certain management practices can be discharged to a standard of diligence through:

- Surveys at a branch or work unit level on the prevalence of managerial practices and their perceived impact on mental health and specifically the:
 - Demands on employees
 - Adequacy of information in their possession to do their job
 - The degree of discretion given them
 - Job fulfillment and recognition
- Commitment from senior management to act on the results of these surveys
- Making this process part of the performance management system

Canada Health Act

Primary objective: “to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.”

The Act provides for (insurers) services that are “medically necessary hospital, physician and surgical-dental services to insured persons (Canadian) residents.”

There are five criteria for the same services:

- *Public administration*
- *Comprehensiveness* (covers all medically-necessary health services provided by hospitals and physicians)
- *Universality* (uniform terms and conditions for all Canadian residents)
- *Portability*
- *Accessibility* (this provision is governed by a “where and as available” rule: in short, where the services are and “as” (read, “if”) they are available.

This qualifier has profound implications for those seeking medical assistance for mental health. The “as available” condition does not just mean remote areas, it means areas where many physicians practice but lack the qualifications or specialist knowledge (psychiatrists) to properly treat mental disorders.

What is Personal Health Information?

(From Philip Bender of Stringer, Brisbin Humphrey Management Lawyers)

Ontario, Manitoba, Saskatchewan and Alberta have health-specific privacy laws to give individuals greater control over how their health information is collected, used and disclosed.

Personal health information is defined as any written or oral information that could identify an individual with respect to physical or mental health and healthcare services.

An employer that received health information about one of its employees from the employee’s doctor becomes subject to privacy laws.

Employer may only use employee health information for an authorized purpose and with consent.

For example, this information cannot – under law – be used in arbitration hearings or to terminate the employee’s job. Also, company medical directors and doctors are bound the same as other physicians. This is the principle underlying MHP.

REPORTS ON SPECIAL CONCERNS

- *Guidelines for Working Parents to Protect the Mental Health of Children*
- *Depression and Heart Disease, A Dynamic Public Health Risk*
(Separate documents accompanying this Report)

THE WAY AHEAD

The Summer Draft of the Roadmap will be rolled out in several ways. The Roundtable web site (www.mentalhealthroundtable.ca) and other web sites – media briefings and coverage – direct distribution to employers including government and unions – and, through the fall, a speaking tour across Canada.

Senator Michael Kirby, Roundtable Senior Chairman Honourable Michael Wilson and Roundtable CEO Bill Wilkerson will lead the speaking tour and encourage employers to use the Roadmap and customize its content to their own particular needs and opportunities.

Further, the Roundtable will engage in a consultation process including roundtables focused on specific items such as:

- Standardized insurance practices for employers, working parents, high risk jobs and mental health, implementing the Wilson principle and the concept of shared care and shared responsibility.

Further comments and input on the Roadmap will be welcome until October 31, 2005. At that point, the final draft will be put to bed and work will begin on a book version of the Roundtable's journey.