RETHINKING WORKPLACE MENTAL HEALTH: A DISCURSIVE STUDY OF PRIVATE DISABILITY INSURANCE POLICIES IN CANADA

By

Cisela Thoren

Submitted in partial fulfilment of the requirements
for the degree of Master of Science

at

Dalhousie University
Halifax, Nova Scotia
August, 2022

Dedication Page

I would like to dedicate this thesis to my father, Allan Thorén, who passed away before I was able to complete my work.

You loved people, you loved to entertain. Everyone enjoyed your company. You lived your life as everyone should, going out on their last dime. Enjoying every moment.

I will always remember your smile that day. Vänta på mig vid stranden. Jag kommer!

Table Of Contents

List of Tables

List of Figures

Abstract

Rehabilitation Consultants (RC) have a central role in Disability Management (DM) related to employee mental health (MH). There is limited published literature about the context within which these professionals operate and its impact on practice and tools available to them. The aim of this research is to obtain information about the policies that influence the practice boundaries of this group of workers, shedding light on employee MH in the Canadian work context. A poststructural approach to policy analysis, *What's the Problem Represented to Be?* was used to examine private disability policies sold to employers for employees in the workplace. Findings indicate the medical model of disability is the basis on which the tools of RC's are based, and that DM is further constrained by the neoliberal, production-oriented, full-time Canadian workplace. With a focus on the importance of occupation to health, options to use occupation as a rehabilitative tool is explored.

List of Abbreviations Used

DM	Disability Management
WDP	Work Disability Prevention
WI	Work Integration
RTW	Return to Work
RC	Rehabilitation Consultant
MH	Mental Health
WPR	What’s the Problem Represented to Be

Acknowledgements

I am grateful to so many people who have supported me over the past four years, and then some!

I wish to thank my supervisor, Lynn Shaw who has tirelessly answered all my questions and guided me along through ups and downs, unexpected events and many challenges. You have inspired me and enabled me to grow as an academic, and as a person. I never knew what the words “Sure, I’ll supervise you” meant and the depth of that commitment. Thank you!

My committee members, Nicola McNaughton and Shanon Phelan, thank you for taking time out of your busy lives to help me see things differently, to help me clarify my thoughts and understandings of the world and how they may differ depending on context.

I say thank you to my fellow students, Gisele Craswell and Tressa Ducharme for letting me vent my frustrations over a long journey that seemed unsurmountable. I want to thank my friend Adeena Wisenthal for encouraging me and believing in me.

Finally, I want to thank my family. My son, Niklas for helping me believe that maybe, after all, I am smart. My daughter, Annika, for understanding the challenges of university work and being my sounding board as a fellow student. My husband, Gord, without whom this project would not have materialized, at least not in its completed format. Thank you for being my support, knowledge source, and my safety net. You are the wind beneath my wings that give me the confidence to learn to fly.

Chapter 1: Introduction

In this introduction an overview of the rise of mental health concerns in society and in particular for workers, is presented. The role of Disability Management (DM) and Work Disability Prevention (WDP) in supporting Work Integration (WI) and Return to Work (RTW) for persons with mental health conditions is overviewed. The challenges in the current context for Rehabilitation Consultants (RC's) are then posited within a private insurance context. The gaps and barriers and opportunities for RC's in supporting delivery of services to support WI are identified. The need for research is highlighted that informs the direction of this inquiry and study.

Mental health problems are increasing globally, and in Canada (Coduti et al., 2016; Dimoff & Kelloway, 2013; The Conference Board Inc, 2012). Four million Canadians were living with a mood or anxiety disorder in 2011 and this is projected to increase to 4.9 million people by 2041 (Smetanin et al., 2011). This expansion of mental health conditions in the Canadian population has been identified as an enormous medical or treatment issue (Dewa et al., 2009; The Conference Board Inc., 2012) a social concern, (Fulcher, 1989; Hocking, 2017), and an economic problem (The Conference Board Inc., 2012; OECD, 2010). In addition, days lost in the workplace due to absenteeism and presenteeism makes this a large issue for employers in Canada (Dewa & McDaid, 2011; Evans-Lacko & Knapp, 2016), costing up to 51 billion annually (Lim et al, 2008). The efforts of insurers and employers to address this problem through DM and WDP are explored.

Case Management and Disability Management

Case management has been in existence for over 100 yrs. It was initially carried out by nurses as a method of coordinating and managing care, and existed in areas such as primary care, acute care, long term care, home care and in the health insurance industry (Kersbergen, 1996). In the early 1900's it was used in the private insurance industry to provide nursing services for clients during illness to prevent payment of death benefits. Later, case management services expanded into other areas such as discharge planning and elder care (Kersbergen, 1996). In the 1970's, case management was associated with the move from institutionalized care to community care and ensuring the continuity of services for the mentally ill (Gursansky, Harvey and Kennedy 2003; Kersbergen, 1996).

Case management is offered in private health insurance, health care benefit management firms and by independent vendors, as well as in acute care and with rehabilitation hospitals. Its purpose is to control health care expenditures for high-cost patients (Henderson et al., 1988). From the early beginnings of case management in acute care to prevent the payment of death benefits to the coordination of services for the deinstitutionalized mentally ill. Thus, case management has had different areas of focus over the years. Through the different areas of focus in case management, an observation can also be made that it is not the coordination of cases that is of prime importance, but the coordination of services (Kersbergen, 1996).

While acknowledging the distinction between the different foci of case management, the area of interest in this thesis is the management of disability and how this is addressed in private health insurance with respect to the workplace. According to the National Institute of Disability Management and Research (NIDMAR), disability management (DM) can be defined to be a “workplace centered and directed approach designed to maximize return-to-work opportunities for the injured/disabled worker while reducing the socio-economic impact of disabilities” (NIDMAR, 2004 p. 49). In this thesis, given that disability management can be considered a specialty area of case management, I will use DM and case management interchangeably.

When writing about case management in 1996, Carol Austin (1996) suggested that case managers do not work in a vacuum. Further the programs’ structure and process establish the boundaries within which the case managers function. Case management in any context reflects the characteristics of the client population as well as the structure of the program funding.

There are many organizations that oversee the practice of case management; VRA Canada has been researching and discussing regulation for nearly 20 years (VRA Canada, 2020), NIDMAR published the second edition of the Code of Practice for Disability Management in 2004 (King, 2004), the University of Calgary and University of Fredericton have offered education in Disability Management since 2010 (Dyck, 2015) and the University of Dalhousie since 2000 (K. Joudrey, personal communication, May 30, 2022). Looking at these programs, and the length of time they have been in existence, combined with the rise in mental health related work absences (Dewa et al., 2019) it appears that case management itself has had to evolve to fit the shifting disability landscape, increasingly focusing more on mental health conditions (Dimoff & Kelloway, 2013). Furthermore, the approaches to case management vary, depending on the school of practice followed and the professional backgrounds of the case managers (Shaw et al., 2008; PSR/RPS Canada, 2017).

The Honourable Michael Kirby, in the foreword to *The Evolution of Workplace Mental Health in Canada* by Baynton and Fournier (2017), commented that in his meetings with provincial ministers in 2005, no one reported concern about mental health, whereas in 2014 there was not one minister who did not report mental health among their priorities. Case management practices were initially based on musculoskeletal conditions (Shaw et at, 2008) and the more recent guidelines seem to be more focused on psychosocial management (PSR, 2017, Tompa, 2019). Consequently, the practice of case management evolved from its early beginnings, toward the inclusion of mental health issues, although the exact date of the move from more musculoskeletal conditions to mental health cannot be surmised.

The Canadian Workplace Context

The Conference Board of Canada, through a series of publications that examine the economic impact in Canada of disability in the labour force, provide a starting point about how disability management (DM) practices in Canada are shaped. The publication *Mental Health Issues in the Labor Force: Reducing the Economic Impact on Canada* focuses on reducing the economic impact on Canada due to poor mental health (The Conference Board Inc., 2012). Costs to employers in the form of absenteeism and presenteeism, employer spending and effects on other employees are identified and recommendations are made to 1) create working conditions that support the employees with mental health issues, and 2) decrease stigma in the workplace with the suggestion that the proper management of this issue can affect Canada's competitiveness among leading economies around the world.

Another publication entitled *Missing in Action: Absenteeism Trends in Canadian Organizations* (Stewart, 2013) examine absenteeism trends in Canadian organizations. This document indicates there is an abundance of data available on the main reasons behind short term disability (STD) and long-term disability (LTD) claims. However, the report also advises that much of the data behind casual or intermittent absences is difficult to pinpoint as many employers do not track this information. In particular, the privacy laws in Canada prevent employers from obtaining this data. Despite the lack of data on the reasons behind intermittent or casual time missed from work by employees, the drivers of absenteeism are listed in this report as organizational influences, personal characteristics of the employee and societal influences. These influences are identified based on a correlation of patterns in a review of literature, not on empirical data or actual causes obtained directly from the employees themselves.

Based on the two publications mentioned, among others, authors of articles published by The Conference Board of Canada provide recommendations for the outlines of a DM program (Chenier, 2013; Thorpe & Chenier, 2013). Recommendations for this DM program is based on the overarching economic goal of positioning Canada as a competitor among the economic leaders globally and using assumed causes of absenteeism to develop solutions. For instance, *Creating an Effective Workplace Disability Management Program* (Chenier, 2013) provides an outline of a Disability Management model to prevent disability and to control health-related costs and is based on recommendations from National Institute of Disability Management and Research

(NIDMAR). This DM program has an objective of a commitment to safe and timely return to work along with ensuring that the employers' benefit plans are aligned with this objective.

Disability Management in Relation to Mental Health

Evidence that links the benefits of return to work for persons with mental health conditions appears to be lacking and seems based on assumptions about mental health conditions. From a psychosocial perspective, Hocking (2017) tells us that occupation is healthy. Yet it is unknown, if an early return to work for those with a mental health condition is equally as beneficial as for those with physical conditions. As mentioned by Dewa, Chau and Dermer, (2009) while a previous disability episode is significantly associated with both mental/behavioural and physical disorders, workers with a mental/behavioural disorder are almost 7 times more likely to have another disability episode. It appears relevant to investigate the early gradual return to work processes and resources to gain an understanding of the outcomes of DM, WPD and WI for those with mental health conditions.

To date the findings about DM programs and mental health (MH) are made about the "employee perspective" (Chenier, 2013; Thorpe & Chenier, 2013). However, recommendations for these programs are largely based on findings from employees who have not taken a leave from work, and a large majority of them are not dealing with MH issues. Questions therefore arise about the employee perspective, and whether it aligns with the assumptions of these DM programs.

The Disability Management (DM) programs outlined in the 3 documents published by The Conference Board of Canada; *Missing in Action: Absenteeism Trends* *in Canadian Organizations* (Stewart, 2013), *Creating an Effective Workplace Disability Management Program* (Chenier, 2013) and *Disability Management: Opportunities for Employer Action* (Thorpe & Chenier, 2013), have the key elements of a strong focus on disability prevention and health promotion, sustained commitments to safe and timely return to work and an organizational structure that sustains the objectives of the program. These elements appear to be based on an economic incentive to help make Canada a competitive participant among the economic leaders in the world (Stewart, 2013; The Conference Board, 2012). DM programs are also based on an assumption of the drivers of absenteeism based on a correlation of data as opposed to empirical data collected from the employees themselves (Thorpe & Chenier, 2013). Furthermore, the programs recommended are based on assumptions of the "employee perspective" of an economic incentive to return to work (RTW) as soon as possible. A timely return to work is recommended as absence from work for a period of time is deemed to be detrimental. Missing from the literature is the input of rehabilitation consultants working for private disability insurance companies who work directly with these employees, and their view of the causes of absenteeism.

In 2010, Gardner and others (2010) stated that the return-to-work coordinator is the most important professional in the DM and WPD process. In many instances in the insurance industry, it is the front-line RC's employed by insurance companies that serve as return to work coordinators. As Pomaki (2017) states, the insurer is the connection between all parties and can collaborate with all stakeholders, which makes these rehabilitation consultants critical to helping employees recover and return to work. As such, a further examination of these professionals is needed.

The DM program proposed by the Conference Board of Canada is developed as a practice from the original problematization of workplace disability absenteeism as an economic issue, followed by an assumption about the drivers of absenteeism and that the solution would be to have these employees return to work as soon as possible. There appear to be limitations and gaps in the literature in relationship to the context of DM and WI in directing or laying a foundation related to MH. While in the report by The Conference Board of Canada *Creating an Effective Workplace Disability Management Program* (Chenier (2013), MH is a large concern, it is not known how, from an economic lens, MH is being addressed. An examination of the research literature is needed of how to assist persons with MH conditions to return to work. There is also a need to look at the costs and processes to assist those with MH conditions, as they are not necessarily the same as for those with physical conditions. It is important to note that RC's and employees with mental health conditions have not been part of the processes of developing practice of DM but have been instrumental in developing the current focus of DM and WDP over time.

Private Disability Insurers and The Role of Stakeholders

The Conference Board of Canada has played a role in the understanding of elements of DM and WDP in Canada (Chenier, 2013; Thorpe and Chenier 2013). Further, they suggest that many individuals can be involved in successful disability management programs, such as the ill employee, senior management, health care professionals and insurance providers. However, as the survey on which they make their recommendations has little information about DM and WDP related to mental health issues, it is relevant to investigate these practices in relation to the segment of the population with mental health challenges.

According to a report from OECD (2010), private disability insurers have a "promising disability feature" although there is an absence in the literature about what this scheme entails. An estimate is made that a quarter of the entire disability bill in Canada is attributable to private insurance (OECD, 2010), clearly demonstrating the significant impact of disability on the workplace and of the significant role that these insurance providers have in the issue of mental health and disability in the workplace. Therefore, the practice of this stakeholder requires examination. RC's, who work in DM with a goal of supporting work integration (WI) for individuals with mental health issues could offer a significant contribution to the field of DM.

Chenier (2013) and Thorpe and Chenier, (2013) advise that there is "abundance of data available on the main reasons behind STD and LTD claims" but much of this cannot be accessed due to privacy laws in Canada. They further stress the importance that employers' benefit plans are aligned with the objective of DM programs for a safe and early return to work. To address this gap in knowledge about the main reasons behind STD and LTD claims, and to determine if benefit plans are aligned with DM objectives, it would be of interest to explore the practices of the RC's employed by private disability insurers. These RC's work directly with the recipients of STD and LTD benefits and conceivably may have useful first-hand information about the drivers of absenteeism. As suggested by Thorpe and Chenier, (2013) employers' benefit plans should align with the focus of a safe and early return to work. There is little information in the published literature about how benefit plans align with early return to work. However, in the private insurance industry, RC's are employed at a practical level to support and implement the DM and RTW process. There are also numerous benefit plans offered by the insurer (Pomaki, 2017), which are operationalized by RC's.

Enacting Disability Policies Within the Private Disability Insurance Context

Based on research by Young et al., (2005, p. 548) "while stakeholders may all have something to gain from RTW, they are also driven by broader objectives." These divergent goals and objectives may present a tension across stakeholders in how they approach RTW and the resources to support it. For instance, a disability insurer may have policies to support ways to approach disability to save costs, and employers may have processes to support return to work based on maintaining Occupational Health and Safety policy, accommodation, as well as production mandates. The rehabilitation professionals may want to support timely and safe return to work and draw on employer disability and health professional and provincial or federal legislation. Differences in views are consistent with the findings by Kirsh et al., (2010) who maintains that discourses represent the realities in which policies are set. Austin (1996 p. 74) adds to this by highlighting that "case management services in any particular programmatic context reflects the specific characteristics of the client population as well as the structure of the program funding".

When examining the practices of rehabilitation consultants employed by private insurers to carry out work integration and disability management, researchers need to consider the context or discourse in which they operate. RC's were initially brought in by the insurance companies as a cost-saving measure (Henderson, 1988). Addressing the gap in the literature about RC's, their DM practices and the context in which they operate may inform a better understanding of the boundaries in supporting those with mental health issues in the private disability insurance context.

Given the central role of the Rehabilitation Consultant (RC) in Work Disability Prevention (WDP), Work Integration (WI), and Disability Management (DM) it is the aim of this research to obtain information about the policies and procedures that underscore and shape the practice boundaries of this group of workers and to understand more about how RC's achieve the goals of WDP, WI and DM. To date there is limited published literature that has explored the impact of RC's on employment outcomes post disability.

Study Purpose

To gain a better understanding of the role of RC's in a DM and WDP context within private insurance, a process of examining disability policies and their implicit discourse can be used to further knowledge on how they shape opportunities and limitations to achieve goals of stakeholders.

To provide the reader with clarity on the meaning of policy, it is important to define how policy is understood in the WPR process, versus the general term of policy. Policy is commonly understood to be in relation to government programs and a course of action (Bacchi, 2009). It is a law or regulation of government or institutions (Centers for Disease Control and Prevention, 2015). Examples of this may be government public policy, health policy or transportation policies, to name a few.

In contrast to the commonly understood definition of policy, the WPR process to policy analysis considers policies or policy proposals to be guides that set out a practice that relies on a problematization of an issue (Bacchi, 2009). What is proposed to be done about a problem indicates what needs to change and thus informs how the problem is constituted. By this definition, the disability policies underwritten by private insurance companies can be considered policies that can be analyzed through the WPR process. Pereira (2013) furthers this argument by advising that analyzing policy as discourse holds a premise that problems are created or given shape in the very policy proposals that are offered as responses. Policies are intertwined with discourse and become the focus of scrutiny. Thus, to better understand the role of the RC in work integration, it is important to understand the context in which they work by examining the disability policies that guide their actions.

The researcher of this thesis is an RC, and my work is largely influenced by the insurance policies that are purchased by employers. In this investigation I aim to examine how the insurance policies purchased by employers in Canada position the problem behind mental health and disability and thereby influence the work of the RCs. Consequently, this will be the focus of this qualitative exploratory study using Carol Bacchi's *What's the Problem Presented (WPR) to be?* (Bacchi, 2009) approach to examine the disability insurance policies or benefit plans and with concern for social justice at the core.

Thesis Overview

Following the first chapter, I provide a review of the literature exploring the significance of mental illness in the workplace and practices to address this issue. In chapter 3 I discuss the research methodology, including paradigmatic positioning and my reasons for employing this approach to analyze disability policies. Results from my analysis of the policies are outlined in chapter 4, including my own proposal to reword the policies with an aim toward social justice. In chapter 5 I discuss implications of a policy change where engagement in work occupation is supported. Finally, I provide suggestions for further directions in the area of disability management through the use of occupation as a disability management tool.

Chapter 2: Literature Review

This literature review examines the significance of mental illness in the workplace and current practices to address this issue, including the role of RC's in WDP, WI and DM. The aim of this literature review is to increase understanding about WI and DM, to better clarify the significance of the important contribution these RC's make and to shed light on barriers and facilitators that have an impact on their roles. Mental health issues are examined as a treatment issue, an employer issue, an occupational issue and a policy issue. Implications for the RC working with employees in the workplace are also reviewed. The specific question of this investigation is "*How are the disability management activities of rehabilitation consultants working for private insurance companies shaped by the disability policies sold by insurers to employers to support their employees in Canada?"*

Mental health problems in the workplace is a large issue in Canada and globally (Coduti et al., 2016; Dimoff & Kelloway, 2013; Smeatanin et al., 2011; The Conference Board Inc, 2012), and a multitude of interventions exist in Canada to address this issue, such as medication, psychological counselling, or changes to the workplace, for instance (Dewa et al., 2009; Dewa et al., 2011; Dewa & Hoch, 2015; Evans-Lacko & Knapp, 2016; Wong et al., 2018). Insurance companies have a role in supporting access to resources, identifying interventions that will lead to positive outcomes for workers with MH conditions, (Sutherland & Stonebridge, 2015 and 2016; OECD, 2010) and Rehab Consultants (RC's) are employees of these insurance companies that are seen as agents of the insurance companies who are able to facilitate access to this funding (OECD, 2010; Coduti et al, 2016; Pomaki, 2017). However, not much is known about the way in which they operate (OECD, 2010; Chenier, 2016). Thus the aim of this study is to analyze the disability policies that are purchased by employers with an aim of supporting their employees who are suffering from WPMH issues in the workplace.

Mental Illness in the workplace: A treatment problem

The economic burden to Canada of mental illness in 2003 was deemed to be $51 billion (Lim et al., 2008) and an illness episode related to a mental disorder can double that of a physical disorder (Dewa, Chau & Dermer, 2009). This number was based on undiagnosed mental illness, use of medical resources, productivity loss due to short term disability (STD) and long-term disability (LTD) claims as well as health-related quality of life. Lim et al., (2008) estimated productivity losses related to mental disorders were about 17.7 billion annually. The Conference Board of Canada (The Conference Board Inc., 2012) project a savings of 29.1 billion by 2030 if Canada makes progress in addressing mental health issues in the workplace. To find a solution, researchers and treatment providers have looked at effective ways to address productivity losses due to mental health issues in the workplace (Dewa et al., 2009; Dewa & Hock, 2015; and Wong et al., 2018). Unfortunately, treatment individualizes mental health problems and suggests that it is the employee with the mental health condition that must change to fit into the workplace and society at large.

A multitude of treatment programs in Canada target absenteeism and presenteeism as drivers of the costs of mental illness in the workplace, (Dewa et al., 2009; Dewa et al., 2011; Dewa & Hoch, 2015; Evans-Lacko & Knapp, 2016; Wong et al., 2018). Dewa and others suggest that with appropriate treatment, and progress in treating mental health issues in the workplace, Canada can make significant financial gains (Dewa et al., 2009; The Conference Board Inc., 2012.) Furthermore, it has been indicated that benefit plans offered by employers through insurance providers should be more generous to support this treatment (Sutherland & Stonebridge, 2015; Chenier, 2016; Sutherland & Stonebridge, 2016). However, research has identified that there are a number of barriers beyond benefit plans (Dewa & Hoch, 2015; Wong et al., 2018). For instance, for individuals with MH problems a lack of recognition that help is needed is the biggest barrier to treatment-seeking (Dewa & Hoch, 2015; Wong et al., 2018), and that stigma has a negative impact on whether treatment is accessed (Pattyn et al.,2014; Wong et al., 2018). Thus, the problem does not rest with benefit plans alone, it is a complex issue.

Insurance companies do have a role in supporting access to resources to support workers with MH conditions. For instance, they have been identified as being able to facilitate access to medical treatment for employees with mental health issues through the extended benefit plans (Sutherland & Stonebridge, 2015 and 2016; OECD, 2010). Additionally, RC's are seen as agents of the insurance companies who are able to facilitate access to this funding (OECD, 2010; Coduti et al, 2016). However, it is also indicated in the literature (OECD, 2010) that not much is known about the way in which they operate. Given the large role that these stakeholders play as gatekeepers to treatment of mental health conditions (Pomaki et al., 2010), it is important to examine the extended benefit plans and disability insurance policies that are purchased by employers to support their employees to find out how they shape the way treatment or services can and are accessed through the insurance system.

Mental Illness in the workplace: an employer problem

Mental illness costs employers, not only in terms of absenteeism and missed days of work, but also costs to replace employees, negative impact on coworkers having an increased workload, as well as reduced productivity (Lim et al., 2008). In the literature, researchers have indicated that workplaces can have a direct impact on employee mental health (Coduti et al., 2016; Pomaki et al., 2011; Dimoff & Kelloway, 2013; Dewa et al., 2009, 2016). Consequently, there is a strong focus on improving the mental health of employees through incentives to create psychologically healthy workplaces (CSA Group & BNQ, 2013; Dobson, et al., 2018). The driving forced behind the creation of a national standard for psychological health and safety in the workplace entitled *"Psychological health and safety in the workplace – Prevention, promotion, and guidance to a staged implementation"*, referred to as the Standard, was the realization that the burden of mental illness would be impacting the workplace in terms of productivity and competitiveness (Baynton & Fournier, 2017; Coduti et al., 2016; Dewa et al, 2016).

Regardless of the success of treatment programs and the current supports in the workplaces, Dewa, Chau & Dermer (2009) found that persons with mental and behavioural disorders are at higher odds of recurrence of illness, to the order of almost 7 x more likely than those with physical issues. Researchers Bakker, A. B., and Demerouti, E., (2007) suggest that employees who are experiencing job stress and disengagement or who are burned out, are likely falling behind in their workflow, creating the perception that the job demands exceed their abilities. These employees would thus complain more about their workload and in turn create a negative work environment. From the findings of these authors, Bakker and Demerouti, it appears that despite appropriate treatment, and with a reportedly supportive work environment, it may still not result in positive work integration for employees with mental health issues. Thus, exploring this gap in the literature to shed further light on DM and WI for individuals with MH issues.

The literature abounds with recommendations to involve all important stakeholders with respect to poor mental health and work integration to determine how they may be able to contribute to resolve identified issues (Kirsh et al, 2010; Pomaki, 2011; Dewa & McDaid, 2011). These stakeholders are reported to be the workers, employers, health care providers, and private insurers among others. According to the OECD, (2010) private disability insurance accounts for a quarter of the cost of disability in the workplace. Based on a review of the OECD by this author there are promising disability prevention features outlined in the OECD (2010) report. For instance, financial incentives for employers to prevent inappropriately long sick absences, improving quality of LTD plans to prevent long term labour market exit and avoid frequent shift from LTD assistance to social assistance, and to connect employers and insurers to facilitate communication and collaboration.

Despite the recommendations to involve all stakeholders in the process of work integration and mental health issues in the workplace, no studies report on the examination of the practices of the front-line rehab consultants working in private disability insurance, at the intersection between the employee, employer and health care practitioners. There is little published information on how RC's practice or what factors impact their ability to assist in the process of work integration of people with mental health issues. Given the significant impact of mental health and illness on workers and the workplace, an examination of private disability insurers and how their policies and procedures impact employee mental health and work integration of individuals with mental illness, could add important information toward the quest for improved employee mental health.

There are many recommendations offered in the literature to create conditions to enable individuals with mental illness to integrate into the workplace (Kirsh et al., 2010, Stuart et al, 2014 a & b, Pomaki et al., 2010). As long ago as in 1986, the World Health Organization conducted a meeting about health promotion and published the *Ottawa Charter of Health Promotion* (World Health Organization, 1986). In this document, it was posited that health promotion goes beyond health care and that policy makers in all sectors and levels should be concerned about health. Further it was underscored that the way a society organizes work should help create a healthy society. 34 years have passed since then, and it is unknown what gains have been made. Problems in the workplace are still a concern for those with mental health problems. For instance, while participation in occupation has been identified as a requirement for health, it has been highlighted that those with mental health issues may have problems performing in the workplace (Bakker & Demerouti, 2007; Dewa & Lin, 2000; Dewa, Long & Bonato, 2014; Dewa et al., 2019). However, Durocher and colleagues (2014) indicate that individuals are all different and have different occupational wishes, habits and needs as well as abilities (Durocher, Gibson & Rappolt, 2014). What is a highly demanding job for one may not be the same for another. As such it appears that a tailored or individualized approach is necessary to ensure that engagement in occupation, such as productive work, truly does lead to improved health.

Participation in occupation is healthy and a large determinant of mental health as well as social integration into society (Stuart, 2006, Coduti, 2016; Caveen, 2006; Stuart et al, 2014a, b; Wilcock & Hocking, 2015; Townsend & Wilcock, 2004). Further to this it is noted that participation in occupation provides structure and routine, can be a source of meaningful goals, self-esteem, financial security and social connections (Baynton & Fournier, 2017; Hocking, 2017; Stuart, 2006), is as necessary for human existence as air, food and water (Whiteford & Townsend, 2011) and that occupation and health are actually inseparable (Wilcock, 2007).

In their examination of occupational justice, Townsend and Wilcock (2004) defined occupational imbalance as referring to populations that do not share in the labour and benefits of economic production, referring to both those who are not working, the un-occupied, but also to those who have too much to do, the over-occupied, or too little, the under-occupied. When employees then, are experiencing mental health issues, and may not meet the demands of their work, they could be said to be in a position of over-occupation, and when they stop working, they move to a state of under-occupation. Both scenarios may be instances of occupational imbalance.

While individuals with mental health issues are away from work, they may attend treatment (Dewa, Thompson & Jacobs, 2011; Dewa et al., 2009) with a goal of then returning to work, hopefully better able to manage the highly demanding work that resulted in them being over-occupied to begin with. The process for reintegrating these individuals back to work has been widely described in the literature as Disability Management and Return to Work Coordination (Durand et al., 2016; Dyck, 2015; Pomaki et al., 2010). While there are some innovative methods to bring an occupational focus to this process in terms of Cognitive Work Hardening programs (Wisenthal et al., 2018), the individual moves from a state of being un-occupied to possibly being over-occupied through the process of return-to-work coordination without achieving occupational balance. There seems to be a gap in the literature examining this transition point, something often referred to as WI, to determine what influences this process and what are the positive and negative influencing factors to support those with mental illness integrate to the workforce.

Mental health issues in the workplace are identified as a global health problem (Dimoff & Kelloway, 2013). Engagement in occupation is seen as healthy and necessary for all human beings (Evans & Lacko-Knapp, 2016; OECD, 2010). Based on these two premises then, it would seem logical to address MH problems with an occupational lens. However, given the gap in current literature it is not known whether DM and WDP practices by RC's and other stakeholders consider the importance of occupation for mental health in DM, WI and WDP. Hence the need to explore the practices of RC's and how the discourses of the policies with which they work influence their practices.

Mental Illness in the workplace: a policy problem

There are many studies in the literature examining the best ways to address employee mental health issues, recommending that improvements in treatment is needed (Dewa et al.,2009; Dewa et al, 2011; Wong et al., 2018), healthy workplaces (Baynton & Fournier, 2018; Coduti et al., 2016; Pomaki et al, 2011) or that involvement in occupation is necessary for the attainment of health (Desrosiers, 2005; Durocher, 2014; Hocking, 2017; Whiteford & Townsend, 2011). Given that researchers have indicated some key areas for improvement, it follows that these may be areas for exploration and investigation of strategies to determine their impact. Likewise, in DM there is a call for research to examine what constitutes good practices in Disability Management or RTW coordination (Chenier, 2013; Durand et al, 2017; Dyck, 2015. Furthermore, in MH, intervention recommendations are to explore macro level issues at play such as sociocultural and political (Antao et al., 2013), financial (Henderson, 1988) or corporate (Hullegie, 2018; MacEachern, 2019, Westerout, 2001; Young, 2016). Kirsh et al., (2010) and Young et al., (2016) have also stressed that discourses shape social practices, meaning that depending on the context, the same "problem" can spawn many different solutions (Bacchi, 2000, 2009, 2012; Pereira, 2014). While many of these recommendations for further study are important for advancing knowledge in DM and employee mental health most are not focused directly on what the RC's are able to do to support change and improve WI. More examination of the links between the RC and successful practice in supporting WI an RTW is needed.

Pomaki et al., (2010) advise that insurance companies can provide value far beyond processing and managing disability claims and that they are the connection between all parties involved in treatment, rehabilitation and RTW of employees who are off work. These private insurers have a special case management program with a goal of optimizing treatment, increasing function, and developing individualized RTW plans. However, no one has examined the practices of these professionals or RC's working with these case management programs, nor the context in which they operate in relationship to achieving the goals of facilitating and sustaining RTW or WI.

MacEachern, (2019), in her book entitled *The Science and Politics of Work Disability Prevention* suggests a direction as to why the solutions presented in the literature have not been successful to date. First, many suggest that prevention is the best way to control costs (Chenier, 2013; Golden et al., 2014; Thorpe & Chenier, 2013), but programs of disability management with the insurers are responsive rather than preventive (Rachinsky, 1996; Golden et al, 2014), thereby trying to address a problem that has already occurred. Others suggest that interventions and policy are influenced by implementation issues (Loisel et al., 2005), budgets, and politics. Further, it is noted that social, economic, and historical contexts of different countries can drive how policies are seen and thus what solutions are possible (MacEachern, 2019).

Based on the views of MacEachern and Loisel, further investigation is warranted to examine the context and discourse within which the RC's working for insurance companies operate to reveal how policy influences practice. As RC's are considered the most important persons in the RTW process (Gardner et al., 2010), and the scope and character of the RC's role are dictated by the program funding (Austin, 1996), this influences the context and discourse in which they operate. Further, they are guided or influenced by the policies they are tasked to implement and operationalize (Kirsh et al., 2010; Bacchi, 2000, 2012; Laliberte Rudman, 2013; Pereira, 2013). Given that discourses are the realities in which policies are set (Kirsh et al. 2010), investigation into the values embedded in these policies may provide insight into how RC's implement RTW coordination (MacEachern, 2019).

Mental Illness in the workplace: RC perspective

There is ample information in the literature about the benefits of treatment, (Dewa et al., 2009) psychologically healthy workplaces (CSA Group, 2013) and the benefit of occupation toward health and of improving the mental health of employees in the workplace (Pomaki et al., 2010; Pomaki, 2017). However, Thorpe and Chenier (2013), in their publication *Disability Management: Opportunities for Employer Action* also recommend that employers ensure that the benefit plans they have meet the needs of their workforce. They provide definitions of coverage:

> Short-term disability leave covers all or part of an employee's pay when they are injured and unable to work for a short time. Many times, employees are required to use sick days before STD kicks in. The time period covered by short-term disability differs from one organization to another, but coverage usually lasts about four to six months.
>
> Long-term disability leave covers part of an employee's pay when they cannot work for a long period of time because of a health issue. Long-term disability usually kicks in after a short-term disability policy has run out. (Thorpe & Chenier, 2013 p. 17)

Despite the recommendation to examine these benefit plans or insurance policies, there seems to be a gap in the research literature about these policies and how they impact the work of RC's and whether they do meet needs of the workers. In line with this, there is also a gap in the published literature that describes the roles of RC's who work for private insurers and who are guided by these policies. This gap is significant as RC's have been said to be the key to the return-to-work programs' success (Garner et al., 2016). Further, it has been stated that private insurance contains many promising features in the mental health of employees (OECD, 2010; Pomaki et al., 2010), but not much is known about them. Finally, Pomaki et al., (2010) indicates that specialized mental health case management programs are provided by the private insurers with the goal of improving function, access to treatment and to assist with work integration (Pomaki et al., 2010). Given their central function in the treatment, rehabilitation and return to work of employees who are away from work due to mental health issues (Pomaki, 2017), it appears relevant to examine how these programs work.

Through conducting this study, I seek to add to the research literature an understanding of how disability policies may guide RC's in DM and influence their focus surrounding mental health and integration in relation to the workplace. Important information about how RC's employed by private insurers approach mental health issues in the workplace and DM can be gleaned through examination of insurance policies or benefit plans purchased by employers to support the needs of the workforce as there clearly is a gap in the research literature.

The question that informed this research is: "*How are the disability management activities of rehabilitation consultants working with employees with mental health issues influenced by private disability insurance policies in Canada?".* The overarching aim of questioning these policies is to increase understanding about WI and DM, to better clarify the significance of the important contribution these RC's make and to shed light on barriers and facilitators that have an impact on their roles in enacting programs to support persons with MH conditions.

Chapter 3: Methodology

This methods section outlines the methodology, the research methods and the research questions that underpin my inquiry and analysis of Canadian disability policies. I respectfully write this in first person and in present tense to align with the paradigm and the processes underscored by the WPR. This section begins with a description of my reasons for the choice of methodology. I follow the reasons for choice of methodology with a description of me as researcher, an outline of the interpretive paradigm, and lastly, I describe how the research design is used to connect the paradigms to the strategies of inquiry and to methods for collecting empirical materials (Denzin & Lincoln, 2008).

Methodology

In 2010, the OECD suggested that an interrogation of the disability prevention features of private insurance plans is necessary to understand disability policy in Canada. Further, Thorpe and Chenier (2013) recommend that employers evaluate whether their benefit plans meet the needs of their workforce. Given my own work in Disability Management for a large insurer, my goal with this thesis is to undertake such an evaluation.

As I examine disability policies, I note that conventional approaches to policy analysis are grounded in an assumption that the purpose of policy is to solve problems (Bacchi, 2009). Implicit in the solutions provided in policies is a suggestion that something needs to change, thereby providing a representation of the problem (Bacchi, 2009; Bacchi & Eveline, 2010). For policies to influence change then, they must be instrumental in giving shape to problems and ways in which they are defined (Bacchi, 2009; Bacchi & Goodwin, 2016). Based on a view that policies define problems to be addressed, I can, by examining a “solution”, deduce what is deemed as needing to change, thereby clarifying what the problem is seen to be. Given that the private insurance industry has a prominent role in "addressing" disability (Baynton & Fournier, 2017; Pomaki, 2010), I look to examine the solutions to mental health and disability presented in disability policies. Through an examination of solutions provided, I am able to see the implied problem represented in the policy and question the assumptions and presuppositions upon which the implied problem is based.

