

BC Partners for
Mental Health and
Addictions Information

Visions

BC's Mental Health and Addictions Journal

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WORKPLACES





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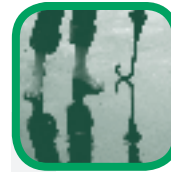
- 3 Editor's Message [Sarah Hamid-Balma](#)
- 4 The Final Frontier in Workplace Health
[Margaret Tebbutt](#)
- 6 The Economic Impacts: Workplace mental illness and substance abuse
[Claudia Steinke and Ali Dastmalchian](#)
- 7 Substance Use: The monster we work with
[MaryAnne Arcand](#)
- 9 Human Rights and Employer Responsibility to Accommodate Disability in the Workplace
[Jennifer Lynch](#)



web-only articles

available at www.heretohelp.bc.ca/publications/visions

- Wired in the Workplace [Deena Waisberg](#)
- Return to Work: Ready or not? [Karen Six](#)
- Taking Care of That Little Girl
[Maureen Lavallee](#)
- Stress in the Workplace [June Earle](#)
- Peer Support for Medical Professionals
[Dr. Paul A. Farnan](#)
- Good News About Workplace Mental Health
[Mary Ann Baynton](#)



experiences perspectives

- 11 A Little Help From My Friend
[Jude Morrison](#)
- 12 Transitioning from Disability Pension to Full-time Work: Scary but liberating
[Tara Timmers](#)
- 14 Insurance Reassurance: Disability income a must for recovery [Ross Taylor](#)
- 15 A Triple Threat: Workplace isolation, West Coast grey and the "black dog"
[Gwen Marsh](#)
- 17 The Bottom Line: There is no health without mental health [Arto Tienaho](#)
- 19 The Mostly Incompetent Employee
[Frank G. Sterle, Jr.](#)

bc partners

Seven provincial mental health and addictions non-profit agencies are working together as the BC Partners for Mental Health and Addictions Information. We represent Anxiety BC, British Columbia Schizophrenia Society, Canadian Mental Health Association's BC Division, Centre for Addictions Research of BC, FORCE Society for Kids' Mental Health, Jessie's Hope Society and the Mood Disorders Association of BC. Our reason for coming together is that we recognize that working together we have a greater ability to provide useful, accurate and good quality information on mental health, mental illness, substance use, and addictions including how to prevent, recognize, treat and manage these issues and improve quality of life.

visions

Published quarterly, *Visions* is a nationally award-winning journal which provides a forum for the voices of people living with a mental disorder or substance use problem, their family and friends, and service providers in BC. *Visions* is written by and for people who have used mental health or addictions services (also known as consumers), family and friends, mental health and addictions service providers, providers from various other sectors, and leaders and decision-makers in the field. It creates a place where many perspectives on mental health and addictions issues can be heard. To that end, we invite readers' comments and concerns regarding the articles and opinions expressed in this journal.

The BC Partners are grateful to BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority, for providing financial support for the production of *Visions*



alternatives approaches

- 21 Employee Assistance Programs
Raymond W. Lam
- 22 Guarding Minds @ Work: A new guide to psychological safety and health
Joti Samra and Merv Gilbert
- 23 Drug Testing in the Canadian Workplace
Scott Macdonald



regional programs

- 25 Healthy Workplaces—Healthy People: Fraser Health's recent focus on mental health
Elayne Preston and Rosemary Nemanishen
- 26 Mental Health Awareness for Managers: An integrated approach
Jan Mitchell
- 27 Quittin' Time: A smoking cessation program for the BC Public Service
Maureen Foxgord
- 29 Employers Who Are Walking the Walk
Donna Panitow
- 31 Mental Health Works
Mary Ann Baynton and Margaret Tebbutt



While reading the stories in this issue, I couldn't help but remember a touching story by a mental health advocate and speaker, Sandy Naiman. Sandy is a veteran journalist with the Toronto Sun who was diagnosed with a rare form of bipolar disorder. In one talk, she described a time when she was having a manic episode at work. It was severe enough that, if I remember correctly, she was in the newsroom in the middle of the night—in her underwear. A building custodian found her and asked if he could bring her some tea and toast. He didn't respond with fear or judgment. He gave the kind of response all employees struggling with emotional distress, mental illness and/or addiction would hope for from their supervisors and co-workers: compassion. It isn't always easy to give, I know. But compassion is a piercing arrow through the heart of stigma and discrimination.

I had a similar experience a long time ago when I was an intern. I had recently been diagnosed with severe depression, but routine really helped me so I still went to work every day. Unfortunately, my doctors still hadn't found a treatment that worked very well, so I hid my symptoms in the workplace. Frankly, I didn't know I had a choice; I didn't know about accommodations. I think I did a good job of hiding my depression and being a valuable employee, but "faking it" takes its toll, and for some reason that I now forget, I sent a note to the head of my team about what had been going on. The next morning, I found a coffee table book called *Moments* on my chair, along with some handwritten words of support on a bookmark. *Moments* turned out to be a book of stories of real people and their journeys of recovery put out by the Canadian Mental Health Association. I felt real hope that day. Like Sandy, I'll never forget that kindness.

This issue of *Visions* includes a lot rational arguments why employers, managers, unions, and insurers should care. You'll hear incredible stats about the impact of inaction on the bottom line, about the legal responsibilities, and how accommodations—small changes to help someone be successful at work—are still cheaper and easier than retraining a new employee. But for my little space here, I just want to remind the workplace community that it's still also, quite simply, *the right thing to do*.

Sarah Hamid-Balma

Sarah is Visions Editor and Director of Public Education and Communications at the Canadian Mental Health Association's BC Division. She also has personal experience with mental illness

subscriptions and advertising

If you have personal experience with mental health or substance use problems as a user of services or as a family member, or provide mental health or addictions services in the public or voluntary sector, and you reside in BC, you are entitled to receive *Visions* free of charge (one free copy per agency address). You may also be receiving *Visions* as a member of one of the seven provincial agencies that make up the BC Partners. For all others, subscriptions are \$25 (Cdn.) for four issues. Back issues are \$7 for hard copies, or are freely available from our website. Contact us to inquire about receiving, writing for, or advertising in the journal. Advertising rates and deadlines are also online. See www.heretohelp.bc.ca/publications/visions.

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The opinions expressed in this journal are those of the writers and do not necessarily reflect the views of the member agencies of the BC Partners for Mental Health and Addictions Information or any of their branch offices

The Final Frontier in Workplace Health



Margaret Tebbutt, BA (Hons.), MèsLettres

Margaret is a graduate of UBC's Sauder Executive Development Program and is the Manager of the Mental Health Works program for the Canadian Mental Health Association, BC Division. She participates on the steering committee for CMHA BC Division's Bottom Line Conference, the board of the Canadian Institute for the Relief of Pain and Disability, and the BC Collaborative to Prevent Needless Work Disability. In workshops and talks she gives about mental health in the workplace, Margaret incorporates both her executive management experience and her personal experience with major depression and anxiety disorders

Workplace mental health affects each of us. You might experience a mental illness while trying to make a living and support your family. You might be a union representative trying to help a union member struggling to stay at work or return to work. You may be the owner of a business or an executive who has to keep the workplace profitable, productive and healthy while respecting your employees' legal rights. You might be the front-line supervisor who's unsure about how to approach an employee whose behaviour has changed, who isn't doing the job as well as usual and who seems upset. You may be a co-worker, concerned about a fellow worker, but also reluctant to "pick up the slack." You might be the insurance provider who is finding that 40% to 45% of claims are due to clinical depression and/or anxiety. At some point in our working lives, we are likely to be in at least one, and probably more than one, of these situations. So we need to learn how we, together, can deal with mental health issues in the workplace.

The Canadian Mental Health Association, BC Division (CMHA BC) has been a leader in this province, bringing workplace mental health to the forefront. With generous support from many sponsors, CMHA BC's Bottom Line Conference on Mental Illness in the Workplace first generated awareness of this issue back in 2002. Every year since then, the conference has been a forum for discussing solutions to supporting mental health in the workplace. These discussions happen with leaders and influencers from businesses, unions and health care, together with people who have experienced mental illness while working.

Our mental health relates closely with work. In addition to financial security, we gain a sense of purpose, self-esteem and social support from being productive and making contributions through work.

Problems arise for us, however, if we are no longer seen as a valued person, but as the "problem" employee. The worker the human resources department has to find a spot for or find a way to get rid of. The invisible "claimant" for disability. The "jerk" nobody wants to work with. The "patient" whose doctor has to write yet another report for the insurance company. The "other" who is someone "we" would not want to be—and yet we very easily could be.

Society loses when discrimination towards workers experiencing mental illness is tolerated. Our society values respect for human rights, and these rights—and obligations—include full participation in society. If there are citizens we do not support or allow to par-

ticipate fully, we lose the benefit of these citizens' contributions, including in workplaces. And, workplace mental health issues not only affect the people directly involved, but the economy as well. The economy suffers because of lost productivity, absenteeism and long-term disability.

Society gains when we understand that sick leave for mental illness is not "just stress leave," but is the same sick leave as for any other illness. Mental health disorders are real. And we gain economically when experienced people with valuable skills and knowledge are able to stay at work. Money is saved when we don't have to hire and train someone to replace them.

There have been major strides in understanding the importance of employees' physical health and safety. Laws and regulations have been created to protect the physical health of workers. There is good knowledge of how to prevent injuries, such as carpal tunnel syndrome, for instance. And there are processes and equipment to accommodate workers who experience such medical conditions and to prevent further injury. This understanding now needs to be extended to workers' *mental* health.

Articles in this issue of *Visions* focus on what workplaces can do to help their employees and members. We also look at how workplace mental health can be improved from a systemic perspective. Some articles describe the workplace factors that can affect mental health and share ways these factors can be monitored and improved. And personal experiences are shared by people who have faced mental illness in the workplace, who have been on long-term disability, and who have stayed at work, or returned to work, with accommodations.

As a society, we've changed how we respond to someone with disabilities in our workplaces. We accept people who cannot see or who have trouble getting around. We understand when someone needs time off for cancer treatment. When these people return to work, they are, rightfully, celebrated as survivors. So, let's change how we behave when our co-workers need time off to get treatment for their mental illness. When they come back to work, let's celebrate *them* as survivors.

In closing, let me take this opportunity to thank everyone who helped me recover from depression and anxiety and return to work. I'm very grateful to all those who helped me get back to being a productive member of society. ■

footnotes

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rights in employment and prevention of discrimination

the legal underpinnings regarding mental disabilities*

from the Canadian Charter of Rights and Freedoms¹

“Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or **mental** or physical **disability**.”

from the Canadian Human Rights Act²

“The purpose of this Act is to extend the laws in Canada to give effect... to **the principle that all individuals should have an opportunity equal with other individuals to make for themselves the lives that they are able and wish to have and to have their needs accommodated**, consistent with their duties and obligations as members of society, without being hindered in or prevented from doing so by discriminatory practices based on race, national or ethnic origin, colour, religion, age, sex, sexual orientation, marital status, family status, **disability** or conviction for an offence for which a pardon has been granted.”

from the BC Human Rights Code³⁻⁴

“The purposes of this Code are... to (a) foster a society in British Columbia in which there are no impediments to full and free participation in the economic, social, political and cultural life of British Columbia...”

“A person must not (a) refuse to employ or refuse to continue to employ a person, or (b) discriminate against a person regarding employment or any term or condition of employment because of the race, colour, ancestry, place of origin, political belief, religion, marital status, family status, physical or **mental disability**, sex, sexual orientation or age of that person or because that person has been convicted of a criminal or summary conviction offence that is unrelated to the employment or to the intended employment of that person.”

*Note: We have added all colour and bold to text for emphasis

I noted a disturbing trend in many of the articles appearing in the recent Schools issue of *Visions*. What was missing was any involvement of students as active delivery sources for drug prevention, promotion of mental health, establishing connection, and developing friendship. Have peer helping and peer education programs left the building? Are students no longer trained and supervised to provide positive peer influence? Are they only seen or used as receivers of education strategies?

Given how much easier it is for students to be in contact with each other in superficial and impersonal ways through technology, it would seem even more important to provide opportunities for personal, meaningful, and genuine engagement. Peer interaction is still the number one priority for students in schools, and it is essential for school and mental health professionals to learn how to make the best use of this unstoppable force.

—*Rey Carr, Victoria, BC*

The recent Aboriginal issue of *Visions* which talked about healing circles got me thinking that a positive move by government would be the establishment, nationwide, of the aboriginal healing/sentencing circle, for crimes where the perpetrators and victims are Aboriginal; and it should be guaranteed upon request by any Aboriginal community. The healing/sentencing circle should be used because our criminal-court system can be unproductive—and even destructive. When I stood before a court judge—a man who, like me, was but a human being with frailties—I found his position up high behind a large wood bench quite intimidating and, at sentencing, frightening. The healing/sentencing circle, on the contrary, has all of those people involved with a crime—the accused, the victim(s) and their families, etc.—sitting in a circle and facing one another apparently with equal status. Furthermore, instead of just shipping an accused off to jail where he can be raped and become a worse person upon his eventual release, he is made to answer directly to those he has hurt and possibly bring about resolution and healing; he hears and responds to his victim’s pain, and may perhaps also express his own painful past which may have corrupted him. Our current often-pompous, adversarial justice system could very well learn a positive thing or two from the Aboriginal healing/sentencing circle.

