



Sad Company

Plan sponsors across the country are becoming more aware of the integral role frontline supervisors can play in promoting mental health and managing mental disorders and addiction in the workplace. Front-line supervisors can easily create a safe—or toxic—atmosphere for their staff members. And because they are often in the best position to detect the early symptoms of an emerging problem, frontline managers can be trained to respond and provide referrals to employee assistance programs (EAPs) and medical professionals. Without question, they are also key players in successful return-to-work initiatives.

Supervisors, however, are often not well-equipped to deliver on their potential. In 2004 and 2005 EKOS Research Associates conducted a national study of 2000 workers and 600 employers in Canada. They discovered one in three supervisors agreed or strongly agreed that they need more training in order to be effective managers.

There's clearly a tremendous opportunity for employers to provide additional support to supervisors on the front line so they are trained and motivated to nurture a mentally healthy workplace. The question for many plan sponsors is, where do I start?

Assess Your Situation

A plan sponsor's first step must be to conduct an audit to assess their current disability experience when it comes to mental disorders. The audit should examine existing disability rates, why some cases have lingered, patterns of return to work and the incidence of long-term disability.

The business case for mental health is strong. Employers are certainly aware of the predominance of depression, mostly, as a source of disability leave and salary continuance, and the prevalence of antidepressant use in their group drug plans.

Rather than resorting to reducing eligibility for benefits, another approach is to dedicate resources to improving early detection and appropriate intervention among frontline supervisors. A good starting point for a comprehensive mental health disability management program includes training for supervisors.

Customize Training

Many people in managerial positions already have the common sense and innate empathy required to approach employees who may be experiencing difficulties. However, they also need an understanding that they have a significant accountability for promoting and maintaining mental health in the work-

place, and that this important role is something they can learn and perform as part of their management function.

Companies need to design customized education programs. Each company needs to establish its own benchmarks, based on current employee satisfaction, productivity, short-term and long-term disability and drug utilization rates. Before supervisors are advised to intervene, sponsors must ensure the necessary external support structures are in place—from EAPs to constructive doctor-insurer-patient relationships.

Two readily accessible resources that can help plan sponsors begin to communicate these messages are:

- Bill Wilkerson's 2006 Business and Economic Plan (available at www.mentalhealthroundtable.ca) which makes a clear case for the need for programs to address mental health in the workplace and provides guidance for supervisors.

- a Conference Board of Canada brochure entitled What You Need to Know About Mental Health: A Tool for Managers (available in the e-Library at www.conferenceboard.ca) It outlines the workplace costs of mental disorders and describes specific strategies managers can use to prevent issues.

Overcome the Obstacles

Often one of the reasons that front-line supervisors are reluctant to approach staff members who appear distressed is a fear of what the employee will tell them and a lack of confidence in their ability to respond appropriately. To confront this issue, some companies offer role-playing workshops so super-



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visors can practice potential conversations and prepare for the reactions of employees that might take them off guard.

Too much enthusiasm may be another reason. Any training program must clearly identify at what point a supervisor may be stepping over the line. Managers must not become diagnosticians, but they should at least be aware that causes of some work performance problems can be related to personal issues and personal distress. Supervisors should focus on workplace evidence: in the form of performance issues, absenteeism and presenteeism —not rumour or innuendo.

Reward Good Management

Incentives are always important when you're implementing a program that hopes to change behaviour, and front-line supervisor training is no exception.

If supervisors are doing a good job, reward them — perhaps with a financial incentive such as a mental health bonus. The expense will pale in comparison to the skyrocketing costs of caring for people whose mental disorder escalates.

Building a Mentally Healthy Workplace

The Provincial Health Services Authority (PHSA) in British Columbia has developed a four-phase plan to improve the way it addresses mental disorders and addiction among employees.

1. Organizational culture

To create an environment of respect and two-way communication, the PHSA is establishing people-centred policies, delivering management and leadership training, and conducting an employee health survey with the goal of developing an organizational health profile.

2. Primary prevention

Staff will receive communication materials, tools and education sessions related to mental health. This phase includes resilience training workshops and the formation of a workplace mental health working group to engage staff at all levels of the organization.

3. Secondary prevention

To support employees who are experiencing mild symptoms related to mental health, the PHSA will develop a workplace self-care manual, complemented by an organization-wide early intervention program.

4. Tertiary prevention

For people with more serious disorders, the PHSA will develop comprehensive return-to-work processes and relapse prevention strategies with a focus on improving understanding of mental health and addiction programs, reducing the stigma, and ensuring employees understand that doing this is part of a healthy workplace strategy.