As I investigate disability policies, I consider a number of issues. One issue with which I am concerned is how to remain objective while employed within, and having a working knowledge of, Disability Management and private disability policies. Researchers Bacchi and Eveline (2010) indicate that a lack of objectivity might otherwise harm the research partners, and that a balance between such objectivity and "insider knowledge" is paramount. Another issue that I must consider is the challenge in gathering information from large organizations, something that is raised by Bacchi and Eveline (2010) as commonly encountered by researchers in policy work. They go on to say that the political environment influences not only how information can be obtained, but also what can be researched. In Western democracies, organizations influence research priorities, with the result that some issues are silenced whereas others are given more weight or importance, and through this, influence research results. As such, as a researcher, I must be conscious of political investments in research practice, and that "truth is a political phenomenon" (Bacchi & Eveline, 2010 p. 328). In line with this, I am privy to information as an employee that I may not share, which silences some areas that may have added to my critique.

A final issue I need to consider when selecting the methodology to be used for analyzing disability policies comes from the suggestion by Carol Bacchi that it is not the intentional shaping of policies and policy makers that is of concern. She indicates instead that policies are created in context and to direct our attention to the taken-for-granted assumptions upon which these policies are created (Bacchi, 2009).

Considering the need to balance objectivity with insider knowledge (Bacchi & Eveline, 2010), and the politics involved in obtaining information about the actions of large organizations, I elect to use Carol Bacchi's methodology *What's the Problem Represented to Be?* (WPR) (Bacchi, 2009) to analyze disability policies. The WPR approach enables me to question the assumptions underlying disability policies and to examine the solutions provided along with the implied problems behind WPMH. I analyze only publicly available information, thereby minimizing the appearance of conflict. Lastly, I examine policies, not as intended solutions to implied problems, but as instruments that give shape to problems, opening up the possibility that things could be different.

A WPR approach to policy analysis uses a Foucauldian-based poststructural paradigm or world view (Bacchi, 2016). Through the use of the WPR methodology, I am able to view policy, not as a means to solve problems, but as all policies make proposals for change, as instrumental in the creation problems (Bacchi & Eveline, 2010). The task in this WPR approach is to question the underlying assumptions within problem representations. In other words, not to evaluate the outcomes of particular policies, but the practices through which the problem representations come to be (Bletsas & Beasley, 2012), with an aim toward social justice at its core (Bacchi & Goodwin, 2016).

Therefore, this aligns with my research question where I ask, *"How are the work integration and disability management practices of rehab consultants shaped by the disability policies sold by insurers to employers to support their employees in Canada?*"

My position as researcher

When undertaking qualitative research, it is important that I shed light on my position as a socially situated researcher (Denzin & Lincoln, 2008). The recognition of my own position in society is in keeping with Bacchi, (2009) who insists that no one sits outside discourse. The understandings I bring to my research, as well as the lens through which I approach my analysis will necessarily be impacted by my historical knowledge. The knowledge I bring with me as a result of my life experiences, social and cultural background, education and economic positioning all impact my findings and research (Denzin & Lincoln, 2008; Gadamer, 1975).

Working role as a Rehabilitation Consultant. The first area that I highlight in my undertaking of this analysis of disability policies in Canada, is that as policies are said to produce or constitute political subjects (Bacchi & Eveline, 2010), and that I, through my role as an RC therefore am situated as a subject governed by the policy (Bacchi, 2009). Being an insider impacts my interpretation of the policy as well as my ability to open up spaces to envision new possibilities, or how things could be different (Bletsas, 2012). The WPR approach supports me and my ability to view policies or ways of being in a new light or to envision new possibilities (Bacchi, 2009; Bacchi & Goodwin, 2016).

Research as a Political Act. A second arena I need to be conscious of as a researcher, is that research itself produces realities, and thereby impacts what I may understand as fact or truth (Bacchi, 2012; Mol, 1999). In conducting an analysis of policy I need to aware and conscious of whose interests are being served through my research, as policies are situated within large organizational objectives and priorities (Bacchi & Eveline, 2010).

Declaring my Historical Context. As researcher I am an active participant in the research process (Bacchi & Eveline, 2010; Gadamer, 1975; Hertz, 1996). Being active in the research process and thereby influencing my findings, I use strategies to reveal my preconceptions and assumptions (Rönnblom & Bacchi, 2011; Smythe, 2008; Spence, 2016). One strategy is through a presupposition interview and the other is through a reflective journal where I demonstrate the path I use and the assumptions I make in using this methodology to analyze the insurance policies (Hammersley, 2008; Ortlipp, 2008; Smith, 1999).

Interpretive Paradigms

The WPR methodology to policy analysis is drawn from the theoretical traditions of social construction theory, poststructuralism, feminist body theory and governmentality studies (Bacchi & Eveline, 2010). I provide a brief outline of these traditions below, in addition to the manner in which they contribute to my thinking about disability, WPMH, DM and work integration. Specifically, these theoretical traditions enable me to question the nature of disability and how it is problematized in the policies reviewed.

Social constructionism. Social constructionism refers to knowledge as a social creation (Bacchi, 2009) and Burr, (2003) adds to this by highlighting that social constructionism claims that my knowledge of the world is historically and culturally specific, and a product of human thought as opposed to based on an external reality. In this vein, I am reminded that the knowledge I possess is thus not necessarily what is true, but that what is accepted as truth and is produced by sociocultural forces and reflects current ways of understanding the world (Bacchi & Goodwin, 2016; Burr, 2003). Social constructionism explains the epistemology of knowledge as being influenced by social and political concerns (Phillips, 1995).

Social constructionism is understood differently from constructivism. Through the latter, I am "active in the creation of meaning of [my] own phenomenological world" and "[my] perception is ideally a matter of internalizing a truthful representation of the world" (Burr, 2003 p. 19). Social constructionism on the other hand, invites my understandings of the world as historically and culturally constructed (Phillips, 1995) and that what is regarded as truth is the current and accepted ways of understanding the world (Burr, 2003). Consequently, the WPR approach to policy analysis does not lead me to view policies as they would be interpreted by individuals, but rather on how the context compels me to understand disability policies with their implicit assumptions and presuppositions.

The importance here is that the focus of the WPR policy analysis is not on social actors, or their intentions, but on the knowledges and practices that produce my perceived reality and locates me as a subject within that reality (Bacchi, 2009; Bacchi & Goodwin, 2016). In this policy analysis, I therefore do not focus on the intentionality of the policies or the policy analysts and writers as "units of analysis" (Phillips, 1995) but seek to discover the unspoken assumptions and presuppositions that underlie the "solutions" proposed in the policies. My goal of analysis in this study is to identify how it is possible for these policies to be created and to “understand the policies *better than* policy makers” (Bacchi, 2009 p. xix).

Feminist Body Theory. Feminist Body Theory allows me to look at how the categories in which people are classified, and the taken for granted assumptions about subjects in these categories, impact people’s daily lives (Bacchi & Eveline, 2010; Burr, 2003). I need to be mindful that these categories are not necessarily real divisions. As opposed to focusing on, for example, gender or sex when classifying people, or on disabled or not, I could just as easily group those with blonde or brown hair or tall and short people (Burr, 2003).

In line with the Feminist Body Theory, the WPR approach enables me to consider how “problems” are represented, thereby creating meanings affecting how people are treated and how they live their lives, including what options are open to them (Bacchi & Eveline, 2010). To challenge the dominant neoliberal assumptions that underpin individualistic and hierarchical practices, Beasley and Bacchi (2007) present the term social flesh as a political alternative of human embodied interdependence. By adopting this theoretical resource of Feminist Body Theory then, the WPR approach enables me to rethink the nature of human connections, not as hierarchical, but as an embodied coexistence (Beasley & Bacchi, 2007). By employing the feminist body theory when analyzing the policies, I am able to see how individuals with WPMH issues are categorized as disabled, and the implications resulting from this categorization.

Governmentality Studies. Concepts of government and of governmentality have their origins in the studies of Michel Foucault. He investigated prisons, and the practice of discipline and punishment as a form of rule and government, as well as how they came to be (Foucault, 1975; 1991). As I analyze policies, I am mindful that government is said to be involved in an activity that seeks to rule, influence or shape the conduct and actions of individuals (Gordon, 1991). Furthermore, to govern, it is imperative to know the territory that is to be governed and that this knowledge “springs of its interests and cannot be accessible to those ruled” (p. 9).

Carol Bacchi, in developing the WPR approach to policy analysis (Bacchi, 2009) advises that this poststructural approach brings attention to how policies play a role in governing (Bacchi & Goodwin, 2016). Policies, by their very nature, set out rules that address how certain “problems” are to be solved (Bacchi, 2009; Bacchi & Goodwin, 2016), thereby requiring individuals to abide by, or be “governed” by these policies. In adopting the WPR approach to the analysis of disability policies in Canada, therefore, I pay attention to how these policies influence behaviours of individuals unbeknownst to those so governed. An example of this is the requirement in the disability policy to for the claimants to provide objective medical evidence of diagnosis (Treasury Board of Canada, 1992). To fulfill this requirement of the policy, the individual claiming benefits therefore must seek medical attention and accept medical treatment, possibly including the ingestion of medication with questionable side effects.

Paradigmatic Positioning of the WPR approach to policy analysis. Employing the poststructural paradigmatic positioning of the WPR approach to policy analysis as developed by Carol Bacchi (2009), I examine disability policies purchased by employers in Canada to support their employees with WPMH issues. In this section, I outline the paradigmatic positioning and premises of the poststructural approach and show how it relates to my analysis of the policies and allows me to problematize, or question their underlying assumptions and proposed solutions, while considering the implications on the health of individuals with mental health issues in Canada.

The paradigmatic thinking underlying the poststructural policy analysis called *What's the Problem Represented to be?* (WPR), is developed by Carol Bacchi (Bacchi, 2009) and inspired by Michel Foucault. The WPR approach, is related to the study of problematizations, to understand how things come to be seen as problems (Bacchi, 2012; Cheek, 2008; Denzin & Lincoln, 2008; Foucault, 1985). By delving into the historical process of producing objects or things for thought (Cheek, 2004), I employ the process of problematization to put into question accepted truths; a description of thinking as practice (Bacchi, 2012). The poststructural perspective embedded in the WPR approach reveal to me the many practices that produce policy discourses, resulting in power differentials, hierarchical practices and inegalitarian forms of rule or governing with an aim toward informing understandings of the impact of policies on social justice (Bacchi, 2016; Cheek, 2004).

Poststructuralism is not a singular theory, but a way for me to question assumptions of reason and science as well as to pay attention to how this produces social inequality (Bacchi & Goodwin, 2016). Through the use of poststructuralism I pay attention to the heterogeneous practices and politics that produce power relationships and assign meanings to concepts and knowledge (Bacchi, 2009; Bacchi & Goodwin, 2016). The value of this concept in my approach helps to inform the need to look at a multitude of practices, which create inequality that may benefit some and results in the disadvantage of others (Bacchi & Eveline, 2010). The poststructural paradigm enables me to question concepts as real, and how they came to be.

In traditional policy analysis, it is assumed that policies exist for the purpose of solving problems (Bacchi, 2009). Conversely, using a poststructural approach enables me to question the reality of the problems that are to be solved, and instead look at policies as producing those problems (Bacchi, 2009; Bacchi & Goodwin, 2016). The WPR type of policy analysis based on a poststructural paradigm allows me to examine the taken-for-granted assumptions upon which the policies are grounded. The reality in which I live is open to questioning and it means that things could be otherwise (Bacchi & Goodwin, 2016). The WPR approach to policy analysis allows me to question the policies that are purchased by employers to support their workforce with WPMH issues, as well as the concepts upon which they are based. Through my questions, I highlight pre-conceived notions and open up the possibility that things could be different. I use the WPR approach to policy analysis to examine the solutions put forth to determine how they problematize various concepts, such as disability. I question how this concept came to be treated as 'real' and result in the practices present in the Canadian Disability Management environment.

As I apply the WPR approach, identifying the discourse of the policy analyzed is of lesser importance than identifying the events, social interactions and rules that shape the discourse within a particular culture (Belzile, 2008; Cheek, 2004; 2008). Further, this post-structural policy analysis is more an analysis of discourses. I am interested in the actions and knowledges that produce subjects who are in turn ruled or governed by the policy in question (Bacchi, 2016). The focus of my analysis is the way in which "governing practices, understood broadly, problematize issues" (Bacchi, 2016 p.8). In applying the WPR approach I examine disability policies in Canada, as well as the practices and modes of thinking and governing that have resulted in the shape they have taken, opening up for consideration that they may have been something completely different and taking away the "taken-for-grantedness" of the way WPMH is approached today.

According to the WPR approach, the subject position is produced by the policy (Bacchi, 2009), and policy is the means by which order is maintained in the world (Bacchi & Goodwin, 2016). Given that I live in the world, this means that I too, am influenced by policies and their impact on governing. As such, I carry out the WPR approach to policy analysis from inside discourse, as opposed to from a position outside discourse. Given that I am therefore a product of the discourse that gives shape to the policies I analyze, the WPR approach allows me to be mindful of my interpretation, not only of the policies, but the documents I use to analyze these policies.

The interpretation that becomes highlighted in the WPR approach, or in the post-structural analysis of discourses, is my own, as researcher and author of the document that I produce (Bacchi, 2012; Bacchi, 2016; Belzile, 2008). Bacchi further maintains that I, as researcher will play a role in establishing, producing or problematizing what is seen as true through my investigations and analysis (Bacchi, 2012; Cheek, 2004). As highlighted by Julianne Cheek, (2004) "texts not only represent and reflect a certain version of reality, they also play a part in the very construction and maintenance of that reality itself" (p. 1144). What follows is an understanding that I, as reader of the texts also bring certain understandings of my own, (Cheek, 2004; Gadamer, 1975), and consequently, the research I produce is political activity (Bacchi, 2012). Keeping in mind that my research methods are "identified as major players in the reinstatement of particular realities", (Bacchi, 2012 p. 6) and that through my research I "reproduce or disrupt modes of governing that install forms of marginalization or domination" (Bacchi, 2016 p. 12), I subject my own problematizations to the WPR approach, something recommended by the WPR approach developed by Carol Bacchi (2009).

When using the WPR approach to policy analysis, Bacchi highlights the importance of the act of interpretation, the subject position, and thus who is doing the interpreting. Thus in this study I, the researcher, I keep a reflective journal, participate in a presupposition interview with my supervisor, and engage in regular discussions with members of my advisory committee to ensure that my historical situatedness is clear to myself as well as to readers (Gadamer, 1975; Hammersley, 2008).

To clarify the distinct approach of a post-structural analysis of policies, I view here a statement by Laliberte Rudman (2013 p. 169) that "it is vital to consider how the problem (and related proposed solutions), has come to be defined, as well as who has had the power to define it and whose interests are best supported". Firstly, this statement assumes that the "problem" is a real entity, and that there has been an intent in calling a certain issue a problem. This is very different from the post-structural view taken in Carol Bacchi's WPR approach to policy analysis and policy as discourse. She is concerned about the practices that have led to the creation of the "problem" as an entity to be seen as "real" (Bacchi, 2009; Bacchi and Goodwin, 2016), and insists that if the problem or entity can be created through practices, it can just as easily be "uncreated" (Bacchi & Goodwin, 2016). Thus, in my research I question the "problems" identified by the policies, and how they have come to be seen as such. Further, as I use the WPR approach do not focus on social actors and their intentions, nor on the intents of the policies, but on the socially produced forms of knowledge, that is discourse, that is unknown to the social actors, but that guides their practices (Bacchi & Goodwin, 2016). Different than the CDA that focuses on language in various texts (Ainsworth & Hardy, 2004; Fairclough, 2013; Laliberte Rudman, 2013) the poststructural WPR approach considers the knowledge, or accepted truth that underlies the policies or texts that are examined (Bacchi, 2009; Bacchi & Goodwin, 2016). In this research I consider the underlying assumptions behind the concepts problematized, such as disability, in order to support me in beginning to open up spaces for me to envision how things might be viewed differently (Bletsas, 2012).

Strategies of Inquiry and Research Design

Denzin and Lincoln (2008) explain that the third phase of the research process begins with the research design and involves a clear focus of the research question, purpose of the study, information that answer the research question, and the strategies that are used to obtain this information. The research design I use in this study is Bacchi's *What's the Problem Represented to be*? (WPR) to policy analysis. I use the WPR approach as it is supported by a post-structural paradigm and enables me to interrogate the policies, revealing a deeper understanding than what is intended by the authors of these policies (Bacchi, 2009). The purpose of using the WPR design is to situate myself in the empirical world and to guide me as I connect the theoretical, post-structural paradigm to strategies of inquiry and methods of collecting empirical materials (Denzin & Lincoln, 2008).

In this section, I describe the techniques of archaeology, genealogy and cross-cultural comparisons that are used to examine the problematizations in the disability policies (Denzin & Lincoln, 2009). These concepts comprise a foundation for the questions in the WPR approach and provide an explanation for my choice of documents used in the policy analysis. I further outline the six questions developed by Bacchi (2009) that guide the collection of empirical materials, which are the documents that assist me as I analyze disability policies, seeking to discover the underlying assumptions upon which they are based.

Archaeology. Archaeology refers to the Foucauldian interest in the history of what could be thought. To answer question two, “What presuppositions or assumptions underlie this representation of the problem?”, the concept of archeology enables me to inquire about the conditions under which certain statements are considered true and others false (Bacchi, 2009). As I perform archaeology to analyze disability policies, I critically interrogate unexamined ways of thinking and reflecting on their possible implications (Bacchi & Goodwin, 2016).

To conduct an archaeology I examine documents of institutions, commercial practices, government legislation and other literature to determine how they contribute to the disability policies that guide and impact the practice of DM and return to work coordination including their impact on those with WPMH issues (Denzin & Lincoln, 2008).

Genealogy. Underlying the methodology of genealogy are Foucault’s claims of what geneaologists do. The genealogist challenges the pursuit of origins. I use genealogy to consider my response to question three, “How has this representation of the problem come about?”.

Genealogy leads me to question how things have developed into their current state (Bacchi, 2009). The goal of genealogy is to challenge assumptions that concepts evolve naturally, with purpose and intention, and are the result of the planned actions of humans (Bacchi, 2009; Denzin & Lincoln, 2008).

Through genealogy, I oppose the claim that history is continuous, with meaning or destiny, and consider instead a counter proposal that history is random, and results from a host of errors (Denzin & Lincoln, 2008; Foucault, 1991). I am open to the notion that my thoughts and knowledge of concepts, things, or practices as self-evident or inevitable, and having developed with purpose from an origin, is false. There are no such origins. They are fabricated, random and unplanned (Denzin & Lincoln, 2008). Instead, I, and the knowledge I have of things, am influenced by history that is invested in power relations, subjectivity and economic use (Bacchi, 2009; Denzin & Lincoln, 2008; Burchell, Gordon & Miller, 1991). As I analyze disability policies then, I consider the claim that the focus of modern society on debts, rules, laws and social, economic, governmental and legal issues diverts attention from its' domination and subjectification effects (Denzin & Lincoln, 2008), I am able to look at disability policies resulting from modern society and consider the hidden domination and subjectification effects they contain. Through genealogy, I examine the power relationships involved in the development of disability policies.

Cross-cultural comparisons. In comparing how problem representations are viewed across cultures or nations, I see how ways of thinking about problems arise from specific institutional and cultural contexts and are therefore contingent, as opposed to being "absolute truths" (Bacchi, 2009). The WPR approach thereby encourages me to question conventional ways of thinking about policy problems and the nature of policy itself.

The cross-cultural comparison helps me answer question three and also question four “What is left unproblematic in this problem representation?”, “Where are the silences?” and “Can this problem be thought about differently?” Through a comparison with other cultures, I am more clearly able to see that things are not naturally any certain way and that they could also be different.

Six Questions of the WPR approach. The six questions developed by Carol Bacchi (2009) and that form the basis of the WPR approach, are based on three propositions. The first proposition is that I am governed through problematizations. The second proposition is that I study problematizations through analyzing the problem representations they contain rather than problems. The final proposition is that I interrogate existing problematizations through scrutinizing the premises and effects of the problem representations they contain.

To help me focus my search for documents to answer the questions of the WPR approach, and analyze the disability policies, I create table 1. In this table, I provide the questions, goals of the questions, and the process to answer each question.

Table 1

Carol Bacchi's WPR approach to policy analysis (Bacchi, 2009)

Question	Goal	Process to answer
1. What is the 'problem' (e.g of problem gamblers, drug use/abuse, domestic violence, global warming, health inequalities, terrorism, etc.) represented to be in a specific policy?	To identify implied problem representations in specific policies or policy proposals.	See what the policy proposes and 'read off' the implied 'problem' from this proposal
2. What presuppositions or assumptions underlie this representation of the 'problem'?	To identify and analyse the conceptual logics that underpin specific problem representations. The term conceptual logic refers to the meanings that must be in place for a particular problem representation to cohere or make sense.	This question involves a form of Foucauldian archaeology, identifying conceptual logics and political rationalities in specific policies. Identify key concepts, binaries, and categories. Think beyond national and/or cultural boundaries to address this question.
3. How has this representation of the 'problem' come about?	To highlight the conditions that allow a particular problem representation to take shape and assume dominance.	This question involves a form of Foucauldian geneaology, focusing on the practices and processes that led to the dominance of this problem representation (or of these problem representations).
4. What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought about differently?	To raise for reflection and consideration issues and perspectives silenced in identified problem representations.	Cross-cultural comparisons and comparisons of problem representations over time (see question 3 will be useful here, alongside the discourse analysis conducted in question 2)
5. What effects are produced by this representation of the problem?	To identify the effects of specific problem representations so that they can be critically assessed.	Consider three kinds of effects: discursive effects; subjectification effects; lived effects. Include effects due to dividing practices. The following sub-questions will assist here: What is likely to change with this representation of the 'problem'? What is likely to stay the same? Who is likely to benefit from this representation of the 'problem'? Who is likely to be harmed? How does this attribution of responsibility for the 'problem'

Question	Goal	Process to answer
		affect those so targeted and the perceptions of the rest of the community about who is to 'blame'?
6. How/where is this representation of the 'problem' produced, disseminated and defended? How could it be questioned, disrupted and replaced?	To pay attention both to the means through which some problem representations become dominant, and to the possibility of challenging problem representations that are judged to be harmful.	Consider past and current challenges to this representation of the 'problem'. Consider the discursive resources available for re-problematisation.

Once completed, through a process of self-problematization I apply this list of questions to my own problem representations as part of the WPR process.

With the above background to the WPR approach, I critically analyze disability insurance policies or benefit plans using Carol Bacchi's *What's the Problem Represented to be?* (WPR) approach (Bacci, 2009). Bacchi (ix) advises that policies are generally associated with a course of action with an implied problem to address, that what I propose to do about something reflects what I think needs to change, and that policies essentially shape the very issue they propose to solve (Bacchi, 2009, 2012, 2016; Bacchi & Goodwin, 2012). Every policy sets out a practice that relies on particular problematizations or ways in which problems are presented (Bacchi, 2012). The purpose of this study is to examine disability insurance policies or benefit plans to see how they problematize the issue of WPMH, thereby shedding light on the taken-for-granted assumptions behind these policies with a goal of being able to see things differently with a focus on social justice (Bacchi, 2009, 2016; Burchell, Gordon & Miller, 1991).

The WPR approach does not work at the level of language or political manipulation. It creates a space to interrogate deep-seated presuppositions and assumptions or knowledges – the unexplained ways of thinking that underpin policies and that can be identified through analyzing policy proposals (Bacchi & Goodwin, 2016). Goodwin, (2012) informs me that policy analysis is a way to understand contemporary social systems and cultural practices. Bacchi and Goodwin (2016) further this by advising that the focus for me as a policy analyst is not problems, but problematizations. As such, even though the private insurers sell disability insurance policies to employers who wish to support their workforce in the event of illness (Thorpe & Chenier, 2013), these policies are not written in a vacuum. The policies are not only reflective of the views of the underwriters in insurance companies, but are also influenced by the social, economic, political and cultural environment in which these companies operate. Further, the WPR approach encourages me to consider the historical origin that influenced the policies to be what they are today, as opposed to something else (Bacchi, 2009; Burchell, Gordon & Miller, 1991).

Using the WPR approach to policy analysis I examine disability insurance policies or benefit plans and gain a further understanding about how they influence the disability management (DM) and return to work activities of the RC's. Through this analysis, I am able to clarify how and whether the disability policies meet the needs of the workforce, which is something Thorpe and Chenier (2013) recommend needs to be done. Central to my analysis is understanding how these disability insurance policies define the "problem" of WPMH. How the problem of WPMH is defined will consequently determine the solutions presented in the policies (Bacchi, 2009), and thereby have an impact on how WPDM is addressed and on the lives of those with mental health issues. Through the use of the WPR approach to policy analysis, within a poststructural paradigm I am able to examine the taken-for-granted assumptions behind the policies being analysed. I am able to consider forms of authority and power and their effects. Examining authority and power positions research as political practice and highlights the importance of self-reflection of my own assumptions (Bacchi & Goodwin, 2016). The production of a research thesis is thus a political text with the possibility to influence its readers. Through examination of the power differentials that are necessarily part of policies (Bacchi, 2009; Bacchi and Goodwin, 2016) the goal of my research is to bring this productive nature of policies to light, with an aim toward social justice (Bacchi, 2016) and to promote less harmful alternatives (Bacchi and Goodwin, 2016 p 25).

Methods

By using the WPR approach to policy analysis I first decide what policy or policies to study. Once the policies are identified, I apply the questions of the WPR approach to the problem representations I identify in the policies through a review of documents. Lastly, I develop my own policy proposal, based on the analysis performed, and then subject that to the full questions in the WPR approach. A description of these methods, including sampling strategies, data analysis and enhancements to the quality of the study are included in this section.

Sampling Strategies

In this section, I describe my sampling strategy to identify the policies chosen for analysis, as well as my approach to collect additional empirical data. The selection of data involves three stages. The first stage is the selection of the disability policies that I analyze, along with related documents to help me answer the first question in the WPR approach to policy analysis, namely "*What's the problem represented to be*?" (Bacchi, 2009). To provide a better understanding of the background to sample disability policies, I give an overview of the insurance industry, disability policies and the federal government plans, all of which serve to provide an understanding of my selection of the disability policies. The Public Service Management Insurance plan – Main Plan booklet and the executive Plan Booklet is referenced in Appendix A, as is another document, Long-Term Disability Insurance – Chapter 3-4.

The second stage of sampling is related to the analysis of the historical, economic, cultural and social context leading to the production of the disability policies, along with how they came to problematize their territory (Bacchi, 2009; Bacchi & Goodwin, 2016). The documents identified are referenced in Appendix A and shared with my committee as are the policies selected in the first stage.

The third stage of sampling is related to the development of my own policy proposal. As I read through the articles to answer questions 1-6, my thinking evolves and judgments about the importance of various ideas in the material gain dominance (Spence, 2017). Consequently, my sampling of the final portion of materials is influenced by my analytic and interpretive work up to this point. The documents I identify at this stage are also included in Appendix A.

Stage 1 – Selecting Disability Policies. I begin by purposively selecting disability policies, which is a deliberate selection of texts on the basis of predefined criteria (Depoy & Gitlin, 2016). According to the WPR approach to policy analysis, policies can include documents, such as organizational files and records, legislation, judicial decisions, bills, speeches, interview transcripts, media statements, organizational charts, budgets, program contracts, research reports, images, videos and digital info

(Bacchi, 2009). It may only involve a single text and is the starting point for data gathering (Bacchi & Goodwin, 2016).

The WPR approach uses texts as “levers” that enable me to reflect on how the way a problem is constituted and solution is implemented and impacts the forms of governing (Bacchi & Goodwin, 2016). Further, to implement this lever, familiarity with other texts that cover the same or related topics is necessary. Through my work as an RC working in DM and with the disability insurance policies being analyzed, I have the familiarity with similar texts. This familiarity also naturally arrives through my background, age, culture and era among others, in which I live and that constitute my background and context. The distinguishing characteristic of the material that can be used for WPR is that it needs to be prescriptive, a form of proposal and a guide to conduct. (Bacchi and Goodwin, 2016), meaning that the policies I select must be documents that can be seen to govern individuals, and to provide rules for action or activity (Bacchi, 2009).

Through my search for disability policies, I learn that those available for public scrutiny are of federal, provincial, or municipal government employers versus those of private employers. I select the Disability Insurance plan of the Federal Government, as that is the plan with which I work mostly in my job as Rehab Consultant, and the plan that initially spurred me to undertake this research. This method of sampling is supported by Bacchi, (2009) where she indicates that I will likely select a policy that interests me due to its relevance to my life, or that it attracts public debate. Further, the WPR approach to policy analysis supports critical scrutiny and therefore those policies that provoke and cause to question are the ones I select (Bacchi & Goodwin, 2016).

To provide a background to my purposive sampling process (Depoy & Gitlin) and assist in the understanding of the choices made in this specific selection of disability policies, I provide here an outline of the insurance industry, disability policies in general, and of the publicly available disability plans of the Federal Government. In this analysis, the disability plans for non-unionized and executive employees is selected.

Insurance Industry. According to the Canadian Life and Health Insurance Association (CLHIA) web site, it is a voluntary association representing 99% of private insurers in Canada (CLHIA, 2020 b). Claiming to have the best interests of consumers in the industry at heart, the CLHIA has objectives about the business conduct of its membership of Canadian life and health insurers as well as guidelines that are designed to promote consistent practices and standards for the life and health insurance industry (CLHIA, 2020 c). The CLHIA expect that member companies adopt the guidelines to the best of their ability, keeping in mind the company's structure, products and business processes including distribution channels, (CLHIA, 2020a). Further they suggest incorporating these guidelines into the company's compliance program. Finally, the CLHIA web site provides a glossary of terms including Short Term Disability, (STD) and Long-Term Disability (CLHIA, 2020d).

Given the CLHIA expects member companies to follow their guidelines and that 99% of private insurers in Canada are members of this voluntary organization, I assume that the policies I analyze follow the directives of the CLHIA. Further, as the CLHIA provides definitions of disability that applies to their members' disability insurance policies or benefit plans, I believe that the disability plans I select are therefore a relevant starting point from which to examine disability policies in a Canadian context. The goal in selecting texts or policies to study is not that they be generalizable or applicable to other situations, because the focus of the analysis is on the historical context of these texts and how they came to be (Bacchi, 2009; Cheek, 2004; 2008). Instead, texts selected are a starting point or levers, to open up reflections on the forms of governing and associated effects as well as how they came to be what they are today, at this particular point in time (Bacchi & Goodwin, 2016).

Disability Policies. In my work as RC, a large number of employees with whom I work fall under the disability policy of the Federal Government. My work in DM with these policies is also what ignites my interest to pursue this study to see how the disability policies influence my daily work with clients with WPMH issues as it seems to me that, despite my best efforts, the "desired" result of recovery from WPMH issues does not seem to be achieved.

Graham indicates that discursive practices construct what it is possible to think. As such when, individual actions within the discourse do not necessarily achieve intended "results" (Graham, 2006), it is easy to look to causes for this, and to develop "solutions". However, as people, and consequently RCs, are located within discourse that underpins policies and consequently hold subject positions within this discourse, I as RC fail to problematize and interrogate the deep-seated concepts and assumptions in the policies that I am tasked to implement (Bacchi & Goodwin, 2016). By using the WPR approach to disability analysis, I am able to question the taken-for-granted assumptions upon which these disability policies are based, with a goal to be able to see things a little differently.

Federal Government Disability Plans. Given that this study is exploratory in nature, and as the insurers covering the disability plans of the Federal Government represent a large portion of the work I do, I begin my exploration with the disability policies representing those in the Public Service. My specific interest is to determine how the policies position themselves in relation to WPMH, and gain an understanding of their premises, assumptions, and how they govern those with mental health issues.

The policies chosen are publicly available, something that is significant, as other policies of private companies, for example, could also shed light on the issue of how their disability policies view the issue of WPMHs. However, disability policies of private companies, do not seem to be publicly available, and I am directed to contact the HR department to locate any such policies. The very fact that disability policies of private companies are not generally available appears to fit with an observation by Foucault (Burchell, Gordon & Miller, 1991) "To know how to govern, one must know the state and its secrets that springs of its interests – knowledge may not be accessible to those ruled" (p. 9). Naturally, if these policies were generally available to the public, the "secrets" referred to by Foucault above would obviously not be secret anymore and therefore not effective in governing.

Policy and Text Selection. To begin my search for the disability plan for Federal Government employees, I inputted Canadian, disability and plan into a Google search, and the Disability Insurance (DI) plan for public servants is the 3rd site identified after the Canada Pension Plans and it is the plan that I have worked with in my employment as an RC. However, as mentioned by Bacchi & Eveline (2010), workers are sometimes bound under confidentiality codes. As such my own political environment or employment status prevents me from including this DI plan as it is underwritten by my current employer and puts me in a position of a conflict of interest.

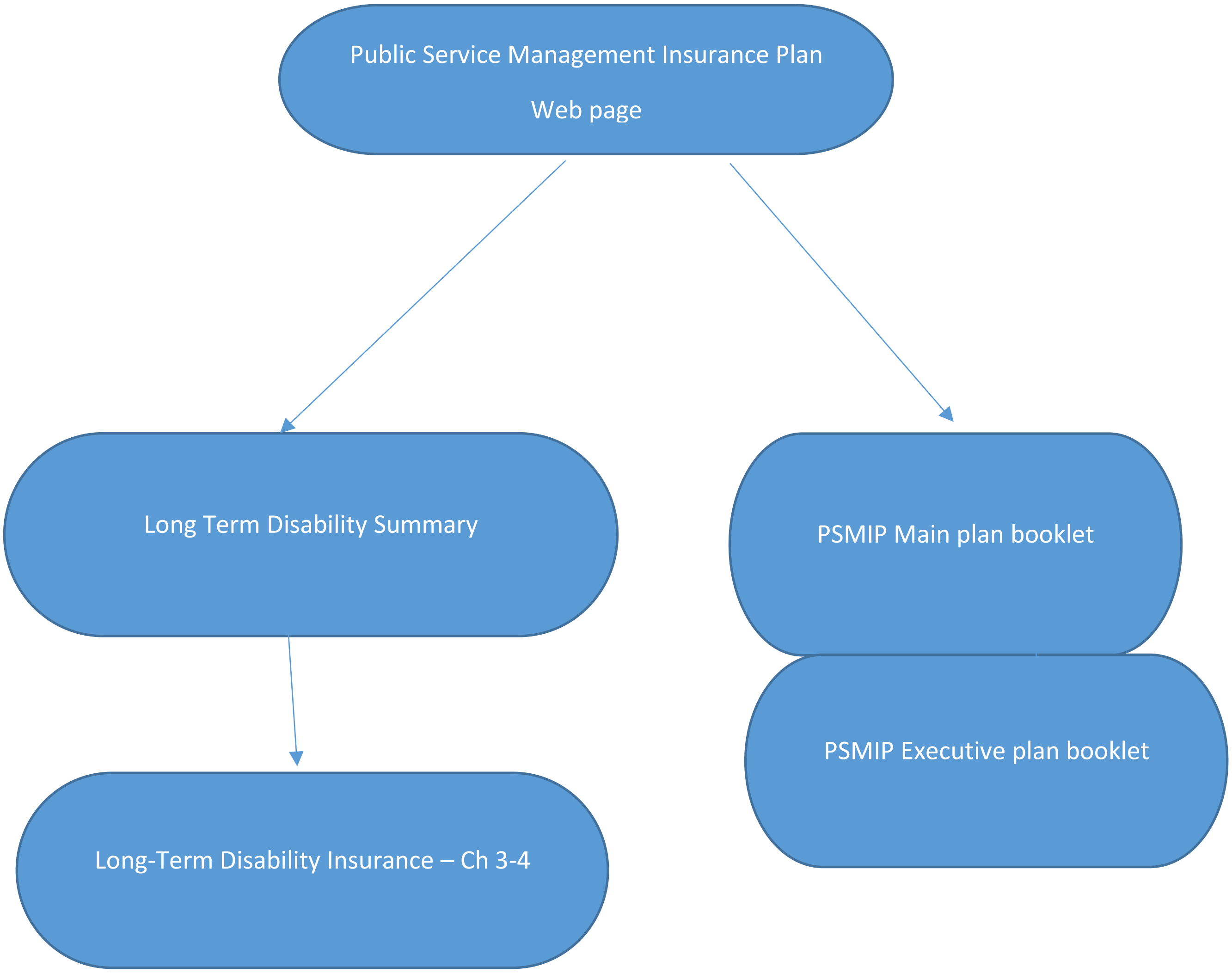
Through my work, I am aware that the DI plan does not cover executives or those excluded from the collective agreement in the Federal Government. Employees who are executives or excluded from the collective agreement are instead insured by another private disability insurer and policies, whose RC's are therefore responsible to work with those so insured, and to follow the guidelines of these policies. The policies analyzed were underwritten written by a private disability insurer and displayed by the Government of Canada on their web site (Government of Canada, 2015; 2016). Examining these other policies does not place me in a situation of a conflict of interest.