—*Frank G. Sterle, Jr., White Rock, BC*

we want your feedback!

If you have a comment about something you’ve read in Visions that you’d like to share, please e-mail us at bcpartners@heretohelp.bc.ca with ‘Visions Letter’ in the subject line. Or fax us at 604-688-3236. Or mail your letter to the address on page 3. Letters should be no longer than 300 words and may be edited for length and/or clarity. Please include your name and city of residence. All letters are read. Your likelihood of being published will depend on the number of submissions we receive.

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Footnotes Reminder: If you see a superscripted number in an article, that means there is a footnote attached to that point. Sometimes the footnote is more explanation. In most cases, this is a bibliographic reference. To see the complete footnotes for all the articles, see the online version of each article at www.heretohelp.bc.ca/publications/visions. If you don’t have access to the internet, please contact us for the footnotes by phone, fax or mail using the contact information on page 3.

The Economic Impacts

Workplace mental illness and substance abuse

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\$tress is a normal part of any life and any job. Stress can be positive or negative. How people react to different stressors is very individual. But too much stress can contribute to, or even lead to, serious health problems and/or mental illness for workers.

No workplace is too big or too small to avoid the impact of mental illness. Nearly 6 million, or 1 in 5 Canadians are likely to experience a mental illness in their lifetime.¹ This makes mental illness the largest untreated epidemic facing the Canadian workforce.² According to the Canadian Mental Health Association, many people face mental illness during their prime working years.³

ductivity due to long-term and short-term disability, and costs to quality of life.⁴

Workplaces that create or maintain high levels of stress pay the price in terms of:

- worker inefficiency
- reduced productivity and competitiveness
- high worker compensation claims
- high rates of occupational injury
- high costs for health claims
- high incidence of disability leave
- high rates of absenteeism and turnover
- low levels of worker job satisfaction
- low levels of customer satisfaction

Mental illnesses have surpassed heart disease as the fastest-growing, costliest disabilities in the country.³ Nearly half of the sick days workers take are because of mental illnesses like depression.⁵ When mental illness accompanies another disability such as a physical disability, the length of time off from work increases two to three times.⁵ For example, a worker who takes one month off work for a back injury may end up being away for two to three months if the back pain is accompanied by depression.

One report shows that we are seeing mental illness follow a pattern of burn-out to depression to short-term disability and then long-term disability.⁶ In fact, mental illness and addiction account for 46% of all long-term and short-term disability claims.⁷

Early intervention and treatment makes cents

It's in the business interest of companies to improve the mental health of their workers and to improve the

way a worker's case is managed if they become sick with a mental illness. For example, when workers get early access to treatment, companies can save \$5,000 to \$10,000 per worker each year.⁵ They save in the cost of prescription drugs, sick leave and average wage replacement. Workers who are diagnosed with depression and who take the prescribed medication save employers an average of 11 absentee days per year.³

Early detection at work is possible. Seventy to 80% of mental illnesses can be treated effectively when properly diagnosed and managed. Unfortunately, only one in four cases is properly diagnosed and only one in four of those cases are properly treated.²

Combating stigma—a top priority

The reality is that mental illness is among the more difficult workplace problems to tackle. Unlike most other disorders, many people choose not to get treatment for mental illnesses, even when treatment is available.

The promise of some relief competes with the fear of being stigmatized. In the business world in particular, nobody wants to admit to having a mental illness. To do so is often viewed as a sign of weakness and thus is a sure-fire career killer. The fear of losing your job and the respect of your colleagues prevents people from seeking treatment.

Mental illness is also a disease that many managers choose not to talk about. This is because they don't know where to start, are uncomfortable with mental illness in general, and some are scared of liability.



66 **In the business world in particular, nobody wants to admit to having a mental illness**

footnotes

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A skyrocketing cost

The economic price tag of mental illness in the workplace is skyrocketing. A recent report puts the price at \$51 billion. This figure includes medical costs, costs from lost pro-

In all cases, combating the stigma of mental illness is one of the most pressing priorities for improving mental health in organizations. It has been well documented that addressing mental illness in the workplace by reducing the stigma makes good economic sense. Yet, less than a third of employers have plans in place to address this important issue.⁸

Creating awareness and educating managers and employees about mental illness are first steps that organizations can take to address this issue. Only by making it acceptable to openly discuss mental illness can we can ever hope to eliminate the harmful stigma that is attached to it. ■

some practical suggestions for employers

Educate your people: It's not a manager's or worker's responsibility to diagnose a mental illness. However, it is the responsibility of citizens everywhere to be informed and to learn how to recognize when there might be a problem. Knowledge is essential for understanding, accepting and knowing how and when to appropriately intervene.

- **Provide background:** Begin with a company-wide briefing on mental illness. Present a broad overview of the facts.

- **Provide depth:** Improve awareness by getting specific about the actual illnesses. While it's important to discuss how stress can be better managed through diet, exercise and sleep, companies need to move beyond this comfort zone and start discussing "the all too often undiscussed."

Customize your benefits plans: Ensure that worker assistance plans and group health plans are customized to better support people with mental

illness. This will help to ensure that people receive timely and appropriate treatment and follow-up.

Engage for the greater good: Support public and corporate education initiatives to eliminate the stigma around mental illness. This is a form of corporate and social responsibility. Companies that engage in the larger social efforts to eliminate the stigma serve as model workplaces that promote and support the mental health of their workers.

Substance Use **The monster we work with**

There's a monster at your workplace that nobody wants to look at. Everybody knows it exists. That it's big. It's ugly. And it's dangerous. We'd rather cover our eyes and pretend it's not there. Maybe we'll peek out once in a while to see if it's gone away yet. The bad news is that it's not going anywhere. As a matter of fact, it's growing!

We don't want to know it's there—because with knowledge comes responsibility. In this liability-conscious age, however, employers cannot get away with pretending they don't know there are substance abuse and addictions issues in their workplaces. "What I don't know won't hurt me" just doesn't cut it for employers or supervisors.

The monster takes its toll

A recent report commissioned by the BC Forest Safety Council found that problem substance use on the job among Canadian workers averages from 10% to 30%, depending on the industry.¹ According to statistics from the 2004 Canadian Addictions Survey, self-reported use of all categories of illegal drugs in BC is higher than the national average.¹

The cost of problem substance use in the workplace is enormous. Lost productivity, treatment for addiction and addiction-related workplace injuries and fatalities

are all very costly. A 2007 study by the Canadian Centre on Substance Abuse estimates that substance abuse across the general population costs the economy:²

- \$24.3 billion a year in lost productivity because of death or illness
- \$8.8 billion a year in health care costs
- \$5.4 billion a year in law enforcement costs

Problem substance use appears to be higher in some industries than others. Industries at higher risk include:³

- construction (e.g., carpenters, bricklayers, crane operators, roofers, steel workers)
- transport (e.g., shipping, trucking, airlines, rail)
- food services/hospitality (e.g., cooks, wait staff, hotel staff, maintenance workers)
- resource industries (e.g., oil, gas, forestry, mining)

Substance use issues that employers end up dealing with include:

- after-effects of substance use (hangover, withdrawal) affecting job performance
- arriving late for work, absenteeism, illness and dismissal because of impairment
- poor job performance and/or reduced productivity (slowed work pace, mistakes, injury and safety infractions)
- preoccupation with obtaining and using substances

MaryAnne Arcand

MaryAnne is the Director of Forestry TruckSafe & Northern Initiatives at the BC Forest Safety Council and Vice-President of the BC Council on Substance Abuse

while at work, interfering with attention and concentration

- illegal activities at work, including selling illicit drugs to other employees
- job performance affected by psychological or stress-related effects of substance abuse by a family member, friend or co-worker

The crux of it: when does the monster become a disability?

There are differences between *problem substance use* (or *substance abuse*) and *addiction*. Each requires different duties of care and due diligence from employers. While both problem substance use and addiction create problems in the workplace, the cost of the solution to each can be very different. The methods and costs range from an initial simple chat with the boss for a worker correcting a behavioural choice (e.g., quitting smoking) to comprehensive treatment and return-to-work programs if there's a full-on addiction.

Problem substance use can be defined as any use of alcohol or other drugs, legal or illegal, that becomes a problem. It's a problem when substance use becomes the focal point of an individual's life and that person continues to use it despite potential serious consequences.

Substance use (e.g., casual or social) can be a problem, but not necessarily an addiction. It can be a problem in that it creates risk and all the other challenges for employers noted above. But if it's a person's choice of behaviour, as opposed to a compulsion, it can be stopped at will.

Addiction is a compulsive or physiological dependence on something habit-forming. Addiction moves along a scale, from habit to compulsion. From compulsion to need. From need to dependence and craving. And, addictions are not limited to substance use; they can include gambling, food, sex, video games and a variety of other activities that in their own way can affect job performance, attendance and safety.

No matter where on the addiction scale a person sits, the distraction caused by addiction impairs judgment and a person's ability to make good decisions. This makes it hard for a person with an addiction to perform his or her work properly, efficiently and safely. The worker's addiction endangers not only him/herself, but fellow workers and others around them as well.

Employer response to problem substance use would generally be part of a progressive discipline policy. The employer would warn an employee two or three times that their problem substance use must stop. If it's a lifestyle choice, and the worker realizes the boss is serious, the worker will stop the problem substance use. However, if the worker is not *able* to stop the substance use, this would be an addiction.

An employer would not 'diagnose' an addiction. *Who* makes that diagnosis and *when* it's made is up

to the individual interpretation of employer, employee and union (if they're involved). It could be an addictions counsellor through an EAP/EFAP program, for instance. An addictions counsellor would have some tests and measurements to help make the distinction between problem use and addiction.

If an employer discovers that one of its employees has an addiction, however, the employer is left with no choice but to recognize the behaviour as a disability.

Employers have a duty to accommodate the monster

Employers and management don't want to look too closely at employees' habits or behaviours. They're afraid they'll find issues that they don't want to deal with.

Whether they like it or not, however, employers in British Columbia have a "duty to accommodate," according to the Canadian Human Rights Commission.⁴ If an employee has an addiction, and thus a disability, the employer must make sure the employee has access to treatment and must proceed with the duty to accommodate. That is, the employer must provide support to enable the employee to either remain in the workplace or to return to work after recovery.

Many employers don't understand their "duty to accommodate." Many don't want to do it. They would rather remove the worker from the workplace completely and permanently—they'd rather ignore the monster and hope it will go away.

Some employers feel it's not fair that they are responsible for helping their employees get treatment, sometimes at the company's expense. They see the problem as "self-inflicted," so don't grasp why it should be their responsibility. This speaks to a lack of understanding and knowledge about the nature of addictions.

There is a tremendous amount of awareness and education that needs to be done for employers and management.

So how do we tackle the monster?

It won't be simple, but there are steps we can take:

- First, we need to stop denying that the monster exists in our workplaces. We need to acknowledge that it is a reality and face it.
- Then, we need to declare—together, as workplace employers and workers—that the monster is not welcome on our work site, in our industry, in our province.
- We need to collectively commit to addressing the monster—the problem of substance use and addiction—and stick to it, despite the inconvenience and short-term cost.
- After that, we need to learn, and understand, the variety of addictions.
- Employers, management and workers themselves need to be armed with the knowledge and tools to identify suspected addictions or addictive behav-

footnotes

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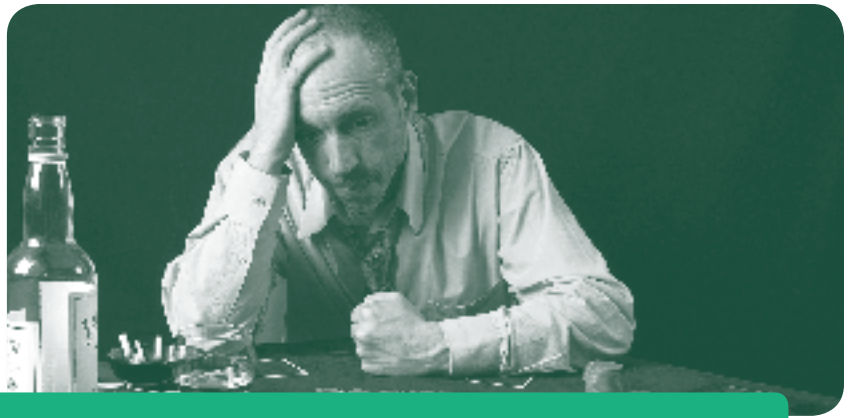
hours. This requires that training, policy changes and other mechanisms be put in place to protect the rights of all concerned.

