Workplace Implementation Of Mental Health Assistance During The COVID-19 Pandemic: An Analysis Of The Impact

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Introduction

The COVID-19 pandemic had a significant impact to the Global and Canadian economies which saw changes in working and studying environments for many Canadians in the public and private sector. According to Arriola et. al (2022), the COVID-19 pandemic had an unprecedented impact on the global economy. Organizations have put policies in place to allow employees and students to work and study remotely to remain safe from the COVID-19 pandemic. A study by D'Angelo (n.d.) detailed that two-thirds of Canadian employers have at least sixty percent of their workforce working remotely. Studies have been conducted by the Centre for Addiction and Mental Health, the Canadian Institute for Health Information, The Mental Health Commission of Canada (2022), Gallagher-Mackay et al (2021) and Jones, Palumbo and Brown (2021), which examine the benefits and drawbacks of working from home for both employers and employees. Many of these studies also examine the impact of these new working arrangements on employees' mental health and have identified how the working arrangements may be harming employees' mental health. Most of the studies have identified similar negative implications which include increased feelings of isolation, blurred lines between work and home, increased anxiety, isolation, and depression.

Organizations have often been unable to provide adequate mental health support to help employees cope with these negative impacts (Wilson, 2022). Many public health guidance and websites provide generic methods of coping with these negative mental health impacts. Tele-health has often been suggested as a method of coping as suggested by websites such as the Centre for Addiction and Mental Health, and websites geared toward employers such as Work Place Mental Health suggested "training" employees or assigning more work. Neither of these options can be considered as an all-encompassing fix. Canada has some national standards created years before the pandemic to support the general psychological well-being of employees such as the National Standard of Canada on Psychological Health and Safety in the Workplace (CSA Group, 2013) and the Okanagan Charter (2015), however the onset of COVID-19 has had many organizations, C-suite executives and policy makers reconfiguring this guidance to better suit the current needs. Organizations such as the Mental Health Commission of Canada

and the CSA Group have created guides which help employers build mental health into their business model. The education, healthcare and retail industries in particular were harshly impacted with changes to working environments and resulting negative mental health impacts. The impact on each sector is discussed in more detail in individual sections of this paper. This paper will seek to examine the current coping strategies, whether they are preventative or intervention strategies, and to determine which of these strategies can be considered as best practice mental health policies in corporations through literature review and surveys and interviews. Additionally, this paper will seek to examine whether any evaluation metrics are in place for these policies and what can be a best practice for use as an evaluation metric to the effectiveness of mental health coping strategies offered by organizations.

Impact of COVID-19 on Global Economy

The onset of COVID-19 in 2020 generated significant impacts on the global economy. Specifically, the global labour market and consumer demand have been impacted (Arriola et al., 2022). Trade costs and fiscal policy measures have also been impacted (World Development Report, 2022). In response to COVID-19 many countries limited social interactions and travel which reduced economic activity in many industries and significantly reduced international trade (UNCTAD, 2022).

Labour markets were adversely affected as individuals were required to stay home because of governmental restrictions, if they were ill, or if they were required to be the caregiver of someone else who fell ill (Arriola, et al., 2022). Government restrictions resulted in reduced labour supply, productivity and demand (World Bank, 2020). Social distancing measures created loss of income due to business closures and heightened uncertainty which reduced demand for some goods and services (Gopinath, 2020).

The hospitality and recreation sectors saw the highest decline, with retail, finance and insurance and other services which could be conducted online seeing less of a decline (Arriola et al., 2022). The hospitality sector lost millions of jobs and saw bankruptcies worldwide (Jones, Palumbo & Brown, 2021).

Global retail shifted to primarily online retail, increasing to $3.9 trillion in 2020 (Jones, Palumbo & Brown, 2021) and $5.2 trillion in 2021 (Chevalier, 2022).

Additional health and safety checks and new border protocols aimed at reducing the spread of COVID-19 generated additional documentation and personnel which have increased trade costs (Arriola et al., 2022). Despite growth in international trade in 2021 losses incurred because of the pandemic have not yet been recovered (Arriola et al., 2022).

Healthcare was one of the most globally impacted sectors, causing significant backlog of medical procedures, supply chain limitations and severe strain on healthcare workers (Lee & Rawstron, n.d.). Many other sectors were able to adapt to digital advancements to provide services which proved difficult for health care services (Lee & Rawstron, n.d.). Healthcare workers faced mental and physical exhaustion which was exacerbated by out-dated hospital infrastructure (Deloitte, 2022). Overall, the global economy was negatively impacted by the pandemic as a result of business closures and increased trade costs.

Impact of COVID-19 on Canadian Economy

The Canadian economy was negatively impacted, particularly the energy, travel, hospitality and service industries (Bank Of Canada, n.d.). The primary changes to the Canadian economy have been adoption of remote working policies, decreased travel and tourism, and a significant increase in the growth of online shopping and entertainment due to physical location closures (PWC, 2021). The changes have led to depressed spending, particularly in the cities of Montreal, Toronto and Vancouver which rely on tourism and city centers with cultural institutions and entertainment districts to generate revenue (PWC, 2021).

The Canadian healthcare sector struggled with inadequate staffing to manage a substantial physical workload which has resulted in a mental toll on healthcare providers and lack of access to critical health service supplies (Chan, 2020). The number of health care workers working overtime in Canada has increased by 27% from March 2019 through April 2022 (Canadian Institute for Health Information, 2022). The healthcare system continues to operate over capacity and more than 1 in 5 health care workers

worked overtime in 2021 (Canadian Institute for Health Information, 2022). The overtime hours worked by health care workers have been linked to decreases in physical and mental well-being of the employees (Canadian Institute for Health Information, 2022).

According to D'Angelo (n.d.) and Sachdeva (2022), remote work has been found to be the new reality. In 2020, two-thirds of organizations had 60% of their workforce working remotely (D'Angelo, n.d.) and in 2022 over 80% of Canadian workers surveyed were unwilling to go back to a fully in office role (Sachdeva, 2022). The Conference Board of Canada (2020) conducted a survey which found 84% of respondents stating their mental health declined after COVID-19 with many respondents detailing mindfulness, connecting with family via technology, exercising and spending time with pets as the most positive and impactful coping strategies.

A large part of Ontario's economy relies on Chinese-made goods for production (McKay, 2020). The global supply chain was disrupted, inclusive of China (Tam et al., 2022; McKay, 2020). Supply constraints can damage businesses and increase business costs which can be passed on to consumers (Canadian Chamber of Commerce, 2022). Increased business costs negatively impact many Ontario companies which have high debts and do not have sufficient liquidity to manage adaptation to new measures, or weather extended periods of closure (McKay, 2020).

Canadian companies in the financial services had to pivot to about 85% of their workforce to work from home (Deloitte, 2020). The change in operating model has created challenges in leadership keeping employees productive and engaged and managing employee well-being (PWC, 2021; Deloitte, 2020). There is an expectation that both employees and consumers will continue to prioritize digitized processes and remote solutions which will create greater efficiencies, technological innovation and productivity (PWC, 2021; Deloitte, 2020).

The insurance industry, specifically Life and Health, encountered challenges of ensuring business continuity, reduction in customer service capacity, increased claims and a strain on capital and reserves (Deloitte, 2020). Insurance companies in the industry launched COVID-19 specific products, such as free virtual health services, which is expected to remain as part of standard group benefits in the future

(Deloitte, 2020). Many organizations have settled into a virtual or hybrid work environment (PWC, 2021).

The retail industry transformed operationally during COVID-19. Many retailers remained open where possible but there was a shift in purchasing behaviour to online (Tarry, 2021; Aston et al., 2020). Retailers had to adapt to provide goods and services which changed the roles and responsibilities of employees (Goddard, 2021; Tarry, 2021). In many instances, employees would have been working from home or laid off altogether for over a year (Tarry, 2021), with job losses up to 200,000 in January 2021 (Evans, 2021). As a result, retail workers are uncertain about their position in their companies, they may not know how to handle their updated roles and requirements and they are experiencing feelings of fear, anger, resentment, and abandonment (Tarry, 2021; Blackwell, 2020).

The shift to online purchasing has seen approximately 30% of dining out spending being transferred to retail (Goddard, 2020). E-commerce in the food and beverage industry increased by 107% altogether by April 2020 (Aston et al., 2020). COVID-19 lockdowns created a need to change food habits and this resulted in most Canadians eating all daily meals at home and changing the frequency and location of grocery shopping (Goddard, 2020). The change in habits created a supply chain issue as grocery stores were not prepared to supply the demand that was generated (Tam et al., 2022; Goddard, 2020).

Further, the loss of employment of many in the population led to greater need for food products in food banks (Goddard, 2020). Grocery stores saw increased costs as they were required to hire more employees, develop in-person protections such as plastic shields for cashiers and distancing for customers and updated inventory management strategies (Buckner, 2020; Goddard, 2020).

Food service retailers – restaurants and bars – employed up to 6.7% of 13.7 million of total employees in Canada over the 2017 to 2019 period (Goddard, 2021). After COVID-19, this reduced to 5% (Goddard, 2021). Online purchasing was a necessary change in the food service industry as the industry could not operationally work from home but needed to be closed to help curb the spread of the disease. Up to 80% of food service orders came from digital sales between 2020 and 2021, however over

10,000 restaurants closed in Canada between March 2020 and March 2021 (Goddard, 2021). Digital orders are typically done via a retail website, or a third-party application such as Skip the Dishes or Uber Eats, which charge restaurants a large percentage fee for delivery that eats into the restaurant profit (Goddard, 2021; Macleod, 2021). Some restaurants did more than change to takeout and delivery, with restaurants such as Beckta in Ottawa offering gourmet three course meal kits to offset loss of revenue during lunch service (Rocha, Leung & Trinh, 2022).

Mental health impacts in the education sector

The policy response to COVID-19 resulted in changes to educational delivery which included fully remote, blended and in-person learning (OECD, 2020). The emergency responses were abrupt as schools and policy makers had to quickly pivot from full in-person learning to remote options (Gallagher-Mackay et al., 2021). School closures were variable across Canada's provinces (Gallagher-Mackay et al., 2021). Access to digital devices required for online learning is not evenly distributed across the population (Albiser et al., 2020). Socio-economically disadvantaged students and families were impacted by education inequalities as a result (Dorn et al., 2021). Additionally, many students may not have had a quiet or dedicated physical space for learning which further deteriorated their quality of learning (Albiser et al., 2020). Previous examinations of loss of learning in Ontario, based on other occurrences such as teacher strikes, have shown increased wage gaps in adulthood (Dorn, et al., 2021 and Gallagher-Mackay, et al., 2021).