The two disability policies included in the current analysis are 1) the PSMIP – Main Plan and 2) the PSMIP Executive Plan that cover a large portion of public servants including those non-unionized and executives. As such these policies form a lever or entry point to examine how people are governed (Bacchi & Goodwin, 2016). The policies provide a starting point into the analysis of disability policies consistent with Bacchi's, (2009) WPR approach to examine the disability policies of Canadian employees as well as the underlying historical circumstances that resulted in the policies being the way they are today.

In addition to the PSMIP Main Plan and Executive Plan booklets, I followed links on the first page found in my Google search, entitled "Public Service Management Insurance Plan" that provides the first entry to the disability plans for federal employees. This page provides links to a page titled "Long Term Disability Summary" and on this page is another link to a page titled "Long Term Disability Insurance – Chapter 3-4". These pages together I believe, based on my background and work with DM, provide the most comprehensive way to analyze how the policies problematizes their territory, the goal of this WPR approach to policy analysis (Bacchi, 2009).

Figure 1

Flow of Policy and text selection



Stage 2 – Collecting empirical materials to identify the concepts behind the policies. My goal in the current policy analysis, based on the WPR approach, is to identify the thinking upon which identified disability policies are created. I aim to discover what taken-for-granted assumptions are involved in the creation of the policies, how employee MH is problematized in these policies, and to create a space to consider how the issues identified in the policies could be seen differently, with an aim for social justice (Bacchi, 2009; Bacchi & Goodwin, 2016). I gathered data from a variety of sources to apply the WPR approach to the disability policy selected, and to deconstruct the policy to identify presumptions and presuppositions that were lodged within the problem representations (Goodwin, 2012). The key in the WPR approach to policy analysis is that as problematizations emerge from practices I can gain access to problematizations from the "practical guides to practice" (Bacchi, 2012). Specifically, in using the WPR approach to policy analysis, I view policies as starting places to access problematizations through which individuals governed. Further through Bacchi's six questions, I identify the history of specific problematizations and consider their effects.

In my selection of texts or documents to aid in my analysis of the disability policy Bacchi (2009) recommends thinking of links or connections between my selected policy and other policy areas, including related economic and political developments (p. 55). To select documents, articles and material that provide responses to questions 2-6 in the WPR approach, I reviewed the six questions in detail, paying attention to the goals of the questions and the process recommended to answer them. I developed a table based on these questions, included in Appendix A, and select articles through Google, that align with WPR and provide insight to help me answer these questions. The specific search criteria for each article differ, depending on the question asked (Adams, 2016), and are outlined in Appendix B, along with my reasoning for their selection.

The articles I choose in stage 2 and put into Appendix A are selected prior to starting the process to answer any of the six questions in the WPR approach, demonstrating my understanding about what mattered most to me prior to my interpretation and analysis (Spence, 2017). In keeping with the WPR approach, interpretation is in part an ongoing process that evolves in the writing and rewriting of sections.

I selected a total of five articles to answer question two, five articles for question three, twelve articles for question four, five articles for question five and nine articles to answer question six. I used total of thirty-six articles to answer the questions in the WPR policy analysis approach. These articles are all included in Appendix A.

Stage 3 – Selecting material to develop my own policy proposal. To develop my own proposal in alignment with Bacchi's WPR method (Bacchi, 2009; Bacchi & Goodwin, 2016), I elected to focus on documents that I had previously read and thus constitute some of my already existing knowledge base (Bacchi, 2009; Spence, 2017). I also gathered some new material based on my thinking at the time in keeping with my social, cultural and educational background. This use of previous and new knowledge reflects that I am constituted in discourse (Bacchi, 2009; Bacchi & Goodwin, 2016; Spence, 2017). This way of selecting documents is consistent with the WPR approach (Bacchi, 2009) as well as with the teachings of Michel Foucault (Burchell, Gordon & Miller, 1991).

Acknowledging that I am myself constituted within the problem representation I identify, and that I am transformed by the process that delivers me to this point (Neto, 2018), all articles reviewed to date influence and shape my proposed policy solution or problematization (Spence, 2017). Additionally, to focus my thoughts and develop my arguments, I selected eight articles from my proposal and five other articles based on my background as an occupational therapist and beliefs, that I feel provide relevant information to aid in my developing policy solution. This follows the WPR approach that emphasizes the contextual nature of policy development and highlights that my research will necessarily be a political act, as indicated by Bacchi (2009; 2012; Rönnblom, 2012).

The thirteen articles that I use to develop my own policy proposal are listed in Appendix A. The search criteria I employed to identify each article, along with my justification for their selection is outlined in Appendix B. As suggested by Adams (2016), the articles selected reflect the question asked, and will as such differ from articles I previously selected to answer other questions.

Integrity in the sampling process. Questions about the impartiality in the selection of text frequently arise (Cheek, 2008; Hammersley, 2007; Marston, 2004). As researcher, I do not sit outside discourse, and my selection of the texts and documents is necessarily not impartial and research is itself a political act (Bacchi, 2009; 2012; 2016; Rönnblom, 2012). However, I justify my choice of texts for analysis in terms of why they were chosen and how they were collected (Cheek, 2008; Hammersley, 2008; Hertz, 1996). This justification is supported by Bacchi, (2009) who advises that text selection itself is an interpretive exercise, with interpretive implications. By keeping a reflective journal attached in Appendix C and providing clear reasoning for my selection of texts in Appendix B, I adhered to the need to justify the sampling and choice of text (Spence, 2017).

Under stage one of the sampling strategy, I outline that the CLHIA ensures that 99% of insurers are members of this organization, and I can therefore be relatively confident that the policies chosen for analysis are common in the world of Canadian disability policies. I also describe that my reasons for choosing Federal disability policies is related to my work with a large disability carrier, and that these policies are publicly available. The explanations of my reasons for choosing the policies satisfies the criteria stated by Michel Foucault where he indicates that it is most important to map out the steps one takes to arrive at decisions made (Burchell, Gordon & Miller, 1991).

In stages two and three of the data selection process, I provide justification as noted in Appendix B regarding my choice of various articles and materials to help me analyze the policies selected (Bacchi, 2009; Whalley & Hammell, 2002). Through keeping a reflective journal as noted in Appendix C I document my choices and delve into my feelings, thoughts and concerns that influence the material selection (Spence, 2017). Through my justification of choice of material and my reflective journal I provide an explanation of my research journey, investigative path and the decisions I make regarding texts selected to help my analysis (Neto, 2018).

Using Google to search for policies, articles and materials for their analysis. To locate disability policies in the first phase of my collection of data, I note that such policies are considered grey literature, (Adams et al., 2016; Depoy & Gitlin, 2016; Godin et al., 2015). Grey literature includes information produced at all levels of government, academics, business and industry and is not controlled by commercial publishers (Godin et al., 2015). As such, disability policies are not available on the academic search engines such as PubMed, CINAHL or Psych info, for example. Consequently, I use Google to find disability policies to analyze.

In the second and third phase of the gathering of information, I again employ Google as the search engine. Google contains information from diverse areas including media, academia, professional bodies and other grey literature and is said to provide contextual information (Adams et al., 2016). In using the WPR approach to policy analysis I pay attention to the context in which policies are created (Bacchi, 2009) and my use of Google as a search engine is an appropriate mechanism from with to gather the documents used to analyze the policies. Additionally, in using Google as a search engine for all documents obtained for this policy analysis enable me to be consistent throughout the research process (Krefting, 1991).

Data Analysis

I conduct the analysis of materials in three stages. I first identify the problematization in the policies. Secondly, I investigate the historical context and concepts leading to this problem presentation. Lastly, I develop of my own policy proposal. In this section, I outline each of these stages and the approaches I use.

Stage 1 - Finding the problematization in the policies. When analyzing policy texts, I consider that policies are about meaning creation and my task is to identify how the message in the policy came to be seen as truth (Bacchi, 2009; Bacchi & Goodwin, 2016). Further, as texts are the product of, as well as producing discursive understandings of aspects of reality (Cheek, 2008; Goodwin, 2012), I ensure that the documents and practices that contributed to this policy is comprehensive. For this reason, I read and re-

read the policies and consulted with members of my advisory committee to ensure that I include relevant document and materials to assist in my analysis.

When working through the WPR framework of questions, I begin by reading the policies first in entirety, to view the disability policy within its own context. The answer to the first question "*What's the problem represented to be?*" in a specific policy or policy is, according to Bacchi, (2009), straight forward, and is a clarification exercise that provides suggestions about the implicit problem and what is suggested to change.

Prior to answering the first question, I review other contextual material. Examples of the material I reviewed include "Contesting Illness" (Moss & Teghtsoonian Eds., 2008), "The Evolution of Mental Health in Canada" (Baynton & Fournier, 2017), "The Standards for Psychological Health and Safety in the Workplace" (CSA Group, 2013), material collected through my literature review and other materials that are identified as my thinking develops through reading the policies and other literature (Spence, 2017). Each decision to gather new material is noted in my reflective journal (referenced in Appendix C as Supplementary Electronic Material), to ensure that the path of my thinking is clearly accounted for (Bacchi, 2009; Cheek, 2008; Hammersley, 2007; Foucault, 1991).

The disability policies are read and re-read several times as new perspectives are gained at each successive read. I take notes of salient points, such as questions about the connections between function and prescription of medication as a remedy. As I progress, I keep decision points noted in my reflective journal. One example of such a decision point is an entry from May 31, 2021when I wrote "Has the evolution gone from a medical toward a social model (focusing on the workplace);" "Is this to the exclusion of other factors that impact mental health of people?” and “What is being overlooked?” When exploring the disability policies, I consulted my supervisor and members of my advisory committee to examine the quality of the processes used and how I come to the interpretations in consistency with the WPR method, as well as how I deal with challenges in this interpretation.

As I analyze the policy, I note that the WPR approach does not focus on the intentional shaping of issues or what the policy makers really meant to do, but to find how the problems that are the apparent focus of these policies are represented and problematized (Bacchi, 2009; Goodwin, 2012). To be able to identify what the problem is represented to be in the policies, the WPR approach suggests working backwards from the policies, programs or policy proposals (Bacchi, 2009; Goodwin, 2012). In following this process, I therefore consider the solutions provided in the policies and thereby gain an understanding of what the problem is considered to be.

Stage 2 - Identifying the historical concepts and context leading to the policy problematization. After identifying the problematization in the disability policies, I apply the six questions of the WPR approach systematically without becoming “immersed in complicated theory” (Bacchi, 2009, p.xxi). The WPR approach is said to be an analytic strategy more than a research method and these strategies enable me to extract knowledge that is significantly different than the existing system of meaning (Goodwin, 2012). It is an approach that enables me to operationalize otherwise abstract ideas.

To remain focused and organized, I develop a table of documents I select to help answer each of the subsequent questions 2-6 attached in Appendix A. I share this table with my committee and invite feedback. I review all the documents for question two before writing out an answer and proceed in this fashion with each subsequent question. Once all questions are answered, I again review all the documents for each question and revise my answers with new insights, this time with the knowledge of all the documents at my disposal. I identify when my analysis is finished when I obtain knowledge critically different from existing systems of meaning, or a new way of seeing the policy (Goodwin, 2012).

Stage 3 - My own policy proposal. Once I develop answers to question 1-6, I gather more documents to help me to develop my own problematization. These documents are included in Appendix A. I base my own proposed solution on my background and experience as an occupational therapist and gather material that reflects this. This is supported by the WPR approach that states that policy analysists are located discourse and are subjects in the very policies they interrogate (Bacchi & Goodwin, 2016; Spence, 2017). As such, my selection of articles to review reflects me and my position within discourse. Once I develop my own problem solution, again in following Bacchi's (2009) WPR approach, I subject my own problematization to the WPR approach.

By undertaking this critical analysis of insurance policies purchased by employers in Canada to support their employees who are unable to work due to mental illness, I hope to add to the research literature on workplace mental health, and how disability management and work integration is shaped by the private insurers through disability insurance policies.

Enhancing the quality of the research

In this section I outline the three techniques I use to enhance the quality of my research. The WPR approach involves a step in which I examine my own problematization, by applying the six questions in the approach to my proposed solution. Secondly, I participate in a presupposition interview recommended to me by my supervisor and advisory committee. Lastly, I document the path of my research by keeping a reflective journal.

Quality thorough the six questions in the WPR approach. Discourse, from a post-structural perspective, consists of socially produced forms of knowledge that produces the "real" (Bacchi, 2016). As I am immersed in this knowledge through discourse and unexamined ways of thinking, the solution or problematization I create is also based in discourse with assumptions (Bacchi, 2016). For this reason, the WPR approach involves a step to examine my own problem representations as I am at least in part shaped through the very problem representations I am trying to analyze" (Bacchi, 2009). In this way, I am reflexive as I use the WPR approach to examine my own recommendations or findings by applying the 6 questions that are part of the WPR approach.

Presupposition Interview. My supervisor and advisory committee recommended that I participate in a presupposition interview. A presupposition interview is an exercise rooted in philosophical hermeneutics which focuses on the existential nature of the human experience (Smythe et al., 2008; Spence, 2017). The presupposition interview assists me as researcher to address my existing prejudices and assumptions. This type of reflexive exercise has been reported as an important part of qualitative research, adding to its methodological rigor (Denzin & Lincoln, 2008; Lincoln & Guba, 1982; Mays & Pope, 2000).

A special aim of the presupposition interview is for me to examine my own assumptions and presuppositions that impact my developing role as researcher, and to bring to light how I influence the very research I am undertaking. In line with this reasoning, I draw on Spence (2017) to explore my prejudices in relation to the research and thus being reflexive through my awareness of these prejudices to maintain methodological integrity. An example of a prejudice is how I think of “the disabled” as a category of people in need of my “help” without questioning why this is so. As I reflect on my assumptions through the presupposition interview, I can better understand how I influence my research, and demonstrate the lens through which my writing develops.

That I participate in a presupposition interview appears particularly important for me while engaged in naturalistic inquiry, to ensure that I maintain quality and validity methodological framework (Denzel & Lincoln, 2008; Lincoln & Guba, 1982; Spence, 2017). Further, as stated by Smythe et al., (2008), “who one is as researcher is fundamental to the thinking of research” (p. 1390). That I investigate my own presuppositions is therefore a fundamental aspect of the research, data collection and analysis and adds to my understanding of how they may or may not influence my findings.

The timing of the presupposition interview is at the completion of the proposal writing and prior to data collection. The timing of this interview is significant as choosing what to analyze is an interpretive act (Goodwin, 2012), and it is important to examine my biases and assumptions prior to my on the selection of a disability policy to analyze and the literature I use to conduct this analysis.

Workplace mental health. The issue of workplace mental health (WPMH) has been a large part of my daily work for the past 15 yrs. While I have worked in my current role in Disability Management (DM) for the past 25 years, the prevalence of WPMH has gradually increased as an issue needing attention. This observation is echoed in the literature review (Baynton & Fourner, 2017; Dewa & Hoch, 2015; Dimoff & Kelloway, 2013; Lim et al., 2008; Smetanin et al., 2011). Through coursework I learn that employee MH issues are a global issue and there are many players with different "solutions" to this issue, such as psychological counselling (Dewa et al., 2009), medication (Chenier, 2013), healthy workplaces (Baynton & Fournier, 2017) and engagement in occupation (Hocking, 2017) to name a few. Unfortunately, despite the best efforts of many players, the "problem" of WPMH seems to be growing.

My presuppositions and the WPR methodology. I have seen through my work how different assumptions about what the "problem" is leads "solutions" about what needs to change (Chenier, 2013; Dewa et al., 2009; Gardner et al., 2010; Wisenthal et al., 2018). Through my literature review, I note a plethora of different "solutions" to the problem of employee MH issues, and I, working for an insurance company, am immersed in operationalizing the "solution" identified in the policy which is yet another way to address the "problem" of 'employee MH. However, until I began this research, I had not been conscious of my role in perpetuating a "solution" proposed by the insurers via the disability policies and I had been "blaming" the insurer and its policy for tying my hands. As stated by Bacchi and Goodwin, (2016 p. 50) "policies are involved in shaping what it is possible for people to become, illustrating how power is a productive force" and that "resistance does not sit outside power, meaning that forms of protest might also involve forms of complicity" (Bacchi and Goodwin, 2016, p. 112). With this reasoning then, both when enacting the disability policies, or when rebelling against them, I may have, unknowingly or unconsciously, been perpetuating the problematizations and subjects created by the policies, such as when offering "treatment" to a plan member meeting the criteria of the disability policy, further supporting the individualization of MH issues (Abberley, 1999; Bacchi, 2011; Grue, 2011; Kielhofner, 2005; Mosleh, 2019; Phelan, 2011).

In using the WRP approach I am able to consider how governmental problematizations produce subjects and their positions. I view my role as RC, and consequently, policy actor, to be governed by the policies i.e the public, employees, or users, and those operationalizing the policies i.e policy writers, professionals, government employees. I do not sit outside the discourse in which the policies operate. For this reason, the WPR approach requires that I reflect on my own role and subject position through a form of self-scrutiny or reflexivity (Bacchi 2009; Cheek, 2008; Phelan, 2011), considering that perhaps the reality I see from my vantage point may not be the same or even similar as that seen by the plan members, something that had not even occurred to me prior to my introduction to the WPR approach.

My assumptions about "things". The work I do in Disability Management centres around the "problem" of the "disabled" employee. I assume that the disabled employee is an "entity" or a "thing" in need of fixing and of treatment; specifically the interventions offered by the insurance company. I do not question what constitutes a "disabled" employee, if this is a characteristic that is inherent to them and how this distinguishes them from me being a "non-disabled" employee. From my viewpoint, this disabled employee, based on my readings about the WPR approach, could be a creation produced by the disability policy itself. How ironic that my focus as an RC working in DM, that is, to help those employees with MH conditions, may be guided by a policy that is “creating” the “problem” I have been hired to “solve”. I, likely similarly to my coworkers, am oblivious to this fact, let alone that I have been responsible for perpetuating disability.

Bacchi and Goodwin, (2016) bring attention to how “things” are created through the productive practices of policies, and that as they are not “naturally occurring” but produced, and are made to be. Foucault addresses the concept or thing of “madness”, questioning how madness has come to be seen as a “thing” and integrated into a field where it is defined as a mental illness alongside other mental illnesses, purportedly defined in a similar fashion, disability, for example. As pointed out by Osbourne (1997 p. 174) as quoted in Bacchi (2016 p. 8) “policy cannot get to work without first problematizing its territory”.

In line with the post-structural perspective, “things” are not singular, fixed, or discrete entities, but are instead open-ended and malleable and can be contested or unmade (Bacchi and Goodwin, 2016, p. 14-15). Hence, by analyzing Disability policies to explore their “solutions”, I am able to determine how they define the “problem”, “thing” or “entity”, keeping in mind that this creation can be “unmade”, and therefore open up alternate ways to approach employee MH as a phenomenon. Another benefit of the WPR approach is that it assists in the analysis of power and forms of authority and of its effects, promoting a view of research as political practice. The goal of the WPR approach to policy analysis is “To govern with a minimum of domination”. (Foucault, 1987 p. 129 as quoted in Bacchi & Goodwin, 2016 p. 25); of “promoting less harmful alternatives” (Bacchi and Goodwin, 2016 p. 25). My goal in using the WPR approach to analyze disability policies is accordingly a hope to benefit the employees away from work with mental health issues.

My blindness to the impact of subject positions, people categories and power differentials. In my job as RC, I do not consider the relation between my subject position as “helper” and that of the plan member, as that of someone in need of help. I do not recognize how this power differential impacts how I truly see the people I purport to help, and how they see me. While I am aware that I am usually seen as “the bad guy” when I start working with the plan members, and also with their physicians and treatment providers, I believe that I have a good rapport and working relationship with my clients. I do not truly reflect on the power inherent in my role over the plan members, and the impacts of this. When analyzing the disability policies using the WPR approach, I question these subject categories and the impacts of this categorization. I also consider how the disability policies, though these criteria, produce the subject that purportedly needs help and perpetuates a power hierarchy.

As I employ poststructural policy analysis I consider how governmental problematizations “produce particular kinds of provisional subjects” (Bacchi, 2016, p.5). Policies produce subjects through problematization (Bacchi and Goodwin, 2016), and in so doing, policies involve relations of power (Bacchi and Goodwin, 2016). Through poststructural analysis I enquire into the practices and knowledges that produce subjects as a particular kind of being and facilitates identification of the mechanisms at work in the production of subjects and objects. As I think of political subjects as made or becoming, I question the conventional notions of an unchanging human essence, and that political subjectivity is relevant to policy analysis because “assumptions about human nature commonly underpin policy proposals” (Bacchi and Goodwin, 2016 p. 49). I see that policies are involved in shaping what it is possible for people to become, highlighting again the productive force of policies (Bacchi and Goodwin, 2016). I see that policies “make” people as a particular type of subject and place them in a category. A post-structural approach to policy analysis enables me to examine what forces are involved in the shaping of people to become certain subjects, thus classifying them into a certain subject category.

I reflect on Withers’ (2012) assertion that the category of disability is a ticket to certain benefits, be they income, equipment or other privileges. I further consider that the category of disability is malleable, and that when the benefits to be gained are small, the category is broad, but that the category becomes narrower, and thus less inclusive, the greater the benefits become. That disability policies have criteria, as outlined previously by Thorpe & Chenier, (2013) and STD or LTD benefits can be accessed if these criteria are met, is something I take for granted. As such, when an employee enters the subject category for which the boundaries are defined by the insurer, the movement of an employee into this category may bring with it a plethora of implications (Withers, 2012), but it is not something I question.

My presuppositions about things, and subjects as “real” and “unchanging” lead me to practice DM without questioning the very nature of these things, and I am therefore blind to other views and alternatives, all the while believing that I am “outside” of the discourse that give rise to the policy. Now, my beginning appreciation that I am also situated within discourse requires that I reflect on my own role in governing and to engage in the productive and political practices of interrogating, theorizing and resisting (Bacchi and Goodwin, 2016).

Spence, (2017) advises me I bring ready-made prejudices to interpretation. Further, philosophical hermeneutics acknowledges that my understandings can change when I am open to other interpretations. Through the presupposition interview, I am made aware of my presuppositions, and am able to be open to other ways of viewing things. This openness enables me to see “things” and people with new eyes and a different perspective, and facilitates my questioning of the policies I analyze and literature I read.

My observations of workers in the field of DM. In my work in DM, I engage with many people working as I do, in DM. Most RCs are health care professionals and some are not. When listening to the dialogue of some, I am disturbed by the negative comments about the “disabled” or “people on claim”, suggesting laziness or lack of motivation and not wanting to return to work. I make assumptions that comments such as this represent the stigma of the general population; those who are not health care professionals or perhaps those who are not occupational therapists, like myself. I assume that with the appropriate background, RCs like myself, would be better equipped to help the employees with MH issues. Given my introduction to the WPR approach, with its clear statement that people do not sit outside discourse that provides the contexts for policies, I see my naiveté in the belief that the health care background will somehow enable me to “rise above” or positively distinguish myself as “better” in relation to the task of DM and supporting those with MH issues.

Observations of the plan members themselves. When I contact a plan member for the first time, it is at a point after they have "jumped through all the hoops" to qualify as "disabled" in the category defined by the insurer, to be able to avail themselves of the "benefits" this might bring (Withers, 2012). Sadly, one of the first statements they make to me is "I am not like all your other clients, I truly am ill and want to get back to wellness and work". This seems to demonstrate that they have made judgements about others claiming "disability" benefits, wanting to distance themselves from this category of "lazy" people and to show to me that they truly do belong in the "disability" category that they have been classified into. To me, this highlights the malleability of "things" created, but also how these things have the power to impact lives through the productive power of policies (Bacchi, 2011, 2016).

The energy required to "see through" taken-for-granted objects or concepts. Finally, in pursuing this research, I am taking a leave of absence from work. In doing so, I observe that my fatigue levels after a day of studies is much higher than after a day in carrying out my regular job in DM. Bacchi (2012) tells me that problematizations provide entry points for reflection and enable me to stand back from taken-for-granted objects and concepts to see how they have come to be and what contributed to their "being". In my job, we are simply given a file with an employee who is "disabled" and asked to assess and then refer to an assortment of rehabilitative programs. We then monitor their "progress" and finally determine if they are "employable" and can start the RTW process. The wellness and recovery of these plan members seems to be measured on whether there are any objective barriers or limitations that are not in congruence with full time, competitive and remunerative work. While this work may result in my fatigue on some level, it still involves working along predetermined processes that do not change much day by day. It is a practice based on taken-for-granted assumptions, not requiring a lot of deep thought on how things could be different.

Consistent with assertions that the Western workplace focuses on productivity and efficiency (Bacchi & Eveline, 2010), I see that I too am involved in the practice of efficiency to quickly and easily “resolve” issues as I operationalize the disability policies through my work in DM. I am using built-in assumptions or taken-for-granted concepts, as though they are fact, resulting in possibly missing important pieces of information through this practice. Bacchi, (2009) advises that problematizations reduce complexity by describing an issue, such as disability, as a particular sort of problem, thereby simplifying practices in dealing with the “disability” as a thing that is taken for granted. It seems to me that pursuing DM without a questioning attitude about the concepts that are taken for granted and acted upon, can lead to unintended consequences, perpetuating power hierarchies and further entrenching the very folks I believe I am assisting.

In contrast to my clinical work, my role in this research, and when applying a poststructural approach to policy analysis, requires that I take nothing for granted about the policies read (Bacchi, 2016). This means that I am continuously questioning and thinking about each step, each concept, task, or phenomenon and this I find to be draining and tiring. The questioning approach that I employ in conducting this research is central to the WPR approach to policy analysis, and is necessary if I hope to be able to ease the lives of those who are governed by disability policies in Canada through “governing with a minimum of domination” (Foucault, 1984, p. 129). I hope to wake from their sleep-walk, those who are impacting DM, and contribute to a more socially just society.

Reflective Journal and Audit Trail. An audit trail is a mechanism whereby I as researcher report on the thinking and actions that I undertake as I gather information and develop knowledge. It is a way for me to report results and to explain how they are obtained (DePoy & Gitlin, 2016). I use the audit trail as a tool to explicate my theoretical understandings of discourse and discourse analysis and to articulate the theoretical framework underpinning the analysis (Cheek, 2004). The importance in my keeping this audit trail is to clarify not only what I do, but why (Cheek, 2008; Hammersley, 2007). Additionally, the reflective journal helps me to be aware of how my positions and interests are imposed at all stages of the research process. In the reflective journal, I document the questions asked, texts or things studied as well as that which is not asked, questioned or studied (Hertz, 1996).

In keeping with a Foucauldian poststructural approach, I am to construct a "text experience that, besides context, [brings] the reader some kind of transformative experiences, not only of what [they are] but what [they] think" (Neto, 2018 p. 3). Through an explanation of my thinking and decisions behind the collection of data along with the resultant findings, my goal is to allow the reader to agree or disagree with my analytical decisions and interpretations. As research is an experience and process that traverses and transforms both the subject (researcher) and the object (research problem), it changes what I, as researcher think, as well as transforming the research problem that is contingently produced (Neto, 2018). When it comes to research in relation to the postructural paradigm inspired by Foucault, he specifically refers to the importance of the audit trail in that "my problem or the only theoretical work I feel is possible for me is leaving a trace in the most intelligible outline possible of the moments by which I am no longer at the place I was earlier” (Foucault, 2011, p 69 as cited in Neto, 2018 p. 13). He saw texts as functional devices that would enable the individual to question their own conduct and shape themselves as subjects (Neto, 2018). I choose to address the integrity of my interpretations and documentation through keeping a reflective journal. I substantiate the decisions I make in the journal that lead to my findings and conclusions, thereby enhancing the quality of my approach (Appendix C).

As I examine Foucault’s work and poststructural discourse analysis, I note that quality is measured in part by explanations about how research is defined, managed in the stages of decision-making process, and produced step-by-step (Cheek, 2008; Burchell, Gordon & Miller, 1991). By drawing on the work of Foucault to present my investigative path, methodological choices and to justify, when necessary, changes trajectory, I aim to uphold the virtue of a classic researcher by being explicit in the discussion of how I carry out my investigative process (Nero, 2018). In writing a reflective journal, I show the thinking behind decisions I make in identifying texts to analyze, material that will bring context, and how I arrive at the conclusions that form the text of this thesis. To assist me in managing and interpreting this material, I use One Note as a means to keep a reflective journal, record empirical findings and to assist me in the interpretation of the disability policies selected. It is my hope that you, the reader, will be able to follow the path I have taken, and come to your own conclusions with respect to the questions posed initially at the beginning of this study, as you will necessarily bring along your own understandings (Cheek, 2004).

Conclusion

Through the current study I analyze Canadian disability policies using Carol Bacchi's post structural WPR approach to policy analysis (Bacchi, 2009; Bacchi & Goodwin, 2016). I identify how the policies problematize their territory to provide solutions within the context of the Canadian disability management arena. Once I make the policy problematization clear, I conduct an analysis of how these policies come to define the identified problem representation through a review of documents and materials investigating the historical context of the problem. Finally, I present my own problematization based on the documents reviewed.

My research contributes to current knowledge in disability management by providing different ways to view disability and consequently alternate ways to approach disability management. Through focusing on engagement in occupation as an overarching goal of DM by altering the definition of disability in the policies to include partial disability, I propose to use engagement in occupation as a path to employee MH.

Chapter 4: Results and Discussion Questions 1-6

Introduction

I have chosen to integrate the results and discussion into one chapter. My reason for doing so is that Bacchi advises problematizations are context-dependent and problems are nested in one another (Bacchi, 2009). As such, for clarity and flow of thought, it facilitates understanding to combine my results and discussion in one chapter.

This chapter is organized by separating WPR Questions 1-7 in sections. Each section begins with an introduction of the significance of each question and its role in producing the discourse of the medical model of disability in the disability policies analyzed. The articles in Appendix A were reviewed sequentially, such that all articles pertaining to each question were reviewed prior to formulating the response to each question.

Answers to six of the questions posed by the WPR method, as described by Bacchi, (2009), are based on my interpretations, and supported by the articles reviewed. The seventh question is my own problematization, essentially the type of policy changes I want to enact which is then subsequently subject to the six questions of the WPR method, paying attention to my own unexamined assumptions and presuppositions (Bacchi, 2009). Bacchi and others posit that what someone proposes to do about something indicates what needs to change, and that no one stands outside of discourse (Bacchi, 2009; Bacchi & Goodwin, 2016; Lilja & Vinthagen, 2018). Thus, for me in using WPR it is especially important to reflect on the origins, purposes, and effects of my own problematizations to ensure that I am not simply buying into others' problem representations (Bacchi, 2009). I have included my reasoning and explanations to back up my answer to Question 7.

Throughout this chapter, reference is made to occupation, which can be defined as "all the things that people need, want or have to do across the sleep-wake continuum, individually and collectively" (Wilcock & Hocking, 2015 p. xi). However, these authors indicate that the word occupation is most often used to mean work for pay, and it is in this context that the disability policies analyzed considers occupation and engagement in such. I will use the term work occupation to refer to employment or work for pay.

When discussing people with disabilities, I note that there has been a debate over the preferred way to refer to those who have impairments. According to Kielhofner, (2005) disability scholars assert that disability is an essential part of the identity of people having impairments and suggests using the term disabled persons to describe people with impairments. Consequently, I will use the term disabled persons throughout this chapter.

Findings and Insights

Question #1: What is the 'problem' represented to be?

The significance of this question is to bring attention to the implied problem representations in the policies analyzed. As the solutions offered in policies suggest what people think the problem is (Bacchi, 2009), it is possible to identify the implied problem by reading backward from the proposed solution. In accordance with Bacchi's WPR approach it is through an examination of the proposed solution, and questioning this problematization, that I, the investigator, am able to open up spaces where I can interrogate the taken-for-granted assumptions underlying seemingly natural solutions (Bletsas, 2016), and to understand how they therefore could be otherwise (Bacchi, 2009; 2012).

Findings. I started with a reading of the overview of long-term disability insurance coverage about the claims procedure, which suggests that proof of functional disability must be supported through claim forms, and more specifically the Attending Physician's Statement of Disability, that provides "objective medical evidence provided on the claimant's condition" (Government of Canada, 1992, 4.91). I also noted in the policy that "a claimant must satisfy the Insurer's medical consultants, on the basis of concrete medical evidence, that he or she is totally disabled within the exact meaning set out in the plan" (Government of Canada, 1992, 4.5).

Functional View of Disability. In reviewing the resource *Long-Term Disability – Chapter 3-4*, I noted the definition of disability that states "benefits are payable for up to twenty-four months in respect of any medically-determinable physical or mental impairment which a) results in the withdrawal of any mandatory license required by the employee to carry out his or her occupation or employment, or b) renders that employee completely incapable of performing substantially all of the essential duties of his or her occupation or employment" (Government of Canada, 1992, 4.5). The policy appears to base the eligibility criteria on a clearly defined individual functional ability to perform tasks. According to author A. J. Withers (2012), a functional view of disability is a subset of the medical view of disability thereby advising me that the eligibility criteria of the policies are based in the medical model.

Need for medical treatment. In addition to this submission of "objective proof of complete inability to perform substantially all of the essential duties of his or her occupation" (Government of Canada, 1992, p. 5), it is stated in both the *Main Plan Booklet* and the *Executive Plan booklet* that the claimant "must be under the active care of a physician who is a registered specialist in the field of medicine related to the claimed disabling condition" (Government of Canada, 2015, "Am I Eligible" para. 2; Government of Canada, 2016, "Am I Eligible" para 2), which, in the case of a mental health condition, would be a psychiatrist. Additionally, the claimant must also be receiving medical treatment or participating in a program of rehabilitation approved by the insurer (Government of Canada, 2015, 2016), where a rehabilitation program is defined as "a program of vocational training or a period of work for the purpose of rehabilitation, either of which is approved in writing by the Insurer" (Government Canada, 1992, 4.7). Based on this description, rehabilitation programs appear to include work-related activities only. There is no mention of any other additional assistance that could be offered to the claimant.

Linking decreased function with need for medical treatment. Given the functional way of viewing the 'problem', it is, as suggested by Bacchi, nested in other problem representations (Bacchi, 2009). For instance, in reading the policy it appears that on the one hand, the employee must have a functional inability to perform the duties of his or her work occupation to qualify for benefits. In addition, the employee must also be under the active care of a physician who is a registered specialist in the field of medicine related to the claimed disabling condition and the employee must participate in a treatment program or program of rehabilitation that is required in the opinion of the insurer. As such then, the language used in the policy appears to contribute to the assumptions underpinning the problem of a functionally disabled employee, defining the type of problem as an individual that is lacking in treatment or rehabilitation as set out in the policy. The policy defines the problem, provides the solution, and exerts control over the mechanisms in which it is administered.

To further explore the seemingly identified two problems in the policy, of a lack of function and a lack of treatment, Bacchi (2009) clarifies that policies are often complex and may combine a range of proposals that may conflict or contradict each other. The requirement that the individual must be under care by a physician and participate in medical treatment or rehabilitation implies that the problem is a lack of treatment or rehabilitation. However, in the policy it is indicated that the problem is a functional disability or in other words a lack of function to which the only solution offered is medical treatment. In linking the solution of medical treatment to a stated problem of a lack of function, the policy appears to contradict itself as suggested by Bacchi (2009), which then opens up a possibility that things could be different (Bacchi, 2009).

