IHE Report

Delivery and Evaluation of a Mental Health Promotion Intervention for Alberta Workplace Supervisors and Managers

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ALBERTA CANADA

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INSTITUTE OF HEALTH ECONOMICS
ALBERTA CANADA

Delivery and Evaluation of a Mental Health Promotion Intervention for Alberta Workplace Supervisors and Managers

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Interpretation of Findings

The views expressed herein are those of the authors and do not necessarily represent the official policy or views of the Institute of Health Economics, any Alberta Government Department, Tiger Calcium Services Inc., or the Alberta Courts.

Declared Competing Interest of Authors

None of the authors has a financial or non-financial interest, either direct or indirect, that would be affected by the research contained in this report, nor has this research placed any of the authors in a position where their judgment could be unduly influenced by a secondary interest, such as personal advancement.

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EXECUTIVE SUMMARY

Background

When an Alberta firm was fined for an environmental offence involving mental health issues, the presiding judge invoked a "creative sentencing" approach. Three-quarters of the fine was awarded to the Institute of Health Economics to undertake and evaluate a mental health promotion project relevant to the improvement of conditions in the Alberta workplace.

Methods

Mental Health Works (of the Canadian Mental Health Association) was commissioned to present a 2-day workshop (sessions were separated by 30 days) for senior workplace staff ("influencers"). Sessions dealt with the recognition of mental health problems, connecting with troubled employees, management influences, and suggested worksite policy and procedural changes. Workshop quality, mental health impact, mental health knowledge, and resultant worksite program activities were measured before and after the workshop sessions and again at follow-up, 3 – 5 months later.

Findings

Workshop session I was successfully delivered to 35 persons, while 28 attended day 2. The findings across our three evaluation components can be summarized quite simply. First, there was strong evidence for workshop quality. For example, all attendees agreed (or strongly agreed) that they would recommend the training to others. Secondly, there was good evidence that participant learning took place. Pre-session confidence in the ability to locate help for someone with a mental illness was fairly high and improved significantly after training. However, confidence in the ability to actually talk to a mentally ill employee did not change, nor did confidence in gaining the engagement of senior management (although, initial levels were relatively high). Respondents were initially high, with subsequent improvement, on both matching symptoms to diagnoses and understanding the relationship with addictive behaviours. Awareness of the influence of disability was initially low, with significant improvement, and attribution of cause showed no change after training, but levels were initially very high and appropriate. Finally, there were indicators that some positive developments were initiated in the workplaces of the attendees, but these had not been extensive, perhaps due to either (1) our follow-up period was not long enough to allow planning to run its course, and/or (2) five of the respondents had left their employment situation and could not, of course, provide a follow-up report.

Discussion

The project made use of a manualized, and therefore replicable, workshop presentation that dealt with important mental health matters and showed meaningful effectiveness and promise. Therefore, a more widespread use of these, or similar, workshops is recommended, with built-in evaluation and provisions for continuous improvement.

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INTRODUCTION

This service and evaluation project originated from the Alberta courts via the collaboration of two Alberta Ministries; (1) Alberta Justice & Solicitor General and (2) Alberta Environment and Sustainable Resource Development. The impetus arose when a judge in an environmental protection case observed a need for additional attention to the mental health needs of workers. An Alberta firm, Tiger Calcium Services Inc., was fined for an environmental offence, and since the root cause of the infraction involved an employee with a mental health problem, the presiding judge invoked a "creative sentencing" approach. That is, three-quarters of the fine was awarded to the Institute of Health Economics to undertake a mental health promotion project relevant to the improvement of mental health conditions in the Alberta workplace.

BACKGROUND

Of relevance to this issue were the findings from a recently completed Institute of Health Economics study on mental health and addictions in the Alberta workforce (Thompson, Jacobs & Dewa 2011). These include:

- The prevalence of mental disorder in the workforce is high - 39% of workers showed at least one of four disorders (anxiety disorder, phobia, antisocial personality disorder or major depression) at some time in their lives (44% for females; 33% for males). Specifically for depression, the lifetime rate was 13% (15.4% for females, 10.6% for males) and 9% within the last year.
- Problem-level addictive behaviours were very low (although alcohol use and general gambling activities were very common). However, problem levels of any addictive behaviour were accompanied by very high rates of mental disorder. In fact as the seriousness of addictive behaviour increased, so did the likelihood of mental illness.
- "Extreme" workplace stress was reported by over 16% of the workforce. Overall stress (moderate plus extreme) has increased gradually since 1992.
- Measures of workplace culture proved to be very potent correlates of differences across mental health measures, addictive behaviours, occupation, industry, and health zones. There were five workplace culture measures: (1) liability risk (probability of negative consequences of work/task failure), (2) after hours work, (3) uncontrollable or unusual work hours, (4) job value/satisfaction, and (5) the already mentioned job stress. The first four of these are generally reported in the literature to reflect or cause job stress and all contribute to other worker difficulties.

These results are similar to findings from elsewhere in Canada. For example, a Conference Board of Canada report (Thorpe and Chenier 2011) indicated that fully 44% of working Canadians had personally experienced a mental health issue at some time in their lives (it should be noted, however, that the definition of a "mental health issue" was very broad, including stress, burnout, addictions and substance abuse).

Mental health issues consistently show a significant effect on employment. Bland et al. (1988) have shown that psychiatric disorders in general are associated with much higher than average levels of unemployment, and Patten and his co-researchers (2009) have shown that depression leads to a premature exit from meaningful work.

Workplace stress is also a significant factor. Results from the Canadian Community Health Survey indicated that in 2010, 23.5% of all Canadians 15 years or older reported that most days were extremely or quite stressful. These figures have fluctuated very little since 2003, with women showing rates that were slightly (2% to 3%) above males (Statistics Canada 2011). These surveys were not restricted to workforce members, but the results clearly indicate that a troublesome level of stress has become part of the lives of many of us.

In conclusion, many workers show mental health vulnerabilities that interact with a negative workplace culture to produce conditions that directly and indirectly affect worker ill-health and productivity while on the job.

Based on the foregoing, we determined that a demonstration project that targeted improvements in worksite procedures and structure would be the most feasible given our mandate and resources. Furthermore, we focused on supervisors, managers, and others with worksite influence in order to maximize effectiveness. Thus, in consultation with the Alberta Departments of Justice & Solicitor General and Environment & Sustainable Resource Development, we decided on the provision and evaluation of a workshop designed to change the behaviour of supervisory and management personnel. This, in order to effect changes in company/organization structure and function and, ultimately, the mental health and productivity of their workers.

METHOD

Advisory Committee

To supplement the IHE project team's scientific and local knowledge, an Advisory Committee was formed to work with team members throughout the project.

The Advisory Committee's duties were to:

1. Advise on local/sectoral issues that might have an impact on the project
2. Provide advice on policy issues that might be raised (or should be raised)
3. Comment on project methodology
4. Review drafts of the final report.
5. Advise on any other matter that might improve the quality of the project

Members represented expertise in the areas of business or mental health program development in health promotion, service delivery, management, and/or evaluation. One place on the Committee was reserved for the Alberta Environment/Justice Liaison representative.

Advisory Committee Membership	
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The Workshops & Participants

To address our concerns that many workshops are held with no discernible effect[1], two procedures were introduced to promote learning and to increase the likelihood that participants would engage their respective firms in, at least, a consideration of mental health programming for their employees. First we decided on a workshop covering 2 days that were set 1 month apart. This gap was intended to allow consolidation between sessions and to create some degree of information redundancy. Secondly, we made it very clear to potential workshop attendees that there was an expectation that each would return to his or her own senior management body and arrange for the consideration of a mental health plan. Firms were recruited by (1) posting an invitation letter (see Appendix A) on the Institute of Health Economics website, (2) placing an ad in the Edmonton Journal's business section, (3) direct recruitment to selected firms by Advisory Board members and the Institute, and (4) electronic distribution to members of the Human Resource Institute of Alberta.

[1] Admittedly, effects may exist, but have been unnoticed. Nonetheless, we adopted the view that change takes more than one exposure to be accepted and that purposeless information is not likely to lead to action.

Regarding the workshop content, we were fortunate in that the Canadian Mental Health Association (CMHA) had recently created a training arm, "*Mental Health Works*", that had already prepared educational sessions that came very close to matching our needs (see Canadian Mental Health Association 2011; Jurgens, Dewa & Barbetta 2011). It took some "switching" of modules and creation of new material, but the CMHA quickly worked with us to prepare a suitable two-day curriculum. The content included information designed to assist attendees to:

1. Understand mental illness
2. Recognize someone dealing with a personal mental health issue
3. Approach a worker who seems to be suffering or at risk, and
4. Determine worksite interventions, including:
    a. Supportive counseling
    b. Referral for treatment
    c. Improvement of workplace culture

More details on this and related curricula are available from *Mental Health Works* at http://www.mentalhealthworks.ca/.

