When Mental Health Accommodation Fails and What OHS Leaders Should Learn from Repeat Claims and Failed Returns

A worker returns from a mental health-related leave, follows the graduated return-to-work plan for a few weeks, then leaves again. The organization treats it as an individual medical issue. The file is reopened, more paperwork is requested, and another modified schedule is developed. A few months later, a second worker in the same department goes off. Then a third begins missing shifts. Supervisors describe the team as “fragile.” HR sees accommodation files. OHS sees nothing because no physical injury occurred.

That’s where many employers miss the bigger warning.

A failed accommodation may be an individual issue, but it may also be a safety signal. If workers are repeatedly struggling in the same department, under the same supervisor, in the same type of work, or after exposure to the same stressors, the employer should ask whether the workplace is contributing to the problem. Accommodation manages the individual case. Prevention examines the system.

That distinction matters because Canadian employers have overlapping duties. They must accommodate workers with

disabilities to the point of undue hardship, but they must also identify and control hazards that may affect worker health and safety. If the work environment is repeatedly producing mental health-related absences, failed returns, conflict, or unsafe behaviour, the issue can’t stay confined to HR or disability management.

The pattern matters more than the individual file

One accommodation file may not tell the employer much about workplace risk. Several related files may tell a very different story.

The employer does not need to disclose confidential medical information to see patterns. It can review de-identified and aggregated information: number of mental health-related leaves, repeat absences, failed return-to-work plans, departments with higher accommodation activity, roles with higher burnout indicators, recurring harassment or violence complaints, overtime trends, staffing shortages, turnover, and near misses linked to fatigue or distraction.

The question is not “What’s wrong with these workers?” The question is “What does the pattern tell us about the work?”

If one unit has high workload, constant vacancies, repeated conflict, and multiple mental health-related absences, the answer probably isn’t another wellness poster. If field workers are repeatedly struggling after violent or threatening client interactions, the answer probably isn’t just resilience training. If supervisors are repeatedly asking HR how to manage “difficult” accommodated employees, the organization may need to examine supervisor competence, role design, workload allocation, and psychosocial hazard controls.

Good OHS practice looks for recurrence. It does this with slips, strains, machine hazards, mobile equipment incidents,

and chemical exposures. Mental health-related accommodation trends deserve the same discipline.

Accommodation data must be handled carefully

Using accommodation data for prevention requires strict privacy discipline. Employers should not share diagnoses, medical restrictions, treatment details, or individual case information with people who don’t need it. The goal is to identify workplace patterns, not expose workers.

This means HR, disability management, and OHS need clear boundaries. HR may hold confidential medical information. OHS may need de-identified trend data to assess psychosocial hazards. Supervisors may need functional information to implement a specific plan. The JHSC may need systemic information about workload, violence, harassment, fatigue, or return-to-work barriers, but not personal medical details.

The employer should be able to explain why information is being used, who can access it, how confidentiality is protected, and how the information supports prevention. Done properly, this approach respects privacy while avoiding the dangerous mistake of treating every mental health accommodation as isolated and unrelated to workplace conditions.

Failed returns should trigger a review of the work

When a return-to-work plan fails, the employer should not automatically assume the worker wasn’t ready. That may be true in some cases, but it should not be the default conclusion.

A failed return should trigger a structured review. Were the duties truly suitable? Was the workload realistic for the graduated schedule? Were the worker’s restrictions translated

into clear work controls? Did the supervisor understand the plan? Was confidentiality protected? Were co-worker dynamics managed appropriately? Were the original workplace stressors addressed? Did the worker receive timely check-ins? Were warning signs documented and acted on? Did production pressure undermine the plan?

This review should also examine whether the plan unintentionally created new hazards. A worker may have been removed from high-conflict tasks but placed in isolated work. Another may have been given reduced hours but the same volume of work. Another may have been reassigned to unfamiliar duties with inadequate training. Another may have returned to the same supervisor whose conduct contributed to the leave.

Those are not medical failures. They are system design failures.

Supervisors need support and accountability

Supervisors are often the weak link in mental health accommodation, not because they don’t care, but because they’re untrained, overloaded, or unclear on their role.

