Help-Seeking Behaviours Of Individuals With Workplace Mental Health Injuries

A thesis submitted to the Committee of Graduate Studies in Partial Fulfillment of the Requirements for the Degree of Master of Science in the Faculty of Arts and Science

TRENT UNIVERSITY

Peterborough, Ontario, Canada

Psychology M.Sc. Graduate Program

May 2022

Abstract

Help-Seeking Behaviours Of Individuals With Workplace Mental Health Injuries

Kara Rutherford

The present study investigated the lived-experiences of individuals with workplace mental health injuries to better understand the thoughts, emotions, and behavioural processes that promote or inhibit help-seeking. This research investigated the interactions and relationships with relevant stakeholders and how they influence help-seeking. Qualitative methodology was employed by conducting semi-structured interviews with individuals (*n*=12) from various occupational classes who had experienced a workplace mental health injury. Interpretative phenomenological analysis and thematic content analysis were combined to analyze the data. Three main themes emerged: 1) self-preservation through injury concealment or distancing from workplace stressors 2) fatigue relating to complex help-seeking pathways, accumulation of stressors, and decreased ability in treatment decision-making, and 3) (mis)trust in the people and processes involved. These findings may help inform the mechanisms behind help-seeking for workplace mental health injuries, which may have implications for future research, policy development, and workplace processes to better facilitate a path to help.

Keywords: help-seeking, workplace mental health, WSIB, mental health concealment, stigma, trust, lived-experiences, self-preservation.

Acknowledgements

It takes a village to successfully complete a masters. I would like to thank my supervisor, Dr. Fergal O'Hagan, for his guidance, support, and patience as we developed and refined this important research. I would also like to thank him for leading by example with his passion and commitment to honest and thorough research. I would like to thank my committee member, Dr. Lara Hiseler, for her positive comments, sometimes when I needed them the most, while still providing me with real-life insights and tough questions that forced me to think outside of academia. I would like to thank my husband, Steve Bennie, for encouraging me to pursue my dreams, and my mother, Cathy Hartwick, for picking up the slack in all areas of my life when all I had time for was researching and writing. Lastly, but equally important, I would like to thank the participants that took the time to contribute their experiences to my research. Their candid disclosure of their real-life help-seeking experiences is what made this research possible. This was a commitment that did not go unnoticed, and I hope this paper will do your voices justice and the findings help build the basis to improve systems and policies to make help-seeking for workplace mental health injuries easier for those that follow.

Table of Contents

Abstract ii

Acknowledgements iii

List of Figures vii

List of Tables viii

Glossary ix

Introduction/Background 1

- **Mental Health in the Modern Workplace** 5
- **Help-Seeking** 11
- **Help-Seeking in the Workplace** 19
- **Legislation, Health Care, and Institutional Supports** 23
- **The Present Study** 28

Methodology 29

- **Design** 29
- **Metatheoretical Orientation** 29
- **Sampling and Recruitment** 30
- **Instrumentation** 31
- **Procedure and Data Collection** 33
- **Data Analysis** 35
- **Strategies for Rigour** 36
- **Reflexivity** 39

Results 40

Participants 40

Themes 49

Workers Concealed Injuries And Distanced Themselves From Stressors As A Means Of Self-Help And Self-Preservation 54

Complex Help-Seeking Pathways And Accumulated Stressors Caused Fatigue Leading To Reduced Independence In Decision-Making 61

Trust Contributed to Resources Accessed 80

Discussion 91

Workers Concealed Injuries And Distanced Themselves From Stressors As A Means Of Self-Preservation Through Self-Help 93

Complex Help-Seeking Pathways And Accumulated Stressors Caused Fatigue Leading To Reduced Independence In Decision-Making 98

Trust Contributed To Resources Accessed 103

Workplace Stress and Help-Seeking Behaviour Models 108

Practice Implications 111

Workers 111

Employers 113

Healthcare Providers 117

Policies and Systems 119

Future Research 121

Strengths and Limitations 124

Conclusions 125

References 127

Appendix A: Interview Protocol 146

Appendix B: The Depression, Anxiety, and Stress Scale Questionnaire & Scoring 148

Appendix C: Participant Demographic Questionnaire 150

Appendix D: Participant Consent Form 152

Appendix E: Participant Debrief Form 154

Appendix F: Trajectories of Participant Accessed Resources: A Sequential Overview 155

List of Figures

Figure 1	Andersen's Emerging Behavior Model	13
Figure 2	Interconnectedness of Help-Seeking Determinants for Workers with Workplace Mental Health Injuries.	53
Figure 3	Sociograms of Participant Experiences in Accessing Healthcare, Insurance, Workplace and Personal Support for their WMHIs	64

List of Tables

Table 1	Summary of Study Sample Demographics	42
Table 2	Summary of Participant DASS-21 Scores and Utilized Supports	45
Table 3	Summary and Description of Themes and Subthemes	50

Glossary

Coping capacity: An individual's ability to respond to and recover from the effects of stress, trauma or mental uneasiness that have the potential to impact that individual's normal functioning.

Employee Assistance Program (EAP): Short-term counselling services for employees which are paid for by the employer and are run by various private companies with varying services (Government of Canada, 2021).

Employment Insurance: Temporary income support to unemployed workers and includes special benefits to workers who take time off work due to illness or injury amongst other reasons. Employers and employees pay into this as part of payroll deductions and the program is overseen by the Canada Employment Insurance Commission (Government of Canada, 2020).

Ontario Disability Support Program: The Ontario Disability Support Program is a means-tested government-funded last resort income support paid for qualifying residents in the province of Ontario, Canada, who are above the age of 18 and have a disability.

Stakeholders: Any individuals who may be impacted or have an interest in the decision-makers' choices.

Workplace mental health injuries (WMHIs): A psychological injury that was sustained in the workplace and is not associated with a physical injury.

Workplace Safety Insurance Board (WSIB): The workplace compensation board for provincially regulated workplaces in Ontario, Canada. It is an independent organization, mandated by the government, that provides indemnification of work-related physical and mental health injuries through loss of income and medical and rehabilitation benefits

Help-Seeking Behaviours of Individuals With Workplace Mental Health Injuries

Introduction/Background

Mental health issues are a significant burden to individuals, the workplace, and society. The personal toll on those affected by mental health issues can be both psychosocial and economic. Psychosocial strain can be great as these individuals are often met with stigma, discrimination, and suffer from feelings of shame and alienation (Rüsch et al., 2014). Changes in behaviour as a result of depression, anxiety, or mood related disorders can negatively impact both the individual and their families (Smetanin et al., 2011). Chronic stress can also affect physical health through immune response and inflammation, leaving the individual more susceptible to a range of conditions (Dhabhar, 2014).

Finding solutions to minimize the personal and financial impacts of mental health issues is not an easy task as help-seeking behaviour for mental health issues is complex and is influenced by many factors. Therefore, it is important to increase our understanding of help-seeking behaviours so that systems, processes, and regulations can be adjusted to ensure individuals have the best possible chance to both discover and access appropriate care. Because of the importance of help-seeking to recovery, researchers have focused efforts on the barriers and facilitators to help-seeking for mental health issues, in general. In a survey conducted by the World Health Organization to identify barriers to mental health treatment, 63,678 people were interviewed face-to-face across 24 countries (Andrade et al., 2014). Low perceived need for treatment and a preference to handle the mental health issue on one's own were found to be common barriers to help-seeking for mental health problems and a perception that treatments are ineffective or negative experiences with the treatment providers contributed to treatment dropout.

Stigma towards mental health issues is prevalent in today's society and can influence help-seeking behaviour for individuals with mental health illnesses. Recent systematic reviews

indicate that stigma towards mental health is a key barrier to help-seeking as both public and self-stigma create embarrassment and a fear of being labelled as an individual with a mental health illness (Clement et al., 2015; Schnyder et al., 2017). Studies such as these facilitate a greater understanding of the behavioural processes and environmental influences that impact help-seeking for mental health issues.

Workplace stress is gaining the attention of researchers due to its increased prevalence and negative effects on individuals and society. Negative personal economic outcomes that can be linked to chronic workplace stress include increased injury rates and higher healthcare expenditures (LaMontagne et al., 2012). In addition to negative economic outcomes, stigma associated with mental health issues can bring social exclusion, loss of status, and lower employability (Nogues & Finucan, 2018), which in turn can further increase stress for these individuals as their livelihood and self-identity is placed in jeopardy. Therefore, it is imperative to find ways to support help-seeking for individuals with mental health injuries to help ease their burden.

The modern workplace is demanding, creating an environment that may result in a steady increase in workplace mental health injuries (WMHIs), increasing the already staggering costs to the affected individual, the workplace, and society. Presenteeism, which is a loss of productivity by employees still coming to work due to struggles with a mental health illness, is an indicator that there may be a gap in the way we support individuals with WMHIs. These individuals may struggle silently as they try to maintain a sense of normalcy and protect their income. Further, individuals who experience WMHIs may be underserved due to systemic obstacles, stigmas, unnecessary help-seeking complexity, and workplace power imbalances, resulting in a lack of trust in social support systems and workplace supports. Employers are investigating ways to

improve the work environment to reduce presenteeism and absenteeism and to attract and retain top talent.

In the workplace, chronic stress can contribute to employee retention issues, which can also have financial ramifications to employers. This can include recruitment costs, time lost to interviewing candidates, reduced productivity during new hire onboarding/training, and costs of reduced morale due to sense of loss and temporary increased workloads amongst teammates (Zaheer et al., 2019). Not only are there costs associated with employee turnover, but there are also costs associated with employees that try and maintain their job while experiencing symptoms after sustaining a WMHI. Just as presenteeism affects the individual, Strömberg et al. (2017) estimated that the average cost of presenteeism to employers is 198 Euros (~292 Canadian dollars) per day plus the employee's wage. Strömberg et al. further notes that the cost is increased or decreased based on the employee's position within the workplace (e.g., individuals that have greater effect on the business operations have higher costs for presenteeism) and that this cost is seldom recognized by employers. Research also suggests that there are more workers absent from work because of stress and anxiety than from physical illness or injury (Goetzel et al., 2018). In fact, absenteeism, resulting from common mental health disorders, has steadily increased for several years and one third of workers reported chronic work stress as the cause (Lemieux et al., 2011). Addressing these costs could result in significant improvements to the financial performance of an organization.

The economic burden of mental health issues on society is significant. Globally, mental illnesses are estimated to have cost $1 trillion (USD) in lost productivity in the year 2017 (Gray et al., 2019). The World Health Organization predicts that within the next decade common mental health illnesses, such as depression and anxiety, will be the leading cause of disabilities

(Fikretoglu & Liu, 2014). Researchers estimate that two out of nine Canadian workers are affected by mental health issues that are significant enough to impact their productivity (Nogues & Finucan, 2018). Further, it is estimated that mental health related issues in the Canadian labour force costs $21 billion (CDN) annually in lost productivity (Wilson et al., 2016). An estimated 500,000 Canadians miss work each day because of some type of mental health issue (Boyer & Howatt, 2015). For these reasons, it is apparent that all stakeholders, including the individual, the employer, and society as a whole, stand to benefit by first understanding and removing barriers to help-seeking for WMHIs and then creating appropriate supports and processes to facilitate timely access to appropriate treatments.

The modern workplace environment has resulted in an ever-increasing prevalence of chronic workplace stress and the power-dynamics that are present in the workplace may influence help-seeking behaviours in ways that are unique to that environment. Further, some existing workplace solutions to WMHIs unintentionally created greater challenges for the individual with the WMHI while they are already in a vulnerable state. Therefore, research is needed to understand how help-seeking for mental health injuries that are sustained in the workplace may differ from help-seeking for mental health outside of the workplace. The present study aims to gain a better understanding of the personal and environmental influences on help-seeking behaviour for individuals who have experienced a WMHI by examining their lived-experiences. This included an investigation into the personal thoughts and feelings of individuals with WMHIs and their relationships with other stakeholders and supports. Secondarily, this study sought to identify barriers and facilitators related to help-seeking to make recommendations to improve practice. Finally, the goal of this research was to take what is presently known about help-seeking behaviours and investigate how help-seeking behaviours for WMHIs is influenced

by the interaction between the person and their workplace environment. Through identifying and understanding the internal, external, and environmental influences on help-seeking for WMHIs, we can better shape policies, procedures, and workplace practices to improve ease of access to services and supports and perhaps inform improvements to workplace environments to help mitigate the effects of the chronic stress found in the modern workplace.

Literature Review

Mental Health in the Modern Workplace

Work is a central part of most people's lives as much of our waking hours are spent contributing to the workplace. Many individuals' self-identities are largely shaped by their profession and employment through knowledge, skills, values, and self-esteem. Therefore, a reduced ability or complete loss of ability to perform at work because of mental health illnesses may negatively affect one's professional and self-identity. Research has indicated that workplace stressors put pressure on self-identity which, in turn, threatens the individual's schemas (Buch & Andersen, 2013) so attention must be given to measures that help mitigate the negative effects of workplace stress.

The rapidly changing workplace environment may be further impacting the well-being of some workers by subjecting them to unprecedented cognitive loads. In developed countries, the workplace has moved away from manufacturing and more towards office work. According to a Pew Research Report (2016), modern day jobs increasingly require higher-level social or analytical skills, or both. Interpersonal skills, critical thinking, writing and communications skills are amongst the most important skills for the demands facing the modern workforce and the demand for higher education, bachelor's degree or higher, has increased from 17% to 33% from 1980 to 2015. Conversely, jobs requiring physical or manual skills, which were prominent 30

years ago, are decreasing. In fact, occupations requiring social skills, such as interpersonal, communications or management skills, increased 83% from 1980 to 2015, while critical thinking skills and computer use increased by 77% over the same period. This represents a marked increase in cognitive load for today's employees, which can potentially result in increased reports of workplace related stress and WMHIs.

The research on modern workplace stressors is compelling. Workplace stressors now fall into two categories: psychosocial or physical (LaMontagne, 2012). Psychosocial stressors include high workplace demands, low autonomy or decision making, job insecurity, bullying, and harassment. Physical stressors include things such as excessive noise and improper ergonomics. All these types of stressors may manifest themselves in psychological injuries including depression, post-traumatic stress disorder (PTSD), and anxiety (Brijnath et al. 2014), which are also the most common WMHIs (Tennant, 2001, McFarlane & Bryant, 2007, Szeto et al., 2013). Costs associated with WMHIs typically outpace those associated with physical health injuries. Disability claims for mental illnesses have been shown to account for 20% to 30% of all disability claims (Lemieux et al., 2011; Scott & Dalton, 2016) and costs for mental health related disability claims are twice as high as physical-related claims (Nogues & Finucan, 2018). Long-term claims have been shown to trigger undesirable secondary effects in the workplace, such as misconduct, conflict, and legal issues (Dewa et al., 2007; Dewa & McDaid, 2011, as cited in Nogues, 2018) which can also affect productivity and profitability. Furthermore, chronic stress has been shown to produce changes in work habits, personality, and lead to job burnout and presenteeism (Anderson & Puluch, 2001; Levin-Epstein, 2002 as cited by Colligan & Higgans, 2006). Presenteeism may be particularly damaging to the individual because, while the employee attempts to deal with the health effects associated with the workplace stressors or traumas whilst

still being subjected to the same stressors or trauma, they can develop a cyclical pattern of injury and reinjury should the workplace environment remain unaddressed. This cycle can be difficult to break and contributes to a building burden that may result in an increase in the severity of the WMHI.

In the modern workplace, environmental conditions such as toxic managers (Brijnath et al., 2014; Goetzel et al., 2018), chronic stress (e.g., relentless demands, increasing workloads) (Brijnath et al., 2014; Dimoff, 2013), constant organizational change, upsets to work-life balance (Dimoff, 2013), or other conditions which exceed the worker's ability to cope with the demand all contribute to the increase seen in WMHI's. Smetanin et al. (2011) warn that if workplace complexity and competitiveness and psychological pressure on the workers continues to increase, the impact of mental illness in the workplace will continue to grow. This provides further evidence of a need to better understand help-seeking behaviours so that psychological pressures can potentially be eased by better facilitating timely access to treatments or supports, which can be important in mitigating illness progression.

Severity of mental illness may increase when individuals do not receive timely help. Delays have been shown to result in worse outcomes for individuals with major depressive and anxiety disorders (Dell'Osso et al., 2013 as cited in Clement, et al., 2015). Conversely, timeliness of receiving treatment has been shown to reduce symptoms of mental health illnesses. Individuals who have experienced severe trauma is a topic that has received significant attention in early intervention research, in hopes of avoiding the development of PTSD. Recent research indicates that behavioural interventions (e.g., exposure therapy) that are administered within 12 hours of experiencing a severe traumatic event may be effective in reducing posttraumatic stress reactions (Rothbaum, 2012). In a study conducted by Rothbaum et al. (2012), 137 participants

with credentials of either a master's in psychology or social work were scheduled to work in an emergency department for twelve hours. After this shift the test group received three sessions of early intervention (within hours of experiencing trauma) which included behavioural therapy while the control group was assessed only. Participants were assessed for posttraumatic stress reactions at four and 12 weeks while depression was assessed at baseline and week four. Results indicated that participants that received behavioural therapy sessions reported less posttraumatic stress reaction and depressive symptoms in the months following than the control group. Studies such as this demonstrate that timeliness to treatment may help avoid the development of chronic mental health disorders. The negative impacts of delaying or leaving mental health illnesses untreated are well documented. For example, in research on duration of untreated depression, Ghio et al., (2015) found that as the duration of untreated depression increased, the likelihood of favourable outcomes decreased. These findings held true for both first and recurrent episodes of depression.

Another way timeliness of treatment influences help-seeking is the individual's likelihood to attend treatment decreases significantly the longer they wait for service. Gallucci et al. (2005) conducted research (*N*=5,901) at a mental health hospital and found that the percentage of missed or cancelled appointments increases linearly with each day between first contact to book the appointment until day of initial appointment. Their findings showed that 12% of patients cancelled or did not show for appointments when provided same-day appointments. This increased to 23% when given next-day appointments, 42% when provided with appointments seven days after initial contact and 44% when the delay in appointments was 13 days. The researchers calculated that, after controlling for other variables, the odds of no-shows increased by 12% per day for every day of delay from initial contact to first appointment.

Workers inherently attempt to adapt to the workplace environment to handle its stressors, however, the continual demand to adapt, caused by the presence of chronic stress, can result in an increased susceptibility to work-related mental health problems (Sisley et al., 2010). Sisley and colleagues discussed the issues of accumulated workplace stress and posited that individuals have a baseline or normal level of stress arousal that they inherently bring with them into the workplace. While at work, these individuals may be subjected to a high-stress incident (e.g., emotional confrontation) which moves the individual above their baseline. If the individual is not afforded the opportunity to fully recover from the stress incident before another stressful event occurs, they continue to remain at an elevated state of arousal. If the days, weeks, and months in the workplace continue to present multiple stressful events (e.g., chronic stress), the individual develops a new "normal" state of stress arousal. This heightened level of arousal makes the individual more prone to an overall decrease in mental well-being. This is further exacerbated for individuals working long hours in a workplace environment with high degrees of chronic stress (e.g., healthcare workers, first responders, etc.).

Type of occupation has been found to play a pivotal role in the prevalence and types of workplace mental health injuries. For example, Canadian first responders (e.g., dispatchers, correctional workers, firefighters, municipal and provincial police, paramedics, and the Royal Canadian Mounted Police) were found to experience high incidence of mental disorders, with PTSD being the most common (Carleton et al., 2018). The frequency of mental disorders for Canadian first responders is 44.5% versus 10.1% for the general population. This disparity may be due to the higher frequency of traumatic event exposure in their employment environment.

In an attempt to address the high incidence of traumatic stress-related WMHIs for first responders, the First Responders' Act (2016) was enacted in Ontario, Canada. This act aimed to

remove barriers for first responders making Workplace Safety and Insurance Board (WSIB) claims for PTSD. WSIB is a public insurance agency, funded by employers, providing financial support for expenses associated with workplace injuries. Research subsequent to this change, which surveyed Ontario correctional workers, demonstrated the need to support first responders as they found high rates of burnout, stress, and depression due to workplace conditions including excessive workloads/shiftwork, workplace violence, and bullying and harassment (Ricciardelli et al., 2020). Further, many correctional workers reported precarious employer relations and self-reported tremendous barriers to treatment, citing benefit coverage, shift work, and wages as the primary barriers to mental health treatments. Such research may indicate that the First Responders' Act does not fully address the mental health needs of these individuals and that the Act may need to be expanded to cover additional WMHIs. To better understand the needs of these workers, more research investigating their help-seeking behaviours is needed.

Companies, and their managers, have a role to play in help-seeking and there is a strong financial reason to support efforts to improve the workplace culture and environment. Supportive managers are key to achieving health and well-being of their employees (Goetzel et al., 2018). Sisley et al. (2010) conducted a literature review when conceptualizing his model for workplace stress. In this review, the Sisley et al. stated that leadership style can influence help-seeking behaviours depending on whether company leadership have an authoritative/coercive style (e.g., used punishment as a motivator) or a transformational style (e.g., promoted openness and inclusion). This may influence the employee's willingness to bring issues to management as coercive managers induce fear whereas transformational leaders promote openness and a sense of belonging. Likewise, if emotional workplace interactions are frequent and widespread, the individual may not feel they have social support within the workplace and therefore need to find

support elsewhere. In a systematic review and meta-analysis, Kuoppala et al. (2008) found that the managers' role in the workplace is related to the well-being of employees and can impact sickness absences. Additionally, in a study by Milligan-Saville et al. (2017) managers (*N*=128) underwent training for mental health knowledge and communication, and results indicated that improvements in manager communication (e.g., regular, supportive, and empathetic communication) played a role in reducing work-related sickness absence. While these results show promise, research indicates that more than one in three workers still worry about the consequences of reporting a mental health injury (American Psychiatric Association, 2019). To respond to this, research is needed that captures the lived-experiences of individuals with WMHIs and the features of their work and workplace that enable and constrain their efforts to be mentally well, including the support they seek when they do not feel mentally healthy.

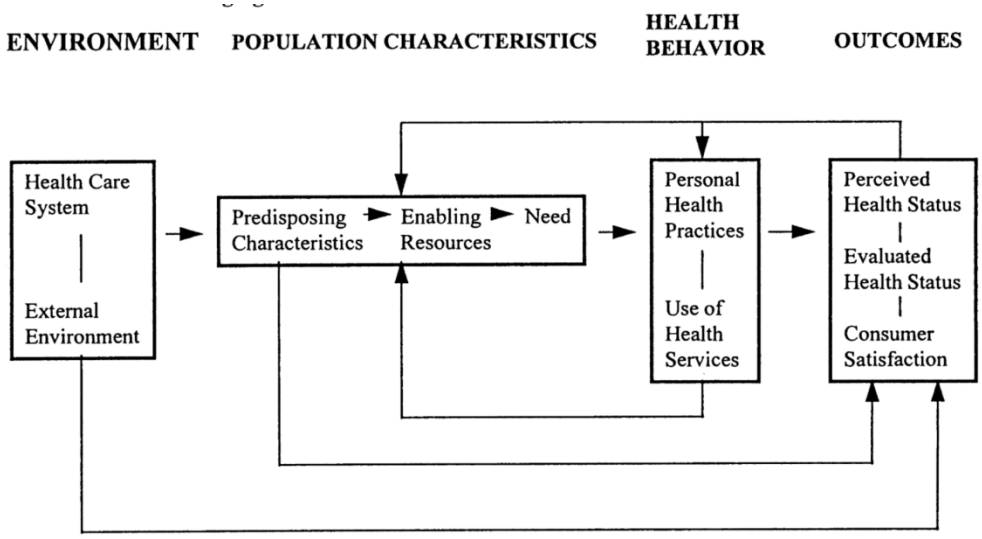
Help-Seeking

Researchers have attempted to create a model in which to better operationalize the complexity of help-seeking behaviors for mental health issues. However, this task is made more difficult as help-seeking is not well defined in the literature. A systematic literature review on help-seeking revealed that there is considerable disparity in both the definition of help-seeking and the way in which it is measured (Rickwood & Thomas, 2012). Past research has focused more on formal help services, rather than informal services, and failed to consistently define what those formal services comprise or to state their definition of help-seeking. A common behavioural model for healthcare help-seeking is Andersen’s (1968) classical model which describes a pathway in the decision-making process for help-seeking starting with predisposing characteristics followed by enabling resources and then need, before moving to seeking help from health services. In 1995, Andersen reviewed his classic model and offered a revised model

(Figure 1), entitled Andersen's Emerging Behavior Model which added more depth to the importance of social networks, social interactions, and culture (Andersen, 1995). Andersen also adjusted his model to include psychological characteristics and genetic factors to account for individuals with mental dysfunction, cognitive impairment, and autonomy. Psychological characteristics, he stated, could explain why someone might behave differently after sustaining a mental health injury than they would before such injury, or after recovering from such injury. Other additions included organizational factors and financial supports within the enabling resources element of the model. Services that provide information on medical care assist the individual in understanding more about types of care and services and, therefore, influence behaviour. Likewise, the presence of financial support or assistance for the treatments or services may remove limitations on what the individual can afford. Andersen asserts his new model is more comprehensive and better represents the dynamic and recursive nature of healthcare use. The revised model includes health outcomes and feedback loops within the model itself. While these additions do make the model more complex, Andersen feels it provides a better overall understanding of health behaviour. Andersen's proposed new model provides an overview in understanding healthcare-seeking behaviours in general and may be useful in understanding help-seeking behaviour for WMHIs.

Figure 1

Andersen's Emerging Behavior Model



Note. From "Revisiting the Behavioral Model and Access to Medical Care: Does it Matter?" by R. M. Andersen, 1995, *Journal of Health and Social Behavior, 36*(1), p. 8. (doi:10.2307/2137284). Copyright 1995 by the Journal of Health and Social Behavior.

While Andersen's model took a narrow view of help-seeking for healthcare services, a literature review from Barker (2007) took a broader approach for defining help-seeking and proposed that help-seeking for mental health problems can be any measures taken by individuals who perceive themselves as requiring personal, psychological, emotional, or social support, care or service, with the goal of meeting this need in a positive way. With this in mind, help-seeking can be viewed as a three-step process wherein the individual must first realize that they have a problem, then accept they need help, and then finally engage in actively seeking help, whether it be from formal or informal supports. Formal support includes professional services, such as medical doctors, psychologists, therapists, and hospital care, while informal support includes assistance from family, friends, clergy, and colleagues.

There are many factors that influence both the individual's propensity to seek help and the type of help they ultimately seek. Researchers still do not fully understand all the variables affecting help-seeking behaviour, but several key elements are beginning to emerge, including demographic, social, and psychological influences. Further complicating the matter is that these variables interact and any of their negative influences on help-seeking can, perhaps, be mitigated by increases in mental health literacy.

Research on individuals with depression has shown that household income, retirement, insurance status, having (or not having) a family physician had no relation to help-seeking behaviours (Schomerus et al., 2013; Slaunwhite, 2015). Increased age, higher education, and social support has been shown to have a positive relation to help-seeking, and the presence of childhood abuse all had a significant positive effect on help-seeking (Schomerus et al., 2013; Fikretoglu & Liu, 2014). Gonzalez et al. (2009) investigated how various demographics influence mental health attitudes and how that can influence help-seeking. Their results suggested that attitudes towards mental health help seeking were influenced by age, race/ethnicity, gender, and education which, in turn, influenced the use of mental health care services. Specifically, lower education did not necessarily mean the individual would not seek help, but rather the help sought was more likely to be generalized, such as seeing an emergency room doctor versus seeing a mental health professional. However, for individuals with college completion, their findings supported an increased likelihood of having a positive attitude towards mental health and increased likelihood of seeking speciality care (e.g., psychologist versus a general medical doctor). This study also indicated that, for 18–34-year-olds, stronger belief in the efficacy of mental health treatments was correlated to likelihood of using these supports. This finding did not hold true for 50–64-year-olds. The researchers attributed this to limited exposure

to mental health care and, therefore, an increased apprehension to use these types of supports. The authors caution that some previous studies found that this group was less likely to take psychiatric medicines and, therefore, suggest that public awareness campaigns should clearly state that help can come in many forms, whether talk-based therapy or medicines.

The attitudes held by society, employers, and individuals contribute to help-seeking behaviour and these attitudes are typically shaped by stereotypes and prejudice. Public stigma is the attitudes and behaviours that people have towards individuals with mental health illnesses and self-stigma is the prejudice individuals with mental health injuries turn against themselves (Corrigan & Watson, 2002). Both public and self-stigma consist of three components: stereotypes, prejudice, and discrimination. Stereotypes are preconceived notions of a group based on past experiences and social norms and, evolutionarily, serves the purpose of allowing individuals to make quick subconscious decisions about the world around them. Unfortunately, stereotypes can lead to prejudice, which is the negative preconceived assessments of an individual from that group. Discrimination is the behavioural reaction resulting from stereotypes and prejudice and can have a very deleterious effect on individuals with mental health issues. In Cheng et al.'s (2017) study, researchers found that self-stigma negatively influences professional help-seeking for mental health issues as it dissuades professional help-seeking for mental health issues. Results, such as these, highlight that not all barriers to help-seeking are external.

Psychological factors are also important in help seeking. In a longitudinal population-based sample of individuals with high levels of psychological symptoms, attitudes toward help-seeking, mental health literacy, and perceived need were shown to be significant predictors of psychotherapy usage and mental health literacy, perceived need and lifetime service use were significant predictors of medication use (Bonabi et al., 2016). Research has also shown that

individuals who have a willingness to seek professional help and those that feel comfortable talking about personal problems with a professional are both significantly more likely to seek that help on an ongoing basis (Mojtabai et al., 2016). These results may help inform practices to improve help-seeking in general, but more research is needed to understand if willingness to seek help and comfort in talking to a work-provided support are dampened because of person-environment interactions specific to the workplace.

Shame is also related to help-seeking with mental illness. A Swiss study surveyed young to middle-aged adults (*N*=8875) using computer assisted telephone interviews to measure attitudes towards help-seeking using predictor variables including shame about a potential mental illness, perceived knowledge of mental health, and satisfaction with their mental health (Rüsch et al., 2014). Results indicated that individuals may associate shame with their mental health illness and, as a result, harbour poor attitudes toward professional help-seeking. In fact, shame, low knowledge, and higher satisfaction with one's mental well-being were shown to be predictors of unfavourable views of professional mental health help. Gonzalez et al. (2009) found that medical patients with emotional issues were more reluctant to seek help as they feared the label of "psychiatric patient". This provides further evidence that attitude and self-stigma are both strongly interrelated and strongly negatively influence help-seeking behaviour and that education may be a key moderator of the effects of negative attitude and self-stigma. However, this "fear of being labelled" needs to be further explored in the context of the workplace to understand if workplace policies, legislation, and company culture reduce this fear, or if internal and external stigmas and attitude exacerbate it out of fear of job loss.

For many, attitudes, stereotypes, and prejudice can be changed by becoming more informed about mental health issues and the legitimacy of them. Mental health literacy is the

knowledge and beliefs one holds about mental disorders and is used internally to aid the recognition, management, or prevention of such disorders (Jorm et al., 1997). In a study conducted by Rafal et al. (2018), college students with low mental health literacy and knowledge also had poorer attitudes towards mental health help-seeking, high self-stigma, and low intentions to seek help. The authors stipulate that if mental health literacy is improved by targeted interventions, then mental health knowledge, beliefs, and negative attitudes could be improved.

Those with high levels of mental health literacy tend to engage in help-seeking for mental health issues more than those with low mental health literacy (Rafal et al., 2018; Cheng et al., 2018). In Cheng et al.'s (2018) study, 1,535 U.S. college students engaged in an anonymous online survey consisting of five measures: depression, anxiety, self-stigma of seeking psychological help, mental health literacy, and attitudes towards seeking psychological help. Further on mental health literacy, Cheng and colleagues (2018) found that higher levels of mental health literacy were associated with more positive attitudes towards help seeking. Therefore, recognition of a mental health issue is the necessary first step in help-seeking and, likewise, failing to recognize the signs and symptoms of a mental health issue results in delayed help-seeking. Increasing knowledge of mental health wellness and the services available to both treat and prevent mental health illnesses is important so that individuals recognize problems early and can begin help-seeking earlier and their peers can recognize and better understand mental health issues, enabling them to provide much needed social support. While these results are from studies focused on college aged participants, they are still relevant to the current study as these individuals will be entering the workforce in the near term, or perhaps are already working on a part time basis.

Trust plays an important role in help-seeking, as individuals with mental health issues are a vulnerable population that often present with feelings of anxiety, fear, and, for those with high degrees of self-stigma, shame. In general, a higher degree of patient-trust in the healthcare system is related to better utilization of services which may result in better health (Ozawa & Shripad, 2013). To better understand the influence of trust in mental health treatment, Alire (2019) conducted research on the contributors to therapeutic alliance and whether development of trust during a first therapy session could predict likelihood to return to therapy. In this study, researchers looked to test participant appraisals of a therapist's attributes (e.g., ability, congruence, empathy) and the resulting likelihood of them believing they would return for another therapy session. Participants (N=162) were asked to self-report on propensity to trust and were presented with a vignette of a hypothetical therapist session. Randomly assigned participants were presented with either a vignette with an ethnic match to the therapist or a racial and ethnic mismatch to the therapist. Participants were then asked to self-report their feelings of relationship to therapist, assessment of therapist ability, trust in physician, and feelings about whether the participant believed they would return to therapy with this therapist after their hypothetical first session. Amongst findings on predictors and moderators of trust and trust development, Alire (2019) found evidence that the development of trust in the therapist led to the increased probability to return for additional therapy sessions after the first therapy session.