- From there, employers and management need an array of available options to present to the employees concerned—everything from counselling to treatment to a return-to-work program. One approach will not work for all situations.

How do you eat an elephant?

It's like the old joke: "How do you eat an elephant?" The answer: "One bite at a time."

For a good first step, visit workdrugfreebc.com and see the wide range of information, tools and training available there for employers and supervisors. Go ahead, take the first bite! ■



If an employee has an addiction, and thus a disability, the employer must make sure the employee has access to treatment and must proceed with the duty to accommodate



Human Rights and Employer Responsibility to Accommodate Disability in the Workplace

When it comes to mental illness and problem substance use in the workplace, employers and employees have both rights and responsibilities. The *Canadian Human Rights Act* (the Act) prohibits discrimination in employment on a number of grounds, including disability. The Act considers both mental illness and drug and alcohol dependence as disabilities.

Under the Act, employers have two main responsibilities toward employees and people who apply for employment. First, employers must not discriminate on the basis of a disability or a perceived disability. Employers must make it clear that harassment in the workplace will not be tolerated. Harassment must be investigated and corrected as soon as employers become aware of it. Every effort must be made to eradicate stigma and discrimination, because they can make a person's experience of,

and recovery from, mental illness or addiction more difficult. Stigma and discrimination can also affect a person long after the symptoms of their illness are gone.

Second, the Act requires that employers do everything they can to accommodate an employee with a disability. Just as someone with a physical disability might need physical aids or structural changes in the workplace, someone with a mental illness might need social or organizational accommodations.

Working together with mutual respect

The employer, employee and union all have a responsibility to work together to choose appropriate accommodations on a case-by-case basis. These accommodations can be as simple as flexible scheduling or modifying duties slightly; they might be temporary, periodic or longer term.

Many employees will know what accommodation they need. Some employees, however, may not take the right steps to get treatment or accommodation. This can be because they haven't come to terms with their illness. Sometimes the very nature of a disability makes it hard for people to deal with it. Some employees might be afraid of a negative reaction.

Employers are not expected to diagnose mental illness or addictions, but supervisors should be aware of changes in employee behaviour and workplace performance. In some cases, managers/supervisors may need to speak with an employee privately to assess whether mental illness or addiction may be a factor in a workplace performance issue. If mental illness or addiction is suspected, the manager/supervisor must support the employee in seeking help and/or putting in a request for accommodation.

Jennifer Lynch, QC

Ms. Lynch is the Chief Commissioner of the Canadian Human Rights Commission and Chair of the International Coordinating Committee of National Human Rights Institutions

An employee seeking accommodation must provide enough information so that the employer can understand the accommodation needed. The employer needs to know how the employee's condition affects their work. The employee does not have to disclose information about the diagnosis, the history of the illness or its treatment.

It's also okay for an employer to ask an employee or applicant to provide supporting documentation from a health care provider. This is so the employer can come up with the best accommodation options.

If an employee is uncomfortable sharing this information with his or her supervisor, it may be useful to involve a third party. A third party could be a member of the human resources (HR) division. The HR person can gather the information and recommend accommodations to the supervisor.

Some important points to keep in mind about information shared/asked for:

- Only information relevant to the work situation needs to be shared—the point is to support the employee with appropriate accommodation
- Medical information shared between the employee and employer is private and must be kept confidential
- Every person is different, so accommodation requests should be considered on a case-by-case basis

Once accommodation has been provided, an employee has a responsibility to meet all essential job requirements and standards of their position or modified position. They must continue to work with their manager or supervisor to make sure that the accommodation remains effective.

Limits on duty to accommodate

There are some limits on the employer's duty to accommodate. If an employee or applicant repeatedly refuses to acknowledge or deal with their mental illness or substance abuse, the employer's duty to accommodate may be set aside.

The employer can also refuse to accommodate if providing accommodation would result in undue hardship for the organization. Health, safety and cost are factors to consider.

To prove undue hardship, an employer must show that it got information about the abilities of the employee and about the disability, and that all possible accommodations were explored. Regarding safety, it's not enough to speak of vague health and safety concerns; the employer must determine whose health and safety is at risk and how high the risk is. And, the cost of providing accommodation would have to greatly affect the viability of the organization to be considered undue hardship.

Resources for employers

The Canadian Human Rights Commission is committed to achieving the highest standards of human rights practice within its own workplace. In October 2008, we created an internal policy and procedural guideline on the accommodation of mental illness. Because we recognize that many other organizations face the same challenges, we are sharing this on our website. (Go to www.chrc-ccdp.ca, click on "Legislation and Policies" and select *Policy and Procedures on the Accommodation of Mental Illness*.)

Our publication, *Duty to Accommodate—Frequently Asked Questions*, is also available on our website (www.chrc-ccdp.ca, then click on "Publications"). It contains further information about accommodation. ■

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The *Canadian Human Rights Act* applies to workplaces under federal jurisdiction. These include federal departments, agencies and Crown corporations; chartered banks; airlines; interprovincial communications and telephone companies; interprovincial transportation companies; and First Nations, among others. The provinces and territories have similar laws about discrimination that apply in their jurisdictions. The BC Human Rights Code is available at www.bchrt.gov.bc.ca

A Little Help From My Friend

The role of unions when a worker has an addiction problem

I never thought much about issues of mental illness or addictions in the workplace until I began working as a labour relations practitioner in health care. I work for a union that represents nurses.

My first experience with addictions or chemical dependency in the workplace arose when I represented a nurse who had siphoned off, from an IV bag, a portion of the morphine that should have gone to a patient under her care. Her employer had immediately terminated her employment with them.

The general trust betrayed

I was shocked on so many levels. My feelings mirrored what most people's response tends to be in such a situation: I felt sad, confused, betrayed and even a bit angry. This was a nurse (I'll call her Francine*). Someone in a caring role. Someone we all instinctively feel we can trust in moments of deep vulnerability, when we are sick or dying.

I had to really think about my own feelings about the situation before I helped this nurse. My role was not only to represent Francine, but also to represent the nurses who work with her. I have to work within the context of ensuring that the workplace is safe for all, including the patients. While unions are there to help the workers they represent, this doesn't mean condoning problematic behaviours.

What the employer called "patient abuse and theft of drugs" certainly was problematic behaviour. Francine had stolen and used a portion of pain-relieving drugs that were prescribed by a doctor for someone else. Her actions meant that the patient didn't get the correct amount of pain relief and likely suffered some ill consequences as a result.

But what had prompted this behaviour?

Francine had a problem—she, herself, was sick. She was an addict and her life was out of control.

So, what does a union do in such a complex situation?

Francine in need of help

Our nurse needed support, not isolation. We first made sure Francine was safe; that she was receiving treatment from a doctor and had other personal supports in place, including a union steward.

Part of the assistance the union provided was to make sure that Francine recognized her illness and that she voluntarily entered treatment. Often nurses in this situation are in a high state of denial. We work with

the nurse to ensure that he or she understands the extent and consequences of their illness, that there is help available and that we will assist them. We helped Francine enter a six-week residential treatment program.

We filed a grievance with the employer, stating they were wrong to fire Francine. To fire her was discrimination based on her illness of chemical dependency. The appropriate employer response would have been to remove Francine from the workplace, but not by firing and publicly humiliating her. She needed to be off on sick leave and she needed help fast. Employers are required by law to do everything possible to accommodate people with illnesses and disabilities in the workplace, so these employees can continue to work when safe to do so.

We also assisted her with her licensing body (nurses must be licensed to practice nursing and must comply with professional standards). We wanted to make sure she could continue to work as a nurse when she had recovered. A registered nurse who has any form of illness that affects their ability to deliver care must seek appropriate treatment and/or voluntarily stop providing nursing care until able to do so safely. Nurses who fail to seek treatment or stop nursing can have their licence taken away. The union works together with the nurse in question and the licensing body to ensure that these professional obligations are met. This usually results in a compliance and monitoring agreement being put in place.

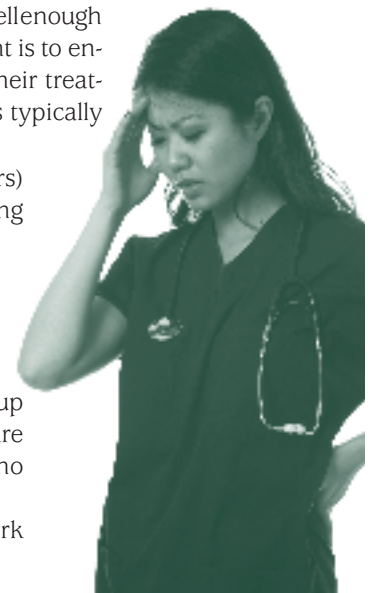
And finally, we made sure that Francine had a similar agreement with the employer for when she was well enough to return to work. The purpose of the agreement is to ensure nurses like Francine are compliant with their treatment and recovery process. These agreements typically include:

- an extensive period of time (one to two years) where the nurse is prohibited from handling narcotic medications
- random urine screening tests (for narcotics and/or alcohol)
- attending an Alcoholics/Narcotics Anonymous support group
- attending Professional Accountability Group meetings (these regular support meetings are specifically for people with addictions who work in health care professions)
- voluntary withdrawal from nursing work upon relapse

Jude Morrison

For the past 17+ years, Jude has worked as a representative for a number of unions in BC. Jude has depression and, given her own family history of depression and alcoholism, she takes a special interest in these issues in her work and life

*pseudonym



The ripple effect

The employer representatives were not the only people who had strong feelings about Francine's behaviour. Her co-workers, particularly the nurses, were very upset.

I got Francine's consent to hold a meeting with her co-workers during her absence to discuss her addiction in general terms and to share that she was in treatment.

The first thing I did was let people talk. They felt angry. They felt completely betrayed that a professional nurse would steal and take narcotic medications. They felt they could no longer rely on her professional judgment and care as a nurse. They would now have to be on the "watch" for her, in addition to their own busy workloads.

Next, I answered their questions and educated them about chemical dependency. Ironically, nurses are quite under-educated in these issues and generally hold the same misconceptions and biases that most of us do.

The nurses were glad to have someone to talk candidly to. When Francine was removed from the workplace they felt there was a lot of attention on her, but none for them. Some sort of debriefing and education with affected staff needs to occur as soon as possible after the incident, so that frustration doesn't build.

Francine's problem in perspective

Given the conditions of their work, it's surprising that the rate of chemical dependency among nurses isn't higher. But roughly the same percentage of nurses suffer from addiction as does the general population: that is, about 10%.¹⁻² However, nursing is still dominated by women—about 94% of registered nurses are women.³ Women tend to take on multiple roles in society: mother, spouse, employee and, increasingly, caregiver for aging parents. Add to this a nursing shortage, which means increased workloads and thus increased risk of injury and stress. Further, add nurses' ready access to narcotics as part of their professional role.

Many of us are what a friend of mine calls "the walking undiagnosed." But we all seem to think that mental illness and/or addiction happens to 'someone else.' When we push these conditions as far away from ourselves as we can, we are helping to create stigma.

So what happened to Francine?

She returned to work as a nurse. She was responsible—not her colleagues—for her own nursing work and her need to stay healthy. She went to accountability and support meetings. She had a two-year compliance agreement wherein she couldn't have access to administer narcotic drugs. She was also subject to random urine tests to make sure she was clean and sober.

Francine relapsed. She went into treatment again. This time her recovery was a little bit stronger. For Francine, each day is a new day and a new journey. ■

Transitioning from Disability Pension to Full-time Work Scary but liberating

Tara Timmers

Tara is a full-time Administrative Coordinator in the mental health and addictions field. She has lived in Victoria, BC, all her life and has a diagnosis of schizophrenia. In 2008, Tara self-published a poetry book called EGO

I've been working toward wellness for the past 14 years. My recovery journey began after I was given a diagnosis of schizophrenia at age 19. I had been a top student throughout high school, but in grade 12 started hanging out with the arty, party crowd. This led to substance use and my mental illness. I was hearing voices and seeing things that weren't there, so couldn't work.

Once diagnosed, I was put on medication. I also needed a lot of help to deal with the stress in my life. A support team was put together for me, consisting of a psychiatrist, a case worker, community agencies—and my mom, who has been a huge factor in my recovery.

Reclaiming my self: an education explosion

Five years ago I began taking courses. In the early days of my illness I couldn't have imagined doing this. But I had learned many coping skills and was on the right meds, so felt I could manage taking on a challenge or two.

Earlier on the recovery path, trauma issues had emerged and I started doing counselling and therapy. One of the helping professionals planted the seed of an idea that I could do anything I applied myself to. That seed grew into a world of possibility. I became interested in reclaiming the high-achieving student I had been.

The Bridges for Women Society in Victoria offers an employment training program to help women

footnotes

visit heretohelp.bc.ca/publications/visions for Jude's complete footnotes or contact us by phone, fax or e-mail (see page 3)

overcome the effects of abuse. In 2003 I attended this program four days a week for a year. They gave me new skills and confidence, and helped me get ready to go back to school. I learned to set boundaries and goals. I worked on communication and job search skills, as well as career exploration. I created a collage representing my dream for the future: I wanted to be a counsellor.