No fee was charged for attendance. Spaces were offered to interested firms on a first come - first served basis. Because the optimal workshop size imposed a limitation, both Day 1 and Day 2 were offered twice. It was made clear to the participating firms that they were being asked to:

1. Support employee time at the workshop.
2. Discuss the mental health needs of their staff following the workshops and to consider formal policies and procedures to address workplace mental health issues.
3. Allow the workshop attendee to provide information/feedback to the research team (interviews or questionnaires) to assist us in the evaluation of the effectiveness of the training sessions.

The first workshop (Day 1) was held in early March, 2012 and was attended by 35 individuals, 34 of whom completed the pre-test questionnaire. Of these, 24 attended Day 2 during the first week of April 2012. An additional four persons attended Day 2 who had not attended Day 1, thus increasing the total to 38. Follow-up surveys were mailed out approximately 10 weeks after Day 2. Of the 26 questionnaires that were ultimately completed, the majority (73%) arrived by the end of August. Follow-up reminders produced the seven later sporadic arrivals, with the last appearing in January. It is interesting to note that five of the non-completers had left their place of employment following their attendance at the workshop.

Table 1: Number of employees at worksite

	#	%
< 10	4	11.8
10-40	11	32.4
50-199	8	23.5
200-499	9	26.5
500+	2	5.9
Total	**34**	**100.0**

Day 1 participants were spread across 12 of the 15 industry categories (North American Industry Classification System; NAIC 2009) used in the Alberta Survey of Addictive Behaviours and Mental Health in the Workforce: 2009 (Thompson, Jacobs, and Dewa 2011). The majority (91%) were located in urban centres of more than 5000 people and they represented worksites of various sizes, ranging from <10 employees to over 500 (see Table 1). Accordingly, span of control also varied, with 26% of the attendees being able to influence at least 200 workers, and 47% directly affecting less than 10.

Study Design and Measurement

A pre, post, follow-up design was used. No comparison group was included. Two of these assessments took place during the training sessions (the first prior to Day 1 and the second at the end of Day 2). The third was mailed out just under three months after the second training session.

Components of each assessment instrument are summarized in Table 2. The questionnaires can be found in Appendices B through E.

Table 2: Assessment instrument content

Pre-test instrument (start of Day 1)	Post-test instrument (end of Day 2)	Follow-up instrument (80-100 days following)
Workshop Quality		
Evaluation (end of day)	Evaluation	
Workplace Issues		
MH* effects		MH* effects
Worker stress	Worker stress	Worker stress
Work strain		Work strain
Job satisfaction	Job satisfaction	Job satisfaction
Job vs. Career		Job vs. Career
Attendee Knowledge		
Cause of MI‡	Cause of MI‡	
Diagnosis matching	Diagnosis matching	
MH & Addiction	MH & Addiction	
MH & Disability	MH & Disability	
Confidence to act	Confidence to act	Confidence to act
Getting help		Getting help
Organization Response		
Readiness for change	Readiness for change	Readiness for change
Incident response		Incident response
Employee Assistance Prog.	Employee Assistance Prog.	Employee Assistance Prog.
MH Policy	MH policy	MH policy
		Work Environment
		MH Initiatives

* MH = Mental health ‡ MI = Mental illness

Analysis Strategy

Comparison of all three testings, the pre-test, post-test, and follow-up (occasionally referred to below as T1, T2, and T3), proved to be complicated by differing attendance and completion rates

and would have produced relatively small samples with low power for detecting differences. To address this, the variables that were presented at all three testings were assessed for statistical significance by using separate analyses, each comparing two test-times; i.e. T1 vs. T2 (potentially 24 cases),T1 vs. T3 (22 cases), and T2 vs. T3 (23 cases).

The evaluation model here comprised of three main levels that generally occur in chronological order. These were:

1. The quality of the workshop (whether information was delivered in a proficient manner)
2. Participant learning of relevant facts and attitudes
3. Consequent changes in worksite behaviour

Items pertinent to these three primary issues were supplemented by additional questionnaire items on perceived worker well-being and prefaced by respondent beliefs about the importance of mental health in the workplace.

Note that some of the items involve the self-report of respondent abilities. Such reports of performance are frequently inaccurate and are often biased by a general tendency of humans to place themselves in a good light in comparison to others (Brown 1986; Alicke and Govorun 2005). For this reason, we have included a number of skill-testing questions to supplement those items that are based on the respondents' perceptions of the performance of themselves or their respective organizations.

Ethics

Names and identifying information were collected from each participant to allow matching of their responses across all three test sessions. Names were then stripped from the data files and restricted to the paper files which will be kept in a locked cabinet for at least five years before they are destroyed (as stipulated by the Canadian Tripartite Agreement; Interagency Advisory Panel on Research Ethics 2008). There will be no reports or presentations of this study that will divulge the identification of any participating person or firm.

The evaluation component of this project was approved by the Research Ethics Board of the University of Alberta.

RESULTS

Is Workplace Mental Health Important?

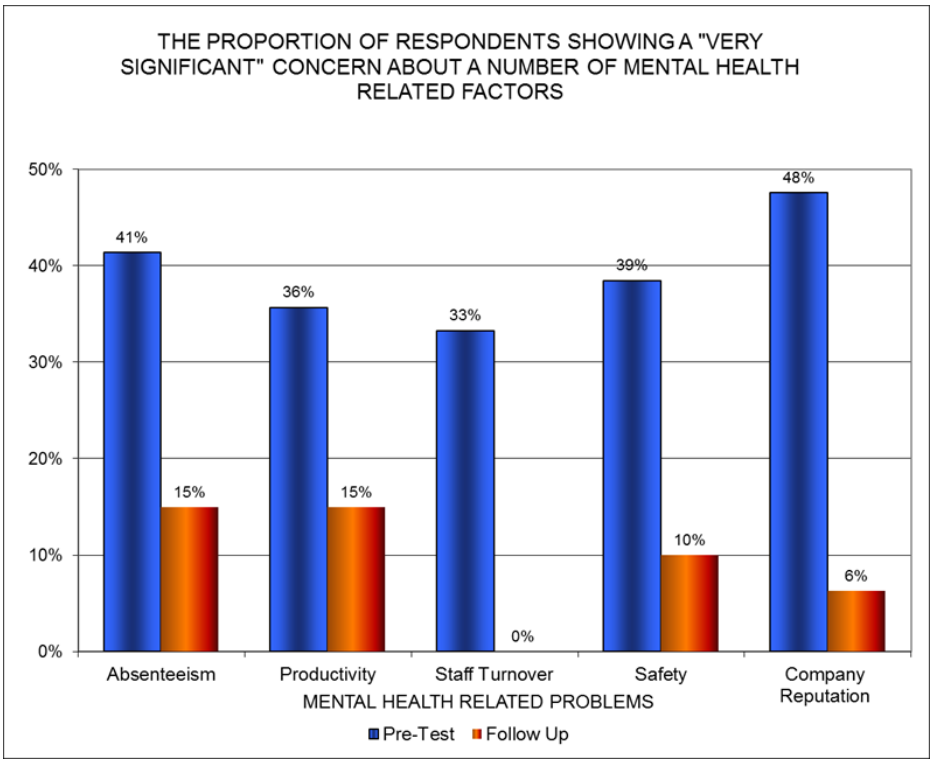
In the first instance, a large proportion of the respondents (48.5%) indicated that their firms were aware that their respective worksites had mental health needs and were thinking of ways to address them (this is one aspect of "readiness for change" and will be discussed further in a later section of this report). This is a clear indicator of the high importance placed on the topic, and may explain why these individuals chose to attend the workshop.

Another set of questions produced a qualified "Yes" to this section's query on importance. There was considerable initial concern about the problems potentially caused by mental health issues, with fears being allayed to some degree at follow-up. Table 3 shows the average ratings for several situations at pre-test and at follow-up (response choices were either "None ", "Somewhat" or "Very Significant"; rated 0, 1, and 2 respectively).

Notably, in comparison to the pre-test, the respondents' reported level of concern had dropped numerically at follow-up in all five cases, although only two showed statistical significance (if the marginal level of p<.10 is included, three of the five paired groupings showed significant comparisons). The accompanying figure shows this change for those areas showing a "very significant" level of concern. It is likely safe to conclude, then, that concern about the effect of mental illness diminished across the board for such issues. There is no obvious explanation for this, but a reasonable hypothesis is that the workshop increased sensitivity and that this allayed some of the fears that have been shown to be associated with mental illness (e.g. see Link et al. 1999).

Table 3: Changes from pre-test to follow-up in the average level of concern expressed for selected mental health-related work factors

	Absenteeism	Productivity	Turnover	Safety	Company reputation
Pre-test	1.26	1.28	1.18	1.29	1.15
Follow-up	1.11	1.11	0.75	0.71	0.64
T (df)	0.80 (18)	0.97 (17)	2.26 (16)	2.88 (16)	1.83 (13)
Signif. (2-tail)	NS	NS	<.05	<0.02	<.10



In spite of these initial perceptions of high importance, most of the respondents underrated the extent of the relationship between disability and mental health when they were asked to estimate the proportion of disability claims that are mental health related. The full range from 1% to 100% was divided into five equal categories and the respondents were asked to pick one. The correct answer (Towers Watson 2010; presented at the workshop) is quite high; "61% to 80%" of disability cases involve mental health. However, only a minority of participants were "correct" at pre-test (8%), with the majority (88%) picking a lower level of association. Workshop attendees were also asked about

the importance of the relationship between addictions and mental health, and in this instance, did show a high level of accuracy (i.e. 79% correctly recognized that people with an addiction are more likely to have a mental illness). These two factors will be discussed more fully in the "Knowledge" section, below.

