Mental Health in the Workplace: Unions’ Role in Identifying and Combating Psychosocial Hazards

by

Miriam Karin Edelson

A thesis submitted in conformity with the requirements for the degree of Doctor of Education

Department of Social Justice Education

University of Toronto

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Abstract

The world of paid work has shifted extraordinarily in the last several decades. Globalization, technology, lean production, the intensification of work, mergers and reorganizations and precarious work have all meant a toughening of the conditions for workers. Unions organize in these conditions, confronting issues of concern to workers. Very little has been written about the role unions play in trying to protect the psychological health of their members. The major question of this thesis is whether unions are identifying and combating psychosocial hazards in the workplace.

The thesis adds to knowledge on this subject by analyzing two data sets. First I conduct an analysis of grey literature on the Internet about psychological health and safety concerns. Second, I explore a series of questions with union health and safety experts representing every major Canadian union from each sector of the economy. The questions probe how unions are dealing with psychosocial risks in the workplace, how unions are organizing resistance and building solidarity. My inquiry also explores the issue of how unions deal with return-to-work for workers who have been absent for mental health reasons.

I am not a neutral observer: I write from the standpoint of workers. My work has a practical utility to the degree that it can be directly applied to these real life problems facing health and
safety practitioners. It attempts to theorize that which these union specialists should do. It also tries to anticipate some practical problems they may need to solve in future as a result of current health and safety practices. I observe real life phenomena and develop theory around them.

One of these is that unions resist employer restraints and power and in so doing bump up against managements’ right to control production and dictate work organization. In this thesis, I show the fledgling ways in which unions are challenging managements’ typical rights in the interests of better working conditions. I give evidence of three promising practices that unions are adopting and propose that these may be adapted further for initiatives in other sectors. I argue that workers’ psychological health is one potential winner of these strategies. I also propose that union representatives be educated to deal more empathically with members that are absent for reasons of psychological ill health, in advocating for them when they return and by building solidarity among co-workers.
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With all this marvelous input, the final result of the thesis remains my responsibility.

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Chapter One
Introduction: Overview and history of the project

The world of paid work has changed extraordinarily in the last several decades. Globalization, technology, lean production, the intensification of work, mergers and reorganizations and precarious work have all meant a toughening of the conditions for workers (Loisel & Côté, 2013; Corbière & Shen, 2006). Employers’ organization of work is meant to bring efficiencies, squeezing more out of workers both physically and mentally. How they have fared in such shifting sands is documented, in some ways, in the literature. Very little, however, has been written about what workers’ protective organizations, unions, do to work against the impacts of these massive changes in conditions. The impact upon workers’ psychological health in the workplace is a key concern and this study seeks to address this in unionized settings.

Information about what unions do and don’t do to protect their members who face mental health challenges is sparse. The same is true of how unions do – or do not – push back against psychosocial risks in the workplace. This thesis adds to the knowledge on this subject by interrogating unions as to their programs of action when it comes to identifying and combating psychosocial hazards in the workplace. Further, it investigates the role that unions are playing in the return to work of workers who have been off due to mental ill health.

The notion of standpoint is important here. I am not a neutral observer: I write from the standpoint of workers and, in particular, those challenged by mental health problems. In the pages that follow I explore unions’ changing role, document the unions’ activities and explore their meaning, showing that there is a gap in the literature to be filled. Very little published research documents unions’ combating of psychosocial hazards in the workplace as part of a health and safety strategy. It is my hope that this thesis, which deals with the experience of the major, but not all, Canadian unions, will partially plug that gap.

By looking at how unions are taking on the power relations embedded in employers’ work organization, a picture of struggle emerges in these pages. Unions are trying to identify and combat psychosocial hazards that exist in the workplace. Doing so means bumping up against managements’ right to control production. In this thesis, three promising practices that advance
workers’ interests are highlighted. These are the OPSEU community nurses direct engagement campaign promising practice, UNIFOR and Chrysler, as well as the PSAC and Treasury Board collective bargaining promising practice, and the mental health and workload promising practice that are illustrated in Chapters Five and Six. They are practices built upon research, organization and the exercise of bargaining power. They show the fledgling ways in which unions are challenging managements’ typical rights, in the interests of better working conditions. The thesis argues that workers’ mental health is one potential winner of these battles.

Encountered in the peer-reviewed literature that follows this introduction was the expression of divergent interests between employer, union, medical establishment and the insurance/EAP industry. Each has a unique set of interests – whether it is psychosocial hazards or return to work that is being interrogated. It is the playing out of the individual-based solutions versus a more structural approach (work organization, for example) that is of interest throughout this study. Suffice to say that these are not neutral players, but rather they carry differing sets of vested interests into every statement of problem and proposed solution.

The question that piqued my interest when I began this study was whether unions could protect their members against circumstances that were psychologically unhealthy. I had lived through a debilitating set of conditions in my work as a union staff member in a human rights and equity issues department. Ironies can run deep in the union movement. In that situation, bullying by a supervisor made it difficult to continue working in the field with members and I eventually sought early retirement. In leaving, I said goodbye to a group of colleagues I had come to cherish; the richness of our relationships stays with me to this day. I did have, however, another set of feelings: I felt betrayed that the staff union of which I was a member had been unable in practical terms to fix the situation that had been so unfair and devastating for a few of us.

Bullying and harassment are complex issues. As I learned in my research, they are rooted fundamentally in work organization. I see now how the supervisor concerned, the bully, was positioned by the employer to take advantage of those who reported to her. It could have been prevented, at many different stages in the story. But it was not prevented; rather, the fact that offensive behaviours continue was meeting the stated or unstated wishes of someone in the organization.
In undertaking this study, I wanted to better understand unions’ potential role in mental health in the workplace. Could the union intervene effectively in a bullying situation? How could other psychosocial hazards be identified and combated? What would the best role be for unions regarding return to work when the absence was due to mental ill health? These and other questions propelled me forward and this thesis is the result.

The thesis begins with the following research objective:

To better understand how unions are dealing with psychosocial risks and issues of mental health in the workplace among their members.

To try and answer this question I read extensively in the peer-reviewed and grey literature, and created reviews of the two literatures in Chapters Two and Chapter Four, respectively. I then conducted interviews with health and safety experts in the union movement, six in English Canada and two in Quebec. I used Thematic Analysis to organize and make sense of the material collected, as explained in part of Chapter Three on Study Design and Implementation. I also read and analyzed pertinent documents from the Internet (Data Set 1) in Chapter Four. Chapter Five and Chapter Six contain the results of the interviews and discussion of the points raised (Data Set 2). This is followed by an analytic commentary and the last chapter is the Conclusion, containing final thoughts and setting some signposts for future research. First off, however, I examine and present my epistemological orientation and feminist standpoint theory to help better situate this research project.

My Epistemological Orientation

Standpoint theory emerged in the 1970’s and 1980’s as a feminist critical theory about relations between the production of knowledge and practices of power (Harding, 2004). That is, it looks at the effect of power relations on the production of knowledge. It stems, in part, from feminist epistemology wherein the notion of the ‘situated knower’ is important. It asks how the social location of the knower affects what they know. The idea of the situated knower tries to account for who can see what from which perspective and what is focused upon. All attempts to know are socially located. Eakin (2010) argues that knowledge and action are situated in a particular context of everyday bodily experience and relations of power. “To take the standpoint of individuals or a group of people is, metaphorically, to ‘stand’ in their shoes and view the world
from their vantage point.” (p. 2) As a researcher, taking the standpoint of workers means locating oneself within the interests of workers, but going beyond what workers would know or recognize or articulate themselves. In this view, as in Marxism, knowledge is a social and practical construct and conceptual frameworks are shaped and limited by their social origins (Jaggar, 2004).

Central to standpoint theory is the notion that critiques of relations between material experience, power, and of the effects of power relations on the production of knowledge are important. Standpoint is developed through the experience of collective political struggle. As such, feminist standpoint theory is both a feminist epistemology and a methodology for feminist researchers in the social sciences. Proponents argue that certain socio-political positions occupied by women can become sites of epistemic privilege and are potent starting points for enquiry into questions about those who are socially and politically marginalized as well as those who occupy the position of oppressors. This means that

“…those who are subject to structures of domination that systematically marginalize and oppress them may…know different things or, know some things better than those who are comparatively privileged (socially, politically), by virtue of what they typically experience….” (Wylie: 2004 p. 339.)

Proponents argue that gender is one dimension of social differentiation that may make such an epistemic difference.

In terms of my research, I must state that I am not a neutral observer. I write from the point of view of workers, and within that group, with particular empathy for workers experiencing mental health problems. This is my standpoint. It defines what I focus upon in the world and my understanding of how knowledge is created originates with that perspective. My focus as a researcher is structured and shaped not just by my union background but also by my experience as a Caucasian woman living with a mental health disability.

Furthermore, I see the practices of the union health and safety specialists from an insider position; I too was a union staff representative for a great many years. My ability to connect with them and to their work aided my research, gave the interviews a depth they would not have had.
otherwise. I was explicit about my background in the interviews and this helps to lend them credibility as a unique data set.

Eakin demonstrated that standpoint influences research and plays a significant role in how one sees and acts within the world (Eakin, 2010). By adopting the standpoint of workers, the objective is to see how the system works or does not work for them.

“To assume a standpoint perspective, one must suspend one’s own point of view as the observer, take up the gaze from where the other is situated, and frame and name phenomena as they are seen from that particular site. From different standpoints, different things are seen because different stakes are held, different interests are at play, and different things matter. Standpoint is largely implicit, embedded deeply in language, practices, texts and in taken-for-granted assumptions.” (p. 2)

In my research, I adopt the standpoint of workers as most significant. I explored the pros and cons of various psychological health strategies with union health and safety specialists. I asked them what worked best and what challenged them most in trying to identify and combat psychosocial hazards in the workplace. We discussed the power relationships with employers that limit their collective ability to protect and defend workers from mental injury. The conversations were open-ended, but rooted firmly in pursuing workers’ interests.

I believe standpoint theory can be used in conjunction with Critical Discourse Analysis (CDA), explained in some detail below, as it too is embedded deeply in relations of power, language, texts and practices. The relations of domination that characterize a CDA analysis are evident in the adoption of workers’ standpoint; there is a relationship in the workplace in which employers dominate workers’ interests and as a researcher one can elect to choose sides. I am trying to decipher what practices will be most helpful to workers, and those experiencing mental health problems in particular. My standpoint is integral to my research project and its recommendations.

In my own experience of work, as mentioned earlier, I encountered a difficult bullying situation in which no one was willing to take responsibility for offensive behaviours in my workplace. That experience has fueled my passion to know what more useful steps could be taken in such a situation and to understand better my supervisor’s motivations
and the benefits they derived from such dynamics. As a union member, I was disappointed in my colleagues’ inability to face squarely this challenge and our staff union, in my opinion, faltered as a result. I believe unions can do better and in this present research some of these questions are touched upon.

Building Theory – How does my work contribute?

In an article entitled, “Building Theory about Theory Building: What Constitutes a Theoretical Contribution”¹ Corley and Gioia call for a view of theorizing that would enable theories with more “scope”, meaning both scientific and practical utility. They assert that theory is a statement of concepts and their interrelationships that shows how and/or why a phenomenon occurs. Four quadrants are proposed to describe theory that has been contributed to the field of interest, in this case, organization and management studies. They distill existing literature into what they call “two dimensions”: originality, which is either incremental or revelatory (a surprising advance in understanding) and utility, which is either scientific or practical.

They also argue for an orientation toward “prescience” as a way of achieving that scope. Prescience involves anticipation of and sensitivity to developing trends and acting to influence those trends. The article states that the best way to predict the future is to influence the conversation about what it could or should be. Prescient scholars “assume the role of making informed projections about coming issues, act as if those issues have manifested, and then infer what theoretical domains need attention or invention.” (p. 25)

According to this article, my work falls into the incremental and practically useful quadrant they propose. It is not revelatory, but builds on work that has been done about unions and psychosocial hazards. Nor is my work particularly scientifically useful -- it has a practical utility to the extent that it can be directly applied to the real life problems facing practitioners. It attempts to theorize with prescience what the health and safety specialists can and should do. My work puts the health and safety specialists’ initiatives into context and tries to anticipate any

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practical problems they may need to solve in future as a result of current practices. I observe real life phenomena and develop theory around them.

Precarious employment: the emergence of psychosocial hazards

Fundamental shifts in the labour market have meant the increase of precarious employment at the expense of full-time jobs. Employment precarity results when people lose their jobs or fear losing their jobs, when they lack alternative employment opportunities in the labour market, and when workers experience diminished opportunities to obtain and maintain particular skills (Kallenberg, 2009). Vosko et al. (2009) understand precariousness in employment as paid work characterized by limited social benefits and statutory entitlements, job insecurity, low wages, and high risks of ill health. Furthermore, the authors refer to studies that show that precarious workers are less likely to challenge hazardous working conditions, both individually and collectively, given their employment insecurity.

In a 2007 study, Clarke and her colleagues looked at the health impacts of precarious work and found that those in precarious employment relationships frequently experienced different physical ailments as well as anxiety and depression (Clarke et al., 2007). These health issues were attributed to high “employment strain”. Employment strain refers to the uncertainty associated with access to future employment; the effort associated with finding and keeping employment; and the support one obtains as the result of being employed. Employees have high levels of employment strain when they experience high levels of uncertainty in their employment and must work hard to find and keep employment. In a study of precarious work and occupational health, Quinlan et al. (2007) found that of 93 published journal articles and monographs/book chapters reviewed, 76 studies found precarious employment was associated with a deterioration in occupational health and safety in terms of injury rates, disease risk, hazard exposures, or worker (and manager) knowledge of occupational health and safety and regulatory responsibilities. The negative impact upon workers’ health, including mental health, due to precarious employment reveals another example of how shifts in the economy are impacting upon workers.
The 2011 Québec Survey on Working and Employment Conditions and Occupational Health and Safety (EQCOTESST) revealed important data on employment insecurity and precarious work arrangements. The purpose of the survey, undertaken under the auspices of the Institut de la statistique du Québec (ISQ, Québec’s statistics institute) beginning in 2007 and in conjunction with pertinent government ministries, public health and occupational health research institutes, was to better understand the links between work organization and health and safety. The specific goal was to enhance research and develop preventive interventions respecting working conditions and occupational health and safety in Quebec. The survey concentrated explicitly on work-related musculoskeletal disorders (MSDs), traumatic work accidents, and mental health in the workplace. It also explored workers’ perceptions of their general health. (Vezina et al., 2011 pp. 1-2)

To attain these objectives, the study targeted all Québec workers 15 years of age and over who had held paid jobs as either salaried employees or self-employed workers for at least eight weeks. They had to have been working 15 hours a week or more. Five thousand workers representative of the general population were sampled via telephone interviews of 35 minutes. Researchers developed and utilized two indicators, “employment insecurity” and “precarious employment relationships.” The first measured the ability to maintain the particular job they had and also took into account the likelihood of their being able to maintain a paid job in general, given other factors such as work-life balance or student status. The indicator was positive if a worker met at least one of the two following conditions: agreed or strongly agreed with the idea that s/he had poor job security and/or had experienced a period of unemployment during the two years prior to the study.

2 The full report is only available in French. Citations in this thesis are taken from the 40-page Summary Report # RR-707.

3 The Institut de recherche Robert-Sauvé en santé et sécurité du travail (IRSST, Québec’s occupational health and safety research institute), the Institut national de santé publique du Québec (INSPQ, Québec’s public health institute), the Institut de la statistique du Québec (ISQ, Québec’s statistics institute), the ministère du Travail (Québec’s ministry of labour), the ministère de la Santé et des Services sociaux (Québec’s ministry of health and social services) and the Commission des normes du travail (CNT, Québec’s labour standards commission).
The second indicator

“…was created to take into account four forms of precarious employment arrangements identified in the scientific literature as being associated with adverse working conditions: working as a part-time employee but wanting to work more hours; becoming self-employed at the request of the employer; holding a job through a placement agency; or having fixed-term employment.”

Psychological Distress— Kessler 6 Scale (K-6)

Researchers found that approximately 18 per cent of the Quebec workers targeted by this survey (21.7 per cent of women versus 15 per cent of men) demonstrated a high level of psychological distress according to the Kessler 6 Scale (K-6) and other threshold levels employed in the study. That is to say, researchers found that precarious work arrangements are strongly associated with psychological distress, particularly in women. (Vezina et al. (2011), p. 14)

It is important to point out, however, that the statistics do not indicate that women were more vulnerable simply because they were female. The organization of work and issues related to psychosocial hazards come into play in significant ways.

Researchers assert that psychological distress

“…applies in the case of exposure to high psychological work demands, particularly if combined with exposure to low decision latitude or low support at work, or when workers do not have adequate means at their disposal to do quality work or are victims of psychological harassment….In workers exposed to tense situations in relations with the

4 The Kessler 6 Mental Health Scale (K6) (Kessler et. al., 2003), developed at Harvard Medical School, is a measure of non-specific psychological distress. The K6 is a tool used for screening mental health issues in a general adult population. The scale was designed to be sensitive around the threshold for the clinically significant range of the distribution of non-specific distress in an effort to maximize the ability to distinguish between instances of serious mental illness (SMI) and other mental health problems. Retrieved from http://www.prosettastone.org/measures/Kessler6Mental%20Health%20Scale/Pages/default.aspx Viewed April 3, 2016.
general public or to emotionally demanding work and who also have high decision latitude at work, high social support at work or high levels of job rewards or recognition, the prevalence of high levels of psychological distress and depressive symptoms approaches the average values for workers not exposed to these demanding work conditions.” (Vezina et al. (2011) pp. 14-15)

This study is significant because it covers a large population and deals with work organization specifically as it interacts with workers’ experience of different aspects of mental health, including psychological distress, depression, anxiety and more serious mental illness.

In a 2013 study entitled It’s More Than Poverty prepared for the United Way Greater Toronto and McMaster University, Lewchuk et al., 2013) found that only half, 50.3 per cent, of those working in the Greater Toronto Area and Hamilton were in permanent, full-time positions that provide benefits and a degree of employment security. The remaining workers were either full- or part-time, but with no benefits or job security, and in temporary, contract or casual positions. The study noted that precarious or insecure work had increased by 50 per cent over the previous 20-year period. (Lewchuk et al., 2013, p. 4)

This study is important in a number of ways. Although labour market analysts now recognize precarious employment as an established feature of the economy, little agreement exists as to its definition. The indicators that Statistics Canada uses are limited in their capture of the scope and impact of precarious work on the texture of workers’ lives, their families and health. The study introduced revealing new indicators that flesh out the economic and social portrait.

Specifically, Statistics Canada defines precarious employment in two ways: a) as people working in temporary employment with a fixed end date, including casual, seasonal and temporary work; and (b) as people who are self-employed but do not themselves have any employees. Lewchuk et al. underscore that there is a difference between the form of employment relationship and the characteristics of that relationship. They assert:

5 It’s More than Poverty (2013) and The Precarity Penalty (2015) were prepared by the Poverty and Employment Precarity in Southern Ontario (PEPSO) research group, a collaborative university-community initiative. Dr.Wayne Lewchuk was the lead researcher.
“Together, temporary employment and own-account self-employment represent the narrowest definition of precarious employment: one based exclusively on the form of employment relationship rather than the characteristics of the relationship. This is an important distinction as it excludes many workers who we would consider not in secure employment. Workers in jobs without a fixed end date are unlikely to be classified as precarious under this Statistics Canada definition even though there are many reasons to argue their jobs are insecure and precarious. For example, in Ontario, many workers hired into jobs without fixed end date are only entitled to a week or two weeks of advanced notice of termination. Even in cases where the job is unlikely to last, these workers would still not be classified as temporary employees by Statistics Canada. For example, workers hired into jobs without a fixed end date who are about to lose their jobs as a result of company reorganization or downsizing would not be classified as temporary employees. This definition of precarious employment also does not include workers in jobs that do not provide any benefits beyond a basic wage or who experience varying hours from week to week.” (Italics mine; Lewchuk et al, 2015) p. 23.

Lewchuk et al., (2013) also introduced new indicators, the Employment Precarity Index (EPI), to provide a more accurate measure of how employment insecurity affects workers and their families. The EPI included several questions that asked participants about the specific nature of their employment -- such as if they were paid for a missed day of work or, over the last 12 months how much their income varied from week to week. Meaningful questions about work scheduling were asked, such as the extent to which a person was on-call during a specific time period and how much lead-time they received for changes to shift assignments. This high level of analysis reflects the report’s breadth and depth as a tool for developing future labour market policy.

In 2015, the researchers updated the study and published a second report known as The Precarity Penalty. They found that only 48 per cent of the workers surveyed are in permanent, full time jobs that pay some benefits beyond a basic wage. This is a decrease from the first report.

The 2015 study also addressed in greater detail the impact of precarious work on a series of variables including employment insecurity and life at home, social interaction, income stress,
and union density. These areas of inquiry helped to shed light on the physical and mental health implications of precarious work.

The findings include that workers in precarious employment are almost twice as likely to report poorer mental health than those in secure employment. This was found to be true even when controlling for factors such as income, gender and race. (Lewchuk et al., 2015 Executive Summary p. 9.) Furthermore, the report found that the impact of unstable work on personal and family life is far-reaching. For example, people in low-income precarious jobs are less likely to have a close friend to talk to than those in more secure employment. The implications of this for mental health are obvious.

Other significant demographic data on the differential impact of employment precarity by sex, membership in a racialized group and immigration status emerged from the study. First, Caucasian men were eight per cent more likely to be in permanent, full-time employment than Caucasian women. Second, non-Caucasians and people who came to Canada less than 20 years ago were more likely to be in insecure work. Third, Caucasian men are 27 per cent more likely than racialized men to be in permanent, full-time employment. (Lewchuk et al., 2015, Executive Summary, p.7)

It is noteworthy that between the publication of the two reports, that is, using data collected in 2011 and 2014/15 respectively, the percentage of Caucasian workers in secure employment increased by six per cent and the percentage of precarious employment for this population decreased by 20 per cent. For racialized workers, during the same period, the opposite occurred. There was a 16 per cent decrease in secure employment and an increase of precarious employment of 30 per cent. (Lewchuk et al., 2015, Executive Summary, p. 8).

Finally, while union membership typically provides some protections for workers of all descriptions, the 2015 PEPSO study found that workers in secure employment are almost three times more likely to belong to a union than workers in precarious employment. (Lewchuk et al., 2015, Executive Summary, p. 22). At minimum, this suggests that it is more difficult for these workers to voice concerns about employment standards and health and safety in the workplace. Furthermore, it indicates the particular and complex challenges unions must confront in all sectors of the economy to better protect all working people.
Taken together, this literature on precarious work suggests both that it is increasing rapidly and that it conveys hazardous conditions for workers’ mental health. The combined contributions of the Quebec 2011 survey and the more local PEPSO 2015 study include that they help to analyze the actual experience of working people in their families, workplaces and communities. Researchers are getting at the crux of work organization as it affects different aspects of psychological health in the workplace and beyond. More research is certainly required but these findings help to paint a fuller portrait of the societal inequities that are currently playing out in the labour market and the challenges unions, governments and the economy face as a result.

In the next section I explore psychosocial hazards.

Vézina et al. (2004 and 2011) and Gilbert-Ouimet et al. (2011) explore the pernicious aspects of psychosocial hazards, placing them in the context of workplaces profoundly impacted by technology, globalization and the intensification of work. Psychosocial factors refer to all organizational factors and interpersonal relationships in the workplace that may affect the health of the workers. The International Labor Organization considers that psychosocial problems make up, in the entire world, one of the principal causes of accidents, illness, absenteeism, and death in the workplace. Vezina’s work, like the literature in the preceding section on evolution of work organization, relies on an analysis of macroeconomic and sociological factors’ impact.

Vézina et al. (2004) and other authors explore the theoretical base of psychosocial hazards pointing to Karasek’s (1979) job demand-control-support model, and Karasek and Theorell’s (1990) job strain model and Siegrist's (1996) effort-reward imbalance model. Taken together, Karasek and Siegrist identify four psychosocial factors in the work environment whose effects on mental and physical health have been documented. The demand-control-support model has two primary components: psychological demands (quantity of work, intellectual requirements, time pressure); and control or decision latitude (use and development of skills, control over work which implies latitude at work, and participation in decisions). According to this model, job strain occurs when high psychological demands are accompanied by low control. A third component takes into account social support of co-workers and supervisors. Job strain results from the combined effects of increased psychological demands and low decision latitude in the workplace, and this brings a higher risk of health problems. Social support is expected to
moderate the effect of job strain. Siegrist's effort-reward imbalance model (ERI) is focused on the lack of reciprocity between efforts extended and rewards obtained (esteem, respect, job status, income, and career opportunities) and that the absence of significant reward can have pathological effects upon health.

According to this theoretical framework, an optimal psychosocial work environment for workers is characterized by demands that are adapted to an individual’s capacities (psychological demands), a satisfactory level of influence (decision latitude), adequate social support from superiors and colleagues, a balance between efforts expended at work and reward received, predictability of work, meaning of work, and interaction with clients. This work provides a framework for analyzing and understanding psychosocial hazards in the workplace. It is by analyzing these hazards and advocating on behalf of their members that unions may become more able to defend the interests of all workers in a workplace and not just those with individual grievances or those requiring accommodations upon returning to work. There is a fundamental strategic question here between individual and collective interests. I posed this question to key informants during the interviews conducted for this project and report on it in Chapters Five and Six.

A major 2011 study in Quebec, Québec Survey on Working and Employment Conditions and Occupational Health and Safety, known as ECQOTESST, (Vezina et al., 2011) provides a series of important observations on the differential impact of psychosocial hazards on men and women.

Several other authors deal with the nature of psychosocial hazards and their impact on the mental health of workers. Bourbonnais et al. (2006b) show the relevance of an intervention on the four selected adverse psychosocial factors (high psychological demands, low decision latitude, low social support, and low reward) among care providers to prevent mental health problems. The authors explain that sick leave for reasons of mental ill health is on a marked increase in the health sector and propose links to the sweeping reforms and restructuring of the sector. The volume of patients has increased, along with the severity of their illnesses, with no improvement in the resources available to staff. Typically, this has led to increases in psychological demands, low control, low social support at work and an increase in psychological distress among care providers. The authors suggest their methodology can be easily exported to other economic
sectors. Interestingly, the Conference Board of Canada has produced a document that essentially calls for good quality management along these lines. (Thorpe & Chenier, 2011). It argues for a workplace culture that is conducive to good mental health, including how work is organized; how much control people have over their work; how they are rewarded and recognized; and how organizations are dealing with bullying, harassment and discrimination that have been identified. That an explicitly employer-side publication should restate worker-friendly points made by Karasek (1979) and others in the peer-reviewed literature is very interesting and suggests there may be a substantial cost to employers where these mental health related issues persist.

According to Caveen et al. (2006), it is well documented in empirical studies that psychosocial work factors, such as lack of control, high workload, and job insecurity are associated with mental illnesses, including depression. In the Caveen study of three large financial institutions, they found that the degree of organizational change due to mergers and restructuring, accompanied by workers feeling that they had little control over their jobs or careers, correlated to the extent of depression-related disability in the organizations. Interestingly they found that more senior employees’ mental health was most affected. Like Bourbonnais et al., (2006a), Caveen found a correlation between restructuring and intensification of work and mental ill health. These findings are helpful in that I will be probing the impact of psychosocial work factors with the key informants to be interviewed as part of this study.

Lavoie-Tremblay et al. (2005) argue that in combating psychosocial hazards, trust among work teams is important as recognition and respect are established among workers and management, especially in light of job restructuring and budgetary reductions. Carried out in a long-term care unit in a Quebec hospital, this study sought to improve the psychosocial work environment and health of health care workers. Few prior studies targeted situational or organizational stressors. By using a participatory model, the authors encouraged workers to speak out on the factors negatively impacting their workplaces. The authors argue that by looking at work constraints they were able to determine that some work-related mental health problems were due to the work environment rather than individual vulnerabilities. This is significant insofar as it points to the context of work as a determining factor in causing mental health problems. The literature examined to this point has not made this breakthrough explicitly.
Some authors have studied work environment (and organization) as a means to assess their impact upon mental health-related outcomes such as anxiety, psychological distress, burnout and irritability in the workplace. Bond & Bunce (2001) examined work organization and the increase of a worker’s job control to assess the impact on their mental wellbeing. Work organization refers to scheduling of work, interpersonal aspects, job structure and design and management style. They define job control as the extent to which workers have choice and discretion in their work; it is key with respect to the stress of work. In a study of British administrative employees, they found that a workplace intervention that involved increased job control to individuals had a positive impact upon mental health and sickness absences. Their study looks at individual responses to general changes in working conditions. Getting at causal factors for good mental health and fewer sickness absences can help point to better work organization practices.

