

Healthcare workers who experience mental health issues: “It’s not OK to be not OK”

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The “business case”

- Mental health problems (esp. depression & anxiety) are the fastest growing category of disability costs in Canada (Wilson et al., 2002)
- Cost of short-term disability related to mental/behavioral disorders estimated at \$18,000/episode (Dewa, Chau & Dermer, 2010)
- Knowledge based economy where “heavy lifting done with our minds, not our backs” (Dewa et al., 2004)

The “business case” in healthcare

- 88% of all healthcare workers report insomnia, headaches, depression and panic attacks related to work stress
- Higher rates of absenteeism
- Higher rates of presenteeism
- Risks to quality of care

(CIHI, 2005)

Rationale for study

- Managerial perspective:
“This is a problem”
- Critical social perspective:
“We need to critically reflect on the social/organizational context within which workers are embedded”

Research questions

What is the experience of healthcare workers who have mental health and/or addictions issues?

How is this experience shaped by the social relations of work?

Method of Inquiry

Informed by Institutional Ethnography

- qualitative approach
- starts from the embodied experience of marginalized individuals
- explores the social relations that structure their every day lives

(Smith, 2005)

Starting point

- Workers with mental health and/or addictions issues who were employed within a mental health care organization
- Location: large, multi-site mental health and addictions treatment facility

Data Collection

Large mental health & addiction treatment facility

Interviewed 20 workers

Interviewed 12 "stakeholders"

Reviewed organizational texts

Recorded field notes

Staff participants

N=20 workers with mental health or addictions issues

- Job tenure: 5 months - 23 years (average 8.3 years)
- Work role: 12 clinical, 8 non-clinical
- Position: 14 front-line workers, 4 managers, 2 students
- Illness: mood disorder (14), addictions (6), anxiety (5), thought disorder (1), 1 not reported
- Disclosure: 4-5 were known consumers when hired, 4 never disclosed to anyone at work
- Sick leave: only 6 had period of absence due to mental ill health

Stakeholder Participants

N=12 "stakeholders" who interacted with employees with mental health/addictions issues

- 2 union reps
- 3 Human Resources
- 2 Occupational Health providers
- 5 management
- Job tenure: 1-31 years
- Work role: 5 clinical, 6 non-clinical

Organizational Texts

- Public documents (eg. corporate brochure, website, annual report, newsletters)
- Internal documents (eg. mission statement, organizational chart, strategic plan)
- Internal policies & procedures (eg. attendance mgmt, therapeutic boundaries, code of conduct, collective agreements, insurance claim forms)

Analysis

Multiple, stratified readings of interview transcripts, texts & field notes to:

- Describe the day-to-day “work” of employees in response to mental health or addictions issues
- Examine the social relations that shape individual experience
- Map how individual & organizational practices are produced & reproduced within the workplace

Mapping discoveries



Disjunctures

Public Discourse

We are an internationally recognized leader in:
Reducing Stigma – we create a platform for individuals to speak about mental illness and addiction issues.

“...open dialogue is where solutions start”

‘Private’ experience of staff

One of the last stigmas is mental... if you are a mental health worker with a mental health problem, well shut the hell up.

“It’s taboo. That’s the impression that I get. You just don’t tell anybody that kind of stuff at work. Never tell anybody.”

Worker Silence

“I didn’t want anybody to see how bad I was feeling... or how hard it was to manage...”

Stakeholder Silence

“Working with addictions and mental health specialists and showing up to my new job completely high and nobody notices...”

“It has to reach a huge breaking point...”

“Workplace culture that it is not okay to be not okay...”

Organizational Silence

“He disappeared from the workplace. ... There has been no talk about it, no mention.”

“The day I came back, they really didn’t have anywhere for me to sit...”

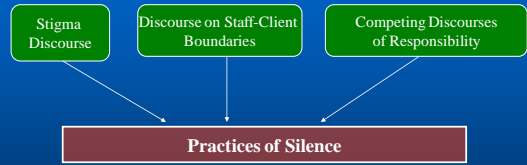
“It seems like no information filters down to the different people that you need for the things that need to be done”

Organizational “web” of Silence



Contexts: Wellness, Illness, Sick leave & Return to Work

Social Production of Silence



Stigma Discourse

“To me that is the worst part of it, dealing with what you are dealing with and then there is the 2ndary piece of fearing recrimination and fearing the labels and the judgement on the other side...”



