Chapter 4

MENTAL HEALTH ISSUES

I. Mental Health Issues in Arbitration

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This paper is about the increasingly important impact that mental health has on both Canadian and American employment, employment law, and in the adjudication of cases that appear in front of arbitrators. Mental illness has the largest or near-largest impact on disability claims and discrimination complaints. It is vital that all people involved in arbitration have a strong understanding of the mental disorders that most often impact the workplace; the relevant laws at the national, state, and provincial levels; the disability assessment process; forensic issues; and the complexity of the relationship among disorders, impairment, and disability.

Canadian spelling is used in this paper unless U.S. sources are quoted.

Mental health has always been an important and essential part of the workplace, although for many years it has lingered in the background behind production, operations, sales, and conduct. Things have changed. We know a lot more now. For example, we know that the impact of mental health on the workplace is highly significant. That is undeniable. We know that employees at all levels of businesses and organizations suffer from depression, anxiety disorders, addictions, and more. We know that, beyond diagnosed conditions or illnesses, even more people are unwell or unable to function at their best. We know about the toxic effects of stress on the mind and body. We know that the financial impact of mental health problems is measured in the billions of dollars annually. We also know that mental health issues can be diagnosed and treated better now than ever before.

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The way that mental health has been treated in the workplace goes against the basic understanding of clinical and workplace psychologists. It should be obvious that every dollar invested in workplace mental health will yield at least a dollar in return, and probably more. It also seems that people who run organizations would want to develop a positive and healthy work environment where everybody could look forward to going to work and being part of something special.

It took some time and grey hairs to realize that my comfort with mental health was not common. I recently presented a seminar on workplace mental health to a group of managers for a large private corporation. I asked the people in the audience to raise their hands if they felt like they understood the most basic elements of mental health and if they felt comfortable dealing with mental health issues in the workplace. These were middle to senior managers, human resource specialists, and labour lawyers. No hands were raised. I have had this experience repeated many times. Sometimes a few people raise their hands and, fortunately, sometimes many people raise their hands. When there has been training, or leadership, I see a better response. So I realized what was happening. In the workplace, the common societal fears and lack of understanding regarding mental health were equally pervasive at work. There is the adage that we can't manage what we can't measure. Let's add to this expression that you can't manage what you don't understand, and you can't manage what you fear and avoid.

Legal Protections

Mental health issues are commonly addressed in employment litigation. Beyond arbitration, they are seen at Canadian Human Rights tribunals, the U.S. Equal Employment Opportunity Commission (EEOC), in the regular courts, courts of appeal, and at both countries' supreme courts. There are significant differences between Canadian and U.S. employment law. One important difference is in relation to privacy. In the United States, most arbitrations are a private matter between the parties, with hearings closed to the public and decisions not published without the consent of all parties.[2] In Canada, hearings are often open to the public, and

[2]Jeffrey Sack,, *U.S. and Canadian Labour Law: Significant Distinctions*, 25 A.B.A. J. LAB. & EMP. L. 241, 258 (2010).

in some jurisdictions they are required to be open to the public. Awards are also published, filed, and open for public viewing.[3] It is therefore easier to track the growing number of mental health–related cases in Canadian than in U.S. arbitrations.

Mental Health

According to the World Health Organization, "there can be no health without mental health."[4] Although the relationship or interplay between mental health and the workplace has not changed, there are significant changes in the understanding of mental health, our openness about mental health, and a plethora of studies that convincingly link employment productivity with mental health issues. The 2011 Dewa, Thompson, & Jacobs study[5] showed increased work productivity associated with treating employees who suffer from depression.

Another significant change is the enactment of laws that have resulted in legal standards and expectations regarding mental health issues in the workplace. In Canada, people with mental illness are protected from discrimination under human rights legislation. Section 15 of the Canadian Charter of Rights and Freedoms sets out general equality protections. Section 15.(1) reads: "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."[6] The Canadian Human Rights Act and its provincial counterparts take those protections to the workplace, seeking to ensure equal employment opportunities and setting out prohibited grounds of discrimination. One of those important grounds is disability, defined as "any previous or existing mental or physical disability . . . and previous or existing dependence on alcohol or a drug."[7] In the United States, the two critically important pieces of legislation are the Civil Rights Act of

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[3] *Id.*

[4] Martin Prince et al., *No Health Without Mental Health*, 370 The Lancet 859–77 (2007).