In one of the few peer-reviewed articles in this area to deal with union’s role, Walters (2011) regards worker representation and psychosocial hazards in Britain. He posits that health and safety representatives’ work on such hazards needs to be joined with the broader collective bargaining and organizing goals of unions. He notes that this is difficult in that the impact of psychosocial hazards is often regarded on an individual basis, not a collective one, in the sense that the effect is usually perceived to be upon individuals. As a result, an individual grievance by a worker is a more likely vehicle for the union to respond rather than a collective bargaining demand. This highlights the power differential between individuals and organized collectivities. Walters suggests that alliances between health and safety representatives and other union officials are necessary to the negotiation of organizational changes in the workplace. This topic will be explored in my interviews with key informants. It is important since a coherent union response to psychosocial hazards is more likely to be effective.
Chapter Two
Troubles in/troubling the literature: Dominant discourses and their challengers

The purpose of this chapter is to explore and analyze how the peer-reviewed literature presents problems related to producing psychologically healthy workplaces. The literature is grouped under a number of headings including the extent of the problem, stigma and mental health, the evolution of work organization, psychosocial hazards, precarious employment, interventions that help workers and disability management/return to work. These topic areas each delve into issues that help or hinder workers from returning to work successfully after an absence due to mental health problems. I am most interested to know whether unions are (or are not) identifying psychosocial hazards in the workplace and then, secondly, if they are combating them for individual workers returning to work after absences due to mental health problems, as well as considering their impact on co-workers. The literature cited below is analyzed based on this concern and how well it answers the question above regarding psychosocial hazards. In my analysis of the literature, I have not found a lot written about unions’ role in identifying and combating psychosocial hazards in the workplace. It is my hope that this study will add to that subject matter. In the first part of this chapter we explore the extent of mental health problems in the workplace and the costs that arise from them.

Medical talk: Psychiatric framing and the scope of mental health problems in the workplace

Much of the language in the section that follows exemplifies the way in which psychiatry conceives of and speaks of mental health problems. It tends to individualize and pathologize those with mental health challenges, rather than looking at structural or environmental concerns and causes in the workplace. A large amount of mental health problems originate in the workplace and must be addressed there. The purpose of this section is to show the breadth and depth of mental health problems and then to critique the language typical of psychiatric – or biomedical – framing.
In terms of the workplace, annually, 12 per cent of Canadians from 15 to 64 years suffer from a mental disorder or substance dependence (Dewa et al., 2004). These are prime working years for many adults. It is worth noting that approximately 10 per cent of the Canadian active working population has a mental health problem (Corbière et al., 2011). Every day, 500,000 Canadians are absent from work due to psychiatric problems; the overall cost of mental illness is pegged at $51 billion annually, including the cost of disability benefits.

The World Health Organization (WHO, 2014) estimates that by 2020, depression will be the second leading cause of global disability. The WHO states that unipolar depression is twice as common among women than men. Further, while gender differences may be seen in rates of common mental disorders – depression, anxiety, and somatic complaints – women predominate. Women are more susceptible to psychosocial hazards than are men, not because they are women but because they tend to have less control over the organization of their work.

Canadian estimates evaluate the annual loss in productivity to be approximately $17.7 billion dollars (Corbière et al., 2011). This loss in productivity is demonstrated in four areas: early retirement, absenteeism, presenteeism and short and long-term disability.

First, an association has been found between mental illness and early retirement. Workers who experience depression at a later age experience a greater likelihood of taking early retirement, once they have had a leave of absence from work due to this disease (Corbière et al., 2011).

Second, in terms of absenteeism, depression is associated with more lost days than most chronic illnesses (Corbière et al., 2011). This is the case for workers of all ages. In the United States, it is estimated that one hour per week is lost due to mental health problems, at a cost of $8.3 billion dollars per year.

Third, presenteeism is defined as having the worker present at work but with altered capacities. Examples include an individual’s lessening of social interaction, understanding and capacity for communication with peers and managers. American estimates suggest that four hours per week, or 10 per cent of work time, are lost due to presenteeism, representing a loss of $36 billion dollars per year (Corbière et al., 2011).
Fourth, short and long-term disability costs for mental health problems represent the fastest growing area of health insurance costs, with 70 per cent of total costs or between 15 and 33 billion dollars spent annually on mental illness (Corbière et al., 2011). Thirty per cent of disability claims are for mental health conditions (Dewa et al., 2004). Further, workers who take a short or long-term medical leave for depression are more likely than workers with other illnesses to experience a relapse and to need another leave of absence. The use of the term “illness” to describe depression should be recognized as an embedded medical bias against this aspect of the human condition.

Furthermore, although employment is a cornerstone of social inclusion, people living with mental health problems face the highest unemployment rate of any disability group. Burke-Miller et al. (2006) suggest that the unemployment rate among people with mental health problems is three to five times higher than among those with no such disabilities. People living with mental illness are capable of making an important contribution in the workforce, and do not need to be symptom-free to be successful. (Martin & McKee, 2015)

A further concern is the level of co-morbidity that occurs between mental health problems and physical conditions such as diabetes, cancers and cardiovascular, musculoskeletal and gastrointestinal disorders (Sairanen et al., 2011). The extent of co-morbidity complicates measurement of disability costs due to mental health problems. The costs are higher when dual diagnoses are included.

These figures paint a portrait of the extent of mental health problems in the workforce along with their implications for the cost of doing business. The authors agree on the significance of the problem. Work can cause mental health problems and periods of absence from employment. In 2012, 28.4 percent of working Canadians reported most days at work are quite a bit stressful or extremely stressful (Statistics Canada Community Health Survey 2010, Sources of stress among workers. Available at http://statcan.gc.ca/daily-quotidien/111013/dq111013c-eng.htm) According to this same study 62 percent of working Canadians identify the workplace as their major source of life stress. Clearly there is a serious problem.

The terms “disorder” and “common mental disorder” are used by the World Health Organization in line with a medical model of disability. If we deconstruct the language, it seems apparent that
the people who live with such illnesses are not accorded a great deal of power. A choice of more neutral language, such as “mental health issue or problem” would make a more level playing field, without necessarily judging the particular population to be weaker.

Similarly, the use of the term “illness” to describe depression should be recognized as an embedded medical bias against this aspect of the human condition. Use of the word “suffer” in this context is suspect as it suggests a negative experience. Many mental health advocates do not see mental health challenges as exclusively reason to suffer, but also to grow. This is complex and layered. Of course there may be suffering – even extreme pain – with mental illness, but the possibility of recovery to a state where the individual defines his or her well-being and is empowered in the process also exists.

We will discuss the factors that contribute to these mental health problems in ensuing chapters. The figures quoted above would be more meaningful if they had broken down the data by gender categories and along union/non-union lines. Nonetheless, it is clear that mental health problems do affect the texture of workplace relationships and the resiliency of workers. Fixing those problems needs to be accomplished in the workplace. In the next section, I explore how the stigma and discrimination associated with mental illness pervades workplaces and society to the detriment of both individuals and organizations. The solutions to these problems most often rest in the workplace.

**Stigma, Discrimination and Mental Ill Health**

One of the consequences of mental health problems is that workplaces may be pervaded by stigma and discrimination against affected workers. Stuart (2004) provides some interesting statistics in a Canadian study on workplace mental health in her articles about stigma and work. She cites large-scale population surveys that have consistently estimated the unemployment rate among people with mental disorders to be three to five times higher than their non-disabled counterparts. These figures are higher than usual unemployment rates and underscore the seriousness of the problem. Sixty-one per cent of working age adults with mental health disabilities are outside the labour force, compared with only 20 per cent of working-age adults in the general population. She maintains that not enough scholarly work has been done on the less serious illnesses such as anxiety and depression, whereas some studies on more serious mental
illnesses are available. Again, the use of the term “illness” in referring to anxiety and depression indicates the extent to which the medical bias is embedded in our understanding of these human experiences.

Stuart states that when people with serious mental illnesses are employed, it is most likely that they will be in inferior positions that are not commensurate with their skills or training. Further, after having been absent because of mental illness, when they return to work, these people often face hostility and reduced responsibilities. Use of the terminology “disorders” in this literature is itself stigmatizing.

In terms of employment possibilities, Stuart cites U.S. studies (Scheid, 1999; Long, 1983; Manning, 1995) that demonstrate that employers are hesitant to hire someone with a psychiatric history. In a random sample of businesses, forty-four per cent said they would be uncomfortable hiring someone who was in treatment for depression. Another study suggested that people returning to work from absences due to mental health problems were unlikely to receive support from colleagues. (p. 3)

Not surprisingly, the job landscape is, to say the least, forbidding for those with psychiatric illnesses. Stuart’s work is useful in that it sets out the context of the workplace in terms of discrimination faced by workers with serious mental health issues. Stigma can be an issue for workers returning to the workplace after an absence due to mental health problems. This is also borne out in the grey literature including Human Solutions Report, Return to Work and Accommodation for Workers on Disability Leave for Mental Disorders (Human Solutions, 2010) that urges employers to consider the stigma facing workers coming back into the workplace after an absence due to mental health reasons. These are very practical considerations that require attention of all parties and are of concern to the present study.

It seems that what is missing in this literature about stigma and employment, however, are the instances in which success has been achieved. Many people with mental health challenges have been employed and developed business savvy in consumer-survivor enterprises such as courier services and restaurants, for example. Dealing only with the negative cases reinforces the notion of the helpless, unemployable mentally ill, with few options and less power. Further, by not
questioning the notion of illness when talking about depression and anxiety, credibility is lent to the medical and psychiatric system’s labeling of these challenging human experiences.

In the next section, we look at rehabilitation and return to work.

**Human resources management talk: Rehabilitation and the “return to work” (RTW)**

Disability management is an area of concern of the present study, and return-to-work (RTW) in particular. There are both prevention and rehabilitation elements to this question. The Canadian Human Rights Commission suggests that successful RTW involves the careful balancing of an employer’s right to manage with a worker’s fundamental right to equality, dignity and respect. In a related vein, only a very small portion of the literature on RTW speaks to the adoption of a “recovery model” for the ill individual. This refers to the orientation that the person is involved in determining how they can best live with their condition, including work challenges.

There is considerable literature on disability management, dealing primarily with physical injuries. This section highlights the kind of language typically used. Disability management is central to the work of authors such as Loisel & Côté (2013) who developed in the Sherbrooke Model a rehabilitation program for workers with musculoskeletal problems. It is a global management program of back pain, joining ergonomic and clinical intervention in a multidisciplinary approach. It involves the worker and the supervisor, with the help of an occupational health professional or ergonomist, identifying and solving RTW barriers, and then implementing return to work solutions in the workplace. The Sherbrooke Model, pioneered in the early 1990’s, signaled a groundbreaking shift in perspective, changing the focus from the individual’s impairment to the worker in a broader social, health and work context and with a key role for the union. This shift is very significant. It takes the focus off the individual’s vulnerabilities and instead locates problems in the interplay between the individual, the work context and the health and insurance systems. The worker is accorded a degree of power and also agency, with respect to the employer. Solutions are sought by workers and unions in the workplace. This is useful in that dealing with how unions and workers face psychosocial hazards in the work environment is my central focus here. For this project, the role of the union in these efforts to achieve effective return to work is central.
Goldner et al. (2004) report that socio-demographic characteristics, job satisfaction and referral to appropriate rehabilitation services are predictors of a more rapid recovery and return to work. Other factors such as a supportive workplace and spirit of cooperation between labour and management are also a consideration. For workers diagnosed with major depression, appropriate and prompt pharmacological treatment seemed to shorten periods of disability. Nonetheless those with moderate to severe depression were significantly less likely to return to work. Side effects related to antidepressants such as difficulty concentrating or sleeping can interfere with a worker’s return to work. Where some degree of work incapacity persists, specific psychosocial interventions foster more complete rehabilitation. This article is useful in its evaluation of treatment protocols but is less valuable in terms of assessing psychosocial hazards in the work environment.

Franche et al. (2005) conducted a major review of the peer-reviewed quantitative literature on return to work initiatives. Using seven databases and looking at 4,124 papers, they determined that ten studies were pertinent to their project. They found strong evidence that the duration of work disability and associated costs to the employer were reduced by the provision of work accommodation measures and contact between healthcare providers and the workplace. Further moderate evidence supports early interventions including contact with the worker by the workplace – both co-workers and supervisors, ergonomic work site visits and the involvement of an RTW coordinator. This is one of the first articles in the peer-reviewed literature to deal with the impact of RTW on co-workers, an important practical point in developing sustainable job accommodations. This study is bolstered by other peer-reviewed and grey literature such as MacEachen et al. (2006) and Franche et al. (2005) and the National Institute for Disability Management and Research (NIDMAR) literature that point to the efficacy of the RTW coordinator’s role and contact between the ill worker and the workplace throughout the person’s absence.

MacEachen et al. (2006) conducted a systematic review of the qualitative peer-reviewed literature on return to work. RTW became a practice supported by workers’ compensation boards in Europe and North America in the 1990’s. It was valued as a practice because it promotes better recovery leads to lower absence rates for the workers concerned. Additionally, it is recognized to contribute to lower compensation premium costs for the employer. The authors
point out that RTW is distinct from vocational rehabilitation programs. Key to RTW is the return to the workplace before full recovery, often in modified jobs while the worker continues with ongoing medical treatment, a model that St-Arnaud (2007) also addresses. Modified work can bring its own challenges in the relationships between injured workers and their co-workers. Like Franche et al., MacEachen et al. analyze the role and behaviour of co-workers. Where co-workers must take up the slack that results in extra workload for them, they may resent the injured worker. In a related vein, where the injured worker is assigned ‘light duties’, he or she may be resented because another worker already had the seniority to carry out those same lighter duties. This study is helpful in that in the interviews for the current project, I probe how different accommodations impact upon co-workers, as perceived by union health and safety specialists.

MacEachen et al. (2006) suggest that return to work involves more players in interaction with one another to support or undermine the possibility of successful outcomes. They cite the role of workers, co-workers, employers, health professionals, unions, organizational environments, and the workers’ compensation and health care systems in relation to one another. Unions may play an important role in facilitating RTW, especially if the union is a full partner in the development and implementation of the RTW program.

MacEachen asserts, however, that resistance may occur where the positions identified for light duties conflict with seniority provisions in the collective agreement. Further, where there are multiple unions in a workplace, legislated requirements for altered or modified work can cause jurisdictional disputes. In some instances, the union – like some physicians – will take the position that rather than an early return, the worker has the right to remain absent until they are fully recovered. Such concerns may work against union participation in the RTW process. The conflict between RTW and seniority clauses in collective agreements can be a challenge for union reps and requires some creative approaches to the problem.

The expertise of the Vancouver Island-based National Institute for Disability Management and Research (NIDMAR) is cited in the literature. They outline several steps in the RTW process:

- Early contact with the worker by the workplace
- Work accommodation offer
• Contact between healthcare provider and the workplace
• Ergonomic work site visits
• RTW coordination (as in the grey literature)

NIDMAR is an international leader in advocacy for injured workers and in training practitioners who deal with disability management in the workplace.

Franche et al. (2005) examine the role of stakeholders, including unions, in implementation of return to work. They start from the premise that the role of stakeholders has not been well documented in the literature. They suggest that while friction between the various parties is inevitable, it can be mediated by collaborative problem solving to meet common goals. They analyze each of the stakeholders’ roles (employer, human resources, medical and nursing personnel), including that of labour representatives, regarding the protection of workers’ rights and their quality of life. They suggest that the labour representative’s involvement may bring about better modified work arrangements. As in MacEachen et al., it is noted that conflict may exist due to the right of another worker with seniority to access the position concerned and it is suggested that where contract clauses tie job allocation to seniority, RTW measures may be hindered. Poor relations between labour and management may also hinder RTW measures.

Finally, for the first time in the peer-reviewed literature it is noted that successful attempts at RTW will likely ensue where employers work to provide better job accommodations while also addressing the concerns of co-workers. This article by Franche et al. expands upon understanding the union’s role and the stakes involved in RTW for the various parties.

Briand et al. (2007) examine return-to-work protocols for absences due to mental health problems and make specific recommendations to employers. They argue that those experiencing frequent difficulty at work due to mental health problems tend to be single people, low paid and with a low level of education, younger people and women. Further, in their research, 9 per cent of subjects said that their personal lives explained their health problem; 32 per cent said paid work; and two-thirds said a combination of the two. They argue further that in establishing a workable return-to-work program that a positive relationship between management and the union, along with full involvement of the worker representatives, is central to its success. This research is pivotal in that it interrogates the relationship between mental health problems and
work situations. That perspective is valuable in that we are exploring psychosocial hazards that have a deleterious effect upon people. These hazards cause mental health problems that then must be addressed by union and management when the person is ready to return to work. St-Arnaud et al. (2007) mention that, for workers with mental health problems, it is important to integrate work as a useful means of rebuilding health and the capacity to continue working. This is similar to the point that MacEachen et al. (2006) make above regarding work constituting part of the individual’s healing process.

Briand et al. (2007) argue that work rehabilitation programs developed for workers with musculoskeletal problems can be adapted in RTW for those with mental health challenges such as anxiety and depression. They cite authors who maintain that the work environment is involved in almost 90 per cent of cases in which people are absent from work for reasons of mental health. As is the case for those with musculoskeletal issues, RTW interventions for mental health problems must consider the influence of a complex set of interrelated factors such as clinical, psychological and work environment. Further, Briand et al. argue, as per Loisel & Côté (2013), long term disability is seen to be more than the consequence of illness, but rather, as the result of interactions between the worker and three main systems: the health care system, work environment and financial compensation systems.

When looking at changing the work environment, something the authors cite as necessary for successful RTW, they ask how to situate the role of various stakeholders and their level of intervention in the work environment. Should the more pathogenic elements of work organization be targeted and by what means? They advocate including the supervisor and co-workers in the RTW process to meet these challenges. Like the work of Loisel & Côté, this study is helpful in that it situates the worker’s illness in a broader work, social and health context, giving the worker a degree of power and agency.

Brouwer et al. (2010) characterize RTW as a complex human behaviour change wherein the worker must make the final decision to return to work, influenced by a variety of personal, social and economic factors. They assert that workers’ attitude toward work, their self-efficacy and perceived social support are pertinent to the time necessary for RTW in all health conditions, but with important differences between physical and mental health conditions. The research does not
specify what those differences were. This work focuses more on individual agency rather than work organization and context and, as such, is less helpful to the current project. It is interesting to note, however, that the worker is accorded considerable agency. Glaring in its absence, however, is concrete information as to the basis of the workers’ power source (giving them agency).

Caveen et al. (2006) seek to unearth what kind of company policies, culture and benefits would assist those with depressive illness to return to work successfully. They note that practices may need to be different for such workers as they may suffer from lack of concentration, maintaining stamina and managing time pressure and deadlines. In their study, the authors found that companies experiencing profound changes, including restructuring generated employees that felt they had little control over their work and careers. Not surprisingly, this had an impact on employee health, including depression-related illness. One can only surmise that workers feel vulnerable in such a situation, see their collective power diminished while their work lives were changing significantly. They also found that supervisors who had been trained and sensitized to the needs of depressed employees were more successful in their RTW initiatives. This study underlines the role of supervisors in successful RTW outcomes. This is an interesting question that encourages exploration of the various parties’ roles.

The role of on-site RTW coordinators was the subject of a study by Shaw et al. (2008). Like Briand et al. (2007), the authors underscore that RTW is a complex process that requires re-establishing sufficient work capabilities and adapting both the worker and workplace to a new situation post-injury. Shaw et al. argue that the role of the return-to-work coordinator is essential, particularly in terms of communications, looking at work organization and arriving at relevant accommodation for the worker. Further, the RTW coordinator is meant to promote ongoing efforts to support safe and sustained work. It is a process that may include medical involvement, senior management as well as line supervision, insurers, co-workers and the worker themselves. The authors argue that while the benefits of RTW coordination have been shown in shortened work absence and lowered costs, the attributes, training and precise interventions of an RTW coordinator remain undefined. They found that where coordination involved assessing workplace factors and developing transitional plans for coverage and maintaining overall responsibility for
facilitating communication between stakeholders, the coordinators were successful. This is helpful in that it defines somewhat the role of the RTW coordinator.

Corbière & Shen (2006) did a systematic review of literature dealing with RTW for reasons of poor mental health. They assert that cognitive behavioural type therapies (CBT) are the most common form of intervention in the case of individuals with depression or psychological distress. The authors agree with Loisel & Côté (2013) that interaction between the four key players, the injured employee, the workplace (employer and/or co-workers), the insurer and health professionals, is essential to tackling the difficulties experienced by the returning worker.

They also argue that it is advantageous to keep the absent worker informed of what is happening within the organization, in that it facilitates the RTW process. The company’s communication efforts, concern and caring influence the employees’ experience, including their readiness to return to work. This would seem to agree with the peer-reviewed and grey literature such as Holmgren & Dahlin Ivanoff (2007) that speaks to early contact between the supervisor and worker to assist in the recovery process.

In an article that offers a commentary on health and safety policy for the European Union, Benach et al. (2002) propose that the health of workers and not economic interests of firms should determine the health and safety agenda. It begins by outlining the sweeping changes in the labour process due to globalization, precarious employment and the intensification of work. Like Vézina (2004), as well as Corbière & Shen (2006), it links these changes to the social hazards. The authors posit that there is strong evidence that unemployment causes negative health outcomes and that, moreover, as per Vosko et al. (2009) and others, the new forms of employment precarity carry many of the same risks due to the lack of a substantial attachment to the workforce. This is one of very few articles that uses a gender lens for the analysis of these issues and further, this suggests that labour leadership is not without challenges in terms of sexist and/or racist treatment of its members.

It argues that the strength of the labour movement impacts what information is generated about workplace hazards. More research on this issue is required to properly inform union strategies. Certainly where the health and safety committees are strong, there is information provided to workers. The article also suggests that labour leadership most frequently focuses on male
occupations and full time permanent jobs at the expense of women, non-white workers and the new types of flexible employment, which are generally non-union.

Jodoin and Harder (2004) argue that a positive relationship between management and labour is a key element to successful return-to-work outcomes. They cite collaboration between the parties in the administering of joint disability management practices as the best-case situation. That cooperation may be in the placement of individual workers, developing appropriate accommodations, or in the entire program. They outline the legalities of the employer (and union) duty to accommodate and suggest that joint positive experience of disability management can improve overall labour relations. Like the practical information available from the National Institute for Disability Management and Research (NIDMAR) outlined above, this article is helpful as a signpost for effective RTW practices.

Noordik et al. (2011) conducted a study of workers on partial disability who were in the process of returning to work, initially on a part-time basis. Management expected that within a two-year period, workers would return to full-time duties. The authors maintain that RTW is a complex multifactorial process characterized as a dynamic problem-solving practice in which the worker attempts to deal with the material work environment. The workers they interviewed suggested that one of the barriers they experienced was in protecting themselves from exceeding their own diminished capacity, particularly after having done the job a certain way for many years. They found that good communication between the worker, supervisor, health care provider and family was essential to the progress made at the workplace. This mention of the family is the first seen in the literature and is a valuable addition. This study reiterates many of the points in the peer-reviewed and grey literature such as Franche et al. (2005) and MacEachen et al. (2006) for successful RTW outcomes.

In a literature review about modified work as an RTW strategy, Krause et al. (1998) assert that modifying work expectations upon return was an effective means of easing workers back into the workplace. This is consistent with Jodoin & Harder (2004), and also with NIDMAR’s publications. They learned that those offered modified work returned twice as often as those who were not offered this opportunity. Modified work shortened the period of disability by one-half and was as such cost-effective. Krause et al. outlined five types of modified work: light duties;
graded work exposure in which performance expectations of a job are gradually increased; work trial in which the worker usually stays on benefits but tries out the position and continues at his/her own discretion or that of the employer; supported employment in which a job coach visits the work site; and sheltered employment which is usually at a lower wage and a special worksite developed as a social service for those with developmental disabilities. Interestingly, Krause et al. posit the specific role of organizational and ergonomic modifications, a topic of concern to me as a future research interest.

Nieuwenhuijsen et al. (2004) conducted a study of non-medical interventions that encouraged return to work among employees absent due to mental health problems. They wanted to know if supervisor behaviour was a factor in the RTW of such workers. Like Caveen et al. and Dewa et al., better communication between supervisor and employee was associated with shorter time periods to full return to work in non-depressed employees. For employees with significant symptoms of depression, this association did not exist. They found that supervisors were more likely to consult health professionals regarding the absent worker where the duration of disability was longer. Further, when there was a cost effect of the worker’s absence, there would be more frequent communication. They also learned that where a supervisor is responsible for RTW in their organization, they were more apt to both consult with health professionals and communicate with the affected employee. Finally, they concluded that an earlier return to work was facilitated where there was ongoing communication between the supervisor and the worker. This is also significant because as part of the RTW process, the supervisor is best equipped to make changes in the organization of job tasks – something that can be of great value to the returning worker. In fact, they found that better accommodation of the worker occurred where there was such communication. This study is useful in so far as it explores the role of the supervisor. It did not, however, consider the union’s role in RTW (the study does not state whether it is a union or non-union workplace).

Holmgren & Dahlin Ivanoff (2007) conducted a study that established supervisors’ and workmates’ support as key to return-to-work of sick-listed employees. Holmgren et al. looked at supervisors’ behaviour from the point of view of the employer. They were interested to know how supervisors look upon their rehabilitation responsibility, including what resources they had available in the return to work process and their demands on employees and other parties
involved. The objective of their study was to explore the supervisors’ views on employer responsibility in the return to work process. They were also interested in looking at the possibilities for and obstacles to supporting employees on sick leave. An important issue was that of creating confidence between the supervisor and affected employee. This required respect for the individual and regular contact. Holmgren & Dahlin Ivanoff suggest that this contact would go beyond telephone or face-to-face meetings and could involve inviting the sick-listed employee to training courses or social activities. In addition, co-workers are encouraged to maintain contact with the ill employee. They note that there also are instances where the affected worker does not want contact with the workplace. They found that where co-workers made a commitment to the sick individual, it facilitated their return to work and strengthened the work group. Duration of absence was shortened although supervisors experienced a conflict between keeping the budget balanced and finding suitable tasks for the sick-listed employees returning to work. In the present study, this fact may be important in terms of how it affects the extent to which a supervisor may alleviate psychosocial hazards and impact work organization. Elements of both prevention and rehabilitation must be addressed. In the next section I explore the role of unions and the changing field of health and safety.

Union talk: The role of unions and changing paradigms in health and safety

In industrial relations, unions operate from a position of limited power, aiming to improve terms and conditions of employment for their members. Wages and working conditions are the primary focus. Just below 30 per cent of the non-agricultural workforce is unionized in Canada, a total of 4.2 million workers in roughly 1,500 union locals (Gunderson & Taras, 2009, p. 75). Unions negotiate terms and conditions of employment that have a spillover effect onto many other non-unionized workers.

Unions collect dues from their members to carry out collective bargaining, education programs, health and safety representation, human rights and equity-related advocacy and training, government lobbying and other activities. Their efforts are rooted on-site at the workplace, often with worker representatives in each building or sector of the employer’s organization. Management runs the enterprise.
“In the absence of unions, management normally controls decisions that affect the internal labour market and the organization of work: how many workers to employ, whom to hire, the types of jobs to be established, the assignment of individual employees to particular tasks, how tasks are to be handled, and so on. For management, decisions about such matters revolve around its desire to minimize labour costs and to maximize productivity. In practice, this means that managers want the rules regulating the internal labour market and the work process to be as efficient and flexible as possible…” (Giles & Starkman, 2009, p. 307.)

The authors suggest that unions look at these issues very differently, and are concerned about too much managerial flexibility as it can result in a “permanent insecurity” for employees, a lack of autonomy for workers and work groups, and the abuse of discretion by managers. Flexibility in this context is characterized by a ready capability to adapt to new, different or changing requirements. Management wants this flexibility in order to maximize profit and control over its workforce. A power imbalance pervades the employment relationship and the collective agreement exemplifies a set of compromises and joint decisions over an array of issues affecting workers.

Health and safety representation is a sphere in which unions attempt to change the conditions under which they are working. Since the 1970’s, unions have been involved in joint health and safety committees with their employers. They have legislative support and training is supported by government agencies. A network of paid health and safety specialists exists across the country.

I now will look at the impact of technology, lean production and the effects of new forms of work organization on psychological health in the workplace. This exploration will reveal the emergence of new psychosocial risks to health that stem from recent changes in the workplace. Since the early 1990’s, the intensification of work, the increasingly precarious nature of work, and the need for employees to adapt to constantly changing technologies have transformed workplaces considerably. These organizational changes have had an impact on the mental health of workers at all levels, as knowledge-intensive work that is characterized by psychological demands has become the norm, replacing much manual labour. While the economies of
industrialized countries once depended on resource extraction and manufacturing jobs, they now rely largely upon the service sector for growth and prosperity. As the economy shifted from manufacturing-based, service industries became the principal sources of jobs in the economy. At the same time, mass production and the information-based economy were increasingly organized around flexible production.