To summarize this section, the responses demonstrate high assigned importance to workplace mental health issues, but suggest a need for more training on the causal relationship between mental illness and factors like disability. Furthermore, there appears to be a need for research on the tempering of the perceived importance of mental health over the course of the two workshop sessions.

I. Workshop Quality

This is about the evaluation of the workshop itself. It pertains to three domains:

(1) the value of the information,

(2) the clarity of the presentation, and

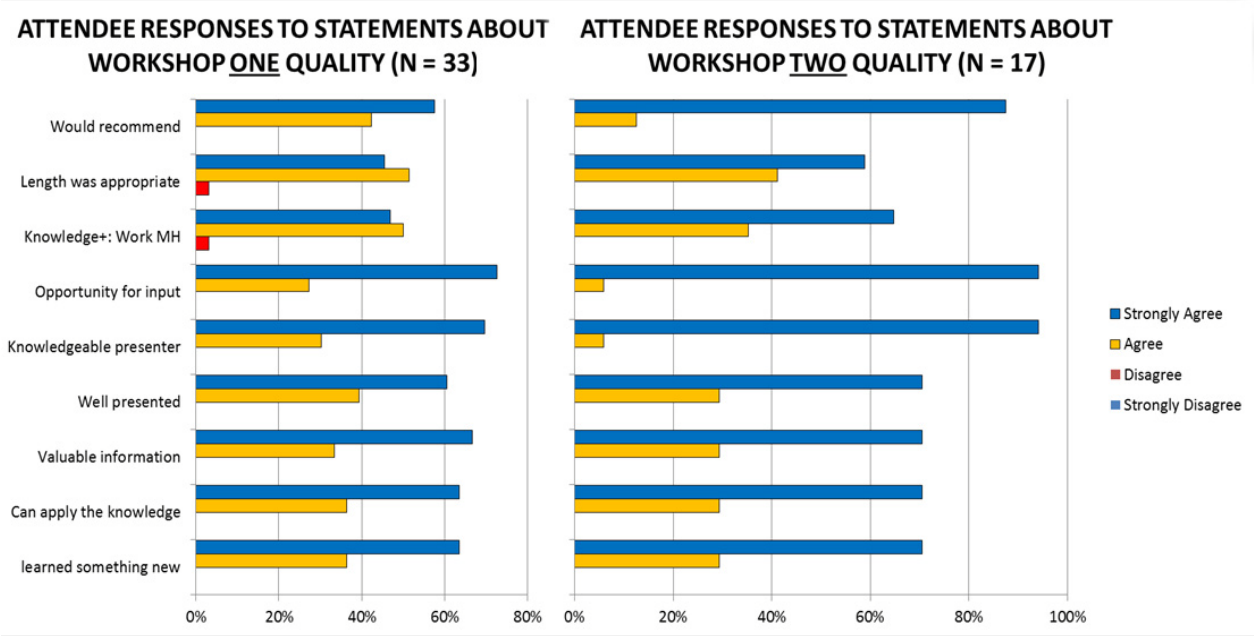
(3) the attendees' general "reaction" to the workshop.

Numerical ratings were obtained on three questions within each of the three domains. For each of these quantitative questions, respondents could choose one of four responses, ranging from 1 = "Strongly disagree" to 4 = "Strongly agree". Additionally, four open-ended opportunities were provided to allow a broader commentary. Note that separate presenters were used for Days 1 and 2. See Appendix B for a copy of the questionnaire. Unfortunately, due an administrative error the presentation evaluations were not distributed on one of the Day 2 sessions. Thus, there were only 17 evaluations collected for Day 2 in comparison to the 34 for Day 1.

The figure, below, shows the summary of the workshop ratings.

Overall, the presentation received highly positive reviews in terms of the quality of the content, the learning experience, and the excellence of the facilitators. Note that most of the response categories showed a 100% positive rating, with the poorest rating being a 94% positive rating on the item dealing with increased knowledge about workplace mental health – a still amazingly high endorsement. It is notable that all of the respondents indicated that they would recommend the workshop to their colleagues.

The open-ended questions provided further valuable information. The introductory workshop was appreciated for the "tools" provided (workplace accommodation plans, scripts for approaching employees with MH issues), the opportunity to interact with others in the class, learning about variation in symptoms depending on the person, and the help to "see things from other perspectives". Nearly one quarter suggested that more knowledge on mental illnesses would be helpful, with more detailed case studies and information on the creation of a friendly atmosphere/healthy workplace being highly desirable.



Comments about the advanced workshop ("Day 2") indicated that they greatly appreciated the resources and reference material pertaining to future action and many indicated that there is much need for a guidebook on workplace mental health promotion.

Both facilitators received glowing comments from the majority of the attendees.

II. Attendee Knowledge

A number of questions covering selected mental health matters were included to see if knowledge increased following the two-day workshop (i.e. from pre- to post-testing) and whether it was maintained at follow-up.

Confidence in dealing with employees and management. These two items deal with the respondents' own comfort-level when, respectively, (1) speaking with an employee about his or her apparent mental health problem and (2) approaching senior management about potential mental health initiatives. Responses were recorded on a 4-point scale that ranged from no confidence to total confidence. The results are shown in Table 4. Notably, there was no improvement in respondent confidence in their own ability to discuss an employee's mental health problem with the afflicted person. Although the levels are relatively positive (average ratings hovering around 3.0 of the maximum of 4.0), it is surprising, and disappointing, that there was no hint that the training sessions made a difference. Confidence in approaching management actually declined from pre-test to post-test, with no real difference from there to follow-up. These perceptions appear to call for increased focus on these skills, but it may actually be something opposite - as noted by Voltaire - that increased knowledge may lead to a decrease in confidence.[2]

[2] Properly quoted as "The more you know, the less sure you are". In Warner CD, Editor. A Library of the World's Best Literature, Vol. XXXVIII. A Library of the World's Best Literature, Vol. XXXVIII (originally published in 1896), Vazoff-Wesley, New York: Cosimo Inc. 2008, p. 15483.

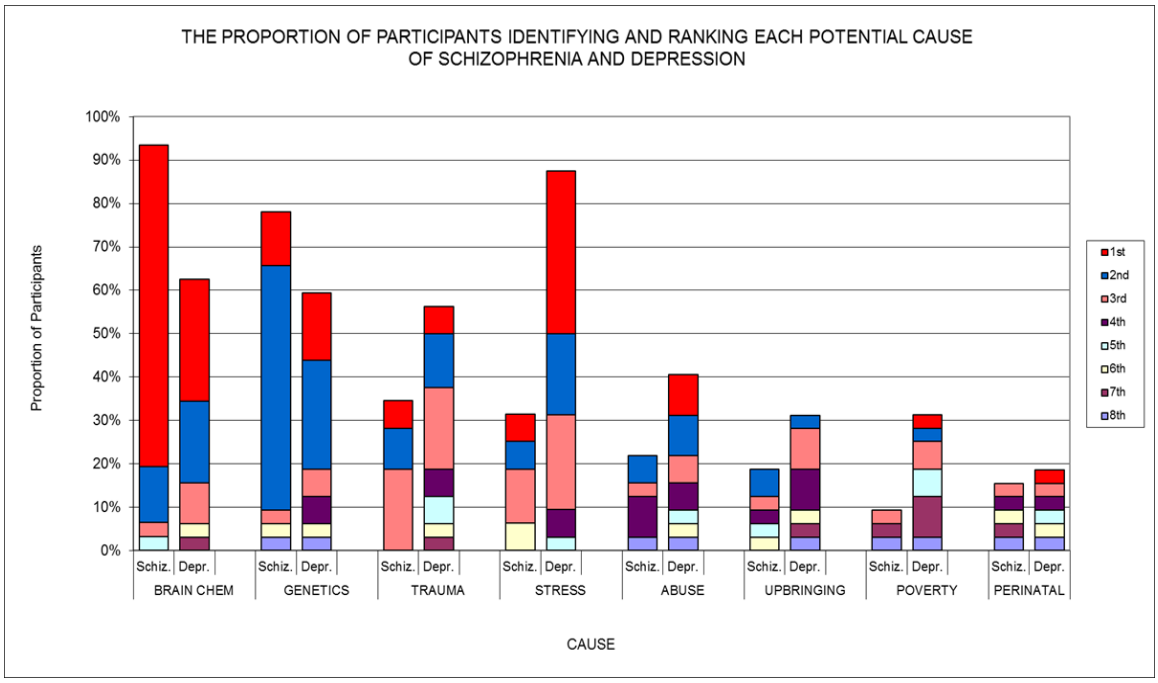
Table 4: Confidence when dealing with mental health issues (with an employee) and mental health initiatives (with senior management)

	Pre-test	Post-test	Follow-up	t	df	Sig.
Employee	2.8	3.0	---	0.21	23	NS
	---	3.0	3.1	0.81	22	NS
Senior management	3.5	3.2	---	-2.89	23	< .01
	---	3.2	3.3	0.53	22	NS

Helping an employee. Knowledge here, though, seemed to make a difference. At pre-test an already healthy 84% of the workshop attendees claimed to know how to arrange help for an employee with a mental health problem, with the figure climbing significantly higher to 95% at follow-up (X^2=5.63, df=1, p<.01; n = 19).

