SPRING/SUMMER | VOLUME 35 | NUMBER 1

OOHNA JOURNAL

JOURNAL OF THE ONTARIO OCCUPATIONAL HEALTH NURSES ASSOCIATION

THE PRACTICE ISSUE

OOHNA KEEPING WORKERS WELL

2016 KEEPING WORKERS WELL

June 8 – June 10

Crowne Plaza Hotel & Conference Centre
Kitchener, Ontario

WELCOME RECEPTION
Wednesday, June 8
(7:30 – 9:30 p.m.)

CONFERENCE
Thursday, June 9 and
Friday, June 10

EXHIBITION
Thursday, June 9

OOHNA

Information available at www.oohna.on.ca

OOHNA
JOURNAL OF THE ONTARIO OCCUPATIONAL HEALTH NURSES ASSOCIATION
SPRING/SUMMER 2016 | VOLUME 35 | NUMBER 1

OOHNA KEEPING WORKERS WELL
ONTARIO OCCUPATIONAL HEALTH NURSES ASSOCIATION

Suite 605, 302 The East Mall
Etobicoke, ON M9B 6C7
Tel: 416-239-6462 Fax: 416-239-5462
E-mail: administration@oohna.on.ca
Website: http://www.oohna.on.ca

MISSION STATEMENT:

To foster a climate of excellence, innovation and partnership, enabling the membership to achieve positive workplace health, safety and wellness objectives.

SUBSCRIPTION RATES

OOHNA Journal is is published 2 times a year in digital format only. $29.38 (Canada, USA & International). Single issues available at $15.25 (Canada, USA & International). Advertising rates upon request. Subscription rates may be obtained from the Association office by sending a cheque or money order in Canadian Funds to the "Ontario Occupational Health Nurses Association".

All submissions are considered to be the views of the author and do not necessarily reflect the policies or views of the Ontario Occupational Health Nurses Association or the Editorial Committee of the Journal.

ISSN: 0828-542X

Return undeliverable Canadian addresses to:
Ontario Occupational Health Nurses Assocation
Suite 605, 302 The East Mall, Etobicoke, ON M9B 6C7
E-mail: administration@oohna.ca
Canadian Publication Agreement #40026127

2007 APEX® AWARDS FOR PUBLICATION EXCELLENCE

Table of Contents

LIFELONG LEARNING – IS IMPORTANT!

Editorial by Victoria Pennick

When I graduated in 1973, I entered a professional world that was very different from today. Most patients were cared for in hospitals, where they stayed until they were fully recovered. In my first job in the community, we spent many hours teaching newly diagnosed diabetics the proper [sterile] technique of self-injecting their insulin. Workplaces that employed nurses and physicians to manage work-related injuries focused more on treatment than on prevention.

During the early years of my career, I took continuing education courses and attended in-service education sessions and conferences to keep abreast of new information. I was limited in my access to journals, since I worked in community agencies that didn't tend to have healthcare libraries.

Things have changed dramatically since then. Healthcare, medicine, nursing, and workplace health and safety have evolved and we, as nurses, have had to keep up in order to maintain our competence and relevance.

Legally, Canadian RNs are accountable to provide competent nursing care, so must maintain and continuously enhance their knowledge, skills, attitude and judgment in an ever evolving healthcare system. Occupational Health Nurses with a Canadian Nurses Association Specialty Certificate [COHN(C)] designation, must renew their certification every five years by demonstrating they have accumulated sufficient continuous learning hours, and rewriting the exam. Attending *Keeping Workers Well*, the annual conference of the Ontario Occupational Health Nurses Association provides both an excellent source of practical knowledge and a significant number of continuing education credits.

Even in 2016, accessing nursing information can present some challenges: few nursing journals have an open access publication policy; CINAHL, the primary nursing literature database, is expensive, and PubMed, the free medical database, only catalogues some nursing journals. However, the number of journals that provide open access is growing. The Cochrane Library (http://www.cochranelibrary.com) provides free access to abstracts of over 6000 systematic reviews, and the full text of reviews published after February 2013 is freely available one year after publication, including reviews published through Work Cochrane (http://work.cochrane.org). Evidently Cochrane, a weekly blog administered by the UK Cochrane Centre, provides easy access to Cochrane evidence (http://www.evidentlycochrane.net). The CNA NurseONE website provides information on nursing educational resources, many of which are available online (https://nurseone.ca/en/professional-practice).

Some funds are available for ongoing courses. The Ontario Occupational Health Nurses Association offers the Pat Ewen Bursary Fund (http://www.oohna.on.ca/education-funding) and the Ontario government provides education and training funds through the Nursing Education Initiative, which is administered by the RNAO (http://www.health.gov.on.ca/en/pro/programs/hhrsd/nursing/all_nurses.aspx). Nationally, the Lifelong Learning Plan allows you to withdraw amounts from your registered retirement savings plan to finance full-time training or education for you or your spouse (http://www.cra-arc.gc.ca/tx/ndvdls/tpcs/rrsp-reer/llp-reep/menu-eng.html).

Lifelong learning really never ends.

While I'm not nearly as involved in accessing current information as I used to be, old habits die hard. I still receive notification of newly published articles from open access journals and enjoy reading on a variety of topics in my new role as copy editor with Cochrane. Lifelong learning really never ends.

Victoria Pennick, BScN, MHSC, is an educator, author, freelance editor and member of the OOHNA Journal's Editorial Board. She is the former Managing Editor of the Cochrane Back and Neck Group at the Institute for Work & Health, Toronto, Canada.

Note: all websites quoted in the article were accessed 25 March 2016

The 2015 Pan Am/Parapan Am Games Cauldron

The world is what you make it

A healthy community is an ambitious one. Through art, sport and cultural support, we inspire and encourage people to chase their dreams. Contributing our steel for the 2015 Pan Am/Parapan Am Games Cauldron is a proud moment in our storied history. We helped ignite the competitive spirit that brought the best athletes from 41 countries to our backyard. That is a once-in-a-lifetime legacy.

See how we are transforming tomorrow at dofasco.arcelormittal.com

transforming tomorrow

ArcelorMittal
DOFASCO | HAMILTON

RISK MANAGEMENT FOR PROACTIVE STRATEGIES by Marisa Cornacchia

Throughout the course of a nurse's day, risk management is embedded in everything we do. It is the process by which we deliver optimal care and ensure safety and security of clients, staff and colleagues. Drawing similar parallels in the field of Occupational Health, risk management becomes the cornerstone in the design, delivery and implementation of any program, and risk treatment strategies become the critical success factor of these programs. By virtue of the work done by Occupational Health Nurses, their roles are further defined by their ability to continuously undertake risk improvement strategies aimed at the enhancement of the overall health of the organization. This makes it critical to ensure that as professionals, we have a solid understanding of risk management in our day to day practice.

What is Risk Management?

A risk management system provides a framework for the process of identifying hazards, assessing the associated risks, taking the required actions, and reviewing the outcomes. Proper risk management implies bringing control to future events; it is a proactive process rather than reactive practice. Further, "Risk management is the process by which vulnerabilities are identified and changes are made to minimize the consequences of adverse patient outcomes and liability". (Raso and Gulinello, 2010).

In the seminal book, *Risk Management Principles and Practice*, the risk management process identifies issues before incidents occur in order to prevent losses. Author Michael W. Elliot (2012) writes:

> "Risk Management is most effective when issues that lead to losses are identified and managed before the loss occurs…if risky issues can be identified before they lead to incidents and before they lead to losses then those issues can either be removed or managed".

How does Risk Management complement nursing practice?

The overall goal of risk management is to mitigate and prevent avoidable occurrences within your organization and within your scope of practice in order to avoid claims. Most frequently, claims of negligence tend to be top of mind. Negligence is defined as failure to take reasonable care or steps to prevent loss or injury to another person. With the evolving risks and a more litigious environment in health care; the changing landscape of Occupational Health Nursing; and the liabilities involved with managing human lives at work, the nursing practice standard of care becomes the foundation of risk management for nurses.

In an effort to make the connection between the scope of Occupational Health Nursing and the risk management process, it should be noted that there is a distinct parallel between the nursing process and the risk management process. This process is highlighted by the Canadian Occupational Health Nurses Association (COHNA) Disability Management Practice Standard (2012):

"By way of a reminder, the nursing process is a systematic, rationale method of planning and providing individualized nursing care. It is the process by which registered nurses deliver nursing care to patients, clients, companies, or workers. The process is supported by nursing philosophies and concepts. A deductive theory, the nursing process was originally an adapted form of the problem-solving process. A patient-cen-

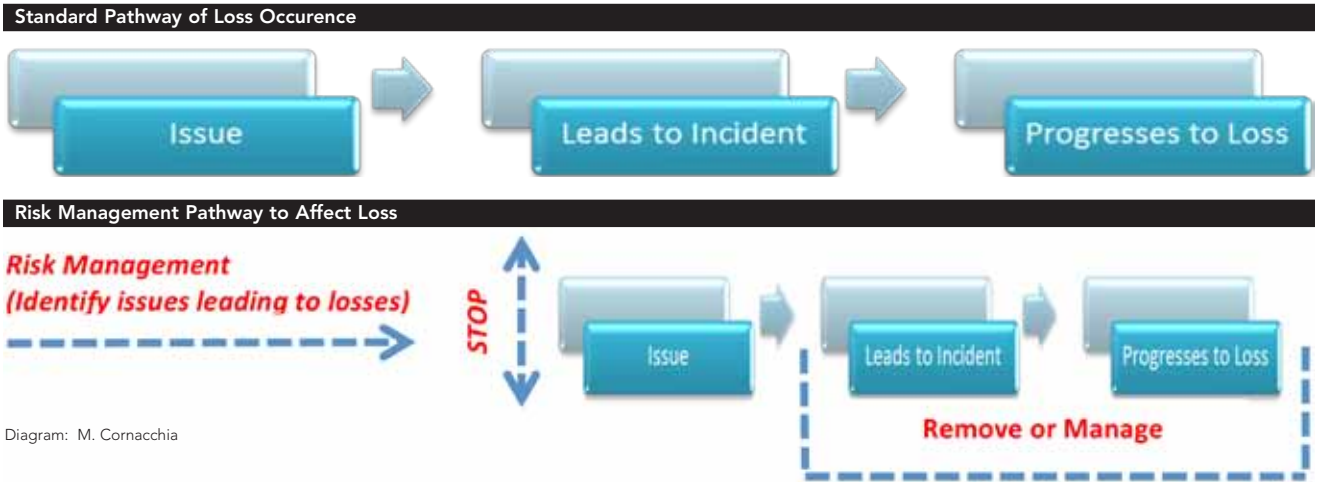

Diagram: M. Cornacchia

tered, goal-oriented method of "caring", the nursing process provides a framework to nursing care. It involves five major steps:

- Assessment *(of company/worker's needs);*
- Diagnosis *(of human response needs that nursing can assist with);*
- Planning *(of company/worker's care);*
- Implementation/intervention *(of care);* and
- Evaluation *(of the success of the implemented care)*

Diagram: D. Alvarenga

How Occupational Health Nursing and Disability Management fit into the Risk Management framework and process

Occupational Health Nurses help organizations identify and control health related risks. Disability Management is a risk treatment tool used to mitigate losses associated with an organization's human capital. According to the Canadian Occupational Health Nurses Association, "a Disability Management Program is a risk management tool that enables an organization to prevent and mitigate workplace illness or injury absences. This approach uses prevention, early intervention, claim management, case management, and graduated return-to-work interventions" (2012). In parallel to this process, the risk management process is also a systemic process that can be described in the following five stages:

1. Risk identification,
2. Risk assessment
3. Risk treatment
4. Process implementation.
5. Monitoring and continuous improvement

Risk Identification

The first stage of the process involves the identification of risks that pose a threat to the achievement of the organization's goals and objectives. Risks may be internal or external. They may be strategic, operational, financial, and reputational risks. Parallel to this process, risk identification helps the Occupational Health Nurse

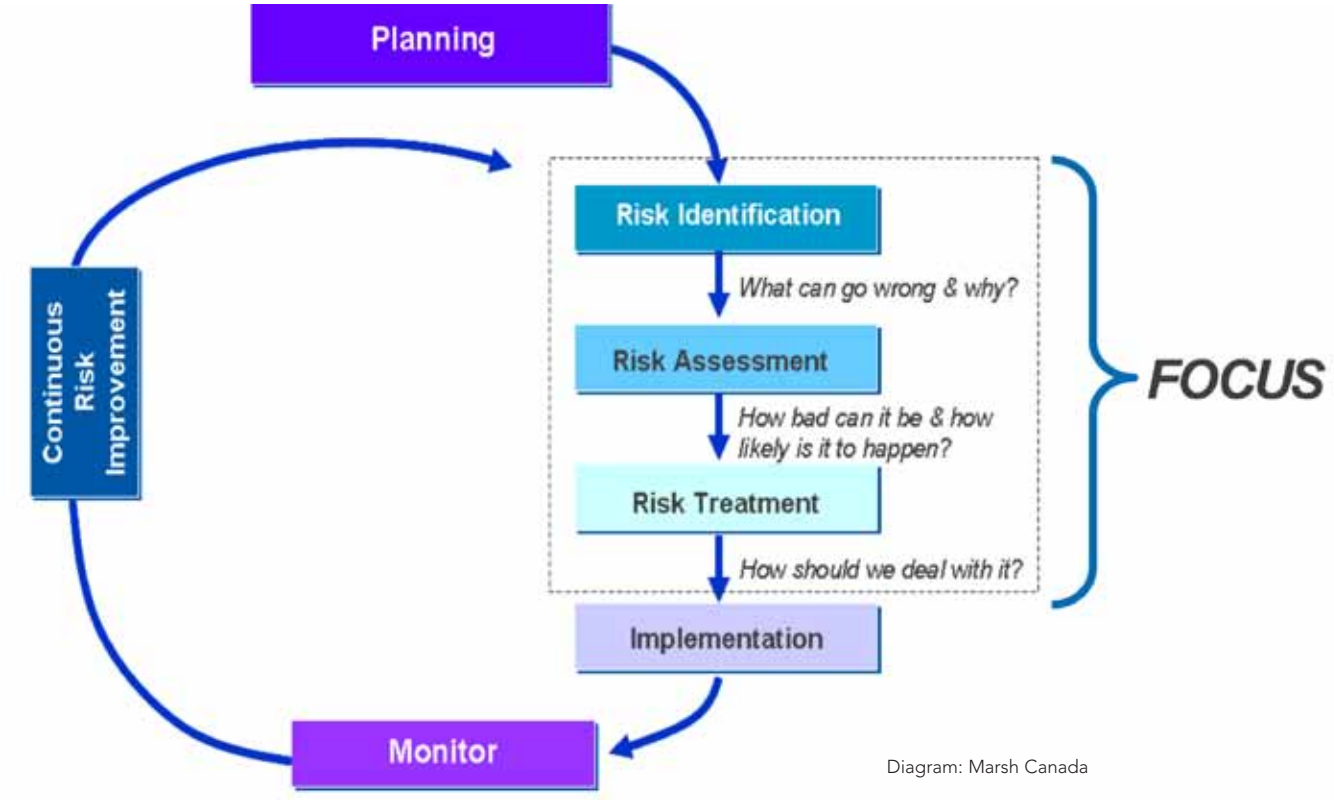

Diagram: Marsh Canada

(OHN) meet the competencies from the Canadian Nurses Association (CNA) *List of Competencies for Occupational Health Nurses* (2013).

Risk Identification
Competency: Identification, Evaluation and Control of Workplace Hazards **Competency: Health Safety and Wellness Management**
The occupational health nurse... 2.1 Implements a comprehensive hazard recognition process (e.g., involvement in the design phase, worksite inspections, health and safety audits, job task analysis, and trend analysis). 2.2 Identifies potential and existing workplace hazards. . . . 6.1.1 Demonstrates leadership in relation to service development and implementation (e.g., gap analyses, needs assessments, environmental scans, benchmarking

Risk Assessment

In the second stage, identified risks are assessed to gauge the possibility or likelihood of occurrence and the potential consequence or impact on the organization's operations. A variety of techniques can be used to prioritize risks. Results from the risk assessment process can be used to develop an organization's risk profile with each risk given a priority ranking. This process has similar attributes in the process undertaken by the OHN by meeting the following competency:

Risk Assessment
Competency: Identification, Evaluation and Control of Workplace Hazards **Competency: Health Safety and Wellness Management**
2.4 Assesses the level of risk and severity of hazards based on probability that harm may occur in a specific situation. 6.2.1 Collects and analyzes internal and external aggregate data.