The shift from resource-based and manufacturing jobs to the service industry has also transformed the nature of work injuries and disability. Although a high rate of acute and fatal injuries was observed in industrialized countries at the beginning of the twentieth century\(^6\), this incidence has been replaced by a sharp increase in the incidence of compensated musculoskeletal and mental health illnesses (Loisel & Côté, 2013). It is instructive to contrast the terms physical disorder with mental health disorder, used in the previous sentence. While there is not necessarily a negative view toward a physical ailment, there is definitely a medicalized view of mental illness conveyed in the use of this term. The term “disorder” suggests an anomaly from the norm that is negative or wanting.

The evolution of work organization over the last few decades and, in particular, the widespread adoption of digital technology has been impacted by globalization as many countries are going through significant periods of organizational restructuring with the rationale of reducing costs and improving efficiency. In this context, efficiency means the ability to produce something without wasting materials, time, or energy. It also means minimizing the cost of human labour. These transformations are often accompanied by a considerable increase in the prevalence of adverse psychosocial work factors, intensification of work, psychological distress, increase in precarious work and increases in short-term sick leave where available and long-term medically certified sick leave where available.

A document by the European Network for Workplace Health Promotion entitled *A Guide for Employers: to promote mental health in the workplace* makes a similar argument to Patrick Loisel regarding the increasingly global nature of our economies and advances in workplace

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\(^6\) It is quite likely that this refers primarily to men, who would have made up the bulk of the paid labour force at the turn of the 20\(^{th}\) Century and because they did not count farm women as working.
technology causing the nature of paid work to change rapidly. It states that the intensity of work is affected as well as its content and organization. It suggests that the rapid change can be rewarding to some, however it can also mean employees may experience greater pressure and demands upon their cognitive, social and psychological skills (Knifton et al., 2011).

Corbière & Shen (2006) take the argument a step further in positing that with the growth of the global economy and increased demands from the information and knowledge industry, the workplace has inevitably succumbed to an atmosphere of anxiety and stress. Job stress has emerged as the most significant health problem for adults working for pay. The work environment is constantly changing, characterized by continuous downsizing, mergers, acquisitions and restructuring. Mental health problems become one of three leading causes of disability, together with cardiovascular disease and musculoskeletal injuries. This literature draws on macroeconomic and sociological factors, and their impact on workers’ mental health.

Conclusion

In this chapter, I explored literature across three approaches in order to reveal the social construction of debates around “mental illness” in relation to work. Through a review of the peer-reviewed literature, this chapter explored, organized and analyzed a number of key issues related to psychological health in the workplace, including the extent of the problem, stigma and discrimination, the evolution of work organization, precarious employment, the emergence of psychosocial hazards and disability management/return to work.

In these pages I showed the different interests manifested by employers, the medical establishment, the insurance/EAP industry and workers. All have their own take on the problems of mental health in the workplace and each advance different solutions. The tension that exists between individual-based and structural analysis/solutions is at the heart of my thesis and will become clear in the ensuing chapters. Revealed is the struggle between the various discourses embedded in each actors’ approach.

The questions I ask in the remainder of this study are constructed to deepen our understanding of the role that unions are playing (or not playing) in identifying and combating psychosocial hazards in the workplace. To what extent are unions resisting work organization that is hurting their members? One point will be how return to work for absences due to mental health problems
are handled. Do they satisfy the needs of the returning worker to engender a successful return to
work? What is the impact on co-workers and, in these instances, does the union negotiate
changes in duties that can improve working conditions for all members? Chapters Five and Six
examine these questions in greater detail by presenting and analyzing the union-based discourse
uncovered in my interviews with union health and safety experts. In the next chapter I examine
the methodology employed in this dissertation.
Chapter Three
Methodology

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. I will describe the strategies for implementing the study, from exploring materials through to focused data collection and analysis.

As mentioned in Chapter One, I have adopted standpoint theory as my epistemological orientation. I am not a neutral observer but write from the standpoint of workers and unionized workers in particular. I take special interest in those who are required for reasons of mental health to be absent from the workplace and then attempt to reintegrate into the workforce. I am interested in how power is conveyed and exerted in language and texts. Throughout this thesis, I use mixed methods: thematic and narrative analysis as well as elements of Critical Discourse Analysis (CDA) to explore and analyze concepts of power relations, marginality and resistance.

Methodological Orientations

The methodological orientation includes elements of Critical Discourse Analysis as well as narrative and thematic analysis. In this section, I look at each of these.

The role of Critical Discourse Analysis is to uncloak the hidden power relations, largely constructed through language, and to demonstrate and challenge social inequities that are reinforced and reproduced. It focuses on the ways discourse structures enact, confirm, legitimate, reproduce or challenge relations of power and dominance in society. Further, CDA researchers are concerned with how discourse (re)produces social domination, that is, the power of one group or institution over others, and how dominated groups may discursively resist such abuse (Weiss & Wodak, 2003, p. 9) Critical discourse analysis focuses on the role of discursive activity in constituting and sustaining unequal power relations (Phillips & Hardy 2002 p. 25).

I use Critical Discourse Analysis to supplement my analysis. I do not claim to have completed a full CDA of all the data. Rather, thematic and narrative analysis are used, with the principles of CDA applied primarily to view the way in which health and safety specialists define a counter
discourse to that of employers by investigating, revealing and resisting psychosocial hazards. Thematic analysis is explained below. Narrative analysis or inquiry uses field texts, such as stories, autobiography, journals, field notes, letters, conversations, interviews, family stories, photos (and other artifacts), and life experience, as the units of analysis to research and understand the way people create meaning in their lives as narratives. My use of interviews, primarily, and documents and field notes are indicative of a narrative analysis of the data. Furthermore,

“One of the researcher’s dilemmas in the composing of research texts is captured by the analogy of living on an edge, trying to maintain one’s balance, as one struggles to express one’s own voice in the midst of an inquiry designed to tell the participants’ storied experiences and to represent their voices, all the while attempting to create a research text that will speak to, and reflect upon, the audience’s voices.”

My research reflects this dilemma of voice, in which I try to capture the meaning of participants but also inject my own views of their stories into the research project. Language used is central to this difficulty.

In CDA, according to Weiss & Wodak, (2003) language use is not a neutral phenomenon. It does not occur in isolation, but in specific social contexts. Language is not simply reflective of reality, but constitutive of social reality (Phillips and Hardy 2002, p. 12). In the review of literature in this study, this meant examining the language for what was included and omitted to explore the social and political ideologies (how the world is represented) that were inherent in the text. This included, for example, looking at how terms that individualize and pathologize are used to present those living with mental illness in the literature. Further, the purpose was to examine the inter-relationship between language and power, as language reflects its unequal distribution in

7 https://en.wikipedia.org/wiki/Narrative_inquiry

society. The language used to cast mental health issues and recipients of mental health services has also been interrogated in the peer-reviewed and grey literature.

Discourse is used to describe the way that language operates to produce meanings. Discourses are “… ways of behaving, interacting, valuing, thinking, believing, speaking….” (Locke, 2004 p. 7). This framework is significant because it seeks to uncover relations of dominance and struggles over power reflected in the language of talk and text. It is a way of thinking about and approaching the research problem. The framework helps us to reveal the motivation and politics involved. In terms of unions, they are typically the dominated group in relation to the employer. For health and safety specialists, in particular, the work they do to counter the overwhelming power of the employer is significant. The research, surveying and organizing of the workforce and making alliances with academics are part of a program designed to resist employer practice and power. The framework helps us to uncover and characterize the relations of dominance that exist in social structures.

In much of CDA, power is written about as the social power – or control – of groups or institutions. Groups have more or less power if they are able to control the acts and minds of other groups. Power is about relations of difference, is a central condition of social life and is exercised in different ways, for example, the military is coercive and parents might be simply persuasive (Locke 2004). Dominated groups can more or less resist, accept, condone or comply with power; the degree of their resistance depends on their ability to exercise their own (limited) power.

Language is entwined in social power. It can express and also challenge power. Power does not derive from language alone, but the latter is a medium of domination and social force. Language is where the research begins and researchers doing CDA often find themselves taking the position of the dominated group(s) they are studying, in solidarity and cooperation. To deal with this, I made sure that critical self-reflection accompanied my research process throughout. I did not complete thirty years as a staff representative in the labour movement without taking on some of the same prejudices and points of view of the key informants. Just as I had to peel away a layer to analyze their comments, I had to be aware of my own location and biases at all stages, especially in sorting the themes that emerged in the interviews. As Locke (2004) suggests, citing
Wodak, critical means having distance to the data, taking a political stance explicitly and a focus on self-reflection as scholars doing research.

I used Thematic Analysis to interpret the interviews that I carried out and of the documents I received. It emphasizes pinpointing, examining, and recording patterns (or "themes") within data. It organizes and describes the data set in rich detail. A theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set (Guest et al., 2012; Paillé & Mucchielli, 2012). My work involved examining the interview transcripts and documents I received to identify and compare/contrast themes that emerge, in view of my research questions. Thematic analysis helped to keep me on track as I focused on identifying and describing ideas that were both implicit and explicit in the data.

Next I look at the research question and objectives for this project.

Statement of research objectives and questions

The primary and secondary objectives of this study are:

To better understand how unions are dealing with psychosocial risks and issues of mental health in the workplace among their members. More specifically,

1) to identify and describe the psychosocial risks and mental health problems that union members face in the workplace according to health and safety specialists, and describe the role of the union in facing these risks and problems,

2) to describe and analyze the type of activities and actions taken by unions to combat psychosocial hazards and mental health problems in the workplace and change work organization,

3) to identify and analyze the practices that are put in place to support accommodations and return to work for workers absent for reasons of mental ill-health.
Study Design and Implementation

The empirical primary research for the thesis is based on two data sets. The first is a collection of web sites and documents that deal with psychosocial hazards and mental health. Many of these originate in unions. The second data sets derives from semi-structured interviews with eight key informants: union representatives from different organizations who specialize primarily in health and safety and are knowledgeable about psychosocial hazards and return-to-work for reasons due to mental health problems. I selected the eight unions in order to cover the major sectors of the economy, and within those sectors, a wide spectrum of occupational groups. This was a very broad selection in terms of representing the Canadian economy and union movement. I was pleased that all of the eight union representatives I approached agreed to participate in this study. I was interested in knowledge created by social and contextual understanding and interviewed from this perspective.

The aim of the interviews was to get at the texture of union representation and involvement, beyond documents found on the web or collected. This was something about which the subjects of this study had an intimate knowledge. The key informants were people working at the cutting edge of what is being called among unions, “mental injury at work”. The advantage of learning the methods, gains and inadequacies of their work directly is to situate my thesis as both a comparative and analytical piece at the front end of such efforts. The current literature does not include a study such as this one.

I identified myself to the key informants as a peer, one who has worked in the labour movement for almost thirty years, primarily as a human rights specialist. I also had to take medical leaves of absence due to depression and anxiety at various points in my career. My experience gave me a strong knowledge base and standpoint from which to conduct this research. Some writers highlight the importance of situating the researcher in the research. Eakin (2010) notes that “standpoint is a perspectival location: a place from where something is viewed.” (p. 2). As such, positionality is an integral aspect that needs to include the influence that the researcher’s presence or position has on who and what can be known.

The first step was the information and debates gleaned from the review of peer-reviewed literature presented in the earlier chapter. Next came the information included in websites that
showcase the key informants’ organizations. From this material I learned about conferences, courses and other events focusing on mental health in the workplace offered to members. Next I sought out any documentation the union had. This included newsletters, course materials, timelines and conference resolutions. For the most part, I requested these prior to the interviews so that I could drill down from an informed knowledge base and use the interview questions to learn more about the union’s activity and program on mental health and psychosocial hazards. I did not always receive such documents until the interview itself.

Next I carried out interviews with the (primarily) health and safety specialists at eight major unions, both public and private sector. I asked for information about what they did, not how they did it. The unions cover the major economic sectors and occupations that are unionized in this country. Five are national unions, and they are based in Toronto and Ottawa. One is a provincial union, based in Toronto. In addition, I interviewed representatives of two national labour centrals situated in Montreal, Quebec. The interviews in Montreal were conducted in French.

The questions I posed (see Interview Guide, Appendix I) aimed to get at the extent to which, if at all, the union identified and intervened on psychosocial hazards that may have contributed to a person’s mental health challenges. The purpose of this line of inquiry was to ascertain whether the union is challenging working conditions, that is, the organization of work, by identifying levers – or terrains of struggle -- that may improve work life for its members. I also asked about any examples that have emerged in collective bargaining. The answers given to my questions provided detailed information as to the activities and programs of the various unions and labour centrals regarding mental health in the workplace, accommodation, return-to-work and the union’s activity in identifying and combating psychosocial hazards.

In this study, I interviewed primarily health and safety representatives. It is worth noting that some unions’ internal structure has health and safety representatives dealing with workers’ compensation but not other cases that involve mental ill health. Most frequently, it is staff representatives who service union locals and the local leadership that deals with return to work. Health and safety representatives are kept aware of the main trends and problems with RTW, through internal processes in their organizations. I did, however, interview the head of health and safety at the Steelworkers who is a very experienced return-to-work representative and has
published on this topic (Leblanc, 2010). So while two key informants could not answer all questions in specific terms, three-quarters were more than adequately informed of their unions’ challenges on RTW, and one was an expert.

Describing the Data Sets

First data set: Grey literature from the Internet

The first data set is material collected via the Internet consists primarily of grey literature, some of which originates with websites of the eight unions I am researching. These sites offer a wealth of information about unions’ intentions and activities around various campaigns, including mental health in the workplace. Chapter Four addresses this subject. I also used this information to fully prepare for the interviews as well as for evaluation and coding in data analysis. The other data are a selection of papers, websites and non-academic articles found from searches of the web that deal with topics related to mental health in the workplace. These documents do not constitute peer-reviewed academic literature.

Pamphlets, courses and conference resolutions will assist me to construct a fuller picture of what the unions are, and are not, doing with respect to psychosocial hazards and mental health in the workplace.

The selection of key informants was based on a purposive sampling to obtain the most productive sample to answer the research questions. These key informants are the most progressive representatives of efforts being made on these issues. The interviews are the most important source in understanding the depth of commitment (or not) and the strategy that has led the union to its work on mental health.

My plan was to carry out eight interviews in September/October 2014. The 11 health and safety specialists I targeted, sometimes in small groups when from the same union, were: (See Appendix V for full union names)

UNIFOR – Sari Sairanen, Director Health Safety and the Environment

OPSEU - Terri Aversa, Health and Safety Officer

Steelworkers- Gerry Leblanc, National Coordinator Health Safety and the Environment
CUPE - Cathy Remus and Corina Crawley, Union Development Officers and Troy Winters, Sr. Health and Safety Officer

CUPW- Jamie Kass, National Childcare Coordinator

PSAC- Denis St. Jean, Health and Safety Officer, Rachel Basharah, Program Officer (Union) Joint Learning Program

CSN- Micheline Boucher, Health and Safety Officer

CSQ- Pierre Lefebvre and Daniel Giroux, Health and Safety Officers

I contacted them by email in mid-July 2014, once my ethical review was approved, and followed up in August by telephone to make appointments for September and October 2014. Three interviews were done in each of Toronto and Ottawa, with two additional ones in Montreal. Each interview lasted for 60-90 minutes.

All participants agreed to have their names used in the study, reflecting the fact that a part of their role is to interact with the academic community on research in this field. Maintaining confidentiality, as such, was not an issue for this group, indeed, it would have deprived them of their authorship.

UNIFOR

UNIFOR is Canada’s largest private sector union, with more than 305,000 members across the country, working in every major sector of the Canadian economy. UNIFOR was officially formed on August 31, 2013, at a Founding Convention in Toronto, Ontario. It marked the coming together of the Canadian Auto Workers Union (CAW) and the Communications, Energy and Paperworkers Union of Canada (CEP) – two of Canada’s largest and most influential labour unions.

Ontario Public Service Employees Union (OPSEU)

The Ontario Public Service Employees Union (OPSEU) has about 130,000 members across Ontario. They are full- and part-time workers and they work for the Ontario government, for
community colleges, for the Ontario Liquor Board, and for a wide range of community agencies in the broader public service such as hospitals, services for families and children, art galleries, ambulance services, school boards, municipal offices, mental health services, correctional services and more.

**United Steelworkers (USW)**

The United Steelworkers is the largest private sector union in both Canada and North America with more than 225,000 members in Canada and more than 800,000 members continent-wide. Members of the United Steelworkers work in every sector of Canada’s economy in many kinds of job. Members work in call centres and credit unions, mines and manufacturing plants, offices and oil refineries, restaurants and rubber plants, sawmills and steel mills and security companies, as well as nursing homes, legal clinics, social agencies and universities.

**Canadian Union of Public Employees (CUPE)**

The Canadian Union of Public Employees (CUPE) has over 628,000 members in Canada. Most work in the public service, including municipalities, education, health care, social services, airlines, communications, and more.

**Canadian Union of Postal Workers (CUPW)**

The 54,000 Canadian Union of Postal Workers’ (CUPW) members work in large and small communities across Canada. A majority of members work for Canada Post as rural and suburban mail carriers, letter carriers, mail service couriers, postal clerks, mail handlers, mail despatchers, technicians, mechanics, electricians and electronic technicians. The union also represents cleaners, couriers, drivers, vehicle mechanics, warehouse workers, mail house workers, emergency medical dispatchers, bicycle couriers and other workers in more than 15 private sector bargaining units.

**Public Service Alliance of Canada (PSAC)**

The Public Service Alliance of Canada (PSAC) represents more than 170,000 workers in every province and territory in Canada and in locations around the world. Its members work for federal
government departments and agencies, Crown Corporations, universities, casinos, community services agencies, Aboriginal communities, airports, and the security sector among others.

**Centrale des Syndicats Nationaux (CSN)**

The Centrale des Syndicats Nationaux (CSN) is a confederation of trade unions with a membership of 300,000 across Quebec. Members work in both the public and private sectors. The labour central was formed in 1921 and has a militant history fighting for social justice.

**Centrale des Syndicats du Quebec (CSQ)**

The Centrale des Syndicats du Quebec (CSQ) is a confederation of trade unions that regroups 200,000 members in a variety of sectors in Quebec including teaching personnel, professional and support staff in schools, CEGEP’s and universities. Members also work in daycares, as well as nurses and other healthcare personnel. The majority of the union’s members work in education.

**Second Data Set: Analysis of the Interviews**

I conducted a narrative analysis using Thematic Analysis of the interviews in order to tease out the major ideas and reflect upon them. I employed an inductive approach to code and group the data and then looked for relationships or themes. My analysis of the data consisted of reducing collected data to make sense of them. Patton (1987) indicates that three things occur during analysis: data are organized, data are reduced through summarization and categorization, and patterns and themes in the data are identified and linked. In terms of data analysis, Merriam (1998) posits that it is a complex process of moving back and forth between data and concepts, between descriptions and interpretation, using both inductive and deductive reasoning.

Another view expressed in the literature is that data analysis be done as data are collected in the field, as soon as possible after the data have been collected, both while the researcher is still in the field and later. LeCompte and Schensul (1999) describe in-the-field analysis as including inscription, description and transcription and suggest that analysis may be conducted in both a top down fashion and a bottom up fashion.
I hired a transcriptionist in English and one in French to transcribe the interviews for my use. I began some analysis of each transcription and my field notes as I approached the subsequent interviews. Nonetheless the greatest part of my analysis was undertaken once I had the bulk of the material transcribed. It was my intent to evaluate my questions after two interviews, to ensure I was eliciting useful responses. This proved to be the case. The main themes to emerge were worker empowerment and education in relation to mental health, accommodation and return to work, as well as the extent to which the union tries to come to grips with psychosocial hazards. A further regard was cast upon the centrality of a mental health strategy as part of the union’s core functions (for example, is mental health part of the collective bargaining agenda?). I needed to interpret the qualitative data to examine its meaning and symbolic content, to form some explanation and understanding of the people and situations I was investigating.

**Ethical considerations**

I sought written informed consent before each interview, meaning the knowing consent of individuals to participate as an exercise of their choice, free from any element of fraud, deceit, duress, or similar unfair inducement or manipulation (Berg & Lune, 2012). I identified myself, as indicated above, as a former union staff representative with 30 years’ experience and a consumer of mental health services. My purpose was to be transparent: to document, contrast and analyze their organizations’ experience and hopefully to develop some signposts for future successful union initiatives. I endeavored to be open about my intent and frank and honest when interpreting the key informants’ words and also provided key informants with the quotes I used from their interviews for their approval.

This research was undertaken with regard to a relatively small number of unions that are doing something – however little or great--on mental health. The unions concerned here are, however, the largest in the country, representing a broad variety of workers in both the public and private sectors, and learning about their practices and policy should assist this study to fill gaps in the literature as to unions’ role in mental health in the workplace.

In talking primarily to health and safety specialists, I learned more about the unions’ purpose, policy and practices regarding psychosocial hazards and mental health in the workplace and less about some aspects that occur on the shop floor. I could have spoken to workers who had
experienced mental health leaves of absence, although appropriate individuals would have been
difficult to identify. Moreover, I did not believe the data I was looking for would come from
individual cases. I believe my approach was worthwhile as the work on psychosocial hazards is
so new that it is important to understand the intentions, gains and limitations of the approaches
taken by key actors, as they understand it. I wanted to know how they evaluate their own efforts.
Their insights also included important reflections on how well the strategies are being
implemented, as well as barriers to their success.

A comprehensive study of RTW in a particular workplace or sector would be an interesting point
to interview workers affected by absences due to poor mental health. The same study could
include interviews with co-workers and supervisors in an attempt to deconstruct the complicated
web of relationships that affect RTW outcomes. It was not the object of this study, but one that
would certainly help broaden understanding of the dynamics of this complex issue. For the
current project, interviewing the health and safety specialists as key informants was the best
decision given my objectives.
Chapter Four

Individual vs. structural solutions to psychosocial hazards

The purpose of this chapter is to comment upon and evaluate critically the first data set: materials found on the web that pertain to the subject of this thesis -- unions’ role in identifying and combating psychosocial hazards and return to work after periods of absence due to mental health problems. I present both results and analysis together here. A great deal more work has been done on mental health by unions than is generally known. The information contained here gives some signposts as to that work. It is my hope that this material and my related comments will assist other researchers in finding information and tools pertinent to the subject area.

I searched the web initially for psychosocial hazards and mental health in the workplace looking for documents both in Canada and internationally that went beyond the peer-reviewed literature. I then searched for union websites. Data collected via the Internet are primarily grey literature, a portion of which originates with websites of the eight unions I am researching. These sites offer a wealth of information about unions’ intentions and activities around various campaigns, including mental health in the workplace. I also used this information to prepare fully for the interviews as well as for evaluation and coding in data analysis. The rest consists of a selection of papers, websites and non-academic articles found from searches of the web that deal with topics related to mental health in the workplace.

In the grey literature that I have viewed, there is not a distinctly Canadian or non-Canadian viewpoint expressed. Rather I found a great deal of overlap, with the European and Australian documents most consistently making use of a structural analysis of the workplace. The solutions proposed in one European publication\(^9\) however, were individual-based, something I find curious given its analysis of work organization problems. Perhaps collective solutions come not always first to mind, especially if the writer is dealing with a non-union workplace. An impressive

There is a characteristic tension of the grey literature between seeing the roots/solutions to problems as lying with individuals and, alternatively, being found in structural reasons. This tension mirrors the difference between medical/management talk and that of union discourse, as viewed in Chapter of this thesis. In the following sections I will comment upon this tension as it appears under various headings.

In my evaluation of these materials, I assess the quality of language (is it respectful of those with mental health problems?) and the nature of power relations that are presented. I will look at the persistent themes and compare and contrast the grey literature with peer-reviewed literature examined in Chapter Two. I will also examine what distinguishes the union documents and, in particular, will unpack the theme of work organization. Does the tension between the individual and structural approaches to mental health problems mirror the medical/management talk vs. union talk sections of the thesis?

The medical/management talk focuses on the role of the individual to heal/be healed whereas the union talk appears much more structural/collective in nature. What responsibility is placed on the individual and to what extent are structural or collective solutions sought? This is the crux of the matter since unions typically emphasize their strength in numbers and view blockages to mental health as a series of problems related to working conditions and organization. Finally, I will compare and contrast some of the tools that unions and other organizations have created to help workers (and others) try to improve their situations.

There are a number of persistent themes that run through the grey literature. These themes include the cost of mental health disabilities, individual responsibility, work organization and other structural problems in the workplace, psychological safety as a recent concept, the impact of technology and globalization on the workplace, stigma and discrimination and more. These

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are important because they reflect levels of concern with issues related to mental health. In this section I will outline these themes critically and discuss the content of some of the documents that contain them.

 Parsing the Grey Literature

In the websites that deal with mental health in the workplace broadly, the high cost of mental disability is often emphasized as a reason that change is needed. The Canada Safety Council (CSC) website indicates that mental health claims are the fastest growing category of disability costs in the country. These costs account for an estimated 30 to 40 per cent of the disability claims recorded by Canada’s major insurers and employers. Three-quarters of employers say mental health issues are the leading cause of short and long-term disability claims in their organizations. It is noteworthy that employer and insurance cost concerns are central to bringing mental health issues to the fore. The CSC publication was generated by an employer-led agency and as such would reflect those financial concerns.

The question of the cost of mental illness to productivity and to the economy is also common in the peer-reviewed literature. Corbière & St-Arnaud, 2011 is one such example and contains a great deal of such information that is quoted in Chapter Two to describe the magnitude of the issue for society.

Not surprisingly, this same cost-concerned literature does not deal with work organization, but focuses upon the experience of individuals. One particularly interesting document by the European Network for Workplace Health Promotion speaks to the work organization problems as well as job insecurity and unclear job roles. But the solutions it advances are almost all individual-based. The piece is generated by a government body and could reasonably be


expected to offer more wide-ranging solutions. In effect, this approach leads to the isolation of workers and a reduction in the power they could wield as a collective voice.

There are also a number of sites, often by non-governmental agencies, that provide basic information on symptoms of mental illness for primarily management audiences. They do not typically advance an analysis of workplace relations or work organization but, rather, explain depression, for example, as a medical condition for which a variety of treatments available. These sites, mainly generated by public agencies and service groups, are useful as introductory information but they do not go far enough in providing solutions to the problems cited. The solutions they offer are primarily individualistic in nature, such as medications, behavioural therapies and relaxation exercises. They do, however, generally utilize respectful language in describing people with mental health challenges. I believe this reflects their work in the trenches with this population.

This type of more general literature is typical of what is contained in websites by such agencies and service groups. It is not at all common in the peer-reviewed literature that tends to be more analytical in nature.

Another theme found in the grey literature is the relatively recent emphasis on psychological safety as a legal concept. Martin Shain’s report, Tracking the Perfect Storm, outlines that for the first time in Canadian history employers are confronted with a legal duty to maintain not only a physically safe workplace but also a psychologically safe work environment.

Shain states that previously only egregious management actions that caused catastrophic psychological harm created risk of legal liability. Now, common workplace practices that create foreseeable risks of mental injury can lead to legal liability under certain circumstances, such as

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chronic stress caused by work conditions, excessive demands from supervisors and management, and unpaid overtime that can lead to mental harm. It argues that a “perfect storm” of liability for employers who fail to maintain a psychologically safe workplace is building strength in the proceedings of courts and tribunals in seven different Canadian legal contexts: human rights, labour law, employment contracts, employment standards, occupational health and safety, workers compensation, and torts and damages (common law).

Shain’s document, commissioned by the Mental Health Commission of Canada, is important in that it provided legal evidence as well as a strong argument for the development of the Canadian Standards Association Standard on Psychological Health and Safety in the Workplace. In pointing out the legal liabilities for employers, the document underscores the need for action on this issue by all workplace parties and points to a legal arsenal that is available to employees. In effect, the legal means noted have the potential to tilt the balance of power toward workers in mental health cases. This evens out the playing field for workers by giving them tools with which to defend against employers’ actions.

I have not come across articles in the peer-reviewed literature that deal with psychological safety per se, and expect that this is so because the legal significance is quite recent.

Psychological hazards are treated in a document developed by the Alberta government in conjunction with a few of its unions, and considers workplace stressors and controls that may be put in place in the healthcare sector. ¹⁵ Psychological hazards are important as they define the risks inherent in the workplace. This piece deals squarely with structural issues and states that the main workplace organizational factors include workplace violence and abuse, critical incident stress, change, technological change and fatigue/hours of work. Legislative and practical prevention tools are examined. This is a very hands-on document, in that it provides many checklists and definitions that may be of value to workers. The tools can help workers and their unions to strengthen their position in relation to the employer. Developing strength and power

vis-à-vis the employer is the express purpose of some of these documents and it is interesting in this instance that government is the coordinating body for their production.

