

# Workplace Antistigma Programs at the Mental Health Commission of Canada: Part 2. Lessons Learned

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## Programmes anti-stigmatisation en milieu de travail de la Commission de la santé mentale du Canada : 2<sup>e</sup> partie - Leçons apprises

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### Abstract

The Opening Minds Initiative of the Mental Health Commission of Canada has worked with many workplaces to implement and evaluate mental illness stigma reduction programs. This article describes the lessons learned from Opening Minds' research and programming initiatives in the workplace target group and details some of the most valuable learnings from collaborating with workplace partners. These insights range from issues such as the recruitment of potential partners to the implementation of evaluation in the workplace. The lessons learned described here are not intended as the optimal ways of developing partnerships or conducting research in a workplace setting but are intended to highlight some of our experiences in implementing antistigma programming. These experiences are provided so that those who are in the same situation can draw from our learnings to make their efforts more efficient. To conclude, we discuss some of our thoughts in which the implementation of workplace mental illness stigma reduction programming should work towards in the future.

### Abrégé

L'initiative Changer les mentalités de la Commission de la santé mentale du Canada a collaboré avec de nombreux milieux de travail à mettre en œuvre et évaluer des programmes de réduction de la stigmatisation en santé mentale. Le présent article décrit les leçons tirées des initiatives de recherche et de programmation de Changer les mentalités dans le groupe cible des milieux de travail, et explique certains des apprentissages les plus utiles obtenus de la collaboration avec les partenaires en milieu de travail. Ces leçons touchent des enjeux comme le recrutement de partenaires potentiels jusqu'à l'exécution de l'évaluation du milieu de travail. Les leçons apprises décrites ici ne se veulent pas des façons optimales de former des partenariats ou de mener une recherche dans un milieu de travail, mais elles visent à faire état de certaines de nos expériences de mise en œuvre de programmation anti-stigmatisation. Ces expériences sont présentées de sorte que ceux qui vivent la même situation puissent profiter de nos apprentissages et rendre leurs initiatives plus efficaces. En conclusion, nous discutons de certaines de nos idées sur l'endroit où la mise en œuvre de programmes de réduction de la stigmatisation de la santé mentale en milieu de travail devrait fonctionner à l'avenir.

### Keywords

mental health, stigma, workplace

This article describes many of the insights and learnings that have been obtained since 2010, when the Opening Minds (OM) initiative of the Mental Health Commission of Canada was formed (see Szeto et al<sup>1</sup>). Overall, our efforts to develop and evaluate evidence-based workplace projects and partnerships have been successful. Programs such as The Working

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Mind (TWM) and The Road to Mental Readiness (R2MR) are having a strong acceptance in both general workplace and first responder settings. The reach of these programs has exceeded our expectations and has encompassed hundreds of sites in various sectors and across most of Canada. Despite our successes, there has been a steep learning curve in taking on projects with employers and organizations of various sizes and types and importing an academic way of doing things to a workplace context. This article offers some of our experiences and lessons learned, not necessarily as the absolute or “best” ways to implement programs and conduct research in applied settings. Rather, we highlight some of our experiences so that others in our situation can maximize their time, effort, and efficacy without necessarily repeating some of the barriers and challenges we encountered.

### **The Recruitment and Adoption Processes**

Although the OM workforce researchers were largely in place by mid-2010, our partnerships, program implementation, and research and evaluations did not really begin until approximately 2 years later. Despite a couple of early adopters, and although some workplaces were willing to discuss workplace mental health and mental illness stigma reduction, many were resistant to formally committing to program implementation and evaluation (this, despite the fact that the program would be offered at cost, the OM team would handle logistics, and the evaluation was offered as a “free” but required service). Our perception was that one of the largest factors that affected uptake by a company or organization was the extent to which the senior managers or executives acknowledged the potential impact of the stigma of mental illness and psychological health and safety in their workplace. Relatedly, other organizations did not see the benefits of reducing stigma or increasing awareness of mental health in the workplace, and some even believed that implementation of such programming would imply that there was a problem within the organization or leave it vulnerable to liability or lawsuits. In other cases, while they were willing to consider some form of program, they were resistant to the idea of evaluation, as this process might represent a formal documentation of what was previously more of a vague concern (and added to the time of workers away from their workplace duties). Suffice it to say, there was a lot of “door knocking” at the initial stages. In many cases, if a partnership was struck, the process from initial agreement to actual implementation was a long and time-consuming “courtship” process. Sometimes the process needed multiple levels of approval or multiple meetings with various levels of leadership. Other times there were delays in attaining approvals. It often took more time to implement and evaluate a program than was expected.

