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Workplace Antistigma Programs at the Mental Health Commission of Canada: Part 1. Processes and Projects

Programmes anti-stigmatisation en milieu de travail de la Commission de la santé mentale du Canada : 1re partie – Processus et projets

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Abstract

The Opening Minds Initiative of the Mental Health Commission of Canada has taken a novel approach to reducing the stigma of mental illness by targeting specific sectors. This first article describes Opening Minds' research and programming initiatives in the workplace target group. This article describes the context of mental illness stigma in Canada and the development of the Opening Minds initiative of the Mental Health Commission of Canada, with a specific focus on the workplace sector. We outline the steps that were taken to develop an evidence-based approach to stigma reduction in the workplace, including reviews of the state of the art in this workplace antistigma programming, as well as the development of tools and measures to assess mental illness stigma in the workplace. Finally, 2 specific program examples (e.g., Road to Mental Readiness and The Working Mind) are used to highlight some of the procedural and logistical learnings for implementing antistigma and mental health initiatives within the workplace. In a second related article, we further examine the Opening Minds workplace initiative, with a discussion of the lessons learned from the implementation and evaluation of antistigma programming in the workplace.

Abrégé

L'initiative Changer les mentalités de la Commission de la santé mentale du Canada a adopté une nouvelle approche en vue de réduire la stigmatisation de la maladie mentale en ciblant des secteurs spécifiques. Ce premier article décrit les initiatives de recherche et de programmation de Changer les mentalités dans le groupe cible en milieu de travail. Cet article décrit le contexte de la stigmatisation de la maladie mentale au Canada et l'élaboration de l'initiative Changer les mentalités de la Commission de la santé mentale du Canada, qui met un accent particulier sur le secteur du milieu de travail. Nous présentons les mesures qui ont été prises pour mettre au point une approche fondée sur les données probantes visant la réduction de la stigmatisation en milieu de travail, y compris des revues des techniques de pointe dans cette programmation anti-stigmatisation en milieu de travail, ainsi que l'élaboration d'outils et de mesures afin d'évaluer la stigmatisation de la maladie mentale en milieu de travail. Finalement, deux exemples de programmes spécifiques (p. ex., En route vers la préparation mentale et L'esprit au travail) servent à présenter certains apprentissages procéduraux et logistiques pour la mise en œuvre des initiatives d'anti-stigmatisation et de santé mentale en milieu de travail. Dans un deuxième article connexe (voir ce volume, Szeto et coll.,

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2018), nous examinons davantage l'initiative en milieu de travail Changer les mentalités, et nous discutons des leèons apprises de la mise en œuvre et de l'évaluation de la programmation anti-stigmatisation en milieu de travail.

Keywords
mental health, stigma, workplace

The Mental Health Commission of Canada (MHCC)[1] was formed in 2007 with a 10-year mandate by the Government of Canada to function as a catalyst to improve the health and wellness of Canadians. Since its inception, the MHCC has explored the many ways in which people living with mental illnesses are viewed in the community with a goal of changing how Canadian society treats people who experience mental illnesses. This was addressed through a series of focused initiatives that targeted conditions associated with mental illnesses, such as stigma, homelessness, and suicide. These initiatives also functioned as a catalyst to bring different mental health stakeholders together to work together on ways to improve the Canadian mental health care system. Subsequently, the MHCC received another 10-year mandate and will continue its work through to the year 2027.

One of the critical aspects related to mental illnesses is the problem of stigma. Stigma is a multilayered process that begins when labels and stereotypes are attached to those with a human difference (e.g., a mental illness), which leads to the separation from the nonlabelled and can result in loss of status, prejudice, and discrimination towards those holding this difference.[2] Stigma is a significant concern for those living with a mental illness and has been identified as a major barrier to timely and accessible care, recovery, and quality of life.[3] Many people affected by mental illnesses fear being stigmatized, which then leads them to remain silent about their illness. This silence can be a barrier to seeking treatment and to pursuing important life opportunities and resources.[4] Combatting stigma has been found to lead to increased readiness to seek professional help.[5] It has the potential to significantly improve the lives of those living with mental illnesses. As such, reducing the stigma and discrimination associated with mental illness has been an important component of the MHCC's mandate.

