Region of Peel Report

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www.mentalhealthcommission.ca

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1 OPENING MINDS: CHANGING HOW WE SEE MENTAL ILLNESS

As part of its 10-year mandate, The Mental Health Commission of Canada (MHCC) embarked on an anti-stigma initiative called Opening Minds (OM) to change the attitudes and behaviours of Canadians towards people with a mental illness. OM is the largest systematic effort undertaken in Canadian history to reduce the stigma and discrimination associated with mental illness. OM is taking a targeted approach, initially reaching out to healthcare providers, youth, the workforce, and media. OM's philosophy is not to reinvent the wheel, but rather to build on the strengths of existing programs from across the county. As a result, OM has actively sought out such programs, few of which have been scientifically evaluated for their effectiveness. Now partnering with over 80 organizations, OM is conducting evaluations of the programs to determine their success at reducing stigma. OM's goal is to replicate effective programs nationally. A key component of programs being evaluated is contact-based educational sessions, where target audiences hear personal stories from and interact with individuals who have recovered or are successfully managing their mental illness. The success of contact-based anti-stigma interventions has been generally supported throughout international studies as a promising practice to reduce stigma. Over time, OM will add other target groups.

For more information, go to: www.mentalhealthcommission.ca/English/Pages/OpeningMinds.aspx

2 BACKGROUND

In the spring of 2009, Opening Minds issued a Request for Interest (RFI) seeking existing programs working to reduce stigma among its initial target groups of healthcare providers or youth. They later extended this RFI to seek programs targeting the workforce and media. At this point, The Regional Municipality of Peel responded to the RFI and entered a partnership with Opening Minds to have their newly implemented supervisors' mental health training program evaluated.

Ethics approval from the Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board and the University of Toronto's Health Sciences Research Ethics Board were obtained prior to the evaluation of this supervisor training program. All supervisors at the Regional Municipality of Peel who underwent the training program were invited to participate in this evaluation.

2.1 Region of Peel Mental Health Module for Supervisors

This supervisors' mental health training program was developed by the Region of Peel in conjunction with Mental Health Works, a nationally available program of the Canadian Mental Health Association (CMHA) that "builds capacity within Canadian workplaces to effectively address the many issues related to mental health in the workplace" (www.mentalhealthworks.ca). The program was offered on a rolling basis to over 500 supervisors in 2011. While the program was not mandatory per se, it was presented to supervisors with the expectation of participation (listed under the company's general supervisor training), and the completion of the program serving as criteria for leading subsequent employee mental health training modules. As a result of this "implied mandatory" expectation, there was a 90% uptake of the program in the first 8 months of release, significantly better than the 10 to 20% uptake of past mental health training offered by the organization on a voluntary basis.

The objectives of the program were to:

• raise awareness amongst all supervisory staff to decrease stigma and better understand the mental health/mental illness continuum;

• identify problems related to mental health earlier and prevent them from escalating;

• improve supervisor self-confidence and efficacy to handle current problem situations related to mental health;

• improve the ability to create a healthy workplace environment

In total, three modules were created around the following topics:

1. Awareness

• Prevalence and impact of mental health and illness issues in the workplace

• Mental health vs. mental illness

• Workplace impact on mental health & illness

• Questioning assumptions

2. Sensitive conversations/communications

• Different ways to look at behaviour

• Ways to plan for and participate in sensitive conversations

• Creating social/environmental support to support mental health

3. Solutions

    - Exploring needs

- Shared commitment for success
- Prevention mindset
- Workplans & accommodation
- Uniqueness

Each module was presented in a self-serve format as a 45 minutes long webinar that was posted on the company's intranet site or provided as a DVD. Each module was accompanied by suggested discussion questions, case studies and supporting resources. Supervisors viewed these webinars either separately or as a group, but met as a group to go over the suggested discussion questions. While in-person training in small groups with a mental health expert would have been ideal, it would have not been cost-effective for an organization of this size. The self-serve approach also allowed people who missed a module or were new to management positions, to still be able to receive the training.

The contact-based component of this program involved viewing a video featuring a person with a lived experience of mental illness talk about their experience. This format is less interactive than traditional contact-based methods (i.e. seeing a live presentation) as it does not present the opportunity for participants to interact with the person with lived experience on a personal level. The evaluation of this program allows an opportunity to gather data on this method of contact-based education, with the aim of understanding whether it is an effective method for anti-stigma initiatives that may not have the opportunity to have live contact-based education incorporated into their programs.

3 EVALUATION METHODS

3.1 Survey Design

The evaluation of the Region of Peel's Supervisor Mental Health Training program was carried out using a pre-post survey design with a 3-month follow-up. The surveys were conducted online, using the secure website, Fluid Surveys. All participants were emailed a link to the pre-survey no more than 2-weeks prior to the start of their training date and a link to the post-survey immediately after the completion of their training. Participants who had completed the pre- or post-survey were contacted 3-months after the completion of their training with an invitation to fill out the follow-up survey. Data were collected from April 2011 – February 2012.

The survey packages contained 1) A shortened (15-item) version of the original 23-item Opening Minds Scale - Workplace Attitudes (OMS-WA) and 2) The Opening Minds Scale - Supervisor Workplace Attitudes Questionnaire (OMS-SWA). The pre-training survey also contained demographic questions, while the post-training and follow-up survey contained a Perceived Impact Questionnaire (PIQ), questions regarding experiences dealing with mental illness in the workplace, and open-ended questions about the program.

3.2 Qualitative Interviews

Qualitative interviews focusing on supervisor's thoughts and feeling about the training program as well as their experiences dealing with mental illness in the workplace were conducted with a subset of supervisors following the completion of the training. Invitations were attached to the post and 3-months post survey. A total of 11 supervisors participated in these 45-60 minute interviews in February and March 2012. Interviews were tape-recorded for transcription and content analyzed for themes by the research team.

4 RESULTS

4.1 Survey Results

4.1.1 Participant Demographics

Figure 1 outlines the response rates for the various survey time-points. Five hundred and fifty-one (551) supervisors participated in the training program and were invited to complete the questionnaires. Of these, 271 people completed the pre-survey (49%). Of those 271, 171 completed the post-survey (63%), and of those 171, 139 completed the follow-up survey (81%). The number of surveys completed at all three stages was 73. While the response rates for the surveys may seem low, this is in line with most workplace health surveys that use email invitations and a web-based surveys[1].

Figure 1. Number of Respondents Completing Surveys at Various Time-points

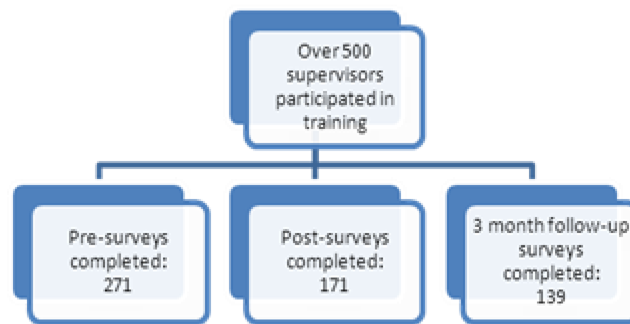


Table 1 outlines the breakdown of participants by various demographic variables. The majority of respondents were female. As well, most of the participants were between the ages of 36-55 years old and most identified as being Caucasian. A side-by-side comparison of demographic variables of the full sample and the sample with complete data are shown, with no major differences to note.

1 Occup. Mod. Vol. 49, Mo. 8, pp. 556-558. 1999

Table 1. Demographic characteristics of respondents

Demographic Variables	Sample with Complete Data (73) % (n)	Full sample (271) % (n)
Sex		
Female	55% (40)	50 (164)
Male	44% (32)	30 (99)
Did not answer	1% (1)	20 (64)
Education		
Less than high school	0% (0)	0.3 (1)
High school	4% (3)	7 (22)
Non-university certificate	29% (21)	25 (82)
Bachelor’s Degree	44% (32)	35 (113)
Post-graduate degree	23% (17)	15 (49)
Did not answer	0% (0)	18 (60)
Ethnicity		
Asian; Asian Canadian	1% (1)	4 (14)
Black; African Canadian	8% (6)	5 (16)
White/Caucasian	88% (64)	69 (226)
Other	3% (2)	4 (12)
Did not answer	0% (0)	18 (59)
Age group		
26-35	4% (3)	21 (8)
36-45	34% (25)	33 (89)
46-55	37% (27)	38 (101)
56-66	23% (17)	19 (51)
Did not answer	1% (1)	3 (9)

The analyses conducted in the body of this report use the 73 subjects providing complete data at all three time points. The identical analyses for unmatched data (i.e. full sample of respondents) are provided in the appendices.

