2021

Healthy Professional Worker Partnership:
Preliminary Comparative Findings

Examining the Gendered Nature of Mental Health Issues, Leaves of Absence & Return to Work Experiences from a Comparative Perspective

The Healthy Professional Worker Partnership

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Key Messages Emerging from the Preliminary Findings

The preliminary findings from our mixed methods research on the pathway from the experience of mental health, the decisions to take a leave of absence from work (or not) and return to work reveals some important areas for attention. Notably, there is a need to de-stigmatize mental health issues and encourage greater awareness and support from supervisors and colleagues. These findings are critical, considering the significant mental health concerns that have arisen during the COVID-19 pandemic.

Pathway from Mental Health to Leaves of Absence and Return to Work:

1. The majority of all professional workers surveyed or interviewed reported experiencing a mental health issue; rates were higher for women than for men:
    - 58% of professional workers who responded to the survey report having suffered from a mental health issue now or in the past.
        - 64% women
        - 47% men
    - 60% made changes to work in response to their mental health issue
    - 57% contemplated taking a leave
    - Only 31% took a leave of absence from work due to their mental health experiences
    - 76% returned to work after a leave, which means one quarter may be lost to the professions

2. Some <u>emerging trends:</u>

    Types of changes made to work in response to a mental health issue:
    - Take sick days or use vacation days
    - Reduce workload
    - Seek help from an allied health professional (psychologist, counsellor, social worker).

    Why a leave of absence from work was not taken?
    - Mental health concern not felt to be severe enough
    - Stigma from disclosure
    - Financial barriers.

    Supports enabling a leave of absence:
    - Financial support or coverage while on leave
    - Supportive colleagues and supervisors
    - Supportive family.

    Barriers to taking a leave of absence:
    - Unsupportive supervisors, colleagues, and union representatives
    - Lack of financial coverage/loss of income
    - Stigma.

Impact of the COVID-19 Pandemic on the Mental Health of Professional Workers:

1. Mental health declined and distress, presenteeism and burnout increased significantly during the COVID-19 pandemic for all professional workers studied.
    - Mental health during the pandemic was notably low for workers in Midwifery, Nursing and Teaching professions, where women predominate.
    - Mental health declines were significantly greater for women in Academia and Medicine; distress was greater for women in Academia, Medicine and Teaching; burnout scores were higher for women in Academia and Dentistry; and presenteeism was higher for men in Accounting.
    - Prior to the pandemic, most of the professional workers reported being within the 'experiencing one or more symptoms of burnout' range. During the pandemic average scores for workers in all the professions increased within this range, with Nursing and Midwifery increasing to the highest average levels.
2. All professions experienced increased work and non-work stress, but this was particularly notable for predominantly female professions.

    Work Stress:
    - Increased workload
    - Digital stress
    - Feelings of being left out of decision-making
    - Physical safety and ethical dilemmas (Nursing)
    - Stress of running a practice and uncertainty (Dentistry)

    Non-work stress:
    - Time pressure
    - Underlying mental and physical health conditions
    - Caring for children
    - Debt/financial concerns
3. The compound effect of declining mental health and increased distress, presenteeism, and burnout can be linked to a rise in intention to leave either the organization or the profession entirely, particularly in the female-dominated Nursing and Midwifery professions.
    - 39% of nurses agreed to having thoughts about leaving their healthcare facility and 31% their profession
    - 34% of midwives agreed to having thoughts about leaving the profession

In sum, we find that the negative impact of the COVID-19 pandemic on the mental health of professional workers has been significant and felt particularly by those professions where women predominate and by women across many of our professional case studies. As we move to the next steps in our research partnership, we will drill down further in the family, work and organizational sources of stress and support that influence the pathway from mental health to leaves of absence and return to work.

Faits saillants émergeant des résultats préliminaires

Les résultats préliminaires issus de notre recherche fondée sur des méthodes mixtes et portant sur le parcours de l'expérience de la santé mentale, de la décision de prendre (ou non) un congé de maladie et du retour au travail identifient plusieurs éléments importants à prendre en considération. Notamment, il est nécessaire de déstigmatiser les problèmes de santé mentale, d'encourager une plus grande sensibilisation et un meilleur soutien de la part des superviseurs et des collègues. Ces conclusions sont cruciales compte tenu des problèmes de santé mentale importants qui sont apparus au cours de la pandémie de COVID-19.

Les parcours de santé mentale, de congés de maladie et du retour au travail

1. La majorité des réponses au questionnaire et des entretiens de tou(te)s les travailleur(euse)s professionnel(le)s ont déclaré avoir expérimenté un problème de santé mentale; les femmes rapportent un score plus élevé que les hommes.
    - 58% des travailleur(euse)s professionnel(le)s qui ont répondu au questionnaire déclarent souffrir actuellement d'un problème de santé mentale ou d'en avoir souffert dans le passé.
        - 64% des femmes
        - 47% des hommes
    - 60% ont effectué des changements au travail afin de répondre à ces problèmes de santé mentale
    - 57% ont envisagé prendre un congé
    - Seulement 31% ont pris un congé autorisé du travail en raison de leurs problèmes de santé mentale
    - 76% sont retournés au travail après leur congé, ce qui signifie qu'un quart pourrait avoir quitté la profession

2. Quelques <u>tendances émergentes</u>

    Les types de changement effectués au travail en réponse à un problème de santé mentale
    - Prendre des jours de maladie ou utiliser ses vacances
    - Réduire la charge de travail
    - Chercher de l'aide auprès d'un(e) professionnel(le) de la santé (psychologue, conseiller(e), travailleur(euse) social(e))

    Pourquoi un congé autorisé n'était-il pas pris?
    - Problème de santé mentale jugé insuffisamment grave
    - Stigmatisation liée à la divulgation
    - Barrières financières

    Soutiens permettant la prise d'un congé autorisé
    - Soutien financier ou protection financière pendant le congé
    - Soutien des collègues et des superviseurs

- Soutien de la famille

Barrières pour prendre un congé autorisé

- Ne pas avoir de soutien des superviseurs, des collègues et des représentant(e)s syndicaux(ales)
- Manque de protection financière/perte de revenus
- Stigmatisation

Impact de la pandémie de COVID-19 sur la santé mentale des professionnel(le)s :

1. La santé mentale a diminué, et la détresse, le présentéisme et l'épuisement professionnel ont augmenté de manière significative pendant la pandémie de COVID-19 pour tou(te)s les professionnel(le)s étudié(e)s.
    - Durant la pandémie, la santé mentale a considérablement diminué chez les sage-femmes, les infirmiers(ères) et les enseignant(e)s, où les femmes sont majoritaires.
    - La détérioration de la santé mentale était significativement plus importante chez les femmes professeures d'université et celles en médecine ; la détresse était plus importante chez les femmes professeures d'université, celles en médecine et en enseignement ; les scores d'épuisement professionnel étaient plus élevés chez les femmes en enseignement et en dentisterie ; et le présentéisme était plus élevé chez les hommes en comptabilité.
    - Avant la pandémie, la plupart des professionnel(le)s ont déclaré « éprouver un ou plusieurs symptômes d'épuisement professionnel ». Pendant la pandémie, les scores moyens des travailleur(euse)s de toutes les professions ont augmenté dans cette catégorie, particulièrement les infirmières et les sages-femmes qui ont atteint les niveaux moyens les plus élevés.
2. Toutes les professions ont connu une augmentation du stress professionnel et non professionnel, mais ce phénomène était particulièrement marqué dans les professions à prédominance féminine.

    Stress professionnel

    - Augmentation de la charge de travail
    - Stress numérique
    - Sentiment d'être exclu du processus décisionnel
    - Sécurité physique et dilemmes éthiques (soins infirmiers)
    - Stress lié à la gestion d'un cabinet et incertitude (dentisterie)

    Stress non professionnel

    - Contrainte du temps
    - Conditions de santé mentale et physique sous-jacentes
    - Soins aux enfants
    - Dettes/préoccupations financières
3. L'effet cumulé du déclin de la santé mentale et de l'augmentation de la détresse, du présentéisme et de l'épuisement professionnel peut être lié à une augmentation de

l'intention de quitter l'organisation ou la profession, en particulier dans les professions d'infirmière et de sage-femme à prédominance féminine.

- 39% des infirmières ont pensé quitter leur établissement de santé, alors que 31% ont pensé quitter leur profession
- 34% des sages-femmes ont pensé quitter leur profession

En résumé, nous constatons que l'impact négatif de la pandémie de COVID-19 sur la santé mentale des professionnel(le)s a été important et ressenti particulièrement fortement au sein des professions où les femmes prédominent de même que parmi les femmes présentes dans nos différentes études de cas. Lors des prochaines étapes de notre partenariat de recherche, nous approfondirons les sources de stress et de soutien familiales, professionnelles et organisationnelles qui influencent le parcours de santé mentale, des congés de maladie et du retour au travail.

Introduction

Every year, one in five people in Canada experience a mental health (MH) issue,[1] with an estimated cost to the economy of more than $50 billion.[2] In the workplace, MH-related leaves account for approximately 30 per cent of short- and long-term disability claims.[3] Yet many women and men in their peak working years suffer in silence, continuing to work despite experiencing significant MH issues [(i.e., presenteeism)]. Indeed, only one in three people who experience a MH problem report that they have sought treatment or services.[4] Moreover, 40% of workers found employers were not accommodating of their MH issues.[5] The combined effects of absenteeism and presenteeism due to MH issues are estimated to cost more than $6 billion in lost productivity.[6]

MH issues experienced by professional workers are uniquely challenging because of the importance of their mental acuity in providing knowledge-based services to clients, patients or students. Both presenteeism despite significant MH concerns and MH-related absenteeism can lead to negative consequences for workers.[7,8] These include loss of income and benefits and difficulties in returning to work in the short term, and challenges with promotion, job advancement, and increased risk of failure to meet performance standards required in the long term. Absences from work can also impose an increased burden on their co-workers and/or employees, in terms of increased workload and burnout, on their employers, in terms of productivity losses, and on society more broadly in terms of accessibility to and quality of services.[9,10]

Negotiating leaves of absence (LoA) and return to work (RTW) can be particularly difficult when MH issues are involved, and when work culture and structures constitute insurmountable barriers to short- or long-term leaves, generating essentially forced presenteeism. These difficulties can be particularly complex because of the intersecting influences of personal, social, and economic factors.[11] Although the issues of MH-related presenteeism and absenteeism are areas of growing concern for professional workers, they are seriously understudied, particularly from a comparative perspective across sectors and workers.

An explicit sex and gender lens is also conspicuously absent in the study of LoA and RTW processes despite being a significant factor in the experience of MH and the help-seeking relationship with health professionals.[12,13,14,15] Men and women may access supports differently and experience tensions created by work absences and subsequent RTW differently due in part to inequities in social relations at work. How sex and gender intersect with other identities – age, profession, and career stage – are also unknown.

