Implementation of a Certified Mental Health Program for Imperial Oil Limited (IOL) Canada Employees

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Abstract

Background: It is noted that one in five Canadians experience a ***mental health*** problem or ***mental illness*** in a given year and every week 500,000 Canadians are unable to work due to mental illness. Mental illness accounts for 30% of disability claims and absenteeism and presenteeism from mental illness accounts for billions of dollars in lost productivity annually (Mental Health Commission of Canada, 2020).

Purpose: To offer a certified mental health program for employees that reduces the ***stigma*** of mental illness, promotes well-being and enhances the organizations ability to support their employees. Additionally, it will assist to create a respectful and inclusive workplace, empower employees, and inspire them to seek support for their mental health concerns.

Methods: An integrative literature review was completed to understand the impact of employee mental illness in the workplace and identify programs that can be implemented in the workplace to promote mental health. Consultations were completed with key stake holders to obtain their thoughts on the company's mental health culture. Lastly, an environmental scan was carried out to provide information on programs that are available and have been implemented in Canada.

Results: Through the completion of the practicum it was evident that poor mental health had a negative impact on employee's ability to work effectively. The lost productivity and expense associated with disability also costs companies millions of dollars annually.

Conclusion: Implementing a Certified Mental Health Program, ***The Working Mind***, has the ability to reduce stigma and increase resiliency, thus improving employee well-being, increasing ***productivity*** and reducing the cost associated with absenteeism and disability claims.

Keywords: ***mental health, mental illness, The Working Mind, productivity, workplace, presenteeism, absenteeism, stigma***

General Summary

Mental illness affects approximately 6.7 million Canadians every year and it affects 1 in 3 Canadians that are presently employed (Mental Health Commission of Canada, 2020). A person with a poor mental health may have a hard time concentrating, learning, and making decisions. This can have a negative effect on their ability to work, they may avoid others and take extended time off work. This can also lead to them being less productive leading to pressure on their relationships with co-workers and supervisors. When an employee is absent from work or being less productive at work due to poor mental health or mental illness this increases costs to the company. The employee may have to be replaced with another worker resulting in paying two salaries and the loss productivity means work is taking longer to complete or not completed as effectively.

Providing a mental health program for employees and supervisors that limits the negativity surrounding mental illness and offers tools to cope better in difficult times will improve the physical and mental health of employees and create a more content and productive workforce.

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To Imperial Oil (IOL), I would like to thank for the financial support in completing my Master of Nursing. For allowing me the opportunity to use the information gained from the practicum to improve the mental well-being of employees and provide a psychologically safe workplace.

To my dear family, Krista, Emily and Alex, who have always been there by my side offering support and encouragement. Krista, you have supported me through the years as I completed my Nursing Diploma, Nurse Practitioner Diploma, Bachelor of Nursing and now my Master of Nursing. You motivated me to never give up and provided the love and inspiration I needed when I was having second thoughts. I could not have done this without you.

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It is noted that one in every five Canadians experience a mental health problem or illness within a given year. It is also known that one in two Canadians under the age of 40 will experience a mental health problem or illness by the time they turn 40 years of age. These numbers have a direct impact on the workplace, as every week 500,000 Canadians are unable to work due to mental health problems or illnesses. Seventy per cent of Canadian employees are concerned about the psychological health and safety of their workplace, and 14 per cent don't think their workplace is healthy or safe. Mental health and illness account for 30% of short and long-term disability claims and in 2011 alone, absenteeism, presenteeism and turnover from mental health issues and illnesses accounted for over six billion in lost productivity (Mental Health Commission of Canada, 2020). A Canadian study in 2017 noted that the primary cause of workers mental health problem or illness, was workplace stress (34%), with depression and anxiety being reported as the top two issues. They also reported a high level of concern regarding the potential impact of their mental health problem or illness on their career, work experience and job performance. The research also demonstrated that mental health problems and illnesses were a primary reason for missing work, with 78% of respondents reporting they missed work due to mental health concerns, and of those missing work, 34% reported missing work for two or more months (Howatt et al., n. d.).

As a nurse with over 20 years' experience in a variety of nursing fields I have seen the negative effects poor mental health can have on employees, colleagues and the workplace. I have witnessed it in large hospitals, isolated nursing health centers, offshore oil installations and large office settings. I have medivaced nurses out of isolated communities and workers from offshore oil rigs due to an exacerbation of a mental illness. My role at present with IOL includes occupational health nurse for St. John's and Nova Scotia and clinical coordinator for Eastern

Canada. I have been with the company for three years now and have case managed a number of cases where poor mental health and mental illness has led to employees having to take extended time off work. In 2019, mental health related conditions accounted for 25% of all absences at one IOL site and Imperial Oil's Employee Family Assistance Program (EFAP) statistics on emerging trends consistently demonstrate that the employees reach out for support in the areas of personal relationships, mental health and personal stress. These trends have been the top three reasons employees utilize EFAP for a number of years now.

IOL does offer an EFAP program, a culture of health website and sporadic sessions on mental health, but no formal program. The Mental Health Experience in Canada's Workplace survey found that 50% of employees who reported their organization had clearly-defined mental health policies and programs also reported positive mental health outcomes. Husky Energy offered the Working Mind program to their employees in 2015 and evaluation post program delivery demonstrated that 54% of respondents stated it increased their resiliency and 48% stated it improved their mental health (Castro et al., 2015). Implementing a similar program for employees at IOL that reduces the stigma surrounding mental illness and promotes recovery and well-being of employees allows the company to support their employees. It creates a respectful and inclusive workplace, empowers employees to be productive, and encourages employees to seek help and support for any mental health problem or illness they may be experiencing.

Practicum Objectives

The overall goal of this practicum is the implementation of a certified mental health program for Imperial Oil Limited (IOL) Canada Employees. The key objectives to meet this goal are:

1. Identify how mental health can impact the psychological health and safety of employees at IOL Canada.

2. Identify an evidenced based mental health program to implement into the IOL culture.

3. Develop an implementation strategy and evaluation plan for the workplace program.

4. Demonstrate Canadian Nurses Association (2019) advanced nursing practice competencies.

Overview of Methods

In order to achieve the goal and objectives of this practicum report, a literature review, consultations with key stakeholders and a consultation scan was completed. I reached out to Memorial University Library and received the assistance of a librarian in proceeding with the literature search. They suggested I use the electronic databases CINAHL Plus, PsycINFO, Google Scholar, and Medline. I searched for relevant material from January 2010 until present. Additional filters included English language only and full text.

For the environmental scan, a telephone interview was completed with Charles Boyer of the Mental Health Commission of Canada and the consultation scan involved completing telephone interviews with six employees of Imperial Oil from various sites across Canada.

Literature Review Summary

The literature review identified four articles that were related to the impact of impaired mental health and/or mental illness on workplace productivity. In addition, the second search for evidence-based mental health programs generated ten results that met the inclusion criteria and were suitable for review. The analysis of the literature clearly demonstrated that poorly managed mental illness and mental health of employees has a direct impact on absenteeism and presenteeism. It was also noted that continued absenteeism and presenteeism results in diminished work output, low effort and reduced work productivity leading to significant financial loss for the employer. The study completed by Evans-Lacko and Knapp (2016) noted that presenteeism in Canadian employees costs approximately $4270 per year for each person

and an aggregate total of 6.8 billion dollars annually. Additionally, a study by Johnston et al. (2019) found a significantly strong linear relationship between depression symptom severity and work and productivity loss. As depression severity increased there was an elevation in absenteeism and as work productivity levels declined depressive symptoms increased.

In the review of the literature to identify evidence-based mental health programs it became evident that when programs are offered at the workplace there is a decrease in the stigmatization of mental illness, an increase in employee resiliency and a reduction in absenteeism and presenteeism. Castro et al. (2015) used an uncontrolled before-after study to determine the outcome of offering The Working Mind (TWM) program to 256 employees of a Husky Energy department in Canada. The results were promising as 74% of individuals indicated that they had reduced stigmatization attitude toward mental illness immediately after the program and at three months later. In terms of resiliency, there was a significant increase in participant's perception of their resiliency skills and the skills were maintained at the three-month follow-up. Similar results were identified by Dobson et al. (2019) who completed a review of surveys that participants completed in eight TWM programs that were offered at various location throughout Canada. The results of the analysis on the effects of the program on stigma and resiliency discovered a statistically significant reduction in stigma and an increase in resiliency skills for front line workers and supervisors and also for employees in the public and private sectors. The authors also suggested that in the short term there may be increased costs associated with the programs, but the implementation has the potential to improve employee's psychological health, improve workplace culture, and increase work productivity. Following the literature review, two programs offered by the Mental Health Commission of Canada seem to be

suitable options; The Mental Health First Aid (MHFA) and TWM. See Appendix A for full literature report.

Environmental Scan Summary

To assist in determining the program that would best meet the needs and objectives of the practicum an environmental scan was completed with Charles Boyer of the Mental Health Commission of Canada. He is the acting manager and business development specialist for both the Mental Health First Aid and The Working Minds programs offered by the Commission. Charles advised that TWM and MHFA are complimentary courses, but he felt TWM would be the right program for the practicum. I had completed the MHFA course three years ago and last month completed the supervisor edition of TWM and I have to agree with Charles that TWM covers the required topics, delivers to the right audience, and can be delivered both face-to-face and virtually.

TWM is an evidence-based program developed in 2012, designed to promote mental health and reduce the stigma around mental illness in the workplace. In reducing stigma and discrimination, TWM helps organizations create a culture that fosters greater awareness and support for positive mental health among employees, managers, and employers (Mental Health Commission of Canada, 2020). The programs main objectives are:

- Understand mental health and mental illness
- Recognize its signs and indicators, in themselves and others
- Reduce stigma and negative attitudes toward people with mental health problems
- Support colleagues with mental health problems
- Maintain their own mental health and improve their resilience

The program is now offered virtually due to the Coronavirus disease 2019 (COVID-19) pandemic and offers both employee and supervisor delivery options. The employee virtual version is five hours in duration and the supervisors is seven hours making delivery to all business lines across the country more convenient. There is also a 'train the trainer' selection that provides participants the knowledge, skills, and certification to facilitate TWM employee and manager courses. This program is designed for organizations looking to deliver meaningful and cost-effective in-house mental health training to their staff.

Consultations Summary

The consultation scan involved completing telephone interviews with six employees of Imperial Oil. The participants from IOL/EMCE provided insightful feedback into the current mental health culture at IOL/EMCE and a sense of what is needed to promote and encourage mental health awareness in the organization. The overall themes from the interviews were that:

- The mental health culture at IOL/EMCE is emerging and evolving and there has been a greater acceptance and openness to talk about mental health in recent years.
- Negative impacts of poor mental health and mental illness in the workplace was demonstrated through an increase in absenteeism, low productivity, job insecurity, decreased work effort and the potential for harassment.
- There remains a stigma regarding mental illness in the workplace.
- All participants felt an evidence-based mental health program would be beneficial to all employees.

There was some disparity among the participants regarding if the program should be mandatory for all employees to complete. All respondents felt it should be mandatory for supervisors, as it would provide them the tools to identify if one of their employees were

struggling, identify supports they could avail of, and the knowledge to assist in accommodating them in the workplace. There were some who sensed that if the program was mandatory, participants would see it as a check mark in their training schedule and not engage in the sessions. My initial intent was to make the program a requirement for all employees, but this approach will require further discussion with management within the organization as I move forward with the proposed practicum project. See Appendix B for full environmental - consultation scan report.

