Mental Health Issues and Work: Institutional Practices of Silence in a Mental Healthcare Organization

by

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A thesis submitted in conformity with the requirements for the degree of Doctorate of Philosophy

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Abstract

Over the past decade, mental illness in the workplace has become a key issue in the health and business communities, fueled in part by recognition of the high prevalence rates and significant costs for individuals and organizations. Although research in the field is starting to emerge, there are significant gaps in what is known, particularly with respect to the workplace context and its impact on workers. The overall objective of this study was to characterize, from a sociological perspective, the experiences of healthcare workers with mental health issues, and to account for how their experiences were shaped by the social relations of work. A qualitative approach, based on principles of institutional ethnography, guided exploration of the interactional, structural and discursive dimensions of work within a large mental health and addictions treatment facility. Data collection included in-depth interviews with twenty employees regarding their personal experiences with mental health issues, interviews with twelve workplace stakeholders regarding their interactions with workers, and a review of organizational texts related to health, illness and productivity. Analysis of the transcripts and texts was based on an institutional ethnography approach to mapping social processes; examining connections between local sites of experience and the social organization of work.

The study findings revealed a critical disjunction between the public mandate of advocacy, open dialogue, and support regarding mental health issues, and the private experience of workers which was characterized by silence, secrecy and inaction. Practices of silence were
adopted by workers and workplace stakeholders across the organization, and were shaped by discursive forces related to stigma, staff-client boundaries, and responsibility to act. The silence had both positive and negative implications for the mental health of workers, as well as for relationships and productivity in the workplace. In accounting for the practices and production of silence, I argue that silence is complex, multi-dimensional, and embedded within the social relations of healthcare work. It serves to maintain institutional order. This conceptualization of silence challenges current beliefs and practices related to stigma, disclosure, early identification, support, and return to work for employees with mental health issues.
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CHAPTER 1 -Mental Health in the Workplace: The Context

Over the past decade, mental health in the workplace has become a key issue in the health and business communities, both nationally and internationally (Canadian Institutes for Health Research (CIHR), 2004, Global Business and Economic Roundtable on Mental Health and Addictions, 2000; World Health Organization, 2000). Mental health issues are cited as the leading cause of work incapacity in many industrialized countries, with a growing recognition of significant costs, not only for individual workers and businesses, but for the overall economy (Lesage et al, 2004). The overall cost of lost productivity due to workplace mental illness in Canada has been estimated at over 4.5 billion dollars per year (Stephens & Jourbert, 2001). Although mental health issues themselves are not new, the positioning of mental health as a business issue is relatively recent.

Increased concerns about the impact of mental health issues at work have been attributed to the changing world of work. Perez and Wilkerson (1998) argue that in the past 2 decades, we have moved from an industrial to an information economy. They explain that the combination of technology innovations and globalization has created an economy in which knowledge has become the single most important factor of production, and managing intellectual assets has become the single most important task of doing business. Innovations in computer technology mean that access to information has increased exponentially, as has the pace of working life (Perez & Wilkerson, 1998). Another outcome of the shift to an information economy is the significant growth of the service sector (Turner, 1987). The service sector depends less on manual labour, and more on knowledge-based skills. Dewa et al. (2004) explain that we are now in a "knowledge based economy", where "the heavy lifting is done with our minds, not our backs" (p. 23). Occupational hazards and injuries are seen as increasingly mental rather than physical, therefore employment based interventions to address mental health issues have been marketed as a “value added” service that makes good business sense (Goetzel et al., 2002; Shain, 1990; Sederer & Clemens, 2002; Smith et al., 2002). Not only has the awareness of mental health issues increased, the mental health of workers is recognized as a valuable commodity for employers.
Recognition of increasing prevalence rates and soaring costs of mental health issues at work has fueled concerns about the nature of the issues and how to address them. Lesage, Dewa and Kirsh (2006) argue that a cultural shift is taking place in terms of awareness and recognition of the importance of the issues. They also feel that momentum for education and research in the field is building. There continue to be gaps, however, in what is known. Historically, the field of workplace health has focused primarily on physical injury and illness (Robson et al., 2010). Research regarding physical health has far exceeded research regarding mental health in the workplace (Archambault, Cote & Gingras, 2004). Archambault, Cote and Gingras (2004), in their bibliometric analysis of research conducted between 1991 and 2002 on mental health in the workplace, found that research papers increased by 75% at an international level. Despite a two to three fold increase in research in this area over the past decade, they also noted that less than 1% of health-related research worldwide is devoted to this area. In 2003, the gaps in research were noted by the scientific directors at the Canadian Institutes for Health Research (CIHR), and they developed a task force of experts in the field to develop a long term research agenda on mental health in the workplace (Lesage, Dewa, Savoie, Quirion, & Frank, 2004). The recently formed Mental Health Commission of Canada has also recognized workplace mental health as a key priority area, with the workforce as the focus of one of their eight central advisory committees (Mental Health Commission of Canada, 2009). Fostering changes to workplace policy, research and practice at a national level is a key item on their agenda, considering the mental health of the overall workforce, as well as both employed and unemployed individuals with mental health issues. Although research is starting to emerge, there continue to be significant gaps to fill, particularly with respect to understanding the experiences of individuals with mental health issues, and the organizational context of work.

The purpose of this study is to characterize the experiences of workers with mental health issues who are employed in a healthcare facility, and to account for how their experiences are shaped by the social context of work. To provide the background for the study, I will review what is known about mental health issues among the working population, how mental health issues impact work performance, and how work in turn impacts the mental health of workers. Since the focus of this study is on workers in a healthcare environment, I will link this research to what we know about healthcare employees. I will explain how the experience of workers provides a key starting point for understanding the relationship between work and mental health,
and that we need to understand how the experiences of workers are embedded within a broader social context.

1.1 Characteristics of Mental Health Issues in the Workforce

To get a sense of what is meant by mental health issues at work, I will begin by providing an overview of what is known about the nature and prevalence of mental health issues in the working population. According to the 2002 Canadian Community Health survey, one out of every ten Canadians aged 15 and over reported symptoms over the previous year that were consistent with a mood disorder, anxiety disorder or substance dependence (Government of Canada, 2006). The lifetime prevalence rates were about one in five. These self-reported estimates may even under-represent the true picture in the population since many people with mental health issues remain undiagnosed (Government of Canada, 2006).

The most common mental health issues among the working population have been identified as depression, anxiety and substance abuse (Dewa, Lesage, Goering & Caveen, 2004; Sanderson & Andrews, 2006). The term "common mental disorders" is often used to identify workers with these conditions (Barnes et al., 2008). The 12 month prevalence rate of mood disorders is reported to be 1 in 20 Canadian adults, with similar prevalence rates for anxiety disorders (Government of Canada, 2006). Other reported mental health issues among workers include post-traumatic stress disorder, bipolar disorder, and psychosis (Kahn & Langlieb, 2003). Individuals with severe and persistent mental illness such as schizophrenia or major depression are typically not employed therefore the prevalence rates are typically lower among the working population (Krupa et al., 2009; Stuart, 2006).

Substance use or addictions issues are often reported separately from mental health issues. According to a national survey conducted in the United States, approximately 15% of employees report using or being impaired by alcohol while at work at least once in the past year, with about one in ten full-time employees classified as heavy alcohol users (Frone, 2006). Other surveys have found that 4-8% of full-time employees report using illicit drugs within the past month (Lim, Sanderson & Andrews, 2001). Other common, yet growing addictions issues include the abuse of prescription medication, internet and gambling addictions; all of which can affect performance and productivity at work (Government of Canada, 2006).
Another feature of mental health issues that complicates the picture concerns co-morbidity. Addictions and mental health issues, for example, often occur together. Research has shown that 30% of people diagnosed with a mental illness will also have a substance abuse problem in their lifetime, and 37% of people who abuse alcohol (53% who abuse drugs) are also living with a mental illness (Skinner, O’Grady, Bartha, & Parker, 2004). Co-morbidity of mental health and addictions issues with other conditions is also common. People with a chronic physical illness such as back problems or a cardiac condition, for example, are twice as likely to develop anxiety or depression (Patten, 2001). Co-morbidity of issues is important to consider since the impact on work performance is typically greater (Lim, Sanderson & Andrews, 2000).

In addition to differences in diagnoses, there may be variation in the nature of the mental health issues. There are varying degrees of severity, for example, with a much higher prevalence of workers with mild to moderate symptomatology (Government of Canada, 2006). These mild to moderate symptoms often respond well to treatment (medication and/or counseling) (Kahn, 2003). Another feature of mental health issues is that they are often difficult to detect because they are less visible than a physical injury or illness, and may have an insidious onset (Kahn, 2003). The variable features of mental health issues combined with poor mental health literacy have been attributed to the limited recognition of mental health issues at work.

### 1.2 Characteristics of Workers with Mental Health Issues

In addition to understanding the mental health issues that may be present in the working population, I propose that it is important to examine characteristics of the workers themselves. There may, for example, be trends among groups of workers, or workers who are more at risk for mental health issues than others. Lesage et al. (2004) argue that when mental health issues occur in the context of work, they affect people in all occupations, education levels, socio-economic conditions and cultures. They state that mental illnesses are "democratic" in that they indiscriminately affect CEOs, administrators, middle managers, union representatives, doctors, nurses, and sawmill workers.

There is some debate, however, about the extent to which mental health and addictions issues are associated with specific occupations. A study by Dewa and Lin (2000) of over 4000 Ontario workers confirmed the hypothesis about the democratic nature of mental illness. They
reported that no single occupational grouping consistently stood out as having a greater risk for psychiatric conditions. Although mental health issues may affect all workers, there are, however, some distinctions between workers in terms of the specific nature of the illness. For example, it has been reported that women have an increased prevalence rate of depressive disorders, whereas men are more likely to experience substance use issues (Marcotte et al., 1999). Substance use issues are also reportedly higher among younger employees, and those with less education and income (Adlaf, Begin & Sawka, 2005). In contrast, depressive disorders are reported to be higher among middle aged workers, as compared to younger or older workers (Marcotte et al., 1999).

In addition to exploring demographic trends, a number of studies have explored the links between specific mental disorders and sectors of the workforce. Alcohol and drug use, for example, is reportedly more common in certain occupations. High risk occupations include those with demanding work conditions, low supervision, low to moderate pay and high staff turnover, such as construction, transportation (eg. truckers), blue collar trades, arts, entertainment and recreation, accommodation and food services and retail service occupations (Adlaf, Begin & Sawka, 2005; Attridge & Wallace, 2009). Prevalence rates of major depressive disorder have also been linked to certain occupations including lawyers, teachers and counselors and secretaries (Eaton et al., 1990). These findings are slightly different than those reported by Kessler and Frank (1997), who found high rates of depression among clerical, sales workers and labourers, yet lower rates among professionals. Dewa and Lin (2000) also reported slightly lower rates of affective and anxiety disorders among professional/managerial groups as compared to the rest of the workforce. It has also been reported that workers in atypical employment situations (eg. temporary contract work) have poorer overall mental health (Sanderson & Andrews, 2006). These studies highlight the ways in which occupation is linked to the mental health of workers.

1.3 Impact of Mental Health Issues at Work

As outlined above, there seems to be a relationship between mental health and work performance. The way in which mental health issues affect work performance is a primary concern for employers. Employees with mental health issues reportedly have higher absenteeism rates, higher relapse rates and more lengthy short term disability claims than employees with
other medical conditions (Conti & Burton, 1994; Dewa et al., 2004). Much of the epidemiological research focuses on the impact of depression, which may be due in part to the identified prevalence of the condition and cost to employers. Dewa et al (2004), for example, report that between 65% and 76% of short-term disability episodes due to mental disorders are attributed to depression. Studies comparing the functioning of depressed and non-depressed workers reported that job performance was seven times worse for the depressed employees (Kessler et al., 1999), and that depressed workers had 1.5-3.2 more disability days per year (Druss, Rosenheck & Sledge, 2000). Not only are absenteeism rates higher, but the duration of sick leave is often longer than for those with physical health issues (Conti & Burton, 1994).

Although sick leave and absenteeism are a concern for employers, it is the high rates of presenteeism that are emerging as an even greater concern for employers with respect to workers with mental health issues. Presenteeism is a new term, coined in the mid-1990's that is often used in reference to employees who are present but not productive (Lowe, 2002; Shamansky, 2002). When workers have mental health issues, the rates of presenteeism and costs of lost productivity are reported to be just as high, if not higher, than the costs associated with absenteeism and short-term disability claims (Lesage, Dewa, Savoie, Quirion & Frank, 2004). Comparisons of workers with mental health issues versus those with physical illnesses have highlighted the increased rates of presenteeism among workers with mental health issues (Burton et al., 2004; Dewa & Lin, 2000; Schultz & Edington, 2007). Individuals with mental health issues are more likely to go to work, but require greater effort to function (Aronsson, Gustafsson & Dallner, 2000; Dewa & Lin, 2000). There is often a long lag time between the onset of symptoms and treatment seeking for psychiatric problems (Kessler & Frank, 1997). The costs of presenteeism are often hidden, however, in the past decade a number of approaches have been developed to track presenteeism and the cost to employers (Aronsson & Gustafsson, 2005; Sanderson et al., 2007).

When individuals continue to work when experiencing symptoms, there are a number of ways in which it can affect their functioning at work. Impairment due to anxiety and depression, for example, has been reported in the following areas: physical symptoms (e.g. pain, weakness, fatigue, gastro-intestinal problems), mood changes (e.g. irritability, tearfulness), cognitive impairment (e.g. poor concentration, decreased ability to problem solve), and social
impairment (eg. withdrawal, conflicts) (Bender & Kennedy, 2004). Attridge (2008) explains that symptoms such as poor concentration, memory lapses, indecisiveness, fatigue, apathy and lack of self-confidence can make it difficult to perform and complete even routine tasks. Other mental health issues, although not as extensively researched, may have a similar impact on work productivity and performance. The reported impact of addictions, for example, includes increased absenteeism, poor work quality, safety concerns, increased on-the-job accidents, damaged customer relations, and workplace conflicts (Attridge, 2009; Mangione et al., 1999). Many mental health issues are chronic in nature; there may be periods of health as well as periods of illness that ebb and flow over time, and the course of the illness may not be predictable (Watson-Wyatt, 2007). The literature on the functional impact of mental health issues highlights not only the impact on the bottom line of productivity, but on broader issues such as workplace safety and relationships in the workplace.

1.4 Impact of Work on Mental Health Issues

The literature cited thus far highlights the ways in which mental health issues affect work however, there is also a growing body of literature exploring how work affects mental health. Psychosocial risk factors in the workplace have been the focus of a number of large scale epidemiological studies. For example, stress, both within and outside the workplace, has been identified as a significant risk factor governing the health of workers (Lowe, 2006). According to the 2002 Canadian Mental Health and Well-being survey, approximately 50% of Canadians reported that their work was stressful to some degree (Statistics Canada, 2003). Furthermore, the survey showed that one in three adults between the ages of 25 and 64 reported work to be quite a bit or extremely stressful. Thirty percent of respondents to another employee survey reported that their job was the major source of stress in their life (Lowe, 2006). There are many identified sources of job-related stress, including the content of work (eg. high work load, demanding work pace, shift work, uncertainty or lack of meaning in work), as well as the context of work (eg. role ambiguity or conflict, job insecurity, lack of control over work, interpersonal conflict, and social isolation) (Harnois & Gabriel, 2002). In a study by Lowe (2006), long work hours (paid and unpaid) was one of the strongest independent predictors of frequent job stress.

Several models explaining the relationship between workplace stressors and employee ill health have been proposed in the literature. The two most widely cited models include Karasek's
"demand-control" model, as well as Siegrist's "effort-reward imbalance" model. (Stansfeld & Candy, 2006). Key elements of Karasek's (1979) model include the concepts of job demands (quantity and pace of work) and decision latitude (control over meeting job demands). According to Karasek, job strain and mental health issues can occur as the result of high psychological job demands, and little flexibility or control (low decision latitude) to meet these demands. Conversely, the model hypothesizes that if the worker has increased decision latitude over his/her work, the negative impact of the job demands is reduced, and health problems are less likely to develop. A slightly different perspective on the influence of organizational forces on health is outlined in the effort-reward model proposed by Siegrist (1996). Siegrist (1996) hypothesizes that jobs that involve high effort and low rewards are associated with an increased risk of common mental disorders and elevated rates of absenteeism at work. A better balance between effort and reward, on the other hand, can mitigate the impact of job stressors. Both models are supported by a considerable amount of research evidence, including large scale population studies in the United Kingdom, Sweden and France (Head et al., 2006; Meichoir et al., 2003; Voss, Floderus & Diderichsent, 2004). In a meta-analysis of this research conducted by Stansfeld and Candy (2006), they noted the combinations of high demands and low decision latitude; and high effort and low reward at work were consistently associated with an increased risk of common mental disorders. There is clear support for the relationship between characteristics of the workplace environment and the mental health of workers. In order to understand the experiences of workers with mental health issues, it is therefore important to understand not only the nature of the illness itself and its impact on work, but the impact of work on mental health.

1.5 Mental Health Issues and Workers in the Healthcare Sector

The healthcare sector represents a particular workplace context for understanding the experiences of workers with mental health issues. In 2000, over 1.5 million people in Canada worked in healthcare and social services; this represents approximately one in ten employed Canadians (CIHI, 2005). Many of these workers provide care directly to patients however, others serve in support roles, teach, do research, manage health programs, or have other responsibilities.
Research indicates that Canadian healthcare workers have a higher incidence of mental health issues than any other occupational group (Occupational Health and Safety Agency for Healthcare in BC, 2004). High rates of illness in the healthcare sector are attributed in part to stressors in the workplace environment (El-Jardali & Shamian, 2007). Studies of healthcare providers have identified a number of common workplace stressors, including heavy workloads, inadequate staffing, inflexible scheduling, role ambiguity, relationship conflicts, lack of support from supervisors, challenging patients, and few opportunities for leadership and professional development (Danna & Griffin, 1999; El-Jardali & Shamian, 2007; Harris, Cumming & Campbell, 2006). Although much of the research has been conducted with physicians and nurses, Harris et al (2006) found that job stress was similar across a range of allied health professionals. Concerns have been expressed about organizational stressors that compromise the mental health of employees, and the need to focus on creating healthy work environments in the healthcare sector (Corrigan, Holmes, Luchins & Buican, 1994; Laschinger, 2007; Moore & Cooper, 1996; Rabin, Feldman & Kaplan, 1999).

One of the identified consequences of stressors in healthcare includes burnout among employees (Prosser et al., 1996; Harris, Cumming & Campbell, 2006; Wall et al., 1997). Burnout refers to a syndrome of emotional exhaustion, depersonalization and reduced accomplishment that can occur in work that involves human service provision (Maslach & Jackson, 1981). Burnout, in turn, can have a negative impact on health, work performance, job satisfaction and quality of life and psychological well being (Rabin, Feldman & Kaplan, 1999). High rates of burnout have been documented among mental health providers, along with the associated risks to their psychological well-being and overall health (Edwards et al., 2000; Rabin, Feldman & Kaplan, 1999).

Absenteeism and presenteeism are also noted to be a concern among workers in the healthcare sector. A national survey of the work and health of nurses, for example, found that the health-related absenteeism of nurses was higher than other Canadian workers by almost 6 days per year (Statistics Canada, 2006). Presenteeism, however, is noted as an even greater concern since many healthcare workers continue to work despite illness (McKevitt et al, 1997; Rosvold & Bjertness, 2001). High rates of presenteeism are of concern because mental health issues at work can have a negative impact, not only on the providers themselves, but on the quality of
patient care (Rabin, Feldman & Kaplan, 1999). Concerns have been expressed regarding the negative impact that mental health issues may have on interactions with clients and on overall work performance (Rabin, Feldman & Kaplan, 1999). Healthcare has therefore been identified as a priority area for addressing workplace health (Silas, 2007).

Much of the research on the mental health of workers in healthcare focuses on healthcare providers in general hospital settings. Less is known about individuals who work specifically in mental health and addictions settings. There may be particular features of this work setting that shape the experiences of staff, especially if the mental health and addictions issues of staff are similar to those of the clients. It should also be noted that much of the research on healthcare providers focuses on nurses. Less is known about non-nursing staff in a mental healthcare environment. There are many workers in healthcare settings from cleaning and food services staff through to administration and high level management; it is not clear how their experiences compare to those of nursing staff or other front-line clinicians. Clearly more research is needed to understand the experiences of workers in mental healthcare organizations.

1.6 Research Problematic

The research discussed up to this point highlights two key messages. First, workplace mental health issues are common, costly for employers, and can lead to many negative consequences for work performance and productivity. Second, the relationship between mental health and work is reciprocal; not only does work affect mental health, but mental health affects work.

There are several limitations to the current research regarding work and mental health. One is that the dominant perspective in the field is managerial or employer-centred. Mental ill-health is largely conceptualized in terms of implications for business; it is positioned as a financial and productivity issue (Goetzel, Ozminkowski, Sederer, & Mark, 2002). In the healthcare field, the focus on mental-ill health relates primarily to its impact on the quality of service provision (Silas, 2007). Much of the research seems to be aimed at creating a business case for increasing the visibility of the issues and mobilizing resources to address the problem. Although these perspectives and concerns are relevant and important, their contribution to the
body of knowledge in the field is limited. Correspondingly little attention is paid to the perspective of those who are actually experiencing mental ill-health at work.

A second limitation of this literature is that it does not go very far beyond an epidemiological investigation of risk factors and their impact on work performance. Population-based statistics document the extent and distribution of problems, but have little to say about what happens with respect to mental health issues in the workplace.

A third limitation of existing research is its polarized focus on either macro-level organizational policies and structures or on micro-level experiences of individual workers. Many of the population-level studies, for example, focus primarily at the level of the organization, while other studies examine the experiences of workers, particularly with respect to stigma and discrimination. There are very few studies which examine the links between micro and macro level analyses. In other words, there is limited research exploring the connections between individual experience and the broader institutional context.

The perspective adopted in this study represents a departure from much of the current research. I am approaching workplaces as social spaces where mental health issues do not occur in isolation, but occur within an organizational context that shapes how the issues are perceived and addressed. I ground my perspective in the standpoint of workers with mental health issues, yet consider how broader institutional forces shape and are shaped by workers' experiences. As outlined earlier, the overall objective of this study is to characterize the experiences of workers with mental health issues within a large mental health and addictions teaching hospital, and to account for how their experiences are shaped by the social context of work.

1.7 Terminology

The terminology used to speak about participants in this study was the product of some discussion and debate over the course of the project. As outlined above, the primary focus was on workers with mental health issues who worked in a mental healthcare setting. The reasoning behind the use of terms "mental health issues" and "workers" will be provided in order to clarify how and why these terms were adopted.
First, the term "mental health issues", as experienced by workers, was the central focus of this study. "Mental health issues", as defined in a study on the Human Face of Mental Health and Mental Illness in Canada, refers to; "alterations in thinking, mood or behavior or some combination thereof, that are associated with significant distress and impaired functioning" (Government of Canada, 2006, p.2). In my study, the term "mental health issues" was chosen instead of "mental illness" or "mental health problems" based on feedback from workers in the organization who felt that the terminology was less stigmatizing and more inclusive. It should be noted that the term "mental health issues" in this study is conceptualized broadly to include addictions issues. Addictions are sometimes discussed separately from mental health issues in the workplace mental health literature (Attridge, 2008; Attridge & Wallace, 2009) however, they often co-occur and will therefore be considered together. Rather than setting strict parameters for what constitutes a mental health issue (e.g. diagnostic categories of mental illness), the study adopted, as a starting point, the participants' self-definition, and treated their understanding of mental health issues as an object of analysis. No restrictions were set on the timing of experience; experience with mental health issues could be in the present and/or in the past.

The second key concept used to speak about study participants is that of "workers". Since this study was not commissioned by the employer, it was felt that use of the term "worker" rather than "employee" would position the study and the investigator in more neutral territory. Furthermore, the term worker implies a generic role rather than a specific job title. Workers in this study included any individuals willing to participate who were employed part-time or full-time by the organization, including clinical and non-clinical roles, and who had themselves experienced mental health issues at work during some point in their lives. Workers were distinguished from "workplace stakeholders"; other individuals in the workplace (e.g. colleagues, managers) who interacted with them.

1.8 Overview of Thesis

Now that I have provided a general introduction to the topic area, the next chapter will position the study within the theoretical and research literature in the field of mental health and work. Chapter three outlines the theoretical orientation of the study and the research methodology. Chapters four through six focus on the study findings; building from a description of the experiences of workers, to an account of what shaped the experiences, followed by an analysis of consequences. Chapter seven is a reflection on the study findings and an explanation
of the key forces which seemed to shape how issues unfolded within the workplace. The final chapter will discuss implications of the study for research and practice, and outline directions for future research.
CHAPTER 2 - Locating the Study in the Theoretical and Research Literature

The theoretical orientation adopted in this study is informed by an institutional ethnography (IE) method of inquiry. This approach is rooted in the day-to-day experiences of individuals, but explores how broad social forces coordinate activities across and beyond local sites of everyday experience (Smith, 1990). Within IE, everyday experience serves as the starting point for research (Smith, 2005). In this project, it is the experience of workers with mental health issues that constitutes the point of entry for the research. I will therefore locate the study in the broader literature by initially considering what is known about the experiences of workers with mental health issues. This will involve reviewing research regarding their experience of stigma and discrimination, managing information about the illness, seeking help, accessing workplace supports and negotiating return to work. The second layer of exploration within IE involves consideration of the social relations of work. Social relations, or "ruling relations" refers to socially organized activities that include expectations or rules for action and interaction (Smith, 2005; Smith, Mykhalovskiy and Weatherbee, 2006). Although the focus of this study is on the social context of work, the focus of research in workplace mental health is often more narrow, with only superficial references to the social relations of work. In order to place this study in context of the literature, I will initially critique several theoretical approaches that are commonly adopted. I will then review studies that are compatible with, and inform the social theory focus of this study. To conclude, I will reflect on gaps and contradictions in the current theoretical and research literature on workplace mental health, and how this study is positioned within this body of research.

2.1 Experiences of workers with mental health issues

The standpoint adopted in this study is of individuals who are employed, yet have some type of mental health or addictions issue. There are relatively few studies, however, which have adopted this perspective. As outlined in the introduction, much of the research in workplace health focuses on workers with physical health issues (Archambault, Cote & Gingras, 2004). When there are studies of individuals with mental health issues, the focus is typically on their difficulties in finding work, and on developing guidelines for supported employment (Marwaha & Johnson, 2005). D'Amato and Zijlstra (2010) argue that workers with mental health issues are
under-represented in workplace health research. There is however, some emerging research which does inform our understanding of workers' experiences. Studies range from population based surveys to focus groups and individual reports from workers themselves. The research seems to cluster into four main topic areas; stigma and discrimination, managing information about the illness, accessing supports for mental health issues, and return to work.

2.1.1 Stigma and discrimination.

One of the recurring themes regarding the experiences of workers with mental health issues is one of stigma and discrimination. The stigma associated with mental illness has a long history, yet despite advances in awareness and management of symptoms, the stigma, and the prejudice and discrimination which accompany it, continue to be a reality today (Martin & Johnston, 2007). Lyons et al (2009) report that that stigma and discrimination remain as strong, damaging and enduring as they were a decade ago. The effects of stigma are profound and Schulze and Angermeyer (2003) assert that it can be more devastating, life limiting, and long-lasting than the mental illness itself.

Link and Phelan (2001) describe stigma as a process of labeling, stereotyping, separating "us" versus "them", and then conferring status loss and discrimination. There are many persistent stereotypes associated with mental health issues, including questions about unpredictability and propensity for violence (Pescosolido, Martin, Lang & Olafsdottir, 2008). According to a 2008 Ipsos Reid poll of over 1000 Canadians, almost half (46%) of respondents felt that the term "mental illness" is used as an excuse for bad behavior (Canadian Medical Association, 2008). Another 27% reported that they would be fearful around someone with a mental illness. Attitudes toward individuals with addictions issues are quite negative as well, with less than half of Canadians viewing alcohol and drug addiction as an illness, and only one in five reporting that they would socialize with someone who has an addiction.

Assumptions commonly associated with workers with mental health issues are similar to the general stereotypes, but include beliefs about competence as a worker. Krupa et al (2009) explain that one of the initial assumptions is that individuals will not be able to meet the demands of work. There may also be fears about instability or unpredictability of the worker. In addition, psychological causes for sick time are often seen as less credible than observable, physical ones (Stuart, 2004). A common assumption is that performance differences are
attributed to poor behavior rather than a health issue (Stuart, 2004). The overall image of instability, incompetence and lack of credibility is one that is not easy to change. Once a diagnosis of mental illness is known, the individual's social identity at work may be recreated in the context of the disorder (Lyons, Hopley & Horrocks, 2009).

Stigma is often linked to discrimination in the workplace (Stuart, 2004). According to the 2002 Canadian Mental Health and Well-being survey, over half of the respondents with mental health issues reported facing discrimination, with the workplace cited as one of the most frequent sites of discrimination (Government of Canada, 2006). Similar findings emerged from a survey of mental health consumers in the United States. According to Wahl (1999), 80% of respondents indicated that they heard people in the workplace making hurtful or offensive comments about mental illness. Another 70% noted that they had at least sometimes been treated as less competent by others once their illness was known, 60% reported being shunned or avoided, and 28% felt unsupported by supervisors and co-workers once their mental health issues were known. There are reports that knowledge of mental health issues can also undermine career advancement (Stuart, 2004). Simmie and Nunes (2001) reported that, following an illness related absence, individuals may return to work to find that they are in positions of reduced responsibility with little or no support from former colleagues. In fact, one Canadian worker reports that "workplaces are like an army that shoots its wounded" (CMHA, 2001). Discrimination based on psychiatric disabilities is one of the leading causes for complaints with the Equal Employment Opportunity Commission (EEOC) in the United States (Pardeck, 1999).

In addition to discrimination that may be experienced from others, self-stigma can be particularly harmful. Stuart (2004) describes the spiral of negative consequences that stigma can have for workers with mental health issues. She explains that negative stereotypes regarding mental illness become internalized and mental health issues are viewed as a personal failure. This in turn results in a further loss of self esteem and self confidence and may lead to social isolation. The stigma of mental illness can be deeply discrediting and isolating, causing feelings of guilt, shame, and inferiority. The stigma associated with mental health issues can make it difficult for people to acknowledge their difficulties, let alone seek help.

Many of the studies regarding stigma and discrimination provide an overview of the general issues that can emerge. Joyce, Hazelton and McMillan (2007) conducted one of the few
studies exploring how the experience of individuals with mental health issues can unfold within the context of work. It is particularly relevant to this study, because it was conducted in a healthcare facility. They conducted an ethnographic study of 29 nurses who had experienced mental health issues. The study findings highlighted how impairments in work performance (e.g., cognitive or social difficulties) were not well tolerated or understood. The authors discussed discriminatory action and ill-treatment that the nurses experienced (e.g. being the target of gossip, being denigrated in front of others), and the moral judgment that seemed to be imposed by colleagues. Central to most coworkers' attitudes was a perception that the individual was to blame for causing his/her own mental health issues. Although a few nurses reported supportive relationships, they were in the minority. The authors concluded that nurses without a mental illness can "emotionally shackle their colleagues" in order to "bring them back into line" (p.379).

These findings were supported by Ross and Goldner's (2009) review of the literature regarding stigma within the nursing profession. They cited a couple of studies highlighting the "horizontal violence" that nurses may experience from supervisors and colleagues, ranging from being ostracized or even fired from their jobs. In fact, the authors felt that the lack of acknowledgement in the literature regarding the experience of nurses with mental health issues represented stigma in the form of "turning a blind eye" to the issues (p.564).

Overall, these studies reflect a consistent message regarding the significance of stigma and discrimination in the workplace; mental health issues among workers are not welcome. Although the research tells us something about the prevalence and nature of the stigmatized beliefs, we know very little about how it plays out in the workplace. Stuart (2004), for example, argued that the first priority for the Canadian research agenda should be to gain a better understanding of the extent and nature of mental health related stigma in Canadian workplaces, including consideration of both the forces that shape stigma and its consequences. I believe that the study by Joyce, Hazelton and McMillan (2007) is a step towards understanding the dynamics of stigma within the social context of work. It does not, however, go far enough in explaining the nature of the stigma and discrimination, or the forces that may be shaping behavior.

2.1.2 Managing information and disclosure.

Considering the potential discrimination associated with the label of mental illness, it is perhaps not surprising that there has been a focus in the literature on workers' approaches to
managing information about their mental health issues. In a study comparing patients who were hospitalized for medical versus psychiatric reasons, over half of the respondents with a past psychiatric hospitalization reported that they would hide this from their colleagues (McCarthy, Prettyman & Friedman, 1995). In contrast, none of the respondents with a medical hospitalization indicated that they would hide this from their peers. According to an Ipsos Reid (2007) poll on mental health in Canadian workplaces, two-thirds of the workers with depression reported that they did not share this information with anyone. Schulze and Angermeyer (2003) assert that many individuals choose not to disclose their mental health issues because of actual or perceived stigma, and may explain absences from work with fictional diagnoses. Stuart (2004) states that individuals often go to great lengths to ensure others do not find out about their mental health issues, avoiding friendships and avoiding treatment. Many workers report that they are concerned about being treated differently once their mental health issues become known; they are concerned that others may avoid, patronize, or harass them, or misinterpret every change in behavior as a result of mental illness (MacDonald-Wilson, 2005). The anxiety and fear that others may find out may in turn take a significant psychological toll on a person. A number of workers who did disclose to others in the workplace report that they regretted their decision at a later date (Goldberg, Killeen & O'Day, 2005).

Studies describing the tendency of workers to hide information from others and the risks associated with disclosure are countered by studies which describe the potential value of disclosure. Personal or psychological benefits of disclosure have been identified, including relief from the stress and energy required to conceal information (MacDonald-Wilson, 2005). Ralph (2002) describes feelings of peace and freedom, as well as potential acceptance and understanding that can occur when others in the workplace know about the issues. In addition to personal benefits, others describe the benefits of disclosure for others; including serving as a role model, increasing public awareness, combating stigma, and educating others about mental health issues (MacDonald-Wilson, 2005; Hyman, 2008).

A study by Ellison, Russinova, MacDonald-Wilson and Lyass (2003) regarding patterns of disclosure found that professionals or managers were more likely to disclose. Goldberg, Killeen and O'Day (2005) also emphasize the importance of considering the workers' stage in the process of recovery and position within the organization, since this will shape the potential
impact of disclosure. All of these studies point to the challenges for workers in managing information and some of the conflicting forces that may shape their experience with disclosure.

2.1.3 Access to support.

Another body of literature that informs our understanding of the experiences of workers, concerns research regarding response to mental health issues at work and how workers access (or do not access) supports. Support may be in the form of treatment for their symptoms or setting up workplace accommodations to enable them to continue to work.

When individuals experience mental health or addictions issues, there are a number of studies which suggest that they are not likely to access medical treatment. According to the 2002 Canadian Community Health Survey on Mental Health and Well-being, only 32% of those with mental health or substance use conditions spoke to a health professional in the previous year (Statistics Canada, 2003). Similar findings were found in another national study of Canadians; only 25-30% of respondents with a mental health condition got appropriate counseling-based treatment (Sareen et al., 2005). If workers experience active symptoms of mental illness or addictions issues, there is often a long lag time before they seek help, if they choose to seek help at all (Kessler et al., 1999). As reported earlier, workers with mental health issues often continue to work despite symptoms rather than take sick leave (Dewa & Lin, 2000). Bender and Kennedy (2004) assert that psychiatric disorders affecting workers are often under-identified and under-treated.

When individuals continue to work despite symptoms, what kinds of supports do they access? In Canada, if a worker has a health-related disability, he/she is legally entitled to supports or accommodations to enable them to work (Hatfield, 2006). "Accommodations" are defined as changes that an employer makes to a job, the work site or the environment that enable a person with a disability to participate in the job (MacDonald-Wilson, 1997). There are a few studies which inform our understanding of the nature of accommodations accessed by workers with mental health issues. MacDonald-Wilson, Rogers and Massaro (2003) conducted a multi-site, prospective longitudinal study exploring accommodations for individuals with mental health issues who were hired in supported employment programs. They found that the most common functional deficits requiring accommodation included social and cognitive limitations, including difficulty interacting with others and learning the job. In addition, there were reports of
difficulty maintaining work stamina/pace and managing stress. The most frequent accommodations reported included job coaching (23%), flexible scheduling (21%), and changes in supervision (11.2%) and training (10.5%). They argued that the cost of accommodation to employers was quite low, with very few direct expenses. Although this study revealed detailed information about the nature and type of accommodation, it is important to note that it was conducted with workers who had a serious mental illness and were employed in primarily entry-level retail and service positions provided by supported employment programs. The experience of workers in competitive employment situations has not been explored in depth. A couple of studies mentioned modifications to working hours and restructuring of job duties for workers with mental health issues (Caveen, Dewa & Goering, 2006; Kirsh, 2000; Nieuwenhuijsen, Verbeek, deBoer, Blonk & van Dijk, 2004), whereas others have highlighted the lack of accommodation with respect to job demands or working hours upon return to work (Kirsh, 2000; Saint-Arnaud, Saint-Jean & Damasse, 2006). Additional research is needed to understand the social forces that shape the process of accommodation (Gates, 2000).

Accommodation has been described, not only as an outcome, but also as a social process that unfolds when a worker has a disability (Gates, 2000). Identifying and implementing supports is supposed to be negotiated process, based on communication between the employee and employer (Tetrick & Toney, 2002). A number of authors have reported that workers with mental health issues are reluctant to ask for accommodations at work (Haslam, Atkinson, Brown & Haslam, 2005; Williams, Sabata & Zolna, 2006). It has been noted that employer commitment to provide accommodations may vary from one workplace to the next, and also from one supervisor to the next (Caveen, Dewa & Goering, 2006). Studies examining accommodation for mental health issues seem to be mixed. According to a survey of Canadian workers, approximately seven out of ten of respondents reported that their employer was either "very" (26%) or "somewhat" (47%) accommodating of employees who require sick leave as a result of anxiety or depression (Ipsos Reid, 2007). One study conducted with Dutch workers reported that criteria for accommodation in return to work were met in 62% of the cases (Nieuwenhuijsen et al., 2004). Another study of workers with disabilities, however, found that when mental limitations were present, the most common response was no accommodation at all (Williams, Sabata & Zolna, 2006). It is difficult to interpret these figures since there was very
little information about how the term "accommodation" was interpreted; also, there was very little information about the process of communication.

Overall, there seems to be evidence that workers with mental health issues tend not to access support in the form of medical treatment or workplace accommodation. We know very little, however, about how accommodation is understood and how the interaction takes place.

2.1.4 Return-to-work following a mental health related sick leave.

The other area of emerging research concerns the experiences of workers with respect to sick leave and return to work after a mental health related sick leave. As outlined earlier, many individuals continue to work when they are ill, and there is often a long lag time before they take sick leave (Aronsson, Gustafsson & Dallner, 2000; Kessler at al., 1999). When they are on sick leave, they are often absent for a longer period of time, and return-to-work is slower in comparison to workers with physical conditions (Conti & Burton, 1994; Dewa et al., 2004). Although population trends have been reported, there are very few studies which explore the actual experiences of workers. In their systematic review of psychological return-to-work interventions, Corbiere and Shen (2006) found only two studies that focused specifically on employees with mental health issues; the majority focused on individuals with physical injuries that may have had associated mental health issues. The main findings from their review highlighted the importance of communication between stakeholders in the return to work process.

A qualitative study, conducted by Saint-Arnaud, Saint-Jean and Damasse (2006), is one of the few that sheds light on the experience of mental health related sick leave and return to work. They conducted interviews with 37 Quebec public servants who had a period of work absence due to a mental health issue, and explored the ways in which the psychosocial work environment shaped the process of work withdrawal and reintegration. They examined the events leading up to the work interruption, factors related to stopping work and the recuperation process, and conditions of returning to work or prolonging the absence. The study findings highlighted the ways in which both management practices and support from colleagues and supervisors affected workers' experiences. In their descriptions of events preceding the sickness absence, the authors highlighted the ways in which the psychosocial work environment contributed to the deterioration of the employee's health, and how coworkers and supervisors
responded differently depending upon the perceived reasons for the sick leave. If the leave was due to a death in the family, for example, there was much more empathy and support than if the leave was seen as the result of not being able to manage personal problems. They reported that many employees resisted taking sick leave due to a mental health problem due to fears that they would be seen as weak and unable to cope with the pressure. When off on sick leave, they were often anxious about meeting their employer's expectations regarding justification of the legitimacy of their leave. Many were apprehensive about returning to work, and used the maximum time of six months for a gradual return. Upon their return, they felt pressure to meet performance expectations which seemed to contradict the goal of a gradual return, and were concerned about returning to the same conditions that precipitated their original absence. The authors concluded that the social dimensions of work had a significant influence on the process of work reintegration.