[5] Carolyn S. Dewa, Angus H. Thompson & Phillip Jacobs, *The Association of Treatment of Depressive Episodes and Work Productivity*, 56(12) Canadian J. Psychiatry 743–50 (2011).

[6] Constitution Act 1982, c. 11 (U.K.), Schedule B, Part I, Canadian Charter of Rights and Freedoms, *available at* http://laws-lois.justice.gc.ca/eng/Const/page-15.html.

[7] Canadian Human Rights Act, R.S.C., 1985, c. H-6, *available at* http://www.chrc-ccdp.ca/about/human_rights_act-eng.aspx.

1964 (Title VII)[8] and its subsequent amendments, and the Americans with Disabilities Act (ADA) of 1990,[9] as amended significantly by the ADA Amendments Act of 2008.

In both Canada and the United States, workers have protection from discrimination with respect to mental disabilities, and they also have the equally important right of reasonable accommodation. Although the ADA was developed to address physical disabilities, mental disabilities now account for the majority of claims filed with the EEOC.[10] The ADA defines "reasonable accommodation" as making changes to the work environment so that the employee with a disability can continue to perform the job or continue to enjoy equal employment opportunities. Accommodations also should remove barriers to the worker with a disability. Some common accommodations include leaves of absence, modified schedules, modified workplace policies, job restructuring, changing supervision methods, additional training, working at home, changes to the environment, and transfer to another position.[11]

It is considered discriminatory in both the United States and Canada to negatively impact an employee directly or indirectly because of a disability. Furthermore, in both countries, occupational health and safety laws require that employers ensure a safe and healthful workplace. In many provinces in Canada, and increasingly at arbitrations, this definition includes both physical and mental safety. Both in common law and through various legislations, negative effects on mental health from different stressors and actions such as harassment can also result in complaints, grievances, and lawsuits. The implications of these policies are broad and far-reaching. Unlike U.S. law, Canadian law now requires that the majority of matters arising from a collective bargaining agreement be adjudicated by an arbitrator, including human rights complaints and tort actions.[12]

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[8]Pub. L. No. 88-352, 78 Stat. 241 (codified as amended in scattered sections of 42 U.S.C.).

[9]Pub. L. No. 101-336, 104 Stat. 327 (codified at 42 U.S.C. §12101 *et seq.*).

[10]JAMES J. MCDONALD, JR. & FRANCINE B. KULICK, MENTAL AND EMOTIONAL INJURIES IN EMPLOYMENT LITIGATION (2001).

[11]Claudia Center, *Law and Job Accommodation in Mental Health Disability*, in WORK ACCOMMODATION AND RETENTION IN MENTAL HEALTH 3–32 (Izabela Z. Schultz & E. Sally Rogers, eds., 2011).

[12]Sainsbury Centre for Mental Health, Policy Paper 8: Mental Health at Work: Developing the Business Case (2007), *available at* http://www.centreformentalhealth.org.uk/pdfs/mental_health_at_work.pdf (last visited Mar. 2012).

Forensic Issues

For the employer and employees, as well as their representative unions, it is necessary to become familiar and proficient with the scope of mental health issues and to develop an understanding of the most common disorders and issues that affect the workplace, the professionals involved in assessing employees and writing reports, the mental health litigation process, and the many perils that lie within. This is essential not only to represent, prosecute, or judge an employee in a case involving mental health problems but also to distinguish when a mental health issue is not involved. For as much as we would like to assume that all people are honest and decent, the truth does not support such an assertion. Wherever there is the potential for gain, there are people who will use deceit and deception to obtain that which is not their due. This applies not only to workers and employers but also to many of the professionals involved in the employment and employment litigation process. Moreover, even when all parties are cooperating faithfully and honestly, there are still requirements for assessments and reports, because it is not enough for a worker to say that he or she has a disability and thus requires an accommodation. In addition, an employer must understand the relevant mental health issues in order to assess whether it has an obligation to provide an accommodation.