Our Research Questions Ask …

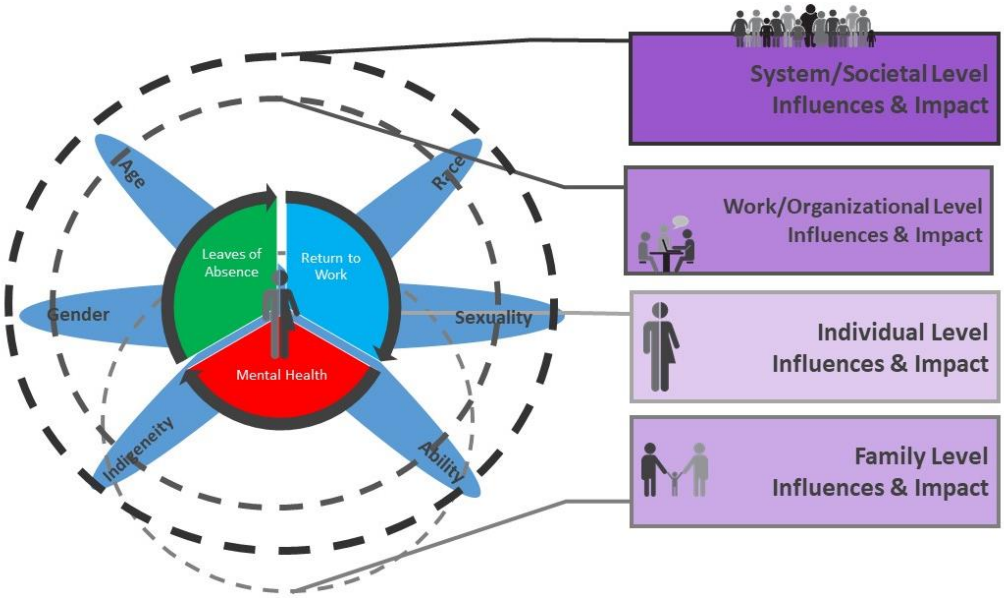
- What are the mental health experiences of professional workers causing them to change their work, consider or take a leave of absence from work?
- What are the key factors – with a focus on personal, family and work context – that facilitate or prevent them from taking a leave of absence and which foster their return to work?
- What is the impact of gender (identity, roles, and relations) on these dynamic processes and what interventions can mediate these gendered experiences?

In this report, we present our preliminary findings that begin to address these three questions.

Conceptual Framework

Figure 1 outlines the intersectional, contextualized path model of mental health, leaves of absence, and return to work experiences framework that guided our study.

Figure 1: An Intersectional, Contextualised Path Model of Mental Health, Leaves of Absence & Return to Work Experiences



Intersectional: We have at the centre of the framework an individual professional worker, of a particular age and (non-binary) gender identity who also has intersecting racial, Indigenous, ability and sexual identities affecting their experiences of mental health, leaves of absence and return to work.

Contextualized: We have enveloped each worker with the different contextual influences at the individual level, at the level of their family, at the level of their work and organizational context, all situated within the broader system and societal level. The individual worker is situated between the work and family level to reflect the tensions that often exist amongst those factors that must be mediated by individual workers.

Path: The pathway from mental health to leaves of absence to return to work is depicted in a cyclical fashion. This reflects that the pathway may be undertaken more than once, but it also recognizes that any individual worker experiencing mental health may or may not follow through with a leave of absence and in turn may or may not return to work. Indeed, although not represented here, we were interested in how professional workers change their work to avoid taking a leave of absence, and whether they contemplated taking a leave even if they did not follow through with that decision.

Depicting the pathway of mental health to leaves of absence to return to work and the influence of different factors and forces for professional workers with different identities can better enable the identification and development of targeted and more effective interventions to promote wellness and foster healthy return to work.

Overview of Methods

Case studies

The seven case studies of professional workers on which we focus (Figure 2) represent a mix of gender composition and work context features that the literature suggests are important to the experiences of MH, LoA and RTW. Dentistry, Medicine, Academia and Accounting are traditionally masculine professions that are feminizing,[16,17,18,19] whereas Nursing, Midwifery and Teaching are considered traditionally feminine professions. Their work contexts range from unionized salaried positions, with both regular and irregular schedules, to independent public sector contractors in solo or group practice to practice owners in the private sector.

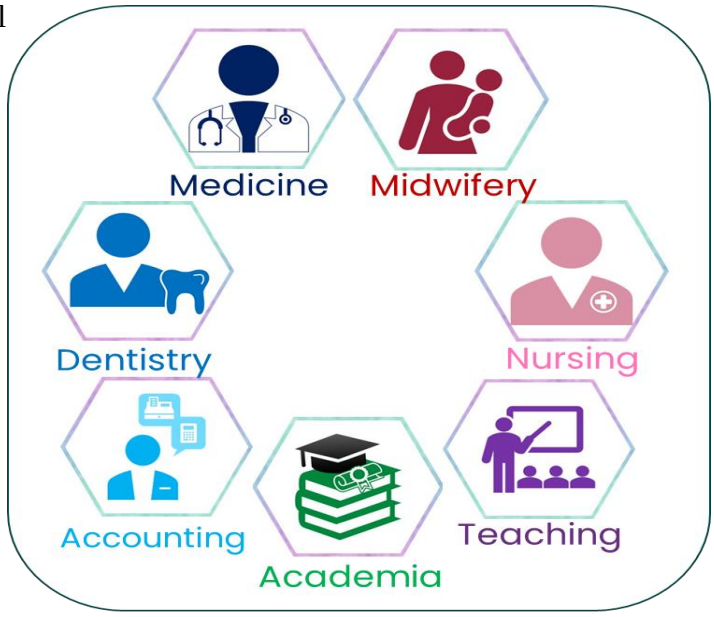


Figure 2 Case Study Professions

Mixed Methodology

An interdisciplinary mixed methodological approach was undertaken to reflect the complexity of the intersectional, contextualized experiences along the pathway from mental health, leaves of absence and return to work (Figure 3).

Document Analysis: For each of the case studies a series of librarian-assisted systemic reviews of the published literature was undertaken to ascertain the state of the knowledge upon which our projected intended to build. A standardised, systematic search strategy capturing inclusive terms for mental health, leaves of absence and return to work, customised for each case study, was developed and applied to key databases from PubMed/Medline, CINAHL, PsycINFO and Sociological Abstracts. Some case study teams have also supplemented the original searches by conducting manual searches (and in particular, by reviewing the reference lists of articles found through original search) to identify any additional articles relevant for document analysis). Covidence software was used to screen (in duplicate) and select articles for extraction. An update to the literature to include a focus on the impact of the COVID-19 pandemic is in progress. Extraction was performed using academic and grey literature extraction tools according to predetermined categories we identified at the outset to capture relevant pieces of information. Nearly 400 articles have been extracted across the seven case studies. A synthesis of these sources will be forthcoming.

Stakeholder interviews: A total of 139 in-depth interviews were undertaken with a range of case specific stakeholders representing the interests of unions, professional associations, regulatory authorities, supervisors/managers, employers, insurers, and those representing cross-cutting expertise (Table 1). The interview guide addressed the knowledge the mental health, leave of

absence and return to work pathway stakeholders possessed, with additional questions addressing the gendered nature of this pathway and the impact of the COVID-19 pandemic. Each of these interviews was conducted with two members of the respective case study team, audio recorded, transcribed with Otter.AI, reviewed and analysed using NVIVO-12 software, applying a combined *a priori* coding scheme that reflects both a set of standardized codes that cut across cases, and case-specific codes that were both developed *a priori* and have emerged through the coding process.

Figure 3 Multi-Methodological Approach

Worker Surveys: Between the end of November 2020 and early May 2021, a bilingual (French-English) online, self-administered survey employing crowdsourcing recruitment via our partner organizations, direct email and social media was undertaken. The survey design included several cross-cutting questions asked of all case studies, particularly focusing on the mental health, leaves of absence and return to work pathway, but also including a component which assessed mental health, distress, presenteeism and burnout during compared with prior to the pandemic. For each case study, an additional set of customized questions specific to their unique work circumstances were included. An initial profession-specific question filtered participants to the appropriate questionnaire which employed a skip-logic invisible to the participants, resulting in a survey taking approximately 20 minutes to complete. Other than this initial question, no other questions were mandatory to complete. A total of 3759 surveys that yielded at least a 90% completion score for the seven case study professions were retained for analysis. To date, descriptive analyses of the survey data have included frequency cross-tabulations with appropriate tests of significance undertaken at a $p<0.05$ criteria. Data from cells with fewer than 5 responses have been suppressed.

Worker Interviews: Concurrent with the surveys, a total of 282 in-depth interviews were conducted either by phone or by Zoom, in French or English between January and July 2021. Recruitment for the interviews was undertaken directly through the same crowdsourcing approach as for the survey and indirectly where survey participants volunteered to undertake a follow up interview after they completed the survey. A set of screening questions were sent to participants to ensure representation by gender, region, work and leaves of absence experiences and other

criteria important to the individual case studies. As was the case with the stakeholder interviews, two team members conducted the interviews with one member being the primary interviewer and the other member taking notes and interjecting to probe for more depth into specific issues. Participants' responses to the survey were not linkable to their interview participation and as such a series of demographic questions were re-asked in the context of the interviews. Other interview questions traced their mental health, leaves of absence, and return to work experiences respecting the integrity of the participant's narrative. Specific questions pertaining to the impact of gender and the COVID-19 pandemic were also included. All interviews were audio recorded, transcribed with Otter.AI, reviewed and analysed using NVIVO software. A combined *a priori* coding scheme that reflects both a set of standardized codes that cut across cases and case specific codes that were both developed *a priori* and have emerged through the coding process were applied to interview segments. At the time of writing this report, coding was still in progress.

For this preliminary report, we focus primarily on the initial cross-cutting analyses of the survey findings augmented with selected quotes from the stakeholder and worker interviews.

Preliminary Findings

Background of Survey Respondents and Interview Participants

Table 1 provides an overview of the survey respondents by province. We can see that the largest number of responses came from the provinces of Ontario and Quebec with Nova Scotia, British Columbia and Alberta figuring prominently.

*Table 1 HPW Survey Respondents by Province**

Province	Academic	Accounting	Dentist	Education	Midwife	Nurse	Physician	Total
BC	23	17	63	36	30	77	29	275
AB	10	29	11	30	12	91	33	216
SK	14	7	0	19	0	40	14	94
MB	8	13	7	10	9	37	7	91
ON	128	62	217	345	111	185	120	1168
QC	94	137	13	358	11	210	41	864
NB	0	0	0	0	0	106	0	106
PE	0	0	0	0	0	12	0	12
NS	15	0	27	124	0	108	9	283
NL	17	0	0	0	0	20	17	54
NT/NU/YT	0	0	0	0	0	0	0	0
Missing	66	35	44	215	19	120	33	532

**Some of the zeros in the table are suppressed data representing less than 5 respondents*

Also important for our consideration is the breakdown by gender identity where respondents who identify as women predominate, even in those professions where the gender breakdown in the population is more balanced (i.e., Academia, Accounting and Medicine) (see Table 2). Overall, 2850 women, 649 men and 53 respondents identified as gender fluid, preferred to self-describe or

preferred not to answer; the numbers in these latter non-binary groups were insufficient to break down by profession but will be reported on subsequently.