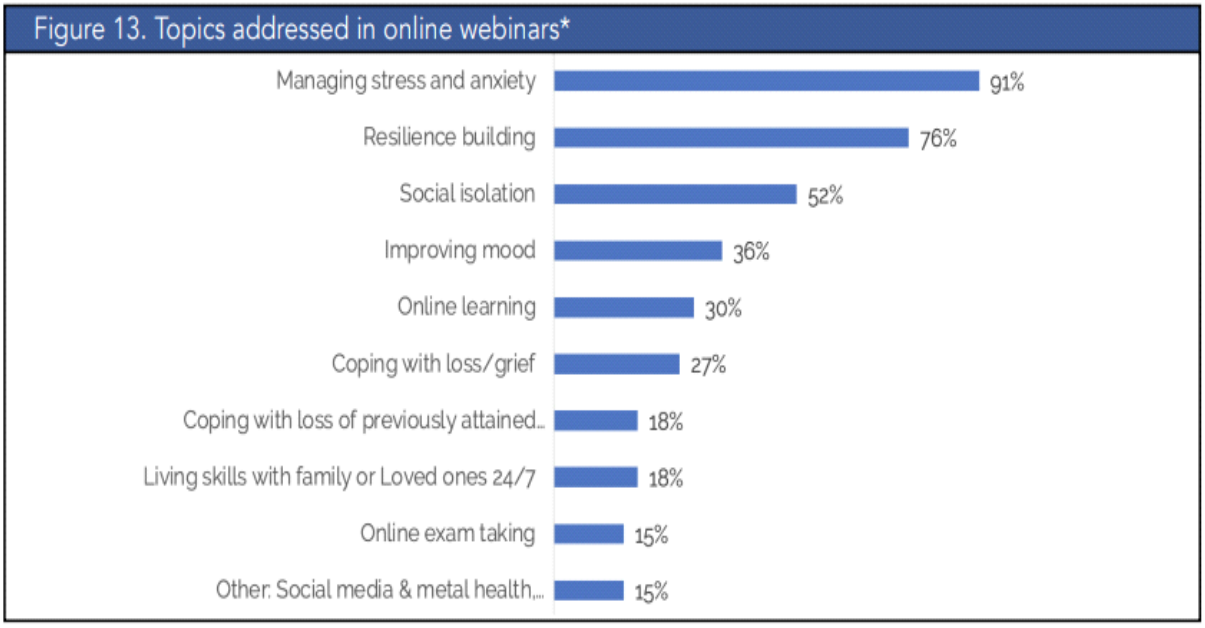
Teachers have had significant changes to teaching methodology with little to no training involved to accommodate for emergency responses (Gallagher-Mackay et al., 2021). In addition to a shift in teaching methods, the teachers are now in charge of in-school safety conditions and supporting stressed students and parents (Herhalt, 2021). Teachers have been found to have high levels of occupational stress, anxiety and difficulties coping with daily stress of teaching. Fewer students have been meeting learning objective compared to pre-pandemic years (Toronto District School Board, 2021)

The shift to primarily remote learning created a loss of access to free or low cost meals provided by schools, lack of access to school based healthcare services and a loss of routine and structure for children with an emphasis on reduced physical activity (Gallagher-Mackay, et al., 2021). This can also trigger loneliness and social isolation (Dorn, et al., 2021 and Toronto School Board, 2021).

As of June 2021, a study of 2,225 grade 7 to 12 students in Ontario reported almost half of the students experiencing moderate to severe levels of psychological distress with symptoms of anxiety and depression (CAMH, 2022). The data indicates that remote learning and lockdowns increased the students' psychological distress post-COVID 19 (CAMH, 2022). CAMH (2022) also reported that a majority of Ontario students surveyed felt depressed about the future because of COVID 19. The changes endured by students would ordinarily take years to decades and had to be managed within a few weeks, which added to the distress (Rashid & Genova, 2020). Students experienced financial losses including loss of on and off campus jobs (Meier, et al., 2022), teaching and research assistantships and loss of financial support from parents and loved ones being laid off (Rashid & Genova, 2020).

Figure 1

Topics addressed in online webinars to support students



Note: online support for students included an emphasis on webinars discussing topics ranging from managing stress and anxiety to living skills with family and loved ones from "Campus Mental Health in Times of COVID-19 Pandemic: Data-informed Challenges and Opportunities" by T. Rashid & L. Genova, 2020, *Campus Mental Health: Community of Practice (CoP)*.

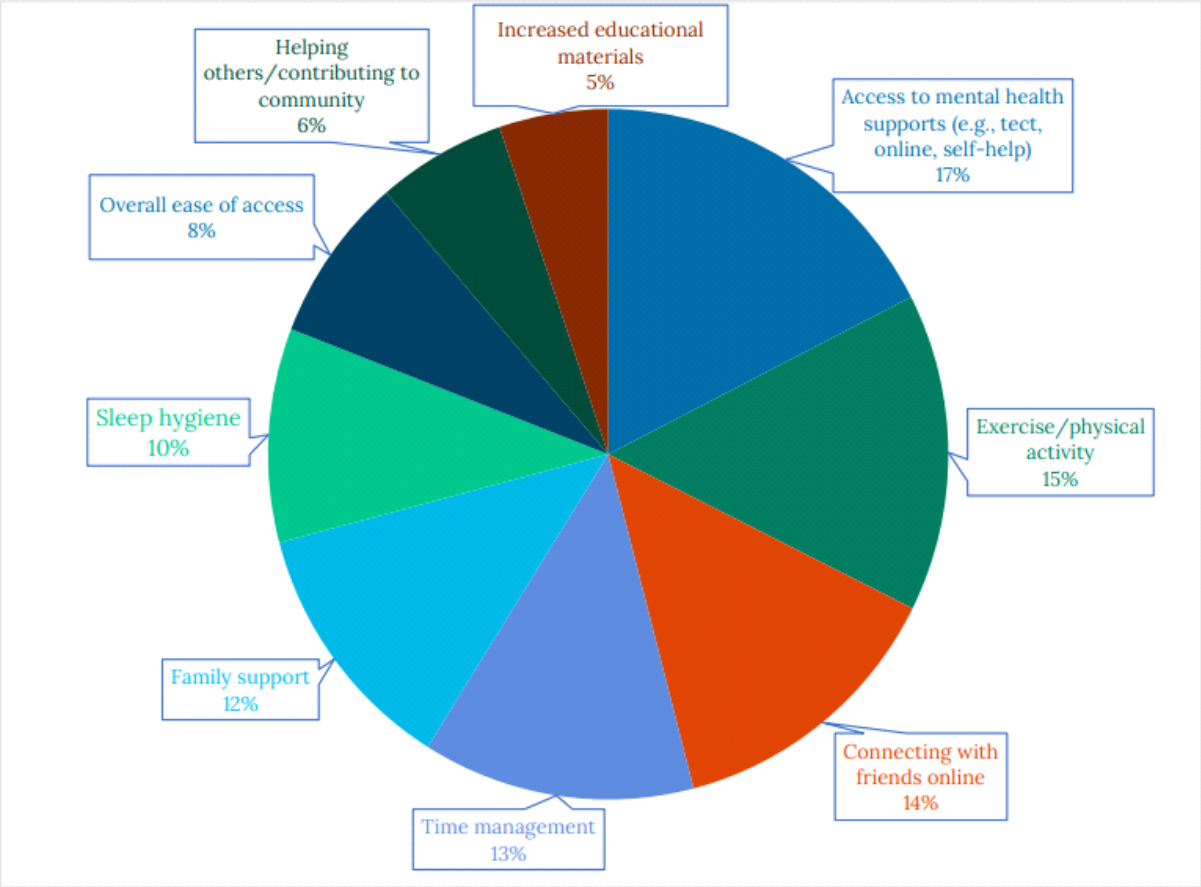
Online support options for students included online therapy through use of Zoom, Webex and Microsoft Teams for therapy and webinars and social media support groups (Rashid & Genova, 2020). Rashid & Genova (2020) found the resources which were the most helpful were virtual resources and online lectures and webinars, which discussed topics found in Figure 1. A study conducted by Klonoff-Cohen (2022) found coping skills development programs, meditation, mindfulness exercises and physical education as the most beneficial coping strategies. The two studies had some overlap in the results as students focused on reducing anxiety and depression, improving resilience and managing loneliness and relationships with friends and family (Klonoff-Cohen, 2022). Rashid & Genova (2020) also found the lack of in person connections with students provided less opportunities to identify any students which were in crisis. In fact, many students have indicated a preference for face to face mental health care instead of online resources (Klonoff-Cohen, 2022).

Students have found exercise and physical activity, connecting with friends online and access to mental health support as some of the most effective adaptive coping strategies (Klonoff-Cohen, 2022). Maladaptive coping strategies included sleeping concerns, social isolation, procrastination, and substance abuse (Rashid & Genova, 2020). Substance use and social isolation have also been observed as maladaptive coping strategies by (Riazi, et al., 2023). The study generated the impression that students who had familial support and access to health and mental health supports were more likely to have adaptive coping strategies (Rashid & Genova, 2020 and Riazi, et al., 2023).

Figure 2

Adaptive Coping Strategies by Students as Endorsed by Student Affairs Professionals

Figure 10. Adaptive Coping Strategies by Students as Endorsed by Student Affairs Professionals



Note: methods students have adopted to cope with mental health issues which resulting from the onset of the pandemic "Campus Mental Health in Times of COVID-19 Pandemic: Data-informed Challenges and Opportunities" by T. Rashid & L. Genova, 2020, *Campus Mental Health: Community of Practice (CoP)*.

A study by McGill University found the negative impacts on post-secondary students includes fatigue, loss of motivation, isolation, loneliness, depression, anxiety and PTSD (Sillcox, 2022). These findings of negative impacts of isolation, anxiety, depression loneliness and PTSD are supported by the research done by Klonoff-Cohen (2022). Students with no mental health concerns prior to COVID-19 experienced psychological distress during the pandemic, indicating social isolation has a significant impact (Sillcox, 2022). Students which already experienced psychological distress prior to COVID 19 saw an increase in negative mental health (CAMH, 2022). A study by Nagib et al. (2022) found increased

use of alcohol consumption, particularly for fourth year university students in Japan at the beginning of the pandemic. A study over three years of 2,284 students found 52% of students increased their alcohol consumption as a coping mechanism (Nagib et al., 2022).

There is a concern that the mental health concerns can be long term and negatively impact students' social and cognitive development (Sillcox, 2022).

Queen's University created a student well-being and academic success study referred to as U-Flourish in 2018. The study captured undergraduate students' responses to a biannual survey on mental health and well-being, related risk and protective factors (King et al., 2022). The study, due to inception date, provides valuable baseline information on students' mental health prior to COVID-19. The study found a significant degree of negative impact to student mental health resulting from the pandemic which underscores the need for planning of student mental health support (King et al., 2022).