4.1.2 Opening Minds Scale – Workplace Attitudes

The OMS-WA is a 15-item measure (shortened from the original 23-item measure) assessing stigmatizing attitudes, beliefs and behaviours in the workplace towards co-workers who may have a mental illness. The questionnaire measures responses to items using a 5-point Likert scale (1-strongly disagree, 2-disagree, 3-unsure, 4-agree, 5-strongly agree). This was an investigator developed scale and psychometric testing on the original version of the scale has shown it to be a good and reliable tool[2] with further testing currently underway to confirm these results.

2 Szeto AC, Luong D, Dobson KS. Does labeling matter? An examination of attitudes and perceptions of labels for mental disorders. Soc Psychiatry Psychiatr Epidemiol. 2013 Apr. 48(4): 659-71.

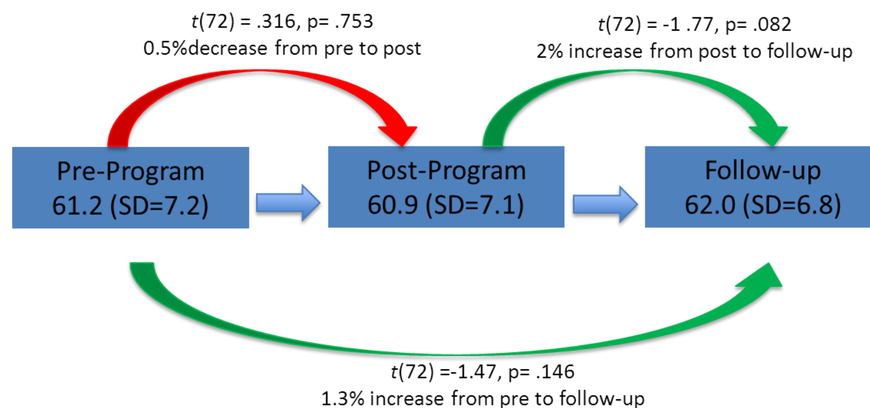
OMS-WA: Total Scores and Overall Change

A paired samples t-test of change was used to test for significant differences in overall scores between various time-points. A p<0.5 represents a change that is considered statistically significant.

Figure 2 shows the average OMS-WA scores at all three survey time-points as well as the paired t-tests for comparison of scores at various time-points, and the overall percent increase or decrease in score. Total scores were calculated by summing the items in the scale for participants who completed 100% of the scale items and dividing by the total number of these participants. Possible scores range from 15 to 75, with higher scores indicating more tolerant (i.e. less stigmatizing) attitudes.

Respondents started off with high scores (i.e. low levels of stigma) on the OMS-WA, with very little change across time. This suggests that because there were already pre-existing high levels of tolerant attitudes in the workplace towards co-workers who may have a mental illness, there was little room for improvement across time even with the anti-stigma training. While there were some increases and decreases in scores between time-points, these differences were not found to be statistically significant (p > .05).

Figure 2. Average Workplace Attitudes Scores at Pre-training, Post-training, and Follow-up*



*increase in score (green arrow) = more tolerant attitudes, decrease in score (red arrow) = more stigma

OMS-WA: Item by Item Change

The differences in overall scores of each item in the OMS-WA were also calculated (see **Table 6** in Appendix A.

There was one item that had significant improvement from pre to post-test, but was not sustained by follow-up

- *I would not want to work with a co-worker who had been treated for a mental illness.*

Two items had significant improvements by follow-up but were not seen immediately post-training

- *Co-workers with a mental illness are often more dangerous than the average employee.*
- *You can never know what a co-worker with a mental illness is going to do.*

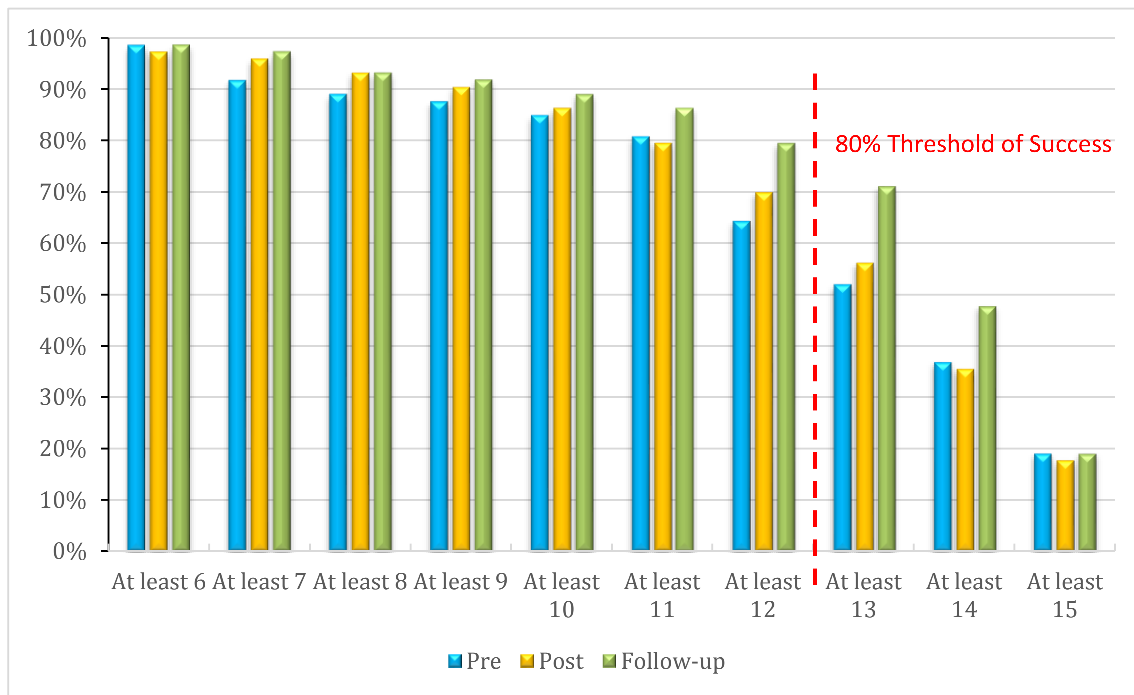
Cumulative Percent of Non-Stigmatizing Responses on the OMS-WA

Another way to look at changes in stigmatizing attitudes on the scale is to look at the proportion of participants who answered a certain percentage of the survey items in a non-stigmatizing way.

Figure 3 shows the cumulative percentages of participants who had non-stigmatizing responses for each possible score out of 15 of the OMS-WA at pre-training, post-training, and follow-up. This figure was derived by recoding each participant's response on the attitude scale to represent a stigmatizing or non-stigmatizing response.

A threshold of 80% (or at least 12 out of 15 "correct" – i.e. non-stigmatizing – answers) was used as an indication of success on the OMS-WA. Almost two-thirds (64%) of participants were above this threshold prior to the supervisor training, and this increased to 70% and 80% post-training and at follow-up respectively.

Figure 3. Cumulative Percent of Non-Stigmatizing Responses on OMS-WA for Pre- Post- and Follow-up (n=73)*



*To reduce the complexity of figure 5, cumulative percent of 100 for at least 5 items and below are not shown.

4.1.3 Opening Minds Scale – Supervisor Workplace Attitudes

The OMS-SWA is an 8-item measure assessing stigma-related attitudes specific to the supervisor role. The questionnaire measures responses to items using a 5-point Likert scale (1- strongly disagree, 2-disagree, 3-unsure, 4-agree, 5-strongly agree). This is an investigator developed tool, and full psychometric testing for this scale has not yet been completed, however Cronbach's alpha (a tool for assessing the reliability of a scale) was done on the current sample and was found to be lower (i.e. <.70) than what is normally acceptable.