Risk Treatment

Once risks have been assessed and prioritized, the OHN must select measures to modify the risk. These measures can include: avoiding the risk, modifying the likelihood or impact of the risk, transferring the risk, or retaining the risk. Risk treatment helps the OHN meet the following competency:

Risk Treatment
Competency: Identification, Evaluation and Control of Workplace Hazards
2.5 Makes recommendations for control measures based on identified hazards

Risk Implementation

In the implementation stage, the organization puts its decisions into action and embeds the processes throughout the organization. This stage is a critical component of an integrated risk management program and helps the OHN meet the following competency:

Risk Implementation
Competency: Health Safety and Wellness Management
6.1.2 Sets goals, objectives, policies and procedures that align with organizational strategies and support service development and implementation. 6.1.3 Coordinates provision of services (e.g., emergency preparedness and response, health surveillance, injury management, training/education, hazard recognition). 6.1.4 Illustrates the cost effectiveness of health, safety and wellness services to senior management (e.g., cost benefit analyses, business plans). 6.1.5 Collaborates with senior management to incorporate health and safety into the organization's strategic plan.

Monitoring and Continuous Improvement

Risk management is a dynamic process that does not stop once the programs are implemented. The purpose of any risk management framework is to integrate risk management within the organization's culture. Elliot (2012) states that "The principle that underlies risk management framework is that risk management should add value to the organization. It should not only reduce negative risk but also contribute to profit, reputation and health and safety." It is important to continually monitor the risks and processes to ensure that management understands the critical risks they face on an ongoing basis and, to gain maximum value from implemented processes.

Risk monitoring helps the OHN to meet this competency:

Monitoring
Competency: Health Safety and Wellness Management
6.1.8 Facilitates continuous improvement through the evaluation and revision of services.

thereby ensuring that the Occupational Health Nurse is the cornerstone of support for the framework and process components designed to meet best practices in risk management.

The Parallels

Nursing Process Risk Management Process

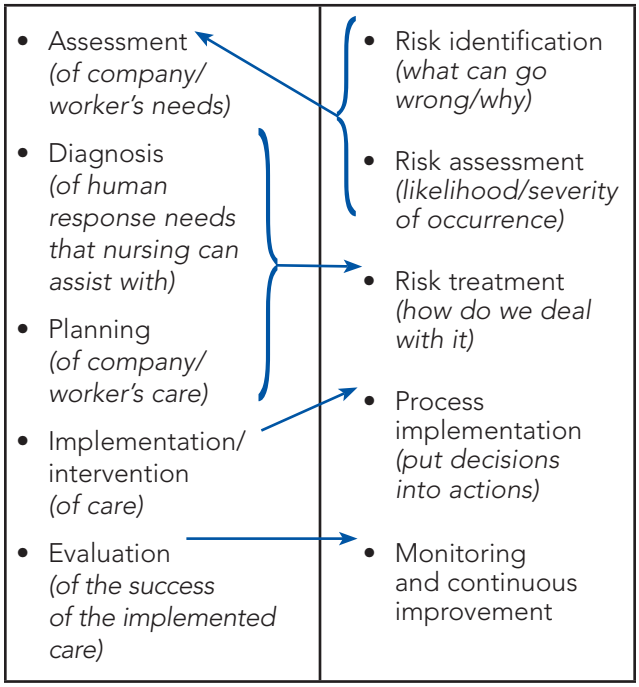

Diagram: M. Cornacchia

A member of the Ontario Occupational Health Nurses Association, **Marisa Cornacchia**, BA, RN, COHN(C), DOHS, MBA is Vice President, Health Care Practice Risk with Marsh Risk Consulting, Toronto, Canada. Email: Marisa.Cornacchia@marsh.com

References

Alvarenga, D. (2016). *Nurse Empowerment Tool: The Nursing Process* https://www.linkedin.com/pulse/nurse-empowerment-tool-nursing-process-alvarenga-msn-arnp-c-pnp

Canadian Nurses Association (CNA). (2013). *List of Competencies for Occupational Health Nurses.* https://nurseone.ca/en/certification/what-is-certification

Dyck, D. (2012). *Disability Management Practice Standard.* Canadian Occupational Health Nurses' Association Inc. / Association Canadienne des Infirmières et Infirmiers en Santé du Travail (COHNA/ACIIST). http://www.cohna-aciist.ca/resources

Elliot, M.W. (2012.) *Risk Management Principles and Practice,* 1st edition. Library of Congress, The Institutes.

Raso, R. and Gulinello, C. (2010). Creating a culture of safety: Risk Management Challenges and strategies. *Nursing Management.* December, Volume 41 Number 12, p 26 – 33.

FOOD ADDICTION: THE HIDDEN SABOTEUR OF WORKPLACE PRODUCTIVITY

by Vera Tarman

Employers lose billions of dollars each year when workers take time off due to illnesses directly related to obesity: diabetes, hypertension, heart disease, stroke, gallbladder disease and gallstones, osteoarthritis, gout, breathing problems, even depression. According to the Integrated Benefits Institute, cited in an article by Bruce Japsen (Forbes, 2012), annual losses in the United States exceed $237 billion from reduced productivity due to illness-related employee absenteeism, or from the lowered efficiency of employees who report to work when unwell. Although not as high, the losses in Canada that same year, $16.6 billion according to the Conference Board of Canada, are not insignificant.

While many workplace weight loss or fitness programs have seen some success in addressing these conditions by directly tackling obesity in their employees, many overweight participants in these efforts often fail to lose weight. This may occur because they have an underlying malady that has gone undetected. The condition, growing in recognition among health care professionals, is food addiction.

What is Food Addiction?

In *Food Junkies: The Truth about Food Addiction* (2014), which I wrote in collaboration with Philip Werdell of ACORN Food Dependency Recovery Services and the Food Addiction Institute, I define this disorder as being equivalent to the disease of alcoholism or drug addiction. In all addictions, biochemical changes occur in the addict that "hijack" the brain's pleasure center, the limbic system, making it impossible for the user to quit using and instead, drives them to seek satiety that never comes. A number of "feel good" neurochemicals, including dopamine, serotonin and endorphins, as well as the hormones leptin and ghrelin, have roles in keeping food addiction active.

The hijacking process can be explained by neuroscience. We know there is a system of neural structures in the brain that controls behavior by creating pleasurable effects. This is known as the *reward system*. The source of addiction—whether alcohol, a drug, the act of gambling, a sexual encounter, or certain foods—causes this part of the brain to react. While there are many things in life that induce pleasure, what matters is the potency of the stimulant. For example, sex gives a dopamine surge of about two hundred units, while cocaine, in comparison, releases four hundred units. It is generally accepted that the brain can handle between one hundred and three hundred units before addiction kicks in (di Chiara and Imperato, 1988).

The payoff of addiction comes about when the reward is unrestrained by the limitation of what life can deliver through natural means. Addiction, with its promise of intense pleasure, overrides the shut-off valve in the brain, and while no one knows precisely when or why a person will cross the line and begin to choose artificial over natural rewards, we do know that artificial substances work because they are more concentrated than natural rewards. We also know that the human brain has not evolved quickly enough to handle these intense surges.

Although the fifth and latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) does not recognize food addiction—only binge eating disorder, a related but not synonymous affliction—addiction professionals remain hopeful that it will one day be included. After the last appeal to the American Psychiatric Association for acceptance of food as an addiction via the *DSM*, the response (posted online at www.addiction.com) was that there was "not yet enough clinical research to prove that food addiction exists as a separate category and diagnosis from disorders such as bulimia or binge eating disorder." Yet there actually are numerous studies (and more coming) that provide science-based evidence for the addictiveness of certain foods. One needs to look no further than mass media bestsellers such as *Salt, Sugar, Fat* by Michael Moss (2013) or *The End of Overeating* by David A. Kessler (2009) to be convinced in layman's terms. The Food Addiction Institute's website (www.foodaddictioninstitute.org) provides a bibliography of nearly 3,000 sources, citing the work of addiction experts such as Nora D. Volkow, Nicole M. Avena, Kelly D. Brownell and Gene-Jack Wang.

Given what we in the field know from clinical experience as well as what these researchers have said about how food addicts abuse food, it is difficult to argue that food addiction does *not* meet the criteria for a substance use disorder. Based on the *DSM-V*'s 2013 revised definition (www.dsm5.org), an affliction of this type "describes a problematic pattern of using alcohol *or another substance* that results in impairment in daily life or noticeable distress." (Page 481)

Diagnosing Food Addiction

While it may be difficult to determine precisely how many patients working with occupational health nurses are undiagnosed food addicts, those who present with disordered eating histories, morbid obesity or diabetes are good candidates for further investigation. Weight alone is not a good criterion, since not all obese people are food addicts and not all food addicts are obese; it is therefore important for the health care professional to be armed with knowledge of the symptoms of food addiction. Does the patient just need nutritional guidance or have they crossed that invisible line that separates eating for pleasure and nourishment from eating for oblivion? Until this addiction is fully recognized and diagnosed with standardized methods, there are at least three diagnostic tools that can provide guidance.

The first is a questionnaire used in various forms by the food-related 12-Step Fellowship's Overeaters Anonymous (OA) and Food Addicts in Recovery Anonymous (FA). Questions used in these quizzes include:

- Have you ever wanted to stop eating and found you just couldn't?
- Do you eat when you're not hungry?
- Do you feel hopeless about your relationship with food?

A second and more vigorously vetted diagnostic tool is the Yale Food Addiction Scale developed in 2009 by Ashley N. Gearhardt, William R. Corbin and Kelly D. Brownell. Gearhardt has described the YFAS as a "standardized self-report instrument for the assessment of food addiction based on the diagnostic criteria for substance dependence." The survey asks respondents to report the frequency of certain addictive behaviors, and correlates each with one or more of the criteria for substance dependence. Examples include:

- I eat to the point where I feel physically ill. (Substance taken in larger amount and for longer period)
- I find that when certain foods are not available, I will go out of my way to obtain them. (Much time/activity to obtain, use, recover)
- I have consumed certain foods to prevent feelings of anxiety, agitation, or other physical symptoms. (Withdrawal symptoms)

The third tool, the foundation for the Yale instrument, is the complete list of substance use disorder (previously called substance dependence) criteria included in the aforementioned *DSM-V*. In order for a person to be diagnosed with this type of disorder, they must display three or four of 11 symptoms, e.g. craving, increased tolerance, withdrawal, loss of control, and negative consequences, within 12 months.

Treating Food Addiction

The first question to address in treating food addiction is the most obvious: What should the food addict eat? Unlike the alcoholic, drug addict or person suffering from a process addiction (gambling, sex, compulsive shopping, etc.), the food addict cannot easily find complete abstinence from their addictive substance. He or she must face their "drug" each day and must be on constant alert to avoid ingesting or even inhaling the seductive aroma of the foods that can trigger craving in the brain's reward center.

The first task is to identify which foods spark the addictive pathways. Sugar leads the list. In a number of surveys of late-stage food addicts, approximately 90 percent identified sugar as the key food they had to eliminate in order to recover from their cravings. The rapidity with which a substance reaches the brain significantly affects its impact; the refining of food is frequently blamed for the rise in its overconsumption, as this processing greatly reduces the amount of time it takes for the pleasure center to be affected. For example, the fibrous stalk that protects the sucrose of sugar cane or the thick bark protecting the sap in a maple tree limits the amount (and speed) of sugar that a primate can ingest. But if one harvests and removes the sugar from the sugar cane or transforms the maple tree's sap into syrup, the result is an experience of an artificial high far more powerful than what the natural version would otherwise allow.

The next two items on the list of frequently identified trigger foods fall tellingly into this same category of processed foods: flour from wheat, rye, oats and other grains that have been stripped of their fibrous husks, and some of the less healthy fats, e.g. trans-fats and saturated fats. Finally, while salt is hard to adulterate, it too can be addictive and the food industry has used this knowledge to engineer potent combinations of sugar, fat, flour and salt (e.g. doughnuts, potato chips, cookies, cakes, pies). While there is still very little clinical research available today to prove that certain food substances are addictive, research on rats and mice as well as 3D nuclear imaging SPECT scans of humans strongly suggest the existence of a link. According to writer Michael Moss, while the medical community may be slow to accept food addiction, food and beverage companies have worked diligently and effectively to find the "bliss point" in each food it engineers (Page 10).

Offering guidance to the food-addicted patient can be a challenge as, without medical verification, insurance companies will not reimburse for treatment of this condition as a primary disease while, ironically, these same companies will

spend billions treating the results. Furthermore, there are few inpatient resources that provide treatment for the condition as an addiction. While alcoholics and drug addicts often have access to detox centers and rehabilitation facilities, food addicts usually do not. Treatment centers that do work with food addicts typically diagnose the client with at least one other "billable" illness such as a recognized eating disorder, in order to bring these patients through the door. The three U.S. facilities providing residential treatment are Shades of Hope in Buffalo Gap, Texas, Turning Point in Tampa, Florida, and Milestones in Recovery in Hollywood, Florida.

While there certainly are treatment centers in Canada, none address food addiction as a primary condition, and will only deal with it as concurrent with another substance use disorder. These centers include Bellwood Health Services and the Centre for Addiction and Mental Health's Donwood Institute, both in Toronto, and GreenStone in Bala, Ontario.

Here in Toronto at Renascent (www.renascent.ca), a rehabilitation center for alcoholics and addicts, we have launched a one-year pilot food addiction program for women. Participants in this trial receive three weeks of residential treatment at no cost, and the program consists of an abstinent meal plan, educational and group therapy and some one-on-one sessions. The difference between this program and the usual eating disorder programs is that it follows an abstinence-based eating plan that eliminates all sugar, flour, grains and extra volume through adherence to weighed and measured portions. So far, in the four months we have been running the program, we have witnessed significant findings: weight loss and freedom from food cravings has been reported by nearly every participant and some clients have actually stopped their insulin or oral diabetic medication, their anti-hypertensives and anti-depressants.

This type of abstinence-based approach to treatment generates a great deal of controversy, as many health care professionals, almost all with good intentions, suggest that moderation in all foods is preferable to the elimination or restriction of certain foods. This is not supported by the volumes of anecdotal evidence we now have from self-diagnosed food addicts who populate the halls of 12-Step, food-related programs. These members maintain that they found no relief from the constant craving for their "trigger foods" until they eliminated them entirely from their diets. (Memoirs such as Michael Prager's *Fat Boy, Thin Man* (2010) and Debbie Danowski's *Why Can't I Stop Eating?* (2000) as well as some of the stories that appear in *Food Junkies* (2014) are just a few of the sources for first-hand validation of the value of abstinence-based eating.)

Because groups such as OA and FA are anonymous, it is difficult to gather data on rates of recovery. A 2010 survey of more than 800 OA members, however, revealed that 69 percent of members had lost weight since joining OA and 51 percent were currently maintaining a healthy weight. It should be pointed out that OA does not endorse any particular eating plan but simply provides a generic definition of abstinence, while some food-related 12-Step groups such as GreySheeters Anonymous (GSA), Food Addicts Anonymous (FAA), Food Addicts in Recovery Anonymous (FA) and Recovery from Food Addiction, Inc. (RFA) do.

ACORN, an American five-day intensive outpatient program which also promotes an abstinence-based meal plan, has attempted to track the progress of its participants. Werdell claims in *Food Addiction Recovery: A New Model of Professional Support*, that one-third of the ACORN's 240 alumnae and alumni surveyed remained abstinent "from a few months to over five years" after attending one of its week-long programs.

Impacts of Food Addiction on Co-workers

As with alcoholism and other addictions, food addiction is recognized as an illness that can negatively impact the addict's family, friends and work colleagues. One need only look to the co-workers of the man or woman who is unable to perform his or her job effectively due to frequent eating breaks, at minimum, or more seriously, near total lack of mobility due to morbid obesity, to reveal potential job site problems. As early as the mid-1980s, food addiction treatment programs included intensive work with the patient's family and friends, as well as an examination of the addict's work environment. Often patients were prescribed a change in jobs—especially those in food-related professions—adding even more costs to the employer who has to financially absorb that loss.

Therefore, it behooves the employer or the occupational health nurse who wants to offer support to the recovering food addict to discourage onsite indulgences, e.g. doughnuts at meetings, sweets for celebrations, vending machines filled with sugary snacks. While such an effort might be launched to encourage a healthier general population, it can carry the added benefit of supporting the food-addicted employee's recovery and restoration to full productivity.

Vera Tarman is a medical practitioner with a specialty in addiction medicine. She was accredited by the Board of Addiction Medicine (ABAM) in 2004 and founded the website Addictions Unplugged, which serves as a portal and discussion forum for medical professionals, front-line addiction workers and those affected by addiction. Although she lectures and teaches on various issues related to addiction, her special interest is in the area of food addic-

tion. Dr Tarman is the medical director for Renascent, Canada's largest residential treatment center for drug and alcohol abuse and is the clinical director for its inaugural food addiction program. She is the author of the recently published *Food Junkies: The Truth about Food Addiction.*

References

di Chiara, G., Imperato, A. (1988). Drugs abused by humans preferentially increase synaptic dopamine concentration in the mesolimbic system of freely moving rats, *Proceedings of the National Academy of Sciences of the United States of America,* 84, no. 14, 5274-78.

