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A NEW HORIZON FOR OCCUPATIONAL HEALTH

APEC White Paper on Workplace Mental Health and Safety

Photo: 'APEC Innovation in Action: Building the Digital Hub for Mental Health' Conference, Vancouver (June 2017)

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Mood Disorders Society of Canada
Société pour les troubles de l'humeur du Canada

UNIVERSITY OF ALBERTA

THE UNIVERSITY OF BRITISH COLUMBIA

CANMAT

Contents

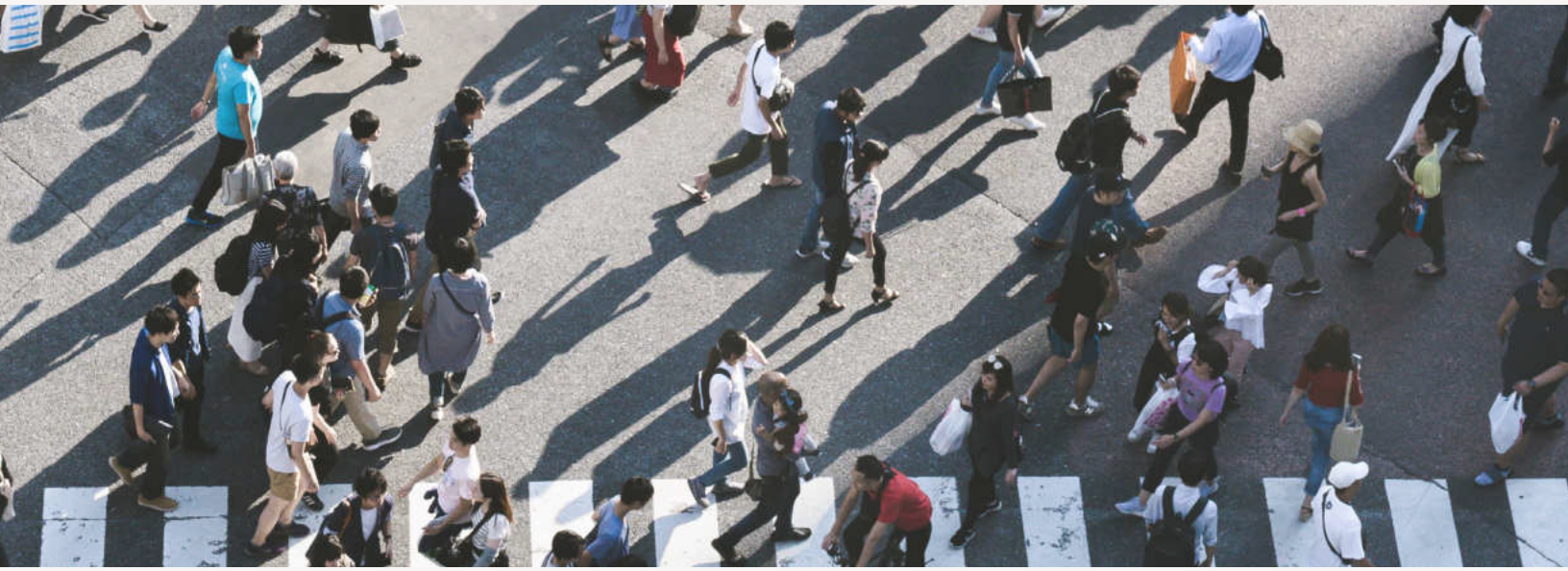
Executive Summary

There is no health without mental health.

Mental health is fundamental to our global collective well-being and economic prosperity. The promotion of mental health, as well as the provision of support to alleviate the suffering of those experiencing mental illness, is a joint responsibility that requires the active participation of all sectors and actors, on local, global and national levels.