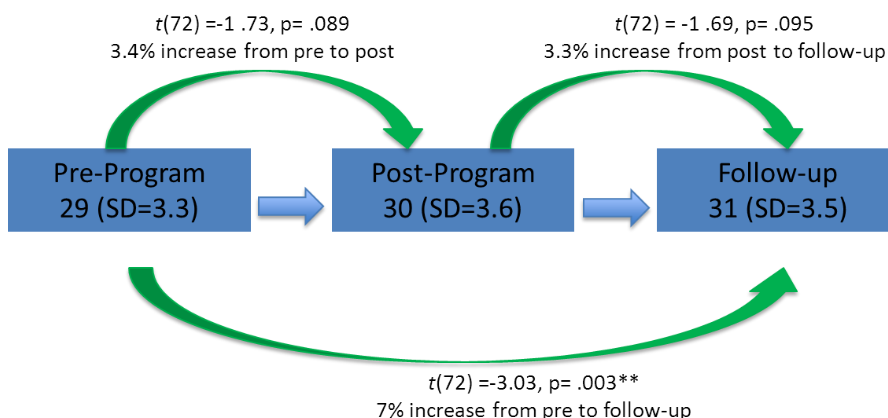
OMS-SWA: Total Scores and Overall Change

A paired samples t-test of change was used to test for significant differences in overall scores between various time-points. A p<0.5 represents a change that is considered statistically significant.

Figure 4 shows the average OMS-SWA scores at all three survey time-points, the paired t-tests for comparison of scores at various time-points, and the percent increase or decrease in score. Total scores of the OMS-SWA were calculated by summing the items in the scale for participants who completed 100% of the items on the scale, and divided by the total number of these participants. Possible scores range from 8 to 40, with higher scores indicating more tolerant (i.e. less stigmatizing) attitudes.

There was a 7% increase in score from pre-training to follow-up, reflecting an increase in tolerant attitudes. A paired t-test (t(72) =-3.03, p= .003) determined that this difference in score was significant. There were no other statistically significant differences found between change in scores of any of the other paired time-points.

Figure 4. Average Supervisor Workplace Attitude Scores at Pre-training, Post-training, and Follow-up (n=73)*



*Increase in score (green arrow) = more tolerant attitude; decrease in scores (red arrow) = more stigma
**Statistically significant difference in scores

The breakdown of total score change from pre to post and from pre to follow-up are shown in **Figures 5 and 6**. These figures show the percent of participants who had a total score increase (i.e., attitudes became more tolerant) of at least 5%, decrease (i.e., attitudes became more stigmatizing) of at least 5% or a score that had no change. A minimum of a 5% change of score in either direction was used to calculate this figure, as it is the typical benchmark to assess whether real change is occurring. 40% of participants' attitudes became more tolerant from pre to post, with this category only dropping to 36% by follow-up. The percentage of participants' attitudes that became more stigmatizing was 19%. While it is of concern that any percentage of participants' attitudes became more stigmatizing, the breakdown of response choices on the items of the scale (**Appendix B, Table 8**) show that the changes in attitudes became more "unsure" as opposed to going from positive to negative attitudes.

Figure 5. Total Score Change Pre to Post OMS-SWA (n=73)

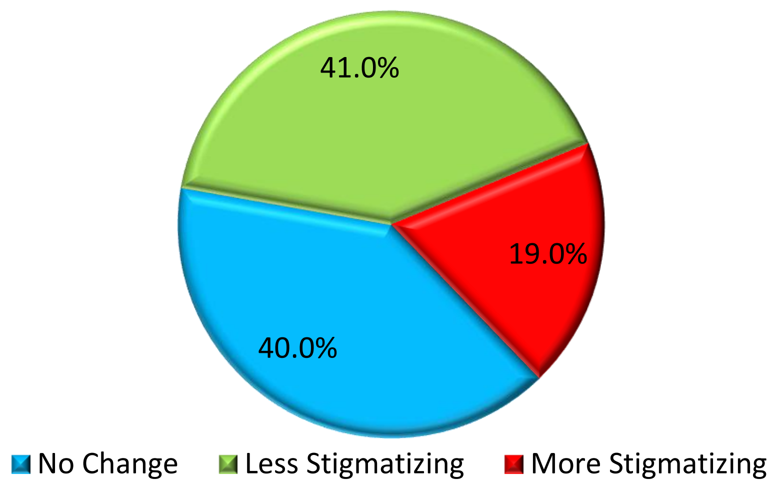
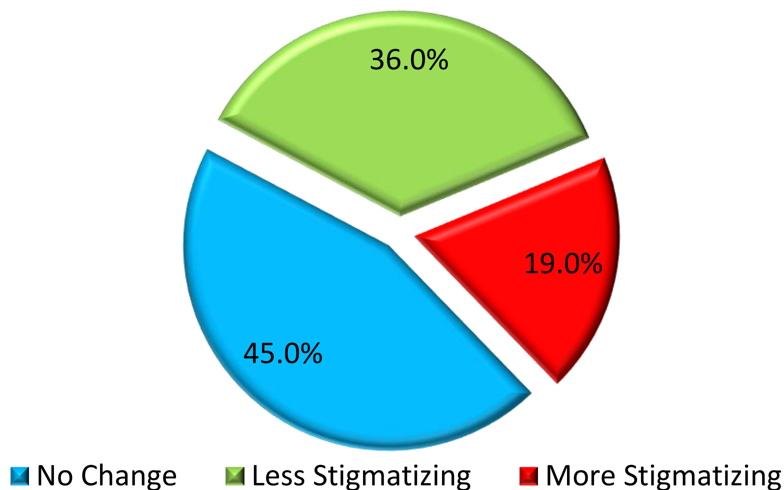


Figure 6. Total Score Change Pre to Follow-up OMS-SWA (n=73)



OMS-SWA: Item by Item Change

In **Table 11** (see **appendix B**) changes for individual items on the OMS-SWA were measured from pre- to post-test and again from pre to follow-up survey.

The only item that had significant improvement from pre to post-test and was sustained at follow-up was

- *Organizations take a significant risk when employing people with mental health difficulties.*

The only two items that had significant improvements by follow-up but were not seen immediately post-training were

- *I would employ someone who I knew had a history of mental health difficulties.*
- *Employers should make a special effort to accommodate the particular needs of employees with mental health difficulties in the workplace.*

OMS-HC scale contains within it three main content areas, each measuring a specific dimension of stigma.

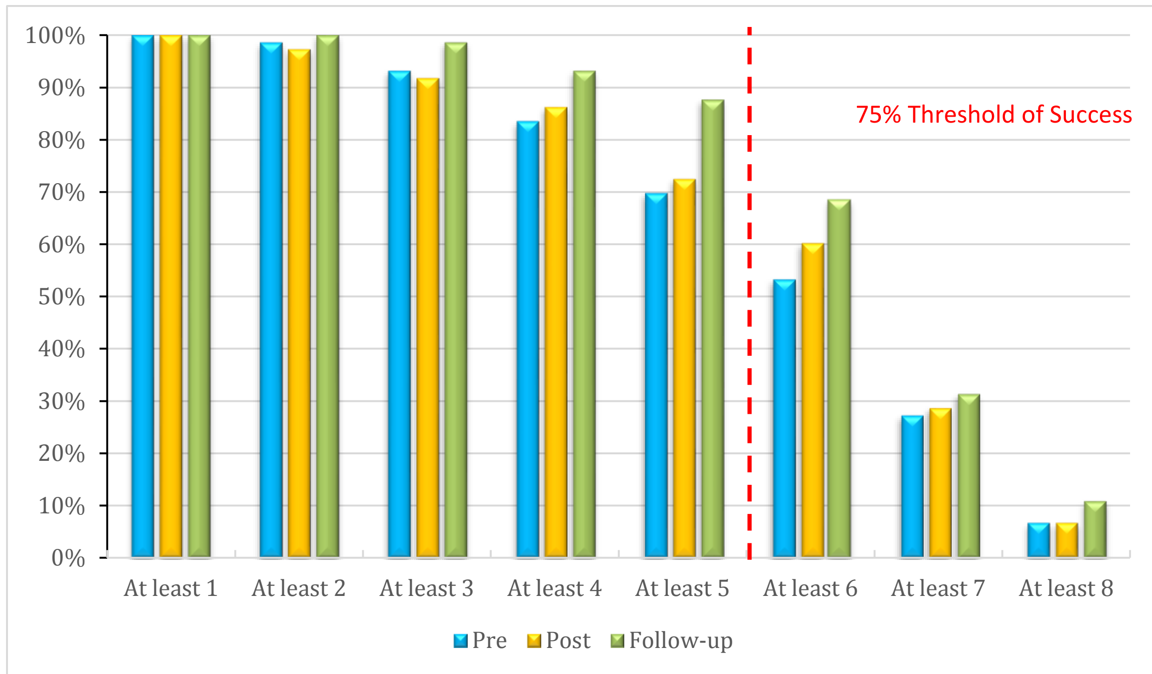
OMS-SWA: Cumulative Percent of Non-Stigmatizing Responses on the OMS-SWA