Another study that investigated patient trust development with health providers employed participants with HIV, as these individuals often require long-term relationships with healthcare providers (Dang et al., 2017). In this study, researchers conducted a longitudinal qualitative study with 21 participants new to an HIV clinic in Texas. Participants were interviewed at three time points; prior to their first visit with their healthcare provider, a second time two weeks after

the first visit, and a final time between six and twelve months after the first visit. Findings included patients describing feelings of anxiety and vulnerability in starting a new relationship with a healthcare provider, first impressions and continuity of care were important to participants and that patients assumed the provider was knowledgeable but were hopeful that the healthcare provider genuinely cared for their well-being. While this study focused on HIV, a physical ailment, the authors draw a parallel to mental health, citing HIV is a stigmatized illness like mental health and, therefore, assert their findings have implications for improving patient experiences for mental health illnesses as well. They further stipulated that patients experienced psychological distress from entering a new relationship with a healthcare provider, experiencing feelings of vulnerability, fear, anxiety, and panic. They posited that stigma is still prevalent in healthcare, and that some providers ask questions that unintentionally assign blame to the patient which ultimately reinforces the feelings of fear, anxiety, shame, and vulnerability. These experiences and feelings of psychological distress could have a negative effect on help-seeking behaviour and possibly cause the individual to conceal their mental health issues.

Help-Seeking in the Workplace

In the workplace, help-seeking is influenced by the addition of multiple stakeholders and unique power dynamics found in most workplaces. For WMHIs, stakeholders include the employer, healthcare providers, and, if applicable, family members but also government and private insurance programs (e.g., employment insurance, WSIB, short and long-term disability insurers, etc.). Insurers bring along additional stakeholders such as case managers, nurses, and potentially employer/insurer selected medical professionals. According to Corbière et al., (2020) the return-to-work process for common mental health disorders is very complex and may include up to eleven stakeholders, spanning from employer to healthcare worker to insurance

stakeholders. However, the input from the health care providers carries particular weight in the readiness for work decision, as their expertise is needed to weigh whether returning to work would be either constructive or damaging to the individual's overall health and whether they have the ability to perform the work (Franche & Krause, 2002). Because of the number of stakeholders, and the differing vested interests involved (e.g., return to work, accommodations), there can be additional stressors placed on the individual with the WMHI and friction on what support is available and how support is accessed.

Stakeholder dynamics are complex and strongly opposing views are often present. Research shows that some stakeholders have concerns related to being taken advantage of. For example, employers may be fearful of being taken advantage of by the employee, insurance companies could be fearful of unnecessarily drawn-out claims and want to reduce or stop paying benefits, and employees may be fearful of navigating the seemingly complex claims process, communicating with busy healthcare providers, or being forced to return to work too soon (Lemieux et al., 2011). For these reasons, the need to communicate effectively and efficiently with one another to assist the individual in rehabilitation and reintegration into the workplace becomes of utmost importance. While important, this may cause additional distress to the individual with the WMHI as fear and distrust issues come into play. Further, the individual is forced to interact with more people and recite details of their injury all over again, which can create even more stress. The information that is communicated from healthcare providers to employers or insurance companies is for the purpose of providing accurate medical background and context to their client’s absence and this information can be difficult to communicate fulsomely, while also maintaining the required confidentiality (Kosny et al., 2011; Reynolds et al., 2006). Similarly, clients knowing that forms are exchanged to other stakeholders, such as

employers, may influence them to not be as forthcoming with their issues out of fear of loss of anonymity, and perceived vulnerability on how disclosed private and personal information will be used. The aforementioned context can then potentially hinder recovery.

Research by Brouwers et al. (2020) found that a focus group, inclusive of people with mental illness, human resources managers, employers, work reintegration professionals and mental health advocates, believed that while disclosure can be helpful to individuals with mental health illnesses, it can also lead to both discrimination and stigma. In sum, the focus group participants believed that if work functioning is either not affected or minimally affected, it is best for the individual's well-being to not disclose to avoid stigma and discrimination. Interestingly, the authors noted that different types of mental health illnesses may yield more positive reactions after disclosure than others (e.g., post-traumatic stress syndrome would be viewed more positively than substance use disorder or bipolar disorder). This could cause anxiety for many individuals with mental health illnesses, as they try to decide how much information, if any, to disclose while worrying about the possible outcomes of doing so. However, without adequate disclosure, insurance companies may push for early return-to-work to reduce costs while the mental health provider continues to prescribe additional time off for the betterment of their client's psychological well-being.

Some employers, out of a need to protect the health of their businesses, may challenge accommodations or feel pressure to expedite the return to work process. Lost time injuries result in higher insurance premiums and workplace accommodations can be costly or difficult to implement or may place undue strain on other employees. However, premature return-to-work or failure to provide accommodations can be detrimental to both the individual and the employer. Research on predictors of recurrent leave, found evidence that supervisor-employee conflicts

resulted in recurrent leaves (Arends et al., 2014). This research used qualitative methods and tracked work disabled employees with common mental disorders (N=158) at 6 months and 12 months after initial sick leave. They found that workers with the highest levels of supervisor social support had the lowest risk of recurrent sick leave.

Individuals with WMHIs may be faced with strong stigma towards mental health injuries from their immediate peers, supervisors, and underlings. Disclosure of mental health illnesses in the workplace has been found to be associated with fear, ambivalence, discomfort, and embarrassment while also bringing the risk of discrimination, victimization, and increased scrutiny (Hampson et al., 2020). Further, the need to conceal the mental health illness created additional stress that could exacerbate symptoms. Brouwers et al. (2020) highlighted another workplace specific issue with disclosing mental health issues, namely discrimination with direct financial implications. Brouwers' focus group participants suggested that, by disclosing mental health illnesses, individuals may get shorter work contracts (temporary workers), lower salaries, or potentially not be hired. While this research did not explicitly state it, companies that are reluctant to hire individuals with mental health illnesses could potentially overlook promotions for individuals already employed that have mental health issues. Because work is a large part of our lives, individuals can be subjected to these conditions on an almost daily basis and, outside of the annual vacation and sick day allowances, they have limited ability to take leave of the pressures, stigmas, and fear of reprisal without taking the risk of disclosing their mental health injury to get medical leave.

Research on physically injured workers in Ontario found that workers had limited knowledge of the claims process, including their rights and responsibilities (Kirsh & Mckee, 2003). Moreover, the WSIB system relies on the employer's participation and willingness to

acknowledge the injury occurred because of on-the-job work activities. For the employer, this system can invoke unanticipated conflicts of interest. For example, employers must choose between their business' financial performance and an individual employee's health due to the costs associated with an injury claim (MacEachen et al., 2010). While the employee can self-report the injury to WSIB, many are concerned about confrontation with their employer about it and fear job loss. This can result in a reluctance to speak up and may lead to increased injury severity. Therefore, research is necessary to better understand how this power dynamic may influence help-seeking behaviour for individuals with WMHIs through the examination of lived-experiences to remove such obstacles to help-seeking.

Legislation, Health Care, and Institutional Supports

Government legislation outlines the minimum requirements on what employers must provide their employees, what the government and its agencies must accept, and what legal rights the employees have in the event their legislated rights are not upheld. The government does provide language to clarify and standardize the definition of mental health injuries. In defining workplace mental stress injuries, Ontario's WSIB states "a workplace mental stress injury is a psychological injury or illness caused by one or more substantial sources of stress at a person's work or by one or more work-related traumatic event" (WSIB Ontario, 2021). This is well aligned with research such as Colligan and Higgins' (2006) which states that WMHIs are typically a result of chronic stress, which is the accumulation of stressors that are both persistent and long-standing. WSIB's definition became the basis, or criteria, by which Ontario's worker's compensation claims are validated and provided employers with a clearer understanding of potential workplace hazards which, in turn, informed the creation of appropriate workplace policies, procedures, and awareness training. The progress to date is encouraging, however, the

effectiveness of the current services, legislation, and policies regarding help-seeking behaviour for WMHIs needs to be better understood so that current regulations can be adjusted if gaps exist.

There are laws that exist to ensure workers have a safe environment to work in. The Ontario Health and Safety Act, for example, governs the rights and responsibility of all parties in the workplace regarding workplace hazards (Government of Ontario, 2020). However, there can be gaps in how mental health injuries are treated and interpreted under the legislation, in comparison to physical health injuries. Mental health issues can be more difficult as they are deemed invisible injuries and harder to establish as being directly caused by a workplace incident or workplace factors/environment. Employers should be aware that when an employee notifies them of a work-related mental health issue, it should trigger an investigation (White, 2019). The employer must be careful not to ignore the complaint because, if the employer dismisses the worker after being notified of the worker's potential WMHI, they are at risk of being found to have discriminated against the worker, even if the worker cannot prove the actual injury. The employer may request documentation to validate the claim and that the injury meets the definition of a disability as set out by Crowley v. LCBO, 2011 HRTO 1429. This definition states that "there needs to be a diagnosis of some recognized mental disability, or at least a working diagnosis or articulation of clinically-significant symptoms, from a health professional in a report or other source of evidence that has specificity and substance." Upon receiving this confirmation, it is then their responsibility to implement the prescribed accommodations, provided these accommodations do not create undue hardship.

While workers have the right and responsibility to identify hazards under this legislation (Government of Ontario, 2013), mental health hazards are not always as visible as physical

health hazards and remedies aimed at addressing those hazards may not be as direct or obvious. Further, not all workers or employers realize that mental health hazards may be covered by the Ontario Health and Safety Act. For these reasons, current legislation has been largely ineffective at protecting workers from mental health hazards in the workplace.

Canadians have several healthcare options available to them in the public health system. These services include various forms of psychotherapy, medications, and interventions and range in effectiveness. However, in Canada, access to mental health services has traditionally been very poor. According to the Canadian Institute for Health Information (2021), more than half of Canadians wait more than a month for community mental health counselling, and one in ten Canadians wait more than four months. In New Brunswick, Canada, one in ten wait up to 260 days for their first appointment. However, family medical practices teams have attempted to help bridge this gap by implementing health teams that, in some instances, include social workers.

In Canada and the U.S., workers who incur a “lost time” workplace physical injury have access to a relatively well-known system, namely workers’ compensation, which ensures they receive some compensation during their time off, as well as access to appropriate treatment. The sole purpose of the WSIB is to administer financial and rehabilitation support for people who have experienced a workplace injury or illness. In May 2017, the WSIB updated their policy to allow for claims related to workplace-caused chronic stress (WSIB Ontario, 2017). In severe cases, claimants are provided with a support team which includes a case worker, a nurse consultant, and an occupational therapist (WSIB Ontario, 2017). The WSIB covers 85% of employees’ take-home pay until the employee is able to return to the workforce or until they reach age 65. In Ontario, common mental disorders are typically not covered by this insurance, unless they are a direct result of a workplace trauma or, more recently, chronic workplace stress.

This is thought to be because common mental disorders are not readily apparent, nor easily linked to workplace issues (Kosny et al., 2011; Lemieux et al., 2011).

In Canada, some workers are fortunate enough to have employer or privately funded insurance policies, known as extended health coverage. Disability insurance provides workers with financial assistance when individuals find themselves in a situation where it is difficult or impossible to work due to mental or physical illnesses or injuries. These benefit plans may include short-term and long-term disability coverage. Short-term disability is used for employees who require time off work for illnesses or injury for one to three months, with the timeframe varying between employers or private benefit packages. Employees with these benefits can submit short-term disability claims for varying levels of financial support, typically 40-70% of pre-disability pay, during their absence from work (Paychek Inc., 2021). Once an employee has reached the maximum allotted time of short-term disability, they may be eligible for long-term disability, which typically pays 50-80% of pre-disability wages. This provides income replacement, at a proportion of pre-disability income, but is often for a maximum of two years (Government of Canada, 2017). After that, entitlement to benefits drops from “disabled from own occupation” to any occupation the individual could reasonably perform given their education, training, and experience.

Some workplaces, such as first responders, may have in-house, peer-support mental health workplace programs. Peer-support programs typically employ co-workers, who have had similar experiences, to provide support and referral assistance and help first responders with WMHIs towards recovery (BC First Responders' Mental Health, 2021). The purpose is not to replace professional services, but rather to supplement them by providing informal listening, mentoring, or peer-support to those that are experiencing difficulties (Conat, 2020). Research is mixed on

the effectiveness of in-house programs in terms of reducing mental health injury severity and impact, or avoiding lost time due to mental health injuries. Rikkers and Lawrence (2021) found low use and usefulness for in-house programs amongst Australian firefighters, acknowledging that their findings are in contradiction to previous research on this population. Nogues and Finucan (2018) reported similar findings, with median participation in workplace programs of less than 50%, with workplace stigma or reluctance to disclose the issue in the workplace being suggested as the primary reasons for such low participation levels. The low participation in workplace programs highlights a need for research to help us understand why these workplace supports are underutilized.

Many workplaces also have employee assistance programs (EAP). EAP programs often provide a small number of visits with a counselor (typically a social worker) along with referral programs to help individuals find an appropriate mental health service provider in their area. However, the EAP service ends there. There is no additional coverage for visits to the referred mental health service provider. Research suggests EAP programs can be effective, but a literature review of this research indicated that many of these studies were based on US populations and were related to drug or alcohol claims and, therefore, cannot be generalized to broadly based mental health counselling (Arthur, 2000). Further, many of these studies lacked a control group, or failed to investigate the long-term effects of the program. Alternatively, while costly, all individuals have the option to pay out-of-pocket for counselling services. For some, the cost is prohibitively expensive, for others, they may start down this path but run out of funds before their mental health injury is fully resolved. More fortunate individuals can complete these out-of-pocket therapy sessions until their issue is resolved. Slaunwhite (2015) states that, despite

Canada's universal healthcare system, there still exists significant inequities in accessing mental health treatments.

The Present Study

There has been meaningful research on mental health issues, barriers to treatment, and the cost to the individual, society, and the workplace to date. However, there is more to be done as there remains significant barriers to accessing help for WMHIs. To remove these barriers, more research is needed so that we can better understand how individuals who sustained a mental health injury in the workplace seek help. We must examine the power-imbalances, the uniqueness of the workplace environment (e.g., policies, processes and workplace culture), the numerous stakeholders that are involved, and the ever-increasing shift to higher social pressures and critical thinking skills needed in the modern workplace to determine the effect on help-seeking behaviours. The present study aims to understand the personal and environmental influences on help-seeking behaviour for individuals who have experienced WMHIs by examining their lived-experiences. This includes not only investigating the personal thoughts and feelings of individuals with WMHIs, but also examining their relationships with other stakeholders and supports (employers, healthcare providers, insurers) to determine how these may have affected help-seeking. Secondarily, this study sought to identify barriers and facilitators that these individuals encountered that were related to help-seeking for WMHIs to make recommendations to improve practice. With this knowledge, future researchers can focus on testing improvements to workplace policies and future legislation which may lead to significant improvements in how help is accessed and how workplace environments may be improved to help mitigate the effects of WMHIs.

Methodology

Design

In psychosocial research, qualitative methodology is often used to answer questions about experiences and to discern meaning and perspective from the viewpoint of the participant (Hammarberg et al., 2015). Qualitative methodology provides an in-depth understanding of individuals' rationale and situational experiences (Van den Hoonaard, 2012). Due to the need for foundational knowledge to inform future mixed methods or quantitative research, a qualitative study was employed and designed to gain insights into individuals' motivations, emotions, and behaviours when seeking help for work-related mental health injuries. Ethics approval was received from Trent University's Research Ethics Board on January 10, 2020 (protocol #26024).

Metatheoretical Orientation

This research takes a critical theory approach to identify and highlight the systems, processes, stigma, and power imbalances individuals experience when seeking help for workplace mental health injuries. Critical theory, in contrast with traditional theory, challenges the status quo and strives for equality in society (Asghar, 2013). Max Horkheimer (1982, 244) succinctly defines critical theory as aiming "to seek human emancipation to liberate human beings from the circumstances that enslave them." Critical theory concerns itself with the imbalance of societal power. Adequate critical theory follows three criteria: 1) it must explain the current state of societal inequities, 2) it must discern what action is required to change it, and 3) it must include an understanding of the status quo to be able to critique and inform change. Critical theory takes a humanistic view to pursue reality utilizing more flexible and independent methods than traditional theories, while emphasizing the duty of the researcher to use caution while observing, analysing, and interpreting the data. By examining the lived experiences of the

participants, any inequalities and injustices they experience can be uncovered. As such, a critical theory approach was taken to give a voice for those that have, or will, experience the difficulties with the current system and processes so that existing standards, mindsets, and policies are challenged with a hope positive change will be deduced.

Sampling and Recruitment

Due to the nature of the research questions in this study and the type of information required, purposive sampling was used. Purposive sampling ensured participants met the inclusion criteria of having sustained a work-related mental health injury. Recruitment methods included social media, specifically LinkedIn and Facebook, and physical posters posted in local and the surrounding area businesses. A recruitment poster was designed for the purpose of this study and was used across all platforms to ensure consistency of information. Initial participants were recruited using social media and physical posters. Snowball sampling (generating participants through referrals from previous participants) was, in effect, employed as some participants forwarded the social media link to friends that they believed may be interested and eligible to participate. Resulting potential participants reached out directly to the primary researcher or the research supervisor if they wished to participate in the study. Individuals whose mental health conditions arose as a consequence of their work were recruited to inform what the thoughts, emotions, and behavioural processes are involved in help-seeking behaviours for workplace mental health injuries. The present study relied upon self-identification of workplace mental health injuries; no verification of the injury, diagnosis, or workplace relatedness was sought by the researchers from healthcare providers. Inclusion criteria included participants who had or were seeking treatment for their problem. Furthermore, participants were eligible regardless of whether their experiences were within a private or public insurance setting or if any

or all help-seeking activities were self-funded. Participants' employment status was also not considered as an eliminating factor for participation in this study. Participants were excluded if the mental health injury was a result of a workplace physical injury. Further exclusion criteria included workers with mental health illnesses or injuries not originating in the workplace.

Instrumentation

The interview protocol, found in Appendix A, was used as a guide to conduct the interviews and helped ensure the interview stayed within the confines of the study. The interview protocol took an exploratory and semi-structured approach to attain a holistic view including the workplace experience leading up to injury, the injury itself, the help-seeking process, and, where applicable, any remedies or mitigation. A literature review of help-seeking behaviours for individuals with mental health illnesses, as well as a review of the current regulatory, insurance options, and return to work literature informed the development of the interview protocol. This resulted in three focus areas: help-seeking behaviours, the insurance process, and stakeholder relationships and involvement. The interview protocol evolved throughout the data collection process, as new questions emerged from previous interviews. In particular, the individual's perception of recovery and their understanding of their injury emerged as an important feature of the trajectory of help-seeking behaviours and was added to the interview protocol. However, the three focus areas of help-seeking behaviour, insurance process, and stakeholder relationships and involvement remained consistent.

The 21-item Depression, Anxiety, and Stress Scale (DASS-21) (Appendix B) was used to assess normative data across the group. DASS-21 is an adapted version of the original 42-item Depression, Anxiety, and Stress Scale which was developed using a sample of 504 student participants and then normed on a sample of 1044 males and 1870 females between the ages of

17-69 years old withing varying occupational backgrounds (Lovibond & Lovibond, 1995). This scale has been found to be reliable in assessing depression, anxiety, and stress with internal consistency reliability $\propto$s = .91, .80, and .84, respectively (Sinclair et al., 2011). Due to the length of time needed for interviewing and the DASS-21's reported reliability, the shortened questionnaire was deemed suitable. The scale includes seven statements for each category, such as "I could not seem to experience any positive feeling at all" (depression), "I was worried about situations in which I might panic and make a fool of myself" (anxiety), and "I tended to over-react to situations" (stress) (Lovibond & Lovibond, 1995). These statements are placed in random order to which individuals responded to using a scale of zero to three on how much they felt that statement applied to them over the past week with zero being it did not apply to them at all and three being it applied to them very much or most of the time. Depression, anxiety, and stress are scored into five resulting categories: normal, mild, moderate, severe, and extremely severe.

A separate section in the questionnaire (Appendix C) was used to collect demographic information (age range, gender, and level of education). The questionnaire also asked about their diagnosed mental health disorder and any treatments received (current or past), how many WMHIs they sustained, and other relevant information to their workplace mental health injuries, such as their employment status and current occupation. The questionnaire was provided to the participant after obtaining consent and prior to the start of the initial interview.

The consent form (Appendix D) described the purpose and focus of the study, confidentiality, that their participation is voluntary, and risks and benefits of the study. A high-level verbal overview was given to certain topics in the consent form including: study purpose, confidentiality, time requirement for participation, and rights to withdrawal to ensure informed

consent was given. Participants were then given time to read, ask questions, and sign the consent form. This study was approved by the Trent Research Ethics Board (protocol #26024).

Procedure and Data Collection

Data was collected between January 15, 2020, and April 6, 2020, and included both the initial interview and the four-week follow-up interview. Meetings were scheduled at the participants' convenience and participants were provided with several options of location of interview including: Trent University, Fleming College, their home, or through video conferencing. These options were suggested to provide a private, confidential environment so that participants felt comfortable during the interview. All participation in the study was consensual and voluntary.

Participants were first screened to determine whether they meet inclusion criteria. After eligibility was confirmed, a date and location for the interviews were selected. Because participants were recruited from across Ontario, some participants could not practically be met face-to-face. Virtual interviews were conducted through Zoom Video Communications Incorporated's online video conferencing software. Prior to the start of the semi-structured interview, all participants were presented or emailed a gift card of their choice, which was preselected by the participant. For in-person interviews, participants were given a paper-based consent form. Participants being interviewed through video conferencing were emailed the consent form prior to the interview to review and sign. All participants were provided a verbal overview of the consent form prior to starting their interview and were asked if they had any questions or concerns. In-person interview participants were then provided a short, paper-based demographic questionnaire as well as the DASS - 21 questionnaire. These documents were sent via email to participants that were interviewing remotely prior to the meeting. Data was then

collected through face-to-face (n = 10) and web-conferencing (n = 2) semi-structured interviews using an interview protocol (Appendix A). During all initial interviews, the primary researcher used the interview protocol to guide the conversation. Discussions occurred on and surrounding the individual's mental health problem and help-seeking to allow for fulsome discovery of responses on the topic. Questions inquired about participants' workplace environment, experiences with the applicable financial support process, and their experiences dealing with other stakeholders in the mental health claim process such as other supervisors, caseworkers, and colleagues. After completing the initial interview, participants were asked if they had anything additional to add. Participants were then provided with both a debrief form (Appendix E) and a verbal overview of the form which included contact information for local and national helplines should they experience any distress after leaving the interview. Finally, participants were asked if they would like a copy of the transcript for their records. Initial interviews ranged from 42 to 93 minutes, depending on the participants' availability and experiences.

Follow-up interviews were conducted approximately four weeks later, either in person (n = 1) or over the telephone (n = 10), to confirm impressions and notions from the initial interview and for any updates regarding the participants' circumstances with their work-related mental health injury. Follow-up interviews were used to increase rapport and provide participants the opportunity to reflect on the previous interview and expand on prior answers by prompting the participant to recall previous answers to confirm impressions and notions. The follow-up interviews also provided an opportunity for member checking. Member checking, or participant validation, is important as it allows the researcher to verify the credibility and accuracy of responses from the initial interview (Birt et al., 2016). Participants 1 through 11 completed all assessments. Participant 12 was unable to complete the follow-up interview due to increased

work demands because of their occupation type being in high demand during the coronavirus disease (COVID-19) pandemic. Follow-up interviews ranged from 14 to 58 minutes.

Data Analysis

In the present research, analytic pluralism was selected, combining interpretative phenomenological analysis and thematic content analysis. Interpretative phenomenological analysis provided a framework to deeply explore lived experiences and thematic content analysis ensured critical interpretation of the data collected and a systematic organization of emergent patterns. Interpretative phenomenological analysis was chosen as it offers a flexible approach to phenomenological research and enables the researcher to hear and understand, in detail, the lived experiences of the participants (Pringle et al., 2011). The implications for this present research are that this framework supported a means to obtain a greater understanding of the help-seeking experiences of participants and their interactions with systems, processes, and policies. To analyze the resulting rich dataset, thematic content analysis was selected. Thematic content analysis is a research method which enables the researcher to uncover, organize, and categorize patterns that emerge from the data (Braun & Clarke, 2006). For this present study it was imperative to conduct a detailed analysis of lived experiences so that a deeper understanding of the perceptions and understandings were attained, as opposed to general claims that would add little to the present body of knowledge. Hence, this framework and method were combined to contribute a deep understanding of help-seeking behaviours of individuals with workplace mental health injuries to the current body of knowledge.

Recorded interviews were transcribed verbatim by both the primary researcher and an undergraduate research assistant. All transcriptions performed by the research assistant were reviewed by the primary researcher for accuracy. A thematic content analysis was then

conducted by the primary researcher by reviewing transcripts line-by-line and applying codes using ATLAS.ti 9 Windows software. To ensure all possible codes were exhausted, the primary researcher employed two methods. First, operational saturation was employed, wherein the transcripts were reviewed multiple times until no new codes emerged. Secondly, the progress and variations of codes were discussed with the research supervisor. Finally, when no new codes were discovered, analysis was considered complete.

During the data analysis, a three-step coding approach was employed. These three steps were: open coding, axial coding, and selective coding. During open coding, labels or codes were developed and applied to important specific phenomena within the transcripts. Important single words, thoughts, or meanings were assigned a code. Next, axial coding was conducted whereby each of the codes were organized into meaningful categories. In the final step, selective coding techniques were utilized, which allowed the categories to be aligned to best explain the core phenomenon of interest, resulting in consequential inferences. The result was an organized and detailed thematic grouping of the data, which provided a meaningful view of participants' thoughts, emotions, and behavioural processes for help-seeking after experiencing a work-related mental health injury.

Strategies for Rigour

Credibility

Credibility in qualitative research refers to the level of confidence in the research findings (Korstjens & Moser, 2018). The first step in ensuring credibility of this research was a thorough review of the interview questions, along with all associated probing questions by the primary researcher and the research committee members. The research committee consisted of the research supervisor, who is a faculty member in the Psychology department at Trent University,

and a practicing clinical psychologist with expertise working with individuals who have suffered workplace mental health injuries. These varying backgrounds and perspectives helped ensure credibility of the research. The research supervisor attended the majority of the initial interviews to ensure the primary researcher's probing questions were robust and fulsome. After each individual interview, the primary researcher and the supervisor held debrief sessions to discuss the context and meaning of participant responses and explore potential follow-up questions. These debriefing sessions allowed for rich dialogue over salient points which, in turn, resulted in the development of more robust themes and subthemes.

Dependability

Dependability refers to the long-term stability of the research findings (Korstjens & Moser, 2018). To ensure dependability, researchers must ensure proper care is taken in research design, data collection, and data analysis and interpretation. To establish dependability, a rich interview protocol was developed and vetted thoroughly with the research committee. All suggestions were collected and used to further refine and clarify the interview protocol.

To further ensure dependability, careful attention was given to uniform and fulsome data collection and analysis. Transcriptions were verbatim records of the interviews, minus any identifiers, and were kept for future access as required. All transcription work completed by the research assistant was reviewed and checked by the primary researcher for accuracy. The progress of the data analysis was monitored regularly by the research supervisor and any difficulties or concerns were discussed at that time. Codes were amended and updated throughout the coding process and a type of mind-map, known as a sociogram, was employed. Sociograms helped capture the full story of each participant, as they provided important information and insight into each participant's help-seeking journey. Further, these

sociograms helped visualize the number of and quality of relationships participants had with various stakeholders in their help-seeking process. Participant help-seeking trajectories were also mapped out to ensure a clear and accurate understanding of the narrative. Data analysis continued until no further themes could be identified, therefore theoretical saturation was achieved.

Confirmability

The ability and degree to which other researchers can confirm your findings is known as confirmability (Korstjens & Moser, 2018). To achieve confirmability, the researcher must be diligent in ensuring the interpretation of the findings is clearly derived from the data and not from the researchers' imagination or preconceived notions. To this end, the primary researcher tested codes against the different perspectives of the research supervisor to generate hypotheses and theory driven codes. Research field notes, supervisor-researcher discussions and committee meetings, and reflexivity were used to triangulate on and validate the data. This approach helped reduce bias of the primary researcher and establish consensus on the resulting themes recognizing that bias can never be completely removed in research. Coding was considered complete when convergence of themes occurred.

Transferability

Transferability speaks to the degree to which results can be generalized, or transferred, to a greater context or wider settings (Korstjens & Moser, 2018). The group of participants found in this study helped ensure coverage of age, gender, and occupations to enhance transferability of findings. Common mental disorders affecting occupational function were included. However, this sample was entirely comprised of Caucasian individuals and cannot be applied across other cultures. Owing to the interest of the study, participants in the sample all had experienced

WMHI's and challenges in help-seeking. We cannot assume that this is representative of the population of individuals seeking help for mental health problems, but it does speak to the nature of the issues faced by individuals in similar circumstances. Efforts were made to characterize the sample fully in terms of the nature of problems and their help-seeking trajectories in order that readers could relate the findings to similar situations.

Reflexivity

While reflecting on myself as a researcher, I was cognizant of past experiences that could influence my interpretation of this present study. A recent example was my experience with chronic and severe back pain, which is much like many mental health injuries in that back pain is often considered to be an invisible illness. After several visits to my family doctor, she suggested I did not have any pain or underlying condition. Despite the doctor's opinion, I insisted tests be performed which had an extremely long wait involving extensive travelling to referred specialists. Luckily, the multitude of tests performed uncovered an underlying cause which gave me both validation and a possible path to recovery. Reflecting on this experience, I can better appreciate the difficulty individuals with mental health injuries experience. With regard to mental health injuries, there are often no physical tests that can definitively show the injury and many symptoms are often invisible to others, much like mine were. As such, these individuals need to either have a strong sense of agency or have a doctor that is knowledgeable about and sensitive to mental health conditions. During my experience, I learned first-hand that persistence is often difficult when suffering from pain. I realized how, for some, it could become easy to simply give up, as coping capacity quickly becomes diminished.

When considering what led me to conducting this research it was largely due to my experience working in Human Resources in the public sector. I was hopeful this would be the

type of job where I could help employees enjoy work and their work environment. However, my job focused more on protecting the employer, which at times, came at the expense of the employee. This coupled with seeing friends and family experiencing mental health illnesses and injuries from the workplace resulted in me wanting to understand the barriers for these individuals in their recovery.

To increase reliability and credibility in qualitative research, it is important to be self-aware of biases you bring. By reflecting on my lived experiences and how they might relate to the present study, I was able to recognize my biases and place proper diligence on the analytic process. By employing proper rigour in vetting the research process, codes, and results, reliability and validity of the research was preserved.

Results

Participants

A summary of participant demographics can be found in Table 1. A total of 12 participants were included in this study with women making up two thirds of the sample. Age ranged from 21 to 60 years with most participants between 41 to 50 years. Participants all resided and worked in Ontario at the time of interview; however, one participant sustained their WMHIs while residing and employed in the United States and shortly thereafter moved to Ontario. To describe the sample and to retain anonymity, participant occupations were categorized according to the Canadian National Occupation Classification. Six of the participants worked in the education, law and social, community and government services category (including social work, police officers, and educational assistants). Of the remaining participants, four worked in business, finance, and administration, one in management and one in health.

Many participants self-reported mental health disorders such as depression and anxiety. Some participants had experienced a WMHI that resulted in a diagnosis of PTSD. The majority of participants had a familial history of mental health disorders; however, most participants did not have any pre-existing mental health conditions prior to their WMHIs. Time elapsed since WMHI onset varied amongst participants; however, most participants had experienced their WMHI longer than 1 year ago and only one participant sustained the WMHI within recent months. Most participants had left their employer where they sustained their WMHI at the time of the interviews; only three participants had stayed with their employer.

Most participants were still actively receiving help for their WMHIs. Participants accessed varying types of resources which were categorized into workplace resources, healthcare resources, institutional resources, and personal resources. Workplace resources included individuals within the workplace who may provide guidance in WMHI recovery such as Human Resources or colleagues, as well as programs provided by an employer such as group therapy, employee assistance program EAP or debriefing sessions. Healthcare resources included formal aspects of mental health supports including primary physicians, psychiatrists, and psychologists amongst others. Institutional resources were defined as financial support to aid in mental health recovery and included programs such as Ontario Disability Support Program, Employment Insurance, and short- and long-term disability through the workplace or private benefits. Personal resources were participant's personal networks which were utilized during their help-seeking journey, this included supports such as partners, family, friends, and clergy. Participants that stated they were not currently receiving treatment, all indicated they had received treatment in the past for their WMHIs.