A union that deals with psychosocial hazards in its web presence is UNIFOR. A document entitled ‘Let’s Talk about Mental Health’\(^\text{16}\) puts psychosocial hazards front and centre in a discussion about what members can do about mental health and safety. The web page describes the union’s participation in the Bell program ‘Let’s Talk’ that is geared towards fostering a national conversation on mental health. As part of the program, Bell donates five cents for every text message sent and mobile or long distance call made (for Bell customers only), every tweet using \#BellLetsTalk and every Facebook share of the Bell Let’s Talk image on on a certain date.

“The biggest challenge is controlling and eliminating the psychosocial hazards in the workplace that cause mental health conditions,” said Sari Sairanen, UNIFOR’s Health, Safety and Environment Director. She states on the web page that a much greater awareness of mental health issues is needed to break down barriers for those suffering. The union participates in Bell’s program while at the same time looking to identify and combat psychosocial hazards, something the employer’s program does not do. This dual role suggests that unions can both support and advocate for members with mental health problems through a management program and also constitute a counter force to the employer in its more focused health and safety activities.

Another union, OPSEU, has undertaken surveys to evaluate the psychosocial hazards in the workplace that affect its members. In a web document called Taking Action on Workplace Stress\(^\text{17}\), a campaign is outlined to use a Danish survey on psychosocial hazards and working conditions for a particular section of the membership. The union has teamed up with OHCOW, the Occupational Health Clinics for Ontario Workers, to use the survey and assess the results.


This, as we shall see in Chapters Five and Six, is a sophisticated diagnostic method that has borne fruit for the union in attacking poor work organization.

The Steelworkers have also participated in campaigns to identify and combat psychosocial hazards. In October 2012, a top Steelworker official sent a letter\(^1\)\(^{18}\) to the Ontario Minister of Labour to draw her attention to a new resource to be used in combating psychosocial hazards in the workplace. It stated,

> “Workplace psychosocial hazards include bullying, harassment, threats of violence, unreasonable demands, lack of support, lack of trust and respect, poor work-life balance and work organization. These hazards take their toll on workers’ mental health and cost our economy in terms of lost productivity, in addition to real costs for our health care system, insurance companies and added stresses to workers’ families.”

The Steelworkers were part of an inter-union campaign, also linked to some academic resources, to bring the issues forward to the government and the public. By banding together with other unions and supportive allies to confront psychosocial hazards, the union developed a core of strength that can be called upon in dealing with employers.

Psychosocial hazards are a common subject in the peer-reviewed literature. As expressed in Chapter Two, writers such as Vezina (2004) and Corbière and Shen (2006) deal with psychosocial hazards in the workplace as factors contributing to mental health problems. The literatures draw similar conclusions about psychosocial hazards and alert the reader to problems that develop in the workplace as a result.

The Public Service Alliance of Canada, that represents primarily federal workers, has vigorously taken up the issue of mental health. In one document (of many) it points to epidemic proportions of depression, anxiety and burnout among its members.\(^1\)\(^{19}\) It names factors such as precarious


work, job insecurity, work intensification, poor work-life balance, harassment and discrimination as among the causes of these problems.

Work-life balance refers to the tension that exists between responsibilities in the home and those at paid workplaces and can include issues of childcare, work scheduling and parental leaves, among others. The PSAC publication outlines the characteristics of a healthy workplace, including good communication and work-life balance, manageable workloads, job security, influence over work and recognition. As it is a document developed to sensitize members to an issue and build support around it, the focus is on identifying the problems and solutions. Using health and safety committees and enforcing the collective agreement are identified as key, as well as confronting stigma and discrimination.

This document is clear in its focus on ill health that is caused by factors external to workers. The document looks to work organization as a causal factor, among others. This is a significant viewpoint for the union to take in framing the issues of psychosocial hazards, and the union’s role in combating them.

In the face of such problems, the union has negotiated some structural reforms. The process is contained in a post from September 19, 2013, where the union addresses the impact of significant cuts to the federal public service over the last several years. It points to the fact that excessive stress can cause physical problems ranging from occupational accidents, to back pain, to burnout. In addition, many people left in the workplace experience psychological problems – anxiety, insomnia, drug abuse, psychological distress and depression. The following quote from the union’s website in this section it is outlines how health and safety committees may try to negotiate improvements in the work processes that affect the workers left after substantial cuts to the counterparts.

“Part II of the Canada Labour Code allows members of health and safety committees to discuss these important issues. Section 125 (1) (z.05) stipulates that the employer must ‘consult the policy committee or, if there is no policy committee, the work place committee or the health and safety representative to plan the implementation of changes that might affect occupational health and safety.’”
More specifically, section 134.1 (4) states that a policy committee

“shall participate in the planning of the implementation and in the implementation of changes that might affect occupational health and safety, including work processes and procedures.”

This workforce adjustment process will presumably have an impact on occupational health and safety at several levels.

This is critical in that it demonstrates that faced with a shrinking work force and the mental health challenges that exist, the union will undertake to negotiate changes in work processes. The purpose is to ameliorate the situation of overwork and stress from understaffing that affect worker health and safety. The broadening of the definition of health and safety to include mental health is worth noting.

Work organization and structural reform -- rather than individual-based solutions -- are also contained in a document produced by the Conference Board of Canada. This document is quite comprehensive in its treatment of how employers need to act in the workplace to deal with employees facing mental health challenges, and those returning to work. It gives many good ideas to front-line managers as well as speaking to the need for higher-level CEO support. It argues, however, that most managers do not yet possess the skill set, training or tools to deal with these issues effectively. It recommends focusing on education and communication to reduce fear, stigma and discrimination with respect to employees returning to work after absence due to mental health problems. Further, it argues for the creation of a culture conducive to good mental health, including how work is organized; how much control people have over their work; how they are rewarded and recognized; and how organizations deal with bullying, harassment, and discrimination that have been identified.

This is very interesting in that the section on what management needs to do, and in particular the points above, speak to the most fundamental level of psychosocial hazards and the need to look at work organization. Firms may be liable if they do not address these questions and it is possible that this motivated the Conference Board to research and educate its members on these issues. The document also underscores the need to educate against stigma and discrimination, which is not always present in these pieces of work.

CUPE, the largest Canadian public sector union, also presents information on the web dealing with work organization.\textsuperscript{21} In a web document called Enough Workplace Stress: Organizing for Change, the union outlines a definition of stress:

\begin{quote}
[a] a combination of physical and psychological reactions to events that challenge or threaten us. In normal circumstances, the stress response is a powerful protective mechanism that allows us to deal with sudden changes, dangers or immediate demands. In abnormal (i.e., highly stressful and/or prolonged stress) circumstances, stress overwhelms our protective mechanisms, leading to serious negative health outcomes\textsuperscript{22}.
\end{quote}

It also outlines liabilities and outcomes and then asks the worker if they have a health and safety problem. It lists the following outcomes:

- Psychological disease and social and behavioural changes.
- Heart disease and other physiological outcomes.
- Personal and family-life conflict.
- Workers divided.
- Work-related musculoskeletal disorders.
- Burnout.
- Synergistic effects of stress and other diseases.
- Critical incident stress.


\textsuperscript{22} Ibid.
A number of strategies are put forward including: reorganizing workplaces to eliminate stress hazards, putting in place measures that increase worker autonomy and the occasion to improve skills. It also suggests that job design be reviewed to lower stress hazards. This is significant in that it stresses the job environment and job design, subjects related to work organization that are central to the focus of this study.

In the peer-reviewed literature there is a certain amount written about work organization. Among the authors of note in this regard are Shaw et al., 2008 and Vezina, 2004. In Chapter Two the topic is discussed more fully as it relates to the evolution of the workplace and production of mental health challenges. Interestingly, to a great extent the grey literature uses poor work organization as a foundation from which it makes various recommendations. This is particularly true of the union documents but is also the case for many of the others. One point of commonality between some of the peer-reviewed literature and Loisel & Côté (2013) in particular, and the grey literature, is the recognition of the importance of the of the power differential between workers and the employer. Workers have agency but they operate within the constraints of a workplace that is controlled down to the fine points by the employer.

An extension of this theme developed in the grey literature speaks to the way in which work and the workplace may itself directly contribute to poor mental health. A document produced by the Australian Human Rights Commission\(^ {23} \) gives an outline of the mental health issues in the workplace, management’s responsibility to be aware of psychosocial hazards, costs to the employer and the relevant legal provisions. The document, produced by a respected government agency, states that it is often presumed that a worker’s mental illness develops outside the workplace. However, an ‘unhealthy’ work environment can cause considerable stress and exacerbate, or contribute to, the development of mental illness. This is an important point for employers and unions to recognize, in trying to combat psychosocial hazards because it suggests that all workers may be vulnerable to issues related to work organization, depending on

conditions in the workplace. If no one is immune, and workers become ill both at work and outside of work, there is an issue to be taken up by the union.

Support for individuals who are experiencing mental health duress is another theme broached in the grey literature. A document produced by a government agency in Europe\textsuperscript{24}, explains why and how to promote positive mental health in the workplace and understand and prevent issues that cause stress and mental health problems. It also suggests how to support employees who develop mental health problems and develop effective policies to reintegrate and employ people who have experienced mental health problems.

The guide goes on to state that in recent decades the increasingly global nature of our economies, and the advances in workplace technology, mean that the nature of work is changing rapidly. This affects the content, organization and intensity of people’s work, which increasingly requires more skills and competencies related to innovation, communication and social intelligence. These rapid changes in the nature of work can be rewarding for employees; however, they can mean that employees may experience more pressure and demands upon their cognitive, social and psychological skills.

In relation to mental health problems, interventions focusing solely on changing individual behaviour are not particularly effective either for employees or for companies. They need to be supplemented with organizational measures addressing the potential sources of stress in the working environment. This suggests the social power of institutions over individuals and lays out a clear structural reform agenda rather than simply individual-based solutions. The medical talk I presented in Chapter Two is mirrored in language about individual solutions, where they are proposed. That language reflects a medical model that suggests individual therapies, medication, relaxation methods and other such modalities. It is not that these modalities are useless – they can, in fact, be very helpful. But to treat the individual without changing the fundamentals of the work process is to allow conditions of psychosocial hazards to persist.

There are peer-reviewed articles that focus on the individual. Brouwer et al., (2010) is one such example. Rather than consider structural problems in the workplace, individual problems and agency are treated as paramount. This is less the case in the grey literature where work organization is frequently cited as the source of problems, rather than individual issues. For the most part, the grey literature does not put pressure on individuals to heal/be healed and instead, looks at the factors external to the individual. There is no evidence of the victim being blamed for inactivity or poor lifestyle, as is sometimes the case on the shop floor or in the medical office.

Identifying the causes and effects of bullying is a major concern in the union documents on the web. For the CUPW, this is a significant preoccupation. In a newsletter from 2010\(^{25}\) the union outlines the behaviour of workplace abuse of power and bullying and how it impacts negatively upon individual workers and the workplace as a whole. It describes the problem, indicates how management can be involved and states that it is the employer’s responsibility to keep the workplace free of such negative behaviours as part of its health and safety obligations.

The newsletter asks that workers stand together against bullying and back one another up if a formal case must be made, and thereby demonstrates the potential power of a collective approach. It is that collective approach that gives the union a chance to take on bullying in a systemic fashion. As we shall see in Chapters Five and Six, unions have found that poor work organization contributes to bullying and harassment. It usually occurs between supervisors and workers, but there is also ample experience of bullying between co-workers in which the union must represent both members involved. Rather than having individuals face these problems alone, the union attempts to create a united front that pushes management to act on the root causes.

There is a considerable literature on bullying in peer-reviewed books and articles. I cited earlier the article by Cox (2014) that speaks to how bullying can result from poor work organization and communication. In Chapters Five and Six I explain how I was surprised to learn that bullying

and harassment are often due to work organization issues and not just expressions of unequal power.

Public sector unions such as CUPE, OPSEU and CUPW all include in their web presence a defense of public services. They are in the dual position of having to reflect their members’ needs, while at the same time defending the services that exist. The previous federal government waged a veritable war against the civil service that resulted in significant cutbacks. Some would argue that these campaigns to defend public services are self-interested, meant to maintain jobs. But the arguments for better services, made in concert with community groups and clients, belie that notion. In the early 2000’s, as just one example, OPSEU hosted mental health fora with members and the public in several cities across Ontario. The purpose was to draw attention to the conditions in the facilities in which union members worked as well as to build links with clients and their families. In building such linkages, the unions are most often trying to increase their power vis-à-vis government decision-makers. When cutbacks are announced these coalitions of families, clients and workers go to the media to build public support against the cuts. The union is using a tried and true strategy to bolster its own strength against a powerful foe. This topic was not covered in the peer-reviewed literature.

Themes related to disability management and return to work are very common in the grey literature. For example, workers have collective interests that are expressed through union health and safety representatives. In effect, their strength in numbers enhances workers’ potential to achieve positive change.

In a document from Cardiff University, the effectiveness of worker health and safety representatives is discussed. The authors, a group of academics, suggest that organized labour operates at a number of levels to make workplaces safer, including collective bargaining and fighting for worker-friendly legislation. They argue that efforts to redress workers’ health and safety concerns directly through collective action are an aspect of the institutional mechanisms of

industrial relations in which trade unions are actively engaged in most countries. So too is the practice of indirectly representing workers’ interests through political lobbying toward achieving improved health and safety laws and regulations. Risks that arise from overwork or poor training which are associated with work reorganization and intensification generally, are directly combated by the role trade unions play in delivering better working conditions and indirectly through negotiating higher wages and the option for shorter hours. Unions also support workers who suffer ill health due to poor working conditions.

In this regard, the paper concludes that worker representatives contribute positively to health and safety performance of employers. How trade unions combat risks due to work reorganization and intensification is critical to this thesis project and this piece takes this question into account.

Another theme regarding RTW is the stated need for cooperation between the parties. Several documents found on the web underscore this point. The first is produced by the Institute of Work and Health\textsuperscript{27}, a non-governmental agency. This document outlines seven principles for successful RTW. They are:

1. The workplace has a strong commitment to health and safety that is demonstrated by the behaviours of the workplace parties.
2. The employer makes an offer of modified work (also known as work accommodation) to injured/ill workers so they can return early and safely to work activities suitable to their abilities.
3. RTW planners ensure that the plan supports the returning worker without disadvantaging co-workers and supervisors.
4. Supervisors are trained in work disability prevention and included in RTW planning.
5. The employer makes an early and considerate contact with injured/ill workers.
6. Someone has the responsibility to coordinate RTW.
7. Employers and health care providers communicate with each other about the workplace demands as needed, with the worker’s consent.

These principles are comprehensive, including mental health although not mentioning it explicitly, and address the need for the parties to have to cooperate in RTW efforts in order to achieve positive outcomes. The principles speak, like some of the peer-reviewed literature, to the role of co-workers and supervisors in job accommodation, Holmgren & Dahlin Ivanoff (2007). The need for coordination of RTW is also underscored.

Cooperation between the parties is a very popular notion in the government and agency documents. Another document emphasizing cooperation between the parties in accommodation and RTW is by the Canadian Human Rights Commission. This document outlines the steps for managers to take in preparing RTW protocols for employees and suggests that several factors contribute to growing rates of prolonged employee absenteeism. These factors include stress related to technological change and organizational restructuring as well as an aging workforce and difficulties balancing work and family life.

The document explains duty to accommodate and the meaning of undue hardship. It suggests that successful RTW involves the careful balancing of an employer’s right to manage with a worker’s fundamental right to equality, dignity and privacy. Employers are given a series of steps to follow in order to treat an employee fairly, including encouraging contact during the employee’s absence, and timely response to a request to return to work. It states that the employer must consult with the union in order to deal effectively with it and co-workers in setting up an accommodation. It further provides case studies to assist employers in carrying out their duties. This site provides a user-friendly approach to employers wanting to carry out an effective RTW.

The RTW steps prescribed are also consistent with both the peer-reviewed and grey literature on the topic, MacEachen et al., (2006) and Shaw et al., (2008). The peer-reviewed literature deals with this notion that cooperation between labour and management is essential to successful RTW. Several authors, including Jodoin and Harder (2004), Noordik et al., (2011), Franche et

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al., (2005) and MacEachen et al., (2006) all speak to the necessity for good communication between the parties to ensure that the worker’s return to work is effective.

Further, Labour – Management committees on accommodation and disability management are viewed as a positive step toward good relations and effective RTW. In a paper that deals primarily with absences due to back pain, it is argued that the lessons learned can be applied to other disabilities. In terms of disability management programs, the paper argues that joint labour-management committees are advantageous, increasing the likelihood of non-adversarial relationships in building a RTW program. Communication between all of the stakeholders is encouraged, including between the union representative and the employee and employer. It underscores the importance of training management and supervisors to take a sympathetic and problem-solving approach to all aspects of disability management including modifying jobs as appropriate for workers. The paper also refers to collective bargaining as a useful vehicle for developing these programs.

The theme that to work can be beneficial for many workers is related to RTW. This aligns with work by Holmgren & Dahlin Ivanoff (2007) in the peer-reviewed literature. I think this depends a great deal on what kind of changes are made to the work process before the person finds himself or herself back in the workplace. Nonetheless, it is a popular view among employers. This document, produced by a non-governmental health agency, provides employers with a brief guide to mental illnesses, their treatment and employment implications, including RTW. Information about mental health disability in Canada is provided along with cost and legal impacts for employers similar to the section of the peer-reviewed literature of this study. A scan of treatment models is included along with outlines about making accommodations. A further section on prevention and fighting stigma is also presented. It outlines the arguments for and


against an early return to work and encourages the employer to involve the union in monitoring employees’ progress as they adapt to workplace accommodations. The final message says to keep the focus on the person and not on the disability.

The Human Solutions site is interesting in its coverage of the role of stigma as a factor in developing workplace solutions, making it a very practical and informed approach to the issues. From a CDA perspective, discussing the role of stigma and discrimination is revealing because it sheds light on the position of the returning worker as the underdog. That is, in the relations of dominance they are at a disadvantage and workplace solutions must take this into account.

Coordination of RTW is a central thrust in some of the grey literature on disability management. Articles speak to the need for one individual to have overall responsibility for coordinating a worker’s return to the workplace – the RTW Coordinator. A guide was developed in conjunction with a broad spectrum of stakeholders, including union representatives. It is found on the site of the Canadian Centre for Occupational Health and Safety, a non-governmental agency.

The authors carried out a systematic search of the literature for narratives that outlined best practices in terms of interventions on return and stay-at-work. They found useful interventions on three levels: organizational, disability management practices and the individual worker. The organizational level includes policies and people-oriented practices that root out stigma and boost early identification of mental health problems. On the disability management level, best practices point to using a trained RTW coordinator for case management. On the individual level, interventions involving workplace accommodations and, like Corbière & Shen (2006) in the peer-reviewed literature, cognitive behavioural therapies are emphasized. They found that such interventions overall led to shorter absence outcomes and some cost savings for employers/insurers. The notion of a central role for a trained RTW coordinator is also found in the peer-reviewed literature (Shaw et al., 2008; MacEachen, 2006; Franche et al., 2005).

Another theme found only rarely in the literature is that of the recovery model for mental illness. In a document created by the Mental Health Foundation of New Zealand, a non-governmental agency, an outline of best practices is provided for employers and others interested. It gives a brief introduction to common mental disorders and stresses a recovery model, involving the individual in determining how they can best live with their condition. The person is considered empowered and with agency. It states that one of the largest blocks in recovery is the discrimination that people with mental health problems experience.

The New Zealand document makes several suggestions regarding appropriate accommodations and the need for both management and co-worker support. It gives several case studies as examples and uses respectful language toward people with mental health problems by dealing with the person first, before the diagnosis. Stressing a recovery orientation is not as common as one might think; it poses the worker as having agency, as playing a role in the decisions that affect their work accommodation, overall treatment and recovery. From this I conclude that this would be a positive direction for RTW programs to adopt.

The uniqueness of this piece is the attention to stigma and discrimination in the lives of people living with mental health problems. Like Stuart’s (2004) work in the peer-reviewed literature, it provides an interesting viewpoint for employers to take into consideration in RTW programs.

In the union literature on RTW, one focus is on how stewards and others should best communicate with members who are having mental health problems. In a guide for union representatives from the United Kingdom, Trades Union Congress stewards are urged to deal with members facing mental health challenges. While it deals with legal matters and workplace accommodations for such individuals, much of it addresses communication with these members and problem solving around issues of disclosure of their illness to the employer. As we shall see

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in Chapters Five and Six, this is a huge issue for union representatives who must advocate for members with mental health challenges.

The document counsels disclosure, as that is what triggers the right to a reasonable accommodation in the work process, if necessary. This can be problematic for individuals who have experienced stigma and discrimination. The union’s desire to protect workers through legal means is well intentioned but sensitivity to the resistance to disclose is necessary. Once disclosed, the person living with a mental illness is typically limited in terms of power and agency. Giving up that power can be a huge decision, even when protection lies in triggering the legal process for an accommodation, for example. The document also provides information about common mental illnesses and an extensive listing of resources and allied organizations. It uses language that is respectful of people with mental health problems, by putting the person first and the diagnosis second. It also uses terms such as mental health problems or mental health challenges, rather than falling into the medicalized view that illness is necessarily present.

Several of the unions encourage members to get involved in activities that support mental health, often in conjunction with agencies like the Canadian Mental Health Association or the Mental Health Commission of Canada. Mental Health Day and “Not Myself Today” are two of the national campaigns in which several unions participate. The websites reflect the activities in the workplace, from lunch-and-learns and speaker events to celebrations. These are part of unions’ attempts to educate members and build awareness about mental health issues and their impact in the workplace. Stigma and discrimination are addressed. These efforts focus attention on the broader societal impact of mental health problems and situate the workplace as part of a nexus of concern. If this were the only thing unions were doing on mental health, and not trying to make inroads on psychosocial hazards and return to work, I would be concerned that they were focusing on the wrong aspect of the question. But as an add-on set of activities that raise awareness of mental health as a workplace issue, these campaigns are useful.

The grey literature makes ample mention of stigma and discrimination in workplaces and, in particular, in RTW situations. Emphasis is placed on confronting potential stigma and discrimination before a worker returns to the workplace and during his or her period of transition. These are difficult situations to navigate as prejudice against mental disability tends to
run high, fueled often by fear. Education is the key and as we shall see in Chapters Five and Six, some of the unions have devised programs that attempt to reduce the impact of stigma in the workplace by advocating on the person’s behalf in relation to co-workers. I did not find that the peer-reviewed literature dealt with the intricacies of workplace re-entry for people with mental health problems. Stuart (2004), for examples, cites statistics and the attitudes of managers to such people, but does not address how to develop a successful re-entry that advocates on behalf of the worker while educating co-workers. This falls to the unions, as one might expect.

Unions and union activities: Alternate forms and activities

Union counseling

One of the most successful programs offered by unions to their members is called “union counseling”. Originating in the 1940’s under the rubric of alcohol addiction issues, the program now is affiliated with the United Way and offers help with a variety of issues facing working people. Training is carried out through the Canadian Labour Congress in communities across the country. Union counselors are not therapists but they are trained to listen, act as peer supporters and tend to be knowledgeable about resources in the community that can help troubled individuals and their families. Union counselors are usually appointed by the local union executive and have credibility with co-workers and local union leadership. They work in conjunction with union stewards and health and safety representatives to assist members with workplace, personal or family challenges on a confidential basis. In addition to substance abuse problems, issues such as domestic violence, school and child care scheduling, housing and elder care may be tackled. Mental health issues are also a concern and the union counselor is presumed to be knowledgeable about resources including websites, hotlines and referral services. When a worker goes on extended sick leave, the union counselor may stay in touch with them and then play a supportive role during their return to work (Dufour-Poirier & Bourque, 2013). Essentially union counseling is a type of peer-to-peer support program. It seeks to empower the individual by providing resources and support, working against the hierarchical relations endemic to most primarily medical interventions.
Employee Assistance Programs

Union counselors are also knowledgeable about the Employee Assistance Program (EAP) in their workplace. Funded by employers, the aim of EAP is to assist individuals with a variety of problems, mainly through offering counseling with trained professionals. The first EAPs were created in 1945 by companies looking for ways to help employees troubled by alcohol dependency. Often these were veterans who had returned from brutal circumstances of the Second World War and faced difficult transition issues. For about thirty years, alcohol dependency remained the focus of EAP services. Around 1975, other problems became more central as employers wanted to keep their workforces healthy and productive.

Issues covered run the gamut from stress and relationships to substance abuse, parenting skills, credit counseling and legal advisory services. Typically EAP provides for brief counseling of about six to eight sessions. Almost half of the cases involve marital issues and one-quarter relate to psychological problems such as anxiety and depression. Union counselors, along with supervisors and human resource staff are often the conduits through which workers are referred to EAP services. These can also include telephone-based counseling and web-based secure chat rooms. Where geographic distances are a concern, these latter two services are particularly apt.

There was considerable growth in EAP coverage during the 1980’s and 1990’s and now approximately 80 per cent of companies, including the large provincial and federal public services, offer the program to their employees. As the economy increasingly builds on assets like knowledge, information, creativity and innovation, employers wish to mitigate stress that can lead to disability and hamper a company’s capacity to compete. EAPs may also aid human resource departments in developing harassment policies and conducting employee surveys, items that are outside their traditional core functions. While the evolution of the EAP has broadened its scope considerably since their inception, one consistent value has been confidentiality. Information is not meant to go into an employee’s personnel file. Reporting is done on an aggregate basis to protect the privacy of plan members.34

EAPs link professionals to individuals in need and, as such, usually demonstrate a hierarchical relationship with the worker, unlike union counseling which is based on a peer-to-peer model. But depending on the severity of the situation, this therapeutic intervention can be helpful to the worker.

**Workplace Health and Wellness Programs**

Many employers, sometimes in conjunction with unions/employee associations, offer health and wellness programs. Typically these focus on health defined broadly (not just in the workplace) and issues stemming from work-life balance challenges. Work-life balance refers to the tension that exists between responsibilities in the home and those at work and can include issues of childcare, work scheduling, parental leaves and elder care to name only a few. It can also refer to the extent to which workers are not treated as human beings, but as widgets, in the cogs of production. As we shall see in Chapters Five and Six, this is a potent observation of some key informants, especially in the post office.

The Canadian Centre for Occupational Health and Safety (CCOHS) makes a distinction between health and safety programs that are legislated, and workplace health and wellness initiatives that are voluntary. They suggest that a joint labour management committee be created for the wellness program, with significant backing from senior management, the union and the human resources department.  

However, workplace wellness initiatives may include flextime for fitness activities, walking clubs, healthy food options in the cafeteria and vending machines, weight loss sessions, behavioural coaching, immunizations, health risk assessments, workplace yoga and stress reduction workshops. Sometimes financial incentives are provided to boost participation in physical fitness clubs. The purpose is to create an overall culture of health in an organization and provides information on reporting relating to EAPs.

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35 www.ccohs.ca/oshanswers/psychosocial/wellness_program.htm Viewed Sept. 25, 2013 provides information on legislated and voluntary health and safety and wellness initiatives.
at a corporate level, to encourage a decrease in the usage of costly employee benefits. In an aging workforce that is more sedentary than in previous generations, concern about chronic health conditions – as well as productivity -- drives the wellness push.

Some unions have negotiated workplace health and wellness programs with employers. The former Canadian Auto Workers Union (CAW) focused on activities such as raising awareness and education that led to skill building, early detection and illness management strategies. The union encouraged partnership with employers and service agencies to develop stress management and overall mental health strategies. “Despite mental health claims being the fastest-growing category of disability costs in Canada, it has been a challenge to convince our employer groups to embrace wellness programs.” (Sairanen et al., 2011, p. 79) With perseverance the union was able to develop a joint program with specific health objectives for members developed by individual workplaces working with community partners.

Workplace wellness programs also come under criticism from union officials. While it is generally accepted that individuals have a responsibility for their own health, it is also believed by some critics from the union side that the emphasis on personal health diminishes employer responsibility for providing a safe and healthy work environment with as few psychosocial risks as possible. Rather than seeing a structural context in which workers become ill, individuals are blamed for their ill health or chronic conditions. This issue is discussed further in this study.