2.1.5 Summary of research regarding workers' experiences.

In summary, the literature reveals that stigma and discrimination can be a significant issue for workers with mental health issues and many workers attempt to hide their issues from colleagues at work. If workers do disclose to others at work, there can be benefits as well as risks in terms of their career as well as personal and social identity. There is some evidence that workers do not seek treatment and continue to work despite illness. In addition, information about workplace accommodations highlights different kinds of supports that may or may not be put in place, but does not provide a definitive picture regarding the accommodation process. Literature on sick leave and return to work highlighted some of the challenges associated with communication and reintegration into the social environment. Overall, much of what we know is based on survey data, which provides a fairly superficial picture of overall trends. The few qualitative studies revealed more depth of understanding regarding the dynamics and diversity of experience, however, explanations for the experiences are still lacking. The literature on experience that I have cited thus far, provides descriptions of the responses of workers, however it does not account for these responses. In an institutional ethnography method of inquiry, experience is only the entry point; it is the explanation of the experience which is the key to understanding (Smith, 2005). The next part of the literature review will therefore analyze the theoretical perspectives regarding the experiences of workers with mental health issues.
2.2 Theoretical Perspectives on Workers' Experiences

There are a number of theoretical lenses adopted in the literature that account for workers' experiences, each with a different set of assumptions and foci for exploration. I have classified these theoretical lenses into four heuristic categories; a medical perspective, work demands perspective, personal choice perspective, and a social context perspective. It should be noted that the purpose of this categorization is to compare and contrast different perspectives rather than classify studies into specific categories. The first three perspectives represent traditional methods for explaining the responses of workers, therefore I will briefly review each in terms of the nature of the perspective outlined in the literature and how it enhances, yet limits our understanding of workers' experiences. I will then discuss the 'social context' perspective in more depth since this is the lens that I will be adopting in this study.

2.2.1 Medical perspective.

The first type of theoretical positioning is driven by a focus on the illness itself and how it shapes experience. Medical classification of symptoms, for example, forms the basis of many studies exploring the prevalence of issues and response of workers (Dewa & Lin, 2000; Lagerveld et al., 2010). Studies are often diagnosis specific, with many focusing specifically on workers with depression (Conti & Burton, 1994; Seelig & Katon, 2008). The nature and severity of illness has also been attributed to the actions of workers with respect to disclosure, seeking help, taking sick leave and return to work. Visibility of symptoms and the severity of illness, for example, have been attributed to an increased likelihood of disclosure (Ellison et al., 2003; MacDonald-Wilson, 2005). Furthermore, obvious signs of mental illness and co-morbidity of illnesses increased the likelihood of seeking help (Bland, Newman & Orn, 1997; Willis, Hendershot & Fabian, 2005). Finally, the health status of workers and associated loss of functional capacity has been identified as the strongest and most direct determinant of productivity and sickness absence (Boles, Pelletier & Lynch, 2004; Hansson, Bostrom & Hrms-Ringdahl, 2006). It is not only the presence of mental health issues, but interpretation and perceptions of these issues that have been linked to the response of workers. The degree to which the worker accepted their mental illness was identified as a key predictor of information sharing (Ralph, 2002; Dalgin & Gilbride, 2003). Dewa and Lin (2000) hypothesized that symptoms may not be interpreted as "illness" since they are difficult to distinguish from typical
day-to-day functioning, and as a result the worker may not see the need to seek treatment (Dewa & Lin, 2000). All of these studies point to the ways in which the perceived nature and severity of the illness governs behavior.

The medical perspective reflected in the literature seems to be consistent in many ways with workplace structures and policies. If a worker takes "sick leave", for example, there are typically requirements for this to be substantiated by medical documentation (Dyck, 2002). Access to workplace accommodations, short-term or long-term disability insurance, and even return to work often requires documentation from a physician to support the worker's claim and eventual readiness to return to work (Dyck, 2002). An illness-focused perspective is central to this approach.

One of the limitations of this medical perspective is that it does not take into account the many non-medical forces which shape day-to-day experience. Emerging research emphasizes the importance of non-medical determinants of behavior (D'Amato & Zijlstra, 2010). There are numerous studies, for example, which highlight differences in response based on demographic characteristics of the worker, such as gender, age and income (Aronsson et al., 2000; Melchior et al., 2003; VandenHeuvel & Wooden, 1995). The workplace context also has also been identified as an important variable to consider in explaining the behaviors of workers with mental health issues. A number of authors have argued that sickness absence and return to work is not solely determined by a health condition, but by a combination of social, personal and working conditions (Lagerveld et al., 2010; Nieuwenhuijsen, Verbeek, de Boer, Blonk & van Dijk, 2004; Saint-Arnaud, Saint-Jean & Damasse, 2006).

2.1.2 Workplace demands perspective.

The second type of theoretical positioning in explaining the experiences of workers focuses on risk factors in the workplace. Instead of focusing on the illness, the focus is on how workplace demands or stressors shape the response of workers, particularly with respect to sickness presence or absence. A number of studies highlighting the links between the mental health of workers and workplace demands were reviewed in the introductory chapters of this paper. In addition to highlighting the risks for mental health issues, a number of the large scale, population based studies have established a correlation between working conditions and sickness absence. For example, factors such as increased job demands, decreased control over work, and
decreased social support have been identified as significant predictors of both high rates of sickness absence and increased duration of absenteeism (Head et al., 2006; Melchoir et al., 2003; Voss, Floderus & Diderichsen, 2004). An understanding of psychosocial risk factors in the workplace also forms the foundation of workplace prevention and health promotion strategies (Vezina, Bourbonnais, Brisson & Trudel, 2004). Tools have been developed to assess psychosocial risks in the workplace, as have primary and secondary prevention programs which are designed to address these risks (Dunnagan, Peterson & Haynes, 2001; Samra, Gilbert, Shain & Bilsker, 2009; Vezina et al, 2004).

Overall, this workplace demands perspective highlights the importance of considering the ways in which the experiences of workers are shaped by the context of the work itself. The research substantiates the ways in which stress and psychosocial demands can affect the responses of workers to mental health issues. Since these studies are typically conducted with large population-based samples, they provide information on general trends in the workplace and factors that may contribute to patterns of responses among workers.

One of the limitations of these studies is that they isolate predictor variables and may therefore ignore other important forces that may not be related to workplace demands. A number of studies, for example, have highlighted variables outside of work (e.g. family responsibilities, social support) that may affect a worker's response to illness (Aronsson et al., 2000; Melchior et al., 2003; Voss, Floderus & Diderichsen, 2004). Furthermore, outcomes (e.g. burnout or absenteeism) in these studies are typically viewed as static end points, rather than a process which evolves over time. One other limitation in the workplace demands perspective is that it tends to be deterministic, with little recognition of personal agency. The role of the worker in the process is not addressed in these studies therefore they do not shed light on how workers actively respond to or resist conditions within the working environment.

2.1.3 Personal choice perspective.

In contrast to the work demands perspective, the personal choice perspective focuses on the workers themselves. Instead of focusing on how their behavior is determined by forces beyond their control (e.g. symptoms or job demands), the focus is on how workers choose to respond to these forces. The worker is characterized as an active agent in making decisions about
whether to share information with others about their mental health issues, whether to continue working or take sick leave, or whether they should return to work.

Information sharing or disclosure, for example, is typically described in the literature as an individual decision making process, where a worker weighs the potential risks and benefits of sharing information (Ellison et al., 2003; Hyman, 2008; Schneider, 1998). Ralph (2002), for example, identified a number of potential risks or barriers to disclosure, as well as benefits that may emerge, concluding that the decision to "come out" is a personal one that depends upon where a person is at in their recovery, and the environment in which the individual lives and works. Ellison et al. (2003), who explored patterns of disclosure among professionals and managers with psychiatric conditions, explained that disclosure was a decision that was made when individuals felt that their job was secure, and that disclosure would not lead to negative consequences. MacDonald-Wilson (2005) describes disclosure as a detailed decision making process that requires consideration of a range of factors. She outlined a detailed process of preparing for disclosure which involves considering personal feelings, past experiences, relevant personal and social factors, need for accommodation, potential employer reactions, reasons for disclosure, risks and benefits, and the process of information sharing. She also described disclosure as a process that involves consideration of who, what, where, when and the why of information sharing.

Sickness absence or presence has also been characterized as the outcome of a personal decision making process or choice on the part of the worker (Pescosolido, 1998). Individuals are viewed as active agents, weighing the costs versus benefits of working despite illness (Johansson & Lundberg, 2004). Voss, Floderus and Diderichsen (2004), for example, assert that "sickness absence is to some extent a conscious choice of the employee, a coping strategy to handle reduced work ability caused by illness, adverse situations at work, or difficulties attributed to private life" (p.1135). Grinyer and Singleton (2000) view sickness presenteeism from a multi-dimensional risk perspective, with sickness absence as risk taking behavior. They explain that workers make the choice to work when ill in order to avoid the negative repercussions of taking sick leave. Decisions regarding sickness absence or presence go beyond simply an evaluation of the extent of ill health, and may include consideration of relationships with colleagues, the individual's financial situation, availability of resources and personal values.
regarding work and health. The worker is viewed as actively dealing with conflicting demands at times regarding how they should handle their symptoms. Taking sick leave, or conversely, a decision to attend work despite illness may be viewed as a coping strategy rather than the consequence of external factors. Ultimately, the individual makes a choice between a risk to his/her personal health and professional risk (e.g. to social relationships at work). Aronsson & Gustafsson (2005), in their epidemiological study of respondents to a Swedish labour market survey, take a similar approach. They developed a conceptual model for exploring sickness presenteeism. At the heart of this model was the worker making a decision whether or not to go to work when experiencing ill-health, disease or capacity loss, based on consideration of personally-related and work-related demands for presence.

This personal choice perspective has also been extended to models explaining return to work. D'Amato and Zijlstra (2010), for example, explain that work resumption is "the observable outcome of a cognitive process in which a person tries to assess whether there is a match between personal strengths and possibilities and environmental strengths and demands, facilitated by policies and procedures for work resumption" (p.77). They described a process of psychological appraisal of personal and organizational factors as critical to return to work. Regardless of whether the condition was related to physical or mental health complaints, they felt that it was important to conceptualize return to work as a decision influenced by "push and pull" factors that may or may not help workers cross the threshold for work resumption.

In general, the personal choice perspective seems to be quite popular in explaining many behaviors, from decisions about disclosure to decisions about sick leave to return to work. This perspective incorporates consideration of both illness and workplace demands, although it positions the individual as an active agent in responding to these issues. Critics of this perspective argue, however, that the agency of the individual is limited by the socio-political context within which the behaviors occur. Dew, Keefe and Small (2005), for example, argue that choice cannot be taken at face value; it is embedded within a system of constraints. Adopting a critical realist position, they emphasize the structurally conditioned nature of actions, explaining that the tactics employed by workers are both enabled and constrained by circumstances. To take choice at face value is to miss an understanding of structure as a process of constraint. In the study by Ellison et al. (2003), for example, over half of the participants
reported that they disclosed because they felt compelled to do so; they were either hospitalized or had symptoms that they felt they needed to explain. Bellaby (1990) emphasizes that individual choices are apparent not real. For some, choices are only made within constraints of the socio-political context. Furthermore, the personal choice model ignores social actions that are based on cultural routines or habits rather than a cost-benefit calculation (Pescosolido, 1998). The emphasis is on a discrete outcome of a decision making process. In other words, it does not account for the ways in which sequences of events are patterned, contingent, and emergent (Pescosolido, 1998).

2.3 Social Perspective on Workers' Experiences

The medical, work demands and personal choice perspectives that have been presented thus far are all limited in terms of how they add to our understanding of workers' experiences. In particular, I propose that they do not adequately consider the social context of work. As outlined earlier, workers' experiences with stigma and discrimination, seeking help, and the process of negotiating accommodation and return to work all reflect social processes. These experiences do not happen to individuals in isolation, but are embedded within the social relations of work. As emphasized by critics of the rational choice model, I assert that it is critical to examine how actions are enabled and constrained by the circumstances within which they occur.

Consequently, I will focus the next section of the review on studies which inform our understanding of the social context of work, including day-to-day social interactions, and how these interactions are embedded within broader social structures and discourses both within and outside the organization. In other words, literature regarding the social conditions of work will be examined from a micro level (day-to-day social interactions), meso level (organizational structures), and macro level (discourses both within and outside of the workplace). I will draw from relevant studies within the broader field of workplace health as well as research specifically addressing workers with mental health issues.

2.3.1 Interactional conditions of work.

Day-to-day interactions with co-workers and supervisors have been described as highly influential in producing and constituting workers' response to illness (Eakin & MacEachen, 1998). From a symbolic interaction perspective, social relations constitute the experience of health and illness; interpretation of how others might perceive the illness or disability will affect
the action that the person will take (Bellaby, 1990). The focus is on meaning in human action, and how meaning emerges through interaction with others (Blumer, 1969; Wallace & Wolf, 1995). Illness is therefore embedded within a process of interpretation and negotiation (Blumer, 1969). There may, for example, be questions about legitimacy and competency from supervisors and colleagues, as well as variable levels of support.

Interactions between workers and their colleagues may be shaped by perceptions of the legitimacy of the workers' illness or injury. Tarasuk and Eakin (1995), for example, in their study of individuals with a work-related back injury highlighted the struggle for legitimacy that the workers experienced and the challenges that unfolded in interactions with both their co-workers and supervisors. Since the pain that the workers experienced was not visible, they often had to defend its validity to others, causing conflict and strain on their relationships at work. Dodier (1985) reported similar findings in his qualitative study of the "sickness careers" of 25 white-collar employees in France. He found that there was considerable negotiation among social actors in the workplace regarding the perceived legitimacy of the illness and illness-related absences, leading to conflicts and negative attitudes at times toward the ill employee. Moral judgments about sickness and health were held by co-workers and led to labeling of employees. Some colleagues made disparaging comments directly to the worker which further strained social relations. Employees would try to manage their symptoms in order to control the perceptions and subsequent moral evaluations of their co-workers.

For workers with mental health or addictions issues, similar themes are evident in the literature. In fact, questions about legitimacy and competency are central to the stigma associated with the psychiatric label (Krupa et al., 2009; Stuart, 2004). Barnes et al. (2008), in their study of beliefs about workers with common mental health issues, described a "strain of morality" in discussions about taking time off work, and the negotiations that ensued about what was a legitimate work absence. Saint-Arnaud, Saint-Jean and Damasse (2006) described employer practices of asking for "expert opinions" for workers on mental health related sick leave and how this was perceived by workers as a questioning of the genuineness of their illness and of their integrity. They also proposed that the way in which the illness was interpreted by colleagues and supervisors shaped the support and welcome offered when the employee returned from sick leave.
Support from colleagues and supervisors has been repeatedly identified as a key social force shaping the experiences and actions of workers with mental health issues. Even studies which consider disclosure and sickness absence to be the outcome of a rational choice, point towards relationships with colleagues and supervisors as a key factor in the decision making process (Crout, Chang & Cioffi, 2005; Ellison et al., 2003; McKevitt et al., 1997). Ellison et al. (2003), for example, explained that feeling appreciated by one's supervisor and respected by colleagues increased the likelihood of disclosure. Conversely, the potential for stigma and discrimination decreased the likelihood of not only sharing information, but of seeking help or accessing workplace accommodations. Perceived support from others at work has also been identified as a key factor in return to work (Lysaght & Larmour-Trode, 2008). Support in the workplace may take many forms and may come from a range of sources. Lysaght and Larmour-Trode (2008) conducted a study exploring the role of social support in the return to work process. The study was not specific to workers with mental health issues, but led to development of a model of social support that is relevant to workers with a variety of disabilities. They described social support as a multi-dimensional concept, including consideration of emotional support (e.g. empathy, trust and a sense of caring), informational support (e.g. guidance with paperwork and procedures), instrumental support (e.g. assistance with work tasks), and appraisal support (e.g. feedback from supervisor or co-workers). Sources of support included supervisor, co-workers occupational health coordinator, and family and friends. They recommended additional research to explore interactions between different dimensions of support.

Overall, the literature related to the interactional conditions of work points to the impact of perceived support on sharing information, accessing accommodations and returning to work. There are many potential forms that this support may take, and meanings that this can have for workers. Focusing on relationships and interpersonal interactions is one important dimension of the social perspective, yet does not consider the broader forces and structures which may shape these interactions.

2.3.2 Structural conditions of work.

A second layer of understanding in the social context perspective involves consideration of organizational structures and their impact on workers' experiences. Organizational structures
may include a range of policies, procedures and practices that shape responses to mental health issues at work.

In terms of policies and procedures that specifically address workers with mental health issues, there is some evidence to suggest that they are lacking in many organizations. A survey conducted by Watson-Wyatt (2003) of employers across Canada found that mental health claims were a top concern among employers, yet few had plans in place to address this concern. Less than one third had return to work processes specific to mental health claims, and only 5% reported that they planned to address stigma surrounding mental health issues. A survey of 134 Ontario businesses reported similar results (Mercer Human Resources Consulting, 2004). Less than one third of survey respondents had taken action to deal with the mental health issues in their organization and most did not plan to do so in the near future. Less than 10% of respondents had managers who were trained to identify and address mental health issues. Stuart (2006) echoed these concerns, explaining that few employers have corporate plans in place to address mental health issues, and few managers have sufficient knowledge or skill to recognize and effectively manage mental illness in the workplace.

One area of legislation that could govern action regarding workers with health issues is that of the duty to accommodate. By law in Canada and the United States, employers are required to provide reasonable accommodations to employees with disabilities who need them when their disabilities interfere with them performing some aspects of their job (MacDonald-Wilson, Rogers & Massaro, 2003; Ontario Human Rights Commission, 2000). Accommodation can be made on the basis of any medical issue that affects physical or mental functioning. The right to accommodation cannot be invoked, however, unless the worker discloses or acknowledges that they have some type of disability (Mancuso, 1990). Access to workplace accommodation is therefore an impetus for some workers to disclose (Goldberg et al., 2005).

In addition to official policies, less formal procedures for accessing sick leave may also shape how workers respond to illness. Bloor (2005), for example, examined illness behavior on a cargo ship, explaining that crew members often worked despite illness since instances of ill health would be logged and they felt that this might inhibit future employability. Similar themes of ill health concealment were noted in Virtanen's (1994) cohort study of blue collar workers in a metal factory in Finland. In the period following a mass layoff at the factory, there was a
significant decline in the rates and duration of absenteeism and use of employer funded health services. The author problematized this apparent "epidemic of good health", arguing that employees continued to work despite illness out of fear that sick leave might jeopardize their job security in the factory. By avoiding contact with the use of employer-funded services, ill health at work could not be tracked. Procedures that made the issues visible coupled with the risks of increased visibility therefore seemed to lead to concealment of the issues by workers.

Another perspective on the structural conditions of work was outlined by Johansson and Lundberg (2004) in their proposed model of presenteeism. They described "attendance requirements" that tend to promote sickness presence over absence. If there is no one to replace the worker and complete the work when they are off sick, then sickness presence is more likely to occur (Aronsson, Gustafsson & Dallner, 2000). These findings are supported in several studies of physicians. McKevitt, Morgan, Dundas, and Holland (1997), for example, in their study of physicians in the United Kingdom National Health service found that physicians were reluctant to take sick leave because of their difficulty in finding someone to cover their caseload if they were away and their reluctance to burden others with extra work. Sick leave was particularly difficult for family doctors in sole charge or small practices and for those who did not have adequate insurance for locum coverage. Pressures to address long waiting lists for service and economic losses associated with sickness absence served as additional pressures to continue to work despite illness. Similar findings were reported in a study of physicians in Norway (Rosvold & Bjertness, 2001). These studies highlight the role of organizational supports (or lack of supports) in shaping patterns of sickness presence.

Organizational supports can also influence the process of sick leave and return to work. Saint-Arnaud, Saint-Jean and Damasse (2006) argued that the success of return to work relates "not only to employees' health, but also to management practices that influence the work reintegration process" (p. 303). Research with other populations of injured workers has examined the role of disability management in return-to-work outcomes, highlighting the key role of company policies and practices with respect to disability management (Habeck et al., 1998; MacEachen, Clarke, Franche & Irvin, 2006). One of the challenges noted in the occupational mental health system is that it is fragmented, with many barriers caused by lack of education, ill-defined roles, inadequate resources, delayed treatment, and unsuitable treatment (Bender & Kennedy, 2004). There are many potential stakeholders including managers,
occupational health providers, employee assistance programs, human resource personnel, union representatives, insurance providers, and healthcare providers (Bender & Kennedy, 2004). The process of communication between stakeholders has been identified as an important element in the return to work process, yet communication between stakeholders has also been identified as an ongoing challenge in the workplace (MacEachen, Clarke, Franche & Irvin, 2006). Caveen, Dewa and Goering (2006) explored the process of return to work for employees with depression, with a particular focus on organizational factors. Findings from their multiple case study approach in three financial institutions pointed to the importance of leadership in disability prevention and management practices, and support from managers in work reintegration. Collaboration and coordination between all stakeholders in the disability management process was identified as a key element in the process. They also recommended further research to better understand the relationship between the many personal and organizational variables which influence depression-related disability and the importance of exploring the workers' point of view.

All of the studies on the structural conditions of work point to the importance of policies, procedures and practices in shaping the experiences of workers, whether this involves managing information, accessing supports, taking sick leave or returning to work. The literature highlights gaps in workplace policies with respect to workers with mental health issues, procedures which do not recognize the challenges associated with disclosure and lack of coordinated supports for workers who may be struggling with mental health issues. Fragmented disability management services seem to add to the challenges. Consideration of structural forces highlights an important aspect of the social context that shapes individual experience, yet the research typically isolates only one or two variables rather than considering the interaction between micro, meso and macro level forces. Workplace structures, for example, may reflect broader discourses which shape the policies and procedures within an organization.

**2.3.3 Discursive conditions of work.**

The third, macro-level of analysis of social context involves examination of discourses that govern the experience of workers with mental health issues. Discourse, within an IE perspective refers to trans-local relations that coordinate the practices of individuals in particular local times and places (Smith, 2005). Discourse is defined a "field of relations that includes not
only texts and their inter-textual conversation, but the activities of people in actual sites who produce them and use them and take up the conceptual frames they circulate" (DeVault & McCoy, 2004, p.772). When considering mental health issues in the workplace, discourses related to mental health, productivity, and sick leave may all have a potential impact on workers. There are, however, very few studies in the literature which specifically examine the discursive conditions of work. Studies of generalized beliefs about mental health issues, workplace culture, and sickness absence provide some clues therefore I will extrapolate how related research informs this study.

First, discourses regarding mental health issues can be viewed as constituting a particular set of stigmatized social relations. As outlined earlier, many negative attributes are ascribed to workers with a known mental illness (Krupa et al., 2009; Pescosolido et al., 2008). The negative attributes or stigma associated with mental health issues are typically explored in terms of how they shape the interactional conditions of work. Less is known, however, about the nature of the discourse itself. One contribution to our understanding of the discourse is found in Krupa et al's (2009) constructivist grounded theory study exploring the stigma of mental illness in employment. Based on their document analysis and interviews with key informants, five key assumptions were identified as central to the stigma discourse: 1) people with mental illness lack the competence required to meet the considerable task requirements and social demands of work; 2) people with mental illness are dangerous or unpredictable in the workplace; 3) mental illness is not a legitimate illness; 4) working is not healthy for people with mental illness; and 5) providing employment for people with mental illness is an act of charity. The study also concluded that there was variation in the intensity and salience of the assumptions, depending upon both the perspective of the stakeholder and the employment situation. As outlined earlier, it has been hypothesized that the discourse regarding mental health issues may constrain workers from sharing information about their experiences and from seeking help when they are struggling (Stuart, 2004; MacDonald-Wilson, 2005). Several authors have argued that more research is needed in order to understand the complex nature and context of workplace stigma as it relates to the range of mental health issues in the workplace (Krupa et al., 2009; Stuart, 2004; Pescosolido, Martin, Lang & Olafsdottir, 2008).
Discourses framing workers as incompetent and a liability to the organization are embedded within broader discourses regarding productivity and performance. Ideas about productivity have been identified as a significant factor shaping patterns of sickness and presence among healthcare workers. Research conducted with registered nurses in Australia, for example, described an ideology among professionals to subordinate personal needs in the caring process, and to always be there for others when needed (Crout, Chang & Cioffi, 2004). The authors concluded that part of their identity as a nurse was linked to a sense of loyalty to their clients and to their team. It was therefore difficult for them to acknowledge the need to take time off and care for themselves when ill. Studies with physicians and with other healthcare providers have come to similar conclusions; their perceived role as a caregiver makes it difficult to attend to personal health needs (Harris, Cumming & Campbell, 2006; McKevitt et al., 1997; Rosvokl & Bjertness, 2001). Also, workers in healthcare may internalize the "duty to work"; a belief that may be reinforced by the professional and/or workplace context within which they are embedded (Dew, Keefe & Small, 2003). The "duty to work" has also been described as a culture of presenteeism that may be communicated within the workplace (Cullen & McLaughlin, 2006). In their study of managers in the hotel industry, Cullen and McLaughlin (2006) discussed the social relations of work in which managers were compelled to work long hours in order to meet standards for success.

Overall, there have been few studies directly examining the discursive conditions of work, although these studies have reinforced the importance of considering how workers are embedded within a workplace context that is shaped by broader discourses regarding health, illness and productivity. These discourses may shape not only the practices of workers with mental health issues, but others in the workplace as well, and how they interact together.

2.3.4 Reflections on the social perspective.

Some of the studies cited above were not specific to workers with mental health issues, although they do inform our understanding of how workers, particularly with less visible illnesses might be perceived. One of the strengths of this perspective is that it recognizes the experiences of workers as embedded within the social relations of work. It recognizes the way in which beliefs about health, illness and productivity are produced and reproduced by social forces. It also views the responses of workers as dynamic and evolving, rather than a static
outcome of predetermined risk factors. It enables recognition of the way in which mental health issues, in particular, may be constructed and how this may influence behaviors such as disclosure, help-seeking and patterns of sickness absence and presence. It focuses not only on the immediate social context of day-to-day interactions, but considers the influence of social organizations, institutional structures and the broader social relations of power (Meltzer, Petras & Reynolds, 1975).

It is important to note, however, that the research typically focuses on one dimension of the social environment, whether it at the level of interactions, structures, or discourses. It does not consider how workers' experiences are shaped by the dynamic interaction of social forces at multiple levels both within and beyond the workplace. If we are to understand how experiences are embedded within the social context of work, I assert that it is important to adopt a broad understanding of the social relations of work that considers the links between the interactional, structural and discursive conditions of work. This study is designed to address this gap in its theoretical orientation to exploring how the experiences of workers with mental health issues are socially organized.

2.4 Summary

By reviewing what is known in the literature regarding the experiences of workers with mental health issues and the forces that may be shaping this experience, I have highlighted how the issues are currently conceptualized in research and practice. The experiences of workers were examined in terms of stigma and discrimination, managing information, accessing supports and negotiating sick leave and return to work. There is an emerging picture of the challenges that workers face in terms of stigma and discrimination at work, and the risks associated with disclosure. In addition, there is data to suggest that workers are reluctant to access help for their mental health issues, may not access workplace accommodations, and experience variable levels of support when returning to work after a mental health related sick leave. I have argued that the ways in which these issues are presented in the literature reflect several different theoretical perspectives. Four main perspectives were presented, including a medical, workplace demands, personal choice and a social perspective, contrasting the central ideas and strengths and limitations of each. I have also argued that more attention needs to be paid to the social
perspective, including consideration of the interactional, structural and discursive conditions of work. I will expand upon this position in the next chapter.
CHAPTER 3 -Theoretical Orientation and Methodology

As previously noted, the overall purpose of this study is to characterize, from a sociological perspective, the experiences of workers with mental health issues within a large mental health and addictions teaching hospital, and to account for how their experiences are shaped by the social relations of work. In the literature review, I outlined the social perspective that was adopted, considering the interactional, structural and discursive conditions of work. The following interrelated research questions therefore guided the investigation:

a) How do workers with mental health issues describe their experience?;

b) How is their experience shaped by relationships in the workplace (e.g. with colleagues, supervisors)?;

c) How do organizational structures and processes regarding health, illness and productivity enter into and govern these day-to-day experiences?; and

d) What is the impact of broader discourses regarding mental health and illness within the organization?

In this chapter, I will describe the theoretical orientation of the study, and outline the method of inquiry, including consideration of the social location and standpoint of the researcher, and the institutional setting. I will describe the strategies for implementing the study, from negotiating entry through to data collection and analysis.

3.1 Theoretical Orientation

The theoretical approach adopted in this study is based on an ontological assumption that the experience of workers with mental health issues is produced in important ways within the social space of a workplace. As outlined in the previous chapter, I have argued that the ways in which workers understand and respond is not simply the outcome of a conscious decision or an outcome determined by one or more workplace risk factors, but an evolving process embedded within a system of social relations that create expectations for action. Workers do not passively respond to these expectations, but actively engage in and shape local and trans-local relations. Social relations that constitute workers’ experiences may include day to day interactions with colleagues and supervisors, organizational policies and procedures regarding sick leave, and
broader discourses regarding health, illness and work. Principles of this theoretical approach are informed by an interactionist perspective, but framed by an institutional ethnography framework on how interactions are embedded within a broader organizational and discursive context.

From an interactionist perspective, social relations constitute the experience of health and illness, therefore interpretation of how others might perceive the illness or disability will affect the actions that they take (Bellaby, 1990). The focus is on meaning in human action and how meaning emerges through interaction with others (Blumer, 1969; Wallace & Wolf, 1995). Mental health issues will therefore be viewed as something that unfolds within a process of interpretation and negotiation (Blumer, 1969). Virtanen (1994) argues that response to illness is "a human activity construed in interaction between the individual and significant others" (p.394). Goffman's (1963) work on stigma and impression management has particular theoretical relevance in understanding the behaviors of workers. He explains that symptoms of mental illness may not be immediately apparent to others, therefore individuals may strategically manipulate the social situation and impressions of others in order to avoid negative repercussions of being found out and labeled as inferior. If disclosure does occur, a wide range of imperfections may be then ascribed to the individual who has limited options for dealing with this new social identity. Public recognition of mental health issues may in turn affect whether or not an individual continues to work despite symptoms that may be impairing performance. According to an interactionist framework, the attribution of meaning, the labeling process and making claims is central to the genesis and trajectory of work-related ill health (Eakin & MacEachen, 1998).

Exploration of micro-level interactions will enable exploration of the ways in which beliefs and actions of workers play out on a day-to-day basis. The link between everyday interactions and the broader ruling relations of the workplace will be explored using Dorothy Smith's (1987) theory regarding the social organization of knowledge. The methodology of institutional ethnography is based on this theoretical approach (Campbell, 2004).

The theoretical underpinnings of institutional ethnography include feminism, Marxism, and ethnomethodology (Campbell, 2003). When Smith's approach was developed in the early 1980's, much of sociology was dominated by what she felt was a masculine view of the world that disregarded the subjectivity of the "knower". Campbell (2003) explains that, instead of an
alienated view of the world, Smith proposed a feminist approach which emphasized embodied experience. She presented an alternative approach to sociology which was grounded, not in abstract concepts, but in the materiality of everyday life. Smith (2005) credits Marxism for influencing her ideas regarding ideology, power, and relations of ruling. She emphasizes the inseparability of micro and macro analysis and is committed to revealing oppressive practices of institutions and marginalization of workers. Another important influence on Smith's work is that of ethnomethodology. Campbell (2003) explains that it offered a specialized way of seeing people's activities as integral to any account of what was happening. There is a particular emphasis on practical reasoning, or the ways in which people make sense of their world.

One of the central concepts in institutional ethnography is that of "ruling relations". According to institutional ethnographers DeVault and McCoy (2006), "linkages between the local settings of everyday life, organizations, and translocal processes of administration and governance" constitute a complex field of coordination and control called "ruling relations" (p.15). "Ruling relations" are broad forces that coordinate activities across and beyond local sites of everyday experience (Smith, 1990). Everyday experience is viewed as the entry point for understanding broader ruling relations. Workers are viewed as actively constituting social relations, yet often unconsciously participating in compliance with expectations or rules. The impact of and response to ruling relations within the workplace, however, may vary depending upon the social location of the worker. Politics and power may affect the way in which systems of relations make certain traits visible. The hierarchical nature of most organizations, for example, could translate to differences in interpretation of employee performance, depending upon the employee's status within the organization. Front-line workers may be viewed differently than those in management positions. There may also be differences in beliefs about mental health issues and sickness presence based on one's position of power within an organization. Pressures for workers to meet performance standards may vary depending upon the nature of the job demands and the position of the organization in the broader labour market. There are many forces which may influence the ways in which workers are perceived by others, and the ways in which they respond to these perceptions.

Another central feature of institutional ethnography is the emphasis on texts, or textual practices. Texts are material words, images or objects which can be read, seen, heard or touched (Smith, 2006). Smith (2006) asserts that, in contemporary society, relations of ruling are often
organized through text-based forms of knowledge and discursive practices. Texts are often implicated in organizing and exercising power, therefore they are a central feature in exploring beyond the locally observable to translocal social relations. Texts are not analyzed in isolation, but in the ways in which they enter into and coordinate sequences of action. Policies and procedures regarding sick leave or performance criteria, for example, are examined in terms of how workers take them up in their day-to-day practice.

Discourse is a related concept within institutional ethnography that is often used to understand the coordination of activities within an organization. Institutional discourses are "any widely shared professional, managerial, scientific or authoritative way of knowing … states of affairs that render them actionable within institutional relations of purpose and accountability" (McCoy, 2006, p.118). Discourses may be inscribed in talk or texts, but the focus of analysis is on how people use them and take up the conceptual frames that they convey (DeVault & McCoy, 2006).

Application of theoretical principles in this study involved focusing on the everyday experience of workers with mental health issues, and how this experience was constituted within the ruling relations of the workplace. For example, textually-mediated processes were explored, such as organizational policies regarding sick leave, and protocols regarding access to employee health services. In addition the discursive environment of the workplace was of interest, including explicit or implicit beliefs about mental health issues, and beliefs about responsibilities of workers regarding health, illness and productivity. These beliefs were explored in terms of how they were reflected in the ways that workers talked about and acted on their symptoms. This theoretical orientation opened up space for critical reflection on how the experiences of workers with mental health issues were shaped by interactional, discursive and structural dimensions of work.

3.2 Method of Inquiry

Informed by an institutional ethnography (IE) method of inquiry, this study begins from the actualities of everyday experience, examining how relations of ruling organize and coordinate people's activities within institutions (Campbell, 2006). The point of entry in this project was the experience of individuals with mental health issues who were working in a large mental health and addictions teaching hospital. The focus of attention, however, was not on the
individual experience, but on social organization of this experience. I was interested in exploring how the day-to-day work of employees was hooked into broader social structures and processes both within and outside of the organization.

3.3 Standpoint and Social Location of Researcher

An IE method of inquiry involves the researcher taking up the point of view of individuals who represent a marginal location in relation to power structures in an organization, then looking from the margins inward toward centers of power and administration in order to explicate the contingencies of ruling that shape local experience (DeVault, 1999). The research begins by locating a standpoint within the social relations of an institution that provides a point of reference from which social organization will be explored (Smith, 2005). In this study, the standpoint of workers who personally experienced mental health issues was the starting point for exploring how their activities were coordinated within the social relations of the institution. The focus was on their embodied experience, located within the context of their day-to-day work environment. From this starting point, I explored how their experiences were organized by institutional relations of ruling.

Although my focus was on the standpoint of workers, I was also a participant in the local and trans-local relations of power (Bravo-Moreno, 2003). Before entering the organization, for example, I had to negotiate official support from an internal supervisor (ie. a staff member who was willing to supervise the research process) and from the ethics committee, as well as support from stakeholders in upper management through to union representatives and front-line workers. In some ways, however, I entered the social relations of the workplace as an outsider. I did not work within the organization and did not have personal experience as a worker with mental health or addictions issues. I positioned myself as a graduate student researcher who was committed to understanding the experiences of workers, the ways in which the workplace shaped their experience, and ways in which organizations could be more responsive to people's needs. This position as a researcher and potential change agent was in fact inscribed in a workplace text which served as a primary recruitment tool. I was interviewed by one of the public relations staff members and a brief article about my study was published online as part of the "daily news" website, accessible via all staff computers within the organization (see Appendix A). Near the end of the article, I am quoted as saying; "Our main goal is to start a dialogue”, and “Hopefully
this study will encourage people to start discussing what’s working and what needs improving so we can create positive change.” Upon reflection, this position as a potential advocate was congruent with the institution's public discourse of advocacy and social change related to individuals with mental health issues. My background as a service provider and advocate in the mental health field meant that I too was embedded in organizational discourses regarding mental health service delivery, which challenged my ability at times to problematize the prevailing ideologies and discursive practices of stakeholders. For example, I was challenged by my supervisor to reflect on the ways in which I valorized the process of seeking professional help, rather than considering the ways in which this could create a vulnerable subject position for workers. Through discussions with my supervisor and reflective journaling, I attempted to track my own values and beliefs and challenge them in the process of analysis. Subsequent versions of the study findings therefore reflect a more nuanced approach to understanding the standpoint of workers.

My position as a researcher shaped not only my own perceptions of the power relations within the workplace, but also created unique power relations in my interactions with study participants. During interviews with workers, I sometimes felt as if disclosure of personal mental health issues would have reduced some of the power differences and vulnerability experienced by participants. Since many described feeling quite isolated by their experience, if I were able to disclose similar issues, they might have responded to me more as a peer than an outsider. Instead, the socially constructed relationship was less equal; they were in some ways educating me about the organization and their experiences within it, but also relating to me as someone who might be able to help advocate for change within the organization. This relationship likely shaped the nature of the information that they shared during the interview.

There were also power dynamics evident in my interactions with workplace stakeholders. For the most part, I felt, particularly from managers, that they shared a belief in the importance and relevance of the issues, and were very open about their struggles and strategies in interacting with employees who had mental health issues. A couple of the stakeholders seemed to be hesitant in sharing any problems that they encountered, emphasizing only positive aspects of the organization. This was a particular issue for stakeholders whose job duties included maintaining the organization's positive image (eg. human resources, public relations staff). Institutional ethnographers emphasize the importance of recognizing when the informant is using institutional
language since it may obscure the day-to-day practices that you are trying to discover and describe (DeVault & McCoy, 2006). When stakeholders began to talk in abstract, general terms, I therefore tried to ask for details about particular workers or situations. I also made note of the institutional language that was adopted in order to understand the overarching discourses associated with behaviors. Some stakeholders appeared more comfortable than others in their role as an educator (since I was a student) and/or in their role as a participant in a research project. After each stakeholder interview, I spent time critically reflecting on the interview process, in terms of not only the content of what was shared, but also what was not shared, and how our interaction unfolded over the course of the interview. DeVault and McCoy (2006) suggest that the process of analysis involves moving back and forth between collected speech and the context that produced it. In analyzing the data, I therefore tried to consider why participants shared certain information, and the motives behind their message. Stakeholders who were very articulate and animated about their experiences, for example, provided insight into how they were drawn into organizational processes related to workers with mental health issues. On the other hand, stakeholders who were very reserved and measured in their responses, revealed areas of tension or discomfort, as well as the ways in which the organization is portrayed to the public. Throughout the project, I reflected on the challenges of conducting research regarding a politically sensitive topic area that involved many stakeholders who were invested in the outcome.

Interviews with participants involved a process of discovery, therefore my perspective as a researcher changed over the course of the study. Each interview was a way to learn about a particular piece of the chain of social relations, and to reflect on how it contributed to the emerging picture of the organizational processes (DeVault & McCoy, 2006). Initial interviews informed and changed subsequent interviews in a dialogic process that is typical of social inquiry (Smith, 2002). For example, interviews conducted with workers at a later stage in the process were an opportunity to follow-up on ideas about differential stigma, as well as "rules" about being ill and accessing services. Overall, my assumption is that all knowledge generated in this study was socially produced and that as a researcher, I was an active participant in the social production of knowledge.
3.4 Institutional Setting

The setting for ethnographic exploration was a large, multi-site mental health and addictions treatment and research facility. The organization employs over 2,700 staff members, including front-line service providers, as well as research and administrative staff. As outlined in their corporate brochure, the organization has three main foci; "a pioneering treatment program"; "groundbreaking research"; and "education, health promotion and public policy". All of these services are designed to "transform" the lives of people with mental health and addictions issues. Assessment and treatment services are provided to over 21,000 clients per year through inpatient, outpatient and community based programs. Research is another priority; they employ approximately 100 full-time scientists and about 300 research staff members on hundreds of research studies per year. Education includes provision of continuing education courses, as well as development of publications for health professionals, clients and the public. In addition, they emphasize collaboration with community partners on health promotion initiatives and public policy development at all levels of government. Services are primarily based in two main locations in the same urban centre, although, at the time of the study, the organization was in the midst of consolidating services to one site. There were many satellite clinics affiliated with the organization that were located across the province.