In 2019 only 5% of Canadian post-secondary institutions offered online therapy sessions (Nath, 2021). Within three weeks of campus shut-downs, 90% of post-secondary institutions offered remote mental-health services in the format of video and telephone (Nath, 2021). Campus wellness centers began posting pandemic specific material to their websites, hosting webinars on managing stress and anxiety and held events like virtual pet therapy and online meditation classes (Rashid & Genova, 2020). Challenges have resulted as a result of the quick pivot to online infrastructure inclusive of technology, confidentially, funding and adapting professional care to suit the virtual environment (Nath, 2021).

The Okanagan Charter (2015) is an international charter for health promoting universities and colleges which requires post-secondary institutions to embed health in to all aspects of campus culture. The Charter was created in June 2015 in collaboration with researchers, practitioners, administrators, students and policy-makers from 45 countries (Okanagan Charter, 2015).

Provinces across Canada have varying frameworks for dealing with post-secondary mental health. There is no nationally required policy or framework for Canada (Monaghan et al., 2020). Ontario has policies which provide guidance and recommendations to strengthen the delivery of mental health services (Monaghan et al., 2020). An emphasis on upstream services is designed to address issues prior to

students needing clinical help (Monaghan et al., 2020). Upstream services include mental health promotion, anti-stigma programming, mental health awareness and programs to foster mental health literacy and resilience (Monaghan et al., 2020). An increase in upstream services will reduce the need for downstream services – such as therapy – which are currently overburdened (Monaghan et al., 2020). The Okanagan Charter is designed to emphasize the values of upstream services. No Canadian postsecondary institution has independently conducted a systematic evaluation of their mental health strategy to date (Monaghan et al.,). Overall, the education sector saw students experience significant negative mental health impacts, an overburdened mental health wellness system and student learning set-backs as a result of the pandemic.

Mental health impacts in the healthcare sector

A study by the Mental Health Commission of Canada (2022) indicates 40% of health care workers are burned out and 50% intend to leave the profession. Health care workers believe promoting psychological self-care and reducing moral distress can prevent exhaustion and increase quality of care. Healthcare workers reported increased mental health distress including elevated levels of depression and PTSD (Wilbiks et al., 2021). Long term psychological distress can increase the risk of burnout (Wilbiks et al., 2021). Burnout involves exhaustion, mental distance and reduced professional effectiveness (Wilbiks et al., 2021). Healthcare workers were less likely to seek out mental health support as a result of heavy workloads which increased from public health measures (Wilbiks et al., 2021). A study of 86 Canadian healthcare workers found 50% of participants reported moderate to severe depression, with approximately 10% reporting suicidal ideation (Wilbiks et al., 2021). The study found employees who were more satisfied with workplace safety measures and clear communication from supervisors experienced lower burnout (Wilbiks et al., 2021).

A study of the 10,117 members of British Columbia Nurses Union (BCNU) found mental health deteriorated in anxiety and depression compared to pre pandemic measurements (Havaei et al., 2021). The study found that continuous uncertainty surrounding the virus, mode of transmission and lack of

treatment early on in the pandemic contributed to increases in negative mental health symptoms (Havaei et al., 2021).

A study surveying critical care nurses across Canada during the third wave of the pandemic found that 100% of the respondents were suffering from high levels of burnout, with many nurses considering quitting, working for a different organization or actively looking for a new job (Crowe et al., 2022). The nurses indicated the negative mental health toll primarily resulted from failed leadership and the traumatic nature of the work environment. Nurses were constantly short staffed and struggled to provide high quality patient care (Crowe et al., 2022). Many nurses cared for dying patients under restricted visitation policies and found the experiences traumatic (Crowe et al., 2022).

The Mental Health Commission of Canada conducted an interview in 2020 with Christine Devine, the Wellness Specialist at Michael Garron Hospital on sharing best practices for supporting the mental health of healthcare workers during COVID-19. Devine (2020) suggested, from experience working at the Michael Garron Hospital, that staff required reassurance from upper management and upper management needed to be seen and available for answering questions. At the Michael Garron Hospital, upper management joined staff screening on mornings and greeted employees, as well as saying goodbye and thank you when shifts changed.

Staff also appreciated that upper management continually made rounds during weekend shifts as well to be available to reassure staff and answer questions. Devine (2020) observed that staff felt reassured when they were able to understand why the procedures in place and why upper management were making decisions. Reassurance increased among staff as a result of consistent daily updates from the doctor who was in charge of infection control team. Devine (2020) found that despite staff being reassured, the stress levels were not alleviated. Upper management then needed to help staff cope with stress in a more productive way.

Dr. Peter Jensen, who provides support to corporations on high performance, suggested a method referred to as energy management which how will you manage your energy to continue to perform (Devine, 2020). The hospital also expedited needs of anyone who needed counselling. Spiritual care team

members have been placed on floors and were supported by social workers. The spiritual care team and social workers help to assist patients, family members and staff, particularly at the end of difficult shifts. A buddy system has also been implemented among physicians which created a system of checking in with a colleague via text at a mutually defined time with specific questions such as “how are you doing today?”, “how were the last 48 hours?”, and “do you need any support?” (Devine, 2020). The buddy system model has been based on a system of peer support.

The hospital also encouraged structured time at home. A ritual that allows employees to leave work behind, such as taking off their lanyard to signify the end of the day, was encouraged (Devine, 2020). Employees were encouraged to use the transition time on the way home for activities that can help relax them, such as listening to podcasts, reading or listening to music (Devine, 2020). Employees were also encouraged to have some time for themselves upon arriving at home and to discuss the boundaries with family and friends (Devine, 2020).

Devine (2020) suggests other measures to help staff improve mental health which include use of a COVID-19 therapy hotline and use of video clips of meditation posted on the employee intranet. The employees could also apply the advice of the Mental Health Commission Continuum of Health which guides users through understanding where they are, what behaviours they are experiencing and how to correct behaviours that may cause harm such as not sleeping and isolation (Devine, 2020). The Working Mind is a resiliency guide inclusive of video, webpage, poster and other resources that employees could also use which is published by the Mental Health Commission of Canada (Devine 2020). Overall, the healthcare sector saw significant negative mental health impacts to workers as they experienced high levels of stress and burnout due to and overburdened system.

Mental health impacts in the retail sector

Individuals working in the food service and hospitality industries were unable to engage in remote working practices which led to a peak unemployment rate of about 15% in April 2020 (Bureau of Labor Statistics, 2020). Employees were often faced with a dilemma of working with exposure to

COVID-19 or lose their jobs which also meant a loss of benefits. This job insecurity was correlated with high depressive symptoms and financial worries was associated with high anxiety symptoms (Wilson et al, 2020). Studies by Chen (2020) found that 69% of tourism and hospitality workers rated the pandemic's impact as severe enough to generate symptoms of PTSD. Lan et al. (2020) found that grocery store workers were over five times more likely to test positive for COVID-19 with increased anxiety and depression when in direct contact with customers. A study done by Rosemberg et al. (2021) found that employees reported mixed messages and poor communication from employers as a source of stress. Additionally, under staffing and lack of resources added to these stress levels. Participants were also concerned about enforcing safety measures due to unpredictable responses from customers.

Employees coped by exercising more, returning to old hobbies or finding new ones such as cooking and reading, spending time outdoors and virtually connecting with friends and family (Rosemberg et al., 2021). Some participants increased alcohol consumption as a coping mechanism (Rosemberg et al., 2021).

A round table was held by the Mental Health Commission of Canada which involved retail and hospitality managers and executives discussing how COVID-19 affected their workforces. The key findings included more training being needed in mental health related topics and companies needing to dedicate more resources to preventative mental health (Mental Health Commission of Canada, 2022). Further, it was indicated that leadership teams need more guidance on using the National Standard of Canada on Psychological Health and Safety in the Workplace (Mental Health Commission of Canada, 2022). One significant finding was employees were very stressed by dealing with customers who are being asked to alter their behaviour and are unwilling to comply or become aggressive and violent (Mental Health Commission of Canada, 2022). It was further found that there remains a stigma surrounding mental health challenges in the workplace which makes it difficult for employees to discuss (Mental Health Commission of Canada, 2022).

Managers in the industry have made it clear that resources are needed, however industry specific information to support the business case for prioritizing psychological health and safety is required,

supported by hard numbers and other key metrics (Mental Health Commission of Canada, 2022). The Mental Health Commission of Canada provided a guide for adopting the National Standard by retail and hospitality industries. The guide observes the importance of stating a commitment via a purpose statement (Mental Health Commission of Canada, 2021). Businesses must then make the effort to understand employee needs through building trust, employee engagement, privacy and confidentiality, showing vulnerability and exhibiting balance, flexibility and boundaries (Mental Health Commission of Canada, 2021). Once employees needs and information have been obtained, the business must identify strengths and weaknesses, and develop a strategy to address the needs and weaknesses found (Mental Health Commission of Canada, 2022). A successful implementation will include building mental health into operations which includes training and competency development so employees understand their roles and responsibilities, company policies and procedures and are equipped with the right tools (Mental Health Commission of Canada, 2022). A checklist for managers has been provided by the Mental Health Commission of Canada to determine whether they are meeting the National Standards guidelines, as seen in Figure 3. Overall, the retail sector experienced reduced workforce and increased anxiety and depression as a result, with a significant shift in industry to online purchasing where available.

Figure 3

Checklist for managers for meeting National Standard

Program or Process	Yes	No	In Progress
Do you have a psychological health and safety policy?			
Have you examined and educated employees about human rights policies and procedures?			
Have you examined and educated employees about employment standards rights and responsibilities?			
Have you examined and educated employees about occupational health and safety rights and responsibilities?			
Is there an engagement process employees can use to bring forward their mental health-related concerns?			
Are there different ways for leaders to understand employees' needs (e.g., through surveys, focus groups, or other means)?			
Do you have a plan in place to build trust within teams?			
Have you considered balance, flexibility, and boundaries?			
Have you compiled information (gathered through engagement) and developed an action plan?			
Have you implemented any of the following programs to improve psychological health and safety?			
• peer support			
• psychological and social support			
• accommodation and return to work			
• workload management			
• wellness			
• performance management			
• growth and development			
• recognition and reward			
• harassment and violence prevention and response			
Have you put psychological supports in place for all employees? (List the psychological supports already in place.)			

Note: a checklist provided by the Mental Health Commission of Canada which is meant to assist Managers to determine whether they are appropriately implementing the National Standard from

"Building mental health into retail and hospitality organizations: A simple guide." by Mental Health Commission of Canada, 2020.

National Intervention Strategies

The National Standard of Canada on Psychological Health and Safety in the Workplace was formed in 2012. The standard aims to improve the mental well-being of all people living in Canada (CSA Group, 2013).