**The Canadian Standards Association Standard on Psychological Safety and Health in the Workplace and Tool Kits**

The Canadian Standards Association (CSA) Standard on Psychological Health and Safety in the Workplace came into effect in January of 2013. It was the result of a joint effort between business, labour, service providers and government representatives along with the Mental Health Commission of Canada and it relied in a significant fashion on the work done by Dr. Martin Shain entitled, “Tracking the Perfect Legal Storm: Converging Systems Create Mounting Pressure to Create the Psychologically Safe Workplace” (Shain, 2010) which made the argument for the first time that employers are confronted with a legal duty to maintain not only a physically safe environment, but also a psychologically safe work environment (Shain, 2010).
The purpose of the Standard, adherence to which is voluntary, is to provide tools and resources to employers so they may reduce any psychological hazards and potential harm to their employees. The Standard includes information on:

- The identification of psychological hazards in the workplace;
- The assessment and control of the risks in the workplace associated with hazards that cannot be eliminated (e.g., stressors due to organizational change or reasonable job demands);
- The implementation of practices that support and promote psychological health and safety in the workplace;
- The growth of a culture that promotes psychological health and safety in the workplace;
- The implementation of systems of measurement and review to ensure sustainability of the overall approach.

The Standard specifies requirements for a documented and systematic approach to develop and sustain a psychologically healthy and safe (PH&S) workplace, and may eventually be seen as a reference for best practices.

**Evaluation of different tool kits, workbooks and e-programs on mental health**

The different tool kits and workbooks available reflect their roots in union, employer, academic or government sources. While there is considerable overlap in content, a point of view is also evident. How work organization is viewed, for example, defines how the role individual is approached in the material. That standpoint is important because it affects whether the individual is held primarily responsible for his or her mental health or whether factors such as work organization are considered significant in determining outcomes. In the next few pages, we will look at a few of these programs to analyze their approach and effectiveness. I am most interested in the tool kit that provides workers with a means to organize around psychosocial hazards and, secondly, one that would help ill individuals to better understand and improve their mental health situation. The questions I ask of the materials include, whether respectful language is used, what kinds of tools are offered for unions and for individuals and whether the program deals with
work organization. The first two tool kits stand out; they provide a comprehensive means to attack the problem of mental health in the workplace, from the point of view of the union and for the individual.

*Mental Injury Toolkit*

In 2009, a group of trade unionists, health and safety specialists and academics came together to create this tool kit. Presented in October of 2012, it provides a comprehensive approach to dealing with psychological health and safety in the workplace, highlighting the dangers of psychosocial hazards and giving concrete examples of how to grapple with them successfully. The authors take the position that they are not interested in diagnosing workers but, rather, in diagnosing workplaces and organizing workers. Identifying stressors at work that affect mental and physical health is the focus. Three broad approaches to psychosocial hazards are outlined: the person, behaviour and the environment. Then three preventive measures are explored.

The tool kit provides information about the health and safety legislation, workers’ compensation, the CSA Standard on Psychological health and safety in the workplace, employment standards, collective agreements and other legal means of protection. Finally, the tool kit includes the well-respected Danish survey, COPSOQ, that is being circulated to assess workplaces in Canada and worldwide for psychosocial hazards. It is presented as an organizing tool, to bring about greater attention to these issues and educate workers as to their rights.

From the perspective of Critical Discourse Analysis, this toolkit lays out an empowering process for workers to assess stresses on the job. Like Loisel & Côté (2013), MacEachen et al. (2006) and also Corbière & Shen (2006) in the peer-reviewed literature, the worker is viewed from within an overarching context, and derives power from a collective rather than individual identity. It reflects clearly a labour-motivated approach, complete with analytic and organizing tools aimed at a collective audience. This is the tool kit best suited to a union local that is trying to identify and combat psychosocial hazards. The tools are presented in an understandable and

comprehensive fashion, useful to groups that want to make a difference to the work organization of their workplace.

**Guarding Minds @ Work**

This website introduces GM@W resources that allow employers to effectively assess and address the 13 psychosocial factors known to have a powerful impact on organizational health, the health of individual employees, and the financial bottom line. The 13 psychosocial factors are:

1) Psychological Support  
2) Organizational Culture  
3) Clear Leadership and Expectations  
4) Civility and Respect  
5) Psychological Competencies and Requirements  
6) Growth and Development  
7) Recognition and Reward  
8) Involvement and Influence  
9) Workload Management  
10) Engagement  
11) Balance  
12) Psychological Protection  
13) Protection of Physical Safety

GM@W was developed by researchers from the Centre for Applied Research in Mental Health and Addiction (CARMHA) within the Faculty of Health Sciences at Simon Fraser University on the basis of extensive research, including data analysis of a national sample and reviews of national and international best practices, as well as existing and emerging Canadian case law and legislation.

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It states that a psychologically healthy and safe workplace is one that promotes employees’ psychological well-being and actively works to prevent harm to employee psychological health due to negligent, reckless or intentional acts.

This website is particularly important in the field of psychologically safe workplaces. The organization pioneered the notion that the traditional view of health and safety had to be broadened to include psychological (as well as physical) issues as part of workplace organization. It established the 13 psychosocial factors to be considered. The web site provides tools through which the dominated group, workers with mental health challenges, can seek rehabilitation and redress. It is developed primarily by academics and speaks to both workers and employers in looking for solutions. It also grapples with work organization in a meaningful way, making it a labour-friendly program. This is the program I would select for individuals trying to make sense of their workplace when dealing with mental health issues, either their own or colleagues’. It allows the person to examine the workplace for factors that are missing and need to be bolstered by management. While much of the program is aimed toward managers interested in improving psychological safety of the workplace, there is also useful information for workers. It is the most comprehensive set of tools currently available to workers and employers interested in creating psychologically safe workplaces and in part, resembles the CSA Standard in terms of the 13 psychosocial factors under consideration.

**Mental Health Works**

Mental Health Works is an initiative of the Canadian Mental Health Association that began in 2001. It is a program that includes website materials and other products and services available to the business community, employees and labour regarding the building psychologically safe and healthy workplaces. It provides skills enhancement training, workshops and awareness education, and stigma reduction efforts to employers and some unions across Canada, in both official languages. A variety of topics, including the role of joint health and safety committees in building mental health, resources available in the community, how to provide a

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socially supportive workplace, are covered. The website also provides advice to individuals struggling with mental health problems about talking to their colleagues, disclosing illness to employers and examples of different workplace accommodations that might be helpful.

For the purpose of my analysis, this site is excellent, providing practical and respectful assistance to all stakeholders. For example, one of their short workshop objectives states that participants will “understand the impact of stigmatizing language and beliefs, their own and that of others”.  

From this approach I conclude that it contains discourses about mental health that are positive and respectful. Mental Health Works provides service to employers and labour alike, and is characterized by a balanced approach to both. In developing the program, both employer and labour groups were consulted and this is reflected in separate sections that support each. It can be used in conjunction with other programs, such as Guarding Minds @ Work, as it provides more intensive assistance to the individual. The organization also offers a series of hands-on workshops of differing length and depth to stakeholder groups at the workplace.


This action guide provides a comprehensive step-by-step approach to uncovering psychological issues in the workplace and then moving to improve overall conditions so that psychological-related illness is diminished. It deals with policy, meaning getting endorsement from organizational leaders; planning, which refers to gathering the facts about employees; promotion, meaning how to create a respectful workplace; and prevention, which refers to steps that may be taken to improve working conditions. The main focus is that a psychologically healthy workplace helps keep workers safe, engaged and productive. This is a cutting-edge tool that explores how employers can make inroads in this area. This document was produced by academics in consultation with labour and employer representatives. It reflects a balanced view

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of the workplace parties and makes suggestions that would get at the root causes in work organization. It is like Guarding Minds @ Work in that regard.

**Great West Life Centre for Mental Health website**

This site\(^41\) is chock full of tools for employers, unions and individual workers to use regarding mental health in the workplace. It provides a series of newsletters and tutorials on related topics, tailored to the audience. For the purpose of my analysis, this is an excellent resource. It was produced in consultation with union and employer representatives and reflects a balanced view of the workplace.

These documents have been primarily written in a kind of human resource management language. They are mainly respectful of people living with mental health challenges. They do not, however, mainly deal with issues of work organization as a root to the psychosocial hazards that exist in the workplace. I would recommend this site to individuals looking for help in identifying mental health challenges in their workplace, similar to Mental Health Works. The solutions that are posed are primarily individual-based and would be useful as such.

**British Occupational Health Research Council**

This leaflet\(^42\) is meant for employers and employees. It is a concise outline of what it calls “common” mental health problems, meaning mild to moderate anxiety or depression. It makes several suggestions as to treatment, including exercise and, like Corbière & Shen (2006) in the peer-reviewed literature, cognitive behavioural therapy. It concludes with the point that everyone needs more information about these issues and that an approach that both considers change to how work is organized and also helps individuals to cope better with stressors would be advisable.


This publication, produced by a government agency considers work organization as well as individual strategies to cope with mental health problems. The suggestions to individuals are similar to the Mental Health Works and Great West Life sites and could be used interchangeably. As such it provides a balanced approach that is introductory in nature for employers and workers.

**CSA Standard on Psychological Health and Safety in the Workplace**

UNIFOR, in particular, has highlighted the CSA Standard in its web communications. One document gives a brief introduction to the 2013 CSA Standard on Psychological Health and Safety, its use meant to identify psychosocial hazards in the workforce and provide tools for managers and workers toward best practices in improving the workplace. This page records what appears to be a presentation given to a primarily employer audience. Three major concepts are first explored:

a) That the Standard provides a methodology for measurable and sustainable improvements in psychological health and safety

b) That the Standard is voluntary

c) That it aligns with international efforts

It then speaks to implementation:

- Baseline measurement
- Credit for what is in place
- Identify workplace specific hazards, risks, and controls
- Process for moving forward
- Integration of best practices with existing systems and processes

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Equip workplace leaders with knowledge, tools and resources to help workers

Connect with community resources

Self-declaration of conformance to CSA Standard

The document outlines the 13 factors that include some psychosocial issues:

a) psychological support,
b) organizational culture,
c) clear leadership and expectations,
d) civility and respect,
e) psychological job fit,
f) growth and development,
g) recognition and reward,
h) involvement and influence,
i) workload management,
j) engagement,
k) balance,
l) psychological protection and 
m) supportive physical environment.

These are the same factors taken from Guarding Minds@Work as GM@W predates the Standard. It drew from GM@W in its development. This program is important because it shows how Unifor is actively campaigning for the adoption of the CSA Standard among employer groups. In so doing, it adopts language and an analysis that is counter discursive, challenging employers to change the organization of work. It is a voluntary Standard that allows employers to sign on to try and meet the objective of a psychologically safe workplace. It was devised with the participation of government, employers and unions. It is a starting point. The full range of workplace mental health issues cannot be addressed by adopting the Standard alone. A comprehensive approach to organizational change is also required.

The fact that it is voluntary remains the most criticized element of the Standard. Unions, in particular, much prefer to see regulations and Codes of Practice that are mandatory. Some are
attempting to negotiate compliance with the Standard into collective agreements, as a means to give its content more legal weight. Nonetheless as stated above, the Standard provides a starting point for effective organizational change.

A further critique of the Standard could be made with a feminist lens, asking whether the processes and procedures recommended have been examined with female workers in mind. Does equipping workplace leaders with knowledge, tools and resources to help workers include concerns related to childbearing and childrearing? Do workplace hazards include the gamut of work-life balance issues? I do not think we will know the answer to these questions until the Standard is put into practice in various organizations, a process that is now underway and being studied by the Mental Health Commission of Canada.

The above-mentioned toolkits, workbooks and e-programs are devised for different audiences: the public, workers, employers and mixed groups. Each contains a particular point of view and offers a valuable set of skills, knowledge and practices for the audience to try when dealing with mental health problems in the workplace. The first two are the ones I would recommend for use first by unions and also by individuals, although all of them are quite good. They can also be used in conjunction with one another; for example, the Guarding Minds @ Work can be used as a framework and Mental Health Works exercises followed as a means for the individual to better understand and challenge the mental health problems they encounter in the workplace.

Summary

The grey literature provides fascinating insight into how the various parties view the issue of mental health in the workplace. I have looked at government documents, agency and service group websites, employer initiatives and union websites and documents. Each provides its respective audience with a perspective from which to view the issues involved. Interestingly, there is some surprising crossover in perspective. Employer websites, for example, sometimes view work organization as central, proposing structural reforms. This is more typical of the union websites that seek to inform and empower their members to act.

The union documents offer some consistent messages. While the discourse is not entirely coherent, central themes emerge. They look at mental health challenges as a result of structural causes, the organization of work. As such, although individual members are affected, the
solutions sought are primarily collective ones. This second message, that workplace solutions be sought collectively shines through the documents from a variety of unions in different sectors. Finally, the unions speak of participation in activities organized by the Mental Health Commission of Canada and in building alliances with community groups. The activities demonstrate the extent to which mental health is entering the unions’ programs. They are building a base that goes beyond just individuals with mental health problems as a means to combating unhealthy work organization that affects all workers.

The most distinguishing feature of the union documents is that work organization is considered in depth as the source of psychosocial hazards and, in turn, mental health problems. The union websites are consistent in this regard. In addition, they are constant in providing collective responses and solutions to problems. This is, of course, second-nature to union organizations as strength is found in the many, not the few. The final point that is expressed in each of the union websites is the encouragement of member participation in activities, whether they are Mental Health Week observances/celebrations or others. This is part of an effort to sensitize members to the issues and bolster their activism on social issues.

In comparison to the peer-reviewed literature, the web presence on these issues is more accessible in terms of language and more immediate in terms of problem solving and recommendations. I think this simply reflects a different audience. The grey literature is meant primarily for public consumption and must therefore be easily digestible. This is evident in the layout of the documents and the use of plain language. Peer-reviewed pieces are not generally governed by these concerns.

I found that the focus on the individual-based concerns and solutions was not terribly strong in the grey literature. Where it was found, however, it reflected the medical talk seen in Chapter Two, putting the responsibility to heal/be healed on the ill individual. Much of the other grey literature adopts work organization and structural problems as the root to psychosocial hazards and mental health problems. The union documents, in particular, are strong in this regard. In Chapters Five and Six we will see how this orientation plays out in practices and programs that the unions undertake to identify and combat psychosocial hazards and return to work.
Chapter Five
Talking to Unions: Key Discoveries

In this chapter I sketch out the themes uncovered through the interviews in light of the research questions and the literature. The first section addresses the broadening definition of health and safety as it is used in the union movement. The second section identifies psychosocial risks and mental health problems that union members face in the workplace. In this section I outline the responses of key informants to a number of questions about identifying psychosocial hazards. Of particular interest is how the psychosocial hazards are embedded in employers’ organization of work.

Health and Safety – A broader definition

The people I interviewed and whose responses form the basis of this study are working in paid union jobs and are in a position to meet with and influence groups of workers and employers toward achieving their goals. Psychosocial hazards have developed recently as a central issue to health and safety representatives. They are now trying different means to combat these hazards and make improvements for workers’ psychological health.

There was a consensus among key informants that the field of health and safety has expanded in the recent past to include psychological health. One representative commented:

“We are in a health and safety environment that doesn’t just take in physical health like it used to.... There was a time when that was all we thought about and the obvious sort of things. You don’t stick your hand in when the chain is moving. But we have to go beyond that now.”

Gerry Leblanc, Steelworkers

Another put it this way:

“My view… is that mental health is directly analogous to physical health and that everyone comes to a workplace with a certain level of physical health. And any job can be adjusted to allow that person to accomplish that job regardless of their physical health
and the same analogy applies to mental health. Everyone comes in with a certain level of … “mental robustness”. And any job should be able to be developed and designed in such a way that anyone can do the job. Everyone has some place on that continuum… and it may vary from day to day….”

Troy Winters, CUPE

I conclude that this process of enlarging the scope of health and safety is sometimes difficult and involves a new way of thinking. It may not be that any person can do any job, but the point is to design and preserve jobs that do not erode mental or physical health.

Another key informant put it this way:

Pour moi, le travail, ce n’est pas seulement une chaise, puis un clavier, puis un ordinateur. C’est tout le travail : l’organisation du travail, la charge de travail, les difficultés avec les superviseurs, et j’en passe. Tout ça fait partie du travail. On doit en tenir compte, comme d’ailleurs des impacts du travail sur la santé. Oui, il y a des impacts physiques, mais il y a aussi des impacts psychologiques et émotifs […]. Et en fin de compte, quand les gens font des burnouts ou que le climat de travail se détériore, à mon sens c’est un signal. C’est un symptôme qu’il y a quelque chose qui ne marche pas dans le milieu de travail et qu’il faut s’en occuper autant qu’il faut s’occuper, par exemple, des produits toxiques par rapport à la santé physique.

“For me, work is much more than a chair, a keyboard and a computer. It’s all of it: planning, workload and difficulties dealing with managers, to name a few. All of that is part and parcel of working. We must also take into account the impact of work on people’s health. Sure, there are physical impacts, but also psychological and emotional ones […]. In the end, if people burn out or the work climate deteriorates, it’s symptomatic of problems in the workplace and they must be dealt with in the same way as one would deal with toxic products that affect physical health.”

Micheline Boucher, CSN
I find that the reasons for psychological health to come to the fore vary. But one characteristic was common to a few unions. Several key informants suggested the shift in their work to encompassing the entire human being was accompanied by a demographic change in the unions’ membership to include more women.

“Well it is a male dominant union but it is changing. You have this notion of ‘you have to toughen up, it’s a sissy thing to bring up emotional issues.’ Emotional issues have no place in the workplace and all that.”

Sari Sairanen, UNIFOR

One person remarked upon the hidden violence and mental health issues that infuse her colleagues’ work:

“I was shocked by what some of the staff reps had to deal with. A lot of our reps have gone through the experience of working with a member who then died by suicide. And we never talk about it. There’s this kind of attitude of you know, suck it up, be tough. If you want to be a rep, you need to be tough.”

Cathy Remus, CUPE

As UNIFOR’s Sairanen comments above suggest, it is quite interesting to note that as women enter the workplace in greater numbers in particular kinds of positions, unions take greater interest in psychological health. It is partially because depression is twice as common in women, according to the WHO, and also reflects the fact that women tend to be more verbal about emotional issues.

One key informant explained:
“When we started to have that conversation in our department, I have to say it wasn’t an easy conversation. Many of the very seasoned health and safety reps (said) ‘oh that’s not my issue. That’s an equity rep, that’s the harassment rep or EAP rep, that’s not occupational health and safety.’ It’s been an educational process for us to start looking at (psychological health).”

Sari Sairanen, UNIFOR

I conclude that overall, the key informants saw this expanded role definition as a positive one that brings new challenges both to the employment relationship and union practices.

The psychosocial risks and mental health problems that union members face in the workplace

Every representative interviewed said that while there were individuals in the workplace living with mental health conditions that sometimes require attention, they believe the major problems facing their members’ mental health are structural in origin, due to the way in which work is organized by management. They point to research about the psychosocial hazards in the workplace that now exist as a result of globalization, mergers and the intensification of work. Psychosocial factors refer to all the organizational factors and interpersonal relationships in the workplace that may affect the health of workers. (Vezina, 2004; 2011).

As one key informant said:

“One of the things I find interesting about this topic is that you can apply a structural view to it. You can look at the systems in the workplace and you can look at how jobs can be adjusted and how workplaces can be adjusted so that people can participate in work. A lot of cases have nothing to do with the individual or whether they have a mental illness. For example, if you have a manager who bullies you every day… that can affect your mental health.”

Cathy Remus, CUPE
I find that this theme is extremely important as it defines the orientation of the health and safety representatives. They investigate the workplace for psychosocial risks as these affect individuals and then look to potential solutions. The approach of health and safety specialists, to achieve a collective -- as well as preventive -- outcome, speaks to the need for individuals to come together in a position of greater strength in order to act upon psychosocial hazards in the workplace. This is significant because the literature suggests individual solutions to psychosocial risks through grievances are the form for union action (Walters, 2011). Some of the health and safety activists I interviewed are proceeding differently.

The major psychosocial hazard, work organization, constituted a significant theme of discussion in the interviews. It gets at the heart of management rights in the employment relationship. According to the Mental Injury Tool Group (or MIT), a group of unions, academics and health and safety experts established in 2009, and to Bond & Bunce (2001), work organization includes not just how work is arranged but involves the influence one has over one’s work; the possibilities of development, to learn new things and take initiative, the meaning of one’s work, feeling that it is important and meaningful and commitment, feeling that the workplace makes a positive contribution. All of these are included under the rubric of work organization.

I asked key informants if they had been able to make any inroads into adapting work organization that was characterized by psychosocial hazards. The results were mixed. The main blockage unions experienced was management’s right to control production in the workplace. This fact is stated clearly in every collective agreement.

One response to the question, out of Quebec, was very to the point:

Oui, il y a des syndicats qui ont fait du travail à ce niveau-là, qui ont amélioré certaines situations. Mais c’est quand même difficile. Pourquoi? Parce que le droit de gérance appartient à l’employeur, l’employeur ne veut pas que le syndicat s’en mêle […] Pour lui le syndicat est là pour savoir si le temps supplémentaire est payé ou si la liste d’ancienneté est respectée, mais pas pour organiser le travail.

“Yes, some unions have done work in this area and have improved some things. But it’s still hard. Why? Because management rests with the employer and the employer doesn’t
want the union to meddle […]. According to them, the union is there to make sure overtime is paid and seniority is applied, but it can’t organize work.”

Micheline Boucher, CSN

From this I conclude that management simply does not believe it falls within the union’s purview to suggest changes in production or to try to adapt the organization of work.

OPSEU’s direct engagement campaign – a promising practice

And yet, some unions have made minor inroads in this contested terrain. OPSEU, for example, is on an interesting trajectory when it comes to combating psychosocial hazards and achieving better work organization. Their strategy provides a promising model for identifying and combating psychosocial hazards. When asked for a specific illustration, health and safety representative Terri Aversa explained that the health and safety staff has worked with academics and the Occupational Health Clinics for Ontario Workers (OHCOW) to develop expertise in this area. Using a survey about working conditions from Denmark called COPSOQ, OPSEU has worked with members to identify psychosocial hazards affecting them. In meetings with the employer, the union has presented the results and explored possible solutions to the problems. In some instances they have successfully changed the way the workplace is organized, bringing about a safer and happier outcome.

In a community nursing agency, for example, workers were being dispatched across the city from a central location to visit patients and had to deal with the extreme traffic involved. New management had increased each nurse’s number of patients and also reduced by 30 minutes the time with each one. Managers also forced people to work overtime, but did not always pay for it. Work demands, a lack of support from management and poor work organization all conspired to create a negative work environment. The workers approached the union and a campaign developed. They carried out the COPSOQ survey and also worked to get a majority of members to sign a group grievance about the situation. In addition, a group complaint was lodged under the employer’s harassment and discrimination policy. In the presentation to the employer, the statistician from OHCOW, joined the delegation and analyzed the work profile. A successful outcome resulted as the employer changed to a collaborative management style, worked out a
geographical method of dispatch that means nurses are no longer spending long periods in traffic and management agreed to reduce overtime, hiring more nurses instead.

This direct engagement example speaks well to the problem raised by Walters (2011) in the literature, in which unions have tended to treat psychosocial hazards as individual grievances -- because the impact of the problem is on the individual -- and not take them to a collective bargaining level. The OPSEU example is interesting because by using a variety of tools in a campaign, the union was able to spark the direct involvement of individual workers, then treat the issue as a collective one and use its research, data and bargaining power to find a positive outcome. In so doing, the union utilized a promising model that challenges the unequal power relations that existed between themselves and the employer and then moved to a negotiated solution.

**Mergers, downsizing and mental health**

Most of the interviews were infused with information about the psychosocial hazards facing union members in changing workplaces. As Loisel & Côté (2013) and Corbière & Shen (2006) argue, in light of globalization, many workplaces experience downsizing, mergers and reorganizations. Mental health problems ensue as one result of the stress and anxiety created. In the interviews, this was as true of government as of business. The impact on workers was described as overwhelmingly negative and, in one instance, emotionally abusive.

“It’s just that in the past 20 years or so, the government, which employs all of us, has made major changes through reorganizations. But each time it happens, there are workers in the field who take the blow, who have more difficulty adapting. The hardest thing is
that those changes are recurrent. Every year or two brings its share of reorganizations, centralization, job cuts, shifting responsibilities, and people can’t say anything. It’s always […] It’s a top down approach that leaves workers with no breathing room.”

Daniel Giroux, CSQ

Not surprisingly, Caveen et al. (2006) found that during mergers and acquisitions workers felt they had little control over their jobs or careers and that this correlated with depression-related disability in the organizations they studied.

The existence of workplace “survivor syndrome”, as it is called in the public service and corporate sector, should ring a clarion call for help by employer and the union alike. It weakens the workforce in fundamental ways. The notion of “survivor guilt” comes from traumas and disasters, such as violent attacks or plane crashes, where the people who survived feel guilt and anxiety. “Survivors” in the workplace – those who escape a round of layoffs – often experience similar feelings of fear, insecurity and a sense of betrayal (Appelbaum, 1997). Recognizing that people not laid off experience psychological distress and a series of common symptoms suggests there a pathology accompanying major reorganizations and mergers. Eventually the survivors may feel resentment at the extra work they are expected to manage without the assistance of their departed peers. Some key informants in this study describe the way in which people become more fragile psychologically at work as a result of reorganizations. Ordinary hazards thus become more potent as workers become more susceptible to illnesses. The stakes for the union are large – a psychologically vulnerable workforce is not one that is easy to defend or in which solidarity flourishes between members.

“The individuals that are left behind after the major transformation or reorganization … it’s the lack of communication on what is really the (purpose). ‘How am I expected to deal with all the other workload issues and communication issues once everybody has left.’ And of course there’s the whole guilt issue as well. Why has she left and I haven’t. When’s my number up?”

Denis St. Jean, PSAC
Key informants also spoke of workers feeling dehumanized, treated like production units or machines. As Vezina et al. (2004) points out, drawing upon Karasek’s (1979) work, the absence of adequate support from supervisors, in particular, leads to negative consequences for workers. The representative of the postal workers expressed it this way:

“It really is just to get the mail out, (workers are) the vehicle to that. So often they talk about being dispensable, feeling dispensable, feeling like Canada Post would want them to quit. Talking about being machines --machines not humans. That comes out a lot.”

Jamie Kass, CUPW

Similarly, Bourbonnais et al. (2006a) write of rewards obtained in the work process, including esteem and respect, as a positive factor. The representative of UNIFOR expressed a related sentiment, namely that of workers want to be valued and to have their work valued.

“As human beings we want to be recognized. We want to be part of the solution. Yeah, we all realize there are problems out there but listen to me, let me be part of finding the pathway. If you’re just dismissed and ignored and not valued then that does create a problem, so then finding those solutions in the workplace becomes so much tougher….”

Sari Sairanen, UNIFOR

From this I conclude that these examples of scarce recognition and lack of esteem in the workplace are consistent with the literature and point to a challenge for workers in the current labour relations climate. This theme, the impact of mergers and reorganization on workers’ psychological outlook reveals the lack of power workers typically experience in employment relationships.

Workload and mental health – a second promising practice

Workload often constitutes a terrain of struggle between the union and the employer. Fighting excessive workloads is a longstanding preoccupation of unions that has bred a variety of approaches. In the examples that follow a second promising practice for identifying and combating this psychosocial hazard is revealed. Several representatives interviewed reported workload issues that are affecting the mental health of their members. One of the results of
reorganizations, lean production and the intensification of work in both the public and private sectors is that of increased workload. In public services, the depth of the interface with clients can suffer. Public service unions pointed out that there is less time for human contact in jobs that typically involved a great deal. In education in Quebec for example the situation is as follows:

On n’a pas beaucoup de temps pour l’humain. Moi je pense que c’est ça qui affecte beaucoup les travailleurs ou les travailleuses. C’est que tu es tellement poussé, tu n’as pas beaucoup de temps, tu n’as plus le temps… Un professeur qui voudrait aider un étudiant après les cours n’a plus le temps de le faire. Ils ont toujours l’impression d’être dans une usine à production, puis il faut produire. Mais l’humain, on l’oublie. On exige des résultats de leur part, mais on ne leur donne pas les outils.

“The human factor doesn’t seem to count for much anymore. I think that’s what has the biggest impact on workers. People are pushed so hard, they don’t have the time for students outside the classroom. They just can’t do it anymore. People feel like they work on an assembly line. They have to produce. No one remembers that they’re human. No one remembers that you can’t keep asking for results without giving people the tools to achieve them.”

Daniel Giroux, CSQ

CUPE representatives echoed this perspective:

“In a nursing home example…workers have really close emotional ties with residents that involve care, looking after people the way you would look after your own mother or grandmother. But because of cuts and short staffing, they can’t spend time doing hair, all of that. They can’t do that anymore. Or they have to leave an elderly woman in her bed, lying in her urine. Or leave a dirty food plate with her because they’re short staffed. And it breaks their heart. So they go home every night feeling sad and guilty, blaming themselves… (because) they can’t look after the patients and they care deeply.”