Summary of Question 1. The problem in the disability policies analysed is represented to be a lack of medical treatment and rehabilitation as the cause of a functional inability to perform the duties of ones' work occupation. The problem stated in the policy is a functional disability or a lack of function to perform the duties of ones' work occupation. The solution of medical treatment is presented somewhat arbitrarily, to solve the problem of a functional inability.

Question #2: What presuppositions underlie this representation of the 'problem'?

The purpose of this question is to examine the background knowledge, assumptions or understandings that are taken for granted in this way of viewing the problem (Bacchi, 2009). Bacchi suggests that it is not the assumptions or beliefs held by the policy makers that is sought, but the socially unconscious knowledge and fundamental world views at is behind specific problem representations.

Findings. In reviewing the selected articles to answer this question, I note how the context of the Canadian environment supports the medical model of disability as evidenced in the policies analyzed. I consider the assumptions in this context, dividing my findings under sub-headings.

Arrival of the medical model of disability in Canada. Dr. Jongbloed, a Canadian scholar, provides some insight into the background in viewing this problem. In 2003 she wrote the Law and Order approach to disability was in existence in Europe from between 1860 and 1890, and was essentially an asylum model of care for senile elders, intellectually impaired, those with mental illness and syphilis, while those with physical disabilities were institutionalized later, in the mid-1990's. The medical and economic models of disability that were practiced between 1910 and 1970 were brought over to Canada by the colonizers from Europe (Stienstra, 2018).

For the medical model of disability to continue, something about the context in Canada must have been conducive to this representation of the problem (Bacchi, 2009). Thus, I knew that further examination of the Canadian context was required to examine what has supported the perpetuation of the medical model that has continued to underscore the disability policy mentioned in question #1. For instance, Rönnblom and Bacchi (2011) caution that I as the investigator must pay attention to how things come to be, and thus paying attention to practice, specifically for things to appear natural requires a repetition of practices. As such, while the medical model of disability may have been brought over by the colonizers, something about the Canadian context has maintained it that way.

Neoliberal View of Productivity shaping the problem of the employee with MH issues as being an individual medical issue. The Canadian context is a market-oriented welfare state with an emphasis on capitalist development versus provision of social entitlements to citizens (Jongbloed, 2003). Further, this idea assumes that all individuals are able to work, based on their functional ability (Bacchi & Eveline, 2010; Jongbloed, 2003; Mosleh, 2019), thereby separating the abled from the disabled and individualizing disability (Bacchi, 2009; Mosleh, 2019). It is this neoliberal mindset of productivity (Bacchi & Eveline, 2010; Lilja & Vinthagen, 2018), that aligns with a medical model of disability given that it is the individual who requires an intervention to be productive and support the capitalist society.

The capitalist and neoliberal Canadian context, which focuses on achievement of the individual and their contribution to the economic growth of society, (Bacchi & Eveline, 2010; Jongbloed, 2003; McColl, 2017), appears to consider a lack of financial contribution to be the fault of the individual. Consequently, treatment and rehabilitation to remedy the individual's lack of achievement and economic contribution to society, appears to have aligned well within the Canadian context. Further, given the Canadian focus on capitalist development (Bacchi & Eveline, 2010; Jongbloed, 2003; Stienstra, 2018), it becomes natural to use performance in the workplace as a measure by which to evaluate the individual employee's performance and to deem anyone falling short of this marker as deficient and in need to help to improve (Beresford, 2020; Jongbloed, 2003; Mosleh, 2019). The productive individual is taken for granted in the Canadian society and thereby becomes an assumption that contributes to the shaping of the problem as being the employee with MH issues in need of medical assistance.

Collectivism: Individual Responsibility for Contribution shapes the problem of the employee with MH issues as being an individual medical issue. Lyn Jongbloed (2003) suggests that the Canadian colonial links to Britain were instrumental in reinforcing the importance of collectivism and financial redistributive welfare legislation. Further, she indicates there was a belief that deficits in budget resulted from spending on welfare programs for low-cost sectors, and that a personal deficit was presumed to be the reasons for unemployment and consequently that rehabilitation was needed to return the individual to work as soon as possible.

With this belief of giving the group priority over the individual, which is central to collectivism (Jongbloed, 2003), it appears to be a dividing practice, separating those able to contribute to the collective from those who are personally deficient, responsible for unemployment and thus contributing less to society and to the tax base. According to Bacchi, (2009), these dividing practices set groups of people in opposition to each other and create members of targeted groups as themselves responsible for the problem. Furthermore, it appears that this dividing practice may contribute to creating the norm of able-bodied, financially contributing individual (Mohammed Abouelleil Rashed, 2019; Mosleh, 2019).

As everyone in the collective needed to contribute to the greater good, those who could not be productive needed treatment to become more functional, meet productivity expectations, and not be a burden on society (Jongbloed, 2003). Perhaps unwittingly, the assumption of a need for the people to contribute to the collective good resulted in those unable to contribute to be considered ‘less worthy’, but also in need of treatment to lessen their burden on the greater good (Jongbloed, 2003). In Canadian society it made sense to treat people who were “functionally limited and biologically inferior” and “representing the individual as a patient with special medical needs who deserves a charitable response in the form of provision of health services” (Jongbloed, 2003 p. 205). The assumption of individual responsibility to contribute to the collective was taken for granted in Canadian society and it perpetuated the medical model of disability as an assumption of problems resting with the individual.

Impact of Physician Roles on the shaping of the employee with MH issues as an individual medical problem. Another aspect of the Canadian context is the role played by physicians in maintaining the medical model of disability. Jongbloed explains that physicians were responsible for health matters in the 19th and early 20th centuries and not the government (Jongbloed, 2003). With this authority given to physicians they had power relating to health that included illness and disability (Martin et al., 2018). With the physicians responsible for health matters, and thereby disability, it follows naturally that the inability to function is viewed from a medical perspective, and the assumption that medical treatment will resolve the issue. The medical model of disability appears to align with the valuing and stature of authority espoused by physicians within the Canadian landscape.

For example, in accordance with the medical model of disability, the problem of MH rests with the individual (Jongbloed, 2003; Beresford, 2020; Stienstra, 2018), and that an authority, the physician, can make the determination of disability (Jongbloed, 2003), as well as the nature of intervention required to remedy the problem (Mosleh, 2019). Given the pervasiveness of the physician roles in Canada, other ways of viewing disability have been overlooked.

Comprehensive vs cause-based systems contribute to the shaping of the employee with MH issues as an individual medial problem. With respect to the benefits, assistance, and income support for people with disabilities, Jongbloed (2003) highlights that many disabled persons are not eligible for the benefits provided by the Canada Pension Plan (CPP), disability insurance through the employer, or through motor vehicle insurance. Ellen MacEachern, Associate Professor and Associate Director of the School of Public Health and Health Systems at the University of Waterloo, Canada, and editor of "The Science and Politics of Work Disability Prevention" adds that Canada does not have a universal disability insurance system regardless of cause. MacEachern, (2019) states that an "an injury can generate very different return to work supports and experiences depending not on the nature of the injury, but its' cause" (p. 51). Through connecting disability to its cause, and from this, the eligibility for benefits, a dividing practice is created (Bacchi, 2009), resulting in further division among those with disabilities, who are disadvantaged from those who are able-bodied, and who need individual intervention to become more like the able-bodied norm (Mohammed Abouelleil Rashed, 2019).

The practice of separating people into categories is perpetuated by work disability policies which, according to Ellen MacEachern (2019), focus on supporting individuals to participate in the workforce to become "active, engaged and financially contributing members of society" (p. 11). Work disability policies, aimed at the eligible, disabled persons could add to further distinguish the disabled from the able-bodied, establishing the norm of the productive, employed, and able-bodied and highlighting the need for intervention to the disabled persons to become more like the norm. As such then, the cause-based system in place in countries such as Canada (MacEachern, 2019) also perpetuate and align with the medical model of disability by assuming that the problem rests with the individual.

Summary of Question 2. The presuppositions in the Canadian environment that have led to the predominance of the medical model of disability leading to the problem of the employee with MH issues in need of medical treatment spring from among others, the neoliberal view of productivity. Other assumptions about the "problem" of disability as a medical issue relate to collectivism and individual responsibility to contribute to the common good. The role of physicians, and their stature within the Canadian environment has also played a part in the acceptance and perpetuation of the medical model of disability within this context. Finally, the cause-based system in Canada impacts work disability policy and its basis is in the medical model.

By opening up spaces to question the Canadian way of viewing disability through the WPR approach (Bacchi & Goodwin, 2016; Bletsas, 2012), I, the investigator, hope to pave the way to elucidate potential changes for how employee MH issues are viewed and addressed with a view to social justice.

Question #3 How has this representation of the 'problem' come about?

Formulating a response to question 3, involves taking a genealogy approach which means to trace the roots or origins of how things came to be the way they are today (Bacchi, 2009). This philosophical approach underpins the need to analyse power relations and examine the practices influencing the way a problem is viewed. The purpose of this exercise was to recognize that competing problem representations can exist over time and space and that things could have been very different (Bacchi, 2009).

Findings. In this section, I highlight the practices in the Canadian environment that have contributed and continue to contribute to why the “problem” of disability is seen to be a medical problem. I separate each practice and how it contributes to the “problem” of MH issues and how disability has come about and assumed to be a medical concern.

Access to Disability Benefits – a practice influencing how the problem of employee MH is viewed. Access to disability benefits with its embedded provision of medical care and treatment is not automatic but a “privilege”; a personal accomplishment as opposed to an earned right of social citizenship for working age adults in the formal job market (Prince, 2008). Prince goes on to claim that to be a member of a particular group or category involves acts and relations of power and that social policies, such as disability benefits, are spaces for contestation relating to among others, personal experience, professional expertise and program eligibility. As such, to receive medical care and treatment is a coveted benefit available only to those belonging to a particular category of people, and the entry to this category involves power relations and actions such as those related to disability policies.

Along with access to supports that belonging to the category of disabled will provide, comes an assumed identity as a person in need (Prince, 2008). That the person is in need, necessarily is interpretive, and clearly contestable as well as up for debate. As such, the social identity of the person claiming benefits from the insurer involves power relations, in that it is up to the insurer representative to decide eligibility and a belonging to the category of disabled (Prince, 2008).

Access to disability income security and treatment is part of the second layer of financing of health services in Canada, with an observation that many Canadians do not have access to this type of supplemental insurance and that this brings concerns about equity (Martin et al., 2018). Prince, (2008) adds to this by highlighting that in Canada, the CPP Disability (CPP-D) is Canada's largest public disability program and often complements private insurance. He also highlights that this social insurance plan relies on the expert knowledges of medical professionals to determine benefit eligibility. While the eligibility criteria might differ between the disability policies analyzed in the current study, the creation of the category of disabled through proof provided by medical professionals is the same. The view therefore of disability as a medical issue is shaped through the practice of the CPP Disability plan.

Based on the view of access to benefits being the issue (Dewa et al., 2016; Thorpe & Chenier, 2013), the assumption of the value of disability supports is unquestioned. The issue that is highlighted are the difficulties, inequities and power relations involved in accessing this coveted service and appears to influence a problem representation of a lack of services and a solution toward which energies must be spent.

Workplace practices influence how employee MH issues are viewed. As policies are said to specify a course of action and typically reflects how the "problem" is understood (Bacchi, 2009), it follows that the focus on employee mental health considers mental wellness or health from a business or workplace lens and how mental illness results in diminished performance on and individual basis (Teghtsoonian, 2008). The consequence of viewing mental health or wellness through the lens of productivity means that diminished performance can be attributed to symptoms of a mental illness and redistributes the focus on the employee with an assumed medical condition, leaving unexamined any larger issues in the workplace itself or society at large. In addition to this, it gives employers privilege in determining the health of their individual employees, underscoring the neoliberalism philosophy/view that privileges the productive individual as the pinnacle of a successful intervention (Teghtsoonian, 2008).

An interesting development from this way of viewing decreased productivity is instead to assume that the problem is the medical issue of undiagnosed depression or a psychological condition, where training programs are offered to managers to encourage the employee to accept and seek a medical diagnosis and treatment (Teghtsoonian, 2008). The apparent concern of management is for the best interest of the employee, and the seeming free choice of the employee to seek help aligns the choices of the individual with those who govern (Teghtsoonian, 2008). It also further relocates the problem to individual employees and can decrease the employer's financial liability as a non work-related matter (Teghtsoonian, 2008). By viewing the problem this way, the medical model of disability is inadvertently developed and established in workplace practices.

Disability Management in the Workplace- influence how employee MH is viewed. Teghtsoonian (2008) suggest that disability management practices in the workplace were created to bridge the treatment goals of the treating physicians with the expectations of the workplace, with the assumption that there is a gap between physicians and their patient's goals and the expectations of the workplace. There is a suggestion that the physician does not understand workplace demands and that rehab consultants must communicate between the two parties to support an early return to work as part of the treatment plan as well as to provide access to mental health professionals and that treatment choices are consistent with the priorities of the employer and the insurer. Viewed in this way, disability management practices have shaped approaches that align with a medical lens to support employee MH issues that require medical treatment to resume the role of the normative productive employee.

Data Collection influencing how employee MH is viewed. Data is required to identify the issues facing Canadians with disabilities along with the barriers they face (Furrie, 2018). The underlying assumption behind the action of data collection is that by understanding the barriers faced, a tool can be created to eliminate these barriers and move toward a more inclusive Canada (Furrie, 2018).

The perhaps unintended consequence of this initiative “to quantify the nature and extent of the barriers faced by Canadians with Disabilities” (Furrie, 2018), is that who exactly falls into this category is unclear. This lack of clarity is especially highlighted in the statements about the 2012 Canadian Survey of Disability (CSD) where there were “filter questions” to identify persons most likely to have a disability (Furrie, 2018). It is unclear what criteria may have been used to distinguish this category of “disabled”. Furthermore, I noted that this survey was not as inclusive of persons with cognitive and mental health related disabilities.

The article by Furrie, (2018) concludes with the hopeful reflection that the addition of filter and screening questions to the methodology of data collection therefore means that the results of the 2017 CSD is more inclusive of disabled persons and more reflective of today’s Canada. She finishes by asserting that the adoption of the 2017 CSD data can be used as a benchmark against which to measure future progress.

The focus of data collection is on the category of disabled persons as the “problem” that is to be fixed by the elimination of barriers preventing their full participation in society. The way this type of data collection directs us to look at the “problem” are the individuals who experience barriers and are therefore in need of assistance. As such, even something with good intentions to improve the Canadian Surveys of Disability can also reflect power relations between those collecting this data and the disabled that influences the way disability is being taken up and addressed by the Canadian society.

The Concept of Full Citizenship influences how employee MH is viewed. The authors of the *In Unison* report, outline the goal of disabled persons as full citizens in all aspects of Canadian society. They advise that the Canadian approach includes the building blocks of employment and income specifically, and as needing the commitment of all segments of society through disability supports (Council of Canadians with Disabilities, 1998). By framing full citizenship as a goal implies that something must be done to help the disabled citizen do something to be worthy of full citizenship. It also appears to suggest that to enjoy full citizenship, one must be employed and engaged in productive activity resulting in income. Consequently, it implies that those without disabilities are able to exercise the rights of full citizenship without assistance, resulting in a dividing practice, separating the abled from the disabled (Bacchi, 2009). The authors underscore that the objective of full citizenship will be met by focussing on policies that promote access to generic programs and services (Council of Canadians with Disabilities, 1998).

In this paper by the Council of Canadians with Disabilities, it is indicated that the vision is not to promote special treatment for disabled persons, but to recognize the need for specialized services within a generic framework for service delivery with a goal to provide the same opportunities as other Canadians to control their lives, be employed, or to contribute to society. In looking at the solution as identified in this paper and using the WPR approach to identify problems by working backward from a proposed solution (Bacchi, 2009), the problem for those with disabilities appears to be assumed to be a lack of opportunity to contribute to society. By improving opportunities of those with disabilities, they will be able to contribute to society, which then will enable them to be full, contributing Canadian citizens (Council of Canadians with Disabilities, 1998).

This narrow view of citizenship suggests that disabled persons cannot be full citizens without help and that they may not be worthy of citizenship as they are. Ironically, this stance that disability is a problem requiring intervention to “normaliz[e] disabled bodies” is the very concept that scholars in Critical Disability Studies (CDS) define as oppressive (Mosleh, 2019). Viewed in this way, of medical treatment as a path to citizenship, makes it a powerful tool. Through the practice of improving the opportunities for disabled persons to contribute to society as productive citizens, the norm of the able-bodied, active, employed and productive person continues to be perpetuated (Mohammed Abouelleil Rashed, 2019; Beresford, 2020; Mosleh, 2019).

To focus on employment and income as indicative of equal citizens, and therefore the goal of the Canadian reform initiative, the aspect of being, and through this, meeting the psychological needs of the individual as a prerequisite of health (Wilcock & Hocking, 2015) is overlooked. The focus is instead on disability supports that will help disabled persons to become employed and thereby productive citizens in the Canadian society (Council of Canadians with Disabilities, 1998).

Recommendations for specialized services influences how employee MH is viewed. The authors of *In Unison* advise that disabled persons represent a diverse group and a variety of definitions of disability exist. However, disabled persons have things in common such as personal, social and economic disadvantages and barriers that prevent access to the same opportunities as other Canadians (Council for Canadians with Disabilities, 1998). While the authors of the document state that it does not promote specialized treatment for disabled persons, the apparent need for specialized services for disabled persons are highlighted. As such, a coordinated system of benefits is recommended for Canadians with disabilities that includes the flexibility to make adjustments for differences in various jurisdictions.

In Unison appears to be based on recommendations that are contradictory; to treat disabled persons the same, but also to treat the individuals in the group differently. As such, it appears that the authors of *In Uniso*n might recognize that the recommendation of specialized services could serve to shape the problem of disabled persons as needing help. However, by recommending specialized services in spite of this, the recognition is lost and the problem of disabled persons as being in need of assistance is emphasized.

As a final reflection, I note that the authors of the *In Unison* document are Ministers of Social Services, basing their work on studies about the system of disability supports and services and referring to disabled persons as “they”. It is not known if any of the authors of this document consider themselves a disabled, thereby rendering the *In Unison* document a potential example of the power inequities in society, whereby the able-bodied determine what those deemed disabled “need” (Bacchi & Goodwin, 2016).

Canada’s Universal Healthcare System and Strong Physician Roles influence how employee MH is viewed. Important contributors to viewing disability as an individual medical problem that can be solved through medical treatment, programs and supports can be traced to two important influences; the work by Tommy Douglas, the founder of Canada’s Universal Healthcare system combined with the powerful influences of the country’s physicians (Martin et al., 2018). With respect to the former, the goal was to eliminate the financial barriers to medical care, thereby positioning the problem as access, leaving unquestioned the benefit of medical intervention and thus solidifying the importance of medical treatment and the medical model.

The way of looking at the problem as a lack of access to medical services elevate the importance of physicians as the unquestioned providers of the scarce commodity of medical care. Through focusing on access of medical services, the services themselves are also unquestioned, and the medical model of disability began to take shape in Canada.

Another practice that may perpetuate the problem as an individual medical issue is the powerful role of Canadian physicians in the healthcare hierarchy. Martin et al., (2018) point out that physicians are mostly self-employed, independent contractors who are able to bill public insurance plans yet have little engagement or accountability to system-wide governance. Through their work in the medical arena, physicians may be unintentionally supporting and promoting the medical model of disability by emphasizing the important value of medical treatment. As such, the role of physicians appears to have largely influenced the medical model of disability that is the basis for disability policies or benefit plans in force today.

In looking at the article by Martin et al., (2018), it is suggested that there is a "deep public coverage of a narrow band of services" (p. 1721). As such, the authors here appear to suggest that while universal health care as envisioned by Tommy Douglas is good, it needs to evolve to include prescription medicine and mental health care. Examined from the lens of the WPR approach the solution is to expand medical care to be accessible to more people. The perhaps unwitting result of focusing then on the expansion of medical care and increasing access to more people, perpetuates the view that it is increased medical care that is needed, as opposed to examining other ways of looking at disability. In addition, the benefit of medical care itself is not questioned in this way of looking at the problem.

Summary of Question 3. The representation of the medical model of disability and employees with MH problems requiring medical care and treatment arrived in Canada from Europe (Jongbloed, 2003) and appears, according to Wilcock and Hocking (2015) to have been defined by physicians in the Industrial Age in Europe. Practices in the Canadian context have perpetuated this way of viewing and dealing with this problem.

I have noted, in my response to the question of how the representation of employee MH is viewed to be a medical issue, has come about through practices in the Canadian environment. Practices such as application for disability benefits, workplace practices, DM, and the act of data collection have and is influencing how employee MH issues are viewed. Ironically, even the concept of Citizenship is assumed to require additional assistance for employees with MH issues to access.

Finally, while perhaps well-intentioned, recommendations for specialized services for individuals with MH issues, and services of the health care system in Canada along the recommendations of the *In Unison* document may all serve to influence how this representation of the problem came about.

Question #4: What is left unproblematic in this representation of the 'problem'?

The goal of this question is to raise for reflection and consideration issues and perspectives silenced in identified problem representations. The process to answer this question is to make cross-cultural comparisons of problem representations over time and the discourse analysis (Bacchi, 2009).

As I am tasked with investigating other cultures/countries to answer this question, I have chosen Sweden as that is where I was born and where I am aware of progressive work with DM, in addition to that they have a social democratic welfare state, different than Canada.

Findings. Through an examination of practices in Sweden, I have seen that the "problem" of employee MH issues is both viewed in a similar way to that in Canada, but also how it is managed differently. I divide my answer to this question into subsections with headings to clarify the practices in this country, and how they make some assumptions about employee MH issues, rendering them unproblematic. However, at the same time, I note that the Swedish environment enables different approaches to employee MH to be practiced.

Labour laws in Sweden: Treating employees with MH issues differently.

According to the Government of Sweden (2012), the Swedish general labour law provides equal rights on an equal basis for all. It is the reason why Sweden has the highest employment rate of Persons with Disabilities in the OECD. Lesser capacity is not an objective ground for dismissal and employers must make all reasonable efforts to retain the worker. The fact employees are not judged negatively based on their capacity is diametrically opposed to the Canadian Disability Policies that are being examined in this study. The Canadian system is an either/or scenario of full-time or part-time working capacity that does not permit part time work and targets those with lesser capacity to work, requiring them to improve their abilities to meet the assumed necessity for productive work.

In Sweden, the general labour law, or LAS serves to promote an inclusive labour market for disabled persons (Government of Sweden, 2012). Its purpose is to keep those with diverse abilities at work. The regulations state that the employer must, in the event of an employee with lesser capacity a) adjust the workplace b) rehabilitate the employee or c) transfer the employee to other suitable work. Granted, by using the wording of lesser capacity, the disability dichotomy is still perpetuated. However, it is at the level of local practices where change can be made (Rönnblom & Bacchi, 2011), and by opening up spaces that enable those defined as disabled to be part of the work force, a step toward decreased inequity in the workforce may be made.

In reviewing these laws it helped me identify a new thought about what is left unproblematic in the Canadian problem representation, which is that of full time, productive work as the norm. In Sweden, full time productive work is not taken for granted. Instead, in Sweden, everyone has the right to employment, regardless of ability. Disabled persons are not compared to a norm of full-time productive employment and are supported by the state to contribute what they are able to, whether this be ten percent, fifty percent or one hundred percent productive work (Government of Sweden, 2012). The all-or-nothing approach to employment in Canada limits the ability of the disabled employee from benefitting from involvement in engaging in productive work occupations (Wilcock & Hocking, 2015).

State-funded MH services: treating employees with MH issues differently. In the article “The Swedish Mental Health System: Past, Present and Future”, Helena Silfverheim and Edna Kamis-Gould (2000) begin by tracing the evolution of how mental health care evolved in Sweden, beginning with ‘lunatic asylums’ where those with mental health issues were viewed from a religious angle. It was in the 1970’s that community care and deinstitutionalization led to a more social model of mental health care.

All mental health care is paid for by the Swedish government agency, the National Board of Health and Welfare. It is also responsible for the supervision and monitoring of social services, health care, dental care, environmental health and the control of communicable diseases. The Swedish disability policy is based on the United Nations documents; “*Convention on the Rights of Persons with Disabilities*” and the “*Standard Rules on the Equalization of Opportunities for Persons with Disabilities*” (Government of Sweden, 2021) and both have a basis in the medical model of disability. The difference then that I gleaned through this comparison between the Swedish and Canadian system is not that mental health care is viewed from different lenses, as they both consider disability from a medical lens. However, as services for mental health conditions is in Sweden paid for by the state to everyone, and not just those who are gainfully employed, result in a difference in the definition of disability not being compared to the norm of full-time work, such as that in Canada (Government of Canada, 1992).

The distinction between the funding of services therefore appears to have an impact on how persons with MH issues are addressed as well as on work integration in both countries. It is perhaps this difference that has enabled the development of the General Labour Law in Sweden, that gives the right to employment to everyone, regardless of ability and that in the event of lesser capacity, Swedish employers must make every effort to retain the worker. What is considered unproblematic or taken for granted in the Canadian context is the full-time productive worker, whereas in Sweden, everyone has a right to work.

Summary of Question 4. What seems to be treated as unproblematic or taken for granted in the representation of the employee MH issues in Sweden is the focus on the medical model of disability. However, the labour laws in Sweden do now allow for lesser capacity to be cause for dismissal, and instead encourage those with diverse abilities to remain in the workforce. Further, Sweden has a state-funded system that pays for MH services for everyone, and that allows the support of disability and health care needs, versus private disability insurance pays for the treatment needs and support for working-age individuals in Canada (MacEachern, 2019).

What is possible in the Swedish system is the value of engagement in occupation for health and well-being (Wilcock & Hocking, 2015) and specifically engagement in work occupation through the general labour law that promote an inclusive labour market for disabled persons (Government of Sweden, 2012). It is this way of viewing the problem of employee MH that builds on the value of engagement in work occupations that is made possible in the Swedish system.

Question #5. What effects are produced by this representation of the problem?

The goal of this question is to identify the effects of specific problem representations so that they can be critically assessed. Through this representation of the problem, dividing practices result allowing sub-questions such as 1) what is likely to change (with this problem representation)? 2) what is likely to stay the same? 3) who benefits? 4) who is harmed? And 5) how does this attribution of responsibility of the problem affect those targeted as well as the perceptions of the rest of the community about who is to blame?

By considering the effects of problems representations, a means arises for assessing policies which is different from the common ways that measure the outcomes produced by 'effective' policies and which is often not subject to scrutiny (Bacchi, 2009). It also allows focus on the power relations involved in the representation of mental illness as a medical issue (Bacchi, 2009).

When examining the effects produced by this representation of the problem, that of the medical model which looks at mental health and illness as being a medical issue (Jongbloed, 2003, Martin et al., 2018; Treasury Board of Canada, 1992; Prince, 2008; Withers, 2012), the WPR method recommends investigating the discursive, subjectification and the lived effects that results from this way of viewing the problem (Bacchi, 2009). Discursive effects are those created by the limitations imposed on what can be thought or said within problem representations. Subjectification effects relate to subject positions available in relevant discourses. Finally, lived effects are the impact of problem representations on peoples' embodied existence (Bacchi, 2009). Problem representations are forms of intervention affecting peoples' day-to-day lives.

Findings. Through the use of the WPR approach, I consider the various effects of viewing employee MH issues as an individual medical problem. The effects are divided into sections that examine how taking the medical model as an explanation for employee MH issues produces effects, perhaps unintentionally, but contribute to how MH issues in the workplace are seen and consequently addressed.

Discursive Effects impact how employee mental health issues are viewed.

A discursive effect impacting how persons with MH are viewed is that of stigma discourse. According to Stuart, (2006), a prominent researcher in the area of stigma, indicates that people must divulge mental illness in order to receive accommodation. In the policies analyzed, claimants must show proof of a functional inability to perform the duties of an occupation or job and that it is due to a medical condition verified by a physician (Government of Canada, 1992 para 4.5). This results in the appearance of an individual deficiency due to mental illness (Pattyn et al., 2014; Prince, 2008; Wong et al., 2018) as well as uses a labelling language of claimants to refer to individual workers applying for disability benefits. Through this activity then, it highlights that the issues lie with the individual and his or her deficiencies (decreased function) and impaired health (in need of medical care) and that this is due to a mental illness that carries stigma and is considered a weakness.

According to Zubair (2015), when people with mental health issues begin psychiatric treatment they start being seen as irrational, unstable and incompetent.

Further, Pattyn et al., (2014) states that it is not until individuals enter psychiatric treatment that they are labelled as having a mental illness. As such, it appears that the solution to the medical problem of disability is indirectly causing stigma through the labelling of persons with mental health issues.

The stigma discourse that is created through the use of the medical model of disability highlights the problem as being stigma this may prevent people with mental health disabilities from seeking treatment (Stuart et al., 2014 a, b; Stuart, 2006; Pattyn et al., 2014; Wong et al., 2018). The provision of information about the effectiveness of treatment and mental health knowledge through the media, research or health care providers for example may serve to direct people to focus more on the medical model of treatment and that help seeking is the correct one. This predominant focus on the treatment and help seeking may also tend to overpower the efforts to focus on stigma reduction that address personal negative beliefs about mental illness in society and less attention on other ways to view MH issues in the workplace such as being related to neoliberal productivity requirements for example.

In short, the stigma discourse, which is a result of the problematization of employee MH issues as an individual medical issue, creates a dividing practice where persons with mental health issues are seen as needing the assistance of medical treatment to recover. The treatment providers first diagnose the issue as a medical problem, then offer a solution of medical treatment to resolve the individualized deficit. The stigma discourse is an effect of the problematization of employee MH issues that services to further instill the problem as an individual medical problem.

Another discursive effect impacting how employees with MH issues are viewed is the full-time Competitive Employment/ Neoliberal Discourse. For instance, the functional ability to perform full-time work is the norm and neoliberal agenda to which people with mental illness are compared (Bacchi & Eveline, 2010). According to this truth of full-time work, more medical treatment will enable people with mental health issues to become like the majority working full-time in competitive work (Stuart, 2006; Stuart et al, 2014; Wong et al., 2018). The concept of full-time work is not questioned but taken for granted as ideal for which to strive. Consequently, possibilities for diverse abilities allowing for part-time work is not an option, and the problem is individualized as the person who is not productive and in need of assistance.

In reviewing the discourse of full time work I believe that the effects created by this problem representation places limits on what can be thought (Bacchi, 2009) such as alternative reasons why people are not working full-time or that the problem does not rest with the individual. In addition, these discourses also contribute to continuing power relations between the employer and worker where the employer expects a productive full-time worker, as well as between the insurer and employee where the former exerts control over funding eligibility based on full-time work as a measure against which the employee is compared.

Subjectification Effects Impact How Employees with MH Issues are viewed. I identify three categories of people or subject positions that are created by the impact of how assumptions of employee MH issues are caused by the medical model of disability. These are disabled persons, physicians and rehabilitation consultants.

The subject category of disabled, that is created by the disability policies analyzed, rewards those who have been able to successfully meet the criteria to enter this category (Prince, 2008; Withers, 2012). Further, the behaviour that is rewarded by the disability policies is that of accepting being sick and incapable and in need of assistance to be “like the rest”. Specifically, the “claimant must satisfy the Insurer’s medical consultants, on the basis of concrete medical evidence, that he or she is totally disabled within the exact meaning of the plan (Government of Canada, 1992 para 4.5). The claimant “must also be receiving medical treatment or participating in a program of rehabilitation approved by the Insurer” (Government of Canada, 2015; 2016, Am I eligible for benefits?).

Belonging to the category of disabled then, does not seem to be advantageous and one might wonder why someone would want to belong to this subject group. A. J. Withers (2012) provides an answer to this by informing that the “benefit” received for belonging to this group is to receive benefits, be they monetary or access to treatment. People do not claim to be marginalized of their own choosing, but that the access to resources that claiming disability provides might make this a necessity (Withers, 2012). As such, the creation of this category consisting of people in need of medical treatment may be inadvertently perpetuating the medical model of the disabled person in need of treatment.

The result of this subjectification effect is that people take on the understandings as their own (Bacchi, 2009) in that they are the ‘problem’, not only being unable to “function” in the workplace, but also needing medical treatment. Further to this the stigma of disability is also internalized (Pattyn et al., 2014; Zubair, 2015). It appears that by viewing employee MH issues through the lens of the medical model results in the creation of the category of disabled persons and the implicit power differential that places them as being in need of assistance.

The subject category of physicians is also created by viewing employee MH issues as an individual medical problem. Pattyn et al., (2014) note that mental illness can be invisible until a physician provides a diagnosis and a label, as well as prescribes treatment. The power afforded to the physician is demonstrated by the statements that the claimant "must be under the active care of a physician who is a registered specialist in the field of medicine related to [their] disabling condition" (Government of Canada, 2015, 2016. Am I eligible for benefits?). Zubair (2015) states that the commencement of psychiatric treatment initiates the process whereby an individual is labelled as irrational, incompetent, and emotionally unstable. By this logic then, it appears that the physician plays a central role in the illumination of employee mental illness as a medical problem.

The disability policies analyzed require that a claimant produce information provided by a physician to submit a claim for benefits (Government of Canada, 2015, 2016). Consequently, the process of applying for disability benefits provides an immediate categorization of the claimant as an individual that is disabled, lesser, in the minority, in need, and lacking power. However, as it is the physician that essentially is a gatekeeper for the individual with mental health issues to gain access to disability benefits (Prince, 2008), and treatment, they are therefore in a position of power. The disability policy, through the medical model, provides a discourse with available subject positions, those with power and those without (Bacchi, 2009). As much as the subject position of the powerless is taken up by the person with MH issues, the subject position of those with power are taken up by the physicians, along with the behaviours available to them from this position (Bacchi, 2009). The subject position as a physician in power is created by the disability policies that view employees with MH issues as in need of medical assistance. A power differential is created by the medical model of employee MH issues, resulting in subject positions that are not natural, and can thus be changed.

Rehabilitation Consultants occupy a subject position between the physicians and disabled persons. They are assumed to belong to the subject group in the majority. They are political subjects (Bacchi, 2009) that are assumed to control their bodies, work full-time and are consequently not viewed as disabled or in need of treatment. While adhering to the guidelines in the disability policies, these RC’s work with those categorized as disabled to get them to submit to medical treatment or participate in rehabilitative programs as required by the policy and approved in writing by the insurer (Government of Canada, 1992). The question of how disability policies impact the work of RC’s who work with people with mental health issues thereby also seems to involve unequal power relations.

The disability management process, involving claimants, RC’s, physicians, rehabilitation professionals, medication etc. is created and limited by disability policies. Along these lines, the medical model of disability creates RC’s in a position of power in relation to disabled persons, meaning that these categories are effects of the problematization of employees with MH issues as a medical concern.

In this analysis of disability policies, it is relevant to note that subject positions such as employers or family members are not mentioned in the policies, thereby rendering them invisible in their possible impact on those claiming disability benefits. As a result of this omission, a significant portion of the context in which the person claiming disability benefits is not considered to be relevant in the application or disability management process.

Lived Effects Impact How Employees with MH Issues are viewed. As I consider the lived effects of viewing employee MH problems as an individual medical problem, I consider the effects on poverty, social relationships and unemployment. These effects are all reported to be consequences suffered by employees with MH issues and I describe them here.

There is an understanding that people with mental health issues (Jongbloed, 2003; McColl et al., 2017) are more likely to have a lower income than people who do not report mental health issues. Further, Stuart et al., (2014) advise that employees with mental health conditions often seek short term and long-term disability, leaving the workforce due to lack of accommodation that would enable them to stay at work and earning an income. Finally, in addition to those with mental health conditions having limited funds, compared to those of the general population (Stuart et al., 2014), they must also pay for treatment that is viewed by some to be a barrier to receiving treatment to begin with, (McColl et al., 2017; Wong, 2018), resulting in even less disposable money.

Poverty has been said to be a contributing factor that can lead to mental health disability (McColl et al., 2017; Raphael, 2016; Stienstra, 2018). If that is the case, as Withers (2012) notes, then why is not more effort focused to address poverty as a contributing cause of mental health disability?

A paradox is emergent here, that people with mental illness have less income than the general population (Jongbloed, 2003; Stienstra, 2018), but also that poverty is a contributing factor leading to MH disability. As such, income seems to be both a proximal and distal cause of employee MH and disability. The apparent conflict is consistent with Bacchi, (2009), who claims that problematizations nest in one another, sometimes with conflicting aims, thereby resulting in lack of progress in either or any direction. The lived effects created by the medical model of disability underlying the disability policies analyzed may contribute poverty as experienced by disabled persons.