In June 2017, the APEC Digital Hub for Mental Health (Digital Hub) 'Innovation in Action: Building the Digital Hub for Mental Health' International Conference identified the need for a high-level position paper that could be used by APEC economies to promote discourse and mobilize governments, decision-makers, employers and other stakeholders to invest in and promote workplace mental health programs. This concept was further developed at a Digital Hub Colloquium held in Ho Chi Minh City, Viet Nam, in August 2017. Based on these discussions, the Digital Hub Workplace Wellness and Resilience Work Group developed this White Paper to illustrate the benefit of implementing mental health best practices and standards in the workplace, as well as the cost of inaction, with specific examples from the Asia Pacific region.

This paper outlines key considerations that open the opportunity for discourse on improved workplace mental health and wellness at national and international levels. This includes an overview of workplace mental health and wellness, the public health and economic impacts of mental illness, the obstacles and opportunities in workplace health and wellness implementation, examples of model programs from the Asia Pacific, and a call-to-action for leaders of all sectors.



Call to Action

It is more critical than ever for workplaces to expand their understandings of health and safety to include mental health, and for leaders to meaningfully and thoughtfully allocate resources and time into implementing policies, processes and procedures that promote mental health and well-being in the workplace.

In a knowledge-based economy, the greatest asset for an organization is its people and their ability to mentally function. Concerted international effort is critically needed to support the dismantling of existing preventable barriers to improved workplace mental health. Cooperation and collaboration between all levels of government, unions and the private sector are essential to this effort.

We call on workplace leaders from all sectors to be champions of change to promote workplace mental health and wellness. This requires visible, active and sustained leadership to provide a pathway for others to follow. You can also strengthen cooperation across private and public sectors through innovative partnerships and common mandates.

To support leaders and organizations in their efforts to raise awareness and spark dialogue around workplace wellness and resilience, we make the following recommendations:

Recommendations for Workplace Leaders

Inspire others within your organization.

No matter what your role at an organization or in society, you can motivate others to take action. Be a trailblazer and leader, and share your journey, approach and successes to drive widespread impact.

Talk openly about mental health in the workplace.

Clearly communicate the importance of mental health for the organization. Ensure that employees understand that everyone experiences challenges in maintaining their mental health.

Raise awareness about existing benefits, services and supports.

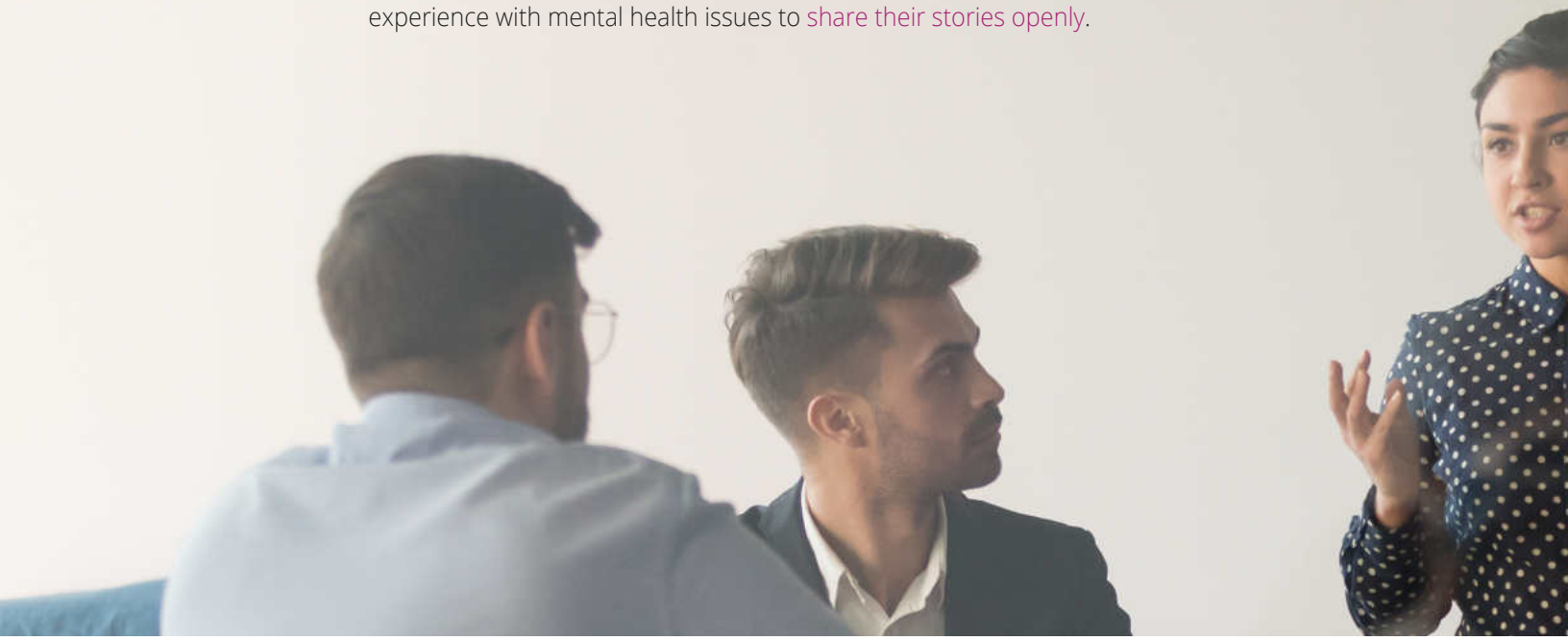
Offer help for those who are struggling or at risk for mental health issues. Promote the use of supports such as Employee Assistance Programs to increase access to services.