This institutional setting provided an opportunity to explore relations of ruling in an organization that employs a range of individuals, from health care service providers to administrative and research staff. Since sickness presence rates are reported to be high among those in caring/service positions (Aronsson, Gustafsson, & Dallner, 2000), my research in this facility enabled me to explore how the social relations of work constituted sickness presence among health care providers, and to compare their experience with those who were not in caring/service positions. Diversity in the nature of work, social position of workers, and even composition of each department provided a good opportunity to study a range of power relations within the workplace.

The other unique lens within this study relates to the organizational context. The focus on mental health and addictions issues among workers is taking place within an organization that

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1 Full reference not provided in order to protect the anonymity of the organization.
is designed to address the needs of individuals with the same issues. It provides an opportunity, for example, to explore the social relations of work within an organization where workers ostensibly have high levels of mental health literacy. There may, for example, be particular relations of ruling and discursive practices regarding health, mental health and mental illness that govern behavior.

3.5 Negotiating Entry

It was anticipated that exploring the experiences of workers with mental health issues would be challenging since it is a politically sensitive topic area. I was warned early on in the project that workers may refuse to participate due to concerns about confidentiality. Since mental health issues are highly stigmatized (Stuart, 2004), I anticipated that workers would be hesitant to disclose their personal experience, particularly to an outside researcher. I was also informed that high-level executives would not be receptive since they were very protective of the reputation of the organization and have refused similar requests for research in the past. Entry to the organization was therefore carefully negotiated through several stakeholders and stakeholder groups over a period of eight to nine months.

There were two individuals employed by the organization who played a critical role in facilitating initial entry. One was a researcher who was willing to be named as the internal principle investigator for the project. This was a requirement for ethics approval, and her involvement as a respected researcher within the organization added credibility to the study. She played a key role in negotiating support and approval for the project from the senior management team. In particular, she was instrumental in establishing connections with the vice president of human resources and organizational development, whose support was critical to obtaining "top-down" approval for the project. Her role as a liaison between the organization and my research included participation on the research advisory committee within the organization, and on my doctoral thesis committee.

The other individual who was instrumental in facilitating my entry to the organization held a key position between the hospital administration and staff members who had experienced mental health issues. She was employed through human resources, and her status as a former consumer of mental health services was well known in the organization. A key part of her job was to facilitate internal employment opportunities for former clients in the mental health
system. She also coordinated an informal peer support group within the organization for employees who have personally experienced mental health issues. She met with me on several occasions throughout the course of the project, and provided useful advice regarding recruitment. Early on in the process of project development, she arranged for me to attend a meeting of the peer support group to talk about my project and obtain feedback regarding its feasibility. The group members provided helpful feedback, and indicated that they would be willing to champion recruitment among their peers.

Other strategies to facilitate entry included meeting with the organization's ethicist to anticipate and address potential ethical concerns related to the project. I then developed a two page project proposal that was circulated to members of the Executive management team. Feedback at this level was positive; they felt that the project was congruent with current strategic planning initiatives to improve the work environment. Union approval was recommended, so I contacted representatives from the two unions within the organization. They too were supportive of the project, indicating that this was an important area of research, and wrote letters of support that were submitted with the ethics proposal. Overall, feedback from the stakeholder groups not only helped to strengthen the proposal and facilitate entry, but also provided important data regarding organizational structures and processes. Despite my initial concerns regarding how receptive people would be to the project, it appeared that stakeholders at all levels of the organization were supportive, and felt that it represented an important area of research. Once I received official administrative approval from the Executive team, and ethics approval from the REB within the organization and the University of Toronto, I was able to proceed with the project.

Subsequent to ethics approval I developed a Research Advisory group as an additional strategy for facilitating entry into the organization, and for facilitating the ongoing research process. The purpose of the group was to advise and support the researcher at key stages in the project regarding sensitivities within the organization that need to be considered. Their input was data in itself, since it helped to alert me to organizational issues. Three in-person group meetings were held; one at the outset to discuss recruitment and data collection; one at a mid-point of the study to discuss progress and one near the end of the project to discuss approaches to dissemination of study findings. Advisory group participants were strategically recruited from across the organization, representing different stakeholder groups. Recruitment was based on a
review of the organizational chart, and on recommendations from several key sources within the organization. Individuals were invited to be part of the advisory group based on these recommendations. The final group was comprised of 13 members, including at least one representative from each of the following stakeholder groups; workers with mental health issues, clinical staff, non-clinical staff, union representatives, managers, occupational health providers, and human resource personnel. Terms of reference for the advisory group are outlined in Appendix B. The advisory group was important strategically in terms of negotiating entry into the organization since they provided recommendations and assistance with recruitment. They also provided feedback at a midpoint and later point in the study regarding initial findings. This feedback served as a barometer regarding receptivity to the findings, and also helped to identify areas for further exploration.

3.6 Ethical Considerations

The politically sensitive nature of the study meant that a number of strategies needed to be put in place to protect the confidentiality and anonymity of study participants. Workers, for example, could feel anxious about sharing information about their mental health and/or addictions issues and about the workplace challenges that they faced. Inappropriate release of this information could lead to personal embarrassment and potential stigma or discrimination, particularly if they had not disclosed their mental health status to others in the workplace. It was anticipated that workers and workplace stakeholders would be anxious about discussing information that could reflect poorly on their employer or themselves. They may fear repercussions, particularly if sharing negative perceptions and experiences (Stake, 2000). Safeguards were therefore put in place to protect the confidentiality of study participants in terms of scheduling meetings, handling data obtained during the project, and presenting the study findings. When initial interviews were set up with workers, they were scheduled outside of work hours at a private location of the participant's choice. The majority of meetings were held in a meeting room within the facility, but outside of their immediate workspace. One third of the workers requested meetings outside of the workplace, so they were held in a private classroom at the university and/or local library. Almost all of the participants had some concerns about the confidentiality of the data, therefore the procedures for handling data were outlined during initial telephone contact, prior to signing consent, and during the interview process. All interviews were audio-taped with personal identifiers (eg. names, specific job title or department) removed.
upon transcription. Pseudonyms were used for workers, and generic job codes for the workplace stakeholders. The original data as well as names and contact information of participants were maintained on a secure, password-protected computer and/or a locked filing cabinet, accessible only to the primary investigator. The letters of information and consent forms for the employees and the workplace stakeholders both outlined procedures for maintaining confidentiality (Appendix C).

Dissemination of the study findings was another important consideration in terms of preserving anonymity of study participants. There were several participants who held key positions within the organization and/or were public figures in the community, therefore it was more difficult to conceal their identity. In presenting quotes from participants, I was careful to ensure that the personal identifiers were removed or disguised. Quotes used in the study findings were reviewed by a couple of workplace "insiders" to ensure that participants and their stories were not identifiable.

One of the goals of an institutional ethnography method of inquiry is to raise consciousness regarding the ways in which relations of ruling could perpetuate oppression of marginalized workers (Smith, 1998). In this project, the study findings were politically sensitive since they highlighted a critical disjuncture between the public mandate of the organization and the private experience of workers. In order to minimize the risk of further perpetuating a system of discrimination against ill workers, the study findings were disseminated gradually and strategically with input from a range of stakeholders, including workers themselves. Dissemination was carefully negotiated so that the study findings would not be compromised, but ideally positioned in such a way that they would be taken up by those in positions of power, and advance the agenda of social change. Members of the research advisory group were consulted at several points, in order to gather their input regarding potentially sensitive issues, and recommendations regarding dissemination strategies and processes. Based on their recommendation, a two-page outline of the findings was submitted to the VP of Organizational Development who then circulated it to members of the Executive team. Starting with a "top-down" strategy was recommended in order to maximize receptivity and uptake at an organizational level. Throughout the process, I continually reflected on the ways in which my own research was embedded within the overall relations of ruling, and my role as a potential bridge between the perspectives of workers with mental health issues and those who held
positions of power within the organization. As a result, I carefully considered the perspectives of each stakeholder group and was careful not to lay blame but rather to facilitate understanding of the complex social relations of work.

Since workers participating in the study had experience with mental health and/or addictions issues, I needed to consider how to respond to workers who were acutely ill. I had prepared a list of mental health resources in the community and information about how to access supports both within and outside the workplace for any work-related issues. This resource information was available to all participants. For the most part, participants were healthy and articulate, speaking about issues that they experienced in the recent or distant past. There were two participants, however, who were actively symptomatic during the interviews. One participant interview needed to be re-scheduled since she was quite tearful, and found it difficult to focus her thoughts. During the follow-up interview, she was also quite distressed at times and was asked whether she wanted to take a break or end the interview. She asked to continue, however, since she felt it was important to share her story. She was not at risk of self-harm and was well connected with supports to help her deal with her illness. Another participant appeared to have difficulty providing a focused response to reflective or abstract questions. His responses were tangential at times, but he did not appear to be in any particular distress and did not appear to be aware of the incongruent nature of his responses. He felt that it was important to share his ideas, and spoke for about an hour with one break at a mid-point in the interview. His responses were used less often in the presentation of the study findings since they were difficult to decipher at times. The experiences of these workers were, however, incorporated into the overall analysis since they provided a helpful contrast to workers who were more removed from their illness experiences.

3.7 Sources of Information & Recruitment

The foundation of institutional ethnography is experiential data; through informants' stories and descriptions, the researcher begins to identify some of the trans-local relations, discourses and institutional work processes that shape their daily activities (DeVault & McCoy, 2006). It is recognized, however, that the local knowledge of informants represents one perspective, therefore it is important to go beyond what they are consciously able to describe (Campbell & Gregor, 2008). In other words, individuals who experienced mental health issues
at work may not be aware of broader institutional forces that shape their actions. Entry level experiential data was therefore supplemented by second level data that provided information about how individual workers' experiences were structured and shaped through organizational processes (Campbell & Gregor, 2008). Sources of this second level data included information from other key stakeholders in the workplace and from organizational texts regarding health, illness and productivity.

In order to gather data about the actualities of everyday experience, employees who experienced mental health issues were a primary source of information. Workers were recruited who met the following inclusion criteria; employed in the organization for a period of at least three months (either full-time or part-time), personal experience with mental health issues, and willing and able to reflect on and describe their experience. They also had to be competent to provide consent. The criterion of "mental health or addictions issues" was defined by the workers rather than by any preset diagnostic category. Criteria were not predefined since participants' interpretations were part of what was being investigated. The language on the recruitment posters was subject to some debate in the initial meeting of the research advisory group. The controversy regarding language was data in itself, and therefore duly noted. "Mental health and addictions issues" was the terminology eventually chosen since it is consistent with the language used in the organization, and "issues" was considered to be more neutral than the term "illness" or "problems".

Posters about the study were displayed on bulletin boards throughout both sites of the organization (Appendix D). Members of the research advisory group were also encouraged to let others know about the project through 'word of mouth'. The most effective recruitment strategy was an article about the project published in the organization's online daily broadcast website (Appendix A). The online article reached the personal desktop of all staff members with computers, and was one of several featured stories over a one to two week period. The photograph and accompanying article seemed to capture the attention of many staff members who regularly used a computer as part of their work. It was more of a challenge to recruit staff members who did not have computer access (eg. housekeeping, food services). There were a few participants recruited by "word of mouth" communication between staff participants who knew of colleagues who also experienced mental health and addictions issues.
In order to gather information about organizational structures and social processes, stakeholders were recruited who represented a range of positions in the web of social relations within which workers with mental health issues were embedded. Stakeholder participants included managers (at various levels), union stewards, occupational health providers, human resources personnel, and co-workers. Identification of potential participants was based on an initial review of the organizational structure of the workplace and evolved over the course of the study as the web of social relations in the workplace became clearer. The research advisory group was consulted regarding key positions and approaches to recruitment. Some snowball sampling also occurred as the study progressed whereby participants suggested individuals who held key positions in the web of social relations. Recruitment of stakeholders involved directly approaching the identified individuals, providing them with a letter of information about the project and following up by telephone and/or email to invite them to participate. In some cases, recruitment was facilitated by a supervisor who either recommended or approved of the individual's participation.

Texts were another key source of information about the ruling relations of the workplace. Smith (2006) explains that texts are an integral part of what people do and know. Texts are material forms of words, images and sound that can be read, seen, heard or touched. They can be electronic or paper documents, or other material representations that can be reproduced, copied, transferred, or disseminated by different users at different times (Smith, 2006). They occur within a time and place and need to be considered in terms of how they enter into and coordinate sequences of action. Smith (2006) further explains that texts enable the researcher to reach beyond the locally observable into trans-local social relations that organize and control the local experience. In the current study, several types of written texts were gathered. Some of the texts reflected the public image of the organization, and were accessed through the organization's website and through public documents available in the staff library. Other texts were internal documents designed for staff employed within the organization. These texts were accessed primarily through the internal staff website and through participant stakeholders. Relevant texts were identified through exploring these sources of data and also when mentioned by study participants. Written texts collected as part of the project are summarized in Table 1.
Table 1 - Organizational Text

<table>
<thead>
<tr>
<th>Type of Text</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>Corporate brochure Website</td>
</tr>
<tr>
<td></td>
<td>Annual report Quarterly newsletters</td>
</tr>
<tr>
<td></td>
<td>Foundation newsletter and posters</td>
</tr>
<tr>
<td>Internal organization documents</td>
<td>Organizational chart Strategic plan 2006-2009</td>
</tr>
<tr>
<td></td>
<td>Strategic plan renewal internal staff survey 2008</td>
</tr>
<tr>
<td>Internal Policies and Procedures</td>
<td>Attendance management policy</td>
</tr>
<tr>
<td></td>
<td>Therapeutic Boundaries policy</td>
</tr>
<tr>
<td></td>
<td>Employee Code of Conduct</td>
</tr>
<tr>
<td></td>
<td>Employment harassment and discrimination policy</td>
</tr>
<tr>
<td></td>
<td>Collective Agreement guidelines re: sick leave &amp; return to work</td>
</tr>
<tr>
<td></td>
<td>Insurance claim forms re: physical &amp; psychological illnesses</td>
</tr>
</tbody>
</table>

3.8 Study Participants

As described earlier, there were two groups of participants recruited in the study; workers who had personally experienced mental health issues, and workplace stakeholders who interacted with ill workers. These groups, however, were not mutually exclusive. There were participants, for example, who volunteered to share their own experiences, but ended up speaking primarily about their interactions with colleagues who had mental health issues. There were also workplace stakeholders who not only shared their perspective as a manager or service provider, but shared some of their personal experiences as well. They were categorized as either a worker or stakeholder when they signed the consent form, although it was recognized that they had multiple perspectives. Participants with dual roles provided valuable insights into the multiple identities that may be assumed.

Participants with personal mental health experience included 20 staff members from across the organization. An overview of the sample of workers is summarized in Table 2.
Table 2 - Worker Characteristics

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>5 male, 15 female</td>
</tr>
<tr>
<td>Length of time in organization</td>
<td>5 months - 23 years (average 8.3 years)</td>
</tr>
<tr>
<td>Work role</td>
<td>12 clinical, 8 non-clinical, 2 students, 14 front-line workers, 4 management</td>
</tr>
<tr>
<td>Location</td>
<td>8 Site A, 7 Site B, 5 off-site</td>
</tr>
<tr>
<td>Self reported illness/condition (may report more than 1 issue)</td>
<td>14 with mood disorder, 6 with addictions issues, 4 anxiety, 1 thought disorder, 1 not reported</td>
</tr>
<tr>
<td>Sick leave/RTW</td>
<td>6 had formal sick leave related to mental health or addiction issues (4 were 3-4 months in duration, 2 were 1.5-2 years in duration)</td>
</tr>
<tr>
<td>Disclosure</td>
<td>5 were known consumers when hired, 2 never disclosed to anyone at work, Others had various degrees of disclosure over time</td>
</tr>
</tbody>
</table>

As outlined in the table, there was variation among participants in terms of their job tenure, work role, position within the organizational hierarchy, and location of work. There was also variation in terms of their mental health experience; they reported a range in severity of symptoms, nature of the illness and the degree to which they had disclosed their experience to others. Some had only a past history of mental health issues, whereas others were actively struggling with symptoms at the time of the interview. In addition, some described only mild symptoms, whereas others felt that their symptoms were significantly debilitating at times. In terms of the nature of the illness, there was a higher percentage of individuals with mood and addictions issues. This reflects prevalence rates of mental health issues in the general working population (Dew & Lin, 2000). Only a few of the participants had taken formal sick leave, therefore purposive sampling was conducted at later stages in the study to recruit additional participants who had experience with sick leave and return to work. The other dimensions of
difference described above (e.g. job tenure, illness severity) emerged naturally in the process of recruitment. The purpose of recruiting participants with diverse experiences was to trace how participants in different circumstances were drawn into a common set of organizational processes (DeVault & McCoy, 2006).

Initially, the plan was to recruit eight to ten workers however, there were many more who volunteered to participate in the study. All potential volunteers were provided with a letter of information about the study (Appendix E). If they met the inclusion criteria, and expressed a desire to tell their story, they were invited to participate. Unlike other qualitative research studies, recruitment in institutional ethnography does not proceed until the point of theoretical saturation, but proceeds until a comprehensive map can be developed regarding the social relations of work (Smith, 2006). As such, informants who were recruited at a later stage in the project were able to fill in the gaps and/or confirm details regarding the emerging findings.

Stakeholder participants included 12 key individuals from across the organization whose role involved in working with employees who had mental health issues. Stakeholders were recruited who could comment on a range of organizational structures and processes that affect the experiences of workers (e.g. policies and procedures regarding attendance, sick leave and return to work). As outlined in table 3, stakeholders included individuals from clinical as well as non-clinical areas and included administrative & service providers (Human Resources and Occupational Health), as well as union representatives, and managers at various levels in the organization. The majority of participants were female, however, there was variation in the length of time employed within the organization. Most stakeholders were based at one site since it was the central location for administrative services.

**Table 3 - Stakeholder characteristics**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>2 male, 10 female</td>
</tr>
<tr>
<td>Length of time in organization</td>
<td>1 year - 31 years</td>
</tr>
<tr>
<td>Work role</td>
<td>5 clinical, 5 non-clinical</td>
</tr>
<tr>
<td></td>
<td>2 union reps, 4 HR/Occ health</td>
</tr>
<tr>
<td></td>
<td>4 managers, 4 directors</td>
</tr>
<tr>
<td>Location</td>
<td>10 Site A, 1 Site B, 1 off-site</td>
</tr>
</tbody>
</table>
All of the stakeholders who were approached agreed to participate in the study. They were provided with a letter of information about the study, and asked to provide informed consent (Appendix C). Recruitment proceeded until key informants within "the chain of action" were interviewed, and their perceptions regarding the local and trans-local relations of work were established (DeVault & McCoy, 2006, p.33).

3.9 Data Collection

Data were gathered primarily through in-depth, semi-structured interviews with workers and workplace stakeholders, and through written texts about the organization. All interviews were audiotaped. Interviews were scheduled between October 2008 and June 2009.

Semi-structured interviews with workers explored their day-to-day experiences at work; their work role, their experience with mental health or addictions issues and the interactions between mental health issues and work. The initial interview guide is listed in Appendix F. The interview guide evolved over time, however, since each interview built upon previous ones, providing an opportunity to learn about a particular piece in the relational chain, develop a picture of how actions were coordinated and identify further avenues for exploration (DeVault & McCoy, 2006). During the interviews, I listened for institutional processes that could be coordinating action, and checked with workers about evolving ideas. Each interview was approximately one to two hours in length, and participants chose when and where the interview took place. Many workers were concerned about confidentiality of the information, therefore the majority of participants chose to be interviewed outside of their work environment; either in another area of the organization, or completely outside the organization in a private space in the community. One participant was interviewed over the phone since she worked in a satellite clinic many miles away.

Interviews with workplace stakeholders explored their perceptions of employees with mental health issues, and the organizational forces which govern the experiences of affected workers. The initial stakeholder interview guide is listed in Appendix G. The guide consisted of open ended questions in three main areas: their role in the organization and experience with workers who had mental health issues; impressions of the workers themselves (eg. stories and situations that stand out); and impressions of organizational responses to workers with mental health issues (eg. policies and procedures, how the organization compares to other workplaces). Stakeholder interviews were approximately one hour in length and, like the worker interviews,
evolved as the study progressed in order to follow-up on emerging ideas. Descriptions of experiences with individual workers were particularly helpful in gaining an understanding of their perspective and response to workers. During the interviews, I listened for “institutional discourses” that reflected professional training and socialization, since those in authority positions often use language that reflects institutional ideology (Campbell & Gregor, 2008, p.70). I also asked them to describe specific situations in order to move beyond their ideological language and explore what happens in day-to-day practice. Most stakeholders were interviewed in their offices. A couple of stakeholders were interviewed twice since the initial interview did not allow for enough time to cover all of the information that they wanted to share.

Textual material was another source of information that was collected. In an institutional ethnography method of inquiry, textually-mediated practices are considered to be a primary organizing force within contemporary organizations (Smith, 2006). Publicly available documents (eg. corporate brochure, annual report, posters) were therefore collected since they often reflect an organization's public discourse. Internal documents (eg. organizational policies and procedures) were also collected since they potentially govern beliefs and action within the organization. If documents were mentioned by study participants, these were collected as well (eg. application forms for disability leave, promotional posters for fundraising campaign). In institutional ethnography, the emphasis is on "texts in action" (Smith, 2006, p.67), so descriptions of documents which shape responses to workers with mental health issues were considered to be particularly relevant. For the most part, participants were willing to share these texts, however, they often found it difficult to identify relevant written material.

Throughout the process of data collection, I maintained a field journal with reflections on interviews, informal interactions with stakeholders and observations of the physical and social environment of the organization. This journal served as another source of data regarding the social relations of work.

3.10 Data Analysis

Analysis of study findings proceeded in conjunction with data collection. Interview transcripts, texts, and field notes were continually reviewed, exploring the ways in which they revealed the social relations of work. Initial findings were followed up on in subsequent interviews in order to clarify or refine emerging ideas. The focus of analysis was on connections between local sites of experience and the overall social organization of work (Campbell, 2006).
I engaged in multiple, stratified readings of the data in order to examine the day-to-day experiences of workers and how these experiences were governed by interactions with others, as well as by broader discursive and structural forces within the organization. The analytic exercise of examining the data from different perspectives and systematically mapping ideas is described by Clarke (2005) as a way of increasing the depth of analysis. Using different layers of analysis (e.g., experience, interactions, discourses, and structural forces) enabled exploration of micro, meso and macro level forces on the day-to-day experiences of workers.

The first layer of analysis involved examining the day-to-day "work" of employees in terms of how they talked about and responded to mental health issues. Work, as defined within an IE framework, is a broad concept, orienting the researcher to what people do that involves some conscious intent and acquired skill (McCoy, 2008). It includes emotional or thought work as well as physical labour or communicative action. Smith (2000) explains that the focus is on what is done, under what conditions, in relation to whom, and with what resources. The initial focus of analysis therefore, was on describing the experiences and practices of workers and workplace stakeholders; exploring how they thought about, and responded to mental health issues. Instead of active dialogue and action, many of the participants indicated that no one spoke about or responded when workers had mental health issues. I began to track these behaviors, referring to them as "practices of silence". The core work of many workplace stakeholders seemed to centre on various practices of silence, therefore this became the primary focus of analysis. Transcripts and texts were reviewed in order to examine silence practices and to identify tipping points at which silence was broken. This analytic focus helped to illuminate social processes within the organization that were not necessarily explicit. Clarke (2005) explains that it is important to examine not only explicit data, but "sites of silence" as well.

The second layer of analysis involved examining how these day-to-day practices of silence were governed by social relations both within and across the boundaries of the organization. In an institutional ethnography approach, it is assumed that what participants do, and what they understand and can talk about is shaped through organized processes (Campbell & Gregor, 2008). These processes can be reflected in the dialogue and actions of participants and inscribed in written texts (Smith, 2005). The way in which participants talked about practices of silence within the organization for example, offered clues as to how social relations operated across the workplace. McCoy (2006) proposes that embedded within participants' descriptions
are ways in which they take up institutional discourses that govern the social relations of work. She defines institutional discourses as widely shared professional or authoritative ways of knowing, that "carry institutional purposes and reflect a standpoint within relations of ruling" (p.118). Individuals may participate in the discourse in various ways; some may adopt terminology and ideas that are consistent with the discourse, whereas others may engage in oppositional or critical talk against the dominant discourse (McCoy, 2006). Through critical reflection on participants' descriptions, I was able to identify a number of institutional discourses that seemed to be shaping patterns of silence within the organization. I included consideration of oppositional talk and how this provided depth of understanding of the dominant discourse.

Organizational texts can be another source of information about institutional discourses, therefore I also examined these documents in terms of how they inscribed courses of action that were (or were not) taken up by workers and workplace stakeholders. Public texts such as the organizational mission statement and posters on the walls, for example, were examined in terms of how they reflected the public mandate of the organization, and how the discourse reflected in these texts were or were not taken up by workers and workplace stakeholders. Similarly, internal policies and procedures were critically examined in terms of how they inscribed certain values regarding health, illness and productivity, and how they governed the behavior of workplace stakeholders. The emphasis in institutional ethnography is on "texts in action", therefore texts were examined in terms of the specific time and place where they were invoked and how they were integral to a sequence of action (Smith, 2006). It should be noted, however, that very few participants referred explicitly to organizational texts, and in fact many talked about the lack of documented policies or procedures to guide their actions. This issue will be discussed further in the chapters on the presentation and analysis of the study findings.

The focus of analysis was at an institutional level, mapping the common social processes which operated across the organization. I wrote analytic notes about emerging ideas, and continually reviewed linkages between these ideas. I considered not only institutional forces, but broader societal discourses which shaped how workers responded to staff members with mental health issues. DeVault and McCoy (2006) describe the product of analysis as "a map that can serve as a guide through a complex ruling apparatus" (p.754). The map that was produced as part of my analysis represents a focused look at key pathways by which the practices of silence are produced and reproduced.
In this chapter, I have outlined the study methodology, including consideration of the theoretical orientation, method of inquiry, and process of data collection and analysis. In the next three chapters, I will outline details regarding the study findings.
CHAPTER 4 - Disjunctures and the Practices of Silence

As outlined in the previous chapter on methodology, the focus of analysis was on the connections between local sites of experience and the overall social organization of work, with the social relations of silence emerging as a key focus of analysis. The study findings regarding the social relations of silence will be presented in three chapters. The first chapter outlines the disjuncture between public and private perspectives on workers with mental health issues, and profiles the practices of silence adopted by workers and workplace stakeholders. The second chapter will focus on the social production of the silence, accounting for how silence practices were produced and reproduced in the workplace. The third chapter will focus on the consequences of silence practices and opportunities for change. A visual map summarizing the findings is presented in figure 1.

Figure 1 - The Social Relations of Silence

- Stigma Discourse
- Discourse on Staff-Client Boundaries
- Competing Discourses of Responsibility

Practices of Silence
- Workers
- Stakeholders
- Organization

- Mental Health of Workers
- Workplace relationships
- Work productivity & performance
In presenting the findings, I will use quotes and examples to illustrate and support the key points. Please note that pseudonyms will be used to represent comments made by workers who participated in the study. Comments made by stakeholders will be identified by abbreviations depicting their role in the organization. Managers, for example, will be identified as "Mgr", union representatives by "U-1" or "U-2", occupational health providers by "OH", and human resource staff by "HR".

4.1 Disjuncture between public discourse and workers' experience

In exploring how the social relations of work shaped the experiences of employees with mental health or addictions issues, it became evident that there was a disjuncture or disconnect between the public image of the organization and the embodied experience of workers with respect to how mental health issues were understood and addressed. Smith (1990) describes this phenomenon from an institutional ethnography perspective as "lines of fault between the objective knowledge of a regime and the reflexive everyday knowledge of workers" (p.633). She explains that the actual experiences of individuals within organizations may be quite different than what is recognized in texts that represent them institutionally (Smith, 2005). In this study, the public image in the organization was one of leadership, open dialogue, respect and support for individuals with mental health issues, yet the experience of many staff was one of secrecy, stigma and silence. Silence was a recurrent theme, central to many participants' descriptions of individual and organizational practices. The social relations of silence therefore became the primary focus of analysis.

4.1.1 Public discourse about mental health and addictions issues.

In order to understand the organizational context within which participants worked, public texts outlining the organization's mandate and services were reviewed. According to their website and corporate brochure, the [name of organization] is Canada's largest mental health and addiction teaching hospital, as well as one of the world's leading research centres in the area of addiction and mental health. The brochure explains that organization "combines clinical care, research, education, policy and health promotion to transform the lives of people affected by mental health and addiction issues". Since the mandate of the organization focuses on clinical 

Full reference not provided in order to protect the anonymity of the organization.
care, public education and research, talk about mental health and addictions issues is fundamental to the work of the organization and its reputation in the community. The organization's annual reports profile its role as a leader in educating the public, researchers and healthcare providers at local, national, and international levels. This public image of leadership and expertise exemplifies an open dialogue and understanding of individuals who may be struggling with mental health issues.

In the lobby of the two main sites, visitors are greeted by life-sized posters on the wall, profiling the "stories" of individuals who have experienced mental health or addictions issues. Each poster features a close-up head shot of a person (many are public figures in business, sports, media or politics) with a story that highlights the challenges they have overcome in their personal and professional lives. These posters are the product of the Foundation, or fundraising arm of the organization. The Foundation also publishes a newsletter designed to feature ways in which the organization is "bringing mental illness and addictions out of the darkness". Similar to the poster campaign, the newsletter profiles the stories of public figures whose lives have been touched by mental health or addictions issues. The goals of the Foundation's poster campaign are to; break down stigma, increase awareness of services, and to encourage people to seek help. They profile people who are willing to speak out about their experience with mental health issues and illustrate that it is a common experience that can happen to anyone, regardless of social position. Public awareness and education is part of the official mandate of the organization.

This public discourse and its emphasis on leadership, progressive thinking and open dialogue provides an important backdrop for understanding how mental health and addictions issues are institutionally framed within the organization. There are a number of ways in which these ideas are taken up through organizational policies and practices. The sense of commitment to the mission of reducing stigma regarding mental illness was evident in many participants' descriptions of their work. Several staff members talked about their efforts at "stigma busting" when they chose to share their personal experiences with others. Disclosure was positioned as a form of advocacy, whether it took place in their day-to-day work with colleagues or in broader public forums. It was a strongly held value for many workers and part of the work that they did within the organization.

*Katie: I’m just such a big fan of stigma busting. Right? That there are people out there who are very high functioning who you would never know have issues; who don’t speak out or don’t seek the help that they need, because they are afraid. And so I’m sort of the*
opposite, in that I will talk about mental health and addictions at any opportunity I get because I believe that, ya know, the more I talk about it, the more people out there will reach out and get help that they need, or not discriminate against people with mental health or addictions problems. If that means telling my personal story because I have that personal connection, then so be it.

Several workers referred to participating in this study as their way of advocating for change. Opal, for example stated: "I thought if I can share my story and based on that story another person doesn't have to go through what I went through, then this would be a good cause." Others echoed her belief, explaining that they wanted to participate in the study to increase awareness of the "reality that yes there is people at [organization] that have issues like that", and that "information in some ways is power".

References to the larger mission of the organization and efforts to be leaders in the field were also made by other workplace stakeholders. Several managers talked about supporting staff members who were struggling with mental health issues, and how their approach to providing supports and accommodations was unique in comparison to other workplaces. One manager, for example, reports: "We try and practice what we are preaching." Another manager asserts: “They are more sensitive here. And so they should be.” Instead of simply firing employees who are not performing, the response is: “You know what, we work for the [name of organization]. Should we not try and help our staff?” These managers felt that the organization should have a higher standard in terms of acknowledging mental health issues and supporting staff.

Mgr-S: I would hope that we are better [than other workplaces] in terms of being able to acknowledge stigma. Acknowledge the difficulty that people have in terms of coming out of the closet about this kind of issue. That we are more sensitive and more likely to pick up on and label the potential mental health or addictions issue as a medical problem rather than bad behavior.

Personal commitment to making a difference in the lives of individuals with mental health issues was evident in how participants talked about the organization's initiatives in hiring individuals who have been recipients of mental health or addictions services. There was, for example, a program that was around for many years, designed to help former clients find work, including jobs within the organization. There is now a newer version of this initiative, and the paid positions have recently become unionized. Overall, people spoke very positively about these programs; managers were generally pleased with the people who have been hired, and the employees themselves expressed gratitude for the opportunities. The spirit of these employment
initiatives was described by one manager as "leading by example", explaining that hiring former clients is "ethically the right thing to do".

Overall, the public discourse regarding the organization's leadership in talking about and addressing the needs of individuals with mental health and/or addictions issues seemed to be well established and was taken up in a number of practices within the organization.

4.1.2 The critical disjuncture: open dialogue or silence?

Recognition of the public discourse of leadership and open dialogue regarding mental health issues stands in stark contrast to the day-to-day embodied experience of workers. Although there were examples of leadership and advocacy, there were many more examples of workers who were afraid to speak out, and who experienced the shame of stigma and discrimination. Many workers talked about the disjuncture between the public mission of the organization and their discomfort in sharing personal experiences.

Greta: On some level, in an environment like this, you think here’s somebody, like if you are feeling really shitty, like here's all these skilled people, that, you know, you think that somebody could help. But like it’s, paradoxically I don't feel that way, you know.

Aden: It's weird that there's this discomfort around speaking openly about it. There is such an irony. It's a mental health institution and these are supposed to be mental health professionals and yet they have such a hard time talking about mental health when it's us and not the clients.

Instead of an open dialogue, workers felt that it was not acceptable to speak out about their personal experience with mental health issues. There was a disjuncture or disconnect, not only with respect to talking about issues, but to responding to the needs of employees who may be struggling.

Theo: There is some kind of a disconnect, if you will, in the work that is- that we do for our clients, yet doesn’t- that doesn’t translate to how we take care of our employees which I think, it becomes detrimental to how well the employees function, or are able to do what they need to do for the clients.

Many workers referred to a double standard in the organization; there was a sense that staff members were not allowed to be ill. Fran, for example, states: "I'm the helper so I can't be the crazy person. A little bit of that stigma still." Her comments were echoed by others who acknowledged the shame associated with mental illness, despite the messages given to clients.
about recovery and rising above the label. Lana reports: "we're supposed to be above that somehow".

The comments expressed by workers regarding institutional silence were echoed by the workplace stakeholders. They too, referred to differences between the public image or mission of the organization and the private struggles of employees with mental health or addictions issues. One manager reports that accepting "people with life experience" is "a value that we want to be good at", but she was not convinced that the organization did it any better than other workplaces.

Overall, there seemed to be a disjuncture between the public discourse about the need to engage in open dialogue about mental health and addictions issues, and the embodied experience of workers within the organization which was often characterized by secrecy and non-disclosure. On the one hand, talk about mental health and addictions issues is seen as valuable and important, yet it seemed to be in reference to circumscribed others, such as clients or members of the public, not staff within the organization.

4.2 Practices of Silence

In order to understand the nature of this disjuncture, I initially examined the presence of silence within the organization. How is silence manifested in the workplace? Who is involved, and when and where does it occur? In exploring these questions, it became evident that silence was enacted by many stakeholders within the workplace, from front-line workers through to high level management. I have used the term "practices of silence" to describe the ways in which silence was taken up and performed in the workplace. There were varied practices of silence, and I considered the context within which they were produced. Silence, for example, seemed to be a dynamic force, shaped by the temporal and social context of work. In interrogating these practices of silence, I considered times when people did not talk, but also when and with whom the speaking occurred or did not occur, and what was said or left unsaid. Findings related to the practices of silence will be presented in three main sections, focusing initially on workers, then on workplace stakeholders, then on the organizational practices of silence.

4.2.1 Workers' practices of silence and the dynamics of disclosure.

As outlined earlier, the public image of open dialogue appeared to be incongruent with internal messages that it is not acceptable for workers to talk about their personal mental health or addictions issues. Managing information about personal history and/or current struggles with
mental health issues appeared to be a form of "work" that many employees engaged in on a daily basis. I will outline how the work of maintaining silence (or conversely, the work of disclosure), was a multi-dimensional, multi-layered process, embedded within the social context of work.

First, it was interesting to note that the study itself created a social context in which participants were required to share personal information. Of the twenty participants in the study, there were two who indicated that they had never disclosed their history of mental health issues to anyone in the workplace. Many participants expressed concerns about the confidentiality of the information that they shared during the interviews, and most requested meetings outside of their work space or even outside the organization, so that others would not know about their participation. Although a few participants had shared their personal experiences in public forums within and/or outside of the organization, they were the exception rather then the norm. All of these observations seemed to illustrate the concerns that workers had about when and how their personal information was shared within the organization.

4.2.2 Impression management: presenting an image of competence.

When listening to workers' descriptions of their day-to-day experiences, it became evident that impression management was a key practice of silence. Workers were very invested in projecting an image of competence. Within the interviews, participants often focused on evidence of their competence, minimizing any negative impact of mental health issues on their work. Monique, for example, emphasized the quality of her work; "When I'm here, I work hard. All my client stuff is excellent. All my feedback is excellent." In some cases, workers explained that they did not need to disclose information because they did not have symptoms that affected their work performance. Evan, for example, indicated that he did not feel the need to share information, emphasizing that "part of me wonders how relevant it is". Similarly, Katie asserts: "I run high anxiety and I am an excellent employee." Many workers considered themselves to be well, and if they did experience symptoms, they felt that it was something they could handle without affecting the quality of their work.

In addition to emphasizing their strengths, many participants talked about how invested they were in performing well at work. Work was meaningful to them, as was their image of competence as a worker. Even during times when they were struggling, they worked hard to ensure that it did not affect their functioning at work. One worker explained: "I just kind of did
what I had to do to get through the day". They would often "hold it together" at work, despite the toll that it was taking on their personal life.

Opal: A part of what ended up happening, I became a perfectionist at work and I took on way more than my mind and my body probably could have handled just to cover up what was really happening with me. ... I didn't want anybody to see how bad, upon reflection, I was feeling or how bad- I didn't want people to see how hard it was to cope, to manage. ... I had sought support and then I stopped seeing the doctor because there, like I said, it was basically trying to get to work, and that was the focus was to be able to survive at work. So everything else went; the house went, the kids went.

Participants described informal strategies that they adopted to ensure that their work performance would not be affected by their illness. Several workers, for example, explained that they came in on weekends or stayed late to make up for the days where they were less productive. One participant talked about planning days off when she felt tension building, and doing so in a way that would limit any inconvenience to other members of the team. Another participant talked about how she arranged to work evening shifts since she was having trouble sleeping and could not get up in time for morning shift. Although these strategies were often effective, informal adaptations seemed to be easier for some individuals than others, depending upon the amount of flexibility in their job.

When struggling with mental health or addictions issues, one option that workers had was to negotiate with their manager for workplace accommodations. Some did approach their manager to request time off for medical appointments, and had a good experience with this. This experience, however, was not consistent across the organization. Very few of the study participants initiated an accommodation request. Workers explained that it was difficult to initiate a dialogue about the need for accommodation, since it implied that they could not handle the work. Greta, for example, explained that she did not want to "talk about anything that's gonna be perceived as like some kind of weakness... unless I really have to." Many were invested in their work, and did not want to be judged or perceived as weak, incompetent, or manipulative. Moral judgment from colleagues was a fear for some. Bryn, for example, explains; "I was very cognizant of not wanting to pull the depression card. Like sometimes it feels like manipulating, you know? ... especially when you are in the system and you've seen people play the system." Furthermore, some found it difficult to advocate for their needs with their managers, particularly when their self esteem was already low.
Parvin: [In previous workplace] I was terrified to ask for the flex time for my medical appointments because I just feel it's like asking for a favour or something. Even though I'd be the first one you know writing down the accommodations, rights, and stuff. But I think when you're in the situation where it feels like you constantly want to judge-prove yourself, then you don't want to ask for anything. It feels like you're asking rather than simply saying "this is what I need".

In general, workers appeared to invest a lot of energy in maintaining an image of competence. Part of the work in maintaining this image involved ensuring that others did not find out when they were struggling. They implemented strategies such as "holding it together" at work, modifying job duties or hours whenever possible, and avoiding a formal request for accommodations or support in order to disguise any problems that they experienced.