Table 2: Participants by Case Study and Data Collection Method

	Stakeholder Interviews	Professional Worker Surveys	Professional Worker Interviews
Academia	18	379 *(250 women/92 men)*	34: *21 women/13 men*
Accounting	3	312 *(202 women/94 men)*	32: *21 women/11 men*
Dentistry	17	397 *(194 women/185 men)*	36: *18 women/18 men*
Medicine*	21	310 *(258 women/46 men)*	29: *24 women/5 men*
Midwifery*	22	202 *(188 women/0 men)*	44: *almost all women*
Nursing	17	1013 *(929 women/60 men)*	54: *46 women/8 men*
Teaching	26	1146 *(829 women/172 men)*	53: 37 women/16 men

**The Medicine and Midwifery cases included trainee participants in the survey and interviews*

There was a total of 300 respondents who identify as Black, Indigenous or professionals of colour that we will report on subsequently with partner organizations.

Pathway from Mental Health, Leaves of Absence to Return to Work

Our primary research objective was to understand the pathway from the experience of mental health issues to the decision to contemplate or take a leave of absence and return to work.

> *In the context of this study, mental health issues include mental or psychological stress or distress, burnout, anxiety, depression, other mood disorders, substance use or dependence, post-traumatic stress disorder, or serious thoughts of suicide. It includes both short term mental health problems that temporarily limit our ability to function as well as more persistent and severe medical health disorders that require medical intervention.*

Figure 4 depicts the proportion of our survey respondents that embarked on this pathway, including steps in between, such as making changes to their work and considering taking a leave, even if one was not taken. Overall, 58% of professional workers who responded to our survey report having suffered from a mental health issue now or in the past. This may seem high but respondents who have lived or living experience with mental health issues are likely self-selected to participate in a study focused on this topic. Of those, 60% made changes to work in response to their mental health issue; 57% contemplated taking a leave but only 31% took a leave of absence from work due to their mental health experiences. The vast majority (76%) returned to work after a leave.

Notably, the only difference we found along this pathway by gender identity was in the experience of mental health issues, which was reported by 64% of respondents who identified as women in comparison to 47% of respondents who identified as men. This was a persistent difference for all professions except for the midwifery (where nearly all identify as women) and nursing professions. Respondents who identify as men were only slightly more likely to change their work (62v59%), they were equally likely to consider taking a leave (57v56%) but women were slightly more likely to take a leave (31v28%) and return to work (77v74%). The uncertainty around those numbers means that they may overlap, thus little can be said about who was more likely to do what.

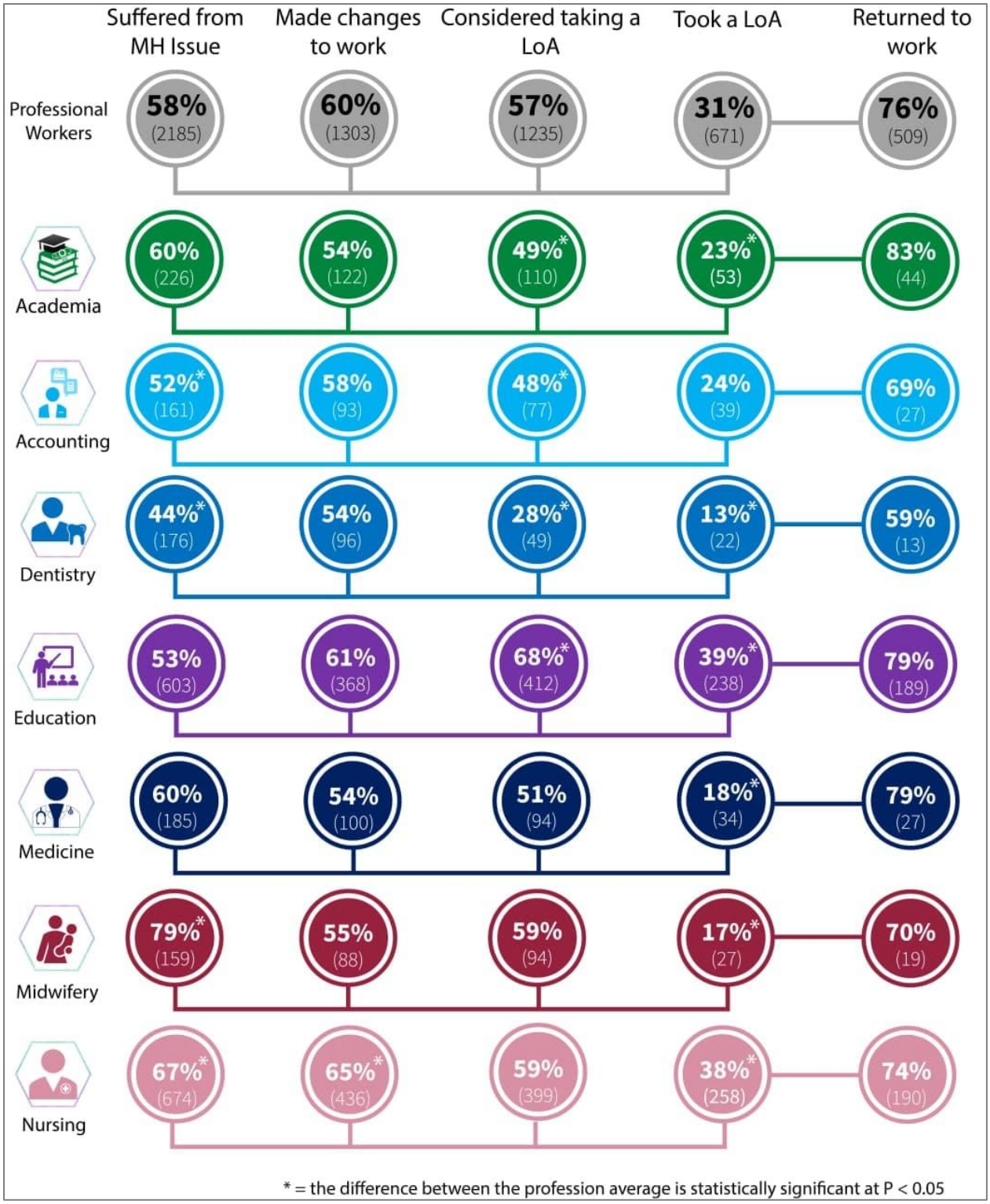


Figure 4 The Experiences of Mental Health and the Pathway to Leaves of Absence and Return to Work, by Profession

Although caution should be exercised in comparing across professions because our respondents do not constitute a representative sample of the professional groups, some interesting differences are notable. In comparison to professional workers overall:

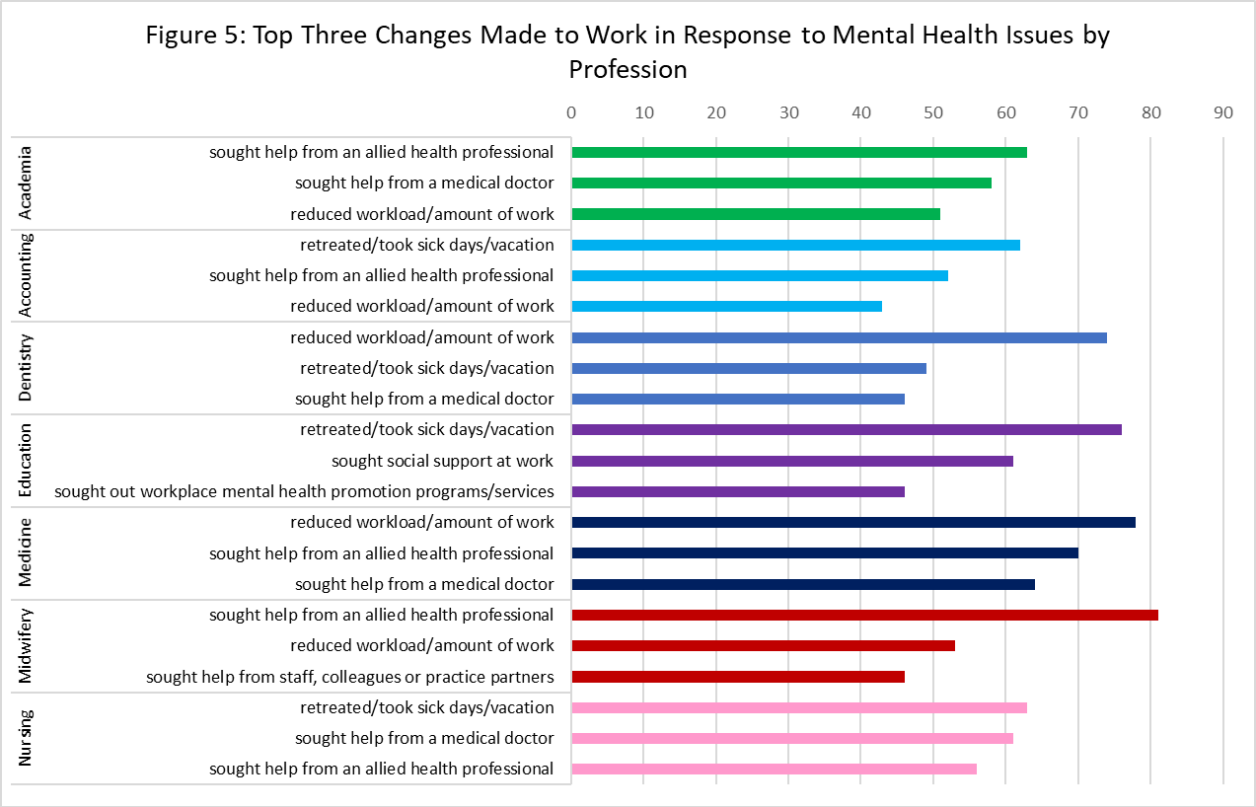
- Respondents from Accounting and Dentistry are significantly less likely to report having ever suffered from a mental health issue whereas respondents from Midwifery and Nursing are significantly more likely.
- Respondents from Nursing were significantly more likely to report having made changes to work in response to a mental health issue.
- Respondents from Teaching/Education were significantly more likely to have considered taking a leave of absence from work in response to a mental health issue, whereas respondents from Academia, Accounting and Dentistry were significantly less likely to contemplate a leave.
- Respondents from Nursing and Teaching/Education were significantly more likely to report taking a leave of absence from work, whereas respondents from Academia, Dentistry, Medicine and Midwifery were significantly less likely to have taken a leave.

There were no significant differences in the rates of return to work, largely due to small sample sizes, nevertheless there are some emerging trends for some professions with lower return to work rates warranting further analysis.