Support employees' efforts to get help.

Make it clear at all levels of the organization that the organization supports employees' efforts to take care of their mental health the same way they take care of their bodies. This may include flexible work arrangements, taking a mental health day, and ensuring that people are not penalized for taking care of their mental health.

Combat the stigma.

Help to normalize mental health by talking about stress management, self-care, and mental health in meetings and communications. Encourage those in leadership roles who have experience with mental health issues to share their stories openly.



Recommendations for Workplace Organizations

Demonstrate commitment.

Clearly communicate that mental health is a priority. This may include adding the enhancement of workplace mental health as a key performance indicator for the organization, dedicating human and financial resources to advance this priority, writing a policy statement or some form of communication to all employees in support of workplace mental health, and supporting senior leaders in sharing their own personal stories.

Identify the organizational need.

Develop a good analysis of the situation in the organization and where improvement is needed. Review relevant data and information, and gather feedback from employees to ensure the organization has a clear baseline on which to set objectives and track progress.

Develop a strategy for a mentally healthy workplace.

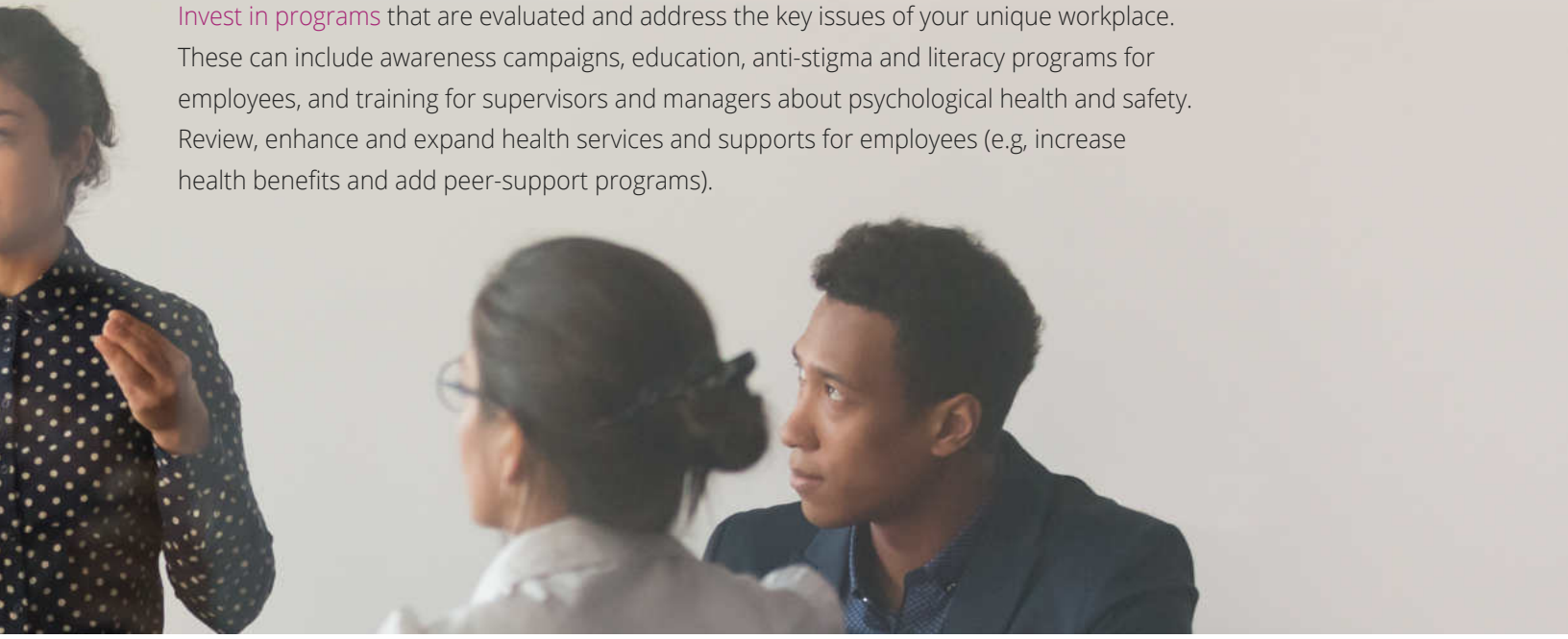
Provide a clear plan and framework to promote workplace mental wellbeing, minimize workplace risks, support those who are experiencing mental health issues and reduce stigma.

Educate supervisors.

Train supervisors to identify the signs of mental health problems and how to appropriately respond. Ensure supervisors and managers have the literacy, tools and competencies to effectively support their employees.

Implement effective, evidence-based programs.