This article discusses some of the experiences of the workplace projects from the Opening Minds initiative of the MHCC. The central focus of this article is on the process that the Opening Minds workplace researchers took to develop an evidence-based approach to workplace stigma reduction, including both prejudicial attitudes and discriminatory behaviours (referred to generally as "stigma" in this article) and some of the workplace partnerships that were formed. We discuss our target populations, our measurement and program challenges, the programs that have been developed to address stigma in the workplace, and future issues. In a complementary article (see Szeto et al.[6]), we discuss the lessons learned from this process and working with the workplace partners Opening Minds has formed through the years.

The Opening Minds Initiative

The Opening Minds (OM) initiative has been discussed elsewhere[7] and so is only briefly reviewed here as a backdrop for the current article. The OM initiative was created to reduce the stigma of mental illnesses by changing the attitudes and behaviours of Canadians towards individuals with mental illnesses. It is the largest systematic effort undertaken in Canadian history to reduce this type of stigma. While many programs exist with the intent to reduce mental illness stigma, many have no evaluation data attesting to their efficacy. OM's philosophy was to build on the strengths of and to promote existing evidence-based programs, rather than to "reinvent the wheel." To this end, OM conducted evaluations of various programs to determine their success at reducing stigma, with the goal of promoting and replicating effective programs nationally. Given the breadth of scope of these issues, OM strategically targeted 4 areas of focus: health care providers, youth, media, and the workplace, as stigma reduction in these 4 areas could have a broad impact on the negative consequences associated with stigma.

Stigma reduction initiatives varied across the 4 target groups. The OM researchers who focused on health care providers, for example, developed a health care provider stigma scale,[8,9] conducted evaluations of antistigma programs in various groups (e.g., pharmacy students[10]), and conducted a meta-regression with 22 antistigma programs on key ingredients for stigma reduction interventions in health care environments.[11] In the youth target group, OM researchers conducted numerous evaluations of various programs as well as created a fidelity/process model for youth antistigma programs.[12] In addition to holding talks and symposiums at journalism schools, OM researchers are conducting the largest media monitoring project in Canada. They have tracked newspaper articles about mental illness from major newspaper outlets since 2005 to examine trends in the tone and content. Some of this project has been described by Whitley and colleagues.[13,14]

In the area of workplace stigma, OM researchers have evaluated numerous workplace programs in different organizations across Canada. Although the workplace was the last target group for OM to initiate, mental health and mental illness has been topical in the Canadian workplace, which has resulted in many opportunities to promote mental heath awareness and education and, in so doing, to implement and evaluate programs. The current article details the processes involved in the creation and maintenance of OM partnerships with work organizations and the "lessons learned" from the implementation and evaluation of workplace

antistigma programs in Canada. The other articles in this series provide information about the outcomes of our program evaluations and directions for further research in this domain.

Why Did OM Target the Workplace?

Several factors contribute to the importance of reducing stigma in the workplace and provided the impetus for our focus on programs in this target group. Beyond moral and ethical reasons to reduce stigma and improve mental health in the workplace, financial and productivity considerations also make these efforts imperative. The financial impact of poor mental health and mental illnesses is enormous. Mental illnesses have been ranked as a leading contributor to the overall economic costs affecting employers in the United States.[15] One estimate sets the cost of mental illnesses to the Canadian economy at approximately $51 billion a year.[16] At an organizational level, poor mental health in employees often results in lost productivity in the forms of absenteeism, presenteeism, and turnover.[16-18] Businesses can also incur significant costs for short-term and long-term disability claims due to mental illnesses. Mental illness–related disability accounts for almost one-third of all work-related disability claims and has been shown to be more costly and longer in duration than non–mental health–related claims.[17]