Similar to the analysis with the general workplace attitudes questionnaire, the proportion of participants who answered a certain percentage of the OMS-SWA items in a non-stigmatizing way was calculated.

Figure 7 shows the cumulative percentages of participants who had non-stigmatizing responses for each possible score out of 8 of the OMS-SWA at pre-training, post-training, and follow-up. This figure was derived by recoding each participant's response on the attitude scale to represent a stigmatizing or non-stigmatizing response.

A threshold of 75% (or at least 6 out of 8 "correct" – i.e. non-stigmatizing – answers) was used as an indication of success on the OMS-SWA. This was reduced from the 80% threshold used as an indication of success on the OMS-WA because of the smaller number of items in the scale (i.e. 7 out of 8 "correct" answers would equal an almost 90% threshold). Prior to the training, 54% of respondents had achieved this threshold of success. Post-training and at follow-up, the percent of respondents who passed this threshold increased to 60% and 69% respectively.

Figure 7. Cumulative Percent of Non-Stigmatizing Responses on OMS-SWA for Pre- Post- and Follow-up (n=73)



4.1.4 Perceived Impact of Training

Table 2 outlines the percent of respondents indicating agreement with items from the perceived impact training questionnaire at post-training and follow-up.

Overall, participants reported that they perceived the training to be useful. The training program appeared to be most effective at increasing knowledge/understanding of how mental illness presents in the workplace, as indicated by the high (i.e. >80%) percentage of respondents agreeing with various statements related to this area. For example, 88% of participants agreed or strongly agreed with the statement that the program "Increased my understanding of how mental illness presents in the workplace" on the post-survey. This percent increased to 94% agreement at the follow-up period.

The areas in which participants reported that the training had less of an impact was around increasing an understanding of how to manage employees with mental health issues on a day-to-day basis (only 71% of participants agreed or strongly agreed with this statement immediately following the training and 77% at follow-up) and increasing an understanding of how to take the necessary steps while an employee with mental illness is away from work (only 71% and 78% of participants agreed or disagreed with this statement at post and follow-up respectively).

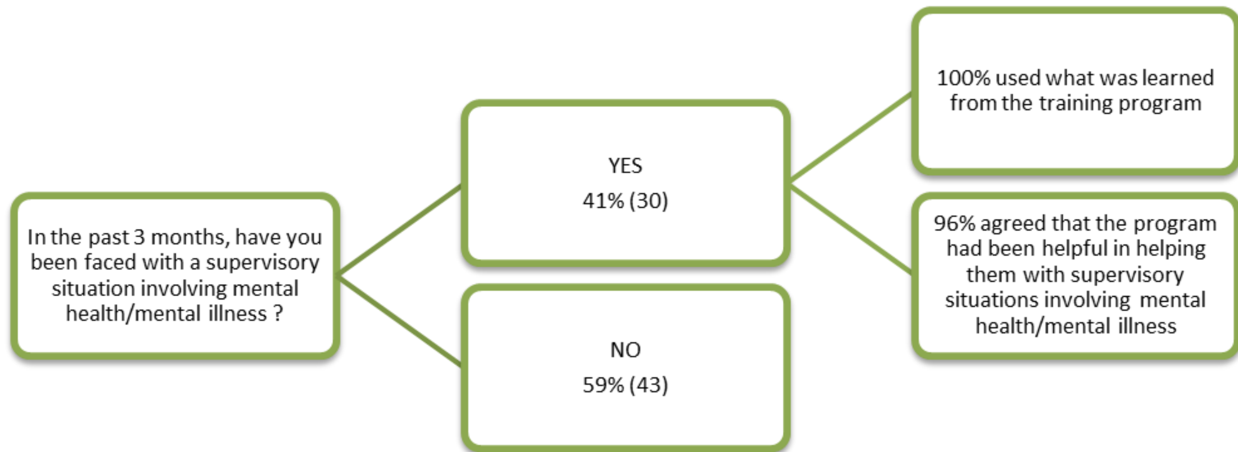
Table 2. Percent of Respondents with Complete Data Indicating Agreement (Agree/Strongly Agree) on the Perceived Impact Questionnaire immediately Post-training and at 3-Month Follow-up (n=73)

Perceived Impact Questionnaire Item	Post	Follow-up
Increased my understanding of how mental illness presents in the workplace.	88%	94%
Increased my sense of openness to learn more about how to reach out to people with mental illness.	86%	88%
Increased my sense that it is OK to talk about mental illness.	85%	89%
Increased my understanding of how to manage employees with mental health issues on a day-to-day basis.	71%	77%
Increased my understanding of how to take the necessary steps while an employee with mental illness is away from work.	71%	78%
Increased my understanding of how to facilitate return to work for an employee with mental illness.	77%	80%
Increased my understanding of management practices that promote the performance and well-being of all employees.	81%	85%

4.1.5 Mental Health-Related Supervisory Experiences in the Past Three Months

On the follow-up survey participants were asked whether they had been faced with a supervisory situation involving mental health/mental illness in the previous three months. As indicated in **Figure 8**, 41% (30/73) indicated that they had. Additionally, all of those 41% indicated that they had used what they learned in the training program, and 96% of those individuals indicated that the program was useful in helping them deal with mental health-related situations in the past three months.

Figure 8. Mental Health-Related Supervisory Experiences in the Past Three Months



4.1.6 Supervisor's Opinions of Mental Health Training Program

Supervisors were asked three open-ended questions on the post survey as part of the evaluation of the mental health training webinar. Below are the questions, with a summary of responses. All responses of participants who completed the post survey were used in this summary (n=139).

1a. Was the approach used in this program effective in enhancing your learning? Which components were particularly helpful? Which components were not helpful?

Overall, participants stated that the program was effective in enhancing their awareness about the issues surrounding mental health in the workplace. However, there were mixed reviews in terms of what components were and were not helpful.

In terms of the format, participants found the case studies and group discussions to be of particular value. One participant said: *"The group activities and discussion were helpful in learning how others approach the issues of mental illness."* Although the majority expressed that this was helpful, there were others who would have preferred discussions around real problems that were happening in their workplace as opposed to made-up scenarios.

Many participants stated that they found the didactic nature of the webinars to be limiting and would have preferred a facilitated session that allowed for more questions and interaction; but, it was also noted that more engaging and energetic videos would help with the current format.

The most salient learning from the program pertained to two main themes. The first was raising awareness (recognizing symptoms & risk factors). As one participant states: *"I really found the Raising Awareness very helpful. Prior to the training, if someone asked me how I could identify if someone was suffering from mental illness it was difficult for me to respond. Now I have a good idea of symptoms"*. The second theme was communication (guide to having open conversations). Participants noted this communication guide could be applied to many situations regardless of whether or not the reason is mental health-related.