Advanced Practice Nursing Competencies

In my proposal I identified a number of advanced nursing competency practices from the Canadian Nurses Association (CNA) that I planned to demonstrate through both practicums, including research utilization, consultation and collaboration, and leadership. Competencies are the specific knowledge, skills, judgment and personal attributes required for a nurse to practise safely and ethically in a designated role and setting (2019). In the first practicum, I had the chance to critique and apply evidence based research through completing an extensive literature review to support the proposed practicum initiative and identify a research-based innovation (The Working Mind) to improve employee and organizational health.

Progressing through the environmental and consultation scans allowed me to collaborate and consult with key stakeholders both within and outside the company, collect and analyze data and identify there is a need for a mental health program within the organization. Collaboration and consultation will continue to be a key competency that will be required as I continue with the implementation and evaluation plan. Effective collaboration and communication with other health-care team members and stakeholders represent important aspects of all nursing practice.

Advanced practice nurses are expected to consult and collaborate with colleagues across sectors and at the organizational, provincial, national and international levels (CNA, 2019).

According to the CNA (2019) leadership competency entails nurses being leaders in the community and organization. They are agents of change, consistently seeking effective new ways to practise and improve care. Implementing a mental health program at IOL is a leadership initiative that will improve the overall health of employees and the mental health culture of the company. It is also an initiative that will support my advancement in the occupational health department and further my ability to provide leadership to nurses across the organization. As I progress this initiative I look forward to building on these competencies and demonstrating additional advanced nursing competency practices.

Next Steps

The initial step in the implementation plan will be to present the proposal to senior leadership to obtain their approval and support for the program which is essential for it being put into practice throughout the organization (See Appendix C). The presentation to the management team will include a power point presentation that outlines:

1. The incidence of mental illness and poor mental health in Canada and within the company.
2. The effects of mental illness on the business including absenteeism, presenteeism and lost productivity.
3. The cost associated with mental illness in the workplace due to low productivity and the length of absence associated with mental health claims.
4. An overview of TWM course, what the course entails and the benefits for employees and the organization as a whole.
5. The plan for roll out to supervisors and employees. The ‘train the trainer’ option.

The second step in the plan will be to have a representative from the Mental Health Commission of Canada present The Working Mind Executive Package to leadership. The Working Mind "Executive" presentation is designed to give decision makers a synopsis of the Working Mind program. It is a 2.5-hour presentation that covers the program in enough detail to garner value. Below is an overview of what the executive presentation entails.

Module 1: Introduction to The Working Mind

Module 2: Mental Health and Stress in the Workplace

Module 3: Stigma Reduction in the Workplace

Module 4: Mental Health Continuum Model (how are you feeling)

Module 5: The Big Four Skills (cognitive behaviour therapy-based coping mechanisms)

Module 6: What You Can Do?

Module 7: Ad-hoc Incident Report (AIR) - a tool to structure a supportive intervention with a group or individual following exposure to any potential distress

Module 8: Workplace Accommodation (reducing disability costs, getting people back to work earlier etc.)

Module 9: Practical Skills and Application (what to do with what you have learned through the first 8 modules – scenario work)

If leadership supports the implementation of TWM, the next phase will involve a detailed plan on how the program can be efficiently and effectively offered to the workforce. The company has business lines located all across Canada and the strategy would be to have select employees trained as providers of the program.

Having in-house trainers has a number of benefits including:

- Cost saving as the cost per participant is less when compared to sending the same number of employees to public training courses or having an external trainer provide the course. The cost for each participant is $200.00 for a virtual course provided by the Commission.

  The train the trainer course is approximately $3500.00 per course and the in-house trainer could then provide the course at no cost to the employees of the company.
- It allows the training to focus on specific topics that are causing issues within the business.
- The course can be offered around the working schedule of the staff and at a location they come to everyday.

The determination of employees who should attend the 'train the trainer' course will be left to each business line location. I would suggest nurses, human resources advisors or safety personal, but in my opinion as long as the participant has a passion for mental health it could be any employee that could be considered who is interested in becoming a trainer.

Evaluation

The Centres for Disease Control and Prevention (CDC, 1999) outlines four outcomes of interest that indicate a program's effectiveness: worker productivity, health costs, health outcomes, and organizational change. A workplace health program that improves employee health by reducing, preventing or controlling diseases can enhance worker productivity and limit costs. Improvements in physical, mental, and emotional health enhance resiliency, concentration, and motivation which lead to greater work output. The cost savings provided by implementation of TWM would be measured through decreased absenteeism rates due to mental illness, reduction in length of disability absence related to mental illness pre and post implementing the program, and a lower incidence of mental health worker compensation claims post introduction.

Providing a mental health program to employees has the ability to improve their health outcomes as they gain knowledge, resiliency and coping skills as well as build a support network among coworkers and supervisors. TWM can enable employees to implement healthy behaviors in the short-term and this may lead to changes in physical, mental, and emotional health in the long-term through self-care activities. Heath outcomes would be evaluated through a review of the company's Employee Family Assistance Program (EFAP), claim reduction, disability stats and Alcohol and Drug cases (policy violation versus disclosure).

Lastly, the CDC lists organizational change as an outcome for evaluation. IOL/EMCE has begun to create a culture of caring, not just about physical health, but also mental health. The organization wants to address employee's health concerns by providing support through the development of policies and practices that address these issues. A change in employee morale is seen as an indicator of positive organisation change and this would be measured through online surveys using the program Survey Monkey. The survey will be e-mailed to the workforce immediately post training at again at 3 months. The survey will be confidential, will reach all of the employees who participated, is not a laborious task, and is presently utilized by IOL at present employee assemblies.

Conclusion

When I first met with Dr. Moralejo in early March to discuss my topic for the practicum I did not realize the impact Coivd-19 would have on the world and my workplace one year later. In that time, we have lost a worker at one of our sites to Covid-19, we had a suicide at one of our remote sites, the Oil and Gas sector has taken a devastating financial loss, and for the first time in the history of the company there were mass layoffs across the country. Employees have never been more unsure of their physical, mental, and financial future and there is still a lot of uncertainty as we move forward. I feel there is now a more urgent need for the company to adopt a mental health program than ever before. The first practicum provided me the opportunity to gain knowledge and to understand the negative effects of mental illness and poor mental health on employees and the organization. It identified a Canadian developed evidence-based course (TWM) and the immense benefits of this course for organizations who has implemented it. The second practicum allowed me to develop an implementation and evaluation plan to ensure the company is aware of the benefits of this program to both employee well-being and productivity.

The goal is that TWM will reduce the stigma around mental illness, promote mental health, change the way employees think and talk about mental health and mental illness, help participants identify poor mental health in themselves and other, give employees the coping skills to manage stress and poor mental health and finally, create a more supportive work environment at IOL of Canada.

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Appendix A: An Integrative Literature Review

NURS 6660 Literature Review

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In completing the practicum proposal one of the essential requirements is the completion of a comprehensive literature review. This will provide an understanding of what published literature exists regarding the impact- of poor employee mental health and mental illness in the workplace and information of evidenced-informed mental health programs that can be implemented in the workplace to promote positive mental health. This literature summary describes the literature review process, how decisions were made regarding study selections, and an in-depth review of the findings to determine if poor mental health/mental illness has a negative impact in the workplace, the review will also identify if there are evidenced-informed programs available for companies to implement to promote or support employee mental health.

Literature Search Methods

In starting the literature search there were two questions that guided the literature review to support the practicum proposal:

1. Does poor employee mental health and mental illness have negative effects in the workplace (i.e. productivity, absenteeism, presenteeism)?

2. Are there evidence-informed mental health programs that have been implemented in the workplace to aid or support employee mental health?

I reached out to Memorial University Library and received the assistance of a librarian in proceeding with the literature search. They suggested I use the electronic databases CINAHL Plus, PsycINFO, Google Scholar, and Medline. I searched for relevant material from January 2010 until present. Additional filters included English language only and full text. To answer the first question they recommended I search in the title for the following MeSH terms:

- Mental health or mental illness or mental disorder or psychiatric illness or anxiety or depression
- Productivity or efficiency or performance
- Workplace or organization or company
- Absenteeism or presenteeism or productivity

The search for the second question included the terms:

- Mental health or mental illness or mental disorder or psychiatric illness or anxiety or depression
- Programs or services or education or training
- Workplace or organization or company
- Stigma* or resiliency*

Inclusion and Exclusion Criteria

In addition to the date published, language, and full text availability additional criteria included:

1. Mental health or mental illness as the focus; not physical health

2. Intervention must be a mental health program or education session aimed at reducing stigma, increasing knowledge and resiliency and not a medical intervention (i.e. cognitive behavior therapy).

3. All study methodologies accepted (i.e. meta-analysis, quantitative, qualitative).

4. Studies that used Employee Family Assistance Program as intervention were excluded.

5. Study could be completed at a single workplace or across multiple workplaces.

Results

The initial search for articles relating to, does poor mental health and mental illness have negative effects in the workplace, resulted in 35 results with four relating directly to the impacts mental health and /or mental illness had on productivity in the workplace (See flow chart in Appendix A). This second search for evidence-based programs yielded 226 literature articles of which nine fit the inclusion criteria and were suitable (See flow chart in Appendix B).

Each of the studies chosen for the literature review have been placed in a literature review summary table (See Appendix C). Information on the author's names, study methodology, main purpose, country of origin, sample, data collection methods, the primary outcomes of the research and strengths and limitations is included. In addition, each study was appraised using the Public Health of Canada's (PHAC) Critical Appraisal Tool Kit (2014) so that the strength of the study design and quality of the study could be determined.

Impacts of Mental Health/Illness in the Workplace

The four articles that met the criteria for inclusion (Beck et al., 2011; Evans-Lacko & Knapp, 2016; Hilton et al., 2009; Johnston et al., 2019). All used a descriptive, cross-sectional, study design. These study designs provide important information about possible factors and effects of a disease and are useful for the formulation of hypothesis (PHAC, 2104). Two of the studies were completed in Australia (Hilton et al., 2009; Johnston et al., 2019), one in the United States (USA) (Beck et al., 2011), and the study completed by Evans-Lacko and Knapp (2016) looked at the data from eight countries (Brazil, Canada, China, Japan, South Korea, Mexico, South Africa, and the USA).

Three of the studies looked specifically at depression and its effect on productivity as determined by absenteeism and presenteeism. During a 25-month period Beck et al. (2011) analyzed data on the relationship between depression and work impairment for 771 patients who had been newly started on antidepressant medication and were working at least part time. The author's utilized the Patient Health Questionnaire 9-item screen (PHQ-9) to obtain data on depression severity. The PHQ-9 is broadly accepted as a valid measure to depression severity and was the same tool Johnston et al. (2019) used in their study to measure depression severity.

A score of 7 to 9 on the scale indicates mild or minor symptoms of depression, a score of 10-14 is considered moderate depression range, 15-19 is may indicate major depression and greater than 20 severe depression. For the purpose of this study, Beck et al. only provided data on individuals with scores of seven or greater leaving out the results of non-depressed individuals. 38% of individuals who were experiencing depression had scores in the moderate range, 34% in the minor range, and 21% in the major, and only 7% in the severe.

The Work Productivity and the Activity Impairment (WPAI) questionnaire, a well validated instrument to measure impairments in work and activities, measured the self-reported amount of absence from work due to mental health problems, as well as the level of presenteeism (productivity impairment when at work) during the previous seven days of work. Patients noted that in the previous seven days and average of 3.1 hours (8%) of their normal working hours were missed due to mental health reasons and 12.1 hours (35.2%) of their productivity was affected while at work. The results demonstrated a significantly strong linear relationship between depression symptom severity and work and productivity loss. Each one-point increase in scoring on the PHQ-9 correlated with an additional 1.65% loss in productivity. When the productivity loss in this sample of patients for depression (38%) is compared to normative data for the WPAI for other conditions, the difference is considerable. Those with conditions such as diabetes (8%), asthma (15%), back pain (16%), obesity (18%), angina (20%) and chronic pain (22%) demonstrated lower levels of lost productivity. The study does have limitations as 74.8% of the participants were female and 90.2% were non-Hispanic white which limits the generalizability, and the fact that the health status was self-reported may have provided less than precise data on depression severity.