Invest in programs that are evaluated and address the key issues of your unique workplace. These can include awareness campaigns, education, anti-stigma and literacy programs for employees, and training for supervisors and managers about psychological health and safety. Review, enhance and expand health services and supports for employees (e.g, increase health benefits and add peer-support programs).



Introduction

Mental health, as defined by the World Health Organization, is "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community" [1]. In contrast, mental illnesses are defined as "health conditions involving changes in emotion, thinking and/or behaviour causing distress and/or problems functioning in social, work or family activities" [2]. Internationally, the leading causes of non-fatal disease burden are attributed to substance use and mental health disorders. [3, 4] In fact, the prevalence is so high and stigma so profound that at least a quarter of us will experience a mental health disorder in our lifetime, but more than half of us suffering will not seek help [5].

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Mental health has been internationally recognized as a significant sustainable development need. September 2015 marked the launch of the Sustainable Development Goals (SDGs) by the United Nations General Assembly, further advancing the Millennium Development Goals, with specific reference to mental health and substance use (Table 1). These goals would mark the first time the promotion of mental health and well-being was recognized by international leaders as a top priority as part of their global development agenda [6].

Table 1. UN Sustainable Development Goals: Goal 3 – Mental Health Specific*

Target	***Indicators***
3.4: By 2030, reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	3.4.2: Suicide mortality rate
3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	3.5.1: Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders 3.5.2: Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol.

