



Making Cents of Mental Health in the Workplace

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Introduction

“In no other field, except perhaps leprosy, has there been as much confusion, misdirection and discrimination against the patient as in mental illness...Down through the ages they have been estranged by society and cast out to wander in the wilderness. Mental illness, even today, is all too often considered a crime to be punished, a sin to be expiated, a possessing demon to be exorcized, a disgrace to be hushed-up, a personality weakness to be deplored or a welfare problem to be handled as cheaply as possible.”

These words were written in a Canadian report on mental illness 50 years ago. For many of you, that's before your lifetime.

To what degree are those words still true today? It makes me uncomfortable to admit it, but reality hasn't changed much since then.

Consider our growing numbers of homeless people – many of them ‘cast out to wander in the wilderness’ -- because of mental illness. And those of you who are business leaders will know that we also have a workforce that is being compromised by mental health issues.

I am here today to speak with you about mental illness. It's an issue that's very dear to me. Like almost everyone in this audience, I have members of my extended family who suffered from mental illness. I want to tell you about the impact of mental illness on individuals and on the economy, and about some of the initiatives that are now underway. Finally -- I'm not embarrassed to say -- I'm going to ask for your help and commitment in dealing with this issue.

Mental Health in the Workplace

First of all, let's take a moment to discuss mental health issues in the workplace. It's an issue business leaders can't afford to overlook. It affects men and women in their prime working years. In fact, 20 to 25% of the labour force is affected by mental health issues – that's one in four employees! What other illness has such an impact?

The economic price tag of mental illness in the workplace is skyrocketing. In 2002, it was estimated that mental health and addiction issues cost Canada 33 billion dollars a year in lost output and redundant wage costs. But in late 2007, a study indicated that mental disorders and addictions cost this much in Ontario alone.

That's just the dollars lost for those employees who are off on disability. Four out of five employees with mental health issues are not being treated. Mental health issues comprise nearly half the time off that employees take for ALL illnesses during the year.

And mental health issues are creating even greater time lost in the form of ‘presenteeism’ – time on the job that is not used efficiently. We are seeing the full continuum – burn-out to depression to short-term disability – and then to long-term disability – all with limited intervention by the health care system.

The total impact on productivity of mental health issues has not been calculated. As a result, many organizations, including those traded on the stock exchange, harbour substantial unfunded liabilities.

These costs, both hidden and direct, can only escalate in the future if nothing is done about them soon.

We need to begin early. Not only do we need to begin early screening in the workplace, we also need to address our future workforce. We know that onset for most mental illnesses begins in youth or childhood. Eighty percent of adults living with mental illness had the illness before age 18. These range from depression and anxiety to eating disorders and substance abuse. To make matters worse, once a child or youth is faced with a single mental health disorder, chances are that they will also be challenged by a second one.

Addressing mental health issues, especially in children and youth, is a pressing need. We can't afford to wait. As a society, we're relying on 'brain power' more and more. We're becoming a 'brain-based economy'.

A recent McKinsey study found that 85% of new jobs coming on stream in the U.S. require brain skills, not physical skills. As one of our Canadian steel industry leaders puts it: "The minds -- not the backs -- of my employees now do the heavy lifting for my business."

More companies understand their role in the community and are developing a strong commitment to social responsibility. Dealing with mental health issues in the workplace should become part of that commitment to social responsibility. It's the right thing to do.

However, if you don't want to do it because it's right – do it because it's a good business decision. Studies by the Mental Health Commission and the Global Business and Economic Roundtable on Mental Health and Addiction have shown that better case management for employees on short-term disability for stress or mood disorders can lead to a quicker return to work – fifteen days earlier, on average. The savings in disability insurance and other costs are two to four times greater than the cost to implement the improved case management – savings that directly impact your bottom line.

Let me repeat. It is in the business interest of companies to improve the mental health of their employees and to improve the way an employee's case is managed if they become sick with a mental illness.