Individual employees do get sick. Although most report their symptoms honestly, many exaggerate, and some completely fabricate. It is axiomatic that the greater the gain, the greater the likelihood of deception. Malingering, the intentional false reporting of symptoms, is a serious issue that is very difficult to assess. How many people, even professionals, can tell the difference between a genuine and a fabricated mental illness? Medical professionals are trained to assume that their patients are telling the truth, and many erroneously believe that they can tell the difference between honest and dishonest reporting of symptoms. Medical professionals assess many employees who honestly report disorders or disabilities that might account for culpable or challenging behaviour in the workplace or create a legal argument for accommodation, and others for whom it is all too tempting to offer a fabricated or exaggerated mental illness toward the same goals. Similarly, others may knowingly or naively suggest a causal relationship between genuinely existing mental illnesses and culpable behaviours, when no such linkage exists. One cannot conclude merely

from the diagnosis of a mental disorder that there is a causal relationship between the disorder and the behaviors of the individual with the mental disorder. Additionally, the symptoms of a mental disorder are not always present, or occurring. A person with memory problems is not always forgetful. A person who is depressed is not always sad. The common mental disorders that affect people in the workplace involve periods of being unwell and periods of wellness. Certainly, people become ill and miss work or misbehave as a result, but people also claim sickness in order to skip work in favor of something else that they would prefer to do.

In addition to having to assess what the employee says, it is also necessary to assess what medical professionals say or write. Although they may be trained in their given specialty, they may not have had adequate training in how to appropriately assess employees in a medical/legal context. When I speak of professionals, I do not mean to be harsh. Many problems come from a lack of time or training. Medical doctors are frequently asked to provide letters to the employer without having the time to complete a proper assessment, relying on the hopefully truthful and uncorroborated self report of the patient. Mental disorders are not like physical disorders; they are often invisible to the observer and cannot be objectively measured by tests like X rays or blood analysis. Although there are paper-and-pencil tests that family doctors can quickly administer, most of these are subject to deception and distortion. Given the weight assigned to medical assessments and opinions of employees in the employment context, it is necessary that they reach a high standard of objective credibility.

There are also clinicians, both forensic and nonforensic, who prepare all kinds of reports for employers and insurance companies. Although most are competent, unbiased, and highly professional, those who receive their reports should be aware that a (one hopes) small number will write whatever report is being requested and paid for by the client. More common, however, is the natural bias of the treating doctor or therapist who generally assumes the role of a trusted and trusting advocate but who is then asked to offer an unbiased professional opinion that may not serve the patient's or client's interests. It can be very hard to refuse a request from a long-term client, and there can be financial implications if the upset client discontinues treatment. So, to ensure a fair process, the arbitrator should expect to see expert reports from both parties. Therefore, many cases turn on the evidence provided, not just about employees but also about reports

prepared by other experts. And, understandably, lawyers can take courses and read books on expert reports, expert testimony, and the process of examining and cross-examining expert witnesses.

For more serious assessments, the parties use qualified specialist forensic experts (such as this author), who prepare reports for legal purposes and who testify as experts. Forensic psychologists and psychiatrists apply their knowledge of mental health science and practice to the legal forum. These experts should be friends to the court, not to the parties involved in the litigation. These experts have specialized skills in assessing and detecting credulity and malingering. They understand the relevant mental health issues, the applicable laws and precedent cases, and the nature and requirements of the different jurisdictions, such as courts of law, arbitrations, and administrative hearings. Forensic experts also routinely evaluate the reports of other professionals.

The Business Case for Workplace Mental Health

The business case for mental health in the workplace cannot or should not be ignored. Beyond the laws identified earlier, every employer should be aware that unaddressed mental health issues cost them real money. In one report from England, 40 percent of employee sick leave was attributed to mental health issues.[13] Additionally, mental health impacts the workforce in terms of reduced productivity and staff turnover.[14] In Canada, the Global Business and Economic Roundtable on Addiction and Mental Health's 2011 annual report[15] estimated the cost of mental health to the Canadian workforce at more than $50 billion, or 4 percent of the gross domestic product. It further estimates the cost to North American and European workplaces at $1.1 trillion.

The most common mental health disorders that impact the workplace are depression and anxiety disorders.[16] Drug and alcohol addiction are equally serious and impactful. Brain injuries also have a mental health impact. Recent data from Canada indicate that mental health claims, which are mostly for depression, are the fastest growing category of disability costs.[17] Hong suggests

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[13] *Id.*

[14] *Id.*

[15] *Available at* http://www.mentalhealthroundtable.ca/report2011/MHR_Final_Report_FA.pdf (last visited Jan. 2013).