**Extracted from: https://sustainabledevelopment.un.org/sdg3*

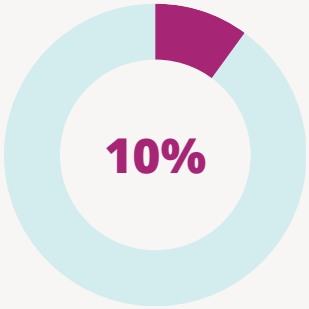
Additional initiatives of note include the WHO's Mental Health Gap Action Programme (mhGAP) [7], launched in 2008, which seeks to scale up support for mental, neurological and substance use disorders internationally, with particular emphasis among middle- to low-income countries for which the scale of burden is significantly higher, the Comprehensive WHO Mental Health Action Plan (2013-2020) [8], which seeks to implement strategies for promotion of mental health and "strengthen information systems, evidence and research for mental health," among other objectives, and the Lancet Commission on Global Mental Health and Sustainable Development (2007-ongoing) [9], which provides a global action plan for the expansion of health services to address the treatment gap in mental health service prevention and care.

We begin this paper by presenting the public health and economic case for the promotion of mental health and prevention of mental illness in the workplace. We then present high-level obstacles and opportunities in the implementation of mental health and wellness policies and practices in the workplace, followed by a call to action.

Public Health Impact

Mental illness and substance use disorders are internationally prevalent.

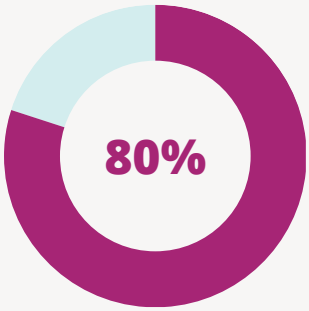
When accounting for all disease groups, mental illness is the leading cause of years lived with disability globally, making up over 10% of the global burden of disease [10]. Hit hardest are countries with lower social economic prosperity, where the concentration of burden among individuals living in low- and middle-income countries is as high as 80% [11].



GLOBAL BURDEN OF MENTAL ILLNESS AND SUBSTANCE USE

The workplace presents an opportunity for change.

Mental health promotion and mental illness prevention are broad-based public health initiatives in which the workplace can play a critical role. Individuals over the age of 18 are estimated to spend over 60% of their waking hours in the workplace [12]. Alarmingly, the leading cause of short and long-term work absences in high income countries due to sickness and/or disability are common mental illnesses such as depression and anxiety [13, 14].Over 300 million people, or 4.4% of the world's population, are estimated to suffer from depression, and by 2020 depression is forecasted to become the second-leading cause of disability worldwide, rivaling heart disease [15]. The WHO has estimated that up to a $1.15 trillion USD is lost globally every year due to lost productivity linked to depression and anxiety. A lack of support for mental health promotion and delivery combined with concerns about stigma and discrimination means that many do not get the treatment they need to live healthy, productive lives or to contribute optimally to workforces.

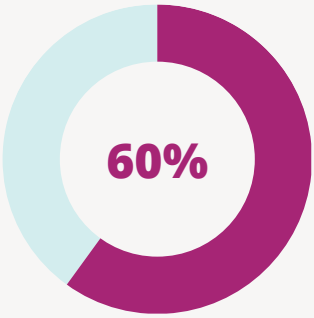


CONCENTRATION OF BURDEN AMONG LOW & MIDDLE INCOME COUNTRIES

Mental health and physical health are inseparable.

If left unaddressed, poor physical health can lead to mental illness. Vice versa, poor mental health is also associated with adverse physical health issues [16-18]. For example, cardiovascular disease, obesity, coronary artery disease, stroke, diabetes, musculoskeletal disorders, and respiratory disorders are commonly comorbid with mental illness [19, 20].

With advances in scientific thinking and evidence we are now recognizing that the traditional definition of health must include mental health. To reduce the global burden of mental health and substance use disorders, we need to close the treatment gap between mental health and physical health conditions by increasing the scope of health care to include mental health treatment. Efforts to scale up resources and political will to bridge gaps in treatment and prevention vary across countries and regions. History, context, and economic prosperity, among other factors, may contribute to low prioritization of mental health. While efforts to address mental health are increasing worldwide, the low prioritization of mental health remains a challenge that is particularly striking in low and middle income countries [21].