To characterize the sample's mental health symptoms, the Depression, Anxiety, and Stress Scales - 21 point (DASS-21) was administered, and results analyzed using the DASS-21 Scoring and Interpretation (Lovibond & Lovibond, 1995) (Appendix B). Participants were scored and categorized using the cut-off scores recommended by the scale developers. Results are shown in Table 2. To further characterize the sample, a comparison was conducted to a study with a sample of functioning, nonclinical U.S. adults (N=503) using DASS-21 (Sinclair et al., 2011). Sinclair's study found a mean depression, anxiety, and stress result of 5.70 (+/- 8.20), 3.99 (+/- 6.27), and 8.12 (+/- 7.62), respectively. To better compare the present study's sample to Sinclair et al.'s findings, the mean and standard deviation (SD) from Sinclair et al.'s larger sample was used to compute Z-scores for each participant for depression, anxiety, and stress; these are reported in Table 2. The majority of Z-scores were less than 1 SD from Sinclair's mean, with four participants greater than 1 SD for anxiety and stress, and two participants greater than 1 SD for depression. Only one participant in the present study was greater than 2 SD from Sinclair's mean for anxiety and stress. This indicates that, while the present study's participants had experienced a WHMI, they fell within Sinclair's non-clinical population results at the time the survey was administered, noting that the time between WMHI and DASS-21 administration varied by participant and can be found in Table 1. When assessing both the results from the DASS-21 categorization and comparing to Sinclair's nonclinical sample, the sample from this study could be described as distressed and still experiencing symptoms but functioning, whereby they are still seeking help, looking for alternative employment, or other means of functioning.

Table 1

Summary of Study Sample Demographics

ID	Gender	Age	Education	NOCC	Pre-existing MHIs	Family history of MHIs	Causal Incidents	WMHIs Sustained	Time Since WMHIs	Occupational Status
1	Male	41-50	Not reported	Business, finance, and administration	Bipolar	Bipolar	1	Depression, anxiety, mania	1 year	Different job, different employer
2	Female	51-60	College diploma	Business, finance, and administration	No	Depression, anxiety	1	Anxiety, PTSD, insomnia	1 year	Different job, different employer
3	Female	41-50	College diploma	Education, law and social, community and government services	No	Depression, anxiety	1	Depression, anxiety	2 months	Same job, but looking for different employer
4	Male	41-50	Master's	Management	PTSD	Bipolar, depression	1	Depression, anxiety, insomnia, NSSRD	1 year	Same job, different employer

5	Female	41-50	College diploma	Education, law and social, community and government services	No	Obsessive compulsive disorder	9-10	Depression, anxiety, PTSD	12 years	Retrained in new occupation, currently unemployed
6	Male	31-40	College diploma	Education, law and social, community and government services	No	No	1	Depression, PTSD, insomnia	4 years	Currently training in new occupation
7	Female	51-60	College diploma	Education, law and social, community and government services	No	No	1	PTSD	1 year	Left employer, looking for alternate occupation
8	Female	21-30	College diploma	Education, law and social, community and government services	Yes – not specified	Depression, anxiety	2	Anxiety, NSSRD	3 years	Same job, different employer
9	Female	41-50	Bachelor's degree	Business, finance, and administration	No	No	1	Depression, anxiety, PTSD, insomnia	6 years	Different job, same employer

10	Male	41-50	College diploma	Education, law and social, community and government services	No	No	1	Depression, anxiety, PTSD, insomnia, NSSRD	9 years	Different job, same employer
11	Female	31-40	Bachelor's degree	Business, finance, and administration	Depression, anxiety	Depression, anxiety	1	Depression, anxiety, insomnia	2 years	Same job, different employer
12	Female	41-50	College diploma	Health	Not reported	Not reported	1	PTSD	5 years	Same job and employer, with accommod-ations

Note. ID = Participant Number, NOCC = National Occupational Classification Category, WMHIs = workplace mental health injuries, PTSD = post-traumatic stress disorder, NSSRD = non-specific stress related disorder, MHIs = mental health illnesses

*Occupations were classified using the Canadian National Occupational Classification system.

** Participants were asked to self-report mental health conditions as diagnosed by their healthcare practitioner, e.g., physician, psychologist and number of mental health injuries they sustained.

***Causal incidents are participant perceived number of incidents relating to their WMHIs.

Table 2

Summary of Participant DASS-21 Scores and Utilized Supports

	DASS – 21 Scores[a]							
ID	Depression	Anxiety	Stress	Currently Receiving Treatment	Workplace Resources	Healthcare Resources	Institutional Resources	Personal Resources
1	Severe (0.77)	Moderate (0.32)	Extremely Severe (1.43)	Yes		PCP, psychiatrist, hospital, counsellor, crisis support group,	Community services	Partner, family, friends
2	Moderate (0.28)	Severe (0.80)	Severe (0.90)	No	Human resources	PCP, psychiatrist, psychologist, occupational therapist	Workplace insurance & benefits	Partner, family, friends, clergy
3	Severe (0.65)	Extremely Severe (1.60)	Extremely Severe (1.17)	Yes	Supervisor, EAP	PCP, EAP	Workplace insurance & benefits	Family
4	Extremely Severe (1.26)	Normal (-0.16)	Mild (-0.02)	No	Human resources	PCP, psychiatrist, psychologist	Workplace insurance & benefits	Friends

5	Severe (0.77)	Extremely Severe (2.55)	Severe (1.03)	Yes	Colleagues, manager, superintendent, union	PCP, psychiatrist, group therapy, hospital	Ontario Disability Support Program	Partner, family
6	Normal (-0.21)	Severe (0.80)	Moderate (0.25)	Yes	Manager, colleagues, EAP, Critical Incident Stress Management	Psychiatrist, psychologist	WSIB	Partner, family, friends
7	Moderate (0.52)	Moderate (0.48)	Extremely Severe (1.17)	Yes	Colleagues	PCP, psychologist, group therapy	Spousal work insurance, community resources	Partner, friends
8	Normal (-0.21)	Normal (-0.16)	Moderate (0.51)	No	Colleagues, workplace group therapy	PCP, psychologist, group therapy	Employment insurance	Family, friends
9	Normal (-0.45)	Normal (-0.64)	Mild (-0.15)	No	Colleagues, EAP, union	PCP, human resources	Workplace insurance & benefits	Friends

10	Severe (0.89)	Normal (-0.16)	Mild (-0.02)	No	Colleagues, workplace mental health training, human resources, unspecified mental health professional	Psychologist	Workplace insurance & benefits	Friends
11	Extremely Severe (1.74)	Extremely Severe (1.92)	Severe (0.77)	Yes	Colleagues	PCP, psychologist	None	Partner, family, friends
12	Severe (0.65)	Extremely Severe (1.12)	Extremely Severe (1.17)	Yes	Human resources	PCP, hospital physician, psychiatrist, psychologist, occupational therapist, social worker, group therapy	WSIB, in-patient program, work transition specialist, caseworkers, nurse consultants,	Partner

Note. ID = Participant number, DASS-21 = Depression, Anxiety, and Stress Scale, 21-point, EAP = Employee Assistance Program, PCP = Primary Care Physician, WSIB = Workplace Safety and Insurance Board

[a]Categorized according to the DASS-21 scoring scheme as developed by Lovibond and Lovibond (1995b) and evaluated on a normal adult sample (N = 717) (Lovibond & Lovibond, 1995a).

*Individual Z-scores are bracketed in corresponding categories of Depression, Anxiety, and Stress according to the DASS-21 point scale and were calculated using Sinclair et al. (2011) mean and standard deviation of a non-clinical U.S. adult sample.

**Workplace resources were defined as individuals within the workplace who may provide guidance in WMHI recovery. Healthcare resources included formal supports for mental health recovery. Institutional resources included financial support to aid in mental health recovery. Personal resources were participant's personal networks which were utilized during their help-seeking journey.

Themes

Interpretative phenomenological analysis of the interview transcripts revealed three main themes: self-preservation, fatigue, and trust. Results demonstrated how participants engaged in self-preservation as a means of coping through concealing their WMHI as well as distancing themselves from the environment where the incident occurred. All participants discussed experiencing feelings of fatigue, both mental and physical, and described complexity of obtaining resource supports as a contributing factor to this fatigue along with an accumulation of workplace stressors. Results suggest that the complexity in obtaining resources combined with the accumulation of workplace stressors may result in decreased ability in independent decision-making in the participants' help-seeking trajectory. Trust impacted participants' decisions on which resources they chose to access. Specifically, individuals discussed trusting referrals from colleagues who were in similar job positions while some individuals received support programs provided by their workplace but felt concern related to the confidentiality and trustworthiness of these programs. As a result, these individuals did not feel comfortable accessing these programs due to privacy and feeling of resulting reduced efficacy. Participants felt a reciprocal distrust between themselves and stakeholders as they described feeling the need to legitimize their injury, by continually describing their injury and its cause, as well as defending the severity of their WMHIs and associated symptoms. A summary of these results are shown in Table 3. Figure 2 illustrates the inter-related nature of these determinants on help-seeking for WMHIs and are discussed in detail in turn.

Table 3

Summary and Description of Themes and Subthemes

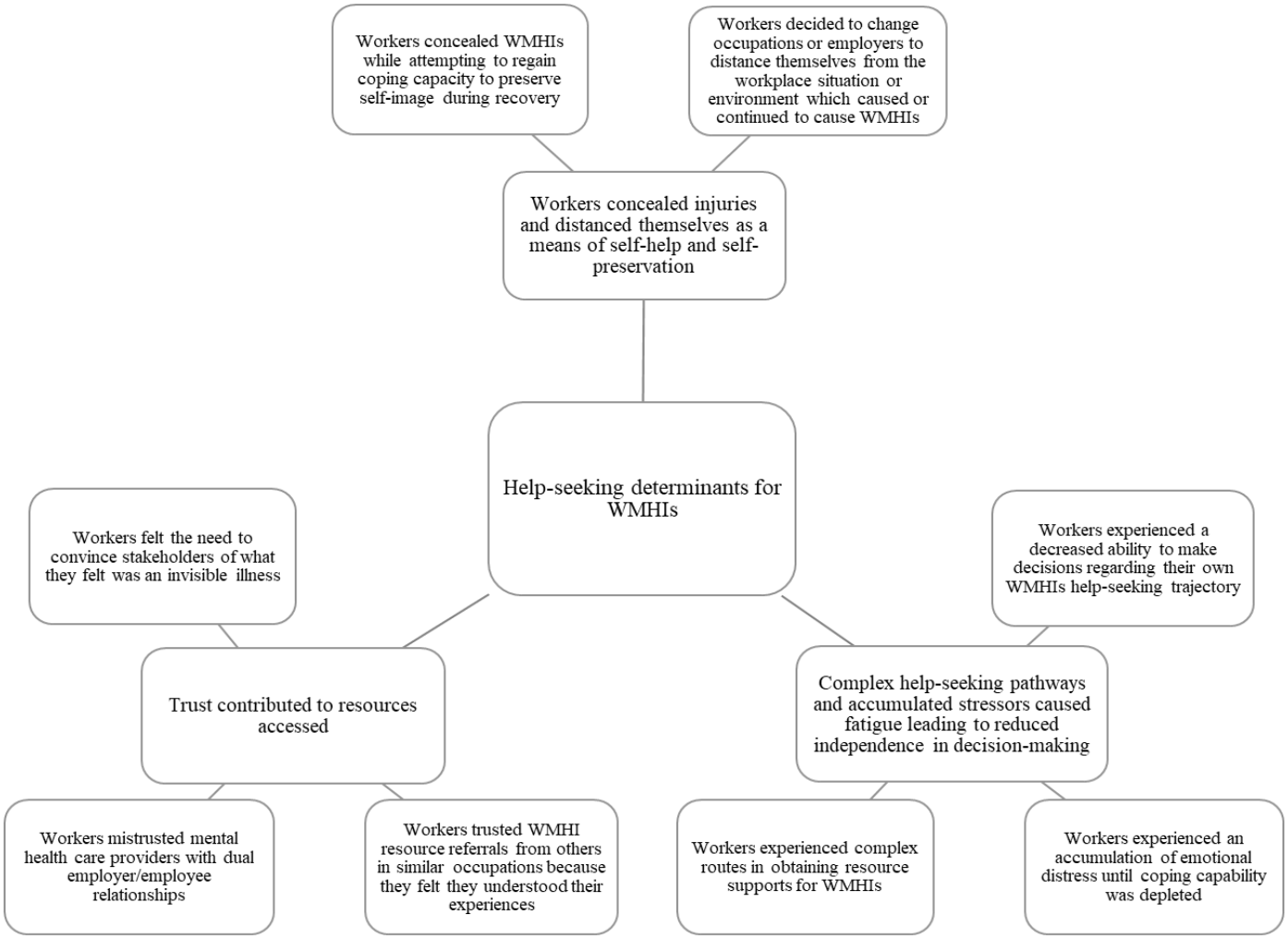
Theme	Subthemes	Description	Participants
Workers concealed injuries and distanced themselves from stressors as a means of self-help and self-preservation.	Workers concealed WMHIs while attempting to regain coping capacity to preserve self-image during recovery.	Individuals used time-off work under the guise of a physical ailment or vacation to regain mental health coping capacity to avoid acceptance of or the label of a person with a mental health issue.	P2, P3, P4, P5, P9, P10, P11
Participants in non-supportive and stigmatizing environments experienced the need to look internally to find strength and strategies in an effort to persevere and overcome the WMHI and associated hardships.	Workers decided to change occupations or employers to distance themselves from the workplace situation or environment which caused or continued to cause WMHIs.	Individuals that decided to change occupations either had previous education allowing them to move to a different occupational field or decided to be retrained in an effort to leave their current occupational field. Other workers decided to leave their employer while remaining in the same occupational field. Individuals felt this was required for mental health recovery.	P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, P11
Complex help-seeking pathways and accumulated stressors caused fatigue leading to reduced	Workers experienced complex routes in obtaining resource supports for WMHIs recovery.	Due to a lack of a prescribed path to resource supports, participants were required to expend significant effort identifying and pursuing resources they felt would help in their recovery.	P1, P2, P4, P5, P7, P10, P11, P12

independence in decision-making. Participants experienced mental and physical feelings of exhaustion as a result of the complexity of obtaining resources and accumulated workplace stressors. This feeling of fatigue resulted in individuals deferring decisions regarding their help-seeking journey.	Workers experienced an accumulation of emotional distress until coping capability was depleted.	An on-going experience of compounding workplace stressors caused diminished coping capabilities resulting in the individual's WMHI.	All participants
	Workers experienced a decreased ability to make decisions regarding their own WMHIs help-seeking trajectory.	Workers experienced a reduced capacity to act independently in mental health recovery decision-making. Individuals unwittingly relinquished decision-making control for resource supports pathways to recovery. This included deferring decisions to physicians, insurance, and colleagues, amongst others.	P2, P3, P5, P6, P12
Trust contributed to resources accessed. Participants felt that reliable and trustworthy resources were best found through individuals who could relate to their occupation. Alternatively, participants experienced a reciprocal mistrust between themselves and stakeholders when trying to access resource supports.	Workers trusted WMHI resource referrals from others in similar occupations because they felt they understood their experiences.	Individuals felt confident in a referee's guidance for mental health resource supports as a result of perceived feelings of relatedness to their job. They felt that the referee had a solid understanding of the context of the individual's situation and needs as a result of their own experiences.	P6, P7, P10, P11 P12
	Workers mistrusted mental health care providers with dual employer/employee relationships.	Participants expressed a lack of trust in the motives of the employer and the employer provided mental health resources due to a perceived conflict of interest. This led to decreased trust, efficacy, and uptake of offered treatments.	P4, P10, P12

Workers felt the need to convince stakeholders of what they felt was an invisible illness.	Participants expressed feeling obligated to continually convince stakeholders of the legitimacy and severity of their mental health injury for the purpose of obtaining access to treatments, workplace accommodations, and financial support. In some cases, individuals were required to continuously describe the incident and answer questions, get supporting doctors notes, and fill out paperwork to convince stakeholders of the injury and resources needed for recovery.	P3, P4, P11, P12

Figure 2

Interconnectedness of Help-Seeking Determinants for Workers with Workplace Mental Health Injuries



Note. WMHIs = workplace mental health injuries

Workers Concealed Injuries And Distanced Themselves From Stressors As A Means Of Self-Help And Self-Preservation

Participants (11 of 12) exhibited an attempt at self-help and self-preservation by concealing or denying their mental health injuries. Initially participants felt that, if given some time to recover, they would be able to gain coping capacity and avoid labels of a mental health injury from themselves and their employer and colleagues. Participant 8 explicitly discussed her belief that if she could just have some time to heal the WMHI when she stated:

> ... I just look at like it's my brain has had some cuts and scrapes essentially, I'm used to in my job using different analogies so you'll have to bear with me but some like bumps and bruises and scrapes but I can continue forward with them like I need time to heal and you know what I mean let them rest and try to heal, there may be a scar there but I'm still kinda continuing on.

This thinking resulted in participants concealing their WMHI as a first attempt to recover without adding additional strain of stigma and labels to their situation.

A commonality amongst most participants was that they distanced themselves from the workplace that they fault caused their injury by changing employers (n = 4) or changing occupational fields (n = 5). Two participants felt that changing jobs but remaining with the same employer was sufficient to aid in their recovery from their WMHI. For some, walking away from their jobs resulted in a decrease or loss of income, but that was considered more psychologically acceptable than further mental stress, complete job loss, or possible permanent disability leave. Participant 4 highlighted the constant stresses of working with a WMHI label when he stated "...you are always worried about your job, what is being said and will they [the employer] in fact find wiggle room to fire you because they're worried you'll take more time off …".

This constant worry creates additional stress during the help-seeking process and further contributes to fatigue and the need to conceal for self-help and self-preservation.

Workers Concealed WMHIs While Attempting To Regain Coping Capacity To Preserve Self-Image During Recovery

Many participants (*n* = 7) used time-off work under the guise of a physical ailment or vacation to regain energy and mental health coping capacity and to avoid self-acknowledgement of mental health issues. Participant 9 discussed her desire to conceal her WMHI as a self-inflicted physical injury when she stated:

> If I can just get through to my vacation, you know, I'll get a nice break and it'll be fine and it just kinda got progressively and progressively worse to a point where, and I tell you this, I said it to my therapist because my therapist was appalled, I literally considered running red lights not so that I wouldn't die but that I would be injured enough so I didn't have to go to work for several months.

Participant 4 also discussed concealing his WMHI and admitted to his own internalized stigma, namely his thoughts that having a mental health injury meant he was mentally weak, which led him to using vacation time to try and recuperate as opposed to taking time off to recuperate.

> I guess I also have a bit of a stigma towards mental health because I certainly feel weaker, having had it ... so it kind of again why I drove myself not to take it, I was just trying to get through the next year to get the vacation up not to admit to myself I needed a break, not to admit to myself I was having a problem that I could fix it myself, um ... yeah that's a blow to the ego for sure.

Participant 10 used an actual physical issue, for which he was accommodated with time off work, to try and recover from his WMHI. In his words, "I was technically accommodated

physically and then I just, for lack of a better word, I piggybacked on to that." Participant 10 was aware of the potential repercussions involved with disclosing a mental health issue, including the loss of personal identity associated with the work role, he stated:

> ...if you start talking about like suicide and you know, marital issues and stuff like that...but we as an industry, we have a big hesitation with any conversation around that because of the self-image and you identify yourself as a cop and if you lose access to your gun, that's the first, you know, it's not even de-masculating, but it's basically part and parcel of your self-image as a police officer, so I think a lot of guys and girls will avoid that conversation and that was the same for me…

Some participants, while trying to conceal their WMHI and resulting symptoms, experienced presenteeism at work, meaning they were still attending work, but they were not completely present nor were they working at full capacity. Participant 1 discussed his experience with this:

> I was still functioning, but I wasn't functioning, so it wasn't like a single moment in time, it was over a period of 3 or 4 months where the stress just kept getting bigger and bigger and bigger and then I walked into work one day and I said "nope that's it", click, locked the doors and walked out.

For the participants that discussed concealing their WMHI to gain pockets of time for recovery, this was largely unsuccessful and, as a result, they felt they needed to employ increasingly drastic self-preservation tactics.

Workers Decided to Change Occupations or Employers to Distance Themselves from the Workplace Situation or Environment Which Caused or Continued to Cause WMHIs

For most of the participants, concealment of the WMHIs was not sufficient for recovery. Hence, most participants (n = 9) switched employers or occupations (n = 2). Some were given the opportunity to switch occupations through WSIB or government social assistance funding for vocational retraining after experiencing a WMHI while others decided they would change employers without institutional supports. To regain control of their mental health, participants described 'escaping' the workplace environment associated with their WMHI. Participant 4 described it simply "...I took a different job to get away…". For Participant 4, he felt the only way to recover was to simply leave the job; "In my case it went away cause I switched jobs, I think I'd probably be back off again at some point if I was still working there." Participant 7 took this a step further and considered leaving the workforce completely, stating "I'm in a position where if we tighten our belt, I can stay home financially", but should she determine she needs to go back to work, she firmly asserted,

> I'm not going back into my field, it's just, it's too triggering, it's too many, for every 10 steps you make forward, I think going back, you'd go back those 10 steps and maybe even more, cause it's my belief that it's harder and harder to get out of it like once you go kind of like back in. Like the bad memories and the nightmares and everything like that. Um, so I'm going to look at going into something else but it's, I mean there are so many unemployed people, right, and I don't know what I'm going to get but anyways, we'll see.

Participant 7 went on to identify possible return to work scenarios, outlining the possibility of accepting a lower stress job at significant financial losses to protect her mental well-being from further damage.

> ...I think I'm going to go into something maybe that realistically doesn't pay what I was making but just something for kind of like gas money and grocery money but also like you have to put a price on your state of mind...

In leaving her job, Participant 7, in a sense, implemented her own mental health accommodation by removing the stressor or triggers that caused or continued to exacerbate her WMHIs. Some participants self-advocated for workplace accommodations, however, they were not accommodated. Participant 8 explained such a self-advocacy experience,

> I had advocated for myself to not be on the floor with that many of them (residents of a youth group home) when they were all struggling. It was like 'this is your job, this is what you signed up for', like really minimizing my feelings and my thoughts.

Participant 4 reported a similar experience of returning to work after a mental health leave and explained,

> … there was a modification to duties because my travel was always last minute, abrupt, so on so forth that the psychologist had written in there that once a month, or twice a month, no, every week for the first month I was not to travel I think it was Fridays so I could attend an appointment and she'd written it in such a way that I was actually supposed to get Fridays off and work did not honour that, they would give me 1 hour to go to the session which was also not possible because it took roughly, depending on traffic, anywhere from 10 to 20 minutes to get to the

> appointment and then 10 to 20 minutes to get back, an hour at the session so you'd need at least a couple hours off and quite frankly after some of the sessions I was kind of wound up and you didn't want to jump back into work and pretend things were fine ... which was why she wrote off having me off for the day but work just didn't honour that … so I just went along and basically didn't go to a lot of appointments because I was travelling on the days I had off or couldn't get enough time off to go so on and so forth so…

Participant's 4 experience demonstrated that, even when prescribed, employers may not always implement workplace accommodations or implement them in a way that renders them essentially unusable thereby inserting an obstacle to the individual's pathway to help or perhaps even putting the individual at risk of further harm.

Participants 9, 10, and 12 were three cases that did not switch employers. However, Participants 9 and 10 did switch jobs within their workplace. After Participant 9 sustained her WMHI, she decided she needed to remove herself from the environment which caused her injury. She felt that this could be achieved through obtaining another job with the same employer but located in a different building. Participant 9 requested a new position within the same pay bracket as her current role from her employer, however, this accommodation was denied. She was advised that she could apply for other positions within the company but there was no guarantee of new job placement. Fortunately, Participant 9 was successful in obtaining another position with the same employer and, as such, removed herself from the situational environment which was causing her mental distress. Participant 10 sustained the WMHI while on a short-term assignment in a third-world country to assist after a natural disaster. As such, he was exposed to numerous traumatic experiences that he was highly unlikely to encounter in Canada. Participant

10 also disguised his mental health sick leave by choosing to disclose only a physical health issue. Additionally, upon return to Canada, he initiated a change in positions due to a physical health issue, wherein he moved to a more administrative role with reduced work-related mental stress. While this position change was not a formal accommodation for the WMHIs, Participant 10 stated the change was beneficial to his mental well-being. Participant 12 received permanent workplace accommodations which entailed moving her from rural work to urban work, where she felt better supported by other first responders and less likely to experience the same type of events which caused her WHMI. She was also supported by WSIB with intensive treatment that afforded her the opportunity to gain treatment that went beyond addressing the single traumatic event that caused the lost-time injury by taking a more holistic approach and addressing all traumatic experiences she experienced during her career. This significant workplace accommodation allowed her some measure of comfort in continuing onward with her career with the same employer, despite her feeling pressure from her workplace for her to resign.

Even with the change of employer, occupational fields, or jobs, the resulting impact of the initial WMHI continued to follow participants into their new jobs as they still felt the need to protect themselves through concealment. Participant 11 discussed what it is like for her in her new job with a new employer:

> It’s good yeah, I like this, the new job yeah it's a lot of the energy is going towards again looking healthy to seem more healthy than I actually am. ...I haven’t disclosed at work that I'm unwell and I’m quite afraid that it might backfire but for as long as I can keep going without disclosing that I’m, I’m going to do that.

While Participant 11 was receiving treatment for her WMHI at the time of interview and had removed herself from the environment which caused the stressors, the impacts and the need for self-preservation appeared to be long-lasting.

Complex Help-Seeking Pathways And Accumulated Stressors Caused Fatigue Leading To Reduced Independence In Decision-Making

Participants (n = 12) recurrently discussed feelings of mental and physical fatigue. Specifically, participants experienced fatigue not only from the work-related mental health problem, but also from the complicated paths to accessing necessary resources as well as multiple and continued workplace stressors that led up to the lost time incident. Results indicate that these resource supports, in relation to mental health help-seeking, can allude to many areas of assistance including mental health assistance, financial assistance, navigation support, and various other means to help an individual achieve a desired goal or outcome. Participant 2 talked about experiencing exhaustion from the WMHI and described this as feeling:

> ...emotionally drained but, yeah it's interesting because people around me don't recognize how emotionally draining it was, they do but when they're not going through it, it's like, oh just come on, just keep going, move forward, keep going.

In other words, Participant 2 experienced a coupled loss of energy and drive. For many of the participants, the consequence of these complex pathways and accumulated stressors was the loss of their independence in decision-making regarding decisions for resources chosen to be accessed.

Workers Experienced Complex Routes In Obtaining Resource Supports For WMHIs Recovery

Participants explored many avenues to get help, but these help-seeking pathways did not always prove to be beneficial. Due to the complexity of paths discussed in participants'

narratives, each participant's help-seeking journey was mapped to help visualize the participants' lived experiences. Both a sociogram (Figure 3) and a trajectory (Appendix F) were developed for each participant to achieve this pictorial view of participant lived-experiences. A theme that emerged from the interpretative phenomenological and thematic analysis, along with the analysis of the sociograms and trajectories, was that individuals were required to navigate complex routes to obtain the resource supports they felt they needed for their WMHI recovery. Sociograms depict participant access to workplace resources, healthcare resources, institutional resources and personal resources. Analysis of the sociograms also demonstrated that there was no singular or prescribed pathway to recovery nor was there commonality between participants on the perceived helpfulness of resources they accessed. Half of the participants accessed over ten resources with reported varying views of helpfulness. For those participants that experienced more straightforward paths, such as Participants 3, 4, 8, and 9, significant effort was still required for them to obtain help as was evidenced by their narratives. This complex help-seeking journey occurs at a time of reduced energy, decreased self-agency, and high stress.

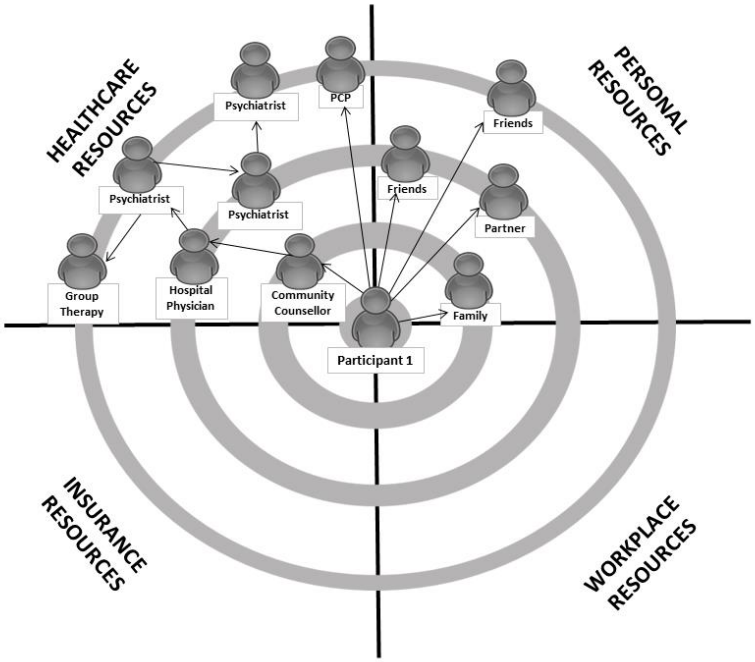
The trajectories shown in Appendix F also present participant-accessed resources, whether they were successful or unsuccessful. Each resource point also includes key details about what occurred during access to that resource such as seeing a physician and what was suggested, prescribed, or provided. These pictorial representations of participant help-seeking trajectories, when viewed together, highlighted that there is no prescribed pathway to treat WMHIs. For some participants, resources were offered but at the time of the interview these resources had not yet been accessed either due to fatigue, timing of the interview, or disinterest or incompatibility with the suggested resource. The trajectories provided a sequential overview of the resources accessed by each participant as well as the outcomes from accessing that resource. While the trajectories

are depicted in a straight line, this is not intended to imply that accessing these resources resulted in participants moving forward in their recovery. In fact, most participants reported an arduous and complex help-seeking journey. Even those that had few points on the trajectory reported difficulty finding or accessing services or healthcare practitioners.

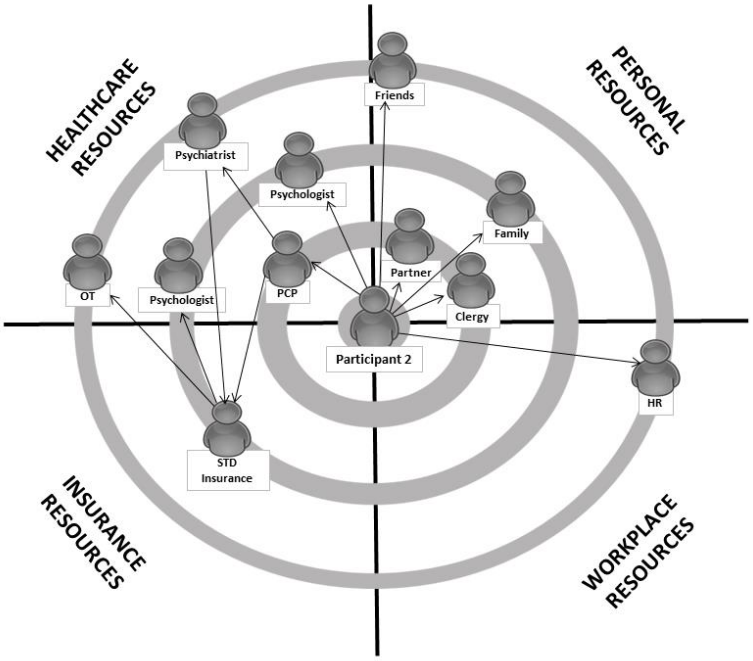
Figure 3

Sociograms of Participant Experiences in Accessing Healthcare, Institutional, Workplace and Personal Support for their WMHIs.