The removal of attitudinal barriers, such as stigma, and inaccurate perceptions about structural barriers (e.g., cost, lack of services) and nonrecognition of one's mental illness can result in reduced losses in workplace productivity.[19] This result implies that workplace programs that address these barriers can reduce losses to workplace productivity related to mental illnesses or poor mental health. In fact, workplace programs that address these barriers have positively affected organizations' finances and have demonstrated positive return on investment outcomes. In their systematic review of economic evaluations of mental health interventions, Hamberg-van Reenen et al.[20] found positive effects for workplace outcome measures (e.g., productivity, disability) and positive financial returns in return-to-work interventions. One economic model simulation[21] found that a comprehensive depression screening program would offer an organization a 4 to 1 return on investment based on reductions in presenteeism and absenteeism alone. Beyond the financial benefits of workplace programs, a 2009 systematic review[22] reported that workplace mental health interventions have positive effects on outcomes such as stress, job satisfaction, and psychological symptomology. In general, mental health programs in the workplace have both positive financial effects and positive outcomes at the individual employee.

Targeting workplaces also makes sense from the perspective of employees. Many individuals spend most of their waking hours at work. It is also during their prime working years that individuals experience mental health–related problems. One Canadian survey found that 44% of their adult working sample has had or currently has a mental health problem, and a Canadian population-based study found a "treated prevalence" (i.e., have ever been treated by a professional for a mental illness) of 16.5% in working adults.[22] These authors also found that this prevalence increased to 27.7% if the participant rated his or her job as extremely stressful.

Many employees have access to employee benefits or employee and family assistance programs that offer confidential psychological services for mental health concerns, but many employees are reluctant to disclose a mental health problem or access these services for fear of potential stigma and negative work-related consequences.[23,24] This reluctance is exacerbated by how employers and managers handle mental health problems. Thorpe and Chénier[25] found that only 26% of their sample believed their supervisor could effectively support someone with a mental illness. Similarly, these authors found that 44% of managers surveyed had not received any training on mental illnesses in the workplace. Programs that reduce stigma and provide workplace mental health knowledge would likely increase help seeking and may even contribute to a more a supportive workplace atmosphere.

The final factor that contributes to the importance the workplace is the unique way stigma presents itself in this context. Social relations within workplaces create multiple avenues where stigma might present itself. For example, stigma might may be directed at an individual with a mental illness by his or her coworker, supervisor, or supervisee or employee. As a result, individuals who experience a mental illness in the workplace may face direct discrimination in the form of negative attitudes (such as feelings of distrust from others) or behaviour (such as avoidance in the workplace),[26] which could in turn lead to experiences of underemployment, failure to advance, unemployment, or labelling and alienation at work. A conceptual model of workplace stigma[26] suggests that stigma operates through multiple pathways, and exclusionary practices may emerge from multiple intentions. Particular assumptions about mental illness are salient in the employment context (e.g., that they lack the task-related and/or social competence to perform the job). These assumptions influence the disposition to act in a discriminatory manner. To counteract these influences, antistigma interventions should identify key assumptions that exist in the workplace, identify where and how they emerge, and directly challenge them. While broad public service campaigns may challenge some of these assumptions in a general manner, these messages may not be applied to all contexts.[23,27] As such, programs are needed that address the unique structure and context of the workplace.

OM Workplace Processes and Projects

Our first step to develop an evidence-based approach to workplace antistigma initiatives was to conduct a scholarly review of relevant antistigma intervention programs. A

review[23] explored workplace antistigma programs from various countries and of various types and formats. The second, a scoping study,[28] identified and described principles and characteristics of 22 antistigma initiatives identified from peer-reviewed, grey, and other relevant literatures. Although multiple programs were identified and many showed promise, both reviews identified a need for more scientific rigor in the evaluation and implementation of these programs. In particular, standardized interventions and validated evaluation tools that could determine the stigma reduction efficacy of programs were deemed to be essential but absent. These 2 major gaps in knowledge were the impetus behind OM workplace team's subsequent activities.