WAKING HOURS SPENT IN WORKPLACE (AGE 18+)

Economic Impact

Inaction is costly.

There are enormous costs associated with mental illness, from both direct costs of medical care and indirect costs (see inset). Approximately 33% of the costs associated with mental health burden are due to the indirect costs associated with mental illness [22, 23]. These costs include increased absenteeism (off work because of illness), presenteeism (working while sick), lost productivity (underperformance and unrealized outputs), safety incidents and injuries, disability claims, overtime and overstaffing (to cover absenteeism) and other associated stress imposed on team members, turnover and associated recruitment and retention, grievances and complaints, and legal considerations [24, 25].

$16.3
trillion USD

The cumulative global impact of mental illness in terms of **lost economic output** between 2011 and 2030 [26].

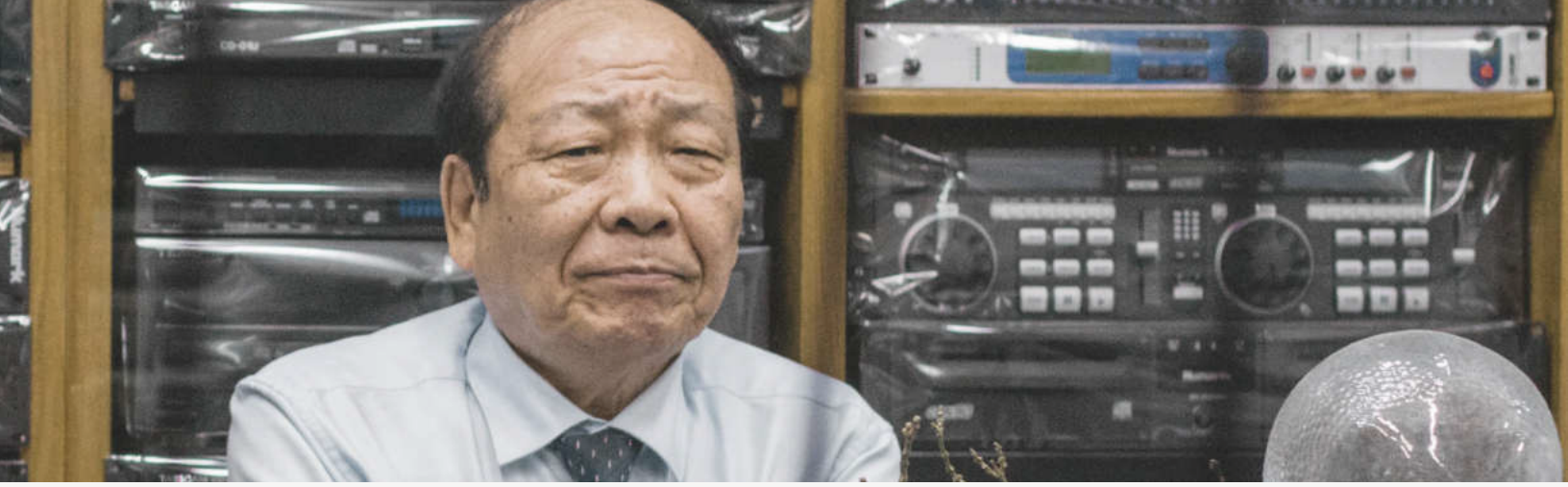
12
billion
work days

Or 50 million work years. Workplace **productivity loss** due to unaddressed depression and anxiety of the 36 largest countries in the world [27].

Beyond the profound impact of mental illness on individuals and their families, there are significant implications and costs to employees, employers and society. Table 2 lists examples of the prevalence, burden and economic impact of mental illness as it relates to the workforce in several APEC economies. These data provide an overview of the economic urgency of committing to improving mental health in the workplace.

Table 2. Selected examples of the economic burden and costs of mental disorders.