As noted previously, Johnston et al. (2019) also used the PHQ-9 questionnaire to determine depression symptomatology in their study to measure how overall levels of depression affected work productivity in a large sample of 4953 employed individuals. They determined work performance (absenteeism and presenteeism) with the World Health Organization Health and Work performance Questionnaire (WHO-HPQ) a tool that has established validity and reliability among populations of people with and without chronic conditions (AlHeresh et al., 2017). As, Beck et al. (2011) only looked at the work productivity based on the previous seven days, this study assed the previous 28 days for absenteeism and presenteeism rates giving a more accurate determination. The results of both studies were similar as Johnston et al. (2019) found a significantly strong linear relationship between depression symptom severity and work and productivity loss. As depression severity increased there was an elevation in absenteeism and as work productivity levels declined depressive symptoms increased. The four most impactful depressive symptoms on productivity found were impaired concentration, depressed mood, self-criticism and sleep difficulties. Although there were limitations with the study, including the oversampling of male dominated professions and the self-reported levels of depression the results did demonstrate a significant relationship between depression severity and workplace absenteeism and presenteeism.

In the study completed by Evans-Lacko and Knapp (2016) they also looked at the effects of absenteeism and presenteeism due to depression in the workforce. They did not focus on a single company or population, but instead estimated the associated costs across eight diverse countries including: Brazil, Canada, China, Japan, South Korea, Mexico, South Africa, and the USA. They hypothesized that depression can influence productivity through absenteeism and

presenteeism, and suggested that presenteeism, being ill while present at work, accounted for the majority of the costs. The collected data through an analysis of figures collected in the Depression in the Workplace in Europe Audit and recruited participants for their study through an online market research panel of employed individuals in the eight selected countries. Participants were asked to complete an on line questionnaire and approximately 1000 were collected from each country. Of the 1000 from each country, ten percent of the respondents were managers. The questionnaire itself measured work performance using the WHO-PGQ tool, the same tool utilized by Johnston et al. (2019). Depression was determined by asking participants the questions "Have you ever personally been diagnosed as having depression by a health professional? An, additional question on depression asked if employees who reported a history of depression did not disclose to their employer, because they feared it would put their career at risk. Interestingly, less than 10% of responders from China and South Korea noted a previous diagnosis of depression, whereas 20.7% in Canada and 22.7% in the USA listed depression as previously diagnosed. The countries where employees feared telling their employer about their diagnosis due to career risk were Japan at 12% and the USA at 11.4%, Canada came in 4th place at 7.3%.

In terms of the costs associated with presenteeism the USA had the highest annual cost per person at $5524/year for an aggregate cost of 84 billion annually. Canada placed fourth on the list with presenteeism costing $4270/year for each person and an aggregate total of 6.8 billion dollars annually. The authors also noted the cost associated with work productivity and depression was 5-10 times higher for presenteeism than absenteeism. As with the previous studies, a limitation noted was that the diagnosis of depression was based on self-reporting which presents a bias, also the study asked about a lifetime experience with depression and this may not

provide an accurate representation of present depression severity. The researchers concluded that workplace programs that support acceptance and openness about depression could be important factors in improving workplace productivity and encouraging employees to seek support and treatment, an important finding to support the goal of my practicum.

The last study by Hilton et al. (2010) again used the WHO-PGQ tool to evaluate employee productivity from chronic and acute mental health disorders. They did not focus specifically on the severity level of depression, as the previous studies did, but instead used the Kessler 6 (K6), a six-item questionnaire to assess the level of psychological distress. The K6 is a valid and reliable measure of psychological distress. Its conciseness and vigorous predictive power for psychiatric disorders confirms its usefulness in clinical and community settings to determine levels of psychological distress (Ferro, 2019).

A total of 59981 full-time employees (25% response rate) of large Australian employers responded to both the WHO-HPQ and K6 questionnaires. Using an ANOVA model the results revealed that as an employee's psychological distress level increased their level of productivity decreased. The total cost associated with lost productivity from employees with moderate to high psychological distress is $ 2.81 billion dollars annually when treatment behavior is not factored in. When treatment seeking behaviour is taken into account the numbers balloons to $5.9 billion annually. The study did have a number of limitations, including the low response rate and non-random sampling, but it is one of the largest samples of employee data collected on psychological distress and productivity. The prevalence of moderate or high levels of psychological distress in Australian employees is evident and the authors note that workplace programs focused on mental health have a real potential to not only provide support for the employee, but also provide a substantial return on investment for the employer.

Quality and Insights

This collection of studies all used a cross-sectional design which according to the PHAC Critical Appraisal Tool Kit (2014) are considered weak research designs that provide limited evidence. They are useful, however, in identifying possible associations and they have the ability to rapidly generate data and deduce on some health related events for policy makers or for generating hypotheses on the topic or for further research (Sedgwick, 2014). Although, a weak study design the quality of the four studies was rated as medium, based on the fact that the data collection sources and methods, and statistics were rated as moderate. The sample size in all studies was adequate and the studies used validated questionnaires for data collection. Two of the studies would be difficult to generalize as the sample used by Beck et al. (2011) included predominately white, females and the participants in the Johnston et al (2019) included an oversampling of people employed in male dominated industries which denotes a greater representation of male employees.

The results from all studies identified a positive correlation between self-reported levels of depression and/or psychological distress and low productivity as determined by absenteeism and presenteeism rates. The cost associated with low productivity was reported as in the billions annually for Canada (Evans-Lacko & Knapp, 2016) and both Hilton et al. (2010) and Evans-Lacko & Knapp (2016) identified that workplace programs that address mental health and illness in the workplace could potentially reduce absenteeism and presenteeism, and reduce productivity losses.

Workplace Mental Health Programs

The ten articles that met the inclusion criteria for the search included five studies from Canada (Castro et al., 2015; Dimoff & Kelloway, 2019; Dobson et al., 2019; Dobson et al., 2020; Szeto et al., 2019), two from Australia (Gayed et al., 2019; Morrissey et al., 2017), and one each from the United Kingdom (Moffitt et al., 2014), Sweden (Hadlaczky et al., 2014) and Germany (Hamann et al., 2016). The study designs included, meta-analysis, randomized control trial (RCT), controlled before-after and uncontrolled before –after that looked at various mental health programs and their effects on aspects of mental health and illness in the workplace and community.

Three studies looked specifically at Mental Health First Aid (MHFA). MHFA is an international, training program that was developed in Australia in 2001. Since 2001, Mental Health First Aid has spread to 23 additional countries (Moffitt et al., 2014). The course is designed for members of the public and includes information about signs and symptoms of mental health problems. The main aims of the program include:

- To preserve life if someone was in danger to themselves or others
- Prevent mental health problems becoming more serious
- Promote recovery
- Offer comfort to those experiencing mental health problems
- Raise awareness of mental health issues in the community
- Reduce stigma and discrimination

Morrissey et al. (2017) completed an uncontrolled before –after study to determine if the MHFA could enhance knowledge and support appropriate assistance for individuals. One hundred and sixty-two (n=162) undergraduate students from programs such as nursing, pharmacy, medicine, business, education, and humanitarian work participated by answering a 16-item quiz before and after (72% response rate) taking the MHFA course. The quiz included

questions on the effects of lifestyle and family relationships, mental illness and suitable responses while dealing with someone in a crisis. After completing the course, the participant correct response rate for the quiz increased from 57.8% to 71.0 %. On a scale of 1-10 participants on average rated their level of understanding as 7.0 post course and the degree to which the course is relevant in their lives a 9.0. The course did have limitations as attendance was mandatory for nursing and medical students, and voluntary for other disciplines and the course focused on how it affected knowledge, rather than choices and behaviour. The study did demonstrate that the course does improve knowledge on the determinates and experiences of mental health as well provide tools to the participants on how to interact with an individual in a crisis.

Similarly, to Morrissey et al. (2017), Moffitt et al. (2014) used an uncontrolled before – after study to determine if mental health programs impact the attitudes and knowledge towards mental health for fire service managers in the UK. One hundred and seventy-six (n=176) fire managers were randomly allocated to complete the MHFA, the "Looking after Well-being at Work" (LWW), or a one-hour briefing session on mental health (LS). In total, 106 attended and 89 completed pre-and –post questionnaires. There were 31, LWW participants, 41 MHFA and 17 LS.

The LWW is a program that was developed by local mental health practitioners and service users. The objectives of the course are:

- To promote understanding on the influence on well-being at work
- To enable people to look after their own and others well-being at work
- To increase awareness of the experiences of mental health problems
- To promote positive approaches to people with mental health problems

Both the MHFA and LWW courses were rated by the participants based on the manual, exercises, and facilitators. Response scores ranged from 1 (poor) to 5 (excellent) and the average

score for LWW was 3.93 and MHFA was 3.75 indicating high quality delivery of both programs. The questionnaire utilized the Attitudes to Mental Illness Scale (AMIQ), a reliable and valid tool, and the Knowledge and Efficacy about Mental Health Problems (KEMHP) questionnaire which had not been validated prior to the research. Additional qualitative feedback was gained as 15 participants from the LWW and MHFA course were randomly selected for phone interviews that were further analysed by a psychologist.

The results revealed that in comparing attitudes and knowledge pre and post course there was significant difference for both the LWW and MHFA, and no significant difference for the LS. Similar results were seen in the impact of each intervention with both LWW and MHFA showing significant difference and LS no difference. In the phone interviews, two themes emerged as participants felt better equipped to manage and respond to mental health problems and they expressed a change in their attitudes and assumptions of mental illness. Although the results, may be limited due to the fact the KAMHP was not a validated tool there was qualitative and quantitative data to support that both the LWW and MHFA programs promoted understanding of the workplace influence on stress, increased awareness of mental health issues, provided guidelines for colleagues and managers to offer assistance to someone struggling, and an overall more positive approach to mental health in the work environment.

Like the previous studies, Hadlaczky et al. (2014) examined the effects that Mental Health First Aid First training has on improving three outcome measures; behavior, knowledge and attitudes. The authors completed a comprehensive meta-analysis estimating the effects of MHFA for both adults and young people, based on results published up to March 2014. A total of 559 papers were initially identified and 15 remained once selection criteria was applied. Even though, the 15 studies involved different designs, they all used similar outcome measures.

Statistical analysis was completed using Meta53 software and results demonstrated significant results in all three outcome measures post MHFA training with a highly robust and moderately high effect size. Additional takeaways suggest that participating in MHFA decrease stigma toward mental illness and increases an individual's ability to provide assistance to those in need.

Three Canadian studies, Castro et al. (2015), Dobson et al. (2019), and Dobson et al. (2020) completed research on "The Working Mind" (TWM), and its effect on stigma reduction and improvement in resiliency skills. TWM is an evidence-based program developed in 2012, designed to promote mental health and reduce the stigma around mental illness in the workplace. In reducing stigma and discrimination, TWM helps organizations create a culture that fosters greater awareness and support for mental health among employees, managers, and employers (Mental Health Commission of Canada, 2018). The programs main objectives are:

- Understand mental health and mental illness
- Recognize its signs and indicators, in themselves and others
- Reduce stigma and negative attitudes toward people with mental health problems
- Support colleagues with mental health problems
- Maintain their own mental health and improve their resilience

Dobson et al. (2019) completed a review of surveys that participants completed in eight programs that were offered at various location throughout Canada. Participants were asked to completed surveys before, immediately after, and three months post. Stigma was measured using the Opening Minds Scale for Workplace Attitudes (OMS-WA), a 22-item scale specifically designed for the workplace and changes in resiliency was measured with a 5-item scale developed for this evaluation. Review of the pooled data noted that 1155 participants completed

pre-and post-surveys, with males making up 36.3% and females 62.3%. Participants self-rated mental health scores revealed that 88.2% considered their mental health good to excellent.

