ALBERTA LABOUR RELATIONS BOARD

June 29, 2005

Directed to: United Nurses of Alberta, Locals 23, 66, 82, 89, 102, 120, 140, 152, 160, 164 - Michael Mearns, United Nurses of Alberta - David Harrigan, Chivers Carpenter - Patrick Nugent, Provincial Health Authorities of Alberta - Dev Chankasingh/Barb Burton, Canadian Union of Public Employees - Linda Huebscher/Yvonne Fast, Laird Armstrong - Russell Albert, Tammy Ander, Chinook Regional Health Authority - Robert Stratychuk/Janet Byrne, Health Sciences Association of Alberta - Kerry Woollard, Health Sciences Association of Alberta - Dennis Bennett, The Alberta Union of Provincial Employees - Ron Hodgins

RE: An application for determination brought by United Nurses of Alberta, Locals 23, 66, 82, 89, 102, 120, 140, 152, 160 and 164 affecting Chinook Regional Health Authority and Health Sciences Association of Alberta – Board File No. GE-04424

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[1] The Chinook Health Region ("Chinook" or the "Employer") operates community mental health clinics in Lethbridge and six other communities in southwestern Alberta. It staffs these clinics with approximately 32 mental health therapists who are currently represented in collective bargaining by the Health Sciences Association of Alberta ("HSAA"). These mental health therapists hold professional qualifications as registered nurses, registered psychiatric nurses, psychologists or social workers. United Nurses of Alberta, Locals 23, 66, 82, 89, 120, 140, 152, 160 and 164 (collectively "UNA") apply for determinations under s. 12 of the *Labour Relations Code* that the eleven mental health therapists who are qualified as registered nurses or registered psychiatric nurses are included in UNA's direct nursing care bargaining unit. Alternatively, UNA applies for determinations that the four of the eleven RNs and RPNs who work in the Adult Mental Health program of the Lethbridge Mental Health Services Clinic are included in its bargaining unit. The Employer and HSAA oppose the applications.

[2] These applications generated preliminary issues that were heard in October 2004 and decided by letter decision at [2004] Alta. L.R.B.R. LD-079. We will not repeat the historical background to these applications or the disposition of the preliminary issues, except to say that these employees were previously employed by the Alberta Mental Health Board and represented by the Alberta Union of Provincial Employees as part of a provincial "all employee" unit. In the realignment of bargaining units and certificates mandated by the "Bill 27" process, the Employer allocated these employees to HSAA's paramedical professional and technical bargaining unit. UNA contests this allocation.

OUR VISION…

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[3] This panel of the Labour Relations Board (Wallace, Leclaire, Halpen) heard the application over four days in April, 2005. We heard testimony from nine witnesses and received 82 exhibits. It is no reflection upon the thoroughness of the evidence and argument presented that we have elected to provide only these brief reasons. Rather, our reasons reflect that the case did not require fine judgments of evidentiary matters, which were largely undisputed; that the case may be decided on the basis of well-settled law; and that a brief but more timely decision will in our opinion serve the parties best.

[4] Chinook's community mental health clinics provide comprehensive outpatient mental health care services to the regional population. These services range from prevention and early detection of mental illness to advocacy, crisis intervention and treatment of acute and chronic mental health conditions across all age groups. The six rural clinics operate with small staffs of generalist therapists. Lethbridge is home to three more specialized mental health programs: the Children and Youth program, aimed at children and adolescents under the age of 17; the Adult program, for patients over the age of 18; and the new Transitional program, for selected patients between approximately 16 and 24.

[5] The Employer requires of its Mental Health Therapists that they hold professional qualifications in one of the fields of Nursing (Registered Nurse or Registered Psychiatric Nurse), Psychology or Social Work. It is a condition of employment that they hold and maintain accreditation in their applicable professional body. Of the 32 incumbents in approximately 28.0 FTE positions at the time of our hearing, eleven are Registered Nurses or Registered Psychiatric Nurses.

[6] The distribution of professions in Chinook's community mental health programs is currently as follows, subject to some minor inaccuracies from temporary absences and cover-off assignments.

- The six rural clinics (Cardston, Blairmore, Fort Macleod, Pincher Creek, Raymond and Taber) employ 13 therapists, of whom two (Linda Roughead and Pat Theroux) are nurses (a third, Sandra Ursel, is in the process of returning from a leave). Two are psychologists. The remaining eight are social workers.

- Children's Services employs six therapists, of whom three (Alison Lux, D'Arcy Benzie and Susan Gin) are nurses. The other three are social workers.

- The Transitional program employs two therapists, one (Lisa Vogt) a nurse. The other is a social worker.

