Wilson Banwell
Human Solutions™

PROACT
Solutions Humaines MC

Human Solutions™

A Quiet Crisis

The Business Case for Managing Employee Mental Health

Human Solutions™ Report | **2008**

Wilson Banwell Human Solutions™ PROACT Solutions Humaines MC
Human Solutions™

Fall 2007

Dear Valued Customer:

It is with pleasure that we are publishing our second Human Solutions™ report *The Quiet Crisis: The Business Case for Managing Employee Mental Health*. This report was written by Dr. Mark Attridge, a leading writer/researcher in the area of mental health and its impact on the workplace. This empirically based report draws from numerous studies from around the world and synthesizes the key findings for you—the HR/Benefits and Business leader—to understand and to take action on.

This second annual report builds on our very successful inaugural report entitled *Under Pressure: Implications of Work-Life Balance and Job Stress* which gave all of our customers a cogent understanding for, and practical ideas on, how to prevent and address job stress. **We have heard from many of you who want factual data that is presented in an easy to understand format and which is actionable, and we are committed to achieving this goal**.

The 2008 report unfurls the many issues related to mental illness and its impact on the workforce. It outlines the most common conditions that afflict large populations of employees, the barriers to proper diagnosis, the evidence-based treatment options and what employers can do to address this growing source of lost productivity and human suffering in their organizations. The message does not discriminate in terms of organizational size, industry type, work category, or geographic location as it has been shown that these are not determinants that are significant.

As a valued customer whose opinions are important to us, we welcome your feedback. Please feel free to provide me or your Account Manager with any ideas that you think would be worthy of future consideration so that we can help you meet your needs.

Regards,

Craig Thompson, MEd, MBA
VP Customer Relations
cthompson@humansolutions.ca
1.888.689.8604

Contents

Introduction 4

Mental Health Conditions and Their Causes 6
1.1 The Prevalence of Mental Health Conditions 6
1.2 Dual Conditions and Health Comorbidity 6
1.3 The Causes of Mental Health Conditions 9

Inadequate Care and the Resulting Cost Burden 11
2.1 Under-Diagnosis and Under-Treatment. 11
2.2 Stigma and Discrimination 11
2.3 Cost Burden: Direct Costs 12
2.4 Cost Burden: Indirect Costs 13

Use and Effectiveness of Mental Health Treatment 15
3.1 Use of Mental Health Services 15
3.2 Treatment: Outcomes. 16
3.3 Treatment: Cost-Effectiveness 16
3.4 Disability Management. 16

How Employers Can Create Mentally Healthy Workplaces 18
4.1 Key Ingredients of a Psychologically Healthy Workplace . . . 18
4.2 The Business Value of Healthy Employees. 20
4.3 Stakeholder Vision of Workplace Mental Health 20
4.4 Resources for Supporting Workplace Mental Health 24

Final Statement 25

References 28

Tables
1. Key Findings From Research on Workplace Mental Health . . . 5
2. Facts About Major Mental Health Conditions in Canada 7
3. Mental Health Conditions And Alcohol/Drug Addiction 8
4. Ten Elements of a Psychologically Healthy Workplace 19
5. Reports on Workplace Mental Health 22
6. Resource Organizations (Canada, US) 23
7. Action Steps 27

Mental ill-health affects many employees yet remains largely misunderstood and poorly treated. The irony in this troubling situation is that diagnostic tools and treatments for mental health conditions are effective when accessed by employees and generate cost savings to an organization's bottom line.

Introduction

Mental health is finally emerging from the shadows in Canada[1]. New evidence documents the critical role that mental health plays in many aspects of society and there is a wealth of information on how mental health affects the workplace—either to make it dysfunctional or to help it flourish. Summary reports that review this research abound[2, 3, 4, 5, 6, 7,8].

Employees with undiagnosed or under-treated mental health conditions often struggle valiantly to stay on the job. Despite their best efforts, many of them experience lapses in productivity, unscheduled days absent, physical illnesses, and alcohol and/or drug addiction. Some of these employees will eventually not be able to work at all and will require short-term disability leave. When they do feel capable of returning to work, managers and supervisors often struggle to know how to best accommodate this return, and co-workers sometime shun them. Still others may never return to work and end up on long-term disability benefits.

Research strongly supports the need for employers to make workplace mental health a high priority business issue. It is not simply 'the right thing to do', it makes a company more competitive and profitable.

The pages to follow present a business-focused review of the key points from these advances in the study of workplace mental health (**see Table 1**). In the *Report*, we translate these facts into what employers and leaders need to know to understand why good mental health is good for business. The *Report* also identifies factors that impact mental health in the workplace and describes practical and cost-effective ways that employers can respond to these issues. The business case is grouped into:

1. **The Problem:** Mental health conditions and their causes.
2. **The Crisis:** Inadequate care and the resulting cost burden.
3. **The Solution:** Use and effectiveness of mental health treatments.
4. **The Future:** How employers can create mentally healthy workplaces.

The sad truth is simply that most businesses do not provide a level of attention and investment in mental health conditions that corresponds to their level of prevalence and cost burden.

TABLE 1: KEY FINDINGS FROM RESEARCH ON WORKPLACE MENTAL HEALTH

Section	Key findings
Section I: The Problem **The Types of Mental Health Conditions and Their Causes**	• Mental health conditions are widely experienced especially in working age populations (1 in 5 employees). Of particular relevance are: depression, bipolar mood disorder, social anxiety and phobias, panic disorder, schizophrenia, and suicide. • Employees with mental health conditions can also have alcohol and drug addictions as well as chronic medical conditions. • Job stress and workplace conditions significantly affect employee mental health.
Section II: The Crisis **Inadequate Care and the Resulting Cost Burden**	• Approximately two-thirds of employees with mental health conditions do not get any treatment and of the third who do seek care, most often it is from primary care doctors untrained to treat mental health concerns. • Inadequately treated mental health conditions result in higher direct job-related costs and disability claims costs, as well as indirect costs from employee absence, and lower productivity.
Section III: The Solution **Use and Effectiveness of Mental Health Treatments**	• 1 in 10 people seek professional care for mental health conditions each year. • Mental health treatments are cost-effective and can be effectively delivered in the workplace by Employee and Family Assistance Programs (EFAPs). • Disability management for mental health conditions can be effective.
Section IV: The Future **How Employers Can Create Mentally Healthy Workplaces**	• Employers can improve the mental health of their employees through prevention, intervention, and rehabilitation. • Ten elements of a psychologically healthy workplace have been identified: transformational leadership, workload and pace, work schedule, role clarity, job future, autonomy, workplace justice, reduced status distinctions, social environment at work, and extrinsic factors. • Of the ten elements of a psychologically healthy workplace, leadership style is the most important. • Changes at the organizational level can improve the mental health of the workplace and lead to employee work performance outcomes and overall company success.

Several mental health conditions are particularly relevant to working-age groups—major depression, bipolar depression, social anxiety and phobias, panic disorder, schizophrenia, and suicide.

SECTION 1: THE PROBLEM

Mental Health Conditions and Their Causes

1.1 The Prevalence of Mental Health Conditions

In Canada, the percentage of the population aged 15-64 that has a diagnosable (i.e. clinically significant) mental health condition at any one-year period is approximately 12% (and about twice that for lifetime prevalence)[9]. Most of these conditions (depression, bipolar depression, social anxiety and phobias, panic disorder, schizophrenia, and suicide) start in the late teens or early 20s, continue for decades, and are found more often among the socially isolated and economically disadvantaged in society and also among women (with the exception of suicide).

Facts about these conditions are provided in **Table 2.**

1.2 Dual Conditions and Health Comorbidity

Among the people with specific mental health conditions, many have more than one mental health condition at the same time or have an addiction problem with alcohol or other drugs. Others with mental health conditions may have chronic or serious medical conditions.

Comorbidity of Mental Health Conditions

Approximately 45% of people with a mental health condition meet the criteria for two or more other mental health conditions. The more severe one condition, the more likely another co-occurs[10]. The most common pairings: depression and anxiety, bipolar depression and anxiety.

Mental Health Conditions and Alcohol/Drug Addictions

The use of alcohol, illicit drugs and prescription medications can lead to dependence and addiction.

Alcohol use. Studies consistently find that men are higher users of alcohol than women and that those in younger age groups (20-24 years) have the highest levels of alcohol use. Drug use is generally higher for males and those of younger age groups. **See Table 3**.

Illicit drug use. About 1 in 6 Canadians have used one or more illicit drugs at some point in their life. Drug use is generally higher for males and those of younger age groups. **See Table 3**.