While participants felt the program gave a good broad overview of mental illness in the workplace, there were many issues that they felt were not dealt with, including: mental illness being described too broadly (need to deal with the issues that are causing the most problems), issues around employees that have not disclosed, assumptions that the leaders are without their own mental health problems, and realistic strategies for dealing with mental illness in the workplace. The following quote exemplifies the last point and stresses the importance of the value of discussing Peel-specific cases:

"It isn't helpful to hear wonderful ideas presented on how you could support an employee with a mental illness only to realize the approach can't be done in the Region of Peel because it's not a corporate practice. My management team especially noticed that many of the suggestions we wouldn't be able to incorporate because of a union environment. Having a disclaimer at the end that says we have to take what we heard with a grain of salt and ensure we follow Regional practices just makes us wonder why we are going through this exercise."

2a. Do you think this program would be useful for other organizations? If so, for whom? If not, why not?

Respondents noted that any organization would benefit from a mental health training program. Specific examples included: front-line healthcare workers, schools/children and the private sector. However, it was also stressed that these programs would need to be developed based on the organization's needs – that a "cookie cutter" approach would not be good enough.

3a. Is there anything else you would like to add about the program or about prejudice and discrimination against people with mental illness in the workplace?

While participants did not disagree that stigma and prejudice against mental illness still exists, many participants noted that sometimes behaviours and actions that may be perceived as stigmatizing are really issues around 1) not wanting to say/do the wrong thing, 2) being realistic that sometimes for some people accommodations are just not going to work, and 3) that willingness to be supportive of mental illness in the workplace can depend on severity and length of the case. The following is a quote highlighting this second point:

"For some, accommodation is just not going to work. In my opinion, there needs to be a realization that talk should occur around whether the work involved (sometimes stressful) is really right for someone with a mental illness. It isn't prejudice to think that sometimes this might be the only option left for management. It of course needs to be conducted in a respectful manner by both parties."

Participants also noted that mental illness in the workplace does not only affect the person who has it but also those who supervise and work with staff who have these kinds of issues. Supervisors also noted the dilemmas that can arise when accommodating people with mental illness, including making sure accommodations aren't perceived as preferential treatment by other staff and balancing accommodations with business operation needs. As one person notes: *"I struggle with the accommodation piece at work. Abilities of people can fluctuate, how do we balance business operations with human compassion?"*

Other points regarding mental illness in the workplace that were stressed included: the tendency of the training to make people feel like supervisors had to be mental health experts when they're not, that there

was a lack of information regarding how to help employees you think may have a mental illness but have not disclosed that information, and doubts about how much change can actually occur as a result of the program. The following quote represents this last sentiment: *"As good as the program was it will not, in my opinion, end discrimination in the workplace. My experience is that by the time a person is diagnosed and treated the damage to their working relationships is already done."*

4.2 Qualitative Interviews

In addition to the quantitative surveys, the second major part of this program evaluation involved in-depth interviews with a subset of supervisors regarding their thoughts on the mental health training program, their supervisory experiences with mental health/mental illness, as well as their experiences of stigma in the workplace. These experiences and opinions were obtained through one-on-one interviews.

A total of 11 supervisors participated in these 45-minute interviews. The participants were selected from a subset of 37 supervisors who indicated on their post or follow-up survey that they would be interested in participating in these interviews. Participants were selected in order to obtain a varied sample in terms of gender, department, age range, change in score from pre to post survey, high and low scores on the pre-survey, high and low scores on the post-survey, and high and low scores for the program evaluation.

Interviews were conducted in a semi-structured format and were audiotaped and transcribed. Questions focused on thoughts about the training and actual experiences of mental health in the workplace. Transcripts were reviewed and a thematic analysis using established procedures for content analyses was completed by the research team. In total, five themes about mental illness & stigma in the workplace emerged.

1. Valuing education: the importance of mental health training

There was strong support from supervisors for mental health training in the workplace. Participants stressed that education around mental illness is important and that it needs to be an on-going approach, akin to other skills training programs such as first aid.

The value of the program was demonstrated by numerous examples given from participants expressing that there was a shift in their thinking and understanding of mental illness, and that they gained knowledge and skills to deal with mental health-related concerns. As one participant notes, his notion of legitimacy of mental illness was changed as a result of the program: "*I hadn't really thought about mental illness as illness. I carried the same stereotypes from the 1950s when I grew up that mental illness was weakness. Mental illness was faking to get out of doing tasks that are unpleasant. And, I'd say that was the change."*

Additionally, supervisors expressed that the education they received needs to extend beyond the supervisor group to all employees. The importance of doing this would be so that 1) colleagues, who have more interaction with each other than supervisors do, can better recognize earlier problems and 2) so that there is transparency for people – who might currently have or may in the future develop mental health-related concerns – about what exactly supervisors are taught about handling mental illness in the workplace. The following participant made note of this last point:

"The training really highlighted the wrong ways, the right ways, and the obligation to support employees. That's why I think it's important – the employees know what we went through, because if you were suffering or had concerns about your own stability and you're thinking your supervisor went to mental health training, are they learning how they can get rid of me?"

A sub-theme emerging from the value of education was related to the methods used in training. Similar to the ideas that were expressed from the open-ended questions on the post-survey, participants noted that the group discussions and case scenarios were regarded as very helpful. Areas of improvement called for more group discussions, examples specific to the Region of Peel, more interaction, more engaging webinars, and a more horizontal discussion of supports rather than "top-down" approach (i.e. an employee supporting a colleague or discussions on what to do if it's your supervisor who has a mental health-related concern vs. only discussing situations involving supervisors supporting employees).

2. Mental health training: the salience of the issue for supervisors

The next theme that emerged from the interview data is related specifically to the salience of mental health training to the role of being a supervisor. Participants noted that there are certain expectations and responsibilities related to employee and performance management. Understanding people and supporting and responding to employees are skills that are required as a supervisor. As one person noted, *"You're supervising people and so you need to understand people."*

Another participant expands on the idea that understanding people encompasses understanding their mental health:

"As employers we're morally and ethically responsible to respond to workplace issues and without proper training we may not be able to identify what some of the unrelated job performance issues could be and they could very well be mental health-related. And think, I've been in the workforce for about 30 years, there is a far better awareness that employees are dealing with different types of challenges in their lives that will affect their work performance – so we should be well trained to support and respond to employees who are having challenges."

While many participants felt that their skills in understanding and responding to mental health-related issues came naturally to them or were pre-existing based on past experience, they noted that not everyone entering a supervisory role would have these skills, and so training would be pertinent.

Also related was the idea that the training wasn't just training in mental health but training on how to be a better supervisor. As one participant notes: "We can train our supervisors to be better managers of people across the board, not only just mental health." There was more to the program than meets the eye – the skills that were taught are transferable to other situations, and the training was an opportunity for supervisors to validate their experiences and reflect on best practices with one another.

3. Responding to supervisory situations related to mental health: key issues

This category relates to the difficulties that come with trying to handle mental health-related situations and the uncertainties that can arise. Supervisors identified that there was a need to understand the nature of different challenges that are experienced. These key issues include:

- Providing supports within certain limitations
  - Supervisors expressed concern about how to support workers with mental illness in the workplace.
  - Questions that arose include: what can actually be offered in the workplace? What are the policies related to accommodation? What are the barriers related to accommodation?
- Having "the conversation" with the employee
  - This situation involves having the discussion about mental illness with the employee.
  - Supervisors expressed uncertainty about situations involving people who don't want help, people who aren't ready to disclose, recognizing the problem but not being able to directly ask an employee about it, and the difficulty of disclosure and confidentiality.
- Employee's self-stigma, guilt, and suspicions about people's motives to help
  - Supervisors noted that some employees may have their own level of self-stigma that prevents them from coming forward with their mental illness. Furthermore, they felt that some employees may feel guilty about using accommodations, especially if it would increase their co-workers' workloads. They also felt that there may be a certain level of suspicion from employees if supervisors were the ones to initiate the conversation to help.
- Distinguishing between what's a personality characteristic and what's a mental illness
  - With a diverse make-up of employees, supervisors noted that there was a level of caution needed in terms of assuming something to be mental health-related.
- Balancing supports while still achieving workload demands
  - Although supervisors had a genuine willingness to support workers with mental illness, there was uncertainty about how to be supportive while still meeting workplace objectives.
- Compassion fatigue and developing an immunity to mental illness concerns
  - Supervisors noted that a prolonged period of support may have the tendency to tire out the person offering support and decrease their sensitivity to mental health-related concerns.
- Boundaries
  - In terms of the key issues related to boundaries, supervisors noted that certain lines become blurred when supporting mental health-related situations. These include: maintaining a professional relationship, how much support to offer, and supporting problems that are happening outside of the workplace.