The results of the analysis on the effects of the program on stigma and resiliency discovered a statistically significant reduction in stigma and an increase in resiliency skills for front line workers and supervisors and for the public and private sectors. The authors also noted that 69.4% of respondents stated they had used what they had learned in the course at home or at work, 29.2% had reached out to a colleague regarding their mental health, and 20.5% said it had opened up the conversation on mental health in the workplace. The study also suggests that in the short term there may be increased costs associated with the programs, but the implementation has the potential to improve employee's psychological health, improve workplace culture, and increase work productivity.

Dobson was also involved in a 2020 study that used a cluster-randomized trial of immediate versus delayed implementation to determine the effects of the TWM program on kitchen and maintenance staff in the Nova Scotia Health Authority (Dobson et al., 2020). The immediate implementation group was comprised of 58 participants and the delayed group consisted of 60 participants. The delayed group received the training three months after the immediate group and measures were assessed pre training, immediately after the program and three months later. Similar to the previous study, the authors utilized the OMS-WA to measures stigma, resiliency was measured with a 5-item scale, and coping using the Mental Health Coping Scale.

In both groups it was found that stigma was significantly reduced form pre- to post test, there was a significant increase in resiliency for both groups, and improvement was also noted in coping for both groups. It was very promising to note the effects were maintained at the time of

the follow up assessment three months later for all outcome measures. The cluster-randomized design of this study and the use of validated outcome measures were a real strength, although the authors did note that the randomization in the immediate group was compromised as it was composed of mostly administrative staff and the delayed group had a good mix of both administration and maintenance participants. The authors felt that the results add further evidence to previous studies about the benefits of TWM in reducing stigma and increasing resiliency in the workplace.

Castro et al. (2015) found similar results to the previous studies using a uncontrolled before-after study to determine the outcome of offering TWM to 256 employees of a Husky Energy department in Canada in which ten sessions were offered over a three-month period. Outcome measures included stigma, resiliency, mental health well-being, and presenteeism and data was collected using surveys completed pre-workshop, post, and three months later. Of the 256 participants who attended the training 188 completed the pre questionnaire, 169 the post, and 63 the three-month follow-up. A parried sample t- test was used in analysis to determine if there was a statistical significant difference in the scores on the questionnaire pre and post program.

The results were promising as 74% of individuals indicated that they had reduced stigmatization attitude toward mental illness immediately after the program and three months late. In terms of resiliency there was a significant increase in participant's perception of their resiliency skills and the skills were again maintained at the three month follow-up. The effect on general mental health and presenteeism did show small gains although not statistically significant, but it is interesting to note that these measures did also not diminish from program completion to three months late.

There are some biases noted in the study as 62.9% of the participants were male, 67.2% were married and because respondents did not complete all surveys at the three points it may affect how the results were interpreted. The authors suggest that due to the fact some knowledge retention was lost over time booster sessions could help maintain what was learned initially, but overall the results indicate that TWM was successful in reducing negative attitudes and increasing resiliency skills.

The final fours studies of the review each looked at a different mental health training programs and their influence in the workplace. Hamann et al. (2016) used a controlled before-after design with the aim to research if a "mental -health at –the workplace" workshop would reduce stigma towards depression. A total of 580 participants (210 women/370 men) from 30 German companies attended a 1- or 1.5-day seminar on "mental -health at –the workplace". All participants were given a questionnaire to complete before and after the workshop with a total of 95% completing both. The questionnaire contained sociodemographic data, plus a depression stigma scale (DSS) to determine a personal stigma subscale and a perceived stigma subscale. Before taking the program participants had a mean score of 19.8 on the DSS, post program the there was a significant decrease to 15.5. Overall, 86% of respondents showed a decrease in personal stigma scores and managers demonstrated an overall increase in knowledge regarding depression. This study was not mandatory so may have only attracted participants who wanted to gain knowledge on depression and the design lacked a control group, it had a good sample size and an excellent response rate.

Dimoff and Kelloway (2019) also used a controlled before-after design to determine if a three hour mental health awareness training workshop would assist leaders in:

A. Recognizing the warning signs of an employee struggling
B. Promoting mental health in the workplace
C. Engaging in behaviors that support employee mental health and well-being

Leaders and employees from two organizations in Canada participated where leaders were assigned randomly to a training group or control group and employees and leaders completed the same set of surveys pre-training, six weeks later and again at twelve weeks. Overall, 56.92% of leaders and 51.25% of employees respond to the survey at all three points. When comparing leaders in the control group to those who completed the workshop the researchers found that for those that completed the training improvements in their ability to recognize warning signs of poor mental health, communicate more openly about mental health and available resources, and direct their employees to available and suitable resources. For employees who had leaders complete the training they felt more at ease with seeking out mental health resources and reported using resources more frequently than their coworkers whose leaders had not completed training. The authors suggest that the findings are consistent with past research that suggest that changes in leaders attitudes and behaviors towards mental health is associated with a positive change in employee behavior. This study did focus on small organizations, which are often overlooked in studies, and did utilize a control group. The study did have limitations, as the relationship between the employee and leader was not known before the study, there was a short period of time for follow –up, and there was a potential response bias as survey completion was optional.

Szeto et al. (2019) completed a meta-analysis on surveys that were completed by 4649 first-responders and supervisors at 16 sites across Canada that completed the program "The Road to Mental Readiness for First Responders" (R2MR). The R2MR Program for First Responders is a four hour program intended for frontline staff. Two of the main goals of the program are to

decrease mental illness stigma and increase resiliency. Participants were required to complete questionnaires pre, post and at three month follow-up. Similar to previous studies the OMS-WA was used to measure stigma and resiliency was measured using a 5-item scale developed explicitly for this study.

Analysis of the data revealed that the mean pretest score was 1.97 for stigma and posttest it was reduced to 1.85 representing a statistical significant reduction in stigma for both frontline staff and supervisors. A statistical significant change was also seen in resiliency as the mean score improved from 3.65 to 3.84 and participants also reported a significant difference in self-rated mental health. Additionally, intentions toward seeking help and providing support to colleagues showed significant improvement, and 59.2% stated that they had used what they had learned at work or home. Szeto et al. (2019) did also note that although it was beyond the scope of this research, there is the potential for a substantial financial gain for a company if the course encourages employees to seek early mental health care and remain off of a disability claim.

In the final study Gaye et al. (2019) compared what effects the mental health program, HeadCoach, would have on manager's attitudes and behaviors toward mental health. HeadCoach is an online program designed specifically for managers to assist them in understanding and supporting the mental health needs of their direct reports. A cluster randomized control trial (RCT) was used with three organizations in Australia, and included both managers and direct reports. A total of 229 managers were assigned to an intervention or control group and each group completed questionnaires at baseline and then at six weeks and four months. Direct reports completed a baseline questionnaire and at five months that measured their level of psychological distress using the Kessler Psychological Distress Scale (K6). The authors listed two primary outcomes for the study. The first, was a noted a change in the manager's

confidence regarding mental health issues in the workplace, which was measured using questions rated with a five-pint Likert scale. The second, was changes in the managers behaviors, measured with the Health and Safety Executive Management Standards Tool.

Follow-up data was available for 47.1% of managers in the intervention group and 63.4% in the control group. Of the 391 direct reports who participated 44% responded to the follow-up questionnaire. A significant difference was noted in both the confidence level and behaviors of managers who completed the course and the results remained evident at follow-up. The study had hoped to identify changes in the direct reports mental health and well-being of managers who attended the training, but this was not demonstrated as K6 scores for staff of both groups did not significantly change.

Quality and Insights

The pool of studies reviewed used a variety of study designs that have varying degrees of strength and quality when examined using the PHAC. The uncontrolled before- after studies (Castro et al., 2105;Moffitt et al., 2014; Morrissey et al., 2017) all rated as weak in design, with medium quality. The controlled before-after (Dimoff & Kelloway, 2019; Hamann et al., 2016) had strong design with medium quality ratings. Meta-analysis that were completed by Szeto et al. (2019), Hadlaczky et al. (2014) and Dodson et al. (2019) demonstrated a strong study design of high quality. Lastly, the RCT completed by Gayed et al. (2019) also displayed a strong design with the quality rating as medium.

There were limitations identified in a number of the studies including, the inability to generalize the findings, the attrition rates for the follow-up questionnaires, and it was unclear as to how long the benefits of the course lingered past the three month follow-up periods. Some of

the studies did state that implementing mental health programs in the workplace had the potential to reduce cost and improve productivity, but only the study by Castro et al. (2105) looked at its influence on productivity and I found no studies that researched program implementations and direct cost savings. That being said, the overall theme from the studies was that mental health education programs implemented in the workplace decrease stigma, increase resiliency and knowledge, and have the ability to create a psychologically safe workplace.

Conclusion

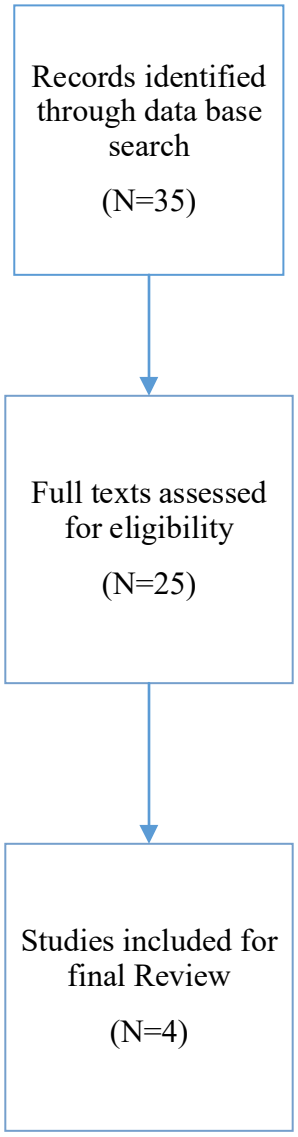
The goal of the literature review was to determine if employee mental health and mental illness have negative effects in the workplace and if there are evidence -informed mental health programs available that have been implemented to support and promote employee mental health. The Government of Canada (2017) notes that:

- One in five Canadians experience a psychological health problem or illness in any given year.
- Psychological health problems and illnesses are the number one cause of disability in Canada
- Psychological health problems cost the Canadian economy ~$51 billion per year, $20 billion of which results from work-related causes.
- Forty-seven per cent (47%) of working Canadians consider their work to be the most stressful part of daily life
- Psychological health problems affect mid-career workers the most, lowering the productivity of the Canadian workforce
- Only 23% of Canadian workers would feel comfortable talking to their employer about a psychological health issue

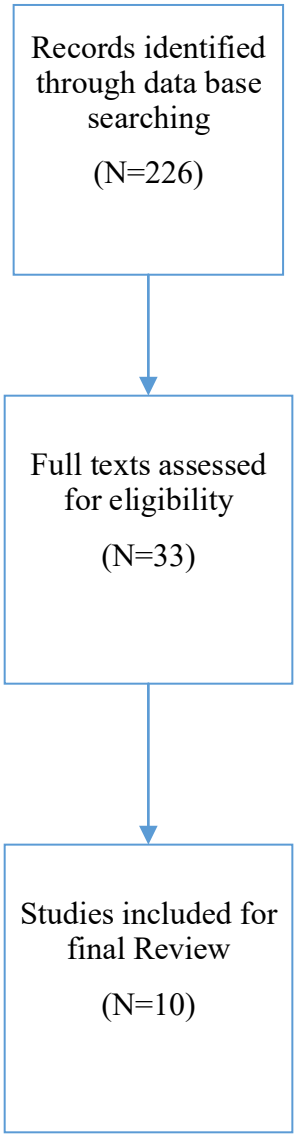
With the above statistics and the results of the literature review there is little doubt that mental health problems are having a negative effect on employees, employers and the Canadian economy. If organizations can implement a mental health program to effectively reduce the stigma associated with mental illness, increase individual resiliency, and enhance knowledge, thus increasing productivity it is something that must be explored and considered. It will not only

improve the well-being of employees and create a psychological safe workplace, but also reduce costs associated with disability claims and improve a company's overall financial health.