[16] *Id.*

[17] Hong, L., Canadian Centre for Occupational Health and Safety, *available at* http://www.ccohs.ca/education/presentations/solutions_102809.pdf (last visited Mar. 2012).

that, worldwide, by 2020, depression will rank second to heart disease as the leading cause of workplace disability.

Depression

Depression can affect any employee, from front line workers to the chief executive officer and the chairperson of the board. Depression is indiscriminate. It can be a recurring problem and can strike without warning at any age. Many people with depression are reluctant or afraid to report their condition to their employers, let alone friends, family members, or their physicians, whereas others are ill but not even aware that they are. Sometimes that is because of a natural tendency to deny having a mental illness, but it can also happen because the symptoms of depression are often masked. Many people with depression are not sad; instead they are angry, irritable, and edgy. Making matters more complicated, depression can be genetic, environmental, or a combination of both; it can be mild to extreme in severity, and it can occur following loss, trauma, stress, isolation and loneliness, harassment and bullying, pain, and/or chronic medical conditions. Depression may also be triggered by many types of life transitions, such as divorce, demotion at work, aging, and children moving away from home.

The main symptoms of depression are sad, empty feelings; loss of interest in eating, sex, and regular interests; low energy and fatigue; insomnia, hypersomnia, and excessive daytime sleepiness; poor concentration, attention, and memory; trouble making decisions; irritability and restlessness; isolation and withdrawal; feelings of worthlessness; hopelessness and pessimism; negative thinking; and thoughts or threats of suicide, or suicide attempts. These symptoms have obvious implications for an individual's performance and personal interactions in the workplace. It is also noteworthy that suicide is primarily related to untreated depression.

Depression can occur once, be recurrent, or be chronic. Some people with depression can continue to work, whereas others will require anything from short leaves of absence to long-term disability leave. Depression can coexist with other physical and mental illnesses, including abuse of drugs and alcohol, as substances are often sought out for the relief that they provide. Treatment becomes complicated when addiction sets in. Even after the

depression is resolved, the addiction will remain. Treatment for depression is more difficult when an addiction is present.

Anxiety

Dictionary.com Unabridged defines "anxiety" as "distress or uneasiness of mind caused by fear of danger or misfortune."[18] Anxiety itself is not an illness or disorder. In the majority of cases, it is both a natural and an adaptive reaction. The young child learns to avoid hot surfaces out of fear of being burned. A teenager studies hard for an exam to avoid the negative outcome of failure. Anxiety leads to arousal, which can improve performance in stressful situations and ensure success in important events. Although too much anxiety can result in impairment, too little anxiety can lead to a lack of interest or motivation.

Anxiety is a natural state characterized by changes to physiology, cognition, and behavior. With anxiety, there is the physical feeling or experience of fear, which includes a racing and heavy-beating heart, sweating, shaking, dizziness, nausea, shortness of breath, and/or chest pains. There is the cognitive or thinking component that involves negative expectations of future events, exaggerated interpretations of one's status or relationships, and strong beliefs that bad things are going to happen. Behaviourally, anxiety is manifested by avoidance of feared objects and situations, including those that are similar but not identical to what is feared. For example, a person with a fear of heights might avoid tall buildings and airplane flights, but also might avoid watching movies about air travel. These generalizations are very common in anxiety reactions.

Anxiety disorders occur when the anxious state cannot be controlled, when the anxiety is greatly disproportionate to the actual situation, and following a serious shock where the fear or horror of the situation does not resolve. There are many anxiety disorders, including panic disorder with or without agoraphobia, obsessive compulsive disorder (OCD), generalized anxiety disorder, post-traumatic stress disorder (PTSD), acute stress disorder, social phobia, and simple phobia. Like depression, anxiety disorders occur in great numbers, and even greater numbers of people

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[18] *Available at* http://dictionary.reference.com/browse/anxiety?s=t (last visited Mar. 2012).

have near-disabling or sub-threshold anxiety that does not rise to the level of an anxiety disorder. In severe cases, anxiety can be paralyzing. Because of the inherent irrationality of anxiety (phobias are often defined as irrational fear reactions), there is often a lack of understanding and compassion. People with severe anxiety are told that there is nothing to be afraid of and then are expected to get back into the swing of life, as if that's all they needed to hear, and as if they've never heard it before.

