

**Ontario Nurses' Association
Submission to**

Ontario Roundtable on Violence Against Women

and

**the Select Committee on
Sexual Harassment and Violence**

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The Ontario Nurses' Association (ONA) is the union representing 60,000 front-line registered nurses and allied health professionals and more than 14,000 nursing student affiliates across Ontario, providing care in hospitals, long-term care facilities, public health, the community, clinics and industry.

Statement of Beliefs: Occupational Health and Safety

ONA believes that it is the right of all its members to work in a healthy and safe work environment. It further believes in the pursuit of the highest degree of physical, mental and social well-being of workers in all occupations. As the largest health-care union in the country, ONA believes it is part of its mandate to exercise a strong leadership role in achieving progressively greater gains in the field of occupational health and safety.

Introduction

It was almost 10 years ago, in 2005, when ONA member Lori Dupont was horrifically murdered in what was one of the most dramatic examples of workplace sexual violence in modern memory. ONA has worked tirelessly during the intervening decade to press for legislation, workplace changes and regulatory enforcement to stem the rising tide of harassment and violence in our health-care workplaces, where according to StatsCan, in 2014 women represented 82 per cent of the sector's workforce. Unfortunately ours is a continuing story of growing harassment and violence in our workplaces.

Legislative Amendments Needed

The *Occupational Health and Safety Act* was amended in response to the Dupont inquest, but "Bill 168" was not enough to engender sufficient progress. While the amendments expressly articulated that harassment and violence are workplace hazards, the "new" violence provisions of the Act are too limiting. The new sections are only explicit about the employer's obligation to take every reasonable precaution to prevent workplace violence that can have *physical* impact on a worker. But the provisions are silent with respect to the very real *mental* injuries that can result from workplace violence.

Similarly, while clear that employers need to prevent workplace violence, the new sections do not explicitly require employers to take reasonable precautions to prevent harassment, which can be and was, in the horrific Dupont case, a precursor to predictable, preventable workplace violence. As the submission by the Labour OHCOW Academic Collaboration (LOARC) explains,

and as explained in expert testimony at the Dupont inquest, harassment is often just the beginning of a full continuum of behaviours that can include sexual harassment and culminate in horrific violence. Expert witness Dr. Peter Jaffe testified at the inquest about dozens of opportunities for preventative intervention that were missed as the harassment towards Ms. Dupont escalated in gravity and frequency.

The limitations on the legislative amendments have been compounded by the Ministry of Labour's (MOL) ensuing narrow interpretation, which has left the female-predominant health-care sector free to continue a culture of tolerance to workplace violence and its physical and mental impacts on workers as well as patients, clients and residents. Just look at the numbers. Even without considering what we know anecdotally to be under-reporting of injuries and illness from violence and other hazards, and using only the Workplace Safety and Insurance Board (WSIB) lost-time claims data which ONA has often proved to be faulty, the health-care sector is a leader in workplace injuries and illness from all forms of hazards including violence.

The attached 2013 infographic (Appendix 1) is based on only accepted WSIB claims for workplace physical injuries. The comparisons to male-dominated construction, mining and industrial sectors of the workforce are striking. WSIB data shows that health care is outpacing those sectors by from eight up to 600 times as many physical injuries from workplace violence, and those numbers don't take into account the mental injuries the WSIB is permitted to continue to ignore. It also doesn't reflect the fact that workplace violence is under-reported by those who work in a culture that accepts harassment and violence as just "part of the job" of caregivers in Ontario.

Premier's Leadership Appreciated

The vast majority of ONA members are women who daily face increasingly difficult circumstances as Canada struggles to reorganize the health-care system. Too often we get reports of our members being kicked, punched, spat on and verbally abused. A sampling of recent reports includes: nurses beaten beyond recognition; one stabbed, narrowly missing her carotid artery; a nurse sustaining a finger amputation in a violent attack; and sexual grabbing and other abuse as our members deal with challenging patient and client populations and the rising public anger with health-care system inefficiencies. One is left to wonder whether we might have seen more aggressive actions to stop ongoing exposure to violence and harassment in a sector where 82 per cent of the workers were men.

We are therefore pleased to see that the Premier herself is taking leadership in this very important mission to eliminate misogyny and its effects in society. We welcome this opportunity to offer our experience to help her lead the province away from misogyny and acquiescence to harassment and violence, including sexual violence, which too many of our members too frequently experience at work.

LOARC Submission, Workplace Factors and Psychosocial Hazards

The LOARC paper well describes the psychosocial hazards that characterize workplaces where harassment and violence thrive.