Our experience was that successful OM partnerships usually started with an employee at the managerial level, such as a human resources (HR) manager. These individuals understood the importance and effects of mental health and mental

illness in the workplace and were often enthusiastic about a partnership with Opening Minds. In most cases, however, these individuals needed approval from senior executives to proceed with a partnership agreement or the delivery of an intervention or an evaluation, and sometimes this is where progress was slowed or stalled. In contrast, at other sites, senior-level executives demonstrated comprehension of the impact of mental illness in the workplace and endorsed psychological safety in the workplace. In these cases, the process from initial interest to implementation of interventions and evaluations progressed with minimal delays. In addition, support by senior executives created a culture that was accepting of interventions or evaluations, as well as mental health more generally. One of the most important lessons learned was that while general approval is needed from senior executives, there is a need for specific endorsement of a given antistigma initiative. If this precursor is not present, the researchers and program providers need to take the time to develop and obtain executive-level endorsement so that the partnership and subsequent actions progress more smoothly.

Sometimes, existing partnerships stalled or ended due to factors that were largely out of anyone’s control or due to unforeseen circumstances. For example, reduced activities often occurred during the summer months, and holiday seasons sometimes delayed planning and progress. Another barrier that affected some potential partnerships was organizational change and restructuring or leadership change. On several occasions, potential partners had expressed interest in partnering with Opening Minds, but workplace mental health had ceased to be an organizational priority as a result of subsequent changes to the organization or leadership. Similarly, when the “champion” of the partnership at the company or organization left, this sometimes dramatically affected the pace with which the partnership proceeded and sometimes led to existing partnerships to stall or end.

### **Program Implementation and Evaluation**

Challenges and barriers also existed after partnerships had been formed and implementation agreed upon. In our experience, research in the workplace setting can result in rich information, but many factors are not under the researchers’ control, especially compared to research conducted in a laboratory setting. The following are some of our lessons with respect to program implementation and evaluation.

#### ***Participation in Program***

Many of the programs offered at partner sites had enrolment rates of less than 50%. This rate was due to the voluntary nature of participation for many of the programs offered in the workplace. Although it is unclear what the impact of low enrolment on stigma reduction and organizational culture change is, we suspect it is not a positive one. The fact that

antistigma programs are optional, in and of itself, sends the signal that the organization has not fully accepted the importance of the topic. Low enrolment in an antistigma intervention can therefore maintain the status quo and reduce the shift to a culture of acceptance regarding mental illness, a finding that has been subsequently supported in qualitative research.<sup>2</sup> There also needs to be support from senior leadership to ensure employees' willingness to participate in evaluations and ensure uptake of a program. A program "champion," especially at the senior leadership role, helps to persuade leadership peers to accept the program and encourage employees to attend.<sup>2</sup> At one of our sites, a departmental vice president (VP) discussed the importance of mental health and participation in programs at various meetings and town halls. This endorsement was associated with an almost 100% program participation in the VP's department of approximately 300 personnel. Another approach may be to strongly recommend a training program of this nature or even to build it into ongoing professional development or training that is needed to be promoted or once promoted.

Similarly, there needs to be an increased sense of expected and mandatory participation, as well as dedicated time in the workplace for participation. At sites where this has occurred, higher uptake has been associated with more ease in program implementation and evaluation. Sites where programs were embedded as part of ongoing training had the highest uptake (e.g., at police and other first responder sites). Embedding antistigma programs into the normal training cycle, and thus making them quasi-mandatory or normative, is ideal to facilitate cultural change in the workplace. While mandatory or universal program delivery may not be viable for all organizations, voluntary attendance is less effective in engaging employees and may end up as a program for employees who have an interest in mental health or already have less stigma.