Appendix A


Records identified through data base search
(N=35)
Full texts assessed for eligibility
(N=25)
Studies included for final Review
(N=4)

Appendix B


Records identified through data base searching
(N=226)
Full texts assessed for eligibility
(N=33)
Studies included for final Review
(N=10)

Appendix C

Study/Design	Methods	Key Results	Strength of Design
Dobson et al., (2019). Meta-Analysis: comparable design with an open trial methodology. Purpose: To determine if The Working Mind program was associated with reductions in stigma and increased resilience.	Country: Canada Sample: • 8 workplaces in Canadian jurisdictions between Dec 2013 and May 2015. • 414 surveys reviewed Data Collection: • Outcomes were assessed before, at its completion, and 3 months later. • Stigma was measured using the Opening Minds Scale for Workplace Attitudes. • Resilience was measured with a 5-iten scale Analysis: • 2-fold approach: the "metan" command was used to show changes in pre-to-post-test. • The Q test was used to assess homogeneity.	Primary Outcomes • Statistically relevant reductions in stigma. A overall mean improvement of .17 scale points • Statistically significant improvement in resiliency skills of .31 scale points	Strength of design: Strong Quality of study: High Strengths: • Multiple sites , large sample, diverse characteristics • Included both quantitative and qualitative measures Limitations: • No control group • Large attrition of participants at the follow up period.

Study/Design	Methods	Key Results	Strength of Design
Hadlaczky et al., (2014). Meta-Analysis Purpose: Estimate the effects of the MHFA program both for adults and young people.	Country: Sweden Sample: An extensive literature search resulted in 15 papers for inclusion. Data Collection: Data was collected on three outcome measures: knowledge, attitudes, and behaviour. Analysis: • All statistical analysis were made in Meta53 software and used an alpha level set to 0.05. • A random effects model was used in all analysis, which reduced the effect of large-sample studies.	Primary Outcomes Knowledge: MHFA is effective in increasing knowledge regarding mental health problems. The effect is highly robust and has a moderately high effect size (Glass's △= 0.56). Attitudes: MHFA decreased negative attitudes towards individuals suffering with mental health problems. The effect is very robust, but moderate (Glass's △= 0.28). Behaviours: MHFA is effective in increasing help-providing behaviors. The mean effect was (Glass's △= 0.25), but likely this is an underestimation of the true effects in behaviour.	Strength of design: Strong Quality of study: High Strengths: • All studies used similar outcome measures Limitations: • Majority of subjects were female.

Study/Design	Methods	Key Results	Strength of Design
Szeto et al., (2019). Meta-Analysis Purpose: To determine the effectiveness of the Road to Mental Readiness program in reducing the negative stigma of metal health and increasing individual's resiliency.	Country: Canada Sample: 4,649 participants completing pre and post surveys. 845 completed follow-up survey. Data Collection: • Outcomes (reduction in mental illness stigma and improvement in resiliency skills) were assessed before, at its completion, and 3 months later. • All implementations were evaluated using a non-randomized quasi-experimental pre-post follow-up design. • Stigma was measured using the Opening Minds Scale for Workplace Attitudes. • Resilience was measured with a 5-item scale.	Primary Outcomes • Statistically significant reductions in stigma were observed with an overall mean stigma reduction of 0.12 scale points. • The resiliency skills scale showed an overall improvement of 0.19 scale points which was statistically significant at the 95% CI. • Additional significant improvement was observed in intentions toward seeking help and behaviours related to openness and supporting fellow colleagues.	Strength of design: Strong Quality of study: High Strengths: • Large sample size, diverse respondents from various geographical locations throughout Canada. • Both quantitative and qualitative scales used Limitations: • The study design was pre-post-test with a follow-up open trial. A randomized control trial would have been preferred. • Attrition at the time of follow-up • Follow-up conducted at 3 months. It is unclear how long these effects might persist beyond 3 months.

Study/Design	Methods	Key Results	Strength of Design
Gayed et al., (2019). Randomized control Trial (RCT) Purpose: To evaluate if the online manager training program, "HeadCoach", assisted in created a mentally health workplace.	Country: Australia Sample: • 229 managers • 391 direct report employees Data Collection: • Questionnaire at baseline, at 4 month for managers and 5 months for direct reposts Analysis: • Self-reported confidence measured using a 5-point Likert scale • Changes in behaviour measured using the Health and Safety Executive Management Standards Indicator Tool. • Direct reports level of mental distress was measured using the Kessler Psychological Distress Scale (K6).	Primary Outcomes: • Manager's confidence and behaviours significantly improved over time when compared to control group. • The direct reports level of psychological distress remained stable from pre to post questionnaire.	Strength of design: Strong Quality of study: Medium Strengths: • RCT Limitations: • Adherence rate for program completion and follow-up surveys was low • Reliance on self-reported measures to evaluate effectiveness of the program.

Study/Design	Methods	Key Results	Strength of Design
Hamann et al., (2016). Controlled Before-After Purpose: To determine if a "mental-health-at-the-workplace" educational workshop would reduce stigma towards depression.	Country: Germany Sample: • A convenience sample of 580 managers of more than 30 companies/employers • 99% agreed to participate and 95% completed both questionnaires Data Collection • Questionnaire immediately before and after workshop • Participants asked to complete the Depression Stigma Scale • Four additional items were generated to specifically address stigma at the workplace. Analysis: • Outcomes measured using the t-test for paired samples and the Wilcoxon's rank sum test.	Primary Outcomes: • Before the intervention participants had a mean scores of 19.8 in the depression stigma scale and post intervention scores were 23.4. Markedly lower personal stigma towards depression • There was also a significant decrease in personal stigma scores. Overall 86% of participants showed a decrease in stigma scores.	Strength of design: Strong Quality of study: Medium Strengths: • Response rate for both questionnaires • Sample size Limitations: • Focused on depression • No control group • Short term results • Participation was voluntary so people interested in the topic attended

Study/Design	Methods	Key Results	Strength of Design
Dinoff & Kelloway (2019). Controlled Before-After Purpose: To evaluate the impact of a leader-focused mental health training on employee's resource use and leader's communication about mental health and mental health resources.	Country: Canada Sample: • Organization A had 20 leaders and 60 of their employees • Organization B had 40 leaders and 100 of their employees • Leaders randomly assigned to a training group or control group Data Collection: • Surveys were issued one week prior to training, 6 weeks and 12 weeks post-test • 37 (56.92%) of leaders responded to survey at all three points. • 82 (51.25%) of employees responded to survey at all three points Analysis: • Two separate repeated measure multivariate analysis of variance were used to test group differences.	Primary Outcomes: • No significant difference seen in leaders stigmatizing attitudes • Significant increase in leaders communication about mental health and resources • No significant difference in consideration for struggling employee • Significant increase in leader's actions to facilitate employee resource use. • Employees noted significant increase in leaders communication about mental health and resources • Significant increase noted by employees in leaders consideration for struggling employees were noted	Strength of design: Strong Quality of study: Medium Strengths: • Incorporated leaders and employees • Did not rely on self- reports • Focus on smaller organizations which are often understudied Limitations: • Short time period of investigation • Sample size limited • Survey completion was optional • Low response rates (below 60%)

Study/Design	Methods	Key Results	Strength of Design
Moffit et al., (2014). Uncontrolled Before-After Purpose: To evaluate the impact of three mental health interventions on attitudes and knowledge towards mental health in fire service managers.	Country: United Kingdom Sample: • 106 line managers were randomly assigned to one of three mental health training programs. Data Collection: • 106 in total attended and 89 completed pre- and post-questionnaires • Data was collected using the Attitudes to Mental Illness Scale and (AMIQ) and the Mental Health Stigma Questionnaire • 15 random participants each from the LWW and MHFA course completed phone interviews. Analyses: • A MONOVA comparison was utilized to compare groups	Primary Outcomes: • Tests for MHFA and LWW for attitudes and knowledge showed a significant difference in AMIQ scores. No significant difference for LS. • The impact of the intervention demonstrated a significant difference for LWW and MHFA participants, but nil for LS. • Evaluations of all aspects of the MHFA and LWW courses rated good to excellent.	Strength of design: Weak Quality of study: Medium Strengths: • Number of participants • Random allocation • Both quantitative and qualitative outcome measures Limitations: • May not be applicable to other organizations • Training sessions carried out by one of the authors so facilitation bias cannot be ruled out

Study/Design	Methods	Key Results	Strength of Design
Morrissey et al., (2017). Uncontrolled Before-After Purpose: To determine if Mental Health First Aid courses enhance mental health knowledge.	Country: Australia Sample: • 219 undergraduate students. 110 female and 109 male. • 162 (74%) completed the quiz pre and post course Data Collection: • 16 item quiz pre and post course Analysis: • Total scores before and after were compared using a paired t-test. • Individual questions were compared using descriptive statistics	Primary Outcomes: • 71% of participants showed an improvement in scores from pre to post quiz. • The course did improve knowledge on the determinates and experiences of mental health as well as how to interact with individuals during a crisis.	Strength of design: Weak Quality of study: Medium Strengths: • Sample size Limitations: • Attendance was voluntary for some and mandatory for others • Results may not be applicable to other groups

Study/Design	Methods	Key Results	Strength of Design
Castro e al., (2015). Uncontrolled Before-After Purpose: To evaluate the effectiveness of "The Working Mind" at Husky Energy.	Country: Canada Sample: • One 300-person department at Husky energy • Of the 256 participants, 188 completed pre questionnaire, 169 completed the post and 63 completed the follow-up Data Collection: • Surveys were completed pre workshop, immediately post and months later Analysis: • The paired sample t-test was used to compare scores • In addition to p-values Hedge's g was also provided with the t-tests	Primary Outcomes: • 74% showed reduced stigmatization attitudes toward those with mental illness in the short term and after 3 months • A significant increase was noted in participant's perceptions of their resiliency skills from pre to post. • There was a statistically significant decrease in knowledge at three months • 54% of participants stated that the program had increased their resiliency and 48% stated it had improved their mental health.	Strength of design: Weak Quality of study: Medium Strengths: • Sample size • Used both quantitative and qualitative measures Limitations • Results may not be applicable to other groups • Low response rates on follow-up questionnaires