Once I started learning, I didn't stop. I needed more entry-level job skills and to become computer literate, so in 2004/05 I did an intensive full-time business administration program at CDI College, completing it with 95% honours. I was finally getting my life back on track.

Getting an education has been very important to me in dealing with my illness. I found that the more information I had, the better I would do.

The REES Network (Resources, Education, Employment and Support), a program of Victoria Cool Aid Society, trained me to provide peer support to other people in recovery. At the same time, I was accepted into the Leadership Victoria action/study program for emerging community leaders. I followed up at REES in the Mentorship program, and then went on to complete a 10-month lay counselling program at Citizens' Counselling Centre. I'm now working on a Leadership Development certificate program at Camosun College. All this helped prepare me for my big transition into the work world.

The giant step to independence

Up until August 2008, I had been on a PWD (Persons with Disabilities) pension, which the provincial government gives to people who have severe mental illness. For two years, I'd had a part-time job with the BC Schizophrenia Society in Victoria as an administrative coordinator. I earned the extra \$500 a month the government allows PWD pension recipients to make.

I'm still doing the administrative coordinator job, but now I'm a full-time, paid employee. My part-time position was actually a job-sharing situation. When my job-share partner decided to leave, I was faced with the

decision about making this leap.

It was a very scary step to take to come off disability. Being on disability pension is safe and comfortable. The jump from being supported financially to being financially independent was an unknown for me. From high school, I knew what it was to be a student; but I'd never really had a job. I had fears: Will my illness get in the way? Will I get too stressed? Will I lose my job?

But I did it. I did it slowly and with care, making sure I stayed well along the way. It took a lot of goal-setting in small steps and getting as much support from doctors and family as I could.

I was lucky to have a great boss who cared about my well-being. I was honest about my situation and showed that I was eager to face my fears and move forward with my life. And, I had settled into the work well over the two years I had been there part-time, so I was already at home with the work.

There are times when I'm not feeling well and am tired. At these times, I make sure that I talk with my support people to work things out. And I make sure I'm using my self-care tools. I eat well, get adequate sleep, walk to work every morning, practise Reiki (a technique for enhancing life force energy) on myself and meditation, and express myself creatively through music and writing poetry.

Now that I'm working full-time, I feel happier and more at peace than I ever have. I'm paying taxes and contributing to my community. I have more independence. I get to help others who are in need. My life has more purpose. And I'm one step closer to my collage goal of being a full-fledged counsellor.

A few words of advice

I wear several hats in my job, including support worker. When I talk to others about the benefits of working, I tell them about the freedom to make choices and live a better quality life. When I'm giving support to someone who is thinking of returning to a work setting, I let them know they should take their time and move along at

their own pace. I also recommend asking for help along the way. This can make all the difference.

I am very grateful for where I am in my recovery and the hope that was given to me by others. It wasn't all easy, but it was worth the wait. Just because you have a disability doesn't mean you must stop living—in fact, it means just the opposite. You now have something to work with, a challenge to overcome, with great learning possibilities. And, you are so valuable to those coming up behind you, because you have your experience to share. It is so important for people with mental illness, or any kind of disability, to achieve their goals. This will help erase stigma from society.

There is no failure in recovery; there's only a chance to better yourself. Working toward wellness can be anything you want it to be; you are the one who is in charge of your dreams. You can do whatever you want in life, including finding work that really gives your life meaning.

I wish all of you luck and hope. ❖



The jump from being supported financially to being financially independent was an unknown for me... I had fears: Will my illness get in the way? Will I get too stressed? Will I lose my job?

Insurance Reassurance

Disability income a must for recovery

Ross Taylor

Ross is a Resource Development Associate for Coast Mental Health Foundation. In his work and volunteer activities, he strives to bring understanding about issues related to mental health, addiction and homelessness and the importance of psychosocial and peer supports. Ross does public presentations and can be reached at ross@coastmentalhealth.com

In 2005, I was in the hospital for six weeks and off work for four months. I cannot imagine trying to get through that period of mood-related psychosis while also having to worry about possibly losing my job, income and apartment. In that year, I started full-time employment at Coast Mental Health Foundation, which has employer funded short-term disability insurance. This insurance coverage provided me with income for this four-month period off work.

Prior to 2005, however, I didn't have that kind of "safety net" in my work situations.

A downward spiral—losing self, losing income, losing self...

In the spring of 1998, I was experiencing paranoia and delusions, as well as depression. I didn't tell anyone, but I believed people could read my mind and there was a conspiracy to humiliate me. I didn't recognize then that I was experiencing mental illness. What I did know was that I had a history of substance use and a serious drinking problem.

At the time, I was working for a large, public institution. I'd gone through a period of manic thinking, but was accomplishing very little and had become exhausted. So, I went on leave from work to 'sober up,' using some of my vacation and sick days. I went to my workplace's Employee Assistance Program (EAP) for substance use problems. The EAP counsellor, and a general practitioner the counsellor referred me to, either didn't know or didn't tell me I had a mental illness.

I returned to work and stayed sober, but only for a month. My then undiagnosed psychosis was in full bloom. While it may have been partly paranoia, I believe it's also true that my supervisor and co-workers were setting me up for failure, often by withholding key information. They were looking for excuses to fire me. And, after I went off work for the second time, I received no phone calls, no flowers and no get-well cards. I had no contact with anyone from my workplace—including human resources. Human resources should have followed up with me about returning to work.

My vacation and sick time ran out quickly. Fifteen weeks of employment insurance ran out. Then I cashed

in an RSP (registered savings plan), which I had bought with an RSP loan.

It was now well into autumn. I couldn't afford to pay full rent, so my roommate moved to a more affordable one-bedroom apartment and let me stay with him. I didn't tell anyone where I had moved to.

Application forms for long-term disability did arrive from my employer and the insurance company—more than six months after I had left work. My employer had no short-term disability coverage, so only sent the forms out when I'd passed the return-to-work date

specified in a letter from my doctor (October 30). There was additional delay because the forms were forwarded from my old address (only because my roommate had filed a change-of-address with Canada Post).

I hid the forms so my roommate couldn't make me fill them out. Why bother? 'They' were out to get me. Meanwhile, I had no income and my RSP cash, which I kept in my knapsack, was dwindling rapidly. I needed to get another job so I could get my own place, but felt so depressed and hopeless I couldn't deal with applying for work.

My roommate discovered the disability application forms—after I threatened to kill myself (early 1999). Upon returning from a Christmas vacation, he found a suicide note. I was nowhere to be found, so he searched through my belongings and found the application forms and my doctor's letter amongst a mountain of backlogged bills.

I didn't kill myself. I did fill out the forms. I went to my physician, who diagnosed me with catatonic depression (i.e., depression with immobility and/or much random, purposeless movement).

A couple of months later I received notice from the insurance company that they had denied me coverage. I believe the insurance company rejected my application because I hadn't told the truth on the application's activity chart. In my depression, I couldn't admit to not being able to concentrate and function. So I said that I did housework, even though my roommate did it all. And that, yes, I "enjoyed reading" (their words, loaded with the implication that I was absorbing whole books).



In actuality, my life consisted of wandering around at night, sleeping, drinking coffee, flicking through the TV channels and reading newspapers (though I couldn't remember much of what I read). Even with TV, it was more about channel-changing than actually being able to watch a show.

Not getting long-term disability insurance deepened and prolonged my depression and fed my psychosis. It fit with my delusional beliefs and paranoia. I figured, in my self-loathing, that I wasn't really sick—I was 'bad.'

I did receive the papers for an appeal, but never filled them out. It was too much effort, and I felt like I didn't deserve it.

The off-work interim

I was off work for two-and-a-half years. I collected several more diagnoses, including major depression, caffeineism (I drank a lot of coffee to try and motivate myself), obsessive-compulsive personality disorder and, finally, bipolar II with mood-congruent psychosis. In looking back, I would say that my addiction issues and mental illness have been life-long conditions.

Eventually I started receiving the provincial disability benefits. In May 2000 I began to volunteer at Coast Foundation and in August began contract work for Coast. Working on contract fit with intermittent periods of not being able to work. It took five years before I had a full-time, stable position, with adequate medical benefits. Still, living with mental illness was—and is—a

daily challenge for me. Ongoing therapy, staying sober and peer support groups help keep me motivated.

A saving grace

Workplace insurance is very important for preventing homelessness. There was no short-term disability available through my workplace when I first got sick. I would have been homeless without my roommate's help. But not everyone has a good friend like that to help them out.

To get insurance in 2005 (and again in 2008 for six months), my employer, friends, family and the hospital social worker filled out all the forms. I just signed them and cashed the cheques. I depended on these people. When I get sick, my delusions and depression make it impossible for me to navigate the complex application process. Again, I was lucky to have a good social support network to help me.

With the insurance in place, I didn't have to worry about my home, my job and whether I'd have food to eat. I was able to just focus on getting better. ■

related resource

Canadian Mental Health Association, BC Division. (2004). *Navigating workplace disability insurance: Helping people with mental illness find the way*. A guide to the workplace disability insurance system in BC, and accompanying video featuring Ross Taylor

www.cmha.bc.ca/advocacy/insurance

A Triple Threat Workplace isolation, West Coast grey and the “black dog”

It was supposed to be an ideal solution. My husband had a new job in a new city. I could keep my old job by working from home. Having flexible hours meant more time for my four-year-old little girl. However, the ideal turned out to be a set-up for disaster.

I work as an interaction designer (i.e., I optimize how people interact with the Web) and market researcher for an online company. Before our move, I was heavily involved in a big project that required me to work long hours. I loved it. Despite the pressure, I was keenly

aware that I was helping build an educational product that would one day help kids make good decisions about their future.

Toward the end of the project, we moved from the sunny Okanagan to the Fraser Valley. And I settled into my new home office.

The big slide

It didn't take long for me to show signs of a slide into depression. I started sleeping a lot during the day. I gained weight. I was short-tempered—jumping between anger and lethargy.

Nothing seemed to matter anymore. I felt disconnected from face-to-face contact with friends and co-workers. My husband was working terribly long hours. I knew no one in the new city—and it was gray and rainy all the time. I felt trapped in an oppressive, ceaseless darkness and couldn't muster the energy to drag myself out of it.

Things got worse. I started avoiding work and just stayed in bed. My husband couldn't understand what was going on and wanted me to “get out of bed and do something!” It all came to a head one day when

Gwen Marsh

Gwen could be described by accomplished deeds (a few), time volunteered (a modest amount) or minutes worked (too many). However, her most memorable and meaningful hours are spent with her family or out in the beautiful BC wilderness, running or cross-country skiing

I found myself yelling incoherently at my innocent daughter. I knew then that I was in deep trouble and that if I didn't get help I risked losing my family and my life.

I went to see my doctor and essentially broke down in his office. There's nothing quite like having someone ask "So how are you?" and not being able to answer because you're sobbing so hard. Needless to say, he recognized I was in crisis.

I was in enough control that hospitalization wasn't needed, but was promptly put on antidepressants and referred to a counsellor. Both



I knew then that I was in deep trouble and that if I didn't get help I risked losing my family and my life

helped immensely. The medication took a few weeks to kick in, but the counsellor was able to see me almost immediately. His guidance helped me deal with the depressive thoughts that were constantly swirling in my head. I learned how to recognize those thoughts and how to challenge them.

Not yet out of the raincoat dark

I still struggled with my work situation, though. I couldn't get anything done; any attempts were half-hearted and lacklustre. I asked for two weeks off—and received it—but these few days weren't going to help. I needed a serious break from work in order to recover. I didn't know what to do. We couldn't afford to live without my income—yet, I was in great danger of losing my job if I didn't get some healing time.

After much despair, I approached my supervisor in person, explaining my situation.* It was difficult to do; I felt I was risking a lot by talking to him about my sickness. I was afraid it would tarnish his image of me—and that I might lose my job.

To my great relief, my supervisor was sympathetic; his mother-in-law had suffered from depression and he was well aware of the various issues associated with the illness. He talked with our human resources (HR) person, and they and my doctor applied to get me on short-term disability. This would stabilize my financial situation while I worked to recover.

At first, the insurance company rejected my claim for short-term disability (six months), expressing doubt about my doctor's diagnosis. It was like a punch to the gut. I felt they thought that I was faking it. That I just wanted to have some good time off. Any doubts I had about myself were pushed even further into the darkness. Maybe this wasn't real; maybe I was just

an inept failure. Maybe the world and my family would be better off without me.

I would have given up if not for the support of my HR person, doctor, husband and counsellor. They insisted that I appeal—which I did. My doctor filled out a disability appeal form, reiterating his initial diagnosis. He was quite frustrated with their paperwork demands, as it was impeding my recovery. And, the delay was creating additional

stress about finances. My husband realized that I wouldn't be able to work until I was better. But if I had to resign from my job in order to heal, our family would take a financial hit, and it would be difficult for me to find a new job later.