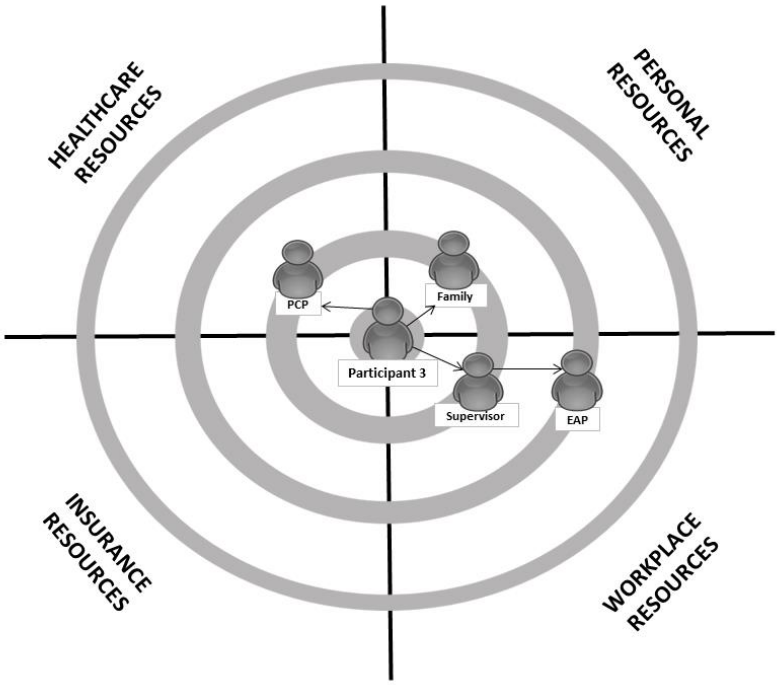
Participant 1 (Male, 41-50, Business, finance, & administration)



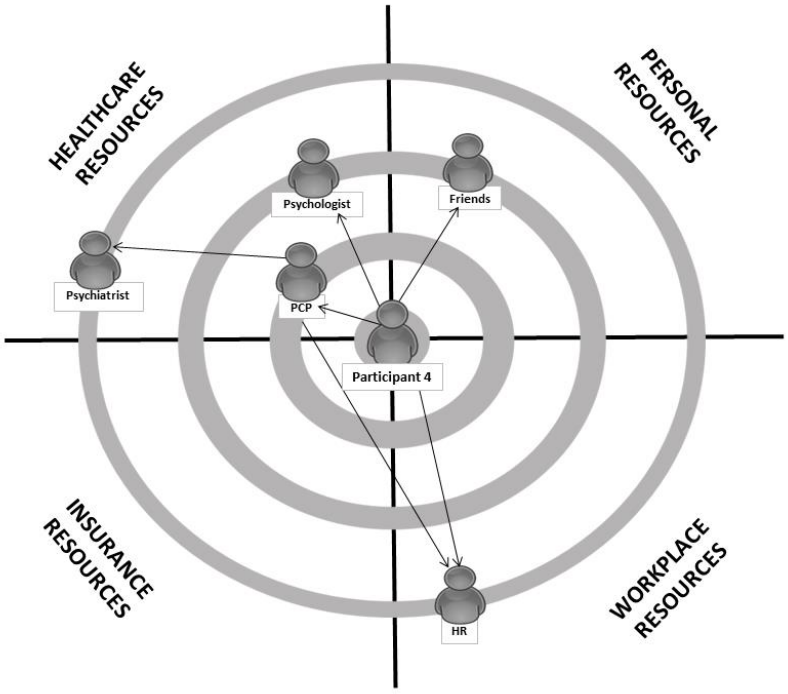
Participant 2 (Female, 51-60, Business, finance, & administration)



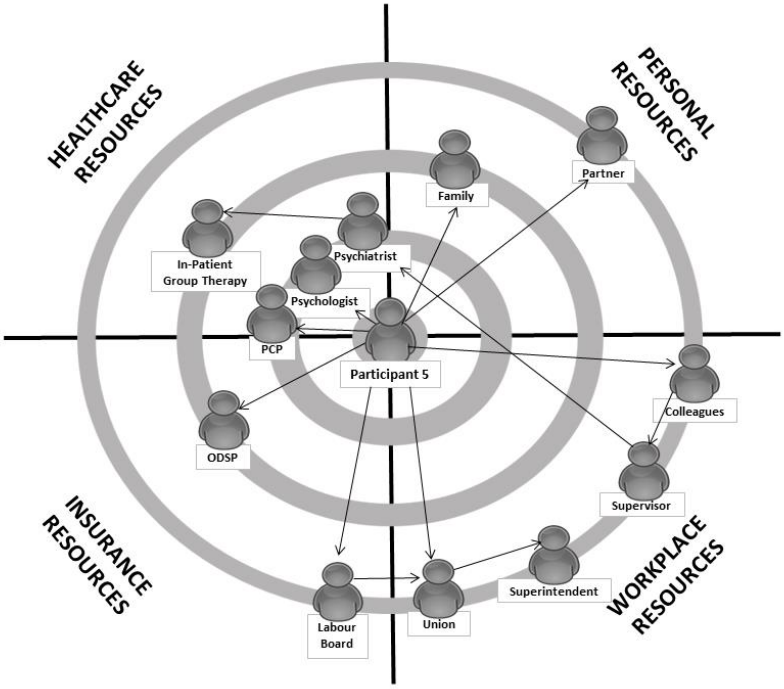
Participant 3 (Female, 41-50, Education, law and social, community and government services)



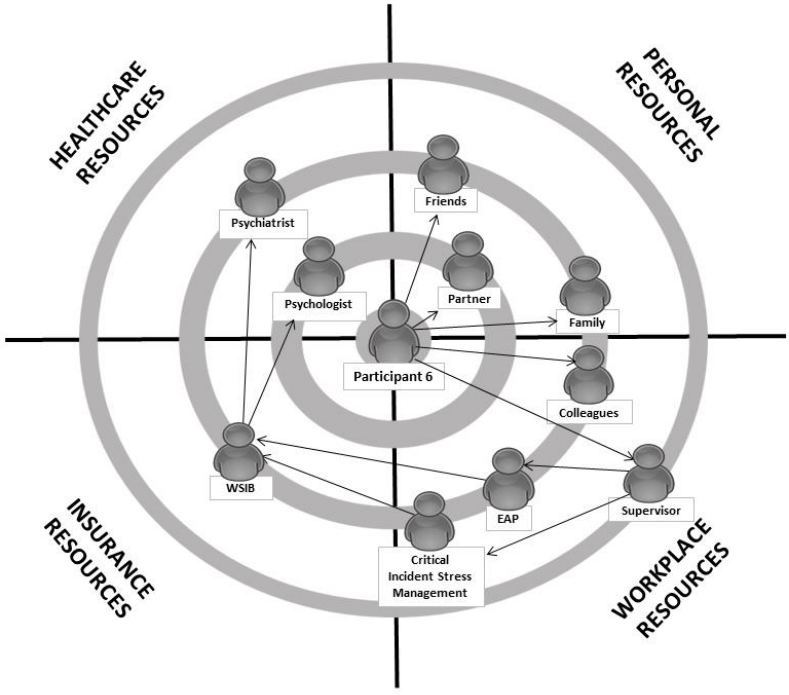
Participant 4 (Male, 41-50, Management)



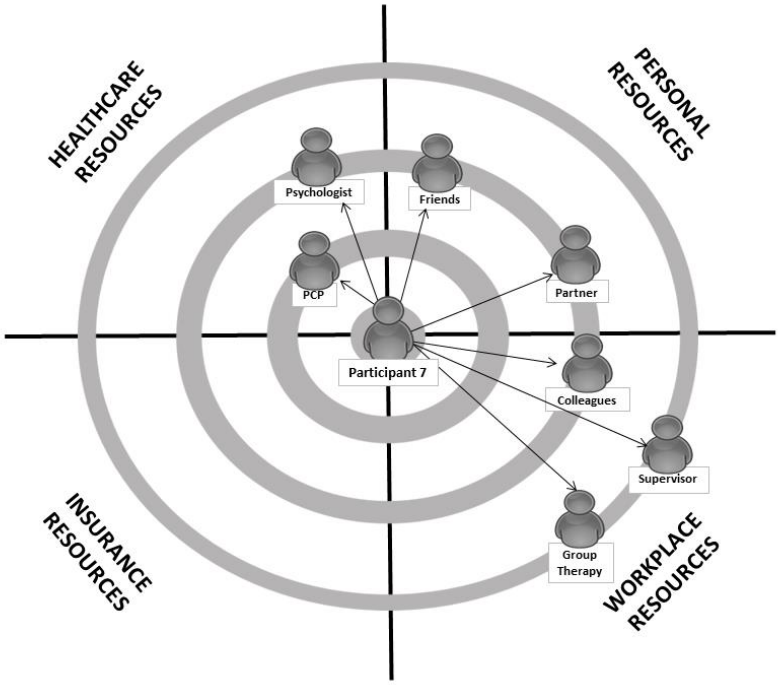
Participant 5 (Female, 41-50, Education, law and social, community and government services)



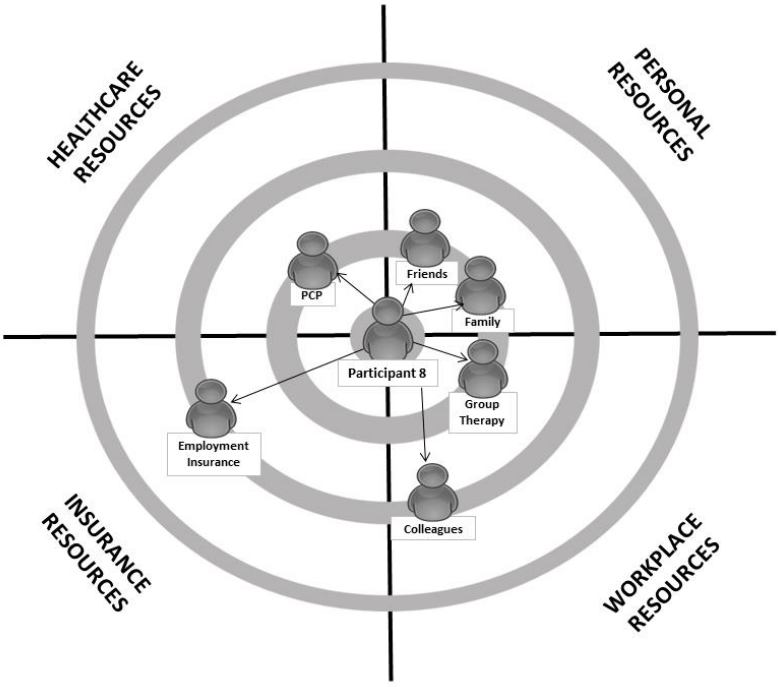
Participant 6 (Male, 31-40, Education, law and social, community and government services)



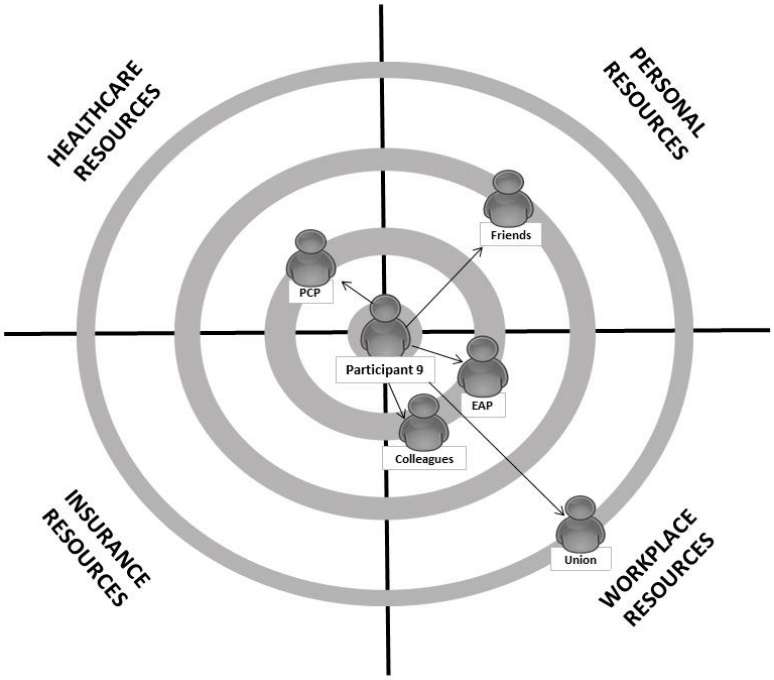
Participant 7 (Female, 51-60, Education, law and social, community and government services)



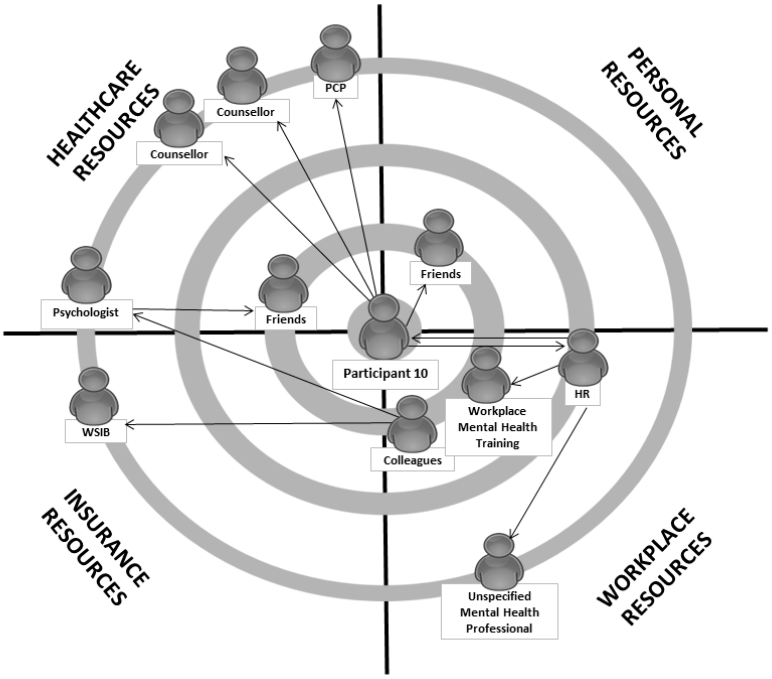
Participant 8 (Female, 21-30, Education, law and social, community and government services)



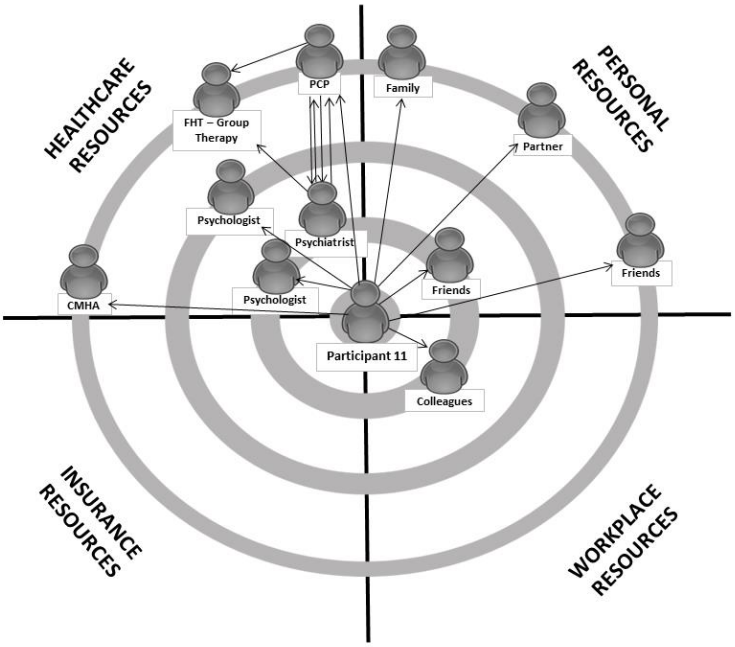
Participant 9 (Female, 41-50, Business, finance, & administration)



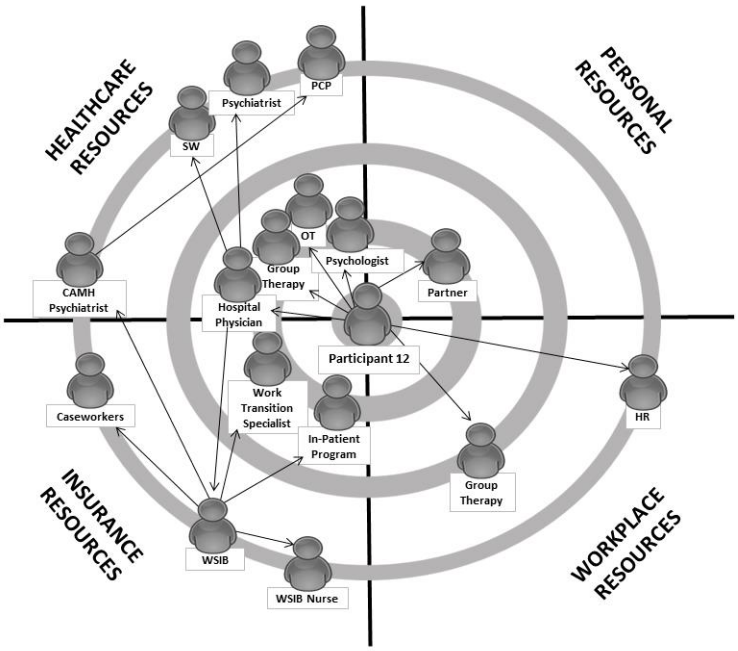
Participant 10 (Male, 41-50, Education, law and social, community and government services)



Participant 11 (Female, 31-40, Business, finance, & administration)



Participant 12 (Female, 41-50, Health)



Note. Rings denote perceived helpfulness (i.e., inside rings, highest perceived helpfulness). Arrows indicate how participants were directed or who referred them to the service.

*PCP = Primary care physician; EAP = Employee Assistance Program; HR = Human Resources; WSIB – Workplace Safety Insurance Board; FHT = Family Health Team; CAMH = Canadian Association for Mental Health; OT = Occupational Therapist; SW = Social Worker; ODSP = Ontario Disability Support Program; STD = Short-term Disability;

In addition to experiencing difficulty in finding help, participants also experienced difficulty accessing the available and suggested treatments. Participant 4, 10, and 11 discussed difficulties in accessing resources because of the times these were offered. For example, Participant 10 discussed how mental health supports in the workplace were scheduled around times that were only beneficial to office administrators, and as a result many of the individuals that worked in the field would not be able to access these workplace resources.

> ...a lot of the workplace health and wellness is designed or borrowed from the corporate world, so the office administrative, it's the same thing with the university staff and you know, the students, you have a bit more of a flexible schedule, a predictable schedule so, people, you know, they can do yoga at lunch, you know, as part of your lunch hour or something.

For Participant 11, some treatments prescribed by primary physicians were only available during regular work hours, thus making it difficult to gain access. This is evidenced during Participant 11's interview when she recalled –

> "…she [primary physician] suggested that I would try, cognitive behavioural therapy group that the family health team has, in where she is practicing, but like it was all during work hours if you are working or if you're studying or doing anything it's impossible to attend that..."

Limiting access to resources in this way adds an additional barrier to recovery for individuals who are not afforded leave from work. For Participant 11, this meant she was unable to attend as time off work was not financially feasible nor supported by the employer. In short, this participant was forced to choose livelihood over mental health injury treatments.

Participant 3 discussed a different barrier to accessing treatment, namely unavailability of appointments. Put bluntly, Participant 3 stated “I was struggling with my doctor being very difficult to get an appointment with…”. This is a significant barrier, as most participants sought out guidance from their primary physician for treatment, resources, or referrals at some point in their help-seeking journey.

Systematic barriers proved to be another barrier to services. When deciding which mental health supports were right for themselves, some participants found themselves on the wrong side of the eligibility requirements despite feeling as though this would be a good fit to help with their WMHI recovery. Participant 10 experienced this firsthand.

> I thought it was extremely appropriate for what I, the kinda counselling I was looking for and when I got that callback and they're like you don't qualify for it because xyz I was so pissed, I was like oh fuck that, so that starts another year or so / ya know you're just angry because you thought you were reaching out when you're supposed to and that wasn't available and so that was a bit of kick.

Following this refusal, it was another year before Participant 10 reached out for help again, even though he felt the WMHI symptoms continued to worsen during this time. While other participants were fortunate enough to be on the right side of the eligibility requirements, such as Participant 12, these participants recognized that some of their colleagues would be excluded from access to appropriate workplace mental health support. Participant 12 reported:

> ...they [the employer] signed on with wounded warriors as a stepping stone almost; however, with the initiative of wounded warriors is good but it’s lip service because you have to be diagnosed with PTSD to use any of their services and you have to get clearance from a psychologist so out of 125 of us, there is probably

> only 8 of us that actually have a diagnosis so everyone else doesn't have access to those services and out of those 8, there is probably only 4 of us that are currently in treatment still so there really only is 4 of us because they're not gonna pay, if I wasn't seeing someone they're not gonna pay for me to be assessed by a psychologist to access those services so it's great and it's flashy and it's like media catching but there is 8 of us / 4 of us that potentially that could get help.

In Participant 12's example, a lack of an official diagnosis by a psychologist unequivocally disqualified individuals with WMHIs from accessing the very services the employer put in place to help. In this instance, the constraints around accessing this workplace treatment resource resulted in many employees being deemed ineligible for this resource and, ultimately, the resource losing its efficacy for positively impacting mental health in the workplace. This resource was only available to individuals who had already sustained a WMHI and was not implemented for any proactive measures to ensure employees' mental well-being. While this resource sounds attractive, further discussion with Participant 12 indicated that there was only minimal financial coverage through workplace benefits for a psychologist. Receiving a diagnosis can take a varied number of sessions, which would mean this seemingly employee sponsored resource could result in a large out-of-pocket expense for the employee.

Participants took varying paths to gain financial support while dealing with their WMHIs. For example, Participant 8 had previous experience making a WSIB claim for a physical injury and, as a result, decided to pursue an Employment Insurance claim for their WMHI to avoid what they considered to be persistent, invasive, and repetitive questioning by WSIB caseworkers which they previously experienced during their physical injury claim. Participant 8 explains:

> ...there's also like way, way, way more questions with WSIB like "who was a witness", "where exactly did this happen in the workplace" like not what were you wearing but ya know what I mean but such specific details where with EI if you get the stuff to back you up like the doctor's note it's [EI is] more helpful with that.

Although Participant 8 felt that EI was not an ideal process because it provided less financial and mental health service supports, Participant 8 selected this avenue because she perceived it as less emotionally taxing than WSIB. In other words, simplicity was more appealing due to the depleted energy levels brought upon by coping with the WMHIs. Meanwhile, Participant 6 and Participant 12 applied for, and received, WSIB financial support but their experience with WSIB differed significantly. While Participant 6 agreed that WSIB required significant detail for claim acceptance, he felt that the experience of the caseworker that was assigned to him allowed them to discuss some of the more specific stressors because the caseworker already had a good understanding of the participant's work environment and the common WMHIs in that occupation. Participant 6 felt that the complexity and barrier to access WSIB was not with WSIB themselves, but rather their employer. This was evidenced when Participant 6 said:

> "...well nothing with the service [the employer] was ever easy because even though I had to go through WSIB with everything, the service never made it easy because, well they [the employer] don't, it's the government, they don't make anything easy. WSIB did a fantastic job, the people that they connected me with, they did everything right. Dealing with my work, that's where the issues have always stemmed.

Participant 12, however, faced barriers to treatment due to timeliness of the WSIB process, causing financial stress due to psychologist therapy expenses. In Participant 12's words, "...for

the first number of visits I had to pay out of my own pocket because I couldn't wait for WSIB at that point I think I was almost ten weeks waiting approval of my claim…" Delays in financial support can be a significant barrier to help-seeking as they may cause financial hardship for individuals with WMHIs which, in turn, could also add additional mental stress to their situation. These delays can also exacerbate the compounding effects of WMHIs that individuals experience when their injuries are not managed in a timely manner. Further, delays may place additional pressures on individuals to return to work prematurely, as out-of-pocket treatment costs can be high. While WSIB experiences varied greatly between these participants, this may be explained by the date of each of these claims. While both participants are classified as first responders, Participant 12's claim to WSIB was submitted prior to the passing of the First Responders Act (2016), which was created to facilitate easier access to mental health supports for first responders. However, the experiences described by Participant 12 may still apply to individuals employed outside of first responder occupations. Interestingly, Participant 10 also applied for WSIB after his WMHI and was approved, however, he never attempted to access any resources. Participant 10 discussed he felt he needed to document the injury as this was protocol, but he had not planned on and never did use any WSIB provided services or resources. He was contacted two years later about closing his claim.

Navigating the various help-seeking options of WMHIs, as well as general help for mental health injuries, can be a difficult and arduous process. Knowing which avenue to pursue was an issue several participants discussed. For example, when Participant 7 was asked why she did not pursue a WSIB claim after legislation had passed in 2018 for chronic mental stress in the workplace, she replied:

> ... it didn't even occur to me at the time, it didn't, it didn't occur to me at all, nobody suggested that it that it should go that way, right, nobody in the union suggested it, cause I think I felt workplace injury you fall and break something, or you know you get cancer from asbestos, right it never occurred to me that that was something WSIB would ever deal with.

This option could have had a large impact on this individual's recovery from their injury as well as their return-to-work plan. Some participants were unaware of many of the available options and were too fatigued to investigate. This included Participant 7, who may have had a strong case for applying to WSIB for assistance, however, was unaware of this option and as a result did not pursue anything beyond taking a leave from work. For some participants, this inability to investigate options due to fatigue may have resulted in a significant handicap to recovery from their WMHIs.

All these experiences provide evidence that help-seeking is a complex process requiring much energy, thought, and action. While knowledge of services is an important part of help-seeking, educating employees on available options is only a part of the solution. Sometimes the inability to obtain proper help, through no fault of their own, can result in a cyclical pattern of WMHIs and workplace absence adding to the complexity of recovery. Participant 5's experiences with WMHIs and her ongoing struggle with recovery exemplifies this cyclical pattern. In Participant 5's words,

> Well, it took years and years and years of being sick at work and I would be off sick for twelve weeks, fifteen weeks, come back for a couple of months, I'd be gone for six months, come back, it was just awful.

Clearly having to endure, what undoubtedly felt like a never-ending cycle of mental health injuries, was detrimental to her ultimate recovery.

Workers Experienced An Accumulation Of Emotional Distress Until Coping Capability Was Depleted

All participants in this study discuss a WMHI which resulted in them eventually seeking treatment; however, participants discussed many similar mental health stressors prior to the WMHI that resulted in time off work or the need for mental health assistance without a declaration of an actual WMHI. Many participants, at time of injury, did not realize that they had endured a multitude of significant mental stressors. This accumulation of workplace stressors negatively impacted their coping capabilities which reduced their ability to employ cognitive and behavioural strategies to manage and recover from additional stressors. Some participants discussed how they eventually came to recognize that it was a gradual erosion of their mental well-being and that there may have been a final stressor or incident that caused them to take leave, but this singular incident alone may not have been sufficient to cause a threshold WMHI. Participant 8 describes this feeling as “a lot of stuff had just built up and this was just almost like a tipping point that pushed me down a slope.” Participant 10 shares a similar sentiment when he stated, “the cumulative effect is almost like ah, you know, like a big nosedive and then slowly with, you know, with a few little speed bumps along the way.” These analogies help us to understand the feeling of reaching a point of depleted coping capabilities leading to sustaining a WMHI. Participant 11 states this feeling more directly when talking about their experience with WMHI’s “...it was I think, it was kind of a cumulative effect it wasn't really one thing but it was just gradual.” Participant 8 and 11 also reported a gradual decline in their mental health but not all participants were aware of this decline in mental health. Participant 12 recollects being

diagnosed and once starting treatment realizing that it was not just one WMHI that was causing her mental anguish, but an accumulation from 20 years of workplace traumas.

> ... I was diagnosed with PTSD within a few weeks and that was basically the last calm my brain could accept because then once I started digging into the box it became an accumulative thing that I've been carrying for 20 years.

Being self-aware of a WMHI is an important part of Participant 7's advice on what to do when one experiences their first WMHI. Participant 7 felt it was important to recognize the injury and address it promptly to avoid years of accumulated burden.

> ...get out as quickly as they think it's starting or to get help as quickly, like the very first time they question, is this happening to them, they need help then, they don't need to wait years and build on it.

The buildup, to which Participant 7 refers, is compounding emotional distress that individuals may feel after each mental health stressor. After each injury, participants' coping abilities decreased, meaning they became less capable of managing previously manageable stressors. Although the WMHI that resulted in time off work may have been no more severe than other incidents they sustained, it was the diminished coping abilities that resulted in the eventual recognition of a WMHI and resulting time off work.

According to participant responses to the pre-interview questionnaire, they did not consider themselves as having a WMHI until they had reached the point of taking time off work. All but two participants stated in their questionnaire that they did not have more than one WMHI (Table 1). However, all participants discussed experiencing ongoing stressors and trying to cope well enough to stay at work before finally accepting the need for time off to recover.

Participants 8's advice to those who have suffered a WMHI consisted of both the suggestion of leaving the workplace, often a continued causal factor, or getting help immediately to avoid this accumulation of unaddressed stressors, Participant 8's advice was,

> To get out as quickly as they think it's starting or to get help as quickly, like the very first time they question, is this happening to them, they need help then, they don't need to wait years and build on it.

Workers Experienced A Decreased Ability To Make Decisions Regarding Their Own WMHIs help-seeking Trajectory

Participants that experienced a straight-forward path to accessing help still felt a sense of reduced capacity in decision-making. For example, Participant 6 had a positive straight-forward help-seeking experience yet still felt WMHI related fatigue, resulting in deferring decision making to other stakeholders regarding his recovery. When asked about the possibility of alternatives to WSIB's provided treatment options, Participant 6 responded "I kind I let them dictate how that was going to go." While Participant 6 agreed to the suggestions and mental health services that WSIB provided, it was evident that Participant 6 felt he had little to no voice in the journey towards recovery when he stated "... basically whatever WSIB said I had to do, I did…"

Decisions that participants discussed that were made by stakeholders were not assessed as good or bad, but instead as a reflection on individuals' decreased ability to make decisions regarding their own WMHIs help-seeking journey. Participant 5 also experienced a reduced capacity in decision making when arriving to work and experiencing a reaction to a pre-existing WMHI.

> "...one day I got to work and I freaked out, like I couldn't go in the gate, I just freaked out in the parking lot and another officer was there and she went and got my manager, my manager said the psychiatrist is in today, I want you to go see him. So, I went and saw the psychiatrist and he became my psychiatrist and he put me in the hospital at one point and that's when I got diagnosed."

Individuals in these situations are more vulnerable and more easily influenced resulting in them more easily accepting suggested courses of action without other considerations. Some participants were resigned to reduced decision-making. Participant 12 best demonstrated this phenomenon when she described their situation for help-seeking:

> Between myself and my husband who is also a paramedic he basically, he kinda took the reins of, like no there is something very wrong, we had been together for a long time and he knew that this had never, he had never seen me like before so he kinda helped me get on that path.

Participant 12 was fortunate in that she had an informal support readily available to her who understood the type of help needed given they were both in the same profession.

Participant 5 realized after her WMHIs the importance of being able to safely defer decision-making and when asked about giving advice to others she suggested:

> That they have to find somebody who will support them in fighting the workplace. Like I think if I had of had support, I probably be, like support financially with work, if like WSIB had of helped me or like some sort of financial way at work because it was a workplace related injury, it was workplace trauma for 12 years, so if work is not helping, you need to find somebody who can support you in fighting that…

Participant 12 echoed this idea with her advice stating:

> …self-advocate or find someone that will, if that means that you have to pass that to your spouse or your work partner to be able to be your liaison with your WSIB case manager because I can't, I'm in crisis, so finding a resource to do that for you that you trust...

Results indicated that some participants thought it was important to self-advocate for help but displayed a low degree of self-agency themselves and a high degree of fatigue, making self-advocacy difficult. As a result, participants suggested taking action to find someone they trusted to defer decision-making.

Trust Contributed to Resources Accessed

While addressing the research question of how individuals that experience WMHIs view their relationships with relevant stakeholders and supports and how these relationships impacted their help-seeking journey, there were several facets of trust that emerged. Participants discussed a higher degree of trust for resource referrals from those with similar workplace experiences and a distrust for treatment resources where the resource had a financial relationship with the employer. Some were reluctant to use legislated mental health leave programs which offered protections to workers during their taking time off. Furthermore, many participants discussed feeling mistrusted by stakeholders and colleagues about their WMHI when trying to access resources. Many participants reported a perception that others disbelieved they had a real injury and, as a result, they felt a constant need to justify time off or a need for treatment. Each of these facets of trust present their own unique barriers to the help-seeking process.

Workers Trusted WMHI Resource Referrals From Others In Similar Occupations Because They Felt They Understood Their Experiences

Participants felt that reliable resources for WMHI recovery were best found through referrals from individuals who could relate to their situation through shared experiences. This went beyond individuals who worked in the same environment but rather trust was afforded to those who were in the same or very similar roles within that environment. Specifically, workplace hierarchy was a factor in level of trust. Participants felt that shared experiences with colleagues resulted in a greater understanding of the type of services they would require for recovery from their WMHI given their awareness of the work environment and conditions. Participant 7 discussed this:

> … so the officers and fire guys and EMS, we all, we all kind of talk and say hey, have you tried so and so or hey, I'm seeing so and so, this is what they do and it's really working or it's not really working. ...I know a lot of the guys and myself included, like, that's your first go to is your, you know, your fellow workers, kind of, that are going through, it wasn't my supervisor by any means, but it's other front-line people, so you, you have the talk ...

Participant 10 also discussed how, when they were at the point of needing time off work for mental health recovery, they sought out a colleague who experienced a similar situation and had also sustained a WMHI and sought help. Participant 10 said "I think the first time I went for a note for work would've been with the woman that my other deployed friend referred me to." And when discussing other colleagues, he stated:

> ...I think ya know the younger officers they just look for guidance from the older ones, it's such a personal thing and it's no different in our job and then I think for

> as much as they can put up like any workplace like posters and fridge magnets and here's the number to call and I / I think for the most part you're like, yeah you don't want to.