4.2.3 Selective disclosure.

Although some workers invested considerable energy in keeping their personal issues a complete secret, others talked about the ways in which they partially disclosed information to colleagues. Disclosure was not an all-or-none process; participants were selective, not only about what they said, but when, and to whom.

Josie: "I do pick and choose. And I think I'm pretty intuitive as a person so if I kind of get this vibe that, like I'm not going around and disclosing to everybody but if it is needed or necessary... it's sort of a contextual thing."

Some participants described "testing the waters", where they would make indirect references to their personal experience and then watch for the response of others.

Greta: Sometimes there is a bit of a temptation to ask about medication or ask about, what do you think about this or that, and like I don't feel that that's appropriate, necessarily. But every once in a while I do "lob" things, you know that are a bit, you know, not necessarily I'm saying this is my experience, but I'm sort of like tossing out stuff like that. .... But I've never sort of really come straight out about my own experience.

The social context for sharing information therefore seemed to be important. In addition to variation in how workers chose to share information, workers reported being selective about the type of information that was disclosed. One worker, for example, explained that she was less likely to disclose an addictions issue than a family history of mental illness or a seasonal mood disorder. Another worker reported that he shared information about his past history of addictions issues, but did not disclose current struggles.
Katie: All of my office mates here in [location] know that I have sort of self-identified as having seasonal affective disorder. ... I’ll share that freely and, you know, talk about [family member] having schizophrenia freely. But when I talk about [family member] having alcohol addiction, I talk about that way less. And when it comes to me and marijuana, nobody knows.

Quinn: I don’t talk directly about it, but I sometimes indirectly, sort of, like let people know that I- Mostly former, like never, never a current thing right? ... Its more of an innuendo that it was former- in the past. Keep it in the past, sort of a thing, right?

Silence, therefore may be partial, in the form of innuendos or indirect comments. It may also involve sharing some information that is "safer" than others (eg. past rather than current experience; experiences that may be less stigmatized).

4.2.4 Strategic disclosure.

Although the predominant finding relates to ways in which workers tried to conceal their mental health issues, there were some reports of workers who intentionally disclosed information to others in the workplace. The context for this disclosure varied. In some cases, disclosure was with colleagues or managers in the process of negotiating supports, in other cases disclosure was with colleagues or members of the public as part of advocacy efforts, and in other cases disclosure was in the context of clinical care with a client. The nature of what was disclosed, when, and with whom, varied from one participant to the next, but in each case highlighted some of the implicit rules about the practices of silence.

First of all, there were times when workers disclosed information to their colleagues or managers as part of their effort to maintain an image of competence within the workplace. Several workers indicated that, when their work performance started to decline to the point that others would notice, disclosing personal struggles with mental health issues became a strategy to explain their behavior and negotiate support.

Lana: I also felt some- like I was letting her down when I would call in sick and I was afraid she would tell my manager and complain "Oh, that [Lana's] getting sick all the time." And my manager would say "Geez, that [Lana's] getting sick all the time and buggering off." So I thought "What should I do? .... It would be against their whole philosophy to criticize someone who is off with mental health issues. But that's why I wanted her to know that it was mental health and not me buggering off on a long weekend.
In each case, the worker rationalized the disclosure, indicating that they thought the manager would be open and responsive to their explanation. Monique, for example, reported: "...they asked me what was going on and I shared really honestly because in my thought 'well, we are [name of organization]...." Workers tried to maintain their image of competence for as long as possible however information sharing was precipitated by questions that were being raised about their ability to perform.

Another example of intentional disclosure relates to workers who shared their personal experiences as a form of advocacy to reduce the stigma associated with mental health issues. Aden, for example, asserted: "I thought maybe I could present a different picture to my coworkers about who an addict is or what someone with a mental illness could achieve". As outlined in the introduction to this chapter, this advocacy was consistent with the public discourse within the organization. Workers seemed to take up this public discourse even in framing their participation in this study. Upon examination of these advocacy efforts, however, it was evident that public disclosure of personal experiences was viewed as important, but it was also associated with considerable personal risk. Almost all of the workers who engaged in this form of advocacy described at least some initial reluctance and/or trepidation associated with exposing their personal history. Aden reported: "On one hand I felt it needed to be done; on the other hand I was just wishing to hell somebody else would do it." Dawn described similar feelings of reluctance: "I mean I've obviously had this big secret for most of my years of employment, right? So it was really having to deal with something I didn't want to do."

Engaging in this form of advocacy was also described as hard work at times, and workers did not always feel up to the challenge. Parvin, for example, lamented: "...other times, I just feel too burnt out and I just let it go. Its like I don't want to be fighting all the time." Maintaining silence regarding personal experiences was easier at times than engaging in advocacy efforts.

The third form of intentional disclosure relates to situations when workers revealed their personal history to clients in the context of their helping relationship. There were three clinical service providers who shared stories about disclosing their personal history of mental health or addictions issues with a client. In each case, the disclosure was described as an exceptional circumstance, and not part of their typical practice. Disclosure unfolded within the context of their relationship with someone who had asked for their help. The disclosure did not happen right away; there was a point where the worker chose to reveal his/her own personal experience as a way of conveying empathy and support to the individual who was struggling. One of the
clinicians, for example, described a longstanding relationship with a client who sensed that the clinician had additional insights and empathy that would not be present in someone without the same personal experience. The client asked directly, and rather than denying it, the clinician admitted to a past history of addictions issues. The client's response was simply "I thought so." The other two clinicians described situations where a client was feeling fairly desperate and alone in their struggles, and the personal disclosure was in the context of providing reassurance and hope that things would be fine. In both cases, the participants explained that their disclosure was effective in relieving the individual's anxiety, and had a very positive outcome for the recipient of information.

What appeared to be a simple extension of a clinical mandate to provide support, however, was reported to be problematic. When asked about how disclosure is taught at school, one worker reported: "their usual message is; don't do it." Several other participants emphasized the importance of caution regarding self-disclosure with clients, explaining that it can be "rife with problems". They talked about the risks associated with sharing personal information that could detract from the focus on the client. One of the workers who shared personal experiences with a client explained that she was fired from a previous job.

In general, strategic disclosure, whether within the context of justifying behavior, promoting advocacy, or providing clinical support, meant breaking the codes of silence. It was not easy, and for many, it meant taking personal risks in terms of their reputation. When workers chose to share their personal experiences with others, this was managed carefully and strategically, since it was outside of the accepted practices of silence within the organization.

4.3 Stakeholder Practices and the Codes of Silence

When their mental health issues were not known to others, workers engaged practices of silence in order to regulate the information that was shared. When their issues became public or visible in some way, other stakeholders in the workplace became engaged in practices of silence as well. Workplace stakeholders included coworkers, supervisors, occupational health providers, union reps, human resource staff, insurance providers and upper management. There were many examples of silence among stakeholders across the organization. Stakeholder practices of silence included; a) not talking about or acknowledging issues, b) dismissing concerns, c) facilitating impression management, and d) sending messages about the unacceptability of disclosure.
4.3.1 Lack of acknowledgement of issues.

As described in the workers' practices of silence, many workers engaged in strategies to conceal their mental health issue from others. Even if their issues became known, however, stakeholders such as managers and co-workers did not necessarily acknowledge their presence. They did not initiate a discussion about them or act when problems were evident.

In terms of acknowledging issues, a number of participants commented that mental health issues among staff were rarely discussed openly within the organization. Quinn, for example, explained that "people have alluded to it", yet direct discussion does not happen. He has tried to raise the issue a few times, but "...it never goes through so I just don't follow through with it." Furthermore, there were reports of stakeholders who did not pick up on clues that a fellow staff member may be ill. Katie, for example, related that she came to work on several occasions when she was under the influence of drugs, but no-one seemed to notice. She was particularly surprised since she worked with addictions specialists. Fran described a similar situation with a colleague who had an alcohol addiction.

Katie:  Like working with addictions and mental health specialists and showing up to my new job completely high and nobody notices. Like, you know, and that’s the disconnect and “No, not my colleague.” ...nobody notices. And I would come into the office and talk a million miles a minute to my admin assistant, right, and that’s all covering up things. And then I, ya know, trip over my words, and clearly, like, clearly I look a little wound up if anything. And, ya know, if they really look, they would be able to tell that I was a little high, too. But nobody really looks.

Fran:  [Explaining manager's reaction to a male colleague]  We were in Las Vegas at a [addictions] conference. This was one of the times I was saying "look, this is a problem, he is drunk. And he [the manager] said; "I didn't notice." How can you not notice he was drunk?  He showed up at a professional conference wearing shorts, loaded in the middle of the day. And he came in and he was like was cheerful, really gregarious and talking a lot. And he wasn't like that.

Participants shared many stories about staff members who struggled with mental health and/or addictions issues for a long period of time before their issues were addressed by anyone within the workplace. These stories were evident all areas in the organization, from administrative, housekeeping and research services through to front-line clinicians and high level managers. A common thread in many of these stories was that the issues and behaviors were
evident for weeks or even months, yet the issues were not acknowledged or acted upon. At times things escalated to the point of crisis before they were openly acknowledged and addressed.

Christine: And it started to seem like he [coworker] was having many personal issues and that was starting to affect other people on the team as well. ... And that sort of escalated and escalated. And it got to a point where actually then it started to seem like he was having some serious mental health issues to the point where he actually became a little delusional and seemed to be imagining things that hadn't actually happened.

Union-2: They found a man, um, hiding under his desk over in the research department. ... there were signs and symptoms for months and months and months and months. That they just- they had research projects to do. They have time- they have timelines and stuff. They don’t have time for this. [SM: Yeah.] Right. So here is this guy one morning, under his desk, cowering under his desk. That’s when they decided, we, “Oh, we should really do something for him.” Nobody says, “Hey are you feeling okay? Are you doing okay?”

There was a general sense that people would look the other way and pretend that the issues were not happening. One stakeholder related the story of an employee whose mental health issues became increasingly obvious to the point where he had an explosive outburst in the workplace. When he finally went off on sick leave, people were relieved, reporting that: "everybody here knew; everybody knew he was getting high.", yet no one said anything for months until a crisis point was reached. Another manager talked about the difficulties associated with co-workers noticing the problems, yet not acting on them.

Mgr-S: I think people see a lot and they just sit with it. Maybe because they don’t know what do with it; that could well be part of it. But in all instances that come to immediate mind, when you go back and talk to folks, it has been going on forever. Very, very long periods of time and they’ve been tolerating and having to put up with some fairly disturbing behavior at times. Which to me is a huge, huge tragedy. To have to come to work and worry and hang on to that and not know what to do with it is...is... it’s not great.

As illustrated in the above examples, lack of acknowledgement of issues was reported across the organization; there were co-workers and managers who did not seem to recognize that problems were occurring, and/or not publicly acknowledge their concerns.

4.3.2 Dismissal of expressed concerns.

Although there were many times when mental health issues were not acknowledged at all, there were also times when concerns were expressed about the mental health of a worker.
These concerns, however, were not always responded to, or acted upon, particularly by managers within the workplace.

As reported earlier, there were often long delays before the mental health issues of staff members were acted upon. One of the union representatives complained that "it has to reach a huge breaking point". A number of participants described situations in which concerns were repeatedly expressed to managers, but they were ignored or dismissed. In one case a physician had an addiction problem, yet the issues were not addressed. In another case, a clinician reported concerns to her manager about a colleague who had a drinking problem, yet the manager minimized her concerns. This incident was clearly upsetting to the participant, and was one of the reasons why she wanted to tell her story as part of this study. She felt that the delay in acting upon concerns led to his untimely death.

Fran: By the time, he was asked to take sick leave he was already psychologically damaged from alcohol. ...And he sat at home and literally drank himself to death. He did that in like 3-4 months. I mean he'd have to drink a lot of alcohol. I mean this was a year and half from the time he'd started drinking to the time he died from alcoholism.

This pattern of dismissing or ignoring issues was also described, not only by stakeholders, but by the workers themselves. Many workers described situations when they disclosed personal information to co-workers or managers, and they felt silenced by the way that their disclosure was dismissed.

Nora: In terms of the anxiety or any of the like mental health piece; no, it doesn't get addressed. ... Anything I have brought up has been pretty quickly brushed aside.

Aden: What I wasn’t expecting was the overwhelming reaction and that was silence. I mean knife-cutting, no eye-contact, scurry out of the nursing station as quickly as possible, silence.

Further silencing was noted in response to workers' requests for support from their manager. Several participants described situations in which the manager was approached proactively regarding the need for support regarding job duties, yet the request was not validated or addressed.

Opal: I was reporting to her [manager] difficulty managing with the shift work because I felt myself burning out, I felt myself severely depressed. I felt I couldn't cope. And I was basically told, "There is nothing we can do." It really was dismissed.
Monique: I was forthright and I said to him [manager], you know, “I’m just struggling with depression, just let me kind of and working with all these adjustments and things, give me the space and time.” And so a week later, um-[pause] And then he started forcing me into doing all these extra sessions. And, you know, and I guess, my reaction was to become quite upset because I had just disclosed that I just, I just need time to get on my feet.

In general, although there were attempts to talk about issues or act on concerns, these attempts were often shut down. Colleagues and/or workers may start to initiate a dialogue, but they were silenced when their concerns were dismissed.

4.3.3 Facilitating impression management.

Some stakeholders played an active role in concealing information about the mental health issues of their co-workers. Several stakeholders, for example, indicated that co-workers may cover for the individual who is struggling rather than report concerns to the manager. There may be an attitude of protection, particularly if the employee is well-liked. As one manager reports: "If they are liked by the general group, they’ll cover for them. They’ll, they’ll hide them; they’ll do their work; that kind of stuff". If they are not well-liked, however, this protection may not happen. 'If people think you are a whiner or a problem employee, and you have even a death, someone will go, 'oh, you're always having a crisis!'" One of the managers dubbed co-worker silence as a "cloak of secrecy", explaining that "people cover for one another, and they protect one another, and they don’t want their friends in trouble."

In addition to covering for the individual who was struggling, there were reports of co-workers who actively discouraged people from sharing information about their personal mental health or addictions issues. Several participants talked about explicit messages that they received from co-workers, advising them against disclosing any information about their experiences. Katie, for example, mentioned to a co-worker that she was looking for help for her mental health issues, and was surprised by the reaction. Instead of offering suggestions, the co-worker stated: “Oh my God, don’t tell me. Don’t tell anyone.” The implicit message seemed to be that "she thought that my job would be in jeopardy." Bryn described similar messages that she has received from a range of co-workers: "I have been told, at times, “Don’t stigmatize yourself, don’t put yourself out there, don’t talk about this”. She reported receiving an even more blunt version of the message: "If you are a mental health worker with a mental health problem, well
shut the hell up." Overall, the data suggest that co-workers are actively engaged in enforcing rules about the silence surrounding mental health issues.

4.3.4 Indirect messages about the unacceptability of disclosure.

A related practice, reported primarily among co-workers, was communicating, often indirectly, about the unacceptability of disclosing personal experience with mental health issues. Many participants, for example, talked about gossip within the organization. When it became known that a staff member had mental health issues, the gossip surrounding the situation was often very negative. Dawn, for example, reported that "if you get your name on a chart here, people know before you blink. ... There's a grapevine here that does people a lot of damage." She was referring to the implications of receiving treatment for mental health issues within the organization and the potential for public exposure through documentation of this treatment. Greta talked about the gossip surrounding an employee who was on sick leave and then returned to work "...there's concerns about her capacity. Like I mean, people are actually; "can she handle the stress?" These examples suggest that the implications of having a known (or suspected) mental health problem are often negative.

When staff members were ill as a result of mental health issues, these negative comments conveyed a message that the workplace was not a safe place to disclose. Workers often picked up on the comments, recognizing the vulnerability associated with disclosure.

Katie: Even my second week of work, my manager and one of my colleagues had this big conversation in the hallway. And what they were essentially doing was gloating about how few sick days they’ve taken. So they were competing with each other, you know, “I haven’t taken a sick day in seven years.” And I had this like 'Holy Shit' moment. Holy shit, I get migraines, and I, you know, occasionally life is too much for me and I need a day to just sleep, or something. But I immediately feel that it is not okay to be unwell. And that was really surprising to me and not what I expected from a mental health and addictions provider. And so it sort of immediately set up the workplace culture for me that it’s not okay to be not okay. And that you just keep it to yourself when you are not okay.

Through comments made in reference to ill employees, co-workers communicated an indirect, but nevertheless a clear message about the unacceptability of being a staff member who has a mental health issue (ie, “it is not okay to be not okay”). As a result, workers stayed silent as a way of protecting their own reputation. Overall, there seemed to be a range of ways in which stakeholders silenced workers with mental health issues, from simply not acknowledging or
dismissing concerns through to direct and indirect messages about not disclosing information in the workplace.

4.4 Organizational Practices of Silence

Although practices of silence were enacted by workers and workplace stakeholders, there were some practices of silence that seemed to be rooted in organizational policies or procedures. Many of these practices were related to communication (or lack of communication) between stakeholders during the process of sick leave and return to work.

4.4.1 Lack of information sharing with co-workers.

Many participants commented on the silence surrounding sickness absence. Unlike employees who were on sick leave as the result of physical health issues, there was very little direct, open dialogue about mental health or addictions issues. One worker explained that the concern that people expressed when she broke her leg was quite different from the silence that she experienced when she was off due to mental health issues. Similarly, a manager related the story of a colleague who was on a mental health related sick leave, reporting that "he disappeared from the workplace". She felt that the situation would be different "if he was off with any other kind of illness [since] people would be calling." When an employee was on sick leave, there was typically very little information shared with co-workers. The lack of communication was described as frustrating at times for workers as well as their colleagues.

Mgr-M: [In reference to a colleague who has been off on sick leave] Staff have been told nothing. They still have his office. There’s somebody covering his position two years later. His shoes are still in the office. His sweater is hanging up. All his personal effects are there. And people that he worked with have been told nothing. And there’s this real discomfort around, like we want to send him a card. Like we want to know if he’s okay, like-. But we don’t get any information.

The lack of communication reportedly extended to the return-to-work process as well. Dawn, for example, talked about feeling "banished" from the workplace and then feeling "undermined" upon her return to work, since none of her colleagues were notified. She described receiving emails from colleagues that she had known for twenty years who wanted to know why they were not notified about her new position. Furthermore, one of the managers described the awkwardness associated with the lack of communication about return to work. She explained that she is not allowed to share any details other than the date of an employee's return. If co-
workers ask questions about the employee's readiness to return, she can only say: "I'm not at liberty to say anything. He's back. And people are only back at work if they are well enough to be here." She was not able to offer any further explanation which she feels can create tensions at times.

At times, the reintegration back to work was difficult because workers felt that their return was not necessarily supported or celebrated. Many of the workers on sick leave explained that returning to work represented an important step in their recovery process. Work represented a return to competence for themselves and their families, yet this was not necessarily recognized by their colleagues at work. Several participants shared heartbreaking stories about the challenges they experienced when they returned to work.

Opal: I remember my doctors, and my children, they were so excited and my friends when I was returning to work. You know, it’s like, it was such a big thing for everyone. Oh my god, she’s going back. I had phone calls, you know, “How did it go?” And then when I started telling people what was happening, it was such a, it was so deflating not for only me but the doctors who were helping me... I went home crying every day. Crying in the subway. Just crying.

Irene: Well the day I came back, and they knew I was coming back, whatever, they really did not have anywhere for me to sit. ... When I came back on the Monday she[replacement worker] had her name over my name on the door and all my pictures were off the bulletin board. And there were ones on the board of her stuff. ... having a table computer there ahead of time would have been a big help than to be standing in the hall.

There was a sense of frustration that the meaning of return-to-work for the worker was not recognized by the organization, and that the lack of communication and support made reintegration difficult.

4.4.2 Lack of communication between disability management stakeholders.

Another organizational practice of silence relates to limited communication between key stakeholders involved in sick leave and/or return to work. There were many potential stakeholders, not just the worker, co-workers and managers, but also human resource staff, occupational health providers, union reps, the insurance company and external health care providers. Gaps in communication were more evident with some stakeholders than others, and occurred at different points in the process of sick leave and return to work.
The procedure to follow when any employee becomes ill involves linking with the Occupational Health and Safety (OHS) department. This procedure is documented in texts describing the role of the OHS department. OHS staff explained that they are supposed to be the initial point of contact; the employee or manager should initiate contact if there are concerns regarding health issues. Their role is to assess the situation and make recommendations regarding how to respond.

Although the employee and/or their manager are supposed to contact OHS for input, this process is not necessarily followed when an employee has a mental health or addictions issue. As described in the workers' practices of silence, employees rarely initiate contact with OHS. In addition, OHS staff feel that they are often contacted "late in the game" by managers. One of the OHS providers shared frustration regarding a decision that was made to send an employee home without their input: "We're really out of the gate, we are pretty far outside of the gate at this point and we now have to come in and really try to win over the employee and let them understand what our role is."

Several managers, on the other hand, complained that OHS was not very responsive. They described limited communication at times when an employee was off sick or returning to work, and the challenges that this created for them as a manager. One manager expressed concern that, "as a manager, I'm not privy to anything", and that typically what happens is the person "just sort of shows up back at work." She talked about the tension that this creates, particularly when there is little follow-up. "I mean, you want to preserve people's privacy, of course. But- And that's fine if Occ Health has the role of supporting them and following up, but they don't. Like, no one does." Since managers feel that they have responsibility for reintegrating the employee into the workplace, they feel that follow-up and open dialogue is important.

Mgr-W: I think, if anybody is off, I think, again, I think you have to have as open a dialogue as possible, and if the person doesn't mind their manager being there, then they should be there. I think it shouldn't be arbitrary. I think it should be; ask the person who they want, if they want someone there. It makes sense to have the manager there to problem solve. Because I am the only one who knows what the job is like. Actually, they're, they're the only ones who know now what they are like. But, I mean, and how I am going to manage their being off and... you have to keep confidentiality. And you have to. But I think if the person wants it, then I think the manager should be really involved with them when they are off.
In addition to these perceived gaps in communication between managers and occupational health, there were also perceived gaps in communication between other stakeholders. One of the union reps, for example, described "lots of these after-the-fact calls", expressing concerns that they were not involved in partnerships with management, human resources, and occupational health. The union rep felt that the employer "knows things that are going on, but they just don't tell us or call us". The tension and communication challenges between unions and the employer were echoed by other participants as well. One manager felt that the breakdown in the process of return to work is that "unions and management are polarized", and that this polarization "creates more problems and gets us derailed".

The process of claims management with the insurance company was also identified as problematic. OHS explained that the communication process with the insurance company was quite different depending upon what union the worker was in. Members of one union, for example, would go on short-term disability after nine days, and follow-up would be through the insurance company. The employer would receive very limited information. For the other union, the communication process was reportedly better, since the OHS department would directly manage the claims. As a result, OHS felt more in control of the process and, from their perspective, communication was better. Workers, however, described that they often felt out of the loop with respect to applying for benefits. They felt that communication regarding the procedure was very limited. One worker, for example, argued; "It is not clear to anybody anywhere, at what point you are to apply for short-term disability." Another explained: "The part of HR is that I have been quite amazed at how it seems like no information goes filters down to the different people that you need for the things that need to be done."

In general, communication regarding disability claims was perceived to be limited, although the source of the communication problems varied, depending upon one's perspective.

Return to work planning was another process that involved many stakeholders, with reports of gaps or miscommunication. There were several stories about situations where stakeholders could not agree on plan of action, and as a result the return-to-work process was delayed. One manager described a situation where it took six months to answer a question about a worker's restrictions, with multiple requests for medical exams and changes to the original agreement. One of the union reps described a situation when all the stakeholders in the room agreed on a course of action, except for the occupational health nurse, and as a result the process was delayed.
Overall, it is important to note that most stakeholders felt that they were left out at times when an employee was on sick leave. Lack of communication was reported between managers and occupational health providers, between human resource, occupational health and union reps, between occupational health and the insurance company, and even between the employer and workers themselves. These communication challenges were particularly evident when an employee was on sick leave for mental health issues and during the return-to-work process.

4.5 Summary

Workers and stakeholders from across the organization engaged in practices of silence with respect to workers with mental health and addictions issues. The nature and timing of these practices varied considerably, depending upon the nature of the illness and the social context of work. Workers' practices of silence involved controlling information about mental health issues that might have a negative impact on their image as a healthy, productive worker. When struggling with mental health or addictions issues, many workers tried to stay at work and maintain competent work performance at all costs. It was very difficult for them to ask others for support. There were times when workers chose to share their personal experiences with others, but this was managed carefully and strategically, since it was outside of the accepted practices of silence within the organization. Stakeholder silence manifested as long delays before action was taken when an employee became ill, and as gaps in communication when workers were off on sick leave. Practices of silence included colleagues and managers denying or ignoring the presence of mental health issues, and co-workers covering for ill employees or actively discouraging disclosure. When a worker did attempt to disclose, stakeholders may silence them through dismissing their comments or requests or by making derogatory remarks. Although the practices varied, they all served to shut down communication rather than open up dialogue regarding staff mental health issues. Organizational silence was also evident in the gaps in communication when a worker was on sick leave or attempting to return-to-work.

In conclusion, the existence of these practices of silence was somewhat surprising considering the public mandate of the workplace and its emphasis on open dialogue and leadership in addressing mental health and addictions issues. In order to understand the disjuncture between the public discourse and private experiences of employees, the next chapter will focus on how the silence was produced.
CHAPTER 5 -Ruling Relations and the Social Production of Silence

Documenting the experiences and practices of workers is an important first step in an institutional ethnography approach (Campbell & Gregor, 2008). Although this is the entry point of the research, understanding the ways in which these practices are socially organized is the crux of analysis (Townsend, 1998). In this chapter, I will argue that there are a number of local and trans-local discourses that are governing the practices of silence within the organization.

Discourse, as conceptualized in IE, refers to relations beyond the local that coordinate practices of individuals within a particular time and place (Smith, 2005). Smith (2005) explains that discourses reflect forms of consciousness and organization that are constituted externally to particular people and the workplace. They are inscribed in texts and reflected in day-to-day practices. People participate in discourse and their participation reproduces it. I will outline three types of discourse in which workers participate: one relates to the stigma associated with mental health issues; the second relates to the importance of staff-client boundaries; and the third relates to competing responsibilities for workers' mental health.

5.1 Stigma Discourse

One of the key forces that seemed to be governing the practices of silence in the organization was a discourse of stigma associated with mental health issues. Many participants talked about the stigma associated with these issues and how workers affected by mental health or addictions issues were viewed as a liability in the organization. In exploring this discourse, I will initially outline the nature of the discourse itself then describe the social relations that produce and reflect stigmatizing beliefs. I will discuss the ways in which this discourse is taken up in the practices of silence, and examine potential pockets of resistance.

5.1.1 Ascribing negative attributes to workers.

According to Goffman (1963), stigma refers to "an attribute that is deeply discrediting" (p.3). He explains that an individual with a mental illness may be inscribed with negative attributes that confers a 'deviant' status. Participants in this study often spoke about the stigma associated with mental illness and addictions, and the ways in which workers were discredited when their issues became known to others. There were a range of negative attributes ascribed to
workers with mental health issues; questioning their competence, credibility, and stability in the workplace.

Questions about competency were a concern to many workers. As outlined in the workers' practices of silence, it was very important for workers to present themselves as competent; they worked very hard to ensure that their work performance was not affected by their mental health issues. Many workers explained that they were afraid to disclose since sharing personal experiences meant engendering a significant amount of personal risk to their reputation as a competent worker, and to their job security.

Rachel: There is so much stigma and the staff notice it, so I don't think that they would even want to admit even among themselves... my gut instinct is that no, if they aren't in a position where they are being paid to be 'out' about their mental health, I don't think that many staff in this environment would come out about it because of fear. ... I think there would be a fear of judging about competency. ... There could be a whole slew of reasons. I do think that the first one that arises in my mind is competency.

For some of the individuals who disclosed, fears about the impact on their reputation did in fact play out in practice. Several workers described negative experiences in the workplace once their issues were made public. They were on the receiving end of indirect, derogatory comments. Rather than an open, honest discussion, comments often insinuated that the staff member was incompetent.

Opal: I remember first when I returned to work, my brain was still foggy and I would forget stuff. And people would say behind my back: "Fucking stupid." ... To say mean things like that- because you do feel stupid. I did feel stupid coming back. ... Those smart ass comments was really difficult [sic].

Some workers felt that their competency was directly rather than indirectly questioned. They were explicitly challenged about whether they should be working at all.

Dawn: [Conversation with manager upon return to work] His comment to me was: "Well, people in your position, normally they don't come back to the job. They go on and find something else." And I said; "Well, I don't know what you are talking about. Am I not allowed to get ill?"

Another, related attribute associated with mental health issues concerns perceived trustworthiness or credibility. Questions were raised, for example, about the legitimacy of the
illness itself. Participants explained that behaviors were sometimes interpreted as within the individual's control, rather than the result of a medical illness.

Aden: Some of the comments that were made about people who were really, really ill—quite often their difficulties were seen as behavioral instead of the illness, the symptoms of the illness. People always let their personal views get in the way. There were all these stereotypes.

Some participants also felt as if the credibility of their health issues was questioned by the employer and/or insurance company. At times requests were made for multiple external assessments, or claims were denied as a result of questions regarding the legitimacy of the illness. There was a separate form to be filled out for the insurance company in the case of "psychological illness" versus "physical illness", implying that the conditions were viewed differently within the organization. One of the union members referred to "a mentality about workers about how much absenteeism they are taking and is it legitimate." She described the practice of sending workers for three independent medical assessments "just to make sure that you are really mentally ill". Several workers talked about extra requirements that they had to fulfill in order to establish credibility regarding their sick leave.

Monique: Every day there was another call from [insurance company rep] wanting to know what I was doing, wanting to know what was going on. And even though my psychiatrist who as I said, like is a specialist who works with mood and anxiety, he produced a letter. That wasn’t enough for them. They forced me to go to an independent evaluator at [location]. And at that point, I mean, staying home was even more stressful to be honest with you, than being at work. Like it was just, it was this horrible situation where I was being called all the time by this woman again and again...

In addition to questioning regarding the legitimacy of the illness and sick leave, some workers felt that their credibility was questioned when they attempted to return to work. When employees indicated to the employer that they were ready to return to work, some were questioned about whether they were really ready to return. Several participants shared stories of workers who had to produce extra documentation to validate their claim. It was felt that they had to jump through "extra hoops" in order to prove their competency to return to work.

Union-1: What should normally happen is ...the employee comes back, they usually come back with a medical note saying that they're fit to return to work. People who leave with a mental health issue seem to have to jump through more hoops when they return to
work. So not only did she need a note saying she was fit to return to work, what they decided to do, was they decided to send a functional assessment form to her physician outlining, “This is her role in the community; can she do her job?” ... That’s not normally the process. Normally the process is your physician gives you a return to work and you return to work. And if there are concerns about your returning to work, Occ Health will say, “Well, you know, could you get your doctor to elaborate more on this?” We don’t say, “No, we don’t want you to return to work ’til we hear from your doctor.” They actually sent her for an independent medical as well.

Overall, the social relations of stigma often manifested in questions about legitimacy and competency. This was particularly evident at an individual level when it became known that the worker was ill. It was also embedded in organizational practices such as insurance coverage and the return to work process.

5.1.2 Differential discrediting: mental illness versus addictions.

Although many workers talked about the discrediting images associated with mental health issues, they also noted that there was variation in how the stigma discourse was taken up by stakeholders across the organization. The nature of the discourse seemed to be shaped, in part, by differences in how mental health issues and addictions issues were perceived in the workplace. The majority of participants referred to distinctions between the two conditions and how this affected responses to a staff member who becomes ill. Even when the study was initially developed, several stakeholders recommended modifying inclusion criteria in order to specify both mental health and addictions issues. They felt that people might respond more readily to one versus another, and that it was important to include both terms.

Throughout the study, many references were made to the stigma associated with mental illness and addiction however, there were differences of opinion regarding which condition was more discrediting. Some, for example, argued that addictions issues were viewed less favourably, whereas others felt that views about mental illness were worse.

Some workers explained that there was more stigma associated with addictions issues, since addictions were considered to be under a person's control. As a result, the person was viewed as responsible and culpable for their behavior.

Katie: I think addictions issues are generally more stigmatized than mental health issues. ... I do see it among service providers and among my colleagues, that same sense of 'you have chosen an addiction but you have inherited a mental health disorder'.
In contrast, other workers explained that mental health issues were more discrediting than addictions issues since there were more questions about credibility or legitimacy.

*Opal:* It's the continuous stereotype with assumptions around mental health and mood because it's a hidden illness. One has to tell you. With substance use, people tell you what they are doing: "I'm drinking every day. I have withdrawal from drinking. My liver is damaged. My kidney is gone. I drink to cope." So it's something we can see. With mental health, one has to tell you "I feel really down." And what does that mean as opposed to it all being in your head? ... I definitely had to defend what was going on.

The following worker reflected on both sides of the argument, explaining that the nature of the stigma may depend on the social context of where one works, and comfort level in dealing with issues on a day-to-day basis.

*Aden:* There seems to be some kind of hierarchy. I mean, I know when I worked in addictions, some of the addictions therapists were uncomfortable dealing with mental illness. Like they wouldn't work with somebody who is floridly psychotic. ... There was a certain uncomfortable-ness that they experienced dealing with acute illness. And then I found with the mental health people there was a huge discomfort dealing with the addictions stuff.

The social context of the workplace therefore appeared to contribute to the differential beliefs. Staff members who had expertise in dealing with addictions issues were less comfortable addressing mental health issues, and vice versa. Part of the difference seemed to reflect historical differences in service delivery. The organization represents an amalgamation of four founding programs; two which were oriented to the treatment of mental illness and two that were oriented to the treatment of addictions. The amalgamation which occurred over a decade ago was justified, in part, on an ideological belief that mental illness and addictions issues were often inextricably linked and therefore needed to be addressed together. In practice, however, many workers continue to see the two issues as distinct. Historical differences in service delivery continue to shape current ideas and beliefs about mental health issues. As one union member explained "there is a huge, huge difference of thinking".

The historical distinction between the sites was reinforced by geographical separation; however, the organization is currently in the midst of re-locating many services to a central site.

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3 Internal document reference not cited here in order to protect the anonymity of the organization
and the stigma discourse seemed to be changing. Although many participants talked about the enduring ideological differences between mental health versus addictions services, there were also a few references to an evolution in beliefs. One manager, for example, referred to changing ideas about alcohol use. She explained that, in the past, it was quite common for people to be drinking at work; there was beer in the fridge and people would drink during the lunch hour and at staff parties. Now, alcohol use is much less acceptable. She mentioned broader anti-drinking campaigns (e.g., Mothers against drunk driving) which have changed public perceptions. Other stakeholders also talked about evolving ideas regarding staff with mental health or addictions issues. In the past, it was quite common for staff working in the addictions field to have personal experiences with addictions. As a result, some workers felt that there was more of an open dialogue and follow-through when staff became ill.

Union-2: In order to be hired at [addictions program prior to amalgamation], you actually had to have had an addiction and been through the program and been clean for two years and then you could be hired. So when the merger happened in ‘98, probably 70% of the staff at the [addictions program] were clients. … Including the managers, by the way. So it was easy for a manager to say, “I see you. I hear you. I know you are deteriorating. Absolutely. Get you in the program, get you fixed up, get you back. Boom. Boom. Boom. Boom.”

Since the merger, however, some felt that there has been a shift in attitudes about staff with mental health versus addictions issues. In the addictions field, there has been a shift towards credentials, with less value placed on life experience. In mental health, on the other hand there is increased acceptance of hiring employees with mental health issues.

Mgr-A: Yeah, well, it’s interesting because on the mental health side, we’ve worked so hard to break down the stigma and accept people, and, you know, value life experience with mental illness. And on the addictions side it has gone the other way. Right? It’s become much more, you know, credentialled. You know, well, and credentialing is a way of ruling people out, right, with the personal life experience.

Overall, the discourse of stigma with respect to mental health and addictions issues was dynamic with beliefs varying over time and place in response to the changing organizational context.
5.1.3 Differential discrediting: Illness hierarchies.

A second, related issue in terms of understanding the stigma discourse relates to perceived differences in the nature and severity of illness. Not all mental health issues were viewed in the same way. When discussing eligibility for the study, many participants talked about diversity in what might be perceived as a mental health or addiction issue. One manager, for example, explicitly talked about the continuum of mental health issues that she sees in her staff:

Mgr-S: Overall, I mean, it depends on how broad you want to use the term mental health. Right? If you want to characterize somebody that's going through a divorce and is having a mild dysphoric episode that lasts for 6 weeks and they're not up to speed at work, but there is a life event that is contributing –that's one thing. All the way through to a major mental illness like schizophrenia or treatment refractory depression or whatever. We have all of those things, or both of those things, and everything in between. ... I mean, part of this is about how you want to slice the pie that you are talking about.

Comments about differentiation based on severity of issues also emerged in other participants' descriptions. They described not just a continuum, but a hierarchy of issues within both the mental health and addictions field. There were distinctions made for example, between individuals who were stressed or experiencing some form of anxiety or depression and individuals with psychotic symptoms or a diagnosis of schizophrenia. Mood or anxiety issues were viewed as considerably more acceptable than psychosis that is not well controlled.

Quinn: My own perception is that it would probably be more acceptable to have like some kind of a mental- minor, relatively minor mental health issue... Like a depression or something, probably with taking anti-depressants. Whoopee, right? ... But if you are a schizophrenic or something, then it would be- I mean you wouldn't be able to do it...

There were similar references to illness hierarchies in the addictions community. An addiction to alcohol, marijuana or prescription drugs, for example, was considered to be much more acceptable than an addiction to "street drugs" such as crack/cocaine.

Aden: Here, there seems to be a hierarchy of substances. It's okay of you are, you know, overdoing "Benzo's" or over-the-counter medications but you know, if you are using crack, "oh my god", you know or "meth", you know, there is no hope for you kind of thing. So you pick up on these attitudes and this hierarchy and what is acceptable and what is not.
Several participants talked about the ways in which illness hierarchies can be misleading or even damaging at times. Workers such as Katie and Rachel who were "merely" addicted to alcohol or marijuana, or Bryn who was "simply depressed", for example, explained that they were significantly affected by their condition, and found it quite frustrating that their concerns were minimized by others as unimportant. On the other hand, there were a few individuals who explained that they had a significant history of street drug use, or psychosis, yet were quite functional at work. Their comments implied that the degree of stigma associated with their condition was not necessarily related to the impact that it had on their current work life. Responses to staff members seemed to be produced by preconceived assumptions about the acceptability of particular conditions, rather than the functional impact it had on their job performance.

5.1.4 Stigma discourse and practices of silence.

Differential discrediting associated with the discourse of stigma shaped the practices of silence among workers in many ways. Workers, for example, were less likely to disclose personal experiences if the risk of being discredited was high. If the worker was seen to be responsible or to blame for addictions issues, his/her colleagues may also be less likely to cover for him/her. Workers may be blamed if their mental health issues were not seen as legitimate. In addition, managers may be less supportive and less likely to respond to requests for accommodations.

Greta: So somewhere it starts to be what people won’t tolerate and it starts to become a performance problem... where you kind of end up blaming people or labeling them as, you know, they are a complainer or whatever.

The attributions associated with the illness therefore shaped the response of colleagues. The impact of illness hierarchies on practices of silence included consideration of a threshold at which a worker becomes defined as ill or in need of help. There was clearly some variability in terms of the threshold of what constitutes a problem. If for example, the individual was somewhat anxious, or admitted to using marijuana, this may be viewed as more acceptable than an individual who presented as paranoid, threatening or under the influence of street drugs. Perceptions of the nature and severity of the illness affected the likelihood of acknowledging and acting upon concerns. As outlined above, illness hierarchies were problematic at times since the
issues of some workers were dismissed as insignificant, and others were ostracized despite their ability to currently function within the workplace.

Illness hierarchies also helped to explain workers' practices of selective disclosure. Workers were more willing to disclose some information than others, depending upon its location within the perceived hierarchy of illness. As outlined in the workers' practices of silence, one of the participants explained that she freely shared information about her experience with seasonal affective disorder, but kept silent about her drug addition. A similar description of selective disclosure was provided by one of the managers; workers may share difficulties related to stress or mood, but are less likely to talk about psychotic symptoms.

Mgr-S: In that situation, it's often tied to a life event, whether it is menopause and my hormones are out of whack, or ya know, and I'm just not feeling well and I need to go off because I am having problems with my mood. Or, ya know, I'm going through a terrible divorce and custody, and or I have had- my kid was killed. People are better able to talk with me about those things than about a psychotic illness.