The types of changes made to work in response to a mental health issue differed for each professional case study (and notably each had a different set of response categories, some of which overlapped) (Figure 5). The most frequently chosen responses were to take sick days or use vacation days (the most frequent response from the Accounting, Nursing and Teaching/Education respondents); to reduce one's workload (the most frequent response for Dentistry and Medicine respondents); and to seek help of an allied health professional, such as a psychologist, counsellor or social worker (the most frequent response category for Academic and Midwifery respondents).

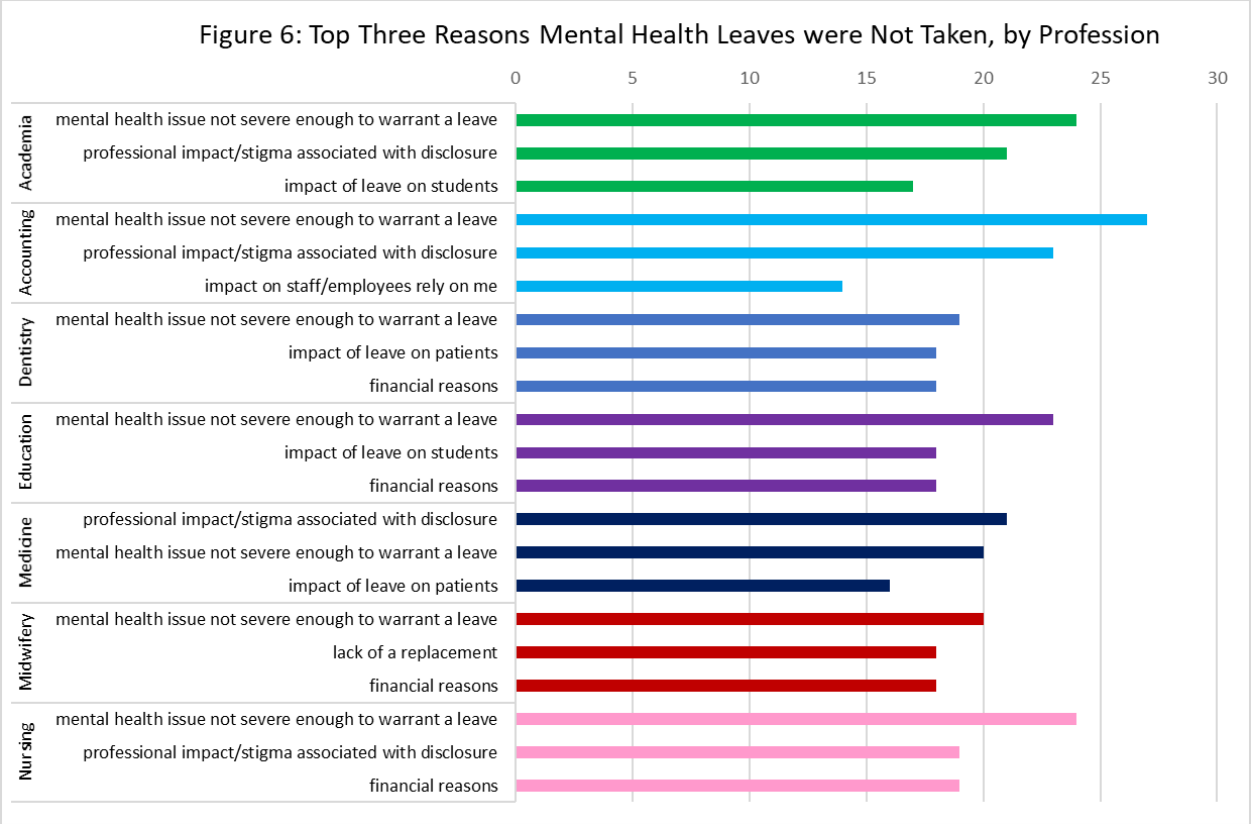
"*I'd actually had … a breakdown. And that's when I called the EAP line to get a counselor. But I didn't take any leave or anything like that, because of the guilt that I felt for not being there to finish my work.*" Accounting Participant

"If you need the [MH] help, you have to go and find it yourself…I'm going to have to pay for it out of pocket too." Nursing Participant



Across all professional respondents, the main reason why mental health leaves were not taken is because they felt that the mental health issue they were experiencing was not severe enough to warrant a leave; the only exception was for respondents from Medicine for whom the most likely response was because of the stigma that disclosure of a mental health issue at work would entail (Figure 6). Stigma and concern about the professional impact of taking a mental health leave from work was a close second for all professional respondents except those respondents from Dentistry and Teaching/Education. Financial barriers were noted in the top three most frequent responses from Dentistry, Teaching/Education, Midwifery and Nursing respondents.

Similarly, the preliminary findings of our interviews show that stigma associated with disclosure of mental health issues is an important consideration for all professional groups included in the study when deciding whether to take a leave of absence. Some other barriers discussed in the interviews include: the belief that nothing will change (accounting), difficulty finding locums to keep the practice running with a source of income while on leave(dentistry), challenges building a caseload upon return (midwifery), difficulty finding coverage for clinical commitments without burdening already busy colleagues (medicine), and a fear of falling behind (academia).



"*Have I ever taken a leave of absence? No. Should I have taken a leave of absence? Solid chance, yes.*" Academia Participant

"What pushed me to take that leave of absence was I wasn't able to, I didn't feel like I could take care of myself outside of work anymore. I felt as though I had given everything I had to, to thrive and work in this environment, that when I went home, I was done, exhausted" Nursing Participant

"*I think just the reluctance to talk about it for fear if word gets out it may affect their practice… So I think the barrier would be still the stigma surrounding this whole issue, this whole area of illness."* Dentistry Stakeholder

"*Individuals identifying as female, I think there isn't the same stigma in identifying mental health concerns amongst themselves or within a safe space*" Medicine Participant

The factor that facilitated the taking of a leave of absence from work for mental health issues was most likely to be the financial support or coverage while on leave, with supportive colleagues, supervisors and family also figuring prominently (Figure 7). Similarly, the barrier experienced when taking a leave most often cited by participants was unsupportive supervisors, colleagues, and union representatives but also a lack of financial coverage while on leave (Figure 8). Indeed, our interviews reveal that unsupportive workplace culture hindered decision to take leave among workers in the health, accounting, and education sectors.

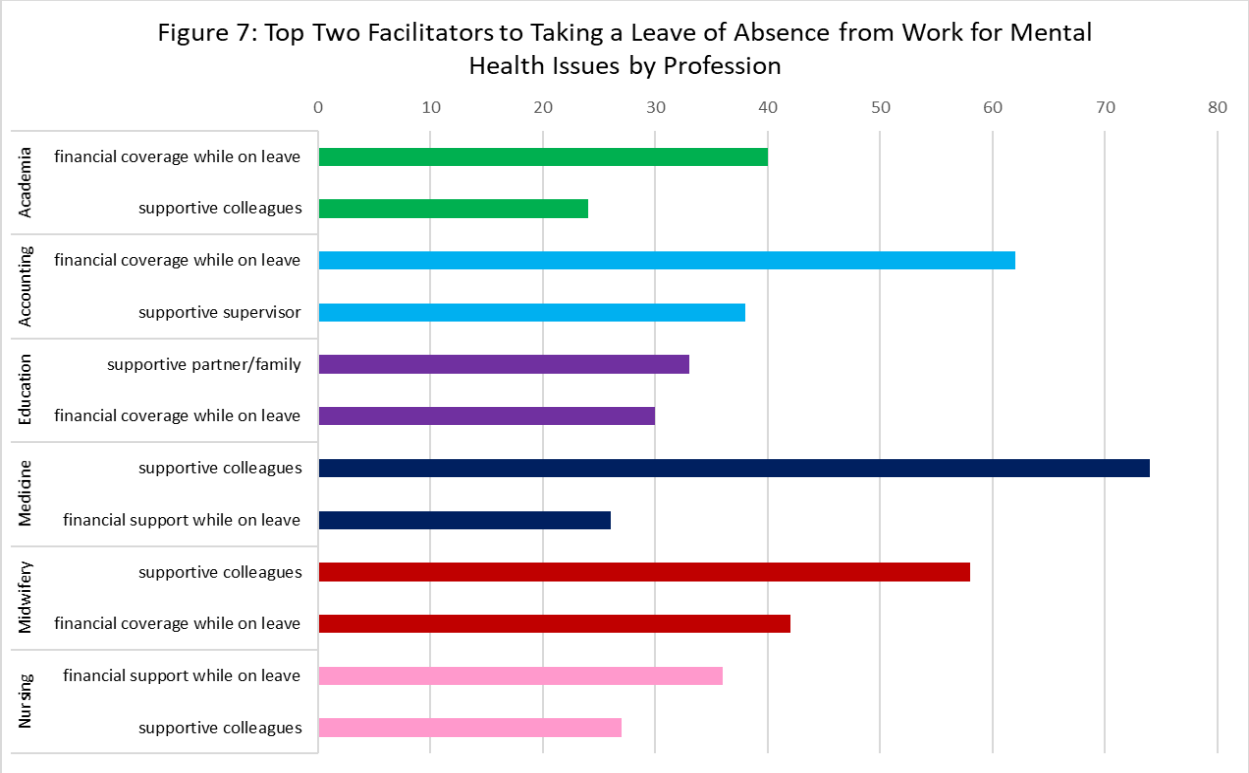


Figure 7: Top Two Facilitators to Taking a Leave of Absence from Work for Mental Health Issues by Profession
0
10
20
30
40
50
60
70
80
Academia
financial coverage while on leave
supportive colleagues
Accounting
financial coverage while on leave
supportive supervisor
Education
supportive partner/family
financial coverage while on leave
Medicine
supportive colleagues
financial support while on leave
Midwifery
supportive colleagues
financial coverage while on leave
Nursing
financial support while on leave
supportive colleagues