Region	***Selected Statistics and Estimates*** *(all costs in USD)*
Canada	• Approximately 500,000 individuals are absent from work per week due to a mental illness [28]. • Mental illness costs almost $40 billion a year [29]. • In the workplace, on average, 30% of disability claims and 70% of disability costs are attributed to mental illness [29].
China	• Mental illness is predicted to cost an estimated $9.4 trillion between 2012-2030 [30]. • Younger adults are significantly affected by mental illness. • Depression rates are particularly high for university students, especially those studying abroad, with 45% reporting depression compared with 11.7% reported by their peers who remained in China [31]. • Suicide is the second leading cause of death for university aged students [32].
Japan	• Total costs in 2005 were estimated as $18.5 billion for depression [33], $20.5 billion for anxiety disorders [34], and $23.7 billion USD for schizophrenia [35]. • Rates of absenteeism and presenteeism were reported to be 51% and 12% of total costs of depression [36].
Republic of Korea	• 21% of workers reported "high job strain," which was experienced by 7% of workers with heart disease, 7% with strokes, 14% with major depressive disorder, and 4% with death by suicide [37]. • The rate of mental illness attributed to factors related to work increased 354% compared to a decade ago [37].



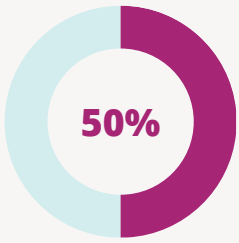
Malaysia	• The burden of mental illness is disproportionately high among younger working-age adults. • For individuals between the age of 20 and 30 years, mental illness accounts for 51% of Disability Adjusted Life Years (DALYs) [11]. • In 2010, a total loss of $10.6 billion was attributed to mental health related illness [11]. • This loss is projected to increase to $24.3 billion by 2030 [11].
Singapore	• 2.3% of workers report having experienced at least one mental health disorder in the last year, with 0.5 days per month of work days lost to absenteeism. This amounts to an estimated 0.3 million productivity days lost each year [38]. • 72% of workers report that workplace stress and mental health issues were affecting their productivity [39]. • Estimated cost per person living with a mental disorder is approximately $7,638 per year [40]. • Indirect costs represent 81% of total costs; approximately half are associated with lack of productivity due to absenteeism and unemployment [40].
United States	• The cost of major depressive disorder alone was $210 billion in 2010, up 21.5% from 2005 [41]. • The costs attributable to absenteeism in 2010 were $23.3 billion and to presenteeism were $78.6 billion [41]. • Employees with depression report productivity levels at 70% of their peak performance [42]. • In a 3-month period, employees with depression miss an average of 4.8 workdays and have 11.5 days of reduced productivity [43]. • Depression accounted for 400 million disability days per year [41] and cost employers $44 billion in lost productivity time [44].
Viet Nam	• Surveys on mental health and stress across several employment sectors (e.g. air traffic control, healthcare services, university staff and factory employees) found a prevalence of stress and/or anxiety ranging from 14% to 28% [45].

Challenges and Opportunities

Challenges

DO NOT RECEIVE ANY TREATMENT

NOT WILLING TO WORK WITH SOMEONE WITH DEPRESSION



WILL NOT TELL FRIENDS ABOUT MENTAL ILLNESS IN THEIR FAMILY

Stigma remains widespread.

Internationally, it is estimated that up to 70% of individuals experiencing mental health issues do not receive any treatment. This may be attributed to several factors, including low help seeking as a result of [46, 47]:

1. lack of knowledge around symptoms of illness and poor treatment access,
2. negative personal and/or social attitudes towards mental illness, and
3. fears (perceived and/or validated) of acts of discrimination against people experiencing mental health issues.

Factors 2 and 3 taken together can be defined as stigma, a significant barrier to the implementation and uptake of mental health promotion, and mental illness treatment and prevention in and outside of the workplace [48]. Canada's Chief Public Health Officer reported that stigma contributes to worsening health outcomes and impedes access to social determinants of health such as housing, income generation and health care [49].