Attributing Cause. Workshop participants were asked to identify the primary cause of two major mental disorders: schizophrenia and depression. Then, for each, they were asked to select any additional contributing causes and rank their choices. It must be admitted that this is an unclear task (the evidence for causes is often equivocal). Nonetheless, existing evidence for schizophrenia favours brain chemistry, genetics, and perinatal complications. Depression, although also showing biological influences, is also characterized by stress, trauma, and abuse. Increases in accuracy, then, should show a drift toward, and a greater reliance on, brain chemistry and genetics for schizophrenia, and movement toward the above-mentioned non-biological components for depression.

One important finding for our purpose here can be expressed very succinctly – there was no meaningful evidence of any pre-post shift in knowledge that could be attributed to the training sessions. However, the findings are of interest because of what they tell us about participant knowledge. The accompanying figure shows the perceived causes of schizophrenia and depression ranked in importance (since there were no pre-post differences, only pre-test data are shown). For example, the leftmost bar shows pre-test ratings for brain chemistry as a cause of schizophrenia. Of all participants, 93.5% rated this as a cause; with the great majority signifying that it was the most important factor by ranking it first (indicated by the size of the top, crimson-coloured, section). Data for depression (the 2nd bar) showed that the proportion judging brain chemistry to be a contributing cause was 62.5%, a meaningful difference. An examination of the remainder of the chart shows that biological causes (brain dysfunction and genetics) predominate in schizophrenia ratings, and social/psychological causes received greater prominence for depression (but with the biological influences still being seen as important). Of the top five, only stress showed a significant difference across pre- and post-testings; a pre-test rank of 2.5 dropping to 4th at post-test (t = -2.22, df = 22, p<.02, one-tailed); a point of view not taught during the workshop.



Differences notwithstanding, these findings are generally in line with current scientific thinking. However, evidence has been available over the past few decades that indicates that perinatal/birth complications are highly important in schizophrenia when coupled with a family history of the disorder (Mednick et al. 1984; Werner and Smith 1992; Stefanis et al. 1999). The lack of awareness of this is not surprising since the earlier findings were generally ignored, and the topic has only recently received serious attention in the literature.

Matching Diagnosis to Symptoms. Respondents were presented with a list of seven diagnoses (anorexia nervosa, bipolar disorder, depression, generalized anxiety disorder, phobia, PTSD, and schizophrenia) and were asked to pick the most prominent indicator for each from a list of 10 symptoms. Again, the workshop participants began with quite a good grasp of this topic – 65% getting five or more (of seven) correct at pre-test. Among those completing the post-workshop test, however, the figure rose to 81%, with 38.5% showing perfect scores. When only the 23 individuals who completed both the pre- and post-test were considered, the mean accuracy figures were, respectively, 5.3 and 5.9 correct, and the observed improvement was statistically significant ($t = 1.75$, $df = 22$, $p<.05$, one-tailed).

Are people with an addiction more likely to have a mental illness? The answer to this is a resounding "Yes", and most got it correct on both, the pre- and post-testings (79% and 87.5%, respectively). This apparent improvement was statistically significant ($X^2 = 4.37$, $df = 1$, $p < .02$).

What percentage of disability claims are mental health related? As suggested above, most respondents under-estimated the influence of mental health; at pre-test only 8% identified the correct disability range ("61% - 80%" of disability cases showing mental health involvement; Towers Watson 2010). When the 24 persons who replied to both session testings were considered, only a minority were "correct" in either instance (8% and 25% of respondents, respectively). Nonetheless, this difference clearly demonstrated a statistically significant improvement in knowledge ($X^2 = 6.55$, $df = 1$, $p < .01$).

Section summary. The findings indicate that a meaningful amount of learning took place during the two days of the workshop, allowing us to assume that enough would be carried forward to provide the underpinnings of planned workplace change. Areas devoid of evidence of knowledge acquisition, when such knowledge might have been expected, can serve as focal points for future investigations to foster improved procedures in the future. It is notable that knowledge levels were often high at pre-test (i.e. prior to exposure to the workshop) suggesting the possibility that some of our knowledge items were set at a level of sophistication that was not high enough to detect improvement.

III. Organizational Responses to Mental Illness

Incident response. Participants were asked to note the "usual response or disciplinary action" undertaken by their organization for each of three workplace situations involving a mental health issue. These were:

1. Signs of mental disorder in a worker,
2. an injury accident where mental illness was implicated, and
3. theft, again where mental illness played a role.

Organization response choices that targeted the employee in question included a warning, suspension, dismissal, referral for treatment (including counseling), or reassignment. The results of this for both the pre-test and follow-up are shown in Table 5.

Table 5: Respondents' report of commonly used responses to worksite incidents involving mental illness: Based on paired responses for Pre-Test vs. Follow-Up, corrected for 'Don't Know' (DK responses)

		Warn	Suspend	Dismiss	Refer for Rx	Reassign
Mental	Pre-test	5.6%	0%	0%	83.3%	5.6%
disturbance	Follow-up	5.4%	0%	0%	100%	31.6%
	Wilcoxon Z	0	0	0	2.00*	2.24*
Injury	Pre-test	7.1%	0%	0%	71.4%	28.6%
accident	Follow-up	10.5%	0%	0%	94.7%	52.6%
	Wilcoxon Z	0.60	0	0	2.53**	1.90‡
Theft	Pre-test	33.3%	0%	0%	73.3%	0%
	Follow-up	26.7%	20.0%	6.7%	80.0%	33.3%
	Wilcoxon Z	0.38	1.73‡	1.00	0.38	2.24*

*p < .05 **p < .01 ‡Borderline

First of all, suspension and dismissal were used infrequently when dealing with incidents involving mental health, except perhaps with an increase at follow-up for cases involving theft. This is not in line with recent findings for substance abuse situations in the Alberta workforce (Thompson, Jacobs & Dewa 2011) which showed much more common usage for these two interventions (e.g. 31% and 39% for suspension and dismissal, respectively, among injury accidents). On the other hand, the present investigation showed that reassignments and referrals for treatment were both well used. A statistically significant increase from pre-test to follow-up was found for reassignments in all three incident situations, and referrals increased for two of the three (mental disturbance and injury

accidents). Warnings were often used, but showed no discernible change between the testings at T1 and T3. It should be noted that there were a considerable number of "Don't Know" responses to this set of questions (ranging from 10% to 33%), higher than for any other section of the questionnaire.

There was no question about where the perceived responsibility for mental health issues in the workplace lies – the great majority felt that it should be the employer (82%), but with meaningful contributions from other relevant stakeholders (see Table 6 – asked at pre-test only). However, only about one in five felt that their organization had a formal mental health policy at both pre- and post-testings (19% and 21%, respectively), with matters apparently worsening at follow-up (12%). However, the drop to 12% was not statistically significant ($t = .57$, $df = 16$, $p = 58$).

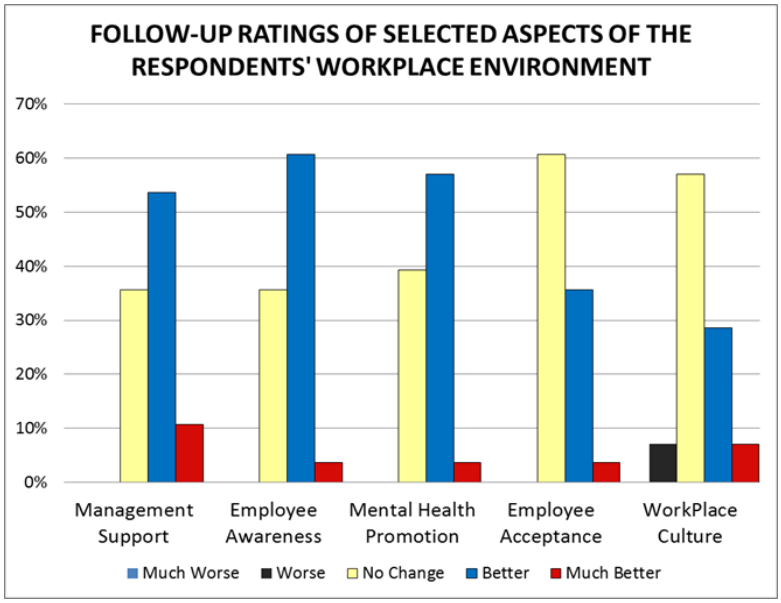
Table 6: Responsibility for work-place mental health

Employer	81.8%
The individual	48.5%
Union	18.2%
Health system	12.1%
Government	12.1%