Bipolar Disorder and Schizophrenia

Bipolar disorder (formerly manic depression) and schizophrenia are far less common than other mental disorders, so they are less frequently seen in the workplace. Schizophrenia generally manifests before age 20, so many people with this condition never enter the workplace. The incidence of schizophrenia is estimated to be between 0.5 and 1.5 percent in people older than 18 years of age, and the incidence of bipolar disorder is estimated at 0.4 to 1.6 percent.[19] Where depression may or may not be disabling, schizophrenia and bipolar disorder are highly disabling. However, although schizophrenia can be permanently disabling, the diagnosis of bipolar disorder requires only one manic episode. Many people with bipolar disorder are fully capable of working between episodes of mania and depression, and medication can be highly effective.

The main symptoms of schizophrenia are disturbances in thought, mood, perceptions, and relationships. The classic symptoms are hallucinations, which are usually auditory (hearing voices) but can be visual, and delusions, which are most often paranoid. There is also disorganized speech, flat affect (blank facial expression), loose associations (bizarre speech with made up words), poverty of speech (saying little), and a lack of motivation.

The most common type of schizophrenia is paranoid schizophrenia, which is characterized by delusions and hallucinations. The hallucinations are generally hostile and threatening. People with paranoid schizophrenia have delusions that people and agencies are plotting against them; they are aware of grand conspiracies; and all sorts of things refer to them. For example, they may believe that their thoughts are broadcast to others, that thoughts

[19]AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS 357 (4th ed. text rev. 2000).

are inserted into their minds, or that they are influenced or controlled by people or agencies.

Bipolar disorder is characterized by episodes of mania and depression. "Bipolar Disorder 1" refers to the severe category of bipolar disorder characterized by episodes of mania. A manic episode is a severe occurrence that involves psychosis and usually requires hospitalization. The *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (DSM-IV-TR)[20] describes a manic episode as "a distinct period of abnormally and persistently elevated, expansive or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary)."[21] The symptoms include inflated self-esteem or grandiosity; decreased need for sleep; increased talkativeness or pressured speech; flight of ideas (rapid speech that switches from one topic to another that is based on loose associations) or feeling that thoughts are racing; distractibility; increased goal-directed behaviour; and excessive involvement in pleasurable activities that have a high risk of painful outcomes. "Bipolar Disorder 2" involves depression and hypomania, which is a milder version of mania, and generally does not include psychosis or require hospitalization. Many people find hypomanic episodes to be personally beneficial, with its increased energy, reduced need for sleep, and inflated self-esteem. It is others, such as family members or co-workers, who experience the hypomanic episode negatively. Inflated self-esteem, or grandiosity, does not always support rational thinking and consideration of the many issues involved in a decision.

Warning Signs

General warning signs may be observed when an employee is suffering from a mental disorder. These signs do not always mean that a mental illness is present, so they must be interpreted with caution. The warning signs include changes in routines; excessive sick leave, absenteeism, arriving late, or sometimes early, for work; being chronically tired; reduced work performance; changes in physical appearance (often looking unkempt, but with bipolar disorder may appear very flashy or bizarre); increased anger, sarcasm,

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[20] American Psychiatric Association, Diagnostic & Statistical Manual of Mental Disorders (4th ed. text rev. 2000).

[21] *Id.* at 357.

and negativity; inappropriate humour; work refusals; paranoia; isolation; and references to death and suicide.

Stereotypes and Stigma

Stereotypes are beliefs attributed to a group based on characteristics common to a sample of individuals in that group or on false information. There are many stereotypes of people with mental illness that increase its stigma. Many people who suffer from mental illness find it difficult to talk about their struggles and to seek help because of the negative ways they view themselves relating to the stigma, because they fear exposure, marginalization, and ridicule, and because of how they are treated when they do ask for help. There is no doubt that this situation is improving, but we have a long way to go. There are still many examples in popular culture where mental illness and people with mental illness are made fun of. Although some humour can be sensitive, that is not always the case. Perhaps it is our way to joke about the things we fear. Unfortunately, the effect of such humour, ignorance, and negativity can lead people with mental illness to isolate themselves. I believe that it is not mental illness, but untreated mental illness, that undermines individuals', families', and society's experience of wellness and enjoyment of life.