There are a number of documents now available that can help you get started. Over the past few years, a series of four Canada-United States mental health and productivity conferences have been held. These Global Business and Economic Roundtables on Mental Health and Addiction brought together leaders in science and business to discuss and develop new initiatives to help businesses address mental health issues.

As a result, we now have comprehensive management guidelines in a document called Business and Economic Plan for Mental Health and Productivity. There is also a leadership package called CEO Guidelines and a CFO Framework for Mental Health and Productivity. These resources and more can help you begin to address mental health issues in the workplace more effectively. They can be found on the website www.mentalhealthroundtable.ca.

Stigma

I would now like to take a few minutes to discuss a very sensitive but important aspect of mental illness.

If I asked for a show of hands by people with a member of their extended family who suffers from mental illness, virtually all of you should have your hands up. One out of four of us is living with a mental health issue. But most people are embarrassed to admit they have a mental health issue. That is because of stigma.

Stigma refers to the negative and prejudicial ways in which people living with mental illness are labelled. This labelling is so pernicious that people living with mental illness are often seen as nothing more than the disease itself – they are no longer a person.

As I indicated in my opening quote – mental illness has the taint of leprosy. Many people living with a mental illness report that the stigmatization of mental illness – particularly the way they are treated by family, friends and co-workers -- often causes them more suffering than the disease itself.

During our consultation with the public, the Senate Committee heard many heart-wrenching stories about stigma. We heard about the shame that those living with mental illness suffered. We heard about having to beg for a referral to a psychiatrist. We heard about losing friends and contact with family. We heard about humiliation at work – all because of mental illness.

Parents even admitted to being embarrassed to acknowledge that their own child was living with mental illness. In a recent study, 38% of parents said they would not admit to anyone – even their family doctor – that they had a child with a mental illness.

But stigma is not just ‘name calling’. It’s also ‘sticks and stones’. It can have concrete consequences.

While 81% of Canadians believe depression is a life-threatening illness, 45% of us also believe that if someone at work was dealing with depression and missed work as a result, they’d be more likely to “get into trouble and maybe even fired.” Let me repeat that. Almost half of workers thought that missing work due to mental illness might have negative consequences.

The Homeless

And what happens when you get fired or can no longer work? What happens to your income? Mental illness and homelessness are close cousins. Between a quarter and a half of the homeless live with mental illness. That rate is even higher in some groups. For example, the Toronto Homeless Task Force reports that 75% of homeless women have a mental illness.

It's important to understand both the absolute numbers and the connections between homelessness and mental illness. Some of the figures are shocking.

Homelessness used to be rare in this country, but it's now commonplace. Between 1994 and 2006, the homeless population here in Vancouver is estimated to have grown by 235% -- an average of about 20% a year.

Studies have also shown that over 11% of the homeless meet the criteria for schizophrenia. Now you might think that 11% isn't high, but it's 10 times the national rate for schizophrenia.

In B.C., it's estimated that 130,000 adults live with severe addiction and/or mental illness. Of these, nearly 10% are homeless and many more are at risk of homelessness.

Our society treats the mentally ill who have no place to live even more poorly than we treat those with mental illness who are not homeless. They are growing in number and in cost to governments which are increasingly unable to afford to help them.

To make matters worse, these people suffer twice the stigma. There's still a widespread feeling that homelessness is somehow a lifestyle choice. Clearly, it isn't, even though it's the life of thousands of Canadians.

What is particularly disturbing is that the fastest growing segments of the homeless population are youth and seniors. One third of today's homeless are between ages 16 and 24.

What disturbs me most, however, is that the homeless population is large and quickly growing -- growing in size and in its connection with mental illness.

The homeless mentally ill have two very large strikes against them -- a mental illness and being homeless -- and the almost impossible challenge of getting effective and sustainable help. Both mental illness and homelessness are hugely complex issues on their own -- and when they're combined, it's virtually impossible to pry them apart.