Social relationships are noted by researchers to impact by employees with MH issues, when viewed as a medical issue (Stuart, 2006; Zubair, 2015). In fact, Zubair (2015) advises that it is the commencement of psychiatric treatment that initiates the process whereby the individuals are labelled. Withers (2012) adds that once someone has been deemed to be disabled under the medical model, it can impact any and every aspect of that person’s life. As such, it can be said that the medical model of disability does paradoxically result in stigma and negatively impacts social relationships (Stuart et al., 2014 a, b; Pattyn et al., 2014; Withers, 2012; Wong et al., 2018).

As definitions of disability differ depending on the context in which it is defined and who defines it (Withers, 2012) the category is not naturally occurring, but a product of society. The creation of a disabled persona can define a person and what he or she needs and can do, for the rest of their lives; it is a dividing practice (Mohammed Abouelleil Rashed, 2019; Bacchi, 2009).

An effect of the problematization of the employee with MH issues as an individual medical problem is lack of work, unemployment and occupational deprivation. Employees with mental health conditions often seek short term and long-term disability, leaving the workforce due to lack of accommodation that would enable them to stay at work and earning an income (Stuart, 2006). Many are also subject to increased supervision by managers and bosses who doubt their competence, and they are also passed over for promotions. Additionally, unemployment rates among people with mental health disabilities are high and 61% of working age adults with mental health disabilities are outside the workforce compared to 20% in the general population (Stuart, 2006).

There is a plethora of research that looks to resolve the issue of unemployment of those with medical issues in Canada (Dewa et al, 2019; Dobson et al, 2018; Kirsh et al., 2010). Unfortunately, despite these undertakings, the number of persons with MH issues in the workplace is growing (Chenier, 2016; Dewa & McDaid, 2011; Pomaki, 2017). Researchers have noted that work is healthy (Stuart, 2006; Wilcock, 2007; Wilcock & Hocking, 2015), however it appears that the system in Canada which uses a medical model of disability among others, may not be supporting of individuals with mental health issues remaining in the workplace (Mosleh, 2019).

The lack of work and employment is defined as occupational deprivation (Christiansen & Townsend, 2010; Wilcock & Hocking, 2015). Whiteford, (2000 p. 201) defines occupational deprivation as "a state of prolonged preclusion from engagement in occupations of necessity and/or meaning due to factors which stand outside of the control of the individual".

Based on the above findings and concepts reviewed to answer this question, unemployment and occupational deprivation can be understood as a lived effect of the problematization of employee MH issues as a medical concern. Considering this view, it is ironic that researchers lament the growing number of employees with MH issues that are costing the Canadian economy millions of dollars (Dewa & Lin, 2000; Lim et al., 2008), yet a possible contributor to this situation may be linked to the disability policies themselves. As specified by the policies, in applying for disability, the claimant must provide proof by a physician that they have a medical condition that renders them functionally unable to perform the duties of their occupation (Government of Canada, 1992). In the absence of such a requirement by the disability policies, or if the individual is not working, for example, a diagnosis or medical treatment by a physician may not be sought.

S**ummary of Question 5 about what can change and likely to stay unchanged.** Based on the findings above, the lived effects of poverty, social relations and unemployment are themselves possible creations that can be linked in part to the disability policies analyzed. By considering the effects of problem representations, I have presented a different way of assessing policies other than the common ways that measure the outcomes produced by ‘effective’ policies (Bacchi, 2009). Through this exercise, I have been able to shed light on the productive nature of policies and identified some conflicting and contradictory practices and ideas.

From the above analysis and drawing on the additional questions in WPR #5, it appears that inherently within the medical model of disability there is a power hierarchy where the employee with MH issues is at the bottom and the physician at the top, with RC’s somewhere in the middle. These power relations are largely invisible (Bacchi, 2009), and therefore not addressed, meaning that any substantive change in the lives of those with MH issues is unlikely. Further, as noted by Rönnblom & Bacchi, (2011), power is productive, and as a result, the forces that are at play create these power inequities and as a result, things are likely to stay the same with this problem representation.

With reference to who benefits from the way of viewing employee MH issues as an individual problem in need of medical treatment are the physicians and care providers who are employed to “help” these people. The attribution of responsibility for the problem to the employee with MH issues who is responsible for the problem and needs to seek treatment, results in adding further to their burden, may also result in experiences of stigmatization, decreased income, possible permanent or periods of unanticipated unemployment and problems with social relationships, to name a few.

The effects of viewing the employee with MH issues as a medical problem are separated above under the headings discursive, subjectification and lived effects. In all instances, I used the literature to elaborate that these effects are linked with the disability policy itself, that is based on the medical model of disability. Given that the effects are shaped by the policy, that means that the effects are possibly malleable and can be changed. One way to do this might be to change the policy itself.

Question #6 Where is this representation of the ‘problem’ produced?

The goal of this question is to pay attention both to the means through which some problem representations become dominant, and to the possibility of challenging problem representations that are judged to be harmful. The process to answer this question is to consider past and current challenges to this representation of the ‘problem’ and to consider the discursive resources available for re-problematization.

Findings. Bacchi suggests that the media, as well as academic research play roles in the process of knowledge production (Bacchi, 2009, 2016), thus these avenues may have an impact on how the ‘problem’ of MH issues are produced. Mosleh elaborated that the medical and rehabilitation community also have an impact on how this phenomenon can be re-problematized (Mosleh, 2019). Consequently, the areas of the media, rehabilitative practices and the research community are summarized under sub-headings, and their contribution to the production of employees with MH issues as an individual medical problem is examined.

Media’s role in producing the view of the employee with MH issues as an individual medical problem. Messages that are made by media include that recovery from mental illness is possible and that the practical route is one that links a comprehensive mental health system of formal supports, community supports, and the broader health and social service industry (Alexander, 2012). This stance thus implies firstly that recovery from, and not living with, mental illness is preferred, and secondly, that the route to this recovery is through the mental health system. Both the concepts of what defines mental illness is taken for granted, as is the individualizing medical model of disability.

The media is reported to be the public’s most significant source of information on individuals with mental illness (Baun, 2009). Unfortunately, persons with mental illness are often depicted as being violent (Baun, 2009) as well as different and not like the norm (Bacchi, 2009), resulting in stigma (Stuart, 2006). While it may not be stated in the articles reviewed that the mentally ill require medical treatment in order to not be “ill” or “violent”, the underlying assumption is heighted by the sentence “Newspaper headlines…transforms a health issue into a public safety issue” (Baun, 2009 p. 32). While on the one hand defending the mentally ill from being wrongly labelled by the media as being different or violent, an underlying assumption of having an individual mental health issue appears to be still taken for granted by these authors.

Rehabilitation/Institutional Practices' role in producing the employee with MH issues as an individual medical problem. It is paradoxical to think that the medical and rehabilitation community, that have as their goals to cure or rehabilitate people, are actually part of the mechanisms that may serve to unintentionally perpetuate the idea of disabled persons as lacking and being in need of rehabilitation. (Mosleh, 2019). Medical care and rehabilitation are interventions to help people "recover" (Dewa, Thompson & Jacobs, 2011; Pomaki, 2017; Thorpe & Chenier, 2013), but upon closer examination, the question can be posed; "Recover to what"? Disability scholars point out that disabled people are compared to a norm, one that is valued in Western societies (Mohammed Abouelleil Rashed, 2019; Beresford, 2020; Beresford & Russo, 2016), and much time and energy is spent looking for ways to get better and return to work and productive activity (Pomaki, 2017; Wisenthal et al., 2018).

The practice of rehabilitating or curing people from illness or disability is in essence creating a dichotomy of able-bodied people on the one extreme and disabled people on the other (Mosleh, 2019). The favoured way of being, is deemed to be better than the other, and is demonstrated through interventions to help the disabled become like the abled (Mohammed Abouelleil Rashed, 2019; Mosleh, 2019).

In her analysis of rehabilitation practices, Mosleh (2019) draws attention to the traditional, or medically based rehab practices and how they currently maintain the view that able-bodied, productive individuals are what is valued in Western society. Anything falling outside of this statistical norm requires treatment to return to the norm that is valued by society (Mosleh, 2019).

Given this view of Western rehabilitative practices, the rehabilitation institutes are continually drawing on the biomedical notion of impairment and use statistical norms to understand what counts as a problem and what should be addressed (Mosleh, 2019). As such, when speaking of ensuring that the resources be available to provide treatment to all who need (Pomaki, 2017; Thorpe & Chenier, 2013) the problem of the employee with MH as an individual in need of medical treatment becomes further entrenched.

Mosleh (2019) recognizes the challenge of the taken-for-granted assumptions upon which modern health care is based and that serves to perpetuate ableist thinking and to problematize disability. Gary Kielhofner, agrees with this sentiment, that rehabilitation practices emphasize reducing impairments and assist people to approximate the lives of normal people (Kielhofner, 2005). By their role of minimizing impairments, the rehabilitation providers may inadvertently be reinforcing the idea that the disabled person is abnormal. The idea of the employee with MH issues as an individual with a medical issue may be a product of the rehabilitation community, and as such, can be unmade.

Research as a vehicle in the creation of the employee with MH issues as an individual medical problem. Through using the methodology of the WPR approach, I question the reality, objectivity or ontology of those that are the disabled, and how they are shaped and possibly created through the policy. However, as mentioned by Malin Rönnblom (2012) through the use of methodology, researchers are shaping the reality they study. Consequently, through questioning the taken-for-granted assumptions underlying the policies, and the realities that are thereby created, I myself am creating my own version of reality.

Being mindful of the role of the researcher in shaping versions of reality, the WPR approach recommends using reflexivity to shed light on ones' own problematizations and biases that should lead to more thoughtful contributions (Bacchi, 2009). With the knowledge in mind that researchers all impact the realities that understood and that no one stands outside of discourse, it appears that all research will be able to do is to perpetuate the status quo.

Rönnblom and Bacchi, (2011), provide some hope to not be discouraged by the seeming conundrum of researchers influencing the knowledge produced, while simultaneously being influenced by the context in which they operate. These authors posit that 'things' are not natural but depend on being 'done' and requires a repetition of practices. This implies that there are spaces or opportunities where it will be possible to intervene and reflect on the taken-for-granted nature or ontology of various problematizations (Bletsas, 2012). If researchers in academic settings are playing a role in perpetuating how things are viewed and addressed through a "continuing practice of crafting" (Bacchi & Eveline, 2011 p. 10), it is important to examine how this is happening, and consequently to open up possibilities for how things could be different.

One example of research that is attempting to address the view of the employee with MH issues as an individual medical issue is Peter Beresford, who is a professor in Citizenship Participation at the University of Essex in the UK. He identifies as a survivor activist and has authored many studies and articles on Mad studies (Beresford, 2020; Beresford & Russo, 2016; McWade, Milton & Beresford, 2015).

When looking at the future of Mad Studies, Beresford provides a list of agenda items for action that Mad Studies can do to challenge the dominance of prevailing individual, medicalized models. However, these items include things such as “building alliances with related causes like the disabled people’s and other movements…”; “focus efforts on survivor organizations…” and “…explain that there is an alternative to the psych system of thinking…” (Beresford, 2020 p. 1341). In following the WPR approach, Bacchi and Goodwin (2012) posit that any policy, program or proposal provides solutions to a problem that is defined as a particular sort of problem that needs fixing. What is suggested to be done constitutes what is thought of as needing to change. As such, it is possible that the recommendations made could also continue to perpetuate the issue versus examining how these issues are problematized. It is important to recognize the contribution of researchers in creating the very reality that they purport to study.

A Spectrum of Madness is a possible avenue through which research may question, disrupt or replace the view of the employee with MH issues as an individual medical problem. Disability is said to be a social construct (Withers, 2012). It is contextual and socially determined and is brought into being only when compared to a norm or a reference group (Mohammed Abouelleil Rashed, 2019). As such, it is not absolute, nor objective, but defined and constructed by the policies that are used to govern society (Bacchi, 2009). It is with this understanding of disability that it becomes clear that disability can also be deconstructed. Put another way, it can be said that a mental illness or deficiency is defined when compared to something, and it is therefore the reference to which is it compared, or the norm, that becomes important when determining what disability is (Mohammed Abouelleil Rashed, 2019). Ability or function, and therefore disability and dysfunction exist on a continuous spectrum and it is the context that determines whether it is disabling or not.

Given the suggestion of disability, not as an absolute, but a variation of a societally accepted norm, Mohammed Abouelleil Rashed (2019), recommends that society must change to accommodate a broader variation in function. He further states that mental illness is less visible than physical impairments and has a more significant impact on the social rather than the physical environment. As such, adjustments will need to be made that focus on social interactions and relationships.

Based on the recommendations of Mohammed Abouelleil Rashed (2019), for society to accommodate a broader variation in function, and thereby deconstruct the social construct of disability, the norm that is representative in the Canadian landscape must be examined (Bacchi & Eveline, 2010). It is the Western bureaucratic neoliberalism that underscore some business activities (Bacchi & Eveline, 2010) and potentially the growing income inequality and unequal distribution of the Social Determinants of Health in Canada (Raphel, 2016) that may be part of the power relations that appear to stand in the way of a true re-evaluation of this norm.

Target audience

While the target audience of the media can be said to be the “general public” (Baun, 2009); of rehabilitative/health care institutions to be the disabled persons (Kielhofner, 2005); and of research to be firstly academia (Rönnblom, 2012; Williams-Witt, 2016), it is also known that health care professionals have access to academia and media, while disabled persons also have access to media and some may read academic journals (Baun, 2009). As such, even though the target audience may be a specific category of individuals, people do not exist in a vacuum (Bacchi, 2009; Raphael, 2016), and that information disseminated through any means becomes part of the context and the environment and impacts everyone, albeit through a slightly different lens depending on individual circumstance.

Summary of question 6. The findings above show that the media, rehabilitation community, and academic research all can have an impact in how employee MH issues are viewed, produced, disseminated and defended. While it may seem to be an arduous task to make an impact on the view of how MH and disability is viewed and treated, especially as it is continuously in the process of being produced, similar to any large vessel, it is always possible to make small alterations to change course.

By not taking the issue of MH issues or disability as an objective truth, and instead question of how it came to be treated and viewed this way (Bacchi, 2009), it may enable people in society to view the issue from another angle. For instance, through the mechanisms by which the problem representation of employee MH issues and disability are viewed as individual medical issues, it is possible to see how the media, rehabilitation community and academia create the category of the disabled. Through the use of the WPR, I am able to question the underlying taken-for-granted assumptions that contribute to this understanding of MH issues as a thing (Bacchi, 2009). I believe that the above analysis of the mechanisms through which this understanding of disability has been perpetuated provides opportunities to question and challenge the medical model of disability that is created in disability policies.

A way forward is to not directly challenge employee MH problems as a medical issue, as this may be met with much resistance due to the many players that stand to gain from this way of viewing the problem and solutions. If instead, the problem can be viewed differently and thereby treated in a different manner with different solutions, unforeseen gains and positive effects may be revealed. However, when developing any new problematization, it is important to consider the unintended consequences that will unavoidably arise.

CHAPTER 5: Results and Discussion Question 7

Question #7: My own problem representation; subjecting it to the WPR method

My approach to answering Question 7

In this chapter I consider the different aspects giving rise to the problem representation of the medical model of disability that appears to be behind the disability policies analyzed. I then subject my own problem representations to the WPR analysis. Specifically, I present the policy changes I wish to enact and then work backwards to see how they represent the problem. Through analyzing my own problematization, I identify suggestions that constitute the "problem" in ways that "minimize losses and maximize gains in terms of [my] overall social vision" (Bacchi, 2009 p. 73). I also suggest possible solutions to my own problematization by drawing on the literature and my new understandings and insights from the WPR approach.

Developing my own Problematization and solution. In developing my own problematization, and therefore "solution", Bacchi's (2009) WPR approach states that there "is always room for resistance and re-problematization" (p. 139). However, by this statement, she does not mean that I argue the pros and cons of a particular problematization but question the terms of reference behind this way of viewing the problem (Bacchi, 2012). She suggests that it is not always useful to dispense with particular problem representations and that the context affects the feasibility of challenging particular problem representations (Bacchi, 2009). Lastly, she mentions that resistance and refusal are always possible, although this can sometimes bring unintended and unwanted consequences (Bacchi, 2009; Lilja & Vinthagen, 2018). For example, a person resisting the medical model as a basis for claim eligibility might not provide information from their physician in their claim documents, and consequently be denied disability benefits.

Use of resistance. It is important to note that resistance always exists and given my subject position within discourse (Rönnblom & Bacchi, 2011), I need to be cognizant of how to resist with the goal of a social justice agenda. Further, in challenging assumptions, I need to reflect on the options available to resist the discourse and the inherent power that underscores the discourse. Specifically, the form of resistance available depends on the form of power exercised, thus showing the vital role of power relations that constrain the form of resistance or challenge possible, and thereby the solutions proposed (Lilja & Vinthagen, 2018). These authors clarify that if power is repressive, such as sovereign power with laws or regulations, counter-repressive resistance can be carried out by the individual toward a direct form of power.

Through the use of the WPR approach, I am instead looking at the terms of reference behind the problematization (Bacchi, 2012) as opposed to directly challenging repressive power. Lilja and Vinthagen (2018), refer to this type of resistance as productive resistance and it occurs within dominant discourses and systems, while simultaneously resisting domination. Through productive resistance, I hope to challenge the discursive power that produces practices and identities, such as the medical model or disability. My goal, through productive resistance, is governance that focuses on social justice (Bacchi & Goodwin, 2016).

I resist the medical model of disability by harnessing the power of that discourse with a slightly different meaning (Lilja & Vinthagen, 2018). I use productive resistance to question the knowledges produced by disability policies. I invite individuals to transform themselves counter to the existing and dominant norm of lacking medical intervention to be healthy, to using engagement in work occupation as a way toward well-being.

In following the WPR approach and to challenge and resist the medical model of disability, my problematization or solution brings in an occupational perspective (Christiansen & Townsend, 2010; Wilcock & Hocking, 2015). The impetus for choosing an occupational lens comes in part from my educational and professional background as an occupational therapist, and partly from suggestions of my advisory committee to examine this policy analysis with an occupational lens. I rely on the articles about the benefits of involvement in occupation from the proposal and the data previously collected. Additionally, further articles are sought to develop my own problematization and to answer the six questions in the WPR approach when posed to my own problematization. Importantly, I note that while keeping the medical model of disability, Sweden, through their labour laws, allow for persons with variable ability to remain in the workforce, and I question whether this might be an option available in the Canadian context.

Concepts used to aid me in the development of my own problem representation.

Through using the WPR approach as outlined by Carol Bacchi (2009) and following the application of the six questions to analyze disability policy, I develop my own problem representation, and then apply the six questions to my “solution”. This reflexivity or self-analysis is necessary as I do not stand outside of discourse and am shaped through the very problem representations that I am analyzing (Bacchi, 2009; Rönnblom & Bacchi, 2011). I divide the concepts used into sub-headings for clarity.

Exploring the Benefits of Occupation. As I begin to question the provision of medical intervention as a route to health and thereby improved function, I reviewed Ann Wilcock's (2007) work. In this article, she states that people are occupational beings and that they need to engage in occupation. Townsend and Wilcock (2004) consider occupation to be health-building and it is recognized in the *Ottawa Charter for Health Promotion* (WHO, 1986) that work is one occupation that is a source of health. Further, it is recommended in the Ottawa Charter that society should organize work to create a healthy society.

Upon closer examination of occupation, I note that Wilcock's work refers to a holistic occupational perspective. In other words, she looks at occupation as all the things that people do to survive, be healthy and experience well-being, claiming that this concept of occupation is not shared by all cultures. This observation is relevant as I develop my problematization, as I am focusing specifically on the occupation of engagement in productive work in this thesis and that it is the occupation of productive work that is referenced in the disability policies analyzed. However, it becomes clear that work is only one aspect of occupations that can contribute to well-being.

Understanding that engagement in productive work is only one contributor to well-being and health that comprises occupational engagement is further highlighted in Townsend and Wilcock's (2004) cases of occupational injustice. In this publication they clarify their concerns are about participation in daily life occupations of a community and is not limited to engagement in productive work occupations. Further, the cases of occupational injustice about which they speak, occupational alienation, occupational deprivation, occupational marginalization and occupational imbalance involve more than the engagement in productive work occupations.

Based on my understandings of occupation and its contribution to well-being, I suggest that the solution to employee MH is through engagement in productive work occupation (Hocking, 2017; Townsend & Wilcock, 2004; Wilcock & Hocking, 2015). The use of engagement in occupation in this context, as a route to well-being, is an alternative approach to the use of medical treatment, that is endorsed by many (Dewa et al., 2009; Lim et al., 2008; Wong et al., 2018).

Norm-Based Definition of Disability. I note that in the Canadian society, the medical model of disability is embedded in the context of the neoliberal work environment (Bacchi & Eveline, 2010; Hocking, 2017; Raphael, 2015). As such, employee MH issues and disability are based on a norm in Canadian society. Withers, (2012) helpfully advises me that disability is context-based and socially constructed, which is brought to light when viewing disability policies in Canada. In the policies, disability is defined based on a norm implying that as the norm changes, so will the definition of disability. Put in other words, a common way to measure the norm or average in a population is the bell curve (Davis, 1995). The most common phenomenon that is measured by this curve is in the centre, while the rarest phenomena are the furthest from the highest point of the curve (Davis, 1995). However, the average or norm is based on the population that is measured. An example therefore would be that if slower workers for instance, were removed from the population, the average speed of work would increase. Disability is "created" in those who are unable to keep up with this faster pace in the Canadian neoliberal, production-oriented work environment (Davis, 1995; Mosleh, 2019; Withers, 2012).

Many authors advise that people with mental health conditions do not represent a homogeneous group (Mohammed Abouelleil Rashed, 2019; Beresford, 2020; Hocking, 2017). The difference between individuals therefore means that some are able to reach the performance levels required in the current Canadian work environment, some excel, and some function below the minimum standards required in the workplace. Consequently, those unable to reach the required performance measures will be occupationally marginalized and experience occupational injustice (Durocher, Gibson & Rappolt, 2014; Townsend & Wilcock, 2004). Through the application for disability benefits, underperformers stop working, and are thus subjected to occupational deprivation, another occupational injustice that has been deemed to have detrimental effects on well-being (Durocher, Gibson & Rappolt, 2014; Townsend & Wilcock, 2004; WHO, 1986; Wilcock, 2007).

As I develop my own problem representation of mental illness in the workplace, I am specifically electing to focus on engagement in work occupations to attain well-being and to combat mental illness in the workplace. In reviewing the cases of occupational injustice presented by Townsend and Wilcock (2004) I focus on the definition of occupational marginalization that relates to the exclusion from participation in occupations based on invisible norms or “a major force of injustice being normative standardization of expectations about how, when and where people ‘should’ participate” (Durocher, Gibson & Rappolt, 2014; Townsend & Wilcock, 2004 p. 81). The understanding of marginalization as an occupational injustice is relevant to the context in which I consider engagement in occupation in that it is the normative expectations of productivity to which the disabled employees are compared. This injustice is further underscored by the suggestion that managerial systems work to seek efficiencies through standardization and that this creates environments that are exclusionary for disabled persons (Townsend & Polatajko, 2013).

In alignment with a Western focus on efficiency and productivity, (Bacchi & Eveline, 2010) a requirement in the disability policies under analysis is that the disabled employee shows an impaired functional inability to perform productive work. Another requirement according to the policies is that this functional inability be validated by a physician who also recommends medical treatment (Government of Canada, 1992). The problem representation takes a norm-based decrease in function to mean that the medically diagnosed individual requires medical intervention to once again be able to function within the norm-based society.

Contrary to the norm-based view of the definition of disability, the context in Sweden supports variable work ability, and that everyone, regardless of ability, is able to remain in the workforce. As such, the maintenance of wellness through engagement in work occupation is something that is available in the Swedish environment through their labour laws. In developing my problematization, I therefore look toward Sweden for guidance in keeping engagement in work occupation as a part of health and wellness.

Ill-Effects Due to Lack of Occupation. An example of the ill-effects of not engaging in work occupation, which, in Western societies is a primary measure of an adult's worth (Wilcock & Hocking, 2015) may then be the lack of an income (Chenier, 2013; Durocher, Gibson & Rappolt, 2014). The availability of earned money can mean acceptance, access to education and inclusion in society, as well as prevention of social isolation, loneliness and isolation that can follow for the unemployed (Hocking, 2012). The occupationally deprived individual will also not benefit from the wellness-promoting aspects of the socially valued role as a capable, contributing member of society (Desrosiers, 2005; Townsend, 2012). Occupational deprivation also means that the individual will not participate in the regular structure of a workday that is central to the adoption of a routine, and that contributes to confidence, a sense of purpose, and to an increased belief in self (Kielhofner, 1985; Wisenthal, 2019). The suggestion that the provision of medical treatment (Dewa et al., 2011; Stuart et al., 2014; Thorpe & Chenier, 2013) as a means to achieve increased productivity and function seems to be counter-intuitive to an occupational approach.

Occupation as a Resource for Health. In developing my own problematization of employee MH issues, I consider Hocking's (2017) claim that the responsibility for achieving occupational justice is situated in policy structures and with policy makers. I also observe the work of Bacchi (2009), whose articles suggest to me that policies are productive, are developed in context and provide solutions to the problems defined in the policy. I then shift my gaze from the person with a disability in need of medical treatment to return to engaging in full-time work, to the context that seems to have created this problematization. The medical model of disability is pervasive in the Canadian disability insurance policies, and is, in turn embedded in the Western, neoliberal context of productivity and efficiency.

As opposed to the "problem" being the individual with a mental health issue and in need of individual medical treatment, my solution is to regain well-being through participation in work occupation, thereby changing the "problem" to a lack of involvement in occupation. I propose to change the way the problem is viewed by altering disability policies from those that only allow benefits to be paid to individuals who are considered totally unable to work, to policies that include a wide range of performance. This change will then enable the capture of those who can work 25%, 50%, or 75% for example, and thereby recognize the inherent need for everyone to be engaged in work occupation (Hocking, 2017; Townsend, 2012). In other words, working backwards, I look through an occupational lens and see a lack of engagement in work occupation as the problem behind employee MH issues (Wilcock & Hocking, 2015).

My proposed way of re-problematization does not directly challenge the medical view of disability (Lilja & Vinthagen, 2018), but in following the WPR approach, recognises contextual constraints of disability as a "thing" that needs to be treated medically (Bacchi, 2009, Mosleh, 2019; Government of Canada, 1992; The Standard Rules on the Equalization of Opportunities for Persons with Disabilities, 1993). My way of re-problematizing MH as a contextual issue also changes the normative view that those considered disabled are compared to the norm of full-time employment. Instead, the implied problem is that people have a diversity of abilities that can better be met through differing levels of involvement in work occupation. (Mohammed Abouelleil Rashed, 2019; Pereira & Whiteford, 2013; Whiteford & Pereira, 2012). Involvement in individually appropriate levels of work occupations becomes a part of daily living versus the end-goal objective of medical treatment (WHO, 1986).

Partly Disabled Category. If people are able to work at their level of ability, whether this be at 10%, 25%, 50% or some other level, and not risk losing their insurance benefits or employment status, persons with MH issues would be able to be contributing members of the workforce. The ability to work according to ability would be similar to the Swedish system (Government of Sweden, 2021; MacEachern, 2019), at least for those who are already in the workforce, where people can be considered partly disabled. Without requiring a complete overhaul of the Canadian political and economic systems, the category of partly disabled could be supported by a combination of insurance and employer contributions, thereby securing the financial stability for those unable to work full-time.

To implement my “solution” to provide an appropriate level of work engagement as a part of daily living, the insurer would need to support those people who are on claim when they are looking to reintegrate to the workforce. The current policies only support people for up to 24 months, after which the definition of disability changes to include only those unable to earn more than 66 and 2/3% of their regular salary (Government of Canada, 1992). The policies also do not stipulate how this money is earned, whether employed in the same job or other work. This means that once the 24-month period is up, and employees are able to earn at least 66 and 2/3% of their regular salary, their benefits stop. It does mean, however, that those employees who are not able to reach this level of earnings will continue to be supported by the disability policy.

My suggestion to change the “all or nothing” definition of disability to allow people to work at their individual level of capacity requires new approaches for the insurer. However, the proposed policy change also requires a different viewpoint on the part of the employers such as financially supporting part-time employees, allowing employees to work in accommodated positions according to their abilities, or possibly hiring more employees to make up for the short fall of work not being addressed. Employees working part-time, or in “accommodated” roles in the long term could also have other, financial impacts such as on the Canada Pension Plan (CPP) and CPP-Disability in that less income tax would be paid by employees earning less and may also impact retirement benefits both earned and contributed to during a working career.

I note that categories, such as that of disabled persons as noted in this thesis, are created by policies (Bacchi, 2009; Bacchi & Goodwin, 2016) and that this is a mechanism through which they govern. It is ironic that my own policy proposal includes the creation of another artificial category, that of partly disabled. However, it is useful to consider that what is insured by the insurer is not any individual injury, but an anticipated financial loss against which the insurer offers a guarantee of compensation (Ewald, 1991). As such, the insurer accepts a risk or liability through the creation of this category, and without this liability, the insurer does not have any responsibility to pay when a worker is unwell and not at work (Prince, 2008). Consequently, while it may be preferable, for example, for an insurer to “top up” the salary of any employee earning below a certain amount, it would be difficult within the context of the Canadian environment, and how insurance is structured, to envision how this could be managed or created. Questions that would seem to arise from a topping up of salary might be: Should every employee earn the same? Should everyone have the same income, regardless how many hours are worked? Who would be paying these altered salaries? The employer, insurer, government or a combination thereof?

Subjecting this problematization to the WPR method

Question 1: What's the problem represented to be? Using an occupational perspective regarding well-being (Christiansen & Townsend, 2010; Townsend & Polatajko, 2013; Wilcock & Hocking, 2015) my interpretation of employee MH issues represents the problem to be a lack of involvement in work occupations within the Western, neoliberal, efficiency workplace. By viewing the 'problem' in this way, the implied solution would be to use engagement in work occupation as a 'treatment modality' to resolve the issue (Wisenthal, 2018; 2019). This use of occupation as a therapeutic tool answers Wilcock's (2007) challenge in the article "Occupation and Health: Are they one and the same" where she asks whether occupation can be used as a therapeutic tool with the "medically defined illness or disability" (p. 3).

Through the placement of occupation as a therapeutic tool in the context of the Western workplace, I highlight the importance of occupation from a capability perspective of justice referred to by Townsend (2012), that she bases on the Central Human Capabilities framework presented by Nussbaum (2006). Based on the understanding that individuals have different occupational habits, needs, and wishes dependent on their individual capabilities and circumstances (Desrosiers, 2005; Durocher, Gibson & Rappolt, 2014; Hocking, 2017), my proposed change is not only involvement in work occupations, but the consideration of what is appropriate involvement based on individual abilities.

The placement of occupation within a justice framework highlights the issue of differences between individuals (Durocher, Gibson & Rappolt, 2014). Differences in what people have the capability to do versus what they receive is acknowledged in an occupationally just society (Hocking, 2017). Authors debating occupational justice argue that these differences between individuals involve power relations (Durocher, Gibson & Rappolt, 2014; Hocking, 2017; Townsend, 2012). Lastly, as the concept of justice is culturally bound (Hocking, 2017; Townsend & Wilcock, 2004) and occupations are performed within contexts that differ depending on culture (Njelesani et al., 2013; Townsend & Wilcock, 2004), my problem representation relates to engagement in work occupations in the current, neoliberal Canadian climate and could be different in other contexts and cultures.

Question 2: What presuppositions or assumptions underlie this representation of the problem? The presuppositions that underlie this representation of the problem are the conceptual logics, or foundational assumptions that are taken for granted in this way of viewing the problem (Bacchi, 2009). Approaches that focus on engagement in work occupations based on individual capabilities carry with them a Western way of thinking about occupation, the productive employee, diversity, and the value that Western neoliberal countries places on the individual (Townsend & Wilcock, 2004; Wilcock, 2007).

In addition to the above-mentioned presuppositions located in the context of Canadian society, such as the productive employee and the value of the individual, are those assumptions that I myself carry, based on my background, educationally, economically, culturally, and socially. As an occupational therapist educated in Canada, I place value on engagement in work occupation as part of healthy living. However, I am also looking at the socially accepted occupations that are available in the Canadian context, and that are considered work for which a salary or money is paid. I am therefore not paying attention to the value of volunteer work, the stay-at-home care givers, retirees, nor the sector of seasonal workers and those of the service industries which typically do not have access to disability benefits (Thorpe & Chenier, 2013).

Question 3: How has this representation of the problem come about? I believe based on my practice as an occupational therapist and RC working with clients in DM that there exists a positive link between work and well-being, and this has been echoed by evidence and knowledge in the literature (Hocking, 2012; Raphael, 2015; Stuart, 2006; Pomaki et al., 2010; Pomaki 2017; Townsend, 2012). I have also reviewed a plethora of research concluding that mental illness has negative impacts on productivity and days lost from work, or presenteeism and absenteeism (Dewa & Hoch, 2015; Evans-Lacko & Knapp, 2016). That decreased worker output results in financial loss and an increased economic burden on Canadian employers is also noted by several authors (Chenier, 2016; Dewa et al., 2009; Lim et al., 2008). With the lens of the economic impact of mental illness on employers, research has been conducted to develop best practices for return-to-work interventions (Chenier, 2013; Durand, 2016; Martin et al., 2012). Using this same economic lens, stay at work interventions have also been examined (Pomaki et al., 2010; Pomaki, 2017). However, through these approaches, the focus is on the economic impact on the workplace and the economy. The focus in these return to work and stay at work interventions do not appear to be on the wellness of the worker.

In the literature I have noted many suggestions to support employee mental health issues, such as developing workplace mental health policies and supports, insured benefit programs, prescription drugs and paramedical services (Chenier, 2016; Dewa, 2015).

Additionally, I note recommendations to utilize specialized return-to-work coordinators and disability managers (Dyck, 2015; Durand, 2017; Gardner, 2010; Shaw et al, 2008). However, the purpose of these programs is to help individuals return to full time productive work as a goal of treatment intervention, albeit with the economic impact of absenteeism and presenteeism as justification.

Some authors have made suggestions that a focus on work is important in the disability management and return-to-work process, such as engaging the employee early in the process (Chenier, 2013; Pomaki, 2017) encouraging coordination between different stakeholders (Kirsh et al., 2010; Martin et al., 2012; Pomaki et al., 2010; Pomaki, 2017) helping the employee adapt to the workplace post-injury (Shaw et al., 2008) and to address the employees' fear of re-injury (Loisel et al., 2005). Along these lines, I find recommendations for workplace-based and workplace-focused interventions that can reduce work absence duration (Pomaki et al., 2010). Specific interventions such as Cognitive Behavioural Therapy (CBT) that is work-based and work-focused have been reported to reduce the time away from work (Pomaki et al., 2010), although CBT that is work-focused, but offered outside the workplace has not been shown to be effective in decreasing work absence duration (Pomaki et al., 2010). As such, suggestions have been made that involvement in work be part of the recovery process through initiatives such as stay-at-work programs and work accommodation (Chenier, 2013, 2016; Dewa et al., 2019; Pomaki et al., 2010; Pomaki, 2017).

Recognition of the importance of work and engagement in occupation has been reported in the literature (Chenier, 2016; Pomaki, 2017; Wisenthal, 2018). However, the policies examined do not seem to reflect this knowledge base. The assumption in the policies still appears to be that treatment such as psychological counselling, prescription medication, psychiatric treatment and employee assistance programs, for example (Dewa & Hoch, 2015; Dewa et al., 2009; Pattyn et al., 2014) will assist individuals with mental health issues to recover and be able to return to work.

The practices and processes that can lead to the dominance of my problem representation of employee MH issues as a lack of engagement in individually appropriate work occupations is grounded in occupational therapy and occupational science (Wilcock, 2007). Further, as clarified by Ann Wilcock in the preface to "*An Occupational Perspective of Health*" (Wilcock & Hocking, 2015) "occupation is used to mean all the things that people need, want or have to do across the sleep-wake continuum, individually and collectively" (*xi*). Occupation is understood in the present day as work for pay.