Cathy Remus, CUPE
In Western Canada, CUPE health and safety representative Troy Winters explained, the union has locals that have a joint workload committee under the terms of their collective agreements. It is their job to track the work, especially after reorganizations. A positive outcome might be:

“They can adjust the work or hire more people. They can try to rebalance the workload so that it’s not causing, mostly, physical injuries. That’s the genesis of it, is people get overworked and they started going off on leave because of things like back injuries. That was the initial genesis of the analogy it but it just happens to have very strong mental health links as well.”

Troy Winters, CUPE

I find that the union uses collective agreement language to argue for the work to be adjusted and for more people to be hired. Where the union is able to convince the employer to engage more workers, a clear gain is almost always made. This example, which illustrates a second promising practice in identifying and combating psychosocial hazards, also shows that a link can exist between physical and psychological injuries. More recently, the strategy was broadened to include mental health, reflecting the fact that the union was becoming more active on this issue.

Health and safety representative Micheline Boucher explained that the CSN has also recently made some inroads on workload both in collective agreements and using a tool that helps members measure their work. It has also developed training for members on how to raise and discuss the issue with the employer.

Il ne faut pas oublier d’intervenir à la source non plus […] Recemment pour intervenir à la source, on a identifié la surcharge de travail, la surcharge quantitative et qualitative de travail comme étant un des facteurs de risque important ou un risque psychosocial important et on a développé un kit (des outils) pour aider les gens à déterminer s’ils sont vraiment surchargés. Et si oui, comment on peut interpeler l’employeur pour ouvrir un espace de discussion sur la charge de travail. Puis là, nous, on accompagne […] Ici, on les accompagne les syndicats. D’ailleurs on a quelques syndicats qui ont commencé des démarches en ce sens.
“It’s important to get to the heart of the problem, […] which is a more recent approach. We have identified work overload, both quantitative and qualitative, as an important risk factor or psychosocial factor and we have developed a kit to help people determine if they are overworked. If so, we try to find ways to start discussing workload with the employer. Then, we facilitate the process […]. In this case, we are working with unions. A few of them have started using this approach.”

Micheline Boucher, CSN

This key informant also points to another approach by the union, one like union counseling aimed at members who are negatively affected by psychosocial hazards.

Une autre partie de notre travail, c’est de dire […] Oui, il faut intervenir sur les facteurs de risques qui sont la cause des problèmes de santé psychologique, mais il faut aussi supporter nos membres qui sont plus fragilisés en mettant en place des réseaux d’entraide. La FTQ au Québec – et peut être d’autres syndicats canadiens – nomment ces pairs aidant, des délégués sociaux. Donc, des gens qui vont en aider d’autres qui sont en difficulté […] C’est pas juste dans les cas d’alcoolisme et de toxicomanie, mais aussi pour des personnes qui sont déprimées ou sur le bord du burnout. On veut que tu saches qu’on est capable de t’écouter et de t’orienter vers une ressource professionnelle qui va t’aider. Voilà le message qu’on veut transmettre à ces personnes.

“Another part of our work is to say […] We have to tackle psychological health risk factors, of course, but we also have to help our more vulnerable members by creating support networks. The FTQ – and maybe other Canadian unions – has "social delegates" who help people with […] Not just people with substance problems, but also people who are depressed, on the verge of a burnout. We want you to know that we can listen to you and refer you to professionals who are there to help.”

Micheline Boucher, CSN

My interpretation of this is that it is one way unions deal with psychosocial risks that occur in the workplace. Working with individuals is a necessary, but not sufficient, way to deal with the psychological issues and mental health challenges that arise. The impact on individual workers
can be great. A high level of frustration and stress may contribute to psychological distress at work and beyond.

The Steelworkers also reported some success on workload issues.

“Depending on the individual (employer), in some agreements workload is grievable. So you can go in and make the argument as to why, especially an increase, it’s a huge increase (in workload) and we have managed to do things like create another position because we’ve shown that this person is constantly bogged down and they’re constantly being asked to work overtime.”

Gerry Leblanc, Steelworkers

I conclude that this strategy revolves around the unions that have successfully fought for more equitable and manageable workloads. As mentioned above, it constitutes a second promising model for identifying and combating this psychosocial hazard. In some cases there is language in the collective agreements, including joint workload committees that are responsible for tracking the problem and then recommending solutions. The union makes a case around a specific service or individual’s situation and is, on occasion, successful at getting workload redistributed or another person hired. The union makes use of workers’ own intimate knowledge of the situation, as per Hall (2006). This could be an effective strategy in public services where, as we saw earlier, workers are sometimes frustrated that cutbacks mean less quality time with clients. It is a strategy than can be broadened across economic sectors and unions, by developing collective agreement language that is responsive to workers’ needs. It is a significant area for improvement as one impact of the intensification of work has been, according to Bourbonnais et al. (2006a; 2006b), added psychological distress from rapidly increasing workloads. Where unions can be prepared for this, with health and safety committees and/or collective agreement language devoted to tracking workload practices, the chances of creating a better working environment exist. Clearly, the union must try through these efforts to overcome management’s firm grip on the control of work organization.
A further psychosocial hazard underlined by the key informants is confusion about work roles and poor communication between workers and with supervisors. These were linked to work organization and to bullying, harassment and violence in the workplace.

When asked what the greatest psychosocial hazard is in the workplace, the representative of the PSAC was adamant,

“By far, bullying. Workplace violence, psychological violence is rampant in the federal government, almost by design.”

Denis St. Jean, PSAC

Other key informants made a link between poor work organization and harassment and bullying in the workplace. I find that sometimes communication problems are elevated into inter-worker conflicts that supervisors should be resolving. When they don’t, and if there are problems around work roles, it can elevate into harassment issues. But the basis is poor work organization.

Puis ce que nous disons à l’analyse, c’est que souvent c’est une mauvaise organisation du travail qui va occasionner des problèmes, qui vont devenir des difficultés de communication et ensuite, qui vont peut-être se transformer en conflit. Mais, un conflit n’est pas du harcèlement et le gestionnaire doit aider à le résoudre avec les personnes concernées. Souvent, à l’origine, c’est que ton travail n’est pas bien défini et le travail de l’autre personne non plus. Toi tu penses que tu as fait ta job et l’autre personne aussi, et le ton monte et ça grimpe. Au départ, c’était pas du harcèlement, c’est un problème d’organisation du travail.

“Our analysis often reveals that it’s poor work organization that causes problems. These problems cause communication to break down and can lead to conflict. However, there is a difference between conflicts and harassment, and managers have to help resolve them with the parties.
These things often start when your job description is vague and so is the other person’s. You think you’re doing your job, the other person thinks the same and things start getting ugly. At the outset, it wasn’t a harassment issue. It was simply bad work organization.”

Micheline Boucher, CSN

A further iteration came from the OPSEU representative:

“If I’m not going to like my colleague, I’m not going to come in just knowing I’m not going to like my colleague. There’s always a work factor behind bullying and harassment. Either my colleague’s not well or they can’t lift and I have to do all their work.”

Terri Aversa, OPSEU

My view of this is that workers who experience harassment and/or bullying may be subject to psychological problems, such as insomnia, loss of concentration, depression and anxiety. These are hazards that warrant attention by employers and unions alike.

UNIFOR health and safety representative, Sari Sairanen indicated that workers in a flight kitchen have pushed back against unhealthy heat and air quality that were causing discomfort, headaches and feelings of anxiety:

“I’m always so amazed that it doesn’t matter how important or how small you believe your job is, people are proud of what they do. You can go to any obscure work location and people take great pride in the work that they do. We represent workers in a flight kitchen in Vancouver and they’re all of diverse 50 different languages that they speak in the workplace. There’s one particular department where you don’t need any kind of linguistic skills, they wash pots and pans all day long. And it’s a very hot, humid atmosphere, they had some really heat stress issues. And finally the employer put in an air conditioner, an upgraded HVAC system there...
They bake cake and they came in and they had this unveiling. Pots and pans, that’s all I do but they took such great pride in the work that they do and the atmosphere that they work in that they had a party to unveil this HVAC system.”

Sari Sairanen, UNIFOR

This example from UNIFOR suggests steps against psychosocial risks are possible where there is unity, research is provided to the employer and bargaining power is exerted.

Several of the representatives interviewed spoke of the role of EAPs in assisting their members. For individuals who are having problems coping with work or various personal issues these EAPs, as described in Chapter Four, can be helpful. Unions have different approaches to these programs. The postal workers, CUPW, for example, are very skeptical about the data that are collected in running the EAP; they do not trust that it is kept confidentially and not used against employees.

Other unions, such as the Steelworkers, encourage their members who are in need to access the program, which they call Employee and Family Assistance.

The CSN, in negotiating the EAP, concerns itself with the selection of firms that provide therapeutic assistance. They will add more services for people with psychological problems, such as increasing the number of therapist visits permitted under the plan. The Steelworkers also negotiate these types of improvements.

UNIFOR mentioned that there was an increase in use of EAP during economic downturns, when the auto industry experiences layoffs and closures. While this is perhaps not surprising, it suggests that the union needs to keep an eye on the EAP usage and ensure that services are adequate for the membership especially at such times.

The union representatives interviewed did not make a coherent critique of the EAP system, wherein individual concerns are paramount. These programs do not address work organization or collective issues. It would be positive to see the unions take a more critical approach to EAP, apart from the question of confidentiality. They need more of an “organization assistance program” in which issues of work process and work organization are considered carefully. This
tension between the individual and structural focus is mirrored in the psychiatric talk examined in Chapter Two and seen throughout this thesis. Unions need to get at the crux of this issue and to confront it squarely on questions such as EAP.

One related issue that is known through the aggregate data collected by insurance companies, is the use by the workforce of prescription antidepressant and other psychotropic drugs. Most of the unions interviewed indicated that usage was up in their workplaces. Some questioned the reason for that increase:

“These psychiatric drugs are number 1, number 2 on the list. So that raises questions about what’s happening in the workplace. What are some of these trend issues? It can’t just be that people are not resilient; people are very resilient out there. What hazards have been created in the workplace … that now you have to have medication for people to get through their day to day existence?”

Sari Sairanen, UNIFOR

From this I conclude that structural problems are causing mental health issues and individuals require assistance to get through difficult times of all descriptions. The unions can be there as a means to referral to help, whether it is to the EAP or to community services. They need to balance offering support to individuals with the overall job of defending the overall situation facing the workforce. This theme portrays the balancing act the union must play to successfully represent its members.

The loss of autonomy by the worker as a result of changes in the production process was another significant psychosocial hazard pointed out by the key informants. For the postal service, where a major transformation has just taken place in the organization of work, the results were severe.

“The outside workers have a lot more independence (than the inside workers). They’d go in and sort their mail and then they’d be out, they identify more with their customers than they would with the employer. Now with postal transformation, it’s shifting again because the whole job has shifted for letter carriers. They no longer have any autonomy over the way they deliver the mail, they don’t have route time to sort, their shifts are
longer, like their walks are much longer, they don’t know when they’ll get home at night….”

Jamie Kass, CUPW

My interpretation is that loss of autonomy affects how the workers are able to do their jobs and the satisfaction they take in completing their tasks. The literature refers to decision latitude and how when it is minimized there are negative consequences for the worker (Vezina et al., 2004).

Representatives of the Centrale des Syndicats du Quebec (CSQ), a confederation of unions, explained that time – motion studies were being applied to workers they represent in education and health, limiting the degree of autonomy exercised in carrying out their jobs.

Il y a un manque croissant d’autonomie dans le travail. Le travail est de plus en plus minuté, de plus en plus compartimenté. Même dans l’éducation où, en principe, les enseignants sont censés être seuls maîtres à bord dans leur classe, c’est de moins en moins vrai. Ils doivent rendre de plus en plus de comptes, atteindre des objectifs quantitatifs, par exemple en termes de réussite scolaire. Donc, ça met énormément de pression. Le travail, même dans l’éducation, est de plus en plus minuté. C’est la même chose dans le secteur de la santé. On dit pour tel acte, ça doit prendre tant de minutes […]

“Workers have less and less autonomy. Work is increasingly timed and compartmentalized. It’s even true in the field of education where, in theory, teachers are supposed to be in command of their classroom. They have to account for more and more things, to reach more quantitative goals, like academic achievement. So there’s enormous pressure. Work, even in education, is increasingly timed. It’s the same thing in the health sector, where time limits are set for each medical act.”

Pierre Lefebvre, CSQ

I find that this pattern in different workplaces wherein workers lack autonomy is worth noting in that it may generate a level of discontent and frustration that can lead to mental health challenges. The imbalance of power between workers and the employer is evident. All of these hazards have negative impacts for workers but are not easily remedied.
It was evident from the interviews that unions’ treatment of mental health plays out under the umbrella of labour relations in general. In a bad climate, mistrust of the employer is high. Progress on mental health, though significant as an issue, is minimal. One participant was particularly blunt, “We were very skeptical of working on mental health issues with the employer. We feel the employer is what makes people sick at Canada Post.”

Jamie Kass, CUPW

This belief was echoed by another union representative. He commented that the federal government employer had made its position clear during a discussion about how to mitigate safety hazards. The employer representative said, “We appreciate everything that you do … but the word is we’re not in a collaboration mode right now, we’re in a confrontation mode.”

Denis St. Jean, PSAC

My view of this is that although this posture has not shut down all discussions about mental health, certain doors remain closed. This kind of labour relations climate does not bode well for progress to be made on an issue like mental health, as it needs good will and leadership on both sides to successfully support creative and practical programs.

A few of the key informants reported on psychosocial hazards that contribute to members’ stress that is experienced both inside and outside the workplace. Jobs are being made more precarious as a result of reorganizations and management decisions. The education sector in Quebec is a case in point. According to Pierre Lefebvre of the CSQ, almost 60 per cent of the workers in education in all categories now have a precarious status and workers are affected negatively. According to Vosko et al. (2009) and Lewchuk et al. (2013; 2015), precarious work is on the rise, often leaving workers without benefits and particularly vulnerable to negative management practices. This includes psychosocial risks in the workplace. Most precarious workers, however, are not currently represented by unions and although their problems are serious, they remain out of reach of typical union organizing practices. My research only scratches the surface of this issue and more investigation and experience is needed as to how best to organize precarious workers and build resistance to difficult working conditions.
Summary

This chapter has outlined the key informants’ responses to a number of questions about identifying psychosocial hazards in the workplace. Their key point is that many of the problems facing union members stem from the way in which work is organized by management. In their undertakings, the union health and safety specialists try to make an impact on work organization as a means to improving their members’ psychological health. They indicated two promising practices that can serve as models for identifying and combating psychosocial hazards. First, we saw evidence of OPSEU’s effective campaign to improve working conditions at a community nursing agency and second was key informants’ testimony that their unions are battling excessive workloads with collective agreement language, workload committees and written measurement tools, and are achieving varying degrees of success.

In this chapter I also showed that from the health and safety specialists’ perspective, mergers and workload affect workers’ mental health. In addition, poor work organization and poor communication can cause conflict between workers, especially when their work roles are not well defined. The key informants also spoke about the loss of autonomy many workers are experiencing and their feelings of mistrust of the employer. The unequal power relations that exist between unions and employers and that are evident in these pages are revealed. Unions’ attempts to create space for change that better protects workers’ psychological health occur in the context of this unequal relationship and are documented further in the next chapter.
Chapter Six
Promising Practices for Combating Psychosocial Hazards

The purpose of this chapter is to interpret and comment upon the previous chapter in light of the research questions and literature. The first major section deals with psychosocial risks and mental health problems that unions face in the workplace. It looks at union actions to combat these psychosocial hazards and includes an exploration of education and worker representation. The final major section deals with return to work. It is important to recall that the comments of union key informants reflect the interests of a non-dominant group. That is, they work in a context in which the employer wields far more power than they do over how work is organized and how union members are treated. At the same time, the health and safety specialists create a language and an analysis that runs counter to the employer and serves to erode, ever so slightly, the power the employer exercises. In this chapter I examine how that relation of power plays out in terms of psychosocial risks. We learned in the previous chapter that unions are taking complaints, carrying out education on psychosocial hazards as well as providing some support to workers who are returning to the workplace. We also became aware that unions are using preventive approaches on a collective basis (involving groups of workers) to fight psychosocial hazards in the workplace. These attempts always occur in the context of the power imbalance that characterizes the relationship between union and employer. In the following pages I will explore the theoretical and practical implications – as well as challenges -- of these approaches in unionized workplaces.

The psychosocial risks and mental health problems that union members face in the workplace

I learned that key informants uniformly try to make an impact on work organization and management decisions as a means to improving their members’ psychological health. They adopt this position and are testing different methods of resisting psychosocial hazards based on a strong union health and safety prevention tradition. Combating risks is complicated because the hazards themselves exist in processes and decision-making that may well be invisible to the workers and union initially. They not only investigate individual problems and solutions, but are taking a lead
in collective approaches to get at structural or systemic issues that negatively affect members’ mental health. As mentioned in the previous section of this chapter, this type of collective activity goes a step beyond that which Walters (2011) indicates in terms of unions’ tendency to file individual grievances, rather than collective bargaining demands, about psychosocial hazards experienced by members.

Evaluating the unions’ actions and programs has to be done in the context of the challenges they experience from employers and governments, as well as the economic situation. Mergers and reorganizations, lean production and the intensification of work all contribute to work conditions that are rife with stresses (Corbière & Shen, 2006; Loisel & Côté, 2013). It is in this difficult economic context that some unions try to create a space for change in work organization that will benefit worker’s psychological health. Furthermore,

“Psychosocial risks are not easy to link directly to traditional understandings of what constitutes a risk to ‘health and safety’. Indeed they are often the consequences of managerial decisions relating to staffing, to restructuring, to changed production schedules…that occur at locations quite remote from the situation in which the psychosocial risk is experienced and the resulting harm suffered….’” (Walters, 2011 p. 600.)

Walters asserts that health and safety representatives most frequently operate in a sphere that is far removed from the decision-making he describes above. This has implications for how effective health and safety representation can be on issues such as psychosocial risks. It is preventive representation, taking aim at the physical and psychosocial risks that exist. In this study, it is the psychosocial hazards, such as workload, loss of autonomy and poor managerial communication, that are embedded in work organization that have become the unions’ target.

There is a gap in the literature in terms of documenting union involvement in combating psychosocial hazards. My research shows there are in fact promising practices among several trade unions, especially where they provide the tools to members so they may engage in resistance at the local level. Unions are representing members in complaints and by providing education and some support in return to work. My research also shows that unions are trying different preventive collective approaches to resist psychosocial hazards. This activity is
relatively new (since about the year 2000 in Quebec, and more recently in the rest of Canada) and management’s control of production remains a major roadblock to union progress. Later in the chapter I will look at some examples in which this control is slightly mitigated by the unions’ research, the data they present and the sheer weight of bargaining power exerted. First, however, I comment upon how unions are using their education programs on mental health issues and present some ideas for improvement.

**Actions Taken by Unions to Combat Psychosocial Hazards - Education**

Since the 1980’s, unions in Canada and elsewhere (Hunt & Rayside, 2007) have developed extensive education programs on issues related to women’s issues, race, LGBTQ, indigenous peoples and people with disabilities. Questions of marginality and resistance, as well as power differentials and inclusion are all included in these equity-related courses and conferences. Some unions have also in the recent past embarked upon education programs on mental health, including stigma and discrimination, following a tried and true path to reach their members. Some organizations are better at education than combating psychosocial hazards, while some do both well. Courses and conferences are the main vehicles meant to ignite change. The rich history of labour education on equity and human rights issues provides a framework from which to view efforts on mental health issues. Stigma and discrimination are about being marginalized; inclusion means working through differences to reach common understanding of workers’ positions. This is consistent with union programs that already occur and have legitimacy.

Delivering information to members about psychosocial hazards and health and safety representation is the starting point for developing an effective campaign strategy. It might also be useful to provide more education along the lines that is used in the training of union counselors as stewards so they will need to learn to treat members facing mental health challenges with more empathy. Unions generally create their own courses, occasionally linking with community partners for expertise on non-union content. The purpose is to sensitize and prepare members for the challenges mental health issues bring into the workplace. The movement is extended and renewed by developing “knowledge activists”. The aim of a knowledge activist is to broaden the health and safety representative’s role to include gathering their own information (separate from the employer’s), assert workers’ knowledge of hazardous conditions, mobilize their co-workers to support demands for improvements, and propose alternative solutions (Hall et al., 2006, p.
My research does not extend the definition of knowledge activism but corroborates the existence of and need for its presence in union settings.

This activism is significant because education is the conduit by which members may realize their working conditions could be different. In the absence of an enlightened employer, it is only when they recognize their own power to change conditions, to confront psychosocial and other hazards that it becomes possible for improvements to be made. As such, we have learned that the union education programs on mental health are an important first step in identifying workplace problems and providing hope that solutions may be arrived at collectively.

From my research and related reflection on the topic I have identified three skill sets that would help the union deal effectively with psychosocial hazards.

1. To educate stewards along the lines of union counselors, where the person is sensitized to the issues related to mental health and can intervene with empathy to help guide individuals toward appropriate help and build support around that individual when they return to work.

2. Develop health and safety activists and stewards who can learn to size up a situation to see if there are psychosocial risks and then build a campaign around them in the workplace, with the help of health and safety resource groups, academics or other community resources.

3. To develop bargaining demands based on those psychosocial risks and potential solutions and then take them to the negotiating table with the employer. This can be at different levels -- be it health and safety committees or transmitted through to central negotiating tables.

With the development of these skill sets, the union would be better positioned to both assist individual members experiencing mental health problems or returning to work and also to confront the psychosocial hazards that are experienced in the workplace. I submit that this would constitute a small step toward chipping away at the imbalance of power that characterizes the relationship between unions and employers. By using some of these skills, unions have organized several approaches to dealing with psychosocial hazards.
Educational activities

The research question, to better understand how unions are dealing with psychosocial hazards and issues related to mental health in the workplace, is explored in this section. Each of the representatives interviewed was asked to explain what they are doing to address psychosocial hazards in the workplace. Each union works to develop strategies and tools for its members to use toward combating psychosocial hazards. They do so to varying degrees and with varying success. Resisting psychosocial hazards is not easy -- it takes research, knowledge, persistence and bargaining power that are not easily organized. Often a workplace campaign is required. Resistance from employers can be strong and pervasive. The effort to create a space for change in work organization, for example, is most frequently met by unrelenting opposition.

My study shows that member education is the central component of these other activities. Each of the unions and labour centrales interviewed had programs on mental health that were meant to educate members to take action on the issues described earlier in this chapter. It was obvious that each union/centrale had developed, or was in the midst of developing, a strategy on mental health. In this section, we will explore some of the initiatives undertaken in order to continue to take stock of union progress on mental health issues in the workplace.

The PSAC has one of the most comprehensive education programs on mental health in the workplace. When it comes to combating psychosocial hazards, health and safety representative Denis St. Jean suggests that although there are some successes, the jury is still out.

“What we’re training our members to do is to bring forward those psychosocial hazards as risks that have to be tackled in the workplace. It gives the opportunity to do an inventory of control measures that are already in place, see how efficient they are and maybe make recommendations for better control measures to try to mitigate the risks a lot better….Is it successful? Hit and miss. It really depends. People like to see the magic wand with health and safety….Well, most psychosocial hazards don’t allow for a quick fix. It really is a commitment and almost a cultural change in the organization.”

Denis St. Jean, PSAC
I learned that in January 2015, the PSAC tabled at negotiations with Treasury Board of the Federal Government the CSA Standard on Psychological Health in the Workplace for adoption in the collective agreements of its members. If accepted, it would be the first time federal contracts would extend to explicitly protect the psychological health of employees. The union’s proposal goes further to urge the Government to work with the union to identify toxic factors in the workplace that are causing the public service’s high levels of depression and anxiety (May, 2015).

Furthermore, in late March 2015, an agreement was signed between the PSAC and Treasury Board, creating a joint Task Force on Mental Health and Safety in the Public Service. One aspect of the Task Force’s mandate will be to review the CSA Standard and identify how its objectives can be achieved in the public service. (Treasury Board Canada Secretariat, 2015). This potential gain is a promising practice in that the union used collective bargaining to get issues of psychological safety into legal conversation with the employer.

In addition, the key informant explained, the health and safety department at PSAC holds a national conference every three years, followed by seven regional conferences. The last one was entirely about mental health. In the previous six years, mental health was an aspect of each of the conferences organized. Close to 1000 members participated over the three-year period. At present the department is developing a major national campaign on bullying and workplace violence to respond to problems identified by members. The union website is also chock full of resources on mental health.

Further, in a joint effort with the employer, PSAC has developed a course about mental health that is being rolled out to members and managers in the federal public service. It is a train-the-trainer model and as a prerequisite they are teaching facilitators “Mental Health First Aid”, a program endorsed by the Mental Health Commission of Canada that teaches basic facts and protocols around mental health issues. This course is also being included in outreach to regional staff who deal with members facing mental health challenges, including accommodations.

In the CSQ, psychological health is a very active file and the Centrale, a federation of unions which is how the labour movement is organized in Quebec, provides key leadership training to health and safety activists of member unions. Health and safety representatives Pierre Lefebvre
and Daniel Giroux spoke in depth about their training programs. Mental health is one of the most important issues they deal with in health and safety. These problems are frequently brought to the fore in education and health, the Centrale’s two main sectors. In 2008, they organized a large three-day meeting on the topic of work organization and focused in on psychological health in the workplace. They tackled the question as to how as unions they could intervene in the organization of work with the purpose of prevention of hazards and harms to workers. That seed work continues to this day.

“When we do this kind of work with union members, the first thing we say is that there is no magic formula, that we can’t give them a universal recipe. We can give them tools, suggest ingredients, but the solution rests at the local level. We can’t tell them: "Do this to solve the problem." The solutions have to come from the members and be based on their experience and precise knowledge of how their workplace is organized.”

Pierre Lefebvre, CSQ

To this end, the key informant continued, the CSQ has developed a network of health and safety activists that meet twice a year for two days at a time. Sixty per cent of the topics discussed are related to psychological health and safety. By educating health and safety leadership in the locals and unions, the program is strengthened. The structure of the Centrale and its member federations and unions, partially determines the strategic approach they have adopted in which local negotiations about health and safety, including workload, are handled.
In addition to the major symposium in 2008, I was told, the CSQ also offers one-day sessions to stewards and members on mental health in the workplace and stress. In these instances, as in other unions, the point is to give activists tools they can use to combat hazards they encounter in the workplace. Twice a year, the network of health and safety reps from all the unions in the central comes together for a two day educational meeting. According to the interview with CSQ health and safety specialists, about 100 people meet and although topics vary, psychological health and safety – especially as it related to work organization -- accounts for 60 per cent of the material covered. The Centrale also participates in academic action research studies along these lines, in conjunction with experts in psychodynamics of work. Members are then trained in the results and how to achieve new pathways for better psychological health and safety.

In 2010, according to the key informant, CUPW negotiated an appendix to the collective agreement that was a joint program to maintain or improve the health and well-being of Canada Post employees. Participation by employees was voluntary. It was called a risk prevention and healthy lifestyle program.

A high level joint committee was established under the collective agreement to review and assess existing data to determine employees’ needs, while protecting their confidentiality. The committee wanted to reach as many employees as possible, to help maintain the health of low risk employees with appropriate prevention and education as well as devise suitable individualized planning for high risk employees. The program included a detailed survey meant to assess members’ knowledge of the topic of mental health. The project was dropped after a series of staff changes that took place at Canada Post, along with a climate of poor labour relations. As the union and company entered a new period of negotiations, this mental health project fell from the joint agenda.

OPSEU was instrumental, I was told by the key informant, along with academics and other unions, in creating the Mental Injury Toolkit that is now being used by the labour movement in Ontario and beyond. It provides a series of measures and tools for carrying out the kind of campaign with community nurses described in the previous chapter. The health and safety staff has adopted the term “knowledge activists”, a term coined by Hall et al., (2006), for those that develop strategy and tactics based on research and knowledge about hazards. These are the
worker representatives who address health and safety concerns in order to impact upon work organization and chip away at other hazards.

As of 2015, the union is also developing a weekend workshop on workplace stress that will be made available to members across Ontario. Staff in the health and safety unit also contributes bargaining issues for the negotiating teams to consider for contract language. Included are notions that the health and safety committees should have a mandatory agenda item on psychological health and safety and, that employers adopt the CSA Standard on Psychological Health and Safety in the Workplace.

CUPE staff told me it has an active program on mental health, involving initiatives by various national departments, including union development, health and safety and the legal branch. At present, the staff responsible is beginning to try and coordinate their efforts across departments, to allow for more cross-fertilization and a coherent strategy.