How many of them are homeless because they are mentally ill? That is hard to estimate. But we do know that the closure of institutional beds in the '90s, and the failure to replace them with community beds, has resulted in the streets and the prisons becoming the asylums of the 21st century.

That said, it's pretty clear that if someone has a place to live -- a permanent, safe, warm and dry place to put their heads -- they can begin to take care of their other problems. If they don't have a place to live, they really can't.

This is why the Senate Committee, in its report *Out of the Shadows At Last*, recommended that the federal government put \$250 million a year for 10 years into supportive housing for the mentally ill. We strongly believed that a concerted attack on the problem of mental illness had to include meeting basic needs for shelter.

And that is why we at the Mental Health Commission of Canada were excited with the recent announcement by the federal government that the Commission would receive \$110 million to fund five demonstration projects for the homeless mentally ill across Canada. These projects will be located in Moncton, Montreal, Toronto, Winnipeg and here in Vancouver. Each project will help us learn more about effective ways to help a distinct group of homeless people living with mental illness. Here in Vancouver, the focus will be on those who not only have mental illness and are homeless, but who also struggle with substance abuse.

These projects will give governments, and service-providers in each of the cities, the opportunity to look at the problems of homelessness and mental illness in a new way. Collectively, the projects will also create a body of evidence that will enable Canada to lead the world in providing services to people living with mental illness who are homeless.

What We're Doing

This research will also support some of our other work at the Mental Health Commission of Canada. Last year, the Federal Government announced the creation of Commission in order to facilitate the development of the first national mental health strategy in our nation's history.

The Commission grew out of the most extensive exercise in consultation on mental health ever conducted in this country. As I mentioned earlier, that consultation process became the basis of the report of a Senate Committee that I chaired called *Out of the Shadows At Last*.

The Commission is non-profit organization with a mandate to focus national attention on mental health issues. It is funded by the federal government, but operates at arm's length from all levels of government. Our Board of Directors includes 11 non-government members and 7 members appointed by the federal, provincial and territorial governments. We have eight advisory committees on Child and Youth; Mental Health and the Law; Seniors; First Nations, Inuit and Métis; Workforce; Family Caregivers; Service Systems and Science.

As we fold up our shirtsleeves and get down to work, we are very aware that a national strategy must be useful and practical. A strategy that sits on a shelf does no one any good. I like to say that the Commission's national strategy must be, "just inside the outer edge

of political feasibility.” That is, we must push the system as hard as possible while still ensuring progress is achieved. It must be a challenge, but do-able. A strategy which is perfect, but never implemented because it’s not politically feasible, is useless.

The strategy will involve consultation with stakeholders. It must be a collaborative effort. Service delivery is a provincial and territorial responsibility, so the implementation of the strategy will be undertaken by that level of government.

The national strategy is not the only initiative on our agenda, however. A second – but not less important -- task of the Commission is to undertake a major, national 10-year anti-stigma and discrimination reduction campaign. A systematic effort to reduce the stigma of mental illness, and combat the discrimination that people with mental illness experience, are key elements in the Commission’s mandate.

The anti-stigma campaign will take a multi-pronged approach that will include education, promoting contact with those living with mental health problems, and challenging discriminatory policies and practices. To begin, there will be a national public awareness campaign, a contact and education strategy that will include a Speakers’ Bureau and a media watch program. The anti-stigma campaign will initially be targeted at children and youth, and healthcare professionals. Children and youth because they are more open and accepting of new ideas than us old folks. Healthcare professionals because people living with a mental illness tell us that they experience stigma from service providers in the healthcare system.

What You Can Do!

Now it’s your turn. You may think I’ve already given you your marching orders. But there’s more.

No matter how good our overall national mental health strategy is, it will be useless without the political will to implement it. Given the magnitude of the changes required, this political will must exist across multiple jurisdictions and over a sufficiently long period of time to allow us to get the job done.