Study/Design	Methods	Key Results	Strength of Design
Hilton et al., (2010). Cross-Sectional Purpose: To estimate employee work productivity by mental health symptoms	Country: Australia Sample: • 59 981 full-time employees of 58 large Australian employers. Data Collection: • Participants completed the World Heath Organizations Health and Work performance Questionnaire (HPQ) • Embedded in the HPQ is the K6, a six-item scale of psychological distress. • The HPQ contains questions relating to three types of mental disorders (depression, anxiety, and other emotional problems) Analysis: • Statistical significance was tested using the Pearson X2 statistic. • ANOVA was utilized to compare outcomes	Primary Outcomes: • Employees in high psychological distress category has significantly lower productivity than both moderate and low. • Moderate and high psychological distress results in a 2.81 billion loss in productivity when treatment seeking behavior not factored in. • When treatment seeking behaviour is factored in losses due to productivity are estimated at 5.9 billion. • 13.1% of male and 14.9% of female employees have either moderate or high levels of psychological distress.	Strength of design: Weak Quality of study: Medium Strengths: • Sample size Limitations: • Non-random sampling • Low survey response rate

Study/Design	Methods	Key Results	Strength of Design
Beck et al., (2011). Cross-Sectional Purpose: To evaluate the relationship between depression symptom severity and productivity.	Country: USA Sample: • 1,168 patients who were newly started on an antidepressant medication and were employed full time. • 771 (66%) were analyzed to determine relationship between depression and work impairment. Data Collection: • The Patient Health Questionnaire (PGQ-9) to determine depression severity. • The Work Productivity and Activity Impairment (WPAI) to determine productivity. Analysis: • The PROC GLM program was used to investigate the relationship between depression severity and productivity loss.	Primary Outcomes: • There is a string linear relationship between depression symptom severity and work and productivity loss. • In the previous 7 days participants reported that an average of 3.1 hours, or 8%, of their total work hours was missed because of a mental health problem.	Strength of design: Weak Quality of study: Medium Strengths: • Valid questionnaire tools • Large real-world sample, results can be generalized Limitations: • Lack of detailed data on health conditions • Individuals only included with PHQ-9 score of > 7

Study/Design	Methods	Key Results	Strength of Design
Johnston et al., (2019). Cross-Sectional Purpose: To investigate the relationship between both overall levels of depression and workplace productivity.	Country: Australia Sample: • 4593 participants from the Australian workforce who were 18 years or older and currently employed. • The presence of depression symptoms of other stress related symptoms not a requirement to participate Data Collection: • The Patient Health Questionnaire (PGQ-9) to determine depression severity. • Participants completed the World Heath Organizations Health and Work performance Questionnaire (HPQ) Data Analysis: • Data was analyzed STATA version 12.1	Primary outcomes • A significant relationship existed between depression severity and both workplace absenteeism and presenteeism • Depression severity was associated with accelerated levels of absenteeism and the relationship between depression and presenteeism showed a steadier decline in performance as symptoms increased.	Strength of design: Weak Quality of study: Medium Strengths: • A validated measure of absenteeism and presenteeism was utilized • Sample size • Results could be generalized Limitations: • A oversampling of people employed in male dominated industries • Self-reporting

Study/Design	Methods	Key Results	Strength of Design
Evans-Lacko & Knapp (2016). Cross-Sectional Purpose: To examine the impact of depression on workplace productivity across eight diverse countries	Country: Brazil, Canada, China, Japan, South Korea, Mexico, South Africa, and the USASample: • Approximately 1000 respondents from each of the listed countries • 10% were mangers Data Collection: • Data was collected in the Global IDEA (Impact of Depression in the Workplace Europe Audit). • On-line survey was e-mailed to participants • Self-reported absenteeism and presenteeism was recorded using the HPQ Analysis: • A modified Park test was used to select most appropriate distribution • All analysis was carried out using SAS version 9.3 and Stata version 11	Primary Outcomes • The USA and Brazil had the highest presenteeism cost per person. • Cost of presenteeism associated with depression tended to be 5-10 times higher than the cost absenteeism • The average cost of absenteeism per employee in Canada is 1,567/year and 4,279/year for presenteeism. • The aggregate cost in Canada for absenteeism is 2,500,380,791 and for presenteeism is 6, 813,417,981	Strength of design: Weak Quality of study: Medium Strengths: • Included a diverse range of countries • Sample size • The human capital approach was used to estimate productivity costs which id the most commonly used approach across health economics Limitation: • Diagnosis of depression based on self-report • Availability of employee assistance programs not factored into analysis

Study/Design	Methods	Key Results	Strength of Design
Dobson et al., (2020). Cluster Randomized Design Purpose: to determine if the "The Working Mind" program will reduce stigma and increase resiliency.	Country: Canada Sample: • 58 participants in the immediate implementation group • 60 participants in the delayed implementation group Data Collection: • Stigma was measured using the OMS-WA • Resiliency was measured using a 5-item sale • Open-ended questions were analyzed for themes Analysis: • Descriptive statistics were conducted using the SPSS Version 25.	Primary Outcomes • Stigma demonstrated a significant reduction from pre-to post-test for both groups • Changes in resiliency was maintained from the post-test to the time of follow-up test for both groups • Improvement was note in mental health coping from pre-to post-test for both groups and was sustained at time of follow-up • 77.38% stated that they had used what they had learned in the program at work or home.	Strength of design: Strong Quality of study: Strong Strengths: • Use of a control group • Validated outcome measures • Using both quantitative measures and qualitative questions Limitation: • Cluster randomized groups were not equivalent at baseline • Study assessed program effect at 3-months, but longer intervals should be considered

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Appendix B – Consultation and Environmental Report

NURSING 6660

Consultation and Environmental Report

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Background

The goal of this practicum is to implement an evidence-based mental health education program at Imperial Oil (IOL) Canada. To support this proposal both an environmental and consultation scan were utilized. The consultations were carried out with six key individuals within Imperial Oil to obtain their thoughts and opinions on the culture of mental health at Imperial Oil. The environmental scan included an interview with a manager from the Mental Health Commission to provide additional information on programs available in Canada, programs that were implemented at other organizations and how the employees and organizations have benefited from these programs.

Environmental Report

For the environmental scan, a telephone interview was completed with Charles Boyer of the Mental Health Commission of Canada. He is the acting manager and business development specialist for both the Mental Health First Aid and Opening Minds programs offered by the Commission. Initially, an e-mail requesting an opportunity to set-up a meeting to discuss the practicum was sent to Mr. Boyer. Mr. Boyer accepted and we had a preliminary phone discussion to review the goals of the practicum, results of the literature review and the plan for implementation and evaluation. He was happy to assist in any way possible and agreed to participate in an audio-taped telephonic interview. Pre-determined questions (see Appendix A) were developed for the interview and Mr. Boyer was assured that the taped interview would be stored on a password protected phone and deleted once the report was completed. The written report would be stored on a password protected personal computer in my locked office.

In total, 13 questions were asked:

Question 1: How long have you been with the Mental Health Commission of Canada (MHCC)?

Mr. Bower has been in his present position for five months with the commission.

Question 2: What mental health programs are presently offered by the MHCC for employers and employees in Canada?

At present due to the Covid-19 pandemic the Commission is offering two virtual mental health programs; The Working Mind (TWM) and Mental Health First Aid (MHFA). These courses can still be offered in person, but only if social distancing can be maintained.

Question 3: For each program listed what is the primary aim of the program for both employees and employers?

TWM and MHFA are complimentary courses. TWM is designed to break down stigma and raise resiliency within a workplace setting. It provides tools for participants to self-identify where they are on their mental health journey and tools to assist in increasing resiliency. The MHFA differs as it provides tools for participants to assist someone in a mental health crisis, similar to a standard first aid course where you learn the skills to assist someone with a physical injury or illness.

Question 4: Are certain programs better applied in certain work environments (i.e. office, field, military, and emergency response)?

"Yes, we recognize that the office is different from out in the field. Both courses have adaptations, for example, TWM first responder adaptation is slanted toward specific first responders (i.e. police, nurses, paramedics) and we also have a module for adults working with youth. With each course we have a train the trainer option which allows someone from within

the organization to get trained and then offer courses to the workplace. It works very well as the individual understands the culture of the organization."

Question 5: Have the courses been successful in decreasing the stigma associated with mental illness and if so, why?

"Yes, the literature and evidence speaks for itself as there are numerous studies that demonstrate the course does increase resiliency. There is a module in the Working Mind that specifically addresses resiliency. There are also the anecdotal stories where participants come up to a trainer after a course and after looking at the mental health continuum recognize where they are from a mental health standpoint. Videos are shown throughout each course with real people telling their stories about their experience with mental health stigma."

Question 6: Have the courses been successful in increasing resiliency and if so, why?

The course offers a specific module on resiliency that provides strategies to increase individual resiliency. It provides specific strategies to increase resiliency, which are known as the Big Four; deep breathing, mental rehearsal, positive self-talk, and smart goal setting. These are tangible tools that are simple to follow and have been proven in the literature to increase resiliency.

Question 7: Are you aware if the course has increased work productivity through a decrease in absenteeism and presenteeism?

"We have heard many anecdotal stories where participants have stated that not only are you saving my marriage, but you are also saving my job." After completing the course and getting on the path to recovery the large blocks of absenteeism seem to decrease and they are more likely to reach out to Employee Family Assistance Programs to get help and allow them to remain at work and remain productive while at work.

Question 8: Is there a course you would recommend that would decrease stigma, increase resiliency and have a positive effect on productivity? If yes, why

"The Working Mind would be the course I would recommend as both stigma reduction and resiliency are primary aims of the program."

Question 9: What is the preferred delivery method for each course?

"The preferred delivery method due to Covid is virtual, prior to the pandemic it was in person delivery. The virtual Working Mind course takes approximately seven hours for the supervisor's version and five hours for the employee , but there is the option to deliver the courses over a couple of days if required. MHFA involves a two-hour self-learning module that must be completed prior to the virtual session, the virtual session is six hours long, but can be administered in two 3-hour sessions."

Question 10: Is there a train the trainer option for the recommended courses?

"There is a train the trainer option for both courses. For the MHFA there are core requirements that must be met before you can be trained. For example, we look for individuals with front line mental health experience to be a trainer in MHFA due to the course content. For TWM, the organization can put forward names and once the training is complete the Commission will decide if the individual has the necessary capabilities to facilitate the course effectively. Once trained for TWM, you can only deliver the course in the workplace you are employed and not outside to other employers."

Question 11: Is there a recommendation that the courses be repeated at a regular interval (i.e. every 2-3 years)?

"There is no requirement to recertify TWM or MHFA as there is with standard first aid, with TWM there are one hour booster sessions on specific modules that are available at 3, 6, and 9 months to the organization. We have also seen organizations offer the full TWM course every two years in their workplace."

Question 12: Are you aware of any other courses that are available outside of those offered by the MHCC?

"There are other courses that are offered by some of the EFAP providers, but we feel the amount of vigor that has gone into developing these courses sets us apart from the rest as these are evidence-based programs. We have had 500 000 Canadians complete MHFA and 200 000 complete TWM."

Question 13: Is there anything else you would like to say that was not brought forward in the interaction?

"We have spoken previously about the course being mandatory for all employees. I certainly feel that the program should be required for leadership and then have the leaders preach the benefits of the course and strongly encourage employees to complete".

Consultation Report

The consultation scan involved completing telephone interviews with six employees of Imperial Oil. The employees chosen included:

- IOL Country Occupational Health Manager (OHM)
- Clinical Coordinator Occupational Health Canada West (CCW)
- Human Resources Advisor Canada East (HRE)

- Human Resources Advisor Canada West (HRW)
- Employee Offshore Canada East. Mental Health First Aid Instructor (EOCE)
- Safety, Security, Heath and Environmental (SSHE) Manager, ExxonMobil Canada East (EMCE)

Pre-determined questions (see Appendix B) were developed for the interview and all participants were assured that the audio-taped interviews would be stored on a password protected phone and deleted once the report was completed. The written report would be stored on a password protected personal computer in my locked office. The aim of the interviews was to:

1. Understand how employees view the mental health culture at IOL.
2. Comprehend employee's opinions of the major impacts of mental health in the workplace.
3. Ascertain employees' knowledge of the resources that presently exist in the organization for employees struggling with mental health issues?
4. Determine if employees feel a mandatory mental health program would benefit their understanding of mental illness and support their own mental well-being.