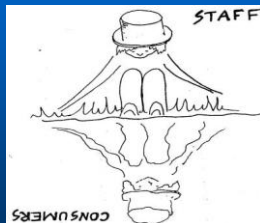
Staff-Client Boundaries



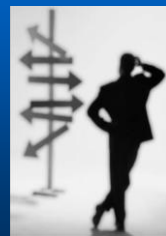
“I think a lot of people carry this sense that they have to be perfect, you have to have the answers and they can't admit that they're struggling - certainly not in the field that they're supposed to be the helper in. “

Staff-Client Boundaries

There's this distinct feeling of "us" versus "them". And 'us' as apart from the mentally ill.

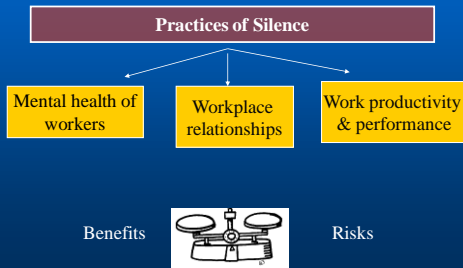


Competing discourses of responsibility



- Individual private issue?
- Employer responsibility?
- Clinical responsibility?

Consequences of silence



Mental Health Consequences

Benefits of Silence

"The only thing that kept me going was actually coming to work. That I had that sort of routine built in. ... at least it was something meaningful that I was doing"

Risks of Silence

"If people had been talking about it a little more and recognizing it, maybe you'd be quicker to go and get help"

Relationship Consequences

Benefits of Silence

"Part of it is not wanting to raise trouble ... Be implicated as the company snitch"

Risks of Silence

"Far too late [manager] started having more frequent meetings [with ill staff member] ... It was far too late to have any patch on my working relationship with him. That was pretty much irrevocably destroyed."

Productivity Consequences

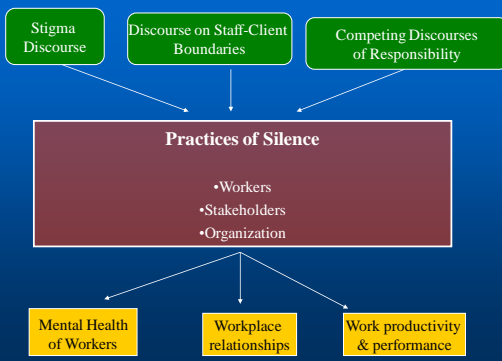
Benefits of Silence

"I feel that if I disclose that would be the assumption. ... that means that she is going to let us down."

Risks of Silence

"If the person won't disclose... then you can't help... and then people keep doing that stuff, then you have to discipline...."

The Social Relations of Silence



Reflections on Findings

- Silence as a way of maintaining institutional order
- Mental healthcare context produces particular discourses re: stigma, staff-client boundaries, and responsibility for action
- Opposition to dominant discourse

Implications for Practice

- Challenging ideas/approaches to:
 - stigma
 - disclosure
 - early identification
 - accommodation
 - RTW communication

Implications for Research

- Value of research that considers:
 - standpoint of workers
 - social relations of work
 - relationship between micro/meso/macro dimensions of the workplace environment
 - practices & production of silence

Future directions

- Comparison with other organizations
 - healthcare organization that is structured differently
 - non-healthcare/for profit organization
- What is the standpoint of other stakeholders (eg. managers)?
- Can we move beyond silence?

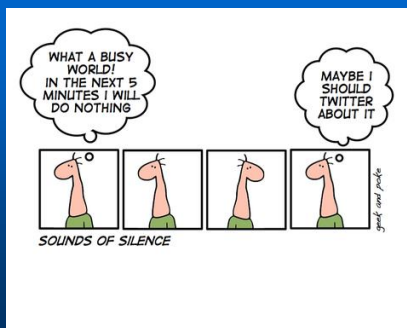
Conclusion

“Silence is the ultimate weapon of power.”
– Charles DeGaulle

“Silence is golden; speech is silver”
– American proverb

“Silence is a text easy to misread”
– A.A. Attanasio

Questions?



<http://geekandpoke.typepad.com/geekandpoke/2008/03/sounds-of-silence.html>