Apparently, many insurance companies initially reject depression sufferers' claims. And the insurance company did accept my appeal application for short-term disability. But, it seems that only those with enough support, will and stamina to continue the application in spite of their illness eventually receive assistance.

Keeping the "black dog" at bay

It took over eight months for me to recover. I learned many things about the journey of life during that time. I learned how to recognize the depressive thoughts and how to challenge them and combat them with exercise. I recognized that some aspects of working at home (i.e., isolation) can help trigger depression, so I try to get out and interact with other people in places like my favourite coffee shop or the local library.

I will always have the "black dog of depression" in my life. Sometimes he will be far away, and other times he will be much closer. I need to be vigilant against him, keeping safeguards—such as exercise, meditation and sunshine—in place.

I'm now back at work. I'm still working from home—but I'm back in the "sunny" Okanagan. This is, indeed, an ideal situation. ■

***Editor's note:** Although Gwen had a supportive response from her employer after disclosing her diagnosis, it's important to note that the employer was only required to know how Gwen's health condition affected her work. An employee does not have to disclose information about the diagnosis, the history of the illness or its treatment.

The Bottom Line

There is no health without mental health

Keeping a lid on panic

My first panic attack happened when I was 24—at work. My youth had been a mix of laughter, play and curiosity—and excessive worry, anxiety and stomach aches. But this was something new.

I was the shop foreman at an ultralight aircraft manufacturing facility. We'd been under the gun for six months, working excessive amounts of overtime to fill the orders. If these orders weren't completed and shipped on time, the contracts would become void. The overtime resulted in more things going wrong—and I had a boss with a temper.

Out of the blue one day my heart started pounding and I sweated profusely. I thought I was either going crazy or having a heart attack—then I lost consciousness. A few minutes later, I felt better, but my boss insisted on taking me to the hospital emergency. They didn't find anything wrong with me.

The following few weeks at work were terrible. I started having these attacks several times a day, not knowing what was happening to me. Because the emergency visit didn't find anything wrong, and because all it took to trigger an attack was thinking about it happening again, I did my best to hide what was going on.

I finally went to my doctor, who prescribed some pills to calm me down. I left the doctor's office without a diagnosis. This was the 1980s, when there was very little awareness about anxiety disorders. I only used the pills occasionally, when I had a really bad day. Increasing my exercise also helped.

But, even as I felt better, I was always aware that the wrong feeling or circumstance could once again trigger an attack. I decided to leave that stressful job.

Reaching rock bottom

Fast forward about 20 years. I experienced varying degrees of panic along the way. I tried different medications and made trips to a psychiatrist. I did lots of research on the Web. I also experienced a number of different work situations—sometimes I left jobs because of stress, sometimes because of my personal desire to learn and grow; other times because of union shakeups or the company folding.

In 2004, I was a self-employed contractor, testing and inspecting hydrogen fuel cell buses. I began having multiple panic attacks every day. My attacks happened mostly at work, even though the pressure I was feeling

had more to do with worry about financial uncertainty. I had purchased a condo the previous year, and the three-year work contract was ending in September. I felt like I was between a rock and a hard place. Being self-employed, I wasn't covered by an extended health plan. I had no paid sick time, so just had to grin and bear my situation as best I could.

I think the attacks happened more at work because of the greater interaction there—and the fear dynamic. Even though it wasn't visibly obvious that I was having an attack (in the way, e.g., a seizure would be), my fear of being witnessed fed the panic.

My way of coping with these attacks at work was to use avoidance strategies. Because of the stigma, I wasn't ready to admit a problem—to others or myself. When the attacks started, I'd quietly remove myself from the situation and the panic would slowly subside.

Once I was off work, I found leaving the house became harder each day. Panic disorder has an unsympathetic way of constantly attaching the triggers that provoke anxiety to more and more areas of one's life. I was afraid to be in public places in case I had a panic attack. A simple trip to the bank or grocery store made me feel like a soldier walking through hostile territory with sniper rifles aimed at me the entire time.

By not leaving the house, however, I was reinforcing the belief that I'd never be okay and my life was about to implode. I was drowning in future negative thinking and had visions of losing everything I'd worked for...

Getting hard-wired for wellness

In my isolation I constantly searched the Internet trying to find out what I could do, what would help. I found out about the Anxiety Disorders Clinic at the University of British Columbia and asked a doctor in a walk-in clinic for a referral. Now all I had to do was wait—for six months!

When I finally received a call in March 2005, it was just a day before I was to start a new job, back in the aviation industry as a full-time employee, with benefits. All I could think of was how bad the timing was. I'd been home for six months, ready and willing to get help, but now that help had come through, I wasn't sure I'd be able to make it to

Arto Tienaho

Arto was born in the Queen Charlotte Islands and has lived in BC all his life. He worked in the aviation industry for over 20 years. Through volunteering and his own experience with anxiety, Arto now works as General Manager of AnxietyBC. He is grateful to be helping others



treatment. I wasn't going to ask for time off, when I was just starting a new job. But, thank goodness, the therapy times were scheduled so I had enough time to get out to UBC after work.

It's amazing how motivation to get better can force a person to do things you otherwise wouldn't think possible. I had developed a fear of driving over bridges, but I did white-knuckle it over bridges and made it to all eight one-on-one therapy sessions.

The therapy I received at UBC is called cognitive-behavioural therapy (CBT). It isn't easy. A big part of it deals with facing your fears. But, because of how much I'd already suffered with anxiety, I was motivated to do whatever it took.

Over the eight sessions I built my own customized tool kit. The tool kit contained relaxation techniques. It contained worked-through scenarios in which I had challenged my negative thoughts and developed more realistic thinking.

I practised bringing on the uncomfortable bodily sensations (e.g., dizziness, being out of breath, being out of body) and allowing them to dissipate naturally, without becoming fearful. I wrote out a list of my most fearful to least fearful activities. Starting at the bottom of the list, with the least fearful activity, I'd repeat the activity until the anxiety level was reduced by at least half. This built confidence in approaching the next activity.

Once you have the CBT tools to help manage your anxiety, they are with you for a lifetime. Even if there is a relapse of some panic, it will never be the same as it once was. The therapy builds on one small victory at a time and will become hard-wired over time.

With the help of the CBT sessions, I was doing quite well overall: getting through my days without having, or worrying about having, a panic attack. In fact, the CBT techniques helped me challenge myself in areas I wouldn't have otherwise, like public speaking. However, we don't always know what life is about to deliver.

Unexpected curve balls

I had been building my confidence for some time, so in September 2005 I applied for a manager's job at my workplace, knowing full well that the work stress would increase. The challenge was too tempting and I was feeling better than I had in years. I was the successful candidate.

Within a month of becoming manager, however, life delivered some heart-wrenching news: my father was diagnosed with terminal cancer. It took only two months of quick deterioration until he died. I made time to be there every day and was with him during his final moments. But my father's illness opened up a new world of things to cope with.

At work, I could feel the stress building, daily. I was expected to work 10 to 12 hours a day, to hire and fire employees, to attend 12 scheduled meetings a week, as well as manage the daily production schedules and large crews of hourly paid employees.

I had constant stiffness in my shoulders, back and neck. I woke up every morning tied up in knots and with

a sore jaw from grinding my teeth at night. And after two years of this I started getting the panic attacks at work again, especially during meetings. My

survival instincts of fleeing the situation would kick in; I'd go to the washroom, rinse my face with cold water and try to pull it together. But I knew my avoidance strategy would not be helpful in the long run.

This spike in anxiety had as much to do with the fact I hadn't been practising the skills I'd learned for keeping anxiety under control—at least not practising *enough*. I tried to practise on walks at lunch time, but on the job there was no opportunity. At home, I was exhausted and still doing work.

I was feeling burned out and decided to pay my doctor a visit. He recommended that I take six weeks stress leave from work and visit him every couple of weeks to update.

The human resources department at my workplace contacted me to find out what was happening (I was on short-term disability) and when I could be expected back at work. I explained my situation, but realized, after the conversation, that they had no understanding of why my doctor had recommended I take time off. I felt pressured to return to work, ready or not. So I decided I'd better reassess my future with this company.

I took a hard look at my life, my values and my needs and decided I should look for something more suitable.

I'm now working for AnxietyBC, where having an anxiety disorder is an asset because I can relate to the experiences of people looking for information.

Ultimately, I continue to learn that there is no health without mental health. ■

Because of the stigma, I wasn't ready to admit a problem—to others or myself

Visions

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The Mostly Incompetent Employee

But does it have to be like that?

Catch-22

A “You f@!\$% clown—can’t you get anything right!” my boss bellowed at me.

Actually, my “boss” was more like my ‘host.’ It was mid 1986, and I was an 18-year-old trainee, basically working for peanuts under a federal employment program.

I’d been told—mumbled to, is more like it—to drive the aircraft forklift from our hangar (I worked for a small-plane charter outfit) to the YVR (Vancouver) South Terminal fuel station. I thought I was to pick up a barrel of some sort of propellant that my boss typically got for free. I asked the fuel station at-

tendant for the barrel of propellant, relaying to him my boss’s name, his airline and his instructions to me. The attendant pleaded ignorance of any such arrangement.

Rather than phoning my boss to tell him about this obstacle, I purchased—on my boss’s account—a barrel full of regular fuel for about \$130. I’d called before in similar situations, only to find my stomach churning because of the abrasive frustration in his voice. So, I took a chance that my efforts would suffice.

As I drove back, however, I couldn’t help feeling that I had screwed up. I dreaded facing my boss when things went wrong—and

I did get his instructions wrong. I was supposed to bring back a low-grade jet fuel that was used as a solvent for cleaning equipment and for welding use, and it *was* supposed to be for free. But I did face him. And, man, did I get an earful!

No boss tolerates incompetence lightly, but when this guy mumbled orders to me, he expected me to get it right, “like a white man [should].” (Now that think of it, perhaps matters would have been worse for me if I hadn’t been white...) And, yes, I should have told him diplomatically that I was having a bit of trouble understanding him; however, hindsight is just that—hindsight.

Frank G. Sterle, Jr.

Frank lives in White Rock, BC. He edits and/or regularly contributes to three mental health publications



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I was, and likely still am, the mostly incompetent type. This is probably due to my low self-confidence, low self-esteem and mental illness—though I wasn't diagnosed and 'certified' until the next calendar year, 1987. (My main challenges are depression and obsessive-compulsive thinking; treatment with antipsychotics has been the most helpful.)

Also, I was prone to self-fulfilling prophecies. For example, when my boss told me to do something, I was convinced I'd get it wrong. Thinking this, it was hard *not* to screw up. Then, when I did, it only heightened the probability that I'd screw up again the next time he gave me an order. It was a vicious Catch-22.

Because of my obsessive-compulsive disorder (OCD), I'd try my hardest to perform perfectly the rare, more-challenging tasks. Inevitably, my efforts were futile. This tendency, along with my boss's abuse, resulted in me getting more depressed and anxiety-ridden as the days went by. And if I'd had the nerve to reveal to him my neurosis and psychosis, he'd either have let me go or abused me even more.

Things got so bad between my boss and me that he told his chief (well-paid mechanic) that I wasn't worth the "space" I took up in this world. He even told me once that he believed I'd take my own life one day, because I was such a "motivational mess."

One day, I couldn't bear any longer being verbally abused by the senior mechanic, who had taken up my boss's comment and dubbed me "Space." I quit.

In the 'doghouse' again

I've since held various jobs, for different employers. One work-training job was at an auto scrap yard in North Surrey. I wouldn't even have gotten the job if not for the assistance of a government agency with formidable influence. The yard was littered with used car parts—mostly retrieved from written-off vehicles that had been in violent accidents. This, along with the minimum wage and my lack of interest in cars or their components job, made my already acute depression worse.

During training, we were told to keep our hands out of our pock-



the boss, rather than abusing the workers, has an opportunity to provide compassionate SUPPORT

ets and not to ask questions. The day that I was fired was inevitable, because I didn't know what to do or how to at least appear busy. My boss expected me to figure this out on my own.

I recall him telling me: "You said on your resumé that you play chess."

"Yes," I replied. "I do."

"Well," he said, "if you're as good at chess as you are around here, you'd lose every game."

Another nice guy, eh?

Compassion just might yield competence

When employees or trainees show signs of low self-esteem or little self-confidence, the boss, rather than abusing the workers, has an opportunity to provide compassionate support. The boss—and co-workers for that matter—should acknowledge that these employees have special needs. And they should recognize the aspects of their workplace that can contribute to employee "incompetence."

I realize that most bosses are very busy, and some may not feel they have what it takes to tolerate "incompetence" and whatever is causing it. However, if, for example, that airline boss of mine had shown me some respect, I would have enjoyed giving 110% effort in my job performance. And I just may have been able, as a result of his compassion, to do a "competent" job of it as well.