Even though participants worked in a mental health treatment facility which presumably is more enlightened regarding mental health and addictions issues, it was recognized that workers were situated within a broader social context and were not immune to the societal discourse of stigma and discrimination. One staff member, for example, indicated: "there are certain things that society imposes on us around mental illness. You can't escape that." She referred to the pervasive influence of the media: "people still go home to the same movies and media and TV shows that everybody else does. And you absorb that; you pick it up." Another stakeholder presented a similar argument, referring to the tendency for people's attitudes to regress at times: "we all grew up with the same messages, right, about people with mental health issues. So, to not be impacted by that is, I guess, impossible." Workers are not only embedded within an organizational context that shapes their views of mental health and addictions issues, they are embedded within a larger societal context as well that governs behavior.

In summary, an understanding of the dynamics of the stigma discourse helps to shed light on many practices of silence within the organization. Workers with mental health issues were questioned regarding their credibility, legitimacy and stability. Rather than viewing the discourse as a force that affects all workers in the same way, however, it seemed to have a differential impact depending upon the nature of the illness itself and how it was perceived.
within the social context of work. This understanding helps to explain variability in the response of workers and stakeholders within the organization in terms of what becomes defined as a problem and the ways in which people respond. The stigma discourse was shaped by organizational forces regarding approaches to mental illness versus addictions issues, as well as by societal views regarding the nature and severity of illness.

### 5.1.5 Challenges to the stigma discourse.

Although there were many ways in which the stigma discourse was taken up by workers across the organization, there were a few notable exceptions. Instead of accepting that employees with mental health issues were a liability to the organization, some workers actively resisted this assumption and engaged in advocacy efforts to try to change attitudes and beliefs. Instead of staying silent, they felt that it was important to challenge discrediting beliefs and practices, and generate an open dialogue about mental health and addictions issues among staff members. Advocacy occurred at an individual, collective and organization level.

As outlined in the workers' practices of silence, there were several workers who intentionally disclosed their personal experiences to others as a form of advocacy. One worker, for example, referred to herself as the "poster child" for the organization, telling her story in order to reveal some of the attitudes that exist in healthcare towards mental health issues. Although some advocacy efforts were directed toward individual co-workers, others were broader educational efforts within the workplace and even to the general public. The workers who engaged in this intentional disclosure felt that they had a personal mandate not unlike the public mandate of the organization to change attitudes and beliefs about individuals with mental health issues. Josie, for example, talked about her sense of personal mission: "the more I talk about it, the more people out there will reach out and get the help they need". Although some were reluctant to take on this role, they nevertheless felt that it was important.

The impact of individual advocacy has been mixed. The following comment exemplifies the mixture of respect and doubt that follows individuals who choose to publicly disclose their personal experiences.

*Lana: And I just thought, “Wow, there is a little bit of a role model.” … Although, I did look at her with different eyes. I mean, it’s just like Margaret Trudeau. She was very animated when she talked. And I was sitting there, “A little hypo-manic girlie?” Ya know, so quick to label.*
Individual advocacy therefore did not necessarily change attitudes. Collective advocacy was another approach used to challenge the stigma associated with mental health issues. Formation of a peer support group for staff members with mental health issues is one example of a collective approach. The group, developed several years ago, meets approximately once a month to provide peer support and discuss issues of mutual interest. When the group was initially formed, there was some resistance from the organization regarding efforts to formalize the group within the workplace. Members felt as if they were 'marginalized' within the organization, explaining that "Diversity [office] is minimizing our diversity issue" and that "Occupational Health and Risk Management said we are too risky". The group persevered, however, on a more informal basis. Attendance at the group varies, in part due to the stigma that continues to exist regarding mental health issues. "Some people will respond and say that they are interested, but they’re nervous. That they don’t want people to see them coming to meet with the group".

Another collective advocacy effort was in response to the union's poster campaign depicting healthcare providers as the victim of violence. This sparked a grassroots advocacy effort among staff within the organization who felt that the ad was misleading; depicting a stereotyped image of clients as violent. There were a number of meetings held, outrage expressed, and letters written in order to rally against the poster campaign. These efforts, combined with advocacy efforts from the broader mental health community, were credited as being successful in ending the poster campaign.

At an organizational level, there have also been some advocacy initiatives. Several participants, for example, referred to the public education campaign of the organization's fundraising foundation. The Foundation's public education efforts were considered to be an important step towards reducing the stigma associated with mental illness. In fact, one worker commented; *I must say that this Transforming Lives campaign has made it much easier to address [mental health issues] in myself and, and disclose to other people.* Others felt that the campaign was useful, but had some limitations. A couple of participants, for example, commented that the posters typically depicted famous people external to the organization, and expressed an interest in seeing more profiles of "ordinary" individuals that one might encounter on a day-to-day basis.
Overall, the individual, collective and organizational initiatives highlighted efforts to create more of an open dialogue and acceptance of individuals with mental health issues within the workplace. In some ways, these efforts seemed to reflect a discourse of advocacy that countered the discourse of stigma and discrimination. In other ways, the efforts to move beyond practices of silence cast light on the barriers that still remain with respect to stigma and discrimination. Workers with mental health issues continue to be marginalized in the workplace despite apparent resistance to the ruling relations of silence.

5.2 Staff-Client Boundaries

A second related discourse governing practices of silence within the organization is one that is captured in rules about staff-client boundaries. When staff experience mental health or addictions issues that are not unlike those experienced by clients, traditional boundaries between service providers and service recipients may be threatened. Instead of being a detached and objective expert, the service provider may be viewed as sharing similarities with clients who are struggling with illness and are in need of assistance. It is my position that the functioning of the organization is based on establishing clear distinctions between service providers and service recipients, and that silence practices are required to maintain this distinction. In order to illustrate how this discourse is taken up on practice, I will initially outline the material practices that reinforce staff-client boundaries, discuss the links between the discourse and practices of silence, review the impact of social position on staff-client boundaries, and then outline challenges to the prevailing discourse.

First of all, it is important to note that an explicit recognition of staff-client distinctions was evident in how participants described the social relations of work. Several workers, for example, talked openly about the boundaries between "us" and "them" as one of the dominant features of the organization.

*Aden:* Well, the culture is one of "us and them". I think a lot of clinicians use that to kind of protect themselves with. That is "them", and this is "us".

*Nora:* There's this distinct feeling of "us" versus "them". And 'us' as apart from the mentally ill.
**5.2.1 Material practices reflecting staff-client boundaries.**

There were numerous structural features of the work environment that reinforced a bounded relationship between service providers and service recipients. Throughout the organization, there were clearly demarked spaces for "staff" versus "clients". Many clinical and administrative staff, for example, worked in offices or meeting spaces that are separated from clients by walls or even locked doors. As you walk into the building, staff in the reception area are enclosed in a locked, glassed area, with only a small round opening for communicating with others. Inpatient units have nursing stations that include walls separating them from patients. Many offices and meeting spaces must be unlocked by a key that is issued only to staff. Client spaces, on the other hand, are often less bounded (eg. lobby, open client resource space in centre of the main building). Inpatient areas are an exception, where clients may have a room in a locked or unlocked ward, and they may have to ask permission to leave. Staff can typically freely move through the client spaces, but this experience is not reciprocal; clients often need permission to enter staff areas. Even the Christmas parties exemplified the boundary differences; clients were not invited to enter the staff Christmas party, although they were served some of the food in the lobby outside of the space in which the party took place. In contrast, all staff were welcome to attend the client Christmas party.

In addition to spatial boundaries, there were outward markers of the distinct subject positions of staff versus clients. Staff were often recognizable through outward appearances; wearing nametags and carrying keys for access to certain spaces. In a recent initiative, clinical staff were provided with personal alarms, signifying that they could potentially be victims of violent acts committed by patients. Patients, however, were not equipped with the alarms, reinforcing distinctions between us and them; between the perpetrators and those that need to be protected from the perpetrators. One of the sources of controversy that erupted during the time that I was in the organization centers on public posters initiated by the union depicting a staff member who was the victim of workplace violence. Part of the subtext of this poster campaign underlined divisions between staff as victims, and clients as perpetrators of violence.

The distinct social position of service providers and recipients was also inscribed in organizational texts, such as the workplace policy on "Appropriate Therapeutic Boundaries", developed in November 2008. The opening paragraph of the policy outlines the organizational mandate for maintaining professional boundaries, and its applicability, not only to clinicians, but also to all staff within the organization:
The reputation of [name of organization] as a leading institution in client service and therapy depends on the integrity of its clinicians, and indeed, all individuals associated with [name of organization] who may have even casual contact with clients. For this reason, [name of organization] requires that its clinicians maintain a professional, therapeutic relationship between themselves and clients that does not extend beyond a defined professional boundary. Moreover, all employees, physicians, contractors, volunteers and students associated with [name of organization] or its programs, are required to maintain appropriate relationships with clients.

The policy goes on to provide examples of boundary violations, and emphasizes the importance of reporting any inappropriate relationships between clients and staff to "Management, Professional Practice or Human Resources". It also makes reference to broader policy, regulations and laws that may be in place to govern therapeutic relationships. In fact, regulated health professionals have professional codes of conduct that also outline standards regarding therapeutic boundaries.

5.2.2 Boundary discourse and practices of silence.

All of these policies and practices highlight ways in which boundaries are maintained between staff and clients. They are fundamental to the functioning of the organization. When staff members become ill, however, these boundaries can be threatened. Practices of silence may therefore be instituted to re-establish the distinctions between service providers and service recipients.

Some workers, for example, felt pressured to present as competent and deny the fact that they may be struggling. The social context within which they work expects them to be an expert service provider. In this role as an expert and helper, there was little or no room to admit that they were ill and needed help.

Fran: I think part of the training of people in my field is really damaging in that you're supposed to be objective and unaffected and- ... I train therapists all around the province, and I think a lot of people carry this sense that they have to be perfect, you have to have the answers and they can't admit that they're struggling -certainly not in the field that they're supposed to be the helper in.

As outlined earlier, workers internalized expectations of competence and engaged in strategies of impression management in order to project this image in the workplace. Workers were careful about how they positioned themselves and their issues in relation to clients within
the organization. For some, it was important to maintain their identity as a service provider rather than service recipient.

*Lana:* When I first got diagnosed and went for therapy and drugs I was… [whispers] "Oh what if somebody knew. I'd be one of those people." I was actually in a therapy group that I eventually dropped because I couldn't hear that somebody who might be a client would join the group and see me in another context.

At an organizational level, there was little recognition that a service provider could also occupy a subject position as a service recipient. A couple of participants explained that mental health issues among staff was not even part of the vocabulary of the organization.

*Aden:* My theory is that a lot of organizations, [name of organization] included, we’ve inserted “wellness” into the corporate vocabulary. So, ya know, we talk about these buzz-words like the “work-life balance”, “maintaining your mental health”, “mental health days” and all this kind of thing. But we never talked about mental illness when it came to employees. We talked about it in relation to clients, but we never mentioned it in relation to ourselves. And I think, because of that, because it was never talked about, it was kind of assumed it didn’t exist. And because people thought it didn’t exist, we never learned to talk about it in a reasonable way. So you know like, the first time your friend’s parent dies or something. You don’t really know what to say. The first time you’ve experience like death or a funeral or someone close… You don’t know what to say because you don’t have yet the vocabulary, the lingo, the sentence, the thing that conveys...

Generalized denial that staff can experience mental health issues, and limited vocabulary to talk about it could therefore contribute to the delays in acknowledging or acting on concerns that were outlined in the stakeholder practices of silence.

A potential exception to the lack of acknowledgement of staff illness is in the addictions field. As outlined in the section about the stigma discourse, many participants referred to the tradition in the addictions field of hiring staff who had personal experience with drug and/or alcohol abuse. The shift away from this tradition and towards hiring individuals based on credentials rather than life experience, was reportedly in response to concerns about staff, who in their own struggles with addictions issues, had difficulty maintaining therapeutic boundaries with clients.

*Mgr-A:* So in the addictions field, right, the, the old traditions were, you having somebody with an addiction, a history of, a personal experience of addiction and that was seen as a valued life experience that you brought as an employment requirement. ...
over time it became clear, that there were ... performance issues that hadn’t been managed well. And so there were a number of people who were struggling and having difficulty and ultimately ... there were some high profile media incidents. ... There was a program assistant who, ya know, took a client off drinking and binging and they did some coke. And that was, ya know, in the [newspaper]. ... over time, ya know, there are people that have been replaced, and we’ve gone to much more credentials. And personal life experience is not one of the requirements of the job, nor is it valued. I think it’s um- I think people are, are weary of it and are afraid to take that on as a manager.

According to comments made by several participants, tolerance for staff members with a personal addictions history has decreased over time. This may, in part, be due to concerns about staff-client boundaries. As the quote above illustrates, credentialed expertise as a service provider is more highly valued, and is associated with less risk that boundaries between clients and staff would be violated.

Another organizational practice which maintains staff-client boundaries relates to systems of supports established for staff members. Many participants referred to the longstanding practice of referring staff outside the organization when they require treatment for mental health or addictions issues. There was a strong sense that "it is not in people's best interest to receive their care and treatment here". This was difficult at times when the organization where they worked provided the best treatment for their condition. One employee laments; "For safety, I wouldn't seek treatment here. Do I believe we have some of the best clinicians? Absolutely." Although there are staff who receive services from other [organization] staff, this is the exception rather than the rule. One of the stakeholders described accessing services within the organization as a "black market" approach.

OH-1: we do have quite a few cases where it’s- where individuals are off work because of mental health issues, and the specialists that we do have around who are the best are at [name of organization]. So what happens is now we're between a rock and a hard place because we are asking an employee to go and see a [organization] doc and that could be seen as conflict of interest, of course. So those are things that we need to steer away from. Now there’s, there’s a, there is sort of an unwritten rule here from what I understand, that an employee cannot be seen by, cannot be treated by a physician who works here at [organization]. ...I have heard that there are some individuals who do, who are treated being treated right now by [organization] physicians, but that’s sort of, through sort of the back door, sort of black market sort of treatment.

By referring staff to services outside the organization, there is less likely to be confusion about staff-client boundaries, and it also maintains silence within the organization about the issues that staff may be experiencing.
5.2.3 Impact of social position on staff-client boundaries.

The issue of staff-client boundaries manifested differently depending upon the individual's social location or role in the organization. It seemed to be a particular issue for staff who held a clinical position. As one worker, a clinical service provider, reports: "it [a history of mental health/addictions] issues wouldn’t have been a big splash at all if I like worked in Dietary." In front line positions such as housekeeping or food services, there were not the same physical or symbolic boundaries between staff and clients. One of the managers describes the difference: "The clients view the housekeeping staff as their buddies more times than not, because we don’t have the power to take away their privileges like the clinical staff do. So more times then not, they will befriend the housekeeping staff." The power differential between non-clinical staff and clients was not as pronounced. Another participant commented on how "refreshing" it was to talk with staff in Housekeeping or Dietary because there was more openness regarding mental health issues.

For clinical staff, there were more expectations to be experts in service provision. The clinician's position of power in the therapeutic relationship formed the basis for policies on therapeutic boundaries. As the policy states; "[Name of organization] requires that its clinicians maintain a professional, therapeutic relationship between themselves and clients that does not extend beyond a defined professional boundary." It was therefore not surprising that practices of silence and concerns about therapeutic boundaries were primarily evident in the comments of study participants who were clinical service providers.

Although to a lesser extent, concerns about boundaries were also evident among workers who held managerial or director positions. As one stakeholder explained, it was important for managers to be perceived as competent or 'sturdy'; "I think you have to be sturdy and you have to be, you know, perceived as tough enough and all that kind of stuff. ... You have to be able to handle the pressure." Since managers hold positions of power within the organization and often have a high profile, it was felt that they needed to maintain an image of competence. Consequently, it was particularly difficult for them to disclose any personal experience with mental health issues.

5.2.4 Challenges to staff-client boundaries

It is important to note that the discourse about staff-client boundaries is not static, it is taken up in different ways across the organization and across social positions. There are also
ways in which ideas about boundaries are being challenged within the organization. I will highlight two sources of challenge to the boundary discourse. One concerns clients who are hired as staff members, and the other concerns staff who disclose their personal experiences with clients.

**Clients who are hired as staff**

When hearing about the focus for the project, the initial response for many was to refer to the organization's initiatives in hiring former clients. There are several in-house programs designed to increase employment opportunities for individuals with a history of mental health or addiction issues. These programs have been developed in response to the mandate of the organization to improve the lives of the client population that they serve. In these programs, the person's history of mental health and/or addictions issues is known by at least one person at the outset of the hiring process. The types of positions available are often in non-clinical support roles where professional qualifications are not required. Five of the participants in this study explained that they were hired through one of these programs. All of these participants emphasized that they were very grateful for the employment opportunity. They were very positive about the support that they received and felt that their needs were accommodated. Hector, for example, who works several hours a week in an administrative position, indicates: "It feels like I'm working with family and my family is supporting me". Similarly, Irene expresses her satisfaction and gratitude: "I'm really fortunate in the area that I work in, and to be working at [organization] too." Stakeholders describe similar themes in the positive feedback that they have received from former clients who have been hired in paid staff positions. Greta, for example, recounts: "we’ve had feedback from one person who said... that the small job that we gave her initially led to another job that might become permanent and its, its had an amazing impact on her life." Staff with mental health or addictions issues in these roles seemed to be an accepted social location. It fit within the overall organizational mandate of helping clients.

Although hiring former clients as staff appeared to challenge traditional staff-client boundaries, the extent to which these boundaries have changed remains questionable. There was a sense that former clients were viewed differently than other staff members whose mental health issues were not known. One worker described his job as a "paid placement". Others expressed concerns about assumptions that were made about their level of competence. As one stakeholder
reports: "once they find out you’re a person with a history... there’s an immediate reduction of-
of their sense of what the person can achieve."

Former clients who were hired in staff roles continued to recognize the boundaries between themselves and the "regular" staff. Some felt as if they needed to be ambassadors to show that they could cross boundaries to assume a new role as a service provider.

Hector: My work experience has been, certainly lately, and with my experience at [organization], to straddle the bit of a boundary between consumer peer employment and consumers integrating into the greater workforce. I like to straddle that. I'd like to make those more fluid boundaries. If they exist, I'd like to make them more fluid.

One of the recent developments in the organization, which represents a challenge to this traditional staff-client boundary separation, is the newly developed role of peer support workers. There were many references to this new position and the ways in which it has challenged traditional views within the organization. One of the stakeholders, for example, comments on the significance of the new role: "And they’re clients. They are clients who have had a mental health background. ... And they are paid staff employees. So that’s brand new. That’s a big thing. That’s a huge thing." One of the study participants who was a peer support provider talked about the pressure on her to ensure that this new initiative is successful.

Rachel: I guess, that worry that if I admit that the job- or that if I got some mental health issues, my worry would be the assumption by the higher ups that peers can’t handle being within [organization] and that it may have negative repercussions for all the peers.

Some stakeholders felt that restrictions have been put on the role such that they are not equal members of the clinical team. One of the managers observed that the rate of pay is the lowest, and they are not allowed to chart, making them "second class citizens on a team". She expressed concern that: "they are already second-class because they are, they’re “out” as somebody with an illness- as someone who has had personal life experience. And then they’re job is second-class. Another participant commented that "they’re not really part of the team."

Although clients hired as staff is viewed as progressive and a potential challenge to the traditional staff-client boundary discourse, there is also a sense that these changes are limited.
Staff who identify with clients

The other potential challenge to the discourse about staff-client boundaries relates to workers whose mental health histories may not be known to others, yet they choose to cross the boundaries and identify with clients.

First of all, it is important to note that there was considerable variation among workers in terms of the degree to which they identified with clients. There were some who were very clear that their experiences were different from clients; "I would really not sort of go and present myself as a consumer-survivor". Others, however, felt that their experiences were more aligned with clients, and described themselves as "passing" as a healthy service provider: "… part of me that identifies with the clients when they come in… It feels kind of like I pass, but I still feel more aligned with them in some ways." One of the stakeholders described a 'continuum' of how people view themselves.

HR1: Some may say, you know, ‘that was me like five years ago,’ some might say, ‘I was never as badly off as that’. I think they would identify probably as an employee at [organization] first because that’s something to be proud of, but I think internally, they would identify more with the clients.

The way that people defined themselves was not necessarily static or fixed. Some participants explained that there were changes over time in terms of how they viewed themselves in relation to others who had mental health issues.

Christine: It’s only kind of over time that I’ve come to see myself as someone with mental health issues. I know that may sound strange, but … when I was having the initial problems [explains situation] … I sort of thought, well, post-partum, that’s different. That’s, somehow I didn’t associate that with mental illness, per say. It’s crazy, but I, I was just, I didn’t really know anything about it. And I saw my situation so specific …[describes stressors] … I just thought so much was due to my very individual circumstances that it didn’t really occur to me to associate myself with people who were having other mental health issues. I guess I didn’t see the common ground at that time. … I might have needed someone else to help me make that connection.

Clearly not all workers identified or aligned themselves with the community of individuals with mental health issues. Through public disclosure and advocating on behalf of people with mental health issues, however, some workers did cross the typical staff-client boundary. As outlined in the section on challenges to the stigma discourse, this action had mixed results which at times, led to questioning of their competency. Another way in which staff
crossed the typical staff-client boundaries was through disclosing their personal experiences to clients. As outlined in the workers' practices of silence, there were several participants who intentionally disclosed their personal history to clients in the context of their helping relationship. In each case, the disclosure was reported to be helpful to the client. This type of self-disclosure, however, represented a departure from traditional clinical practice, and was described as "rife with problems". In fact, one of the participants explained that she was fired from a previous job because she had disclosed her personal experiences to a client. Unlike disclosing physical health issues, disclosure of mental health or addictions issues was not considered to be acceptable.

Opal: I have never shared with clients my own struggle. ... Sometimes clients are "I absolutely don't want to take medication. I am totally against medication. And then I'll use the line: "you know, yes, yes there is concerns and so on, but some people need to have medication. You know, like myself, I have arthritis in my knees so I need to take medication for my knees." So I'll disclose to that extent, but nothing more.

Nora: [in response to question about disclosing to a client]. At this point, I don't feel that I have enough experience to do so kind of ethically. ... I think the most disclosure I've had with any client is; "I used to have a dog too, and I know they're bloody hard to toilet train!' [laughter] That's the extent of my disclosure. But nothing about mental illness.

One participant provided a different perspective on the issue of disclosure. She felt that crossing the boundary with clients would change her relationship with them and increase expectations for advocacy.

Lana: I just, I didn't feel comfortable telling them. I didn't, I was afraid, I was afraid that it would take the therapeutic relationship to a different level of expectation and intimacy. And I was afraid they would make more demands on me. Like, "you know what it's like, you should advocate for us better. You know what it's like - now you are one of us and you should go out there and, you know, make everything better for us." And I couldn't. I just didn't want that expectation.

In general, although there were staff who acknowledged that their issues were similar to those of clients, many did not. Those who publicly acknowledged these similarities often did so despite risks to their image of competence.

At the outset of this section, it was emphasized that the organization has clear boundaries between "us" (the staff) and "them" (the clients). The discourse regarding staff-client boundaries was embedded in the day-to-day beliefs and practices of the workplace, with little recognition of a subject position for service providers which recognized that they may have mental health issues.
of their own. Although there were challenges to these boundaries in the form of clients being hired as staff, and staff identifying with clients, change continues to be slow.

Parvin: [In response to question about whether there has been a shift in openness about mental health issues over time] Yes and no. I think there's more people working in the system, because from my own experience working in the mental health system -that's my whole working career- When I started, there were consumers and there were professionals -and so I think there's more quote/unquote professionals who are talking about their own mental health histories and experiences. But I'm not- I don't think it's reached a critical mass yet.

As with the discourse on stigma, there is a sense that the traditional staff-client boundary discourse may be changing. The workers who represent an "in-between" subject position category may be involved in the process of change.

5.3 Competing Discourses of Responsibility

The other main force that seemed to govern practices of silence relates to discourses about responsibility for addressing the mental health issues of workers. As one stakeholder observed, *there’s lots of misunderstandings about what people’s rights are, and what their responsibilities are*—*it’s not well understood.* In my opinion, there are three competing discourses which govern practices of silence and inaction among stakeholders: a) individual responsibility, b) clinical responsibility, and c) managerial responsibility discourses. I will outline the nature of each discourse, its impact on practices of silence, and the ways in which it was produced. I will then consider how these competing discourses shape action.

5.3.1 Individual responsibility discourse.

The primary discourse of responsibility that seemed to shape practices of silence was based on a view of mental health as a private, individual issue. This discourse includes an emphasis on individual responsibility rather than a collective, workplace responsibility for the mental health of workers. This discourse was taken up by both workers and stakeholders.

Nature of the "individual responsibility" discourse

When describing development of their mental health and/or addictions challenges, most workers attributed these challenges, at least in part, to the stressors that they experienced at work. Stressors included high workload demands, interpersonal tensions, and inadequate workplace supports. There was little recognition, however, of the role or responsibility of the employer in
addressing these workplace issues. Lana, for example, complains that the organization is "very blaming instead of looking at why people are having more sick time." The focus was not on the source of the stress, but on the employee's ability or inability to handle these stressors. Some workers felt as if they were blamed for the problems that they experienced.

Monique: There's lots of pressure. Lots and lots of pressure. And lots of things going on... [explains system changes, reduced staffing, extra responsibilities] So all the stuff was coming down from the, from the higher ups. We were all saying: "we're bursting, we're tired, we're exhausted". ... And so, he said to me, “Well, if you can't- part of your job is that you assume these extra responsibilities, and if you can’t do your job, then you should go on disability.”

In contrast to a focus on prevention and reduction of workplace pressures, the focus was on the employees' maladaptive response to these pressures, and the employee's responsibility to address mental health issues that may be impacting on their work. As outlined in the stakeholder practices of silence, there were managers who dismissed or refused to accommodate workers' requests for support. Monique, for example, was feeling overwhelmed with her workload and asked for "space and time", yet her manager kept increasing work demands. Bryn asked for support from a summer student, but her manager dismissed the request. In the following quote, Lana tried to explain to her manager that she was struggling with interpersonal tensions and unrealistic expectations at work, yet felt that her manager's response redirected the conversation to Lana's responsibility to change.

Lana: I didn't want her to think I was buggering off and pretending to be sick, so, you know, I explained that- And her take was, “Well, let's do what- let's do what you need to do so that you don't, so it doesn't reach the point where you need to take sick time.” So to me, that was like; "learn to be assertive and learn to have these conversations so that you can get it over with and not have to run away from it". And save her money.

The implicit message in all of these examples was that it was the employee's responsibility to find a way to meet performance demands. Workers' concerns about the impact of the work environment on their mental health were ignored or silenced.

**Individual responsibility discourse and practices of silence**

Many employees seemed to internalize this expectation of individual responsibility. It was evident in their strategies of impression management; they wanted to present as competent and did what they could to manage their illness so that it would not affect work. Few accessed
workplace supports such as EAP or occupational health. Instead, they sought out supports on their own and outside of work. One worker explained "to me it was a very private issue". Another worker stated "it is part of my modus operandi which is I take care of things myself". By not talking about their issues as a workplace concern, they seemed to be taking up the discourse that mental health issues were an individual responsibility.

The discourse was also evident in some of the tensions experienced by managers and colleagues. One manager, for example, described a situation in which she was trying to address signs of mental illness that she noticed in one of her staff members. The response from her managerial colleagues was that she should not act, since it was not her responsibility to intervene when there was no disruption to work performance.

**Mgr-M:** I was looking to my peer group for some help and support and got nothing. Absolutely nothing. ... I was trying to keep it kind of a high level of, “Ya know, am I obligated to do something? Is there something I should do?” And people were essentially saying, “Look. There’s no disruption. There’s no trouble. It’s not a problem that she is sick in the workplace. Even if she is, it is none of your business.” ...it's not our responsibility to look at what their options and opportunities are and what their support systems are.

Similar feelings of ambivalence regarding responsibility to act on concerns were evident in co-workers' practices of silence. Participants explained that "people don't want to intrude on other people's toes. They just want to mind their own business". Rather than risking repercussions of addressing issues directly, another stakeholder explained "it's best not to even say a word".

**Social relations shaping the individual responsibility discourse**

The response (or lack of response) to mental health issues was different than the typical approach to physical injury or illness. Several stakeholders reported that they were more likely to act if they were concerned about an employee's physical health rather than mental health.

**Union-1:** You would have no problems saying to your colleague “Mmm, looks like, you know, you're-, I don’t know, you're your blood sugar seems to be out of whack, have you seen your doctor?” We often see members who are decompensating and nobody will deal with the issue because people are uncomfortable.

The silence associated with mental health issues may be due in part to the lack of organizational structures to support action. Several stakeholders indicated that there were no
established standards or guidelines for communicating with employees who were struggling with mental health issues. As a result, they were not sure when or how to act.

Mgr-A: And there’s no standards, right? So it’s all individual. ... I think there’s a lack of comfort. Like it’s a grey area for us. ... we don’t know what the best practices are in terms of, um, you know, how do I communicate? What am I supposed to communicate?

U-1: There is no procedure. It is left up to whether your manager will approach you and say, “Is there something going on? Is there something I can help you with?” ...Because most people will not do that.

The absence of communication standards implies that there is no official mandate for managers to address the mental health issues of employees. It reinforces the discourse that the responsibility for mental health remains with the worker.

The one policy directive that participants did reference relates to privacy legislation governing confidentiality of the health information of workers. Stakeholders were acutely aware of the mandate to keep personal health information confidential. This mandate was at times used to justify the lack of communication between stakeholders. Personal health information was considered to be private, and not something that would be shared collectively with the team. One of the managers, however, talked about her struggles with respecting confidentiality, with questions such as "How do you disclose to the team what is and isn't happening? How do you stop the rumour mills while still respecting confidentiality?" She acknowledged that without direct communication, there would be indirect communication in the form of gossip and rumours. She felt that there was no good way of communicating information to others without compromising the privacy of the worker.

Mgr-M: So I don’t think people are aware of the impact of the lack, like absolute silence around these things as well. There has to be a way as an organization that we can help people understand that people are off in a way while respecting privacy and confidentiality. But we are struggling with that and I don’t think we have a really good answer yet.

The mandate to maintain privacy regarding the mental health of workers, coupled with perceived lack of direction regarding the roles and responsibilities of managers seemed to contribute to stakeholder practices of silence. Causality, however, cannot be determined; it may be that these forces shaped the practices of silence, or that they were used to justify the silence.
5.3.2 Clinical responsibility discourse.

When there was a belief that mental health issues were an individual concern, there was little incentive for others to take action when an employee was ill. There were colleagues and managers, however, who did raise concerns about workers and act on these concerns. Upon closer examination, it appeared as if there was an alternate discourse in play, one that was clinical in nature.

Many managers and co-workers were trained as clinical service providers. This professional training formed the foundation of their response to ill staff members. They instinctively drew upon their specialized knowledge and skills in assessing and treating individuals with mental health issues. As a result, their role seemed to shift from that of a colleague or manager to that of a service provider. One manager explicitly stated "it's no different than our work with clients".

When an employee's problems became public, for example, the response of some co-workers was governed by a clinical perspective. They began to monitor the mental status of the identified worker, interpreting any change in mood or behavior as a potential relapse. Instead of ignoring issues and leaving workers to handle them on their own, some staff became hyper-vigilant in their approach to monitoring behavior.

Mgr-M: if you’ve disclosed a mental health or addictions issue, people will look at you twice and think, “So is this just a bad day or is she getting sick? Or is she drinking? Or is something else going on?” And it brings in a different level of scrutiny that I think is uncomfortable. .. nobody will ever say, ya know, it’s never an issue anymore. People will always look and wonder and, and I think that’s part of the, the label that gets put on...

As illustrated in the above comments, when colleagues were governed by this clinical discourse, the nature of the relationship with the worker changed; they became more of a clinician monitoring behavior than a colleague providing support.

Participants also shared many examples of managers who adopted a clinical role in attempting to help the ill staff member. As one manager explained; "there are a number of people who become, when they’re their bosses, they become their therapists to try and support them". As a result, they may attempt to explore issues with workers and provide therapeutic support, or they may make special arrangements to support an employee without going through the formal organizational channels for accommodation. There were reports of managers, for
example, who drove employees directly to the hospital or home when they were concerned about
the employee's health. Some managers offered their home phone number; another even brought
in a staff psychiatrist to evaluate an employee's behavior. Concerns were expressed that they
went beyond their role as a boss.

Mgr-M: One was to help the front line leadership realize that they were in a leadership
position and not a therapist position. So helping them pull that apart which is really hard
in a clinical environment. People feel a need to respond clinically. And I keep saying,
“That’s not your role. You are not their therapist. You don’t have the same
confidentiality issues. There is a documentation mandate. There are a lot of people you
have to inform.”

Although the managers' behavior was described as a "human" response and was typically
well intentioned, it was nevertheless considered to be problematic. Several stakeholders
explained that talking about and addressing health issues with clients was outside of the
manager's mandated role.

Mgr-A: What our managers have done, because they want to be supportive; they want
people- you know, they are clinicians. They end up accommodating people because they
want to help people, but there’s nothing documented

It should be noted that the clinical approach was more likely to be adopted by managers
and co-workers who were trained health care providers. Their training in identifying and
managing mental health and addictions issues provided them with a particular lens for
interpreting behavior. Managers and coworkers without this clinical training were less likely to
adopt this approach. Unlike the individual responsibility discourse that reflected the mandate for
employees to fend for themselves, the clinical responsibility discourse did spur stakeholders to
action. This action, however, often changed the power dynamics of the workplace relationship
from a collegial to a therapeutic connection.

5.3.3 Managerial responsibility discourse.

One other exception to the discourse of individual responsibility was a managerial
discourse regarding work performance. Unlike the clinical discourse, this appeared to be the
official discourse that was supposed to govern the behavior of managers. As one participant
explained; "their role is to manage the workplace and make sure that the work is done." Central
to the managerial discourse is the mandate of managers to meet productivity and performance
standards. As another stakeholder explained; "we understand that the person needs to be away for whatever reason, but we still need to operate a business and we still need to have the- and the organization still needs resources". If an employee is not meeting performance expectations, then their behavior becomes actionable from a managerial perspective. The manager is expected to intervene to objectively address the issue and restore productivity.

*Mgr-W:* Well, I think for me, um, that I probably always try and have my manager hat on the majority of the time because I have to think about productivity and I have to, if they are not producing, if they are not working well, then we are not serving clients. And we have to be able to serve clients.

The official course of action depends upon whether it is considered to be a "performance" issues or a "health" issue. If there is a performance issue, for example, the manager may contact Human Resources for consultation:

*Mgr-A:* [Describing procedure for dealing with an employee who is displaying threatening behavior at work] Well, consultation first, right? I mean, I would call-, I would call HR first to talk it through. What are my legal options? ... We’ll have a meeting with the union and the manager, and HR present.

If there is a health issue, on the other hand, managers are supposed to refer to Occupational Health rather than try to address the issue themselves.

*OH1:* There’s a process that needs to be followed if you are concerned. That you should be contacting my department and we should be making some arrangements to have the employee seen within Occ Health and maybe- And of course, leaving it up to sort of occupational health and their clinical skills to assess the individual and make the referral.

Although the threshold for action was often quite high, managers were prompted to act when there were significant concerns about an employee's performance. Performance issues were in fact a trigger for action in many cases, from concerns about safety through to concerns about attendance and productivity. Safety in the workplace, for example, was a fundamental concern. If an employee's behavior presented a risk to themselves or others, then managers were compelled to act. There was a written code of conduct for workers and a recently developed "whistle blower" policy designed to encourage staff to report concerns about workers who were violating the code of conduct. If a worker, for example, was threatening towards co-workers or
jeopardizing client care, then they were clearly in violation of the employee code of conduct, and managers were compelled to acknowledge and act on the issues.

Union-1: There was just again another big incident in the program where- Like no judgment at all. Like just when into a situation where she could have been seriously injured or seriously injured a client. And that's when the manager said "Okay, now I'm getting it."

Union-2: It has to reach a huge breaking point. Or it reaches a point where the members say to the manager; "I don't want to work with that one because I don't think they are safe to work with."

To a lesser extent, managers may act if the employee is missing time from work. There was an attendance management policy which outlined the importance of regular attendance. It is interesting to note that the first point outlined in implementation of the policy stipulates "Employees are responsible for ensuring their regular attendance at work." The message is about the individual responsibility of the employee, consistent with the individual responsibility discourse. The policy does, however, go on to state that, "When an employee is considered to be excessively absent, the employee's immediate director will implement the procedures outlined in this policy in order to assist the employee to address this problem". The manager's responsibility is triggered by "excessive absence", but again, the primary responsibility rests with the worker. There were several examples provided where managers approached employees with concerns about attendance, although this was not as commonly reported as concerns about safety. One of the tensions described by a number of managers was balancing productivity expectations with the accommodation and support needs of individual employees.

Mgr-M: Our pendulum swings. I mean certainly the direction it has swung in now is; 'accommodate return to work at all costs'. Well there are some costs that we can't afford. So, safety and management within a workplace environment. So there have been times where as a manager I was forced to bring in on accommodation an employee who offered no benefit to the workplace at all. Like they were given meaningless work. And that wasn't good for the staff member either.

Managers were aware of their responsibility to meet productivity expectations, but also struggled with their mandate to support employees as well. Accommodating employees with mental health issues were considered to be particularly challenging.
Greta: If somebody needs time off because it's a Muslim holiday or what, ya know, that's- I think we do very well in that. Ya know, people have those accommodations. I think that the being different, being different because you might be considered behavioral, you might be considered odd or, ya know, some of those other kinds of things, I don't think we're as good at. Not withstanding the population we serve.

One of the managers called it a "grey area". Some managers struggled with how to 'do the right thing' for workers without putting their own reputation at risk.

Mgr-M: So we’re all a bit, I think, immobilized with it and it’s a very helpless and frightening feeling especially if you don’t know how the organization is going to support you and going back to what you said before, everybody just wants to do the right thing. If nobody is telling you what the right thing is and isn’t, you feel also that you are at risk yourself. You do not want to be on the other end of a human rights complaint. So at what point are things a human rights issue, at what point is it a workplace safety issue, at what point is it a return to work and OcHealth issue, when is it a performance and human resources issue?

Overall, the managerial discourse was recognized as an important part of the mandate of the organization, yet there were reported challenges in translating this discourse to day-to-day practice. Other than threats to safety within the workplace, other guidelines for intervention were not as clear.

5.3.4 Influence of competing discourses of responsibility.

With three discourses of responsibility circulating in the workplace, each with different guidelines for responding to employees with mental health issues, it is perhaps not surprising that they are taken up in different ways by stakeholders across the organization. The individual responsibility discourse seemed to lead to silence and inaction, whereas the clinical and managerial responsibility discourse did outline a mandate to act. The mandate to act, however, was not uniformly accepted or clearly outlined in policy directives. It may in fact be difficult for workplace stakeholders to "do the right thing" if the right course of action is not clearly defined.

Misunderstandings may also occur if stakeholders take up competing ideas about what to do when a worker has a mental health issue. There may be times, for example, when colleagues feel a clinical obligation to help the worker, yet this is not appreciated by a worker who subscribes to an individual responsibility discourse. There may be other times when co-workers feel that the manager has a responsibility to act, yet the manager subscribes the individual responsibility discourse and stays silent. One of the stakeholders commented on the
differences of opinions and how it can create barriers in the workplace; *if everyone doesn’t buy into the idea, then it will not be successful; it will fail. It’s inevitable. Everyone needs to be on the same page*. Several stakeholders recommended training and education within the workplace regarding roles and responsibilities so that there would be more of a shared understanding and coordinated efforts in supporting employees with mental health issues.

5.4 Conclusion - The Social Production of Silence

The purpose of this chapter was to move beyond the day-to-day experiences of workers with mental health issues and make visible the institutional relations which created the conditions of individual experience. Consistent with an institutional ethnography method of inquiry, the focus was on understanding the local and trans-local social relations which shaped practices of silence among workers and stakeholders (McCoy, 2006).