Foushi, M., Weldon, C., Werdell, P. (2007). *Food Addiction Recovery, A New Model of Professional Support: The ACORN Primary Intensive.* Sarasota: EverGreen Publications.

Japsen, B. (2012). U.S. Workforce illness costs $576B annually from sick days to workers' compensation. *Forbes.* Retrieved January 2016 from http://www.forbes.com/sites/brucejapsen/2012/09/12/u-s-workforce-illness-costs-576b-annually-from-sick-days-to-workers-compensation/

Kessler, D. (2009). *The End of Overeating: Taking Control of the Insatiable American Appetite.* New York: Rodale Inc.

Medina, J. (2015). Symptoms of Substance Use Disorders (Revised for DSM-5). *Psych Central.* Retrieved January 2016 from http://psychcentral.com/disorders/revised-alcoholsubstance-use-disorder

Meule, A., Gearhardt, A. (2014). Five years of the Yale food addiction scale: taking stock and moving forward. *Springer Publishing.* Retrieved January 2016 from http://fastlab.psych.lsa.umich.edu/wp-content/uploads/2014/06/MeuleGearhardt_FiveYearsof theYaleFoodAddictionScale-TakingStockMovingForward_2014.pdf

Moss, M. (2013). *Salt, Sugar, Fat: How the Food Giants Hooked Us.* New York: Random House.

Overeaters Anonymous. (2011). 2010 Membership Survey Report. Retrieved January 2016 from https://www.oa.org/pdfs/member_survey.pdf

Schulte, E., Avena, N., Gearhardt, A. (2015). Which foods may be addictive? The roles of processing, fat content, and glycemic load. *PLOS One.* DOI: 10.1371/journal.pone.0117959

Stewart, N. (2013). Missing in action: absenteeism trends in Canadian organizations. *Conference Board of Canada E-Library.* Retrieved January 2016 from http://www.conferenceboard.ca/e-library/abstract.aspx?did=5780

Tarman, V. (2014). *Food Junkies: The Truth about Food Addiction.* Toronto: Dundurn Press.

Werdell, P. (2009). Bibliography on science and treatment of food addiction. Food Addiction Institute. Retrieved January 2016 from http://foodaddictioninstitute.org/FAI-DOCS/Full-Bibliography.pdf

COGNITION AND RETURN TO WORK by Nancy J Gowan

Have you ever stopped to think about how often we use our brain at work? (Many of you may be saying...not enough!) Our brains are amazing! We have the ability to do our day to day activities without even consciously thinking about it. We breathe, move, get ready every morning and even drive without having to think about each step. We really only appreciate the importance of our brain when something goes wrong... we can't remember a name, our grocery list or we have trouble organizing our thoughts.

When we are ill or injured, our brain can be effected.

Did you know that a common symptom of depression is loss of concentration? Sometimes it takes up to a year to get concentration capacity back once depression is treated.

Learning disabilities and autism spectrum disorders effect our information processing capabilities and medications to treat illness can impact how we think and perform job tasks.

Concussions are common injuries. We know that concussions are frequent and can impact memory, concentration and our ability to organize our thoughts. A simple bang on the head during soccer, football or hockey can lead to a concussion but multiple concussions can lead to long term brain effects. A whiplash injury can lead to mild damage in the brain that effects our memory and even emotions.

You may not realize how our habits impact our brain. What we eat, drink and our leisure activities have huge impacts on our ability to process information.

Hidden Disabilities

The number of people in the workplace with disabilities, including hidden disabilities, has been rapidly increasing since the early 1990s.

> Cognitive disabilities can impact an employee's basic skills, social skills, or both.

Hidden disabilities include cognitive, chronic health, and psychological disabilities. The Participation and Activity Limitation Survey in 2006 reported that "4.4 million Canadians living in households reported having an activity limitation yielding a disability rate of 14.3%." This is an increase from the 2001 disability rate of 12.4%, when 3.6 million Canadians reported limitations in their everyday activities due to a physical or psychological condition or to a health condition. The increase is due to a number of factors, including aging of the population and changing reporting behaviours.

The BrainFx website quotes Neuroscience Canada (2010), which indicates one in three individuals will experience a brain disorder during their lifetime and 85% of these brain disorders are mild. Brain Dysfunction can occur as a result of mental health issues, trauma to the brain, learning disabilities and other chronic health conditions. This makes understanding employees' cognitive strengths and challenges, and monitoring changes over time all the more important. As with physical health, early detection and intervention improves brain health outcomes. For those experiencing brain dysfunction, better understanding means targeted work adjustments and intervention options, key to improving quality of work. Employees who have experienced mental illness, chronic conditions, physical trauma or learning disabilities may struggle to return to work without a proper assessment and return to work plan. Therefore, it is now more important than ever for employers to be knowledgeable about all types of disabilities and their responsibilities under the law.

In addition to knowing the law, it is important to know the facts about hidden disabilities and how they impact people in the workplace. Employers often believe that people with hidden disabilities, such as learning disabilities or psychological problems, will not be able to fulfill their job responsibilities effectively. This is a grave misconception. Employees with disabilities can perform their tasks just as well as anyone when provided with reasonable accommodations. In fact, employees with hidden disabilities often work harder, or are more motivated, than non-disabled employees.

Cognition

"Cognition" refers to "understanding"—the ability to comprehend what you see and hear, and to infer information from social cues and body language. People with these impairments may have trouble learning new things, making generalizations from one situation to another, and expressing themselves through spoken or written language.

Impact of Cognitive Disabilities in the Workplace

No matter what type of work you do; you are always using your

brain. The more routine that we build in our work the less conscious we are of our tasks and how to do them.

When we are first learning a task our brains are working hard to focus on our learning of each step; what tools do we need; what type of analysis are we doing; and what problem solving or organizational strategies we need. We take notes, reread information and practice the skill we are trying to learn.

As we learn, our brain builds working memory of our tasks. Eventually we complete our tasks less consciously. However, when illness or injury interferes with our brain function, working memory is impacted and we may need to go back to develop new tools that do not necessarily rely on our internal brain functions.

Cognitive disabilities can impact an employee's basic skills, social skills, or both. In some cases, the "academic" areas such as reading, writing, and math are affected; in other cases, the employee has difficulty reading social cues and interacting with people. Other problems that may exist include inability to manage time, restlessness, distractibility, poor memory, and the need for extra time to complete projects.

It is important for the employer to know that these are real disabilities—no less real than visual, hearing or mobility impairments. One of the most frustrating things to deal with for people with cognitive disabilities is the disbelief of others regarding the authenticity of their problems. Individuals with cognitive disabilities are of average or above average intelligence, yet often they are treated as "stupid". In many cases they work much harder than their peers to achieve the same results, yet they are sometimes seen as "lazy" or getting "special treatment".

What does your job require of your brain? What thinking skills do you use and what complex cognitive resources are part of completing your job tasks? A Cognitive Demands Analysis (CDA) can provide details of each skill or resource an employee will require to meet the essential duties of the job. Just as a Physical Demands Analysis will outline how much strength or agility an employee requires, a CDA defines cognitive requirements.

When looking at returning an employee to the workplace or assisting the employee to stay at work through illness or injury a CDA is critical in matching the job demands to the employee's function. It is important to also understand what the employee's cognitive functional strengths and limitations are related to the job. A Functional Cognitive Assessment can provide objective information about working memory, concentration, problem solving skills, organizational skills, and complex analysis.

Once you have both pieces you can develop a stay at work / return to work plan that will support success at work. A skilled occupational therapist can help you develop strategies to bridge any gaps that may be present between an employee's functional cognitive limitations and the job demands. Accommodations such as a flexible schedule, screen-reader or quiet work environment are no different for someone with a cognitive disability than a wheelchair is for a person with a physical disability.

Contextual Influences on Cognitive/Behavioural Work Demands and Worker Performance

Workplace factors need to be considered in evaluating the impact of contextual factors on worker productivity and performance:

- Time pressures
- Deadline pressures
- Safety pressures
- Security pressures
- Life and death pressures
- Exposure to emotional situations
- Exposure to confrontational situations
- Exposure to high risk with regard to safety and physical well being
- Exposure to environmental stimuli (i.e. noise, people, machines, distractions, etc)

The consideration of the environment, and how it shapes the way work unfolds in a given environment, is essential for designing a successful RTW program.

Cognitive Demands Analysis

In parallel to a Physical Demands Analysis, a Cognitive Demands Analysis (CDA) is a work specific objective evaluation of the cognitive, emotional and psychological skills required to perform the *essential* duties of a position.

It is *job specific,* not worker specific. Any measurements must be taken of the workstation, not the worker. It describes what the worker must be able to do, using reproducible measurements.

One example of a JDA tool is the City of Toronto Job Demands Analysis Tool (CoT), which addresses physical, cognitive, and behavioral aspects of work. This instrument was developed by therapists, ergonomists, occupational health personnel, and a consulting psychiatrist based on their experiences with a broad spectrum of jobs and workers over several years. A four-point rating scale is provided for each item, with "4" representing the highest level of demand. Unique descriptions are provided for each rating level within each item.

Functional Cognitive Work Assessment

Once the cognitive work requirements are understood, the therapist may then take steps to identify cognitive performance strengths and weaknesses of the worker, acknowledge gaps or mismatches between the worker and the work requirements, and develop a comprehensive RTW intervention that matches a worker's abilities to suitable job demands.

The assessment involves a comprehensive review of the work duties, processes and productivity requirements; a meeting with the manager to discuss any behavioural or performance concerns and a comprehensive functional cognitive assessment of the employee. The occupational therapist provides a report that will indicate the employee's current cognitive functional strengths and areas of challenge and strategies that will allow the employee to improve their function in the workplace.

Following the performance assessment, a report is generated that can be shared with the health care team and functional results can be provided to the employer to assist with determining any adjustments that may be needed at work.

Concussions and Our Brain

Current research indicates that concussions are more common in sports, following falls or motor vehicle accidents than we ever realized. Small bruises of the brain can cause difficulty with concentration, memory and even our moods.

For return to work planning consider the following steps after a concussion:

- Gradual work hours may be needed.
- Build in rest breaks as there can be cognitive and physical fatigue.
- Reduce heavy physical activities.
- Consider external memory aids.
- Watch for signs of mood changes and provide support.
- Reduce cognitive demands initially to allow for healing.
- Consider ways to manage headaches (area to rest, reduced high focus activities, lighting).

There are many types of learning disabilities. It is important to assess what areas of learning are difficult for your employee through a thorough Functional Cognitive Assessment.

Learning Disabilities and Our Brain

There are many types of learning disabilities. It is important to assess what areas of learning are difficult for your employee through a thorough Functional Cognitive Assessment. The functional assessment will provide you with the strategies that will be best suited for the employee's needs.

While strategies should be specific to the employee's function and job demands, some examples include:

For reading:

- Allow employee to seek out different sources and intensities of light.
- Allow privacy for reading aloud
- Provide a space with minimal distractions.
- Make shorter assignments and/or allow more time for completion.
- Rewrite difficult written material required for a job task, using simpler language.
- Provide tape-recorded instructions, messages, materials (on the job).
- Listen to books on tape or books on computer disk.
- Use scan and read software and other technology.
- Use screen reader software.

For writing:

- Provide a workspace with minimal distractions.
- Allow employee to seek out different sources and intensities of light.
- Discuss the purpose and rationale for each writing activity.
- Provide models of practice with on-the-job writing tasks.
- Begin with small writing tasks and allow plenty of time.
- Build writing practice into the training by setting aside time for daily journal entries on the subject being taught.
- Suggest that the employee use a tape recorder to dictate what he/she wants to write, then play it back and write it down.
- Encourage use of assistive technology.
- Use report writing mind mapping software.

For calculating:

- Allow use of calculators and other computational tools to solve problems on the job.
- Allow extra time for tasks involving math.
- Reduce chunks of assigned task to avoid overloading memory and attention span.
- Assign group work with roles for different employees so math is not required of everyone.
- Use calculators and low-tech aids, such as pocket-sized multiplication tables, measurement equivalents, etc.

For organization:
- Seat employee in area free of distractions.
- Help keep employee's work area free of unnecessary materials.
- Provide opportunities for movement.
- Help employee develop an organized space (notes on one subject kept together, supplies kept together, file folders for organizing, etc.).
- Break work into smaller amounts.
- Allow employee to decide what task to do first, second, third, etc.
- Help employee set time goals for each task.
- Use calendars and to do software to schedule blocks of time for tasks and deadlines.
- Help employee develop a checklist for each step.

There are many technological software solutions available but the first step is getting a clear assessment to ensure that the software is suitable. Then make sure to build in training time for implementation. Perhaps a Job Coach may be required to implement the tools.

Mental Illness and Our Brain

Mental Illnesses can impact how someone feels, behaves and thinks. Cognitive challenges are an important symptom of most mental illnesses. Depression can cause concentration difficulties for up to a year after proper diagnosis and treatment. Anxiety can lead to difficulty with organization of thoughts, concentration and problem solving. Having strategies to manage these symptoms at work will improve the success of an employee remaining at work or returning to work.

Some strategies for managing these symptoms can be implemented through simple work adjustments.

Concentration:
- Identify high energy times during day.
- Perform tasks that require energy during high energy day times (do the tasks that are less rote or automatic).
- Use time blocking to allocate tasks.
- Routine and rote tasks should be in less desirable energy times.
- Review task list for least desirable tasks.
- Understand the characteristics that make them less desirable.
- Find strategies that allow for improved timeliness and punctuality (see below).
- Break down tasks into smaller goals and day to day goal setting to allow for improved goal achievement. Explore www.mindtools.com for training options and tools.

Memory:
- Use Outlook reminders to check emails on a regular basis, reminders for deadlines on projects, and checklists to ensure that the company processes are followed.
- When being assigned a project, ask for clarification when required. Write down specific details regarding the project. When completed, the details of the project should be reviewed before giving the finished project to the project manager or the creative director.
- Write down important or complicated issues.
- Ask for instructions in writing.
- Take minutes at meetings.
- Ask for assignments in writing.
- Ask for additional training time.

For sequencing problems:
- Break lengthy sequences into parts.
- Provide cue sheets or prompts (e.g. schedule of events, list of jobs, steps in a process).
- Maintain regular schedules and routines in class or on the job.
- For problems with recognizing important information and classifying/sorting, highlight or color code written material to draw attention to critical features and show relationships.

These are just a few strategies but it is important to assess the employee's functional abilities and job demands to find the right fit of strategies.

Lifestyle and Our Brain

Alzheimer disease is expected to increase threefold in the next decade. Researchers have found that the impact of lifestyle on the brain and the diagnosis of Alzheimer's is proven. High fats, high sugars and alcohol have been shown to have a degenerative effect on the brain, while high stress levels, heavy workloads and low rewards increase cortisol levels in the body and blood which impact brain function.

Fitness and cardiovascular health have a positive effect on brain function, as do mindfulness, stress management training and relaxation.

What can you do as an employer?
- Promote physical fitness and diet related health programs.
- Build a social support program that encourages healthy eating habits and exercise.
- Provide programs to support reduction in obesity.
- Create group challenges at work (we make changes when supported by groups).
- Encourage brain exercises (challenges that encourage use of the brain: word games, memory challenges, creative tasks).
- Educate employees on the connection between lifestyle and brain function.
- Educate managers on ways to improve mental health support in the workplace.
- Provide mindfulness training and resiliency training.

Cognition is impacted by many hidden disabilities and as an employer it is important that you are able to evaluate the demands of the job and the capabilities of the worker in all situations—especially where cognition is involved. It is beyond the capabilities of a family physician to provide you with the information that you will require to perform a thorough return to work plan when dealing with cognitive challenges. Looking to resources that can support assessment of cognition and cognitive demands will be the difference between a sustainable return to work and one that fails. An employer cannot afford to guess at these issues as these invisible cognitive concerns can lead to safety risks, performance concerns and additional lost time.

Nancy Gowan, BHSc (OT), OT Reg(ON), CDMP is an Occupational Therapist and Certified Disability Management Professional working in Stay at Work/ Return to Work. As President of Gowan Consulting she has assisted employers with the development of disability management strategies. She has written *A Human Resource Managers Guide to Managing Disability in the Workplace* with Carswell, Thomson Reuter's publications in 2010 with the 2nd edition coming out in 2016.

References:

BrainFX materials (www.brainfx.com). Accessed 2015.