While participants discussed a preference for treatment advice from colleagues with shared experiences, it was mentioned that it was often management, specifically human resources, that provided information on offerings for mental health resources. Some participants felt employer provided resources were provided due to compliance issues as opposed to providing resources that could be beneficial. In other words, these employer sponsored resources were a band aid for or postering over the problems in the workplace rather than a meaningful attempt to solve the workplace mental health problems. Participant 4 talked about their human resource department and their role in providing mental health resource supports:

> ...they would do a typical poster you'd see at work, ya know here's an employer, I think it was called EAP, employer-employee assistance program and there's mental health in it and they would say ya know "take a walk at lunch time for mental health" so on and so forth ... it was a poster of points every couple of months from HR, it was kinda an afterthought, certainly with physical stuff was more important...

Referrals were not the only aspect that participants relied on colleagues for help with WMHIs. Participants also discussed how, due to rules and laws around confidentiality, they were only permitted to talk to workplace colleagues about workplace incidents for debriefing. This left these participants unable to use their informal supports without breaking the law. Participant 7 discussed this:

> Sometimes just a good old gab session between some friends is very therapeutic. But with my line of work, because of confidentiality again the only people that I could talk to is police because they knew the same confidential information that I did.

For individuals who were fortunate to have informal supports to help with their mental health coping, they were still bound by law not to utilize these supports to their fullest. This left them to turn to colleagues for this support. While Participant 7 had workplace colleagues to debrief with, not all of the participants in similar situations had work colleagues they felt they could turn to as some reported experiencing high levels of stigma in the workplace. While Participant 12 thought that attitudes towards WMHIs were improving, she still thought the older generation's culture (i.e., stigma towards mental health issues) in the workplace was predominant.

> I think as any first responder I think there is starting to be a little bit of a change, I think it's more of a change that will affect the younger kids coming in versus the older crowd, the older crowd have already that suck it up mentality I think it will help the younger group that honestly the millennials don't care that they're identified as whatever, they don't care whereas our generation, the older group fear that because that means weakness

Alternatively, Participant 2, was unable to use any part of her informal supports because of a non-disclosure agreement. Participant 2 said "I also signed a non-disclosure so I can't talk about anything right, directly, so and, and I mean even within our family…" Informal supports are often more readily available and are easier to talk to because long-term relationships have fostered a high degree of trust, removing this support resulted in the participant discussing feelings of loneliness and isolation through their WMHI recovery.

Interestingly, over a third of the participants discussed a preference and higher degree of trust for gaining referrals for mental health supports from colleagues (n = 5). However, analysis of the sociograms indicated that this preference did not align with their actions, meaning that participants did not actually act upon the referrals. In fact, only Participant 10 discussed accessing a resource that was referred by a colleague. After accessing this resource, he found this was not a successful fit for him, however, this resource did lead him to his next resource which he asserted was very helpful to his recovery.

Workers Mistrusted Mental Health Care Providers With Dual Employer/Employee Relationships

Not only did participants have concerns around how attuned their employer or management was with their needs for mental health supports, but participants also had concerns around confidentiality of the supports being provided by employers. Some participants expressed feeling concerned about who was funding the mental health resources due to concerns around privacy. Participant 4 expressed this concern when stating:

> "…part of me also thinks, the company pays for it, maybe it's not as confidential as going some of the other routes, more regulated, like the psychiatrist with the patient doctor confidentiality and the psychologist was paid for by me so there's no obligation to come back or write anything to the employer."

Participant 10 discussed a previous subtheme of how individuals with WMHIs select resources through colleagues but added that there is distrust in employer-provided mental health supports.

> ... it's a lot easier if you're ya know speaking to your colleagues about versus reaching out and do what the company's offering cause there's that mistrust, the

> suspicion, ya know if I tell them this, am I gonna get burned on that ya know that sorta thing.

Participants expressed concerns around losing out on promotions and losing their jobs if they made it known they were experiencing a mental health issue. This also fueled a hesitancy to utilize, and prejudice towards, employer-provided mental health supports. Even when the resource utilized was governed by law, participants were still hesitant to make use of the program. Participant 4, who was working in the USA at the time of injury, exercised his right to take protected time off work for mental health under the Family Medical Leave Assistance program. Upon return to work, Participant 4 reported experiencing a toxic and hostile work environment which resulted in poorer mental health than pre-leave. Participant 4 recapped his experience after utilizing this US program:

> I mean this is an example even after I got the leave approved completely legitimate under the US law and very specific guidelines around what an employer can and can't do, upon return to work, I was feeling a bit better, but the day back I got an email to all of my peers saying I wasn't doing my job, he [Participant 4's manager] said he had to do my work for me, which of course is true because I was off, but it was just now you're walking around the building with a bunch of people thinking you're not doing your job and also confidentiality of it lead to even more stress and anxiety because by law he was not allowed to tell anyone why I was off but he even told external suppliers why I was off so it was a very hostile, toxic environment.

Fear of scenarios such as this can deter individuals from accessing appropriate mental health supports which many of the participants discussed throughout their help-seeking experiences for their WMHIs.

While some of the actions taken by employers are done with the intent of protecting the employee from harm, some of these actions can still be a deterrent to employees in accessing appropriate supports. Participant 10 explains,

> [talking about a colleague] after he went for help and I'd imagine had some ya know suicidal ideations as part of his post traumatic issues, that's the first thing they do, obviously take your access to your gun away because that's the most immediate path to ya know that sorta thing so … I think with the posters and all the good the workplace has been trying to do there is still that reluctance to step forward, if you got 15 or 20 years to go in your career and suddenly you're not able to ya know do the full job then you're gonna be stuck doing something administrative potentially for the rest of your career so when I think amongst the younger officers that would be part of the peer pressure that keeps people from stepping forward because of that pride and that's why a lot of girls and guys join to do the actual front line policing. So, I think the risk or what holds some people back.

And while some participants were aware of these possible outcomes, other participants had actually experienced them. Participant 5 described her experience after taking time off work for her WMHIs:

> So, they didn't want to hire me full time, so they basically said there was no position for me. And they tried to make me feel guilty by saying, you know, there's other people that come to work every day and they deserve the rollover [conversion to full-time employment] more than you and so you know, you shouldn't fight it and let them have it. …they sent me a letter saying that I was a good employee and,

> but they had to, but they were saying goodbye, in a way that made it look like I wasn't being fired.

Examples such as Participant 5's experiences, highlight the stigma that exists in the workplace and provides a strong disincentive to disclosing WMHIs and hesitancy towards utilizing employer provider mental health services. This unofficial workplace policy of withholding conversion to full-time employment because of mental health leaves certainly hinders the individual's recovery by reinforcing a reluctance to come forward and seek help but can also hurt the employer in the long-term as employees with WMHIs may suffer in silence and lead to presenteeism, additional sick days taken, or more severe injuries due to continued building of burden.

Workers Felt The Need To Convince Stakeholders Of What They Felt Was An Invisible Illness

While participants felt that they may not always be able to trust stakeholders involved in the process they also felt that they, themselves, were not trusted throughout the process. They felt the need to constantly convince others of what seemed to be an invisible illness to the outside world. When Participant 12 experienced a WMHI and sought help through workplace resources, she felt she had to go through the incident meticulously and justify it was severe enough to cause injury just to receive support.

> I really forensically went through the call too, so then I could take it to them because at that point it became me having to justify why I was having the reaction that I was having so I had to like explain whether it was scary enough to be able to be approved and, and that's what has happened every uhm, recurrence since, is it has to be scary enough to have brought my PTSD symptoms back.

Mental health injuries are invisible and often misunderstood or stigmatized, resulting in some believing the injured person is faking with the goal of getting paid time off or workplace accommodations. Many participants discussed this explicitly, including Participant 3 who spoke to the invisibility of mental health injuries when stating "...you always feel like you're having to prove yourself … because I don't have anything visible, you know…". Participants also perceived workplace attitudinal differences between mental health and physical injuries because of visibility of physical injuries. Participant 8 stated "I'm sure if I had broken my leg or my arm ya know what I mean in a cast it would have been a lot different because there was something physical instead of me just being off work for mental health." Participant 8 felt stakeholders would react differently to their injury had it been physical in nature, a sentiment shared across many of the participants, such as Participant 3 who echoed this feeling when stating "I'm off sick for mental health versus you know, I don't have a fever, I don't have a broken leg, I don't have a physical, visible illness."

Participant 12 pointed out the need for education to eliminate the difference in the handling of and ill perceptions of mental health injuries.

> I think that knowledge is power, we need to educate, first responders that it, it is in your head, that there is something structural that's different, it would be no different than me breaking my leg and expecting it to heal even though it's still sticking out…

Participants noted there were additional stakeholders that needed to be convinced of their invisible illness. These additional stakeholders resided outside of the workplace environment. Participant 11, for example, felt they had a difficult time in convincing her doctor that she had sustained a WMHI and the severity of her injury. Participant 11 explained:

> I went to my family doctor, that was my first step and at first it was insomnia and increased really high anxiety and she prescribed medication to me she gave me really, she didn't really consider it being, work related injury she was just trying medication for sleep and to decrease anxiety and then when things gradually got worse I was trying to convince her to refer me to a psychiatrist because I wasn't / improving it took months and she was switching different medications and finally I got her to refer me and that took a long time I waited for a long time to see a psychiatrist…

As a result of time spent trying to convince her primary physician, additional delays were incurred in obtaining care by a psychiatrist. This can be especially problematic in Ontario, as there is a lengthy wait list depending on location and type of psychiatric care required.

Participant 10's WMHIs help-seeking trajectory did not necessitate constant validation of his WMHIs because his time off work coincided with a physical injury work leave and he was no longer in the environment which had caused the injury. Because of this overlap, Participant 10 did not feel the need to disclose symptoms of his WMHI. However, he understood the potential impact that continuous validation of injury could have when he said:

> I think other people have [had to constantly validate] maybe if they have a questionable claim they have go get a doctor's note every 3 months or 6 months or whatever and I've seen the guys who have had to do that [constantly validate] and it retraumatizes people every time you have to go kinda restate your case again with a doctor or a psychologist…

Having seen this happen to colleagues may have had an impact on the decision Participant 10 made to not disclose a WMHI to their employer and take time off for the WMHI, but instead

utilize time off during a physical ailment to try and recover from both the physical and mental injuries, aligning with self-preservation and the feelings of needing to conceal a WMHI. And even though Participant 10 had not accessed resources through WSIB after being approved for his WMHI, he ultimately found himself in a situation where he was asked to re-explain his incident to a WSIB caseworker, he stated:

> ...about two years later I got a call and they had handed my file, I think they were trying to close it as quickly as possible, I think that's what they do, and it was some 20 year old kid, little squeaky voiced kid he was like "hey, uh can you just explain to me" I'm like holy fuck I am not gonna reexplain this to some kid who just got my file cause {previous caseworker} moved on, I was like fuuuccckk so that I could really see at the time, like after the {workplace provided mental health centre program} rejection thing when I thought I had found the group that I needed then the WSIB thing where I'm like, why am I, why do I have to keep proving ya know the trauma when I didn't actually want anything from them, I felt like they were just trying to close your file...

Participant 3 also experienced something similar whereby the employer required additional assessments by employer-approved doctors.

> I'm actually surprised that after two weeks that, and it may happen this week coming, that the board hasn't sent me out all the paperwork to you know, especially with mental health, they sometimes challenge it and want you to be seen by one of their doctors, be re-assessed by one of their doctors, but I think in my situation and I think because of all of the incidents that there's been and all of the reports that I've filled out about workplace violence and all of

> the workplace injuries and all of the restraints we been in with this student, I don't think that they're in a position to really question, I think they can see, yeah ok, she's got the, she's got all the paperwork done already so I don't think they're really challenging that, um, but we'll see, I'm interested to see if they want to have a functional assessment done before I return.

Without having paperwork of physical incidents, Participant 3 felt as though there would be additional hurdles when trying to access time off work for their WMHI. Having to relive, validate, and convince the new doctors of their WMHIs just to continue with the time off for treatments could contribute to accumulated stress.

Help-seeking behaviours are complex and influenced by many external and internal factors. Despite this complexity, careful analysis of the data revealed three main themes: self-preservation, fatigue, and trust with fatigue emerging as ever-present throughout the help-seeking experiences of all participants. The results indicated the perceived need to conceal WMHIs as a means of self-help and self-preservation, a frustration with the complexity of navigating treatment options resulting in fatigue and a deference of decision making, and the influence trust had on treatment decisions. It is also relevant to note that lost productivity was a by-product of the barriers to help-seeking as the data revealed, either explicitly or implicitly, that both absenteeism and presenteeism increased throughout their experiences. Finally, most participants eventually felt the need to leave their employer, whether their WHMIs were resolved or not.

Discussion

The present study aimed to understand the internal and external processes that affect the help-seeking behaviours of individuals that have experienced a WMHI. Help-seeking behaviours

and attitudes are intertwined and complex and, as a result, the path to recovery can be difficult to navigate. Further, the costs to society, employers, and the individuals who sustain a WMHI can be great (Zaheer et al., 2019). Through examination of the lived-experiences of 12 individuals with WMHIs, key barriers and facilitators to help-seeking were uncovered that extend the current body of research in three main ways. First, self-help as a means of self-preservation was a theme that was demonstrated through concealment of the injury and actions towards preventative measures to escape continued exposure within that environment. Secondly, the lack of a prescribed pathway to help-seeking necessitated time and energy being spent on investigating, evaluating, and trialing treatment options. Individuals with WMHIs experienced an accumulation of stressors throughout their experiences. These reasons all contributed to a high degree of fatigue amongst those with WMHIs, which influenced how the individuals struggled to enact help-seeking. Thirdly, in line with other research, trust was found to play a critical role in help-seeking as stakeholder relationships were found to impact the help-seeking resources and paths chosen by individuals.

All three themes were found to be interconnected, providing further evidence of the complexity of help-seeking behaviour. Each of these themes is discussed from an individual and organizational perspective, highlighting both the individual and the workplace environment when examining the help-seeking behaviours. These findings underscore the need for additional helpful considerations for both employee, employer, healthcare provider, and WMHI processes and policies.

Workers Concealed Injuries And Distanced Themselves From Stressors As A Means Of Self-Preservation Through Self-Help

The need for self-preservation through self-help emerged as one of the behavioural processes that influenced help-seeking behaviours. Self-preservation refers to the coping mechanisms individuals utilize to prevent or avoid further mental injury, emotional distress, or job loss with consequent loss of income. Participants commonly exhibited self-preservation through avoidance, specifically through concealment of their WMHI, which was shaped by emotions such as fear or shame. One participant discussed the fear, shame, and vulnerability he felt because of his WMHI and demonstrated that these emotions were not necessarily unfounded as he described the treatment both he and a co-worker received after disclosing separate mental health injuries to their employer. Specifically, he was met with hostility and public attacks on his work performance from a manager. Another participant in law enforcement described the belief that his firearm would be immediately removed and he would be subsequently delegated to a desk job because of a WMHI. This was conveyed as an extremely negative outcome for him. In both these examples, fear and shame were an integral emotional experience, contributing to concealment tendencies for these participants. As a result of personal or observed experiences such as these aforementioned examples, many participants concealed their WMHI through using vacation days or sickness absence attributed to physical ailments. Their efforts of self-preservation demonstrated that they were trying to help themselves manage their WMHI to avoid turning to additional resources which, in their minds, may be met with stigma leading to marginalization or, worse, employment dismissal. While self-preservation may relate more to personal aspects of adaptation, there were also environmental issues that contributed to this behaviour.

Concealment and withdrawal are strategies employed by individuals with mental health illnesses to attenuate stigma (Link, 1987; Link et al., 1989 as cited in Perry & Pescosolido, 2015). Concealment could relate to feelings of both external and internal stigma. External stigma is the negative perception others hold towards people with mental illness (Yu et al., 2021). Internal stigma is the negative emotions, beliefs, and behaviours towards oneself because of a mental illness (Mak & Cheung, 2010). Both result in a feeling of a tainted and discounted identity for the individual (Ablon, 2002). External stigma may have influenced help-seeking behaviours because the individual feared alienation or adverse treatment from employers or peers whereas internal stigma may have influenced the decision for concealment because the individual had a perception this would protect their self-identity from being tainted. Many participants demonstrated the external stigma-concealment association by taking time off work, citing a physical injury or ailment to their peers and employers (e.g., flu), to obtain time away from the workplace stressors.

Concealment behaviour can be seen as a normal adaptive strategy. The individual is attempting to self-help to protect their job, their reputation, their peers, and their employer. Many participants used this strategy for long periods as they attempted to adapt to their WHMIs and the workplace environment for which they sustained their injury but were ultimately unsuccessful. This is not surprising, as concealment can be detrimental to mental health because social relationships have been demonstrated to be an important part of well-being (Perry & Pescosolido, 2015). Social relationships are a means of obtaining needed support, advice, and information in times of crisis. Further, some individuals employed selective disclosure, whereby they only disclosed WMHIs to those with attitudes that they perceived as supportive and understanding of mental health issues or to those that have also experienced WMHIs (Perry &

Pescosolido, 2015). This concealment strategy, while a common response when anxiety is experienced due to internal stigma, can be counterproductive as it can contribute to feelings of isolation, loneliness, and inferiority. Therefore, internal self-isolation may be an artifact of internal stigma, a perception that only weak people can sustain a mental health injury or the belief that they are alone. Concealment and internal stigma can be difficult to emerge from because the individual may begin to approach social interactions with anxiety. This, in turn, could create further damage to the individual's mental health and a tendency to further self-isolate to avoid feelings of anxiety. Thus, feelings of isolation can result in a self-fulfilling prophecy.

Finally, employers that focus on individual-focused treatments (e.g., anger or stress management courses), as opposed to workplace environment-focused solutions (e.g., workplace redesign to reduce chronic stress in the workplace), often fail to address the workplace conditions that may have contributed to the WMHI and workplace culture (e.g., stigma) (Noblet & LaMontagne, 2006). To decrease the likelihood of concealment, individuals need to feel safe to discuss their WMHIs with their managers which is made possible when workplaces are both . open and supportive and actively promotes positive mental well-being.

A second self-preservation tactic was to escape, or create distance from the stressor, which included changing employers, changing jobs with the same employer, or changing occupations. While resigning may be considered a drastic and maladaptive coping strategy, participants in the study largely felt that resigning was necessary to recover from their WMHI. If they did not resign, participants believed they would be negatively impacted, or worse, their mental well-being would further deteriorate. A possible explanation of their behaviour may be that these individuals tried to regain control by leaving an environment where they did not feel supported

and where they felt their self-identity was being compromised. Taking this view, their actions can be interpreted to be adaptive. It takes considerable mental stamina to conceal mental health issues, seek services, and actively participate in treatments while also maintaining acceptable work performance. Workers that are trying to conceal their WMHI may begin to realize this approach perpetuates their problem because the employer may not be aware of the workplace issue and therefore there is no impetus on them to implement change. The worker may conclude that it is unlikely the environment will improve yet may perceive that the risk of disclosure of their WMHIs is too great, because they believe they may be labeled as unstable, unreliable, or underperforming. Therefore, individual workers often feel it necessary to conceal their WMHIs to maintain their positive workplace self-image. When it becomes too burdensome to conceal the WMHI symptoms while also remaining in the very workplace environment that caused the injury, the individual may naturally look for options to alleviate or manage their stresses. This, for most participants, manifested itself by acting upon the emotional and toilsome decision to change jobs, even if this decision came with personal financial difficulties. The perceived pressure of potential dismissals was shown, for some, to contribute to the decision to switch employers. For others, the continued exposure to the workplace environment or situations that ultimately resulted in a WHMI may have been too overwhelming, thereby hindering recovery.

Participants revealed that escape did not necessarily eliminate the WMHI, as many felt the injury was permanent. When asked how they perceived their mental health injury, some participants felt that there was a permanent change in their brain. One participant described it to be akin to a permanent physical scar. There has been much research that supports the presence of structural changes of the brain after a mental health crisis. For example, Sin et al. (2018) reported that loneliness, such as the self-isolation felt by many of this study's participants, can result in

weaker ventral striatum activation in response to pleasant social cues, and reductions in white matter column in many parts of the brain which has been reportedly related to low self-efficacy. Self-efficacy is described as one's confidence in their ability to perform certain behaviours to attain a desired outcome (Bandura, 1977, 1986, 1997 as cited by Carey & Forsyth, 2009). Because any mental health illness could potentially cause changes to the brain, participants of this present study may have sustained changes to their brain because of the WHMI, which could have further implications for seeing a decrease in self-efficacy. To that end, many participants continued to experience problems after the change in employment and some reported continued concealment of their mental health problems and struggles with managing the stress in their new workplace. Thus, leaving the workplace does not necessarily work in the long-term. While it may provide temporary, necessary relief from stress it does not allow the individual to gain skills in managing stressors. Further, by starting a new job some social supports may be left behind at their previous job. This can have a negative impact on the individual's recovery, as research has indicated that social support can mitigate stress as it influences how stressful events are perceived (Mahar et al., 2014). Further, social support has been associated with beneficial biological responses to major stressors, particularly in the limbic and cortical brain areas, suggesting social supports help regulate subsequent stress responses and have antidepressant effects.

In sum, worker tendencies to conceal injuries and escape from these environments demonstrate the need for organizational change focused on creating a climate where people feel safe bringing forward their mental health struggles knowing they will be addressed and be referred for prompt treatment of WMHIs. Stigma plays a large role in concealment behaviours because stigma contributes to an unhealthy workplace environment where individuals

fear repercussions of disclosing their WMHI and where external stigma further reinforces any existing internal stigmas. Many individuals felt changing environments was their only recourse, but for some, their WMHI followed them to their new position, potentially due to the changes in the brain that can be caused by mental health illnesses, or possibly because of the repercussions of self-stigma. Considering this, concealment is both a normal and necessary adaptive behaviour for individuals with WMHIs and why healthy workplaces environments can support mental well-being.

Complex Help-Seeking Pathways And Accumulated Stressors Caused Fatigue Leading To Reduced Independence In Decision-Making

Due to the complexity of obtaining resources and support, participants often found themselves too mentally depleted to participate in decision-making around help-seeking. Participants implicitly described deferring decision-making related to treatment types, treatment providers, and financial resources to trusted members of their social network or workplace peers. While the proclivity to defer their decision-making to others was not assessed as a good or bad choice, it highlights a diminished ability to act independently. The pictorial representations of participant help-seeking (Figure 3 and Appendix F) helps us begin to understand the reason for deferral of decisions. The sociograms and the trajectories show the complex routes and the numerous decisions the participants encountered, which left these individuals experiencing overwhelming fatigue. A lack of knowledge of mental health resources meant that most of these individuals had only a low level of understanding of the effectiveness and suitability of each choice. Further, internal and external factors influence selection of supports to access (e.g., trust, cost) oftentimes outweighing efficacy of the support. Because of these factors and the urgency of wanting relief, the act of help-seeking itself may have exacerbated some of the very symptoms

these individuals were seeking help for. Deferring decision making may have been one way of self-preservation by allowing individuals to focus what little energies they had on coping with the injury and outsourcing the investigation and selection of available treatment options to others with the capacity and energy to do so.

Many participants discussed how their WMHI resulted from chronic workplace stressors (i.e., a consistently elevated state of arousal beyond what the individual could manage over a long time period) as opposed to an acute stressor in the workplace. Participants did their best to remain productive in the workplace but, over time, some reported the need to use vacation days, sick days, and other reasons to take time away from work to address mounting symptoms and fatigue. Fatigue, which is a common feature of mental health disorders, was prevalent for many participants. It is possible that increasing fatigue was influenced by the chronic and accumulated workplace stressors they experienced, leaving the participants in a vulnerable position when it came to making decisions and navigating this unfamiliar territory. In fact, research shows that mental fatigue creates a drop in performance but does not decrease motivation (Gergelyfi et al., 2015). In this research, neural, autonomic and psychometric, and behavioural measures of mental fatigue were taken in healthy participants. Sudoku tasks were performed for 120 minutes to induce mental fatigue and motivation was manipulated with monetary rewards. Results supported that, as mental fatigue increased, performance decreased. Measures of task engagement remained constant throughout the study and monetary incentives failed to moderate the effects of mental fatigue. A parallel can be drawn from this research to mental health injuries to help explain help-seeking behaviours. In the context of this present study, reduced performance led to deferral of decision making as the individuals with WMHIs experienced mental fatigue to a level that required them to focus energies on self-preservation. However,

these individuals also remained motivated, as they had a strong desire to maintain their livelihood and regain their mental health. In the case of individuals with WMHIs, the cause of the mental fatigue may have been rooted in the analysis of available treatments and supports and the concern over their health, their reputation, and work performance.

Most participants had no straightforward workplace process available to them to provide feedback to the employer and the previously discussed concealment strategies further exacerbated the building of burden. Concealment, complexity of help-seeking, and workplace and internal stigmas created additional stress for these individuals and left them with the perception that relief could only be found through leaving the workplace. Therefore, the accumulation of stressors played an important role in help-seeking behaviours and was heavily interrelated to the theme of self-preservation. Interestingly, most participants did not recognize the building of burden until later, when reflecting on their experiences. This building of burden may have resulted in a depletion of their ability to adapt, which may have influenced their help-seeking behaviours (e.g., feeling the need to escape or defer decision-making out of the resulting fatigue). Early recognition of a building of burden problem by both the individual and manager could have prompted appropriate early preventative measures. This provides evidence of the need for workplace training on identifying the early signs of chronic stress and the need to make this a frequent topic of discussion in workplace well-being conversations.

Some research has posited that an individual's ability to adapt adversity can vary over time because coping and adaptation requires energy. Conceptually, the ability to adapt can be viewed as a gasoline tank, whereby it is full, empty, or any degree in-between (Gallo, de los Monteros, & Shivpuri, 2009; Gallo & Matthews, 2003 as cited in Schetter & Dolbier, 2011). Chronic or extreme stressors can deplete the ability to adapt, whereas social supports, time off from work,

and stress management tools help can fill it back up. Participants in this study described the complexity of the help-seeking process as a stressor, contributing to the depletion of energy. Individuals will face varying degrees of workplace demands and have their own ways of adapting to workplace stressors. Individuals may have varying degrees of adaptability, depending on many factors such as recent vacations, social supports, and chronic workplace environmental stressors (e.g., shift work). The gas tank conceptualization of energy depletion can help us understand how environmental factors influence the ability of individuals to adapt to stressful or traumatic situations and can be useful in further understanding how an accumulation of workplace mental health stressors can impact an individual. It is difficult for an individual to adapt to an extremely stressful work environment if the stressor is chronic in nature and there is a lack of support from employers and peers in how to manage or mitigate that stressor.

While some participants obtained doctor-prescribed workplace accommodations (e.g., reduced work hours to accommodate regular therapy attendance), participants lacked the knowledge, energy, or support to assert their rights to such accommodations when employers denied or failed to implement the prescribed accommodations. Employers may not understand why the accommodation is necessary and beneficial to their business despite evidence demonstrating the benefits of accommodation. In a study conducted by Bolo et al. (2013), individuals with workplace accommodations because of a mental health disorder were associated with improved mental well-being which resulted in positive impacts to workplace productivity. Bolo's study compared outcomes for individuals (N=715) with mood and anxiety disorders that received or did not receive workplace accommodations. Specifically, participant inclusion criteria included major depressive disorder, dysthymic disorder, manic episodes, social phobia, generalized anxiety, and panic disorder. Participants were asked to provide detail on the number

of accommodations granted versus accommodations required and requested. Bolo et al. found that 30.8% did not receive any accommodations and only 24.5% received all the accommodations requested. For those that received all required accommodations, there was a decreased likelihood of experiencing a mood or anxiety disorder one year later. These findings support that workplace accommodations may directly support decreases in both absenteeism and presenteeism, which could coincide with increased workplace productivity.

Despite such evidence, some employers remain skeptical. Their skepticism is potentially rooted in a lack of trust coupled with their inability to see the financial return versus the cost, effort, and energy associated with implementing the accommodation. Gold et al. (2012) conducted an exploratory focus group study, to examine the perspectives of employers, employees with disabilities, and vocational rehabilitation service providers regarding reasonable workplace accommodations. Results indicated that, while all stakeholders agree that there is a need to build relationships based on trust, employees bear the burden of proving the need for accommodation and the benefits to the employer of providing such accommodations, and that employees and employers have differing opinions about their obligations. In Canada, patient-doctor confidentiality, as per the relevant legislation of the Canadian Personal Information Protection and Electronic Document Act and the Personal Health Information Protection Act, means that details of the injury are kept to a minimum of what is only absolutely relevant to know. L. Hiseler, a Peterborough area clinical psychologist who often works with clients with WSIB claims, (personal communication, August 20, 2021), asserts that often psychologists write letters outlining specific accommodations to be met but do not divulge the diagnosis because it is not relevant to the employer and, if it was disclosed, could bring the risk of adding in another aspect of stigma. The employer is required to have a certain level of trust in the healthcare

provider and their employee of both the legitimacy and the necessity of the prescribed accommodation. Further, the Canadian Employment Equity Act and Ontario Human Rights Act make it a legal responsibility for employers to provide reasonable accommodations (Bolo et al., 2013). While this legal requirement should provide motivation for employers to abide by doctor prescribed orders, there remains a number of barriers for employers in implementing and upholding accommodations, which is to the detriment of the injured employee and the employer's productivity.

Trust Contributed To Resources Accessed

Some individuals with WMHIs reported feelings of distrust towards workplace funded resources. In fact, the sociograms highlight that few participants accessed workplace supports. Individuals felt that the employer provided mental health care provider had a dual relationship, meaning they had an obligation to both the employer and themselves. This resulted in fear that confidential information would be reported to the employer, which could result in marginalization or dismissal. This, in turn, contributed to a sense of mistrust. Thorpe and Chenier (2011, as cited by Eggertson, 2011) posit that stigma and lack of trust about the privacy of health information were barriers to accessing workplace supports. Participants in the present study believed that, because of this dual relationship, there may be a reduced level of employee-healthcare worker confidentiality or that workplace funded services may expedite them back to work before they are fully recovered out of a desire to minimize costs and disruptions to the business. This distrust may result in a decreased use of workplace funded supports and increased difficulty in finding appropriate external mental health resources.

Processes like workers' compensation involve a high degree of communication about the needs and progress of the injured worker with the employer, creating the perception of dual

relationships with providers contracted by compensation boards to provide support. Some additional services, such as EAP, are funded by employers and, despite EAP's contracts prohibiting them from disclosing information to employers and their assurances that information is not disclosed to employers, some workers remain suspicious of EAP services as the perception may be that this provider is essentially on their employer's payroll. As a result, some participants reported a lack of trust with treatment providers in a dual relationship between the employer and employee.

Lack of trust is counterproductive to treatment, as it has been found that trust is associated with willingness to self-explore, disclose, and contribute to therapeutic progress and change (Okun, 1976; Patterson, 1985, as cited in Alire, 2019). Researchers have demonstrated that trust has a moderately strong relationship to therapy completion (Meier et al., 2006). Lack of trust in the provider can result in a lack of trust in the treatment itself, resulting in treatment dropout (Sharf, Primavera, & Diener, 2010; Acosta, 1980; Dyck et al., 1984; Grimes & Murdock, 1989; Kokotovic & Tracey, 1987, as cited in Alire, 2019). Low therapeutic alliance can result in an unwillingness to disclose some or all the emotions, thoughts, and attitudes to the therapist which may result in reinforcement of concealment tendencies, thereby creating additional barriers to help-seeking and overall hindrance of recovery. Addressing this aspect of trust can be important because, for some individuals, employer sponsored mental healthcare may be all they can afford or be able to access. Therefore, not having this resource functioning optimally can be a burden on both the employee and employer.

Worker mistrust and cynicism may arise from the low efficacy of traditional workplace health programs (Reif et al., 2020; Dimoff & Kelloway, 2013). Reif et al. (2020) conducted a longitudinal study on 4,834 university employees which studied the effects of workplace

wellness programs. Specifically, Rief et al. (2020) research focused on physical health and well-being aspects, investigating efficacy of onsite health screenings, health assessments, and wellness activities on individual health outcomes. This study found no significant effects on health outcomes after 12 or 24 months. Another study by Song and Baicker (2019) performed a randomized controlled trial on 32,974 employees from U.S. warehouse, retail, and worksites which examined workplace wellness programs outcomes and found no effect on absenteeism, worker performance and job tenure (employment outcomes), or in any clinical measures of health. While both studies focused on individual wellness programs, employee experiences with employer sponsored programs such as these can negatively influence overall perception of workplace health programs, potentially resulting in future low uptake in new programs. While one of the participants in the present study found the employer sponsored program EAP helpful in their recovery, three others discussed how they were skeptical of not only the efficacy of their employer sponsored programs, but also of the confidentiality. It is possible for these three participants that they may have been less likely to continue utilizing this resource or be more guarded in the information they shared.

Research has shown that standalone individual-focused mental health interventions have low effectiveness (Whatmore et al., 1999). Individual-focused mental health interventions are targeted at addressing the individuals' symptoms and do not address the environmental and systemic sources of stress. Whatmore et al. investigate the efficacy of stress management interventions in a UK based study which sampled 270 governmental employees and compared a control group to those that took stress management training at pre intervention and three- and six-month post intervention intervals. Results indicated that benefits were only sustained for a short period of time (less than 6 months) and the researchers attribute this finding to the fact that

stress management programs fail to address the workplace environment. In other words, the workplace stressors are not addressed or removed, placing the onus on the individual to adapt to the workplace stress. This may explain why most participants changed employers if they perceived that the employer did not recognize the need or was unwilling to investigate and change the workplace environment and that they, themselves, were unwilling to accept that the burden of change was laid solely on themselves. Therefore, employers should consider looking beyond EAP and programs alike and work directly with employees in a proactive manner to address stressors in the workplace.