Applying the standard in the workplace can be done in up to seven phases dependent on the size of the organization, but there are four main key phases which are used. The four phases typically are:

- Leadership commitment and engagement, employee engagement and creation of action teams (CSA Group, 2013).
- Identifying opportunities to make a positive difference, which can be done through data collection, data trends and analysis and an organizational risk assessment (CSA Group, 2013).
- Building an action plan which requires developing a vision, setting objectives. Phase three also includes several training sessions for building employee resilience, creating a respectful workplace, mental health first aid training. Additionally phase three works on implementing prevention of significant psychological distress, inclusive of stress management training, supporting work life balance and providing self-care tools (CSA Group, 2013).
- Implementing the action plan and creating a process for continuous improvement. Workplaces must establish key success factors and establish a performance monitoring process (CSA Group, 2013).

The National Standard was implemented by 40 participating organizations in from 2014 - 2017 and this case study found several barriers to implementation (Mental Health Commission of Canada, 2017). Limited access to psychological health data was identified as a major barrier as it is difficult for organizations to distinguish the psychological or mental impact on available health data such as flu outbreaks or absenteeism (Mental Health Commission of Canada, 2017). Inconsistent support by

leadership and lack of knowledge on psychological health were identified as other major barriers (Mental Health Commission of Canada, 2017).

Public Health Ontario has proposed intervention strategies to support mental health and resilience of the workforce (Public Health Ontario, 2021). The strategies suggested are inclusive of:

- Education and training
- Mental health support interventions
- Peer and social support
- Staffing and workload management
- Prevention and prioritization
- Communication
- Effective leadership

The Ontario Hospital Association compiled mental health resources which can be easily accessed by healthcare workers, leaders and organizations. The resources are inclusive of links and toolkits which are linked and listed according to availability in Ontario and availability Canada wide (Ontario Hospital Association, n.d.).

A survey conducted by the Canadian Standards Association surrounding psychological health and safety in the workplace identified varied methods of support for employees. The survey had 295 respondents which indicated that support can be offered via benefit and employee assistance programs, peer support and community support (Lee-Baggley & Howatt, 2022). Programs offering support can include wellness programs, accommodation strategies for return to work, peer support programs and psychological and social support (Lee-Baggley & Howatt, 2022). A significant finding from the study observed that communication and listening to employees, as well as regular check-ins and flexibility in responding to employee needs were the most important (Lee-Baggley & Howatt, 2022). Respondents noted the need for mental health resources and leadership training in psychological health and safety (Lee-Baggley & Howatt, 2022). The CSA survey also allowed respondents to identify whether the

strategies were prevention or intervention strategies (see Figure 4) which assists in understanding the implementation of the strategy.

The School Mental Health Ontario is another provincial organization that works with the Ministry of Education to help develop and provide a systematic and comprehensive approach to school mental health (School Mental Health Ontario, 2023). The organization has a focus on preventative and early intervention services as schools act as one of the earliest points of contact for mental health service provision (Short et al., 2022). The organization provides services through implementation coaching, resource development and training portfolios and communication and technical support (Short et al., 2022). The resource development and training include mental health promotion and student and family engagement (Short et al., 2022). The School Mental Health Ontario places emphasis on measurement and monitoring and has been operational since 2012 (Short et al., 2022).

The National Standard of Canada on Psychological Health and Safety in the Workplace, the Public Health Ontario policies and the School Mental Health Ontario processes make up the majority of standards and processes available for use in implementing mental health wellness programs, however there is no evidence to suggest they are widely implemented.

Figure 4

Common practices, policies or programs being offered by organizations during COVID-19

Table 10: Practices, Policies, or Programs Offered by Organizations During COVID-19

Initiative	Offered	Primary Intention			
	Yes	Prevention	Intervention	Both	Unsure
Daily communications	147 (86.5%)	23 (16%)	5 (3.5%)	109 (75.7%)	7 (4.9%)
Adjusted work-from-home policy	145 (84.8%)	48 (33.6%)	6 (4.2%)	83 (58%)	6 (4.2%)
Upgraded technology	130 (77.8%)	21 (16.5%)	8 (6.3%)	71 (55.9%)	27 (21.3%)
Employee and family assistance program	127 (75.6%)	11 (8.7%)	9 (7.1%)	103 (81.7%)	3 (2.4%)
Adjusted flexible worktime policy	110 (64.3%)	41 (37.6%)	4 (3.7%)	57 (52.3%)	7 (6.4%)
Facilitate social connections	105 (62.1%)	21 (20.2%)	4 (3.8%)	74 (71.2%)	5 (4.8%)
Adjusted sick time policy	93 (55%)	25 (27.2%)	12 (13%)	50 (54.3%)	5 (5.4%)
Promote local community resources	92 (54.8%)	13 (14.3%)	2 (2.2%)	76 (83.5%)	0 (0%)
Educational webinars on various topics	88 (52.4%)	14 (16.1%)	4 (4.6%)	65 (74.7%)	4 (4.6%)
Leaders trained in how to support employee at risk for mental health	85 (50.9%)	17 (20%)	7 (8.2%)	58 (68.2%)	3 (3.5%)
Digital mental health AP	66 (39.3%)	15 (22.7%)	6 (9.1%)	44 (66.7%)	1 (1.5%)

Initiative	Offered	Primary Intention			
	Yes	Prevention	Intervention	Both	Unsure
Pulse checks to monitor employees' experience	57 (33.7%)	10 (17.9%)	4 (7.1%)	40 (71.4%)	2 (3.6%)
On-demand resources	56 (33.1%)	6 (11.1%)	0 (0%)	46 (85.2%)	2 (3.7%)
Leaders trained in how to be a psychological safe leader	54 (32%)	6 (11.1%)	0 (0%)	46 (85.2%)	2 (3.7%)
Resiliency training	46 (27.4%)	11 (23.9%)	2 (4.3%)	33 (71.7%)	0 (0%)
Adopt or adapt the CSA psychological health and safety "Standard"	39 (23.1%)	11 (28.2%)	2 (5.1%)	26 (66.7%)	0 (0%)
Cognitive behavioural therapy (CBT)	38 (22.5%)	2 (5.4%)	5 (13.5%)	29 (78.4%)	1 (2.7%)
Peer support program	37 (22%)	6 (16.2%)	3 (8.1%)	28 (75.7%)	0 (0%)
Paramedical psychological services	35 (21%)	1 (2.9%)	3 (8.6%)	31 (88.6%)	0 (0%)
Caregiver support (CSA B701)	32 (19.4%)	3 (9.7%)	6 (19.4%)	20 (64.5%)	2 (6.5%)
Workplace survey designed to obtain employees' perceptions and mental health benchmark (e.g., Mental Fitness Index)	31 (18.5%)	6 (19.4%)	1 (3.2%)	23 (74.2%)	1 (3.2%)
Suicide prevention training for mangers	27 (16.3%)	5 (18.5%)	2 (7.4%)	20 (74.1%)	0 (0%)
Buddy system	10 (5.9%)	3 (30%)	0 (0%)	7 (70%)	0 (0%)

Note: a listing provided by the Canadian Standards Association which details the prevention and intervention strategies being offered to employees by 295 organizations as a result of COVID-19 from "Psychological Health and Safety in the Workplace. Employer Practices in Response to COVID-19" by D. Lee-Baggley & B. Howatt, 2022, *Canadian Standards Association Group*.

The results of the literature review show the negative mental health impacts of COVID-19 are consistent among the three industries examined. Many employees, students and stakeholders experienced increased levels of anxiety, isolation and depression. The healthcare sector saw increased levels of burn out as employees were required to work longer hours, and the retail sector saw a reduced workforce due to business closures, both of which exacerbated the negative mental health impacts. The education sector

saw students particularly negatively impacted by social isolation. Organizations offered assistance in various formats inclusive of therapy, well-being seminars and peer support groups, while individuals sought to improve their mental health primarily by engaging in social connection, prayer and meditation and exercise. There is little evidence to support that organizations were tracking the effectiveness of the support being offered.

Methodology

This study leveraged data from a comprehensive literature review which examined the mental health impacts and intervention and prevention strategies across three industries: the education sector, the healthcare sector and the retail sector. A review of the global and Canadian economies was first conducted and the findings in this information led to identifying three industries which were significantly negatively impacted by COVID-19. Searches were subsequently conducted using Google, Google Scholar and various academic journals to obtain literature relevant to the subject. A survey was then prepared to further obtain data to examine the negative mental health impacts, the prevention and intervention strategies in use by individuals and their workplaces and the effectiveness measures of those strategies.

Analysis Approach

A constructivist grounded theory methodology was applied to the data collection and analysis process. Glaser & Strauss (1967) define grounded theory as the discovery of theory from data systematically obtained from social research. This theory is used as a strategy for handling data in research, providing a method to conceptualise, describe and explain research (Glaser & Strauss, 1967). The theory in this methodology must provide clear categories and hypotheses and be readily understandable by both sociologists and researchers as well as students and laypeople (Glaser & Strauss, 1967). The constructivist grounded theory approach focuses on exploring and discovering new concepts, mechanisms or processes which build a theory by using inductive coding (Chandra & Shang, 2017).
A mixed methods approach was used to gather data. Mixed method research involves collecting both qualitative and quantitative data (Creswell & Creswell, 2018). Qualitative and quantitative data are

merged and this integrated mixed methods design indicates the procedures which are used in research (Creswell & Creswell, 2018). The procedures used are informed by a theory (Creswell & Creswell, 2018) which is where the grounded theory is applied.

Two procedures were used for data gathering. Survey research includes a questionnaire and semi structured interviews. The questionnaire results will be enhanced by the interview results as the interviews provide more comprehensive and contextual responses.

Semi structured Interviews

Qualitative, in-depth interviews were conducted with stakeholders in post-secondary student services. The responses to these interviews were analyzed through inductive data coding. Inductive data coding refers to coding paragraphs, sentences or words at the lowest or most basic level without being predicated on any theory (Chandra & Shang, 2017). Once qualitative data has been gathered using interviews, the topics or themes which emerge are grouped together which forms the basis of codifying the data (Creswell & Creswell, 2018) and is used to construct the qualitative data analysis report. Purposive case sampling was used to obtain the sample of interviewees. Purposive sampling involves identifying and selecting individuals or groups of individuals that are especially knowledgeable about or experienced with a phenomenon of interest (Creswell & Plano Clark, 2011). Participants for the interviews were identified through contacting Universities with COVID-19 well being programs to understand the impact and effectiveness of the well being program on employees and students.
The questions for the interview were designed to elicit contextual and in-depth information from participants as to the impact of COVID-19 to working and learning environments, ways employees or students have been impacted, the mental health issues observed or reported, the most offered mental health intervention strategies offered to employees or students and whether these intervention strategies are measured for effectiveness, as well as their usage rates by employees and students. Additionally, interviews are expected to provide avenues of discussion for ideas or related issues which may not have otherwise been considered. Interviews will be conducted remotely via telephone or via Microsoft Teams

or Zoom to facilitate ease of contact and flexibility for participants. All participants were informed of the nature and purpose of the interviews, their right to withdraw or decline to answer specific questions and the time required. Interviews are expected to last approximately 30 minutes.