Stable employment is a very important aspect of daily life, whether you're a mental health consumer or a non-consumer. However, employment status may be much more important to consumers, because they often have a greater need for self-validation. Stable employment can give the consumer a sense that life is not so dreadful after all. It can provide much-needed encouragement. It can also keep him or her mentally occupied in a positive way, add a sense of accomplishment and, yes, validate the consumer's self-worth. ■

Employee Assistance Programs

Front-line resources for workplace mental health

Workplace depression is a term used to describe the clinical impact, costs and disability associated with depression (and anxiety) as it relates to working people and workplace settings. Many symptoms of clinical depression, such as low energy, poor motivation, impaired memory and lack of concentration, can greatly affect work function. So, it is not surprising that depression causes loss of productivity and leads to more absences from work.

Clinical depression (also called major depression) is most commonly found in the working-age population. Seven out of 10 people with clinical depression in Canada are still working while depressed.¹ In fact, the economic costs of depression in Canada are estimated to be \$4.5 billion a year in lost productivity alone.²

Because of these troubling statistics, many businesses and employers now recognize the importance of optimizing the mental health of their employees. Unfortunately, not all businesses have the resources needed to provide services within the company that meet the mental health needs of their workers.

One solution for employers is an Employee Assistance Program (EAP)—sometimes called an Employee and Family Assistance Program (EFAP). EAPs are usually outside agencies that contract with employers. EAPs provide confidential counselling and referral services for employees who are dealing with stress, family or work conflict, or other mental health issues.

Depression in the workplace—a study

For many workers suffering from clinical depression, EAP service providers are often their first contact with mental health professionals. There has been little research, however, about how well EAPs help with clinical depression.

I am currently heading a workplace depression research program at the University of British Columbia Mood Disorders Centre, which will provide more information in this important field. My colleagues and I have collaborated with Paula Cayley, president and CEO of Interlock EAP, to develop and evaluate programs for improving outcomes in clients with depression. Interlock (www.interlockeap.com) provides short-term counselling services, delivered by experienced clinical counsellors with master's or doctoral qualifications. Its services are provided to more than 350 organizations within BC and across Canada.

In our first study, we examined the clinical records (anonymously) of over 1,400 clients attending Inter-

lock services.³ After EAP counselling, most clients improved in both their symptoms and function. However, the 27% of clients identified as having depression were still not as well as those without depression.

These results show that clients with depression may need more intensive treatment than what is usually offered by EAPs. Consequently, we are now looking at ways to improve treatment for these clients.

We know that evidence-based therapies such as cognitive-behavioural therapy (CBT) are very effective short-term treatments for depression and anxiety. It's very difficult for people to access CBT in our health care system, however, because there are still not enough practitioners that offer this service, and it is not paid for by medical services. So, EAPs may be an important resource to provide CBT and other brief counselling to working people. But EAPs don't always offer CBT, or they may have only a limited number of counselling staff trained in CBT.

There are other barriers that make it difficult for working people to access counselling. Having to take time off work, the cost of transportation and, particularly in rural areas, having to travel long distances to counsellors' offices can all cause problems.

We are now looking at a new idea that may overcome many of these barriers: counselling delivered by telephone. Studies done in the United States have shown that telephone-delivered CBT is helpful for people with clinical depression who are being treated by family doctors.⁴

Counselling over the phone has promise for workers with depression

Interlock recently ran a pilot project on telephone counselling with BC's Interior Health Authority (IHA). IHA employees with depressive symptoms, who were attending the Interlock EAP, were offered telephone-delivered counselling. Interlock counsellors were trained to use a telephone-delivered CBT program that proved useful in the US studies.⁴ Fifty clients agreed to participate in phone counselling sessions, and 31 completed the eight-session telephone CBT program. The telephone

Raymond W. Lam,
MD, FRCPC

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“the economic costs of depression in Canada are estimated to be **\$4.5 billion a year** in lost productivity”

sessions were scheduled at the client's convenience, including lunch time, evenings and weekends.

There was high client satisfaction with the program, especially because of its convenience and not having to take time off work to go to a counsellor's office. Clinician and client ratings showed a lot of improvement in depression scores, overall function and work productivity.

These results suggest that telephone counselling may become an important service offered by EAPs to clients with depression. Further studies are underway to more closely look at the clinical and economic impact of telephone counselling.

footnotes

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EAP services needed for all workers

EAPs are a front-line resource for employees with mental health concerns. EAPs can also be considered "primary care settings" for identifying and treating people with mental health conditions. There is great potential for EAPs to develop, apply and evaluate early intervention strategies. Early intervention improves personal and work outcomes for clients with clinical depression and anxiety.

The mental health services provided by EAPs should be available to all workers. ■

Guarding Minds @ Work

A new guide to psychological safety and health

Joti Samra, PhD, RPsych and Merv Gilbert, PHD, RPsych

Dr. Samra is an Adjunct Professor and Scientist. Dr. Gilbert is a principal in Gilbert Acton Ltd., Occupational Health Consultants and is an Adjunct Professor. Dr. Samra and Dr. Gilbert are members of the Consortium for Occupational Mental Healthcare (COMH) at the Faculty of Health Sciences at Simon Fraser University. Further information on COMH research activities can be found at www.comh.ca

Workplace risks that can lead to physical illness and injury in employees have been accepted as an employer responsibility. Protection against these risks is built into health and safety laws and policies. However, the same has not been true for psychosocial risk factors. Psychosocial risk factors are those aspects of work that impact an employee's mental health and safety. Psychological disorders are not easy to see in the way that, for example, a broken arm is which is why they are often referred to as "invisible." But the impact of psychological disorders is anything but invisible.

Psychological disorders are associated with workplace conflict, turnover, accidents and injuries. They are also associated with a reduced ability to tap into the knowl-

edge and leadership provided by experienced employees. Workplace factors don't cause psychological disorders; but they can trigger and worsen a mental health condition.

Workplace factors can also create supportive environments that can help employees heal. These environments are known as 'psychologically safe' workplaces. This is a fairly new term in the area of occupational health and employment law. A psychologically safe workplace promotes quick identification and treatment of mental illness. It also lessens the impact of the illness on the person's life. Psychologically safe workplaces don't harm employee mental health in careless or intentional ways.

There is a growing need to identify and address mental health risks in the workplace. There have been

recent changes in law and policy at the provincial and federal levels. There have also been court rulings that hold employers accountable for the psychological health of staff, most recently in Quebec¹ and Saskatchewan.² These changes have placed increasing responsibility on businesses to deal with psychosocial risk factors.

While Canadian employers are aware of the prevalence and impact of mental illness, many are not sure about how to act. How do employers figure out what psychosocial risks exist in their workplaces? How do they know what programs, policies or services will best address those risks? How do they know whether a new or existing intervention works?

These challenges exist for all organizations, be they large or small,



unionized or non-unionized, urban or rural. However, larger organizations, particularly in bigger cities, are more likely to have practices, staff and resources to deal with mental health issues. The same cannot be said for smaller employers in more remote areas.

A new resource is on the way

In order to help organizations answer these questions, a new resource is being developed by a team at the Consortium for Organizational Mental Healthcare (COMH). COMH is an independent, not-for-profit, academic research centre located within the Faculty of Health Sciences at Simon Fraser University. *Guarding Minds @ Work: A workplace guide to psychological safety*

and health is a new Canadian resource intended to help employers identify and deal with psychosocial risks in their workplaces. It was commissioned by The Great-West Life Centre for Mental Health in the Workplace and funded by The Great-West Life Assurance Company. The project team includes Drs. Joti Samra, Merv Gilbert, Martin Shain and Dan Bilsker.

Guarding Minds @ Work is intended to provide employers with evidence-based tools, that is, tools with good research evidence. These tools include:

- strategies to identify and assess psychological risk factors within their workplace

- criteria for selecting the best programs, policies or services to address these risks
- a framework to evaluate if their efforts are effective

Guarding Minds @ Work is grounded in science and law from Canadian and international sources. A guiding principle will be to make sure that the program is accessible, relevant, practical and clear. It will be able to be used by employers across the country, including small and medium-sized companies or work units. This unique guide was launched at the end of April 2009. It's now available for any employer to download for free or order at www.guardingmindsatwork.ca. ■

footnotes

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Drug Testing in the Canadian Workplace

In Canada and most other countries, it is illegal to drive a car while impaired by alcohol. Most experts agree that the use of the breathalyzer by the police to detect alcohol-impaired drivers has helped reduce alcohol-related crashes. Given the success of the breathalyzer, some companies have used breathalyzers to identify workers impaired by alcohol. Drug testing programs have also been implemented to identify workers who use other drugs, such as marijuana or cocaine.¹

How common are drug testing programs in Canada?

According to a recent survey, about 10% of Canadian worksites and 18% of BC worksites with 100 or more employees have drug testing programs.¹ These programs are much more common in the United States, where legislation in the 1980s made drug testing more widespread in all types of companies. In Canada, drug testing is primarily conducted in situations where safety is a concern.

What are they and why are they used?

The most common reason that companies adopt drug testing in Canada is to reduce industrial accidents related to drug use. Some employers have argued that

simply using drugs, whether on or off the job, increases the likelihood that employees will have a job accident.

The most common form of drug testing in Canada is urinalysis. This test analyzes urine from employees for recent use of drugs such as cannabis, cocaine, opiates and amphetamines. Saliva, hair and blood can also be analyzed for drugs.

There are several situations where employees may be asked to comply with a drug test. Testing is sometimes requested from job applicants. Employees may be tested either on a random basis or after a job accident. If employees test positive for drugs, there are often negative consequences, which can include being fired.

Are drug testing programs effective?

Urinalysis tests have limitations. The biggest limitation is that they cannot identify whether a person is under the influence of drugs at the time of the test.

Breathalyzer tests for alcohol measure impairment at the time of the test, but most drug tests can only be used to determine whether a person used drugs some time in the past. For example, marijuana use up to three weeks prior to the test can be detected, and cocaine use three to five days prior to the test can be detected. If someone used drugs the night before, it doesn't mean



Scott Macdonald

Scott is Assistant Director at the Centre for Addictions Research of BC and Associate Professor at the School of Health Information Science, University of Victoria. He has been involved in research on addictions issues for over 25 years

he or she is a danger in the workplace the next day.

The degree to which drug testing programs are effective in reducing accidents in the workplace is disputed. Some studies have found that employees who use drugs have higher job accident rates than employees who do not use drugs.² But research hasn't demonstrated that the reason for the higher rates is due to employees' drug use.

Drug users as a group are more likely to be younger males, who tend to take more risks than other groups. It appears likely that other factors, such as risk-taking, put them at higher risk of job accidents. The best field studies comparing drug use (with urine tests) of crash-involved drivers to a control group have not shown that testing positive for drugs is related to a higher likelihood of crashes.³

I have given my expert opinion about drug testing in the workplace in numerous court cases. These cases have involved employees and human rights organizations acting on behalf of employees, who have contested drug testing by employers in the workplace. Under Canadian law, it is reasonable for employers to prohibit employees from being impaired by alcohol or drugs at work. Unfortunately, drug tests cannot detect whether someone is under the influence of a drug at the time of the test, so the tests don't achieve the employer's desired purpose.

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Never a substitute for good accident prevention programs

I don't recommend urinalysis testing programs, because they are not proven to be effective for determining whether someone is fit for work. Many factors are more important causes of job accidents than drug use. Failure to follow proper safety measures is a primary reason for job accidents. Fatigue and stress are much more important causes of job accidents than drug use.⁴

Other approaches to ensure workers are fit for work are preferable. Supervisors can be trained to identify behavioural symptoms that can affect workplace safety. For example, the Ontario Law Reform Commission has recommended using performance tests that can directly evaluate psychomotor performance. Performance can be affected by a number of factors besides drug use, including fatigue or stress.⁵ Employee Assistance Programs can help employees receive treatment for substance abuse problems, which can assist employees to deal with personal problems that might affect their work performance.⁶ In comparison to drug testing programs, these are approaches with little controversy.

Drug testing is not a substitute for a good accident prevention program. ■



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Healthy Workplaces—Healthy People

Fraser Health's recent focus on mental health

Since 2002, the Fraser Health (FH) Workplace Health Team has focused on making sure we have healthy employees who are safe at work. Our Occupational Health Nurse (OHN) Team and our Disability Management Team both help employees off work due to injury or illness to return to work.

We've had many ways of helping people with physical problems, such as back or repetitive strain injuries and illnesses such as multiple sclerosis or heart disease. For employees who were having trouble with their mental health, we've had an Employee and Family Assistance Program (EFAP), but not much else... However, we were getting information from our long-term disability benefits provider that about 35% of the people in health care who are receiving these benefits have depression as a diagnosis.¹

In 2005, Workplace Health decided to pay more attention to mental health issues. We talked with our union partners to get started. We talked with other employers and health authorities to find out what they were doing to support their employees' mental health. And we started working with our benefits provider to figure out ways to help.