Trust issues are experienced by both the injured employees and the stakeholders in the process. Since mental health injuries are similar to back injuries in that they are an 'invisible injury', some employers question the legitimacy of the injury, holding the belief the employee is simply looking for accommodations or paid leave (Tarasuk & Eakin, 1995). Malingering can, and does, occur. In cases where mental health professionals suspect malingering, there are tools readily available to detect such behaviour. One such tool is the Structured Inventory of Malingered Symptomatology, which is a 75-item, true-or-false survey specifically designed to identify psychopathology and neuropsychological malingering (Widows & Smith, 2021). However, it is unlikely an individual will go through the arduous process of seeking help to receive workplace accommodations or leave, especially since neither of which are guaranteed, and all seemingly come with some level of stigma towards the individual claiming the WHMI. Brijnath et al. (2014) found that workers are more likely to underreport WMHIs out of fear of negative impacts on current and future employment prospects than to report in order to obtain sickness absence. In fact, one general practitioner interviewed in their study asserted 99% of claims are genuine, because to make a mental health claim, one must be very committed as the

claims process itself is a long and arduous, which is supported by the present study as evidenced from the participant trajectories and sociograms. Further, Brijnath et al. (2014) found that individuals with mental health conditions struggled with the balance of "doing the right thing" for their well-being versus returning to work before full recovery to avoid the perception of malingering, like several participants in the current study. Balancing personal needs versus a sense of duty to the employer and colleagues was also observed in this present study's findings. This provides further support for Bolo et al. (2013) assertion that individuals were reluctant to ask for workplace accommodations to avoid burdening their peers and employers and could be used to help build trust with employers.

Many participants discussed a higher degree of trust for referrals received from colleagues, yet the sociograms displaying participants' pathways to resources demonstrated that only one participant acted upon such a referral and did not find the resource beneficial to them. One possible explanation for this is the high degree of fatigue individuals with WMHIs may experience. Following through on the referral requires energy (scheduling appointments, potentially needing time off work to attend appointments, feelings of exhaustion from treatment) which may be already depleted. Another possible explanation or contributing factor could be that by following through on the referral, the individual is internally recognizing they have a WMHI which then puts them in conflict with their internal stigmas. These individuals may have a higher degree of trust in peer-provided referrals over employer-provided referrals because a) there is a feeling that their peers better understand the injury and b) to obtain an employer-provided referral these individuals would have to disclose the WMHI to their employer, which puts them at conflict with the perceived external stigmas, including damage to workplace image and possible long-term consequences (e.g., loss of promotions). The latter is supported by research

which indicates that most employees are not comfortable discussing mental health issues with their managers and perceive that their managers are not very knowledgeable about mental health (Thorpe & Chenier, 2011 as cited in Eggertson, 2011).

As previously discussed, employers place the burden of proof of the need for accommodations and the presence of a WMHI on the employee (Gold et al., 2012). This puts the individual with a WMHI in a difficult position as it can be difficult to self-advocate due to the perceived power imbalance in the workplace and the overlying feeling of fatigue. Farh et al. (2007) examined this power dynamic with a questionnaire given to a sample of 163 supervisor-subordinate dyads from various Chinese companies, including banking, transportation, electronics, and hotels. Results indicated that this power imbalance is further exaggerated for employees in lower-level positions within an organization, which in literature is described as an increased power-distance (Farh et al., 2007). A higher power distance was also found to increase the tendency to leave a position (escape), as the individual feels low connection to the organization and their ability to influence it. Efforts to address the barrier could have a positive effect on employee retention, fatigue, and overall workplace environment.

Workplace Stress and Help-Seeking Behaviour Models

Sisley's et al. (2010) proposed workplace stress models help to explain the accumulation of stressors theme that emerged from the present study's participant lived-experiences. Many participants discussed experiencing multiple workplace stressors. Further, the data collected shows that many participants also engaged in what Sisley et al. referred to as restorative measures, namely vacation days, sick days and yoga. The model would suggest that because participants were experiencing chronic workplace stress without adequate restorative measures, these individuals attained a new baseline of stress arousal. Many participants also reported sleep

disturbances which, according to the model, meant that the individual's stress arousal state would continue to climb over time, further exacerbating the stress arousal issue. Consequently, the data supports the model in that participants experienced a high amount of chronic workplace stressors which outweighed the positive effect of the restorative measures taken by participants.

Considering Andersen's emerging behaviour model, the results for this study align well with the four new proposed model components, namely environment, population characteristics, health behaviour, and outcomes. Each of these components are evident in the data as influencers of how individuals with WMHIs seek-help. Further, participant's lived-experiences appeared to follow the predicted flow within the revised model, including the feedback loops between components.

Participants actively discussed environmental concerns, including access to treatment options both in the public and private setting and how this impacted services accessed. Further, workplace culture had an effect on participant help-seeking behaviour as toxic, stigma rich workplaces meant that individuals felt they could not openly discuss or disclose WMHIs and felt hesitant to access workplace supports out of fear of non-confidentiality of those services. The present study's results coupled with Andersen's model would indicate that efforts to improve access would have a beneficial effect on help-seeking.

In terms of population characteristics, predisposing characteristics, enabling resources, and need (the three original components of Andersen's model) all influenced the behaviour of the participants in this present study. The influence of the predisposing characteristics sub-component of Andersen's model were also evident in participant help-seeking behaviour. Participant 1 had familial history of a mental health disorder and first hand experience with a prior diagnosed disorder. This individual was able to recognize signs of mental health illness that

directly influenced both the speed in attempting to seek help and the types of services accessed. Occupational class seemingly influenced help-seeking, as participants in first responders occupations reported an overall aversion to seeking help from mental health professionals. The enabling resources sub-component included the social supports, both in the workplace and outside of the workplace, and were evident in deferred decision making. The need sub-component of the model is particularly interesting in relation to this study. Self-stigma was present in some participants which meant these individuals attempted, either consciously or unconsciously, to deny they had a serious mental health issue, believing time off work would bring relief and allow them to recover. Once it became evident that self-help techniques (e.g., vacation, sick days) were not working, individuals took a concertive action in seeking help through various means.

The health behaviour component of Andersen's model is difficult to discern from the present study's data as the interview design did not investigate health care beliefs in general, nor how individuals historically used health services. That said, there is minor evidence that supports the addition of this component to the model. The participant that worked in healthcare was a strong self-advocate for care and accessed many types of services to repair her mental health.

Finally, the outcomes component of the model shows that perceived health status, evaluated health status, and consumer satisfaction all play a role in behaviour. The present study's participants demonstrated this to be true in that several perceived that their WMHI followed them to their new occupation and, subsequently, many felt the need to continue treatment as they were not yet attaining their desired level of well-being. Further, unsatisfactory outcomes from any particular support accessed led the individual to re-evaluate their needs and

pursue other options. Both these observed behaviours support the feedback loop included in Andersen's emerging behaviour model.

Therefore, by looking at the results from this present study through the lens of Andersen's emerging behaviour model, we may presuppose that efforts to improve any singular component within the model will provide incremental benefit. However, if a more holistic approach is taken, where barriers within each component are addressed in concert, substantial improvements may be attained. A holistic approach would not be easy, as it involves numerous and diverse stakeholders coming together and agreeing upon the solution.

Practice Implications

Workers

Changing employers was common amongst most participants. This behaviour was motivated by self-preservation, a need to leave the workplace environment which caused the WMHI, and an attempt to start a new job with feelings of a clean slate. However, entering a new job can come with a period of additional stress as the surroundings, expectations, and workplace processes are all new and close workplace social supports are non-existent (Feldman & Brett, 1983). Even those that switch positions but remain with the same employer (job changers) experience new stressors (Feldman & Brett, 1983). According to a study done by Feldman and Brett (1983), job changers typically have higher expectations placed upon them than new hires would if placed in that same position. This research shows that job changers typically employ the strategy of working longer hours to cope with the demands and stressors of their new position, whereas new hires typically establish and rely on social supports to counter the stressors of being with a new employer.

Since the present study found that some of the individuals carried their concealment strategies with them from their previous job, finding necessary social supports may be more difficult. Switching employers or switching positions but remaining with the same employer may have the unwanted result of additional stressors being accumulated by the individual. It is unsurprising that some participants found that even after switching jobs their WMHI persisted. This provides support for the need for individuals to continue seeking treatment for their WMHIs, to help them prepare for the acute stressors associated with new jobs or new positions, and to ensure they manage their expectations with regards to recovery during the employment transition. Further, it highlights the need for these individuals to address internal factors that perpetuate their difficulty coping. Workers considering job change should also explore workplace supports in alternative employment situations, such as inquiring about benefit coverage and workplace programs aimed at employee wellness, so that they can be more selective in finding workplaces that embrace and meaningfully support total employee well-being. Finally, during counselling/psychotherapy, workers should be encouraged to consider that a new workplace may not actually yield any recovery so that they can better evaluate whether a change in career is truly beneficial in the long-term.

While in an idealistic workplace, employee required accommodations should be met within reason, the burden is on the employee to find support from healthcare providers in requesting appropriate accommodations. Further, individuals must provide the employer with evidence of how these accommodations will support their recovery and productivity. Therefore, employees requiring accommodations should consider requesting specific written accommodation instructions and relevant mental health evaluations from healthcare providers to ensure they have strong supporting documentary evidence of their needs.

Employers

There are a number of barriers for employers to recognize and understand the high financial cost of presenteeism, absenteeism, and employee turn-over. By understanding these costs, they can better understand the fulsome benefits of creating a sustainable approach to mental well-being in the workplace. Further, employers need to understand and value the impact of workplace environments on mental health and their obligation to provide a safe place to work. Participants in the present study demonstrated self-preservation behaviours that were, in part, driven by a need to conceal WMHIs possibly due to perceived workplace stigma. Thoughts of isolation and shame were driven, in part, by external stigma, potentially as a result of the workplace environment. This may be a sizable problem for the employer because, due to the workplace environment, there may be many employees struggling with WMHIs. While evidence shows that traditional workplace health programs have low efficacy on their own, this does not mean these programs do not have a role to play in a more holistic workplace mental health program as they can provide temporary relief and tools for future use. Workplace programs need to be comprehensive in nature. They should include the traditional elements of wellness programs such as training, (e.g., stress and conflict management) and EAP but also include programs and processes centered on improving the overall workplace environment. These additional programs and processes should focus on prevention (e.g., reducing chronic stressors through job analysis and redesign), communication (e.g., facilitating open dialogue within the workplace between individuals and their managers), and rehabilitation for those that sustain WMHIs. Employers could also consider mirroring the job analysis that occurs after a physical injury and applying it to WMHIs. In some instances, it may be that a job analysis would reveal relatively simple to implement work redesign to minimize further exposure to the offending

workplace stressors. Other relatively simple additions, like including mental health issues in safety moments, which are brief safety talks about workplace concerns held at the beginning of meetings, could help reinforce that mental health should be included and discussed as openly as physical health. Safety moments that include mental health issues may bring forth workplace environmental concerns that could be addressed promptly and potentially avoid the need for reactive measures such as treatment or time off work. Regardless of the selected program or process, the design needs to be grounded on the premise of creating a feeling of support for all employees and especially those with WMHIs.

Individuals with WMHIs often require workplace accommodations, either temporary or permanent. To obtain workplace accommodations, a reciprocal relationship of trust needs to be built between employers and workers so that workers feel confident that by sharing their WHMI there will be no consequences and employers feel confident that the accommodations are necessary and will have a mutually favourable outcome (Gold et al., 2012). Employers have an important role to play in establishing trust and in implementing reasonable accommodations. They should take a supportive and collaborative role in assisting in the development of reasonable accommodations for the individual with the WMHI. They can also encourage and assist with training supervisors to be well versed in employment law, sensitive to mental health issues, and supportive of workplace accommodations. The employer should also ensure workplace accommodations are effectively communicated to relevant colleagues who interact with the individual in a manner that does not disclose any personal health information. Finally, they could do more to help assess the effectiveness of the modification on employee well-being and check in with the individual to provide support and solicit feedback as to their progress.

In the workplace, a consistent, fair approach is needed to foster openness about mental health issues. Managers can be an integral part in this approach. Company culture can be negatively influenced by tolerated poor behaviours, (e.g., if a supervisor consistently behaves poorly and senior management ignores it, the overall workplace culture can become toxic), and managers that use fear and coercion as motivators can be a significant barrier to improving organizational trust. However, if all managers are held accountable to foster a respectful, fair, and considerate workplace environment, employers may begin to see their employees more willing to identify workplace mental health issues. This may help to reduce the tendency of individuals with WMHIs to internalize and conceal their injury, and perhaps reduce their proclivity to leave the workplace. To accomplish this, employers could implement mental health awareness training for managers and supervisors and provide appropriate follow-up to ensure reinforcement of positive behavioral change. In a Canadian study by Dimoff (2013), a three-hour mental health awareness training program was developed for leaders (N=142) at large organizations. Results demonstrated improved mental health knowledge, self-efficacy, promotion intentions, and attitudes amongst managers and leaders in the intervention group up to eight weeks post training. Moffitt et al. (2014) investigated the effectiveness of Mental Health First Aid training for fire service line managers. Mental Health First Aid training aims to provide the tools to assist others that are developing or experiencing a mental health problem or are in a mental health crisis until appropriate support is found. Study results found a positive improvement in attitude towards and knowledge of mental health issues. More specifically, after Mental Health First Aid training, these managers were more able to recognize and respond to mental health problems and helped these managers better understand the workplace influences

on stress and how they can assist. These types of trainings equip managers with the knowledge they need to help build a company culture that is supportive of individuals with WMHIs.

The World Health Organization asserts that employers have an obligation to focus on prevention by addressing all modifiable workplace environmental risk factors and strengthening protective factors within their control (Goetzel et al., 2018). To identify environmental risk factors, organizations need to engage their employees. To solicit such feedback, employers could use existing anonymous employee surveys, bring mental health into safety moment discussions, and make mental health a priority in workplace health and safety training and plans. Additionally, workplace mental health early prevention tools that help to measure mental well-being or identify early signs and symptoms of stress, depression, and anxiety could be implemented, as they have been shown to be beneficial (Goetzel et al. 2018). Self-assessment tools could also be made available, so that individuals could recognize issues early and take appropriate actions before they become severe. Alternatively, or in conjunction with, employers could consider workplace audits to identify and address environmental stressors similar to existing workplace health and safety audits which are typically performed by employee-based health and safety committees. This would empower employees to identify the mental health hazards and create a process in which these hazards are reported to management along with possible mitigation actions.

To facilitate reporting of WMHIs, employers should ensure mental health injuries are handled through the same process, and taken as seriously, as physical health injuries. Employees should be encouraged to promptly bring forth mental health hazards, mental health stressors and scenarios, and injuries, so that the employer can investigate and follow up on the cause and implement preventative measures aimed at eliminating recurrence. While this measure is more

reactive in nature, it would further signal that the employer wants issues promptly brought forward while also signaling that WMHIs are considered equally as important as workplace physical injuries. This could help address internal and external stigma. Left unaddressed, these stigmas may negatively influence help-seeking behaviours and potentially drive the individuals to conceal workplace issues that may be impacting other workers or see these individuals change occupations to avoid them.

Healthcare Providers

Individuals with WMHIs described the complexity of the help-seeking process and reported feelings of fatigue throughout the help-seeking experience. As a result of fatigue, some participants reported deferred decision-making to trusted supports (e.g., partner), while others had no such supports available to them. Even for those who were able to defer decisions, the individual they selected may have little knowledge of mental health illnesses or the appropriate available treatments. Providing a knowledgeable resource, such as a patient navigator, for people to easily access in these situations is important, so that they may have some agency over their recovery and have a clearer view of the roadmap to recovery.

Since the primary care physician was a common resource amongst all but one participant, these healthcare professionals need to be comfortable in asking the question “is this a workplace injury” and knowledgeable in what the next steps are if the answer is yes. Currently, many emergency care workers and physicians are currently asking this question when you arrive at the hospital with a bodily injury. Primary care physicians and other healthcare providers need to understand this process and refer these individuals to a resource that is knowledgeable in assisting individuals with WMHIs.

Like patient navigators for cancer patients, implementation of patient navigators for mental health should be considered. Patient navigators are a resource for the patient that reduces barriers by helping to explain and answer questions related to procedures and treatments while also assisting the patient select options based on their desired outcomes. They also educate the patient on any community support groups that may be available. In a study on the effectiveness of oncology patient navigators in the US, researchers sampled 2601 women who were examined for breast cancer (Hoffman et al., 2012). Researchers found a significant difference in diagnostic resolution time for navigated patients (25.1 days) versus non-navigated patients (42.1 days). Interestingly, researchers found statistically significant reductions in time to diagnosis for both uninsured and privately insured women and no significant difference for those with government insurance. Ferrante et al. (2008) found a similar reduction in diagnostic resolution times in a sample of 105 minority women with abnormal mammograms, with a mean diagnostic resolution time of 25.0 days for navigated patients versus 42.7 days for non-navigated patients. Additionally, Ferrante et al. found that, for patients with navigators, feelings of anxiety were also reduced. Participants completed the Zung Anxiety Self Assessment Scale after receiving a diagnosis and anxiety was shown to be statistically significantly reduced for navigated patients (mean anxiety index: 30.2) versus non-navigated patients (mean anxiety index: 42.8). Timely access to treatment and reduced anxiety are beneficial to individuals with WMHIs because mental health disorders can progress to more complex disorders which can be more difficult to treat and increase likelihood of recurrence (Kessler & Price, 1993). While a patient navigator may help reduce time to treatment and reduce anxiety, there may be opportunity for further improvement by providing a resource that also helps these individuals understand the costs and

the available financial resources. Alternatively, adding the financial component to a mental health patient navigator training could result in a more streamlined solution.

Another possible improvement where healthcare providers could play a leading role is to help alleviate the (mis)trust issues individuals with WMHIs felt when accessing dual-relationship supports. Openly and clearly discussing what they are required to report back to the employer, as well as further clarifying and emphasizing what remains confidential, may moderate the tendency to conceal during treatment sessions. By paying particular attention to building strong trust with these vulnerable individuals early in the process, treatments may be more effective and dropout rates may decrease.

Policies and Systems

Early reporting of mental health issues helps ensure problems are addressed before they escalate and cause greater morbidity. Workplace health and safety regulations call for immediate reporting of injuries to help prevent others from getting injured in the same manner but also to ensure the individual that was injured is afforded effective treatment at time of injury and to avoid lost time off work. While this systematic process is already in place, it was created to address workplace physical injuries. Despite the WSIB now recognizing chronic mental stress in the workplace as a legitimate injury, 94% of claims in the first year were denied (The Star, 2018). This may be because it is difficult for individuals with WMHI to prove without employer support and strong healthcare advocates that the injury sustained was caused from the workplace. Couple that with the high levels of fatigue and the already complex route for help-seeking, and many individuals give up or pursue other easier to access options. This was evidenced in this present study, with some participants admitting they chose a less financially beneficial option because of the perceived difficulty in working with WSIB claims and how invasive they felt this

process was. Some participants described a cycle of revalidating the legitimacy of their injury which resulted in additional feelings of fatigue and stress. Improvements to WSIB could include improved efficiency on submitting and working through the claim and supports to the individual with WMHI in advocating for their claim with both WSIB and the employer. These changes, while important, still do not fully address the issue of reporting WMHIs. Research shows that workplace injuries are under-reported out of fear of reprisal from employers, lack of knowledge of the system, eligibility concerns, fear of being marginalized, income loss, limits on future career opportunities, and stigma towards workers compensation (Howse, 2017). Claim suppression by employers is also an issue. A research report prepared for the Manitoba Workers Compensation System (Prism, 2013a) determined that 11.5% of interviewed workers in Manitoba either experienced or were aware of overt claim suppression practices. A similar research report for WSIB in Ontario (Prism, 2013b) found that overt threats were made against Ontario workers in 20% of reviewed workers compensation claims. The present study supported previous findings of under-reporting of injuries for many of these same reasons, finding the main internal process for concealment of injuries was for self-preservation. Furthermore, stigma remains a significant barrier to overcome. The previously discussed workplace educational programs may help break down existing workplace stigma, but greater public education on mental health issues could also support this effort. Finally, employer education and stronger enforcement may help reduce claim suppression practices so that fear is reduced, and individuals feel more confident in filing claims for their WMHIs.

In Canada, there is some movement towards standardizing expectations towards workplace mental health issues and legislation to expedite mental health claims for occupations at higher risk of WMHIs. The Ontario government recognized that first responders frequently experience

high levels of stressors in their jobs and created The First Responders Act (2016). This act provides automatic approval of WSIB claims for WMHIs for those classified as first responders. In terms of prevention and handling mental health issues, the Canadian Standards Association (CSA) created the first world standards for workplace mental health, providing a much-needed framework to guide employers on workplace mental health issues but it stops short, as it is voluntary, and therefore not enforceable, leaving it up to individual employers on whether or not to follow the standards (Mental Health Commission of Canada, 2021). While these are both steps in the right direction, these policies and standards need to be taken a step further, where WSIB, CSA, and provincial governments work with employers to prevent or address WMHIs more holistically, so that not only are there financial supports and guidance documents, but an improved workplace culture that encourages individuals to discuss WMHIs and hazards and work together to mitigate them. This would require the government to take the lead and, through workshops with the relevant stakeholders, develop effective legislation that ensures workplace mental health standards become workplace requirements that are enforceable by law, and that individuals with WMHIs have their claims successfully processed.

Future Research

This study included individuals from a wide variety of occupations and, as such, made conclusions on help-seeking behaviours based on the themes that emerged from the entire sample, rather than themes based on singular occupational classes. Future research would benefit from looking at WMHI's in specific occupational classes to compare and contrast. However, for professionals that work with a variety of WMHI cases, the results from the present study could be used to inform the creation of an assessment tool for early detection and confirmation of WMHIs. As mentioned, primary care physicians were largely utilized in participants' recovery.

This finding could serve as a basis for additional research aimed at developing an assessment tool, for healthcare professionals, for determining whether there is a specific type of WMHI that warrants standardized referrals to specific mental health supports, so as to avoid additional delays for individuals seeking help.

Future research could also focus on cultural differences in help-seeking. For example, prior research conducted in Norway suggests that some immigrants may approach help-seeking for depression differently than non-immigrants, finding significant differences in how some ethnicities utilized religious, family, and semi-formal online supports (e.g., internet forums) (Markova, Sandal & Pallesen, 2020). These cultural differences are important to identify and understand, so that any improvements to healthcare services and institutional or insurance processes are made equitable and inclusive so that all have an equal chance of receiving the help needed to recover from a WMHI.

Due to the complexity of accessing resources and its effects, a potential improvement to the systems or process of help-seeking, would be a patient, or mental health, navigator role. Not all individuals with WHMIs have social supports. A patient navigator is a more patient-centered approach to healthcare, and the navigator is often an experienced healthcare provider who has a good working knowledge of the system and options and can also act as an advocate for the patient (Knesek & Hemphill, 2020). Having an easy to access resource available to present, explain, and help navigate both treatment options and financial supports could result in a reduced mental burden, faster treatment selection, and, ultimately, less time off work. Researchers could further explore whether, through the implementation of patient navigators, streamlining help-seeking trajectories or improving perceptions of the helpfulness or effectiveness of a service improved WMHI recovery outcomes. With this information, it may be possible to understand if

the WMHI associated costs to the individual (e.g., income) and to society (e.g., lost productivity) is significantly reduced. Finally, if this option is found to be beneficial, it could also mitigate the oft cited problem of doctor availability, by offering an alternative to seeking the counsel of the primary care physician at various points during help-seeking.

Finally, future research could explore whether a systems approach, which has been suggested to effectively reduce workplace stress, could be applied more broadly to mental health in the workplace to better understand its efficacy in treating or preventing WMHIs (LaMontagne et al., 2012). The systems approach, as described by LaMontagne, provides primary, secondary, and tertiary interventions in the workplace which could provide a more prescribed approach to help-seeking and potentially reduce fatigue, avoidance, and the escape behaviours for individuals with WHMIs. A primary intervention is described as proactive measures aimed at reducing or preventing the occurrence of stressors by involving employees in job planning, workplace improvements, and decision-making. Secondary interventions are corrective in nature. Much like the process with workplace physical injuries, once a specific workplace hazard is identified, proactive measures are taken to try to mitigate recurrence of exposure to that hazard. With physical injuries, there is a job evaluation after injury, which may result in job redesign. In the case of mental health, it may be the implementation of targeted stress management programs, coping support tools, or skills development programs (e.g., time management, conflict resolution, etc.) Finally, tertiary interventions are reactive in nature, meaning that once a WHMI occurs, efforts to assist affected individuals are put into place. This includes supports like EAP services, return to work programs, and group talk. Much research has been conducted on approaches to rehabilitation for mental health issues. For example, Kosny et al. (2016) found that healthcare providers noted that individuals that returned to work too early were susceptible to

psychological recovery setbacks and a strong chance of a recurring need for additional time off work for recovery. Alternatively, within the same study, results demonstrated that returning to work at the appropriate time had strong benefits such as social connection, decreased financial concerns, and structured routine, all aiding in recovery. Therefore, workplace modifications and accommodations for those trying to reintegrate into the workforce is a feasible course of action to help facilitate a successful return, including constructive dialogue between the individual, the healthcare professional, and the employer. A systems approach that incorporates these three phases of interventions could create a workplace environment where employees feel empowered to openly discuss mental health issues, support peers with WMHIs, and prevent WMHIs through improvements to the workplace environment learning from past incidents. This could lift the burden off individuals with WMHIs and provide a more prescribed approach to help-seeking, thereby reducing the fatigue they experience and reduce or eliminate the desire to conceal the injury.

Strengths and Limitations

This study's strengths lie in the diversity of the sample (i.e., the range of occupations, age, gender), the lived-experiences of the participants, and the exploratory qualitative approach and follow-up interviews for data collection and analysis. Moreover, the sample was a random sample, meaning participants were not selected through any particular system which could potentially influence help-seeking trajectories in some manner. This diverse sample of age, gender, occupations, resources utilized, and injuries experienced, creates a foundation by collecting broad observations on WMHI help-seeking behaviours, which will enable future researchers to build upon to better understand any nuances between occupational classes or workplace environments. Results from this study provide direction for mixed methods or

quantitative research that may be more statistically generalizable to various sub-populations. Further, the granular and detailed analysis contributes to our understanding of the complexities of seeking help for WMHIs and the internal and procedural barriers individuals often encounter as they attempt to navigate their return to well-being.

Some limitations should be noted. First, the participants in this study came from a wide variety of occupations. While this was beneficial in creating a foundational understanding of help-seeking experiences and behaviours for WMHIs, delving further into the specifics of an occupation may allow for a better understanding of the nuances of WMHI help-seeking. For example, the passing of the First Responders Act in 2016 (Flynn, n.d.) may influence the help-seeking experiences of first responders because of the automatic acceptance of WMHI claims. Second, this present study relied on self-reporting of the WMHI and subsequent diagnosis of the injury as access to this information for verification would be difficult to obtain both ethically and logistically, and, as such, was unable to confirm participant diagnosis or verify the mental health issue was solely a result of workplace incident or workplace environmental factors. Finally, as with all qualitative methods-based research, causality of the specific help-seeking behaviours is difficult to discern and may not be statistically representative.

Conclusions

This qualitative study of help-seeking behaviours added to the current body of knowledge on help-seeking as it points to specific features of the individual and environment that influence help-seeking that are present in the workplace. This study included a diverse sample of occupations and WMHI types. Careful examination of the data revealed three common themes: 1) workers concealed injuries and distanced themselves from stressors as a means of self-help and self-preservation, 2) complex help-seeking pathways and accumulated stressors caused

fatigue leading to reduced independence in decision-making, and 3) (mis) trust contributed to resources accessed. These insights can be used to improve practice through targeted intervention programs that improve workplace environment, employer knowledge, and public and private healthcare systems improvements as well as individual-focused interventions and supports. More broadly, these findings demonstrate that, while we have progressed in dealing with physical health problems in the workplace, there is still much room for improvement in how we address mental health problems in the workplace. Future research should focus on whether additional supports, such as patient navigators, would help mitigate help-seeking complexity and investigate help-seeking behavioural differences associated with occupational class, culture, and the efficacy of a systems approach to workplace mental health. These additional areas of research may help improve time to recovery, workplace policies and procedures, workplace environment, and potentially, reduce fatigue, and simplify help-seeking pathways to get workers the help they need.

References

Ablon J. (2002). The nature of stigma and medical conditions. *Epilepsy & Behavior, 3*(6S2), 2–9. https://doi.org/10.1016/s1525-5050(02)00543-7

Alire, L. U. (2019). *Appraisals of trust development within the therapist-client relationship: impacts on client retention in a hypothetical first session of therapy* (Publication No. 27543379) [Master's thesis, University of Massachusetts Boston]. ProQuest. https://scholarworks.umb.edu/masters_theses/589

American Psychiatric Association. (2019, May 20). *About half of workers are concerned about discussing mental health issues in the workplace; a third worry about consequences if they seek help.* Retrieved from American Psychiatric Association: https://www.psychiatry.org/newsroom/news-releases/about-half-of-workers-are-concerned-about-discussing-mental-health-issues-in-the-workplace-a-third-worry-about-consequences-if-they-seek-help

American Psychological Association. (2020). APA Dictionary of Psychology. Retrieved from American Psychological Association: https://dictionary.apa.org/escape-behavior

Andersen, R.M. (1968). Families' use of health services: A behavioral model of predisposing, enabling, and need components. (Publication No. 6902884) [Doctoral dissertation, Centre for Health Administration Studies, Chicago]. ProQuest Dissertations Publishing. https://www.proquest.com/docview/302351484

Andersen, R. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36*(1), 1-10. doi:10.2307/2137284

Andrade, L. H., Alonso, J., Mneimneh, Z., Wells, J. E., Al-Hamzawi, A., Borges, G., Bromet, E., Bruffaerts, R., de Girolamo, G., de Graaf, R., Florescu, S., Gureje, O., Hinkov, H. R., Hu,

C., Huang, Y., Hwang, I., Jin, R., Karam, E. G., Kovess-Masfety, V., Levinson, D., … Kessler, R. C. (2014). Barriers to mental health treatment: results from the WHO World Mental Health surveys. *Psychological Medicine, 44*(6), 1303–1317. https://doi.org/10.1017/S0033291713001943

Arends, I., van der Klink, J., van Rhenen, W., de Boer, M., & Bültmann, U. (2014). Predictors of recurrent sickness absence among workers having returned to work after sickness absence due to common mental disorders. *Scandinavian Journal of Work, Environment & Health, 40*(2), 195-202. https://doi.org/10.5271/sjweh.3384

Arthur, A. R. (2000). Employee assistance programmes: The emperor's new clothes of stress management? *British Journal of Guidance & Counselling, 28*(4), 549–559. https://doi.org/10.1080/03069880020004749

Asghar, J. (2013). Critical paradigm: A preamble for novice researchers. *Life Science. 10*. 3121-3127. https://www.researchgate.net/publication/260675135_Critical_Paradigm_A_Preamble_for_Novice_Researchers

Barker, G. (2007). Adolescents, social support and help-seeking behaviour : An international literature review and programme consultation with recommendations for action. *World Health Organization*. https://apps.who.int/iris/handle/10665/43778

BC First Responders' Mental Health. (2021). *Overview of Peer Support Programs*. Retrieved from BC first responders' mental health: https://bcfirstrespondersmentalhealth.com/resource/overview-peer-support-programs/

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research, 26*(13), 1802–1811. https://doi.org/10.1177/1049732316654870

Bonabi, H., Müller, M., Ajdacic-Gross, V., Eisele, J., Rodgers, S., Seifritz, E., Rössler, W., & Rüsch, N. (2016). Mental health literacy, attitudes to help seeking, and perceived need as predictors of mental health service use: A longitudinal study. *Journal of Nervous & Mental Disease*, *204*(4), 321–324. https://doi.org/10.1097/NMD.0000000000000488

Bolo, C., Sareen, J., Patten, S., Schmitz, N., Currie, S., & Wang, J. (2013). Receiving workplace mental health accommodations and the outcome of mental disorders in employees with a depressive and/or anxiety disorder. *Journal of Occupational and Environmental Medicine, 55*(11), 1293–1299. https://doi.org/10.1097/JOM.0b013e31829fd065

Bonabi, H., Müller, M., Ajdacic-Gross, V., Eisele, J., Rodgers, S., Seifritz, E., Rössler, W., & Rüsch, N. (2016). Mental health literacy, attitudes to help seeking, and perceived need as predictors of mental health service use: A longitudinal study. *Journal of Nervous & Mental Disease*, *204*(4), 321–324. https://doi.org/10.1097/NMD.0000000000000488

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Brijnath, B., Mazza, D., Singh, N., Kosny, A., Ruseckaite, R., & Collie, A. (2014). Mental health claims management and return to work: Qualitative insights from Melbourne, Australia. *Journal of Occupational Rehabilitation*, *24*(4), 766–776. https://doi.org/10.1007/s10926-014-9506-9

Brouwers, E.P.M., Joosen, M.C.W., van Zelst, C., & Van Weeghel, J. (2020). To disclose or not to disclose: A multi-stakeholder focus group study on mental health issues in the work

environment. *Journal of Occupational Rehabilitation, 30*(8), 84–92. https://doi.org/10.1007/s10926-019-09848-z

Buch, A. & Andersen, V. (2013). (De)stabilizing self-identities in professional work. *Nordic Journal of Working Life Studies, 3*(3). https://doi.org/10.19154/njwls.v3i3.3016

Canadian Institute for Health Information. (2021, May 26). *New CIHI data available: Wait times for mental health counselling and for home care services*. Retrieved from CIHI.com: https://www.cihi.ca/en/new-cihi-data-available-wait-times-for-mental-health-counselling-and-for-home-care-services

Carey, M. P., & Forsyth, A. D. (2009). Teaching tip sheet: Self-efficacy. Retrieved from American Psychological Association: https://www.apa.org/pi/aids/resources/education/self-efficacy4

Carleton, R. N., Afifi, T. O., Turner, S., Taillieu, T., Duranceau, S., LeBouthillier, D. M., Sareen, J., Ricciardelli, R., MacPhee, R. S., Groll, D., Hozempa, K., Brunet, A., Weekes, J. R., Griffiths, C. T., Abrams, K. J., Jones, N. A., Beshai, S., Cramm, H. A., Dobson, K. S., Hatcher, S., … Asmundson, G. (2018). Mental disorder symptoms among public safety personnel in Canada. *Canadian Journal of Psychiatry, 63*(1), 54- 64. https://doi.org/10.1177/0706743717723825

Cheng, H., Wang, C., McDermott, R. C., Kridel, M., & Rislin, J. L. (2018). Self-stigma, mental health literacy, and attitudes toward seeking psychological help. *Journal of Counseling & Development, 96*(1), 64–74. https://doi.org/10.1002/jcad.12178

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S. L., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and

qualitative studies. *Psychological Medicine, 45*(1), 11-27. http://dx.doi.org/10.1017/S0033291714000129

Colligan, T. W. & Higgins, E., W. (2006). Workplace stress. *Journal of Workplace Behavioral Health, 21*(2), 89-97. doi: https://doi.org/10.1300/J490v21n02_07

Conant, J. (2020, August 28). *Peer Support: The missing piece of the mental health puzzle*. https://www.ems1.com/mental-health/articles/peer-support-the-missing-piece-of-the-mental-health-puzzle-5vITjH2EZaQz8FaX/

Corbière, M., Mazaniello-Chézol, M., Bastien, M.-F., Wathieu, E., Bouchard, R., Panaccio, A., Guay, · Stéphane, Lecomte, T., & Molson, J. (2020). Stakeholders' role and actions in the return-to-work process of workers on sick-leave due to common mental disorders: A scoping review. *Journal of Occupational Rehabilitation, 30*, 381–419. https://doi.org/10.1007/s10926-019-09861-2

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry: Official Journal of the World Psychiatric Association, 1*(1), 16–20. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1489832/

Dang, B. S., Westbrook, R. A., Njue, S. M., & Giordano, T. P. (2017). Building trust and rapport early in the new doctor-patient relationship: a longitudinal qualitative study. *BMC Medical Education, 17*, (32). https://doi.org/10.1186/s12909-017-0868-5

Dhabhar, F. S. (2014). Effects of stress on immune function: the good, the bad, and the beautiful. *Immunologic Research, 58*(2–3), 193. https://doi.org/10.1007/s12026-014-8517-0

Dimoff, J. K. (2013). Mental health awareness training (MHAT): The development and evaluation of an intervention for leaders [unpublished master's thesis]. Saint Mary's University. https://library2.smu.ca/handle/01/25057

Dimoff, J. & Kelloway, K. (2013). Bridging the gap: Workplace mental health research in Canada. *Canadian Psychology/Psychologie Canadienne. 54*, 203. doi:10.1037/a0034464.