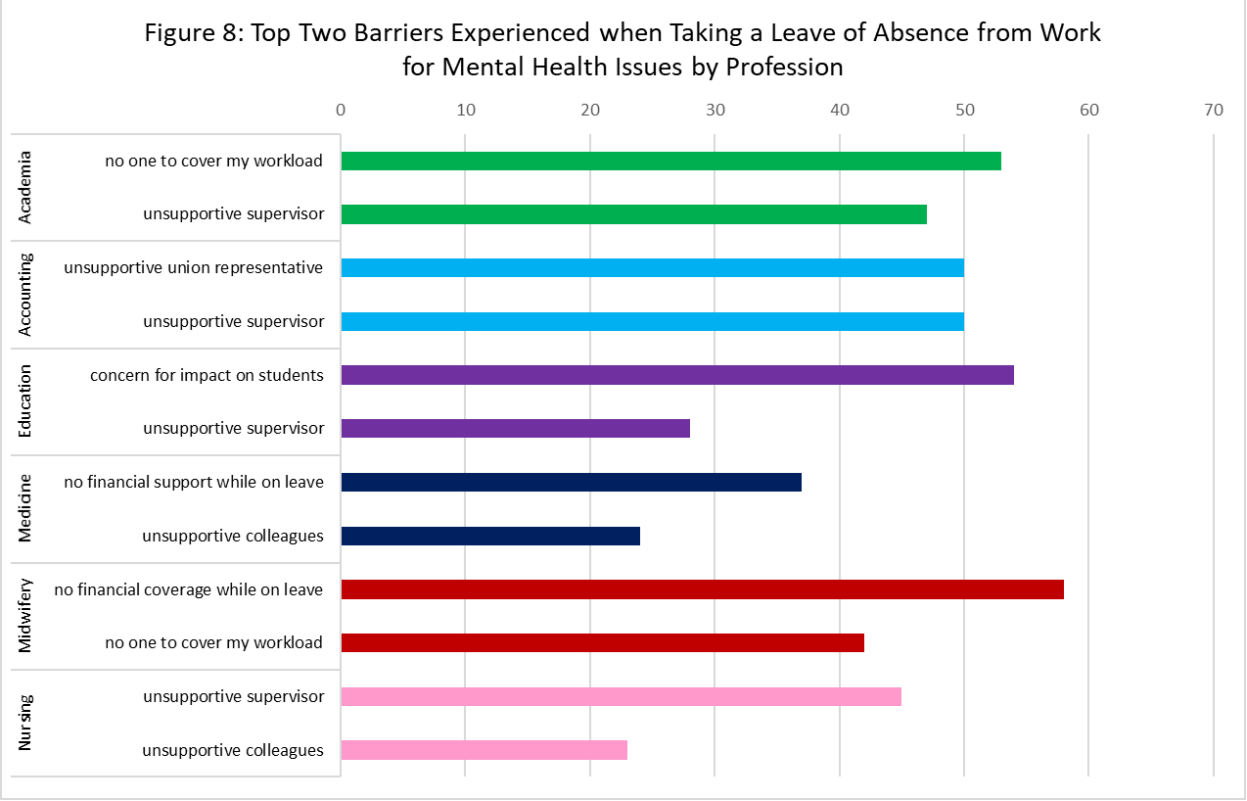


Figure 8: Top Two Barriers Experienced when Taking a Leave of Absence from Work for Mental Health Issues by Profession
0
10
20
30
40
50
60
70
Academia
no one to cover my workload
unsupportive supervisor
Accounting
unsupportive union representative
unsupportive supervisor
Education
concern for impact on students
unsupportive supervisor
Medicine
no financial support while on leave
unsupportive colleagues
Midwifery
no financial coverage while on leave
no one to cover my workload
Nursing
unsupportive supervisor
unsupportive colleagues

"Trying to accommodate everybody else and the resentment that comes from that. And I think it's a time where resources are already stretched so midwives find that it's easy to justify undue hardship." Midwifery Stakeholder

"*…you can't get a locum here to save your life*" Medicine Participant

"*…it's just not financially feasible*" Medicine Participant

"*I'm a strong person. I feel like a failure that I have to take this time off*." Teaching Participant

As noted in the pathway diagrams above, most professionals who take a leave of absence return to work, but some do not (Figure 9). This speaks to the challenges many face in returning to work, especially if there are no changes made to the work or accommodations made (Figure 10).

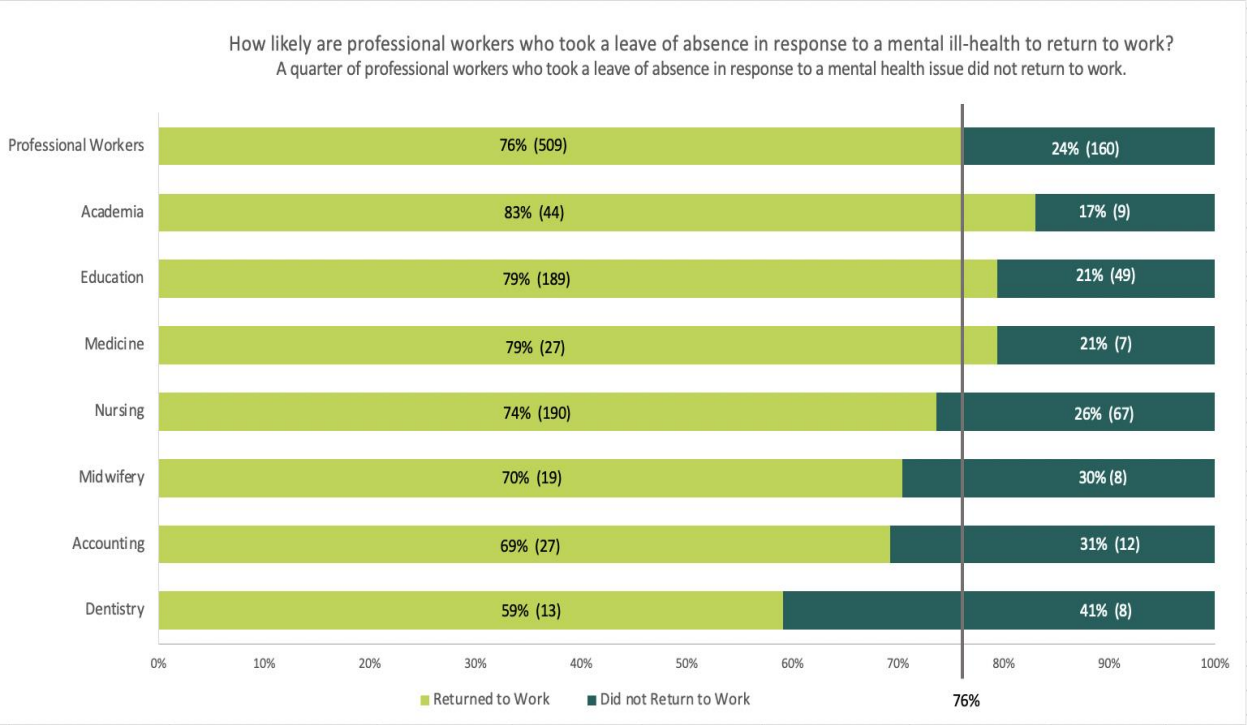
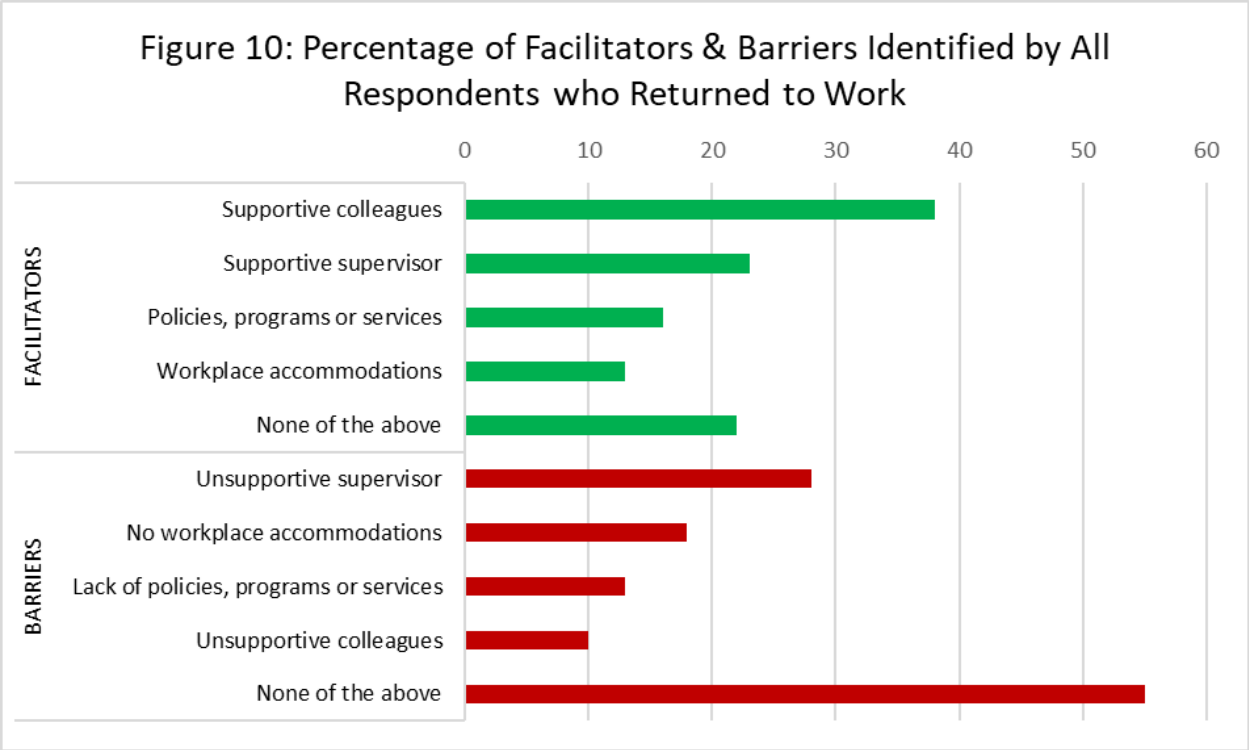


Figure 9 The percentage of professional workers who took a leave of absence from work for mental health issues and returned to work, by profession

Having supportive colleagues and supervisors figured prominently in facilitating return to work after a leave of absence due to mental health issues. Similarly, unsupportive supervisors and a lack of workplace accommodations, policies and programs were barriers.

The preliminary findings of our interviews reveal that some of our participants felt pushed to return when not ready and that they were going back to the same toxic working environment that led to leave in the first place.



"I was really fearful to go back and, and see that, you know, the environment hadn't changed, and everything is still the same…I went back into the same toxic environment."

Nursing Participant

"…the first day is, is pretty brutal… having a structure when you can go back progressively, is very important, because otherwise it's very difficult mentally" Medicine Participant

In sum, the preliminary findings from our research on the pathway from the experience of mental health and the subsequent decisions to take a leave of absence from work (or not) and then to return reveals some important areas for improvement. Notably, there is a need to de-stigmatize mental health issues and encourage both greater knowledge and support from supervisors and colleagues. These findings are critical, considering the significant mental health concerns that have arisen during the COVID-19 pandemic.

Impact of the Pandemic on the Mental Health of Professional Workers

Although the impact of the pandemic was not part of our original set of research questions, as it unfolded, it was clear that it was having an important impact on the mental health experiences of professionals at work and at home, which affected their broader experiences of burnout and presenteeism. In the series of charts below, the measures of mental health, distress, presenteeism scale and burnout were significantly impacted by the pandemic for all professions.

Mental Health

For all professions, self-reported mental health dropped significantly from before to during the pandemic from a midpoint between good and very good to the midpoint of fair to good. Self-reported mental health during the pandemic was notably low for the professions of Midwifery, Nursing and Teaching, where women predominate. The decline in mental health because of the pandemic was significantly greater for those who identify as women in the Academic and Medical professions (Table 3).