Due to the lack of well-validated measures to assess stigmatizing attitudes towards people with mental illnesses in the workplace, we created 2 new scales. The Opening Minds Scale for Workplace Attitudes is a 22-item measure that assesses stigmatizing attitudes, beliefs, and behaviours in the workplace. This measure was initially validated on a student sample, was used in subsequent research,[29] and is being evaluated in both an employed community sample and other workplace samples. The Opening Minds Scale for Supervisor Workplace Attitudes[30] is an 11-item measure of stigma-related attitudes, beliefs, and behaviours specific to the supervisor role. This measure was derived from items from various market research studies[31-33] and is undergoing psychometric evaluation.

Coincident with the development of tools to evaluate programs, we cultivated partnerships with a wide range of organizations across a range of occupational categories groups and antistigma program developers. We targeted medium and large organizations as they have the structural capacity to implement initiatives. As well, many antistigma initiatives were more practical for a larger organizational context. The learnings from these organizations could serve as a model for smaller sized businesses. Our goal was to connect employers with appropriate programs and engage employers to implement and evaluate these programs. Our plan was to create a database that would then enable a systematic evaluation of program outcomes and consequent decisions regarding best practices for program content and implementation in workplace antistigma programs. Within each partnership, our team, in consultation with the employer and/or program developer, designed an evaluation framework. The framework served as a guide to the evaluation process. It provided an opportunity to clearly identify the need for an intervention in the specific workplace context and address the potential issues related to implementing and evaluating programs in the workplace. For example, 1 eastern Canadian site identified the stressful demands of the job and wanted to implement an initiative that would increase uptake of its health and wellness initiatives while another site prided itself on offering the most up-to-date workplace health initiatives to employees. Some issues that did appear in implementation included the cost related to time away from work to participate in interventions, recruitment issues for evaluations, and concerns with privacy or confidentiality.

Although the "gold standard" for experimentation is the randomized control trial, even employers who were ready to implement stigma reduction programs wanted fairly rapid implementation of workplace programs. As such, our research design usually consisted of a pre, post, and 3-month follow-up design. In this scenario, participants received evaluation measures prior to the intervention (pre), immediately after the intervention (post), and approximately 3 months after the intervention. This type of an evaluation design was used for many reasons such as its flexibility to fit into organizational processes and timelines (e.g., scheduled mandatory training). This design, however, resulted in some limitations of the resulting data as is expanded upon below. Following data collection and analyses, partner organizations that wished as well as program developers (if applicable) received a final report and debriefing on the program results.

OM Workplace Projects

The OM workplace team was formalized in 2010. Since then, numerous programs at various sites across Canada have been evaluated. Partner sites range from medium to large (from fewer than 50 employees to greater than 10,000), come from various sectors (e.g., public, private, education), reflect a range of occupational categories (e.g., sales and service, social and government services, health services), and operate at all levels (i.e., local, provincial, and national). Although each partnership had its unique considerations and processes, we describe below examples of projects to give a sense of the breadth and depth of work. Table 1 provides a summary of the following description and includes a summary of the key purposes, processes, programs, and evaluation strategies used in this work.

One of the early experiences for the OM workplace group was with an industrial company. The leadership of this particular company was fairly certain that there were mental health concerns in its workforce, which was predominantly male and had a significant proportion of immigrant workers. As an initial stage of consultation, the OM researchers came to the company and met with the leadership as well as a few workers in focus groups. We were advised by the workers that they did not experience particular concerns, so we employed a survey of mental health concerns and stigma. When the results were analysed, the data suggested that the average worker was not significantly distressed and did not report significant stigma. These results were shared with the leadership, who ultimately advised us that they were concerned about bullying in the workplace. Based on our results, they did not plan further activities, as they were satisfied that the issues had been investigated.