In total, 14 questions were asked:

Question 1: How long have you been an employee with IOL/EMCE?

- IOL Country Occupational Health Manager (OHM) – Ten years with IOL
- Clinical Coordinator Occupational Health Canada West (CCW) – Twelve years with IOL
- Human Resources Advisor Canada East (HRE) – Three years with IOL
- Human Resources Advisor Canada West (HRW) – Two years with IOL

- Employee Offshore Canada East. Mental Health First Aid Instructor (EOCE) – Twenty there years with EMCE
- Safety, Security, Heath and Environmental (SSHE) Manager, ExxonMobil Canada East (EMCE) – Four months with EMCE, but 15 years with ExxonMobil

Question 2: How would you describe the culture of mental health at IOL/EMCE?

The participants offered terms like emerging and evolving when describing the culture. Individuals who had been with the company greater than ten years noted that mental health was a topic rarely discussed in the past, but in recent years there is now an openness to it in the workplace. The OHM stated that "supervisors are more understanding and accepting of psychological limitations than they had been in previous years, but there is still more work that needs to be done to get full buy in." The HRE felt that the company had made a commitment to mental health awareness, but it does not reach all levels of the organization and stigma remains. The SSHE manager offered an interesting view as he had spent the previous 15 years in the United States (US) and returned to Canada four months ago. He felt there was still a lot of stigma surrounding mental health in the communities and workplaces he had spent time in the US. and it was viewed as a weakness by many supervisors. In his short time in Newfoundland and Labrador (NL) with EMCE he has noted more acceptance both in the community and the workplace.

3. Is employee mental wellness a stated priority in the organization? If Yes, please elaborate or if No, please elaborate.

Every participant stated that they felt mental wellness was a stated priority in the organization, but a number did not feel it had been actioned to its full potential. The OHM voiced that there were discussions four years ago to implement a mental health program similar

to TWM, but due to logistical issues it was never pursued. Many also felt that the Covid-19 pandemic has caused a pivot toward mental wellness as a priority and the company has provided more communication in the way of mental health webinars and mental health moments than it had in previous years. The HRW identified that IOL had created a mental health working group to focus on an awareness campaign for mental wellness and mental health.

4. What do you feel are some of the negative impacts of poor mental health and mental illness in the workplace?

Common themes that emerged from participant discussions were increase in absenteeism, low productivity, job insecurity, decreased work effort and the potential for harassment. The HRE and the CCW both referenced that poor mental health does not only affect the individual, but has the potential to affect the entire workgroup if it is not addressed. The CCW spoke of a particular situation where an individual with an untreated mental illness was not completing their work on time and the other team members had to take on the extra work to complete the project. She noted there was increasing tension and resentment building in the group and the supervisor had to refer the employee to occupational health department (OHD) for a fitness for work assessment.

The HRE also shared that every single mental health case she has been involved in thus far this year has been linked to the impact of Covid-19 pandemic. For example, whether it was working from home issues, childcare concerns, or fears over contracting the virus at work there has been a link to Covid. She reported that addressing the mental health of the workforce should be a primary goal of the organization as we transition into 2021.

5. Do you feel there is a stigma attached to poor mental health and mental illness? If Yes, please elaborate or if No, please elaborate.

The general consensus from the group is that there is still a stigma associated with mental illness in the workplace, although, all agreed that stigmatization has also been decreasing in recent years. The HRW, who is also involved in alcohol and drug policy development, senses that individuals are more empathetic to persons with mental illnesses such as anxiety and depression, but there remains a large amount of stigmatization toward those with substance abuse disorders. “Some still view it as a self-inflicted wound.” In the offshore environment the EOCE has seen workers with a physical diagnosis who required time off work treated differently when they returned than the individual who experienced a mental illness. Individuals more readily approached the person who was off with a physical diagnosis to ask how they were doing and welcome them back than the worker returning from a mental health absence.

The HRE recalled an incident where a supervisor repeatedly sent an individual back to their room to sleep and get some rest because they were presenting with a mental health concern, instead of suggesting they see the nurse as they would have done with an individual suffering from a physical ailment.

6. Do you feel like you can talk to someone or ask for help with mental or physical health issues at work? If Yes, please elaborate or if No, please elaborate.

The majority of participants stated they would feel very comfortable calling EFAP, approaching HR or OHD, and reaching out to their supervisor if they felt they were struggling mentally. One individual had reached out in the past to EFAP and OHD and felt it was an excellent experience and would not hesitate to reach out again. The HRW admitted that they say they would feel comfortable, but they have never been in that situation and is unsure as to how

they would exactly react. The SSHE participant indicated they would feel comfortable reaching out for help, but not internally. Instead, they would approach their family physician as they feel if the supervisor was aware of their condition it could affect job advancement. One participant recognized that employees may be more reluctant to come forward now with the pandemic and its effect on the oil and gas industry. There have been a number of layoffs recently in the company and individuals may feel that presenting with a mental health or physical issue may put them at increased risk for being terminated from the company.

7. Would you feel comfortable supporting a colleague with a mental health problem? If Yes, please elaborate or if No, please elaborate.

The group of participants interviewed included two nurses, a physician, a human resources advisor, Mental Health First Aid (MHFA) instructor and an engineer. All participants, except the engineer stated they would feel very comfortable supporting a colleague with a mental health problem or crisis. They all had experience in the area and two individuals had completed the MHFA course. The engineer was skeptical and was concerned he would not know what to say or may say the wrong thing and exacerbate the situation.

8. Do you feel the majority of the workforce would feel comfortable supporting a colleague with a mental health problem? If Yes, please elaborate or if No, please elaborate.

Overall, the response was positive as all participants feel the company has a caring culture and individuals would be willing to support a colleague in distress. The SSHE and OHM did question whether the workforce had or felt they had the knowledge to support someone in distress and this may cause them to be reluctant in offering support to a colleague. The participants from the East coast of Canada were more confident in employee's willingness and knowledge in providing mental health support as a number of employees in the East have

completed the MHFA course in recent years. The MHFA assists participants in recognizing if an individual is struggling mentally and the tools to support the individual. Two respondents felt that the stronger the relationship between colleagues the more likely they will recognize a change in someone's well-being and start the conservation about how they are doing.

9. How would describe our employees understanding of mental health and mental illness?

The general premise from the group was that employees have a fairly good concept of mental health and mental illness, but more education is needed. They are aware of what services are available for assistance but may lack the insight to know when they are struggling mentally until in the later stages. The OHM noted that the oil and gas sector in NL has been an industry leader when it comes to mental health awareness in the workplace. He feels the 2009 Cougar helicopter crash off the coast of NL that killed 17 people was a trigger that brought the need for mental health education, support, and training to the forefront for the East coast. He also commented that supervisors still have difficulty accepting work limitations that are related to a mental illness. If an employee had a broken ankle, they understand he cannot climb a ladder, but when someone has a work limitation such as, reduce time requirements for deadlines, related to a mental illness they may have issues accepting.

In the West, the CCW still sees cases where supervisors or managers are very reluctant to come forward with a mental health concern of their own. They may recognize it in an employee they supervise and refer them to OHD, but in cases she has followed the manager or supervisor are very unwilling to admit they are having concerns about their mental health.

10. Would you be interested in having access to more mental health resources at work? If Yes, please elaborate or if No, please elaborate.

Even though the company has an EFAP program, HR department and occupational health department at each site all participants unanimously felt there was a need for further mental health resources. The OHM stated "there is still a lot to do" and would like to see a formal mental health education program implemented as he feels it is an integral part of harm reduction and health promotion. The CCW would like to see mental health training for all employees and not just targeted at supervisors. Many of the respondents also noted it is needed more now than ever with the stress of the pandemic and job uncertainty within the company,

11. Have you completed a mental health educational program, (i.e. MHFA, The Working Mind)? If yes, how did you feel about the program?

Only two of the participants have completed a mental health education program. The EOCE has completed the MHFA and is a certified instructor in MHFA. He is very passionate about mental health and has been a champion for mental health in the East and for the offshore workers. He was working offshore when the Cougar crash occurred, and it deeply affected him, and he witnessed how it also affected his colleagues. He stated, "Completing the course helped me see I was struggling and led me to seek help, and in becoming an instructor I have seen others realize they were suffering and seek the appropriate support."

The HRE had completed both the MHFA and TWM. Their opinion is that the MHFA goes beyond what every worker needs to understand when it comes to mental illness as it is similar to the physical first aid course and would only be required by a small number of employees for crisis intervention. TWM targets both employees and supervisors and provides general information on stigma and resiliency and they feel it is a more suitable course for the entire employee population.

12. If offered, would you attend a mental health program that was provided by the company? If Yes, please elaborate or if No, please elaborate.

All respondents stated they would attend a mental health program if offered. They see it as an opportunity to further their understanding of mental health and develop new resiliency skills or build on the ones they already have. The SSHE felt it could help him as a supervisor to better identify when an employee is struggling mentally and understand what resources are available to offer to the employee.

13. Do you think a mental health program that reduces stigma and increases resiliency should be mandatory for all employees?

Most of the respondents felt strongly that the program should be mandatory for all employees. The EOCE stated "it could be one of the most valuable tools we can offer our workforce" and the HRW expressed that "destigmatizing mental illness needs to be a priority for the organization." The OHM felt that we must be sell the idea to leadership to get their buy in and gain their backing to proceed with implementation of the program.

There was a concern raised by the HRE that if we made the sessions mandatory, the employees may see it as a "check in the box" in their training matrix and not become engaged fully in the sessions. She recommends that the program be mandatory for supervisors and then have the supervisors encourage and support their direct reports to take the program. She felt getting support and cooperation from leadership may be the biggest obstacle.

14. Is there anything else you would like to say that was not brought forward in the interaction?

A common theme for the participants that responded was there is a need for increased mental health awareness in the workplace and at home and this has been exemplified now with the Covid-19 pandemic. There is no better time to implement a mental health program that is

required for all members of the organization to complete from the floor technician to the top executive.

Implications for the Practicum Project

Charles Boyer of the Mental Health Commission of Canada provided valuable information on what evidence-based programs were available in Canada offered by the Commission. He explained the goals of each program and advised which program would be the most beneficial in reducing stigma and increasing resiliency within the workforce. He may prove to be a valuable resource as I move forward with the implementation and evaluation plan for a proposed program for Imperial Oil.

The participants from IOL/EMCE provided insightful feedback into the current mental health culture at IOL/EMCE and a sense of what is needed to promote and encourage mental health awareness in the organization. I have only been with the organization for three years so getting feedback from employees who have been there over 10 years and providing a historical view of mental health at IOL will be very useful as I move forward with the practicum. Their support and assistance will be vital in accomplishing my goal of implementing a certified mental health program at IOL/EMCE.

Appendix A

Phone Interview Questions

1. How long have you been with the Mental Health Commission of Canada (MHCC)?
2. What mental health programs are presently offered by the MHCC for employers and employees in Canada?
3. For each program listed what is the primary aim of the program for both employees and employers?
4. Are certain programs better applied in certain work environments (i.e. , office, field, military, and emergency response)?
5. Have the courses been successful in decreasing the stigma associated with mental illness and if so, why?
6. Have the courses been successful in increasing resiliency and if so, why?
7. Are you aware if the course has increased work productivity through a decrease in absenteeism and presenteeism?
8. Is there a course you would recommend that would decrease stigma, increase resiliency and have a positive effect on productivity? Is yes, why?
9. What is the preferred delivery method for each course?
10. Is there a train the trainer option for the recommended courses?
11. Is there a recommendation that the courses be repeated at a regular interval (i.e. every 2-3 years)?
12. Are you aware of any other courses that are available outside of those offered by the MHCC?
13. Is there anything else you would like to say that was not brought forward in the interaction?