- Repercussions for team culture
    - Another key issue that needs to be understood is the effect of how a mental health-related situation is handled in the workplace can affect the entire team.
    - Issues that can arise include: backlash from other staff if accommodations are seen as preferential treatment and how to get colleagues to report behaviour issues that may be mental health-related without feeling like they are "throwing someone under the bus."
- Return to work
    - Return to work was identified as a specific issue that supervisors would like more clarity and confidence in handling.
    - Challenges that were noted included: how to effectively support employees while they are off, breaks in communication when employees return to work, employees that return to work into a new department, and how non-disclosure of a mental illness can add to the issue of return to work when the employee returns.

The following quote highlights the issue of boundaries, compassion fatigue and repercussions for team culture. This supervisor speaks about his concerns on the issue of over-sharing:

"How do I tell someone who is wanting to share certain things, that they're completely entitled to do - to share those things with their colleagues who become their friends and often become their families. But how do you stop them or avert those discussions because they are impacting the rest of your staff… Because they should be able to talk about it but at the same time balancing the morale and the repercussions. There's nothing wrong with talking about mental health. But it has to be kept in check. Because it cannot become a daily routine - it's exhausting."

4. Assumptions of legitimacy

This category is about a concern that supervisors had that people may use mental illness to gain advantage in the workplace. The legitimacy concern is not of whether or not mental illness is an illness, but rather whether it is being used to manipulate a situation somehow. This abuse, or worry about abuse of policies, affects the relationship of how they manage a situation. Participants worried about the repercussions on team morale and how this might reduce co-workers' willingness to support situations that are truly related to mental illness. These concerns are demonstrated in the following two quotes:

"I feel like in government there's a lot of risk aversion to perhaps being a little bit stronger on certain things, especially when we know they're not being entirely honest about it. But because they've expressed it there's very little you can do. And that affects the morale because team members also realize."

"What does concern me is because now the message is out there, people will take advantage of it. I'm not saying everyone, but we have had a couple instances where you know somebody was on the verge of having perhaps a disciplinary meeting with their supervisor or even a meeting where their supervisor was going to give them direction, and all of a sudden we got a message that no now they've contacted the nurse and there's probably some mental health issues going on so we need to back away. That, I find, is unfortunate because it then gives those who legitimately suffer from any form of illness a bad rep."

5. Organizational culture

This final theme features the idea of organizational culture as the catalyst for reducing stigma towards mental illness.

It was repeatedly expressed that Peel is an employer who tries to reinforce a culture of acceptance (e.g. with their Regional Values). Being able to effectively respond to mental health-related concerns in the workplace "trickles down from the top" – as one participant noted, supervisors need to lead by example in implementing the organization's cultural values:

"We have our Regional values and you know respect is one of them, and it's really up to the supervisor and manager to make sure that an environment is set that is respectful. I mean you're never going to get everybody to play by the rules, but if the supervisor is, as the leader, respectful and, so on and so forth, it does set the tone."

Participants felt that in order to reduce stigma, organizational policies specific to mental illness – rules and regulations to follow – need to be put in place. The idea is that people will have to act accordingly even if they may not agree, and that over time it will be accepted. Furthermore, participants felt that addressing this issue of mental illness is something that makes an employer a better one. The following quote highlights this point:

"If we put our heads in the game on this and think of mental illness as illness – we're at the front of the curve. Not at the back. The slow employers are the ones at the back of the pack still treating this as loafing or con artistry. The better employers, the ones who quite frankly are going to attract the brightest and the best, the younger employees, are the ones who have sunk their hearts and hands into this issue."

Finally, having workplace resources/experts available (mental health nurse, consultations with human resources, EAP program awareness) was repeatedly cited as a factor that facilitated their ability to respond to mental health-related situations. Supervisors noted that if they were unsure of how to respond to a particular situation, there would be someone within the organization to help guide them.

5 SUMMARY AND CONCLUSIONS

The results of the general workplace attitudes survey (OMS-WA) showed virtually no difference pre to post and pre to follow-up scores. However, with participants starting off with such low levels of stigma on the measure to begin with, any improvements that were made would have been too modest to be captured. While there was no statistically significant change in the overall score, specific items on the scale did show changes in a positive direction that were found to be statistically significant. Additionally, the proportion of respondents answering 80% of the scale items in a non-stigmatizing way increased at post and follow-up.

The area that was most amenable to statistically significant levels of change had to do with items that addressed issues salient to supervisors and their role (OMS-SWA). For this measure, significant improvement in overall score (i.e. less stigma) was seen at follow-up as compared to prior to the training program. 41% of respondents' scores became less stigmatizing post program and dropped only to 36% at follow-up. While there was a proportion of 19% of participants who's scores became more stigmatizing after the program, a closer look at the data show that participants attitudes did not necessarily become outright more stigmatizing, but that there was a higher level of uncertainty on items in this scale. Qualitative data outlining the dilemmas associated with navigating supervisory responsibilities and mental health concerns in staff support this finding.

Participants' evaluation of the program was very positive. There was a high level of agreement that the program was useful in terms of better understanding and accepting mental illness in the workplace; however, there seems to be a need for more skills-building in terms of managing mental illness in the workplace, on a day-to-day basis and while an employee is off work.

The comments for the open-ended portion of the program evaluation offered a glimpse of some possibilities for improvements to future anti-stigma initiatives. The most commonly noted area for improvement was around increasing the amount of interaction/group discussions, having more engaging and energetic videos, and including content specific to what supervisors actually deal with at the Region of Peel. Supervisors noted the value and benefit of the program, and suggested that this training should continue for new staff, with real workplace scenarios built into the training.

The qualitative interviews provided data that were very informative to specific issues that supervisors face in practice. As participants noted, there is still much uncertainty about how to navigate these issues. This, along with the value that participants placed on the discussion portion of the program suggests that it would be beneficial for future training to take on a problem solving suggestive inquiry approach.

Appendix A

Table 3. Percent Across Scale Options OMS-WA (n=73, matched sample)

	Item	Pre-training					Post-training					Follow-up				
		Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
1	I would not be close friends with a co-worker I knew who had a mental illness.	1%	3%	8%	44%	44%	0%	0%	8%	51%	41%	1%	1%	3%	47%	48%
2	I would visit a co-worker in hospital if they had a mental illness.	26%	47%	17%	8%	1%	23%	47%	23%	4%	3%	25%	47%	25%	1%	3%
3	I would try to avoid a co-worker with a mental illness.	1%	6%	0%	45%	48%	1%	1%	4%	55%	38%	0%	1%	4%	51%	43%
4	I would not want to work with a co-worker who had been treated for a mental illness.	1%	3%	1%	40%	55%	3%	1%	7%	45%	43%	0%	0%	4%	48%	48%
5	I would stick up for a co-worker who had a mental illness if they were being teased.	67%	26%	0%	3%	4%	52%	40%	1%	0%	7%	55%	36%	3%	0%	7%
6	I would help a co-worker who got behind in their work because of their mental illness.	12%	62%	22%	3%	1%	11%	60%	19%	8%	1%	12%	67%	19%	1%	0%
7	I would not want to be supervised by someone who had been treated for a mental illness.	6%	21%	0%	47%	27%	0%	4%	25%	50%	21%	0%	1%	22%	51%	26%
8	The quality of the work performed by people with mental illness is unlikely to meet the expectations of the job.	3%	18%	0%	52%	27%	1%	4%	8%	56%	29%	0%	3%	14%	55%	29%
9	Jobs with tight deadlines and high demands are harmful to people with mental illness.	10%	37%	0%	37%	16%	0%	13%	36%	42%	10%	0%	6%	31%	53%	11%
10	Social interactions at work are hampered by having people with mental illness in the workplace.	7%	11%	0%	51%	31%	0%	3%	7%	60%	30%	0%	1%	7%	62%	30%
11	Co-workers with mental illnesses often don't try hard enough to get better.	6%	12%	0%	51%	32%	1%	1%	14%	43%	40%	0%	1%	8%	59%	32%
12	Co-workers with a mental illness are often more dangerous than the average employee.	4%	18%	0%	44%	34%	0%	4%	12%	44%	40%	0%	1%	8%	51%	40%
13	You can't rely on a co-worker with a mental illness.	1%	10%	0%	59%	30%	0%	3%	11%	58%	29%	1%	3%	11%	52%	33%
14	You can never know what a co-worker with a mental illness is going to do.	7%	25%	0%	48%	21%	0%	4%	19%	52%	25%	0%	7%	12%	53%	27%
15	Co-workers with serious mental illnesses have no place in the workforce.	3%	19%	0%	38%	40%	0%	3%	15%	38%	44%	0%	1%	18%	45%	36%