Canadian Mental Health Association – Ontario Division. (www.ontario.cmha.ca)

Conference Board of Canada. (2001). *Tapping the Talents of People with Disabilities: A Guide for Employers* (www.conferenceboard.ca)

Employment Accommodation Service Adaptive Technology Resource Centre, University of Toronto (http://www.adaptech.org/en/team/atrc)

Gowan Consulting (www.gowanhealth.com)

Job Accommodation Network in Canada (JANCana) (www.jan.wvu.edu)

Learning Disabilities Association of Canada. (http://www.ldac-acta.ca)

Microsoft Accessibility (www.microsoft.com/enable)

Shaw, L. and Lysaght, R. (2008). Cognitive and behavioural demands of work. In K. Jacobs (Ed.) *Ergonomics for therapists,* (pp. 103-119). Mosby Elsevier Inc.

Statistics Canada. (2006). *Statistics Canada, Participation and Activity Limitation Survey*

MEDICAL MARIJUANA AND TRUCKING: IMPLICATIONS ON HEALTH POLICY

by Nora Constas

Throughout the course of the last several years, numerous changes within medicine and pain management have created some riffs between various stakeholders. It is the purpose of this article to review current practices in healthcare regarding the use of psychoactive drugs including medical marijuana in the management of pain and its implications on safety, health policy and the trucking industry. For the purposes of this article, the intent is to provide information and education regarding new and emerging practices, implications for the industry as well as Human Resources related implications.

Medical marijuana is not a new issue in Canada. In 2001 Health Canada began the Medicinal Marijuana Access Program (MMAP) in an effort to provide improved access to medicinal marijuana for persons with chronic and palliative conditions who have had little success with conventional lines of therapy. This access would require the support of their primary care medical or nurse practitioner.

Many Canadians suffer constant pain as a result of underlying chronic or complex medical conditions. Many have stated that the cannabinoid medicine has provided some relief from various ailments including spasticity, nausea, vomiting, Wasting syndrome, and discomforts associated with HIV/AIDS, neuromuscular disorders or cancers. There are conflicting positions regarding the efficacy and safety of cannabis in the management of complex and chronic diseases including chronic pain management. Furthermore, in 2013, the College of Family Physicians (CFPC) put out a position statement regarding the scarcity of available scientific evidence demonstrating the role of medical marijuana in the management of these clinical presentations. Moreover, the CFPC stated in the position statement that it looks to Health Canada to provide further guidance on the risks and benefits of cannabis as a form of therapy with appropriate evidenced based rigorous scientific studies. They should also consider providing guidelines regarding guidelines and precautions. The CFPC also states that there are currently no medications out there in which the prescribed method of delivery would be smoked given the known carcinogenic effects of smoking. That being said, there are two off label THC (synthetic cannabinoids) used in the management of nausea (Nabilone) and inhalation and Savitex for spasticity and management of neuropathic pain.

Despite these attestations, there are various underlying variables that need to be taken into consideration when developing appropriate workplace policies for organizations that operate in safety sensitive roles.

It is the position of the National Safety Council's Committee on Alcohol and Other Drugs that it is unsafe to operate a vehicle or other complex equipment while under the influence of cannabis (marijuana), its primary psychoactive component, Δ9-tetrahydrocannabinol (THC), or synthetic cannabinoids having comparable cognitive and psychomotor effects, due to the increased risk of death or injury to the driver and the public (August 14, 2012).

Safety for All – Employers and Employees

Safety in trucking is a critical part of the day to day operations for any fleet organization. Workplace policies, rules and standards have to be designed to reflect the safety component and need to demonstrate the relationship between job safety and performance and not impede on an individual's human rights. According to the Canadian Human Rights Commission: "When determining whether a job is safety sensitive, one must consider the context of the industry, the particular workplace and an employee's direct involvement in a high-risk operation. Any definition must take into account the role of properly trained supervisors, and the checks and balances present in the workplace". (2013).

Characteristics of safety sensitive positions include:

- One in which incapacity due to drug or alcohol impairment could result in direct and or significant risk of injury to the employee, others or the environment.
- One must consider the context of the industry, the particular workplace and the employee's direct involvement in a high risk operation.

Based on the aforementioned definition, trucking and transportation are in compliance with the definition of a safety sensitive position.

It has been established that marijuana, like many other controlled substances such as opioids, can reduce reaction time, impact short term memory and motor coordination. Furthermore, there are several studies that have demonstrated similar findings in controlled settings. According to the National Safety Council Committee on Alcohol and Other Drugs: Position on the use of Cannabis (Marijua-

na) and Driving: "Studies evaluating actual driving performance demonstrated dose-dependent THC impairment in road tracking, even following low to moderate THC doses that were required due to safety concerns" (2014). Not unlike other medications used in the management of pain and complex medical conditions, persons who are ingesting psychotropic medications to manage an underlying medical condition are at higher risk. This then begs the question—what is the role of the employee? Furthermore—what is the role of the employer? In order to answer these questions, numerous variables need to be taken into account.

Role of the Employee

It is the role and responsibility of the employee to be an active participant in the safety of the organization as well as themselves. It is important to note that employees should be encouraged to come forward and disclose (in confidence to their employers) their dependency on drugs or the use of cannabis as part of their medical treatment for underlying medical conditions. There is a stark difference between individuals who consume cannabis recreationally and those with an identified disability. That being said, an employee must be accountable for their own actions.

Role of the Employer

Once a dependency has been diagnosed by a professional, the employer should accommodate the employee through support, treatment and rehabilitation options. The employer may also be justified in the temporary removal of that employee from a safety sensitive position. Upon successful completion of a rehabilitation program, the employee may then be able to return to their position. The employer may also implement conditions for that return including random drug testing. This is because, given the underlying nature of the dependency, there is an inherent risk of relapse upon which the employee may require accommodation to the point of undue hardship.

Random testing in these scenarios should be part of a broader more holistic medical assessment, treatment and planning and support for the employee. Once the employee has reached a pivotal point (the six-year mark), random testing is no longer required. The Canadian Human Rights Commission's Policy on Alcohol and Drug Testing (2009) has established that six years is the point at which the risk of relapse "is no greater than the risk of a member of the general population will suffer a substance abuse problem".

Random testing is also permissible in the following situations for those in safety sensitive positions:

- Post-accident or incident
- Near miss
- Report of dangerous behaviour
- Reports to work in an unfit condition

Despite the aforementioned reasons for testing, it is imperative to note that testing positive for cannabis does not necessarily constitute impairment. Given the extensive half-life of the drug, there can be evidence of cannabis in urine or blood toxicology for weeks or months after consumption.

It should be noted that although random drug testing may be permissible in safety sensitive positions as a condition of employment, the employer needs to be able to accommodate and provide supportive and rehabilitation options for these employees.

Conclusion

Medical marijuana will continue to present a challenge for employers in safety sensitive positions. Like all medications that can potentially impair judgement or slow down reaction time, organizations and employers need to adopt programs and policies that focus on identifying safety risks and impairment. These programs cannot be punitive in nature, but rather supportive and remedial. A comprehensive set of policies focused on health, education and health promotion activities should be implemented within the workplace to ensure safety for employees, risk mitigation and organizational resiliency.

Nora Constas, MBA, MN, NP-PHC, is Senior Vice President at Marsh Risk Consulting and is MRC's National Practice Leader in Healthcare and Clinical Risk. She is also a licensed Primary Care Nurse Practitioner. Email: nora.constas@marsh.com

References:

Canadian Human Rights Commission's *Policy on Alcohol and Drug Testing* Revised October 2009. Retrieved from: http://www.chrc-ccdp.gc.ca/sites/default/files/padt_pdda_eng.pdf

College of Family Physicians of Canada: *The College of Family Physicians of Canada Statement on Health Canada's Proposed Changes to Medical Marijuana Regulations* (2013). Retrieved from: http://www.cfpc.ca/uploadedFiles/Health_Policy/CFPC_Policy_Papers_and_Endorsements/CFPC_Policy_Papers/Medical%20Marijuana%20Position%20Statement%20CFPC.pdf

National Safety Council Committee on Alcohol and Other Drugs: *Position on the use of Cannabis (Marijuana) and Driving.* (2012). Retrieved from: http://www.nsc.org/NSCDocuments_Advocacy/CAODMedicalMarijuanaPosition.pdf

WORKPLACE BULLYING IN NURSING – PART 2: PREVENTION AND MANAGEMENT

by Henrietta Van Hulle with Donna Marshall

As mentioned in Part 1 (2015 Fall/Winter OOHNA Journal, Vol. 34, No. 2), bullying creates a toxic work culture that can have negative consequences to everyone in a workplace. Recognizing the signs of bullying early and stopping the behaviours from penetrating deeper into the team dynamics is absolutely critical. Three components that lend support for implementing a comprehensive bullying prevention program are:

1. Legislation

Workplace bullying and harassment are not only psychologically destructive but violate current legislation and standards. Under the Ontario Occupational Health and Safety Act (OHSA) workplace harassment is defined as, "engaging in a course of vexatious comment or conduct against a worker in a workplace that is known or ought reasonably to be known to be unwelcome".

This is a very broad definition that is open to subjective interpretation. What one person finds "vexatious" another may not. Organizations need to respond responsibly and seriously to all reported incidents of workplace harassment because in this case, harassment is "in the eye of the beholder." The OHSA requires all workplaces to implement harassment policies, measures, procedures, and programs to ensure the psychological safety of all workers in Ontario

2. Standards

The National Standard of Canada for Psychological Health and Safety in the Workplace (the Standard), was published in January 2013 by the Canadian Standards Association and the Bureau de Normalisation du Quebec (BNQ). It defines a psychologically healthy and safe workplace as one that "actively works to prevent harm to workers' psychological health, including in negligent, reckless, or intentional ways, and that promotes psychological well-being".

The Standard is voluntary and includes a set of guidelines, tools and resources to assist workplaces. One of the attractive qualities of the Standard is that it can be implemented in whole, or in part and it can be done piece by piece, over time. Implementing the Standard can help workplaces move to a culture where harassment and bullying will not be accepted by anyone in the workplace.

3. Case law

In April 2014 the Workplace Safety and Insurance Appeals Tribunal (WSIAT) ruled that the legislative limits for "mental stress" claims were discriminatory. The ruling was based on the case of a nurse who claimed that a doctor had harassed her for the last 12 years of her 28 years of employment, repetitively and consistently demeaning and belittling her in front of her colleagues and patients. Her employer was aware of the incidents but did not address them. When the nurse finally made a formal complaint, the hospital responded by reducing her duties ("punishing" her for reporting—which is another act of bullying against the employee). Both the doctor's behaviour and the nurse's demotion caused her to suffer a mental stress disorder. According to the magazine *HR Professionals*, the WSIAT found that the sections of the Workplace Safety and Insurance Act (WSIA) limiting mental stress claims were unconstitutional because they discriminated against those with mental disabilities compared to workers with gradual onset physical disabilities (2015).

What to Do

As a result of recognition of work-related mental stress claims arising from repeated workplace harassment/bullying, employers should seriously consider the need to implement best practices to avoid a toxic environment. The Conference Board of Canada Primer lists the following "Good Practices:"

- Define bullying and develop policies, procedures and programs to prevent and manage bullying in the workplace;
- Proactively curb bullying through employee education including organizational and legislative expectations, what to do and what not to do and the consequences of bullying behaviour;
- Teach employees about how to self-manage interpersonal conflict;
- Promote constructive interpersonal behaviours and self-awareness; and
- Educate employees and managers about why bullying

should be addressed including the business case against bullying (2015).

How to Do It

Developing a Program

As with any other workplace hazard, organizations should be applying the RACE principle: Recognize, Assess and Control workplace bullying and harassment, and then Evaluating that the measures they have put in place are actually working (See PSHSA's *Bullying in the Workplace: A Handbook for the Workplace,* which is a free download and contains tools to assist).

Recognize – Recognition can be achieved by the employer or supervisors actively identifying if bullying exists, or has the potential to exist. This includes training management on how to create a transparent and accountable culture where employees feel safe to report as well as gathering information through observations and monitoring feedback from exit interviews and one-on-one meetings.

Assess – Assessing the risks can include culture surveys; Leadership 360 assessments that measure behaviour; reviewing the conditions and practices that can lead to bullying; and monitoring if they occur at worksites (excessive criticism, denying opportunities, work overload, gossip or false rumours, etc.).

Control – Controlling the risk requires the development of policies, measures, procedures and programs to report, investigate and come to judgement regarding incidents of bullying and harassment in the workplace. A comprehensive training program along with appropriate mechanisms of accountability for all staff, regardless of their seniority in the organization, is crucial to success.

Evaluate – Evaluation through follow up culture surveys and Leadership 360's can measure if the strategies are effective and identify gaps for improvement. Usually these are monitored by Human Resources with consultation of the Health and Safety representative or Joint Health and Safety Committee.

Programs, Training and Skill Development

Understanding and addressing psychological issues such as bullying and harassment and their impact on the mental health of employees is a complex area, requiring the expertise of mental health professionals to develop psychologically safe training and programs.

I spoke with Donna Marshall, who is the CEO of BizLife Solutions and a keynote speaker and educator on workplace bullying, psychological safety and mental health issues in the workplace. She and her business partner, Dr. Stephanie Bot (a Toronto psychologist specializing in workplace bullying and harassment) developed the Harassment Education Advisory Response Team (HEART ™) program that is running in over 1,000 workplaces in Ontario, throughout Canada and the United States. The HEART™ Program has been endorsed by the Ontario Psychological Association as the "gold standard" approach to dealing with workplace bullying. HEART™ teaches and supports employees on how to investigate, manage and prevent workplace bullying and harassment in a psychologically sound and effective manner that bypasses the power differentials at the root of these issues.

BizLife Solutions has developed a comprehensive system to help organizations understand, prevent and manage workplace bullying that includes:

- Online training library that educates on legislation and standards, understanding bullying and its impact on individuals and the organization and communication and interpersonal skills training for all employees;
- The HEART™ Program that provides policies, measures, procedures and programs to implement organizational best practices to identify and address workplace bullying;
- Performance reviews that integrate behavioural best practices and create accountability for respectful behaviour and communication;
- Treatment and training for employees with aggressive behaviour;
- Treatment and resources for employees who have been bullied and harassed.

I asked Donna Marshall to provide two real life workplace bullying scenarios and how she would handle them.

Scenario #1:

I am an Occupational Health Nurse. A worker in one of my departments has reported to me that a co-worker is constantly "picking" on her. She explained that if she asks a question in a meeting the co-worker rolls her eyes and ridicules her; if she arrives a couple of minutes late to a meeting the co-worker points it out in a condescending tone (even though others frequently arrive after her); and she consistently leaves her out of relevant meetings. The frequency of these kinds of incidents is increasing and the worker tells me she is experiencing anxiety, an inability to sleep and dreads coming into work every day. What is

my responsibility under the OHSA and how do I handle this situation appropriately?

Donna:

The OHSA requires that you report "any contravention of the Act or the regulations or the existence of any hazard of which he or she knows." This can be tricky if the worker specifically asks you not to say anything. If they request confidentiality, document the details of the complaint for your own files and tell the worker that you won't share the information without their consent. You can advise the worker of the options they have within the organization to make a formal complaint (through HR) and, if you are comfortable, offer to support them in that complaint. Explain the organization's investigation procedure and advise them of any resources the organization offers such as EAP or Psychological Counselling through extended health coverage; and/or suggest they seek legal advice. If there is a HEART™ team in the organization encourage them to report to a member of this team. OHN's should be aware that if they believe the situation may progress to physical violence they are required under the OHSA to report it and notify the worker as such. The OHSA defines one indicator of violence as "a statement or behaviour that is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker."

Scenario #2:

I am an Occupational Health Nurse in a large facility and part of an HR team. My manager micromanages me excessively and frequently criticizes my work, often in front of others. His approach is flippant and reactionary instead of specific, focused and constructive. I am open to hearing feedback in order to improve but I find his approach attacking and condescending. In the last month he added several extra responsibilities to my role, which I welcome, but are somewhat out of my area of expertise. I feel I need training to be successful and I'm happy to learn new skills but I feel I'm being set up for failure. Am I making a big deal out of nothing? What should I do?

Donna:

You are not making a big deal out of this. All the behaviours you identified fall within the parameters of workplace bullying and harassment. 78% of incidents of bullying are from a senior person to a more junior employee. Unfortunately, when targets of harassment report they are often seen to be "trouble makers" and if bullying bosses are high performing leaders, organizations tend to protect them. You need to examine your organization's policies and programs on harassment and learn from HR what their process for investigation is. Does the organization have a reputation for holding all employees equally accountable for respectful behaviour, regardless of their role? If so you can likely feel confident that you will be safe in reporting. If not, start by documenting in detail every incident with dates, times, factual statement of what was said by whom, when. Follow up communication with an email and keep copies of all your emails and your boss's emails. As much as possible do not have private meetings with your boss. After public meetings, document who was in the meeting so they can be approached to be witnesses should an investigation be launched.