In posing the question of whether occupation and health are one and the same, Wilcock (2007), I am challenged to consider if, or how, engagement in work occupations could be used as a therapeutic tool to address illness and disability. As early as in 1985, engagement in occupation was identified by Gary Kielhofner as being central to human behaviour (Kielhofner, 1985). Further, through the development of Occupational Science, Wilcock, (2007) and Yerxa (1993), among others, examine the power of occupation and its' contribution to health (Hocking, 2017), and as a conceptual basis for the practice of occupational therapy (Wilcock, 2007).

To further clarify the importance of involving work and occupation as a part of daily life for all, I posit that it is important to distinguish between the different approaches that keep the attainment of full-time work ability as a goal while providing therapy and intervention and having engagement in work occupations at the centre of intervention (Fisher, 2013; Nielsen et al, 2020). Occupation-focused is referred to as intervention where the immediate focus is on "evaluating and/or changing a person's quality of occupational performance" (Fisher, 2013, p. 166), while occupation-based refers to employing participation or engagement in occupation to evaluate and treat individuals. To clarify then, occupation-based is when the individual is involved in occupation as the therapeutic method for both assessment and intervention.

A relatively new documented therapeutic tool to deal with employee MH issues, Cognitive Work Hardening (CWH), uses engagement in a simulated work environment to improve occupational performance and contribute to recovery (Wisenthal, 2018, 2019). Through involvement in graded work tasks to simulate job demands, the employee with a disability will be able to return to being a fully productive individual in the workplace (Wisenthal, 2018). A simulated occupation-based program is needed, due to the requirement for individuals to return to work as fully productive individuals once symptoms have resolved.

Question 4: What is left unproblematic in this problem representation? My problematization of lack of engagement in work occupations appropriate to individual abilities as a detriment to health rests within the medical model of disability and the Canadian neoliberal ideology. As such, my problematization has been shaped by this context and a predominance of the medical model that is based on a cure. In Question 4 that examines disability policies in Sweden, it was noted that these policies are also carried out within the context of the medical model. However, in the literature reviewed, Sweden's general labour law provides persons with disabilities equal employment rights with others (Government of Sweden, 2012). In Sweden then, the medical model of disability is predominant but the potential benefits of engagement in productive work occupations is maintained through their labour laws.

The perspectives that I leave unproblematic in the representation of lack of engagement in individually appropriate productive work occupations for health are the perspectives of the Western world view. Specifically, Western perspectives place at the forefront the concern for individual meaning, sense of fulfillment, or freedom of choice and autonomy (Bacchi & Eveline, 2010; Townsend & Wilcock, 2004). In other words, my Western way of viewing the problem silences the voices of the colonized in Canada who may view the collective more important than the well-being of the individual, for example, who might not value autonomy or who views work occupations differently (Council of Canadians with Disabilities, 1998: Jongbloed, 2003; McColl et al., 2013; Stienstra, 2018). Changing disability policies to encourage engagement in individually appropriate work occupation in alignment with Mohammed Abouelleil Rashed's assertion that people have differing abilities (Mohammed Abouelleil Rashed, 2019) also does not address challenges for immigrants (Hocking, 2012; Lilja & Vinthagen, 2018) and does not consider the health of the unemployed, youth or aged who are not covered by disability policies (Chenier, 2016).

Question 5: What effects are produced by this representation of the problem? The effects produced by the representation of the problem as being lack of engagement in individually appropriate work occupation needs to be considered in the terms of the discursive, subjectification and lived effects that will result (Bacchi, 2009). To answer this question, I need to pay attention to changes that are likely to occur with this representation of the problem. I need to consider who is likely to benefit, and how those who are considered as responsible for the problem will be impacted. (Bacchi, 2009).

If disability policies were worded such that people would be free to work at a level commensurate with their abilities, it would apply to everyone, not just those with mental health issues. A lack of differentiation between physical and mental disability may decrease mental health stigma, possibly removing a barrier that has been identified as being problematic for persons with disabilities (Stuart, 2006). Increased engagement in work occupation may also lessen dependence on health care professionals, treatment or medication due to an acceptance of the diverse ability of function. The power differential between the disabled persons and treatment providers may decrease due to a decreased need of the former to seek medical treatment, thereby decreasing the number of these encounters. However, an increased acceptance of diversity in the workplace may also result in a decreased dependence on the health care system, resulting in job loss or change in the provision of services for health care professionals such as physicians, psychologists, psychiatrists or occupational therapists, to name a few. Increased access to engagement in work occupation, may also result in decreased revenue for the pharmaceutical industry, a breakdown of the power structure inherent in the current rehabilitation industry and between the health care providers and the disabled. Increased access to work occupations for all may result in consequences as yet unknown.

An issue that is likely to stay the same even with the proposed change to disability policies are the plights of situations of those not yet working, such as children and youth. The situations for seniors and retirees who are dealing with mental health issues would also not change, in addition to those who have never been employed for a plethora of other reasons, such as poverty, lack of education, immigrant status or language issues (Hocking, 2010; Raphael, 2016).

The final portion of this question refers to how the attribution of responsibility of the problem would affect those who are to be blamed. In Sweden, it is the social system that bears the responsibility for its citizens, and that is everyone, not just those who are employed (MacEachern, 2019; Silfverhielm & Kamis-Gould, 2000). In Canada, many people who work have access to disability benefits. However, the Canadian system currently does not support everyone (Thorpe & Chenier, 2013). If Canadian insurance companies would support those who were able to work part time, and employers were able to accommodate individuals indefinitely, a dividing practice would be produced. Other people with mental health issues, such as youth and seniors, the unemployed, and those in occupations where disability benefits are not offered might be disadvantaged. The distinction between those working and those not, could become smaller in terms of hours spent at work. Consequently, questions might arise as to why insurance companies would cover a portion of the population categorized as employed, versus those not working, if the hours spent at work were minimal.

The representation of the problem as lack of engagement in a work occupation being the issue behind employee MH issues, may result in blame attributed to the employers that cannot afford to support part time work. Further, insurers might also be blamed as this system would require them to revamp their systems to allow for longer disability claims, something that could be a costly endeavour.

Question 6: How and where is this representation of the problem produced, defended and disseminated? I note the production of the problem behind wellness and health as a lack of engagement in occupation has been researched in occupational therapy and occupational science since its first introduction in the 1990's (Wilcock, 2007; Yerxa, 1993). Further, in Canada, there is a recognition of the value of occupation to health and well-being (WHO, 1986; Christiansen & Townsend, 2010; Townsend & Polatajko, 2013). However, it appears that Canada continues to lag behind countries such as Sweden, Finland, France, Germany and Switzerland, referred to as having Comprehensive Social Security Systems (MacEachern, 2019), in terms of employment for the people with mental illness and disability.

Bacchi (2009) advises that problematizations and policies are context dependent. Further belief in the value of occupation and equitable distribution of assets and opportunities (Desrosiers, 2005; Hocking, 2017; Townsend, 2012; Wilcock & Hocking, 2015) is contextual. To implement any problem representation in a context other in that which it was initially developed, presents challenges (Loisel, 2015; MacEachern & Ekberg, 2019). Consequently, I must pay attention to the relevant sociopolitical conditions in Canada that shape work disability policy.

As a way forward, I propose to follow Foucault in his aim for a social justice agenda and not look to make sweeping reforms, but instead to propose a change at the level of local practice (Rönnblom & Bacchi, 2011). I propose the Canadian Federal Government policies that were analysed, and represent the executives and those employees not covered by collective agreements, start by changing the definition of disability to encompass anyone not able to work on a full-time basis. This change will then mean that individuals do not need to be completely unable to work in order to qualify for disability benefits but could qualify if they can work at a level less than full time. This suggestion then looks at involvement in work occupation as an ongoing part of well-being versus an end goal of therapy and medical intervention as highlighted by the answer in Question 3. By engaging in work occupation, individuals' mental and physical capabilities may improve (Desrosiers, 2005; Wilcock, 2007), their financial situation alleviated (Raphael, 2016) and important aspects of doing, being, belonging and becoming that contribute to people as social beings (Wilson & Hocking, 2015) may be met.

Given the contextual constraints involved in making policy changes and taking into account possible unintended consequences of my altered policy proposal (Bacchi, 2009; MacKenzie & Bacchi, 2010; Bacchi & Goodwin, 2016) it will be important to research this area further prior to any policy implementation. It is suggested by policy researchers Catherine MacKenzie and Carol Bacchi (2010) that the best way to transfer research into policy is increased collaboration between researchers and the organizational or government areas involved. Consequently, a next step might be to coordinate with the insurer in question to conduct a small pilot study to examine the feasibility of a policy change. As mentioned by Bacchi (2009), any policy proposal may reflect deep-seated cultural assumptions, and that policies give shape to problems versus address them. Further, any changes initiated must be sensitive to the complexities and ambiguities of organizational priorities and practices (MacKenzie & Bacchi, 2010).

In what has been called the policy/research divide (MacKenzie & Bacchi, 2010), it is the personal and professional networks that affect the likelihood of research influencing policy. Further, if researchers know where decisions are made, they are then able to access decision points. As such, it would be imperative for researchers to have a close and intimate knowledge of the area of insurance involved, as well as of the importance of engagement in occupation to mental health.

Chapter 6: Conclusion

The final chapter of my thesis discusses the implications of the findings of this study in terms of their meaning, importance, and relevance to the practice of RC’s in disability management in Canada as it relates to employee mental health issues and disability. The question that is examined in this research is “How are the disability management (DM) activities of rehab consultants (RC’s) working for private insurance companies shaped by the disability policies sold by insurers to employers to support their employees in Canada?”

I use Carol Bacchi’s post structural approach entitled *What’s The Problem Represented to Be?* with a view toward social justice. I discuss my findings that the disability policies analyzed are based on a medical model of disability nested in context of a normative category of what it means to be able-bodied. I posit that these views guide and constrain the work of RC’s in their work in DM. I consider these findings in relationship to the literature and how my research adds to the research and recommendations of other investigators in the field.

As part of the WPR approach, I explore a work-relevant occupation-based approach to mental health as my own proposed solution to address employee MH issues, and examine implications of this for disability policies, the development of future policies, and the practice of DM by RC’s. Suggestions for future policy development, implications of such and future research directions are made. Study limitations and strengths are reviewed, and final reflections on my research journey concludes the chapter.

Key Research Findings

The major findings of my research are that the medical model of disability, within a norm-based definition of ability, underlies the disability policies analyzed. Specifically, in order to qualify for disability benefits, the employee with MH issues must demonstrate a functional inability to perform the duties of his or her work occupation, that this be supported by documentation by a physician, and that medical treatment must be provided to help the employee return to return to the norm-based productive workplace.

As supported by Bacchi (2009), it is a medical discourse, nested within the norm of the ableist, neoliberal Canadian workplace that limits what can be thought by RC's as they work in DM. Additionally, the disability policies constrain the resources and interventions that can be provided to employees with mental health issues.

My findings align with the literature about DM in the Canadian context, where interventions to help or assist disabled employees are based on or the medical model (Mosleh, 2019; Prince, 2008; Withers, 2012). Further, given that the disability policies examined espouse a norm-based medical model of disability, the approaches of DM are restricted to those that can be envisioned and enacted within this paradigm. Finally, my results show that the discourse of the medical model leaves assumptions about disability as a medical issue unquestioned and consequently the resultant "solutions" offered through RC's in DM.

Implications of the normative, medical model of disability on DM interventions

In line with the research of Mosleh (2019) and Prince (2008), my findings show that disability policies are based on a medical model of disability situated within a normative view of the able-bodied employee. It is within this discourse that current efforts are developed to address employee mental health issues. Given that there is no escaping discourse, and nothing that exists is outside of discourse, any interventions or efforts to address employee mental health issues are limited by the medical model of disability (Bacchi & Goodwin, 2012). In line with this thinking, I refer back to the literature review to show how the medical model limits the way employee mental health issues can be addressed within the current DM context.

Implications of Viewing Mental Illness in the Workplace as a Treatment Problem. As demonstrated in the literature review, efforts are made to find effective ways to address productivity losses due to mental health issues in the workplace (Dewa et al., 2009; Dewa et al., 2011; Dewa & Hoch, 2015; Evans Lacko-Knapp, 2016; Wong et al., 2018). Further, it is suggested that facilitating access to treatment is recommended to address these productivity losses due to employee absenteeism and presenteeism (Dewa et al., 2009; The Conference Board Inc., 2012). To remedy apparent limitations in seeking treatment, recommendations are made to increase benefit supports to enable employees with mental health issues to access treatment (Chenier, 2016; Sutherland & Stonebridge, 2015, 2016). Additionally, RC's are seen as agents of the insurance companies who are able to facilitate access to this funding (OECD, 2010; Coduti et al., 2016).

My research demonstrates that the disability policies individualize employee mental health through the normative medical model by creating a category of disabled individuals through comparison to an able-bodied norm. Further, the medical model on which these policies is based, limits available interventions to those involving medical treatment for functional limitations that are validated by medical practitioners. As a result of this way of thinking, medical treatment is posited as a solution to identified medical problems.

If, as recommended by researchers in the literature review such as Chenier (2016) and Dewa et al., (2009), funding is increased to access treatment to “cure” employees with mental health issues, other issues that are invisible from my review and analysis may be instrumental in perpetuating the issue of employee mental illness. These include assumptions about the full-time employee such as, the neoliberal productive work environment or the role of the disability policies in creating the category of disability to begin with would be ignored or overlooked. Other issues that may also be overlooked include exploring alternate options for people with MH issues who are already in the workforce, such as part-time work arrangements or examining the variety of occupations available to them. Consequently, the solution of increased treatment provision would be ineffective and the “problem” of employee mental illness would remain.

Implications of Viewing Mental Illness in the Workplace as an Employer Problem. As demonstrated in my review of published literature, employee mental illness costs employers due to absenteeism, reduced productivity and negative impacts on coworkers in terms of increased workloads (Lim et al., 2008). Consequently, initiatives have been taken to create psychologically healthy workplaces with the belief that workplaces can have a direct impact on employee mental health (Coduti et al., 2016; Pomaki et al., 2011; Dimoff & Kelloway, 2013). Additionally, recommendations are made to involve all stakeholders in the process of work integration and mental health issues in the workplace (Kirsh et al., 2010; Pomaki et al., 2011).

Given that my research demonstrates that disability policies are based on the ableist normative medical model, a category of disabled employees is artificially created (Mohammed Abouelleil Rashed, 2019; Mosleh, 2019). The creation of a mentally healthy workplace overlooks the spectrum of abilities in a population (Mohamed Abouelleil Rashed, 2019), takes for granted that employees with mental health issues are in need of support to function as the norm (Beresford, 2020), and that disability policies continue to create a category of disabled employees who need special treatment (Mosleh, 2019).

While it may be beneficial to have a healthy workplace, the issue of employee mental health problems and disability will not be addressed as it is a function of the policy. The policy, though its wording, creates a category of disabled employees. By looking at the problem of employee mental health issues through the lens of healthy workplaces ignores the individualization of the medical model by the disability policies and that employees with mental health issues are still seen as being in need of support to function as the other, able-bodied employees. By identifying employee mental health issues as a problem that can be solved through healthy workplaces, other issues are taken for granted and ignored and thereby perpetuated and nothing would change.

Implications of Viewing Mental Illness in the Workplace as an RC issue. According to the literature reviewed, RC's are able to provide services and specialized mental health case management programs with a goal of improving function, access to treatment and to assist in work integration (OECD, 2010; Pomaki et al., 2010). As such, recommendations are made to utilize these services with a goal of addressing employee mental health and disability in the workplace. Given that there is not much information in the published literature on how these RC's work, it was the purpose of this research to explore the policy context in which these professionals function.

Based on my findings I reveal that the disability policies with which the RC's work, guide their actions and limit what they are able to do. The medical model of disability that is the base upon which the analyzed disability policies lie, individualizes employee mental health issues and creates the category of employees who are considered disabled. Further, the medical model of disability therefore guides the interventions that can be implemented to assist employees and limits or prevents others. Options such as exploring alternate work occupations, engagement in part-time work or job-sharing arrangements are not available to RC's in the current policy context. In summary, any solutions developed within the medical model of disability may instead perpetuate the status quo.

Implications of a Changed Disability Policy on DM practice in MH

As demonstrated by my research findings, the discourse of the medical model of disability limits the development of solutions to employee mental health issues, such as treatment, healthy workplaces or RC interventions. Further, the interventions supported by the disability policies analyzed are based on taken-for-granted assumptions that limit what can be thought or alternative options beyond the intent of the policy. If this way of viewing employee mental health and disability is not changed, I contend that mental health issues in Canada will continue to grow, unchecked. Treatment interventions will continue to be developed, medically based interventions and those explicitly supporting treatment remove efforts to continue to produce healthy workplaces, and the rehabilitation industry will continue to support employees deemed disabled by the disability policies. The hierarchy within the medical system will continue and the power differentials between the disabled and those employed to provide assistance will continue. In other words, nothing will change.

Through the WPR approach to policy analysis, I have been able to question the assumptions of the full-time productive employee, and the medical tools available to the RC working in DM. Based on my findings, I consider the possibility of engagement in work occupation as a tool to be used in DM. This aligns with the recommendations of Antao et al., (2013) and Wong (2005) among others, who advocate for the provision of flexible benefits to enable participation in work occupation. Through the WPR approach, by subjecting my solution to the 6 Questions I also consider the values embedded in my own proposal, which aligns with MacEachern (2019) where she recommends that to approach work disability prevention (WDP) requires a consideration of the values that are embedded in the policies and that guides how they are implemented.

Implications of the Assumption of the Normative, Neoliberal, Production-Oriented Canadian Workplace for Enacting Disability Policy. The goal of DM is to provide assistance or treatment for employees with MH issues to return to the norm of the productive full-time employee in the workplace (Baynton & Fourner, 2017; Coduti et al., 2016; Dewa et al, 2016). The norm-based assumption of the productive employee found in my review of the policies and in my experience serves to steer DM in a certain pre-determined direction, which is toward full-time employment. The end goal of a full-time, productive employee restricts the actions of RC's working in DM to those individuals who can be expected, with medical treatment, to be able to return to work on a full-time basis. The role of the RC is to reach this result as cost-effectively as possible and limit intervention to that which has the greatest financial reward (Henderson et al., 1988). Those individuals who are not able to reach full-time work are thereby excluded from intervention as it is the role of the RC to contain costs and to spend money in a cost-effective manner (Henderson et al., 1988), and only those who have the ability to return to work on a full- time basis are measured as successful outcomes of rehab intervention.

This finding has implications for the way RC's can address employee mental health issues. The individuals referred for DM intervention are limited to those with potential for full-time work, creating a dividing practice, resulting in social injustice (Bacchi, 2009). My findings are in accordance with Antao et al., (2013), and demonstrate that the issues for those with mental health issues are similar to those experienced by individuals with chronic pain and episodic illnesses who experience challenges with income and employment when they cannot attain full time work. Through the definition of full-time work in the disability policies, and the necessary goal of reaching this level upon completion of RC involvement, intervention is limited to cost-effective tools that will assist perhaps those with less severe mental health issues only. Consequently, my findings support the recommendations of Antao et al. (2013) as well as those of the episodic disability network (Wong, 2005), for flexible benefits to facilitate work participation for those who are unable to work on a full-time basis.

Implications of the Medical Model for Enacting Disability Policy. My findings of the medical model of disability as the basis for the creation of the category of claimants able to receive income benefits, the eligibility criteria of full-time work and the requirement to submit to medical treatment to recover demonstrate that the DM activities of the RC's are produced in and limited by the medical model in the disability policies.

That the medical model of disability limits what can be done in DM by RC’s is consistent with the knowledge of other researchers such as Stienstra (2018), who notes that the medical model has been in existence for well over 100 yrs. and was brought over to Canada by the colonizers. Further, other researchers in work disability prevention concur that the medical model is entrenched in Canadian society and has continued to influence and guide rehabilitation interventions and DM, since the early 1980’s (Gursansky, Harvey & Kennedy, 2003; Henderson et al., 1988; Baynton & Fournier, 2017).

As a result of the medical model’s prevalence in DM interventions, my findings show that the rehabilitative tools offered in the Canadian environment do not question the medical model, nor their ability to resolve the issues faced by those with MH issues. However, by that same token when the medical model is taken for granted, it becomes part of the solutions provided and perpetuated. A consequence of this is that other approaches or solutions, that are not part of the discourse of the medical model, are not examined or considered. A result of the limitation posed by the medical model on DM in the Canadian context prevents the development of other approaches that may have the potential for impacting change. This finding is consistent with Bacchi’s (2009) assertion that with this way of understanding the problem, little will change.

Positing an Occupation-Based Approach in the Provision of Flexible Income Supports as a Therapeutic Tool. Using the WPR approach to Questions 1-6 helped to reveal how the medical model of disability guides and limits the options and tools available to the RC working in DM in Canada. Further, my analysis of the disability policies show that the medical model of disability is nested in the context of the Canadian neoliberal, production-oriented workplace that requires full time working ability.

In Question 7 of the WPR approach I develop my own solution or proposal to DM carried out by RC's. By changing the definition of disability to include any level of engagement in work, means that individuals can qualify for benefits without needing to satisfy the all-or-nothing approach of a total inability to perform full time work. A part-time disability definition changes eligibility criteria and allows people to work part-time and still be financially supported. The opportunity to receive income support and health benefits when working at less than 100% capacity has been recommended by many (Antao et al., 2013; MacEachern, 2019; Wong, 2005), and thus my proposed solution based on my findings is in accordance with the literature. However, based on my review of disability policies, it is not something that has been implemented within the private disability policies to date.

In light of the limitations on the work of RC's in DM by the policy constraints of the medical model, I recommend an occupation-based approach to address employee mental health issues. I discuss the implications of this approach, as well as provide the evidence in support of this proposal and argue the benefits of how this could inform a change in disability policy and opportunities for employee MH.

An occupation-based approach focuses on engagement in occupation as an important aspect of health (Nielsen et al., 2020; Wilcock & Hocking, 2015). Further, occupation is used in this approach as a primary therapeutic agent (Fisher, 2013). Consequently, occupation-based methods are used when a person's engagement in occupation is the basis for evaluation and intervention and the therapeutic agent of change. (Fisher, 2013).

An occupation-based approach to health draws upon the literature and evidence from occupational therapy and occupational science (Fisher, 2013; Nielsen, 2020; Wilcock, 2007; Wilcock & Hocking, 2015; Yerxa, 1993). Evidence supports the therapeutic use of occupation and that it leads to improved health outcomes (Stuart, 2006; Wilcock, 2007; Wilcock & Hocking, 2015). Conceptually occupation as central to health is the base upon which the field of occupational therapy and the discipline of occupational science lay (Hocking, 2012; 2017; Townsend, 2012; Townsend & Wilcock, 2004; Wilcock, 2007; Yerxa, 1993). Further, there is evidence to support that engagement in occupation is central to health and well-being (Wilcock, 2007; Wilcock & Hocking, 2015). In the Canadian disability insurance policies analyzed, interventions that can be offered for those with MH issues have to date been limited by the medical model. The underlying assumptions of the interventions offered have led to the exclusion of other approaches that may benefit outcomes in employee MH, and the use of the productive worker as only full time is shaped by society and the disability policy.

As documented in the literature, individuals with episodic illnesses, chronic pain and mood disorders, to name a few, may experience difficulties to be 100% productive at work (Wong, 2005). Further, it is suggested they experience difficulties participating in the workforce due to disincentives inherent in public and private insurance programs and policies. Based on my findings, employees experiencing mental health issues can be seen to share these challenges. My findings are aligned with Antao et al, (2013) and Wong (2005) who recommend reform in disability income support programs to meet the needs of these individuals.

Through flexible income supports for those individuals not able to be 100% productive in the workplace, persons with limitations could work on a part time basis and continue to be supported financially. As noted in my findings, this approach has not been implemented to date. However, based on my research, framing the provision of flexible income support to enable participation in work occupation as a therapeutic intervention that may lead to increased health is a novel approach that could be explored further.

Occupation-Based Interventions. As my thinking has evolved through the collection of data and its analysis, I have noted the absence of the therapeutic use of work occupation in the interventions offered in the research literature about the Canadian context. Based on my findings, it appears that this omission has been created by the disability policies analyzed that restrict interventions to those aligned with the medical model. In keeping with the methods of Foucault (Burchell, Graham & Miller, 1991) and the WPR approach to policy analysis, I have looked further into the literature to examine if occupation-based approaches or involvement in work occupation is used in other contexts in Canada.

To situate my findings in the arena of the therapeutic use of occupation, I have looked to the literature and see that the involvement in occupation exists in Canada in a few different programs, such as the Northern Initiative for Social Action (NISA) (Rebeiro Gruhl, Boucher & Lacarte, 2021); to assist university students in transition (Keptner, 2017), or to promote independence in Activities of Daily Living (Morgan & DiZazzo-Miller, 2018). However, none of these use occupation in relation to work for pay, which is the focus of my research.

In parallel with my research, I am examining Cognitive Work Hardening and the therapeutic use of occupation in the current Canadian landscape. The article "*Fostering Change Through Occupation-Based Intervention: An International Joint Group Concept Mapping Study*" (Wærens et al., 2022) was shared with me by my colleague doing this research. According to this article, the goal was to establish evidence for occupation-based occupational therapy. Specifically, the authors looked at the considerations required to use occupation as an agent of change. Despite this research not involving involvement in work occupations, I felt that this article was relevant to review as it appeared to address the core element of my findings; of using an occupation-based approach to workplace mental health.

The countries represented in the article were; Australia, Austria, Belgium, Canada, Denmark, Finland, Japan, Netherlands, Scotland, Sweden, Switzerland and the United States resulting in a mostly Western perspective, making the findings applicable to the Canadian context being studied. However, the participants in this study were 83% occupational therapists and 100% PhD level occupational science researchers, thus situating findings in academia. Academic research plays a role in knowledge production (Bacchi, 2016), and thus it is important to consider how the model developed by these researchers might influence the practice of occupation-based interventions for use in supporting persons with mental illness conditions in resuming or participating in productive work occupations.

The model developed for occupation-based intervention by the researchers in the Wærens et al., (2022) study was divided into 7 clusters; Artful use of occupation, Evidence-based use of occupation, Collaboration to promote occupation, Co-ordinating intervention to fit, Client factors, Sociocultural contexts and Structural influences. These clusters were then placed within 3 dynamics of Client Factors, Socio-Cultural Context and Structural Influences, where all clusters were considered important to occupation-based interventions. However, the authors were surprised to find that statements gathered during the collection of their data did not rate structural influences of the process important. Instead, it was seen that elements of the therapeutic relationship such as Artful use of occupation and Collaboration were important or very important. The authors postulated that their findings could be attributed to their roles as researchers and not involved in clinical work, and thus may have over-estimated the importance of the therapeutic relationship.

One idea put forth in the background information gathering of the Group Concept Mapping (GCM) approach used in the article by Wærens et al., (2022) was the question if engagement (in occupation) is possible within the given context. As noted in my research, the option for RC's to use occupation as a therapeutic tool within the current Canadian context is not available, rendering any aspect of the therapeutic intervention seemingly irrelevant or secondary. Consequently, it appears that structural influences are more significant than is apparent in this article. However, given that the research involved participants from several different countries, it is not known where the comment about whether engagement in occupation came from, and if it was taken for granted in some countries and not in others.

Implications of a Work-Relevant, Occupation-Based Intervention. In my findings in answering Question 7 I noted that there is an intervention available in the Canadian context that does use engagement in occupation as a tool toward WPMH, which is Cognitive Work Hardening (Wisenthal, 2018; 2019). However, this tool is limited, in that the end goal of intervention is a full-time productive employee. While accommodations, restrictions and limitations may be recommended that would better enable the individual with mental health issues to integrate to the workplace (Chenier, 2013; 2016; Pomaki et al., 2010; Pomaki, 2017; Wisenthal, 2019), the accommodations are time-limited to the 'rehabilitation programs' available under the disability insurance policy (Government of Canada, 1992).

Based on my findings in the disability policies examined, I note that the limitations imposed is that that successful recovery is defined by the goal of full-time work, and that involvement in work-relevant occupation-based approaches is not available to employees with MH disability. This constitutes an injustice and is exclusionary, and limits how the RC works in DM. However, as noted by Bacchi (2009) as well as Loisel (2019), policies must be adapted to the context in which they exist. As such, to make changes that promote social justice, I need to consider the context of the disability policy and put the assumptions underpinning the policy in question. This stance is in keeping with findings by MacEachern (2019) who recommends that I consider the values imbedded in the policies, as well as the existing sociopolitical conditions.

The occupational approach to health appears to exist in Sweden, where they report having the highest employment rate in the OECD (Government of Sweden, 2012). However, while Sweden appears to be implementing an occupational approach to MH issues, my investigation about the about the Swedish system seem to focus on accessible medical treatment, the same as in Canada (Wallace, 2020). This is understandable, given that they focus their disability policy on the *Standards Rules on the Equalization of*

Opportunities for Persons with Disabilities and the *UN Convention of the Rights of Persons with Disabilities*, both UN documents taking the needs of persons with disability for granted (Government of Sweden, 2021). However, as demonstrated through my findings, any intervention undertaken is context-dependent (Bacchi & Goodwin, 2016; Loisel, 2019; MacEachern, 2019), and as such, the occupation-based approach used in Sweden may not have the same outcome in the Canadian context, despite both countries placing importance on medical treatment.

To explore the feasibility of engagement in work-relevant occupation-based approaches it might be advisable to promote studies of these types of interventions where a partial capability to work is promoted and available, such as in Sweden. A positive aspect of promoting research in that country is that they, similar to Canada, also espouse the medical model of disability, demonstrating that it is not necessary to eliminate the medical model of disability to promote social justice. However, it is important to consider the context in which the disability policies exist and through what conditions they restrict possibilities for engagement in work-occupations as a therapeutic means to health. In summary, engaging in occupation as part of a recovery process and a journey to health is in line with foundations of occupational therapy and occupational science (Fisher, 2013; Nielsen et al., 2020; Townsend, 2012; Yerxa, 1993). Based on my findings, work-relevant occupation-based interventions to achieve health are currently excluded in the current Canadian context of private disability insurance, that espouses the medical model of disability. However, with a view to social justice, furthering research to determine the success of such programs in other contexts may be a starting point on the road to a more inclusive and socially just society.

Limitations

The current study was limited in its scope of being based within a Western world view, and on Canada specifically, that has been shown to be production-oriented and individualistic (Bacchi & Eveline, 2010). As such, the findings reflect practice limitations of the RC in the Canadian environment only.

Another limitation of this study is that, while the research found that mental illness is growing globally (Dewa & Lin, 2000), the current research result is only applicable to the full-time employed individuals who have access to disability policies. Consequently, the youth, seniors, retirees, the unemployed and the seasonally employed are not represented by this research and any mental health issues they are experiencing would not be impacted by any possible positive implications of recommended practices.

The current study focused on two disability policies only. In particular, the findings are only in relationship to individuals who have access to disability policies through their jobs. The disability policies analyzed are only applicable to executives in the Canadian Government, as well as those not covered by the collective agreement. As such, the disability policies analyzed may not be reflective of other policies, other insurers or in other countries. However, the context of the Canadian neoliberal productivity-oriented workplace, and the prominence of the medical model of disability were the only two taken-for-granted assumptions that have been questioned in this research in relationship to only two disability policies with implications on DM. There may be other assumptions that could also play a role in understanding aspects of disability policies that could inform changes toward social justice for those who can live and work with a mental health condition.

Recommendations

It is beyond the scope of this study to delve deeper into the effectiveness of the approach of using engagement in occupation as a gateway to mental health in the workplace. Additionally, it is also not known whether changing the definition of disability in disability policies would be feasible in the current environment, or if the practice of RC's would be impacted by such a change. However, two areas that would benefit from further investigation would be to examine how engagement in occupation is impacting the mental health of employees in Sweden, as this is a country where this approach seems to be practiced, while keeping a medical model of disability and treatment intervention. Another area that might benefit from further exploration is to research occupation-based therapy, mental health and change, as a continuation of Wilcock's (2007) invitation to consider engagement in occupation as a therapeutic intervention.

Based on the importance of engagement in occupation to health, and the lack of options to use occupation as a tool toward employee MH issues in the RC's DM activities, I believe it will be important to further investigate potential benefits of work-relevant occupation-based interventions. Further, this research would build on the conceptual model of occupation as a means to foster change developed by Wærens, (2022). Specifically, a further exploration of the structural elements and context surrounding occupation-based interventions requires further scrutiny. As demonstrated by this research, using engagement in work occupation as a rehabilitative tool and a path to health is not available in certain contexts.

Final Reflections and Conclusions

The WPR approach to policy analysis in this study was used to identify how disability policies impact DM activities of RC's. The findings from data collected shows that the medical model of disability is the basis on which the tools of RC's are made available, and that DM is further constrained by the neoliberal, production-oriented, full-time Canadian workplace. I began this study with the belief that RC's were doing their best to help individuals with whom they worked within the constraints of the disability policies crafted by the insurers. Through the process of questioning these policies, both in terms of the assumptions behind the medical model, and the normative assumptions of the productive, Western, neoliberal workplace, I have seen that the RC's, as well as other health care professionals have been, unknowingly, instrumental in producing the knowledge in the disability policies. I have also noted that the norm of the productive employee has been socially produced and contingent, just like that of the disabled employee. Finally, I have noted that, within the current Canadian context, an occupation-based intervention that uses participation in work, at a level that is commensurate with individual ability, is not possible except on a short-term basis.

My strong belief in the importance of occupation and work to MH is borne out of my background as an occupational therapist working in DM with a large disability insurer. Seeing that the discourse of the current Canadian context does not allow for the use of engagement in work occupation according with individual abilities inspires me to seek avenues to increase the possibility of using occupation-based intervention in DM as practiced by RC's working for private insurance companies.

I believe it is important for me to conclude with a statement of my personal beliefs regarding the concept of disability. As stated by Kielhofner in 2005, the language used to describe individuals who have impairments is significant, and in following his recommendations, I have elected to use the term disabled persons to refer to this group of individuals. However, I also note the important contributions of Withers, (2012) who reports to be classified as disabled for the sake of receiving disability benefits. According to this author, disability is a construct, and is created based on the context.

Despite my conscious attempt to refer to individuals with impairments as disabled persons, as per Kielhofner (2005) mentioned above, I have in other places throughout this thesis, referred to mental illness, those with a mental illness, and to workplace mental health as well as to rehabilitation. Through the use of this wording, as well as that of disabled persons, I am not meaning to give space to any discourse that serves to define these terms or to create them as real. I follow along the statements of Mohammed Abouelleil Rashed (2019) in that ability falls along a spectrum, and that it is the context that defines disability (Withers, 2012). As such, disability is not a real, objective thing, as if the context were changed to reflect an understanding of ability as being on a scale of variability, the very concept of disability would not exist.

Going forward, I can see pathways that I might embark on to further this important work in three ways; 1) Become involved in the research community to explore how the use of occupation in Sweden is impacting employee MH in that environment and to explore the feasibility of bringing a similar approach to the Canadian context; 2) Further the research by Wærens et al., (2022) to explore the structural context of occupational based interventions, and additionally to differentiate between those occupation-based interventions that relate to employee MH, and those occupation-based interventions that have another goal not related to the work environment to see if there is a difference between them; and 3) Begin an exploratory study with insurance companies to determine the feasibility of an altered definition of disability and how this impacts the use of occupation-based interventions to impact employees with MH issues.

Bibliography

Abberley, P. (1987). The Concept of Oppression and the Development of a Social Theory of Disability. *Disability, Handicap & Society*, 5-19.

Abberley, P. (1999, April 15). The Significance of Work for the Citizenship of Disabled People. *Paper presented at University College Dublin*. Dublin.

Adams, J., Hillier-Brown, F. C., Moore, H. J., Lake, A. A., Araujo-Soares, V., White, M., & Summerbell, C. (2016). Searching and synthesizing 'grey literature' and 'grey information' in public health: critical reflections on three case studies. *Systematic Reviews*, 1-11.

Ainsworth, S., & Hardy, C. (2004). Critical discourse analysis and identity: why bother? *Critical Discourse Studies*, 225-259.

Alexander, T. (2012, July). *Mental Health: A Friend, a Home, a Job.* Retrieved from ontario.cmha.ca: https://ontario.cmha.ca/wp-content/files/2012/07/olm_stigma_matters_200902.pdf

Antao, L., Shaw, L., Ollson, K., Reen, K., To, F., Bossers, A., & Cooper, L. (2013). Chronic pain in episodic illness and its influence on work occupations: A scoping review. *Work*, 11-36.