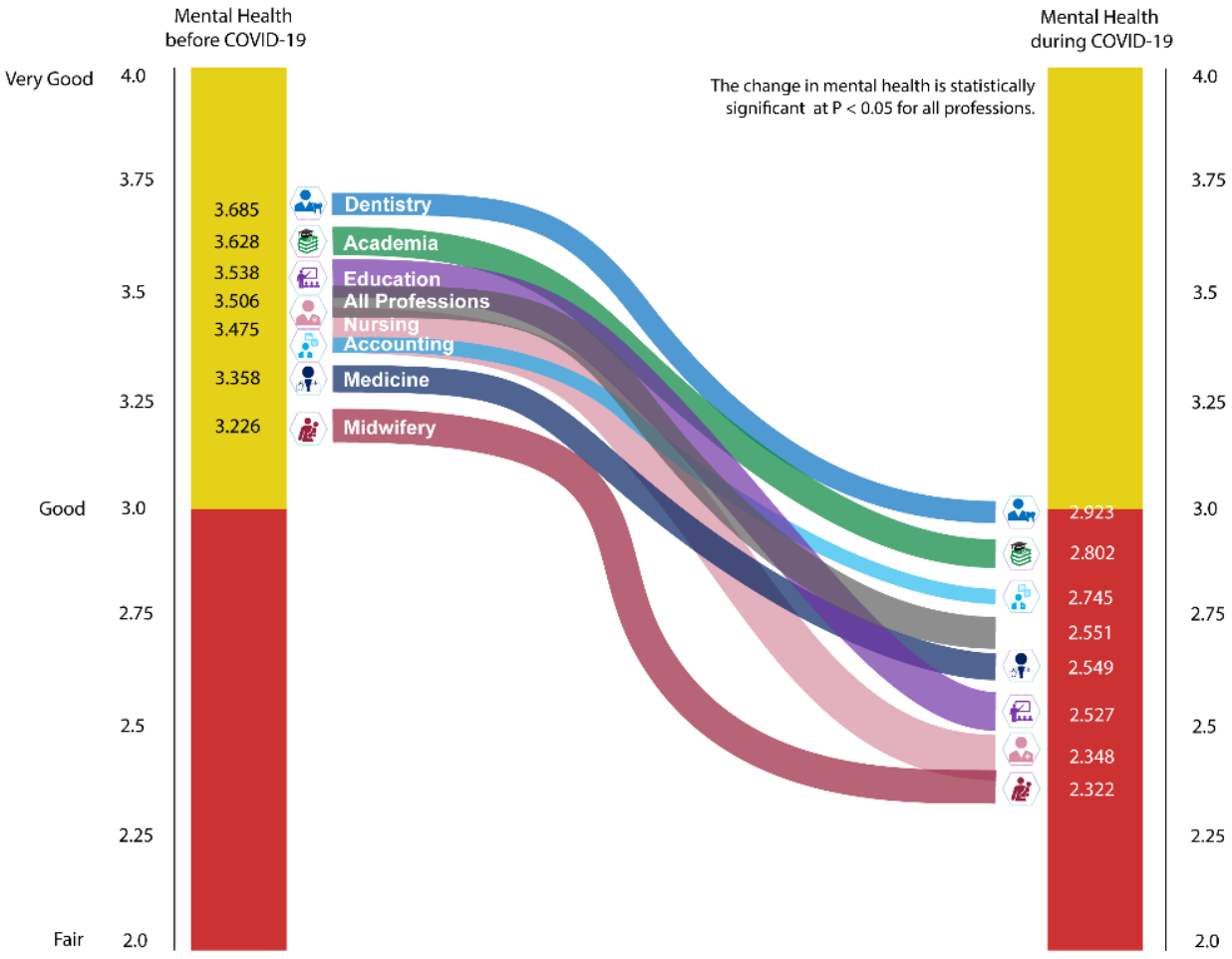


Figure 11 Mental Health Before & During the COVID-19 Pandemic by Profession

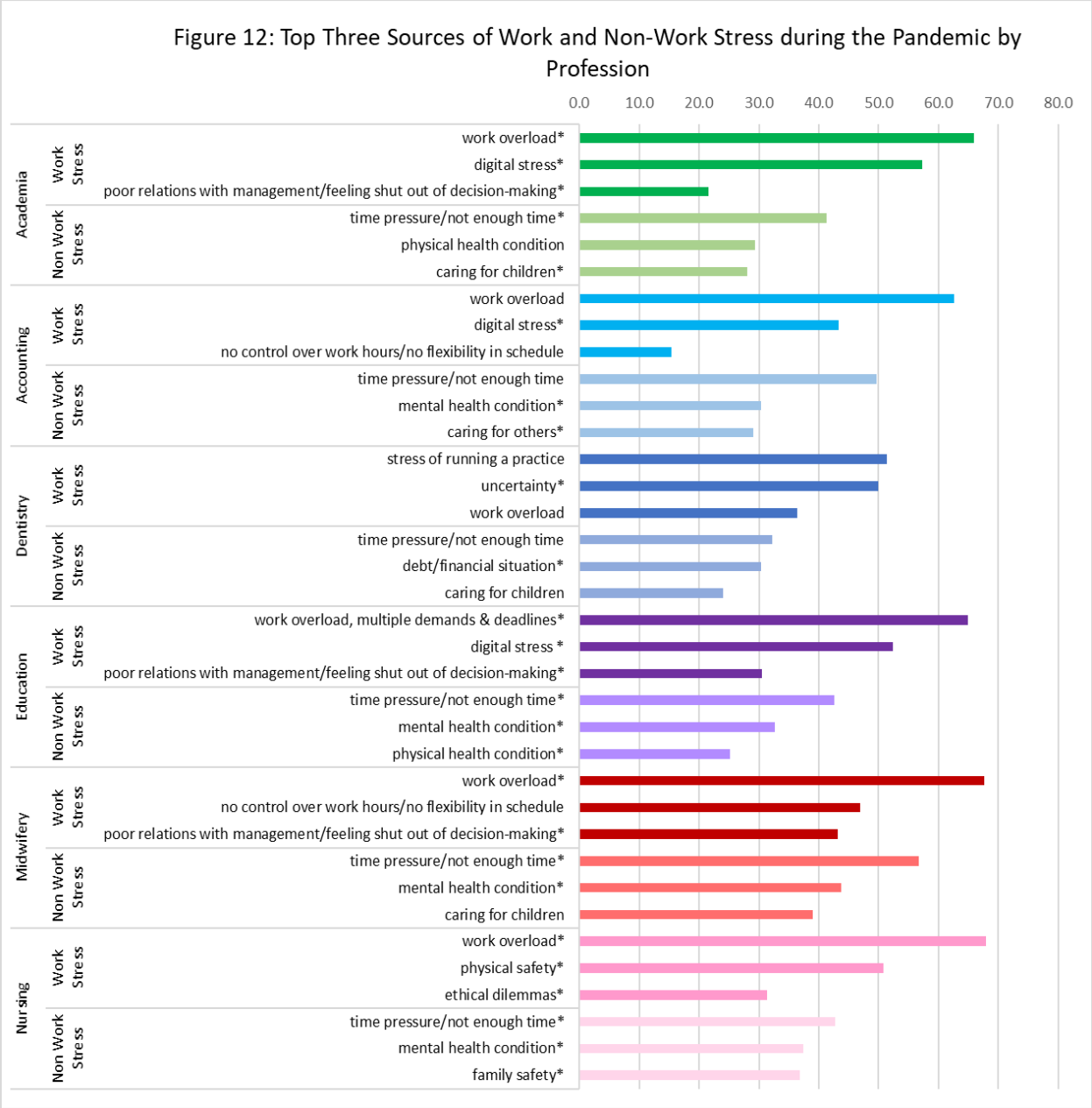
Table 3 Change in Mental Health, Distress, Presenteeism & Burnout by Profession & Gender

PROFESSION	GENDER	General Mental Health	Distress	Presenteeism	Burnout
Academia	Women	***-0.91***	***4.28***	2.00	***0.71***
	Men	***-0.58***	***2.55***	1.88	***0.43***
Accounting	Women	-0.67	3.38	***1.30***	0.53
	Men	-0.86	3.34	***2.41***	0.67
Dentistry	Women	-0.74	4.04	n/a	***0.61***
	Men	-0.78	3.30	n/a	***0.37***
Education	Women	-1.03	***5.25***	n/a	0.87
	Men	-0.92	***4.19***	n/a	0.81
Medicine	Women	***-0.86***	***4.21***	1.52	0.63
	Men	***-0.52***	***2.59***	0.84	0.42
Midwifery	Women	-0.88	4.35	1.91	0.89
Nursing	Women	-1.14	5.20	1.81	0.92
	Men	-0.95	4.69	1.91	0.64

* Blue indicates significant gender difference

Work & Non-Work Stress

The pandemic also had a significant impact on the sources of work and non-work stress (Figure 12). An increase in workload (significant for Academia, Midwifery, Nursing and Education/Teaching), digital stress (significant for Academia, Accounting, and Education/Teaching), figured prominently as well as feelings of being left out of decision-making (significant for Academia, Midwifery and Education/Teaching). Unique stressors were noted by our Dentistry (e.g., stress of running a practice and uncertainty) and Nursing (e.g., physical safety and ethical dilemmas) respondents. Each of these reflects the unique stress profile related to the profession and the pandemic.



In terms of non work stress, time pressure was noted as a top stressor by all respondents asked this question and was notably significant for Academic, Midwifery and Nursing respondents. Underlying mental and physical health conditions were also identified. Caring for children was noted by three different categories of respondents, significantly impacted by the pandemic for Academics. Again, we see unique non work stressors identified by Dentistry (e.g., debt/financial concerns) and Nursing respondents (e.g., family safety).

Distress

In Figure 13 to the right, we see those self-reported measures of distress, as measured by the Kessler 6 scale, have increased significantly for all professions during the pandemic as compared with before its onset. Although these scores are still below the cut-off score of 19, they are cause for concern.

Similar to what was found for self-reported mental health, levels of distress during the pandemic were particularly noted for professions where women predominate: Nursing, Teaching and Midwifery. The increases in self-reported distress were significantly higher for those who identify as women in the Academic, Medical and Teaching professions (Table 3).