Although there were many potential forces producing practices of silence, there seemed to be three primary discourses that shaped behavior within this workplace, including beliefs about the stigma of mental health issues, staff-client boundaries, and responsibility to address mental health issues among workers. These ways of knowing within the institution were sometimes inscribed in texts (e.g., therapeutic boundary policies, codes of conduct, attendance management policy), but typically were more implicit in participants' talk and actions. They were taken up in different ways by stakeholders within the organization and, through their participation in the discourse, they reproduced and modified it. Rather than static beliefs about staff members with mental health issues, the ideas were clearly evolving. Beliefs about the stigma associated with mental health and addictions issues, and about staff-client boundaries, for example, were challenged at times through advocacy initiatives and client employment initiatives, respectively. There were also competing ideas about responsibility for addressing the mental health issues of workers that created tensions among stakeholders at times and had a variable impact on day-to-day practice. It is important to note that these discourses were not mutually exclusive, and may have a combined effect on practice. Concealing information about mental health or addictions issues among workers, for example, may be produced by fears of being discredited (stigma discourse), by the need to project an image as a competent, objective service provider (staff-client boundary discourse), and by beliefs that their private health issue should not be disclosed at work (individual responsibility discourse). In addition, delays among stakeholders in addressing issues may be produced if; a) they minimize or do not recognize the
threshold at which a worker is legitimately ill (stigma discourse), b) their vocabulary to address illness among staff members is inadequate (staff-client boundary discourse), and c) they feel that it is not their responsibility to intervene (individual responsibility discourse).

Overall, I have argued that discursive forces seemed to explain how practices of silence were produced in the workplace. In the next chapter I will focus more on the consequences of the silence practices.
CHAPTER 6 - Consequences of Silence

The first two chapters of the study findings detailed the practices of silence within the organization and the social forces that governed them. The focus of this chapter is on the consequences of the practices of silence, including the consequences for; a) the mental health of workers, b) workplace relationships, and c) overall work performance and productivity. A central finding that crosses all areas is that silence can have paradoxical consequences, both ‘functional’ (beneficial or instrumental effects), and ‘dysfunctional’ (risky or problematic effects). I will discuss both sorts of consequences and the relationships between them.

6.1 The Mental Health of Workers

The first consequence of silence that I will discuss relates to the mental health of the workers. All of the participants experienced mental health or addictions issues at some point in their working lives even though many were currently in good health. I will highlight the functional and dysfunctional implications for participants' mental health in terms of working despite illness, access to workplace accommodations and beliefs about responsibility to act.

6.1.1 Working despite illness.

There were times when participants admitted that they were experiencing symptoms, yet continued to go to work. Working despite illness had a number of positive as well as negative implications for their mental health.

Many participants talked about how important work was to them during the times when symptoms of mental illness began to surface. They felt that the routine of going to work was actually helpful and important in maintaining their mental health. If they did not talk about their problems, they did not have to acknowledge to themselves or others that they existed, and they maintained their external image of competence. Participants also claimed that continuing to work had therapeutic value in the management of their illness; they were able to stay motivated, maintain a regular routine, avoid rumination, and maintain a sense of meaning and purpose. Dawn, for example, talked about her experience with depression, indicating that: "the only thing that kept me going was actually coming to work." For Dawn, the routine of work was critical: "at least it was something meaningful that I was doing." Similarly, Parvin explained that she
tries not to take sick days because if she is on her own, her thoughts get worse: “if I stay too long on my own I won’t even get out of the house. So even the interaction kind of breaks through the monologue.” Although sick leave is typically the result of illness for many workers, this was not necessarily the case for participants in this study. Since work was associated with mental health, they kept silent about their symptoms in order to stay at work and prevent their mental health issues from getting worse.

There were limits, however, to this approach of working despite illness. Some participants indicated that they just kept going and did not realize the impact that the illness was having on them. It was not until after they stopped working or stopped to reflect, that they recognized the extent to which they had been affected. Katie, for example, stated; "At the time I didn't see solutions, I just kept working. ... It was only after I was out of the situation that I realized, you know, how severe it had gotten."

Over a third of the participants admitted that there were times when they needed prompting from others, or hit a crisis point before they acknowledged that they were not doing well. They described a build-up of issues over time until they reached a point where they could not continue any longer. A few participants described problematic behavior that happened at work (eg. crying, or angry outburst at a meeting), but most referred to "falling apart" at home or outside of work. Workers were often reluctant to admit their difficulties.

Bryn: I definitely knew that I was not doing well, and getting worse, but it really wasn’t until the doctor said, “You know, you are a mess. And you can’t keep going like this.” But even though part of me knew that, I hadn’t officially told myself that kind of thing. ... ... so both of those times it took someone to come out and say it. And at first there is a little bit of a, [gasp and dramatic tone] “No. I’m fine!” Ya know, like, there is a reaction of wanting to say, “No, no, no, no, I’m fine. I can handle it.” But it definitely, it breaks down a wall of, ya know, then, “Oh my God, they are right. I’m not coping. I’m not holding it together.”

Difficulty in acknowledging mental health issues may contribute to the pattern of working for as long as possible. According to many participants, the problems often escalated to the point of crises before action was taken. Workers seemed to find it difficult to distinguish between whether they should continue working to maintain their mental health, or whether they should take sick leave in order to maintain their mental health.
6.1.2 Accessing support.

A related mental health implication of staying silent, concerns the motivation and ability of workers to seek help when they are unwell. In the organization, there were a number of supports available, including an employee assistance program and occupational health services, as well as the right to health-related accommodations in the workplace. These supports were rarely used, however, and there seemed to be tensions associated with asking for help.

There were tensions, for example, among workers who "don't speak out or don't seek the help they need because they are afraid". These workers were anxious about how they might be perceived by others if they admitted that they needed psychiatric help. Dawn, for example, talked about her desire to seek out therapy at times, but holding back "because I don't want to have to deal with like; 'I've got to go [to a therapy appointment]". For some workers, it was easier not to say anything than to ask for accommodation to seek psychiatric treatment. The risk of admitting to others that they were struggling deterred many from seeking help.

Others acknowledged that they might need assistance, but were not sure how to access services in a way that would ensure confidentiality. "There is nowhere to go anonymously", asserted one worker. As outlined in the chapter on social production of silence, participants recommended that workers seek help externally in order to maintain confidentiality. With the stigma associated with mental health and addictions issues, however, it was difficult for workers to find confidential support either within or outside the organization.

In the examples described above, silence served to protect the workers' image as a healthy, competent worker. There were, however, a few exceptions to the patterns of silence that illustrated the potential value of an open dialogue regarding mental health issues. There were several workers, for example, who indicated that they shared information with their colleagues about supports that may be available. Through disclosing their own challenges, they felt as if they were able to help others. Theo, for example, talked about sharing resources that he has used, including contact information, with the hope of “pointing people in the direction of information”. Josie talked about the sense of purpose she felt in using her experiences to help others; That’s the reason why everything came up and happened to me, because now it is my turn to, not to like save the world or whatever, but if there is someone else out there to be able to say like, “It’s
okay and you are going to get through it. And we are here to help you”. She described the importance of instilling hope in others who may not be doing well.

Participants suggested that if workers reached out to others and acknowledged the issues, they might be able to access the help that they needed on a more timely basis.

Josie: If in a few weeks, within a few weeks of my getting high, or starting to get high, somebody said to me, “Hey. You need to get out of here for a few days. You're getting all- ya know, get down to Occ[upational] Health. I'll take you down there. I'll whatever. “That would be great.

In addition, it was suggested that if mental issues were discussed more openly, others would be better able recognize the issues and willing to seek help. Aden, for example, draws parallels with other conditions such as fibroids or menopause, and the value of hearing the experiences of others. She suggests that increased openness might lead to increased acceptance of the issues and need for support.

Aden: I felt like I was pretty prepared for the first time I had a hot flash, because I'd heard so much about it and it really helped me. And why can’t it be the same for like if you start to feel like you are experiencing symptoms of depression? If people had been talking about it a little more and recognizing it, maybe you’d be quicker to go and get help.

Whether or not workers access supports for their mental health issues seems to be shaped by practices of silence. On the one hand, an open dialogue may be helpful in encouraging workers to recognize not only their mental health issues but the resources that are available to them. Without this awareness, workers may not seek treatment or support when they need it. Accessing support, however, carries a risk to one's image of competence and consequently might be a significant deterrent to action.

6.1.3 Responsibility for action.

Another mental health implication of silence relates to the extent to which others assume responsibility for acting upon the mental health issues of workers. One the one hand, silence can absolve others from responsibility; however, it is also recognized that this represents risks to the mental health of workers.
One of the functional implications of the practices of silence is the potential to absolve employers from the responsibility to address the mental health of workers. As one manager asserted; "it's not our responsibility to look at what their options and opportunities are and what their support systems are." Some workers felt as if they were being blamed while the employer remained blameless. One participant, for example, complained that: "instead of looking at the source of the stress and why people are taking time off and looking at motivation and all that, it's just well, let's blame the nurses because they are calling in sick too much". This comment suggests a perception that the employer is shifting responsibility for mental health issues from the organization to the individual worker. Another participant implicated that this approach would be beneficial for the employer since costs would not need to be incurred to accommodate the mental health needs of staff members, or to address workplace-related factors that contribute to mental health problems. Furthermore, the employer would not be expected to develop training programs within the workplace to combat stigma and discrimination.

In contrast to comments about lack of acknowledgement and action on the part of the employer, there were some participants who expressed concern regarding these practices of silence. For example, one of the union representatives reported; "my experience has been that people go off when they're absolutely unable to function in the workplace anymore. ... The manager usually says "Oh my God, okay you have to- we have to get you out of here." This point was echoed by another stakeholder who lamented that "we are a very reactive organization". They were concerned that workers did not get the help they needed in a timely way. Another manager asserted that the organization should take a more proactive approach to provide supports to employees who are struggling.

Mgr-M: As a compassionate employer we need to know what’s out there so at least we are prepared in the workplace to know are they going to be able to get any support outside of [organization]? What, what does it mean if they can’t? How much do we know and not know about what’s available out there? What can our Occ Health department do? ... But I really do think that a great place for us to start right now is, I think we are primed as an organization to have some open, structured sort of collaboration sessions to say: What is our stance?; How are we going to openly support people?

When asked about changes that they would like to see in the organization, many workers also called for more proactive involvement on the part of the employer. Instead of leaving responsibility for mental health up to the individual worker, they felt that the employer should
assume more responsibility in the process. Parvin, for example, argued that the employer should set an example; making it clear that this is a workplace that supports people with disabilities, and different types and different life experiences. She felt that this was a "minimum expectation" in a mental health and addictions organization. Christine felt that there should be a screening process when individuals are hired in the organization as a standard part of the Occupational Health assessment. Individuals who appear to be under a lot of stress could therefore be provided with additional support to ease their transition. Theo felt that manager training would be particularly important to recognize people in varying degrees of distress, and then encourage workers to seek out supports. All of these examples, point to a desire on the part of workers for more active involvement on the part of the employer to identify and provide supports to workers with mental health issues.

Overall, there were many arguments for the importance of breaking the silence in order to prompt the employer to take more responsibility for addressing the mental health of workers. However, the arguments made by both workers and stakeholders illustrate the tensions surrounding the issue of responsibility. Although some argue that less silence and more action would improve mental health, this approach would incur costs for the employer. There could be financial costs as well as costs to the reputation of the organization.

6.2 Workplace Relationships

The second area of consequence is for workplace relationships. Although mental health issues are experienced by individual workers, each worker is embedded within a broader social network. Consequently, the impact of the issues may extend beyond the individual to other members of his/her workplace network. The study findings suggested that practices of silence may serve a function in maintaining social order, but may also present challenges to working relationships. I will outline the benefits and risks of silence as it relates to; workplace discrimination, tensions between colleagues, and social roles

6.2.1 Workplace discrimination.

One consequence of silence for workplace relationships lies in its role in shaping discrimination against workers with mental health issues. In some ways, silence appeared to protect workers from discrimination. When workers attempted to conceal their issues and
present an image of competence, they reduced the likelihood of being stigmatized by others. As outlined in chapter four on the practices of silence, workers were strategic or selective in their disclosure based, in part, on consideration of how responsive and supportive their colleagues might (or might not) be to this disclosure. If they felt that they would be discriminated against, they were less likely to disclose. Quinn, for example, reported that he would not disclose his addictions issues to anyone at work since he was convinced that he would be "ostracized". By concealing mental health issues, workers hoped to reduce their vulnerability to discrimination.

In contrast to the functional aspects of silence, some data suggest that silence might ultimately perpetuate stigma against individuals with mental health issues. Speaking out, or breaking the silence was identified as a key strategy to counter stigma at both an individual and organizational level.

At the level of day-to-day interactions, some workers disclosed information to their colleagues in an effort to engage their support. Several participants hypothesized that colleagues might be more empathic if they knew that the difficult behaviors at work were related to an illness, and therefore outside of the individual's control. Instead of being angry, they felt that colleagues might be more understanding, supportive, and motivated to help. As one manager said; "with their coworkers or their peers, unless they disclose to them what’s wrong, or what’s going on, they don’t have empathy for them. They just think that they are lazy... They are not thinking that there could actually be something wrong with this person." Breaking the silence could therefore counter negative images of the workers' behavior.

At an organization level, some participants advocated for a collective effort in being open about mental health issues. It was felt that this might ultimately help to reduce stigma within the organization and lead to greater acknowledgement and acceptance of diversity in levels of mental health and wellness among staff members. If employees were aware that they were working alongside individuals with mental health issues, for example, they might be less likely to make discriminatory comments.

_Aden: You aren’t going to talk about crazy people in a really derogatory way if you know you are working with crazy people. And pretty soon I think it will be everybody jumping on someone saying, “You can’t say that.” Or “That’s not acceptable.”_
A number of participants referred to changes in attitudes that they are starting to see due to increased visibility in the organization of workers who have experienced mental health issues. For example, the organizational practice of hiring consumers of mental health services has reportedly increased awareness within the workplace and prompted a "shift" in thinking.

HR1: I think the culture shifted and I think the communication, right? Like people now knew. Like nobody was walking around here before saying, 'I'm a consumer and I...' nobody was. So, I think it’s becoming- people aren’t in shock anymore. You know what I mean? It's becoming something that- I think people have done a lot of learning. ... I can’t put my finger, but I can smell that there’s been a change and there has been’. I guess starting with; people aren’t as shocked as they used to be.

In addition, increased openness regarding mental health issues, both inside and outside the organization was identified as an important contributor towards decreased discrimination. Parvin, for example, credits "more quote/unquote professionals who are talking about their own mental health histories and experiences." Another proposed explanation is that there is more awareness and training, both within the organization, as well as in professional programs.

Aden: I think the shift has just been more people disclosing. The[support group for employees with mental health issues] is getting a little more publicity and now being part of orientation [within the hospital] and stuff. I think it's becoming more clear to new staff that discrimination shouldn’t happen. And you know, stigma and all that kinda stuff. And I think a lot of- we’ve hired a lot of new grads recently. And they come out of school with, ya know, courses in diversity already, and anti-stigma, and anti-oppression. They learn those kinds of frameworks right away. And so I think that kind of brings a better perspective to the work. Even though they are inexperienced, at least they’ve got those frameworks to go by. Whereas a lot of people don’t-

Breaking silence therefore was seen as an important step towards decreasing stigma and discrimination in the workplace. As one of the workers explained; I think it just would make for a kindler, gentler workplace if everyone was just a little bit more open and it was treated just like any other health issue. Despite the changes that were noted, however, it was recognized that stigma continues to exist, and that silence can in fact be a strategy to protect workers from discrimination.
6.2.3 Tensions between colleagues.

Another workplace relationship implication of silence noted by many of the stakeholders was the role of silence in either reducing or producing social tensions between workers and their colleagues.

First of all, stakeholder practices of silence such as ignoring or not acknowledging issues were described as ways of avoiding social tensions. Co-workers may, for example, avoid saying anything or "cover" for their ill colleague, particularly if he/she was well liked or respected. As one manager explained "part of it’s not wanting to raise trouble, get somebody in trouble. Be implicated as being the company snitch." Breaking the silence, even with the intention of helping the ill worker, can increase tensions in workplace relationships. Stakeholders spoke of what can happen when a worker does not agree with the concerns that are expressed.

Union-1: And the problem with mental health, as well, is a lot of times people don’t necessarily have insight into their behaviors. Right? So you are kind of stuck between a rock and a hard place. It can also be viewed as people interfering in people’s confidential medical information. It can be viewed sometimes as manager harassing me.

Mgr-A: Within a few days he [employee off on sick leave] came back to work. Very angry, and in any sort of context, inappropriately telling people [in a disgusted tone], “Oh, my manager sent me on a psych consult.” You know, so you could see that he still was not well. ... He made threatening comments towards me...

The examples provided above illustrate the ways in which strategies of openly addressing mental health issues among workers can be risky for workplace stakeholders. Managers and co-workers may be negatively labeled or even threatened by exposing the issues. Silence or "looking the other way" can therefore serve as a way of avoiding this uncomfortable tension.

Although practices of silence could be functional for workplace stakeholders, they also posed a number of risks to workplace relationships. Social tensions can be increased, for example, when the ill worker is not able to meet performance demands, thereby increasing the workload of his/her colleagues. As one manager reports; it gets to the point where they get angry. It’s like, you know, we are making the same money. Why should I protect him? Why should I cover for him? I’m putting my health at risk. And so I am not going to do this anymore." Another manager asserts that there is less tolerance for workers with mental health issues:
Aden: There’s some things that people will go out of their way to help someone with. You got a cast on your foot; people will do all kinds of things for you. Because they also know that it is time limited. There’s this idea that if you have mental health, "oh my god, I’m going to have to carry your weight for years. It’s going to last forever."

In addition, mental health and addictions issues often affect an individual's ability to interact with others. Depending upon the nature and severity of the symptoms, some individuals become withdrawn and avoid social situations. Several workers explained, for example, that when they become ill, their energy is low, they are overly sensitive to criticism from others, and can be quite tearful at times. Others explained that they become highly anxious in social situations and avoid people whenever possible. Another response is to become irritable or even abrasive with others. One worker described herself as being "snappy and angry and not tolerating things very well". These behaviors can strain relationships with colleagues. Co-workers’ responses to these behaviors can vary from confusion to frustration to anger or even fear. Anger or threatening behavior, in particular, can damage relationships.

OH1: [Describing response to colleague] During the project, he started wandering off. And it started to become irritating to me. It's like; why is he acting like this? He is acting strange. It never crossed my mind why. ... And in the beginning I started feeling sorry for him, but then I started to get annoyed, like you are really annoying now. And then...he started being abusive.

Mgr-S: That was a really bad scenario. It was bad because that event, and the staff witnessing that level of agitation, scared the bejeezus out of 'em. The woman that was the victim of this verbal attack, was not sleeping, was not eating. She was preoccupied and anxious. It had an effect on her in the workplace. ... it took her a long time to feel safe again. There were a lot of her friends who were appalled and upset and worried and felt like they were walking on eggshells.

Silence and delays acting on concerns reportedly damaged relationships at work; often to the point where they could not be repaired.

Christine: I think, far too late, she started having more frequent meetings with the manager and she was trying to find ways to hold him to account. And sending him, just basically supervising him closely, monitoring his deadlines and so on. But it was far too late to have any patch on my working relationship with him, anyway. That was pretty much irrevocably destroyed.

Irreparable damage to workplace relationships can be a particular problem in if an employee is to return to work following a mental health crisis. Although an employee may be
expected to return to their former job, the success of re-integration may be jeopardized by co-workers who may not be receptive to the worker's return. There may be unresolved feelings or questions about whether there might be a recurrence of the problems that led to the initial crisis.

*Union-2:* I think there is a standoffish response when somebody comes back to work after being ill. People hold back. They don't want to work with people again. I've known people to ask for a different shift. I've known people to switch programs. That their level of being uncomfortable is so great to them... I do know that my colleagues have said "I just can't... I can't work with her. I know like she's ill. I can't." The level of trust apparently that's gone.

Workplaces are social spaces therefore the impact of ignoring mental health or addictions issues can be costly in terms of relationships in the workplace. Since privacy concerns preclude open discussion with co-workers, managers felt that there was little opportunity to resolve potential conflicts. Whereas physical conditions may be discussed more openly, mental health issues are more secretive.

*Mgr-S:* I think generally people have a lot more anxiety about coming back to work when they have been mentally ill as opposed to, you know, when they have got a cardiac problem. ... And it's a challenge because I can't go up to the treatment teams and say "Joe's coming back because he's had an episode of mania and it is now all well controlled. And we need to support him." Like I can't do that. But if it is somebody who has been out for cardiac rehab, chances are they've already told all their colleagues. ... I would guess that it's still a very different transition.

One manager did spend time talking with staff about an incident that occurred before one of the workers left on a sick leave due to mental health issues. She felt that she was able to use mediation skills that were part of her professional training, but indicated that this work was very challenging and time consuming.

*Mgr-S:* Because you are walking a fine line, right? I spend a lot of time with the team after the fact. Kinda- Not doing a debrief, but really supporting them. They needed to tell their story. They needed to tell me how frightened they were. They needed to go over that a hundred times. So I spent a lot of time listening and supporting and problem solving while this woman was off. And, you know, giving people a clear message about the need to support one another.

Despite the hours that the manager spent with the co-workers both before and after the staff member returned to work, ongoing tensions remained and eventually the staff member who had been on sick leave transferred to another department in the hospital.
Mgr-M: So I don’t think people are aware of the impact of the lack, like absolute silence around these things as well. There has to be a way as an organization that we can help people understand that people are off in a way while respecting privacy and confidentiality. But we are struggling with that and I don’t think we have a really good answer yet.

Overall, the risks of silence include resentment that can build up among colleagues if they need to cover the workload of the ill worker. Co-workers may also be angry and/or frightened of changes in behavior that may occur, particularly if they do not realize that they are associated with mental health issues. Conflicts or tensions may jeopardize return-to-work following sick leave, and these tensions are often deep-seated and not easily resolved. Although silence may be a strategy employed by stakeholders to initially avoid social tensions, there may also be a negative impact over time.

6.2.3 Social roles and boundaries.

In addition to the relationship impact of silence on discrimination and social tensions, silence can have consequences (both functional and dysfunctional) for established social roles within the organization.

As outlined in the previous chapter, staff-client boundaries are central to the functioning of the organization. Since staff are expected to be objective service providers, it can be problematic when they experience the same mental health issues as the clients in the program. One of the functions of silence therefore may be to maintain staff-client boundaries. If workers do not disclose their personal issues with clients, professional boundaries are maintained, and the distinction between service provider and service recipient remained clear. Furthermore, if workers did not disclose their personal issues to colleagues or managers and their issues remain hidden, the nature of their workplace relationships may not change. If they do disclose, there is a risk that they will be treated differently by others:

HR-3: If you have disclosed a mental health issue, and your supervisor or colleague, rather than dealing with you on particular business matters, makes a comment like, "I treat people like you all the time. I know what your problem is." That really diminishes the validity of your business issues with that person, and puts you in a very, I would think, vulnerable situation. Very, very condescending.
Silence therefore can circumvent the change in social position with respect to both clients and colleagues. The risk of changing the nature and power dynamics of the relationship is reduced.

Although silence may be functional in some ways with respect to maintaining social roles, it may also have negative consequences. One of the potential risks of silence is that it reduces opportunities for peer support and mentorship. Several workers talked about the sense of isolation and lack of direction that they felt when they were experiencing mental health issues. Mental health issues can be scary and isolating at times. Aden, for example distinguishes between her need for support when she is simply feeling "down": "I don't need to come in here and tell people I'm feeling down today because everybody feels down once in awhile.", from her need for support when she feels as if she might be getting ill: "when I'm scared that I'm slipping too much and things could be going wrong- I mean it scares the crap out of me and I wish sometimes that I could bounce that off someone." Another worker describes a similar need for "lifelines": It's a stressful situation and people need help. And lifelines, you know? One of the challenges reported is that workers may not know what to do with their symptoms and have few supports outside of the workplace. If workers needed to seek help from others either within our outside the organization, they felt that options were limited. Peer support or mentorship among staff was identified as a potential resource for overcoming this isolation and helping the person develop strategies for dealing with their issues at work.

Nora: It would have been helpful inasmuch as if there was some sort of mentorship in place. If I could have gone and had lunch with someone and said; "How have you, as a more experienced clinician, worked through mental health with respect to your job? How do you mediate this aspect of yourself in this setting?" It would have helped because I maybe could have gotten reassurance; Yes, I'm feeling anxious, but it hasn't negatively impacted this aspect. And maybe some adaptation of how I do things, and some guidance on how to do that. I'm only [age]; I don't know how all this stuff works.

As outlined above, silence may isolate workers and restrict opportunities for peer support, whereas an open dialogue has the potential to challenge the role of "objective staff member" in a positive way. On the other hand, breaking the silence carries the risk of disrupting social roles and the distinctions between workers and clients that are central to the functioning of the organization.
6.3 Productivity and Performance of Workers

The third implication of silence relates to the productivity and performance of employees within the organization. I will profile both positive and negative productivity consequences as they relate to the use of workplace supports or accommodation, and to the quality of service provision.

6.3.1 Workplace supports.

This study suggests that access to workplace supports was shaped by practices of silence. As noted in chapter four, very few workers negotiated formal workplace accommodations related to their mental health issues. Instead, they often implemented their own strategies to ensure that their work performance was not affected, and were more likely to continue to work than take sick leave. Silence, in this case, could be considered functional for the employer since there may be cost savings associated with reduced absenteeism or sick leave. In addition, the employer did not have to assume responsibility for negotiating and providing supports for the worker.

Although maintaining silence served a number of important functions for the employer, there were times when silence was more problematic, particularly when mental health issues appeared to interfere with job performance. Workplace accommodations could be put in place to enable optimum job performance if there was an open dialogue between the worker and employer regarding functional limitations and accommodation options. If workers were not willing to admit that they had difficulties, they could not access accommodations that could enable them to meet their job demands. Many stakeholders talked about their frustrations and challenges associated with workers were not willing to disclose.

Greta: But if the person won't disclose, you know, that they're struggling, then you can't help, or isn't aware, then you can't help, you know, and if you can't help and then people keep doing that stuff, you know, then you want to discipline... It’s very challenging.

OH2: And then I had to deal with a coworker who was a substance abuse [sic] and would come to work under the influence. And the manager would send him here. It’s like, okay, what do we do? He was not admitting to anything. “I'm not. I didn’t drink anything. No, no it is not true!” Yet he doesn’t want to get the help, right? And the manager says, well, because of safety he cannot operate machinery. He is under the influence and so we have to send him home. ... It is very difficult.
In addition to situations where the employee did not initiate a discussion about workplace accommodation, participants shared stories of managers who refused to discuss accommodation. As outlined in chapter four, some workers asked for extra support to help them meet workload demands, yet these requests were dismissed and the workers ended up feeling "burned out" and unable to continue to work. One of the stakeholders, for example, shared the story of an employee whose request for a quiet space to work was denied: "She just didn't come to work one day and said, "I just cannot do this anymore". And so spent a lot of time asking for help and getting none." Productivity was compromised since the employee was not able to meet the job demands without additional supports.

In contrast, workers who were able to negotiate accommodations seemed to fare better in terms of meeting job demands. Several managers described their proactive approach to initiating a problem solving process regarding workplace accommodations with their employees. One manager, for example, approached a worker who was having "significant attendance issues" to the point where her colleagues were "getting angry and very resentful". Instead of taking a punitive approach, the manager asked: "was there something I could do to support her in the workplace?" since "this was affecting her performance and her reliability as an employee." Another manager described a similar negotiation process with an employee who was able to proactively schedule time off "instead of not coming in or getting upset". In both cases, the accommodations were considered to be successful in enabling work performance.

Overall, it appears as if an open dialogue regarding workplace supports or accommodation could have a number of advantages for employers in terms of workplace productivity. It should be noted, however, that both employers and employees may be reluctant to engage in this dialogue due to the risks that it presents, particularly in an organization that is not receptive to mental health issues among workers. In the case of the employer, there may be financial risks associated with providing supports, and for the employees, there may be social risks associated with admitting that they are ill and in need of support to function at work.

**6.3.2 Quality of service provision.**

Quality of service delivery is another one of the productivity consequences which seemed to be shaped by practices of silence. As outlined in chapter four on the workers' practices of silence, most employees were very invested in being and appearing to be competent, and
engaged in many strategies to ensure that their work performance was not affected by their mental health issues. Silence surrounding the mental health issues of workers was functional in the sense that it helped staff maintain an image of competence. Disclosure, on the other hand, could lead to questioning of their competence at work. "I feel like if I disclose that would be the assumption. That- well, that means that she is going to let us down." This viewpoint was challenged by several workers who argued that mental health issues did not necessarily detract from their work performance. They emphasized the feedback that they received, not simply on their basic competence, but on their excellence as a worker.

Although many workers emphasized their competence at work, there were those who admitted that their work performance was affected by mental health issues. Silence in this case meant that the quality of work could decline if the issues were not addressed. Participants reported that mental health issues could have a range of effects on work performance, including not being able to concentrate, difficulty getting along with others, and difficulty maintaining regular attendance. Workers may not recognize that they are not doing well, and managers may not know if they should support or discipline workers who are not maintaining standards of work. As one of the stakeholders reported; "There is not a clear demarcation between where performance is acceptable and where it's not. That intersection of where a mental health and addictions issues is impacting on performance." The point at which the silence should be broken is not clear, in terms of preserving quality of work performance.

Another, perhaps less obvious, risk of silence in relation to service provision is the potential to ignore the value that workers with personal experience of mental health issues can bring to clinical practice. Several workers felt that their personal understanding of what it is like to have mental health issues made them a more empathic and effective clinician. Even though they may not have the exact experience, they felt as if they had an enriched sense of what clients may be going through.

*Nora: I can certainly empathize with a couple of my clients at least, when their behavior that they manifest when they are extremely anxious, and the coping strategies that they've used- ... So it makes it a little bit more human for me as opposed to feeling like oh, this rigidity is pathological. It’s a bit easier to see how; OK, no maybe it’s a little more adaptive than people recognize.*
Rachel: I don’t know what it is like living with that specific diagnosis. But I do know what it is like to live with mental health issues. I do know what it’s like to live with stigma. I do know what it is like to live with labels. I do know what it’s like to live with discrimination. You know, like all these, the hard parts. Like no, I don’t know all the specifics for this one disorder, but I do know what it is like living as someone being labeled as “other than”. And that, I think, is the key.

As a service provider, they felt as if they had the potential to be less judgmental and more empathic, even if they did not disclose directly to their clients. Opal, for example, asserts that she is able to establish "great" rapport with clients because "they will feel that we get what they are saying." Similarly, Quinn feels that he is a better clinician than most because he is "more empathic with people. ... Especially if they have substance issues then I can speak to them more directly."

Since mental health and addictions issues are often poorly understood, this insight into client experiences was described as "rich experiences for learning, not only for ourselves, but how to do better with clients". Parvin, for example, reported educating her colleagues regarding the differences between "how the system works on paper versus how it works in the real world". Similarly, Aden felt as if she could offer insights to her colleagues into clients' behaviors; I can offer suggestions in terms of what's gonna work with them or how you can approach certain situations." Instead of being a liability, workers may add value in terms of being less judgmental, more insightful clinicians that are responsive to the needs of clients

Although silence can be functional in maintaining individuals' reputations as competent workers, they also carry a risk of not recognizing the "value added" that experience with mental health issues might bring to healthcare work. The perceived quality of work may also be shaped by the extent to which mental health issues are openly addressed when symptoms start to affect work performance.

6.4 Summary

Clearly, the practices of silence are complex in terms of the implications for workers, their colleagues and the organization as a whole. There are ways in which silence preserves the mental health of employees, workplace relationships and overall productivity. There are also ways in which the same practices of silence represent a risk to mental health, workplace relationships and productivity. For example, the silence associated with working despite illness
may help preserve the mental health of workers, yet may also exacerbate mental problems if silence gets in the way of seeking help. Stakeholder silence regarding mental health issues may prevent escalation of social tensions among workers who are not willing to acknowledge the issues, but may also generate social tensions if issues are not addressed. Silence may preserve images of competency among workers, yet may also suppress recognition of the additional talents that workers may bring to the organization.

Furthermore, breaking the practices of silence can be a double-edged sword. Disclosure of mental health issues may increase the likelihood of workers accessing support for their problems, yet may also make them more vulnerable to discrimination. Open dialogue regarding mental health issues among workers may increase tolerance in the workplace, but may also threaten staff-client boundaries and social roles which are fundamental to maintaining institutional order. Although there are many arguments for breaking the silence, there are also many counter-arguments for the role that silence plays within the organization.

In presenting the findings related to the consequences of silence, I have highlighted the many reasons why silence is produced and reproduced in the workplace. Although changes in the practices of silence are evident, there are many trade-offs to consider. In the next chapter, I will reflect further on the practices and production of silence.
CHAPTER 7 - Reflections on the Practices and Production of Silence

The overall objective of this study was to describe and analyze, from a sociological perspective, the experiences of individuals with mental health issues who were working within a large mental health and addictions teaching hospital. A core issue that emerged was that of silence, and how the organization's public images of open dialogue regarding mental health issues seemed to contrast with silence regarding staff with these issues. In presenting the findings, I illustrated the ways in which workers and a range of workplace stakeholders engaged in various practices of silence and how these practices shaped the day-to-day experience of workers. I argued that silence was produced and reproduced by organizational discourses related to stigma, staff-client boundaries and responsibility for action, and that silence had powerful and complex consequences for the mental health of workers, workplace relationships and workplace productivity and performance.

In this chapter, I will reflect on these findings in relation to the practices and production of silence, accounting for how these practices were constituted within the organizational context of work. I will draw upon the perspective of institutional ethnography, initially examining the issues from an interactional perspective, then examining how interactions are embedded within a broader organizational and social context. In particular, I will argue that the practices of silence constitute relations of ruling within the workplace; they coordinate actions of workers and workplace stakeholders across and beyond the local sites of everyday experience (Smith, 1990). Furthermore, I will explain how silence served to organize and exercise power, contributing to the marginalization of workers who do not meet the standards of mental health and competence within the workplace. The discussion will be divided into three main sections. The first will focus on the practices of silence themselves; what the findings tell us about the concept of silence and how silence is taken up (or not taken up) by workers and workplace stakeholders. The second section will outline the ways in which the mental healthcare workplace creates a particular context for the production of silence. The final section will focus on accounting for resistance to the institutional order, and what this tells us about the production of silence in healthcare work.
7.1 The Practices of Silence

*The only wise one, is the one who understands silence.* (Erik Gustaf Geijer, 1840)

The concept of silence has many different dimensions of meaning. As the quote above, by Swedish philosopher Geijer (as cited in Alerby & Elidottir, 2003), suggests, wisdom can be gained from an understanding, not only of what is said, but by what is left unsaid. Alerby and Elidottir (2003) in their exploration of the "sounds of silence" in the field of education, explain that "we can assume that silence means different things to different people and that it can communicate many and different things" (p.41). They emphasize that silence may be elected or imposed, and that a non-message is also a message. Silence always tells us something.

Silence is defined in the dictionary as "the absence of sound" or "a period of time without speech or noise" (Collins English Dictionary, 2003). In this study, however, silence was not simply an absence, but rather an active practice adopted by stakeholders at all levels of the organization. The practices of silence included work such as concealing issues and identities, withholding information, ignoring cues, closing down dialogue and subverting attempts to make issues visible. It included rules about when and when not to speak, and about what information could and could not be revealed. Establishing, maintaining, enforcing and reinforcing silence was a dynamic process, embedded within a complex web of social relations. There was variation in the nature of the practices, in who engaged in the practices, and in motivation for maintaining the silence. To interrogate the practices of silence that emerged in this study, I will initially discuss the workers and their practices of concealment, followed by reflection on the silencing practices of workplace stakeholders.

7.1.1 Silence as a form of concealment.

Early on in the study, it became evident that many workers attempted to project an image of competence; they adopted strategies to ensure that their work performance was not affected by their mental health issues (eg. working late, strategic use of vacation days), and they were reluctant to ask for accommodations or seek help from the employee assistance program or occupational health services. When experiencing symptoms, they worked hard at maintaining their performance at work, even if it was at the expense of their functioning at home. The pattern of workers trying to conceal their mental health issues is well documented in the research
literature (McCarthy, Prettyman & Friedman, 1995; Schulze & Angermeyer, 2003). Details regarding how the silence is maintained within the context of work, however, are rarely provided. The study findings therefore provide an opportunity to explore practices of concealment in more depth, including consideration of the interactional, organizational and discursive dimensions of work.

From a theoretical perspective, participants' efforts to maintain an image of competence in the workplace seemed, in many ways, to be consistent with the practices of impression management described in Erving Goffman's seminal work on stigma. Goffman (1963) proposed that a stigmatizing condition such as mental illness meant that individuals affected by the illness were potentially "discreditable". In other words, there was a discrepancy between an individual's virtual social identity as someone who is healthy and competent, and their actual social identity as someone who is associated with the stigmatized category of being mentally ill (Goffman, 1963). He hypothesized that individuals with mental illness would carefully manage information about their hidden disability to guard against being discredited. In fact, Goffman (1963) argued that individuals may expend considerable energy managing outward impressions in order to avoid the negative repercussions of being found out and consequently labeled as ill or deviant. The act of projecting an image of normality is described as "passing". The experience of passing is discussed in the disability studies literature with respect to individuals whose illnesses are not visible (Linton, 1998). Passing is conceptualized as a way of gaining social acceptance through strategies that project membership in a social group that is not his/her own (Renfrow, 2004). In my study, workers could be seen as trying to maintain their position in the workplace and social identity as a competent worker by presenting as someone who had no personal experience with mental health and/or addictions issues.

This perspective on social interactions could help to explain some of the workers' practices of selective and strategic disclosure. Goffman (1959) argues that communication techniques such as "innuendo, strategic ambiguity and crucial omissions" (p.62) are strategies of impression management. These strategies seemed to be adopted by some of the study participants, when they hinted at issues rather than discussing them directly or when they shared some information, but not others. Some instances of direct disclosure to managers could also be considered an impression management strategy. Some workers, for example, did not share information regarding their mental health issues until their symptoms started to interfere with
Work performance. At the point where they were concerned about being disciplined or labeled as a behavior problem, they explained their health situation to their supervisor (or colleagues). By framing their performance problems as a health rather than a behavior issue, they hoped to be supported rather than blamed. It appeared as if they weighed the risk of being identified as ill against the risk of being identified as a "bad" employee. They seemed to be trying to salvage their social identity as a good worker.

At one level, day-to-day interactions inform our understanding of patterns of concealment. I propose, however, that we need to not only focus on interactions, but how they are embedded in a broader institutional context. As previously outlined, the social relations of work, as conceptualized in this study, includes consideration of organizational and discursive forces. According to an institutional ethnography perspective, these discursive forces are often outside the consciousness of workers (Smith, 1995). "Decisions" made by workers to conceal or disclose may therefore be embedded within a broader social context of which they may not be aware. In particular, I have argued that discourses regarding stigma and staff-client boundaries may shape how workers manage information about their mental health issues. As outlined in the findings, workers seemed to be embedded within a discourse that frames staff as competent, objective and healthy. Being ill was not considered socially acceptable. Silence practices such as impression management therefore may have been produced by discursive constructions of what it means to be a "good" worker. Silence was not simply a choice of whether or not to disclose, it was influenced by "rules" about the importance of being healthy and competent. Workers took up the discourse of competence, and in their efforts to be a good worker, they may have ignored or concealed the signs of illness. Since work represented a place where they were healthy and competent, it was difficult for some workers to admit that they were struggling or even too sick to work. Their practices of silence seemed to be embedded within a broader discourse of staff-client boundaries, where competence is paramount. Furthermore, the discourse of individual responsibility implies that mental health issues are a personal, private matter and therefore something that is not discussed in the workplace. As a result, workers were reluctant to seek help, and kept information to themselves about any challenges they were experiencing. Workers who took up beliefs about individual responsibility for health, and its imperative of silence were likely to conceal any health issues at work.
Overall, practices of concealment seemed to be embedded within day to day interactions, yet governed by broader organizational images of what it means to be a good worker. Concealment appeared to be a social process that unfolded in response to various forces within the organization. Church (2006) described a similar process in her study of disabled employees. She called it the "choreography of concealing", explaining that concealing one's disability is like choreography in that it can be "highly elaborate, characterized by invisible micro-decisions within each transactional moment in the workplace" (p.12). Like those in Church's study, the workers in this study appeared to be active agents in the process of managing the information that was (or was not) revealed to others within the workplace. At another level, however, I have pointed to discursive forces that seemed to be shaping their actions. This multi-level understanding of the social relations of silence extends our understanding of the social embeddedness of the day-to-day actions of workers.

7.1.2 Workplace stakeholders and the power to silence.

Workers actively engaged in practices of silence, however, practices of silence were also adopted by other stakeholders in the workplace, including co-workers, managers, occupational health providers, union reps, and human resource personnel. There was considerable variation in the silencing practices of stakeholders. For example, silencing practices included ignoring, minimizing or negating the presence and experiences of workers with mental health issues, or even explicitly advising them against sharing information. Silencing practices also encompassed situations when silence was broken (eg. when staff with known mental health issues were subject to "over-monitoring", or when mental health issues reached a point of crisis). Despite variation in the methods for enforcing (and/or breaking) silence, there were some patterns in the motivation or "stakes" in maintaining silence. In accounting for stakeholder silencing practices, I will reflect on the ways in which they were shaped by the social relations of work, and how they served to maintain institutional order.