Dunkel Schetter C., (2011). Psychological science on pregnancy: stress processes, biopsychosocial models, and emerging research issues. *Annual Review of Psychology, 62*, 531-558. doi: 10.1146/annurev.psych.031809.130727

Eggertson L. (2011). Lack of workplace mental health resources increases pressure on health care system. *Canadian Medical Association journal = journal de l'Association medicale canadienne, 183*(12), E767–E768. https://doi.org/10.1503/cmaj.109-3945

Farh, J., Hackett, R. D., & Liang, J. (2007). Individual-level cultural values as moderators of perceived organizational support--employee outcome relationships in China: Comparing the effects of power distance and traditionality. *Academy of Management Journal, 50*(3), 715-729. http://dx.doi.org.proxy1.lib.trentu.ca/10.5465/AMJ.2007.25530866

Feldman, D. C., & Brett, J. M. (1983). Coping with new jobs: A comparative study of new hires and job changers. *Academy of Management Journal*, *26*(2), 258–272. https://doi.org/10.2307/255974

Ferrante, J. M., Chen, P. H., & Kim, S. (2008). The effect of patient navigation on time to diagnosis, anxiety, and satisfaction in urban minority women with abnormal mammograms: A randomized controlled trial. *Journal of Urban Health, 85*(1), 114-124. doi:10.1007/s11524-007-9228-9

Fikretoglu, D., & Liu, A. (2015). Perceived barriers to mental health treatment among individuals with a past-year disorder onset: Findings from a Canadian population health survey. *Social Psychiatry and Psychiatric Epidemiology*, *50*(5), 739–746. https://doi.org/10.1007/s00127-014-0975-0

Forero, R., Nahidi, S., De Costa, J. et al. (2018). Application of four-dimension criteria to assess rigour of qualitative research in emergency medicine. *BMC Health Serv Research, 18***,** 120. https://doi.org/10.1186/s12913-018-2915-2

Flynn, K. (n.d.). *Bill 163, Supporting Ontario's First Responders Act (Posttraumatic Stress Disorder), 2016*. Retrieved from Legislative Assembly of Ontario: https://www.ola.org/en/legislative-business/bills/parliament-41/session-1/bill-163

Franche, R. L., & Krause, N. (2002). Readiness for return to work following injury or illness: Conceptualizing the interpersonal impact of health care, workplace, and insurance factors. *Journal of Occupational Rehabilitation, 12*(4), 233–256. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=12389476

Gallucci, G., Swartz, W., & Hackerman, F. (2005). Impact of the wait for an initial appointment on the rate of kept appointments at a mental health center. *Psychiatric Services, 56*(3), 344–346. https://doi.org/10.1176/appi.ps.56.3.344

Gergelyfi, M., Benvenuto, J., Etienne, O., & Alexandre, Z. (2015). Dissociation between mental fatigue and motivational state during prolonged mental activity. *Frontiers in Behavioral Neuroscience*. 9. 176. https://doi.org/10.3389/fnbeh.2015.00176

Ghio, L., Gotelli, S., Cervetti, A., Respino, M., Natta, W., Marcenaro, M., Serafini, G., Vaggi, M., Amore, M., & Belvederi Murri, M. (2015). Duration of untreated depression influences clinical outcomes and disability. *Journal of Affective Disorders 175*(4), 224-228. https://doi.org/10.1016/j.jad.2015.01.014

Goetzel, R. Z., Roemer, E. C., Holingue, C., Fallin, M. D., McCleary, K., Eaton, W., Agnew, J., Azocar, F., Ballard, D., Bartlett, J., Braga, M., Conway, H., Crighton, K. A., Frank, R.,

Jinnett, K., Keller-Greene, D., Rauch, S. M., Safeer, R., Saporito, D., Schill, A., … Mattingly, C. R. (2018). Mental health in the workplace: A call to action proceedings from the mental health in the workplace-public health summit. *Journal of Occupational and Environmental Medicine*, *60*(4), 322–330. https://doi.org/10.1097/JOM.0000000000001271

Gold, P. B., Oire, S. N., Fabian, E. S., & Wewiorski, N. J. (2012). Negotiating reasonable workplace accommodations: Perspectives of employers, employees with disabilities, and rehabilitation service providers. *Journal of Vocational Rehabilitation, 37*(1), 25–37. https://doi.org/10.3233/jvr-2012-0597

Gonzalez, J. M., Alegría, M., Prihoda, T. J., Copeland, L. A., & Zeber, J. E. (2011). How the relationship of attitudes toward mental health treatment and service use differs by age, gender, ethnicity/race and education. *Social Psychiatry and Epidemiology*, *46*, 45–57. https://doi.org/10.1007/s00127-009-0168-4

Government of Ontario. (2020, August 26). *Guide to the Occupational Health and Safety Act.* https://www.ontario.ca/document/guide-occupational-health-and-safety-act

Government of Canada. (2020, September 14). *Hierarchy and Structure*. Retrieved from National Occupation Classification: https://noc.esdc.gc.ca/Structure/Hierarchy/0364c43179de4822891887a9e4ce94eb?objectid=%2Fd0IGA6qD8JPRfoj5UCjpg%3D%3D

Government of Canada. (2020, December 23). *Employment Insurance (EI)*. Retrieved from Canada.ca: https://www.canada.ca/en/employment-social-development/programs/ei.html#:~:text=The%20Employment%20Insurance%20(EI)%20program,illness

Government of Canada. (2021, April 07). *OSH Answers Fact Sheets*. Retrieved from Canadian Centre for Occupational Health and Safety: https://www.ccohs.ca/oshanswers/hsprograms/eap.html#:~:text=An%20EAP%2C%20or%20employee%20assistance,alcoholism%20programs%20of%20the%201940%27s

Government of Ontario. (2013, October). *Rights and Duties: FAQs*. Retrieved from Ministry of Labour, Training, and Skills Development: https://www.labour.gov.on.ca/english/hs/faqs/rights.php#duties

Gray, P., Senabe, S., Naicker, N., Kgalamono, S., Yassi, A., & Spiegel, J. M. (2019). Workplace-based organizational interventions promoting mental health and happiness among healthcare workers: A realist review. *International Journal of Environmental Research and Public Health*, *16*(22). https://doi.org/10.3390/ijerph16224396

Hammarberg, K., Kirkman, M., & de Lacey, S. (2016). Qualitative research methods: When to use them and how to judge them. *Human Reproduction, 31*(3). 498–501. https://doi.org/10.1093/humrep/dev334

Hampson, M.E., Watt, B.D., & Hicks, R.E. (2020). Impacts of stigma and discrimination in the workplace on people living with psychosis. *BMC Psychiatry 20*(6), 288. https://doi.org/10.1186/s12888-020-02614-z

Hoffman, H. J., LaVerda, N. L., Young, H. A., Levine, P. H., Alexander, L. M., Brem, R., Caicedo, L., Eng-Wong, J., Frederick, W., Funderburk, W., Huerta, E., Swain, S., & Patierno, S. R. (2012). Patient navigation significantly reduces delays in breast cancer diagnosis in the District of Columbia. *Cancer epidemiology, biomarkers & prevention: A publication of the American Association for Cancer Research, cosponsored by the*

American Society of Preventive Oncology, *21*(10), 1655–1663. https://doi.org/10.1158/1055-9965.EPI-12-0479

Horkheimer, M. (1982). *Critical theory: Selected essays.* New York: Continuum Pub. Corp.

Howse, D. J. (2017). *Injured workers' moral engagement in the compensation system: The social production of problematic claiming experience.* [Doctoral dissertation, University of Toronto]. TSpace. https://tspace.library.utoronto.ca/handle/1807/80854

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). "Mental health literacy": A survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *The Medical Journal of Australia*, *166*(4), 182–186. https://doi.org/10.5694/j.1326-5377.1997.tb140071.x

Kessler, R. C., & Price, R. H. (1993). Primary prevention of secondary disorders: A proposal and agenda. *American journal of community psychology*, *21*(5), 607–633. https://doi.org/10.1007/BF00942174

Kirsh, B. & McKee, P. (2003). The needs and experiences of injured workers: A participatory research study. *Work, 21*(3), 221-231. https://www.researchgate.net/publication/9024666_The_needs_and_experiences_of_injured_workers_A_participatory_research_study

Knesek, G., Hemphill, T. (2020) Mental health navigation – a model. *Health Promotion International*, *35*(1), 151–159. https://doi.org/10.1093/heapro/day109

Korstjens, I. & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice, 24*(1), 120-124, doi: 10.1080/13814788.2017.1375092

Kosny, A., MacEachen, E., Ferrier, S., & Chambers, L. (2011). The role of health care providers in long term and complicated workers' compensation claims. *Journal of Occupational Rehabilitation, 21*(4), 582-590. doi:10.1007/s10926-011- 9307-3

Kosny, A., Lifshen, M., Tonima, S., Yanar, B., Russell, E., MacEachen, E., …Cooper, J. (2016) The role of health-care providers in the workers' compensation system and return-to-work process: Final report. *Institute for Work & Health*. Retrieved from http://www.ciwa.ca/wp-content/uploads/2016/12/Final-report-HCP-study-Kosny-et-al-Dec-14-2016.pdf

Kuoppala, J., Lamminpää, A., Liira, J., & Vainio, H. (2008). Leadership, job well-being, and health effects—A systematic review and a meta-analysis. *Journal of Occupational and Environmental Medicine, 50*(8) 904-915. doi:10.1097/JOM.0b013e31817e918d

LaMontagne, A. & Keegel, T. (2012) *Reducing stress in the workplace: An evidence review: Summary report.* Victorian Health Promotion Foundation. http://dro.deakin.edu.au/view/DU:30061224

Lemieux, P., Durand, M. & Hong, Q. N. (2011). Supervisors' perception of the factors influencing the return to work of workers with common mental disorders. *Journal of Occupational Rehabilitation, 21*(3), 293-303. doi:10.1007/s10926-011-9316-2

Lovibond, P.F. & Lovibond, S.H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy, 33*, 335-343. doi: 10.1016/0005-7967(94)00075-u

Lovibond, S.H. & Lovibond, P.F. (1995). Manual for the depression anxiety stress scales. (2nd. Ed.) Sydney: Psychology Foundation.

MacEachen E, Kosny A, Ferrier S, & Chambers L. (2010). The “Toxic Dose” of system problems: Why some injured workers don’t return to work as expected. *Journal of Occupational Rehabilitation*, *20*(3), 349–366. https://doi.org/10.1007/s10926-010-9229-5

Mahar, I., Bambico, F. R., Mechawar, N., & Nobrega, J. N. (2014). Stress, serotonin, and hippocampal neurogenesis in relation to depression and antidepressant effects. *Neuroscience and Biobehavioral Reviews, 38*, 173–192. https://doi.org/10.1016/j.neubiorev.2013.11.009

Mak, W. W. S., & Cheung, R. Y. M. (2010). Self-stigma among concealable minorities in Hong Kong: Conceptualization and unified measurement. *American Journal of Orthopsychiatry,* 80(2), 267-281. http://dx.doi.org.proxy1.lib.trentu.ca/10.1111/j.1939-0025.2010.01030.x

Markova, V., Sandal, G.M. & Pallesen, S. (2020). Immigration, acculturation, and preferred help-seeking sources for depression: Comparison of five ethnic groups. *BMC Health Services Research 20***,** 648. https://doi.org/10.1186/s12913-020-05478-x

Martire, I. L., Caruso, D., Palagini, L., Zoccoli, G., & Bastianini, S. (2020) Stress & sleep: A relationship lasting a lifetime. *Neuroscience & Biobehavioral Reviews*, *117*, 65-77. https://doi.org/10.1016/j.neubiorev.2019.08.024

McFarlane, A. C., & Bryant, R. A. (2007). Post-traumatic stress disorder in occupational settings: anticipating and managing the risk. *Occupational Medicine, 57*(6), 404–410, https://doi.org/10.1093/occmed/kqm070

Meier, P. S., Donmall, M. C., McElduff, P., Barrowclough, C., & Heller, R. F. (2006). The role of the early therapeutic alliance in predicting drug treatment dropout. *Drug and Alcohol Dependence*, *83*(1), 57–64. https://doi.org/10.1016/j.drugalcdep.2005.10.010

Mental Health Commission of Canada. (2021). *National Standard*. Retrieved from Mental Health Commission of Canada: https://www.mentalhealthcommission.ca/English/what-we-do/workplace/national-standard

Milligan-Saville, J. S., Tan, L., Gayed, A., Barnes, C., Madan, I., Dobson, M., Bryant, R. A., Christensen, H., Mykletun, A., & Harvey, S. B. (2017). Workplace mental health training for managers and its effect on sick leave in employees: a cluster randomised controlled trial. *Psychiatry*, *4*(11), 850–858. https://doi.org/10.1016/S2215-0366(17)30372-3

Moffitt, J., Bostock, J., & Cave, A. (2014). Promoting well-being and reducing stigma about mental health in the fire service. *Journal of Public Mental Health, 13*, 103-113. https://www.semanticscholar.org/paper/Promoting-well-being-and-reducing-stigma-about-in-Moffitt-Bostock/75ee3b1905283d290e80d4fd6ec9d390ca7bc132

Mojtabai, R., Evans-Lacko, S., Schomerus, G., Thornicroft, G. (2016). Attitudes toward mental health help seeking as predictors of future help-seeking behavior and use of mental health treatments. *Psychiatric Services, 67*(2), https://doi.org/10.1176/appi.ps.201500164

Noblet, A., & LaMontagne, A. D. (2006). The role of workplace health promotion in addressing job stress. *Health Promotion International*, *21*(4), 346–353. https://doi.org/10.1093/HEAPRO/DAL029

Nogues, S., & Finucan, J. (2018). Economic evaluations of workplace mental health interventions: A critical review. *Canadian Journal of Administrative Sciences*, *35*(4), 551–562. https://doi.org/10.1002/cjas.1502

Ozawa, S., & Sripad, P. (2013) How do you measure trust in the health system? A systematic review of the literature. *Social Science & Medicine, 91*(8), 10-14. https://doi.org/10.1016/j.socscimed.2013.05.005

Paychek Inc. (2021, May 14). *Short term disability insurance vs. long term disability insurance.* Retrieved from Paychek Inc.: https://www.paychex.com/articles/employee-benefits/short-vs-long-term-disability-insurance

Perry, B. L., & Pescosolido, B. A. (2015). Social network activation: The role of health discussion partners in recovery from mental illness. *Social Science & Medicine, 125*, 116–128. https://doi.org/10.1016/j.socscimed.2013.12.033

Pew Research Center. (2016, October 6). *The State of American Jobs*. Retrieved from Pew Research Center: https://www.pewresearch.org/social-trends/2016/10/06/1-changes-in-the-american-workplace/

Pfeffer, J., Vilendrer, S., Joseph, G., Kim, J., & Singer, S. J. (2020). Employers' role in employee health: Why they do what they do. *Journal of Occupational and Environmental Medicine*, *62*(11), 601– 610. https://doi.org/10.1097/JOM.0000000000001967

Pringle, J., Drummond, J., McLafferty, E., & Hendry, C. (2011). Interpretative phenomenological analysis: a discussion and critique. *Nurse researcher*, *18*(3), 20–24. https://doi.org/10.7748/nr2011.04.18.3.20.c8459

Prism, 2013a. Economics & Analysis. Claim Suppression in the Manitoba Workers Compensation System: Research Report. https://www.wcb.mb.ca/sites/default/files/Manitoba%20WCB%20Claim%20Suppression%20Report%20-%20Final-1.pdf

Prism, 2013b. Economics & Analysis. Workplace Injury Claim Suppression: Final Report. Retrieved from https://fightwcb.org/files/Prism%20Report.pdf. Accessed August 12, 2021

Rafal, G., Gatto, A., & DeBate, R. (2018). Mental health literacy, stigma, and help-seeking behaviors among male college students. *Journal of American College Health, 66*(4), 284–291. https://doi.org/10.1080/07448481.2018.1434780

Reynolds, C. A., Wagner, S. L. & Harder, H. G. (2006) Physician-stakeholder collaboration in disability management: A Canadian perspective on guidelines and expectations. *Disability & Rehabilitation, 28*(15), 955-963. doi:10.1080/09638280500387112

Ricciardelli, R., Carleton, R. N., Gacek, J., & Groll, D. L. (2020). Understanding needs, breaking down barriers: Examining mental health challenges and well-being of correctional staff in Ontario, Canada. *Frontiers in Psychology*, *11*, 1036. https://doi.org/10.3389/fpsyg.2020.01036

Rickwood, D., & Thomas, K. (2012). Conceptual measurement framework for help-seeking for mental health problems. *Psychology Research and Behavior Management*, *5*, 173–183. https://doi.org/10.2147/PRBM.S38707

Rikkers, W., & Lawrence, D. (2021). Mental health help-seeking experiences and service use among Australian first responders. *Australian Journal of Psychology*, 73:2, 125-133, doi: 10.1080/00049530.2021.1882271

Rothbaum, B. O., Kearns, M. C., Price, M., Malcoun, E., Davis, M., Ressler, K. J., . . . Houry, D. (2012). Early intervention may prevent the development of posttraumatic stress disorder: A randomized pilot civilian study with modified prolonged exposure. *Biological Psychiatry, 72*(11), 957-963. doi:10.1016/j.biopsych.2012.06.002

Rüsch, N., Müller, M., Ajdacic-Gross, V., Rodgers, S., Corrigan, P. W., & Rössler, W. (2014). Shame, perceived knowledge and satisfaction associated with mental health as predictors

of attitude patterns towards help-seeking. *Epidemiology and Psychiatric Sciences*, *23*(2), 177–187. https://doi.org/10.1017/S204579601300036X

Schetter, C. D., & Dolbier, C. (2011). Resilience in the context of chronic stress and health in adults. *Social and Personality Psychology Compass*, *5*(9), 634–652. https://doi.org/10.1111/j.1751-9004.2011.00379.x

Schnyder, N., Panczak, R., Groth, N., & Schultze-Lutter, F. (2017). Association between mental health-related stigma and active help-seeking: Systematic review and meta-analysis. *The British Journal of Psychiatry : The Journal of Mental Science*, *210*(4), 261–268. https://doi.org/10.1192/bjp.bp.116.189464

Schomerus, G., Appel, K., Meffert, P., Luppa, M., Andersen, R., Grabe, H., & Baumeister, S. (2013). Personality-related factors as predictors of help-seeking for depression: a population-based study applying the Behavioral Model of Health Services Use. *Social Psychiatry & Psychiatric Epidemiology*, *48*(11), 1809–1817. https://doi.org/10.1007/s00127-012-0643-1

Scott, L. & Dalton, C. (2016). *Rethinking mental health disability claim management.* Organizational Solutions Inc. http://orgsoln.com/wp-content/uploads/2021/05/Rethinking-Mental-Health-Disability-Claim-Management.pdf

Sharf, J. & Primavera, L. & Diener, M. (2010). Dropout and therapeutic alliance: A meta-analysis of adult individual psychotherapy. *Psychotherapy* (Chicago, Ill.). 47. 637-45. 10.1037/a0021175.

Sin, E., Liu, H. L., Lee, S. H., Huang, C. M., Wai, Y. Y., Chen, Y. L., Chan, C., Lin, C., & Lee, T. (2018). The relationships between brain structural changes and perceived loneliness in

older adults suffering from late-life depression. *International Journal of Geriatric Psychiatry*, *33*(4), 606–612. https://doi.org/10.1002/gps.4831

Sinclair, S., Siefert, C., Slavin-Mulford, J., Stein, M., Renna, M., & Blais, M. (2011). Psychometric evaluation and normative data for the depression, anxiety, and stress scales-21 (DASS-21) in a nonclinical sample of U.S. adults. *Evaluation & the Health Professions. 35.* 259-79. https://doi.org/10.1177/0163278711424282

Sisley, R., Henning, M. A., Hawken, S. J., & Moir, F. (2010, June 1). A conceptual model of workplace stress: the issue of accumulation and recovery and the health professional. *New Zealand Journal of Employment Relations*, *35*(2), 3. https://www.researchgate.net/publication/284072058_A_conceptual_model_of_workplace_stress_The_issue_of_accumulation_and_recovery_and_the_health_professional

Slaunwhite, A. (2015). The role of gender and income in predicting barriers to mental health care in Canada. *Community Mental Health Journal*, *51*(5), 621–627. https://doi.org/10.1007/s10597-014-9814-8

Smetanin, P., Stiff, D., Briante, C., Adair, C. E., Ahmad, S., & Khan, M. (2011). The life and economic impact of major mental illnesses in Canada: 2011 to 2041. RiskAnalytica on behalf of the Mental Health Commission of Canada. Retrieved from http://www.mentalhealthcommission.ca

Song Z, Baicker K. Effect of a Workplace Wellness Program on Employee Health and Economic Outcomes: A Randomized Clinical Trial. *JAMA.* 2019;321(15):1491–1501. doi:10.1001/jama.2019.3307

Strömberg, C., Aboagye, E., Hagberg, J., Bergström, G., & Lohela-Karlsson, M. (2017). Estimating the effect and economic impact of absenteeism, presenteeism, and work

environment–related problems on reductions in productivity from a managerial perspective. *Value in Health, 20*(8), 1058–1064. https://doi.org/10.1016/j.jval.2017.05.008

Szeto, A. C. H., & Dobson, K. S. (2013). Mental disorders and their association with perceived work stress: An investigation of the 2010 Canadian community health survey. *Journal of Occupational Health Psychology, 18*(2), 191-197. doi: 10.1037/a0031806.

Tarasuk, V., & Eakin, J. M. (1995). The problem of legitimacy in the experience of work-related back injury. Qualitative Health Research, 5(2), 204–221. https://doi.org/10.1177/104973239500500205

Tennant, C. (2001). Work-related stress and depressive disorders. *Elsevier, 51*(5), 697-704. https://doi.org/10.1016/S0022-3999(01)00255-0

Van den Hoonaard, D. K. (2012). *Qualitative research in action: A Canadian primer* (1st ed.). Don Mills: Oxford University Press Canada.

Whatmore, L., Cartwright, S. & Cooper, C. (1999). United Kingdom: Evaluation of a stress management programme in the public sector. In M. Kompier & C. Cooper (Eds), *Preventing Stress, Improving Productivity* (pp. 149-174). New York: Routledge.

White, P. R. (2019). *When Does an Employee's Mental Illness Trigger an Employer's Duty to Accommodate?* https://employmentlaw101.ca/when-does-an-employees-mental-illness-trigger-an-employers-duty-to-accommodate/

Widows, M. R., & Smith, G. P. (2021). *SIMS. Structured Inventory of Malingered Symptomatology*. Retrieved from PAR Inc.: https://www.parinc.com/Products/Pkey/410

Wilson, S., Guliani, H., & Boichev, G. (2016). On the economics of post-traumatic stress disorder among first responders in Canada. *Journal of Community Safety and Well-Being, 1*(2), 26-31. https://doi.org/10.35502/jcswb.6

World Health Organization. Occupational Health. Stress at the workplace. Retrieved July 20, 2021, from http://www.who.int/occupational_health/topics/stressatwp/en/

WSIB Ontario. (2017, October). *WSIB Chronic Mental Stress Policy Consultation Summary*. Retrieved August, 13, 2021, from https://www.wsib.ca/en/search-results?search=WSIB%20CHRONIC%20MENTAL%20STRESS%20POLICY%20CONSULTATION%20SUMMARY

WSIB Ontario. (2021). *Work-Related Mental Stress Injuries.* Retrieved August 13, 2021, from https://www.wsib.ca/en/injured-or-ill-people/claims/work-related-mental-stress-injuries

Yu, B. C. L., Chio, F. H. N., Mak, W. W. S., Corrigan, P. W., & Chan, K. K. Y. (2021). Internalization process of stigma of people with mental illness across cultures: A meta-analytic structural equation modeling approach. *Clinical Psychology Review*, *87*. https://doi.org/10.1016/j.cpr.2021.102029

Zaheer, S., Ginsburg, L., Wong, H. J., Thomson, K., Bain, L., & Wulffhart, Z. (2019). Turnover intention of hospital staff in Ontario, Canada: Exploring the role of frontline supervisors, teamwork, and mindful organizing. *Human Resources for Health 17*,66. https://doi.org/10.1186/s12960-019-0404-2

Appendix A

Interview Protocol

Help-Seeking Behaviours Amongst Individuals with Work-Related Mental Health Injuries

Individual Initial Interview Protocol (Principle Data)

Record: Date: Place: Time in & out:

1. Interviewer's Role- Ensure the Following:
   a) The interviewee is aware the tape recorder is going to be turned on
   b) Turn on the tape recorder
   c) Take field notes- record observations of the answers, important points of discussion
   d) Introduce purpose, boundaries, and guidelines for the discussion
   e) Facilitate the discussion, including asking questions and prompting discussion
   f) Debrief the participant during completion of interview
2. Process- Check to ensure these are completed:
   - ☐ Time is started
   - ☐ Recording device on
   - ☐ Purpose/guidelines/ boundaries discussed
   - ☐ Debrief
3. Introduction to the Study and Consent
   - ☐ Thank you for agreeing to participate in the study
   - ☐ Review study information and re-establish consent
   - ☐ Discuss any questions or concerns
4. Introduction to Interview:

   a) The WSIB process is not familiar to many and mental health claims can oftentimes be more challenging because the injury or symptoms are not always as straight-forward as physical injuries. Your experiences with the WSIB process are important, as they may help inform future policy and process changes to streamline workplace mental health injury claims.
   b) We are also interested in learning more about the types of services you were utilized, and types of treatments along with your experiences communicating with your case manager, employer, and healthcare provider(s).
   c) Please remember that there are no right or wrong answers to the questions. Your answers will reflect your experiences. The questions that I will be asking are to act more as guidelines for discussion than anything else, so please feel free to discuss and answer any and all parts of a question, whether referring to a good or bad experience.
   d) To give you an idea of the outline of this interview, I will start by asking you about what drew you to participate in this study, and then ask a few questions about your experiences submitting a WSIB claim along with any motivations you had in trying different types of services or treatments.

Warm-up

1. What interested you about participating in this study?

2. Without mentioning your employers name, can you tell me about the circumstances that lead to your workplace injury?
    a. Probing to see if blue collar, white collar, mix
    b. Explore the company culture – do they actively promote a safe work environment?

Help-Seeking

1. Can you tell me about the resources you have tried or resources you tried to access?
    a. Were there any resources you would still like to try?
        i. Are there any reasons that have prevented you from trying those treatments/services?
2. What motivated you towards those resources for help?
3. Were these services helpful? If so, how?
4. What about informal sources of support – family, friends?

Facilitators/Barriers & Stakeholders

1. Can you tell me about some of the people involved in the process and what your relationship was/is like with them?
    - WSIB case worker, psychologist, physician, private insurance, family, employer
2. Can you tell me about who or what helped you work through the process of WSIB/insurance?
3. Can you tell me about any difficulties or barriers you faced during this process?
    a. Did you experience any workplace, home life, or other forms of stigma?
4. Can you tell me about anyone in particular that you felt you trusted throughout this process?
    a. Psychologist, physician, family, supervisor, colleagues

WSIB/Disability Insurance Process

1. Can you tell me about your experience with the WSIB/Disability Insurance process?
    a. How was the application process?
    b. How were steps and decisions communicated to you?
    c. Can you tell me about what type of supporting documents you were required to provide? Physician notes, psychologist referrals etc.

Wind-Down

1. How could the current system be improved to address mental health workplace injuries?
    d. For yourself or other stakeholders.
    e. Advice you would give anyone else who is starting down this path?
2. Is there anything else that we haven't discussed that you would like to add?

Thank you for your participation, I really appreciate your time. Would you like a copy of the transcript to keep for your records?

Appendix B

The Depression, Anxiety, and Stress Scale Questionnaire & Scoring

DASS21 Name: Date:

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **over the past week**. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree or a good part of time
3 Applied to me very much or most of the time

1 (s)	I found it hard to wind down	0	1	2	3
2 (a)	I was aware of dryness of my mouth	0	1	2	3
3 (d)	I couldn't seem to experience any positive feeling at all	0	1	2	3
4 (a)	I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5 (d)	I found it difficult to work up the initiative to do things	0	1	2	3
6 (s)	I tended to over-react to situations	0	1	2	3
7 (a)	I experienced trembling (e.g. in the hands)	0	1	2	3
8 (s)	I felt that I was using a lot of nervous energy	0	1	2	3
9 (a)	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10 (d)	I felt that I had nothing to look forward to	0	1	2	3
11 (s)	I found myself getting agitated	0	1	2	3
12 (s)	I found it difficult to relax	0	1	2	3
13 (d)	I felt down-hearted and blue	0	1	2	3
14 (s)	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15 (a)	I felt I was close to panic	0	1	2	3
16 (d)	I was unable to become enthusiastic about anything	0	1	2	3
17 (d)	I felt I wasn't worth much as a person	0	1	2	3
18 (s)	I felt that I was rather touchy	0	1	2	3
19 (a)	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3
20 (a)	I felt scared without any good reason	0	1	2	3
21 (d)	I felt that life was meaningless	0	1	2	3

DASS 21 Scoring and
Interpretation

Add together the scores in each sub-scale – Depression, Anxiety and Stress

Before interpreting the scores, the summed numbers in each sub-scale need to be multiplied by 2 (this is because the DASS 21 is the short form of the scale).