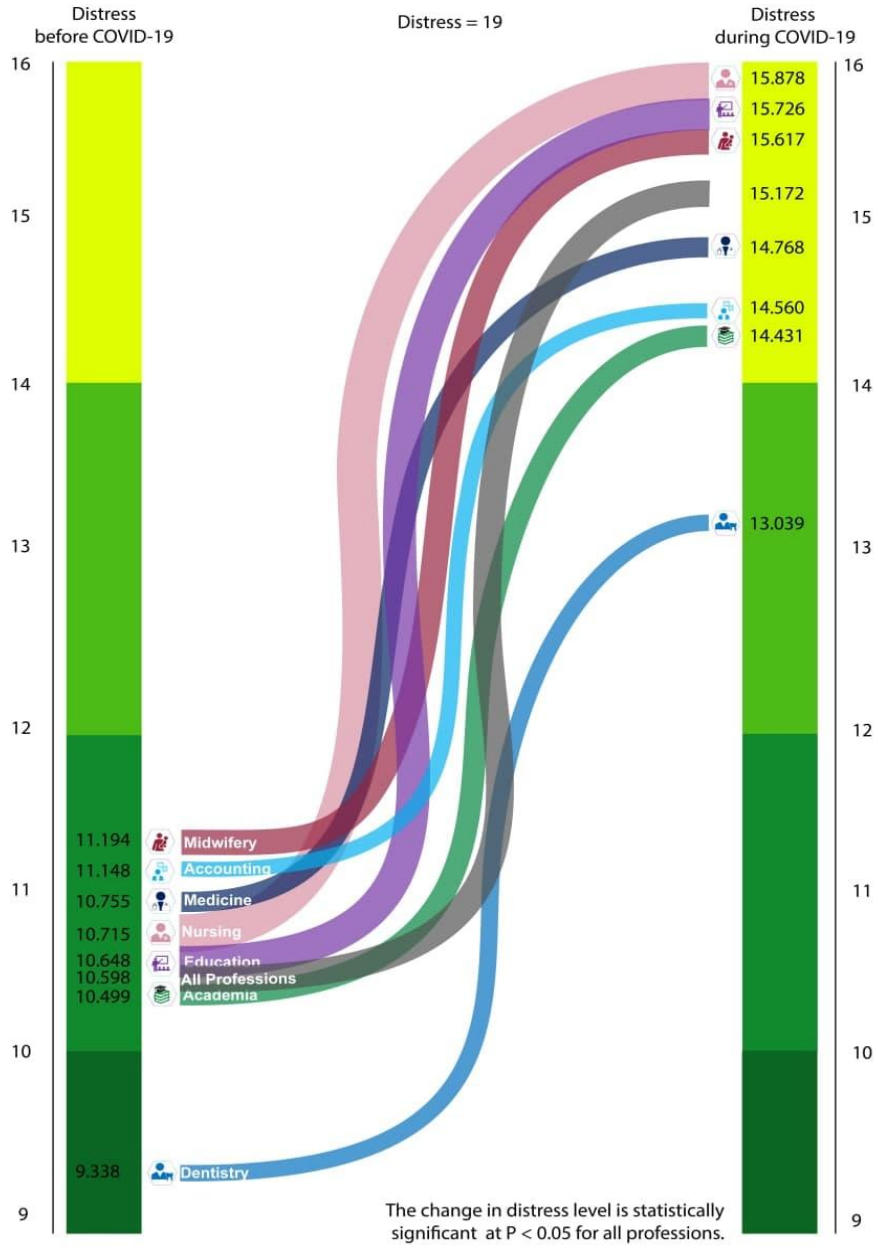


Figure 13 Levels of Distress (as measured by the Kessler 6 Scale), Before and During the Pandemic, by All Professions

> *"It's a perfect storm then, for people. … It's just relentless*." Medicine Participant

Presenteeism

Presenteeism, as measured by the Stanford Presenteeism Scale (SPS-6)[20] and depicted in Figure 14, has also gone up significantly, exceeding the cut- off score of 15. Again, this was particularly notable for the professions where women predominate, Midwifery and Nursing. The increase in presenteeism was significantly higher for those who identify as men in the Accounting profession (Table 3).

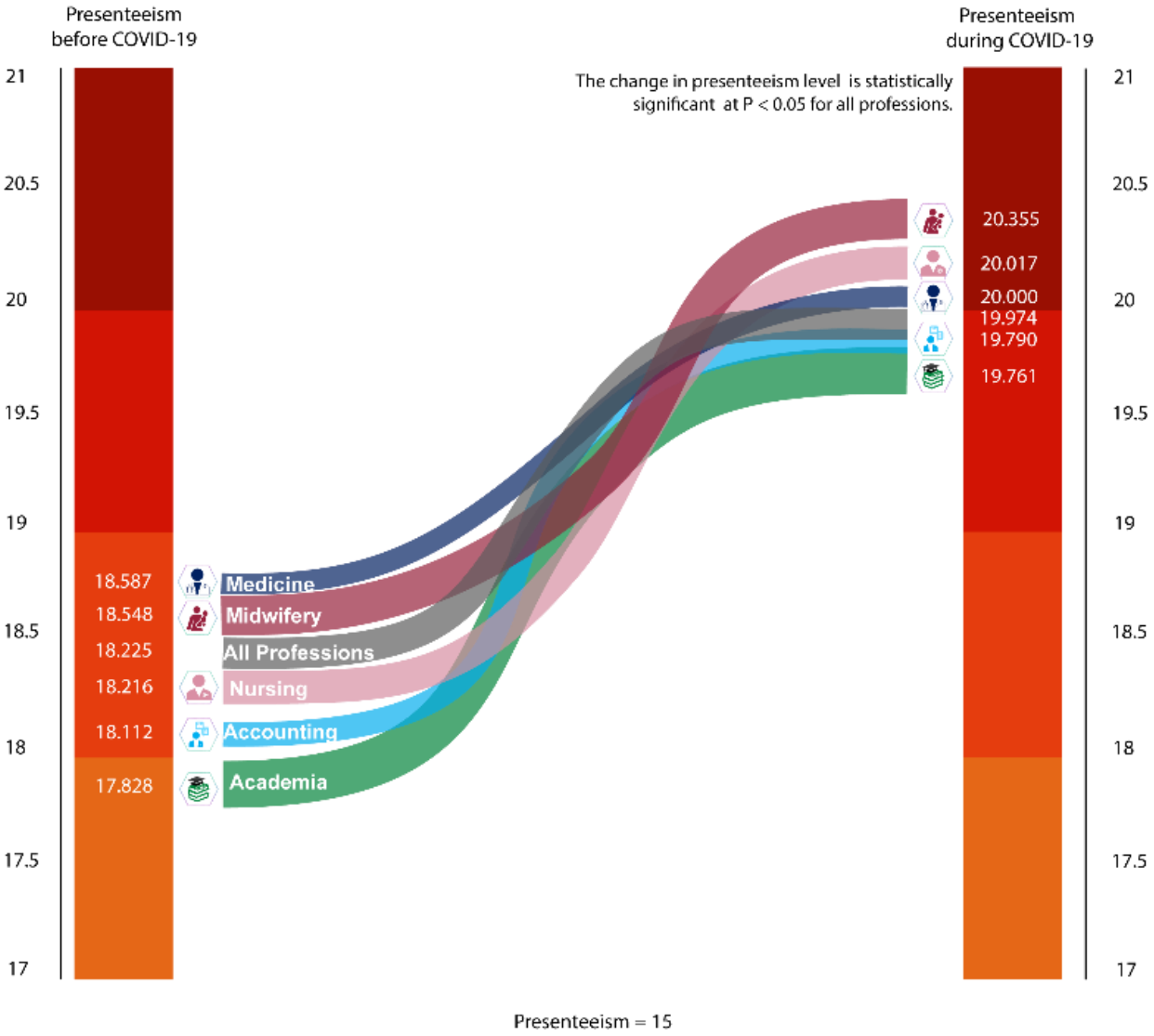


Figure 14 Levels of Presenteeism (as measured by the Stanford Presenteeism Scale (SPS-6)), Before and During the Pandemic, by Select Professions

Burnout

Rates of burnout have also increased during the pandemic according to the Physician Worklife Survey Single Item Burnout Question[21] (Figure 15). Whereas prior to the pandemic, most professions were within the 'occasionally burned out' range, the pandemic has caused several professions to shift into the 'experiencing one or more symptoms of burnout' range. Again, the trend is most pronounced for professions where women predominate, Nursing and Midwifery. Significantly higher scores were reported by those who identify as women in the Academic and Dentistry professions (Table 3).

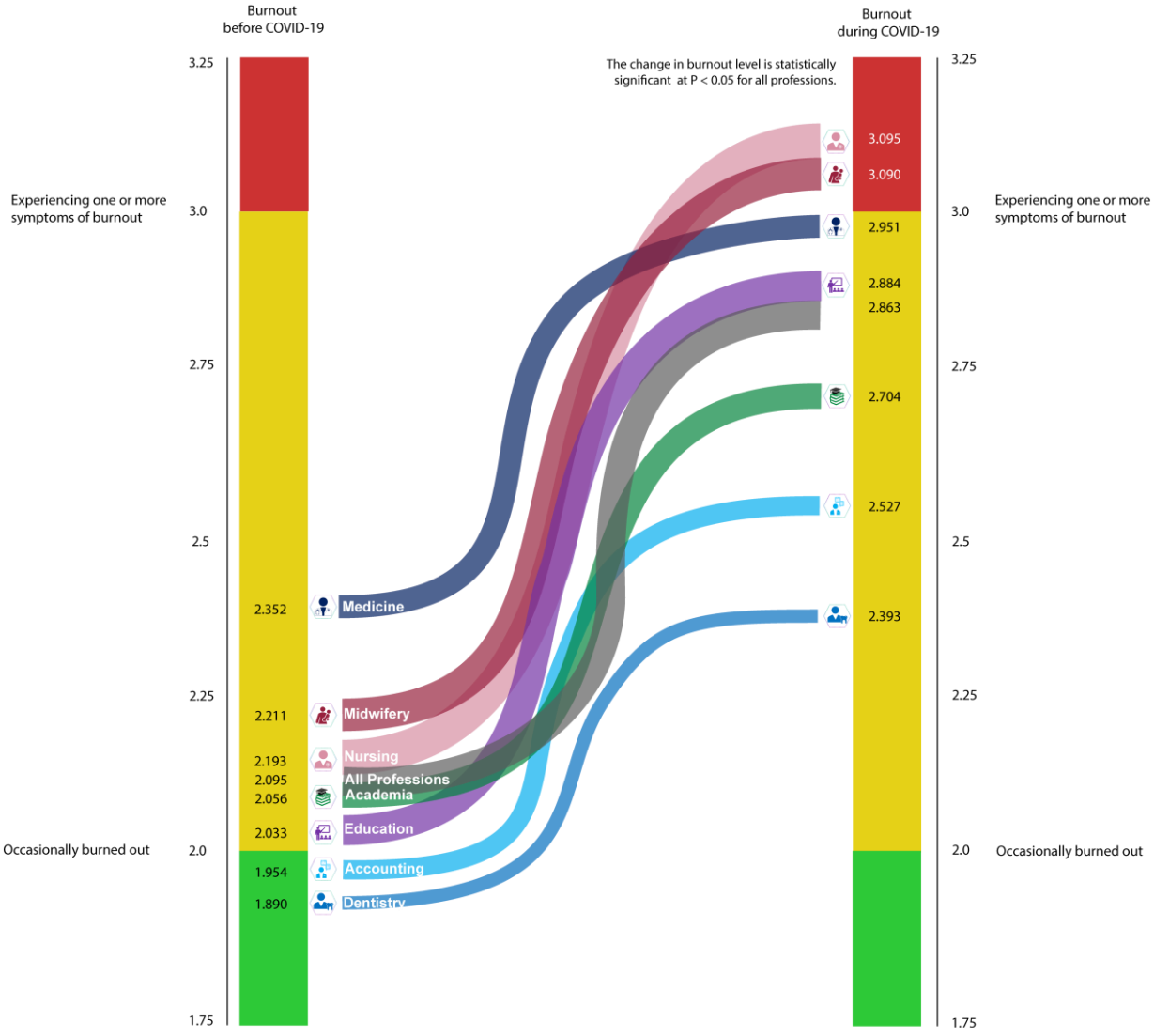


Figure 15 Levels of Self-Reported Burnout, Before and During the Pandemic by All Professions

Intention to Leave

> *"What we hear is them [nurses] saying, 'No, I'm done. This isn't what I signed up for anymore and someone else can take up the reins', they don't feel like they're in an environment where their [professional] standards can be met."* Nursing Participant
>
> *"It makes you wonder like, well, how long is my career actually going to be? …Most of the time I have very happy babies come out of really happy moms and make happy families. … That is a wonderful, powerful feeling. … I love it, but it might destroy me in the process."* Midwifery Participant

The compounded effect of declining mental health and rising rates of distress, presenteeism and burnout is a rise in intention to leave either the organization or the profession entirely. Figure 16 presents data on the intention of selected professionals to leave their organization and Figure 17 to leave their profession. While respondents to our survey are more likely to have intentions to leave their organization or practice/health care setting than to leave their profession, there is sizeable proportion who either agree or completely agree with this statement. Particularly notable are the intentions to leave both their organizations and professions by respondents from the Nursing and Midwifery professions. This is likely linked to the higher rates of distress, presenteeism and burnout noted in the diagrams above.