You might consider getting counselling from a psychologist specializing in workplace bullying and/or seek legal advice. If you are experiencing medical issues related to the harassment, see your healthcare practitioner. The files from these professionals can be included in any future action you decide to take.

Once you are confident you have the information you need, consider

OOHNA KEEPING WORKERS WELL

Keeping Workers Well 2016

45th Annual OOHNA Conference

June 8 – 10, 2016, Crowne Plaza Hotel and Conference Centre, Kitchener, Ontario

THANK YOU SPONSORS!

levittsafety

parklane SYSTEMS

BELLWOOD
PART OF THE EDGEWOOD HEALTH NETWORK

mri APPOINTMENTS

Wednesday, June 8, 2016

1930 – 2130	**Welcome Reception** Sponsored by Levitt Safety Inc. and hosted by the OOHNA Board of Directors
2000 – 2020	**Keynote presentation:** Chemical Splash Treatment – Bruce Gibson

Thursday, June 9, 2016

0730 – 0900	Registration
0830 – 0900	Opening Ceremonies and Awards
0900 – 1000	**Keynote:** Leadership and Women – Dr. Samantha Nutt
1000 – 1100	Networking Break in Exhibits
1100 – 1200	Dealing with Violence and Harassment at Work: New Obligations under Bill 132 – Janice Rubin, LLB
1200 – 1400	Lunch and Exhibits
1400	Exhibits close
1400 – 1500	Breakout Sessions ▶ **THA** Expanding your "Wellness" without Expanding Your Time – Elizabeth Rankin Horvath and Denis Ropp
	▶ **THB** Workplace Alcohol, Drugs and Mental Illness: Practical Tips for Occupational Health – Dr. Elizabeth Reade
1500 – 1515	Networking Break
1515 – 1600	Knowledge Exchange
1600 – 1700	An OHN's Guide to Medical Marijuana in the Workplace – Dr. Mick Markus and Aaron Spodek
1700	Conference Day One Ends

OOHNA KEEPING WORKERS WELL

Keeping Workers Well 2016

45th Annual OOHNA Conference

June 8 – 10, 2016, Crowne Plaza Hotel and Conference Centre, Kitchener, Ontario

Friday, June 10, 2016

0730 – 0900	**Registration**
0900 – 1000	Developing Leadership in Resilience – Gregg Brown
1000 – 1015	Networking break
1015 – 1200	Breakout Sessions
	▶ **FC** Change Management: Excelling through Change – Lorraine Behnan
	▶ **FD** Overcoming Return to Work Challenges – Dr. Elizabeth Scott
1200 – 1330	Lunch and Annual General Meeting
1330 – 1430	Your New Lenses are Ready for Pick-up: Seeing Changes and Challenges in a New "Light" – Susan Stewart
1430	Keeping Workers Well 2016 ends

EXHIBITION Thursday, June 9, 2016 (one day only)

Company	Booth Number
Bellwood Health Services	12
Canadian Centre for Occupational Health & Safety (CCOHS)	14
Gowan Consulting	13
Homewood Health	10
Levitt Safety Inc.	7 & 8
MRI Appointments Your Medical Imaging Partner	11
Parklane Systems	5
PROergonomics	1
Public Services Health & Safety Association (PSHSA)	4
Renascent	6
SOS Emergency Technologies	3
Synergy	9
Workplace Medical Corp.	2

THANK YOU SPONSORS!

Renascent
The road to recovery starts here.

synergy

gowan consulting

Homewood Health | Santé

making a formal complaint to HR. Reach out to your EAP provider, friends and/or family who can support you through the reporting and investigation process as it is often stressful. Complete the self assessment entitled "Are You Being Bullied", free in the PSHSA handbook, to help your self-awareness. If you have a HEART™ team in your organization you can confidently go directly to a member of this team for support, as your organization by virtue of implementing HEART™ has shown a genuine commitment to creating a psychologically safe workplace.

Henrietta Van Hulle, BN, MHSM, COHN (C), CRSP, CDMP (hvanhulle@pshsa.ca) is Executive Director, Health and Community Services, at the Public Services Health & Safety Association.

Donna Marshall, M.A., Counselling Psychology, CEO, BizLife Solutions (donna@bizlifesolutions.com; www.bizlifesolutions.com; www.bizlifeinstitute.com)

References:

Marshall, D. (2015). The Toxic Workplace and Employee Mental Health: Two Sides of the Same Coin. *HR Professionals* Magazine

McKay, R. B., & Fratzl, J. (2015). Conference Board of Canada. *Workplace bullying primer: What it is and how to manage it.*

CSA Group, (2013). CAN/CSA-Z1003-13/ BNQ 9700-803/ *Psychological health and safety in the workplace – Prevention, promotion, and guidance to staged implementation.* http://shop.csa.ca/search?q=z1003-13&categories=shop

Resources:

Assembling the Pieces: An Implementation Guide to the National Standard for Psychological Health and Safety in the Workplace. Developed by CSA Group and the Mental Health Commission of Canada. http://shop.csa.ca/search?q=spe-z1003-implementation-hb&categories=shop

Ministry of Labour Guideline for Workplace Harassment – http://www.labour.gov.on.ca/english/hs/pubs/wpvh/harassment.php

PSHSA Bullying in the Workplace: A Handbook for the Workplace- https://www.pshsa.ca/wp-content/uploads/ShortpixelBackups/2013/02/BullyWkplace.pdf

USING AN INTEGRATED APPROACH TO MAXIMIZE THE EFFECTIVENESS OF DISABILITY MANAGEMENT PROGRAMS

by Elizabeth Rankin-Horvath and Denise Ropp

"Disability need not be an obstacle to success. I have had motor neuron disease for practically all my adult life. Yet it has not prevented me from having a prominent career in astrophysics and a happy family life." These are the words of Professor Stephen W. Hawking in the Forward to the Summary World Report on Disability published by the World Health Organization (WHO) in 2011. We can draw very important insight from Professor Hawking's experience. He credits the benefit of first class medical care and reliance on a team of personal assistants who make it possible for him to live and work in comfort and dignity. His home and workplace have been made accessible, and computer experts have supported him in his communication needs. In short, through collaboration of a caring family, medical and social support systems, and a conscientious workplace, he was supported in his full range of needs.

Unfortunately, disability is part of the human collective. When a worker experiences any type of disability, whether it is physical or mental, there are many occupational and personal factors that will affect their ability to remain at work or return to work. Identifying and understanding these factors can be pivotal.

However, in many organizations, data collection and efforts are in silos because separate departments or individuals manage different aspects of worker health, safety and wellness. Thus, the full impact of a worker's health-related absence on the organization is poorly understood. As a result, it may be difficult to keep workers who are experiencing health issues at work and it may take longer to get them back to productive work following an absence. Efforts may be duplicated and costly and may have limited success.

> Employees who are supported in their ability to function at work and in their personal lives are more engaged.

While understanding the business case is critical, care doesn't come out in the numbers! Most diseases, injuries and other health conditions are multifactorial, especially as the worker ages (Schulte et al., 2012). In a recent study (Angeloni, 2013) it was demonstrated that employees who are supported in their ability to function at work and in their personal lives are more engaged. They are less likely to take time off work for health-related issues and more likely to return to work earlier and safer. The crucial key is to understand the complete range of the worker's needs in the context of their environment, so they can be supported, engaged and productive both in and outside the workplace.

There is a growing mountain of evidence that proves using an integrated approach combining Occupational Health and Safety (OH&S) with Health Protection and Promotion (HP&P) can maximize the outcome of your disability management program. It brings stakeholders together to work collaboratively across the organization and within the community to address the challenges and barriers that affect a worker's ability to function in the event of an injury, illness or disease (Sorensen et al., 2014). According to the Disability Management Employer Coalition, "companies with integrated programs have been especially successful in cutting costs and effectively returning their employees to full productivity." (Angeloni, 2013).

The integrated approach is powerful because we gain knowledge of:

- The full impact of the worker's absence, thereby motivating the employer to invest in integrated interventions, which may include workplace accommodation and other interventions to support the worker in their environment in and out of the workplace; and
- The medical and non-medical challenges or barriers that may be distracting or hinder the worker from functioning at full capacity at the time and in the context of their environment.

The Occupational Health Nurse (OHN) is in a unique position to implement an integrated approach to disability management with their knowledge of the organization; its strategic goals and operations; its culture and the various social climates, combined with rapport and connections with internal and external stakeholders and knowledge

of the support or lack of support available in the community. OHNs are privy to sensitive and confidential information at every level, and are often the one person in the organization that many employees (workers and management) trust enough to reveal their innermost challenges and frustrations with work and non-work issues that may be affecting their wellbeing. This unique perspective empowers the OHN to break down barriers that may be keeping workers from being fully engaged and productive.

Understanding the Business Case for Integrated Disability Management

In a recent study, (Fabius et al., 2013) stated that corporate health is defined as the overall integration of safety and health in the workplace, enhancing employee well-being and satisfaction, and the company's overall productivity. Yet, in 2006, the Integrated Benefits Institute reported that nearly half of American CFOs surveyed believe that health-related lost time has an adverse effect on business performance. Most CFOs are surprisingly ill-informed about just how much health-related issues are actually costing their organizations. By extrapolation, we can assume the situation in Canada is not much different.

In 2015, Statistics Canada published the Initial Findings from the Canadian Survey on Disability (CDS), which revealed that 3.8 million adult Canadians (13.7%) reported being limited in their daily activities due to a disability. Furthermore, the Public Health Agency of Canada reported that three out of five Canadians adults over the age of 20 have a chronic disease, and four out of five Canadians are at risk. Chronic disease is increasing at an alarming rate of 14% each year. Four major chronic diseases (cardiovascular disease, respiratory disease, diabetes and cancer) account for nearly 75% of premature deaths among Canadians. Treatment of chronic disease consumes 67% of all direct health care costs, and cost the Canadian economy $190 billion annually—$68 billion is attributed to treatment and the remainder to lost productivity.

> Measuring the Value of Investment is far more meaningful than Return on Investment.

Disability from chronic diseases may or may not be included in the CDS results. For example, a person suffering from a chronic disease may be disabled due to the primary effects of the disease, or from side effects of drugs or treatment, which may include symptoms that are not included in the ICD-9 codes used to classify disability. As noted by the Integrated Benefits Institute (Parry, 2006), "If we rely on medical claims data and ICD-9 codes to prioritize our investment in employee health, we may miss primary causes of lost productivity in the workplace".

For example, the Integrated Benefits Institute surveyed more than 100,000 employees using the WHO Health and Work Performance Questionnaire (HPQ). The results were striking:

- The top 15 drivers of lost work time (including absenteeism and presenteeism) were identified as: sleep disorders, depression, fatigue, back/neck pain, anxiety, hypertension, other emotional, arthritis, obesity, chronic pain, headache, irritable bowel, high cholesterol, heart disease, and allergy;
- Many of the 15 most prevalent health conditions reported are not typically found in medical claims databases and did not have medical diagnostic codes;
- Of the 27 health conditions surveyed, only about 40% were being treated; and
- Treatment ranged dramatically, from a high of 89% for diabetes to a low of 11% for obesity.

We have recently learned that mental health conditions are a significant cause of lost work time. In 2013, the Mental Health Commission of Canada reported that more than 6.7 million Canadians are living with a mental health problem and illness, and that half of everyone will have experienced a mental illness by the time they reach 40 years of age. The cost to Canadians is at least $50 billion per year, with $6 billion attributed to lost production (from absenteeism, presenteesim and turnover). The total cost to the economy is expected to soar to more than 2.5 trillion over the next 30 years.

According to Pronk (2014), measuring the Value of Investment (VOI), is far more meaningful than Return on Investment (ROI) which is typically limited to financial return over time. VOI takes into account both direct and indirect costs as well as other investment and outcomes, and is measured on two levels:

1. Employer investment versus business outcomes.
2. Employee investment versus impact on employee health and wellness.

Whereas ROI is a profitability ratio, Pronk (2014) showed that VOI measures outcomes on the basis of benefits, harms and costs, which can be utilized to help make more fully informed decisions on investments for the overall well-being of the workforce as well as for integrated interventions and accommodations for workers with injury, illness or disease. Pronk

(2014) noted that according to the National Business Group of Health, business outcomes can be measured in three areas:

- Workforce health and safety – which measures health care, disability and workers' compensation costs;
- Productivity and performance – which measures costs associated with absenteeism, presenteeism and performance; and
- Employer of Choice – which measures costs associated with turnover, recruitment and workforce engagement.

There is evidence that accommodating workers with disabilities often shows a very high cost effectiveness when measured by means of VOI, and that about half of all implemented accommodations have little to no cost. (Pronk, 2014).

This is where the strength of Integrated Disability Management (IDM) comes in. Through collaboration, you can systematically collect data from all areas of the business to help senior executives in your organization understand the full impact of not accommodating or supporting the employee. For example:

- Health care and insurance costs;
- Benefits utilization;
- Engagement and performance;
- Workflow;
- Production;
- Quality;
- Compliance with regulations and standards;
- Health and safety;
- Delivery of goods and services;
- Internal and external customer satisfaction;
- Hiring of temporary labour;
- Knowledge or skills gaps;
- Turnover; and
- Retraining.

Embracing a New Paradigm – Integrated Disability Management

Employment and Social Development Canada (2013) gathered evidence through consultations with Canadian private sector companies and found that approximately 795,000 working-aged Canadians with disabilities are not working, but it is not their disabilities that are preventing them from doing so. It is often environmental or attitudinal barriers that are keeping them out of the workplace. Why? Until recently disability management focused on the medical aspects of an individual's disease or impairment and have we have assumed that disability was a problem of the minority of the population. (Angeloni, 2013)

> How we define disability makes a significant difference in how we approach disability management and our results in getting workers back to work.

The environment has been designed for the fully functional population, with some modifications to help persons with certain physical disabilities (e.g. wheelchair ramps and elevators, Braille on some signs, beeping signals at intersections). In the workplace, the marketplace, and the community at large, accommodation of a person with a disability has often been regarded as costly and burdensome, and has led to significant physical and social barriers for individuals with disabilities. (Angeloni, 2013)

With 3.8 million Canadians with disabilities and rapidly rising chronic disease rates, we can no longer afford such thinking.

In 2001, the World Health Organization (WHO) defined "disability" as "the outcome or result of a complex relationship between an individual's health condition and personal factors, and the external factors that represent the circumstances in which the individual lives". According to the WHO, the term "disabilities" is an umbrella term, which includes impairments, activity limitations, and participation restrictions:

- Impairment is a problem of body function or structure;
- An activity limitation is a difficulty encountered by an individual in executing a task or action; and
- A participation restriction is a problem experienced by an individual in life situations.

The Human Resources and Skills Development Canada (HRSDC) definition aligns with the definition of the WHO. According to HRSDC:

> Disability is a complex phenomenon, reflecting an interaction between features of a person's body and mind and features of the society in which they live. A disability can occur at any time in a person's life; some people are born with a disability, while others develop a disability later in life. It can be permanent, temporary or episodic. Disability can steadily worsen, remain the same, or improve. It can be very mild to very severe. It can be the cause, as well as the result, of disease, illness, injury, or substance abuse. (2013).

Using this definition, we must reject the view that a health problem is always related to a decrease in capacity and performance and accept that disability occurs when the environmental and social conditions fail to adapt to the health conditions of the person, creating obstacles and barriers to the activity and participation of that person (Angeloni, 2013). This is a new para-

digm that is inclusive and universal, as it concerns all people whether they have a limitation or not.

For a person with a limitation, the environment and attitudes of people should work to facilitate ability, not pose barriers that result in disability.

IDM is based on the capabilities approach, which looks at performance and capacity qualifiers and the need for environmental supports. As noted by Angeloni (2013), when a person experiences a motor problem and they are helped by other people, they have the ability to leave their home. A person with the same motor problem who is not helped by others may not be able to leave their home when they want, and is deprived of the potential opportunity. They are not disabled because of the motor problem, but because of a failure in society to help them.

Any time a person is off work due to a disability there is always an impact on mental wellbeing. Experience has shown that most workers experience a stress reaction within five days of absenteeism (Pronk, 2013). Being away from work often causes a sense of isolation from the person's normal social circle. The brain goes into survival mode, dealing with expectations versus reality in terms of loss of immediate or continuing health, income, lifestyle, cost, ability to meet personal obligations, dreams, etc. Faster reconnection, particularly within the first week, often improves healing and lessens overall healing time, unless the worker is in a toxic or unsupportive work environment.