Severity and chronicity of mental health conditions are worsened when drug and alcohol use are also present. The health conditions are more difficult to diagnose, more resistant to treatment, and more likely to recur.[11]

TABLE 2: FACTS ABOUT MAJOR MENTAL HEALTH CONDITIONS IN CANADA

SYMPTOMS	CHARACTERISTICS	PREVALENCE IN CANADA
MAJOR DEPRESSION (MILD TO SEVERE)[9,12,13,14]		
• A variety of symptoms, including: low or depressed mood, loss of pleasure/interest in nearly all activities, changes in appetite/weight, decreased energy, feelings of worthlessness, increased irritability.	• One of the most common and most debilitating disorders. In extreme cases, the person may not be able to perform self-care or maintain self-care.	• The lifetime rate of depression is between 8% and 14% of working age groups (about 1 in every 10 employees).
BIPOLAR DEPRESSION[9,12,15]		
• Similar to major depression but also has recurring episodes of mania (swings from very positive mood to irritability, recklessness, poor judgement).	• Associated with younger age, low income, having a substance abuse disorder and having an anxiety disorder, less social support.	• Lifetime prevalence rate of 2.4% of the adult working population (about 1 in every 40 people).
SOCIAL ANXIETY AND PHOBIAS[9,12,16]		
• Intense fears of being socially scrutinized or embarrassed in interpersonal situations (social anxiety). A marked fear and avoidance of a specific object or situation (phobia).	• Most people with one anxiety also have another anxiety condition. • Commonly have other difficult life experiences (e.g. never marrying, divorce or separation).	• Lifetime prevalence rate of 8% of the working age population (about 1 in 12 employees).
PANIC DISORDER[9,12,17]		
• Recurrent and unexpected panic attacks (discrete periods of intense fear that occur in the absence of any real danger).	• Can result in a kind of behavioural paralysis due to the fear and being homebound.	• Lifetime prevalence rate of 2.1% of the working age population (about 1 in 50 employees).
SCHIZOPHRENIA[9,12]		
• Chronic disorder punctuated by episodes of psychotic symptoms, (hallucinations and delusions).	• Symptoms are often so severe that the individual with schizophrenia cannot work.	• Lifetime prevalence rate of about half of one percent of Canadians (0.5% or about 1 in 200 people).
SUICIDE[9,12,18]		
• The completed act of intentionally ending one's own life.	• The majority of people who kill themselves have a mental health condition (e.g. depression, substance abuse).	• One in twenty-five Canadians will attempt suicide during their lifetime (4.0%).

TABLE 3: MENTAL HEALTH CONDITIONS AND ALCOHOL/DRUG ADDICTION*

Figure	Description
> 600,000	Number of Canadians estimated to be alcohol dependent.[19]
> 200,000	Number of Canadians estimated to be dependent on illicit drugs (e.g. marijuana, heroin, cocaine)[19].

ALCOHOL USE AND ADDICTION[20]

Figure	Description
80%	Number of people aged 15 and older who reported that they consume alcohol.
20%	Number of drinkers who report that their alcohol use has caused harm to themselves or to others in their lifetime.
10%	Number of drinkers who report that their alcohol use has caused harm to themselves or to others in the past year.

The large difference in utilization rates shows how much greater the risk of problems is for alcohol than for other drugs.

ILLICIT DRUG USE AND ADDICTION[20]

Figure	Description
45%	Percentage of Canadians who have used one or more illicit drugs at any time in their lifetime (e.g. marijuana, hallucinogens, cocaine, speed, ecstasy).
17%	Percentage of Canadians who have used one or more illicit drugs at any time in their life excluding marijuana.

Figure	Description
33%	Percentage of Canadians with a diagnosed mental health condition who have a substance abuse problem.

*Numbers are rounded to the closest percentage point.

Comorbidity of Mental Health Conditions and Physical Health Conditions

People who have physical health conditions often have a mental health condition at the same time. It's not always clear whether mental health conditions cause physical health conditions or whether they are a consequence of such conditions. Most likely, the causal associations travel in both directions.

Mental health conditions like depression and anxiety have been linked to a wide variety of health conditions, including heart disease[21], diabetes[22], chronic pain[23], and difficulty with sleep[24]. The depression-sleep relationship is interesting because a lack of sleep has also been linked to lower general immune system functioning and may help explain why depressed patients have higher rates of medical conditions.

1.3 The Causes of Mental Health Conditions

QUESTION

What is the contribution of family and work pressures?

Events in one's family can be a major source of stress that can manifest itself in the workplace.

Many employees in the prime of their working careers are in a double bind of caring for both young children and for an aging parent[25]. This so-called "sandwich" generation of employees is particularly stressed from family care obligations. Based on national survey data from Canada in 2002, it was estimated that over one million employed persons, mostly women aged 45–64, provided informal care for seniors with chronic health conditions or disabilities[26].

Many caregivers experience significant employment-related consequences from having to balance greater amounts of time devoted to providing family support with time at work. For some people, that stressful path reaches a point where the burdens of family care and working a job can no longer both be managed. The consequence? The employer loses a good employee to family care obligations.

Caring for children and aging family members is not the only source of work stress. There is also an increased risk for mental health conditions due to the social influences of trying to adapt to a faster pace of life, rapid technological advances, globalization, and more time spent working. According to a 1986 survey, Canadian employees spent 4.2 hours in various activities with their spouse or children, on average each work day[27]. By 2005, that figure had dropped to 3.4 hours. That is a 19% decrease in family time in less than 20 years, mainly due to more time spent working.

Businesses have responded to these social changes in many positive ways. For example, many companies have adopted more family-friendly Human Resources policies and offer more flexible working hours for employees (this issue was explored in the 2006-07 Human Solutions™ Report *Under Pressure: Implications of Work-Life Balance and Job Stress*).

Stress and Workplace Factors

The role of stress is important to recognize because it is a precursor to more serious mental health conditions. Stress is widespread in society and in the workplace. Hundreds of research studies have examined how aspects of jobs and organizational behaviour can create stress for employees and contribute to mental health conditions and other physical health problems[28].

QUESTION

What is known about stress levels in employee populations?

Stress is a significant problem for many employees. For example, analysis of the responses of more than 6,600 adults in the Canada National Population Survey showed that over a six-year span, 43% of people reported at least one episode of psychological distress and 19% had two or more stressful episodes[29]. Similar results were obtained from the Canadian Community Health Survey of over 22,000 adults[30]. This study found that 31% of people experienced chronic work stress alone or in combination with a chronic physical condition, a psychiatric disorder or both.

On average, **employees spend 20% less time with family** and/or spouse than they did 20 years ago[27].

For some employees, the pressures of work and family cannot be managed thereby leading to the loss of a good employee to family obligations.

Most studies also find that women tend to report higher levels of stress than men and that stress levels (regardless of gender) are associated with having mental health and physical health conditions, lower education, lower income, and divorce.

QUESTION

What are the most common sources of workplace stress?

Recent national surveys show that one in four employees in Canada consider that most workdays are "quite a bit" or "extremely" stressful. The most common sources of workplace stress are: long hours and heavy workload demand (34%), poor interpersonal relations (15%) and risk of accident or injury (13%)[31,32].

QUESTION

What is the influence of work environment on employee mental health?

Employee perceptions of work environment are key predictors of health outcomes. Jobs that are characterized by psychologically demanding work coupled with little decision-making opportunity create a working experience that has been labeled "job strain." When employees have job strain, it is associated with increased risk for depression and drug dependence. Other factors that negatively impact physical and mental health include: job insecurity, excessive physical demands, and low co-worker support[33].

QUESTION

What is the influence of leadership and management behaviour(s) on employee mental health?

The behaviour of management and supervisors has also been associated with employee health and work performance. Several summary reviews of the research studies conclude that low levels of perceived organizational support (particularly from the supervisor) predict increased job strain symptoms among employees, such as fatigue, anxiety and headaches[34,35].

KEY MESSAGES

- Having multiple mental health conditions is common and affects close to half of all people with a mental health condition. There is also an overlap among those with mental health conditions and alcohol/drug dependence conditions in about a third of cases.
- Multiple mental health conditions contribute significantly to lost productivity, absence, lower morale, workplace conflict, etc.
- Multiple mental health conditions and also having drug or disease co-morbidities can lead to higher costs for care and longer courses of treatment before employees return to normal levels of functioning.
- Psychological and social/environmental causes and/or contributors to mental health conditions include many factors relevant to the workplace: work-family demands, time pressures, the nature of how work is organized, workplace conflict, leadership style, etc.

Most people with mental health conditions are treated minimally from a primary care doctor who has not been sufficiently trained to deal with these issues. Studies clearly demonstrate under-diagnosis and under-treatment of these conditions.

SECTION 2: THE CRISIS

Inadequate Care and the Resulting Cost Burden

2.1 Under-Diagnosis and Under-Treatment

One of the most troubling aspects of mental health conditions is how few people who need treatment actually get proper treatment. Most do not.

The 2002 Canadian Community Health Survey on Mental Health and Well-Being, found that only 32 percent of those suffering from mental health conditions or substance use conditions spoke to a health professional during the prior year[36]. A more recent national study found that only one-fourth to one-third of Canadians with either a perceived need for care or with a diagnosis for a mental health condition actually got appropriate counselling-based treatment[37].

To make matters worse, studies consistently show that physicians and other medical providers involved in the delivery of primary care have the most contact with the largest portion of people seeking mental healthcare[38]. In fact, about half of all care for common mental health conditions is delivered in general medical settings by primary care providers (e.g. antidepressant medication).

The central role of primary care doctors in the diagnosis and delivery of mental health treatment, however, poses a number of difficulties. These limitations include:

- Lack of adequate training in assessment and/or treatment to be able to make a diagnosis for mental health conditions.
- Lack of sufficient resources to adequately deal with such care. And,
- Lack of coordination between doctors and mental health professionals.

2.2 Stigma and Discrimination

Probably the most important factor underlying the lack of treatment for mental health conditions among employees is social stigma[39]. People with mental health conditions report that they often do not seek care because of fears about possible negative reactions from others and workplace consequences of losing their job or not getting promoted.