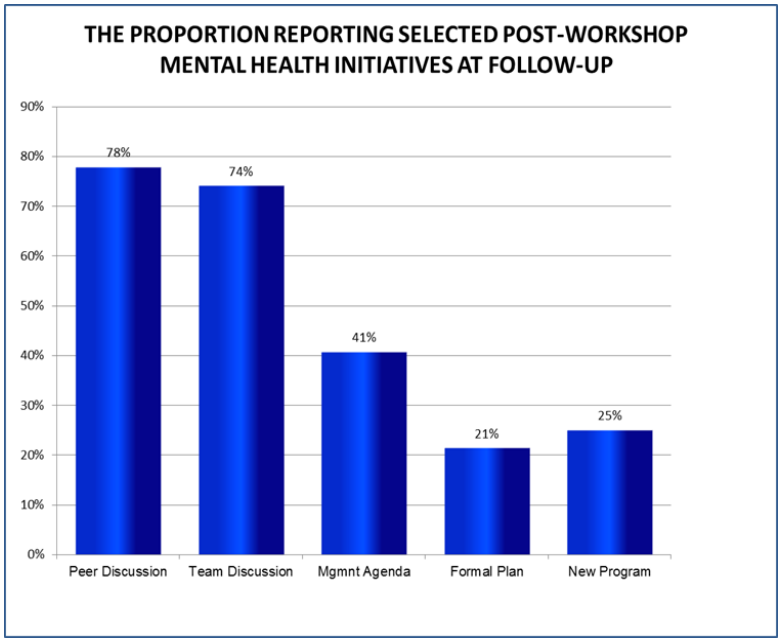
Employee Assistance Programs (EAPs). The vast majority stated at both, pre-test and follow-up, that their workers had access to an employee assistance program (96.9% and 95.8%, respectively) and that in most cases costs were covered by the employer (85.2% and 90.5%) with the remaining cases (14.8% and 9.5%) covered by an employer/employee co-payment arrangement. Notably, these levels were (1) virtually unchanged across the course of the study, and (2) this level of coverage is much higher than that found in the recent survey of addictive behaviours and mental health in Alberta's workforce (Thompson, Jacobs and Dewa 2011) which showed 53% of firms reporting access to an EAP and 68% of these being funded by the employer. In addition to the already positive attitude shown toward EAPs in the present study, 45% of respondents to the follow-up survey indicated that they felt that the provision of such programs should be increased. No one endorsed a decrease.

The Workplace Environment. Workshop attendees were asked (at follow-up) to rate recent change in five aspects of their workplace environment. These were:

1. Management support for those with a mental illness
2. Employee awareness of mental illness
3. Mental health promotion activity
4. Employee acceptance of peers with mental health issues
5. The workplace culture overall



The accompanying figure depicts the following important two findings: (1) the estimates were extremely positive in all five areas, and (2) when ratings were compared against a "no change" criterion, all five areas showed mean scores that were above this and significant (workplace culture at $p<.02$, and the remainder at $p<.001$).[3] Only two responses indicated any post-workshop worsening (both about work culture).



Post-Workshop Program Development Activities

Respondents were asked at follow-up whether a selected array of relevant program development activities had taken place. The responses to this are shown in the figure below, which also includes the frequency of occurrence for each. Remembering that we had asked workshop participants to

[3] t values, respectively from left to right, were 6.15, 6.55, 6.01, 3.96 and 2.59; all with df = 27.

discuss the possible need for a mental health program at their respective worksites, the level of peer discussion at nearly 80% is not surprising, but it is nonetheless encouraging. As the level of progress toward the implementation of a new program increases (moving to the right in the figure), action diminishes, but with activity in all areas. This observation assumes that base level activity would normally be set at zero, but it is possible that some mental health planning might have arisen for reasons not related to our workshop. Thus, we set the hypothetical expected proportion of an activity at a more conservative 10% before applying chi-square analyses to the data. In comparison to this value, all findings were statistically significant, with the higher three showing X^2 values of 137.8, 123.2 and 28.35, respectively (all at $p<.001$), and the latter two showing X^2 values of 4.06 ($p<.05$) and 7.00 ($p<.01$). Note that setting the expected level of program development at 15% produces non-significant differences for the "formal plan" and "new program" levels.

Company/Firm readiness for Mental Health Promotion

While treatment through Employee Assistance Programs is highly important, it is not the whole story when it comes to the mental health of individuals. Recognition, followed by a sensitive approach to the appearance of mental illness is crucial, as are programs designed to uplift mental well-being and/or change workplace culture. Is there reluctance on the part of these firms to develop such employee programs? Our adaptation of the readiness for change scale (Prochaska and DiClemente 1983) was used to shed some light on this issue.

Table 7: Worksite readiness for change – all three testings

Stage		Pre-test (n = 33)	Post-test (n=28)	Follow-up (n=25)
0	No intention to change – no thoughts on the issue	6.1%	3.6%	7.7%
1	No intention to change – programs are adequate	15.2%	14.3%	0%
2.	Aware of need and, thinking of ways to address the issues	48.5%	57.1%	53.8%
3	Acknowledged a problem and have a plan to take action	3.0%	3.6%	15.4%
4	Taking action and changing policies and procedures	12.1%	21.4%	15.4%
5	Changes made – maintaining improvements	15.2%	0%	7.7%

This simple approach involves the assessment of the stage of readiness for change pertaining to a particular issue (ranging from no interest in the issue to completed implementation). The Readiness for Change Scale dominated the literature at one time, but has received serious criticism in the last decade indicating that evidence of its validity is lacking outside of the smoking realm (West 2005; Armitage 2009). Thus, our adaptation of the scale is of the same stature as any other set of untested questionnaire items. Our version was administered at all testings thus allowing for an assessment of progress across the duration of the project. Table 7 shows the response distributions at pre- and post-testing as well as at follow-up. Note that about one-half of the worksites were aware of the need and were thinking of ways to address the issue. However, the majority of worksites are nonetheless below stage 3 (having a plan; see numeric in the left hand column) which is the first level that indicates any tangible action.

The totals for stages 0 through 2 are 70% at the pre-test, 75% at the post-test, and 62% at follow-up. While some changes in the profile have occurred over the workshop presentations, these do not

appear to reflect improvement or greater action. When a comparison was made on only the 23 persons who completed the pre- and the post-scales, the mean stage of change ratings were nearly identical; 2.22 and 2.26, respectively – placing them within the "awareness" range, and not statistically different ($t = 0.13$, $df = 22$, $p = 0.89$). When we compared the 22 persons who completed both the post-test and follow-up questionnaires, we found an apparent slight improvement in the readiness score of 0.3 units, but this too fell well short of statistical significance ($t = 1.16$, $df = 21$, $p = 0.26$).

Worker stress, work strain, job satisfaction, and career vs. "a job". Although we were aware that the follow-up period was not likely to be long enough to assess changes in worker well-being, we nonetheless included some straight-forward questions on this to see if there would be any effect over the course of the project. Respondents were asked at all three testings to estimate the proportion of workers at their worksite who would rate their own jobs to be "extremely", "somewhat", or "not" stressful, and to provide estimates of employee ratings for job satisfaction (high, moderate and low). Similar ratings were obtained at pre-test and follow-up for the meaning on one's work (i.e. as a "job", "career", or "both") and for work strain (a composite of four items[4]; after Karasek 1979).

The results are shown in Table 8. None of the factors was seen to have changed over the course of the study (i.e. none reached statistical significance). However, the estimated levels of these factors in the sample's firms, if they are in any way accurate, is worrisome. Attendee estimates of extreme stress ranged from over 22% to about 33% in comparison to the above-noted estimate of 16% for the Alberta workforce – a number that is troubling enough (Thompson, Jacobs & Dewa 2011). Similarly, the belief held by our respondents that about 45% of their colleagues are being subjected to worksite strain, perhaps corroborating the findings on stress, needs to be examined more fully with a view to possible intervention.

Table 8: Perceived worker stress, work strain, job satisfaction, and job meaning; estimated worker proportions across testings

	Pre-test	Post-test	Follow-up	t	df	Sig.
Extreme Stress	25.6%	31.8%	---	-1.09	19	NS
	---	32.9%	22.5%	1.59	19	NS
High Job Satisfaction	46.7%	48.8%	---	-.48	19	NS
	---	41.2%	39.1%	0.32	20	NS
Work Strain	45.3%	---	45.1%	0.05	14	NS
Work seen as "a job"	31.8%	---	30.0%	0.38	17	NS

Section Summary. In the opinions of our respondents, there were improvements in the appropriateness of post-incident interventions (with more needed) and in the overall worksite environment (on average). There were reported increases in post-workshop mental health initiative-related activities with a gradient running through meaningful program and planning, a higher level of formal management review, to worker and team discussion at the highest level of occurrence. In contrast, there was no change in company readiness for change vis a vis mental health promotion.

[4] Work Strain is the average of (1) being responsible for objectives without the authority to control them, (2) work that does not make use of their abilities, (3) insufficient participation in decisions that affect their work, and (4) often being asked to work extra time take on extra work.

Finally, and as expected because of the relatively short follow-up period, there was no change in the estimated levels of worker well-being.