Table 4. Percent Across Scale Options OMS-WA (full sample)

	Item	Pre-training (n=266)					Post-training (n=171)					Follow-up (n=139)				
		Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
1	I would not be close friends with a co-worker I knew who had a mental illness.	2%	3%	7%	41%	47%	0%	1%	9%	49%	42%	1%	1%	5%	49%	43%
2	I would visit a co-worker in hospital if they had a mental illness.	28%	46%	20%	4%	3%	21%	43%	37%	6%	3%	22%	54%	20%	2%	3%
3	I would try to avoid a co-worker with a mental illness.	.5%	.5%	6%	46%	47%	1%	1%	4%	52%	43%	0%	1%	6%	51%	42%
4	I would not want to work with a co-worker who had been treated for a mental illness.	1%	2%	3%	40%	54%	1%	1%	4%	45%	49%	0%	0%	4%	47%	50%
5	I would stick up for a co-worker who had a mental illness if they were being teased.	58%	33%	2%	2%	6%	50%	43%	1%	1%	5%	7%	1%	2%	37%	52%
6	I would help a co-worker who got behind in their work because of their mental illness.	17%	59%	20%	3%	2%	17%	58%	17%	7%	2%	1%	1%	22%	63%	14%
7	I would not want to be supervised by someone who had been treated for a mental illness.	0%	4%	18%	54%	23%	1%	4%	20%	49%	26%	1%	1%	21%	52%	25%
8	The quality of the work performed by people with mental illness is unlikely to meet the expectations of the job.	0%	3%	19%	50%	28%	1%	4%	12%	54%	30%	1%	1%	16%	50%	32%
9	Jobs with tight deadlines and high demands are harmful to people with mental illness.	0%	9%	36%	38%	17%	0%	12%	34%	37%	17%	1%	9%	30%	51%	9%
10	Social interactions at work are hampered by having people with mental illness in the workplace.	0%	6%	14%	50%	31%	1%	3%	10%	50%	37%	0%	2%	8%	57%	33%
11	Co-workers with mental illnesses often don't try hard enough to get better.	0%	2%	15%	49%	35%	1%	1%	12%	45%	41%	1%	1%	11%	56%	32%
12	Co-workers with a mental illness are often more dangerous than the average employee.	0%	4%	19%	43%	34%	0%	2%	10%	46%	41%	0%	1%	8%	51%	40%
13	You can't rely on a co-worker with a mental illness.	0%	2%	14%	52%	33%	1%	2%	8%	55%	35%	1%	1%	8%	56%	34%
14	You can never know what a co-worker with a mental illness is going to do.	0%	6%	26%	44%	24%	0%	4%	19%	52%	25%	0%	4%	18%	52%	25%
15	Co-workers with serious mental illnesses have no place in the workforce.	0%	4%	21%	31%	44%	0%	4%	14%	38%	45%	0%	4%	16%	45%	36%

Table 5. Independent samples t-tests for differences between overall OMS-WA scores

Total Scale Score	
Pre-test (n=266)	4.1 (SD .5)
Post-test (n=171)	4.1 (SD .5)
Follow-up (n=139)	4.1 (SD .4)
Test for difference	
Pre-post	p>.05
Post-follow-up	p>.05
Pre-follow-up	p>.05

A p<0.56 represents a difference in score that would be considered statistically significant

Table 6. OMS-WA Item Scores, Percent Change, and Paired Samples T-tests (n=73, matched sample)

	Item/Total Score**			Percentage Change		Paired Samples T-Tests			
						Pre-Post		Pre-Follow-up	
	Pre	Post	Follow-up	Pre-Post	Pre-Follow-up	T-value	P-value	T-value	P-value
I would not be close friends with a co-worker I knew who had a mental illness.	4.3	4.3	4.4	0	2.3	-.76	.45	-1.14	.26
I would visit a co-worker in hospital if they had a mental illness.*	3.9	3.8	3.9	-2.6	0	.36	.72	-.11	.92
I would try to avoid a co-worker with a mental illness.	4.4	4.3	4.4	-2.3	0	1.45	.15	.36	.72
I would not want to work with a co-worker who had been treated for a mental illness.	4.4	4.3	4.4	-2.3	0	2.33	.02	.000	1.00
I would stick up for a co-worker who had a mental illness if they were being teased. *	4.5	4.3	4.3	-4.4	-4.4	1.15	.26	1.18	.24
I would help a co-worker who got behind in their work because of their mental illness.*	3.8	3.7	3.9	-2.6	2.6	.81	.42	-1.12	.26
I would not want to be supervised by someone who had been treated for a mental illness.	4.0	3.9	4.0	-2.5	0	.88	.38	-.63	.53
The quality of the work performed by people with mental illness is unlikely to meet the expectations of the job.	4.0	4.1	4.1	2.5	2.5	-.40	.69	-.59	.56
Jobs with tight deadlines and high demands are harmful to people with mental illness.	3.6	3.5	3.7	-2.8	2.8	1.09	.28	-.91	.37
Social interactions at work are hampered by having people with mental illness in the workplace.	4.1	4.2	4.2	2.4	2.4	-1.11	.27	-1.45	.15
Co-workers with mental illnesses often don't try hard enough to get better.	4.1	4.2	4.2	2.4	2.4	-1.03	.31	-1.18	.24
Co-workers with a mental illness are often more dangerous than the average employee.	4.1	4.2	4.3	2.4	4.9	-1.18	.24	-2.42	.02
You can't rely on a co-worker with a mental illness.	4.2	4.1	4.1	-2.4	-2.4	.63	.53	.62	.54
You can never know what a co-worker with a mental illness is going to do.	3.8	4.0	4.0	5.3	5.3	-1.70	.09	-2.57	.01
Co-workers with serious mental illnesses have no place in the workforce.	4.2	4.2	4.2	0	0	-.82	.42	.000	1.00

Table 7. OMS-WA Item Scores and Paired Samples T-tests (full sample)

	Item/Total Score**			Independent Samples T-Tests			
				Pre-Post		Pre-Follow-up	
	Pre	Post	Follow-up	T-Value	P-value	T-value	P-value
I would not be close friends with a co-worker I knew who had a mental illness.	4.3	4.3	4.3	-0.41	0.68	-.24	0.81
I would visit a co-worker in hospital if they had a mental illness.*	3.9	3.7	3.9	2.0	0.04	0.43	0.67
I would try to avoid a co-worker with a mental illness.	4.4	4.3	4.3	0.61	0.54	0.60	0.55
I would not want to work with a co-worker who had been treated for a mental illness.	4.4	4.4	4.5	0.84	0.4	-0.15	0.88
I would stick up for a co-worker who had a mental illness if they were being teased. *	4.3	4.3	4.2	0	>1.0	0.71	0.48
I would help a co-worker who got behind in their work because of their mental illness.*	3.9	3.8	3.9	0.75	0.45	0	>1.0
I would not want to be supervised by someone who had been treated for a mental illness.	3.9	3.9	4.0	0.12	0.90	-0.49	.62
The quality of the work performed by people with mental illness is unlikely to meet the expectations of the job.	4.0	4.1	4.1	-0.91	0.36	-1.22	0.22
Jobs with tight deadlines and high demands are harmful to people with mental illness.	3.6	3.6	3.6	0.45	0.65	0.34	0.73
Social interactions at work are hampered by having people with mental illness in the workplace.	4.1	4.2	4.2	-1.67	0.10	-1.97	0.05
Co-workers with mental illnesses often don't try hard enough to get better.	4.1	4.2	4.2	-1.35	0.18	-0.27	0.79
Co-workers with a mental illness are often more dangerous than the average employee.	4.0	4.3	4.3	-2.87	0.00	-3.1	0.00
You can't rely on a co-worker with a mental illness.	4.1	4.2	4.2	-0.99	0.32	-0.80	0.42
You can never know what a co-worker with a mental illness is going to do.	3.8	4.0	4.0	-1.77	0.08	-1.66	0.10
Co-workers with serious mental illnesses have no place in the workforce.	4.1	4.2	4.1	-1.20	0.23	0.11	0.91