Those disease-specific organizations that have succeeded in establishing a strong presence on the political agenda, and keeping their cause – their disease -- in the public eye, have at least two factors in common. The first is a national organization of volunteers. The second is a not-for-profit charitable organization that allows individuals and corporations to contribute money and receive a charitable tax receipt.

The volunteers in these organizations do many different things. They raise money; they volunteer in the health institutions that serve the people battling the disease; they mount campaigns designed to persuade government to increase funding for treatment and research; and they do everything they can to ensure that the public never loses sight of their concerns.

Therefore, a major task of the Commission in the coming months will be to duplicate for mental health the kind of volunteer organization that exists for breast cancer, diabetes, and heart and stroke, to name some of the most familiar. We must build on past efforts of mental health organizations, but move everything to the next level.

We need your support to make this happen. We need you to encourage your friends, neighbours and employees to take mental health issues out of the shadows, to talk about and to volunteer for mental health causes.

This will reinforce the Commission's efforts to address the stigma attached to mental illness. Stigma has been the biggest single obstacle to developing a national social movement to help those living with mental health problems and illnesses.

Yet, in order for us to build a vibrant volunteer movement, we need to overcome the hesitancy many people may have to becoming openly involved in mental health advocacy. In other words, stigma must be fought so that the tens of thousands of Canadians can become fully engaged in improving mental health services and supports.

At the same time, the very fact of building a national volunteer organization will greatly contribute to the work of the Commission's goal of reducing stigma. A well-organized and funded grass roots organization – one that undertakes a series of community-based activities every year – will help ensure that mental health is a topic of ongoing publicity and public discussion. It's only by making it completely acceptable to discuss issues relating to mental health and mental illness in public that we can ever hope to fully eradicate the scourge of stigma.

For the Commission to be a catalyst for reforms, we must create new partnerships and engage a new generation of volunteers; we must be the catalyst to create a great social movement, such as those that formed around fighting diseases such as cancer and heart and stroke. We want to live to see the day that our corporate titans put their names on the psychiatric wings of hospitals or community-based housing for people living with a mental illness.

This mental health social movement will ensure that mental health stays out of the shadows forever.

The first thing you can do when you leave this luncheon is to tell your friends and neighbours how important it is that mental health issues be addressed. Tell them about the state of crisis I described to you this afternoon, educate them about the issues involved and ask them to get involved. The second thing you can do is to join our national mental health movement and encourage your friends, neighbours and employees to join. Use the movement as a way to become an active supporter of mental health.

We believe that for the vast majority of Canadians living with mental illness, recovery is possible. That is, people living with a mental illness can lead reasonable lives within the limitations imposed by their illness.

The Commission can be a catalyst leading to change. But only you can make our efforts successful.

With the help of each and every one of you in this room I believe – truly believe – that we can turn the words of Roy Muise into a reality. Roy is a person living with a mental illness who testified before the Senate Committee in Halifax. He challenged all Canadians with these words:

“To the people of Canada, I say welcome us into society as full partners. We are not to be feared or pitied. Remember, we are your mothers and fathers, sisters and brothers, your friends, co-workers and children. Join hands and travel together with us on our road to recovery.”

Please think about these words when you leave here today – and promise yourself that you will accept this challenge.

Additional Facts (Bill Wilkerson’s Fredericton Speech)

- 7.5 million Canadians suffer from depression, anxiety, substance abuse or other mental disorder each year
- 43% of respondents to a 2006 Mercer/Marsh reported the frequency and cost of depression/anxiety/related claims among their employees is increasing
- Over 10% of general drug plan costs are for mental illness drugs and over 21% of all drug claims are to treat mental illness
- When medical conditions co-occur with mental illness, specifically depression, total pharmacy costs related to mental illness increase by a factor of three
- The number of mental illness-related pharmacy claims increased 5.4% from 2004 to 2005, as compared to a total pharmacy claims increase of 3.8%