DISCUSSION

The findings across our three evaluation components can be summarized quite simply. There was strong evidence for workshop quality, there was good evidence that participant learning took place, and there were indicators that some positive things occurred in the respective workplaces of the attendees.

A strength of this project was the use of a manualized, and therefore replicable workshop presentation that was delivered by experienced specialists. It is clear that these workshop sessions were successfully delivered and were enthusiastically received by the attendees. While any procedure should be considered for improvement, we see no reason to recommend any major revisions to this aspect of the project and we are convinced that the workshop communicated its message, the intended message, to those in attendance.

The first level of the evaluation, then, indicated that the workshop delivered the right message. The second stage of the evaluation indicated that it did so effectively. That is, that the attendees' knowledge of mental illness increased over the two workshop presentations. Respondents showed an increased ability to match diagnoses with their symptoms and correctly noted the strong relationship between disability and mental disorder. The absence of a statistically significant change in items dealing with causes of mental illness and in the relationship between addictions and mental health is likely due to a ceiling effect – i.e. a pre-existing level of very high knowledge among the attendees. In retrospect, this high level of awareness should not be surprising – those who chose to attend the sessions would have had some sensitivity to the topic and perhaps some workplace responsibility for mental health matters, thus predisposing increased motivation and awareness.

In addition, it should be noted that the Canadian public, in general, has been ahead of the rest of the World in terms of sophistication about mental illness for some time. A little over a decade ago, Canadians were the only known nationals to view schizophrenia as a disorder of brain function, as opposed to holding traditional views involving stress and other psychosocial factors (Thompson et al. 2002). It seems clear that the attendees returned to their places of work with a high and improved level of knowledge about workplace mental health in the context of more positive attitude.

The measurement of organizational responses to mental health issues indicated overall movement toward the creation or enhancement of mental health programs. In the first instance, workshop attendees noted post-workshop improvements in management support, employee awareness & acceptance, support for a mental health promotion approach, and in the workplace culture generally. Furthermore, there was an increase at follow-up in the reported use of referrals for treatment and for reassignment to other duties when dealing with mental health-related worksite incidents. Interestingly, the perceived "readiness for change" of the organizations represented by the attendees did not show any meaningful modification across the three testings even though increased engagement in the planning activities related to the same goal was reported.

CONCLUSION

Overall, these workshops can produce change in knowledge and attitudes which can lead to positive changes in the functioning of the workplace. Importantly, our findings point to activities that are in line with the more broadly-based National mental health strategy that has been proposed by the Mental Health Commission of Canada (2010). Thus, we recommend:

1. That CMHA-like workshops be made available for workplace "influencers" across the Province.
2. That evaluation procedures be built into a selection of such workshops as a developmental tool to monitor and improve workshop effectiveness.
3. That further research involving comparison groups and longer follow-up should be given an early priority.
4. That the Government enhance its ongoing development of a Provincial approach by providing a standardized model for a Mental Health Plan to be used by Alberta's employers, and that this model be distributed via direct mail and website placement to key parties including governments, utilities, human resource associations, trade unions, construction firms, engineering, procurement, construction, maintenance (EPCM) corporations (e.g. SNC Lavalin, Fluor, Bechtel) and major energy sector firms (such as Shell, Esso, and Suncor), and any and all employers.

REFERENCES

Alicke MD, Govorun O (2005). *The better-than-average effect*. In MD Alicke, DA Dunning, JI Kruger (Eds.). The self in social judgment. New York: Psychology Press. pp. 85–106.

Armitage CJ (2009). Is there utility in the transtheoretical model? *British Journal of Health Psychology* 14:195-210.

Brown JD (1986). Evaluations of self and others: Self-enhancement biases in social judgments. *Social Cognition* 4(4):353-76.

Bland RC, Stebelsky G, Orn H, Newman SC (1988). Psychiatric disorders and unemployment in Edmonton. *Acta Psychiatrica Scandinavica* 77(Suppl 338):72-80.

Canadian Mental Health Association (2011). Mental Health Works. Available: *www.mentalhealthworks.ca* (accessed 23 June 2011).

CDC (2011). Workplace Health Promotion – Health Model. Available: *http://www.cdc.gov/workplacehealthpromotion/model/index.html* (accessed 24 June 2011).

Interagency Advisory Panel on Research Ethics (2008). *Draft 2nd Edition of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*. Ottawa: Interagency Secretariat on Research Ethics.

Jurgens K, Dewa C, Barbetta R (2011). *Workplace mental health promotion in small and medium sized enterprises in Canada*. Toronto: Canadian Mental Health Association.

Karasek RA (1979). Job demands, job decision latitude, and mental strain: implications for job redesign. *Administrative Science Quarterly* 24:285–308.

Link BG, Phelan JC, Bresnahan M, Stueve A, Pescosolido BA (1999). Public conceptions of mental illness: labels, causes, dangerousness, and social distance. *American Journal of Public Health* 89:1328–33.

McLuhan M. Famous-Quotes.com. Retrieved from 1-Famous-Quotes.com website: *http://www.1-famous-quotes.com/quote/565445* (accessed 24 June 2011).

Mednick SA, Cudeck R, Griffith JJ, Talovic SA, Schulsinger F (1984). *The Danish High-Risk Project: Recent methods and findings*. In NF Watt, EJ Anthony, LC Wynne, JE Rolf, eds. Children at Risk for Schizophrenia: A Longitudinal Perspective. New York: Cambridge University Press. pp. 21-42.

Mental Health Commission of Canada (2012). *Changing directions, changing lives: The mental health strategy for Canada*. Calgary, AB: Author.

NAIC (2009). North American Industry Classification System. Available: *http://www.naics.com/search.htm* (accessed 11 June 2010).

Patten SB, Wang JL, Williams JVA, Lavorato DH, Bulloch A, Eliasziw M (2009). Prospective evaluation of the effect of major depression on working status in a population sample. *Canadian Journal of Psychiatry* 54(12):841-5.

Prochaska JO, DiClemente CC (1983). Stages and processes of self-change in smoking: Toward an integrative model of self-change. *Journal of Consulting and Clinical Psychology* 5:390-5.

Prochaska JO, DiClemente CC, Norcross JC (1992). In search of how people change: Applications to addictive behaviours. *American Psychologist* 47(9):1102-14.

Siegrist J (1996). Adverse health effects of high-effort/low-reward conditions. *Journal of Occupational Health Psychology* 1(1):27-41.

Statistics Canada (2011). Perceived life stress, 2010. Available: *http://www.statcan.gc.ca/pub/82-625-x/2011001/article/11466-eng.htm* (accessed 22 June 2011).

Stefanis N, Frangou S, Yakely J, Sharma T, O'Connell P, Morgan K, Sigmudsson T, Taylor M, Murray R (1999). Hippocampal volume reduction in schizophrenia: effects of genetic risk and pregnancy and birth complications. *Biological Psychiatry* 46(5):697-702.

Thompson AH, Jacobs P, Dewa CS (2011). *The Alberta survey of addictive behaviours and mental health in the workforce: 2009*. Institute of Health Economics, Edmonton, Canada.

Thompson AH, Moisey SD, Stewart C, Jin Y, Ziolkowski S, Cui X (1998). *Monitoring client and community outcomes in mental health programs*. Edmonton, Canada: Alberta Mental Health Board.

Thompson AH, Stuart H, Bland RC, Arboleda-Florez J, Warner R, Dickson RA (2002). Attitudes about schizophrenia from the pilot site of the WPA Worldwide Campaign Against the Stigma of Schizophrenia. *Social Psychiatry and Psychiatric Epidemiology* 37(10):475-82.

Thorpe K, Chenier L (2011). *Building mentally health workplaces: Perspectives of Canadian workers and front-line managers*. Ottawa: Conference Board of Canada.

Towers Watson (2010). The 2009/2010 Staying@Work™ Survey Report. Available: *www.towerswatson.com*.

Werner EE, Smith RS (1992). *Overcoming the odds: High risk children from birth to adulthood*. New York: Cornell University Press.

West R (2005). Time for a change: *Putting the Transtheoretical (Stages of Change) Model to rest*. Addiction 100:1036-1039.

APPENDICES

Appendix A: Recruitment Information Letter

Under the provisions of the "creative sentencing" mandate of the Alberta Court of Queen's Bench, funds were allocated for the provision of a workplace mental health promotion intervention. The presiding judge awarded funding to the IHE to deliver this service and evaluate its outcome.

The Institute has significant experience in this field. Most recently, we released The Alberta Survey of Addictive Behaviours and Mental Health in the Workforce: 2009, a comprehensive picture of many issues related to the mental health of workers across all the province's business sectors. Dr. Gus Thompson, IHE's lead mental health expert, was lead author of the Alberta Survey and will head up the court-mandated study.

A key component of this project will be two one-day workshops delivered a month apart by the Canadian Mental Health Association (www.cmha.ca). Offered free-of-charge to the first 60 employers who register, these sessions are designed to be delivered to individuals with supervisory and/or managerial responsibilities. Participants will:

- Learn to recognize signs of employee mental health difficulties,
- Be provided the tools that will allow employers to accommodate affected workers,
- Be shown the benefits of implementing corrective and preventative policies geared to fostering good mental health in the workplace, and,
- Be provided an overview of effective approaches to mental health improvement, employee productivity, and employee retention.