Questionnaire

These interviews were supplemented with questionnaires which sought to understand participants' level of psychological impact due to COVID-19, best methods of coping and effectiveness of those methods. Additionally, the questionnaires sought to understand whether well being programs were offered by participants' educational institutions and/or workplaces, and whether those programs were being evaluated for effectiveness. Section 1 obtained respondent demographics of age, sex and industry of work. Section 2 examined respondent's mental health before the onset of COVID-19, during pandemic lockdowns and other restrictive measures, and after the return to work and school. Section 3 identifies respondent's personal mental health intervention strategies while Section 4 identifies any mental health intervention strategies provided by respondents' institutions of work and school. Section 4 additionally measures whether the strategies provided by institutions are evaluated for effectiveness. They layout of the sections in the questionnaire was designed to determine if a respondent experienced mental health impacts what was the optimal intervention strategy used and whether that strategy was evaluated for effectiveness. Industry, age and sex were considered in the questionnaire and results were standardised using age and industry to determine top impacts. The questionnaires were formulated using information generated from the literature reviews which generated lists of prevalent mental health impacts and potential intervention strategies. A random sampling approach was used to obtain responses for the questionnaires. The questionnaire includes an introductory paragraph which details that participation is voluntary and responding to the questionnaire is considered as informed consent. Social media is used as the population and participants for the questionnaires were obtained through sharing the link to the survey on social media websites LinkedIn and Twitter and asking contacts to re-share the link on their profile with their networks. The survey was administered through online survey tool Survey Monkey which

records responses in one central cloud-based database. Questionnaire responses rely on a 5-point Likert scale which is used to allow individuals to express how much they agree or disagree with a particular statement (McLeod, 2019). The Likert scale ranges from 1 “not at all” to 5 “very much” with higher scores reflecting the response showing the greatest impact. Analysis of Likert scale responses will include observing the response modes and visual representation of data responses (McLeod, 2019). The Likert scale allows for identifying themes in responses and ease of analyzing responses.

Data Analysis

The interview and questionnaire questions were tested and revised. Researchers also tested and validated the coding scheme for consistency, comparability and uniformity of results.

Questionnaire data was analysed using basic statistical analysis by manipulating and reviewing responses from Survey Monkey. This included calculating percentages and calculating the mean (M) and mode (Mo).

Open ended questionnaire data were analysed thematically. The data is organised by identifying patterns and provides the potential for rich and detailed data. The data analysis used inductive coding. Inductive coding assigns codes to the data patterns identified. Braun and Clarke’s guide was used to code the interview data. The six step process requires transcribing and becoming familiar with the data, generating the codes, grouping codes into themes, reviewing themes, naming and refining themes and selecting patterns to report. The questionnaire data had limited open ended questions and so this process was less applicable as the themes were fewer and more easily identifiable. Interviews were unable to be secured and so generated no data for analysis.

Limitations

Methodological limitations were encountered which did not invalidate research results. The questionnaire data is highly dependent on a stable internet connection for both respondents and researchers. The questionnaire available only in English which can limit the number of respondents. The

sample size is limited in interviews, however there is no prescribed sample that is considered effective or impactful for achieving quality data. The questionnaire relies on goodwill of first respondents sharing with others to reach a broader population base via social media. Thematic analysis relies on researcher judgement which can be influenced by implicit bias. This is mitigated by ensuring a second researcher has reviewed the coding prior to thematic analysis. An objective review reduces the risk of bias.

Data collection proved to be difficult as the questionnaire was opened for three weeks to collect responses. Attempts to obtain interviews with key stakeholders was difficult and unable to be secured within the time frame needed and so the data obtained is less robust than initially planned. Limited survey responses and inability to secure interviews reduce the confidence to apply the results to a larger population. This is mitigated by observations that the survey responses are in line with the trends and themes identified in the literature review.

Results

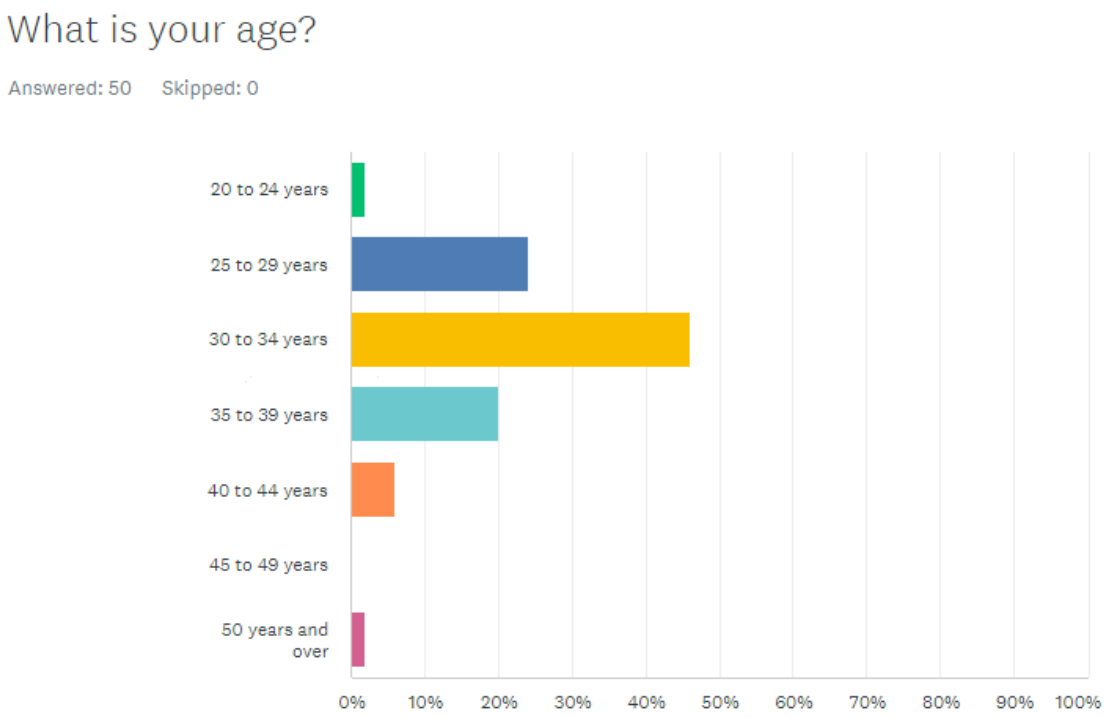
The results are based on survey responses from 50 respondents over a range of ages, genders and industries in which participants are employed or working. The full list of survey questions can be found at Appendix B.

Demographics of the sample

Figures 5, 6 and 7 illustrate the demographics of the sample, such as age, gender and industry.

Figure 5

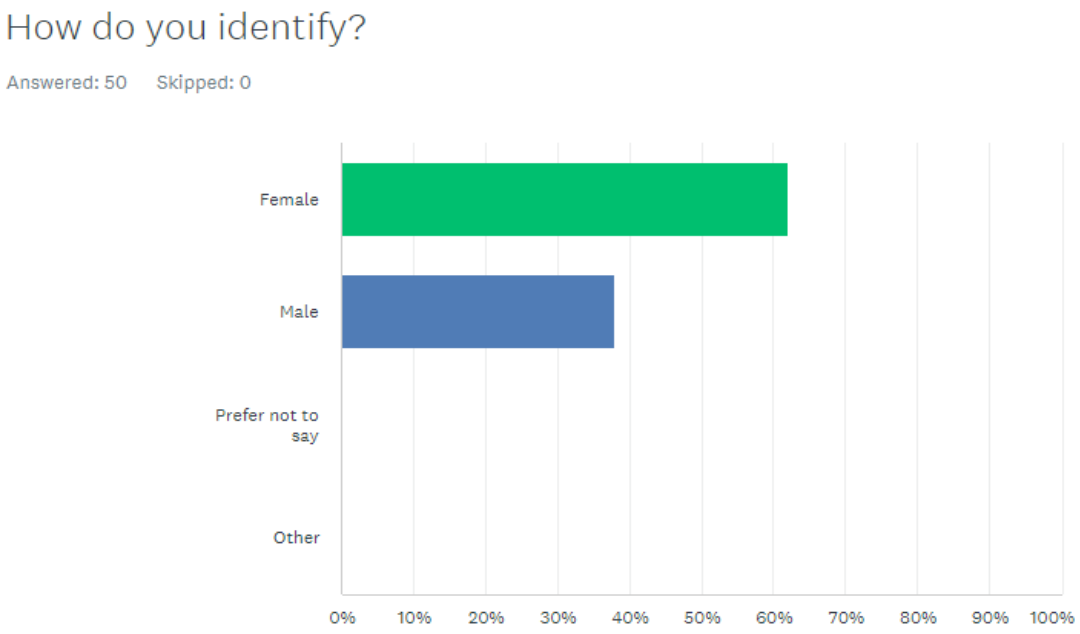
Detailing the age demographics of respondents



46% of participants are between 30 to 34 years. 24% of participants are 25 to 29 years and 20% of participants are between 35 to 39 years.

Figure 6

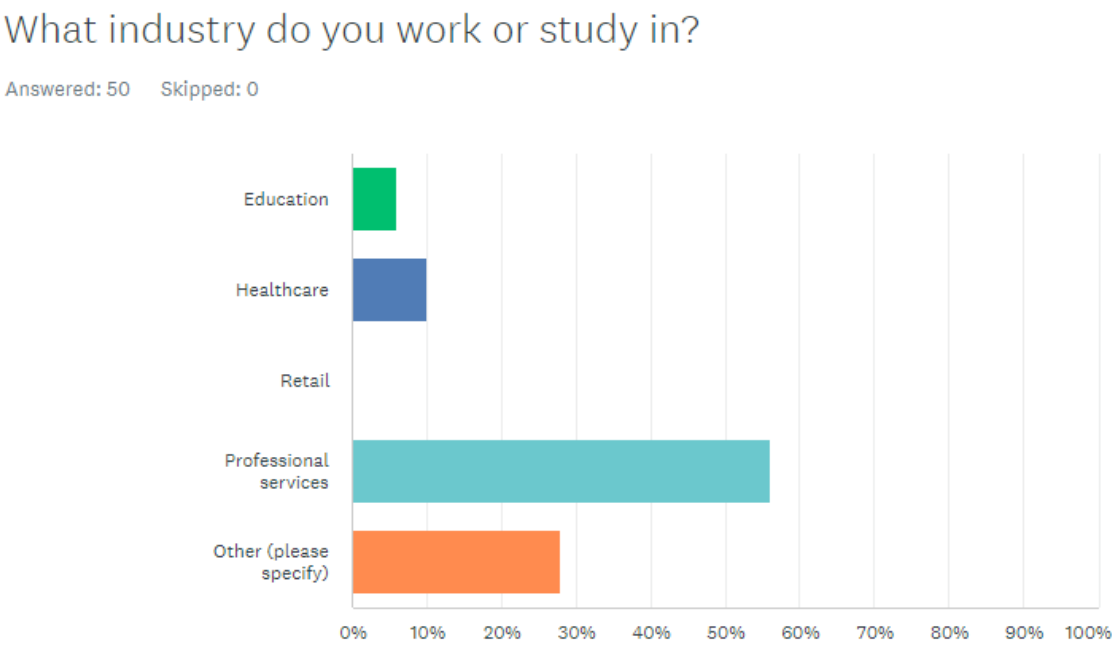
Gender demographics of respondents



62% of participants are women (Mo) and 38% of participants are men, indicating responses heavily based on the opinion of women.