In 2012 the CUPE health and safety branch held a national conference with a focus on mental injuries and their prevention.

“That is where we developed the concept of ‘mental robustness’…. This analogy of the physical injury that you’ve been dealing with forever applies to your mental health as well. If you were having mental health problems caused by work, the (health and safety) committee is in fact the place to go. It was a revolutionary thing for a lot of members….”

Troy Winters, CUPE

Key informants told me that the union development department of CUPE has run many workshops across the country, though they have been mostly one-off events. They are now developing modules to be taught as part of steward training that deal with how to engage with members with mental health issues and support them. Another is on psychological health and safety, looking at the hazards that exist in workplaces and how to combat them. The education program reaches tens of thousands of members each year and so the potential is considerable.

Beginning in 2002, according to the key informant, delegates to CSN conferences passed motions regarding the psychological health of members. This labour central is the only
organization interviewed with a dedicated staff position on psychological hazards as part of its health and safety department. The department also teaches a regular session to members called Psychological Health and Work Organization, to give them the tools to identify and combat psychosocial hazards in the workplace. In individual cases that arise, staff will assist members to make a case to the employer. The health and safety department has also developed a series of online tools for members to learn about all aspects of health and safety, including mental health.

In 2008, the key informant told me, the CAW passed a resolution on mental health in the workplace calling for action on mental health, as it concerns members and their families. UNIFOR now provides an in depth 40-hour course to its membership on stress as a workplace hazard. It is paid for by the employer and is offered two to three times a year. According to the health and safety specialist interviewed, approximately 1,500 people have gone through it so far. In addition, workshops on mental health are offered to different levels of membership.

UNIFOR and Chrysler: A third promising practice

In a significant breakthrough in the Big Three negotiations with major automakers in 2012, Chrysler included in the collective agreement language for the parties to look jointly at trends in psychological health and safety. It creates the space for the first time for work to be done on this issue with the employer. This breakthrough indicates a third promising model that unions may adopt and adapt to identify and combat psychosocial hazards. In a related vein, UNIFOR was involved in framing of the CSA Standard and is quite actively pursuing it with the many employers it represents.

In other economic sectors such as rail, health and safety conferences on the issue of mental health have been held.

The union also has a preventive campaign on cancer. During our interview the health and safety specialist mentioned they’ve added an “exposure logbook” to it. She extrapolated:

“I think the next sort of evolution from physical hazards or chemicals that you’re exposed to is looking at training people on the psychological hazards and marrying that, sort of looking at yourself as that entire individual and not just ‘okay, I’ve got those
chemicals’. But also looking at some of the psychological hazards so it becomes part of the conversation in the workplaces and people start identifying it.”

Sari Sairanen, UNIFOR

The Steelworkers Union is also actively pursuing a relatively new agenda on psychological health and safety. A resolution was debated and carried on Workplace Mental Health in 2013.

In 2014 it held a health and safety conference that centred on mental health in the workplace, bringing in speakers with lived experience to recount their stories as a means to combat stigma and discrimination, along with other experts in the mental health community.

The Steelworkers is also one of the unions to actively support the CSA Standard.

“I am quite happy with it and would like to see it written into legislation. But at the very least, right now we’ve asked locals to try to bargain language and ask employers to look at the Standard and try to look at them as a way of building the program it suggests. (They need to) graduate the program into a healthy and safe, psychologically safe workplace.”

Gerry Leblanc, Steelworkers

The union is also planning to develop a course on mental health in the workplace that would be taught to stewards and members.

In describing workplace problems, the key informants report that work organization is at the crux of the issue. One concern that arose in three separate interviews is the way in which work is organized and job roles are blurred. A result of poorly defined roles is conflict between workers, sometimes escalating into bullying or harassment but at minimum, manifesting as bad feeling that eats away at solidarity. Each of the key informants pointed to bullying and harassment as significant issues in the workplaces they represent. Most indicated work organization and poor management as the underlying causes. I was initially surprised by their analysis that blamed work organization for psychological harassment, but as Vezina & Dussault point out,
“…Real prevention of psychological harassment is achieved by analyzing and eliminating organizational factors and cultural aspects that constitute a fertile breeding ground for the emergence of violent behaviours between members of the same work organization. These factors are mainly intensification of work, weakness of the hierarchical authority, precariousness of the ties to employment, as well as the banalization or negation of the phenomenon, tolerance of incivility, and inequity or injustice in the workplace.” (2005, p. 42)

From this I conclude that this is a significant finding for unions on the ground, that is, in how they develop their strategies to struggle with harassment and bullying. Getting at the underlying reasons for bullying and harassment by pinpointing work organization issues that require attention could save a lot of effort that now goes into what is characterized as “he said/she said” personal dynamics. Measures such as harassment investigations and devising remedial steps for individuals concerned would still be necessary. But where it is possible to point to underlying root causes or problems, it could help minimize the way in which union solidarity is undermined.

The CSA Standard on Psychological Health in the Workplace

In conversation with the key informants about psychosocial hazards, the topic of the CSA Standard on Psychological Health and Safety in the Workplace came up several times. There tends to be a great deal of interest in seeing it adopted by employers and applied to workplace conditions and relations. Some unions are also adopting it as employers themselves. One key informant commented that it was less a matter of whether the employer has formally adopted the Standard, than ensuring they apply the principles and objectives in their workplaces.

The Standard has promise, but has yet to be proven as an effective strategy for unions. If the question of adoption is viewed as a first step only, and then, the principles and practices are applied with some depth, it will constitute a significant tool for building psychological health and safety in the workplace. Some key informants indicated that it would be best as legislation and thereby mandatory. They also plan to try and get its language incorporated into collective agreements. It is early days yet and the next few years will demonstrate how effective the Standard can become.
As mentioned above, UNIFOR convinced the automaker Chrysler to allow collective agreement language that provides for joint work on health and safety trends related to psychological health. This collective bargaining strategy is the third promising model I’ve uncovered in this study in that it creates the space for work on psychosocial hazards and other issues related to mental health in the workplace. By putting psychological health on the collective bargaining agenda not based on individual problems only but by looking at the global impact of hazards, UNIFOR moved the bar higher. Trying to get the CSA Standard adopted into collective agreements is a related strategy. UNIFOR’s strategy is very significant in that it relies upon the existing bargaining power of the union and then builds in a mental health component. The approach creates the space for joint union/employer study of psychosocial hazards, and a vehicle for change to be effected and monitored directly through the collective agreement.

Summary – three promising practices

These are the activities and actions brought into evidence through the interviews conducted for this study. As evidenced by the comments of the key informants, they suggest that work organization is at the root of the psychosocial hazards experienced in the workplace and they are organizing and training members and representatives to undertake specific strategies to combat them. Each union has adapted its own methods. We have seen that there are varying degrees of success in these efforts. Unions are developing strategies to impact upon work organization and management decisions that cause negative psychological health outcomes for their members.

Three different models have been presented: the direct engagement model as per OPSEU, involving a campaign for better working conditions and specific goals. Second, practices in which joint workload committees attempt to ameliorate situations where work intensification is too great by using written measurement tools and collective agreement language, such as we saw in CUPE, Steelworkers, the CSN and CSQ. Third, a collective bargaining model linked to the objectives contained in the CSA Standard such as accomplished by UNIFOR at Chrysler as well as the PSAC and Treasury Board. Each of these promising practices (two outlined in Chapter Five and one in Chapter Six) suggest that some unions are working to create space for resistance to psychosocial hazards. It must be remembered, however, that these are relatively early days. Different organizations are trying different strategies, reflecting the variety of employers, sectors and workers in the labour market. Each union is undertaking the strategy that seems to best fit
their employer, the membership and conditions in the workplace. I believe this experimentation will contribute to a union health and safety practice in terms of psychosocial hazards that is broad and more effective.

Education of worker representatives is one component of the strategies unions have undertaken. Most of those interviewed have robust education outreach to their members. Progress can be made by training knowledge activists and also pushing for language to be adopted at negotiating tables. A further skill, the empathic outlook of the union counselor is also needed in developing a mental health alert steward body. Both of these measures are underway in some instances and can certainly be expanded.

The literature on this topic is sparse -- unions have not been studied in depth in terms of their work on psychosocial hazards. As stated previously, Walters (2011) found that union tended to focus on individual grievances rather than collective efforts of this sort. My research suggests that the situation in Canada has evolved somewhat and unions are indeed taking on the fight against psychosocial hazards using collective strategies. More in depth case studies are required to flesh out the texture of those health and safety prevention models and the changes in relations between unions and employers.

The comments of the key informants represent efforts to work in a situation in which the bulk of control, or power, is in the hands of the employer. But it is interesting to note that the discourse produced by the health and safety specialists is one that questions power, going against the grain and looking for concrete results. Their work is based on research into psychosocial hazards primarily in Quebec and in Europe, and this thinking is reflected in the examples they brought forward from their practice in the interviews. As I have argued, minor successes are taking place, but much work remains.

The key informants told me that work organization and management decisions are causing psychosocial hazards to increase in the workplaces they represent. The unions/centrales equip their members with tools to combat psychosocial hazards and they also provide education on the issue of mental health in the workplace. These are the two major prongs of unions’ strategy on the issue of mental health in the workplace. We have seen several examples of effective organizing and negotiating – at both a local and more centralized level – for improvements. All
of the key informants recognize that there is more to be done, that psychological health is a relatively new area for union involvement. Health and safety specialists and others are experimenting with different methods; this is captured in my research and suggests a role for unions that goes beyond what the literature posits to date (Walters, 2011).

Return to Work (RTW)

In this section I present the findings of my interviews and discuss the state of return to work as presented by the key informants, in light of the research question and literature on this subject. In the following, I am exploring whether unions are putting practices into place to support accommodations and workers returning to work from absences due to mental ill health. The Canadian Human Rights Commission suggests that successful return to work involves the careful balancing of an employer’s right to manage with a worker’s fundamental right to equality, dignity and respect. Several authors in the literature, MacEachen et al. (2006) and Jodoin & Harder (2004) point out, among others, that return to work functions best where there is a climate of good labour relations. A climate of good labour relations was not always present for the unions interviewed.

Some key informants began the conversation about return to work by citing the levels of absence due to mental ill-health. In Quebec in the health and education sectors respectively, 40 and 50 per cent of absences were due to psychological reasons. (Pierre Lefebvre, CSQ) The Centrale in Quebec reports that these high rates of absence are the reason that mental health is such a priority issue for them as a health and safety department. As noted before, the literature states that every day 500,000 Canadians are absent from work due to psychiatric problems. Dewa et al. (2004) cited 30 per cent of disability claims for mental health conditions. In 2013, the Canadian Mental Health Association, BC Division estimated that 50 per cent of sick days in Canada are due to mental health reasons.

Some key informants indicated the propensity for some employers to blame workers who become ill, for whatever reason, as a means to avoid responsibility for what may be occurring in the workplace.

“I think there is a tendency from employers…to somehow blame workers for being ill or being hurt. And also, very much trying to look at pre-existing or outside influences. I
think for mental health, that’s a really easy one for them to focus on and say ‘it must be something else, you must have had this problem before or you’re having troubles in your personal life….’”

Gerry Leblanc, Steelworkers

I can only conclude that this kind of practice does not speak well to the ongoing labour relations climate.

It was also pointed out by the key informant that in workplaces where workers might become injured for any reason, mental health issues arise. The WSIB (Workplace Safety Insurance Board, or equivalent) process moves slowly and can take several months. Claims are frequently denied and have to be appealed and, by that time, the person is likely to develop a mental health issue.

“Things change when you’re injured and can’t go to work. The whole social network breaks down. Again, it’s a huge cultural thing. You see European men, particularly, come in, in tears saying ‘I can’t support my family, this is wrong. I’m not a man anymore.’ They were having serious psychological problems and not so much from the pain of the injury but from what it leads to.”

Gerry Leblanc, Steelworkers

In the literature, several authors make the point that successful return to work is a multi-factorial process, in which each of the stakeholders has a role to play, Noordik et al., (2011), St-Arnaud et al. (2007), and Briand et al., (2007). According to Franche et al. (2005) and MacEachen et al., (2006) where co-workers must take up the slack, there can be resentment against the returning worker. Key informants also made this point:

“There’s a lot of conflict over accommodations and it’s often not handled well…. Everybody has a duty to support accommodations because it might be you next time. If it was you would you want people gossiping about you and filing a grievance because you are accommodated?
It can get quite nasty, especially when everyone is struggling with workload. It’s a long term project.”

Cathy Remus, CUPE

My view is that the individual returning can be quite challenged by the kind of reception they receive from colleagues.

As Cox (2014) puts it in her study,

“According to the union representatives, laissez-faire management of injured workers temporarily assigned to light work or returning to work with functional limitations created fertile ground for psychological harassment. Injured or recovering workers were not always welcomed by teams of already overburdened workers. If the employer didn’t prepare the injured or handicapped worker’s arrival, staff members sometimes reacted by rejecting their new colleague and even harassing her or him” (p. 11)

I find that it is obvious that returning to a workplace where staff is overburdened and work has been intensified can be very challenging.

The representative from the Steelworkers pointed out:

“(Mental health) is probably the toughest. I’ve done a lot of work around accommodation, return to work and there’s definitely a huge difference. I think of someone who breaks their ankle, they go off and eventually they come back in on their crutches for some modified duties and everybody says, ‘what a trooper’ and everything. Even if it’s not known but people pretty well say, ‘oh it was a nervous breakdown’. (The person) comes back and people avoid them, they really do. I think it’s just that level of comfort is not there, still not there.”

Gerry Leblanc, Steelworkers

The key informant from the CSQ raised a further issue concerning the timing of an individual’s return to work.
If the duties of the position or work process are not altered in any way, there can be problems. If a long time has passed since the worker was present, things may have changed in the workplace such as roles and responsibilities or computer programs utilized.

He spoke to a problem that exists due to psychiatric assessments done at the behest of the employer whereby workers are being sent back into the workplace before they are ready. A second period of illness is not unusual.

On va demander une expertise en psychiatrie pour déterminer si elle est vraiment malade psychologiquement. Et souvent, les experts que l’employeur paie viennent dire qu’elle n’est pas malade psychologiquement puisqu’elle est apte au travail […]. Et il y a des personnes qui reviennent au travail trop rapidement et là ça brime les autres travailleurs. Parce que les autres travailleurs ne veulent pas ou ne peuvent pas faire le travail de la personne qui a de la difficulté […], étant eux-mêmes surcharges de travail ou parce que ce reaménagement du travail devient trop lourd physiquement … la personne se retrouve isolée, c’est difficile pour ces personnes-là parce qu’elles ont l’impression d’être toutes seules au monde, mais il reste le syndicat pour les représenter. Mais il y a un contexte où il y a une grande pression sur le plan médical et juridique pour qu’elle retourne trop vite au travail et ces gens-là ont tendance à rechuter […]

“The employer orders a psychiatric evaluation to determine if the employee is truly sick. Often, the experts paid by the employer decide that the employee’s not sick and is fit for work […]. So, some people come back to work too early and that disturbs the other employees because they don’t want to have to do his or her work or cannot do it […]. With time, these people become isolated. They feel completely alone and that’s hard, but they still have the union to represent them. The medical and legal pressure is such that people go back to work too soon and tend to relapse.

Daniel Giroux, CSQ

I conclude that questionable management practices are likely evident in such an approach if workers’ jobs are not modified or they are forced back too soon. Briand et al., (2007) and Nieuwenhuijzen et al. (2004), among others, speak to the pivotal role of supervisors in successful
early return to work from absence due to mental health problems. One of the roles of the supervisor, sometimes in concert with the union rep, is to devise modified duties, taking into account the returning worker’s needs. A study by Krause et al., (1998) found that modifying work expectations upon return was an effective means of easing workers back into the workplace. In a related vein, in their study, Caveen et al., (2006) found that supervisors who had been trained and sensitized to the needs of depressed employees were more successful in their RTW initiatives. It was not the view of the key informants that most supervisors are stepping into this role with adequate training on workers’ rehabilitative needs and the best practices available.

It seems obvious from the comments made in the above section that a difficult labour-management relationship also plays out in terms of less than favourable return to work practices. There seem to be problems that are not being addressed by the management or the union. A positive example affecting RTW given by the representative of UNIFOR is the Bell Canada Peer Support Program. Workers volunteer and are trained to contact co-workers who are on disability leave for reasons of mental ill-health.

“They set up this volunteer program…they found that the simple act of making a social connection, not that people just suddenly became better overnight. They started to see there was a shift in how the (sick) individual started viewing their connection to the workplace and there was an incentive….I see that often in our workplaces, somebody who is off on sick leave or long-term disability, they lose connection. The only connection they have is with the insurance company calling them saying, ‘hey, what’s going on?’ … So the person is really isolated. There’s that stigma, it may not be intentional stigma but they feel disconnected.”

Sari Sairanen, UNIFOR

I find that although this approach involves colleagues, not supervisors, this example aligns with the points made in the literature that early contact with the workplace is a positive step in RTW (Franche et al., 2005; Corbière & Shen, 2006).
One area of concern is to explore the stakes involved for union solidarity and aspects of strategy, including education of members on the duty to accommodate, and how to improve upon current conditions. As reported, key informants described several problems affecting workplaces where there had been an absence due to mental ill health, including strained relationships between members. In terms of a broader program for RTW, however, none of the union representatives interviewed indicated that there was a defined protocol. Rather, individual situations were handled on a case-by-case basis. Most of the unions offer courses to stewards and members on the duty to accommodate, that include the steps involved and how to handle questions of confidentiality. The literature speaks to the role of the union in helping to shape accommodations; as evidenced in the interviews, this would appear to happen on an ad hoc basis.

MacEachen et al. (2006) and other writers speak to the multi-factorial nature of successful RTW in which each player has a role: supervisor, union representatives and human resources. As mentioned above, the notion of a coherent RTW program from the union perspective did not emerge in these interviews. The reason for this gap is most likely that unless there is a joint RTW process and committee, employer human resources drive RTW and may not keep the other parties abreast of the timing of a worker’s departure or re-entry. Moreover, there is not a regulated forum for discussion of appropriate accommodations or, for example, a potential shifting of workers’ duties in a team situation.

In a positive scenario, the union representative would be involved in all aspects of the RTW program, including the fashioning of the accommodation, according to St-Arnaud (2007). I agree wholeheartedly, especially in terms of mental health where the sensibilities involved often suggest that some education of co-workers may be necessary. Achieving greater involvement in the RTW process may require the union to push hard in collective bargaining and/or at the health and safety committee for a joint role in all aspects of a program, including the development of suitable accommodations. No doubt, the unions’ success will depend on the relative bargaining power and the will of the employer to share responsibility for how work is organized on the shop floor.

Further, although strained worker relations in RTW were discussed in the interviews, I heard only a small amount of evidence of work being done with co-workers to smooth the absent
worker’s re-entry in the workplace. An education staff representative at CUPE verbalized a keen insight:

“One of the things we realized early in the process (of teaching duty to accommodate) is that an important part of the training is how to talk about an accommodation with others. If someone’s needing an accommodation, how to support them in their confidentiality while at the same time building support for that person in the workplace so that they don’t encounter bullying or retaliation of different kinds.”

Corina Crawley, CUPE

Another key informant said she was aware of one case where a local union leader held an information session for staff before a fellow worker came back into the workplace from an extended leave due to mental health reasons. The return was relatively smooth and few problems were encountered by the returning worker or colleagues. Two union representatives suggested that staff and stewards tend to be so occupied by other responsibilities, especially due to mergers and reorganizations which mean fewer on-site union representatives, that there is little time for this very demanding activity except on an ad hoc basis. After 30 years working as a staff member in the labour movement I am not surprised that a gap exists between the theory and practice of RTW because the human resources of the organization do not always permit ideal practices, but I suggest strongly that steps be taken to diminish it. A brief information session, a lunch and learn, on mental health issues, stigma, discrimination and recovery, would be a powerful tool in a workplace dealing with an individual’s re-entry. There are always issues of confidentiality and this ground would have to be negotiated carefully, perhaps with the returning person’s consent. I do not think the task is easy, but the point is to make such efforts a priority so that co-workers react to a psychological illness no differently than they do to a physical one. Building solidarity around workers returning from a leave due to mental health problems should be a priority, in line with the equity and human rights education that the union delivers to members.

In a related vein, a point made frequently in the literature (Franche et al., 2005; Holmgren & Dahlin Ivanoff, 2007, for example) is that early contact between the worker absent due to mental health reasons and the workplace, usually via the supervisor, is meant to help facilitate the worker’s return.
For the most part this issue did not arise in the interviews. One exception was UNIFOR. As outlined earlier, the union is working with Bell Canada in an effort whereby co-workers (not supervisors) trained for the task initiate and, if wanted, maintain telephone contact with workers off due to ill mental health.

In a recent study in Quebec of unions’ role in RTW, it was found that the union’s primary role is to offer the worker support consisting of “…providing information on the services available, the terms and conditions of the return to work, and the employee’s rights and responsibilities, while respecting confidentiality throughout” (Corbière et al., 2014, p. 4). But they found that union involvement is rarely systematic or even formal and varies considerably depending on the context. Often, the ad-hoc contact depends on the worker’s relation to the union before they became ill. Of great interest is that they view

“…union stakeholders (as) front-row observers of the return to work within an organization by virtue of their roles of intermediary and conciliator between the various parties involved (employer, co-worker, physicians and medical service providers, and employees). This position affords them a unique viewpoint on the factors facilitating and hindering return to work of individuals…” (Corbière et al., 2014, p. 5).

From this I conclude that this latter point is significant in that it points to a unique and important role for union representatives in a successful RTW process.

In the interviews, there was little discussion about developing sustainable accommodations for returning workers. It seems that primarily supervisors and whatever specialized people the employer used carried out accommodations. Krause et al. (1998) writes of the successes of workplaces that provide modified duties for returning workers. Some of the union representatives interviewed maintained, however, that if changes were not made in job duties, workload or pace of work, the chance of a worker becoming ill again were much greater. This is important to understand and suggests that unions should be more involved, with management, in the overall structuring and carrying out of an RTW program, including working with co-workers to improve their understanding of mental health challenges and their own responsibilities. There is room here for improvement at the ground floor as returns to work that cause friction between workers are disruptive in the workplace and hurt union solidarity. At present, too often workers
end up pitted against one another. This is significant in that until unions are full partners in RTW programs, it is unlikely that they will be involved in systematically shaping accommodations or preparing the necessary groundwork needed with co-workers before and during a member’s return to the workplace.

With respect to return to work, my research aligns with that of Corbière et al., (2014), who found that the role of the union representative in return to work tends to be ad-hoc. Negotiated, joint RTW programs would help advance the notion that unions be involved in all aspects of return to work. For those cases involving psychological health and safety in particular, training representatives toward the provision of more empathic representation could offer promising possibilities. In the meantime, my study offers one chain in the link of research that is developing knowledge in this field.

In this chapter I have presented and analyzed actions taken by unions to combat psychosocial hazards, as reflected in the interviews with key informants. Issues related to education of worker representatives were also explored. The final section of this chapter dealt with significant issues that emerge for workers and their unions in return to work after absences due to mental health challenges. In the next chapter, the threads of the arguments presented in the thesis are woven together, followed by a concluding chapter in which I suggest areas for further research.
Chapter Seven
Analytic commentary

As we have seen, emerging research indicates that mental health problems in the workplace are on the rise. Costs to employers and society are high. To combat this, some unions are developing strategies that focus on work organization. They are trying to resist and remove psychosocial hazards embedded in organizational structures that put workers at risk. I am interested in looking at relations of dominance and how power is exercised over certain groups or institutions in society. In unionized settings where health and safety specialists and committees resist certain employer-designed practices, the organization of work is not static. Pressure is brought to bear by workers and small changes may occur. The underlying power of the employer is being partially limited by the grass-roots strength of the workers and their union.

This same dynamic is at play in a variety of issues that divide workers and employers. The question becomes one of identifying how workers’ mental health is impacted. We have seen that where there is downsizing and mergers or poor communication with supervisors about work roles, psychosocial hazards emerge that affect workers negatively. A loss of autonomy in the work process, such as that seen at Canada Post among letter carriers, can similarly affect workers. Unions try to organize collective strategies against these hazards, and are successful in protecting workers’ psychological health to varying degrees. But the vast bulk of the power remains with the employer.

It is in this context that health and safety specialists are seeing a broadening of their discipline to include issues of psychological safety. Although psychiatry and the biomedical model frames these issues as individual problems with individual solutions, the unions’ perspective leads to a structural analysis and looks to flaws in work organization, role confusion and workload for example. Collective solutions are sought, notwithstanding that persons with diagnosed illnesses may be in the workplace and require certain attention and care. That care must address the social dimension of stigma and discrimination. The biomedical framing of mental illness works at cross purposes to social change; it increases the sense of difference and augments the desire for social distance by managers and co-workers. Therefore, the role of the union is necessarily changing, to
embrace psychological safety issues as a core concern in relations with a variety of employers, just as psychological safety is becoming a more significant legal concept.

Martin Shain’s report, *Tracking the Perfect Storm* (2010), suggests that for the first time in Canadian history employers are confronted with a legal duty to maintain not only a physically safe workplace but also a psychologically safe work environment. As seen in Chapter Four, he makes an argument for a new legal liability facing employers in a many different legal contexts from human rights to labour law to workers’ compensation. Unions are preparing for these battles by documenting workplace practices and taking problems to the negotiating table and into legal settings in defense of workers’ rights.

The interviews demonstrate that where mistrust of the employer is high, the labour relations climate suffers. The particular history of negotiations may be at fault or there can be flashpoint issues between the parties. Whatever the cause, it will be difficult to make progress on psychological health if relations are not improved. Working jointly with a tool like the CSA Standard, with its interim goals and timelines may help to repair bad relations. Participation in the process itself may erode some of the mistrust, but likely only in enterprises and agencies with a labour relations climate that is already positive.

Union health and safety specialists are also aware of how precarious work is affecting their members. Not just poorly paid service jobs, but highly skilled education and healthcare workers are concerned. Precarious work causes stress both on the job and off, creating psychosocial hazards for workers to contend with. Workers are unduly stressed by not knowing when their shifts are scheduled, for example. The unequal power between employer and workers is especially acute for those in precarious situations. While it is beyond the scope of this study to go into detail here, further research on this dynamic and its impact on the mental health of workers is ongoing and will aid a growing and vulnerable part of the labour force.

Workers are also made vulnerable through mergers, downsizing and the accompanying layoffs that occur. Survivor syndrome, as we have seen, has a difficult impact on the workers who remain on the job. The union tries to bring assistance to bear in such situations so that workers do not feel so isolated and vulnerable. Women on the job are more vulnerable to these issues, as they frequently have less control over their work – not because they are women.
In this study we saw that there is a role for some non-collective bargaining interventions to aid workers. These interventions can be double-edged, as they don’t get at the root issues of unequal determination over work organization. But providing workers with union counseling and wellness programs can improve life on the shop floor and beyond. Further, EAP – to the extent that it is carefully negotiated between the parties and skillfully applied to provide maximum coverage – is a useful tool. These programs can be molded to workers’ interests, but only to the extent they get at root causes. Unfortunately, many function more as window dressing to deeper concerns. Yoga, for example, is a tool but not a destination in and of itself.

Education of union health and safety representatives is another terrain of struggle. In essence, the health and safety specialists are trying to diminish the power of the employer by training up workers to research and reveal psychosocial hazards in the workplace. They are also trained to advocate among co-workers to build support for the union’s position. This is the skill set of the “knowledge activist” seen earlier in this paper. It is a different approach than the more technically based health and safety expert who relies on measurement of noise, for example, as an indication of a hazard. Knowledge activists are political animals, seeking to develop the empowerment of workers through knowledge of and action about those hazards. The knowledge activist also educates members, sensitizing them to the stakes involved in the risks they are experiencing at work.

In this study I also identified two other types of education of representatives that would be valuable: first, the union counselor role where empathic communication is stressed for returning workers and second, training health and safety committee members to bring bargaining demands that attempt to deal with psychosocial hazards in the workplace. To bring about these types of education representation, health and safety specialists must use counter discursive arguments, emphasizing the validity of the union’s point of view. The duality of union representation is that they must make arguments about structural and collective issues related to work organization and also represent individual needs in the workplace.

As such, at the same time that systemic change is sought by the union, it must service the needs of workers who are suffering due to psychosocial hazards. This can happen on-the-job or during a period of return-to-work. The union counseling type of role is invaluable: it can help workers
to survive divisive, negative working conditions and where necessary workers may be referred to outside psychological services. Change starts with the individual and may be generalized among co-workers. Solidarity may be built from individual situations where there is care taken to both advocate and build support on a member’s behalf – in mental health as with any other issue.