Table 8. Percent Across Scale Options OMS-SWA (n=73, matched sample)

	Item	Pre-training					Post-training					Follow-up				
		Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
1	It is in the interest of employers to support people with mental health difficulties so as to retain their skills and experience.	32%	56%	10%	0%	3%	39%	51%	7%	0%	3%	34%	59%	7%	0%	0%
2	I would employ someone who I knew had a history of mental health difficulties.	13%	49%	34%	3%	0%	16%	51%	27%	4%	1%	23%	49%	26%	1%	0%
3	Organizations take a significant risk when employing people with mental health difficulties.	3%	15%	30%	49%	3%	1%	16%	23%	44%	15%	0%	8%	25%	55%	12%
4	Negative attitudes from co-workers are a major barrier to employing people with mental health difficulties.	4%	53%	30%	8%	4%	6%	51%	31%	10%	3%	8%	37%	32%	21%	3%
5	Employers should make a special effort to accommodate the particular needs of employees with mental health difficulties in the workplace.	7%	66%	19%	8%	0%	15%	58%	25%	3%	0%	21%	58%	20%	1%	1%
6	If one of my employees had a mental health difficulty, I would want him/her to tell me.	12%	57%	22%	6%	4%	10%	56%	25%	3%	0%	21%	53%	23%	3%	0%
7	If I knew that an employee had a mental health difficulty I would be likely to reduce the responsibility given to them.	0%	11%	34%	52%	3%	0%	12%	37%	44%	7%	0%	10%	43%	41%	7%
8	If you knew that an employee had a mental health difficulty you would be unlikely to consider them for a promotion.	0%	4%	18%	63%	15%	0%	6%	18%	66%	11%	3%	17%	60%	21%	0%

Table 9. Percent Across Scale Options OMS-SWA (full sample)

	Item	Pre-training (n=265)					Post-training (n=170)					Follow-up (n=139)				
		Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
1	It is in the interest of employers to support people with mental health difficulties so as to retain their skills and experience.	35%	56%	7%	1%	2%	38%	55%	6%	1%	0%	34%	60%	6%	0%	0%
2	I would employ someone who I knew had a history of mental health difficulties.	14%	54%	31%	2%	0%	17%	49%	30%	3%	0%	20%	52%	28%	0%	0%
3	Organizations take a significant risk when employing people with mental health difficulties.	2%	14%	27%	47%	11%	0%	12%	23%	48%	17%	0%	10%	20%	58%	12%
4	Negative attitudes from co-workers are a major barrier to employing people with mental health difficulties.	8%	47%	31%	11%	2%	11%	45%	30%	13%	3%	9%	41%	29%	20%	2%
5	Employers should make a special effort to accommodate the particular needs of employees with mental health difficulties in the workplace.	11%	61%	22%	6%	0%	22%	54%	21%	2%	1%	18%	60%	18%	2%	1%
6	If one of my employees had a mental health difficulty, I would want him/her to tell me.	14%	56%	22%	7%	1%	22%	55%	21%	3%	0%	18%	55%	23%	4%	0%
7	If I knew that an employee had a mental health difficulty I would be likely to reduce the responsibility given to them.	0%	9%	40%	48%	4%	0%	12%	41%	39%	8%	0%	11%	40%	44%	5%
8	If you knew that an employee had a mental health difficulty you would be unlikely to consider them for a promotion.	0%	4%	18%	60%	18%	0%	3%	17%	62%	18%	0%	2%	15%	65%	18%

Table 10. Independent samples t-tests for differences between overall OMS-SWA scores

Total Scale Score	
Pre-test (n=265)	3.7 (SD .4)
Post-test (n=170)	3.8 (SD .5)
Follow-up (n=139)	3.8 (SD .4)
Test for difference	
Pre-post	p=0.02
Post-follow-up	p>.05
Pre-follow-up	p=0.02

A p<0.5 represents a difference in score that would be considered statistically significant

Table 11. OMS-SWA Item Scores, Percent Change, and Paired Samples T-tests (n=73, matched sample)

			Paired Samples T-Tests	
	Item/Total Score*	Percentage Change	Pre-Post	Pre-Follow-up

	Pre	Post	Follow-up	Pre-Post	Pre-Follow-up	T-value	P-value	T-value	P-value
It is in the interest of employers to support people with mental health difficulties so as to retain their skills and experience.*	4.1	4.2	4.3	2.4	4.9	-.93	.36	-1.35	.18
I would employ someone who I knew had a history of mental health difficulties.*	3.7	3.8	3.9	2.7	5.4	-.28	.78	-2.49	.01
Organizations take a significant risk when employing people with mental health difficulties.	3.3	3.5	3.7	2.7	12.1	-2.15	.03	-3.91	.00
Negative attitudes from co-workers are a major barrier to employing people with mental health difficulties.*	3.5	3.5	3.3	0	-5.7	-.24	.81	1.68	.10
Employers should make a special effort to accommodate the particular needs of employees with mental health difficulties in the workplace.*	3.7	3.8	3.9	2.7	5.4	-1.40	.17	-2.28	.03
If one of my employees had a mental health difficulty, I would want him/her to tell me.*	3.7	3.9	3.9	5.4	5.4	-1.67	.10	-1.98	.05
If I knew that an employee had a mental health difficulty I would be likely to reduce the responsibility given to them.	3.5	3.5	3.5	0	0	.15	.89	.15	.88
If you knew that an employee had a mental health difficulty you would be unlikely to consider them for a promotion.	3.9	3.8	4.0	-2.6	2.6	.96	.34	-.93	.36

**Higher scores are an indication of less stigmatizing attitudes; *Reverse scores items; Statistically significant difference at $p<.05$

Table 12. OMS-SWA Item Scores and Paired Samples T-tests (full sample)

				Paired Samples T-Tests			
	Item/Total Score*			Pre-Post		Pre-Follow-up	
	Pre	Post	Follow-up	T-value	P-value	T-value	P-value

It is in the interest of employers to support people with mental health difficulties so as to retain their skills and experience.*	4.2	4.3	4.3	-0.87	0.39	-1.06	0.29
I would employ someone who I knew had a history of mental health difficulties.*	3.8	3.8	3.9	0.27	0.78	-1.10	0.27
Organizations take a significant risk when employing people with mental health difficulties.	3.5	3.7	3.7	-1.78	0.08	-2.14	0.03
Negative attitudes from co-workers are a major barrier to employing people with mental health difficulties.*	3.5	3.5	3.3	-0.22	0.83	1.22	0.22
Employers should make a special effort to accommodate the particular needs of employees with mental health difficulties in the workplace.*	3.8	3.9	3.9	-2.45	0.02	-1.91	0.06
If one of my employees had a mental health difficulty, I would want him/her to tell me.*	3.7	4.0	3.9	-2.64	0.01	-1.35	0.18
If I knew that an employee had a mental health difficulty I would be likely to reduce the responsibility given to them.	3.5	3.4	3.4	0.40	0.69	0.52	0.61
If you knew that an employee had a mental health difficulty you would be unlikely to consider them for a promotion.	3.9	3.9	4.0	-0.28	0.78	-1.0	0.32

**Higher scores are an indication of less stigmatizing attitudes; *Reverse scores items; Statistically significant difference at p<.05