The relationship between physical health and mental health is cyclical, both affecting the other (Allen and Kelly, 2014). According to the Centres for Disease Control and Prevention (2005), chronic diseases can exacerbate symptoms of depression, and depressive disorders can themselves lead to chronic diseases. In 2008, the Canadian Mental Health Association (CMHA) reported that "Those with mental illness are more likely to develop certain chronic physical conditions, such as heart disease and stroke, than those without. Meanwhile, those in poor physical health are more likely to developmental illness such as depression—but that depression frequently goes undiagnosed by healthcare practitioners dealing solely with the management of chronic conditions."

An individual with mental health issues is not going to take much interest in their other health problems, therefore, it is important to learn how to address mental health problems in order to help such individuals. From an occupational standpoint, conformance with the National Standard of Canada on Psychological Health and Safety in the Workplace may help organizations identify and address workplace factors that can affect the mental health and safety of workers.

IDM will help in many cases, especially with complex ones, because it goes beyond the physical, mechanistic approach in which you would seek to determine whether the worker is able to perform the essential duties of the job, focusing only their physical and cognitive functional abilities and limitations as related to the job demands. IDM seeks to care for the whole person. It embraces the systems view of life, that is, the concept that we are all complex beings (body, mind and spirit) living in a complex world where everything is interconnected (Capra and Luisi, 2014).

Since IDM employs compassionate care of the whole, we can reach out to the community to provide support to and through the worker's social support circle, which can greatly improve the person's quality of life and ability to function. We can work collaboratively with the worker and other stakeholders in the organization and the community to identify and address challenges and barriers, both in and out of the workplace, that may actually hinder or demotivate the worker. Such as, difficulty in personal grooming, transit, or meeting personal obligations (e.g. child or elder care), the physical and mental drain of attending appointments and treatment, the financial impact of their health condition on their current commitments, lifestyle and future expectations. We can also validate and respect a worker's need for rest and rejuvenation, and build it into the disability management plan. We increase likelihood of an early and safe return to work and enhance the worker's ability to be engaged and productive.

Angeloni (2013) suggests that IDM should operate through a single management system for occupational and non-occupational disability. IDM empowers organizations to provide services that are advantageous to their entire workforce, by tackling multiple risk factors and health conditions concurrently, thereby addressing and influencing organizational culture and social climates at multiple levels within the organization. This inclusive approach helps all workers to experience higher levels of wellbeing, regardless of impairment. By providing programs for the whole rather than for a few, employers reap the benefits of economies of scale.

Following the plan-do-check-act management system model, Angeloni (2013) points out that IDM should integrate policies, programs and activities in the following areas:

- Prevention of injury, illness and disease at all ages;
- Promoting mental and behavioural health;
- Promoting active aging;

- Reducing presenteeism and enhancing the means for greater employee engagement;
- Reducing and managing absenteeism through accommodations and return to work; and
- Promotion of effective employer incentives and strategy.

According to Allen and Kelly (2014), a truly integrated model of disability management has all aspects coordinated and working together for maximum results. Elements to consider include:

1. An approach that promotes wellness and disability prevention, which also ties into programs that encourage rehabilitation and return to work.
2. Employee health-related programs that work in tandem to promote productivity and manage disability (e.g. group health benefits, workplace health and safety, workers' compensation, sick leave/absence management, short-term disability (STD), long-term disability (LTD), and employee and family assistance programs (EFAPs).
3. Providers who play a role in returning employees to productivity by working together. This may include case managers, physicians, nurses, return-to-work coordinators, rehabilitation specialists and mental health practitioners. Engaging managers and the affected worker in the process through early intervention is critical.

Based on our own experience and research, we recommend the following steps to developing an IDM:

- Review your organization's policy and procedures for protection of personal health information and ensure compliance;
- Develop a policy, with worker input, to define the organization's commitment to taking an integrated approach to worker health, safety and wellbeing and disability management;
- Address attitudes and stigma by educating all employees on the current understanding of disability and the goals of IDM;
- Include workers and management in discussions to address their questions, concerns and fears with respect to collection of information related to their health, safety and wellbeing and how that information will be used;
- Determine a model and technique that your organization will use to systematically collect relevant data and assess occupational and personal risk factors that can contribute to, or result in, injury, illness or disease, and the environmental and social factors that can contribute to or cause disability;
- Employ a systematic method to give workers the means to explore their personal level of wellbeing, the challenges and barriers they face, and what motivates them; and
- Identify internal and external resources to help support workers with disabilities in being engaged and productive in and out of the workplace.

If you are already using an integrated approach, congratulations! If not, taking on an integrated approach may be a radical shift from the way your organization is currently operating, but it well worth the investment and the effort.

Elizabeth Rankin-Horvath is a consultant specializing in helping organizations develop and implement fully integrated management systems for employee health, safety and wellbeing. She has nearly 20 years' experience in Occupational Health and Safety and is President of HALE Health & Safety Solutions Ltd.

Denise Ropp is an Occupational Health and Safety RN Consultant with more than 20 years' experience in the provision of custom solutions for businesses and individuals to enhance the engagement of their employees leading to high levels of participation. She is Vice President of Operations for Synergy Wellness Services.

Resource:

A recent study (Sorensen et al, 2014) listed a summary of research studies showing the benefits of using integrated approaches research. Employee outcomes are measured in terms of health improvement, overall wellbeing, and quality of life.

1. Greater improvements in behavior change (Sorensen et al, Cancer Cause Control 2002, (Sorensen et al., *Am J Public Health* 2005);
2. Higher rates of employee participation in programs (Hunt et al., *Health Educ Behav* 2005);
3. Potential reductions in occupational injury and disability rates (Shaw et al., Work 2006; Shaw et al., *J Occup Rehabil* 2003);
4. Stronger health and safety programs (LaMontagne et al., *Occup Environ Med* 2004);
5. Potentially reduced costs (Goetzel et al., *J Occup Environ Med* 2001);
6. Facilitates better use of limited resources and improves overall health, productivity and resiliency of the workforce (Sorensen et al., *Am J Public Health* 2005; Hymel et al., *J Occup Environ Med* 2011);
7. Internal collaboration across multiple departments may lead to improved processes and outputs, and an enhanced work climate; and
8. Maximizes health, productivity and resilience of the workforce (IOM report, *Integrating employee health: a model program for NASA,* 2005)

References:

Allen P. and Kelly, A. (2014). The Missing Link – Understanding the connection between physical and mental health is key to an integrated disability management program, *Benefits Canada,* 21-24. Retrieved February 15, 2015 from the World Wide Web: http://www.benefitscanada.com/benefits/health-wellness/the-missing-link-49009

Angeloni, S., (2013) *Integrated Disability Management: An Interdisciplinary and Holistic Approach,* SAGE Open, October-December, 1-15, Retrieved November 27, 2015 from the World Wide Web: http://sgo.sagepub.com/content/3/4/2158244013510303

Canadian Mental Health Association. (2008) *Recommendations for Preventing and Managing Co-Existing Chronic Physical Conditions and Mental Illnesses,* Policy Paper. Retrieved from the World Wide Web: https://ontario.cmha.ca/public_policy/recommendations-for-preventing-and-managing-co-existing-chronic-physical-conditions-and-mental-illnesses/

Capra, F., and Luisi, P.L., (2014). *The Systems View of Life, A Unifying Vision.* Cambridge University Press.

Employment and Social Development Canada. (2013.) *Rethinking Disability in the Private Sector – Report from the Panel on Labour Market Opportunities for Persons with Disabilities: ESDC.* Retrieved January 30, 2016 from the World Wide Web: http://www.esdc.gc.ca/eng/disability/consultations/rethinking_disabilities.shtml

Employment and Social Development Canada. (2013). T*he Disability Reference Guide: Its Purpose and Function: ESDC.* Retrieved January 15, 2016 from the World Wide Web: http://www.esdc.gc.ca/eng/disability/arc/reference_guide.shtml

Fabius, R., Thayer, R.D., Konicki, D.L., Yarborough, C.M., Peterson, K.W., Isaac, F., Leoppke, R.R., Eisenberg, B.S., Dreger, M. (2013). The Link Between Workforce Health and Safety and the Health of the Bottom Line, Tracking Market Performance of Companies That Nurture a "Culture of Health". *Journal of Occupational and Environmental Medicine,* Vol.55, No.9, 993-1000. Retrieved January 22, 2016 from the World Wide Web: http://www.cancergoldstandard.org/sites/default/files/attachments/Link_Between_Workplace_Health_and_the_Bottom_Line_0.pdf

House of Commons Canada, Report of the Standing Committee on Health, 41st Parliament. (2012). *Chronic Diseases Related to Aging and Health Promotion and Disease Prevention.* 1st Session, Retrieved November 19, 2015 from the World Wide Web: http://www.parl.gc.ca/content/hoc/committee/411/hesa/reports/rp5600467/hesarp08/hesarp08-e.pdf

Integrated Benefits Institute, (July 2006). *IBI Research Insights: It's Time to Rethink Health's Impact on Lost Work Time.* Author: Parry, T. Retrieved January 4, 2016 from the World Wide Web: https://ibiweb.org/research-resources/detail/its-time-to-rethink-healths-impact-on-lost-work-time

Mental Health Commission of Canada (2013) *Making the Case for Investing in Mental Health in Canada: MHCC.* Retrieved February 10, 2013 from the World Wide Web: http://www.mentalhealthcommission.ca/English/node/5020

Pronk, N.P. (2014). Placing Workplace Wellness in Proper Context: Value Beyond Money. *Prevention of Chronic Disease,* Vol. 11. Retrieved December 15, 2015 from World Wide Web: http://www.cdc.gov/pcd/issues/2014/pdf/14_0128.pdf

Pronk, N.P. (2013). Integrated Worker Health Protection and Promotion Programs, Overview and Perspectives on Health and Economic Outcomes, *Journal of Occupational and Environmental Medicine,* Vol. 55, No.12, S30-S37, Retrieved December 5, 2015 from the World Wide Web: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4155035/

Public Health Agency of Canada, Chronic Disease Surveillance Division. (2014). *Monitoring chronic diseases in Canada: The Chronic Disease Indicator Framework, Chronic Disease and Injuries in Canada,* Vol. 34, Sup. 1. Retrieved January 16, 2015 from the World Wide Web: http://publications.gc.ca/collections/collection_2014/aspc-phac/HP33-1-34-1-1-eng.pdf

Schulte, P.A., Pandalai, S., Wulsin, V., and Chun, H.K. (2012). Framing Health Matters, Interaction of Occupational and Personal Risk Factors in Workforce Health and Safety, *American Journal of Public Health,* Vol. 102, No. 3, 434-448, Retrieved January 22, 2016 from the World Wide Web: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3487655/

Sorensen, G., McLellan, D., Dennerlien, J.T., Pronk, N.P., Allen, J.D., Boden, L.I., Okechukwu, C.A., Hashimoto, D., Stoddard, A., and Wagner, G.R. (2013). Integration of health protection and health promotion: rationale, indicators, and metrics. *Journal of Occupational Medicine,* Vol. 55 (Suppl. 12), S12-S18. Retrieved January 13, 2016 from the World Wide Web: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4184212/

Statistics Canada (2015), *Fact Sheet: Disability in Canada: Initial findings from the Canadian Survey on Disability.* Retrieved January 4, 2016from the World Wide Web: http://www.statcan.gc.ca/pub/89-654-x/89-654-x2013002-eng.htm

U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention. (2005). *Review: The Vital Link Between Chronic Disease and Depressive Disorders.* Authors: Chapman, D.P., Perry, G.S., Strine, T.W. Retrieved December 12, 2015 from the World Wide Web: http://www.cdc.gov/pcd/issues/2005/jan/04_0066.htm

World Health Organization (WHO). (2011). *Summary World Report on Disability.* Retrieved January 15, 2015 from the World Wide Web: http://www.who.int/disabilities/world_report/2011/accessible_en.pdf

COGNITIVE BEHAVIOURAL THERAPY FOR ANXIETY: A LOOK AT ADAPTED APPROACHES AND THERAPIST EXPERIENCE

by Lisa Landon

Mental illness accounts for 40% of all illnesses in the working population under 65 years (Layard, 2013). Due to the high prevalence it is becoming necessary in everyday Occupational Health practice to be able to recognize the various mental health disorders and have knowledge about the appropriate evidence based treatments to facilitate employee recovery. This is especially true for anxiety disorders. In modern Canadian workplaces where economic factors are driving business (Wang et al., 2010), there is pressure to adapt to increasing workplace challenges (Dimoff & Kelloway, 2013). Data collected from the 2012 Canadian Community Health Survey showed that 2.6% of Canadians aged 15 and older reported symptoms consistent with generalized anxiety disorder (Pearson, Janz, and Ali, 2013) and one in four Canadians (25%) will have at least one anxiety disorder in their lifetime (Health Canada, 2009). In fact, anxiety is the most common mental illness in Canada (Health Canada, 2009). These disorders interfere with normal living and tend not to go away without treatment (Mayo-Wilson and Montgomery, 2013).

Traditional face-to-face Cognitive Behavioural Therapy (CBT) is an effective therapy for anxiety and has been well supported in past literature. For Occupational Health Professionals (OHPs) managing employees with anxiety in the workplace, fast and easy access to an effective CBT treatment can be key to successful outcomes and long term recovery. This literature review focuses on peer reviewed evidence published in the last five years related to adapted methods of CBT therapies such as self-help (SH), guided self- help (GSH), media and internet supported CBT (mCBT and iCBT). The aim is to provide evidence based information for OHP's on the efficacy of such methods as an intervention for anxiety. Experience and qualifications of those administering these therapies arose in the literature as a variable considered when measuring outcomes. This issue will also be discussed in this article.

Traditional face-to-face Cognitive Behavioural Therapy (CBT) is an effective therapy for anxiety and has been well supported in past literature.

Methods

The abstracts and titles of peer reviewed literature were searched in the databases EBSCO Host Health and Psychology, ProQuest Health and Medical Complete, Psychology Journals, Ovid and CINAHL Plus and Medline Databases. Keyword search was used and the words "Cognitive Behaviour Therapy", "anxiety", "stress", "panic", "self-help", "computer", "media", "Internet", were entered in various combinations. Date limits of January 2010 to December 2015 were applied.

Following the electronic search, the reference lists of the articles identified were hand searched to ensure that all relevant literature on the topic was identified and considered for this review. The articles included studied effects on subjects over the age of 16 years and suffering from the following anxiety disorders as classified by the *Diagnostic and Statistical Manual of Mental Disorders* – DSM IV (American Psychiatric Association, 2000): Health Anxiety (HA), Social Anxiety Disorder (SAD), Generalized Anxiety Disorder (GAD), Panic Disorder (PD) and Phobias. Three articles examined subjects that had either anxiety, depression or suffered from both. Comorbidity rate for these two disorders can be 58-70% (Brown, Campbell, Lehman, Grisham, & Mancill, 2001); therefore, these articles were included in order to gain population representation. The setting requirement for inclusion was primary care, outpatient clinics, or follow up medical clinics. A total of 12 articles were included in this literature review.

Adapted Delivery of CBT

Access to treatment continues to be a problem for individuals with mental health disorders for many different reasons (Dear et al., 2015; Titov, Andrews, Schwencke, et al., 2009). It is reported that one third

Table 1 – Definitions of Adapted CBT	
Self-Help (CBT)	Defined as a therapeutic intervention administered through text-audiotape, videotape, or computer text, through group meetings or individual exercises such as "therapeutic writing" and designed to be conducted predominantly independently of professional contact (Mayo-Wilson and Montgomery, 2013)
Guided self-help (GSH)	Usually involves minimal contact that is primarily "of supportive or facilitative nature" and is meant to support the patient in working through the standardized psychological treatment (Cuijpers, Donker, van Straten, Li, and Andersson, 2010).
Internet or Media guided CBT (iCBT or mCBT)	An approach that can increase access to treatment and teach the same skills as face-to-face CBT but via the internet using structured material, often with therapist support via email and telephone (Dear et al., 2015). Patients review CBT materials over the Internet and providers offer support and directions, most commonly through weekly emails or phone calls (Hadjistavropoulos, Alberts, Nugent, and Marchildon, 2014).

of Canadians do not receive the health care they need for mental disorders and that counselling was the most common need cited by those reporting inadequate treatment (Statistics Canada, 2013).

The efficacy of adapted CBT which includes media assisted (or iCBT), SH, or GSH modes for anxiety are all methods that can remove some of the financial, scheduling, cost and stigma related barriers to seeking treatment (Dear et al., 2015). Refer to Table 1 – Definitions of Adapted CBT.