- The Adult Services program employs eleven therapists, four of whom (Tammy Ephraimson, Marla MacPherson, Tammy Ander and Brent Winder) are nurses. Marla MacPherson shares her job with Al Vas, a social worker. Besides Mr. Vas there are three social workers in the Adult program and three psychologists.

[7] The Employer maintains a uniform job title of Mental Health Therapist for the positions in the community mental health clinics. There is a common position description for all mental health therapists. The Employer recruits to these positions without a stated limitation to, or

preference for, any particular eligible profession. Historically, though, the nurses in these positions have been classified as "Staff Nurses" for purposes of the collective agreement and have enjoyed slightly different levels of pay and working conditions from their colleagues. This is a remnant of the practice of the Alberta Union of Provincial Employees and the Alberta Mental Health Board before Bill 27 and the transfer of community mental health clinics to the regional health authorities. It is a practice that Chinook seeks to end. Its allocation of all the mental health therapist positions, including those occupied by qualified nurses, would, if upheld, serve that purpose.

[8] The primary function of all of the mental health therapists in Chinook's community mental health programs is assessment, diagnosis and treatment of mental health conditions in their patients. No witness disagreed with this proposition. There is no formal specialization or division of labour among the professions represented in the group of mental health therapists. This is so by necessity in the rural clinics; very often only one therapist is on duty. In Lethbridge, the model the Employer seeks to achieve is that of an interdisciplinary team in which any therapist may, with the support and input of his or her colleagues, treat the entire range of mental health conditions that presents to the clinic. To a large degree it has succeeded in realizing this model. Shortly we speak of the differences in caseload character that exist among therapists in the Adult Services program; but outside that program it is impossible to discern any meaningful differences in functions or duties between mental health therapists who are nurses and those who are not.

[9] This case, we find, is governed by a principle set out in this Board's leading decision on functional bargaining units in the health care industry, *UNA, Loc. 151 et al. v. Alberta Hospital Association et al.* [1986] Alta. L.R.B.R. 610. At 623, Chair Sims stated for the panel:

> In our view the community of interest of a nurse performing other than direct hands on bedside nursing or teaching therein logically falls with one of the three bargaining units: the direct nursing care unit, the paramedical professional unit or the general support unit. When the position requires a nursing background and accreditation, or in practice functions in a way that makes it clear, despite a job posting to the contrary, that it requires a nursing background then in our view the community of interest remains with the direct nursing care unit.
> Where, however, the position in question requires a health discipline background of some type, of which nursing may be one of the eligible disciplines, then the community of interest falls with either the paramedical professional unit or the general support unit. Which of the two will depend on whether the nurse's skills are being put primarily to a paramedical or to an administrative use. If a job like a community outreach person is such that it can be done by an appropriately skilled nurse or a dietician or a social worker, then the job is almost of necessity a support position rather than one involving primary nursing care. This is so even giving "primary nursing" a definition that recognizes the profession's increasing specialization and scope.
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> In such situations, nurses are usually called upon to exercise their professional skills for the purpose of advancing health care rather than for the purpose of more general hospital administration; as professional health care providers rather than as skilled administrators. In such cases we see their utilization being similar

> to, and their community of interest lying with, other paramedical professionals such as social workers, laboratory scientists and psychologists.

[10] This principle often applies to the phenomenon of interdisciplinary health care teams. Unless individual positions on the team are, by clear practice or by the employer's posting and recruitment decisions, limited to nurses, the interdisciplinary team is considered to comprise positions that "require a health discipline background of some type, of which nursing may be one of the eligible disciplines": see, e.g. *UNA v. Calgary Regional Health Authority [Labelle]* [1999] Alta. L.R.B.R. 458. This principle recognizes the community of interest that exists among the members of the interdisciplinary team. It recognizes the detrimental effects of dividing representation of team members among two or more bargaining agents and two or more collective agreements with different seniority, posting, promotion, wage and other provisions. In our view, this principle from *Alberta Hospital Association* remains sound. We have not been convinced to modify or qualify it for application to these facts.

[11] We say this even though we do not accept without reservation the Employer's evidence and argument that nursing qualifications are not necessary to any of the mental health therapist positions in its program, and that it always attempts to hire the best candidate. That may be true within limits, i.e., as long as the mental health therapist group contains a minimum complement of each eligible discipline. At the extremes, if the number of (say) nurses diminishes to a very small number, hiring another non-nurse risks the dilution or loss of the benefits of an interdisciplinary team. At such an extreme, a qualified nurse begins to look like the best candidate against all but the very best non-nurses. But for all that, we think that it would be inconsistent with the principle of community of interest to allocate certain members of an interdisciplinary team, who perform functions common to nurses and other occupations, to the direct nursing care bargaining unit, unless there is evidence of some strength that their particular positions *must* be occupied by employees with nursing credentials.