Although treatments are successful, **shockingly large numbers of employees never receive treatment**—some are misdiagnosed, others do not seek care because of lack of awareness or stigma.

Stigmatization and discrimination affect individuals with mental health conditions and addiction in many ways. News, TV shows, and movies tend to portray both patients and mental healthcare providers in overwhelmingly negative ways. People with severe mental health conditions are routinely excluded from social life and are often denied basic rights in housing, employment, income, insurance, higher education, criminal justice, and parenting. Individuals with mental health conditions and addictions also face discrimination and rejection by service providers both in the mental health system and the broader healthcare system and discrimination by policy makers. It seems that it is somehow different and less acceptable for people to suffer from anxiety, depression, schizophrenia or alcohol dependence than to suffer from cancer, diabetes or heart disease. These more "medical" health conditions are socially accepted, widely supported and dramatically better funded than mental health conditions.

Indeed, for many individuals with mental health conditions and addictions, the stigmatization and discrimination they experience can be as important a source of distress as the condition itself. This happens to such a degree that there is also self-stigmatization among those with mental health conditions. Self-imposed fears of social consequences from disclosing their condition prevents many people from taking advantage of available therapeutic resources, either from the traditional healthcare system or from services in the workplace. This kind of social rejection and self-censure for having a mental health condition is one of the underlying reasons why so many people don't get the level of care that they need as it would hurt even more to get care for their mental health condition.

2.3 Cost Burden: Direct Costs

This part of the report examines the direct cost of providing treatment for mental health conditions. It also discusses the even greater costs associated with not providing enough care or the right kind of care for employees with mental health conditions. These include the costs of additional medical care services and disability claims related to mental health conditions.

Direct Costs of Mental Healthcare

In 1998 there were an estimated three million visits to Canadian psychologists and social workers to treat depression and distress, with three-fourths of these visits paid for on a fee-for-service basis[40]. The total direct costs for these fee-for-service visits to non-medical mental healthcare providers was estimated at $278 million dollars. Considering that no centralized data tracking of these costs exists, it can be assumed that the actual costs are much higher.

What is interesting in this data is the comparison of the relatively small amount of dollars spent on the treatment of mental health conditions (which is in the millions) compared to the costs of the consequences for not treating these conditions on areas of health costs, disability costs and work loss (which is in the billions). This also points to the need to spend much more on the prevention and early treatment of mental health issues and not just on care once the person has more severe symptoms and work limitations.

Direct Costs of Medical Care

People with an untreated mental health condition cost more than those without mental health conditions for total direct costs of the use of general healthcare services. Employees with mental health conditions often use more inpatient and outpatient healthcare services in group health plans for medical (non-psychiatric) conditions. Depressed employees in particular, tend to have higher overall healthcare claims costs and the majority share of these costs is usually for conditions other than depression. For example, one study found that the treatment for depression accounted for only about one-fourth of the total healthcare expenditures (28%), with the rest of the money (72%) spent on treating other physical ailments[41].

Of the ten leading causes of disability worldwide, five are mental [health] conditions: major depression, alcohol use disorder, bipolar depression, schizophrenia and obsessive-compulsive disorder[42].

A major study conducted by the Health Enhancement Research Organization also merits review[43]. It asked the question: *What is the additional medical expense generated by employees who exhibit any one of 10 common modifiable health risk factors (smoking, sedentary lifestyle, high cholesterol, hypertension, poor diet, being overweight, excessive alcohol consumption, high blood glucose, high stress and depression)*? Results showed that depression was the risk factor associated with the largest medical cost increase. Controlling for demographics and other risk factors, employees who reported being depressed were 70 percent more expensive in terms of their medical costs when compared to their non-depressed counterparts. Those who reported being highly stressed—and incapable of managing that stress—were 46 percent more costly than non-stressed employees. And employees who experienced both depression and high stress were 147 percent more expensive.

The overall disability rate for employed Canadians is close to 10 percent (2 million people), with disability rates increasing with increasing age of the employee[44]. The most common kinds of employer accommodations for employees with a disability are modified or reduced work hours and job redesign. Of interest to this report, 15 percent of men and 20 percent of women with a disability claim reported mental health conditions as the cause of disability.

When compared to all other diseases (such as cancer and heart disease), mental health conditions and addiction rank first and second in terms of causing disability in Canada and they account for about two-thirds of all disability insurance claims[1,45]. Short- and long-term disability related to mental health conditions accounts for up to a third of the number of all claims and about 70 percent of the total costs—$15 to $33 billion annually[8].

The costs of these trends for specific companies is staggering. A large Canadian insurance company estimates that 30 percent of their disability insurance claims relate to mental health conditions, and in the remaining 70 percent, a quarter or more have mental health conditions as a secondary or underlying diagnosis[5]. At another major Canadian insurance company, mental health conditions produced disability absences averaging 95 days, compared to only 40 days for other illnesses[5].

2.4 Cost Burden: Indirect Costs

Although healthcare and disability costs tend to get the most attention from employers, innovative new studies reveal that these direct costs actually account for only a minor portion of the total health- and productivity-related costs faced by businesses. Indeed, many studies have found that mental health conditions and addictions are among the most important causes of absenteeism and lost productivity worldwide[46]. Though most of the research in this area of indirect costs has come from the US, more studies of workplace costs associated with mental health conditions are beginning to be conducted at select Canadian companies[47,48].

Indirect Costs of Employee Absence

More employees are absent from work from stress and anxiety than because of physical illness or injury[49]. Some relevant findings:

- Employees with one or more mental health conditions missed work at a rate fives times higher than employees without these conditions[50].
- Among those with a mental health condition, absenteeism and productivity losses were about five times greater for those who had multiple mental health conditions at the same time (such as having both depression and substance abuse)[50].
- Job performance was seven times worse for depressed employees compared to non-depressed employees[51].
- Depressed employees had twice as high an absenteeism rate[51].
- Bipolar disorder was associated with 66 lost workdays, and major depressive disorder with 27 lost workdays, per ill employee per year[52].

20% of the productivity of a depressed employee is lost because of poor concentration, memory lapses, indecisiveness, fatigue, apathy, and lack of self-confidence.

Indirect Costs of Employee Productivity Loss: Presenteeism

When mental health and personal or work-life conditions interfere with an employee's ability to perform at normal productivity, this is considered a "presenteeism" problem. Various researchers around the world have attempted to estimate presenteeism costs associated with mental health conditions. Some have estimated that depressed employees lose as much as 20 percent of their productivity because of poor concentration, memory lapses, indecisiveness, fatigue, apathy and lack of self-confidence.

Several studies show the dominant role of productivity losses from mental health conditions. A major study examined archival cost data from medical claims, pharmacy, absence, STD and employee reported productivity on validated survey instruments that assess presenteeism[53]. The results of this study, based on over 370,000 US employees, found that presenteeism losses accounted for the majority of per person annual total costs for 9 out of the top 10 most expensive health conditions (only heart disease had the majority of total costs accounted for by medical claims).

In another study, the indirect costs to employers for employees with depression was estimated at over $44 billion to the entire US economy, with about 80 percent of the loss for presenteeism and only 20 percent for absence[54]. A recent study from the Netherlands examined the direct and indirect costs for nine common mental health conditions using data from over 5,000 adults[55]. A key finding from the study was that the bulk of the costs (85%) were related to work productivity losses. Also, the findings showed that the total costs for mental health conditions were the same or greater than the total costs for physical illnesses. Similar results were also obtained in a recent study from Sweden[56].

These research studies show that workplace performance losses due to mental health conditions are very costly when examined carefully for their full impact. Alas, many employers do not track employee absence and productivity with enough detail to link these records with other sources of data on employees with mental health conditions (and do so without violating employee personal privacy prohibitions).

KEY MESSAGES

- Even though many employees may need treatment, most of them will probably not get the level of care that they need due to: lack of access to providers, lack of enough qualified providers, lack of identification of mental health conditions, stigma, and fear of discrimination.
- Employees with mental health conditions often use more inpatient and outpatient healthcare services in group health plans for medical (non-psychiatric) conditions.
- Mental health conditions and addictions are among the most important causes of absenteeism and lost productivity worldwide.
- The indirect costs of mental health-related absence and productivity losses are often much more than the direct costs of healthcare or insurance benefit claims for these employees.
- More employees are absent from work from stress and anxiety than because of physical illness or injury.
- Employees with one or more mental health conditions miss work at a rate fives times higher than employees without these conditions.
- Among those with a mental health condition, absenteeism and productivity losses are about five times greater for those who have multiple mental health conditions at the same time (e.g. depression and substance abuse).
- Job performance is seven times worse for depressed employees compared to non-depressed employees.
- Depressed employees may lose as much as 20 percent of their productivity because of poor concentration, memory lapses, indecisiveness, fatigue, apathy and lack of self-confidence.
- When compared to all other diseases (such as cancer and heart disease), mental health conditions and addiction rank first and second in terms of causing disability in Canada and they account for about two-thirds of all disability insurance claims.

Mental health care treatments are one of the most well-researched and well-established interventions in all of health care. Cost-benefit analyses demonstrate significant cost savings when appropriate care is delivered in a timely manner.