### **Evaluation Research**

Organizational support and a culture of "expectation" of participation are also important factors to increase the participation in evaluations. Careful attention to recruitment processes is also important. The ability to conduct evaluations onsite and right at the time of the program's delivery increases participation. In addition, dedicated time for the completion of evaluation measures increases participation, as it reflects corporate or organizational interest and relies less on individual goodwill to obtain evaluation data.

A common problem that we encountered in our OM work was that evaluation was not prioritized within the organization. Participation in the project not only involved organizations to sign up to offer a program but involved program evaluation that went beyond "internal program improvement." Organizations had to be a part of a larger evaluation research project that involved getting ethics clearance, with some occasions needing clearance from the

internal workplace ethics board in addition to the university-based research ethics board. This process, although generally supported by organizations, needed to be explained to the organization and increased the timeline for the projects.

Workplace research needs to align with the existing culture and established processes in each workplace. This type of applied research sometimes requires trade-offs such as lack of research control (e.g., random assignment) in order to make logistical sense in the organization, maximize the generalizability of results, and ensure realism in the obtained results. For example, in some partner police organizations, program implementation was restricted by specific training schedules. In many cases, the program was given a specified amount of time, which left little time for participants to complete the evaluation instruments. Another example of lack of control pertains to our general research design. Ideally, we would have liked to conduct a randomized control trial at many of our partner sites. However, organizations were largely unreceptive to this request, and where the possibility existed, logistics, timing, and other factors prevented this type of research design. In large part, our partnerships were cooperative in nature, which required a balance between the needs and goals of the program evaluation and the goals and needs of the organization. This generally resulted in compromise and the research team relinquishing control over some aspects of the program and evaluation.

Another lesson learned was the need to be explicit about the research process, particularly the issue of confidentiality. It is incumbent on the researchers to address the concerns of the participants as well as the organizations themselves on issues of confidentiality. These concerns were generally alleviated when the evaluation process was explained in greater detail and how survey instruments were anonymous and would not be given to employers for review. In cases where evaluation reports were created for the partner organization, it was stressed that all results would be aggregated and could not reveal responses from individual participants.

Finally, one strategy we used in the evaluations to maintain anonymity but retain ability to connect pre-, post-, and follow-up data was to develop a system whereby the participants could generate a unique identification code through 3 pieces of what should be permanent information (e.g., the first 2 letters of the mother's maiden name). Unfortunately, many participants did not complete this process carefully, which resulted in considerable nonmatching evaluation questionnaires over the multiple time points. To adequately measure change over time, as a function of the intervention, and conduct the appropriate statistical analyses, each participant's questionnaires need to be linked. A related problem is participant attrition, in that some participants only completed the first of 2 or 3 questionnaires (e.g., just before and after the R2MR<sup>3</sup> or TMW<sup>4</sup> workshop). Ideally, a dedicated person could organize and coordinate the research at each site, to ensure proper completion of all sets of questionnaires and reduce attrition rates. In the absence of such a person,

clear communications are needed to reduce both nonmatches and attrition.

### **Communication**

Another factor that affected intervention implementation and evaluation was the nature of the communications plan. Although this problem occurred only in a small number of sites, there were some communication problems related to program uptake, as well as confusion surrounding program elements, how to participate, and methods to complete evaluations. In contrast, a clear communications plan helps to create enthusiasm for the initiative and makes it clear that the current initiative is a part of continuing actions to address employee mental health in the workplace. Such a communications plan and its implementation may be best left to internal organizational units (i.e., communications department) if one exists or a coordinated approach with an internal stakeholder or champion who may know the most appropriate way to promote the project.