Figure 7

Industry demographics showing breakdown of various industries that respondents worked in



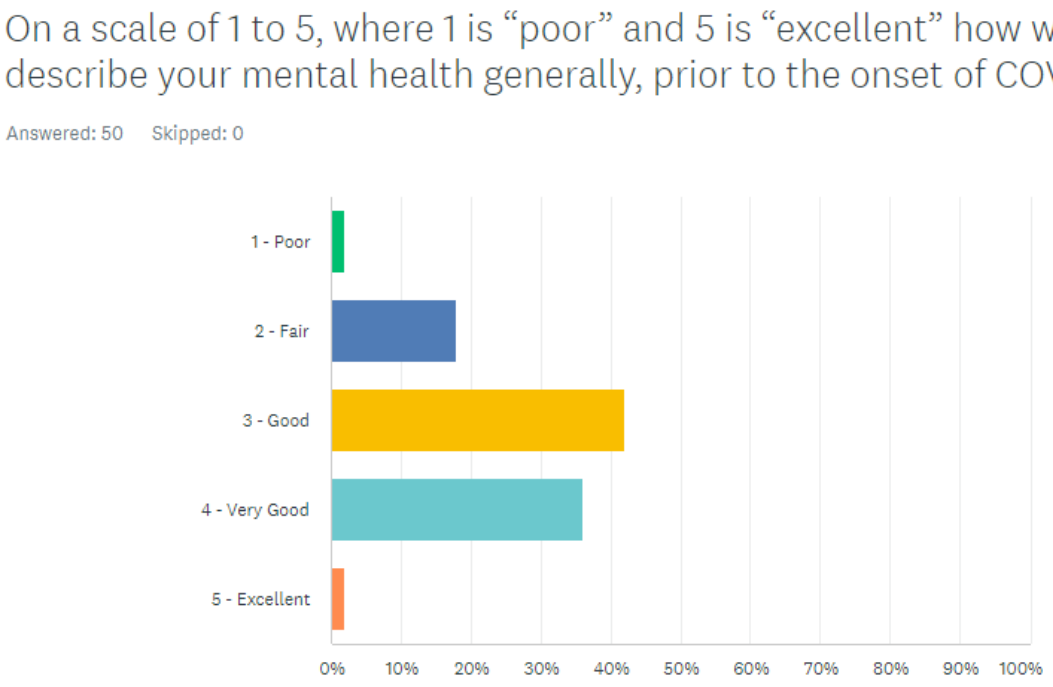
56% of participants work in professional services, 10% in healthcare and 6% in education. 28% of participants were documented in other industries inclusive of Aviation, Insurance, Agriculture, Telecommunications, Marketing, Trade, Public Relations and Creative.

Mental health baseline

Figure 8 and 9 demonstrates the baseline of mental health before the onset of COVID and how mental health improved after COVID lockdown measures were eased or removed.

Figure 8

Baseline of respondent's mental health before the onset of COVID

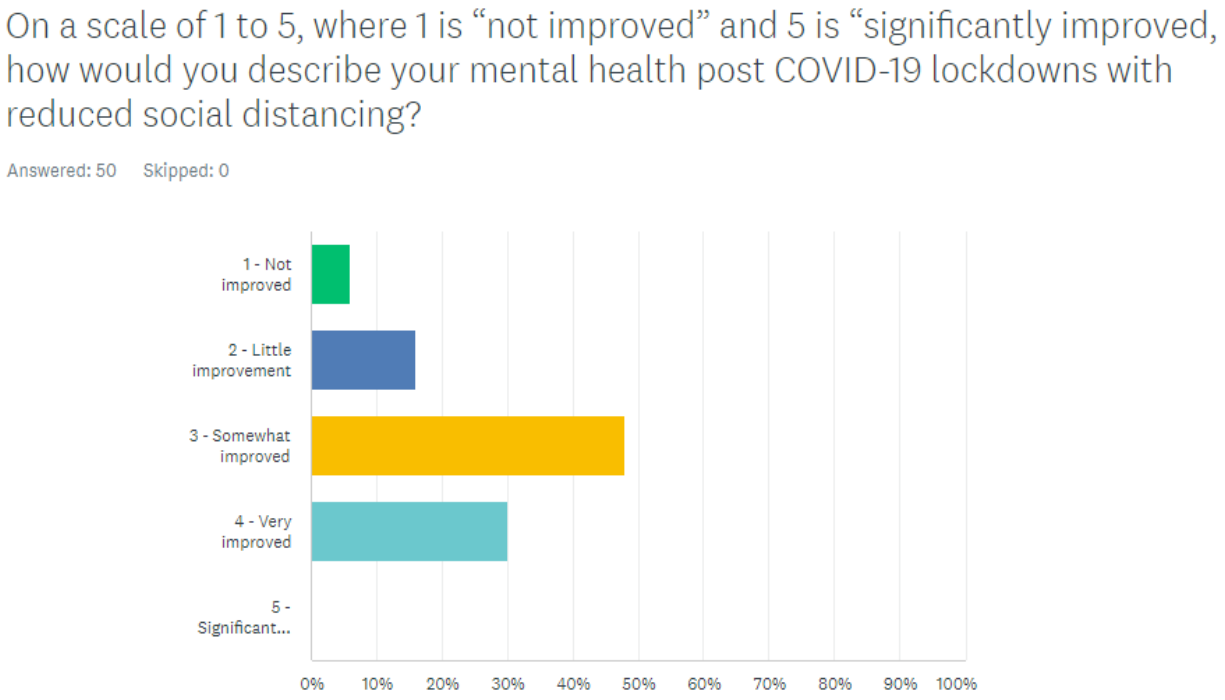


Generally, most respondents indicate their mental health as being good to very good prior to COVID. 19 respondents, or 38% of all participants indicated their mental health was very good or excellent prior to the onset of COVID. 42% of the 19 respondents are 30 to 34 years old and 53% of the 19 respondents work in professional services. 21 respondents, or 42% of all participants indicated mental health of good prior to the onset of COVID. 10 respondents, or 20% of all participants indicated mental health being fair

or poor prior to the onset of COVID. 80% of the 10 respondents are 30 to 34 years old. 70% of the 10 respondents are female and 50% of the 10 respondents work in professional services.

Figure 9

Measurement of respondents' mental health after COVID lockdown and social distancing measures are reversed or lessened.



Generally, most respondents indicated their mental health somewhat improved after COVID. 24 respondents indicated their mental health was somewhat improved and 15 respondents indicated their mental health was very improved after the removal of most COVID lockdown measures. 8 of those 15 respondents, or 55% are 30 to 34 years old, 9 of 15 respondents, or 60% are female and 10 of 15 respondents, or 67% work in professional services.11 respondents indicated they experienced little improvement in their mental health. The least improved demographic after the removal of most COVID lockdown measures are females (7 of 11 respondents, or 64%) between the ages of 30 to 34 years (7 of 11 respondents, or 64%) working in professional services (6 of 11 respondents, or 55%).

Mental health impacts

Figure 10 illustrates the impact to participants' mental health resulting from COVID 19. This data is presented as a word cloud, with the larger text illustrating the mental health impacts that were most observed by participants.

Figure 10

Major mental health impacts identified by questionnaire participants.

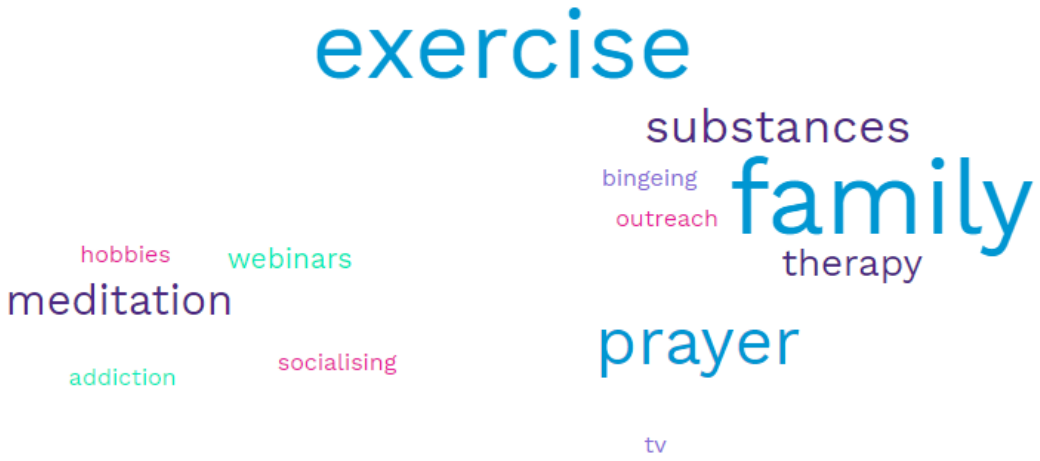
Loneliness, isolation, stress, anxiety and depression are all observed as prevalent mental health impacts for participants which agrees with the literature findings. Havaei et. al. (2021), Sillcox (2022) and Lan et. al. (2020) all identified anxiety, depression, isolation and loneliness as an increased impact to individuals' mental health resulting from COVID.

Intervention strategies used by employees and organizations

Figures 11 and 12 illustrates strategies utilized by employees and their organizations to improve mental health as a result of COVID. This data is presented as a word cloud, with the larger text illustrating the activities that were most observed by participants.

Figure 11

Activities engaged in by individuals to improve their mental health



The primary strategies utilized by respondents include prayer or spiritual guidance, physical exercise and spending time with family and friends. The use of these strategies is supported by the research done by Rashid & Genova (2020) and Rosemberg et al (2021). A study conducted by Nagib et al. (2022) of Japanese university students observed an increase in alcohol consumption during the beginning of the pandemic. Alcohol consumption regulated over the next two years as the students adapted to their new way of living (Nagbi et al., 2022). This is supported in the survey results as the survey is answered 3 years after the pandemic, and substance abuse would likely have been regulated from the beginning of the pandemic.