SECTION 3: THE PROBLEM

The Use and Effectiveness of Mental Health Treatment

3.1 Use of Mental Health Services

Who Provides Care? Most mental healthcare in Canada is provided as part of the national healthcare system and delivered by psychiatrists, psychologists, social workers and other kinds of trained counsellors[57]. Treatment tends to occur in outpatient clinics and therapist offices.

Utilization. Recent national surveys have explored the annual rates of experiencing various mental health conditions and the range of reasons for seeking care across Canada and between the different provinces within the country[58]. About 1 in 10 Canadians sought care for mental health conditions during the past year. This number is similar to the US experience[14].

The overall use of services for mental healthcare differs across provinces. The highest use is in Nova Scotia and British Columbia (both 11.3%) whereas the lowest use is in Newfoundland and Labrador, and Prince Edward Island (6.7% and 5.4%).

User Characteristics. Individual factors associated with use of mental health services include being of younger age, lower education, and single. It is commonly found that women use mental healthcare about twice as often as men. However, careful analysis of the research shows that the use of mental healthcare services depends more on social family context than gender[59]. Specifically, the more social roles a person has (e.g. being employed, a parent, or a marital spouse), the less often they use mental health services, regardless of gender. Among individuals who are single or unemployed parents, the rate of mental healthcare use is similar for women and men.

Access Issues. There may be a lack of resources for providing appropriate mental healthcare treatment in some parts of Canada, particularly more rural areas. Another factor that restricts access to mental health treatments is out-of-pocket costs. Healthcare coverage typically covers care provided by a psychiatrist or medical doctor. Thus, much of the treatment by psychologists, counsellors, therapists, social workers and other mental health professionals is provided on a fee-for-service basis and is paid for by clients or their guardians unless the employer has provided a mental health benefit (e.g. Employee and Family Assistance Program or EFAP).

There is widespread agreement for the clinical effectiveness of most of the commonly used psychotherapy and pharmaceutical treatments. Yet most of those who would benefit from these treatments do not receive them.

3.2 Treatment: Outcomes

When an employee or family member with a mental health condition begins to receive professional treatment, the outcome is likely to be very good. Mental healthcare treatments are among the most well-researched and well-established interventions in all of healthcare.

According to a landmark review study in 1993 that examined over 300 meta-analysis papers (each paper itself a review of many original studies), modern era mental health treatment is largely effective at improving patient functioning[60]. More recent major reviews of the literature have been conducted by the World Health Organization and government agencies in Canada and the United States[45,61,62]. All of these objective reports have come to a similar conclusion that supports the general effectiveness of most mental healthcare interventions.

The success rates for treating the most common mental health conditions are quite high. Patients with major depression, bipolar depression, anxiety, social phobias and panic conditions typically get relief and can work again. For example, cognitive behaviour therapy (CBT) and interpersonal therapy have proven helpful in treating patients with depression and social anxieties, and panic disorder responds well to CBT. For more severe or chronic mood disorders (e.g. major depression, bipolar mood disorder) and for schizophrenia, pharmacologic treatments (i.e. drug therapies) are often successful. A combination of medications and counselling can sometimes be the best method of treatment, and may be helpful at preventing relapse.

Some of the more recent studies have begun to provide evidence for the effectiveness of psychological treatments conducted within the primary care health system in collaboration with medical doctors. There is also evidence supporting the effectiveness of mental health treatments delivered over the telephone.

Substance abuse and other addictions can be treated with success but these conditions typically last many years and have a complicated course toward achieving lasting improvement and lifelong sobriety or substance-free living. Co-occurring conditions or combinations of mental health and substance abuse conditions can also interfere with the clinical success of therapy. The co-morbidity of mental health and physical health conditions among people with mental health conditions also suggests the absolute necessity of providing a more integrated treatment approach between mental health providers and physicians.

3.3 Treatment: Cost-Effectiveness

A critical business question is whether or not it makes good financial sense to invest in certain kinds of employee benefits. Mental health treatments have been shown to yield positive financial returns in dozens of cost-benefit studies. These studies show significant dollar savings to businesses in the areas of reduced overall healthcare costs, reduced disability costs, fewer missed days from work, improvements in employee productivity and less turnover. The financial savings are often great enough to more than cover the costs of providing the treatment. Although few of these studies have been conducted on Canadian companies, the sheer number of high-quality studies that have been done in other similar settings is compelling. Indeed, there is enough evidence worldwide on this topic that the World Health Organization and government health organizations in Canada and the US have all issued major reports that acknowledge the general cost-effectiveness of mental healthcare[1,61,62,63,64].

3.4 Disability Management

According to the WHO, five of the 10 leading causes of disability worldwide are mental health problems (major depression, schizophrenia, bipolar disorders, alcohol use and obsessive-compulsive disorders)[42]. These disorders—together with anxiety and stress—have a serious impact on working populations. When left untreated they may also develop into long-term conditions with accompanying forms of disability.

Mental health conditions are one of the key drivers of the increases in disability costs and are projected by the WHO to be one of the top causes of disability worldwide in 2020, second only to heart disease[42].

Does it make good financial sense to invest in mental heathcare benefits? Cost-benefit studies show significant dollar savings in areas of reduced overall healthcare costs, reduced disability costs, fewer missed days from work, improvements in productivity and lower turnover.

Some employees who suffer from mental health conditions can end up becoming disabled and cannot work anymore. To respond to these situations, employers in Canada commonly offer two types of disability income insurance plans: short-term disability (STD) and long-term disability (LTD). STD plans replace a percentage of pre-disability employment earnings (70% for example) for periods of less than one year's duration (e.g. six months). LTD plans typically commence payments after the disabled individual has been off work for a significant period, such as six months, and replace a specified percentage of the person's pre-disability employment income, for example 70 percent.

There are opportunities for the education of disability care providers in the medical care system to help them to better understand and identify employees who use these services who have mental health conditions. The management of disability cases with mental health conditions and co-occurring medical conditions can be a challenge. Recent advances in disability management include offering a more holistic approach that addresses not only the physical health but also the mental health aspects of disability[65]. There is also a trend toward increased collaboration between EFAP providers and disability insurance providers. The goal is to offer psychosocial assessments for disability cases in order to find the co-morbid mental health conditions that can be missed by more medical approaches to case management. Recent work in this area has promising results for co-managing employee depression through the collaboration of the EFAP and physician care[66].

There are also many people with a mental health disability who would like to work and contribute to the workforce if given a chance. Employers can make efforts to hire people who have mental health conditions for appropriate kinds of work. Studies in the US have shown that supported employment can assist individuals with disability from mental health conditions to obtain and maintain employment. When this model was examined in British Columbia, it also had success, especially when it focused on an individual placement and support approach[67].

KEY MESSAGES

- Encouraging mental healthcare treatment is a cost-saving approach for a company. Most forms of modern treatment for mental health conditions are cost-effective. The cost of providing the clinical treatment is more than offset by greater cost savings in other areas.
- Employers should know that treatment with drugs alone is often not enough to achieve long-term success in managing mental health conditions. The preferred approach is often to use psychotherapy methods, such as cognitive behavioural therapy, short-term counselling and interpersonal therapy, as part of the treatment plan or referral options from an employer.
- Introducing and supporting mental health benefits results in better employee work performance, etc.
- EFAP providers are not equa in their level of quality and effectiveness. It is important for employers to work with EFAP providers who emphasize validated assessment tools for mental health and alcohol conditions, who provide access to EFAP staff who can deliver psychologically-based brief therapy sessions in the modality preferred by the client (in-person, phone or online) and who offer comprehensive referral options to employees and family members in need of direction and assistance.
- Employers can select disability management vendors and partners who are more active in incorporating mental health assessments, counselling and other psychologically-oriented treatments as part of the clinical management process.
- Employers can ask their EFAPs to become better service partners with disability management programs.
- Employers can help create return-to-work practices and workplace job accommodations that are supportive of mental health conditions.

Most employers are very concerned about how to find good employees and how to keep them working at a productive level. It is important to offer EFAP services and sponsor access to mental health providers. But it is possible to do even more through changing the work culture, leadership style and other organizational factors.

SECTION 4: THE FUTURE

How Employers Can Create Mentally Healthy Workplaces

4.1 Key Ingredients of a Psychologically Healthy Workplace

Many studies show that organizational approaches to improving mental and physical health generate more important, longer-lasting effects than intervention strategies directed at individuals[68]. Worksite-based preventative interventions seek to remove work-related practices and behaviours that contribute to employee stress and mental health conditions.

A recent literature review paper from the IRRST in Canada concluded that many kinds of workplace interventions are effective[69]. Their review identified the following list of workplace attributes that contribute both to profitability and to better mental health:

- employment security
- self-managed teams
- decentralized decision-making
- extensive training
- reduced status distinctions. And,
- reduced barriers to sharing financial and performance information across the organization.

International studies show a similar pattern of results. A major review study conducted in the UK concluded that when organizations address the six major conceptual areas of workplace functioning—demands, control, support, relationships, role and change—the company benefits in greater employee performance and other business outcomes[68]. Another review concluded that there is fairly convincing evidence that organization-level interventions that change working conditions lead, over time, to improved employee performance and productivity (measured objectively and self-reported) and also lead to less employee absenteeism and less turnover intention among employees[70].

A recent comprehensive review of workplace performance literature by renowned Canadian researcher Dr. Julian Barling has identified ten key organizational elements of a psychologically healthy workplace and the impact that work design factors have on the health and well-being of employees and their work performance [71]. **See Table 4**.