Did You Know?

Effective January 1, 2007, the Employment Insurance Maximum Insurable Earnings will increase to \$40,000. The Maximum Weekly EI Benefit payable for 2007 will be \$423 [(\$769 x .55) = \$423].

In a July 14, 2006 technical interpretation, CRA notes that when a sole proprietor implements a Cost-Plus Plan, it must provide coverage for at least one employee other than the sole proprietor. Otherwise, it is NOT the nature of insurance as the proprietor has not undertaken to indemnify another person.

In a July 29, 2005 Tax Court of Canada case, the taxpayer purchased 'over-the-counter' medications, as advised by his doctor, for throat cancer. These expenditures were denied as a medical expense because they were not 'recorded by a pharmacist'. The Court noted that there are laws throughout Canada that describe the records that a

pharmacist is required to keep. Medications purchased off the shelf do NOT meet these requirements.

The April 2006 Canadian Benefits Bulletin reported a federal government consultation on the expansion of eligibility criteria for the EI Compassionate Care program. This program provides a temporary absence from work without suffering income or job loss, to EI eligible workers, to provide care or support to a person who is at significant risk of death within 26 weeks. The requirements to qualify for the Compassionate Care Benefit are the same as for EI sickness, maternity and parental benefits:

- 600 hours of insurable employment in the qualifying period in the 52 weeks prior to the start of the claim, and
- an interruption of earnings or a reduction of more than 40 per cent in normal weekly earning.

Effective June 15, 2006, the criteria

for eligibility will include those providing care to a sibling, grand parent, grandchild, in-law, aunt, uncle, niece, nephew, foster parent, ward, guardian, or a gravely ill person who considers the claimant to be like a family member.

This expands the criteria from those caring for a parent, child or spouse, including common-law and same-sex couples living conjugally for at least a year.



Cardiovascular Disease

Cardiovascular disease (CVD) is a group of conditions, such as stroke, angina, acute myocardial infarction (AMI), and peripheral artery disease (PAD), that affect the heart and circulation. It is estimated that one in three Canadians has some form of CVD, which accounts for more Canadian deaths every year than any other disease, including cancer. In 1999, it was estimated that 35% of all male deaths were due to heart disease; for women, the toll was even higher at 37%.

Risk Factors

The most important risk factors contributing to the development of CVD are categorized as being either modifiable or non-modifiable. Modifiable risk factors are those where an individual can actively participate in controlling, reducing or eliminating their impact on health. These include:

- high blood pressure
- dyslipidemia (elevated total and LDL cholesterol, or "bad cholesterol")
- sedentary lifestyle
- diabetes
- obesity
- smoking

On the other hand, non-modifiable risk factors are those an individual cannot control. They include:

- age (men over 40 years of age, women over 50 years of age and/or

after menopause)

- family history of heart disease
- personal history of heart disease

Diagnosis

Since CVD is not a single entity but one with multiple components, diagnosis is not as clear as with other diseases. A patient is assessed on his or her total risk of CVD by considering the person's overall risk based on the presence of modifiable and non-modifiable risk factors.

Treatments

Clinical guidelines, recently updated in Canada, help guide physicians to the most effective and safe treatment choices for CVD. Many treatment options are available to reduce, control and eliminate the impact of modifiable risk factors. Non-pharmacological

strategies leading to lifestyle changes should always be part of the overall plan. Smoking cessation, weight reduction to achieve normal body mass index (BMI), lowered fat and caloric intake, limited alcohol intake, an active lifestyle, reduced sodium intake and stress reduction are examples. Pharmacological intervention is most often required in addition to non-pharmacological strategies.



Canada's Updated Food Guide to Help Canadians Live Healthier

February 5, 2007, Health Minister Tony Clement launched the new 2007 version of Canada's Food Guide - "Eating Well with Canada's Food Guide".

The new Food Guide was developed through widespread consultation with dietitians, scientists, physicians and public health personnel with an interest in health and chronic disease prevention.

For the first time, Canadians can find detailed information on the amount and types of food recommended for their age and gender. The new Food Guide encourages Canadians to focus on vegetables, fruit and whole grains, and to include milk, meat and their alternatives, and to limit foods that are high in calories, fat, sugar and salt. Health Canada is also now recom-

mending a Vitamin D supplement for Canadians over the age of 50.

Given the growing concern about the rates of overweight and obesity among Canadians, providing advice on the portion sizes and the quality of food choices was a key consideration in the development of the Food Guide. The Food Guide also emphasizes the importance of combining regular physical activity with healthy eating.