Overall, the evidence from randomized controlled trials (RCTs) lends support to the efficacy of various forms of adapted CBT methods. RCTs favour iCBT when treatment was tested on subjects with Panic Disorder (PD) (Wims, Titov, Andrews, & Choi, 2010), social anxiety disorder (SAD) (El Alaoui et al., 2015) and Generalized Anxiety Disorder (GAD) (Andersson, Carlbring, & Furmark, 2012; Dear et al., 2015; Titov, Andrews, Robinson, et al., 2009). Anxiety symptoms were found to be improved in relation to the control groups which were wait listed (Andersson et al., 2012; Dear et al., 2015; Newby et al., 2013; Titov, Andrews, Robinson, et al., 2009; Wims et al., 2010).

The SH, GSH, mCBT or iCBT delivered approach also has systematic review and meta- analytical support in the literature and published RCTs that lend support to the efficacy of these CBT methods. Results from a large systemic review of 101 RCTs showed a slight effect in favour of traditional face-to-face CBT when it came to self-reported anxiety levels post treatment. However, there were no significant differences found between traditional face-to-face and adapted methods of CBT when it came to response to treatment and recovery of clients suffering anxiety with, or without, comorbid depression. In addition, there was moderate quality evidence that demonstrated medium effects of adapted CBT on secondary outcomes such as recovery from illness, depression, mental health related disability and quality of life when it was compared to no intervention at all.

No significant differences were found in the effects on drop-out rates, mental health related disability or depression levels between traditional CBT methods and adapted SH or iCBT methods (Mayo-Wilson and Montgomery, 2013). Despite the summarized findings of significant improvements to anxiety symptoms when adapted CBT was applied, the consensus of the systematic reviews published was that larger, better quality trials are needed to build stronger evidence and evaluate the long-term benefits in clinical populations (Coull and Morris, 2011; Cuijpers et al., 2010; Mayo-Wilson and Montgomery, 2013).

Therapist Experience

The question of who should deliver the adapted CBT programs emerged as a debated topic in the literature (Andersson et al., 2012; Coull and Morris, 2011; Cuijpers et al., 2010; Newby et al., 2013; Robinson et al., 2010; Titov, Andrews, Schwencke, et al., 2009). The articles published on adapted CBT, addressed therapist or clinician experience to a greater extent than the literature on traditional approaches. This is likely due to the minimized time necessary for therapist involvement in these therapies and the various means of supporting the client through email, chats and telephone.

Included in the review were RCTs that were designed to test this variable and compare outcomes of adapted delivery of CBT by experienced clinicians versus technician-assisted therapy. Similar positive outcomes on anxiety symptoms post-program were demonstrated in both groups in these stud-

ies, regardless of the experience level of the administrator (Andersson et al., 2012; Robinson et al., 2010; Titov, Andrews, Schwencke, et al., 2009). It should be noted that technicians in these studies were able to refer patients to an experienced clinician when necessary; however, it was reported that only 10% of the patients required this (Robinson et al., 2010). Results of all three trials showed that experience of the therapist/clinician did not result in significant differences in anxiety outcomes. The only difference found in the Andersson et al. (2012) trial was that the less experienced clinicians (psychology students) logged more time supporting their group of patients but improvements to symptoms were similar in both groups.

There is support in the literature for adapted CBT methods that treat more than one condition simultaneously (trans-diagnostic) (Coull and Morris, 2011; Cuijpers et al., 2010; Newby et al., 2013). Findings in the articles that included subjects with anxiety as well as those with anxiety and comorbid depression, found similar results when the outcomes were compared to waiting list controls (Coull and Morris, 2011; Cuijpers et al., 2010; Newby et al., 2013). In addition, these programs did not always have licensed experienced therapists but rather were administered in primary care settings by general practitioners, nurses, students and other allied health professionals. These practitioners had various levels of prior CBT familiarity but received intervention-specific training and support. The outcomes in primary care settings with respect to anxious and depressed symptoms were still positive even though the adherence to treatment was lower than when these adapted programs were administered in the research settings (Coull & Morris, 2011; Newby et al., 2013).

Limitations

The results of this literature review need to be considered in light of some limitations. Some studies had small sample sizes which may have caused sampling errors and many used media recruitment of subjects, which could alter population representativeness. Motivation levels may differ with self- selected subjects and this is an important limitation to note when considering the transfer of these conclusions to the clinical setting.

Wide variations also existed across trials in the number of CBT sessions provided, the content of programs, the way in which the treatment was monitored, how often subjects had contact with the administrator, for how long and by whom. In addition, there was no general agreement or clear definition of what SH, GSH, or iCBT/mCBT programs consisted of and each study had different interventions. Measurement scales of responses rating anxiety symptoms also differed across research designs and, in addition, most responses were self- rated.

The media and SH materials used as interventions in the research were created for that purpose and not available to the clinical community for use. For these reasons, it is difficult to know whether the results of these studies can be replicated (Mayo-Wilson and Montgomery, 2013). Caution should be exercised when generalizing the conclusions to long-term outcomes since most studies evaluated post treatment commonly at three, six and twelve months and not beyond. Lastly, the studies selected for the review focused primarily on the diagnosis of GAD, SAD, PD and HA; therefore, the results of this review may not generalize to other types of anxiety disorders such as OCD, specific phobias and PTSD. These factors collectively weaken the conclusions of this review.

Conclusions

In examining the literature published over the last five years regarding the efficacy of CBT as a treatment for anxiety, OHP's can conclude that employees suffering with anxiety disorders should be encouraged early in the illness to seek out CBT as a treatment (Linden, Zubraegel, Baer, Franke, and Schlattmann, 2005; Mayo-Wilson et al., 2014; Olatunji et al., 2014; Stanley et al., 2009; Tyrer et al., 2014; Zhipei et al., 2014). There is recent evidence to support that various forms of adapted CBT methods have proven to be effective in the research environment. There is also evidence to support that these programs may fit nicely into a "stepped care" model which begins with a SH media based program, progresses to further treatment (i.e. medications) if necessary and includes administrator access to a psychologist or psychiatry experts when needed (Andersson et al., 2012; Newby et al., 2013; Robinson et al., 2010; Titov, Andrews, Schwencke, et al., 2009).

Early results of more recent trials indicate that findings regarding the efficacy of adapted CBT may be transferrable to primary health care settings (Andersson et al., 2012; Berger, Boettcher, and Caspar, 2014; Coull & Morris, 2011; Cuijpers et al., 2010; Dear et al., 2015; El Alaoui et al., 2015; Mayo-Wilson and Montgomery, 2013; Newby et al., 2013; Robinson et al., 2010; Titov, Andrews, Robinson, et al., 2009) and may be effective for those with comorbid depression (Berger et al., 2014; Coull and Morris, 2011; Cuijpers et al., 2010; Newby et al., 2013). Final judgment on these adapted forms of CBT being equally effective as face-to-face within clinical settings, requires further higher quality, clinically based research trials that randomly assign patients from the actual clinical settings (Coull and Morris,

In Canadian workplaces where mental health disability claims are rising, and time off work for these issues impacts the financial state of companies, an expansion of the role of the OHP in improving the psychological health of workers may be worth further inquiry.

2011; Mayo-Wilson and Montgomery, 2013). However, it is important to note from the literature that prescribing adapted forms of CBT is better than no intervention at all for those patients that would otherwise not receive treatment. This method of CBT is a good alternative when face-to-face CBT therapy is not possible, affordable, readily available or sustainable (Mayo-Wilson & Montgomery, 2013).

The issue of "who" should administer the therapy is still unclear since there is not an overabundance of clinical trials to date testing the "therapist or administrator effect" in clinical populations. Results in the research setting showed positive outcomes when adapted CBT was administered by less experienced providers such as nurses, psychology students, trained primary care professionals or care managers (Andersson et al., 2012; Berger et al., 2014; Coull and Morris, 2011; Cuijpers et al., 2010; Newby et al., 2013; Robinson et al., 2010; Titov, Andrews, Robinson, et al., 2009).

Future Considerations

The clinical OH implications of these findings may be worth investigating further within the Occupational Health research field. If the issue of access to a trained therapist delays or prevents an anxious employee from accessing treatment, it may be worth examining the role of the Occupational Physician and/or nurse to see whether these professionals could work closely with a psychologist or Employee Assistance Program (EAP) provider to prescribe and administer adapted methods of CBT as an early first step.

Although the effect of therapeutic alliance was not tested or described in the literature reviewed, it surfaced in the literature as an important factor that can have an impact on adherence and outcomes of anxiety treatments (Cuijpers et al., 2010; Monti, Tonetti, and Ricci Bitti, 2014; Zhipei et al., 2014). In workplace settings the OHP may already have an established trusting relationship with employees; therefore, this could be an important factor that may remove barriers to access and adherence to a treatment program.

The type of training and education OHPs would require to adequately prepare them to safely administer adapted methods of CBT would be of upmost importance to investigate. Client safety, risk assessment, concise emergency referral protocols, professional practice standards, and comprehensive policies and procedures would all be areas in need of further inquiry prior to considering an expansion of OH roles. Practices around client consent, privacy and storage of electronic transcripts would have to be well established and compliant with privacy laws.

Further study is needed to inventory the adapted CBT programs that exist and are available in the clinical setting and match them with consumer needs to create effective best practice protocols for workplace populations. The question of whether such an intervention would be cost-effective for workplaces with OHPs, is a question the employer would want answered.

In Canadian workplaces where mental health disability claims are rising, and time off work for these issues impacts the financial state of companies, an expansion of the role of the OHP in improving the psychological health of workers may be worth further inquiry.

Lisa Landon, RN, BScN, DOHN, COHN(C) leads an Occupational Health team for GE Hitachi Canada and is an executive member of the Ottawa Occupational Health Nurses Association. Lisa has over 24 years of experience in nursing and occupational health, and is currently pursuing post graduate studies in nursing with research interests in workplace psychological health, early intervention, and reducing the impact of mental health disability in the workplace. Lisa can be reached via email at lisa@landon.ca.

References:

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders : DSM-IV-TR* (4th ed., text revision. ed.). Washington, DC: American Psychiatric Association.

Andersson, G., Carlbring, P., and Furmark, T. (2012). Therapist Experience and Knowledge Acquisition in Internet-Delivered CBT for Social Anxiety Disorder: A Randomized Controlled Trial. *PLoS ONE,* 7(5), 1-10. doi:10.1371/journal.pone.0037411

Berger, T., Boettcher, J., and Caspar, F. (2014). Internet-based guided self-help for several anxiety disorders: A randomized controlled trial comparing a tailored with a standardized disorder-specific approach. *Psychotherapy, 51*(2), 207-219. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=psyc10&AN=2013-32697-001

Brown, T. A., Campbell, L. A., Lehman, C. L., Grisham, J. R., and Mancill, R. B. (2001). Current and lifetime comorbidity of the DSM-IV anxiety and mood disorders in a large clinical sample. *Journal of Abnormal Psychology,* 110(4), 585-599.

Coull, G., and Morris, P. G. (2011). The clinical effectiveness of CBT-based guided self-help interventions for anxiety and depressive disorders: a systematic review. *Psychological Medicine, 41*(11), 2239-2252. doi:10.1017/S0033291711000900

Cuijpers, P., Donker, T., van Straten, A., Li, J., and Andersson, G. (2010). Is guided self-help as effective as face-to-face psychotherapy for depression and anxiety disorders? A systematic review and meta-analysis of comparative outcome studies. *Psychological Medicine, 40*(12), 1943-1957. doi:10.1017/S0033291710000772

Dear, B. F., Zou, J. B., Ali, S., Lorian, C. N., Johnston, L., Sheehan, J., and Titov, N. (2015). Clinical and cost-effectiveness of therapist-guided internet-delivered cognitive behavior therapy for older adults with symptoms of anxiety: a randomized controlled trial. *Behavior Therapy, 46*(2), 206-217. doi:10.1016/j.beth.2014.09.007

Dimoff, J. K., and Kelloway, K. E. (2013). Bridging the Gap: Workplace Mental Health Research in Canada. *Canadian Psychology, 54*(4), 203-212. doi:10.1037/a0034464

El Alaoui, S., Hedman, E., Kaldo, V., Hesser, H., Kraepelien, M., Andersson, E., and Lindefors, N. (2015). Effectiveness of Internet-based cognitive-behavior therapy for social anxiety disorder in clinical psychiatry. *Journal of Consulting and Clinical Psychology, 83*(5), 902-914. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=psyc11&AN=2015-22651-001

Hadjistavropoulos, H. D., Alberts, N. M., Nugent, M., and Marchildon, G. (2014). Improving Access to Psychological Services Through Therapist-Assisted, Internet-Delivered Cognitive Behaviour Therapy. *Canadian Psychology, 55*(4), 303-311 309p. doi:10.1037/a0037716

Health Canada. (2009). *Mental Health – Anxiety Disorders.* Retrieved from http://hc-sc.gc.ca/hl-vs/iyh-vsv/diseases-maladies/anxiety-anxieux-eng.php

Layard, R. (2013). Mental health: the new frontier for labour economics. *IZA Journal of Labor Policy, 2*(1), 1-16. doi:10.1186/2193-9004-2-2

Linden, M., Zubraegel, D., Baer, T., Franke, U., and Schlattmann, P. (2005). Efficacy of Cognitive Behaviour Therapy in Generalized Anxiety Disorders. *Psychotherapy and Psychosomatics, 74*(1), 36-42.

Mayo-Wilson, E., Dias, S., Mavranezouli, I., Kew, K., Clark, D. M., Ades, A. E., and Pilling, S. (2014). Psychological and pharmacological interventions for social anxiety disorder in adults: a systematic review and network meta-analysis. *The Lancet Psychiatry,* 1(5), 368-376. doi:10.1016/S2215-0366(14)70329-3

Mayo-Wilson, E., and Montgomery, P. (2013). Media-delivered cognitive behavioural therapy and behavioural therapy (self-help) for anxiety disorders in adults. *Cochrane Database of Systematic Reviews*(9). Retrieved from http://ezproxy.csu.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=2012599829&site=ehost-live

Monti, F., Tonetti, L., and Ricci Bitti, P. E. (2014). Comparison of cognitive-behavioural therapy and psychodynamic therapy in the treatment of anxiety among university students: an effectiveness study. *British Journal of Guidance & Counselling,* 42(3), 233-244. doi:10.1080/03069885.2013.878018

Newby, J. M., Mackenzie, A., Williams, A. D., McIntyre, K., Watts, S., Wong, N., and Andrews, G. (2013). Internet cognitive behavioural therapy for mixed anxiety and depression: a randomized controlled trial and evidence of effectiveness in primary care. *Psychological Medicine, 43*(12), 2635-2648. doi:10.1017/S0033291713000111

Olatunji, B. O., Kauffman, B. Y., Meltzer, S., Davis, M. L., Smits, J. A. J., and Powers, M. B. (2014). Cognitive-behavioral therapy for hypochondriasis/health anxiety: A meta-analysis of treatment outcome and moderators. *Behaviour Research & Therapy, 58,* 65-74. doi:10.1016/j.brat.2014.05.002

Pearson, C., Janz, T., and Ali, J. (2013). Mental and substance use disorders in Canada: Health at a Glance. *Statistics Canada Catalogue.* Retrieved from http://www.statcan.gc.ca/pub/82-624-x/2013001/article/11855-eng.htm

Robinson, E., Titov, N., Andrews, G., McIntyre, K., Schwencke, G., and Solley, K. (2010). Internet Treatment for Generalized Anxiety Disorder: A Randomized Controlled Trial Comparing Clinician vs. Technician Assistance. *PLoS ONE, 5*(6), 1-9. doi:10.1371/journal.pone.0010942

Stanley, M. A., Wilson, N. L., Novy, D. M., Rhoades, H. M., Wagener, P. D., Greisinger, A. J., and Kunik, M. E. (2009). Cognitive Behavior Therapy for Generalized Anxiety Disorder Among Older Adults in Primary Care. J*AMA: Journal of the American Medical Association, 301*(14), 1460-1467. Retrieved from http://ezproxy.csu.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=37367585&site=ehost-live

Statistics Canada. (2013). *Canadian Community Health Survery: Mental Health 2012.* Retrieved from http://www.statcan.gc.ca/daily-quotidien/130918/dq130918a-eng.pdf.