The most common stereotypes are that people with mental illnesses are weak, deserving of their problems, weird, lazy, or not trying hard enough to get better. It is believed that mentally ill people cannot work productively or that they are using their problems to not have to work. These beliefs could not be farther from the truth. Another popular stereotype is that people with mental illness are violent. Although that is true in some cases, such as when people with schizophrenia experience command hallucinations telling them to kill or when someone tries to intervene with a person in the throes of a severe manic episode, the real danger is when mentally ill people abuse drugs or alcohol. Substance use with mental illness can lead to violent outbursts. Although it is true that many violent acts take place while an individual is experiencing symptoms of a mental illness, the significant majority of people with mental illness are never violent.

A common manifestation of stigma is the discomfort related to mental illness. People feel uncomfortable talking about these issues, so the person with mental illness is avoided or his or her issues are ignored. Although we would ask a co-worker how he or

she is feeling about a cold or a recent surgery and wish him or her well, we are shy about similar discussions regarding mental illness.

One of the most erroneous stereotypes is that people with mental illness don't get better and that they are unable to continue to work. It was once thought that people with mental illness needed to be hospitalized for life, both for their protection and the protection of others. Fortunately, the past 50–75 years have seen tremendous changes in the understanding, diagnosis, treatment, and care of these individuals. When I started in the field, there were still large mental institutions, and the majority of individuals with mental illness were institutionalized. People were called schizophrenics and manic depressants, not people with schizophrenia or people with manic depression. Now, pharmacology and psychological therapies have advanced to the point that most people with mental disorders can look after themselves, work competitively, and enjoy life to its fullest. At the very least, they can expect some improvements over the non-treated condition. People with mental illness also benefit from support groups, life skills programs, short-term focused hospitalizations, and family therapy.

Roles of the Employer and Union

Employers and unions need to take a leadership role in reducing the stereotypes of mental illness, just as with other areas of diversity. People with mental illness are part of the workforce, and their legal rights have been set out. One of the best ways to reduce stigmas and stereotypes is to ensure that all people with disabilities are treated with respect, compassion, fairness, and equality. Working hard to provide accommodations when needed and reintegrating people who have been sick back into the workforce both go a long way toward setting the right example. An accommodation should attempt to take full advantage of an employee's skills and experience and should be as close as possible to the employee's usual level of work.

Conclusion

There should be no doubt that mental health and mental illness have significant relevance to arbitrators and the arbitration process. Our collective discomfort with mental illness has resulted in avoidance and misunderstanding. Increasingly, cases are being brought forward where unions seek to protect their members from

discrimination, employers seek to operate efficiently, and arbitrators have to make judgments on very subtle and highly complex issues. Although most people would agree that mental illness is a serious issue, for many of the reasons discussed in this paper each case brought before an arbitrator has to be considered on its own merits. With better understanding of mental health disorders and issues, arbitrators will be in a better position to make informed and just decisions.

II. Approaches to Evaluating, Presenting, and Resolving Workplace Disputes Involving Mental Health Issues

Workplace disputes involving the actual or claimed results of an employee's mental illness can be among the most troubling to advocates and arbitrators alike. Post-traumatic stress and other anxiety disorders, bipolar disorders, depression, substance abuse and other addictions, even schizophrenia are among the mental illnesses encountered in the workplace these days. This is particularly true in light of advances in medical treatments for these conditions as well as statutes and regulations that support accommodation of employees' mental disabilities in the workplace. Unions, employers, and arbitrators increasingly find themselves tackling questions about whether a mental health issue has impacted an employee's behavior or job performance and whether and how an employee's mental status should impact application of terms of a collective bargaining agreement or the appropriate discipline to be imposed after a work rule violation. For example, is an employee less culpable because of the effects of a mental disability, and should that reduced culpability mitigate a penalty? And what should happen if an employee does not recognize and/or obtain treatment for a mental illness until after discipline or even discharge?

In this session, a psychologist with extensive experience as an expert forensic witness in labor and employment arbitration provided guidance to arbitrators and advocates alike on approaches to evaluating, presenting, and resolving workplace disputes where an employee's mental illness may be a factor. The arbitrators on the panel offered additional insight into their decision-making