Empathic communication with members returning after periods of absence due to mental health problems sounds sensible, but it can be complicated in workplaces where division between workers is rife due to poor communication and workload issues. The challenge for the union is to support the returning worker, advocate on their behalf, while building solidarity among co-workers. This is a tricky dance. Moreover, return to work is dominated by employer objectives and the extent to which a worker receives modified duties or an accommodation depends in part upon the power of the union to exact them. In this situation, as with others mentioned above, there is a struggle between union and employer. There is an additional legal discourse in return to work, the duty to accommodate, but it is not absolute. Unions battle for a joint RTW program, to better serve their members. But, it is the balance of forces that continue at play in determining whether and how well a worker is accommodated.

Return to work is facilitated where there is language in the collective agreement that outlines procedures and responsibilities. Not all employers want to see this kind of language but it generally makes it easier to reach sustainable accommodations and modified work when there is a framework of responsibilities and accountability set out. Return to work coordination and supervisor involvement can strengthen these efforts, as we saw in the peer-reviewed literature by Franche (2005).

Peer support programs can also be helpful to workers returning from leaves due to mental health problems. The union can contribute to the success of such efforts, sometimes in conjunction with management as at Bell Canada. It requires recognizing that return to work is complex, that there are different roles to be played and that the lack of solidarity that is often manifest by stigma and discrimination can be countered by planning, education and trying to exert good will.

Our data show how unions are devising education programs about mental health in the workplace. They sometimes pinpoint accommodation issues, in steward training for example, but are mostly broad-brush training for members about hazards in the workplace such as workload
and loss of autonomy. It would be interesting to study if greater familiarity with mental health issues by members – and knowledge about psychosocial hazards -- leads to more grievances and bargaining demands on the topic. Certainly this is the hope. A more knowledgeable workforce may well prove to be a more militant one.

I have written this dissertation from a particular standpoint. I have taken the workers’ standpoint in researching and explicating what is at stake in identifying and combating psychosocial hazards. I did not, however, write about the experience of individual workers who have been absent due to mental health problems, nor about the experience of workers who have had to adjust to accommodations provided to one or more of their coworkers. It would be an interesting study to understand the complexity of their challenges, but quite complicated due to concerns about confidentiality. Accessing the data itself could prove very difficult. I chose, instead, to explore the ideals and programs of the health and safety specialists with regard to the topic. My research shows how the relations of dominance that employers enjoy put workers at risk. Hazards due to poor work organization are rampant and unions, so far, have been able to make only small inroads against the grain.

Interestingly, none of the health and safety experts outside of Quebec spoke at any length about workers’ compensation programs and mental health problems members are experiencing. Just as forty years ago it became possible for unions to push issues of physical health in those compensation forums, the same must become true for psychological health. Harassment and issues with mental health components affect workers deeply and workers’ compensation programs may be one avenue to pursue.

Nor did the union health and safety experts talk at length about achievements made in collective agreements on issues of mental health, with the exception of language that exists to deal with workload. I believe that this absence is due to the fact that progress is quite minimal at this point; more issues related to psychological safety will find themselves in collective agreements as the unions take these concerns to the negotiating table. Opposition to employer organization of work, as such, is not found in the collective agreement except to the extent that the union moves it forward as an issue.
My research showed that bullying and harassment arises due to poor work organization. As I have mentioned, this was a surprise to me even though I had been the target of a bully and had also taught member groups about bullying dynamics. Understanding these unwanted and offensive behaviours as a result, for example, of poor communication or work role definition due to work organization opens up the possibility of new strategies. Instead of relying on he said/she said examples, the union can intervene in a positive way to relieve poor work organization such as workload and communication issues. It cannot be done without the agreement of management, but an alleged harassment or bullying situation can also signal to the employer that some intervention is required for the workplace to run smoothly. Health and safety committees can assist equity representatives to see the broader picture in these matters and come up with sustainable solutions.

Health and safety specialists speak a language and forge a purpose that is counter discursive to the employer. By teaching health and safety committee members to identify hazards and to research and organize around them, they are taking on the dominance of the employer in the organization of work. In building worksite campaigns that question the authority of management, they encourage rank and file activities that build solidarity among workers. The union is strengthened when even small gains are made, such as seen in OPSEU’s community nursing agency direct engagement campaign, in union bargaining for manageable workloads and, in UNIFOR’s negotiations with Chrysler, as well as PSAC’s with Treasury Board, to include psychosocial hazards. Each of these is a promising model for identifying and combating psychosocial hazards that may be adopted and adapted for other economic sectors and organizations.

In this study I have shown how unions and sometimes, small sections of unions, have battled to erode management control of work organization. Health and safety departments are not necessarily at the centre of determining overall union strategy; they must fight to be listened to. Unions are not homogeneous organizations; various parts compete to be heard. In part it is the ability of the health and safety specialists to bring the rank and file onside that affects their relative strength or influence in the union. Strategies such as we saw in OPSEU where a thoughtfully run campaign brought about change in management structure of a community nursing operation is a good example. Solidarity was built among the membership and the central
union chose to support these efforts. Was there something particular in this case that led to success? The union reached out to the Occupational Health Clinics for Ontario Workers, an ally with a great deal of technical expertise, to prepare and analyze the survey it used. A top-notch union staff representative helped to motivate and organize the workers. In effect, a cluster of factors led to a positive solution to the workers’ problems.

Combating psychosocial hazards is not easy. Nor is it rocket science. Campaigns such as OPSEU waged with surveys and group grievances are common in building support around bargaining demands and in civic elections. But they rely upon union leadership accepting the possibility that management control can be chipped away at, that there is hope that the union can come out on top. It does not have to be the union by itself, but can be with help from allies in the community including health clinics and universities. Strategic concerns -- such as the fact that women tend to be more acutely affected by psychosocial hazards because their jobs typically have low decision latitude and low support -- must be taken into account.44

The websites and programs we saw in the first data set suggest that unions, and others, are taking up the clarion call for improving psychological health in the workplace. The data indicate that programs such as calls for mental health weeks and other activities are becoming prominent. It will also be interesting to see if the CSA Standard has an impact in developing safer workplaces. The fact that it is simply voluntary is most definitely not a point in its favour. Certainly a societal push will be required to reap measurable results and unions are one of the institutions at the forefront.

Few entities other than unions and some researchers are unearthing the psychosocial hazards in the workplace. With evidence-based campaigns the unions are putting workers’ psychological health first. Why does this matter? It matters because employers cannot be counted upon to protect workers. That is not their objective. Their aim is to maintain control of work organization and the work process, while maximizing profits. Unions are subordinate in a relation and ongoing struggle of domination and their attempts to erode employer power are documented in

this project. Prior to my research we did not know, in any systematic way, that such steps to protect workers, however small, were being taken. That is the major contribution of my findings.

It may be of value to the union representatives interviewed for this project to know they are on a unique path of study and activism. I will alert them to my findings at the appropriate time. Certainly they can learn from one another and I hope my work will prove informative in this regard. My hope is that my work will help union health and safety specialists to see the variety of ways in which they are making headway and that they will be motivated to push further, using differing methods, to wrestle away bits of management’s control over work organization. Just as several of the unions are active on the issue of workload, they may take on further strategic, smart campaigns to identify and combat other psychosocial hazards at work.

There is a further link between these campaigns and the unions’ commitment overall to equity education programs. Whether dealing with LGBTQ issues, anti-racism, disability or First Nations, linkages exist between the marginal groups concerned. Unions undertake a social inclusion approach in equity education and a similar line is needed to link to those members experiencing mental health problems in the workplace. The union has the tools to make these linkages and build social inclusion; doing so strengthens the rank and file force of the organization on any number of issues. Reaching out to members on the margins can help to create a core of activism that builds resistance. That strength can be valuable in health and safety or collective bargaining. It is in this way that confronting mental health problems can be transformative, for both individuals and the union as a whole.
Chapter Eight
Moving Forward

There is general agreement in developed countries that psychosocial hazards and mental health problems in the workplace have increased in recent years. A substantial literature points to the impact of globalization, technology, restructuring, and the intensification of work. With few exceptions, unions are the one entity now beginning to face the challenge of increased psychosocial risks from the standpoint of workers. But unions are often stymied in this endeavor by employers’ organization of work and the power that they wield. Work organization includes not just how work is arranged but involves the control and demand one has over one’s work and the possibilities to learn new things, develop and take initiative. Included as well is what the work means: what is the effort/reward balance? How psychosocial risks are embedded in work organization is thus a central question for unions and for this study.

In this regard, a gap was found in the literature -- there is little documentation of concerted union initiatives vis-à-vis psychosocial hazards. Through the course of the interviews I learned that unions do in fact play such a role and that it is growing. At present, unions are experimenting with different means of trying to minimize psychosocial hazards. Three particularly promising strategies were highlighted in previous chapters and can serve as models that may be adopted and adapted for other economic sectors and unions. These were the OPSEU campaign with community nurses where a new management system was achieved; second, the efforts to make headway on achieving workload reductions; and third, the negotiation by UNIFOR with Chrysler of collective agreement language, and the PSAC and Treasury Board, to explore impacts on psychological health. In the first and second cases the union provides tools to the members so they may take on the health and safety issue at the level of the workplace. Members need to believe that they can exert influence to make change in their working conditions, something for which the central union can offer both expertise and encouragement. In these strategies strong leadership is required and must be found and nurtured within the health and safety committees and other levels of local leadership.
It means thinking of the union as a provider of preventive tools, tools that will protect members against the potential harms in the workplace. It means building leadership on health and safety and is a fuller notion of health and safety than just the physical aspects, taking into account the hazards to psychological health. Union members may learn that their organizations can in fact protect them from harm. Negotiating change at a local level can be laborious when the entire breadth of the union is considered. Nonetheless, it does create terrains of struggle where union members’ sense of identification with the union as a vehicle for improving working conditions is enhanced.

In the third case mentioned, that of UNIFOR and negotiations with Chrysler, as well as the PSAC and Treasury Board, the union made a commitment at a very high level to ensure that some headway was made on the issue of psychological health. The union used its bargaining power to glean a small but significant gain from the employer. In other organizations with large memberships and centralized negotiations it ought to be possible for similar advances to be made. These take place further away from the membership base and require that members are educated as to the efforts and gains made. Subsequent steps in working jointly on psychological health will likely require greater membership involvement at the plant/office level and the UNIFOR health and safety specialist spoke to the possibility of deepening this strategy by creating a member logbook for psychological hazards, such as the union uses in its cancer prevention campaign.

My study breaks new ground by examining how unions are combating psychosocial hazards. No other party in the workplace is taking on these issues. The hazards are of prime importance because the health of all workers is affected. Further research of specific workplaces and unions is required to nail down exactly what the results are when union officials provide in-depth training to health and safety activists or other local union leadership. The examples I have highlighted are promising practices that can be repeated and adapted to specific work situations. The importance of these models cannot be overestimated as unions can learn from one another’s practice.

My work has a practical utility to the extent that it can be directly applied to these real life problems facing health and safety practitioners. It attempts to theorize that which these union
specialists can and should do. My work tries to anticipate any practical problems they may need to solve in future as a result of current health and safety practices.

The recommendations for union education regarding worker representation, including an empathic approach to members suffering psychological distress, are highlighted as they are specific to issues of mental health and advance the theory in this area by specifying a compassionate mode of interpersonal contact followed by advocacy. I have not seen any literature on either return to work or combating psychosocial hazards that makes these precise points, with the exception of Hall et al., (2006) who introduce the term “knowledge activism”. But that paper was dealing with health and safety representation as a whole, not with a particular emphasis on mental health. The literature that comes closest to this study in terms of RTW is that of St-Arnaud et al., (2014) done most recently in Quebec. That comprehensive work points out the prime role for union representatives in RTW and how involvement tends to be on an ad-hoc basis. My research came to similar conclusions.

Unions are trying to make psychological health a central issue at play in the employment relationship, not unlike how physical health and safety entered the legislated employment relationship in the 1970’s. As one key informant put it, “if we think about labour history, maybe people will look back at our time and say that the rights we won at this time, (were) made in the area of mental health…. (Cathy Remus, CUPE).

Based on my study, it seems evident that the unions are on the cusp of important gains on psychosocial hazards and still have a way to go in developing return to work programs that will genuinely advance the interests of workers.

Unions, my work and some academics are the main bodies investigating work organization and psychosocial hazards with a view to improving workers’ health. It is within the purview of union health and safety specialists to carry out this work but human resource professionals might also benefit from these insights. Workers have the most at stake when it comes to the pernicious impact of psychosocial risks but employers control the means of production and how work is organized. It is in this context that the unions’ efforts must be evaluated.
Several question emerge from this study that bear further examination. In terms of combating psychosocial hazards, further case studies would advance knowledge of how exactly unions are able to marshal their resources to identify and then militate against hazards affecting psychological health. Members benefit when these initiatives become collectivized, that is, by moving away from the individual grievance model to a campaign model. Further study would help create the conditions for moving the bar, to foster the expectation among members that the union can be part of devising the solution to problems they experience.

In terms of RTW, the gap between the peer-reviewed and grey literature and the more ad hoc practice found in this study, suggests that there is some distance between the theory and what occurs on the ground. I believe we need studies of individual workplaces and how union people on the ground handle RTW, along the lines of the St-Arnaud et al. 2014 Quebec study cited previously. A project on return from absences due to mental ill health of a unionized workplace with a negotiated joint RTW process in the collective agreement might bear interesting data and promising practices. Such a study could highlight the experience of returning workers as well as their healthy co-workers. Further study could provide a practical pathway for greater coherence to return to work efforts.

A key issue, as one of the key informants from CUPE put it, is for local leadership and others to learn how to speak about mental health issues and accommodation in an empathic fashion that helps to build support around individuals facing such challenges. Confidentiality is vital and the balance between too much and too little information to coworkers can be tricky. Nonetheless, with one in five people likely to face mental health problems some time in their lives, it makes sense for us to develop such capacity for mental health literacy in the workplace. Unions can choose to play a positive role in this effort; at present many are actively reaching out to their members on this issue but further study of their methods is required.

With respect to the personal situation I described in the introduction to this study, that of a bullying episode where the union proved unable to protect workers, the outcome might have been different if work organization was considered and acted upon. The supervisor was simply out of control and allowed by management to operate in this manner. Had the union investigated how this behaviour was achieving some goal of the administration, it might have ended
differently. The dysfunction in the department was making the work less effective and a key element of equity/human rights work was stymied: bringing challenges to the leadership about practices and policies. In a sense, the bullying situation acted as a distraction that shielded the administration from further equity critiques.

It is how unions combat specific psychosocial hazards in each situation that demonstrates the effectiveness of the particular organization in this regard. In this study I have shown some examples of unions making progressive changes that impact workers’ psychological health. It is important to note, however, that all of these strategies are very much at the experimental stage. No method is etched in stone. With further study and practice, unions and their members will become more adept at combating psychosocial hazards and I believe this terrain will become a more central part of the employment relationship. In the meantime, unions will need to continue to learn from each other, to share the successes and failures, so that the movement as a whole can advance and better embrace the needs of all members, including those with mental health challenges.
References


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travail, Institut national de santé publique du Québec and Institut de la statistique du Québec. The full report is only available in French.


Appendices

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Appendix I: Interview Guide for Key Informants

1. What is your role in the union and what do you do?
2. How did you arrive at this position?
3. Is mental health important to you? Why?
4. How do you view mental health problems in the workplace?
5. Define psychosocial hazards. What are the psychosocial hazards that your members face?
6. In your role, how many incidences of workers’ absence due to mental health problems are you aware of?
7. Does your union make mental health a priority? Have there been conferences or courses for members?
8. Has your union taken any actions regarding mental health? How are they making it a priority?
9. Has your union taken any actions against psychosocial hazards?
10. Have you or your union been successful in advocating for changes to work organization? If so, what are they? If not, what have been the major stumbling blocks?
11. In return to work, do you think the major problem is the individual worker returning or the context? What about co-workers?
12. Is the worker involved in fashioning accommodation?
13. As far as you know, do workers returning after absences due to mental health challenges encounter discrimination?
14. How do accommodation measures arrived at affect other workers?
15. What has been the history of grievances re mental health issues in your organization?
16. Has the issue of mental health entered the union’s collective bargaining agenda?
2. Comment avez-vous obtenu ce poste?
3. La santé mentale, c’est important pour vous? Pourquoi?
4. Comment voyez-vous les problèmes de santé mentale en milieu de travail?
6. Dans votre rôle, vous devez avoir connaissance d’absences qui sont liées à des problèmes de santé mentale. Combien y en a-t-il?
7. Est-ce que la santé mentale est une priorité pour votre syndicat et comment? A-t-il organisé des conférences à ce sujet? Des cours pour les membres?
8. Est-ce que votre syndicat a pris des mesures concrètes en matière de santé mentale? Comment fait-il de cette question une priorité?
9. Votre syndicat a-t-il pris des mesures contre les risques psychosociaux?
10. Est-ce que vous, ou votre syndicat, avez réussi à convaincre l’employeur d’apporter des changements à l’organisation du travail? Si oui, décrivez les changements apportés. Sinon, décrivez les principaux obstacles que vous avez rencontrés.
11. À votre avis, quelle est la plus grande difficulté lorsqu’un employé retourne au travail : le contexte ou l’employé lui-même? Qu’en est-il des collègues?
12. Est-ce que l’employé touché participe au choix des mesures d’adaptation?
13. À votre connaissance, est-ce que les employés qui se sont absentés en raison de problèmes de santé mentale sont victimes de discrimination lorsqu’ils retournent en milieu de travail?
14. Quel est l’impact des mesures d’adaptation sur les autres employés?
15. Y a-t-il eu beaucoup de griefs liés aux problèmes de santé mentale dans votre organisme?
16. Est-ce que la santé mentale fait partie des enjeux de négociation que défend votre syndicat?
Appendix II: Research Ethics Approval

PROTOCOL REFERENCE # 30415

July 4, 2014

Dr. Margrit Eichler
DEPT OF HUMAN, SOC SC & SOC JUSTICE EDUCATION OISE/UT

Ms. Miriam Edelson
DEPT OF HUMAN, SOC SC & SOC JUSTICE EDUCATION OISE/UT

Dear Dr. Eichler and Ms. Miriam Edelson,

Re: Your research protocol entitled, "Mental health in the workplace: Unions' role in identifying and combating psychosocial hazards"

ETHICS APPROVAL

| Original Approval Date: July 4, 2014 |
| Expiry Date: July 3, 2015 |
| Continuing Review Level: 1 |

We are writing to advise you that the Social Sciences, Humanities, and Education Research Ethics Board (REB) has granted approval to the above-named research protocol under the REB's delegated review process. Your protocol has been approved for a period of one year and ongoing research under this protocol must be renewed prior to the expiry date.

Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Any adverse or unanticipated events in the research should be reported to the Office of Research Ethics as soon as possible.

Please ensure that you submit an Annual Renewal Form or a Study Completion Report 15 to 30 days prior to the expiry date of your current ethics approval. Note that annual renewals for studies cannot be accepted more than 30 days prior to the date of expiry.

If your research is funded by a third party, please contact the assigned Research Funding Officer in Research Services to ensure that your funds are released.

Best wishes for the successful completion of your research.

Yours sincerely,

Sarah Wakefield, Ph.D.
REB Chair

Dean Sharpe
REB Manager

OFFICE OF RESEARCH ETICS
McMurrich Building, 13 Queen's Park Crescent West, 2nd Floor, Toronto, ON M5S 3S8 Canada
Tel: +1 416 946-3275 • Fax: +1 416 946-3783 • ethics.review@utoronto.ca • http://www.research.utoronto.ca/for-researchers-administrators/ethics/
Appendix III: Interview Request

August 1, 2014

Dear xxx,

I am writing to ask that you agree to participate in a research project I am conducting for my doctorate at OISE/UT. My background is thirty years in the labour movement, having worked for various public and private sector unions on equity issues, communications and research.

The subject of my research is the role of unions in workplace mental health and, in particular, how unions are (or are not) identifying and combating psychosocial hazards in the workplace. In addition I am looking at accommodation and return-to-work related to mental injury in the workplace.

I am interviewing health and safety staff representatives from the major unions, including Quebec, and would hope to meet with you in September. It will take approximately 60 minutes of your time in a face-to-face, audiotaped interview. I will provide you with the questions in advance and you will have an opportunity to see and discuss what I intend to include in my formal write-up before it is finalized.

I will follow up with a telephone call later this month to try and set up an appointment at your convenience.

With best wishes,

Miriam Edelson
Bonjour,

Je sollicite par la présente votre participation à un projet de recherche que je mène dans le cadre de mes études doctorales à l’Institut d’études pédagogiques de l’Ontario (OISE)/Université de Toronto. Militante syndicale de longue date, j’ai travaillé pendant 30 ans pour divers syndicats, tant du secteur public que privé, dans plusieurs domaines : équité en emploi, communications et recherche. Mon projet de recherche porte sur le rôle des syndicats dans la promotion de la santé mentale en milieu de travail. Deux sujet m’intéressent plus particulièrement : 1) que font les syndicats pour cerner et combattre les risques psychosociaux en milieu de travail; et 2) les mesures d’adaptation et le retour au travail des personnes souffrant d’un problème de santé mentale.

Pour mener à bien ce projet, je rencontre des représentantes et représentants en santé et sécurité des principaux syndicats canadiens et québécois. J’aimerais vous rencontrer en septembre pour un entretien d’environ une heure qui sera enregistré. Je vous fournirai les questions à l’avance; vous aurez également l’occasion de lire et commenter les extraits que j’inclurai dans ma thèse avant qu’elle ne soit finalisée.

Je communiquerai avec vous par téléphone au cours du mois pour que nous puissions convenir d’une date pour notre rencontre.

Cordialement,

Miriam Edelson
Appendix IV: Key Informant Consent

Informed Consent for Participation in Interview Research

You are being invited to participate in a research study conducted through the OISE/UT. Your participation would be voluntary and no payment will be received.

The purpose of this study is to explore how unions are dealing with mental health issues in the workplace and, as a subset, job accommodation and return-to-work due to mental health problems. Unions are only one of the workplace parties dealing with these issues, but they do have the potential to negotiate improved working conditions and better the lives of their members in a meaningful way.

This study will interrogate how unions are identifying and combating, or not, psychosocial hazards in the workplace. There is no doubt that negotiating changes in the work process or creating limits on workload required are daunting tasks. The union and its representatives occupy a position of potential influence in this complex terrain between workers and management and it is their actions that will be investigated.

This research is being conducted by Miriam Edelson as part of her doctoral program at OISE/UT. The data will be analyzed and used in her thesis. Participants can contact the Office of Research Ethics at ethics.review@utoronto.ca or 416-926-3273, if they have questions about their rights as participants.

Participation involves approximately 60 - 75 minutes of question and answer with the researcher. Written notes will be made during the interview and an audiotape will be made. This is the first study of this kind and will be made available to participants at no cost.

The participant will be referred to by name in the thesis to be produced. S/he is being approached as a participant due to his experience and knowledge of mental health issues in the workplace. All ten of the interviewees are seasoned practitioners with
strong professional reputations. Should the participant decide that they wish to withdraw, they may do so without penalty.

I have read and understand the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study. I have been given a copy of this consent form.

_________________  __________________
Signature          Date

_________________  __________________
Printed name       Signature of researcher

m.edelson@sympatico.ca
Consentement à participer à un projet de recherche

Nous vous invitons, par la présente, à participer à un projet de recherche mené sous les auspices de l’IEPO/Université de Toronto. Votre participation est volontaire en non-rémunérée.

Le projet de recherche a pour but d’étudier comment les syndicats abordent les problèmes de santé mentale en milieu de travail. Nous examinerons aussi deux autres aspects de cette question : les mesures d’adaptation et le retour au travail des personnes souffrant de problèmes de santé mentale. Les syndicats ne sont qu’un des intervenants dans ce dossier, mais leur rôle est important puisqu’ils peuvent négocier de meilleures conditions de travail et, ainsi, améliorer grandement la vie de leurs membres.

Que font les syndicats pour cerner et combattre les risques psychosociaux en milieu de travail? Tel est le propos de ce projet de recherche. C’est un fait incontestable : négocier des changements aux processus de travail ou des limites aux charges de travail est une tâche énorme. Mais dans les relations entre employés et employeur, les syndicats et leurs représentants peuvent exercer une certaine influence – et ce sont leurs interventions que nous étudierons.

Le projet de recherche est mené par Miriam Edelson dans le cadre de ses études doctorales à l’Institut d’études pédagogiques de l’Ontario (OISE)/Université de Toronto. Les données seront analysées et incorporées dans sa thèse. Mme Margrit Eichler Ph.D. (margrit.eichler@utoronto.ca) supervisera le travail de Mme Edelson. Pour toute question sur les droits des participants à cette étude, veuillez communiquer avec le bureau d’éthique de la recherche (Office of Research Ethics) : ethics.review@utoronto.ca ou 416-926-3273.

Votre participation consiste à rencontrer la chercheure pour un entretien d’environ 60 – 75 minutes, qui sera enregistré et durant lequel la chercheure prendra des notes. Comme il s’agit de la première étude de ce genre, nous en remettrons une version électronique sans frais aux participants.
La chercheure utilisera vos nom et prénom dans sa thèse. Vous avez reçu cette invitation parce que vous connaissez bien le dossier de la santé mentale en milieu de travail. Les dix personnes qui seront interviewées sont des praticiens chevronnés, qui se sont forgé une solide réputation. Vous êtes libre de mettre fin à votre participation en tout temps au cours de cette recherche, et ce, sans préjudice.

J’ai lu et je comprends l’explication qui m’a été fournie. On a répondu à toutes mes questions de façon satisfaisante et j’accepte de plein gré de participer à ce projet de recherche. J’ai obtenu copie du formulaire de consentement.

_____________________________  ____________________________
Signature                     Date

_____________________________  ____________________________
Nom en majuscules              Signature de la chercheure

m.edelson@sympatico.ca
Appendix V: Union Acronyms

<table>
<thead>
<tr>
<th>Union Name</th>
<th>Acronym</th>
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<tbody>
<tr>
<td>Unifor</td>
<td>UNIFOR</td>
</tr>
<tr>
<td>Ontario Public Service Employees Union</td>
<td>OPSEU</td>
</tr>
<tr>
<td>Canadian Union of Public Employees</td>
<td>CUPE</td>
</tr>
<tr>
<td>Canadian Union of Postal Workers</td>
<td>CUPW</td>
</tr>
<tr>
<td>United Steelworkers of America</td>
<td>USWA</td>
</tr>
<tr>
<td>Public Service Alliance of Canada</td>
<td>PSAC</td>
</tr>
<tr>
<td>Centrale des Syndicats Nationaux</td>
<td>CSN</td>
</tr>
<tr>
<td>Centrale des Syndicats du Quebec</td>
<td>CSQ</td>
</tr>
</tbody>
</table>
Glossary

CAW: Canadian Autoworkers Union
CBT: Cognitive Behavioural Therapy
CCOHS: Canadian Centre for Occupational Health and Safety
CDA: Critical Discourse Analysis
CEP: Communications, Energy and Paperworkers Union of Canada
COPSOQ: Copenhagen Psychosocial Questionnaire
CSA: Canadian Standards Association
CSA Standard: CSA Standard on Psychological Safety and Health in the Workplace
CSN: Centrale des Syndicats Nationaux, confederation of Quebec public and private sector trade unions
CSQ: Centrale des Syndicats du Québec, confederation of Quebec trade unions predominantly in the educational and health sectors
CUPE: Canadian Union of Public Employees
CUPW: Canadian Union of Postal Workers
EAP: Employee Assistance Program
ENWHP: European Network for Workplace Health Promotion
EPI: Employment Precarity Index
ERI: Effort-Reward Imbalance (model)
K6: Kessler 6 Mental Health Scale, a tool used for screening mental health issues
NIDMAR: National Institute for Disability Management and Research
OHCOw: Occupational Health Clinics for Ontario Workers
OPSEU: Ontario Public Service Employees Union
PEPSO: Poverty and Employment Precarity in Southern Ontario research group, a university-community joint initiative
PH&S: psychologically healthy and safe (workplace)
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>PSAC:</td>
<td>Public Service Alliance of Canada</td>
</tr>
<tr>
<td>RTW:</td>
<td>Return to Work</td>
</tr>
<tr>
<td>SMI</td>
<td>Serious Mental Illness, refers to schizophrenia and bipolar disorder for example</td>
</tr>
<tr>
<td>UNIFOR:</td>
<td>UNIFOR was the Union was formed in 2013 as a merger of the Canadian Auto Workers Union and the Communications, Energy and Paperworkers Union of Canada</td>
</tr>
<tr>
<td>WHO:</td>
<td>World Health Organization</td>
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<tr>
<td>WSIB:</td>
<td>Workplace Safety and Insurance Board</td>
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</table>