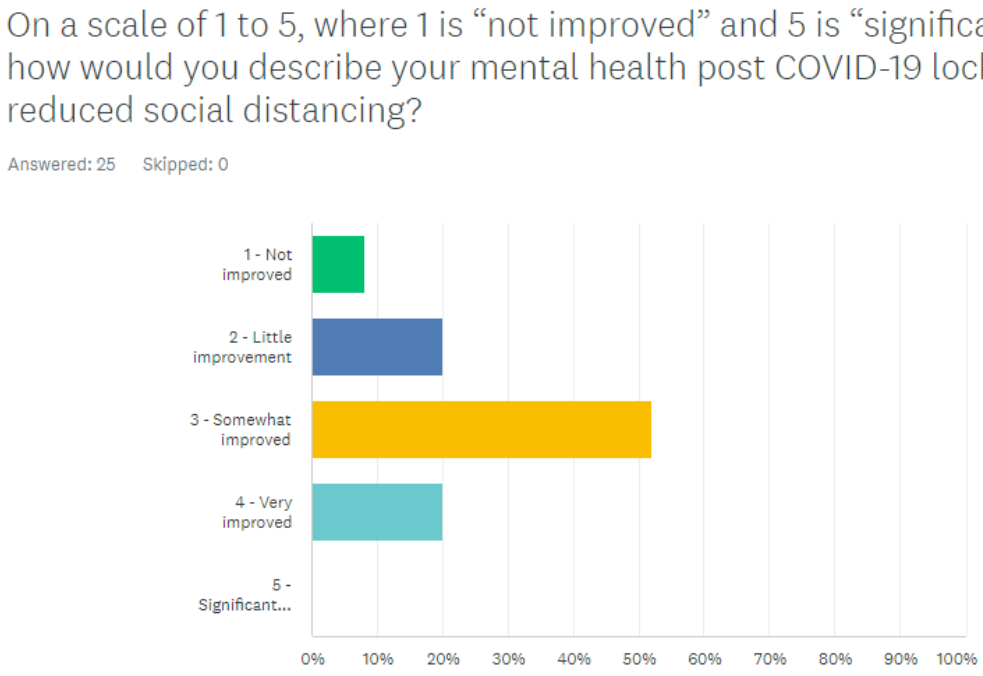
Figure 12

Mental health support offered to employees by their workplaces

50% of respondents indicated their workplaces do not offer any form of support. Those that do offer support primarily offer well-being seminars, access to virtual therapy, time-off and creation of peer support groups. The literature confirms the use of well-being seminars, peer-support and therapy as main attempts by workplaces to introduce intervention strategies for improving mental health. Devine (2020) indicated the buddy system being implemented in the Michael Garron Hospital and the Canadian Standards Association conducted surveys which captured peer support, webinars and therapy as offerings by workplaces. 88% of respondents indicate that their workplaces do not conduct any assessment to determine whether the support offered is helpful to employees.

Figure 13

Mental health improvement of employees who indicated their workplaces provided intervention strategies



The survey results show that those employees who were provided intervention strategies by their workplaces showed some improvement. 13 of 25 respondents indicated their mental health was somewhat improved and 5 of 25 respondents indicated their mental health was very improved. Conversely, employees who were not provided with mental health strategies showed a higher percentage of very

improved at 10 of 25 respondents. The inference can be made that the strategies provided by employers are not effective at improving employees' mental health.

Discussion

This study aimed to examine the current coping strategies and to determine which of these strategies can be considered as best practice mental health policies in corporations. The study also seeks to examine whether any evaluation metrics are in place for these policies at workplaces or schools. If evaluation metrics are being used, this study would identify what is considered useful evaluation metrics of mental health coping strategies offered by organizations.

Best Practices for Prevention and Intervention Strategies

The results of the literature reviews and survey indicate primary strategies offered by companies to be consistent. Companies have been offering therapy, peer support programs, well-being seminars and time-off as mental health intervention strategies (Lee-Baggley & Howatt, 2022). The survey results indicate that employees were found to prioritize connection with family and friends, exercise and prayer or spiritual guidance as intervention strategies. These employee preferred strategies are supported by the research of Rashid & Genova (2020), Devine (2020) and Rosemberg et al (2021). The research by Devine (2020) and Lan et al (2020) also supports employees requiring more consistent communication from leadership as a means to reduce stress and anxiety levels. According the Canada Mental Health Association (2019), social connection can reduce anxiety and depression and help emotional regulation. Social connection can even improve immune system health (Canada Mental Health Association, 2019). The Mayo Clinic (2017) identified exercise as another way to improve anxiety and depression. Exercise helps produce feel good chemicals called endorphins in the brain which creates a more positive mood (The Mayo Clinic, 2017). Both exercise and social connection are inexpensive and easily accessible intervention strategies which allows individuals to utilize them more than some other more costly methods such as therapy and well-being seminars.

The National Standard of Canada on Psychological Health and Safety in the Workplace, and the Canadian Standards Association Group supports strategies such as daily communication from leadership, facilitating social connections through peer support programs or buddy systems and training leaders on how to support employees at risk for mental health issues among other measures.

The strategies proposed by the National Standard of Canada on Psychological Health and Safety in the Workplace and the Canada Standards Association Group are very good baseline suggestions for implementing a well-rounded workplace approach to not only improving employee mental health, but preventing any potential breakdowns in mental health. The promoted strategies, inclusive of preventative or upstream services, are supported by Mental Health Commission of Canada (2022) as well as Monaghan et al. (2020). The implementation of preventative services, inclusive of educating leadership on mental health literacy, increased and consistent communication from leadership, anti-stigma programming and mental health awareness programs will reduce the need for intervention strategies such as therapy. The significant increase in the need for intervention strategies has therapy, counselling, tele-health and other similar systems overburdened (Monaghan et al, 2020) and unable to provide individuals with the quality of care they require to improve their mental health.

Training sessions for leadership are an important step as this will set the tone at the top of organizations that mental health wellness is valued and that mental health literacy is important. Leadership advocating for mental wellness helps the organization secure the budget required for these initiatives as well as helps drive change within the organizational culture (Deloitte, 2019). Reducing the stigma by showing leadership is supportive of promoting good mental health will allow a more open dialogue from employees who may be hesitant to share their mental health struggles for fear of being ostracized or punished at work.

Evaluation of intervention strategies offered by organizations

The literature reviews, as well as the surveys conducted, have found that evaluative metrics are often missing from workplaces. The national standards include a step of establishing key success factors

and performance monitoring. Organizations can leverage these standards to identify key priorities for their individual organizations (Deloitte, 2019). The School Mental Health Ontario organization does include a system of measurement and monitoring in its operations however the organization works with a handful of schools in one province. Setting key performance measures and a structure for evaluating strategies provided in an organization is important to ensure that members are deriving value from the organization's initiative and that the organization is not wasting resources in providing programs which are not achieving the desired results.

Harris (2021) demonstrates some basic effectiveness measurements as employed by fortune 500 company W.W.Grainger. The metrics used are a mix of both qualitative and quantitative data. Quantitative data includes number or percentage of users or engagement with the program, number of mental health events or sessions, rate of employee burnout, number of employee sick days and employee retention numbers. Some qualitative measures include employee feedback on programs, perceived value of the initiatives or strategies by employees and employee morale. Deloitte (2019), Harris (2021) and Beuermann-King (n.d) have all indicated the need to employ data capture and measurement as part of evaluating an organization's mental health wellness program.

Prior to implementing strategy evaluations, organizations first need to identify the mental health baseline of employees (Beuermann-King, n.d.). Baseline measurements can be captured through use of employee mental health surveys, identifying pre-program participation rates, tracking absenteeism patterns, conducting employee morale checks and assessing employee stress levels (Beuermann-King, n.d.). Having a baseline of this information will allow the evaluation to determine whether employees are improving and the strategies are creating value and achieving the set goals.

Harris (2021) and Beuermann-King (n.d.) have indicated the need to split the evaluations into three measurement steps. The first step is process measurement which examines a short term approach as to whether the strategy is meeting its objectives and can include employee engagement rates, management participation rates and employee satisfaction (Beuermann-King, n.d.). The second step is impact measurements which review a medium-term approach to understand whether mental health beliefs and

attitudes are improved (Beuermann-King, n.d.) and whether the program is achieving the initial key performance indicators that were set (Harris, 2021). A strategy with a targeted outcome of a percentage of employees joining peer support groups would be an impact measure through assessing whether the organization has achieved that percentage. The final measurement step is outcome measurements which track long term, organization driven results (Beuermann-King, n.d.) inclusive of metrics such as reductions in sick days or absenteeism and employee retention rates (Harris, 2021).

One limitation is that qualitative measurements may be more difficult to obtain through employee pulse or health surveys as discussing mental health is difficult for employees who feel there remains a stigma surrounding metal health challenges (Mental Health Commission of Canada, 2022). Employees who feel uncomfortable may be less honest in mental health surveys and evaluations and it may be difficult to obtain an accurate evaluation of strategy effectiveness.

Recommendation

According to the research conducted there remain gaps in the provision of mental health services. Organizations have increased the offerings for employees, however there is some disconnect between what employees have identified as their preferred intervention strategies and what employers are offering. Further, many organizations are not conducting evaluations on whether the support being offered is effective.

There is evidence to support that some organizations have implemented a systematic approach to providing mental health prevention and intervention strategies as well as evaluative metrics for those systems. The schools operating within School Mental Health Ontario provide both prevention and intervention strategies to students. Forty organizations in Canada, at minimum, implemented the National Standard Of Canada For Psychological Health And Safety In The Workplace. Both of these structures of support evaluating the impact of the support being offered. Despite this, many other organizations do not have any systems of support and evaluation in place.

Canadian organizations should be required, at minimum, to employ the checklist provided by the Mental Health Commission of Canada (2020) in Figure 3 as a baseline for what should be the key processes required to begin meeting the national standard. The Mental Health Commission of Canada has a toolkit which was created to provide assistance for organizations on how to implement the standard. The following steps can then be taken based on the National Standard to implement a comprehensive process for mental health wellness:

Figure 14

Four step process for implementation of the National Standard Of Canada For Psychological Health And Safety In The Workplace

Note: the four key steps identified by the National Standard Of Canada For Psychological Health And Safety In The Workplace. "The National Standard for Psychological Health and Safety in the Workplace Assembling the Pieces (Mental Health Commission of Canada)" by The Mental Health Commission of Canada and the Canadian Standards Group, n.d.