[12] With that in mind, we may assess the status of the eleven employees in question program by program. In the Children's Services program, there is no evidence of any force that the three positions in question require a nursing background or accreditation. The three incumbents who are nurses perform duties that appear indistinguishable from those of their colleagues. We find that the three therapists qualified as nurses — Lux, Benzie and Gin — are included in the paramedical professional and technical bargaining unit.

[13] The two qualified nurses in the rural clinics — three when Ms. Ursel returns — are in much the same situation. In these small clinics, therapists serve the entire area population and see the entire range of mental health conditions. There is no room for specialization. And because no one clinic can be certain of having a qualified nurse on staff, let alone on duty, there is no scope for the clinics to provide services that are within the exclusive scope of practice of nurses. We heard, for example, that Linda Roughead administers injectable medications to one or two long-time, housebound patients, occupying as little as 1% of her time. With insignificant exceptions like this one, therapists in the rural clinics rely upon family physicians to perform all of the medical services that could be provided to a client exclusively by a registered nurse. We find, then, that the rural clinic therapists qualified as nurses — Roughead, Theroux and Ursel — are also included in the paramedical professional and technical bargaining unit.

[14] We heard no evidence of substance that Ms. Vogt's position in the Transitional program specifically requires nursing credentials. Though she administered injectable medications during her time in the Adult Services program, she does not do so now. And any theory that this position requires a nurse is gravely undermined by the evidence that Ms. Vogt was hired into the position only after the preferred candidate in her competition, a non-nurse, declined the job offer. Ms. Vogt is also in the paramedical professional and technical bargaining unit.

[15] As counsel for UNA predicted in his opening, the case for the four nurses in the Adult Services program is stronger. There is a level of informal "specialization" among the mental therapists in that program, and there is scope for a certain amount of exclusive nursing practice in the work they do. The intake officer on duty (usually psychologist Keith Jones) assigns new patients to a therapist at least in part based upon the apparent condition of the patient and the training, skills and interests of the available therapists. Workloads and patient preferences, among other factors, also play a role in the assignment. The result is that the four nurses on the Adult Services team carry more than their share of patients with psychotic and other chronic conditions. In the extreme example of Marla McPherson's caseload, well over half of the patients suffer from psychoses and all of them have chronic mental health conditions. The nurses also see more of the patients with significant complicating physical conditions, like diabetes, than their non-nurse colleagues. They perform some interpretation of laboratory test results that the non-nurse therapists are not qualified to perform. Medication management is a larger task in the nurses' caseload than in other therapists' caseloads. And the four nurses, alone among any of the mental health therapists employed by Chinook, administer injectable medications like antipsychotics to patients of the clinic.

[16] These differences in caseload, however, are not absolute. All therapists have something of a broad, general practice; it is rare that a therapist will not have, at any one time, some patients with psychoses, some with affective disorders, and some with behavioural disorders. To the extent that a non-nurse therapist treats patients with contributing physical conditions and medication issues, they are expected to rely upon consultation with their nurse colleagues, family physicians, and consulting psychiatrists (just as nurse therapists are expected to rely upon the expertise of their psychologist and social worker colleagues in managing patients with conditions outside their own core area of training).

[17] The Employer does not mandate referral of certain patients to certain therapists. Referral patterns appear to be driven as much by workload and the therapist's personal areas of interest as by discipline. The caseload differences noted are, in our opinion, not significant enough to undermine the similarities of function among all the mental health therapists. Injection of medications is the only significant task performed by these four nurses that is within the exclusive scope of practice of nursing. Even this task is only a minor part of a nurse therapist's duties: generously calculated, it occupies only between 6% and 12% of a nurse therapist's time, on average. All the other significant functions, including the prime functions of assessment and therapeutic treatment of mental health conditions, are functions shared with psychologists and social workers. That being so, we conclude that these four therapists qualified as nurses also fall into the principle of *Alberta Hospital Association* noted above. Their nursing qualifications make them eligible to be mental health therapists, and their nursing training is doubtless of great value to the interdisciplinary team model the Employer uses. But it

would be simply wrong to say that their positions *require* nursing training within the *Alberta Hospital Association* principle.

[18] Accordingly, all eleven of the mental health therapists in issue perform a paramedical professional and technical function and fall within the bargaining unit represented by HSAA.

[19] The application is dismissed.

J. Leslie Wallace, Vice-Chair