Another early experience was an evaluation of a mental health awareness program implemented by an oil and gas company. This program used contact-based education,

Table 1. Main Features of Programs within the Opening Minds Initiative.

Program Feature	Sample Content
Purposes	• Examination of current mental health status of employees • Promotion of mental health awareness and literacy • Development of mental health programs • Program development and evaluation
Processes	• Discussion of employer concerns and issues • Meeting with senior leadership • Program adaptation and delivery • Program evaluation and reports to employers
Programs	• The Road to Mental Readiness (R2MR; renamed the Working Mind for First Responders) • The Working Mind (TWM)
Evaluation	• Mental health literacy • Stigma reduction • Mental health service utilization • Program evaluation and qualitative experiences of employees and employers

which has been cited as an important antistigma program component.[4,28] The presentation consisted of a detailed and impassioned description of a worker's past and continuing struggles with mental illness. There was relatively little emphasis in the talk about resources or adaptive coping. Our evaluation revealed that this presentation was associated with increased stigma ratings on our measures, which we attributed to the fact that the personal story did not emphasize recovery in mental illnesses, provide descriptions of help seeking, and describe the adaptive tools to deal with mental illnesses.[11]

Our process of workplace antistigma programs took a dramatic turn when we discovered that the Canadian Department of National Defence had developed and was using a program it called the Road to Mental Readiness (R2MR) to engage in stigma reduction, provide mental health literacy, and develop coping resources. We were able to work with defence experts to examine the program, and with their approval, we modified the program for use with a large urban police service. Major adaptations included a dedicated antistigma component (i.e., a dedicated module on stigma) and fully incorporated contact-based education.

The Road to Mental Readiness created by the Opening Minds Program[34] has several foci, including mental health knowledge and literacy, stigma reduction, building resiliency, early help seeking, and reconceptualising how one talks and thinks about mental health and mental illness. These core components are embodied in the mental health continuum model, the Big 4 skills, and contact-based education. The mental health continuum model[35] is a key component of the R2MR program and a common thread that connects all other components of the program. Rather than a diagnostic framework, it categorizes signs and indicators of good to poor mental health into a 4-colour continuum: green (healthy), yellow (reacting), orange (ill), and red (injured). This model teaches that everyone is on the mental health continuum model, and it uses the intuitive idea of color coding to train individuals to look for signs and indicators in themselves (and others) for each colour. The model also recognizes that there can be desynchrony among various signs and indicators, so for example, one's sleep may be dysfunctional, even though other aspects of functioning are all right, at least for a time. The model also emphasizes that mental health can ether move "up" or "down" the continuum and that even being in the "red" (i.e., having an acute mental illness) is not a permanent attribute. The model proposes appropriate actions at various stages of the continuum, to either stay mentally healthy or take action when signs and indicators emerge.

The Big 4 skills are 4 coping strategies (SMART goal setting, mental rehearsal, positive self-talk, and diaphragmatic breathing) that have been widely used (especially in sports psychology) to help people manage stressful situations and increase their performance. These skills are roughly consistent with several aspects of cognitive-behavioural therapy[36] but adapted to promote effective workplace performance. The final core component is contact-based education, wherein individuals who have experienced and recovered from mental illnesses present the workshop and can discuss their experiences with mental illness and stigma. Most critically, these issues include help seeking, recovery, and receiving social support. This first-person discussion is supplemented with prepared video clips from actual employees, who present material relevant to different parts of the program. This use of contact-based education is consistent with research, as it is one of the most effective ways to reduce the stigma of mental illnesses.[4,34]

Although implementation is not identical across our partner R2MR sites, the most popular and sustainable form of implementation is where the organization holds a train-the-trainer session, in which internal candidates take a weeklong course to become facilitators of the program. Afterwards, successful facilitators can provide the half-day workshop for employees and frontline staff or an extended full-day leadership/supervisor workshop. R2MR has now been translated into a French-language version and has been further adapted for use by a variety of first responder groups, including firefighters, corrections workers, and emergency service providers. With each adaption, we engage in a consultation process with the relevant target group to adapt the materials to the context, and new videos are created to highlight the challenges for each unique type of first responder group.