The most recent dramatic example that underscores LOARC's assertions is the very public CBC Ghomeshi case where investigation revealed a "culture of fear" that allegedly existed among his staff. This revelation resonates with ONA members who learned from the Dupont inquest of similar working conditions. In a 2010 presentation to the Canadian Bar Association Ronnie Nordal wrote that the inquest exposed,

"...there had been a lengthy history of abusive and/or destructive behaviour by [the doctor who murdered her] including damaging hospital equipment, having broken another nurse's finger, shouting, swearing, etc. The inquest heard of a workplace culture of 'physician dominance' at the hospital and that nurses commonly did not bring forward complaints, as they had previously not been responded to by management and the nurses feared reprisals."

Dr. Jaffe spoke of dozens of opportunities to intervene, change those conditions and prevent the workplace death of Lori Dupont.

ONA is often frustrated that systemically, lessons learned are not acted upon, as when despite the Dupont revelations, insufficient steps were subsequently taken to prevent a recurrence of something similar. Why else would we have the recent matter of a former physician partner who was criminally convicted of mischief and uttering threats against a nurse, yet he was allowed to retain his privileges and remain at work both during the criminal trial and subsequent to his conviction, while she, the victim, has been required to move from her position to an alternative and inferior position "for her protection."

And ONA recently won a seminal Workplace Safety Insurance Appeals Tribunal (WSIAT) case that involved a nurse who was harassed by a physician (in this case female to female) for years with insufficient employer interventions, with the nurse finally suffering Post Traumatic Stress Disorder (PTSD). In deciding this matter, WSIAT struck down legislative restrictions on benefits for mental stress as unconstitutional, yet that lesson has not been applied. As LOARC explains, the WSIB is still permitted to continue to refuse compensation to workers who suffer mental injuries that the Honourable Romeo Dallaire says must also be considered as “honourable” as physical injuries.

Inadequate Enforcement

As explained by LOARC, many inspectors feel only able to write orders for policies and procedures, but not able to penetrate beyond this surface response to evaluate the sufficiency of the measures, procedures, equipment and training to prevent or address workplace violence and harassment.

The organization of MOL enforcement resources was configured in the late 1970s at a time when Ontario's workforce looked very different. While there have been adjustments, including adding a handful of health-care inspectors (6-8), the core arrangement of MOL's 200+ inspectors into discrete mining, construction and industrial units persists. Today's health-care sector represents a much greater proportion of the workforce than it did in the late 70s and is populated with a large majority of female workers who are leaders in workforce injury and illness statistics. Yet the MOL has not adjusted its resource distribution to reflect the reality and real needs of the changing demographics.

MOL statistics (Appendix 2 attached) reveal a disturbing lack of attention by its officers to the burgeoning health-care sector when compared to the male-dominated construction and mining counterparts, where significantly fewer workers are now employed. There are fewer visits, fewer orders issued and infrequent prosecutions for violations despite the staggering proof of ongoing harassment and violence and other health and safety violations in health care. ONA has heard all levels of the MOL complain that ONA is demanding too much of its time in complaints and appeals and pleas for investigations and should instead develop better relations with the very employers who have been permitted to maintain a long history of impeding our Joint Health and Safety Committees (JHSCs) and failing to protect our members without being held to account.

And there is confusion among enforcement agencies about who is responsible to keep health-care workers safe when, for instance, they report sexual assault in the workplace. In a recent case a nurse was grabbed and restrained by a large challenged patient as he ground his body and private parts against her. Reportedly the police initially failed to investigate because of the nature of the patient, and initially the MOL dismissed the complaint as a police matter. The worker was traumatized and disabled from working for some days. Steps that could have been taken to prevent the incident were only taken after the fact, to prevent a recurrence.

Occupational health and safety law and interpretation is woefully inadequate in that it was argued the matter didn't result in *physical* injury and thus needn't be reported. Further, the reported initial police interpretation of criminal law was that because the patient's penis was not exposed, a sexual assault did not take place.

With diminishing staff and refusal by many employers to engage security staff who can intervene, these kinds of sexual assaults are far too common particularly in health-care units caring for mentally challenged patient populations. Much can be done to protect workers (and others) from these hazards, and employers should be taking preventive steps such as safe staffing, appropriate security, presence personal panic alarms linked to security, a flagging system to electronically and visually alert all workers at risk of a person's history of violence and their triggers and other preventive measures, instead of inconsistently implementing such measures only after workers have been sexually violated.