Austin, C. D. (1996). Aging and Long Term Care. In *Perspectives on Case Management Practice* (p. 83). Milwaukee: Families International Inc.

Bacchi, C. (2000). Policy as Discourse: What does it mean? Where does it get us? *Discourse: Studies in the Cultural Politics of Education*, 44-57.

Bacchi, C. (2009). *Analysing Policy: What's the problem represented to be?* Pearson.

Bacchi, C. (2012). Why Study Problematizations? Making Politics Visible. *Open Journal of Political Science*, 1-8.

Bacchi, C. (2016). Problematizations in Health Policy: Questioning How "Problems" Are Constituted in Policies. *SAGE Open*, 1-16.

Bacchi, C., & Eveline, J. (2010). Mainstreaming politics: Gendering practices and feminist theory. Adelaide, South Australia, Australia.

Bacchi, C., & Goodwin, S. (2016). *Poststructural Policy Analysis: A Guide to Practice.* New York: Springer Nature.

Bakker, A. B., & Demerouti, E. (2007). The Job Demands-Resources model: state of the art. *Journal of Managerial Psychology*, 309-328.

Baun, K. (2009). Stigma Matters: The Media's Impact on PUblic Perceptions of Mental Illness. *Ottawa Life*, 31-33.

Baynton, M., & Fournier, L. (2017). *The Evolution of workplace mental health in Canada: Toward a standard for psychological health and safety.* The Great-West Life Assurance Company: Friesens.

Beasley, C., & Bacchi, C. (2007). Envisaging a new politics for an ethical future: Beyond trust, care and generosity - towards and ethic of 'social flesh'. *Feminist Theory*, 279-298.

Belzile, L. (2008). Good for all students: a Foucauldian interrogation of teachers' discourse of inclusion. Edmonton, Alberta, Canada: Library and Archives Canada.

Beresford, P. (2020). 'Mad', Mad Studies and Advancing Inclusive Resistance. *Disability and Society*, 1337-1342.

Beresford, P., & Russo, J. (2016). Supporting the Sustainability of Mad Studies and Preventing its Co-Option. *Disability & Society*, 270-274.

Bletsas, A. (2012). Spaces between: Elaborating the theoretical underpinnings of the "WPR" approach and its significance for contemporary scholarship. In A. Bletsas, & C. Beasley, *Engaging with Carol Bacchi: Strategis Interventions and Exchanges* (pp. 37-52). Adelaide: University of Adelaide Press.

Burchell, G., Gordon, C., & Miller, P. (1991). *The Foucault Effect.* Chicago: The University of Chicago Press.

Burr, V. (2015). Social Constructionism. In *International Encyclopedia of the Social & Behavioural Sciences 2nd Edition* (pp. 222-227). Elsevier Ltd.

Canadian Life and Health Insuance Association. (2020, August 22). *G3*. Retrieved from www.clhia.ca: https://www.clhia.ca/web/CLHIA_LP4W_LND_Webstation.nsf/page/13CD6FF39333FBBE8525784F0058BAC4/$file/Guideline%20G3.pdf

Canadian Life and Health Insurance. (2020, August 22). *Canadian Life and Health Insurance Facts, 2019 Edition*. Retrieved from www.clhia.ca: http://clhia.uberflip.com/i/1162310-canadian-life-and-health-insurance-facts-2019/1?

Canadian Life and Health Insurance Association. (2020, August 22). *Guidelines*. Retrieved from www.clhia.ca: https://www.clhia.ca/web/CLHIA_LP4W_LND_Webstation.nsf/page/D99B8079BC50934685258226006FE573!OpenDocument

Canadian Life and Health Insurance Association Inc. (2020, August 22). *Glossary of Insurance Terms*. Retrieved from www.clhia.ca: https://www.clhia.ca/web/CLHIA_LP4W_LND_Webstation.nsf/page/FF801CA8A20C46568525780E00665851?OpenDocument

Canadian Standards Association (CSA Group) & Bureau de normalization du Quebec (BNQ). (2013). *Psychological health and safety in the workplace: Prevention, promotion and guidance to staged implementation.* Mental Health Commission of Canada.

Caveen, M., Dewa, C. S., & Goering, P. (2006). The Influence of Organizational Factors on Return-to-Work Outcomes. *Canadian Journal of Community Mental Health*, 121-142.

Centers for Disease Control and prevention. (2015). *Definition of Policy.* Retrieved from https://www.cdc.gov/policy/analysis/process/definition.html

Chang, H. (2008). *Autoethnography as Method.* Croydon: CPI Group (UK) Ltd.

Cheek, J. (2004). At the Margins? Discourse Analysis and Qualitative Research. *Qualitative Health Research*, 1140-1150.

Cheek, J. (2008). The Practice and Politics of Funded Qualitative Research. In N. K. Denzin, & Y. S. Lincoln, *Strategies of Qualitative Inquiry, 3rd Edition.* Thousand Oaks: Sage Publications.

Chenier, L. (2013, October). Creating an Effective Workplace Disability Management Program. Ottawa, Ontario, Canada: The Conference Board of Canada.

Chenier, L. (2016). Healthy Brains at Work: Employer-Sponsored Mental Health Benefits and Programs. Ottawa: The Conference Board of Canada.

Christiansen, C. H., & Townsend, E. A. (2010). *Introduction to Occupation.* Upper Saddle River: Pearson Education Inc.

Coduti, W. A., Anderson, C., Lui, K., Rosenthal, D. A., Hursh, N., & Ra, Y.-A. (2016). Psychologically healthy workplaces, disability management and employee mental health. *Journal of Vocational Rehabilitation*, 327-336.

Coles Notes. (2012). *Statistics.* Mississauga: John Wiley & Sons Canada Ltd.

Convention on the Rights of Persons with Disabilities. (2006, December 13). Retrieved from https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities

Council of Canadians with Disabilities. (1998). *In Unison: A Canadian Approach to Disability Issues.* Retrieved from ccdonline.ca: http://www.ccdonline.ca/en/socialpolicy/poverty-citizenship/income-security-reform/in-unison

Davis, L. J. (1995). *Enforcing Normalcy: Disability, Deafness and the Body.* New York: Verso.

Denzin, N. K., & Lincoln, Y. S. (2008). *Collecting and Interpreting Qualitative Materials.* Los Angeles: Sage Publications Inc.

DePoy, E., & Gitlin, L. N. (2016). *Introduction to Resarch 5th Edition.* St. Louis: Elsevier.

Desroiers, J. (2005). Participation and occupation. *Canadian Journal of Occupational Therapy*, 195-203.

Dewa, C. S., & Hoch, J. S. (2015). Barriers to Mental Health Service Use Among Workers With Depression and Work Productivity. *Journal of Occupational and Environmental Medicine*, 726-731.

Dewa, C. S., & Lin, E. (2000). Chronic physical illness, psychiatric disorder and disability in the workplace. *Social Science and Medicine*, 41-50.

Dewa, C. S., & McDaid, D. (2011). Investing in the Mental Health of the Labor Force: Epidemiological and Economic Impact of Mental Health Disabilities in the Workplace. In I. S. Rogers, *Work Accommodations and Retention in Mental Health* (pp. 33-51). Toronto: Springer Science+Business Media.

Dewa, C. S., Chau, N., & Dermer, S. (2009). Factors Associated With Short-Term Disability Episodes. *Journal of Occupational and Environmental Medicine*, 1394-1401.

Dewa, C. S., Hoch, J. S., Carmen, G., Guscott, R., & Anderson, C. (2009). Cost, effectiveness, and Cost-Effectiveness of a Collaborative Mental Health Care Program for People Receiving Short-term Disability Benefits for Psychiatric Disorders. *The Canadian Journal of Psychiatry*, 379-388.

Dewa, C. S., Hoch, J. S., Nieuwenhuijsen, K., Parikh, S. V., & Sluiter, J. K. (2019). Toward Effective Work Accommodations for Depression: Examining the Relationship Between Different Combinations of Depression Symptoms and Work Productivity Losses. *Journal of Occupational and Environmental Medicine*, 75-80.

Dewa, C. S., Loong, D., & Bonato, S. (2014). Work outcomes of sickness absence related to mental disorders: a systematic literature review. *BMJ Open*, 1-15.

Dewa, C. S., Thompson, A. H., & Jacobs, P. (2011). The Association of Treatment of Depressive Episodes and Work Productivity. *The Canadian Journal of Psychiatry*, 743-750.

Dewa, C. S., Trojanowski, L., Joosen, M. C., & Bonato, S. (2016). Employer Best Practice Guidelines for the Return to Work of Workers with Mental Disorder-Related Disability Leave: A Systematic Review. *The Canadian Journal of Psychiatry*, 176-185.

Dimoff, J. K., & Kelloway, E. K. (2013). Bridging the Gap: Mental Health Research in Canada. *Canadian Psychology/Psychologie canadienne*, 203-212.

DiZazzo-Miller, R. (2018). The Occupation-Based Intervention of Bathing: Cases in Home Health Care. *Occupational Therapy in Health Care*, 306-318.

Dobson, Keith S; Szeto, Andrew; Knaak, Stephanie; Krupa, Terry; Kirsh, Bonnie; Luong, Dorothy; McLean, Robyn; Pietrus, Micheal;. (2018, October). Mental health initiatives in the workplace: models, methods and results from the Mental Health Commission of Canada. *World Psychiatry*.

Durand, M.-J., Nastasia, I., Coutu, M.-F., & Bernier, M. (2017). Practices of Return-to-Work Coordinators Working in Large Organizations. *Journal of Occupational Rehabilitation*, 137-147.

Durocher, E., Gibson, B. E., & Rappolt, S. (2014). Occupational Justice: A Conceptual Review. *Journal of Occupational Science*, 417- 430.

Dyck, D. E. (2015). Disability Management Education. *Workplace Health and Safety*, 65-69.

Ellis, C., Adams, T. E., & Bochner, A. P. (2010). Authoethnography: An Overview. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Resarch* , 1-17.

Evans-Lacko, S., & Knapp, M. (2016). Global patterns of workplace productivity for people with depression: absenteeism and presenteeism costs across eight diverse countries. *Social Psychiatry and Psychiatric Epidemiology*, 1525-1537.

Ewald, F. (1991). Insurance and Risk. In G. Burchell, C. Gordon, & P. Miller, *The Foucault Effect: Studies in Governmentality* (pp. 197-210). Chicago: The University of Chicago Press.

Fairclough, N. (2013). Critical discourse analysis and critical policy studies. *Critical Policy Studies*, 177-197.

Fisher, A. G. (2013). Occupation-centred, occupation-based, occupation-focused: Same, same or different? *Scandinavian Journal of Occupational Therapy*, 162-173.

Fulcher, G. (1989). *Disabling Policies? A comparative approach to education policy and disability.* New York: Farmer Press.

Furrie, A. (2018, November 28). *The evolution of disability in Canada: keeping in step with a more inclusive Canada.* Retrieved from Statistics Canada: https://publications.gc.ca/site/eng/9.863801.tml

Gadamer, H.-G. (2004). *Truth and Method.* New York: Continuum Publishing Group.

Gardner, B. T., Pransky, G., Shaw, W. S., Hong, Q., & Loisel, P. (2010). Researcher perspectives on competencies of return-to-work coordinators. *Disability and Rehabilitation*, 72-78.

Gencturk, S. (2018). Analysis of Presupposition Triggers in English Reading Textbooks: Learner's Familiarity. *International Journal of Science and Education*, 1-10.

Godin, K., Stapleton, J., Kirkpatrick, S. I., Hanning, R. M., & Leatherdale, S. T. (2015). Applying systematic review search methods to the grey literature: a case study examining guidelines for school-based breakfast programs in Canada. *Systematic reviews*, 1-10.

Golden, T. P., Zeitzer, I., & Bruyere, S. M. (2014). New Approaches to Disability in Social Policy: The Case of the United States. In T. Dereli, *Labor and Employment Relations in a Globalized World* (pp. 73-114). Switzerland: Springer International Publishing.

Goodwin, S. (2012). Women, Policy and Politica: Recasting policy studies. In A. Bletsas, & C. Beasley, *Engaging with Carol Bacchi: Strategic Interventions and Exchanges* (pp. 25-36). New York: University of Adelaide Press.

Government of Canada. (1992, October 1). *Long-Term Disability Insurance - Chapter 3-4.* Retrieved from Government of Canada: https://www.tbs-sct.gc.ca/pol/doc-eng.aspx?id+13848

Government of Canada. (2015, July 23). *Public Service Management Insurance Plan executive plan booklet.* Retrieved from Government of Canada: https://www.canada.ca/en/treasury-board-secretariat/services/benefit-plans/managment-insurance-plan/public-service-management-insurance-plan-executive-plan-booklet.html

Government of Canada. (2016, February 10). *The Public Service Management Insurance Plan - Main Plan Booklet.* Retrieved from Government of Canada: https://www.canada.ca/entreasury-board-secretariat/services/benefit-plans/management-insurance-plan/main-plan-booklet.html

Government of Canada. (2018, January 2). *Long-Term Disability Summary*. Retrieved from Canada.ca: https://www.canada.ca/en/treasury-board-secretariat/services/benefit-plans/management-insurance-plan/public/service-management-insurance-plan-long-term-disability-glance.html

Government of Canada. (2021, March 1). *Public Service Management Insurance Plan*. Retrieved from Canada.ca: https://www.canada.ca/en/treasury-board-secretariat/topics/benefit-plans/plans/management-insurance-plan.html

Government of Sweden. (2012, December 31). *Building an inclusive labour market*. Retrieved from zeroproject.org: https://zeroproject.org/view/project/ab212816-eb11-a813-000d3ab9b226

Government of Sweden. (2021, June). *Disability Policy*. Retrieved from sweden.se: https://sweden.se/life/equality/disability-policy

Government of.Canada. (1992, October 1). *Long-Term Disability Insurance - Chapter 3-4*. Retrieved from Canada.ca: https://www.tbs-sct.gc.ca/pol/doc-eng.aspx?id=13848

Graham, L. J. (2006). Caught in the net: a Foucauldian interrogation of the incidental effects of limited notions of inclusion. *International Journal of Inclusive Education*, 3-25.

Grue, J. (2011). Discourse Analysis and Disability: Some Topics and Issues. *Discourse & Society*, 532-546.

Gursansky, D., Harvey, J., & Kennedy, R. (2003). *Case Management: Policy, Practice and Professional Business.* New York: Columbia University Press.

Hammersley, M. (2007). The issue of quality in qualitative research. *International Journal of Research & Method in Educattion*, 287-305.

Henderson, M. G., Souder, B. A., Bergman, A., & Collard, A. F. (1988). Private Sector Initiatives in Case Management. *Health Care Financing Review*, 89-95.

Hertz, R. (1996, March 1). Introduction: Ethics, reflexivity and voice. *Qualitative Sociology*, pp. 3-9.

Hocking, C. (2012). Working for Citizenship: The Dangers of Occupational Deprivation. *Work*, 391-395.

Hocking, C. (2017). Occupational justice as social justice: The moral claim for inclusion. *Journal of Occupational Science*, 28-42.

Hullegie, P., & Koning, P. (2018). How disability insurance reforms change the consequences of health shocks on income and employment. *Journal of Health Economics*, 134-146.

Jongbloed, L. (2003). Disability Policy in Canada. *Journal of Disability studies*, 203-209.

Karttunen, L. (1973). Presuppositions of Compound Sentences. *Linguistic Inquiry*, 169-193.

Keptner, K. M. (2017). Long-Term Follow-Up of an Occupation-Based Group Addressing Occupational Performance and Satisfaction in University Freshmen. *Occupational Therapy in Mental Health*, 308-325.

Kersbergen, A. L. (1996). Case Management: A Rich History of Coordinating Care to Control Costs. *Nursing Outlook*, 169-172.

Khaleel, L. M. (2010). An Analysis of Presupposition Triggers in English Journalistic Texts. *Journal of College Education For Women*, 523-551.

Kielhofner, G. (1985). *A Model of Human Occupation: Theory and Application.* Baltimore: Williams & Wilkins.

Kielhofner, G. (2005). Rethinking Disability and What To Do About It: Disability Studies and Its Implications for Occupational Therapy. *Americann Journal of Occupational Therapy*, 487-496.

King, A. (2004). *Code of Practice for Disability Management, 2nd Ed.* Victoria: National Institute of Disability Management and Research.

Kirsh, B., Krupa, T., Cockburn, L., & Gewurtz, R. (2010). A Canadian model of work integration for persons with mental illness. *Disability and Rehabilitation*, 1833-1846.

Krefting, L. (1991). Rigor in Qualitative Research: The Assessment of Trustworthiness. *The American Journal of Occupational Therapy*, 214-222.

Laliberte Rudman, D. (2013). Critical Discourse Analysis: Adding a Political Dimension to Inquiry. In M. Cutchin, & V. Dickie, *Transactional Perspectives on Occupation* (pp. 169-181). Springer Science + Business.

Laliberte Rudman, D., & Molke, D. (2009). Forever productive: The discursive shaping of later life workers in contemporary Canadian newspapers. *Work*, 377-389.

Lilja, M., & Vinthagen, S. (2018). Dispersed Resistance. *Journal of Political Power*, 211-229.

Lim, K.-L., Jacobs, P., Ohinmaa, A., Schopflocher, D., & Dewa, D. (2008). A new population-based measure of the economic burden of mental illness in Canada. *Chronic Diseases in Canada*, 92-98.

Lincoln, Y. S., & Guba, E. G. (1982). Establishing Dependability and Confirmability in Naturalistic Inquiry Through an Audit. New York, New York, United States.

Lippel, K. (2008). Workers' Compensation and Controversial Illness. In P. Moss, & K. Teghtsoonian, *Contesting Illness.* Toronto: University of Toronto Press.

Lippel, K. (2019). Strengths and Weaknesses of Regulatory Systems Designed to Prevent Work Disability After Injury or Illness: An Overview of Mechanisms in a Selection of Canadian Compensation Systems. In E. MacEachern, *The Science and Politics of Work Disabiility Prevention* (pp. 50-71). New York: Routledge.

Loisel, P. (2019). Reflections on the Sherbrooke Model and the Way Forward for Work Disability Prevention. In E. MacEachern, *The Science and Politics of Work Disability Prevention* (pp. 18-28). New York: Routledge.

Loisel, P., Buchbinder, R., Hazard, R., Keller, R., Scheel, I., van Tulder, M., & Webster, B. (2005). Prevention of Work Disability Due to Musculoskeletal Disorders: The Challenge of Implementing Evidence. *Journal of Occupational Rehabilitation*, 507-524.

MacEachern, E. (2019). *The Science and Politics of Work Disability Prevention.* New York: Routledge. Taylor and Francis Group.

MacEachern, E., & Ekberg, K. (2019). Science, Politics, and Values in Work Disability Policy. In E. MacEachern, *The Science and Politics of Work Disability Prevention* (pp. 261-283). New York: Routledge.

Mackenzie, C., & Bacchi, C. (2010). University-Public Sector Research Collaboration. In C. Bacchi, & J. Eveline, *Mainstreaming Politics: Gendering Practices and Feminist Theory* (pp. 263-282). South Australia: University of Adelaide Press.

Marston, G. (2004). *Social policy and discourse analysis: Policy change in public housing.* Hampshire: Ashgate Publishing.

Martin, D., Miller, A. P., Quesnel-Vallee, A., Caron, N., Vissandjee, B., & Marchildon , G. P. (2018). Canada's Universal Health-Care System: Achieving its potential. *The Lancet*, 1718-1735.

Mays, N., & Pope, C. (2000). Assessing Quality in Qualitative Research. *British Medical Journal*, 50-52.

McColl, M., Jaiswai, A., Jones, S., Roberts, L., & Murphy, C. (2017). *A Review of Disability Policy In Canada.* Kingston: Canadian Disability Policy Alliance.

McWade, B., Milton, D., & Beresford, P. (2015). Mad Studies and Neurodiversity: A Dialogue. *Disability and Society*, 305-309.

Mohammed Abouelleil Rashed. (2019). In Defense of Madness: The Problem of Disability. *The Journal of Medicine and Philosophy*, 150-174.

Mol, A. (1999, May 1). Ontological Politics: A Word and Some Questions. *The Sociological REview*, pp. 74-89.

Morgan, R., & Dizazzo-Miller, R. (2018). The Occupation-Based Intervention of Bathing: Cases in Home Health Care. *Occupational Therapy in Health Care*, 306-318.

Mosleh, D. (2019, Nov 14). *Critical Disability Studies with Rehabilitation: Rethinking the human in rehabilitation research and practice.* Retrieved from Journalists for Human Rights (JHR): https://www.jhrehab.org/2019/11/14/making-thmakinge-case-for-critical-disability-studies-with-rehabilitation-sciences/

Moss, P., & Teghtsoonian, K. (2008). *Contesting Illness.* Toronto: University of Toronto Press Inc.

Neto, J. (2018). Michel Foucault and Qualitative Research in Huma and Social Sciences. *Qualitative Social Research*.

NIDMAR. (2004). *Code of Practice for Disability Management.* Ottawa.

Nielsen, K. T., la Cour, K., Reffstrup Christensen, J., Sampedro Pilegaard, M., von Bülow, C., Brandt, Å., . . . Ejlersen Wærens, E. (2020). Lessons learned about occupation-focused and occupation-based interventions: A synthesis using group concept mapping methodology. *Scandinavian Journal of Occupational Therapy*, 481-492.

Njelesani, J., Gibson, B. E., Nixon, S., Cameron, D., & Polatajko, H. J. (2013). Towards a Critical Occupational Approach to Research. *International Journal of Qualitative Methods*, 207-219.

Nussbaum, M. C. (2006). *Frontiers of Justice: Disability, Nationality, Species Membership.* Harvard University Press.

OECD. (2010, July 30). *Sickness, Disability and Work: Breaking the Barriers. Canada: Opportunities for Collaboration*. Retrieved from OESC.org: https://www.oecd.org/canada/sickness-disability-and-work-breaking-the-barriers-9789264090422-en.htm

OECD. (2015). *Fit Mind Fit Job: From Evidence to Practice in Mental Health and Work.* Paris: OECD Publishing.

Ortclipp, M. (2008). Keeping and Using Reflective Journals in the Qualitative Research Process. *The Qualitative Report*, 695-705.

Pattyn, E., Verhaeghe, M., Sercu, C., & Bracke, P. (2014). Public Stigma and Self-Stigma: Differential Association With Attitudes Toward Formal and Informal Help Seeking. *Psychiatric Services*, 232-238.

Pereira, R. B. (2014). Using Critical Policy Analysis in Occupational Science Research: Exploring Bacchi's Methodology. *Journal of Occupational Science*, 388-402.

Pereira, R. B., & Whiteford, G. E. (2013). Understanding Social Inclusion as an International Discourse: Implications for Enabling Participation. *British Journal of Occupational Therapy*, 112-115.

Phelan, S. K. (2011). Constructions of Disability: A Call for Critical Reflexivity in Occupational Therapy. *Canadian Journal of Occupational Therapy*, 164-172.

Phelan, S. K., Wright, V., & Gibson, B. E. (2014). Representations of disability and normality in rehabilitation technology promotional materials. *Disability and Rehabilitation*, 2072-2079.

Phillips, D. C. (1995). The Good, the Bad, and the Ugly: The Many Faces of Constructivism . *Educational Researcher*, 5-12.

Pomaki, G. (2017). Return-to-Work Strategies for Employees With Mental Health Conditions. *Benefits Quarterly*, pp. 50-55.

Pomaki, G., Franche, R.-L., Khushrushahi, N., Murray, E., Lampinen, T., & Mah, P. (2010). *Best Practices for Return-to-Work/Stay-at-Work Interventions for Workers with Mental Health Conditions.* Vancouver: Occupational Health and Safety Agency for Healthcare in BC.

Pomaki, G., Franche, R.-L., Murray, E., Khushrushahi, N., & Lampinen, T. M. (2011). Workplace-Based Work Disability Prevention Interventions for Workers with Common Mental Health Conditions: A Review of the Literature. *Journal of Occupational Rehabilitation*, 182-195.

Posen, D. (2013). *Is Work Killing You?* Toronto: House of Anansi Press Inc.

Prince, M. J. (2008). *Contesting Illness.* Toronto: University of Toronto Press.

Psychosocial Rehabilitation/Readaptation Psychosociale (PSR/RPS) Canada. (2017, March). *Competencies of Practice for Canadian Recovery-Oriented Psychosocial Rehabilitation Practitioners*. Retrieved from psrrpscanada.com: https://static1.squarespace.com/static/5925c8ff17bffca44277c23e/t/5cc73fb115fcc0936ba5fc27/1556561843130/Competencies+of+Practice+Second+Edition+2017+%28ed%29.pdf

Rönnblom, M. (2012). Post-structural comparative politics: Acknowledging the political effects of research. In A. Bletsas, & C. Beasley, *Engaging wiith Carol Bacchi.* Adelaide: University of Adelaide Press.

Rönnblom, M., & Bacchi, C. (2011). Feminist Discursive Institutionalism - What's Discursive About it? Limitations of conventional political studies paradigms. *2nd European Conference on Politics and Gender*, (pp. 1-19). Budapest.

Rachinsky, J. W. (1996). Disability Management Key to Today's LTD Ins. *National Underwriter*, 14.

Raphael, D. (2016). *Social Determinants of Health.* Toronto: Canadian Scholars' Press Inc.

Rebeiro Gruhl, K. L., Boucher, M., & Lacarte, S. (2021). Evaluation of an occupation-based, mental-health program: Meeting being, belonging and becoming needs. *Australian Occupational Therapy Journal*, 78-89.

Robertson, J., & Larson, G. (2016). *Disability and Social Change: A Progressive Canadian Approach.* Halifax: Fernwood Publishing.

Samra, J. (2017). *The Evolution of Workplace Mental Health in Canada: Research Report 2007-2017.*

Science and Business. (2020, April 16). *Strengthening prevention and treatment in mental health: Sweden Leads the way*. Retrieved from SceinceBusiness: https://sciencebusiness.net/report/strengthening-prevention-and-treatment-mental-health-sweden-leads-the-way

Shaw, W., Hong, Q.-n., Pransky, G., & Loisel, P. (2008). A Literature Review Describing the Role of Return-to-Work Coordinators in Trial Programs and Interventions Designed to Prevent Workplace Disability. *Journal of Occupational Rehabilitation*, 2-25.

Silfverhielm, H., & Kamis-Gould, E. (2000). The Swedish Mental Health System: Past, Present, and Future. *Science Direct*, 293-307.

Smetanin, P., Stiff, D., Briante , C., Adair, C., Ahmad, S., & Khan, M. (2011). *The life and economic impact of major mental illnesses in Canada 2011-2041.* Ottawa: RiskAnalytica on behalf of the Mental Health Commission of Canada.

Smith, B. A. (1999). Ethical and Methodologic Benefits of Using a REflexive Journal in Hermeneutic-Phenomenologic Research. *Jounral of Nursing Scholarship*, 359-363.

Smythe, E. A., Ironside, P. M., Sims, S. L., Swenson, M. M., & Spence, D. G. (2008). Doing Heideggian hermeneutic research: A discussion paper. *International Journal of Nursing Studies*, 1389-1397.

Spence, D. G. (2017). Supervsing for Robust Hermeneutic Phenomenology: Reflexive Engagement Within Horizons of Understanding. *Qualitative Health Research*, 836-842.

Stewart, N. (2013, September). Missing in Action: Absenteeism Trends in Canadian Organizations. Ottawa: The Conference Board of Canada.

Stienstra, D. (2018). Canadian Disability Policies in a World of Inequalities. *Societies*, 1-13.

Stuart, H. (2006). Mental illness and employment discrimination. *Current Opinion in Psychiatry*, 522-526.

Stuart, H., Chen, S.-P., Christie, R., Dobson, K., Kirsh, B., Knaak, S., . . . Whitley, R. (2014). Opening Minds in Canada: Targeting Change. *Canadian Journal of Psychiatry*, S13-S18.

Stuart, H., Chen, S.-P., Christie, R., Dobson, K., Kirsh, B., Knaak, S., . . . Whitley, R. (2014S8-S12). Opening Minds in Canada: Background and Rationale. *Canadian Journal of Psychiatry*.

Sutherland, G., & Stonebridge, C. (2015). The Footprint of Mental Health Conditions: Healthy Brains at Work. Ottawa: The Conference Board of Canada.

Sutherland, G., & Stonebridge, C. (2016). Healthy Brains at Work: Estimating the Impact of Workplace Mental Health Benefits and Programs. Ottawa: The Conference Board of Canada.

The Conference Board Inc. (2012, July). *Mental Health Issues in the Labour Force: Reducing the Economic Impact on Canada.* Retrieved from Conference Board Research: www.e-library.ca

The Standard Rules on the Equalization of Opportunities for Persons with Disabilities. (1993, December 20). Retrieved from http://www.un.org/esa/socdev/enable/dissre00htm

Thorpe, K., & Chenier, L. (2013). Disability Management: Opportunities for Employer Action. The Conference Board of Canada.

Tompa, E. (2019, October 17). *New Canadian standard proposed for work disability prevention management systems*. Retrieved from Centre for Research on Work Disability Policy: www.crwdp.ca/en/node/695

Tossebro, J. (2016). Scandinavian disability policy: From Deinstitutionalization to non-discrimination and beyond. *Science Direct*, 111-123.

Townsend, E. (1998). *Good Intentions Overruled.* Toronto: University of Toronto Press Incorporated.

Townsend, E. A. (2012). Boundaries and Bridges to Adult Mental Health: Critical Occupational and Capabilites Perspectives of Justice. *Journal of Occupational Science*, 8-24.

Townsend, E. A., & Polatajko, H. J. (2013). *Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Well-being & Justice through Occupation.* Ottawa: CAOT Publications ACE.

Townsend, E., & Wilcock, A. A. (2004). Occupational justice and client-centred practice: A dialogue in progress. *Canadian Journal of Occupational Therapy*, 75-87.

Treasury Board Secretariat. (2015, July 23). *Canada.ca*. Retrieved from Public Service Management Insurance Plan executive plan booklet: https://www.canada.ca/en/treasury-board-secretariat/services/benefit-plans/management-insurance-plan/public-service/-management-insurance-plan-executive-plan-booklet.html

Treasury Board Secretariat. (2016, February 1). *The Public Service Management Insurance Plan - Main Plan Booklet*. Retrieved from Canada.ca: https://www.canada.ca.ca/en/treasury-board-secretariat/ervices/benefit-plans.management-insurance-plan/main-plan-booklet.html

VRA Canada. (2020, July 15). Retrieved from VRA Canada: vracanada.com

Wallace, N. (2020). *How to Strengthen Prevention and Treatment in Mental Health.* Retrieved from sciencebusiness.net: https://sciencebusiness.net/system/files/reports/SB%20Report%20HM%20Stockholm%20Mental%20Health%202020.pdf

Wærens, E. E., Nielsen, K. T., & Cutchin, M. (2022). Fostering Change Through Occupation-Based Intervention: An International Joint Group Concept Mapping Study. *OTJR: Occupation, Participation and Health*, 10-21.

Westerout, E. (2001). Disability Risk, Disability Benefits, and Equilibrium Unemployment. *International Tax and Public Finance*, 219-243.

Whalley-Hammell, K. (2002). Informing Client-Centred Practice through Qualitative Inquiry. *Britizh Journal of Occupational Therapy*, 175-184.

Whiteford, G. (2000). Occupational Deprivation: Global Challenge in the New Millennium. *British Journal of Occupational Therapy*, 200-210.

Whiteford, G. E., & Pereira, R. B. (2012). Occupation, inclusion and participation. In G. Whitedford, & C. Hocking, *Occupational Science: Society, Inclusion, Participation* (pp. 187-207). Blackwell Publishing Ltd.

Whiteford, G., & Townsend, E. (2011). Participatory Occupational Justice Framework (POJF, 2010): Enabling occupational participation and inclusion. In F. Kronenberg, N. Pollard, & D. Sakellariou, *Occupational therapies without borders - Volume 2: Towards an ecology of occupation-based practices* (pp. 65-84). London, UK: Elsevier.

Wikipedia. (2020, August 22). *Fortune Global 500*. Retrieved from https://en.wikipedia.org/wiki/Fortune_Global_500#Breakdown_by_country_2

Wikipedia. (2021). *Sweden and the United Nations*. Retrieved from Wikipedia: The Free Encyclopedia: https://en.wikipedia.org/wiki/Sweden_and_the_United_Nations

Wikipedia. (2021, July). *United Nations.* Retrieved from wikipedia: https://en.wikipedia.org/wiki/United_Nations

Wikipedia. (2021). *Universal Declaration of Human Rights*. Retrieved from Wikipedia: The Free Encyclopedia: https://en.wikipedia.org/wiki/Universal_Declaration_of_Human_Rights

Wilcock, A. A. (2007). Occupation and Health: Are They One and the Same? *Journal of Occupational Science*, 2-8.

Wilcock, A. A., & Hocking, C. (2015). *An Occupational Perspective of Health.* Thorofare: Slack incorporated.

Williams-Witt, K., Bültmann, U., Amick 3rd , B., Munir, F., Tveito, T. H., Anema, J. R., & Hopkinton Cnference Working Group on Workplace Dis. (2016). Workplace Interventions to Prevent Disability from Both the Scientific and Practice Perspectives: A Comparison of Scientific Literature, Grey Literature and Stakeholder Observations. *Journal of Occupational Rehabilitation*, 417-433.

Wisenthal, A., Krupa, T., Kirsh, B. H., & Lysaght, R. (2018). Cognitive work hardening for return to work following depression: An intervention study. *Canadian Journal of Occupational Therapy*, 21-32.

Wisenthal, A., Krupa, T., Kirsh, B., & Lysaght, R. (2019). Insights into Cognitive Work Hardening for Return-to-Work Following Depression: Qualitative Findings from an Intervention Study. *Work*, 599-613.

Withers, A. J. (2012). *Disability Politics & Theory.* Halifax: Fernwood Publishing.

Wong, E. C., Collins, R. L., Breslau, J., Burnam, M. A., Cefalu, M., & Roth, E. A. (2018). Differential Association of Stigma with Perceived Need and Mental Health Service Use. *The Journal of Nervous and Mental Disease*, 461-468.

Wong, S. (2005, May 4). Canadians living with episodic disabilities call for reform to benefit programs. *Statement of Common Agenda on Disability, Full Participation & Work*. Ottawa.

World Health Organization. (1986). Ottawa Charter for Health Promotion. Ottawa: World Health Organization.

Yamaguchi, S., Niekawa, N., Maida, K., Chiba, R., Umeda, M., Uddin, S., . . . Junichiro, I. (2015). Association Between Stigmatization and Experiences of Evidence-Based Practice. by Psychiatric Rehabilitation Staff in Japan: A Cross-Sectional Survey. *Journal of Mental Health*, 78-82.

Yerxa, E. J. (1993). Occupational Science: A New Source of Power For Participants in Occupational Therapy. *Occupational Science: Australia*, 3-9.

Young, A. E., Viikari-Juntura, E., Boot, C. R., Chan, C., Ruiz de Porras, D. G., Linton, S. J., & The Hopkinton Conference Working Group on Workplac. (2016). Workplace Outcomes in Work-Disability Prevention Research: A Review with Recommendations for Future Research. *Journal of Occupational Rehabilitation*, 434-447.

Young, A. E., Wasiak, R., Roessler, R. T., McPherson, K. M., Anema, J. R., & van Poppel, M. N. (2005). Return-to-Work Outcomes Following Work Disability: Stakeholder Motivations, Interests and Concerns. *Journal of Occupational Rehabilitation*, 543-556.

Zubair, A. (2015). Effects of Stigma on Therpeutic Relationships. *Australian Nursing and Midwifery*, 34-35.