Well-structured organization level approaches to improving mental and physical health generate effects that are stronger and longer-lasting than interventions delivered at the individual level.

TABLE 4: TEN ELEMENTS OF A PSYCHOLOGICALLY HEALTHY WORKPLACE

Factors that contribute to psychological well-being at work

Element	Description
1. **Transformational Leadership**	A transformational leader is someone who can elevate employees through his or her ability to demonstrate humility, values and concern for others. This management style offers motivation, stimulation and individual consideration to employees and the results are strongly associated with well-being and work productivity.
2. **Work Load and Pace**	Employees benefit most from a workload that is moderate, appropriate to their skill level, allows time for recovery from demanding tasks, and provides discretion around how to complete tasks.
3. **Work Schedule**	Employees benefit from work schedules that fit work/life needs and allow some form of perceived control over the scheduling of work.
4. **Role Clarity**	This concerns the perceptions that the job will continue into the future in a stable manner and that there is realistic opportunity for career advancement.
5. **Job Future**	This concerns how well the employee's job is defined and the degree to which an employee has control over how to perform the work.
6. **Autonomy**	Employees need to know that they have some individual choice over significant components of their work and that they can use personal knowledge and skills to best accomplish tasks.
7. **Workplace Justice**	This reflects the perceptions of employees that they are being treated fairly from management and co-workers.
8. **Reduced Status Distinctions**	This involves the reduction of company culture status distinctions among employees at different levels of the company. For example, the size of offices, office furniture, job titles, differences in work clothing or uniforms, preferred parking or dining areas.
9. **Social Environment**	Employees prefer to have positive social relationships at work and satisfaction with interpersonal aspects of the work environment.
10. **Extrinsic Factors**	This area includes basic physical comfort such that employees have adequate control over the level of noise and temperature of the workplace.

4.2 The Business Value of Healthy Employees

What is the end result of making improvements at the company level to create a more psychologically healthy workplace? Does the value or profitability of a company improve when it has healthier employees?

There is evidence that the overall mental health of a company is related to company success. An early white paper by The Conference Board of Canada found that employers who engaged in health promotion along with initiatives toward improving psychosocial and physical work environments saw results in overall healthcare cost savings, improved productivity, and better employee retention[72]. Similarly, the book *Leveraging the New Human Capital* presents an extensive review of over 75 studies that address business outcomes from providing comprehensive and integrated mental health, work-life, wellness and organizational interventions[73].

A more rigorous test of this proposition was conducted through a series of studies by Watson Wyatt[74]. These studies used a comprehensive survey of company-level management practices and employee benefits and linked the patterns of organizational care to the actual stock performance of companies over time. The analyses examined more than 750 firms from the United States, Canada and Europe. The results of the early study and the aggregated studies showed that future business success (stock gains) was predicted relatively better by how the company treated its people than by its own past financial performance. These kinds of demonstration studies are important as they begin to link the benefits and Human Resources practices of a company to its level of overall success as a business.

A qualitative study was recently conducted that involved interviews with 16 Canadian CEOs on the topic of mental health[75]. Themes from the study indicated that the CEOs perceived mental health risks of employees in their organizations for developing conditions such as stress, burnout or depression. The risks are attributed to increased pressures of a fast-paced work environment, the need to acquire new skills and a corresponding fear of skill obsolescence—particularly among older employees. Most of the CEOs also felt that employees are more at risk for mental health conditions now than they were five years ago. Most also had the opinion that their senior managers were more concerned about the mental health of employees in their organizations than they were five years ago.

The majority of health and benefits managers consider employee mental health conditions to have a negative impact on absenteeism, productivity, group healthcare benefits, and STD claims[76].

These studies reveal that most business leaders have an appreciation of how strongly mental health conditions among employees and family members affects the success of a company. This level of employer interest is likely to only get stronger in the future as the causal conditions for creating workplace stress and mental health conditions are only getting worse. For example, given the demographic trends of an aging society and the resulting tighter labour pool in Canada, it is important for employers to be seen as providing a good place to work and supporting health benefits in order to attract new employees, retain existing employees and keep everyone healthy and productive[77].

4.3 Stakeholder Vision of Workplace Mental Health

This final part of the report looks ahead to how the future of workplace mental health is envisioned by key stakeholder groups: employers, employees, scientists, and the Canadian government. The future envisioned is one in which mental health plays a more central role in the management of the workplace and in defining the relationship between employer and employee.

Employers

Most jobs today demand cognitive skills to a much higher degree than the jobs of past generations. In the modern knowledge economy, the mental health of the workforce is critical. Reflecting these themes, the last decade has witnessed a greater realization among employers that employee productivity is closely linked to positive mental health. Several surveys of business leaders on mental health issues are now examined to illustrate this point.

Employees

Employers are not alone in recognizing the significance of mental health conditions at work. About half of adults in Canada either know someone who is affected by a mental health condition or are affected by it themselves[78].

A public opinion study was conducted this year on depression and the workplace[79]. The results of the study found that the vast majority of Canadians believe that depression is a life-threatening disease and that it is caused by a chemical imbalance in the brain. This study also found evidence of stigma, with people believing that someone with depression would not disclose it to others in the workplace "for fear of hurting their future opportunities." The personal experience and opinions of these employees on mental health at work sends a clear message that much greater attention is needed to address these issues from employers and other sources.

9 out of 10 employees surveyed felt that company leadership should make helping employees with mental health conditions a key human resources priority.[79]

Scientists

As the premier source of global advocacy on health issues, the World Health Organization has released one or more literature review reports every year since 2000 on the scientific findings related to various aspects of mental health. Similarly, the scientific community in Canada has long been concerned about mental health topics and more recently with issues specific to mental health in the workplace. The recent increased governmental awareness and funding for these areas will translate into even more research being done on mental health in Canada. Leadership for this work is provided by the Canadian Institutes of Health Research (CIHR), which is the Government of Canada's major health research funding agency.

CIHR has undertaken a 10-year research funding agenda to advance research on mental health in the workplace.

To carry out these future studies, Canada has a number of highly productive research centers and programs at major universities that address different aspects of mental health and the workplace (**see Table 5**). These institutions offer many resources for employers and can bring needed intellectual capital to future collaborative endeavors in this area.

Government

The Canadian Government has recently become much more active in the area of mental health. It prepared three major white paper reports on mental health in 2004[45], a final report in 2006[1], and created a new National Mental Health Commission in Canada in early 2007[80].

The National Mental Health Commission has three major objectives:

1. The Commission will conduct a 10-year campaign against the stigmatization of mental health conditions and against all forms of discrimination against people with mental health conditions.
2. The Commission will build a pan-Canadian Knowledge Exchange Centre that will allow governments, providers, researchers and the general public to access evidence-based information about mental health and to collaborate on relevant activities. And,
3. The Commission will facilitate a process to develop a national mental health strategy for Canada.

Employers will be interested to learn that the Commission also includes mandates on improving workplace mental health and includes funding for new applied research projects in this area.

TABLE 5: REPORTS ON WORKPLACE MENTAL HEALTH

Attridge, M., Riccuiti, J, Steacy, R., et al. (2007). *Mental Health in the Labour Force: Literature Review and Research GAP Analysis.* Watson Wyatt Worldwide. Toronto, ON, Canada.

http:// www.mentalhealthroundtable.ca/documents.html

Bilsker, D., Gilbert, M., Myette, T. L., & Stewart-Patterson, C. (2004). *Depression and Work Function: Bridging the Gap between Mental Health Care and the Workplace.* Depression in the Workplace Collaborative.

http://www.carmha.ca/publications/index.cfm

Bilsker, D., Gilbert, M., & Samra, J. (2007). *Antidepressant Skills at Work: Dealing with Mood Conditions in the Workplace.* British Columbia Mental Health and Addiction Services. Vancouver, BC, Canada.

http://www.bcmhas.ca/research

Bond, F. W., Flaxman, P. E., & Loivette, S. (2006). *A Business Case for the Management Standards for Stress.* Health and Safety Executive (HSE) [Special Report #RR431]. HSE Books, Sudbury, Suffolk, United Kingdom.

http://www.hse.gov.uk/research/rrpdf/rr431.pdf

Brun, J-P. (2005). *Mental Health at Work: From Defining to Solving the Problem (Booklets 1-3).* Université Laval, Chair in Occupational Health and Safety Management. Canada.

http://www.cgsst.com/chaire/eng/monographies.asp

Depression in the Workplace (2006). A Special Issue of *Managed Care Magazine, Vol. 1, Issue 1.* Six papers by various authors.

http://www.managedcaremag.com/workplace

Langlieb, A. M., & Kahn, J. P. (2005). How much does quality mental health care profit employers? *Journal of Occupational and Environmental Medicine, 47(11):* 1099-1109.

http://www.workplacementalhealth.org/Employerprofit.aspx

The Mental Health Policy Group of The Centre for Economic Performance. (2006). *The Depression Report: A New Deal for Depression and Anxiety Conditions.* The London School of Economics. London, England.

http://eprints.lse.ac.uk/818

Mental Health and the Workplace. Special Issue of *HealthcarePapers*, Volume 5, Issue 2. Seventeen papers by various authors.