True Leadership is Prevention

As LOARC points out, the keynote speaker at the Minister of Labour's Summit on Work-Related Traumatic Mental Stress in March 2015 said that, "True leadership is prevention." Yet the prevention arm of the MOL, the Chief Prevention Office (CPO) has been conspicuously silent with respect to the horrendous harassment and violence and other hazards plaguing the health-care sector. Since its inception, the CPO has made numerous statements and taken strong public steps, including overseeing an official review, to address the hazards that the construction and mining sectors face.

The CPO has sector-specific safety associations under its umbrella that develop products and deliver training to help workplace parties establish safe and healthy workplaces.

The Public Services Health and Safety Association (PSHSA) has been helpful to the health-care sector with its violence and harassment challenges.

But despite ONA meeting and presenting evidence, the leadership of the CPO has thus far not demonstrated sufficient commitment to the problematic health-care sector where violence is rampant, harassment is escalating and a culture of acquiescence screams out for ministry leadership in prevention.

WSIB and No Compensation

Romeo Dallaire also spoke of the need to treat mental injuries as “honourable injuries.” Yet as LOARC writes, despite evolving law, WSIB has permitted employers to continue to discriminate against “honourable injuries” and not compensate injured workers for preventable ill health from their work. ONA represented witnesses to the horrific murder of their colleague and friend, Lori Dupont, when WSIB denied their WSIB claims.

In Manitoba, the Manitoba Nurses Union (MNU) is pressing the government to acknowledge the increased susceptibility of nurses to PTSD and is calling for presumptive legislation to make it easier for nurses with PTSD from work to obtain benefits.

Across Canada there is a growing movement to help emergency responders such as fire, police and EMS deal with PTSD. British Columbia and Alberta have made PTSD a presumptive condition for those professions, and we understand Ontario has entertained similar legislation.

With health care a leader in accepted physical claims for violence-related injuries, in a culture of acceptance where the incidence of violence and harassment including sexual harassment won't soon end, and with the mental traumas that naturally flow from these and other health care psychosocial hazards, it begs the question why similar legislation is not being considered for female-predominant occupations in health care.

Leadership in Canada and Abroad

As LOARC explains, many jurisdictions are ahead of Ontario in acknowledging and responding to psychosocial hazards that can lead to work environments where harassment and violence can thrive and generate mental distress. Ontario's Mental Injuries Toolkit (MIT), the Canadian Standards Association (CSA) Standard for “Psychological health and safety in the workplace,”

and various European Union guidelines and practices are but a few tools and approaches that LOARC mentions.

Best practices are also identifiable. Locally, Toronto East General Hospital (TEGH) in collaboration with their JSHC has developed measures, procedures, equipment and training that are having significant impact in reducing incidents of harassment and violence in its workplace. Key to their program is the engagement of appropriate security staff to promote peace in the workplace and intervene appropriately when workers and others may be at risk of exposure to harm from the entire spectrum of behaviours, ranging from harassment, including sexual harassment, to outright violence. We need other employers to follow the TEGH lead, and on a higher level, we need enforceable security standards in health care, similar to standards that exist in other areas.

Further, a Toronto jail has practices that can be replicated when dealing with difficult patient populations. We have recently learned of the facility where nurses treat inmates, but because of adequate measures, procedures, equipment and training, we have been told that there have been no attacks of nurses in 18 years. Lessons can be learned from male-dominated workplaces that can translate into the health-care sector where sadly the majority of nurses can expect to be assaulted more than once in their career.

Conclusion

Like LOARC, we applaud the Premier's commitment to eliminating misogyny and its appearance in the form of harassment, including sexual harassment, in our workplaces. And we appreciate the Minister of Labour's commitment to recognizing injuries from workplace mental stress.

But we also believe the key to success will begin with this government examining its own agencies and law, with expeditious legislative amendment and changes in MOL and WSIB policy and practice. The government, particularly the Ministries of Labour and Health and Long-Term Care need to lead by example.

We look forward to a day when our members can go to work secure in the knowledge that they will be free from harassment, including sexual harassment and violence in our workplaces.

Post Script

ONA was unable to arrange calendars of our spokespeople to appear in person before the Select Committee on Sexual Violence and Harassment, but would be most interested in arranging to present our experiences at a mutually convenient time.

ONA is also most interested in being part of the Premier's permanent stakeholder roundtable on Violence Against Women. As you can appreciate, we believe we have much to offer from our workplace experiences that can assist the government's continuing work to end sexual harassment and violence.