The best intervention practices as identified by the literature and the data analysis provided by the survey research indicate use of social support programs, exercise, therapy and training on well-being through seminars and other methods. The most important prevention practices based on the research are training of leadership on mental health importance and responses, communication from the organization to its members and overall change to the organizational culture. Organizations can use this data as a starting point for implementation of the four-step process for creation of their mental health wellness

program, along with obtaining a baseline of members' mental health. Organizations should also place emphasis on step four which creates a process for continuous monitoring and process improvement. The evaluation, monitoring and process improvement can also use the basic steps as laid out by Harris (2021) and Beuermann-King (n.d.) which breaks the evaluation process into process measurement, impact measurements and outcome measurements.

Conclusion

The review of the research and current literature show that the most important intervention and prevention strategies to improve mental health for employees and students to be social connection, exercise, spiritual guidance, therapy, training through well-being seminars, training of leadership on mental health wellness and increased communication from leadership.

The research also indicates there are standards and processes which exist for the implementation and evaluation of mental wellness programs. These standards are not required to be implemented by organizations.

Employees and students would benefit through seeing improved mental health if organizations implement mental wellness programs with a focus on their preferred intervention and prevention strategies. Improved mental health can only be maintained if the mental wellness programs being implemented are effective, so these mental wellness programs must be evaluated.

This paper provides recommendations on use of the Mental Health Commission of Canada's guide for implementing the National Standard for Psychological Health and Safety in the Workplace, as well as specific methods for ensuring an effective evaluation system is in place. These recommendations will ensure both organizations and its members will receive the best outcome for mental health wellness programs.

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Appendix

Appendix A: Participant Consent Form

CONSENT TO PARTICIPATE IN RESEARCH FOR UNIVERSITY CANADA WEST.

The Progression Of Mental Health Assistance Offered To Employees In The Workplace After Covid-19

I am a MBA researcher at University Canada West currently researching the best intervention strategies for improving mental health which was specifically impacted by the onset of COVID-19. Particular focus has been placed on whether these intervention strategies have been rated for effectiveness and whether workers or students are able to easily access these strategies through their institutions. The results will be published in my MBA Thesis, but may also contribute to other academic outputs such as papers in relevant conferences and journals.

I am using a mixed methods approach which includes quantitative data from this questionnaire as well as qualitative data through focused interviews. The study will include employees across many industries, inclusive of education, healthcare and retail, as well as students and staff in educational institutions who have direct contact with implementing or providing mental health intervention strategies.

I request your assistance with answering the following questions. All responses will be anonymous and participants are free to withdraw at any time. All data recorded will be retained for one year and destroyed thereafter.

PURPOSE OF THE STUDY

Many papers written on the Covid-19 impact on employees' mental health have worked on identifying the impact of Covid-19, not how employers can assist employees in managing their mental health impacts. Many public health websites suggest a general method of tele-health as a way of managing negative

mental health issues that developed from Covid-19. Other websites targeted to employers, like Work Place Mental Health seem to suggest generic intervention strategies such as “training” with no detail, or assigning employees more work, which is not an all-encompassing fix. This paper will seek to create a more specific recommendation for workplace mental health assistance by reviewing current literature and any current policies which are in place and determining what are the best practice mental health policies in corporations through literature review, questionnaires and interviews. Additionally, this paper will seek to recommend a method of evaluation of policies in place to verify that corporations are using the best practices as relates to their individual employees.

PROCEDURES

Participants will be required to complete a 5-minute questionnaire. Select participants will be required to engage in an interview, approximately 30 minutes long. All questions will be geared toward identifying mental health impacts related to COVID-19, best intervention strategies and methods for evaluating the effectiveness of these intervention strategies.

POTENTIAL RISKS AND DISCOMFORTS

There is no known risk or discomfort anticipated except for the time required for participating in the interview. If you are not comfortable at anytime during the interview we can move on to the next question by letting the interviewer know.

POTENTIAL BENEFITS TO THE PARTICIPANT.

Participants will be able to receive a copy of the final research paper inclusive of recommendations for best practice for intervention strategies and a framework for evaluation of these strategies.

CONFIDENTIALITY

Any information that is obtained during the interview and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. All responses will be

anonymous and participants are free to withdraw at any time. All data recorded will be retained for one year and destroyed thereafter.

RIGHTS OF PARTICIPANT

You can choose to withdraw at any time without consequences of any kind.

You may also refuse to answer any questions you don't want to.

IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact my University Canada West thesis supervisor Dr. Anthony Masys by email at anthony.masys@myucwest.ca, or the Program Chair of the MBA Program: Dr. Michele Vincenti. Dr. Vincenti can be reached at: 604-915-9607 or by email at michele.vincenti@ucanwest.ca

SIGNATURE OF RESEARCH PARTICIPANT (Where applicable)

I understand that I will participate in an interview. I understand that my participation is completely voluntary, and that I am free to withdraw from the study at any time I choose, without penalty. I understand that the results of this research may be published but that my name will not be associated in any way with any published results without further consent.

I understand the procedures and conditions of my participation described above. My questions have been answered to my satisfaction, and I agree to participate in this interview. I have been given a copy of this form.

_____

Name of Participant

_____

Signature of Participant

_____

Date

STATEMENT and SIGNATURE OF INVESTIGATOR

In my judgment the participant is voluntarily and knowingly giving informed consent and possesses the legal capacity to give informed consent to participate in this research study.

_____ _____

Signature of Investigator / Date

Appendix B: Questionnaire
Best Practices for Mental Health Issues Resulting From COVID-19

A. Demographics

1. What is your age?
    - 20 – 24 years
    - 25 – 29 years
    - 30 – 34 years
    - 35 – 39 years
    - 40 – 44 years
    - 45 – 49 years
    - 50+ years

2. How do you identify as?:
    - Male
    - Female
    - Other
    - Prefer not to say

3. What industry do you work or study in?
    - Education

- Healthcare
- Retail
- Professional services/Finance
- Other (Please specify)

B. Mental Impact

4. On a scale of 1 to 5, where 1 is “poor” and 5 is “excellent” how would you describe your mental health generally, prior to the onset of COVID-19?
    - 1-Poor
    - 2-Fair
    - 3-Good
    - 4-Very Good
    - 5-Excellent

5. On a scale of 1 to 5, where 1 is “poor” and 5 is “excellent” how would you describe your mental health during the COVID-19 lockdowns?
    - 1-Poor
    - 2-Fair
    - 3-Good
    - 4-Very Good
    - 5-Excellent

6. Did you experience any of the following impacts to your life as a result of COVID-19? Please select all that apply.
    - Loss of job/income

- Difficulty meeting financial obligations
- Death of family member/friend/colleague
- Other (please list)

  _____

7. How would you describe impacts to your mental health as a result of COVID-19? Please select all that apply.
   - Grief
   - Anxiety
   - Stress
   - Loneliness
   - Isolation
   - Depression
   - Anger
   - Other (please list)

8. On a scale of 1 to 5, where 1 is “not at all” and 5 is “to a great extent”, how much did COVID-19 impact your daily life?
   - 1-Not at all
   - 2-Very little
   - 3-Somewhat
   - 4-Very much
   - 5-To a great extent

9. On a scale of 1 to 5, where 1 is “not at all” and 5 is “to a great extent”, did you experience difficulty adapting to workplace or school shifting to virtual environments (working from home and online study)?
    - 1-Not at all
    - 2-Very little
    - 3-Somewhat
    - 4-Very much
    - 5-To a great extent

10. On a scale of 1 to 5, where 1 is “not at all” and 5 is “to a great extent”, did you experience increased pressure at work or at school resulting from the virtual work/learning changes?
    - 1-Not at all
    - 2-Very little
    - 3-Somewhat
    - 4-Very much
    - 5-To a great extent

11. Did increased pressure at work or school (Question 10), difficulty adapting to virtual environments (Question 9) and impacts to life (Question 6) lead to worsening mental health impacts?
    - Yes
    - No

12. On a scale of 1 to 5, where 1 is “not improved” and 5 is “significantly improved, how would you describe your mental health post COVID-19 lockdowns with reduced social distancing?

- 1-Not improved
- 2-Little improvement
- 3-Somewhat improved
- 4-Very improved
- 5-Significant improvement

C. Mental Health Coping Practices

13. Have you engaged in any of the following to help improve your mental health as a result of COVID-19? Please select all that apply.
    - Communicating with family/friends
    - Communicating with a professional (such as therapist)
    - Meditation
    - Prayer or spiritual guidance
    - Exercise
    - Wellness webinars
    - Alcohol/drugs
    - Other (please list)

      _____

14. What was your preferred method of coping practices in question 13 above? Please select a maximum of 3.
    - Communicating with family/friends
    - Communicating with a professional (such as therapist)
    - Meditation
    - Prayer or spiritual guidance

- Exercise
- Wellness webinars
- Alcohol/
- Medication/prescription drugs
- Other (please list)

  _____

15. On a scale of 1 to 5, where 1 is “not at all” and 5 is “very easy”, have you found obtaining access to support services or coping practices to be easy?
    - 1-Not at all
    - 2-Very little
    - 3-Somewhat
    - 4-Very much
    - 5-To a great extent

16. What have been some difficulties in accessing support services or coping practices?
    - Financial
    - Time
    - Internet
    - Location
    - Familial/work responsibilities
    - Other (please list)

      _____

D. Support provided by the workplace or school

17. Does your workplace or school provide support (in the form of therapy, well being seminars and resources, or well being activities and days)?
    - Yes
    - No

18. What sort of support do they offer? Please select all that apply.
    - Therapy
    - Exercise (classes or gym access)
    - Well being seminars
    - Time off
    - Peer support
    - Other (please list)

      _____

E. Effectiveness of coping mechanisms

19. On a scale of 1 to 5, where 1 is “poor” and 5 is “excellent”, how would you rate the effectiveness of your primary coping mechanism?
    - 1-Poor
    - 2-Fair
    - 3-Good
    - 4-Very Good
    - 5-Excellent

20. Has your coping mechanism of choice reduced emotional distress (anxiety/stress/loneliness etc) experienced during COVID-19?
    - Yes
    - No

21. Has your workplace or school conducted an assessment (such as questions to staff or polls) to determine the effectiveness of assistance they have offered to students or employees?
    - Yes
    - No

Appendix C: Interview Questions

1. Describe the impact COVID-19 has had to your work/learning environment?

2. How have your employees/students been impacted by the pandemic and the shift to virtual work/learning?

3. What are the three most prevalent mental health issues observed or reported by employees/students

4. If employees or students have not reported any mental health issues, how has the company/school identified any potential mental health issues?

5. Can you describe the assistance offered by your company/school for coping with mental health issues that resulted from COVID-19?

6. If assistance is being offered, how has it been advertised to the employees/students?

7. If assistance is being offered, what has been the uptake by employees/students?

8. Could you describe the effectiveness of the intervention strategies?

9. How did you evaluate the effectiveness of the intervention strategies?