From a theoretical perspective, there are several ways in which to account for these practices of silence. First, from an interactionist perspective, the silence could be viewed as reaction to the stakeholders' interpretation of the situation (Plummer, 2000). For example, it has been hypothesized that, co-workers will be supportive if the worker is well-liked and his/her symptoms at work are considered to be a temporary reaction to a stressful experience (Hinshaw,
Cicchetti & Toth, 2006; Saint-Arnaud et al., 2006). If images of the worker and his/her situation are positive, colleagues are more likely to "cover" for him/her, rather than complain about poor performance. If, on the other hand, the worker is labeled as incompetent and unreliable, then the silencing responses of others might be more punitive in nature (e.g. ignoring requests for support, derogatory comments) (Krupa et al., 2009; Stuart, 2004). The basis for many explanations of stigma and discrimination in the workplace are based on the view of stigma as defined and enacted through social interaction (Pescosolido, Martin, Lang & Olafsdottir, 2008). Social characteristics (e.g. age, class, social distance), illness characteristics (e.g. concealability, perceived contagion, course of disease and culpability), and behaviors (e.g. visibility, frequency, severity) may all affect the process of marking and labeling the individual, and ultimately how others respond (Pescosolido et al., 2008; Saint-Arnaud et al., 2006). In my study, the differential responses of workplace stakeholders could be accounted for by understanding the interpretations of others that take place through day-to-day interactions. There were, for example, direct references to employees who were well-liked and whose colleagues "covered" for them, as well as other employees who were blamed for their problems and had their requests for support ignored. There were also situations where the individual was already labeled as ill, and therefore treated as incompetent and unstable. The ways in which behaviors were interpreted seemed to shape the stakeholders' response.

Not unlike my reflections on the workers' practices of silence, however, I propose that these day-to-day interactions need to be considered in terms of how they are embedded within a broader institutional context. From an institutional ethnography perspective, the institutional context includes consideration of ruling relations in the workplace that are inscribed in texts as well as in organizational discourses surrounding these texts (Smith, 1990). In fact, Smith (2005) argues that one of the ways in which issues become visible and actionable is through talk and texts. In my study, the dearth of talk or texts meant that mental health issues were not officially visible or actionable. Organizational silence included the absence of clear policies and practices regarding staff with mental health issues. In addition, multiple stakeholders, layers of responsibility and confidentiality policies meant that information sharing was very limited. Since there were few structural supports for discussing issues directly, this may have contributed to stakeholders' silence.
In addition to the lack of organizational policies and procedures described above, there were discursive forces that seemed to govern stakeholder practices of silence. I believe that, like the workers, stakeholders took up the discourse regarding what it means to be a good worker. In taking up this discourse, they were involved in enforcing rules about productivity and performance. Direct and indirect messages about the unacceptability of mental health issues among staff, for example, were ways of enforcing rules about workplace performance. The stigma of mental illness and importance of maintaining staff-client boundaries were reflected in these messages. In addition, messages about individual rather than employer responsibility for action were reflected in patterns of ignoring requests for support.

Overall, I have argued that the silencing practices of workplace stakeholders can be accounted for by considering how interpretations of workers' mental health issues are embedded within, and governed by, organizational structures and discourses regarding mental health and productivity. Although the stakeholder practices varied, they all served to effectively silence open, direct dialogue.

7.1.3 Silence and institutional order.

Thus far, I have argued that workers and workplace stakeholders were engaged in practices of silence that could be accounted for by examining day-to-day interactions that are embedded within a broader discourse regarding images of what it means to be a good worker. In the literature, the actions of workers and workplace stakeholders are often explained through a focus on stigma enacted through day-to-day interactions with little consideration of broader organizational forces that may be shaping action (Pescosolido et al., 2008). An institutional ethnography perspective, on the other hand, provides an opportunity to cast light on the ruling relations of an organization, and the practices which serve to maintain social order within the institution. The findings of this study suggest that the practices of silence had a central role in establishing institutional order.

Institutional order is a term that is used within an institutional ethnography method of inquiry, but is not clearly defined. In this study, the term refers to the particular way in which the workplace is socially organized, including the regular patterns of social relations, interactions and authority that characterize organizational life and practices. One of the analytic goals of institutional ethnography is to make visible this order and to trace how it governs and reflects the
local conditions of work and individual experience (Smith, 2005). Part of this process involves examining the ruling relations located in the language or discourse that coordinates people's work at different levels of institutional organization (McCoy, 2006).

Discourses in this study which coordinated practices of silence served to maintain institutional order by reinforcing expectations regarding productivity and performance. Closer examination of these discourses provides a window into relations of power within the organization. For example, the stigma associated with mental health issues, as well as beliefs about staff-client boundaries and individual responsibility for health reinforced the message that it is not socially acceptable for workers to be ill. Employees internalized beliefs about the importance of being a healthy, competent worker, and worked hard to conceal their mental health issues and meet productivity and performance expectations. Stakeholders, in turn, reinforced these beliefs by ignoring or suppressing information about employee mental health issues. Employees who did not meet the standards of the "good worker" were marginalized, and norms regarding productivity and performance were sustained.

7.2 Accounting for the Social Relations of Silence in Healthcare

In the previous section, I argued that practices of silence were produced and reproduced within the social relations of work, and that these practices served to maintain institutional order. To build on this argument, I will assert that the context of mental healthcare creates particular conditions for the social production of silence. Discourses regarding staff-client boundaries, stigma, and responsibility for action, for example, are constructed in particular ways within mental healthcare institutions.

Before focusing on the production of specific discourses, it is important to note that there was a sense that "things should be different" within this organization. In other words, the secrecy and silence regarding mental health issues should not occur within an organization designed to support people with mental health issues. As noted in the findings chapters, there seemed to be a disjuncture between the public mandate of leadership and support for clients with mental health issues and the private experiences of secrecy and stigma reported by staff with the same issues. Understanding the apparent discrepancy between knowledge and action requires consideration of ruling relations within the workplace, including consideration of social structures and organizational discourses.
7.2.1 Stigma in healthcare.

The stigma associated with mental health issues seemed to be part of a key organizational discourse that produced practices of silence. As outlined earlier, the stigma surrounding mental illness is not new, however, it was somewhat surprising to note how extensive it was within this mental health facility. Since staff members were well educated about mental health issues, it was felt that they would readily identify and respond to colleagues who were struggling. Instead, stigma and silence prevailed.

The stigma noted in this study is consistent with reports in the literature regarding attitudes toward mental health issues within healthcare organizations. There is emerging evidence that stigma is a significant issue in healthcare. Many individuals with lived experience of mental illness rate the stigma experienced in trying to access healthcare as one of their primary concerns (Liggins & Hatcher, 2005; Schulze & Angermeyer, 2003). Examples of discrimination experienced by clients include healthcare providers questioning the legitimacy of their health problems and ignoring their requests for care (Liggins & Hatcher, 2005; Thornicroft, Rose & Kassam, 2007). Schulze's (2007) review of the literature regarding the attitudes of mental health professionals concluded that, in many ways, their attitudes towards mental health issues did not differ significantly from the negative perceptions held by the general public. Despite being well informed about mental illness, healthcare providers do not always hold positive opinions about the people who access their services (Schulze, 2007). Ptasznik (2010) asserts that clinicians often see people at their worst in clinical settings since clients are often acutely ill, significantly disabled, and may be difficult to treat. As a result, service providers may have a skewed image of the impact of mental health issues and less appreciation of the possibility for recovery.

Another reason for the prevalence of stigmatizing attitudes in a healthcare environment relates to the issue of "stigma by association". Many mental health providers are stigmatized by virtue of working with a stigmatized clientele (Schulze, 2007). Compared to other healthcare providers, their social status is considerably lower. In response, healthcare providers may attempt to distance themselves from the clients that they treat.

Stigma in the context of healthcare is often associated with clients, however, when a staff member experiences mental health issues, the stereotypical images associated with mental
illness, and the reluctance to associate with the affected individual may produce social tensions. In other words, the stigma associated with clients may be transferred to staff members with similar issues and thereby change the social relations of work. Consequently, practices of silence may be adopted as a way of resisting stigma and discrimination.

As described above, stigma-related silence may be socially produced in the context of day-to-day interactions within a healthcare institution. There are trans-local forces, however, which may also contribute to the production of stigma and silence within healthcare. For example, published research on work and mental health often represents workers as a liability and a drain on the profitability and productivity of the organization (Lesage et al., 2004; Stephens & Jourbert, 2001). Even studies exploring the health of workers in the healthcare field use terms such as "burnout", "compassion fatigue" and "vicarious trauma" (Conti-O'Hare, 2001; Harris, Cumming & Campbell, 2006; Prosser et al., 1996; Rabin, Feldman & Kaplan, 1999). Although they are pointing towards the stresses associated with healthcare work, the terms still depict workers as damaged in some way and as an organizational liability. These images of workers combined with the generalized stigma associated with mental health and addictions issues create a highly undesirable social position, therefore it is not surprising that healthcare workers engaged in practices of silence in order to conceal their issues from others. The combination of local and trans-local forces within healthcare seemed to contribute to stigmatized beliefs about mental health issues, and the resultant practices of silence. The silence practices in turn served to enforce rules about the importance of staff being healthy and competent.

### 7.2.2 Staff-client boundaries in healthcare.

Beliefs about staff-client boundaries form the basis of a second organizational discourse that was produced in particular ways within the context of healthcare. As outlined in the findings chapters, the importance of maintaining a boundary or distinction between service providers and service recipients was reflected in comments made by study participants, and in written policy documents. Organizational policies regarding therapeutic boundaries, for example, provided guidelines for maintaining social distance and objectivity. Beliefs about boundaries governed practices of silence among workers as well as stakeholders, restoring order when there was a danger that boundaries might be violated.
Similar principles about staff-client boundaries are evident in the training and competency guidelines of a range of healthcare professions (Malone, Reed, Norbeck, Hindsman & Knowles, 2004). Peterson (1992) explains that maintaining therapeutic boundaries is an ethical responsibility for health-care providers and involves defining and protecting the space between the provider's power and the client's vulnerability. The importance of staff-client boundaries is also consistent with traditional views of doctor-patient relationships within the healthcare system. Clinical service providers are often positioned as objective, detached experts with specialized knowledge and expertise (Gabe, Bury & Elson, 2004). They are supposed to be separate from the subjective knowledge of illness since intervention is based on principles of objectivity and affective neutrality (Parsons, 1951). Lupton (2003) explains that social distance between the provider and patient is essential to meet the requirements of objectivity. In the context of healthcare, therefore, the importance of maintaining boundaries, particularly for clinical service providers, is paramount.

In a mental healthcare organization, clients are expected to have mental health and addictions issues, and staff are expected to be the service providers. As outlined above, distinctions between staff and clients are inscribed in institutional policies and professional values, and are central to the smooth functioning of the organization. If staff-client boundary distinctions are violated, disorder could ensue since staff with mental health issues could be in need of service provision, and their ability to provide services could be compromised. Practices of silence (e.g. concealing information about mental health issues among staff, or silencing workers whose mental health issues become public) could be ways of responding to potential threats to the established order. Silence regarding mental health issues of service providers may therefore serve a functional purpose in maintaining social order within healthcare facilities.

7.2.3 Discourses of responsibility in healthcare.

Another way in which the context of mental healthcare creates particular conditions for the social production of silence, relates to competing discourses of responsibility. As outlined in the study findings, lack of consensus regarding who, when and how to act on employee mental health issues often led to patterns of silence and inaction. There were conflicting beliefs about whether it was an individual or employer responsibility to act, or whether there was a clinical mandate to assist employees who were experiencing mental health problems.
Golden (2006) notes that one of the challenges in healthcare is that there are disparate stakeholder groups and competing interests at times, particularly due to the combination of business and human service delivery perspectives. Hospitals can be highly bureaucratic, with an emphasis on institutional efficiency that may conflict with the supportive focus of a people-processing organization (Gabe, Bury & Elston, 2004). This conflict seemed to be reflected in the comments made by managers in my study, when they described their uncertainty over the extent to which they should support employees who were not performing as a result of (actual or suspected) mental health issues. Although the managers felt that the organization, by virtue of its public mandate, should be supportive of workers with mental health issues, they also had a responsibility as a manager to ensure that productivity and performance standards were met. In the absence of clear policies, practices were variable, as were the tipping points for action. In fact, one of the few policy directives noted by many participants relates to confidentiality. The policy of not sharing employee health information to others within the organization (beyond occupational health staff) was often invoked as justification for silence, particularly between stakeholders. The motivation for stakeholders to act therefore seemed to be complicated by competing values regarding support versus productivity, and by policies that did not provide clear directives other than the importance of limited information sharing.

The potential for multiple stakeholders to become involved when an employee became ill also seemed to contribute to tensions regarding responsibility to act. Study participants from various positions within the organization (eg. managers, human resources, unions, occupational health) commented on gaps in communication and the tensions that the lack of communication created in the workplace. Hospital settings, like other large organizations, have many layers of bureaucracy and accountability structures including stakeholders within the organization (identified above) as well as outside the organization (eg. health care providers, insurers). The nature and complexity of the relationships between multiple stakeholders can create tensions in communication, since there are different expectations regarding what needed to be said to whom, and when this needed to happen. The response of many stakeholders, as outlined above, was to err on the side of caution by protecting the confidentiality of the worker. The communication challenges noted in this study are consistent with reports in the literature regarding the competing interests and accountability structures of workplace stakeholders (Franche et al., 2005a; Young et al., 2005). The structural features of healthcare organizations, in terms of the multiple
stakeholders and layers of communication, meant that responsibilities were often unclear. This lack of clarity seemed to contribute to practices of silence and inaction when employees experienced mental health problems.

Overall, this section highlighted how study findings regarding the discursive production of silence reflect not only local, but trans-local discourses within the field of work and mental health, related to stigma, staff-client boundaries, and responsibility for action. I have argued that mental healthcare institutions, in particular, create the conditions for the social production of silence. This argument is based on examination of how local and trans-local discourses govern day-to-day practice, and serve to maintain institutional order.

7.3 Challenges to the Institutional Order

Thus far, I have focused on accounting for the practices of silence; how they are socially embedded within the context of mental healthcare work and serve to maintain institutional order within the organization. It is also important to note, however, that there was some resistance to organizational discourses and challenges to the institutional order that in turn shaped the practices of silence. McCoy (2008) argues for the importance in institutional ethnography of examining not only the ways in which people take up the dominant institutional discourse, but also the ways in which they engage in oppositional or critical talk. Oppositional talk involves taking a deliberate stance that is in opposition to the dominant discourse. I will therefore examine local and trans-local sources of resistance, and how they inform our understanding of the social relations of silence.

7.3.1 Resistance to stereotypical images of incompetence.

As outlined earlier, one way of maintaining institutional order is through images of workers as competent and productive. Since mental illness is seen to be associated with incompetence, instability and unreliability (Stuart, 2004), workers with mental health issues may be viewed as a threat to the effective functioning of the organization. Rather than taking up practices of silence to conceal the presence of mental health issues, some of the study participants talked about directly challenging stigmatizing beliefs. They asserted that they shared personal experiences as a form of "stigma busting" or awareness-raising within the organization. They talked about the potential value of confronting and challenging beliefs that associate mental
health issues with incompetence and instability, even though there were personal risks associated with disclosure.

Discourses of opposition to the stigma associated with mental illness noted in this study can be linked to a broader social movement within the field of mental health. A growing number of health care providers are "coming out" about their own personal history of mental health or addictions issues, despite risks to their reputation (Hatchard & Missiuna, 2003; Hyman, 2008; Holbrook, 2000; MacCulloch & Shattell, 2009). Hinshaw (2008) recently assembled a collection of stories from mental health professionals regarding their personal and family experiences of mental health issues, arguing that it is important to break the silence regarding their personal experiences. McLoughlin (2008) argues that there is an "untenable double standard" with respect to health professionals who have personally experienced mental health issues, and that accessing mental health services does not equate to incompetence, nor an inability to provide safe and effective patient care (McLoughlin, 2008, p.394). There is a small, but growing body of literature regarding "wounded healers" (Conti-O'Hare, 1998, p. 71), which profiles the ways in which healthcare workers with personal experiences of mental health or addictions issues can transcend their own personal trauma to help others (Conti-O'Hare, 1998; MacCulloch & Shattell, 2009). A central argument in this literature is that workers with personal experience have the potential to be more compassionate, less judgmental and inspire hope in others who may be struggling. By challenging stereotypical images of workers with mental health issues, an alternate viewpoint is being put forth; one in which is governed by an expanded view of competence. A shift in beliefs about the potential value of workers with mental health issues may also create a work environment where disclosure does not carry the same risks of stigma and discrimination.

There does, in fact, seem to be a shift happening in the field of mental health in which the imperative of secrecy surrounding mental health issues is being challenged. Anti-stigma campaigns within the organization in this study, as well at a national and international level, are based on evidence of the importance of individual stories in combating stigmatizing attitudes (Martin & Johnston, 2007). At the heart of these campaigns are individuals with mental health or addictions issues who are willing to disclose their experiences in a public forum. Instead of an imperative to remain silent, there seems to be a new imperative for individuals to come forward and share their stories for the purpose of public education. In fact, many of my study
participants invoked this alternate discourse when explaining their reason for participating in the study. The goal is to present alternate, more positive images of individuals who have experienced mental health issues.

Earlier, I argued that practices of silence play a key role in maintaining institutional order since the image of competence among healthcare employees is not challenged. Do practices of disclosure therefore oppose the established order? In some ways, the imperative of competence remains, even though the image of what constitutes competence seems to be changing. If workers project an image of competence by educating others that their illness does not affect their work performance, then they continue to present themselves as a "good worker". If their illness does affect performance, however, then institutional order may be threatened, and they may be compelled to engage in renewed practices of concealment. Disclosure therefore becomes another selective strategy within the workplace, based on consideration of whether it can be framed in a way that does not threaten their image of competence. Resistance through breaking the silence surrounding mental health issues illustrates ongoing sources of tension in the ruling relations of work; on the one hand strategic disclosure appears to be a progressive force that confronts stigma within the workplace, but on the other hand, it may simply be creating new expectations for workers to present as competent, despite their mental health issues.

### 7.3.2 Resistance to maintaining staff-client boundaries.

A second source of potential resistance to the established order relates to the discourse regarding staff-client boundaries. Acknowledgement of workers who occupy a position "in between" that of staff and client, and disclosure by these workers served to challenge the dominant discourse.

For some participants, personal experiences as a consumer of mental health services were known when they were hired, and in fact, were part of the conditions of employment. They were hired through a special program within the workplace designed to increase employment opportunities for mental health consumers. In their role, they crossed the boundary from (former) client to staff member. Disclosure was typically limited in terms of what was shared and with whom, however, the manager was often aware of their former status as a mental health consumer. In other cases, staff members' personal experiences of mental health issues were not initially known to others at work, but emerged over time, either through intentional disclosure or
through being 'found out'. These boundary crossings occurred in the other direction; from a position as staff to that of potential client. Instead of a distinction between "us" and "them", these individuals represented an alternate position that blurred the established boundaries.

Boundary blurring and challenges to traditional beliefs about staff-client boundaries also reflect trends occurring in the broader mental health and addiction field. Hiring individuals with lived experience of mental health issues as peer support providers, for example, is an emerging trend across the country (Standing Senate Committee on Social Affairs, Science and Technology, 2006). Not unlike the findings in this study, peer providers have reportedly challenged traditional staff-client boundaries in mental health programs (Mowbray et al., 1996; Carlson, Rapp & McDiarmid, 2001). As outlined earlier, the growing number of mental health providers who are publicly sharing their experience with mental health issues are also disputing the boundaries between staff and clients (Hyman, 2008; Hollbrook, 2000). Like the peer workers, these healthcare providers represent a subject position that is not easily classifiable as "us" or "them".

On the surface, it appears as if the established institutional order is being threatened; there are exceptions to the practices of silence which serve to maintain distinctions between staff and clients. It is important to note, however, that workers in this "in-between" position were often viewed differently from other staff members. Former clients, for example, felt as if they needed to prove themselves at work, and staff who disclosed in the workplace often felt as if they were treated differently once their condition was known. The varied responses to workers in this "other" category served to draw attention to the polarized positions within the organization, particularly for those in clinical roles. Perhaps there are new "other" positions being created, instead of fundamental changes to the established institutional order. The ideal image of staff continues to be one of a service provider who is objective and detached from the subjective experience of mental illness.

7.3.3 Resistance to competing discourses of responsibility.

The third source of potential resistance to the established order relates to competing discourses of responsibility, and its effect on shaping patterns of silence and inaction. As outlined earlier, the lack of consensus on when and how to respond to workers with mental health issues seemed to immobilize participants at times, and create tension between
stakeholders at other times. Institutional order seemed to be maintained through an individual discourse of responsibility. If workers experienced mental health issues, they were expected to deal with the issues on their own so that they did not interfere with their performance and productivity. If the issues were not acknowledged, then the employer was not expected to address them.

There were, however, study participants (both workers and stakeholders) who felt that the employer should have more proactive, clearly defined strategies to openly discuss and address mental health issues among staff members. Several participants expressed this sentiment directly; they complained about the organization being reactive rather than proactive, and argued for the need to develop not only a culture, but organizational practices where there was more recognition of the issues and an opportunity for direct dialogue. These comments seemed to reflect emerging beliefs within the organization regarding the need for a clear role for the employer regarding workers with mental health issues.

The sentiments of some study participants seemed to mirror trends in the broader field of workplace mental health which emphasize a growing role for employers in establishing a collective, coordinated approach to action (CIHR, 2004; Lesage et al., 2004). As outlined in the start of this paper, there is a clearly established business case for employers to act, and there does seem to be some uptake in the business community regarding the importance of acknowledging and addressing the needs of employees with mental health and addictions issues (Goetzel et al., 1990, Sederer & Clemens, 2002). Employer education and training resources are also being developed on how to address mental health issues at work (Dunnagan, Peterson & Haynes, 2001; Moll et al., 2007). These initiatives seem to reflect a movement away from considering mental health issues as an individual, private issue and towards a coordinated employer-based approach to addressing the issues.

Overall, beliefs about when and how to act when an employee has a mental health issue seem to be changing. Emerging research regarding best practices in the field of workplace mental health provides direction on the course of action that should be taken by various stakeholders in the process. It appears as if there is a shift away from beliefs about individual responsibility for mental health issues, to one of corporate responsibility and open dialogue for change. I propose, however, that critical reflection is needed on this apparent shift in beliefs. Many of workplace
initiatives such as screening, mental health promotion and employee assistance programs continue to focus on the individual worker; identifying workers at risk of mental health problems, building their resilience to workplace stressors, and linking them to services that are designed to address their individual problems (Vezina et al., 2004). Most of the focus continues to be on changing individual workers rather than changing the workplace. These initiatives could be considered another form of silencing workers regarding mental health issues in the workplace. Attention to the fundamental sources of workplace stress and changes directed at the level of employers is much less common.

7.4 Summary

In this chapter, I have accounted for the practices and production of silence by considering micro-level interactions between workers and workplace stakeholders and how these interactions are embedded within the discursive context of the organization, as well as broader society. Workers practices of concealment, for example, can be understood as a strategy of impression management, governed by organizational expectations for staff to be competent, objective and healthy. Similarly, stakeholder silencing practices can be understood as a response to their interpretations of workers' behaviors which are embedded within an organizational mandate for productivity.

I have also argued that the ruling relations of mental healthcare work governed the practices of silence in particular ways. The stigma associated with mental health issues, for example, permeates many aspects of healthcare work, and as a result, workers may be reluctant to disclose their experiences to others for fear of being labeled and having their competence questioned. In addition, prescribed standards for staff-client boundaries means that public acknowledgement of the similarities between staff and client mental health issues is not welcome. The bureaucratic structures of large healthcare institutions seem to shape how silence is produced and reproduced. Although silence served to maintain institutional order, resistance to the established order was also evident. Resistance to stereotypical images of staff with mental health issues, traditional staff-client boundaries and discourses of responsibility underlined the complexity of the practices of silence. Despite apparent shifts in the relations of ruling, the imperative of individual competence remains. In the next chapter, I will discuss implications of these findings for change within the field of workplace mental health.
CHAPTER 8 - Implications for Practice and Research

In the previous chapter, I focused on accounting for the production of silence, highlighting not only the forces producing and reproducing silence, but also points of tension or resistance to the established institutional order. In institutional ethnography, one of the objectives of analysis is to "open up possibilities for people… to have more room to move and act" (Campbell, 2006, p.91). Explaining how issues unfold in a particular way can increase an individual's awareness of the ruling relations that govern him/her, and awareness of the potential opportunities and barriers to change (Campbell, 2006). I believe that the study findings not only open up possibilities for individual workers, but for organizations, service providers and other stakeholders in the field of workplace mental health. The focus of this chapter will consider implications of the study findings for practice and research in the field of workplace mental health. I will start by highlighting the potential implications for workers and for addressing prevailing beliefs regarding stigma and disclosure. I will then reflect on the implications of the findings for best practice guidelines regarding early identification, negotiating workplace accommodations, and facilitating return to work. Next, I will reflect on the quality of the study findings, based on critical appraisal of the defensibility of design, methodological rigor, credibility of the findings and contributions to the field. Finally, I will present potential directions for future research.

8.1 Implications for Workers with Mental Health Issues

One of the assumptions of Institutional Ethnography is that many social forces are outside the consciousness of the workers who are embedded within these forces (Smith, 2005). One of the functions of the study findings, therefore could be to raise the consciousness of workers regarding the social relations of work, and the social production of silence. Workers may not, for example, be aware of the many ways in which they are silenced by other workplace stakeholders, including colleagues, managers and service providers. They may find it helpful to hear that they are not alone in their experience, and that their colleagues with mental health issues may have similar challenges. Furthermore, they may not be aware of how their own silence is shaped by broader discourses related to stigma, responsibility, and staff-client boundaries. With increased awareness of the complex forces shaping the silence and the potential risks and benefits of silence practices, workers may be better able to understand the
context of their experiences and be better positioned to manage information about their mental health issues.

Another feature of an institutional ethnography method of inquiry is its emphasis on an activist agenda to create positive change for marginalized groups (Smith, 1990). It is not clear from this study, however, whether study findings would encourage staff to continue to be silent, or conversely, to speak out against prevailing discourses that maintain the silence. The findings profile the complexities of the process of change. As a result, they do not necessarily point to a clear course of action to better address the needs of workers with mental health issues, but they do provide a roadmap of how silence serves to maintain social order, and how silence at times, has benefits for both individuals and the organization. In addition, the findings highlighted a number of points of tension or challenges to established practices and the discourses that governed them. Silence practices were dynamic, and discourses regarding stigma, staff-client boundaries and responsibility were not universally adopted across the organization. By pointing out cracks in the established social order, workers (and workplace stakeholders) can be more aware of how they participate in maintaining or challenging beliefs about staff as always healthy, invincible and immune to the mental health issues that are experienced by clients.

8.2 Understanding and Addressing Stigma

In addition to considering implications of the findings for individual workers and organizations, there are a number of broader implications for the field of workplace mental health. One relates to the issue of stigma in the workplace. As outlined in the introduction to this paper, the challenges of stigma and discrimination in the workplace are well documented in the literature (Stuart, 2004; Simmie & Nunes, 2001). Although the challenges are well documented, considerably less is known about the dynamics of stigma and discrimination within the social context of work (Stuart, 2004). One of the contributions of this study therefore was the opportunity to examine how stigma shapes practice within the context of a mental healthcare institution. In addition, it raises some questions about how to address stigma in the workplace.

Practices of silence, as reported in this study, were often in response to stigmatizing beliefs about mental illness. The stereotypical image of individuals with a mental illness, not just in this study, but in the broader literature, paints a picture of workers who, by virtue of their experience with mental health issues, are less than fully competent, unstable and a liability to the
organization. Many study participants, however, countered this stereotype, explaining that they were highly invested in their work, and that they worked hard to not only meet, but even exceed performance expectations. They concealed their illness experiences from others in order to protect their reputation. As a result, they felt that their strengths and contributions as a worker with mental health issues were often hidden because others were not aware of their status as someone with mental health issues. Silence was typically broken only when a crisis point was reached and the worker was in fact unable to do his/her job. Dramatic, mental health crisis situations were highly visible within the organization, whereas the day-to-day accomplishments of workers with mental health issues were considerably less visible. If the mental health issues of workers were acknowledged only at a point when they were unstable and unable to work, this served to perpetuate the entrenched negative stereotypes. One of the unfortunate consequences of the silence is that it prevents development of alternate perspectives.

The silence noted in this study is also reflected in the broader literature. There are relatively few published stories of workers who are competent in their job, despite a history of mental health or addictions issues (Hinshaw, 2008). Although anti-stigma campaigns are trying to counter negative images, the predominant view, particularly in the media has perpetuated stereotypes of individuals with mental illness as unstable and a threat to society (Martin & Johnston, 2007). Other, more balanced images of individuals with a range of abilities and challenges are often overshadowed by sensationalized images of individuals in the media as violent and threatening. Martin and Johnston (2007), in their review of evidence based strategies to reduce stigma, argue that the most effective stigma reduction strategy involves direct, peer-based contact and personal stories. In particular, they recommend contact with a person of equal status, including an opportunity to get to know each other, work together and disconfirm negative stereotypes. Simply providing education, they report, is less effective; it is the human contact and opportunity to discuss issues that breaks down the "us-them" barriers. Interactions with individuals who have experienced mental health issues would therefore provide an opportunity for workplace stakeholders to consider the range of strengths and challenges that individuals bring to the workplace.

The arguments presented above point to the potential value of disclosure as a stigma-reduction strategy in the workplace. Recommendations are often based on a belief that if workers make their personal experiences known to their colleagues, this could foster attitude
changes (MacDonald-Wilson, 2005; Hyman, 2008; Ralph, 2002). I suggest, however, that the solution is not as simple as it appears. Rather than focusing only at the level of interactions, the findings of this study prompt consideration of broader workplace structures and discourses within which workers are embedded. Pescolido et al. (2008) argue that stigma lies at the interface of community and individual factors, therefore one needs to consider the organizational and community influences on the enactment of stigma in the workplace. Furthermore, Krupa et al. (2009) show that stigma processes are complex, operating through multiple pathways. Breaking the silence at the individual level may be thwarted by institutionalized prejudice and discrimination within the workplace and in broader society. Silence can be functional for employers, therefore both the benefits and risks associated with an open dialogue about mental health issues among workers need to be considered. Change may initially need to happen at an organizational or societal level in order to create an environment where it is safe to disclose.

8.3 Disclosure and Information Sharing

As outlined above, practices of disclosure are closely linked to issues of stigma and discrimination. Much of the literature in the mental health field focuses exclusively on the concept of disclosure, with little attention to the practices of silence. Furthermore, current research on disclosure provides, what I propose to be a narrow view of the nature of information sharing. The findings from this study can serve to extend current ideas about disclosure, and inform practice recommendations for workers with mental health issues.

Disclosure, as conceptualized in the literature, seems to be based on a number of underlying assumptions. One is that it is an "all or none" event; the outcome of a decision whether or not to share information with others (Goldberg, Killeen & O'Day, 2005; Schulze & Angermeyer, 2003). Another assumption is that disclosure is something that a worker chooses to do or not do, based on consideration of both the costs and benefits of sharing information (Corrigan & Matthews, 2003; Ralph, 2002). There is an emphasis on the personal agency of workers.

These assumptions were challenged in several ways by the findings of my study. Rather than an "all or none" event, variations in practices of disclosure, including selective and strategic information sharing, were noted. Study participants recounted stories of sharing some
information, but not others, and how they carefully departed from established practices of silence in their efforts to negotiate support or advocate for others. Although the concept of strategic disclosure has been identified in the literature (MacDonald-Wilson, 2005), little is known about the varied ways in which it might unfold within the social context of work. Another limitation in the literature is the emphasis on disclosure as a cognitive decision making process, rather than as a social process. There is little recognition of the interactive process of impression management and how this process is embedded within a system of individual, social and structural constraints.

One of the main arguments of my study is that it is important to consider the social dimensions of information sharing. Other stakeholders in the workplace are involved, and the ways in which they receive, perceive, and respond may shape the experience and actions of workers. Furthermore, expectations regarding what it means to be a good worker may be internalized by workers and govern their patterns of concealment. Silence is not simply the antithesis of disclosure, but an active practice of maintaining institutional order, and one that involves not only workers, but other workplace stakeholders as well.

This re-conceptualization of disclosure as part of a complex social process has important implications for service providers who may be counseling workers about the issue of disclosure. First, instead of simply discussing whether or not to disclose at the outset of employment, service providers may need to facilitate reflection on disclosure as a process that unfolds over time. Workers may need to hear about the work involved in managing impressions in the workplace, and how the work evolves depending upon who they work with and what they share with them about their mental health issues.

Second, instead of prescriptive advice regarding when, what and how to disclose this study points to the importance of broadening the discussion between workers and healthcare providers to include consideration of the practices of silence. Workers may need to consider how impression management strategies can serve particular functions within the workplace, such as protecting them from discrimination, and absolving others from the need to provide support. Workers may not be aware that concealing their problems could maintain their social identity as a competent worker (at least until problems start interfering with relationships and/or work performance). In addition, they may be aware of how they may internalize expectations regarding silence, and how their efforts at disclosure may be silenced by others. As outlined
earlier, the study findings can serve to raise the consciousness of workers regarding silence and disclosure as embedded within organizational discourses. With increased awareness of these issues, workers may be able to make more informed choices about sharing information about their personal experiences with mental health issues.

**8.4 Implications for Early Identification**

Another way in which the study findings inform workplace practice relates to best practice approaches to early identification. One of the consistent recommendations in the workplace best practice literature is to intervene early when health problems are evident in order to prevent them from escalating in the workplace (National Institute for Clinical Excellence, 2009). This recommendation is based on research evidence that delays in seeking treatment can increase the duration of sickness absence (Brouwers, Terluin, Tiemens & Verhaak, 2009), and that mental health and addictions problems resolve more quickly if they are addressed early (Bender & Kennedy, 2004). In this study, there were a number of findings which supported the recommendation for addressing issues earlier rather than minimizing or ignoring them until they escalated to the point of crisis. Some of the workers, for example, explained that they should probably have sought help at an earlier stage before they reached a 'breaking point' at work. When problems were not addressed, work performance was affected and there were reports of irrevocable damage that could occur in workplace relationships. These findings support the value of identifying issues at an early stage so that workers can access treatment and support.

On the other hand, the study findings point to some of the complexities inherent in early identification. Identification of employees with mental health issues involves a system of surveillance where managers are trained to identify potential mental health or addictions issues and then proactively approach workers to encourage them to seek help. The importance of training managers in this role has been emphasized in the literature (Caveen, Dewa & Goering, 2006; Corbiere & Shen, 2006; Couser, 2008; National Institute for Clinical Excellence, 2009). Other recommended approaches include screening workers that are at high risk for depression (Couser, 2008).

These approaches to early identification, however, require critical reflection. First of all, the point at which identification should occur is not clear. As outlined in the study findings, many workers concealed their issues from others and tried to maintain optimal work
performance for as long as possible. In this case, approaches to screening would need to be highly sensitive to pick up on potential changes (e.g., drinking that is becoming “problematic” or mood changes that are beyond that which is “normal”). The risk of a highly inclusive approach to screening, however, is the potential for false positives, or marking individuals as having a mental health problem when this may not be true. Since mental health and addictions issues are highly stigmatized, the risk of marking the employee as ill creates vulnerability to stigma and discrimination. In fact workers report that the discrimination associated with the illness may be worse than the symptoms themselves (Krupa, Kirsh, Cockburn & Gewurtz, 2009). Furthermore, for some individuals, continuing to work was important in maintaining their mental health. Early identification therefore creates risks associated with discrimination and possibly undermining the efforts of individuals to maintain their work performance. Furthermore, Vezina et al. (2004) argue that strategies such as identifying "at risk" workers and linking them to appropriate supports continues to reinforce the individual nature of the problem. The emphasis is more on changing the worker rather than changing the work environment. Putnam and McKibbon (2004) also argue that there is a risk to individualizing and medicalizing issues that would be better dealt with at an organizational level (e.g., conflicts or stress in the workplace).

Based on the arguments presented above, the practice of early identification might require reconsideration. On the one hand, if a worker ends up receiving help early, this may prevent escalation of problems within the workplace. On the other hand, it may create new challenges associated with being marked as disabled or different. It also reproduces micro-politics of power within the workplace whereby workers are identified as the primary source of the problem. By focusing on the worker as the problem, the focus is shifted away from problems related to the conditions of work (e.g., high job demands, few supports). This shift in focus serves to absolve the employer from responsibility in contributing to mental health issues, and to maintain workers in a marginalized position. This study did not specifically examine the process of early identification, but points to the need for further research to explore the personal and social impact on workers with mental health issues.

### 8.5 Implications for Workplace Accommodations

Another best practice approach in workplace mental health is to provide workplace accommodations to enable optimal job performance (Corbiere & Shen, 2006; MacDonald-
Wilson et al., 2003). Employees are legally entitled to reasonable accommodations if they have a health issue that interferes with their work. As outlined in the literature review, accommodation may range from flexible scheduling to modification of job tasks. Accommodation is supposed to be a negotiated process, based on communication between the employee and employer (Tetrick & Toney, 2002).

In this study, practices of silence could disrupt or circumvent the process of accommodation. For the most part, workers did not ask for accommodations; they were invested in maintaining their image as a competent worker and/or they did not feel that they wanted to or needed to initiate a discussion about accommodation. If they did ask for support, some were silenced by managers who ignored their request. These findings are consistent with reports in the literature of workers who are reluctant to ask for help, and of employers who are reluctant to provide workplace supports (Stuart, 2006).

In order to understand the practices of silence surrounding workplace accommodations, I believe that it is important to consider how the silence is governed, not only by interpersonal relationships, but by discursive forces, including an underlying message that employees are not supposed to have mental health issues and if they do, they are not supposed to talk about it. These messages shut down any dialogue regarding accommodation. Conversely, asking for accommodation disrupts the institutional emphasis on individual competency. If workers have to admit that they need support to do their work, they risk being devalued or having their reputation questioned. In the accommodation process, workers are supposed to admit the need for support. The role of the employer is to acknowledge that the workers have a legitimate illness and a need for support, and then assume responsibility (including financial responsibility) in providing these supports. The legal discourse regarding the right to reasonable accommodation is in direct competition with organizational discourses regarding the individual responsibility of workers to present as healthy and competent.

Overall, initiating a discussion regarding accommodation was clearly a double edged sword for workers; on the one hand it might enable an individual to stay at work, but it also presents a risk of being marked with a stigmatized social identity, and being identified as a burden for the employer. Several authors have suggested that system changes need to be made at an organizational level, whereby a culture of tolerance for diversity is cultivated, and flexibility
in meeting workplace demands (MacDonald-Wilson & Whitman, 1995; Mancuso, 1995). They argue that this might circumvent the process of identifying a worker as ill and in need of workplace accommodations. Further research is clearly needed to examine the implications of different approaches to initiating a dialogue about workplace accommodations.

8.6 Implications for Return-to-Work

A final contribution of the findings to best practices in workplace mental health centers on the practices of silence surrounding sick leave and return-to-work. Workplace accommodation (as described in the previous section) may be part of the return-to-work process, but the focus here is on the process itself and the interactions between stakeholders.

Best practice recommendations in the workplace literature outline the importance of clear communication between all stakeholders in the process of return to work (Corbiere & Shen, 2006; Franche et al., 2005b). Corbiere and Shen's (2006) systematic review of return-to-work interventions concluded that if all stakeholders in the process (i.e. the injured employee, the employer and/or coworkers, the insurer and health professionals) worked together, this would enhance the outcome. Similarly, a systematic review conducted by Franche et al. (2005b) concluded that the return-to-work process entails many opportunities for miscommunication and misunderstanding, and that good relationships among stakeholders (workers, managers, supervisors, unions, and health-care providers) are critical to success. Open communication and dialogue are viewed as key components of work reintegration. Clear, collaborative communication between workers and the employer, for example, is a prerequisite to successfully negotiating workplace accommodations (Tetrick & Toney, 2002). Provision of clear information regarding sick leave and return to work procedures is reported to be important for workers, as is support from supervisors and co-workers (Lysaght & Larmour-Trode, 2008; Saint-Arnaud, Saint-Jean & Damasse, 2006). The involvement of a return to work coordinator, and an inclusive disability management process has also been identified as helpful in coordinating communication between stakeholders (Caveen, Dewa & Goering, 2006; Lysaght & Larmour-Trode, 2008). Proactive, clear communication and a climate of cooperation have been repeatedly identified as the key to success of work re-entry (NICE, 2009). All of these findings emphasize the value of breaking silence and opening a dialogue between stakeholders.
I propose, however, that the ideal of open communication needs to be problematized. The consistent message in the literature is that silence between stakeholders is not conducive to the return to work process. Is an open dialogue necessarily a good thing and desirable in all situations? The implications of resistance to or departure from the practices of silence need to be carefully considered.