http://www.longwoods.com/home.php?cat=350

Partnership for Workplace Mental Health (2006). *A Mentally Healthy Workforce: It's Good for Business.* The Partnership for Workplace Mental Health—American Psychiatric Association. Washington DC, USA.

http://www.workplacementalhealth.org/employer_resources/business_case.aspx

The Standing Senate Committee on Social Affairs, Science and Technology, Hon. Michael Kirby (Chair) and Hon. Wilbert Joseph Keon. (2006). *Out of the Shadows at Last: Transforming Mental Health, Mental Health Condition and Addiction Services in Canada.* Highlights and Recommendations. Government of Canada.

http://www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/soci-e/rep-e/rep02may06high-e.htm#_Toc133724663

Wilkerson, W. (2006). Business and Economic Plan for Mental Health and Productivity. *The Global Business and Economic Roundtable on Addiction and Mental Health*. Toronto, ON, Canada.

http://www.mentalhealthroundtable.ca

Human Solutions Report 2008 **Creating Mentally Healthy Workplaces**

TABLE 6: RESOURCE ORGANIZATIONS

CANADA

Organization	Website
British Columbia Business and Economic Roundtable on Mental Health	www.bcmentalhealthworks.ca
Canadian Health Network	www.canadian-health-network.ca
Canadian Institute for Health Research (CIHR)	www.cihr-irsc.gc.ca
Canadian Mental Health Association (CMHA)	www.cmha.ca
Centre for Addiction and Mental Health (CAMH) at the University of Toronto	www.camh.net
Center for Applied Research in Mental Health and Addiction (CARMHA) at Simon Fraser University	www.carmha.ca
Centre for Addictions Research of British Columbia	www.carbc.ca
Employee Assistance Society of North America (EASNA)	www.easna.org
Global Business and Economic Roundtable on Addiction and Mental Health	www.mentalhealthroundtable.ca
Mood Disorders Society of Canada	www.mooddisorderscanada.ca
Occupational Health and Safety Agency for Healthcare in British Columbia	www.ohsah.bc.ca
Ontario Healthy Workplace Coalition	www.thcu.ca/workplace/coalition.htm

UNITED STATES

Organization	Website
American College of Occupational and Environmental Medicine	www.acoem.org
American Psychiatric Association: Partnership for Workplace Mental Health	www.workplacementalhealth.org
American Psychological Association: Psychologically Healthy Workplace Awards	www.phwa.org
Institute for Health and Productivity Management	www.ihpm.org
National Institutes Mental Health (NIMH)	www.nimh.nih.gov
National Registry of Evidence-Based Programs and Practices	www.nrepp.samhsa.gov
Substance Abuse Mental Health Services Association (SAMHSA)	www.samhsa.gov

4.4 Resources for Supporting Workplace Mental Health

The past few years have seen a significant increase in the availability of highly credible reports on the nature of mental health conditions and what can be done to help improve the situation. Some of these reports are listed in **Table 5**. These particular resources were selected because they are the most recent, the most comprehensive, written for business readers, and – most importantly - are available at no cost online from the website listed for each report. Please note that most of the featured reports are supported by organizations that are devoted to promoting workplace mental health and thus many other resources are also available at their websites.

Table 6 provides a list of Canadian and American organizations that offer workplace mental health information and resources.

Educational Resources

Employers can champion the importance of positive mental health to the employees at their company by offering educational programs and services. One example of the kinds of high-quality resources available is the three part series prepared by The Chair in Occupational Health and Safety Management at Université Laval (**see Table 5**). These booklets describe: the scope of the problem and how workplace stress is shown, the multiple causes or sources of workplace stress, and methods of preventing stress in the workplace. These kinds of reader-friendly, science-based, resources can help improve the general understanding of workplace mental health conditions.

Another example of a useful resource is the free self-care guide *Anti-Depressant Skills at Work: Dealing with Mood Problems in the Workplace* (**see Table 5**). This workbook uses plain language and includes various easy-to-use self-assessments and skill-building exercises and tools.

Many EFAP providers also are well equipped with various kinds of print- and web-based materials for educating employees and management about the nature of mental health conditions and how to combat work stress. EFAPs also conduct on-site trainings and workshops to promote these issues at the worksite.

Employer Case Studies and Best Practices

There are many case studies of employers who have found success when improving their workplace mental health using these kinds of organization-level prevention practices.

- The American Psychological Association has made awards for employers of all sizes (both in the US and Canada) who have achieved a psychologically healthy workplace.
- The newly created employer database compiled by the Partnership for Workplace Mental Health features many good examples of different employers who have made positive changes at the company level to improve the mental health of their employees.
- The National Quality Institute (NQI) in Canada has added mental health into its criteria for the Healthy Workplace Award.
- There are specific workplace-based intervention programs that can be considered as "best practices that have already been developed and tested in controlled research studies" and now are available for use at other companies (see programs listed at the NREPP website and the University of Toronto website).

KEY MESSAGES

- Creating well-structured organization level approaches to improving mental and physical health usually generate effects that are stronger and longer-lasting than intervention approaches delivered at the individual level to specific employees.
- Transformational leadership (a management style that motivates employees and offers individual consideration) is most strongly associated with well-being and work productivity.
- Other psychological factors that contribute to well-being and productivity at work have been identified, namely: work load and pace, work schedule, role clarity, job future, autonomy, workplace justice, reduced status distinctions, satisfactory social environment, and comfortable physical environment (extrinsic factors).
- The mental health of the workforce is critical in a global economy that is based on the skills of knowledge-workers. Surveys of CEOs and benefits managers in Canada document a growing recognition of mental health conditions in general and of how they are connected to company costs and success.
- Opinion polls reveal that employees believe leadership should make recognition and support for mental health conditions a human resources priority.
- The last five years has seen almost a doubling of output from the scientific community in Canada and worldwide on mental health and how it affects the workplace. The World Health Organization, the Canadian Institutes of Health Research (CIHR), and major universities in Canada all have released major review papers and stepped up their efforts in this area.

Final Statement

Is there sufficient evidence to support a business case for workplace mental health? The business case has been made. The facts and evidence in this area are so strong that they cannot be dismissed—mental health conditions are already depleting the human capital of Canadian companies.

There now exists overwhelming research evidence of the critical role that mental health plays in the success of businesses of all sizes and in any industry. The problem facing most employers is that a high percentage of their employees (up to 1 in 5) and their family members are likely to have mental health conditions. A third of these employees are also likely to have a more complicated health status that is characterized by having more than one mental health condition, also having an alcohol or drug dependence problem or having a physical health condition or chronic disease as well as their mental health condition.

Fortunately, the basic solutions to this problem are already known and practiced today at some pioneering companies. What helps is to make sustained efforts at the organizational level to prevent the kinds of workplace factors that contribute to causing or exacerbating mental health conditions and to also open doors to finding the right kinds of treatment at the right time for employees and their family members who must respond to more acute mental health conditions. Once an employee receives care from a properly trained provider of mental health services, the personal and workplace outcomes from the treatment are likely to be quite good. While mental health conditions may not improve right away or be "cured," employers can be assured that with proper care, employees with mental health conditions will be more productive and less costly employees.

What is surprising is that the majority of employees with mental health conditions suffer alone and fail to get the care they need. Social stigma and other factors contribute to inadequate care. Those who do attempt to get help for their condition often use a care-seeking pathway that starts and stops with a visit to a medical doctor in the primary care health system. Although this source of care can be effective, what is more typical is that the doctor lacks the appropriate training in mental health to do the job right. In many cases, the employee will only get drugs to treat the symptoms

Many companies face a quiet crisis—comprehensive measurements now reveal that the costs of lost productivity and absence from mental health conditions is 3 to 4 times larger than the amount of dollars lost from healthcare and disability claims for these same conditions.

The traditional care-seeking pathway for employees with mental health conditions is clearly inadequate—the consequences of which include needless suffering on the part of employees and enormous cost burden for employers.

of the problem and will not experience the benefits of psychotherapy and other psychological interventions that may be necessary for full recovery.

A consequence of this chain of events is a massive number of employees with mental health conditions who get either no care or inadequate care. This in turn, results in an enormous cost burden to employers and to society in general.

Yet the future can be different if we open our eyes to this quiet crisis and take steps to bring mental health out of the shadows. Although there is a great deal of work to do in this arena, there are signs of positive change:

- Social and political tides are moving toward greater recognition of the value of mental health.
- Businesses are learning what other employers have done to create mentally healthy workplaces.
- Companies are implementing policies and practices that are supportive of the needs of those with work stress and mental health conditions.
- CEOs and managers are seeing the signs of a weary workforce and the need for interventions.
- Employees are more aware than ever of these issues and are looking to their employers for leadership. And that leadership is taking note.
- The federal government has begun a historic quest to finally address mental health in Canada. And,
- There are resources and tools available now from the scientific community that can be used to guide making changes within organizations and for sharing with employees and their families.