The R2MR incorporates mental health literacy and knowledge, coping skills, and antistigma components. The OM research group realized that these components could be easily modified into a version that could be created for other nonmilitary workplaces, such as office settings. The

Working Mind (TWM[37]) program was thus developed and incorporates the core elements of R2MR. It also has both a shorter half-day version for frontline office workers and a longer full-day version for managers and leaders, which highlight their extended roles to assess, support, and manage issues related to mental health and illness in the people who report to them.

Evaluation results of the 2 types of workshops (frontline and leaders/managers) for both of the R2MR and TWM programs have been positive (see Dobson et al.[38]; Szeto et al.[6]). These results indicate that participants show significant decreases in stigma from pre to post and that these reductions are generally retained at the 3-month follow-up. Resiliency (i.e., perceptions of their ability to deal with stressful situations) show significant and positive gains as well. Anecdotal experience suggests that the adaptation of the program to different work settings and the use of the train-the-trainer models have helped to ensure that the programs are relevant and sustainable. In general, the implementation of these 2 programs has been successful, and we are encouraged by our preliminary results. We have been especially encouraged by the widespread adoption of these programs, as over 100,000 first responders in Canada have taken R2MR, and TWM has now reached over 40,000 employees, reflecting government, postsecondary institutions, and the private sector at the time of writing this article.

Continuation of This Approach and Beyond

It is now clear that the approach the OM workplace team adopted was successful and having tangible impact across Canadian workplaces. To date, approximately 140,000 people have received 1 or more of the programs described above. A lot of the draw for employers was the evidence-based and evidence-informed approach OM took to address the problem of stigma and poor mental health in the workplace. Workplaces, particularly in the first responder sector, gravitated to our approach in working with them to develop a program that was relevant and respectful of their needs, restrictions, and contexts.

As some of the larger evaluation projects wind down, OM has begun to address some of the issues that have arisen from scaling antistigma and mental health programming from limited sites to large-scale implementation and programs across Canada. Some of these issues are discussed in subsequent articles in this volume (i.e., Dobson et al.[38]; Knaak et al.[39]; Szeto et al.[6]). One logistical issue is how to maintain the momentum the programs have generated in workplaces (and the learnings gained). Currently, "booster sessions" have been developed and being pilot tested at various sites. These boosters should serve the dual purpose of reinforcing the learnings from the programs as well as keeping employees thinking about mental health generally, sustaining the importance of mental health in the workplace. Other current OM endeavours include working with different organizations to develop and pilot more accessible forms of program delivery, including exploring blended approaches (i.e., online and face-to-face), or enhancing the current programming, such as the development of a version of R2MR for first responder families (see Dobson et al.[38]).

Beyond this, OM has also taken a similar approach to address stigma and mental health in postsecondary students. The Inquiring Mind is a program that contains the core components of R2MR and TWM (i.e., stigma reduction, coping skills, and the mental health continuum model). This program was developed with a stakeholder committee composed of postsecondary students, faculty members, and student services staff, with extensive student consultation. Currently, The Inquiring Mind program is being pilot tested and evaluated at more than 15 universities and colleges in Alberta, Nova Scotia, New Brunswick, and Newfoundland.

Despite initial successes, more work is still needed to address workplace mental health and the stigma associated with mental illnesses. For example, more clarity is needed in regards to the economic returns on implementation of antistigma and mental health programming in the workplace despite some positive research (see above). Similarly, more research is needed to examine the longitudinal effects of programming. This extends to both the impacts of programming at the individual level (e.g., stigma reduction, resiliency) and at the organizational level (e.g., culture surrounding mental health). Some recent research has shown the limitations of program retention beyond 12 months.[40] These opportunities, as well as others, are what the OM workplace researchers hope to address as a part of the renewed mandate of the MHCC.

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