Appendix B
Participant Interview Questions

1. How long have you been an employee with IOL/EMCE?
2. How would you describe the culture of mental health at IOL/EMCE?
3. Is employee mental wellness a stated priority in the organization? If Yes, please elaborate or if No, please elaborate.
4. What do you feel are some of the negative impacts of poor mental health and mental illness in the workplace?
5. Do you feel there is a stigma attached to poor mental health and mental illness? If Yes, please elaborate or if No, please elaborate.
6. Do you feel like you can talk to someone or ask for help with mental or physical health issues at work? If Yes, please elaborate or if No, please elaborate.
7. Would you feel comfortable supporting a colleague with a mental health problem? If Yes, please elaborate or if No, please elaborate.
8. Do you feel the majority of the workforce would feel comfortable supporting a colleague with a mental health problem? If Yes, please elaborate or if No, please elaborate.
9. How would describe our employees understanding of mental health and mental illness?
10. Would you be interested in having access to more mental health resources at work? If Yes, please elaborate or if No, please elaborate.
11. Have you completed a mental health educational program, (i.e., MHFA, The Working Mind)? If yes, how did you feel about the program?
12. If offered, would you attend a mental health program that was provided by the company? If Yes, please elaborate or if No, please elaborate.

13. Do you think a mental health program that reduces stigma and increases resiliency should be mandatory for all employees.
14. Is there anything else you would like to say that was not brought forward in the interaction?

Appendix C – IOL Power Point Presentation

NURSING 6660

Imperial Oil Leadership Presentation

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ExxonMobil

Imperial

The Working Mind: Supporting Mental Health

Robert Wiscombe

Mental Heath & Mental Illness

- Mental health and 'mental illness' are increasingly being used as if they mean the same thing, but they do not. Everyone has mental health, just like everyone has health. As the World Health Organization famously says, "There is no health without mental health." In the course of a lifetime, not all people will experience a mental illness, but everyone will struggle or have a challenge with their mental well-being (i.e., their mental health) just like we all have challenges with our physical well-being from time to time.

- When we talk about mental health, we're talking about our mental well-being: our emotions, our thoughts and feelings, our ability to solve problems and overcome difficulties, our social connections, and our understanding of the world around us.

- A mental illness is an illness the affects that way people think, feel, behave, or interact with others. There are many different mental illnesses, and they have different symptoms that impact peoples' lives in different ways.

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Mental Health Problems and Illness

- 1 person in 5 will experience a mental health problem or illness within a given year
- 1 person in 3 will experience a mental health illness in their lifetime
- Psychological health problems and illnesses are the number one cause of disability in Canada
- Psychological heath problems cost the Canadian economy ~ $51 billion per year, $20 billion of which results from work-related cause.
- 47% of working Canadians consider work to be the most stressful part of life

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Mental health problems and illness are prevalent in society and workplaces

A 2012 survey of over 6,600 employed Canadians (2,317 of which were managers or supervisors) showed:

- 71% of Canadian employees report some degree of concern with psychological health & safety in their workplace
- Over 50 % reported experiencing frustration, exhaustion or irritation often at work within the previous month
- Only 23% of Canadian workers would feel comfortable talking to their employer about a psychological health issue.
- 91% of managers and supervisors felt it was important to improve their "emotional intelligence" in the workplace
- 2 out of 3 managers and supervisors felt additional training and support would help them do their jobs more effectively

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IOL/EM Morneau Shepell Health Issues Dashboard

Your Top Diagnosis by Duration are:

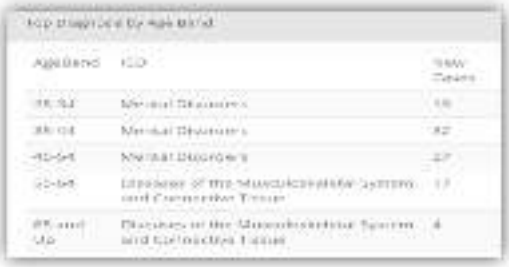
- Diseases of the Blood and Blood-Forming Organs (65 days)
- Neoplasms (61.8 days)
- Mental Disorders (48.5 days)

Your Top Diagnosis by IncidentRate are:

- Diseases of the Respiratory System (49.3%)
- Mental Disorders (8.1%)
- Diseases of the Musculoskeletal System and Connective Tissue (5.2%)

Your Top two diagnosis that had largest increase in emerging issues are:

- Diseases of the Respiratory System (1000)
- Mental Disorders (91)



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IOL/EM Morneau Shepell Health Issues Dashboard

Top Diagnosis by Gender

Gender	ICD	New Cases
Female	Mental Disorders	30
Male	Mental Disorders	53

Top Diagnosis by Years of Service

YOS	ICD	New Cases
1 to 5 Years	Diseases of the Respiratory System	19
10+ Years	Mental Disorders	41
6 to 9 Years	Mental Disorders	28

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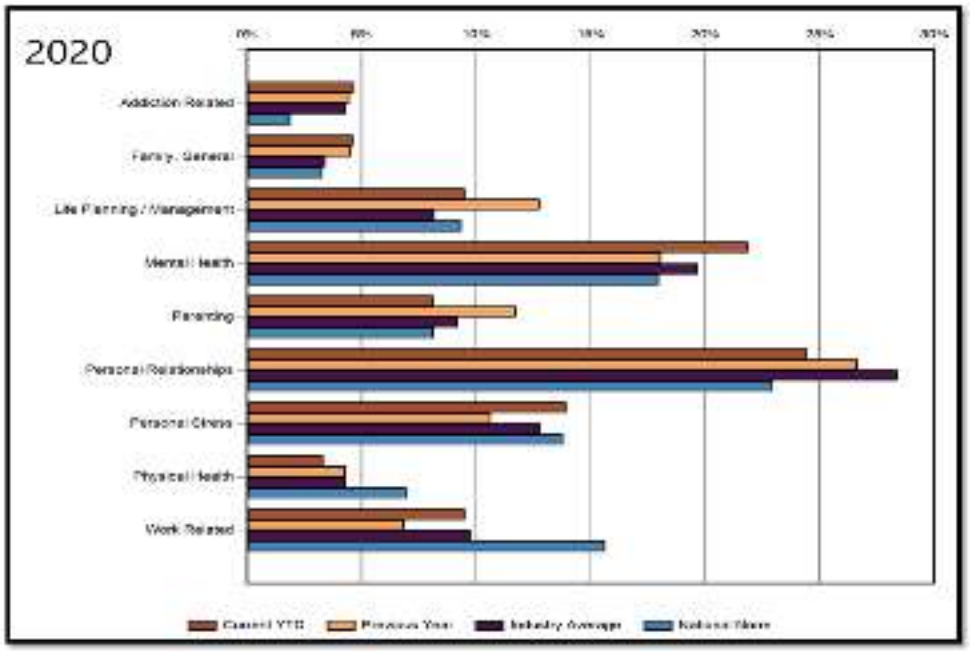
IOL/EM Emerging Issues Dashboard



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The Effects of Mental Health Issues in the Workplace

In 2011, mental health problems and illnesses among working adults in Canada cost employers more than $6 billion in lost productivity from absenteeism, presenteeism and turnover.

Absenteeism/Presenteeism

- Presenteeism occurs when employees are physically present, but due to an unaddressed physical or emotional issue; they are distracted to the point of reduced productivity.
- Lost productivity from presenteeism was at least 7.5 times greater than productivity loss from absenteeism.

Effects of poor mental health:

- Changes in work habits
- Making more mistakes than usual
- Producing work of a low standard
- Low productivity
- Lack of care about results

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The Working Mind (TWM)

TWM Program Objectives:

- Reduce the stigma of mental illness and promote positive psychological health in the workplace
- Re-conceptualize how people thing and talk about mental health in themselves and others
- Teach coping skills to manage stress and poor mental health and increase resiliency
- Help participants identify poor mental health in themselves and others
- Create a more supportive environment

The manager and employee courses:

- The Working Mind Executive Package (2.5-hour presentation that covers the program in enough detail to garner value)
- Managers (eight hours), and employees (four hours)
- Managers course includes additional training on workplace accommodations and return to work and communicating with employees about mental health illness

The 5 day train the trainer:

- Equips people with the tools and skills to present both the **employee** and **manager** course
- 5 day course

The Working Mind

Benefits:

- Endorsed by the Mental Health Commission of Canada
- **Supports our Safety Culture**: Nobody Gets Hurt - Protecting the health and safety of our people is core to who we are and drives what we do.
- **Aligns with our Culture of Health Mission** : To improve the health, quality of life and productivity of employees by providing an environment and resources that actively and consistently promote healthy and safe behaviors.
- Cost Effective
- Utilized by industry peer Husky with good outcomes
- TWM was offered at various location throughout Canada. The results on the effects of the program on stigma and resiliency discovered a statistically significant reduction in stigma and an increase in resiliency skills for front line workers and supervisors and also for employees in the public and private sectors (Dobson et al. 2019).
- Disability Claim reduction and reduction in substance abuse cases

Husky Research Findings

- 500 Husky employees and leaders participated in the training (2015-2017)
- Improved resiliency: Increased by 7.4% (Employees 8.3% and Leaders 5.7%)
- Reduced Stigma: Reduced by 9.8% (Employees 9.1% and Leaders 11.6%)
- 47% Informative, changed how I thought, learned a lot
- 62% Reported using what they learned from TWM at home and at work
- 50% Reported improved mental health and increased resiliency

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Course Formats

The Executive Package (Virtual) 2 hours:

➢ $1000 for a group of 8-20 executives.

The Working Mind Employee (Virtual) 5 hours:

➢ $1800 for a group of 8-15 participants

The Working Mind Manager (Virtual) 7 hours:

➢ $2500 for a group of 8-15 participants

Retrieved from: https://theworkingmind.ca/home

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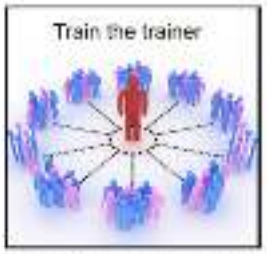
Course Formats

Train the Trainer: 5 days (On Hold)

- $3000.00/participant
- $250.00 license renewal every 2 years. $10 participant fee



Booster Sessions: (30-60 minutes)

- Free
- Instructor-led
- Allow participants to review knowledge, skills, and attitudes around key components of the course.

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Implementation Plan

In House Trainers

Advantages:

- Courses can be offered when it suits the organization.
- Cost saving.
- Trainers are informed about the local/company resources available to your employees.

Disadvantages:

- Staff changes

IWM Trainers

Advantages:

- Resource immediately availability, experience.

Disadvantages:

- Increase in cost with future course offerings, resource availability

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Implementation Plan

- Presentation to leadership (2nd quarter 2021).
- Leaders to complete The Working Mind Executive Package (2nd quarter 2021).
- Leaders/ Managers to complete the training program prior employees (3rd quarter 2021).
- Training mandatory for supervisors and optional for employees.
- Employees to begin program 4th quarter 2021.
- Employee facilitators identified at proposed sites for train the trainer option once available.

Evaluation Plan

Short term:

- Survey (Survey Monkey) completed immediately post-training and again at 3 months post training.

Long Term:

- EFAP trends
- Claim reduction
- Disability stats
- A&D cases (policy violation versus disclosure)

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