Titov, N., Andrews, G., Robinson, E., Schwencke, G., Johnston, L., Solley, K., and Choi, I. (2009). Clinician-assisted Internet-based treatment is effective for generalized anxiety disorder: randomized controlled trial. *Australian & New Zealand Journal of Psychiatry, 43*(10), 905-912. Retrieved from http://ezproxy.csu.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=2010443064&site=ehost-live

Titov, N., Andrews, G., Schwencke, G., Solley, K., Johnston, L., and Robinson, E. (2009). An RCT comparing effect of two types of support on severity of symptoms for people completing Internet-based cognitive behaviour therapy for social phobia. *Australian & New Zealand*

Journal of Psychiatry, 43(10), 920-926. Retrieved from http://ezproxy.csu.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=2010443059&site=ehost-live

Tyrer, P., Cooper, S., Salkovskis, P., Tyrer, H., Crawford, M., Byford, S., and Barrett, B. (2014). Clinical and cost-effectiveness of cognitive behaviour therapy for health anxiety in medical patients: a multicentre randomised controlled trial. *Lancet, 383*(9913), 219-225. doi:10.1016/S0140-6736(13)61905-4

Wang, J. P., Smailes, E. P., Sareen, J. M. D., Fick, G. H. P., Schmitz, N. P., and Patten, S. B. M. D. P. (2010). The Prevalence of Mental Disorders in the Working Population Over the Period of Global Economic Crisis. *Canadian Journal of Psychiatry, 55*(9), 598-605.

Wims, E., Titov, N., Andrews, G., and Choi, I. (2010). Clinician-assisted Internet-based treatment is effective for panic: a randomized controlled trial. *Australian & New Zealand Journal of Psychiatry, 44*(7), 599-607. doi:10.3109/00048671003614171

Zhipei, Z. H. U., Li, Z., Jiangling, J., Wei, L. I., Xinyi, C. A. O., Zhirui, Z., and Chunbo, L. I. (2014). Comparison of psychological placebo and waiting list control conditions in the assessment of cognitive behavioral therapy for the treatment of generalized anxiety disorder: a meta-analysis. *Shanghai Archives of Psychiatry, 26*(6), 319-331. doi:10.11919/j.issn.1002-0829.214173

HEALTH AND SAFETY AT CANADA'S STRATFORD FESTIVAL by Janet Sellery

From 1999 to 2008, I developed the health and safety program at the Stratford Festival, North America's largest classical repertory theatre, located in Stratford, Ontario. The Stratford Festival began in 1953 with its unique thrust stage set inside a giant canvas tent. Since then, it has grown to include thirteen productions at four theatres plus numerous Forum events, tours and activities. The mission is "to produce, to the highest standards possible, the best works of theatre in the classical and contemporary repertoire, with special emphasis on the works of William Shakespeare."

At the same time, their health and safety commitment states: "the safety of the public and of our personnel is of prime concern. There is no task so urgent that it cannot be completed safely." My role was to ensure that both of these goals were compatible.

I was responsible for developing and administering all aspects of the health and safety program for the four theatres, as well as the wardrobe, props and scenic construction shops. It's often said that seven people work behind the scenes for every actor you see onstage and I've found that to be true. Each season involves about 620 staff members and 345 self-employed actors, directors, designers and musicians working under nine collective agreements (about 85% of the payroll is seasonal, contract staff), plus185 volunteers and 500,000 patrons each season.

When I began, I was the only full-time health and safety person in a theatre in Canada. As awareness spread, elements of this program, and the importance of a strong safety culture, have been adopted by many Canadian arts organizations. How did this happen in an industry that historically operated under the legislative radar?

When I began, I was the only full-time health and safety person in a theatre in Canada.

Most of us who are passionate about health and safety have experienced a wake-up call and mine came in high school. Thanks to a brilliant and inspiring theatre arts teacher, I learned about the special kind of magic it takes to create a live performance. When I was seventeen and working on a community theatre production, I had a serious fall from a set so I developed a concern for safety even before I went to theatre school.

After graduating from the Technical/Production Theatre program at Ryerson Theatre School, I began work in stage management at the Stratford Festival in 1985. I was involved with a critical injury involving a much-loved actor in 1995. She had become disoriented (possibly due to a mask that limited her vision) and fell about nine feet from the balcony of the Festival stage during a technical dress rehearsal of *Macbeth*. Her injuries included a fractured skull, broken shoulder, broken ribs, and a punctured lung. She was off work for more than four months but made a full recovery and worked as an actor until her mid-eighties. As the assistant stage manager on that show, I gave first aid and I was involved with the Ministry of Labour investigation in my role as worker co-chair of our Joint Health and Safety Committee (JHSC).

We believed we had taken all the necessary precautions for that scene, yet still this terrible incident occurred. For over forty years, no one had ever fallen from the balcony so it was not recognized as a serious hazard until an actor nearly lost her life. Seeing an actor bleeding on the stage and hearing the ambulance siren was traumatizing; we didn't know if she would live.

That incident was a life-changing experience for many of us and I felt that someone should step up and take action. I started to give health and safety chats for each acting company. In my role as an assistant stage manager, I didn't have the resources or the authority to make any significant, sustainable changes, but I began spreading awareness and tried to figure out how we could do a better job recognizing hazards.

In 1999, after the Shaw Festival had a Workwell audit, Stratford Festival's new director of human resources persuaded senior management that health and safety needed to become a stronger focus. With no formal training, I made the transition from "squeaky wheel" to health and safety co-ordinator. It was a much bigger job than I had imagined and I needed specific education and training. I began taking courses for my Occupational Health and Safety certificate, at Ryerson University building the Festival's health and safety program as I went along.

Within a short time as health and safety co-ordinator, I began to receive calls from other theatres asking for advice. My manager, director of human resources, Shel-

ley Stevenson and Antoni Cimolino (then executive director, now artistic director) encouraged me to share information throughout Canada's theatre community.

I also volunteered on advisory committees for the Ministry of Labour, Workplace Safety and Insurance Board and the Ontario Service Safety Alliance. These committees were a source of learning for me, and a chance to make our industry's voice heard on issues that would affect our work.

While compliance with legislation and reduction of costs are important, in my opinion, the most compelling reason for the arts community to focus on health and safety is because we have something very special to protect: the incredible people who create and support our productions.

There are three words that guide how I approach my work: Respect, Respond, Require.

Respect the incredible diversity of artists and the unique nature of each project. The work in scenery, props and wardrobe shops and rehearsal halls is different every day, and it takes place in an atmosphere of continuous creativity and change.

Respond to questions and requests as quickly as possible. Artists and workers who ask questions or challenge health and safety information are engaged and should be encouraged. If there isn't an immediate answer, refer them to someone else or let them know when more information will be available. I often act as a "translator" between our world and the world of regulators and worker's compensation.

Require people to comply with legislation, wear personal protective equipment and report all hazards, injuries and incidents to their supervisors.

I try not to say "no" to anything, rather I make sure people stop, identify the risk, get information and support, and take adequate precautions to control that risk before going ahead. Sometimes the controls will be too expensive or time-consuming so another option will be chosen.

When I began to create the Stratford Festival's health and safety program, I met with resistance. Some people said that health and safety would destroy art: "We're special, we're different, it's temporary; it's not a construction site, we're not a factory." However, it is not acceptable to me that artists, craftspeople and support staff should be any less protected than a factory worker. Quality of life for people who work in the arts is of prime importance.

The creative process presents many health and safety challenges, especially when scenes must look dangerous. Each season and every production is unique and during technical and dress rehearsals, there may be many variables (lighting, sound, scene changes etc.) occurring at same time.

Artists must take creative risks every day but they must recognize when a creative risk crosses the line and becomes a safety risk. At that point, the activity must be assessed and any risks controlled, before it is attempted.

Attitudes matter too: "The show must go on" is real and sometimes it means "in spite of the risks involved". This sort of attitude

BUILDING THE HEALTH AND SAFETY PROGRAM

1. **Health & Safety Audit –** In 1999, with the assistance of the Ontario Service Safety Alliance (now Workplace Safety & Prevention Services), we conducted at mock Workwell audit. The result was very discouraging, but it helped me plan what needed to be done.
2. **Health & Safety Handbook –** I was determined to have information ready for staff in time for the beginning of the 2000 season (just six months after I started the job). It was ambitious, but I pushed ahead on the premise that "a good plan today is better than a perfect plan tomorrow."
3. **Health & Safety Orientation –** With the first version of the handbook complete, we began orientations for all staff and volunteers.
4. **Joint Health & Safety Committee (JHSC) –** The work of the JHSC was formalized with its first Terms of Reference.
5. **Training –** In the first year, WHMIS training and Fire Drills were added and, in subsequent years, training grew to include topics such as Supervisor Due Diligence, JHSC Certification, Fall Protection, Elevating Work Platforms, Lockout, and Ergonomics. Scheduling with a highly-mobile workforce was tricky but not impossible.
6. **Health & Safety Policy Manual –** Building on the information contained in the Health & Safety Handbook, the policy manual grew each year. Beginning with the basics, policies were added to address the theatre's unique work activities.
7. **Risk Assessment –** Risk Assessment is a robust process that allows us to assess unique hazards and select appropriate controls, the precautions that keep people safe. We conducted Risk Assessments for all departments in preparation for JHSC Part 2 Certification training in 2001, and the Technical Directors began to conduct Risk Assessments for individual productions.
8. **Annual Evaluation –** Each year we arranged a mock Workwell audit to assess the progress of our program and set priorities for the year ahead.

can be an obstacle to speaking up about health and safety concerns.

The good news is that when theatre people truly understand workplace safety, they do an excellent job and find creative ways to comply with the law within the theatre.

We also benefit from existing practices. While they are not thought of as being part of health and safety, these proactive activities ensure readiness and precision. During the rehearsal process, every movement, both onstage and backstage, is worked out carefully. Paperwork such as checklists and cue sheets documents the details for running the show. Prior to each performance fight warm-ups take place, along with pre-show checks of all the equipment and systems including lighting, sound, scenery, props and costumes. During the performance, every change in lighting, sound, scenery and special effects is cued by the Stage Manager.

> *Woman falls 40 feet during show at Sagebrush Theatre.* (Kamploops, BC)
>
> *SM awarded £3.7m compensation after being left paralysed* (London, U.K.)

Working at heights takes place on ladders, scaffolds, elevating work platforms, catwalks and elevated scenery, plus there may also be a risk of falling from the stage into an orchestra pit or trap in the stage. When I first began asking about the potential for serious falls at our theatres, one of the responses I got was "only stupid people fall". Many of the stage hands had worked at the Festival for twenty to thirty years and change was going to be difficult.

Despite the push back, the Stratford Festival developed a Fall Protection Program that included training, fall protection equipment, engineered systems, rescue planning and procedures. Fall protection became such a focus that we reached the point where the same people who said that harnesses were unnecessary, would feel uncomfortable working without them.

> *"Probe launched after opera fire-spitter burned onstage"* (CBC News, February 6, 2013)

Whether a production calls for a candle, a torch, a fireplace or a fire-breathing stilt-walker, working with live flame and flammable liquids and gases is inherently dangerous. For best results, I always like to involve the people who do the work, therefore the Flame Effects Policy was written in consultation with the stage crew. We reviewed resources, including the relevant National Fire Protection Act (NFPA) standard and consulted with our local Fire Department. The resulting policy gave guidance to future productions and was developed into a Safety Guideline for the Live Performance Industry in Ontario by the Ministry of Labour Advisory Committee.

High risk activities such as pyrotechnic special effects, performer flying and stage fights must take place under strictly controlled conditions. Here are four suggestions to ensure those activities are safe.

1. **Planning Safety** is the responsibility of the top person in any organization. Time, people, money and health and safety must be considered. Safe and successful high-risk activities require the artistry and expertise of a competent specialist (such as a Flying Director, Pyrotechnician, etc.), appropriate design (including engineering, as needed), construction and selection of systems and equipment. Expensive? Perhaps. But, if you can't afford to perform tasks safely, you can't afford to do it at all.
2. **Risk Assessment –** The purpose of a Risk Assessment is to keep people and productions safe by identifying and eliminating or controlling health and safety hazards onstage and backstage. It is often done informally, but the greater the risk, the greater the need for a written assessment. As the show evolves, the Risk Assessment must be updated to ensure controls are still adequate.
3. **Procedures –** These include inspection and maintenance of equipment and systems, as well as pre-show checks. Backstage running sheets should describe each activity in detail, as well as how performers, crew, spotters and stage management will communicate if there is a problem.
4. **Training and Rehearsal Time –** Adequate time, as determined by the relevant specialist (e.g. Flying Director, Pyrotechnician etc.), must be scheduled to train and rehearse principal performers, stunt doubles, swings and understudies, as well as alternate crew and stage management. Expect and allow sufficient time for changes to be made, especially on a new, evolving and complex production.

Unfortunately, very few theatres have human resources people, and health and safety people are even more rare. Health and safety education is now included in most technical theatre programs at the post-secondary level, so many Production Managers and Technical Directors understand they need to implement health and safety in their areas. Unfortunately, health and safety is not included in Arts Administration and Cultural Management programs, so there can be a gap in understanding at the leadership level. In order to be successful, Executive Directors and General Managers need to be aware of their duties so they can support health and safety as required.

How many injuries and illnesses occur in the theatre industry?

Accurate statistics are hard to find because many theatre professionals do not have worker's compensation coverage. For example, in Ontario, theatre is a

"by application" industry, so coverage is not mandatory. Large arts organizations often have coverage, but within that coverage they may exclude performers. Some actors, dancers, musicians and technicians have extended health coverage through their associations and unions, but many do not. Serious injuries make the news, but many injuries and illnesses—including those that end careers—are not officially "counted".

The Stratford Festival's most important contribution to health and safety in Canada is that it has shown a comprehensive approach is both possible and desirable. With the support of a strong leadership team and active worker involvement, we were able to figure out how to achieve compliance, make meaningful progress and change how health and safety was regarded in our industry.

After leaving the Stratford Festival and with their support, I have continued to share my approach to health and safety in the arts by customizing programs and training for a wide variety of arts organizations and giving presentations across the county. I've also been involved with developing health and safety resources for the theatre community, including the *Safety Guidelines for the Live Performance Industry* (Ontario), *Safe Stages* (Alberta) and *Play It Safe* (British Columbia).

To keep each other safe and to keep our productions and events on track, we need to get this right the first time, every time. I believe that the arts are vital to the heart and soul of our communities and, together, we need to take care of the people who devote their lives to creating the productions for all of us to enjoy.

Janet Sellery is one of Canada's leading experts in health and safety and the arts. After a career in stage management, Janet pioneered the health and safety program at the Stratford Festival. Her work as a Health & Safety Consultant (Sellery Health + Safety) focuses on customizing programs, training, and resources that reflect the constantly evolving and unique demands of the live event environment. She has been awarded the "Ron Epp Memorial Award for Professional Achievement" (Canadian Institute for Theatre Technology, 2012) and "Canada's Safety Manager of the Year" (Canadian Occupational Safety Magazine, 2007). Janet is committed to "setting the stage for people to create their best work."
Email: janet@selleryhealthandsafety.com
Website: www.selleryhealthandsafety.com

RESOURCES:

Actsafe (British Columbia)
http://www.actsafe.ca

Arts, Crafts & Theatre Safety, New York
www.artscraftstheatersafety.org

ESTA Technical Standards Program (TSP)
http://tsp.esta.org/tsp/about/index.html

Event Safety Guide (Event Safety Alliance)
http://eventsafetyalliance.org

Play It Safe – A Safety Manual for School Theatres/Studios (Actsafe, B.C.)
http://www.actsafe.ca/?s=Play+It+Safe

Safe Stages (Theatre Alberta/WorkSafe Alberta), 2007 https://work.alberta.ca/documents/WHS-PUB_safe_stages.pdf

Safety Guidelines for the Live Performance Industry in Ontario (Ministry of Labour)
http://www.labour.gov.on.ca/english/hs/topics/performance.php

Join **Levitt-Safety** at the 45th Annual Ontario Occupational Health Nurses Association (OOHNA) Conference!

As a Sponsor and Exhibitor for the OOHNA Conference, Levitt-Safety is proud to showcase:

- Prevor Diphoterine®, the world's most dynamic solution to chemical burns and splashes
- Medical surveillance equipment, including audiometers, spirometers, vision screeners, and more
- Wellness products, including innovative health kiosks and cutting edge wellness apps.
- First aid and medical products, including ZOLL Aed's

And please join us **Wednesday June 8th at 8pm** at the **Welcome Reception** for a presentation on the latest development in **Chemical Splash Treatment by Prevor.**

Visit us at **Booths 6 & 7** to enter our draw for a chance to win a **Fit Bit Activity Bracelet**.

CANADA'S BEST MANAGED COMPANIES

www.levitt-safety.com/healthcare | **888.453.8488**

levittsafety | HEALTH CARE SOLUTIONS

2016 KEEPING WORKERS WELL

June 8 – June 10

Crowne Plaza Hotel & Conference Centre
Kitchener, Ontario

WELCOME RECEPTION
Wednesday, June 8
(7:30 – 9:30 p.m.)

CONFERENCE
Thursday, June 9 and
Friday, June 10

EXHIBITION
Thursday, June 9

OOHNA

Information available at www.oohna.on.ca