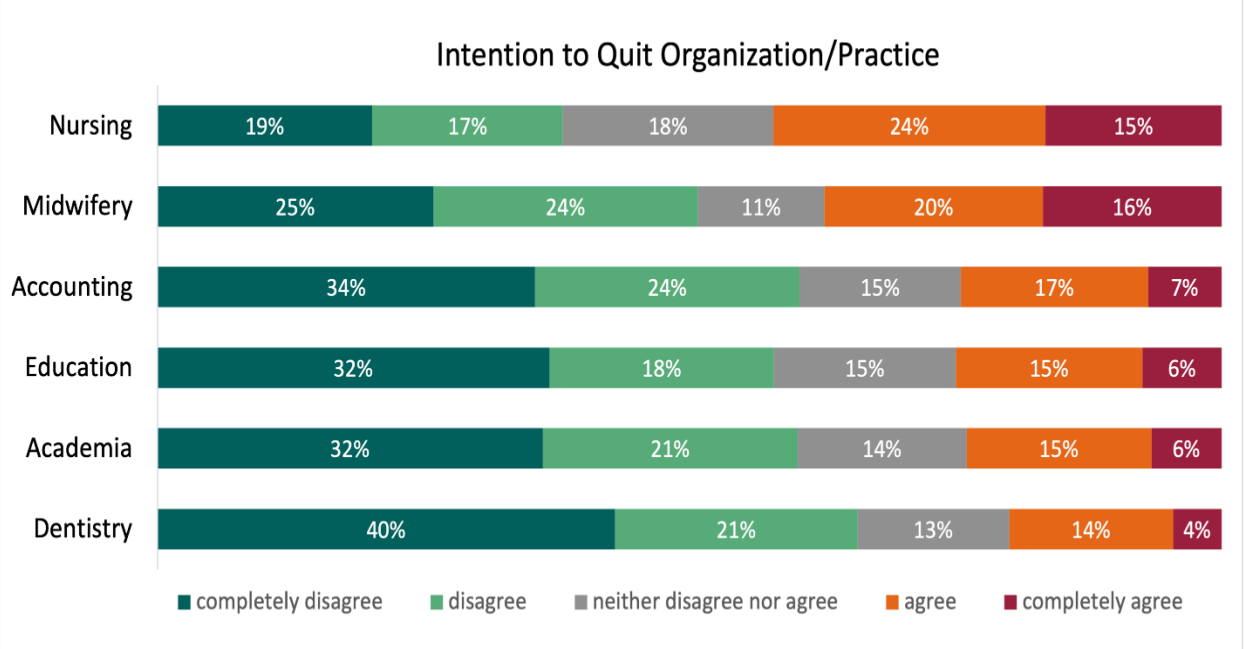


Figure 16 Intention to Quit Organization or Practice or Health Care Setting by Select Professions

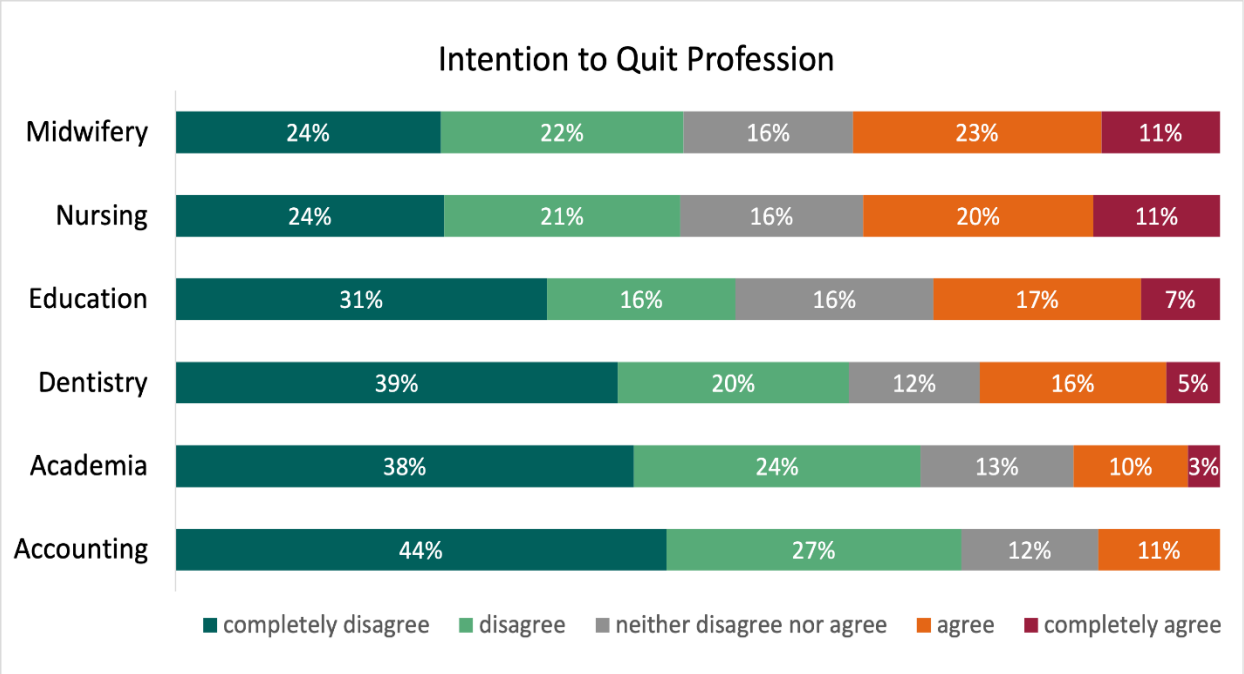


Figure 17 Intention to Quit Profession by Select Professions

In sum, we find that the negative impact of the COVID-19 pandemic on the mental health of professional workers has been significant and felt particularly by those professions where women predominate and by women across many of our professional case studies. As we move to the next steps in our research partnership, we will drill down further in the family, work and organizational sources of stress and support that influence the pathway from mental health to leaves of absence and return to work.

Next Steps

The findings we have presented to date are remarkable, but they only scratch the surface of an enormously rich dataset – both quantitatively from the survey and qualitatively from the in-depth interviews with stakeholders and professional workers. Augmenting these initial comparative analyses across professions, each of the teams are undertaking case specific analyses which will be forthcoming in the following months.

In terms of the qualitative data, the teams are applying a set of themes within and across the cases that complement the lines of questioning in the survey. Accompanying these will be the emerging codes which will in turn help to guide the next steps of the survey analytic process.

In both cases, a more complex gender-focused analysis will be undertaken within and across the cases, intersecting with age and years working in the profession to identify cohorts impacted by the pandemic.

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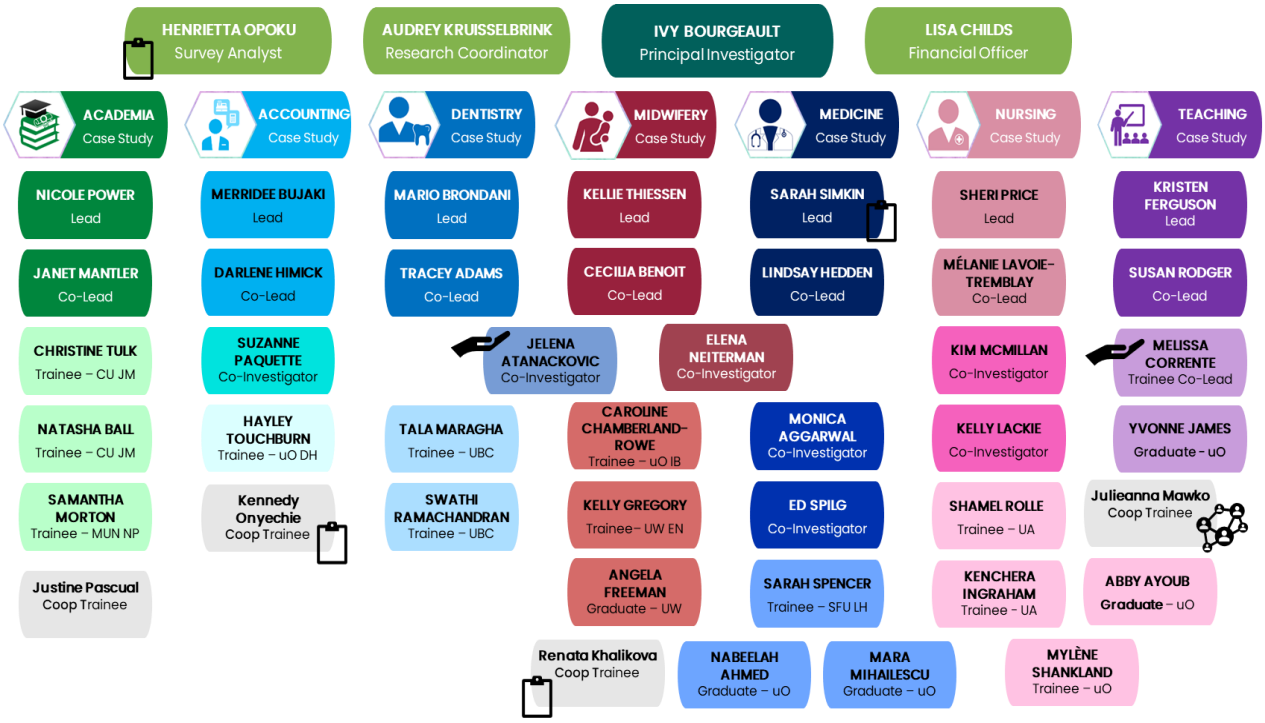

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