Piloting mental health initiatives

In October 2006, we were chosen by our benefits provider Healthcare Benefit Trust (HBT) to be part of a one-year pilot project. A hospital site in Abbotsford worked with FeelingBetterNow.com,[™] a Web-based assessment tool developed by Mensante Corporation, a group of Canadian and American psychiatrists.

Employees can log on to FeelingBetterNow.com website, create their own user name and password (to maintain their confidential-

ity), and do an assessment of their own mental health. If the person is at risk for a mental illness (based on how they answered the questions), they can print out a letter to take to their doctor. The program also provides other information about the best treatment for their illness. Our pilot project was very successful and we are now starting to make it available at some other FH sites.

In September 2008, we started another pilot project with HBT. This three-month project has given a selected number of managers within FH access to an online manual, *Mental Health Resource Guide for Managers*. This guide was devel-



oped by Healthcare Benefit Trust and by Dr. Merv Gilbert, an organizational health psychologist based in Vancouver.

The guide has information on what managers need to know about mental illness and how it can affect their employees at work. It gives managers ideas about how to talk with their employees they have concerns about. It also gives ideas about how to help employees, who are off work because of mental illness, successfully return to work. We are now looking at rolling its

use out right across Fraser Health.

On our Workplace Health intranet site (i.e., a private website available only to FH personnel), we have created an "Employee Health and Wellness" page that has links to helpful resources. Employees can find and print out information such as self-help workbooks and wellness brochures, as well as information on how to bring laughter, yoga and massage to their workplace.

We have also taken part in a research study by the Occupational Health and Safety Agency for Healthcare (OHSAH) in British Columbia to. This five-year study, which began in the spring of 2005, is looking at how to improve the mental health of nurses, practical nurses and unit clerks on some of our hospital units.

Eleven units were chosen randomly across FH; five had interventions and six were control groups. Our OHNs were trained to work with employee groups on the units. Each intervention unit was given \$4,000 to spend on things that would make their workplace better. (Control groups weren't given any funds.) Some units chose to improve their staff rooms. Others chose to get vests with logos indicating the unit they worked on. Some chose to have lunches or a BBQ.

Employees on the units were surveyed before intervention and again after their projects were completed (in September 2008) to see whether their choices made a difference for them. We're still in the process of evaluating the September survey results, and there will be another follow-up survey in September 2009.

And, we are just about to embark on our newest, most exciting project yet. Our OHNs will take on a

Elayne Preston

Elayne is a Managing Consultant, Health and Wellness, within Workplace Health at Fraser Health. Fraser Health covers the Lower Mainland from Burnaby to Boston Bar and has 23,000 employees

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footnotes

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new role as health coaches for our employees. Coaching recognizes that people are all different. Referral criteria for health coaching are still being finalized, but employees can self-refer.

The OHNs will be available to work with individual employees or with groups. They'll help our em-

ployees set their own health goals, name their strengths and identify what might stop them from reaching those goals. They'll support employees in meeting their health goals, whether about their physical or mental health, and will provide information and education when necessary. The OHNs will get to know

the employees—and assist them to be the healthy people we believe our employees want to be. ■

for information on Fraser Health's approach to workplace substance use, see a sidebar to this article at:
www.heretohelp.bc.ca/publications/visions

Mental Health Awareness for Managers

An integrated approach

Jan Mitchell, MEd, CHRP

Jan has worked with Healthcare Benefit Trust for 16 years. She has been Workplace Health Consultant, Manager of Prevention and Health Promotion and, more recently, Interim Manager of Stakeholder Education and Communication. Recent projects include development of mental health awareness forums for managers and a web-based mental health resource guide

Sigmund Freud once said, “Love and work are the cornerstones of our humanness.” Freud was perhaps one of the first to recognize the connection between work and mental health. Since his time (1856-1939), a lot of research has shown that work is important, if not essential, to a person’s mental well-being.¹⁻²

Over the past decade we have seen a worrisome trend: mental health conditions are on the rise and workplaces are seeing a steady increase in mental health disability claims. When compared to all other diseases (e.g., cancer and heart disease), mental illness and addiction rank first and second in terms of causing disability in Canada, the United States and Western Europe. The estimated cost of these disabilities to the Canadian economy is \$25 billion dollars per year.³

Healthcare Benefit Trust (HBT) is a health benefits provider for the health care and community social services sector in BC. We at HBT have seen, first-hand, the impact that poor mental health has on claims costs. One quarter of all HBT’s long-term disability claims are for mental health. Depression alone accounts for two-thirds of these claims.

In recent years, HBT has taken steps to help its member organizations lower rising claims costs. We do this through prevention and health promotion, early intervention and disability management programs.

Prevention and health promotion —a new mental health resource

On the prevention side, HBT recently launched an online resource guide for managers. The guide is tailored to the needs of the health care and community social service sector. Supported by the research literature and assessed needs, HBT partnered with industry representatives and subject matter experts to develop a web-based resource titled *Mental Health Resource Guide for Managers*.

This comprehensive guide is made up of seven modules that touch on workplace mental health. The modules are:

1. Understanding Mental Health
2. Recruitment and Orientation
3. At Work and In Distress
4. Off Work
5. Return to Work and Accommodation
6. Self Care for Managers
7. References and Resources

The guide provides practical information to help managers take positive steps to support employees who have mental health concerns. It covers everything from recruiting and training a new employee, to supporting someone who is in distress at work, to helping that person return to work. The guide also outlines human rights laws and industry-specific collective agreements that govern the actions of management. There are also references and links throughout the guide to provide managers with even more information.

There is a specific section in the guide on how managers can look after their own mental health. We recognize that managers, in order to look after others, first need to look after themselves.

The guide is supported by additional resources that use multimedia and multi-format approaches to accommodate various learning styles. One-day educational forums showcase each module within the guide. These forums provide opportunities for industry members to explore issues in greater depth and learn from each other. In addition, a handy reference booklet was developed that managers can keep close at hand for quick access to key pointers from each module.

The guide was piloted from September to December 2008 by 60 managers within health care and the community social services. Participating managers received a bi-weekly e-mail survey asking for feedback

footnotes

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on each module. This feedback was used to make further improvements to the guide prior to its release to all 650 HBT member organizations in the spring of 2009.

Early Intervention

HBT provides its members with an Early Intervention Program (EIP). The EIP provides medical case management for permanent employees that have been off work for more than five consecutive days. Services may include assessment, treatment and management of employees with mental health and addiction issues.

The focus of EIP is to proactively assist workers—in a caring, safe and timely manner—to reduce sick leave and to prevent or shorten a long-term disability claim. It's a collaborative program involving the employee and their physician, as well as an HBT medical case manager, the union and the employer. The case manager works with the eligible employee to ensure that all necessary medical care is provided and, in cooperation with the employer and union, to develop a return-to-work plan.

Disability management

The HBT Disability Management Services (DMS) program offers rehabilitation and medical coordination services to health care and community social service employers. An effective disability management program goes a long way to improving outcomes for individual employees by assisting them to stay at work, or, to return to work as soon as they are able.

An HBT member organization can access DMS if an employee is struggling to remain at work due to a medical issue, or if the employee is off work with a disability but hasn't yet qualified for disability benefits. The goal of the DMS is to help eligible employees stay at work safely, or shorten or avoid their use of sick leave.

The program offers services such as case management and service coordination, functional assessments, vocational assessments and retraining, exercise or work conditioning programs, counselling and return-to-work program planning.

Supporting mental health in the workplace

Mental disabilities are often more challenging to identify and respond to appropriately in the workplace. What research and experience has shown is that we can make a difference in our workplaces through:⁴⁻⁵

- effective leadership and management
- supportive policy and procedures
- management and employee education and training
- communication efforts that strive to reduce stigma
- early intervention and disability management programs that follow best practices

HBT is one of many partners in health care that are raising awareness of employee mental health. Through collective action and shared learning, we can improve mental health practices in our workplaces and reduce both the economic and human costs. ■

Quittin' Time

A smoking cessation program for the BC Public Service

In October 2007, the BC Public Service Agency launched Quittin' Time, a five-month smoking cessation pilot program. This program is now available to approximately 35,000 employees working for the government of British Columbia. The goal of the program is to support employees and their family members in their efforts to quit smoking. The BC Public Service Agency, with its Corporate Human Resource Plan *Being the Best*,¹ aims to be recognized as a leader in public service excellence in Canada.

Thirteen percent of BC Public Service employees smoke. While this is lower than the provincial average of 16.4%,² smoking remains the number one preventable cause of death in BC. Smoking can cost an employer over \$3,000 per smoker each year in health care costs, absenteeism and productivity losses.³

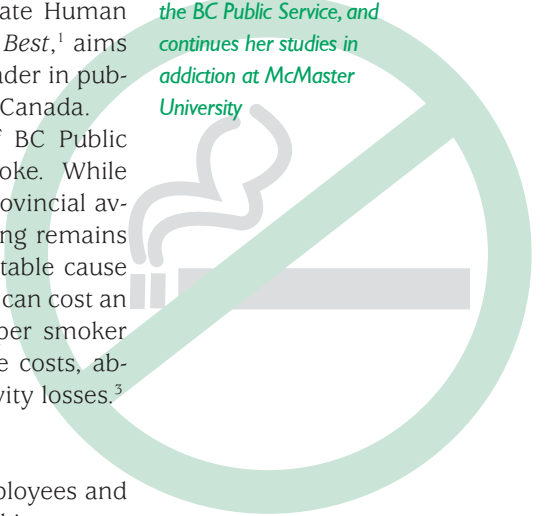
The program

Quittin' Time offers employees and family members a smoking cessation program, which can be tailored to each person's specific needs. The program design is based on smoking cessation research.⁴⁻⁷ We also used the expertise and experience of partners at the BC Lung Association and Ministry of Health.

A first big challenge was creating or finding a quitline service that met our high security and privacy needs, and we were fortunate to find this in our home province of BC. In choosing to work with an existing service provider, the challenge was then to make sure the service met the specific needs of our Quittin' Time program.

Maureen Foxgord, BA, MPA

Maureen has worked at the BC Public Service Agency for several years, in a research and communications capacity, supporting policy and corporate health areas. She recently took on the role of Manager of Mental Health Programming for the BC Public Service, and continues her studies in addiction at McMaster University



The program has four main parts:

1. Telephone-based counselling:

This is provided by a program of the BC Lung Association called QuitNow By Phone. This quitline counselling service has been enhanced for BC Public Service employees and their family members. They receive several additional outreach support calls during the critical first stages of quitting on top of what QuitNow typically provides. The service also confirms participation in counselling, so employees are eligible for extended health reimbursements.

2. Extended health plan reimbursement:

Health benefits were expanded to cover recommended nicotine replacement therapy or eligible prescriptions for people in the program.

3. Support for employees:

Awareness is enhanced by providing information for managers, supervisors and employees. A web-based information resource* provides a variety of helpful smoking cessation tips and includes regional resources such as the Employee and Family Assistance Program.

4. Positive social marketing strategy and incentives:

A social marketing and incentives campaign reinforces the positive benefits of quitting. The marketing strategy targets all employees, including managers and supervisors, smokers and non-smokers alike, to make sure that all are well informed and supported at the worksite. Key messages include: smoking is an addiction that needs the support of all of us; quitting with support increases success—you don't have to quit alone; the program can change your life; smoking is a major cause of death and disease—helping em-

ployees to quit is the right thing to do. Incentives have included, for example, recognition cards to acknowledge smoke-free milestones and a participant draw for iPods.

Moving Quittin' Time forward

Strong executive and leadership support was an important initial component of the program. In fact, Quittin' Time used this support in a very visible way. We featured BC Public Service deputy minister—and ex-smoker—Larry Pederson on one of our large promotional posters.

The BC Lung Association, Ministry of Health and ActNow BC have been key partners in moving Quittin' Time forward. They've shared information and resources and have provided expertise. We've worked together with all our partners to problem solve and find the best way to run the program.

Also very helpful is regular feedback from program participants. Participants are invited to make comments and suggestions directly by e-mail.

Now in its second year . . .

Just over a year has passed since Quittin' Time first launched. This has been enough time to hear about some success stories. The Corporate Health and Benefits team reports that they mostly hear stories of success. This includes the statistic that, as of mid-January 2009, approximately 36% of those public service employees who smoke (or smoked) have participated in the Quittin' Time program. This is far better than the usual rate of 1% to 4% for quitline participation.^{8,9}

While hard numbers are important, equally important are the comments from program participants about the support they received during their quit process. Many of these success stories come

from long-time smokers, and speak to the value of several parts of the Quittin' Time program. This includes the extended coverage and the support of telephone-based quit specialists (counsellors). One successful participant, who shares her story on the Quittin' Time website, highlighted the value of quit specialist support:

My first appointment with the counsellor set the tone for the next month. She was incredibly supportive, gave me a number of tips, was totally non-judgmental (unlike me!) about the fact that I was still smoking while pregnant and helped me develop a plan to quit... My second phone appointment was with a different counsellor who offered me all sorts of additional tips and really made me feel great about how well I was doing. He supported me to continue with one [per] day for another week and to stick with my plan to quit on January 31. We booked another appointment for quitting day and I felt confident I could achieve the goal.