One of the issues outlined previously, is that sharing information about a worker's mental health issues risks marking him/her with a stigmatized social identity. Findings from this study are consistent with reports in the literature that workers are often treated differently upon return from a mental health related sick leave (Simmie & Nunes, 2001; Stuart, 2004; Wahl, 1999). They may experience discrimination in the form of derogatory comments, over-monitoring of their mental status, or even reduced opportunities for promotion. Instead of support, disclosure may create additional barriers to successful return to work. In addition, the lack of clear guidelines for communication and the lack of consensus regarding the responsibility of different stakeholders may lead to an increase in tension when silence is broken. Tensions between stakeholders reported in this study are not unlike the tensions reported in the literature, and may come from a number of sources. Several authors, for example, have reported that the accountability structures and assumptions of the various stakeholders are different, thereby creating challenges to effective communication (Franche et al, 2005a; Friessen, Yassi & Cooper, 2001). There may be competing interests, for example, between the manager's concerns about productivity, the union's concerns about the rights of the worker, and the occupational health provider's concern about health and safety. In fact, competing interests between stakeholders in my study reportedly delayed or complicated return-to-work planning. Open communication did not necessarily lead to coordinated efforts or consistent support with respect to return to work.

Thus far, I have presented some of the challenges associated with information sharing in the process of return to work. Simply opening lines of communication, as outlined in the best practice approaches, may have unanticipated consequences. The alternative, maintaining practices of silence, can be a double edged sword as well. On the one hand silence maintains the privacy of the workers and their image of competency, yet on the other hand they prevent access to workplace supports, and may fragment the disability management process.

Overall, there are many stakes involved in return to work for both workers and other workplace stakeholders. Careful consideration of the implications of information sharing is
needed, beyond simply adopting the recommended "best practice" approach of open communication.

8.7 Summary of Implications for Practice

Many of the best practice approaches to workplace mental health espouse actions that directly oppose practices of silence. Instead of silence, public disclosure of mental health issues is recommended as a strategy to reduce stigma, and as a necessary first step in negotiating workplace accommodations. In addition, stakeholders are encouraged to move beyond silence; it is recommended that they be proactive in identifying potential mental health problems among workers, and to communicate clearly with all participants involved in sick leave and return to work. A consistent message underlying these best practice recommendations is the value of open communication regarding mental health issues among workers. I have argued, however, that these approaches may not take sufficient account of the complex ways in which silence is produced and reproduced in the workplace. Although there may be benefits associated with open communication, there are also risks, including the risks for workers related to stigma and discrimination. Furthermore, breaking the silence can disrupt institutional order in an organization where staff are assumed to be mentally healthy and competent. The interactive and structurally embedded nature of the silence practices cast doubt on suggested action points for change. Thoughtful reflection on both the positive and negative implications of such sensitive information sharing in the workplace is needed.

8.8 Reflections on Research Quality

In discussing implications of the study for practice in workplace mental health, I emphasized the importance of reflecting on the assumptions underlying current research in the field. All research has strengths and limitations, and this study is no exception. To put the findings of my study in context, I assert it is important to reflect on the quality of the research.

In the field of qualitative inquiry, there continues to be considerable debate regarding how to appraise the quality of the research (Eakin & Mykhalovskiy, 2003). Central to this debate is concern about adopting a procedural approach that is too restrictive and unable to account for the "non-formulaic complexity of the qualitative research process" (Eakin & Mykhalovskiy, 2003, p. 190). There are different schools of thought about how to approach
assessment of quality. Murphy et al. (1998) profile several approaches, from adopting conventional criteria of reliability and validity; to adopting criteria that are specific to the qualitative research paradigm, to rejecting any standard criteria altogether. Rather than completely dismissing the idea of quality criteria, I will highlight the key strategies adopted to enhance the quality of the research that were grounded generally in the ontology and epistemology of qualitative inquiry, and specifically an institutional ethnography approach. The four principles of quality assessment outlined by the National Centre for Social Research in the United Kingdom will frame the discussion, namely; defensibility of the study design, rigour in the conduct of the study, credibility of the findings, and contributions to the field (Spencer, Ritchie, Lewis & Dillon, 2003).

**8.8.1 Defensibility of design.**

In terms of study design, I was guided by principles of an institutional ethnography method of inquiry, focusing on the social relations of work within one healthcare organization. I adopted this perspective since it enabled me to explore not only the day-to-day experiences of workers, but how these experiences were shaped by broader social forces both within and beyond the organization. I felt that a multi-layered understanding of social relations would provide depth of understanding of workers' experiences.

In my approach to institutional ethnography, I focused on one organization. The organizational case study provided an opportunity for in-depth exploration of the issues within the workplace. One of the advantages of a case study is the opportunity to get close to the social actors and interactions as they unfold in day-to-day practice. Flyvbjerg (2001) argues that "the most advanced form of understanding is achieved when researchers place themselves within the context being studied" (p.83). He explains that it is the only way in which researchers can understand the viewpoints and behaviors of the social actors. Unlike survey or experimental research which typically yields a general, broad perspective on the issues, this research provided an opportunity for in-depth awareness of the backstage dynamics that unfold when workers experience mental health or addictions issues. One of the strengths of this study, therefore, was the opportunity for in-depth exploration of the ways in which the social context of work shaped the day-to-day experience of workers. As outlined in the literature review, there is a need for contextually relevant research in the field.
Although an institutional ethnography approach guided my research, it is important to note that the focus on silence appears, in some ways, to be a significant point of departure from the traditional focus within this method of inquiry. Within institutional ethnography, textually-mediated practices are considered to be a primary organizing force within contemporary organizations (Campbell, 2006). Smith (2005) explains that texts "transform the local particularities of people, place and time into standardized, generalized, and especially trans-local forms of coordinating people's activities (p. 101). She goes on to say that "texts perform at the key juncture between the local settings of people's everyday worlds and the ruling relations" (p.101). The emphasis is on "texts in action" in terms of how they inscribe institutional discourse, and how they govern day-to-day practice (Smith, 2006, p.67). Although texts were collected as part of the study and examined in terms of how they reflected ideological beliefs within the institution regarding mental health and addictions issues, it was, in fact, the absence of texts that was noted in the descriptions of many study participants. For the most part, mental health or addictions issues among staff were not publicly recognized within the organization, and there was no mandated organizational response to addressing these issues. There seemed to be few textually-mediated practices which governed behavior. Overt examples of texts in action were very limited.

The study findings point to silence as a form of text. They highlight the importance of considering not just the presence, but the absence of information inscribed in texts as reflective of the ruling relations within the organization. The absence of textually inscribed practices in this study meant that there was no explicit articulation of what to do. Governing practices (e.g. the imperative of competence, staff-client boundaries, and individual responsibility for action) were not necessarily outlined in written documents, but appeared to be inscribed in organizational silence.

There are a number of parallels that can be made between the way that silence functioned in this study and the proposed way that texts function according to an institutional ethnography method of inquiry. Silence appeared to be a primary organizing force within the organization, not unlike the way that texts are described in institutional ethnography (Smith, 2005; Turner, 2006). Like texts, silence in this study seemed to perform “at the key juncture between local settings of workers’ everyday worlds and ruling relations” within the organization (Smith, 2005, p.101). Practices of silence taken up by workers and stakeholders reflected broader relations of
ruling concerning the importance of staff presenting as objective, competent service providers. Silence was not passive, but actively practiced, and inscribed within institutional discourses. Instead of ‘texts in action’, there were examples of ‘silence in action’; whereby silence was enacted locally, yet reflected broader discourses both within and outside the organization. Study findings regarding silence therefore represent an extension of the focus of institutional ethnography beyond simply the presence of texts to the absence of texts as well. This conceptualization of silence as a governing force is a theoretical contribution to an institutional ethnography method of inquiry.

8.8.2 Methodological rigour.

A second important consideration in evaluating the quality of the study relates to methodological rigour. Rigour in the conduct of the study, as outlined by the UK National Centre for Social Research, includes systematic and transparent collection, analysis and interpretation of qualitative data (Spencer, Ritchie, Lewis & Dillon, 2003).

The notion of transparency as a criterion of quality is based on the ontological assumption that there is no universal truth; rather all data are socially constructed (Murphy et al., 1998). Hammersley (1990) explains that research findings are a representation of reality and reflect the assumptions that the researchers bring to the analysis. Within institutional ethnography, it is understood that the researcher engages in a primary dialogue with informants and collaboratively produces data through the interaction (Smith, 2005). Informants' perspectives are shaped, not only by their social location within the organization, but by their perceived location in relation to the researcher. Smith (2005) explains that the researcher is an active participant in the social production of knowledge. Researchers engage in dialogue with informants, then also engage in a secondary dialogue with the transcripts and field notes to figure out what to make of the data. The accounts of experience which are constructed through the interview and analysis process are embedded within discursive frameworks that shape not only the perspectives of informants, but the perspective of the researcher as well (Campbell & Gregor, 2008). Rather than trying to establish the neutrality or objectivity of the researcher, the goal is to be transparent or explicit about the social production of the study findings (Green et al., 2007). One of the strategies adopted in this study to maximize transparency was to provide a detailed
description of the data collection and analysis process. These details were provided in the methodology chapter.

Reflexivity was another key part of this process. Reflexivity refers to "sensitivity to the ways in which the researcher's presence in the research setting has contributed to the data collected, and to their own a priori assumptions that have shaped the data analysis" (Murphy et al., 1998, p.188). In the methodology chapter, I provided details regarding my standpoint and social location as a researcher, including consideration of how this shaped the social production of knowledge in the process of data collection and analysis. I described my role and relationship to the study participants, as well as my changing perspective on the area of inquiry. Through field journal reflections and peer debriefing, I reflected upon my own impact on the setting, the assumptions that I carried into the process, and how my perspective changed over time. I was mindful of how my experience as a professional in the field contributed to my understanding of the relationships between staff in the organization, yet I also used it as a point of contrast when participants shared information that was unfamiliar or surprising. There were points when my advisor and committee challenged my assumptions (e.g. in relation to the use of language regarding mental health and mental illness). I was conscious of the importance of asking participants to explain their perspectives, including their use of language. Since data collection took place over a period of nine months, there was time for ongoing reflection during the data collection and analysis process. Finally, in the process of synthesizing and discussing the study findings, I continued to be challenged to consider how my professional background as a mental health clinician threatened at times to over-ride my research stance. For example, I was often tempted to prescribe changes that should take place within the organization, rather than map out the sources of tension. Using feedback from my research advisory committee within the organization as well as from my academic committee, I tried to provide a reasoned and fair representation of the study findings. Although I adopted many reflexive strategies over the course of the study, it is also recognized that there are limits to my abilities to be transparent about all the values, beliefs, knowledge and biases that I bring to the research process (Cutcliffe, 2003).
8.8.3 Credibility of findings.

A third consideration for appraisal concerns the credibility of the study findings; the extent to which they offer "well-founded" and "plausible" arguments regarding the significance of the evidence generated (Spencer, Ritchie, Lewis & Dillon, 2003). This includes consideration of strategies related to participant recruitment and sampling, data analysis and presentation of the findings.

One important element of credibility relates to whether the selection of study participants was relevant and appropriate. Unlike quantitative research, the focus is not on obtaining an unbiased, representative sample for the purpose of statistical generalization. Instead, the focus is on recruiting informants who are able to provide depth and breadth of understanding, so that phenomenon can be understood in context (DeVault & McCoy, 2006). Justification for the sampling strategy includes consideration of how it maximizes the diversity and richness of data (Eakin & Mykhalovskiy, 2003). In institutional ethnography, for example, the focus is on developing a comprehensive map regarding the social relations of work, therefore participants need to be positioned differently within the "chains of action" within the workplace (Smith, 2006). By including individuals from a range of standpoints, a clearer picture of the common organizational processes can be developed (DeVault & McCoy, 2006). I propose that one of the strengths of the study was the range of perspectives that were explored. As outlined earlier, participants in this project included workers from across the organization in a range of work roles and positions within the social hierarchy (e.g. from front-line workers to high level managers). This range of perspectives helped me to see common social processes (e.g. practices of concealment, stigma, boundary issues) that affected workers across the organization regardless of their position within the social hierarchy. Although there were individual differences in how these issues were experienced (e.g. increased boundary pressures for clinical staff), it was the commonalities that were particularly noticeable. Other sources of variation included workers' experience of mental health issues, including the nature of the issues themselves, the timing of when they were experienced (current and past), and their impact on work performance. The stakeholders who participated in the study also represented a range of standpoints; they had varied roles and relations to workers with mental health issues. The diversity in perspectives increases the likelihood that the findings of the study reflect social relations of work that are common across the organization (DeVault & McCoy, 2006).
Another important aspect of credibility relates to inclusion of negative cases. Negative cases are cases that do not appear to fit the emerging model, and serve to either disconfirm parts of the model or suggest new connections that need to be made (Ryan & Bernard, 2000). Credibility is strengthened if the study findings can account for these negative cases (Spencer, Ritchie, Lewis & Dillon, 2003). As ideas about silence started to emerge in this study, efforts were therefore made to include and account for perspectives that reflected exceptions to the practices and production of silence. This meant, for example, exploring public disclosure of mental health issues as well as the silence, and including the perspectives of those who spoke against the current practices as well as those who accepted them. McCoy (2006) explains that, within institutional ethnography, it is important to examine not only the ways in which people take up the dominant institutional discourse, but also the ways in which they oppose these discourses. In the presentation and discussion of the study findings, therefore, I was careful to include consideration of resistance to the dominant discourses. By reflecting on these "exceptions", I was able to refine my understanding of the rules surrounding the silence and the limits of silence practices and develop a more sophisticated, coherent analysis. Since the study findings highlight the complexities and contradictions inherent in the practices of silence, Flyvbjerg (2001) asserts that is a sign that the study has uncovered a particularly rich problematic.

8.8.4 Contributions to the field of workplace mental health.

The final criteria to consider in asserting the quality of qualitative research concerns the extent to which the study advances knowledge in the field (Hammersley, 1990). I have argued that the findings challenge a number of prevailing ideas in the field, including ideas about stigma and disclosure. By focusing on the concept of silence, I have emphasized new ways of understanding the experiences of workers with mental health issues; considering not only what is said, but what is not said, and considering patterns of inaction as well as action. Questioning issues at a conceptual level is one of the key contributions of qualitative research (Murphy et al., 1998). In addition to advancing theoretical ideas, I have presented alternate perspectives on best practice research related to early identification, negotiating workplace accommodations and return to work. Findings from the study therefore, have the potential to contribute to the field at both a theoretical and a practical level.
In order to make claims about advancing knowledge in the field, however, the extent to which the study findings can be generalized beyond the current study must be considered. I have argued that some of the findings are particular to the organizational context of mental healthcare work therefore one might ask whether they are relevant for other workplaces.

In order to address the issue of generalizability, it is important to note that this concept in qualitative research focuses not on statistical generalizability, but on conceptual or analytic generalizability (Murphy et al., 1998). Since sample sizes in qualitative research studies are usually small, and the findings are intimately tied to the context within which they are found; transferability of specific data to other organizations or to the public at large may be considered problematic (Murphy et al., 1998). The broader theoretical ideas, however, may have wider relevance and applicability. DeVault and McCoy (2004) explain that the purpose of institutional ethnography is not to generalize about the group of people interviewed, but to find and describe social processes that have generalizing effects. Furthermore, according to the authors, the relevance of the inquiry stems from the capacity of research to disclose features of ruling that operate across many local settings. By focusing on broad trans-local forces, the potential for application in other workplaces is strengthened. In this study, for example, discourses related to stigma, responsibility and staff-client boundaries reflect broad trans-local forces that may operate across a number of healthcare organizations.

In some ways, the organization in this study could be considered a critical case for understanding practices of silence regarding workplace mental health. Flyvbjerg (2001) argues that some case studies have strategic importance in furthering understanding of specific phenomenon. The organization profiled in this study, for example, could be considered one of the least likely workplaces where practices of silence regarding mental well-being would occur. When one considers that the organization has a public mandate to increase the visibility and acceptability of mental health and addictions issues, more of an open dialogue would be expected. Furthermore, since many of the workers had high levels of mental health literacy, a greater acknowledgement of the issues would be expected as well. Since the practices of silence were so pervasive within this organization, it is anticipated that silence may also be evident, although perhaps in a different form, in other workplaces where mental health issues are less known and less accepted.
Overall, I have made a number of arguments regarding the quality of the research. The study design is grounded in a methodological approach that enabled in-depth exploration of the issues in a way that was contextually relevant, yet not restrictive. Adopting an institutional ethnography method of inquiry enabled exploration of the ruling relations of work, even when they were not grounded in organizational texts. In order to strengthen methodological rigour, strategies of transparency and reflexivity were adopted. Credibility of the findings was also strengthened by strategic recruitment and sampling strategies, as well as by accounting for negative cases. Finally, I have argued that the findings contribute new theoretical and practice knowledge to the field of workplace mental health and have relevance beyond the organization where the study was completed.

8.9 Future Research Directions

Although this study contributes to a conceptual understanding of the practices and production of silence in the workplace, there are several areas of research that would contribute to further development of these ideas. Research in other workplaces will help to build on and challenge the ideas that have been generated through this project. Also, future research adopting a similar methodological orientation will contribute to emerging knowledge regarding the social forces that shape the experiences of workers with mental health issues.

Expanding the research to other workplaces would contribute to further conceptual development of the ideas regarding the social production of silence. Murphy et al. (1998) emphasize the importance of building on knowledge through development of research that is designed to modify, extend and elaborate previous analyses. Since the social production of silence in this study was linked to institutional structures, policies and discourses regarding health, mental illness, and productivity, it would be useful to examine organizations with contrasting features. For example, one of the arguments made in this study is that silence was constructed in particular ways within a healthcare context. Discourses which produced practices of silence (eg. staff-client boundaries, clinical discourse of responsibility) were linked to the social relations of healthcare work. Conducting a similar study in a non-healthcare organization would provide an opportunity to compare the ways in which silence is practiced and produced. In particular, the discursive forces shaping the experiences of workers could be the focus of analysis. In a profit oriented business, for example, there may be qualitative differences in
discourses regarding productivity, and in discourses regarding mental health issues. It would be useful to contrast how these discourses contribute to silence practices in this type of organization.

Another important focus for comparison among workplaces relates to organizational structures and policies. This study was conducted in a large organization with many stakeholders (e.g., unions, human resources, occupational health), but few clear policies related to workers with mental health issues. It was hypothesized that the silence was inscribed in organizational policies and practices, and served to maintain institutional order. Conducting a similar study in a smaller hospital or community mental health organization would provide an opportunity to explore how different policies and structural features of an organization shape behavior. It might be particularly interesting to examine an organization with clear policies and procedures related to workers with mental health issues. If there is public recognition regarding mental health issues among staff members who provide services to clients with mental health problems, how do they reconcile staff-client boundary issues? Also, what are the processes for supporting these workers? Comparative data may help to inform our understanding of the implications of departures from the practices of silence.

A final thought on future research concerns issues of standpoint and methodology. When outlining the rationale for conducting this study, I argued that much of the current research is written from the standpoint of managers, conceptualizing mental health in the workplace in terms of its administrative and business significance. The findings of this study were grounded in the standpoint of workers, documenting mental health as an interpersonal, human issue. Since workplaces are social spaces, I believe that examining the social relations of work provides an added dimension of understanding that is largely missing in current approaches to research. Research which explores not just the experiences of workers, but how these experiences are shaped by broader institutional and societal forces, will provide contextual data that can inform workplace practice. Research using qualitative methods, informed by social theory therefore has the potential to add unique, in-depth knowledge to the field of workplace mental health.

8.10 Conclusion

In presenting the findings of this study, I have focused on the concept of silence, mapping how silence is practiced and produced in relation to workers with mental health issues. I profiled
many forms of silence, and the ways in which they were enacted by a range of workplace actors. By describing day-to-day interactions, and how they are embedded in and governed by broader social forces, I have cast light on the social relations of silence at a micro, meso and macro level, and the functions that silence serves in maintaining institutional order.

There are many clichés in society regarding the concept of silence; some which valorize it and others which condemn it. On the one hand, silence is considered to be "golden", or an oasis for reflection in a world of noise and chaos (Alerby & Elidottir, 2003). On the other hand, silence, particularly in the feminist literature, has been condemned as a form of oppression; where individuals and groups are marginalized and do not have a voice (Clair, 1998). Depending upon one's viewpoint, efforts would be made to either promote silence, or to overcome silence as a way of inducing positive change. Rather than subscribing to one of these polarized positions, I have provided an alternate viewpoint; one which portrays silence as having complex opposing implications for individuals and organizations. I have argued that silence is shaped by many social forces, and there is a need to understand the social context within which silence occurs.

Paradoxically, there is very little research in the field of work and health documenting the silence surrounding workers with mental health issues. Much of the focus of research and workplace practice has been on the antithesis of silence; from individual practices of disclosure to public dialogue about mental health in the workplace. Less is known about the social dimensions of silence itself, and the many functions that it serves for individuals and organizations. This study, therefore points attention to the largely hidden practices of silence in the workplace. By looking beyond what people say to what they do not say, much wisdom can be gained. Through an understanding of the complexities of silence, and generating a dialogue about the silence itself, we can learn how to move forward in addressing workplace mental health.
References


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Bolsover, G.N. (2000). Doctors are unsympathetic to colleagues who are psychologically vulnerable. *BMJ; 321*, 635.


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Appendix A - Recruitment article on staff website

Workplace mental health - exploring social forces that shape experience

“There is a growing body of evidence documenting the prevalence and cost of mental illness and addiction in the workplace. This research is important, but it does not capture the day-to-day human experience of illness within the context of work,” says PhD candidate Sandra Moll.

Under the direction of [organization]’s Dr. Carol Strike and Dr. Joan Eakin at the Dalla Lana School of Public Health at U of T, Sandra is conducting a new study at [organization] that will fill this information gap and provide valuable information on how the social and structural dimensions of the workplace impact the experiences of staff with mental health or addictions challenges.

[photo]

Ph.D Candidate Sandra Moll (right) is working under the direction of [organization]’s Dr. Carol Strike (left) to explore how the day-to-day experience of illness interacts with social forces in the workplace. She’s studying these effects at [this organization].

As Sandra explains, mental illness in the workplace has become one of the leading reasons why workers are unable to do their job. We’re learning that illness is only part of the picture; interactions with supervisors and colleagues, organizational policies and procedures, and beliefs about health, illness and productivity may influence how someone responds to symptoms, or whether someone discloses an illness. “This is a tough, complex issue – this is about human relationships. We need to understand the unique social experiences that make up the workplace so that we can create environments that are more responsive to peoples’ needs,” says Moll.

Sandra is currently interviewing [organization] staff who have experience with mental health or addictions challenges. She’s also interviewing people at all levels of [organization] who’ve come in contact with staff experiencing these challenges, and reviewing organizational policies and procedures. According to Sandra, it’s very important that this research looks at all aspects of working life so we can begin to understand how an organization and its culture shapes the experiences of staff.

“Our main goal is to start a dialogue. Hopefully this study will encourage people to start discussing what’s working and what needs improving so we can create positive change.”- Sandra Moll

“This is not an easy subject to talk about,” says Sandra, “but people have been very generous with their time and willing to share their experiences. The personal stories that people have shared have been incredibly helpful in illustrating issues faced by staff across the organization.”

With data collection nearing completion, Sandra will continue to work with her research advisory group to determine what to do with the findings. This group, made up of 14 staff from across [organization], will help guide decisions about the best format for information sharing, and where will it have the most impact.
If you’re interested in sharing your story with Sandra, either as a staff member living with a mental health or addiction issue, or someone who’s come in contact with a staff person experiencing these challenges, contact her at sandra.moll@utoronto.ca.
Appendix B - Research Advisory Group Terms of Reference

**Purpose:** To advise and support the project coordinators as needed regarding research methodology issues unique to [organization]. This is not a [organization] committee; it is an independent advisory committee for the study researchers.

**Functions:**
- Provide input on recruitment and data collection (e.g. suggest ways of letting people know about the project and indicate individuals or groups that may be important to include in the study)
- Provide suggestions regarding policy documents and other written materials that may be relevant to the study.
- Alert researchers to sensitivities within the organization that need to be considered.
- Respond to emerging findings from the study.
- Provide input regarding ways in which study findings could be shared or disseminated within the organization once data analysis is complete.

*Please note: Committee members will not be privy to any information about the identity of any individuals who participate in the study.*

**Membership:** Representatives from major stakeholder groups in the organization will be invited to be part of the advisory team (e.g. occupational health, human resources, unions, management, clinical practice staff and non-clinical staff). Additional members may be added, as needed, over the course of the project. The committee will be in place for the duration of the study.

**Meetings:** The plan is to schedule three in-person meetings: an initial meeting at the outset of the project (to discuss recruitment, data collection etc.); a meeting at the mid-point of data collection (to discuss progress), then near the end of the project (prior to presentation of the study findings). Between these meetings, communication will primarily occur via telephone and/or email.
Letter of Information/Consent Form -Workers

Name of Study: Mental Health and Work: Exploring Workers' Experiences with Mental Health Issues

Investigators:
- Dr. Carol Strike, Health Systems Research and Consulting Unit, [organization]
- Dr. Joan Eakin, Professor, Dalla Lana School of Public Health, University of Toronto
- Sandra Moll, Graduate student, Dalla Lana School of Public Health, University of Toronto

What is this study about?
You are invited to take part in a research study exploring how people, policies and ideas about mental health and illness at [organization] affect the experience of employees. By hearing from workers who have experienced mental health issues, and other [organization] staff, we hope to learn how to make work life better for people with mental health challenges.

Who is in charge of the study?
The study is conducted by a graduate student in Public Health Sciences at the University of Toronto as part of her doctoral research. Her supervisor is Dr. Joan Eakin, a faculty member in the Dalla Lana School of Public Health Sciences. Dr. Strike, a Research Scientist in the Health Systems Research and Consulting Unit at the [organization] is in charge of work being done at [organization].

Who can take part in the study?
To take part in this study, you must have worked at [organization] for at least 3 months, and have personal experience with mental health challenges such as anxiety, low mood, or problems coping. Formal diagnosis or contact with mental health services is not required. We hope to interview at least 10-12 workers. Also, we plan to meet with at least 6-10 other [organization] staff who may affect the experience of workers such as yourself (e.g. human resource staff, occupational health providers, union reps).

What will you be asked to do?
We want to meet with you at least once to learn about your day-to-day work experiences, and how you and others have responded to mental health issues. Interviews will take place outside of work hours at a time a place that works for you. The meeting will take about an hour, and if you agree, it will be audiotaped. You may be asked to take part in a second follow-up interview. At the end of the study, you will be asked if you would like a written summary of the study findings.

How will I benefit if I take part?
There are no direct benefits to you from taking part in this study. We hope that study findings will teach us how to make work life better for people with mental health issues. You will receive a gift card of $15 at the start of each interview, and any costs that you may have (e.g. travel, childcare) will be covered.
Are there any risks?

Some people find it helpful, but others find it stressful to think about and discuss their struggles at work and their experiences with mental health issues. It is important to know that you do not have to answer questions that are uncomfortable for you, and you can stop the interview at any time.

What if I decide not to participate?

You may choose to withdraw from the study at any time by contacting one of the researchers. If you decide to withdraw, you can review written records from your interviews and ask to remove some or all of the information. If you decide not to continue in the study, no one will know, and this will not affect your employment at [organization] in any way. Any payment will be yours to keep.

What will happen to the information that I share in the interview?

Your interview will be typed out in written form. Names and other personal information that could be used to identify you or your co-workers will be taken out. All information, including the audiotapes, will be kept in the researcher’s locked file, where only the researcher and her supervisor can reach it. Information that you share will be kept private, and we will not use names or identifying information in any report about the study.

Please note that if you tell the interviewer that you are currently struggling to the point of harming yourself or others, she does need to respond. She has a list of resources that you could call to get support.

As part of continuing review of the research, a person from the Research Ethics Board may contact you to ask you questions about the research study and your consent to participate. They will not be given personal information about your mental health status. They must protect your confidentiality to the extent permitted by law.

What if I have questions about the study?

If you have questions about the study at any time, you can contact:
Sandra Moll, student researcher, by phone: (905) 467-2155 or email sandra.moll@utoronto.ca
Dr. Carol Strike, [organization] supervisor, by phone: (416) 535-8501 ext. 6446 or email: Carol_Strike@camh.net
Dr. Joan Eakin, Research supervisor, by phone: (416) 978-8502 or email: joan.eakin@utoronto.ca

If you have questions about your rights as a study participant, you can contact Dr. Padraig Darby, Chair of the Research Ethics Board at the [organization]. Dr. Darby may be reached by telephone at 416-535-8501 ext 6876.

This study has been approved by the University of Toronto and [organization] research ethics board.

AGREEMENT TO PARTICIPATE

___ Yes, I would like to take part in this study about mental health issues at work.
___ I have read the letter of information, and have had the study explained to me.
___ All of my questions have been answered.
___ I know that I can drop out of the study at any time.
___ I understand that I will get a signed copy of this form.

_____________________________  _____________________________
Name of Participant (please print)   Name of Investigator (please print)

________________________   ____________________________
Signature of Participant    Signature of Investigator

___________________    ______________________
Date                       Date
Letter of Information/Consent Form - Workplace Stakeholder

Name of Study: Mental Health and Work: Exploring Workers' Experiences with Mental Health Issues

Investigators:
Dr. Carol Strike, Health Systems Research and Consulting Unit, [organization]
Dr. Joan Eakin, Professor, Dalla Lana School of Public Health, University of Toronto
Sandra Moll, Graduate student, Dalla Lana School of Public Health, University of Toronto

What is this study about?
You are invited to take part in a research study exploring how people, policies and ideas about mental health and illness at [organization] affect the experience of employees with mental health issues. By hearing from workers who have experienced mental health issues, and other [organization] staff, we hope to learn ways of improving work life for this group of workers. You are invited to take part in this research study because your role in the workplace provides a unique perspective on employees with mental health issues.

Who is in charge of the study?
This study is conducted by a graduate student in public health sciences at the University of Toronto as part of her doctoral research. Her supervisor is Dr. Joan Eakin, a faculty member in the Dalla Lana School of Public Health. Dr. Carol Strike, Research Scientist in the Health Systems Research and Consulting Unit at [organization] is the principle investigator for the work being done at [organization].

Who can take part in the study?
One part of the study involves interviewing at least 10-12 employees who have experienced mental health challenges, and the other part involves interviewing key people in the work environment who interact with this group of workers. Key people may include managers or supervisors, occupational health providers, human resource personnel, union representatives, and co-workers. Additional people may be identified as the study progresses. We hope to interview at least 6-10 people who can provide information about workplace policies and procedures and/or informal relationships and practices that may affect the experiences and actions of workers.

What will you be asked to do?
Participants will be contacted by email and/or phone to set a time to meet. During the interview, you will be asked about your experience with workers who have mental health issues, and about the conditions of work that may affect the experience of workers. It is expected that the interview will take about an hour. With your permission, interviews will be audio-taped. At the end of the study, you can have, if you want, a written summary of the study findings.

How will I benefit if I participate?
You will not receive any direct benefit by taking part in the study. If the interview is conducted off site and/or outside of working hours, there will be some compensation for time and expenses. We hope that information gathered in this study will be used to identify positive changes that can be made in workplaces to better serve the needs of workers with mental health issues.

Participant Initials:
Are there any risks involved?

There are no anticipated risks for taking part in the study. It is important to know that you do not have to answer questions that are uncomfortable for you, and you can stop the interview at any time.

What if I decide not to participate?

Participation in this study is voluntary. You may choose to withdraw from the study at any time by contacting one of the researchers. You can review the written record of your interview and ask to remove some or all of the information. If you decide not to participate or to withdraw from the study, we will not tell anyone from [organization], and this will not affect your employment in any way either now or in the future. Any payment you may have received will be yours to keep.

What will happen to the information that I share?

With your permission, we will tape the interview. When the interviews are typed out, names and other personal information that could be used to identify you or your co-workers will be taken out or changed. All information, including the audiotapes, will be kept in the researcher's locked file, where only the researcher and her supervisor can get to it. Information that you share will be kept private, and you will never be mentioned by name or be identifiable in any report of the study.

As part of continuing review of the research, your study records may be assessed on behalf of the Research Ethics Board. A person from the research ethics team may contact you (if your contact information is available) to ask you questions about the research study and your consent to participate. The person assessing your file or contacting you must maintain your confidentiality to the extent permitted by law.

What if I have questions about the study?

If you have questions about the study at any time, you can contact:
Sandra Moll, student researcher, by phone: (905) 467-2155 or email: sandra.moll@utoronto.ca
Dr. Carol Strike, [organization] investigator by phone: (416) 535-8501 ext. 6446 or email: Carol_Strike@camh.net

If you have questions about your rights as a study participant, you can contact Dr. Padraig Darby, Chair of the Research Ethics Board at the [organization]. Dr. Darby may be reached by telephone at 416-535-8501 ext 6876. This study has been approved by the University of Toronto and [organization] ethics board.

AGREEMENT TO PARTICIPATE

___ Yes, I would like to participate in this study about mental health issues at work.
___ I have read the letter of information, and have had the study explained to me.
___ All of my questions have been answered to my satisfaction.
___ I know that I can drop out of the study at any time.
___ I understand that I will receive a signed copy of this form.

__________________________________________  _____________________________
Name of Participant (please print)   Name of Investigator (please print)

__________________________________________  _____________________________
Signature of Participant    Signature

__________________________________________  _____________________________
Date                       Date
Appendix D - Recruitment Poster

[Organization logo removed]

[Organization] Employees

Have you ever experienced mental health &/or addictions challenges?

If so, please consider participating in a research study:
"Mental Health and Work"

Purpose of Study
To explore the day-to-day experiences of staff at [organization] with a current or past history of mental health &/or addictions challenges. We hope to learn about the relationship between these experiences and the workplace environment.

What is involved?
- An initial interview (about 1 hour long)
- A second interview (if needed)
- Interviews will take place outside of work hours at a time and place that works for you

Who is in charge of the study?
A graduate student in public health sciences at the University of Toronto is conducting the study as part of her doctoral thesis. She is supervised by Dr. Joan Eakin at the Dalla Lana School of Public Health, University of Toronto. Dr. Carol Strike from the Health Systems Research & Consulting Unit is responsible for the research done at [organization]. Dr. Strike can be contacted at: 416-535-8501 ext. 6446 or email Carol_Strike@camh.net.

*If you would like more information and/or are interested in participating, please contact Sandra Moll by email: sandra.moll@utoronto.ca or phone: (905) 467-2155

[Organization] is a Pan American Health Organization/World Health Organization Collaborating Centre
Affiliated with the University of Toronto

ALL QUERIES ARE STRICTLY CONFIDENTIAL
November, 2008

Dear [employee]

You are invited to take part in a research study called Mental Health and Work. The purpose of the study is to explore how workers who have had mental health challenges (e.g. anxiety, low mood, problems coping), are affected by people, policies, ideas about health and illness, and the nature of work. By hearing from workers and the people around them, we hope to learn about ways of making better, healthier workplaces.

The study is part of my doctoral research in public health sciences at the University of Toronto. Dr. Joan Eakin is my faculty supervisor at the Dalla Lana School of Public Health, and Dr. Carol Strike, from the Health Systems Consulting and Research Unit is responsible for the [organization] part of the study.

To take part in this study, you must have worked at [this organization] for at least three months (either part-time or full-time), and have personally experienced mental health challenges. You may or may not have had a formal diagnosis or treatment. We are looking for people who are willing to talk about their ideas and experiences. We hope to meet with each person once, or possibly twice for about an hour each time. Meetings will be set up outside of work hours at a time and place that works for you. All participants will receive a $15 gift card at each interview, and any costs (eg. travel) will be covered.

If you would like to take part or get more information, please contact me by phone 905-467-2155 or email: sandra.moll@utoronto.ca. I will then contact you to discuss the study and answer any questions you may have.

Thank-you for considering this request. I look forward to hearing from you.

Sincerely,

Sandra Moll, PhD (Cand)
Dalla Lana School of Public Health
University of Toronto
Dear [stakeholder]:

You are invited to take part in a research study called *Mental Health and Work*. The purpose of the study is to explore how workers who have had mental health challenges (e.g. anxiety, low mood, problems coping), are affected by the people, policies and ideas in their workplace. By hearing from workers and the people around them, we hope to learn about ways of making better, healthier workplaces.

The study is part of my doctoral research in public health sciences at the University of Toronto. Dr. Joan Eakin is my faculty supervisor in the Dalla Lana School of Public Health, and Dr. Carol Strike, from the Health Systems Consulting and Research Unit is responsible for the research being conducted at [this organization].

One part of the study will involve interviewing workers with mental health issues about their experiences at work. We also feel, however, that it is important to hear from those in the workplace who interact with these workers on a day-to-day basis, including managers, supervisors, human resource personnel, union leaders and occupational health providers.

We hope to meet with each participant once for a period of about an hour. Meetings will be set up at a time that fits with your schedule and at a quiet location of your choosing. Participation in this study is voluntary, and you may withdraw at any time. Your involvement will not be made known to other participants or [organization] employees.

If you are willing to participate and/or would like get more information about the study, please contact me by phone 905-467-2155 or email: sandra.moll@utoronto.ca. Thank-you for considering this request. I look forward to hearing from you.

Sincerely,

Sandra Moll, PhD (Cand)
Dalla Lana School of Public Health
University of Toronto
Appendix F -Employee Interview Guide

The purpose of this interview is to learn more about your day-to-day experience at work. I have some general questions to guide our discussion, but will really want to hear from you in terms of what is important to know. If you are uncomfortable with any of the questions, you do not need to answer. If you need a break at any time, please let me know.

*Note: Questions are provided as an initial guide, but will evolve and become more refined over time in order to explore emergent issues.

A. Nature of work & workplace interactions
   - Tell me about your job.
   - How long have you been working here?
   - Describe a typical day at work.
   - Describe your supervisor/co-workers.

B. Nature of mental health challenges
   Sample questions
   - Have you ever personally experienced mental health challenges/problems?
   - Tell me about the kinds of things you have experienced.
   - Have you ever sought out assistance for your mental health concerns? If so, describe.
   - How have you dealt with mental health issues that arise?

C. Mental health challenges and work
   - Do you ever find that your mental health affects your work? If so, how?
   - What do your co-workers know about your mental health concerns? [Listen for details re: who knows, what they know, when & why]
   - How have others responded to you?

D. Organizational response to mental health issues
   - Do you know of others at [this workplace] who have had mental health challenges at work? What has their experience been like?
   - Do you think the response that you have had from others would be the same if you were in a different job or place in the organization? What about if you had a different type of illness (eg. diabetes, RSI)?
   - Are there people or departments in the organization who have an impact on the experience of workers?
   - In general, how 'mental health friendly' do you think this organization is?
   - Are there some things you would like to see changed?

Any other things you'd like to add before we finish?
Appendix G - Stakeholder Interview Guide

The purpose of this interview is to learn more about your experience with employees who have mental health issues, and perceptions of the workplace environment. Although I have some general questions to guide our discussion, I will follow your lead in terms of what is important to know. If you are uncomfortable with any of the questions, you do not need to answer. If you need a break at any time, please let me know.

*Note: Questions are provided as an initial guide, but will evolve and become more refined over time in order to explore emergent issues.

Nature of Work & Workplace Interaction
- Tell me about your role in this organization.
- What contact do you have with workers who have mental health issues?
  Tell me about some of your experiences.

Impressions of Mental Health Challenges at Work
- How have you heard about workers with mental health challenges?
- Are there some situations that stand out for you?
- How do you feel mental health issues affect work?

Organizational Response to Workers with Mental Health Issues
- Within [organization], do you feel that there are differences in how people think about and/or respond to workers with mental health issues? Explain.
- What kinds of policies and procedures are here that might affect workers?
- Do you think this organization is different than others in terms of how they think about and respond to employees with mental health issues? [explore comparisons with other health care facilities or private industry]

Anything else you would like to add that would be important for me to know in understanding the experience of workers with mental health issues in this organization?