Human Solutions Report 2008 **Final Statement**

TABLE 7: ACTION STEPS

It is up to individual employers and employees to see the connection between the success of a business and the mental health of its employees. The first step on this course of action is to raise awareness of these important issues. The next step is to start or strengthen existing efforts to create a workplace that truly supports mental health. Potential next steps include:

- **Share this report with others at your company.**
- **Educate your workforce about the range of causes of mental health conditions.**
- **Offer educational and assessment services to help employees cope with work and family pressures.**
- **Conduct organizational assessments to determine what aspects of the job environment or organization culture can be changed.**
- **Strive to create better data tracking processes to measure absenteeism, productivity and health-related costs stemming from mental health conditions.**
- **Require detailed reporting and analysis from healthcare and disability service providers to examine the costs associated with mental health conditions.**
- **Investigate tools that can provide company-specific estimates of the financial losses (both direct and indirect costs) from mental health conditions and alcohol/drug conditions[81]. Some examples:**
  - **www.alcoholcostcalculator.org**
  - **www.bipolarsolutions.com**
  - **www.depressioncalculator.com**
  - **www.intelliprev.com**
- **Introduce and/or support mental health benefits.**
- **Select disability management vendors and partners who are more active in incorporating mental health assessments, counselling and other psychologically-oriented treatments as part of the clinical management process.**
- **Ask your EFAP to become a better service partner with your disability management program(s).**
- **Create return-to-work practices and workplace job accommodations that are supportive of employees with a mental health condition.**

References

[1]Kirby, J. L., et al. (2006). *OUT OF THE SHADOWS AT LAST: Transforming Mental Health, Mental Illness and Addiction Services in Canada (Report 4).* The Standing Senate Committee on Social Affairs, Science and Technology. Ottawa, ON, Canada.

[2]World Health Organization. (2005). *Mental Health and Work: Impact, Issues and Good Practices.* WHO. Geneva, Switzerland.

[3]World Health Organization. (2005). *Mental Health Policies and Programmes in the Workplace.* WHO. Geneva, Switzerland.

[4]Bond, F. W., Flaxman, P. E., & Loivette, S. (2006). A business case for the Management Standards for Stress. *Health and Safety Executive (HSE) [Special Report #RR431].* Sudbury, Suffolk, United Kingdom: HSE Books.

[5]Watson Wyatt Worldwide. (2007). *Mental Health in the Labour Force: Literature Review and Research GAP Analysis.* Attridge, M., Riccuiti, J, Steacy, R., et al. Watson Wyatt Worldwide. Toronto, ON, Canada.

[6]Wilkerson, W. (2006). *2006 Business and Economic Plan for Mental Health and Productivity*. Global Business and Economic Roundtable on Addiction and Mental Health. Toronto, ON, Canada.

[7]Goetzel, R. Z., Ozminkowski, R. J., Sederer, L. I., & Mark, T. L. (2002). The business case for mental health services: Why employers should care about the mental health and well-being of their employees. *Journal of Occupational and Environmental Medicine, 44,* 320-330.

[8]Langlieb, A. M., & Kahn, J. P. (2005). How much does quality mental health care profit employers? *Journal of Occupational and Environmental Medicine, 47*(11), 1099-1109.

[9]Dewa, C. S., Lesage, A., Goering, P., & Caveen, M. (2004). Nature and prevalence of mental illness in the workplace. *HealthcarePapers, 5*(2), 12-25.

[10]National Institutes of Mental Health. (2006). *The Numbers Count. Mental Disorders in America: A Fact Sheet Describing the Prevalence of Mental Disorders in America*. NIH Publication No. 06-4584. Revised 2006.

[11]Skinner, W., O'Grady, C., Bartha, C., & Parker, C. (2004). *Concurrent Substance Use and Mental Health Disorders: An Information Guide*. Centre for Addiction and Mental Health. Toronto, ON, Canada.

[12]Statistics Canada. (2004). *Canadian Community Health Survey, Mental Health and Well-Being 2002 (updated).* Ottawa, ON, Canada.

[13] Gilmour, H., & Patten, S. B. (2007). Depression and work impairment. *Statistics Canada: Health Reports, 18*(1), 9-22.

[14]Vasiliadis, H. M., Lesage, A., Adair, C., Wang, P. S. & Kessler, R. C. (2007). Do Canada and the United States differ in prevalence of depression and utilization of services? *Psychiatric Services, 58,* 63-71.

[15]Schaffer, A., Cairney, J., Cheung, A., Veldhuizen, S., & Levitt, A. (2006). Community survey of bipolar disorder in Canada: Lifetime prevalence and gender differences. *Canadian Journal of Psychiatry, 51*(1), 9-16.

[16]Shields, M. (2004). Social anxiety disorder: Beyond shyness. *Statistics Canada Annual Report: Focus on Mental Health. Supplement to Health Reports, 15,* 45-61.

[17]Ramage-Morin, P. L. (2004). Panic disorder and coping. Statistics Canada Annual Report, Focus on Mental Health. *Supplement to Health Reports, 15,* 31-43.

[18]Langlois, S., & Morrison, P. (2002). Suicide deaths and suicide attempts. *Health Reports: Statistics Canada,* Catalogue 82-003, Vol. 13(2).

[19]Tjepkema, M. (2004). Alcohol and illicit drug dependence. *Statistics Canada Annual Report: Focus on Mental Health. Supplement to Health Reports*, *15*, 9-19.

[20]Canadian Center on Substance Abuse. (2004). *Canadian Addiction Survey: Highlights on Prevalence of Use and Related Harm.* CCSA/ Health Canada. Ottawa, ON, Canada.

[21]Frasure-Smith, N., & L'Espérance, F. (2005). Reflections on depression as a cardiac risk factor. *Psychosomatic Medicine, 67* (Supplement 1), S19–S25.

[22]Goldne, R.D. et al, (2004). Diabetes, depression, and quality of life: A population study. *Diabetes Care*, *27*, 1066-1070.

[23]Kopec, J. A. & Sayre, E. C. (2004). Work-related psychosocial factors and chronic pain: A prospective cohort study in Canadian employees. *Journal of Occupational and Environmental Medicine, 46*(12), 1263-1271.

[24]Motivala, S. J., & Irwin, M. R. (2007). Sleep and immunity: Cytokine pathways linking sleep and health outcomes. *Current Directions in Psychological Science, 16,* 21-25.

[25]Duxbury, L., & Higgins, C. (2005). *Report Four: Who Is at Risk? Predictors of Work-Life Conflict.* Public Health Agency of Canada.

[26]Pyper, W. (2006). Balancing career and care. *Statistics Canada: Perspectives* (November), 5-15.

[27]Turcotte, M. (2007). Time spent with family during a typical workday, 1986 to 2005. *Statistics Canada: Canadian Social Trends* (February), 2-11.

[28]Barling, J. (Ed.). (2005). *The Handbook of Work Stress.* Newbury Park, CA: Sage.

[29]Marchand, A., Demers, A. & Durand. P. (2005). Do occupation and work conditions really matter? A longitudinal analysis of psychological distress experiences among Canadian employees. *Sociology of Health and Illness, 27*(5), 602-627.

[30]Dewa, C. S., Lin, E., Kooehoorn, M., & Goldner, E. (2007). Association of chronic work stress, psychiatric disorders, and chronic physical conditions with disability among employees. *Psychiatric Services, 58*(5), 652-658.

[31]Shields, M. (2006). Stress and depression in the employed population. *Statistics Canada: Health Reports, 17*(4), 11-29.

[32]Williams, C. (2003). Sources of Workplace Stress. *Statistics Canada: Perspectives* (June), 5-12.

[33]Wilkins, K., & Beaudet, M. P. (1998). Work stress and health. *Statistics Canada: Health Reports, 10*(3), 47-62.

[34]Rhoades, L, & Eisenberger, R. (2002). Perceived organizational support: A review of the literature. *Journal of Applied Psychology, 87,* 698-714.

[35]Parker, C. P., Baltes, B., Young, S., Altmann, R., LaCost, H., Huff, J., & Roberts, J. E. (2003). Relationships between psychological climate perceptions and work outcomes: A meta-analytic review. *Journal of Organizational Behavior, 24,* 389-416.

[36]Statistics Canada. (2003). *Canadian Community Health Survey, Mental Health and Well-Being 2002.* Ottawa, ON, Canada.

[37]Sareen, J., Cox, B. J., Afifi, T. O., Clara, I., & Yu, B. N. (2005). Perceived need for mental health treatment in a nationally-representative Canadian sample. *Canadian Journal of Psychiatry 50*(10), 643-651.

[38]Wang, J. L., Langille, D. B., & Patten, S. B. (2003). Mental health services received by depressed persons who visited general practitioners and family doctors. *Psychiatric Services, 54*(6), 878-883.

[39]Stuart, H. (2004). Stigma and work. *HealthcarePapers, 5*(2), 100-111.

[40]Stephens, T., & Joubert, N. (2001). The economic burden of mental health problems in Canada. *Chronic Diseases in Canada, 22*(1), 18-23.

[41]Birnbaum, H. G., Greenberg, P. E., Barton, M., et al. (1999). Workplace burden of depression: A case study in social functioning using employer claims data. *Drug Benefit Trends, 11,* 6-12.

[42]Murray, C. J. & Lopez, A. D. (Eds.). (1996). *The Global Burden of Disease and Injury Series: Volume 1, A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries, and Risk Factors in 1990 and Projected to 2020.* Cambridge, MA, Published by the Harvard School of Public Health on behalf of the World Health Organization and the World Bank, Harvard University Press.

[43]Goetzel, R. Z., Anderson, D. R., Whitmer, R. W., Ozminkowski, R. J., Dunn, R. L., & Wasserman, J. (1998). The relationship between modifiable health risks and health care expenditures: An analysis of the multi-employer HERO health risk and cost database. *Journal of Occupational and Environmental Medicine, 40*(10), 843-854.