Looking ahead

An evaluation of Quittin' Time is currently underway. The goal is to find out how many participants quit smoking and have stayed smoke-free over time. This assessment will help us decide whether this program has been successful in terms of our ultimate goal: reducing the number of BC Public Service employees and family members who smoke.

While the evaluation data is not yet in, the high participation rate, positive results and encouraging participant comments provide good support for continuing the program. It seems clear from the participant feedback received so far that Quittin' Time has already been successful. ■

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***for more information, visit**

www.quittintime.gov.bc.ca

Employers Who Are Walking the Walk

Employers are just starting to recognize that mental health issues are a big problem in the workplace. They are also realizing the benefits of giving staff tools and resources that promote healthy work environments and work relationships.

Many employers in BC have begun to set examples of what it means to include mental health in their vision of a healthy workplace. These employers are coming up with innovative approaches and unique solutions to the issue of mental health in the workplace. And they're starting to see results.

The Canadian Mental Health Association, BC Division (CMHA) has worked with many of these organizations through our work with Mental Health Works and the Bottom Line Conference on Workplace Mental Illness. Following is a look at just a few employers we've worked with.

District of North Vancouver From crises and financial burdens to solutions

Cindy Rogers is human resources manager for District of North Vancouver municipal operations, including the fire department. She admits there were a few telling signs that mental health issues had to be addressed in her workplace. A couple of years ago, she noticed that large amounts of the District's extended health care costs were going toward medications to treat mental illness. Visits to Employee Assistance Program counsellors for therapy were increasing. On top of that, several District workers were affected by a tragic event (non-workplace). District service workers were called upon to attend this tragic event, in which family members of an employee died.

The employees directly affected by this event began having symptoms of post-traumatic stress disorder. Experiencing these symptoms also brought on feelings of 'shame' at having mental illness. They took two to three months sick leave from work, under medical care.

The human resources department (HR) saw that management didn't have the skills to deal with the mental health concerns of their staff, especially the cases of major trauma. The managers needed to feel comfortable talking about mental health issues. To



help them feel more comfortable, HR looked to CMHA's Mental Health Works training workshops.

The "Complex Issues. Clear Solutions." workshop was offered to District managers. This workshop taught participants how to start conversations with employees who are struggling. Participants also learned how to avoid falling into a therapist role when talking to employees with mental health issues.

The following year, Mental Health Works' Awareness of Workplace Mental Health workshop was offered to interested employees. Forty people turned out. This workshop aims to increase the comfort of employees when facing a co-worker who is ill. It also teaches employees how to effectively respond with support.

While still suffering from the grief of loss (which can last for years), the employees whose lives were

shattered by the tragedy returned to work. Because of the mental health training done in the workplace, these employees were greeted with positive support from both management and co-workers.

Rogers notes that proper support and an environment where people aren't afraid to reach out for help lessens the shame of mental illness. She adds, "We're still learning.

Identifying and responding to mental illness on an individual basis is still a challenge."

Coast Capital Savings Credit Union Do the math—mental health pays off

Lynn Roberts, vice-president of Human Resources at Coast Capital Savings Credit Union, believes that leadership is crucial to reducing workplace stigma around mental illness. In fact, Coast Capital CEO Lloyd Craig has been championing senior management's support of mental health for over 10 years. He lost his son to a depression-related illness, so knows first-hand the toll mental health issues can take.

Even the most motivated leaders still have to face the issue of money. But, says Lynn, "Do the math. The cost of recruiting and training a new hire to replace

Donna Panitow

Donna is a Communications Assistant with the Canadian Mental Health Association, BC Division

an employee who falls victim to mental health challenges far exceeds the small cost of providing [health] resources per year.” For her company, this amounts to no more than \$200 per employee annually. Resources include: staying in touch with employees who are on short- or long-term disability; ensuring employees get the help they need; disability management; and carefully crafted return-to-work plans. Counselling resources are brought in to work areas where stress, grief or anxiety levels are high.

Three keys to success

Coast Capital focuses on three areas of mental health promotion for its employees:

- **Raising awareness** about the importance of mental health and taking a holistic approach by placing just as much importance on physical health. This is done through management training and employee education.
- **Encouraging early intervention** by providing employees with access to help, such as Employee and Family Assistance Programs (EFAPs), counselling services and online assessment tools.
- **Creating a support system** that follows up with employees and stays in touch with those on short- or long-term disability leave.

These measures have produced a noticeable difference in the workplace in the short time they’ve been used. There have been more early interventions, and there is a higher awareness among staff of mental health issues.

Provincial Health Services Authority A healthy workplace strategy

The Provincial Health Services Authority (PHSA) consists of a number of agencies including: BC Cancer, BC Children’s Hospital, BC Women’s Hospital, and BC Mental Health and Addiction Services (BCMHAS). BCMHAS provides a variety of direct, specialized mental health and addiction services to people around BC and offers support and resources to other service providers.

BCMHAS has worked closely with PHSA Corporate Human Resources and other agencies to develop a mental health and addiction strategy for all PHSA employees, based on best and promising practices. Its first goal is to make the culture within the workplace supportive, as well as mentally and physically healthy. This includes the relationships between staff and management. As a starting point, PHSA’s human resources department surveyed employee health. They used a questionnaire provided by Healthcare Benefit Trust, who partnered with PHSA to analyze the survey data. The survey included questions about chronic conditions such as depression and diabetes, as well as health factors such as sleep, diet, exercise, stress and anxiety, mood and productivity.

As a result of survey findings, PHSA now has an early prevention program, and is developing relapse prevention and other return to work strategies for its employees.

Information and education resources, as well as self-assessment and self-care tools available to the workplace community include:

- A customized health promotion intranet site that gives staff members tools for tackling their own mental health and addiction issues, as well as those of their loved ones
- CMHA’s Responding with Respect mental illness first aid course for managers and directors (www.mifa.ca)
- FeelingBetterNow.com,[™] a web-based self-assessment tool for early diagnosis¹ (www.feelingbetternow.com/phsa)
- *Antidepressant Skills at Work*, a self-care manual developed by BCMHAS (www.bcmhas.ca) in partnership with the Centre for Applied Research in Mental Health and Addiction at Simon Fraser University (www.carmha.ca)

Peter Coleridge, vice-president of Education & Population Health, stresses the importance of total-body health, including both mental and physical aspects. He cites this as a key part of their overall strategy.

Partnerships are also important. BCMHAS works with other organizations, exchanging ideas and tools around mental health issues in the workplace.

Advice to employers and managers

“You don’t have to reinvent the wheel,” Coleridge advises managers who want to introduce a mental health strategy in their organization, but may have limited resources. There are resources online (www.cmha.ca, www.gwlcentreformentalhealth.com, www.bcmentalhealthworks.ca, plus the links noted above) and in the community that employers can use; some of them are free.

Coleridge also assures that investing in the improvement of an organization’s culture, when it comes to mental health, is not as daunting as it might seem. In fact, it may be easier for a smaller employer to engage and interact with its employees because of the smaller, more intimate work environment.

As for managers who haven’t yet taken a step in this direction, Coleridge stresses that they are risking more than just poor employee health and productivity. Newer generations of workers consider healthy workplace culture more important than traditional priorities like position and job security. An effective approach to workplace mental health can go a long way toward both recruiting and keeping employees in a quickly changing and mobile workforce. ■

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Mental Health Works

In 2001, the Global Business and Economic Roundtable on Mental Health and Addiction¹ approached the Canadian Mental Health Association (CMHA) in Ontario. The Roundtable wanted to address the issue of workplace mental health. Mental Health Works developed over the next two years and was piloted in Ontario in 2003.

Mental Health Works is an education and training initiative that is now available across Canada, with services provided in both English and French. CMHA has offered its services in BC since 2005.

Our mission is “improving working lives.”

What we do

We improve working lives by helping people in the workplace to assist individual employees who have mental health issues. We also address organizational issues that affect overall workplace mental health.

What began with the creation of a single workshop has expanded into a program to improve understanding, develop skills and increase awareness through:

- nine distinct workshops, ranging from one hour to a full day, aimed at a various audiences, including supervisors, managers, senior executives, small business owners, human resources, occupational health, union reps and employees
- customized talks, including keynote addresses, for annual general meetings, association events, conferences, etc.
- interventions for situations where an individual is returning or staying at work and mental health is a factor, as well as situations of workplace conflict or unrest
- consulting services for organizations who wish to train their own staff to provide workplace mental

health training or awareness initiatives

The program uses multimedia approaches, including a website, publications, a self-study CD, training videos as part of the workshops and presentations, online audio clips and an e-newsletter.

Our trainers all have real-life experience in management and all are Mental Health Works certified to deliver our workshops and presentations.

Management training: from recognition to accommodation

Mental Health Works recognizes that the day-to-day interaction with employees who may be struggling rests with the front-line supervisors. These individuals rarely have the experience or knowledge to feel comfortable in this role.

Through practical training, supervisors learn to recognize when an employee *might* be experiencing a mental health issue. They learn how to tell a mental health issue from a performance issue or a negative attitude. And they learn skills to improve their effectiveness and comfort level when approaching staff and members who appear to be struggling. From here they learn strategies to help employees remain productive in the workplace and/or to access resources that assist in their recovery.

Workshop participants such as supervisors, managers, union reps and human resources staff practise strategies and approaches that assist them to more effectively:

- help employees resolve conflict
- improve or maintain employee performance
- create accommodations that enable an employee to stay at work or successfully return to work

Employee training: from awareness to self-care and response

The workshops and presentations aimed at employees help to increase awareness of what workplace mental health problems may look like. This helps individuals recognize when they themselves may be struggling or when a co-worker may be experiencing symptoms.

Trainers talk honestly about common fears, concerns, myths and stereotypes involving co-workers with mental health issues. Participants learn how to address fears or concerns and how to respond if a co-worker is struggling. They learn how to choose healthier ways to deal with their own workplace and life stressors and how to influence

Mary Ann Baynton,
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Mary Ann is the Director of Mental Health Works

With contributions from Margaret Tebbutt, BA (Hon.), MèSLettres

Margaret is the Manager of Mental Health Works for the Canadian Mental Health Association, BC Division



A tour of a CD called Working it Out, one of many Mental Health Works training tools

the stress of others. We use videos of real people who share their experiences and offer practical solutions.

Some recent initiatives and upcoming resources

Currently, Mental Health Works is offering a special workshop through Chambers of Commerce, boards of trade and other business, trade and professional associations. It's called

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Issues & Solutions and is aimed at small- to medium-sized business owners across the country. Business owners are provided with practical ways to identify and work with employees who are in emotional distress.

This one-and-a-half to two-hour session is endorsed by the Men-

tal Health Commission of Canada (MHCC). The initiative supports MHCC's desire to reach smaller employers across Canada who normally don't access this specialized information due to limited time or resources.

The Surrey Board of Trade held one of these sessions in December 2008. Managers from firms in biotech, hospitality, insurance and other sectors found it practical and relevant to their work. Similar presentations are already booked for Whistler, Prince George, Vancouver and Sechelt in 2009.

Mental Health Works has also developed a workshop for joint health, safety and wellness committees. (These committees consist of labour and management representatives who meet on a regular basis to deal with health and safety issues.) This workshop is designed to help committee members include mental health or psychological safety considerations in their work.

We have also begun to create a video-based resource by and for workers with mental health concerns. Those who appear on this resource will be workers who

have been unwell and have successfully navigated workplace issues, including disability leave, conflict and fear of job loss. The resource will be available at no charge through the www.gwlcentreformentalhealth.com website in late fall. It will also be available as a DVD through Mental Health Works (www.mentalhealthworks.ca) and their partner on this project, the Mood Disorders Association of Ontario (www.mooodisorders.on.ca).

mental health works in bc

Over 2,000 people—in workplaces from Bella Cooola to Victoria, Vancouver to Prince George and even Whitehorse—have participated in over 100 workshops in workplace mental health.

BC workshop participants have valued the following:

- o *“Strategies that can be used right away. Focus on the employee’s success.”*—private sector manager
- o *“Good tools—practical, simple, realistic, outcome focused”*—manager from insurance industry
- o *“The exercises—practical practice provides great hands-on value—and sharing.”*—occupational health return-to-work specialist
- o *“The human element, personal stories, which really drove the process home.”*—manager from insurance industry
- o *“The feeling of empowerment that I should take action to help our co-workers instead of just listening to complaints.”*—health care union representative

Keeping workers healthy helps the bottom line


In this time of economic instability, more employees will experience distress about finances, job uncertainty and other issues. More than ever, employers can benefit from investing in helping employees stay engaged and mentally healthy at work.

For a small investment, workplaces have the potential to make sure that those in management and union positions are able to create and sustain a mentally healthy work environment. Not surprisingly, “improving working lives” also improves the bottom line. ■

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