### **Increasing Program Efficacy**

Despite the above challenges, our experience was generally that once an organization adopted a program and had formally agreed to the OM evaluation process, a best faith effort was made. Indeed, many organizations wanted context-specific and tailored programs to maximize the employees' identification with and adoption of the program's ideas. As stated above, the train-the-trainer model required employees from the local organization to be trained and to deliver the program. Furthermore, the training and handout materials that were developed included the opportunity for organizations to add their own logo and identification. Our experience was that another key aspect of identification was the production and utilization of videos that were from the workplace sector in which the program was used. Thus, we had videos created with police officers when the program was presented in the policing context, firefighters when working with fire departments, and so on. Although the content of the program was therefore consistent across domains, this customization process allowed participants to better identify with the program and its messages. Beyond the standardized R2MR and TWM programs, in some cases, internal organizational champions did speak to their lived experience and offered contact-based education that was very powerful and relevant for employees. Some caution is needed in these cases so that the person conveying the message is credible and the message content is consistent with best practices.<sup>5,6</sup>

As the R2MR and TMW programs evolved, it became clear that some tangible tools were needed. As such, the program includes a workbook for each participant, as well as a wallet-sized card that quickly summarizes the continuum model of mental health, the coping strategies that are embedded in each program, and local resources for the workplace where the program was delivered.

One of the emergent needs for the program was for some form of continuing education or booster training. Thus, while the core program was generally viewed favorably, and the feedback suggested that the materials were useful, some type of refresher materials was needed. We were advised that it would not be practical to have employees retake the core program but that some form of a quick and accessible version of the program materials would be a benefit. The OM initiative of the Mental Health Commission of Canada has now completed a contract to create a web-based delivery mechanism for booster training of the R2MR program. This booster program will be evaluated, and if its results are positive, other web-based delivery of training is possible. As with all other aspects of the OM workforce programs, this development is being conducted in a purposeful and evidence-based fashion to ensure that the work meets local need and has maximal opportunity for success.

### **The Future of Workplace Antistigma Programs**

The experience of the workplace Opening Minds program has been enlightening in many respects. The program has moved from a position of trying to find workplaces that might be willing to conduct workplace mental health programs, without any clear measures and limited success, to having 2 well-established and widely used programs that have been disseminated to a wide variety of workplace settings. In doing so, we have had some stumbles, such as evaluating programs that were unsuccessful and having discussions with organizations that ultimately withdrew from action. We can be criticized for not insisting on a randomized trial in at least some settings but instead allowing open trials and broad roll-out of programs, which precludes strong evaluation of the program's efficacy. We are fortunate to be in the process of now conducting a first randomized trial, which will provide improved efficacy data.

Notwithstanding the above limitations, the Opening Minds has had remarkable success in the development, adaptation, and dissemination of workplace mental health programs for both first responder groups and the general workplace at large. These programs use evidence-based elements such as contact-based education, group discussion, and other methods that have validity to reduce stigma, communication strategies to address mental health issues in the workplace, psychoeducational aspects of mental health literacy using a nondiagnostic and nonmedicalized framework, coping skills from cognitive-behavioral therapy,<sup>7</sup> and application of reasonable workplace accommodations. The use of a train-the-trainer model helps to ensure that there are staff members in the businesses that adopt program, to continue their delivery with high fidelity and competency.

One of our major implementation insights is the critical importance of cultural shifts within organizations<sup>8</sup> to permit discussion related to mental illness in the workplace, to signal a receptivity to enacting programs that treat mental and

physical illness in the same manner, and to facilitate the training, growth, development, retention, and recognition of employees who either have had or may have a mental illness. Ultimately, it is this type of shift that leads to the ability to openly talk about mental health problems without fear of stigma, retribution, or discrimination.<sup>9,10</sup> This type of shift is not easy, and it does take time and perseverance, but it can happen. Our belief is that such a cultural shift leads to business efficiency such as improved return to work, reduced absenteeism and presenteesim, and a financial return on investment.<sup>11</sup> We continue to work with agencies to try to operationalize and directly measure the return on investment model by pairing them with researchers with expertise in financial analysis to collect relevant data.

Of most importance is that workplace stigma reduction and mental health education programs are of direct benefit for those who deal with these issues and their families. All adults seek meaning and value in their lives, and for most adults, the workplace and the development of a career are a significant part of that meaning. A civil society such as Canada has the ability and the moral necessity to address these issues, and we are pleased to have taken a small part of action on the behalf of employed Canadians.

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