There is no cost to attend the workshops; however, employers who decide to participate in this important, valuable endeavour are asked to:

1. Support their employee's time at the workshop (including an assessment of learning),
2. Send the same supervisor or manager to both sessions,
3. Give formal consideration to an internal review of workplace mental health policy,
4. Allow a pre- and post-workshop assessment of participant learning and your firm's mental health promotion activities, and
5. Facilitate completion of a well-being questionnaire by other staff.

Once the study is completed, participating firms will receive a debriefing in the form of a final report. For more information or to register for the workshops, please contact:

Jessica Moffatt
Research Associate and Workshop Coordinator
(780) 448-4881 (ext. 236)
JMoffatt@ihe.ca

Appendix B: Workshop Quality Questionnaire[5]

MENTAL HEALTH WORKS: EVALUATION FORM

1. Value of Information				
	Strongly Disagree		Strongly Agree	
I learned something new	1	2	3	4
I will be able to apply this knowledge in my position	1	2	3	4
The information presented is valuable to me	1	2	3	4

2. Presentation				
	Strongly Disagree		Strongly Agree	
Information was well presented	1	2	3	4
Presenter was knowledgeable	1	2	3	4
There was opportunity for my input	1	2	3	4

3. Reaction				
	Strongly Disagree		Strongly Agree	
The workshop increased my knowledge of mental health issues in the workplace	1	2	3	4
The length of the workshop was appropriate	1	2	3	4
I would recommend this training to a colleague	1	2	3	4

a) What did you value the most? _____

b) What did you value the least? _____

c) What else could assist you in addressing mental health issues in the workplace?
_____

d) Comments and suggestions. _____

Thank you for your feedback. Please leave this questionnaire on the table.
If you would like to be added to our e-newsletter list, please print your

E-mail address: _____

[5] Provided by Mental Health Works

Appendix C: Pre-Test (T1) Questionnaire

MENTAL HEALTH WORKSHOP PARTICIPANT SURVEY

This is the first of three questionnaires that we will ask you to complete. The second will be given at the end of the second day of the workshop – it will be very brief and will focus on your learning experiences during the workshop. The third, similar to this one, will be sent to you about two months after the second and will ask about any post-workshop changes or planning activity that your firm might have engaged in.

Please note that you are free to choose not to complete this questionnaire, and that this will not compromise your participation in the workshop. However, your answers will serve as a valuable aid to our understanding of workplace issues and we request that you complete every question. Feel free to ask for clarification whenever needed. We are asking for your name and for your company name solely to allow us to match today's responses with those from the follow-up questionnaires. Once the surveys have been matched, we will remove all names from all of our records that are linked to your responses. We are required to produce a summary report on the project and we hope to present the findings in the scientific literature and/or at professional conferences. It is important to note that no company or person will be identified in any way in any of the reports on this project.

Name: _____ Company/Business: _____

Telephone (work): _____ E-mail (work): _____

Please indicate your main or primary business [Select the closest fit from the list below]

__ Primary industry: farming, oil/gas, forestry, fishing, hunting, mining

__ Utilities

__ Construction

__ Manufacturing

__ Retail/wholesale

__ Transportation, warehousing

__ Information (telecommunication, broadcasting)

__ Finance. insurance, real estate

__ Knowledge services: professional, technical, scientific, management

__ Education

__ Health, social services

__ Leisure: arts, entertainment, recreation

__ Hospitality: accommodation, food services

__ Public administration

__ Other

Is your worksite located in:

__ A city (over 5,000 population)

__ A town <5,000

__ Rural area

Approximately, how many people does your organization currently employ in Alberta (do not include sub-contractors when calculating this number)?

[**PLEASE CHOOSE ONLY ONE RESPONSE**]

__ less than 10 employees
__ 10 to 49 employees
__ 50 to 199 employees
__ 200 to 499 employees
__ 500+ employees

How many of these are at your present worksite?

__ less than 10 employees
__ 10 to 49 employees
__ 50 to 199 employees
__ 200 to 499 employees
__ 500+ employees

How many people in your organization fall within your area of influence. This would include either (a) supervisees plus all their supervisees and so on down the line (in the case of line authority) or (b) those affected by your policies &/or decisions (as in the case of a senior Human Resources manager)?

[**PLEASE CHOOSE ONLY ONE RESPONSE**]

__ less than 10 employees
__ 10 to 49 employees
__ 50 to 199 employees
__ 200 to 499 employees
__ 500+ employees

In general, to what degree are the effects of mental illness (e.g. depression, anxiety, schizophrenia) a concern in your area or work unit in terms of:

	None	Some-what	Very Significant	Don't Know
Absenteeism				
Low productivity while at work				
Staff Turnover				
Employee safety				
Organization's reputation				

What would be your organization's usual response or disciplinary action for each of the following incidents, assuming that this was the first such incident for the employee in question?

[CHECK ALL THAT APPLY]:

	No Action	Warning	Suspension	Dismissal	Refer for Treatment	Reassign to less sensitive area	Don't Know
An employee showed up for work showing signs of mental disturbance							
An employee was involved in an injury accident in which mental disturbance played a role							
An employee was caught for theft in which mental illness played a role							

In your opinion, whose responsibility is it to take the lead regarding mental health problems in the workplace?

__ The employer

__ Unions/ employee associations

__ The individual worker him- or herself

__ The health system

__ Government

Do employees in your organization have access to an employee assistance program?

(i.e. an EAP)?

__ Yes

__ No

__ Don't Know

If yes, how is the employee assistance program funded?

__ 100% by the employer

__ Employees and the employer

__ Employees only

__ Don't Know

If you felt an employee had a mental health problem, would you know how to arrange help?

__ No

__ Yes

__ Don't know

Is there a formal (written) policy for employee mental health at your work?

__ No

__ Yes

__ Don't know

Please select the option below that best reflects your firm's position on the use of a mental health program for employees. [SELECT ONE]

__ No intention to change existing practices (it is not on our radar)
__ No intention to change existing practices (current programs are adequate)
__ Aware that there is a work mental health problem & we are thinking of ways to address it
__ We have acknowledged a problem and have devised a plan to take action
__ We are in the midst of changing our policies and procedures
__ We have made significant changes in policy and procedures and we are working to maintain the improvements

What percentage of your employees would fall into the following categories?

	%
Are often responsible for meeting objectives that they do not have the authority to control	
Their work makes good use of their talents and abilities	
They participate sufficiently in the decisions that affect their work	
Are often asked to work extra time or take on extra work	

What percentage of your employees would rate their overall job satisfaction to be:

	%
High	
Moderate	
Low	
Total	100%

What percentage of your employees would see their work as:

	%
A career	
A job	
Both	
Total	100%

What percentage of your employees would rate their jobs to be:

	%
Extremely stressful	
Somewhat stressful	
Not at all stressful	
Total	100%

To the best of your knowledge, what is the primary cause of serious mental illnesses like schizophrenia (on the left-hand panel) and depression (on the right)?

Schizophrenia Please place the number "1" beside the factor that, to the best of your knowledge, is the primary cause of this disorder	
	Rank
Brain chemistry	
Genetics	
Stress	
Trauma	
Upbringing	
Abuse	
Poverty	
Problems during pregnancy/birth	
If there is more than one cause, please place a number "2" by your second choice, "3" by your third, and so on - as needed.	

Depression Please place the number "1" beside the factor that, to the best of your knowledge, is the primary cause of this disorder	
	Rank
Brain chemistry	
Genetics	
Stress	
Trauma	
Upbringing	
Abuse	
Poverty	
Problems during pregnancy/birth	
If there is more than one cause, please place a number "2" by your second choice, "3" by your third, and so on - as needed.	

In which of the following cases does the employer hold the legal responsibility for protection of its employees (in the workplace)? [Select only as many as needed]

__ Harassment

__ Injury

__ Management competence

__ Psychological well-being

__ Environmental hazards

__ Accidents on the job

Are people with an addiction more or less likely to have a mental illness?

__ More likely

__ No Difference

__ Less likely

Approximately what percentage of workplace disability claims are related to mental health issues?

__ None
__ 1%–20%
__ 21%-40%
__ 41%-60%
__ 61%-80%
__ 80%-100%

Please use the four point scale to rate your confidence in each of the two workplace situations. Responses can range from 1 (not at all confident) to 4 (totally confident). Circle one number for each condition.

	Not at all Confident		Totally Confident	
How confident do you feel about discussing an apparent mental health problem with an employee whose performance is below par?	1	2	3	4
How confident would you feel about approaching your senior management colleagues about the creation of a new mental health initiative for employees?	1	2	3	4

Please match the diagnosis in the left-hand panel with its primary symptom (shown in the right panel) by placing the symptom number in the "symptom #" column beside the appropriate diagnosis. Please select only one symptom per diagnosis (note: there are more symptoms than are needed, so some will go unused).