The DASS is not a clinical instrument and cannot diagnose depression, anxiety or stress.

It will give an indication whether any of these issues are having a significant effect on the person's life at present. Should the person score highly on any of the issues, these will need further exploration through conversation and thought may need to be given to a referral to a specialist who could then conduct a clinical interview.

DASS Severity Ratings

(Multiply summed scores by

2)

Severity	Depression	Anxiety	Stress
Normal	0 - 9	0 - 7	0-14
Mild	10 - 13	8 - 9	15-18
Moderate	14 – 20	10 – 14	19 – 25
Severe	21 – 27	15 – 19	26 – 33
Extremely Severe	28+	20+	34+

Appendix C

Participant Demographic Questionnaire

Help-Seeking Behaviours Amongst Individuals with Work-Related Mental Health Injuries Questionnaire

The purpose of this questionnaire is to obtain descriptive information that will aid in analysis of the interview data. Please respond only to those questions you are comfortable providing information about.

1. **Please complete the contact information below.**

   Name: _____

   Address: _____

   Address 2: _____

   City/Town: _____

   Province: _____

   Postal Code: _____

   Email Address: _____

   Phone Number: _____

2. **Age Range....**

   - ○ <20 Years Old
   - ○ 21-30 Years Old
   - ○ 31-40 Years Oldγ
   - ○ 41-50 Years Old
   - ○ 51-60 Years Old
   - ○ >61 Years Old

3. What is your gender?

○ Male ○ Female ○ Non-Binary/Third Gender ○ Prefer to Self-Describe

○ Prefer Not to Answer

4. How long ago did you sustain your work-related mental health injury?

_____

5. Are you currently receiving treatment for your work-related mental health injury?

○ Yes γ ○ No γ

5b. If No, have you in the past received any treatment for your work-related injury?

γ ○ Yes γ ○ No γ

6. What is the type of mental health illness you sustained at work? (Check all that apply)

○ Depression ○ Insomnia

○ Anxiety ○ Non-Specific Stress-Related Disorder

○ PTSD ○ Other _____

7. What is your current occupation?

_____

8. What is your highest level of education achieved?

○ No formal education
○ High school diploma
○ College degree
○ Bachelor's degree
○ Master's degree
○ Doctorate degree
○ Other:

Appendix D

Participant Consent Form

Trent University
Department of Psychology 1600 West Bank Drive
Peterborough ON K9J7B8
Contact: Kara Rutherford, Masters Candidate, B.Sc. 705-868-9761
Supervisor: Fergal O'Hagan, PHD 705-748-1011 # 7086

"Help-Seeking Behaviours Amongst Individuals with Work-Related Mental Health Injuries"

Consent Letter for Interested Participants

Thank you for your interest in our study!

Purpose: The purpose of this study is to understand help-seeking behaviours amongst individuals with work-related mental health injuries. Researchers hope to learn about how you have or are seeking help and how you have or are currently navigating any treatment options you have discovered. As an individual with a work-related mental health injury, your experiences will help individuals with future work-related mental injuries access help more expeditiously. Please read on to understand your involvement in the study.

Description of the Study: You will be asked to complete a demographic questionnaire to help us determine any age, gender, or injury related differences in responses. This questionnaire should take approximately 5-10 minutes to complete. Next, you will be asked to participate in a personal interview with the researcher that will last approximately 1 hour. Another follow-up interview, either in person or on the telephone will be requested 4 weeks later to confirm impressions and notions from participants to ensure data is being represented accurately and discuss any further developments the participants may want to discuss. The follow-up interview will be approximately 30 minutes. All interviews with the consent of the participant will be audio-recorded to ensure accuracy during data analysis. The interviews will ask you about your experiences in seeking help for your work-related mental injury. Throughout the study you will be given the chance to ask questions about your participation and are able to withdraw at any time without consequence.

Benefits: There will be no direct gain to the individual for taking part in this study, however you will be aiding in the research of building an understanding of patient perspectives in help-seeking for work related mental health injuries. The results of this study will provide information to future researchers on where to direct their efforts to best explore improvements to help-seeking in the work compensated mental health injury system.

Potential Harm: An unlikely risk of participation is emotional distress over discussing challenges in seeking help for your work-related mental health injury. If you find the interview distressing and feel that you need additional support, your interviewer, Kara, will aid in contacting a support phone line or counselling services in your area. For Peterborough call: 1-866-995-9933 for 24-hour free, confidential crisis support. You also have the right to choose what to share and what not to share in the interview if there are particular topics you find distressing.

Confidentiality: Your involvement in the study will not be revealed to anyone but the researchers involved in the study. Strict confidentiality will be respected and no information regarding identity will ever appear in any publications or presentations. Specifically, the research team will maintain

confidentiality by removing names and other identifying information from the transcript and exclude names from written reports.

Participation: Participation is entirely voluntary and you have the right to refuse to participate or to withdraw from this study at any time without penalty. Your data will also be withdrawn from the study unless you give permission to still use it.

Information Storage: You understand that the researchers will store any information gathered from you in a secure cabinet and laboratory at Trent University that only the researchers involved in this study will have access to. You understand that any computer files containing your information will be secured with passwords and stored on secure computers. Any computer files sent over electronic media will be encrypted. After five years, all data will be destroyed.

Use of Information: You understand that this information will be used in reports, presentations, and journal articles. This information may be used to develop subsequent theories, programs, or practices to improve help-seeking for work related mental health injuries.

Conflict of Interest: You understand that the researchers have no commercial interest in completing this study. You also understand that this study is not funded by any commercial interest.

Consent: The research study and procedures have been explained to you and any of your questions have been answered to your satisfaction. The potential harms have been explained to you and you also understand the benefits of taking part in this study. You know that you may ask now, or in the future, any questions that you have about the study or the research procedures. You have been assured that no information will be released or printed that would disclose your personal identity.

Limits to Confidentiality: You understand that if harm to self or others or abuse of children is disclosed, researchers have a legal obligation to report this information.

If you have questions about the study you can contact the researcher listed at the top of this page. This study has been reviewed and approved by the Trent University Research Ethics Board. Please direct questions pertaining to this review to Karen Mauro, Certifications and Regulatory Compliance Officer, Trent University, Phone: 705-748-1011 ext 7896, Email: kmauro@trentu.ca. You will be provided with a copy of this consent form for your records.

Participant Name: _____

Signature: _____

Date: _____

Telephone number: _____

Witness Name: _____

Signature: _____

Date: _____

Researcher Name: _Kara Rutherford_____

Signature: _____

Date: _____

Appendix E

Participant Debrief Form

Trent University
Department of Psychology
1600 Westbank Drive
Peterborough ON K9J7B8
Contact: Kara Rutherford, BSc., MSc. Candidate
Supervisor: Fergal O'Hagan, PhD 705-748-1011 #7086

"Help-Seeking Behaviours Amongst Individuals With Work-Related Mental Health Injuries"

Debrief Letter for Participants

Thank you for participating in this study. Your time and effort are very much appreciated.

We are interested in understanding the help-seeking behaviours amongst individuals with work-related mental health illnesses. We hope to learn about how you have or are seeking help and how you have or are currently navigating any treatment options available to you. We also hope to learn how your experiences with the Workplace Safety and Insurance Board influenced or are influencing your ultimate decisions on help-seeking. This research will provide insight and guidance to future researchers on where to direct their efforts to best explore improvements to help-seeking in the work compensated mental health injury system. By sharing your experiences, you will help us meet this objective.

If you would like a copy of the summary of the study, please provide your name and phone number OR email Kara at: kararutherford@trentu.ca

Should you want to talk to someone confidentially because you experienced distress during this interview, the following services are available:

- **Telecare Distress Centre of Peterborough:** 705.745.2273
- **Canada Suicide Prevention Services:** 1.833.456.4566 or text to 45645
- **Four County Crisis:** 1.866.995.9933

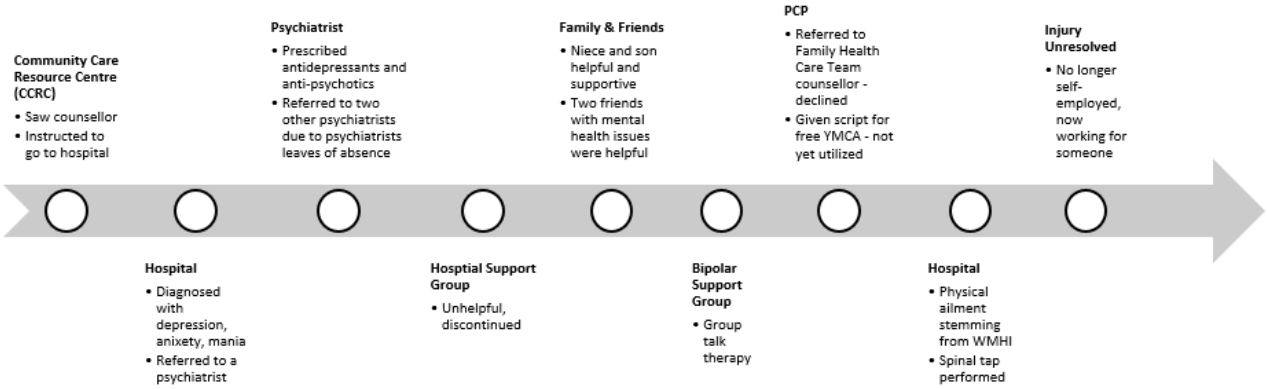
Telecare Distress Centre of Peterborough provides a non-judgemental confidential listening ear for those in need, while Canada Suicide Prevention and Four County Crisis offer suicide prevention and crisis support respectively. All services are available 24 hours a day and 7 days a week.

This study has been reviewed and approved by the Trent University Research Ethics Board. Please direct questions pertaining to this review to Jamie Muckle, Certifications and Regulatory Compliance Officer, Trent University, Phone: 705-748-1011 ext. 7896,
Email: jmuckle@trentu.ca.

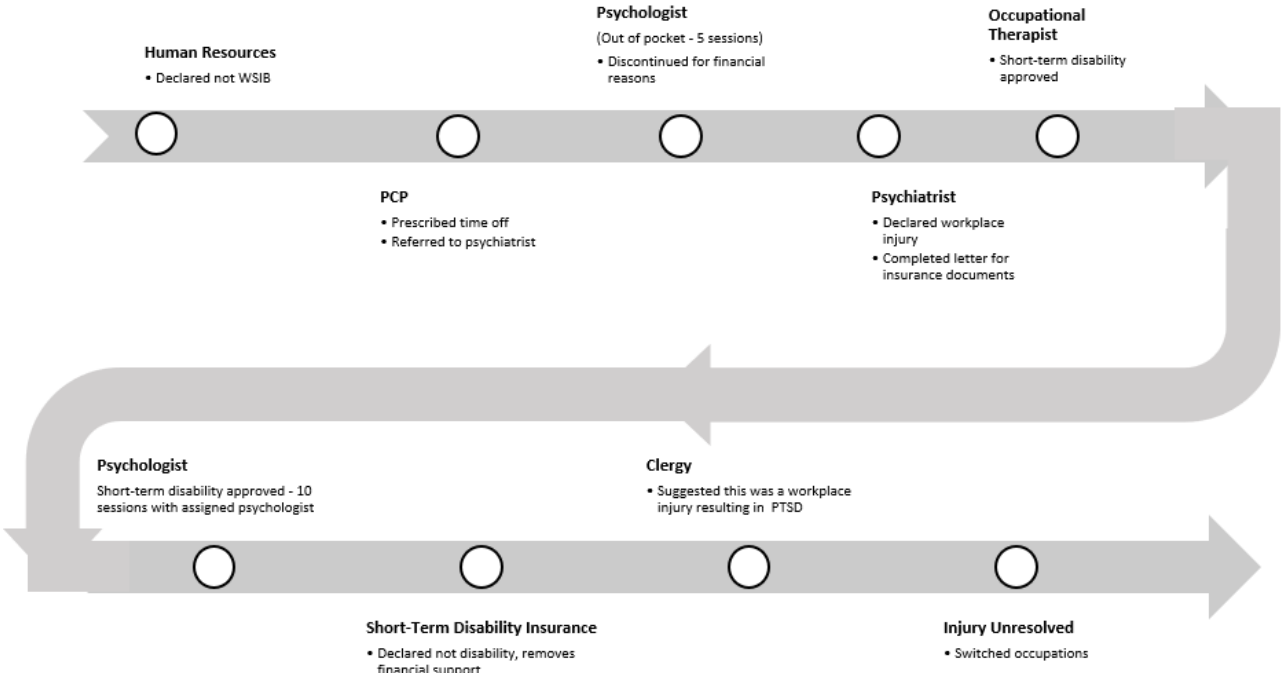
Appendix F

Trajectories of Participant Accessed Resources: A Sequential Overview

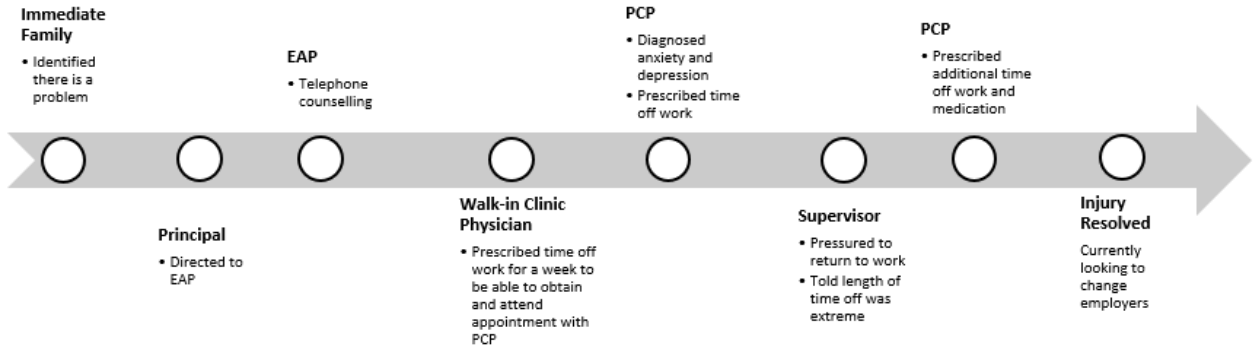
Participant 1 (Male, 41-50, Business, Finance, & Administration)



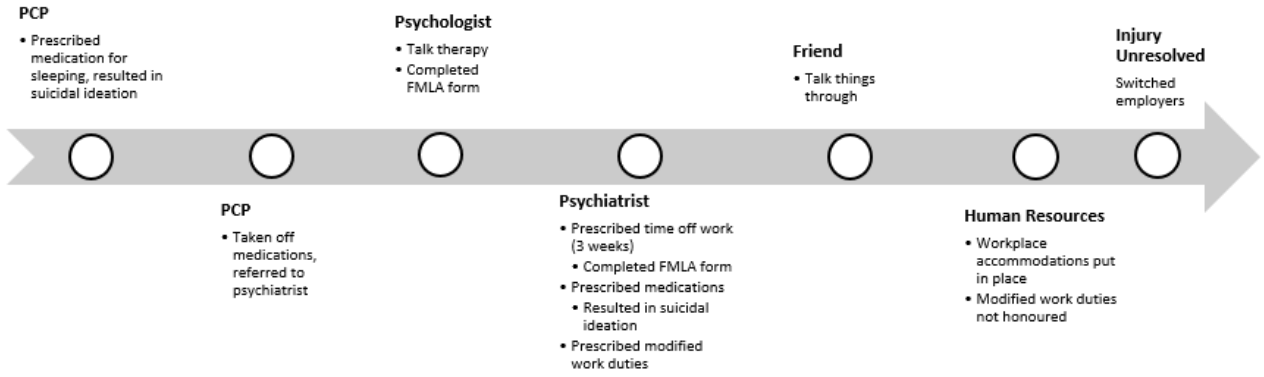
Participant 2 (Female, 51-60, Business, Finance, & Administration)



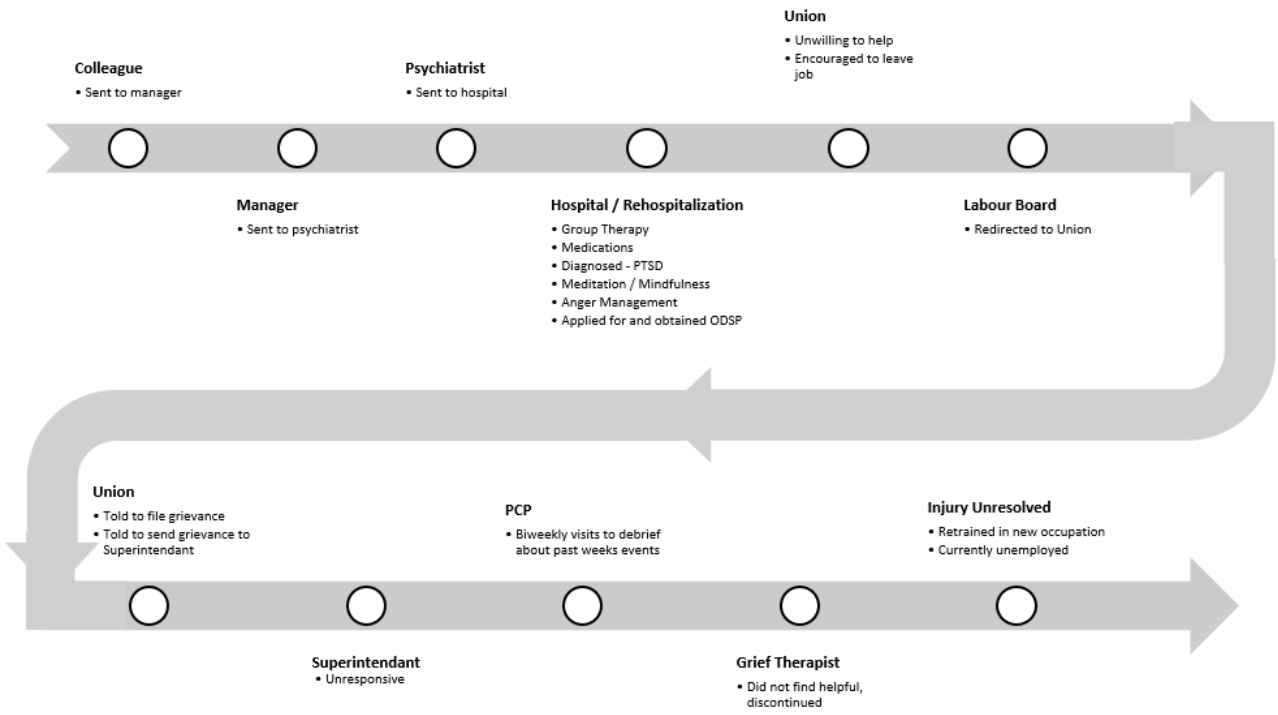
Participant 3 (Female, 41-50, Education, Law and Social, Community and Government Services)



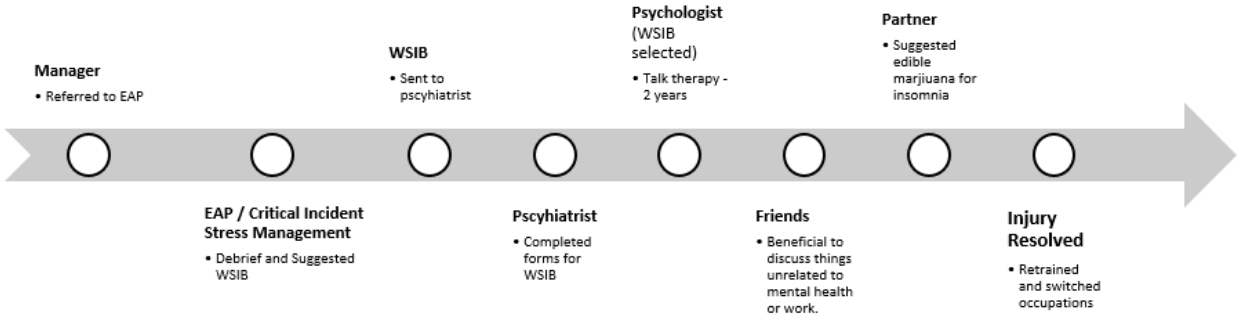
Participant 4 (Male, 41-50, Management)



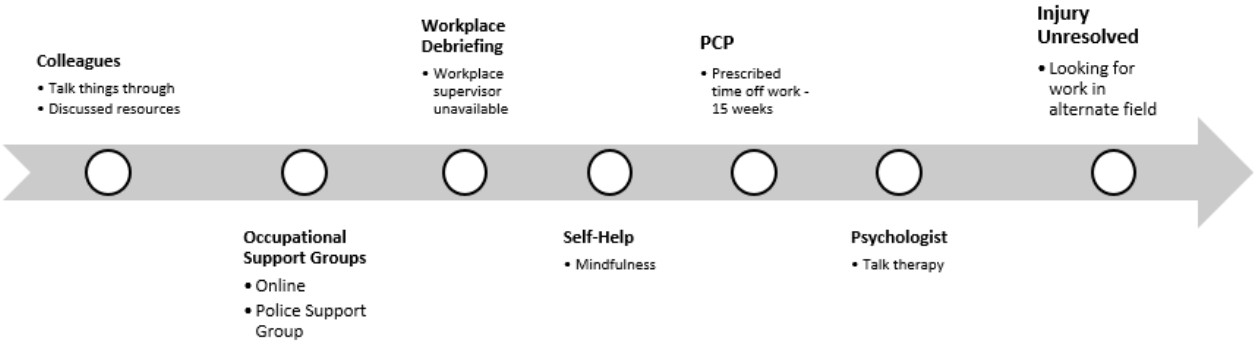
Participant 5 (Female, 41-50, Education, Law and Social, Community and Government Services)



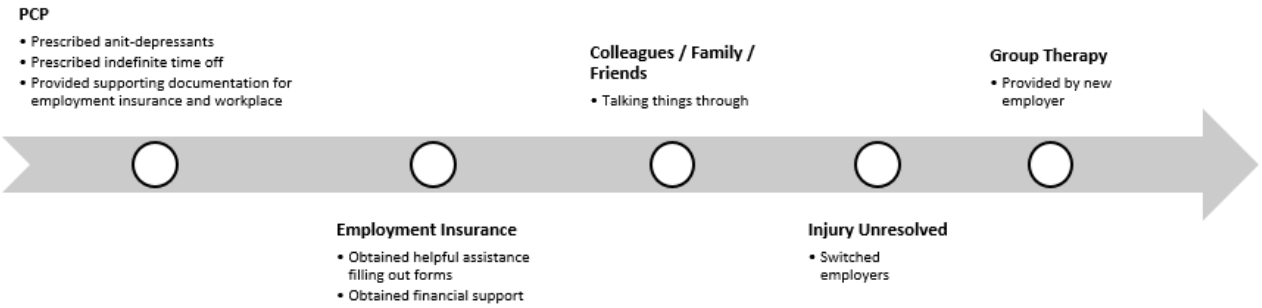
Participant 6 (Male, 31-40, Education, Law and Social, Community and Government Services)



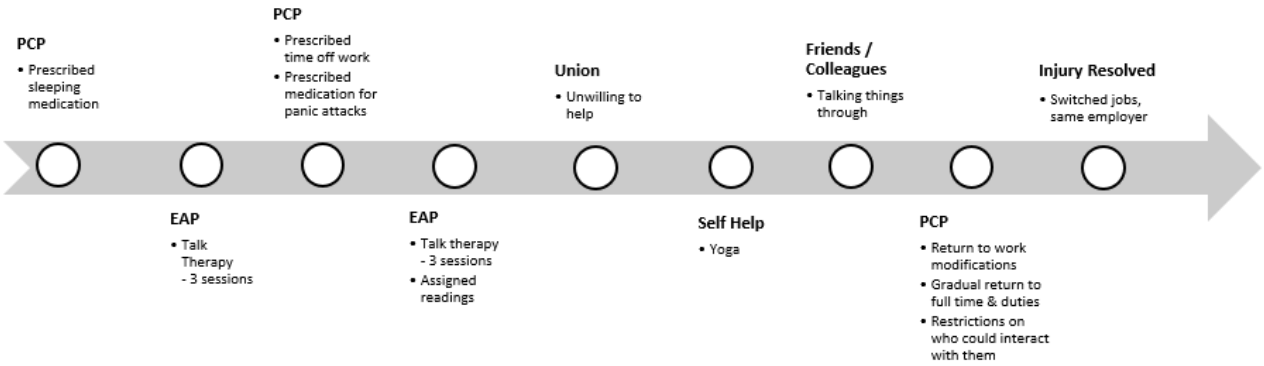
Participant 7 (Female, 51-60, Education, Law and Social, Community and Government Services)



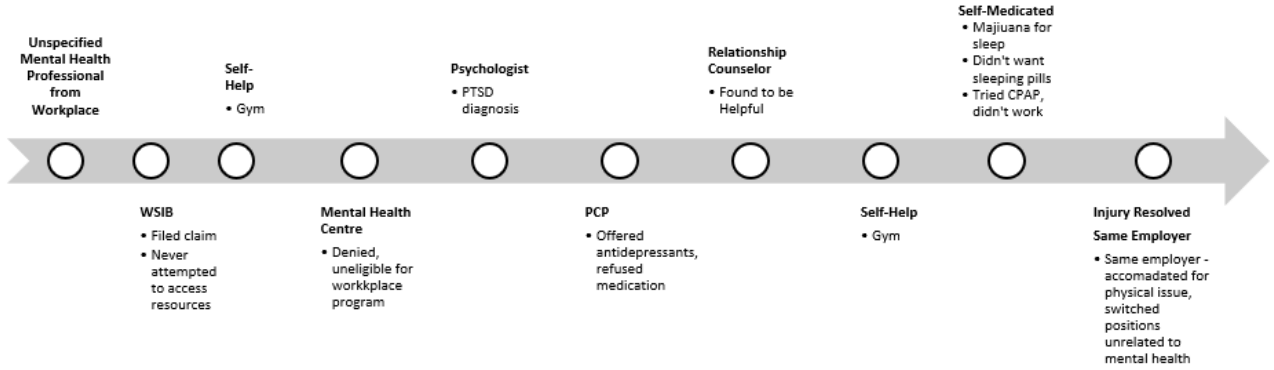
Participant 8 (Female, 21-30, Education, Law and Social, Community and Government Services)



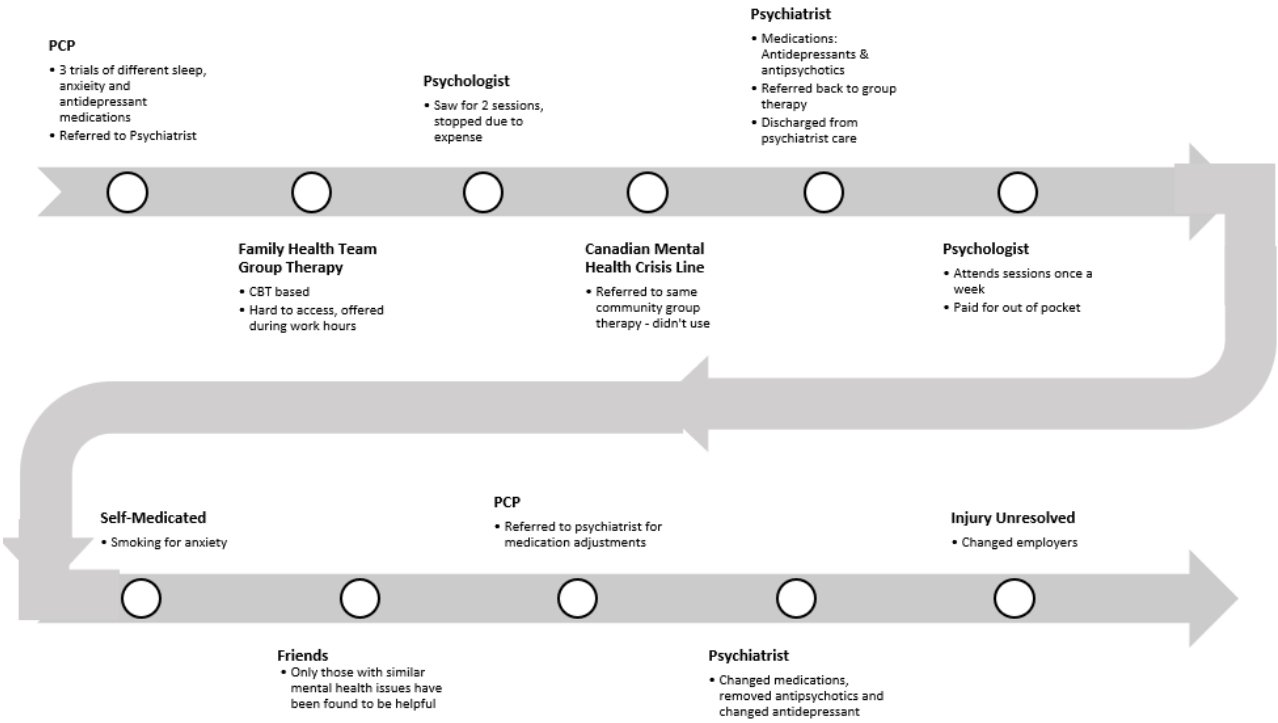
Participant 9 (Female, 41-50, Business, Finance, & Administration)



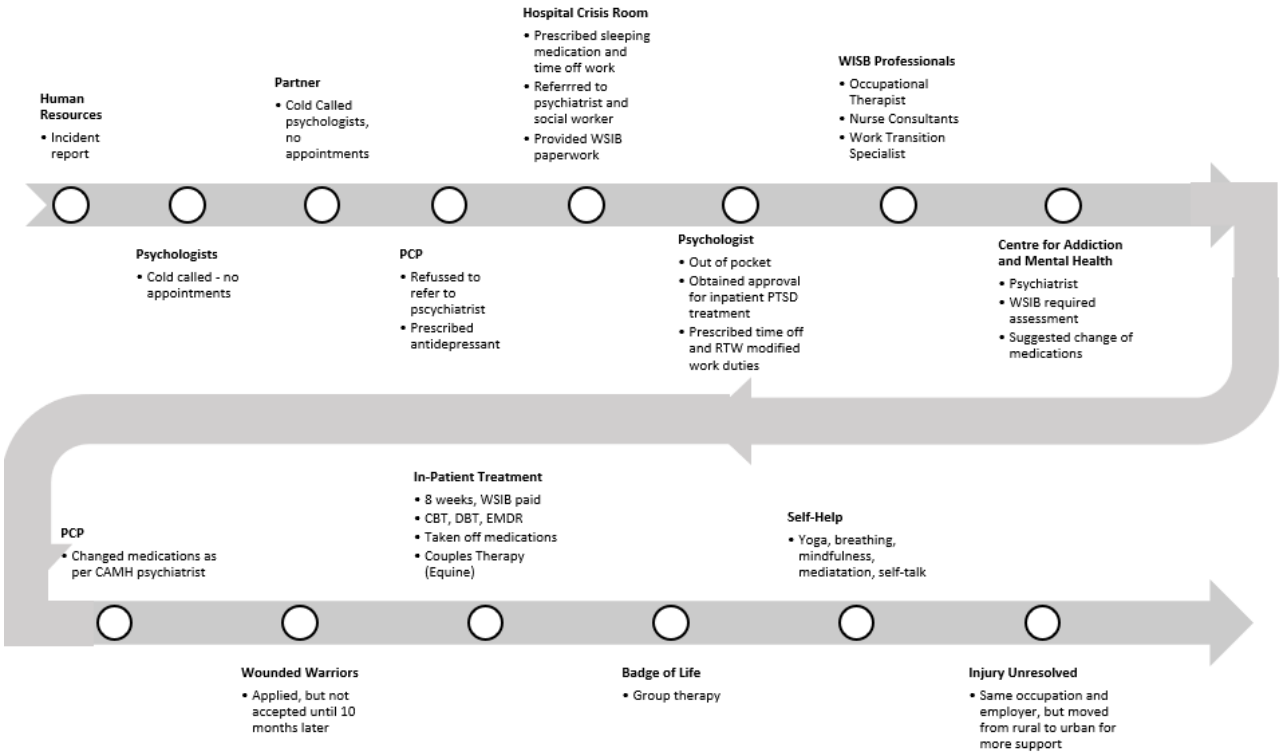
Participant 10 (Male, 41-50, Education, Law and Social, Community and Government Services)



Participant 11 (Female, 31-40, Business, Finance, & Administration)



Participant 12 (Female, 41-50, Health)



Note. CAMH = The Centre for Addiction and Mental Health; CBT = Cognitive behavioural therapy; CPAP = Continuous positive airway pressure; DBT = Dialectical behavioural therapy; EAP = Employee Assistance Program; EMDR = Eye movement desensitization and reprocessing; FMLA = Family and Medical Leave Act; ODSP = Ontario Disability Support Program; PCP = Primary care physician; PTSD = Post-traumatic stress disorder; RTW = Return to work; STD = Short-term disability; WSIB = Workplace Safety and Insurance Board