"Canada's new Food Guide reinforces the Heart and Stroke Foundation's messages to Canadians about the importance of consuming vegetables and fruit, limiting trans fats and combining a healthy diet with regular physical activity."

HSF Canada CEO, Sally Brown.

Canadians now have a wealth of information available at their fingertips with an enhanced, interactive Web component. "My Food Guide" will help users personalize Food Guide information according to their age, sex and food preferences, and will also include more culturally relevant foods from a variety of ethnic cuisines.

Canadians have relied on various versions of the Food Guide for nutrition advice since it was first published 65 years ago, but it has never wavered from its original purpose of guiding food selection and promoting nutritional health, using the best, most current information available.

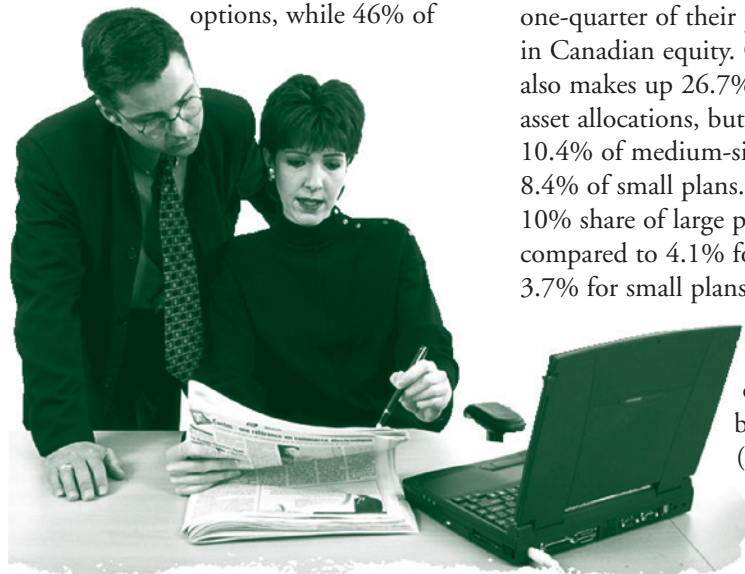
Back Stretch

A major preoccupation for many sponsors of defined contribution (DC) pension plans is monitoring their plan members' choice of investment. Are they making appropriate fund selections? Should there be a default fund for those who fail to make a choice? What should it be?

DC plan investment trends are one of the issues uncovered in the First Canadian Defined Contribution Benchmark Report, which is based on response to the Benefits Canada/Canadian Pension Fund Capital Accumulation Plan Survey in the fall of 2005. A total of 394 respondents representing small, medium and large DC plans answered the survey to provide a snapshot of what peers are doing in a number of areas, including asset allocation.

Once enrolled in a DC plan, all members face the primary question of where to invest, and in the majority of cases that means a lot of options: 40% of survey respondents offer 11 to 25

options, 10% offer between 26 and 50, and 7% provide more than 50 investment options—while 26% offer between six and 10 options, and 17% offer fewer than five choices. Broken down by plan size, members of very small plans are likely to have the most choice: 43% of plans with less than \$1 million in assets offer 11 to 25 options, while 46% of



plans with assets over \$250 million offer fewer than five.

One favourite asset class for all DC plans, regardless of size, is Canadian equity. The survey found that large plans (over \$50 million in assets), medium plans (\$10 million to \$50 million in assets) and small plans (under \$10 million in assets) each have about one-quarter of their portfolios invested in Canadian equity. Canadian bond also makes up 26.7% of large plans' asset allocations, but represents only 10.4% of medium-sized plans and 8.4% of small plans. U.S. equity gets a 10% share of large plans, investments, compared to 4.1% for medium and 3.7% for small plans. Medium and

small plans have a greater percentage of assets invested in balanced funds (28.1% and 23.5% respectively) than do large funds (12.8%).

While money market makes up only 2.5% of large plans' portfolios, medium-sized plans have 4.2% in money market and small plans have 6.7%. The popularity of GIC is also stronger with smaller plans. Large plans have 2.9% in GIC, compared to 8.2% for medium plans and 13.3% for small plans.

Certainly, a major concern for all DC plan sponsors is what to do with members who don't choose from the options available. For 34.6% of survey respondents, the answer is to put them in the money market fund. Balanced funds are the default position for 29% of plans. Other less popular default options include daily interest (12.1%), cash (4.3%) and asset allocation (3.9).

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