Diagnosis	Symptom #
Anorexia Nervosa	
Bipolar Disorder (Manic Depression)	
Depression	
Generalized Anxiety Disorder	
Phobia	
PTSD	

Symptom
1. Hallucination
2. Harming others without remorse
3. Avoidance of situations or things that do not present a danger to the person
4. Unpredictable outbursts – often involving swearing and/or shouting
5. Constant worry about matters that most would not find troubling
6. Severe anxiety disorder that develops after an overwhelmingly stressful event

Schizophrenia	

7. Dramatic mood swings from a positive to negative mood
8. A difficult to treat condition involving a deep suspicion of others
9. Loss of interest in activities that used to be rewarding
10. Excessive weight loss and a distorted body image

Appendix D: Post-Test (T2) Questionnaire

This is the second of the three questionnaires that we will ask you to complete. The third will be sent to you about two months – it will be very brief and will ask about any planning activity that your firm might have engaged in following the workshop.

Please complete every question. Feel free to ask for clarification whenever needed. As mentioned earlier, we are asking for your name and for your company name solely to allow us to match today's responses with the other questionnaires. Once the surveys have been matched, we will remove all names from our data base. We are required to produce a summary report on the project and we hope to present the findings in the scientific literature and/or at professional conferences. It is important to note, however, that no company or person will be identified in any way in any of these reports on this project.

Name: _____ Company/Business: _____

Telephone (work): _____ E-mail (work): _____

Is there a formal (written) policy for employee mental health at your work?

__ No

__ Yes

__ Don't know

Please select the option below that best reflects your firm's position on the use of a mental health program for employees. [SELECT ONE]

__ No intention to change existing practices (it is not on our radar)

__ No intention to change existing practices (current programs are adequate)

__ Aware that there is a work mental health problem & we are thinking of ways to address it

__ We have acknowledged a problem and have a plan to take action at some future time

__ We are in the midst of changing our policies and procedures

__ We have made significant changes in policy and procedures and we are working to maintain the improvements

What percentage of your employees would now rate their jobs to be:	
Extremely stressful	
Somewhat stressful	
Not at all stressful	
Total	100%

What percentage of your employees would rate their overall job satisfaction to be:	
High	
Moderate	
Low	
Total	100%

To the best of your knowledge, what is the primary cause of serious mental illnesses like schizophrenia (on the left-hand panel) and depression (on the right)?

Schizophrenia Please place the number "1" beside the factor that, to the best of your knowledge, is the primary cause of this disorder	
	Rank
Brain chemistry	
Genetics	
Stress	
Trauma	
Upbringing	
Abuse	
Poverty	
Problems during pregnancy/birth	
If there is more than one cause, please place a number "2" by your second choice, "3" by your third, and so on - as needed.	

Depression Please place the number "1" beside the factor that, to the best of your knowledge, is the primary cause of this disorder	
	Rank
Brain chemistry	
Genetics	
Stress	
Trauma	
Upbringing	
Abuse	
Poverty	
Problems during pregnancy/birth	
If there is more than one cause, please place a number "2" by your second choice, "3" by your third, and so on - as needed.	

In which of the following cases does the employer hold the legal responsibility for protection of its employees (in the workplace)? [Select only as many as needed]

__ Harassment
__ Injury
__ Management competence
__ Psychological well-being
__ Environmental hazards
__ Accidents on the job

Are people with an addiction more or less likely to have a mental illness?

__ More likely
__ No difference
__ Less likely

Approximately what percentage of workplace disability claims are related to mental health issues?

__ None
__ 1%–20%
__ 21%-40%
__ 41%-60%

__ 61%-80%

__ 80%-100%

Please use the four point scale to rate your confidence in each of the two workplace situations. Responses can range from 1 (not at all confident) to 4 (totally confident). Circle one number for each condition.

	Not at all Confident			Totally Confident
How confident do you feel about discussing an apparent mental health problem with an employee?	1	2	3	4
How confident would you feel about approaching your senior management colleagues about the creation of a new mental health initiative for employees?	1	2	3	4

Please match the diagnosis in the left-hand panel with its primary symptom (shown in the right panel) by placing the symptom number in the "symptom #" column beside the appropriate diagnosis. Please select only one symptom per diagnosis (note: there are more symptoms than are needed, so some will go unused).

Diagnosis	Symptom #
Anorexia Nervosa	
Bipolar Disorder (Manic Depression)	
Depression	
Generalized Anxiety Disorder	
Phobia	
PTSD	
Schizophrenia	

Symptom
1. Hallucination
2. Harming others without remorse
3. Avoidance of situations or things that do not present a danger to the person
4. Unpredictable outbursts – often involving swearing and/or shouting
5. Constant worry about matters that most would not find troubling
6. Severe anxiety disorder that develops after an overwhelmingly stressful event
7. Dramatic mood swings from a positive to negative mood
8. A difficult to treat condition involving a deep suspicion of others
9. Loss of interest in activities that used to be rewarding
10. Excessive weight loss and a distorted body image

Appendix E: Follow-Up (T3) Questionnaire

Please complete every question. Feel free to ask for clarification whenever needed. We are asking for your name and for your company name solely to allow us to match today's responses with those from the previous questionnaires. Once the the surveys have been matched, we will remove all names from our data base. No company or person will be identified in any way in any of our reports on this project.

Name: _____ Company/Business: _____

Telephone (work): _____ E-mail (work): _____

Since your attendance at the workshop, has the quality of your work environment changed? Please check one selection per row)

	Much better	Better	No Change	Worse	Much worse
Mental health promotion					
The workplace culture overall					
Employee awareness of mental illness					
Employee acceptance of peers with mental health issues					
Management support for those with a mental illness					

Please describe any **enabling factors** that aided you in approaching upper management and addressing mental health policy change within your workplace:

_____
_____
_____
_____

Please describe any **barriers** that limited you in approaching upper management and addressing mental health policy change within your workplace:

_____
_____
_____
_____

Since your attendance at the mental health promotion workshop, have any of the following taken place? … [Please circle either "YES" or "NO" for each question]

The possibility of workplace mental health initiatives has been discussed at team or unit meetings	YES	NO
You have discussed potential mental health programs with peers or those who report to you	YES	NO
The potential for mental health programs has been discussed formally (i.e. as an agenda item) by your senior management / executive	YES	NO
A mental health plan has been formally initiated for your area or for your worksite?	YES	NO
A new, or enhanced, mental health program has been initiated in your area or worksite?	YES	NO

In general, to what degree are the current effects of mental illness (e.g. depression, anxiety, schizophrenia) a concern in your area or work unit in terms of:

	None	Somewhat	Very Significant	Don't Know
Absenteeism				
Low productivity while at work				
Staff Turnover				
Employee safety				
Organization's reputation				

What would be your organization's usual response or disciplinary action currently be for each of the following incidents, assuming that this was the first such incident for the employee in question [CHECK ALL THAT APPLY]:

	No Action	Warning	Suspension	Dismissal	Refer for Treatment	Reassign to less sensitive area	Don't Know
An employee showed up for work showing signs of mental disturbance							
An employee was involved in an injury accident in which mental disturbance played a role							
An employee was caught for theft in which mental illness played a role							

Do employees in your organization have access now to an employee assistance program

(i.e. an EAP)?
__ Yes
__ No
__ Don't Know
If yes, how is the employee assistance program funded?
__ 100% by the employer
__ Employees and the employer
__ Employees only

Do you feel that access to an employee assistance program should be changed?
__ Increased
__ Unchanged
__ Decreased

If you felt an employee had a mental health problem, would you know how to arrange help?
__ No
__ Yes
__ Don't know/ No response

Is there currently a formal (written) policy for employee mental health at your work?

__ No

__ Yes

__ Don't know

Please select the option below that best reflects your firm's position on the use of a mental health program for employees.

__ No intention to change existing practices (it is not on our radar)

__ No intention to change existing practices (current programs are adequate)

__ Aware that there is a work mental health problem & we are thinking of ways to address it

__ We have acknowledged a problem and have a plan to take action at some future time

__ We are in the midst of changing our policies and procedures

__ We have made significant changes in policy and procedures and we are working to maintain the improvements

What percentage of your employees would rate their jobs to be:

Extremely stressful	
Somewhat stressful	
Not at all stressful	
Total	100%

What percentage of your employees would fall into the following categories?

Are often responsible for meeting objectives that they do not have the authority to control	
Their work makes good use of their talents and abilities	
They participate sufficiently in the decisions that affect their work	
Are often asked to work extra time or take on extra work	

What percentage of your employees would rate their overall job satisfaction to be:

High	
Moderate	
Low	
Total	100%

What percentage of your employees would see their work as:

A career	
A job	
Both	
Total	100%

Please use the four point scale to rate your current level of confidence in each of the two workplace situations. Responses can range from 1 (not at all confident) to 4 (totally confident). Circle one number for each condition.

	Not at all Confident			Totally Confident
How confident do you feel about discussing an apparent mental health problem with an employee?	1	2	3	4
How confident would you feel about approaching your senior management colleagues about the creation of a new mental health initiative for employees?	1	2	3	4

Any further questions or comments:

_____
_____
_____
_____
_____
_____
_____

Thank you for your time

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