Some supervisors avoid accommodated workers because they’re afraid of saying the wrong thing. Others overstep and ask inappropriate medical questions. Some quietly resent the accommodation because it disrupts scheduling. Others try to be supportive but fail to document objective concerns. A few treat the worker as a performance problem rather than someone returning under a legally protected process.

OHS leaders should work with HR to define what supervisors must do. They should understand the worker’s functional restrictions, not the diagnosis. They should know how to assign work within the plan, monitor safety-related concerns, document objective observations, respond to reported barriers,

and escalate issues early. They should also understand that retaliation, stigma, gossip, and isolation can undermine both accommodation and safety.

At the same time, supervisors must be held accountable for implementing plans properly. A return-to-work plan that exists in HR’s file but isn’t followed on the floor is not a real control. If a supervisor repeatedly ignores restrictions, overloads workers, mishandles conflict, or fails to report concerns, that’s a management issue with OHS consequences.

Repeat claims may point to psychosocial hazards

Mental health-related accommodation trends can reveal hazards that traditional inspections miss. A safety walk-through may identify blocked exits, damaged equipment, or poor housekeeping, but it may not capture unreasonable workload, chronic role ambiguity, public abuse, bullying, poor change management, lack of recovery time, or excessive emotional demands.

Those hazards often appear in other data first. Absenteeism increases. Workers transfer out. HR receives more complaints. Short-term disability use rises. Supervisors report more interpersonal conflict. Near misses mention rushing, distraction, or fatigue. Workers describe feeling unsafe, unsupported, or overwhelmed.

When those indicators align, OHS should treat them as risk intelligence. The response may include workload assessment, staffing review, violence prevention improvements, harassment intervention, schedule redesign, supervisor coaching, clearer job expectations, better debriefing after traumatic events, or changes to how work is assigned.

The employer doesn’t need to diagnose the workforce. It needs to examine whether the work is being organized in a way that

creates foreseeable harm.

Wellness benefits don’t replace hazard control

Employee assistance programs, mental health apps, counselling benefits, peer support, and awareness campaigns can be useful. They may help workers access support and reduce stigma. But they don’t replace hazard control.

If the cause of repeated mental health accommodation is excessive workload, offering counselling while leaving the workload unchanged is incomplete. If workers are repeatedly exposed to violence, resilience training without prevention controls is inadequate. If harassment complaints are driving leave, an EAP does not substitute for investigation and corrective action.

This is the same principle used in physical safety. You don’t control a machine hazard by telling workers to cope better with dangerous equipment. You fix the machine, redesign the task, guard the hazard, train workers, supervise the process, and verify the control. Psychosocial hazards require the same seriousness.

The JHSC can help identify systemic risk

The JHSC should not manage individual accommodation files, but it can play a useful role in reviewing systemic mental health and psychosocial hazard trends. The committee can discuss workload concerns, violence reports, harassment trends, fatigue, staffing impacts, incident themes, and barriers identified through de-identified return-to-work reviews.

This requires maturity. The discussion must stay focused on hazards, not personal cases. The committee should not speculate about diagnoses or individual workers. It should ask whether conditions in the workplace are creating risk and

whether controls are adequate.

Used properly, the JHSC can help move mental health from an HR file into the internal responsibility system. That’s where prevention belongs.

What OHS leaders should ask after a failed accommodation

After a failed return or repeat mental health-related absence, OHS leaders should ask whether the original workplace hazard was identified and controlled, whether modified duties were actually safe and suitable, whether the supervisor followed the plan, whether workload was adjusted or merely compressed, whether the worker had a confidential way to raise concerns, whether co-worker dynamics affected the return, whether violence, harassment, fatigue, or isolation played a role, and whether similar issues are appearing elsewhere.

These questions should be asked without blame. The goal is not to prove that the worker, supervisor, HR, or OHS failed. The goal is to learn why the system didn’t support a sustainable return and what must change before the next one.

The better standard

A strong employer treats mental health accommodation as both an individual obligation and a prevention opportunity. It protects confidentiality, respects the worker’s dignity, and develops reasonable accommodations based on functional needs. But it also looks at patterns. It asks whether the work itself is contributing to harm. It connects disability management data with OHS prevention without exposing personal medical information.

That’s the shift Canadian employers need to make.

A failed accommodation is not always just a failed

accommodation. Sometimes it’s the clearest warning the workplace will get that the hazard was never controlled.