[44]Williams, C. (2006). Disability in the workplace. *Statistics Canada: Perspectives* (February), 16-24.

[45]Kirby, J.L., et al. (2004). *Mental Health, Mental Disorders and Addiction: Report 1, Overview of Policies and Programs in Canada. Report 2, Mental Health Policies and Programs in Selected Countries. Report 3, Issues and Options for Canada*. Standing Senate Committee on Social Affairs, Science and Technology. Ottawa, ON, Canada.

[46]Michie, S., & Williams, S. (2003). Reducing work-related psychological ill health and sickness absence: A systematic literature review. *Journal of Occupational and Environmental Medicine, 60*, 3-9.

[47]Brun, J-P., & Lamarche, C. (2006). *Assessing the Costs of Work Stress.* Université Laval. Unpublished paper.

[48]Gnam, W., Sarnocinska-Hart, A., Mustard, C., Rush, B., & Lin, E. (2006). *The Economic Costs of Mental Disorders, Alcohol, Tobacco, and Illicit Drug Abuse in Ontario, 2000*. Canadian Association Mental Health.

[49]Marlowe, J. F. (2002). Depression's surprising toll on employee productivity. *Employee Benefits Journal*, March, 16-20.

[50]Kessler, R. C., & Frank, R. G. (1997). The impact of psychiatric disorders on work loss days. *Psychological Medicine, 27*, 861-873.

[51]Druss, B. G., Rosenheck, R. A., & Sledge, W. H. (2000). Health and disability costs of depressive illness in a major US corporation. *American Journal of Psychiatry, 157,* 1274-1278.

[52]Kessler, R. C., Akiskal, H. S., Ames, M., Birnbaum, H., Greenberg, P., Hirschfeld, R. M. A., et al. (2006). Prevalence and effects of mood disorders on work performance in a nationally representative sample of US employees. *American Journal of Psychiatry, 163*, 1490-1491.

[53]Goetzel, R. Z., Long, S.R., Ronald, M.S., Ozminkowski, J., Hawkins, K., Wang, P., et al. (2004). Health, absence, disability and

presenteeism cost estimates of certain physical and mental health conditions affecting US employers. *Journal of Occupational and Environmental Medicine 46*(4), 398-412.

[54]Stewart, W. F., Ricci, J. A., Chee, E., Hahn, S. R., & Morganstein, D. (2003). Cost of lost productive work time among US employees with depression. *Journal of the American Medical Association, 289*(23), 3135-3144.

[55]Smit, F., Cuijpers, P., Oostenbrink, J., Batelaan, N., de Graaf, R., & Beekman, A. (2006). Costs of nine common mental disorders: Implications for curative and preventive psychiatry. *Journal of Mental Health Policy Economics, 9,* 193-200.

[56]von Knorring, L., Akerblad, A. C., Bengtsson, F., Carlsson, A., & Ekselius, L. (2006). Cost of depression: Effect of adherence and treatment response. *European Psychiatry, 21,* 349-354.

[57]Mojtabai, R., & Olfson, M. (2006). Treatment seeking for depression in Canada and the United States. *Psychiatric Services, 57,* 631-639.

[58]Vasiliadis, H.-M., Lesage, A., Adair, C. & Boyer, R. (2005). Service use for mental health reasons: Cross-provincial differences in rates, determinants and equity of access. *Canadian Journal of Psychiatry, 50*(10), 614-619.

[59]Drapeau, A., Lesage, A., & Boyer, R. (2005). Is the statistical association between sex and the use of services for mental health reasons confounded or modified by social anchorage. *Canadian Journal of Psychiatry, 50*(10), 599-604.

[60]Lipsey, M. W. & Wilson, D. B. (1993). The efficacy of psychological, educational, and behavioral treatment confirmation from meta-analysis. *American Psychologist, 48*(12), 1181-1209.

[61]World Health Organization (2004). *Prevention of Mental Disorders, Effective Interventions and Policy Options: Summary Report.* WHO. Geneva, Switzerland.

[62]Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General.* U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Rockville, MD, USA.

[63]Hosman, C.M.H., & Janè-Llopis, E. (2005). The evidence of effective interventions for mental health promotion. In World Health Organization. *Promoting Mental Health: Concepts-Emerging Evidence-Practice*. (pp. 169-188). WHO. Geneva, Switzerland.

[64]World Health Organization (2006b). *Dollars, DALYs and Decisions: Economic Aspects of the Mental Health System.* World Health Organization.

[65]Bilsker, D., Wiseman, S., & Gilbert, M. (2006). Managing depression-related occupational disability: A pragmatic approach. *Canadian Journal of Psychiatry, 51,* 76–83.

[66]Preece, M., Cayley, P. M., Scheuchl, U, and Lam, R. W. (2006). The relevance of an Employee Assistance Program to the treatment of workplace depression. *Journal of Workplace Behavioral Health, 21*(1): 67-77.

[67]Corbière, M., Bond, G. R., Goldner, E. M. & Ptasinski, T. (2005). The fidelity of supported employment implementation in Canada and the United States. *Psychiatric Services, 56,* 1444-1447.

[68]Mackay, C.J., Cousins, R., Kelly, P.J., & McCraig, R.H. (2004). Management Standards and work-related stress in the UK: Policy background and science. *Work and Stress*, *18*, 91-112.

[69]Brun, J-P., Biron, C., Martel, J. & Ivers. H. (2003). Analysis of Workplace Mental Health Programs in Organizations. *IRSST Report A-342.*

[70]Harvey, S., Courcy, F., Petit, A., Hudon, J., Teed, M., Loiselle, O., & Morin, A. (2006). Organizational Interventions and *Mental Health in the Workplace: A Synthesis of International Approaches.* Report R-480, Montréal, IRSST.

[71]Barling, J. (2007, May). Ten Key Factors in Building a Psychologically Healthy Workplace. Presentation at the *2nd Canadian Congress on Research on Mental Health & Addiction in the Workplace*, Vancouver, BC, Canada.

[72]Bachmann, K. (2002). *Health Promotion Programs at Work: A Frivolous Cost or a Sound Investment?* The Conference Board of Canada. Ottawa, ON, Canada.

[73]Burud, S., & Tumolo, M. (2004). *Leveraging the New Human Capital: Adaptive Strategies, Results Achieved, and Stories of Transformation.* Palo Alto, CA: Davies-Black.

[74]Watson Wyatt Worldwide. (2005). *Maximizing the Return on Your Human Capital Investment. The 2005 Watson Wyatt Human Capital Index® Report.* Watson Wyatt Worldwide.

[75]Global Business and Economic Roundtable on Mental Health and Addictions. (2004). *Results of CEO Research on Mental Health.* Global Business and Economic Roundtable on Addiction and Mental Health. Toronto, ON, Canada.

[76]Mercer. (2005). *Mental Health Issues in the Workplace: 2004 Survey Results*. Mercer. Toronto, Ontario, Canada.

[77]Grafstein, J.S., et al. (2006). *The Demographic Timebomb: Mitigating the Effects of Demographic Change in Canada*. Report of the Standing Committee on Banking, Trade and Commerce. Ottawa, ON, Canada.

[78]Desjardins Financial Security. (2006). *Desjardins Financial Security Survey on Health and the Desjardins National Financial Security Index: Edition 2006*. Vancouver, BC, Canada.

[79]Ipsos Reid. (2007). *Premier North American Public Opinion Study on Depression and the Workplace*. Report available from the Global Business and Economic Roundtable on Addiction and Mental Health. Toronto, ON, Canada.

[80]Kirby, M. (2007, May). *Mental Health is the Business of Business—and all Canadians.* Presentation to the Vancouver Board of Trade. Vancouver, BC, Canada.

[81]Loeppke, R., Hymel, P. A., Lofland, J. H., Pizzi, L.T., Konicki, D. L., Anstadt, G. W., et al. (2003). Health-related workplace productivity measurement, general and migraine-specific recommendations from the ACOEM expert panel. *Journal of Occupational and Environmental Medicine, 45*(4), 349-360.

ABOUT THE AUTHOR

Dr. Mark Attridge is a consultant in independent practice as President of Attridge Studios (**mark@attridgestudios.com**), a consulting firm that specializes in designing measurement systems and outcome research studies for workplace health services, writing literature review white papers, and development and customization of ROI analysis tools.

Mark has authored more than 100 articles and conference papers on topics in healthcare, psychology and communication and he is co-editor of a research-based book on the integration of employee assistance, work/life and wellness.

Previously, Mark was the Director of the National Data Cooperative (NDC) for the US Group and Health Care Practice of Watson Wyatt Worldwide. Prior to that position, Mark was a Principal at Optum/United Health Group during which he managed an internal research department and directed a variety of applied research projects involving healthcare claims, operational data, and surveys. Mark is also past Chair of the Research Committee for the Employee Assistance Professionals Association.

Mark holds a Ph.D. degree in psychology from the University of Minnesota and a M.A. degree in communication from the University of Wisconsin-Milwaukee.

©2008 Wilson Banwell PROACT Human Solutions™. All rights reserved.

For additional information on this report or our services please feel free to contact us.

1.888.689.8604

busdev@humansolutions.ca

www.humansolutions.ca

Wilson Banwell
Human Solutions™

PROACT
Solutions Humaines MC

Human Solutions™