Appendix A

Table of documents to review to answer questions of WPR (Bacchi, 2009)

Question	Goal	Process to answer	Documents associated with policy, techniques or mechanisms developed to implement
1. What is the 'problem' (e.g of problem gamblers, drug use/abuse, domestic violence, global warming, health inequalities, terrorism, etc.) represented to be in a specific policy?	To identify implied problem representations in specific policies or policy proposals.	See what the policy proposes and 'read off' the implied 'problem' from this proposal	PSMIP Main plan booklet https://www.canada.ca/en/treasury-board-secretariat/services/benefit-plans/management-insurance-plan/main-plan-booklet.html PSMIP executive plan booklet https://www.canada.ca/en/treasury-board-secretariat/services/benefit-plans/management-insurance-plan/public-service-management-insurance-plan-executive-plan-booklet.html Long-Term Disability Insurance – Chapter 3-4 https://www.tbs-sct.canada.ca/pol/doc-eng.aspx?id=13848
2. What presuppositions or assumptions underlie this representation of the 'problem'?	To identify and analyse the conceptual logics that underpin specific problem representations. The term conceptual logic refers to the meanings that must be in place for a particular problem representation to cohere or make sense.	This question involves a form of Foucauldian archaeology, identifying conceptual logics and political rationalities in specific policies. Identify key concepts, binaries, and categories. Think beyond national and/or cultural boundaries to address this question.	1) Disability Policy in Canada, Jongbloed, 2003 http://video.med.ubc.ca/videos/osot/faculty/lj/Disability_Policy_in_Canada.pdf 2) A Review of Disability Policy in Canada Mc Coll et al., Dec, 2017 http://www.disabilitypolicyalliance.ca/wp-content/uploads/2018/01/A-Review-of-Disability-Policy-in-Canada-3rd-edition-Final-1-1.pdf 3) Canadian Disability Policies in a World of Inequalities, Deborah Stienstra, 2018 file:///Users/ciselathoren/Downloads/Canadian_Disability_Policies_i.pdf

Question	Goal	Process to answer	Documents associated with policy, techniques or mechanisms developed to implement
			4) The Evolution of Workplace Mental Health in Canada, (Dr. Joti Samra, 2017) https://assets.website-files.com/5f1ef6c66ef3f7ef7ec798ac/5f288a4095f3b14aa299a25f_EvolutionofWorkplaceMentalHealthSummaryReport_EN.pdf 5) Disability Management: Opportunities for Employer Action, (Thorpe & Chenier, 2013) https://www.sunlife.ca/static/canada/Sponsor/About%20Group%20Benefits/Group%20benefits%20products%20and%20services/The%20Conversation/Disability/DisabilityManagement_SUNLIFE_EN.pdf
3. How has this representation of the ‘problem’ come about?	To highlight the conditions that allow a particular problem representation to take shape and assume dominance.	This question involves a form of Foucauldian geneaology, focusing on the practices and processes that led to the dominance of this problem representation (or of these problem representations).	1) and 2) Contesting Illness: Process and Practices; Teghtsoonian, KA & Moss, P (Eds.) Ch 2 “Claiming a Disability Benefit as Contesting Social Citizenship” M. Prince (2008); Ch 4 “Managing Workplace Depression: Contesting the Contours of Emerging Policy in the Workplace” K. Teghtsoonian (2008) https://web-b-ebscohost-com.ezproxy.library.dal.ca/ehost/ebookviewer/ebook/ZTAwMHhuYV9fNDY4ODAyX19BTg2?nobk=y&sid=ea5547b1-6ce2-4983-88a9-14e4e9d5b5d9@sessionmgr102&vid=3&format=EB&rid=1 3) The evolution of disability in Canada: Keeping in step with a more inclusive Canada (Adele Furrie, 2018) https://www150.statcan.gc.ca/n1/pub/89-654-x/89-654-x2018003-eng.htm 4) In Unison: A Canadian Approach to Disability Issues

Question	Goal	Process to answer	Documents associated with policy, techniques or mechanisms developed to implement
			http://www.ccdonline.ca/en/socialpolicy/poverty-citizenship/income-security-reform/in-unison 5) Canada’s universal health-care system: achieving its potential (Martin 2018) file:///Users/ciselathoren/Downloads/Canada's_universal_health-care.pdf
4. What is left unproblematic in this problem representation? Where are the silences? Can the ‘problem’ be thought about differently?	To raise for reflection and consideration issues and perspectives silenced in identified problem representations.	Cross-cultural comparisons and comparisons of problem representations over time (see question 3) will be useful here, alongside the discourse analysis conducted in question 2)	1) OECD Wikipedia https://en.wikipedia.org/wiki/OECD 2) UN Wikipedia https://en.wikipedia.org/wiki/United_Nations 3) Sweden and the United Nations, Wikipedia https://en.wikipedia.org/wiki/Sweden_and_the_United_Nations 4) Universal Declaration of Human Rights https://en.wikipedia.org/wiki/Universal_Declaration_of_Human_Rights 5) Sweden’s disability policy – web site https://sweden.se/society/swedens-disability-policy/ 6) UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities, Dec, 1993 https://www.un.org/esa/socdev/enable/dissre00.htm 7) UN Convention on the Rights of Persons with Disabilities

Question	Goal	Process to answer	Documents associated with policy, techniques or mechanisms developed to implement
			https://www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx 8) Scandinavian Disability Policy: From deinstituationalization to non-discrimintation and beyond (Jan Tossebro, 2016) https://www.sciencedirect.com/science/article/pii/S1875067216300049 9) Sweden: Building an inclusive labour market – Zero project https://zeroproject.org/policy/sweden/ 10) The Swedish Mental Health System: Past, Present, and Future (Silfverhielm, Kamis-Gould, 2000) https://www-sciencedirect-com.ezproxy.library.dal.ca/science/article/pii/S016025270000039X 11) Strengthening prevention and treatment in Mental Health; Article in Science/Business https://sciencebusiness.net/report/strengthening-prevention-and-treatment-mental-health-sweden-leads-way 12) How to strengthen prevention and treatment in mental health; report summarizing debates at Science/Business roundtable in Stockholm, Sweden, Feb, 2020 https://sciencebusiness.net/system/files/reports/SB%20Report%20HM%20Stockholm%20Mental%20Health%202020.pdf 13) The Science and Politics of Work Disability Prevention, (MacEachern, 2019)
5. What effects are produced by this representation of the problem?	To identify the effects of specific problem representations so that	Consider three kinds of effects: discursive effects; subjectification effects; lived effects.	1) Opening Minds in Canada: Background and rationale (Stuart, H et al., 2014)

Question	Goal	Process to answer	Documents associated with policy, techniques or mechanisms developed to implement
	they can be critically assessed.	Include effects due to dividing practices. The following sub-questions will assist here: What is likely to change with this representation of the 'problem'? What is likely to stay the same? Who is likely to benefit from this representation of the 'problem'? Who is likely to be harmed? How does this attribution of responsibility for the 'problem' affect those so targeted and the perceptions of the rest of the community about who is to 'blame'?	https://journals-sagepub-com.ezproxy.library.dal.ca/doi/pdf/10.1177/070674371405901S04 2) Opening Minds in Canada: Targeting Change (Stuart, et al., 2014) https://journals-sagepub-com.ezproxy.library.dal.ca/doi/pdf/10.1177/070674371405901S05 3) Mental Illness and Employment Discrimination (Stuart, 2006) file:///Users/ciselathoren/Downloads/Mental%20illness%20and%20employment%20discrimination.pdf 4) Public Stigma and Self-Stigma: Differential Association with Attitudes Toward Formal and Informal Help-Seeking (Pattyn et al., 2014) https://ps-psychiatryonline-org.ezproxy.library.dal.ca/doi/pdf/10.1176/appi.ps.201200561 5) Differential Association of Stigma with Perceived Need and Mental Health Service Use (Wong et al., 2018) file:///Users/ciselathoren/Downloads/Differential%20Association%20of%20Stigma%20with%20Perceived%20Need%20and%20Mental%20Health%20Service%20Use.pdf
6. How/where is this representation of the 'problem' produced, disseminated and defended? How could it be questioned, disrupted and replaced?	To pay attention both to the means through which some problem representations become dominant, and to the possibility of challenging problem representations that are judged to be harmful.	Consider past and current challenges to this representation of the 'problem'. Consider the discursive resources available for re-problematisation.	1) mental health: a friend, a home, a job Dr. Taylor Alexander, (Ottawa Life, Feb, 2009) 2) Stigma Matters: The Media's Impact on Public Perceptions of Mental Illness and again will give good insight to the impact of the media on public perceptions of mental illness (Baun, 2009)

Question	Goal	Process to answer	Documents associated with policy, techniques or mechanisms developed to implement
			https://ontario.cmha.ca/wp-content/files/2012/07/olm_stigma_matters_200902.pdf 3) In Defence of Madness: The Problem of Disability (Mohammed Abouelleil Rached, 2018) https://academic-oup-com.ezproxy.library.dal.ca/jmp/article/44/2/150/5077410 4) Mad' Mad studies and advancing inclusive resistance (Beresford, 2020) https://www-tandfonline-com.ezproxy.library.dal.ca/doi/full/10.1080/09687599.2019.1692168 5) Supporting the sustainability of Mad Studies and preventing its co-option (Beresford and Russo, 2016) https://www-tandfonline-com.ezproxy.library.dal.ca/doi/full/10.1080/09687599.2016.1145380 6) Critical Disability Studies with Rehabilitation: Re-thinking the human in rehabilitation research and practice (Mosleh, 2019) https://www.jhrehab.org/2019/11/14/making-the-case-for-critical-disability-studies-with-rehabilitation-sciences/ 7) Engaging with Carol Bacchi: Strategic Interventions and Exchanges, 2012 Ch 9 – (Rönnblom, 2011) https://library.oapen.org/bitstream/handle/20.500.12657/33181/560097.pdf?sequence=1 8) Effects of stigma on therapeutic relationships (Zubair, 2015) file:///Users/ciselathoren/Downloads/Effects_of_stigma_on_therapeut.pdf

Question	Goal	Process to answer	Documents associated with policy, techniques or mechanisms developed to implement
			9) Mainstreaming politics: Gendering Practices and Feminist Theory, Ch 11 (Bacchi & Eveline, 2010) https://www.adelaide.edu.au/press/system/files/media/documents/2019-04/uap-mainstreaming-ebook.pdf
7. My own problem representation	To subject my own problem representation to the WPR analysis using self-analysis or reflexivity	As I am immersed in in the conceptual logics of my era, I subject my problematization to the questions of the WPR to ensure that I do not buy into problem representations without reflecting on their origins, purposes of effects.	1) Dispersed Resistance: unpacking the spectrum of glaring and everyday resistance (Lilja & Vinthagen, 2018) https://www.tandfonline.com/doi/full/10.1080/2158379X.2018.1478642 2) Working for citizenship: The dangers of occupational deprivation. (Hocking, 2012) https://web-p-ebscohost-com.ezproxy.library.dal.ca/ehost/pdfviewer/pdfviewer?vid=1&sid=9e3846c8-d076-47cc-9aab-42a680dc8722%40redis 3) Boundaries and Bridges to Mental Health: Critical Occupational and Capabilities Perspectives of Justice. (Townsend, 2012) https://www-tandfonline-com.ezproxy.library.dal.ca/doi/pdf/10.1080/14427591.2011.639723?needAccess=true 4) Occupational Justice: A Conceptual Review. (Durocher, Gibson, Rappolt, 2013) https://www-tandfonline-com.ezproxy.library.dal.ca/doi/full/10.1080/14427591.2013.775692 5) Participation and occupation Desrosiers, 2005 https://www.proquest.com/docview/212952241/fulltextPDF/2E521A9BB02E4CB4PQ/1?accountid=10406

Question	Goal	Process to answer	Documents associated with policy, techniques or mechanisms developed to implement
			6) Occupational justice as social justice: The moral claim for inclusion. (Hocking, 2017) https://www-tandfonline-com.ezproxy.library.dal.ca/doi/pdf/10.1080/14427591.2017.1294016?needAccess=true 7) Prevention of Work Disability Due to Musculoskeletal Disorders: The Challenge of Implementing Evidence. (Loisel et al., 2005) https://link-springer-com.ezproxy.library.dal.ca/article/10.1007/s10926-005-8031-2 8) Towards a Critical Occupational Approach to Research. (Njelesani et al., 2013) file:///Users/ciselathoren/Downloads/ojsadmin,+Journal+manager,+12538_galley.pdf 9) Occupational justice and client-centred practice: A dialogue in progress (Townsend & Wilcock, 2004 CJOT) https://www.proquest.com/docview/212952011/fulltextPDF/DD6F5E0E06204AEAPQ/1?accountid=10406 10) Occupation & Health: Are They One and the Same? (Wilcock, 2007) https://www-tandfonline-com.ezproxy.library.dal.ca/doi/abs/10.1080/14427591.2007.9686577 11) Cognitive work hardening for return to work following depression: An intervention study. (Wisenthal et al., 2018) https://journals-sagepub-com.ezproxy.library.dal.ca/doi/full/10.1177/0008417417733275 12) International Conference on Health Promotion 1986.

Question	Goal	Process to answer	Documents associated with policy, techniques or mechanisms developed to implement
			https://www.euro.who.int/__data/assets/pdf_file/0004/129532/Ottawa_Charter.pdf
			13) Insights into cognitive work hardening for return-to-work following depression: Qualitative findings from an intervention study. (Wisenthal et al., 2019) https://web-p-ebscohost-com.ezproxy.library.dal.ca/ehost/pdfviewer/pdfviewer?vid=1&sid=174c6500-7141-4c37-9f6e-e369d055db9d%40redis
			14) Lessons learned about occupation-focused and occupation-based interventions: A synthesis using group concept mapping methodology. (Tomra Nielsen, K. et al, 2020 https://www-tandfonline-com.ezproxy.library.dal.ca/doi/full/10.1080/11038128.2018.1561940
			15) Occupation-centred, occupation-based, occupation-focused: Same, same or different? (Fisher, 2013) https://www-tandfonline-com.ezproxy.library.dal.ca/doi/full/10.3109/11038128.2012.754492

Appendix B

Justification for Literature Searches

Literature Search for Question 1

To find the policy I aimed to analyze, I inputted public service management plan into google and the first result on the page was the Government of Canada's Public Service Management Insurance Plan web page (Government of Canada, 2021). Clicking the sub-heading "Long-Term Disability Summary" on this web page brings another web page that states the long-term disability benefits provided under the Public Service Management Plan (PSMIP-LTD) covers employees that are excluded from collective bargaining, designated groups and executive employees of the public service (Government of Canada, 2018). Finally, clicking the link PSMIP-LTD on this page links to a page entitled *Long-Term Disability Insurance – Chapter 3-4* that provides an overview of the long-term disability insurance coverage under the Public Service Management Insurance Plan and advises that this is a mandatory plan providing 70% of income to employees unable to work due to total disability (Government of Canada, 1992).

The next step was taken to assist me in gaining a thorough understanding of the insurance policy to be analyzed. Thus, I clicked on the sub-heading of the first web page entitled Additional resources. Under the sub-header of services and information, I located the heading *Main plan booklet*, which provides general information on the major benefit provisions of the PSMIP (Government of Canada, 2016). On the same page was the *Executive Plan booklet* (Government of Canada, 2015) which I also reviewed for comparison and collaboration.

Literature Search For Question 2

To answer Question 2, I have identified five articles that are listed in Appendix A. The first 3 were chosen through a Google search with the words Canadian, disability and policy. The articles were chosen from the first 10 on each page, where a review of each entry resulted in a selection of the 5th, 7th and 9th in the list of results based on the inclusion criteria of information on Canadian disability policies with a focus on their historical development and context. Google was chosen as the appropriate venue as I did not want to focus on only scholarly articles, such as in Google Scholar, and was looking for a broader view and context.

The first article, entitled *Disability Policy in Canada* was written by Lyn Jongbloed, Professor Emerita in the School of Rehabilitation Sciences at the University of British Columbia. She focuses her research on the interrelationships between disability and social, economic and political environments (Jongbloed, 2003). The second article by McColl et al., (2017) entitled "*A Review of Disability Policy in Canada*", is a policy scan or review undertaken as a research activity of the Canadian Disability Policy Alliance (CDPA). Finally, the third article, entitled *Canadian Disability Policies in a World of Inequalities* by Deborah Stienstra with the department of Political Science at the University of Guelph.

The last two sources were identified through a review of the bibliography from my proposal, where the *Evolution of Mental Health in Canada*, the book (Baynton & Fournier, 2017), was based on a study by Dr. Samra (2017) with the same title and supported by the Great-West Life Centre for Mental Health in the Workplace (currently known as Workplace Strategies for Mental Health supported by Canada Life), the Mental

Health Commission of Canada, and the University of Fredericton. The book itself was written by Mary Ann Baynton, director for the Centre for Workplace Mental Health and Leanne Fournier. The article by Dr. Samra was chosen to answer Question 2.

"*Disability Management: Opportunities for Employer Action*" provides recommendations to employers how to address workplace disability (Thorpe & Chenier, 2013). This article was published by the Conference Board of Canada with the support of Sun Life Financial, another large disability insurer alongside of Great-West Life. Other contributors to the article were Morneau Sheppell, Centric Health, Banyan Work Health Solutions and Sanofi Canada along with The Conference Board of Canada's Canadian Alliance for Sustainable Health Care. This report was based on the results of a 2013 survey of employees and managers and was researched by Karla Thorpe, Director of Leadership and Human Resources Research and Louise Chenier, Senior Research Associate, Leadership and Human Resources Research.

Literature Search for Question 3

The first source I read to help me answer this question came from the book "*Contesting Illness: Process and Practices*", that was referenced in the book *Disability and Social Change* by Jeanette Robertson and Grant Larson Eds., (2016) that I purchased after our committee meeting in October, 2020, and following the suggestion that I examine various Disability Models to help me in my analysis. Jeanette Robertson is associate professor at Thompson Rivers University in British Columbia, Canada at the School of Social Work and Human service where she has taught disability studies for 17 years. Grant Larson is a retired associate professor of social work and human service at

Thompson Rivers University, and has research and teaching interests in mental health, disabilities, social work, disaster rehabilitation and social work education.

Chapter 2 in the above-named book was written by Michael Prince, 2008, and entitled "*Claiming a Disability Benefit as Contesting Social Citizenship*". This chapter appeared appropriate as my investigation is about disability policies, how they impact the role of rehabilitation consultants and to gain insight into the way the problem of employee MH issues are viewed in these policies.

Michael Prince is a political scientist and a Lansdowne Professor of Social Policy at the University of Victoria in BC, Canada. He is an advisor and researcher to community agencies and government agencies regarding public policy and governance issues. Dr. Prince has also chaired a national task force on building the research and knowledge mobilization capacity of the disability community in Canada (Moss & Teghtsoonian Eds., 2008).

The other chapter in this book that I deemed relevant to answer question three was by Katherine Teghtsoonian entitled "*Managing Workplace Depression: Contesting the Contours of Emerging Policy in the Workplace*". I looked at these two chapters in relation to my answer in Question one, where the "problem" is defined by the insurer in placing those with a disability into a category of a functional inability to perform the duties of their occupations on a full-time basis and then determining that these individuals require medical treatment as determined by them.

Katherine Teghtsoonian is Associate Professor in Studies in Policy and Practice at the University of Victoria, in BC, Canada. She researches feminist and other critical literatures and addresses the ways in which neoliberal ideological framings and technologies of rule have shaped public and organizational policies in Canada. Her research also focuses on government and organizational policies intended to address mental illness (Moss & Teghtsoonian Eds., 2008).

Bacchi (2009), recommends that researchers think of social developments that may have taken place around the time of the development of the policy being analysed. As such, I inputted Canadian, Disability, Social, and Medicine into google and the 6th article was "*The evolution of disability data in Canada: Keeping in step with a more inclusive Canada*" (Furrie, 2018). It is a document from Statistics Canada, demonstrating concepts that may be embedded in governmental practices and programs (Bacchi, 2009), and how these influence the governmental power relations in society. Specifically, it is a document presented by Statistics Canada comparing disability statistics from 2012 and 2017. While the percentage of disability appears higher in 2017 than in 2012, it is also pointed out that the measures were more inclusive in 2017 than in the prior census. Therefore, the two years cannot be compared and 2017 can instead be taken as a "benchmark" for future studies.

In the document, "*The evolution of disability data in Canada: Keeping in step with a more inclusive Canada*", (Furrie, 2018) the report "*In Unison: A Canadian Approach to Disability Issues*" (Council of Canadians with Disabilities, 1998) is mentioned as a document that provides a vision and guiding framework for moving toward an inclusive Canada. Specifically, it suggests an inclusive Canada will be developed by eliminating barriers preventing full participation in society. As such, it presents relevant information about the "problem" of disability and how Canada should be addressing this issue. This document is thus an important contribution to finding information about the processes that led to the problem representation in the insurance policy examined, the context, and specifically how this representation of the “problem” of individuals requiring medical treatment to be able to ‘function’ in the workplace came about.

To obtain information about the health care angle on the ‘problem’ of the ‘disabled’ person receiving ‘the benefit’ of treatment for their condition, I inputted ‘the evolution of Canadian health insurance’ into Google. The 4th article was “*Canada’s universal health-care system: achieving its potential*” (Martin et al, 2018).

This article is the first in a series of two papers about Canada’s health system and global health leadership, and builds on the visions of Tommy Douglas, former Social Democratic Premier of Saskatchewan and founder of universal public health insurance coverage in North America. This work lead to the *Canada Health Act* of 1984, and is thus a significant document to examine the pervasiveness of the medical model of disability in Canada.

Literature Search for Question 4

Organization for Economic Co-Operation and Development (OECD)

I began by inputting the OECD into google, as I had learned about this organization when writing my proposal for this study. Wikipedia advises that the OECD has 37 member countries, of which Sweden is one, and was founded in 1961 to stimulate economic progress as well as world trade. Due to its mandate focused on economic progress, I chose not to delve further into specific documents on Sweden on this website, as my assumption therefore would be that disability and mental health would be viewed from a financial perspective primarily, and I am looking for a broader lens through which to view these issues.

United Nations

I elected instead to investigate the UN and inputted the words United Nations into the search bar of Google. According to Wikipedia, the United Nations was founded on October 24, 1945 in the United States with an original roster of 51 founding countries, Sweden joining in November, 1946, and a current membership of 193 member states. Its aim is to maintain international peace and security, to develop friendly relations among nations, achieve international cooperation, and be a centre for harmonizing the actions of nations (United Nations, 2021).

The objectives of the United Nations are listed to be peacekeeping and security, human rights, economic development and humanitarian assistance and other global issues such as colony independency and environmental programs. Under the objective of economic development and humanitarian assistance is the World Health Organization that focuses on international health issues and disease eradication (United Nations, 2021). Given that Sweden is a member of the UN, I felt that it would be of interest to investigate this link with health to examine Sweden's approach to health, disability and mental health issues specifically.

Sweden and the United Nations

Based on the information learned, I inputted into Google Sweden and the UN. The third result was the Wikipedia link, that gave information about the UN, and Sweden. It appears that Sweden joined the UN in November, 1946 after its founding in October, 1945. It is mentioned on this website that Sweden meets or exceeds the UN humanitarian spending target of .7% of GDP, having spent 1.4% of GDP in 2017. On this website is also included reference to the fact that Sweden adopted the *Universal Declaration of Human Rights* on Dec 10, 1948, as well as a link to this document. Upon a review of the *Declaration of Human Rights*, it seemed to confirm my assumptions that the UN is about issues other than those that are strictly economic. Instead, it appears that Sweden looks at both humanitarian issues as well as those of human rights and I felt that viewing Sweden through the lens of their involvement in the United Nations may provide insight and a contextual background into their disability policy.

Sweden and Disability Management

The fifth source of information was found by googling Sweden and Disability Management. Of the 10 results on the first page, the third result met the inclusion criteria of Sweden and Disability Management and was a link to the website for Sweden's disability policy. On this website, there were also links to the *UN Standard Rules on the Equalization of opportunities for Persons with Disabilities* as well as the *UN Convention on the Rights of Persons with Disabilities*, the second of which was ratified in 2008, and is described as legally binding and that these two documents underpin disability policy in Sweden. For this reason, I deemed it to be significant to review both of these documents to understand how Sweden approaches its disability policy.

The eighth source was found by googling Sweden and Disability Management, examining the first page with 10 results, and after following the inclusion criteria of Swedish disability policies with the seventh result gave the article *Scandinavian Disability Policy: From De-Institutionalization to non-discrimination***.** The authors of this article discuss the two UN documents upon which Swedish Disability is built, and the angle that is taken by Sweden and Norway. The ninth document was the tenth result from this same search, after applying the inclusion criteria and gave a link to a web site entitled Sweden: *Building an inclusive labour market – Zero Project***.** This website discusses employment rights, disability and equality. Outlined here is why Sweden has the highest rate of employability of disabled persons in the OECD. Specifically, it outlines how the LAS, the employment protection act of 1982, has acted to uphold a high standard of employment protection for persons with disabilities, highlighting that lesser capacity because of age, illness or acquired disability is not an objective ground for dismissal.

Sweden and Mental Health

The final articles were found by inputting Sweden and Mental Health into the search bar on Google. Of the results on the first page, I applied the inclusion criteria and identified the third article "*The Swedish Mental Health System: Past, Present, and Future*" (Silfverhielm, 2000) as appropriate for answering the fourth question. The abstract of this article gives an idea of how persons with mental illness have been viewed over time and history in Sweden and is anticipated to provide light on how this problem' may be viewed differently in a different country.

The fourth result gave a link to a journal article in Science and Business entitled "*Strengthening Prevention and Treatment in Mental Health*" comparing the approaches to Mental Health in a few European countries. This article puts the problem as lack of evidence-based treatments for people with mental health problems, that this treatment gap is a threat to the sustainability of the health system and that examining how Sweden addresses this issue will be a way forward to "solving" this 'problem'. This emphasis on the need for evidence-based care in mental health indicates that perhaps this 'problem', lacking treatment for a mental health issue, is not viewed differently in Sweden. The actual article entitled "*How to Strengthen Prevention and Treatment within Mental Health*" is a summary report based on a meeting on a roundtable meeting in Stockholm on Feb 25, 2020. This article is separated into eight subsections, each dealing with a different area of how to address issues of those with mental health issues. This article outlines how Swedes proposed addressing the issue mental health, that is reported to be costing employers large amounts of money due to employee absence (Science and Business, 2020).

Literature Search for Question 5

The five articles chosen to help me answer question 5 were all taken from the bibliography of my proposal. The first two were in the *Opening Minds* series, examining effective ways to deal with stigma in Canada which appear to have an impact on the population which I am investigating. I anticipate that the way Canada proposes to deal with the stigma of mental health issues will give useful information about the discursive, subjectification and lived effects of the way the problem representation of mental illness from a medical discourse is viewed. The third article was by Heather Stuart, known for her work on the stigma of mental illness, discussing mental illness and employment discrimination, which appears an appropriate avenue to examine employee MH issues and how it may contribute to its discursive, subjectified and lived effects.

The final two articles speak to the connection between mental health or illness and current attempts to 'remedy' these with medication and treatment, which would highlight what is, and what is not, working within the current climate, as well as plans on future directions. Given that WPR is a poststructural analysis that informs my analysis of disability policies, it will open up spaces to consider the assumptions upon which the current efforts are made to address the “problem” of WPMH, with the hopes of bringing to question that perhaps things could indeed be approached differently.

Literature Search for Question 6

The first two articles were located through a google search with the words mental health and the media with the fifth article being “M*ental Health: a Friend, a Home, a Job*” by Dr. Taylor Alexander, Chief Executive Officer of the Canadian Mental Health Association, National Office published in Ottawa Life (Alexander, 2012). This article was written as an introduction to another article “*Stigma Matters: The Media’s Impact on Public Perceptions of Mental Illness*” by Kismet Baun (2009). The former implies that the desires of the mentally ill are not very complicated, and thus queries why this is such a difficult goal attain. The author suggests that all that is needed is to route comprehensive mental health systems though connection of formal services, community supports with the broader health and social services systems.

The third article is written by Mohammed Abouelleil Rached (2019) that was located in my search of models of disability at the recommendation of the supervisory committee when I was preparing my proposal, as were the fourth and fifth articles. The third article, “*In Defence of Madness: The Problem of Disability*”, analyzes the medical and social models of disability and questions our ready acceptance of a medical model of disability for mental illness, as well as innovative ways to look at mental illness, all the while explaining why change is so very difficult (Mohammed Abouelleil Rashed, 2019). The fourth article is entitled “’*Mad’ Mad studies and advancing inclusive resistance*” (Beresford, 2020) and addresses that a united front of the Mad Studies movement is needed to counter the biomedical philosophy currently dominating professional and political debates as well as those among mental health service users. Several action items are included in this article that are suggested methods to counter the biomedical model of mental illness, and I view this article through the WPR lens, which indicates that proposals produce problems as particular sorts of problems. As a consequence, this movement may actually perpetuate the biomedical model versus countering it.

The fifth article is another one by Beresford and with Russo from 2016 and is titled "*Supporting the Sustainability of Mad Studies and Preventing its' Co-Option*" (Beresford & Russo, 2016). It mentions how other movements, such as that of using peer support and recovery have been criticized for reinforcing neoliberal and market-driven approaches to stress and how to make sure that the Mad Studies movement can be protected from this fate. It is possible that any movement will have unintended consequences, something raised often by Bacchi (2009). In accordance with Bacchi, "protecting" mad studies from criticism may not be possible. Article four and five relate to disability studies and how they view the issue of mental health and illness and their take on the 'problem' of mental illness.

The sixth article "*Critical Disability Studies with Rehabilitation: Re-thinking the human in rehabilitation research and practice*" (Mosleh, 2019) was also found during my exploration of disability models, and this article combines disability studies with rehabilitation, suggesting a possible way forward of looking at the 'problem' of disability in a different way, combining a biomedical view of disability with a different way of viewing the 'problem'.

The seventh article was found when I was exploring the methodology of the WPR method, and I purchased the book *Engaging with Carol Bacchi: Strategic Interventions* *and Exchanges*; I am choosing Chapter 9 for review to answer question 6. The title of this chapter is "*Post-structural comparative politics: Acknowledging the political effects of research*" by Malin Rönnblom, and I believe that this will shed important light on how research can contribute to the way employee MH is viewed (Rönnblom, 2012).

The eighth article was found by scanning the bibliography of a paper I did for a course in my Master's program and is about the medical profession and that they can contribute to the stigma of the person with mental health issues. It was written by Zubair, (2015) and is entitled "*Effects of Stigma on Therapeutic Relationships*". Given that question 6 looks at how the representation of the person with mental illness is seen to be in need of medication and treatment, is produced and disseminated, it would seem quite relevant to examine how the medical profession and resulting stigma might perpetuate this view.

The book *Mainstreaming politics: Gendering Practices and Feminist Theory* was discovered in March, 2021, when I was researching articles to review for each of the questions in the WPR analysis. I found it looking at Bacchi's blog of 01/03/2021 asking the question if it is possible to blend WPR with other forms of social and discursive theory such as a Critical Discourse analysis. In this blog, references were made to Rönnblom & Bacchi (2011) "Feminist Discursive Institutionalism – What's discursive about it?" and in this article, a reference to Bacchi and Eveline, (2010) where Foucault's recommendations that sweeping reform producing a new eutopia is not a goal and it is instead at the local level that changes can be made. As this sixth question is looking at where the representation of the "problem" is produced, I felt that this work by Bacchi and Evelyne, 2010 would be able to shed some useful light on this scenario.

Literature Search for Question 7

To explore resistance to accepted discourses, as mentioned by Bacchi, 2009, I inputted “challenging problematizations of resistance” in Google and the 8th article was Lilja and Vinthagen’s (2018) article “*Dispersed Resistance: Unpacking the spectrum of glaring and everyday resistance*”. I also reviewed the concepts of occupational justice and injustice and their component parts, occupational apartheid, occupational deprivation, occupational marginalization, occupational alienation and occupational imbalance (Durocher, Gibson & Rappolt, 2014, Hocking, 2017, Townsend & Wilcock, 2004). With the intent to consider the benefits and possible negative effects of engagement in work occupation, I inputted the words occupational deprivation into Google and the 10th result is the article “*Working for citizenship: The dangers of occupational deprivation*” (Hocking, 2012). My supervisor recommended this article to me.

The third article found on occupational justice is through a google search with the words occupational justice, and the 8th result is “*A Framework for Occupational Justice*” with the key reference being Elizabeth Townsend’s (2012) “*Boundaries and Bridges to Adult Mental Health: Critical Occupational and Capabilities Perspectives of Justice*”. Having reviewed literature for my proposal, being an occupational therapist, and having taken courses on occupational perspectives and occupational justice, I am familiar with Dr. Townsend as a prominent author in the areas of occupation.

The fourth article to help me answer Question 7, that of developing my own problematization, is entitled “*Occupational Justice: A Conceptual Review*” (2014) by Durocher, Gibson & Rappolt, and is taken from my proposal bibliography. This article is chosen based on the premise that participation in occupation can affect health and that being excluded from occupations can be said to constitute a form of social injustice. She explores engagement in meaningful occupation specifically having an impact on individual and community health. I believe that this article will help me to develop my problematization of disability policies.

The fifth article is also chosen from my proposal and is entitled "*Participation and Occupation*" by Joanne Desrosiers, (2005). The idea of participation is closely related to the concepts of Doing, Being, Becoming and Belonging, consistent with literature in occupational therapy and occupational science (Wilcock, 2007; Wilcock & Hocking, 2015). Participation is reported in the abstract of this article to be a pivotal outcome of successful rehabilitation (Desrosiers, 2005).

Articles six and seven are chosen from my proposal. The sixth article is "*Occupational justice as social justice: The moral claim for inclusion*" (Hocking, 2017). As Bacchi, (2009) suggests that the policies analyzed are with a view to social justice, I deem it significant to include this article as my thoughts on my own problematization develop. The seventh article is by Patrick Loisel, orthopaedic surgeon, trained in Paris, France, and practicing at the Université de Sherbrooke in Quebec, Canada. He conducts research in work disability and occupational interventions and is in the process of developing Return to Work programs (MacEachern, 2019). I therefore believe that his insights in the article "*Prevention of Work Disability Due to Musculoskeletal Disorders: The Challenge of Implementing Evidence*" (Loisel, 2005) will provide valuable information in the development of my response.

The eighth article is entitled "*Towards a Critical Occupational Approach to Research*" (Njelesani et al., 2013) and is recommended and provided to me by my research committee. This article advises that assumptions and ideologies underlie human activity and that knowledge is produced through engagement in occupation. Given Bacchi’s (2009) assertion that knowledge is produced through policies, this article aligns well with the WPR approach, as it becomes apparent through both these views, that knowledge is not objective or a pathway to truth but is itself a product of our actions and practices (Bacchi, 2009; 2012; Njelesani et al., 2013).

The next four articles are also chosen from my proposal. The ninth article entitled “*Occupational justice and client-centred practice: A dialogue in progress*” (Townsend & Wilcock, 2004) introduces occupational justice. The methods these authors use to explore the concept of occupational justice are based on literature reviews as well as workshops and presentations in Australia, Britain, Canada, Portugal, Sweden and the United States with participants such as occupational scientists and therapists, as well as from sociology, social work, nursing and urban planning (Townsend & Wilcock, 2004). Given my familiarity with the literature of Dr. Townsend and Dr. Wilcock, in the area of occupation, coupled with the countries represented by the research, as well as the professional backgrounds of the participants, I believe that this article will be of value as I consider the development of my own problematization.

Article 10 is entitled “*Occupation and Health: Are They One and the Same*?” by Ann Wilcock (2007) and I believe this is relevant to my occupational perspective that I am exploring. Articles 11 and 13 are by Dr. Adeena Wisenthal, who uses an occupationally based intervention to improve functioning of people with depression (Wisenthal et al., 2018, 2019). In formulating an alternative to the medical model of disability and treatment, I believe these articles will add to my problem representation of employee MH issues. The 12th article is the *Ottawa Charter for Health Promotion* (WHO, 1986) from my proposal. However, it is also noted to be referenced in other publications, such as in Townsend (2012), Townsend and Wilcock (2004), and Wilcock (2007). The Charter's focus on health promotion will help me to consider health promotion in context.

Lastly, as my thinking has evolved through conducting this research, as well as working with a colleague on a related paper, the article by Tomra Nielsen et al., (2020) entitled "*Lessons learned about occupation-focused and occupation-based interventions: A synthesis using group concept mapping methodology*" is provided to me by this colleague. Given my evolving thinking about occupation-based interventions, I believe that this article will help me to develop my arguments about the benefits of engaging in work-relevant occupation as part of intervention for employees with MH issues. I also selected an article upon which this paper is based in terms of occupation-focused and occupation-based by Anne G. Fisher, (2013) entitled "*Occupation-centred, occupation-based, occupation-focused: Same, same or different*?". These articles are included as number 14 and 15 in Appendix A.

APPENDIX C

Reflective Journal

This document has been uploaded to DalSpace as supplementary electronic material