There exists considerable systemic or structural prejudice against people with mental illness. A US public survey reported that 30% of respondents would not be willing to socialize with an individual diagnosed with depression, and 47% would not be willing to work with someone with depression [50]. A 2008 survey found that 55% of Canadians said that they would not engage in a romantic relationship with an individual managing a mental illness, and 42% were unsure whether they would continue interacting with a friend managing a mental illness [51]. Another survey reported that only 50% of Canadians would tell friends or co-workers that they have a family member with a mental illness, compared to 72% who would discuss a diagnosis of cancer and 68% who would disclose a family member with diabetes [52, 53]. An individual's belief of root cause of mental illness may influence the stigma associated with the illness. For example, in Japan, individuals believing mental illness was caused by "personality," versus as a result of trauma or a virus, were more likely to endorse a "weak-not-sick" stigma [54].

Social or structural forms of stigma can be internalized, potentially contributing to "self-stigma." Self-stigma can be associated with shame and lower self-esteem in individuals experiencing mental health issues, as well as reluctance about disclosing symptoms or diagnoses to friends, family or colleagues [55]. Self-stigma in turn may be associated with physical symptoms that make it difficult to access mental health care [56].

Lack of organizational reporting is also a cause and reinforcer of stigma. In Canada, 39% of respondents stated that they would not tell their supervisors at work if they had a mental health related problem [51]. In Chile, an important source of stigma is the poor management of complaints regarding workplace harassment and discrimination, aggravated by the lack of a legal definition of harassment [57]. A person facing mental health problems may be blamed for their predicament, and face being removed from work duties [57].

There is significant underfunding of mental health prevention and treatment internationally [58].
High income countries spend an average of USD $50/person on treatment and prevention of mental illness, and low and middle income countries spend an average of USD $2/person [59]. In all cases, need for treatment and prevention services does not currently match supply or service availability.

> "Establishing a culture of health and well-being at work creates an environment where employees feel valued, supported, and stimulated to perform their best in work they find meaningful [59]".

Work culture may also influence mental wellbeing.
In some economies, specific employment sectors may experience distinct challenges. For example, teachers in some regions may be placed under immense pressure based on student performance on examinations, as the outcome of their students' success are considered a reflection of their own performance. Highly-skilled workers in white-collar urbanized professions (for example, lawyers, bankers, accountants, technology engineers, etc.) may face highly competitive environments with long work hours. China, for example, has seen exponential growth within the technology sector, and typically supports a demanding work culture of "9-9-6" (work 9am to 9pm, 6 days a week), or even fostering a "0-0-7" work schedule (work from midnight to midnight, 7 days a week) [61, 62].

Workplace health and wellness may be influenced by factors external to the work environment.
Although these factors fall outside the scope of this paper, their acknowledgement is important, as the pressures associated with these factors may manifest themselves within the workplace as well. Examples raised by the working group include government policy (example: effects of the one-child policy in China), domestic violence, sexual harassment and lack of elderly care or welfare.

Socio-economic disparity is linked to mental health.
Generally, higher socioeconomic status is associated with greater access to health care and lower risk of factors associated with mental disorders, such as increased exposure to stress and lack of social supports [63]. Individuals with mental disorders and low socioeconomic status also have higher rates of disability [64] and poorer prognosis [65].

Gender inequality influences mental wellness.
Gender differences influence the response and treatment of individuals in the workplace. For example, workplace bullying has been linked to an increase in risk of cardiovascular disease and depression [66]; men reported experiencing abusive work conditions more frequently than women, whereas women reported emotional abuse and incidents of professional discredit more frequently than men [67, 68]. The reporting of bullying incidents may also vary based on level of seniority. Women in management positions report more bullying than men, but men in non-managerial positions report more bullying than women [69].

Opportunities

Despite these challenges, there are significant opportunities to advance workplace mental health and wellness.

There is an untapped business case for investing in mental health.

Evidence supports treating anxiety, depression and other mental health conditions as an affordable and cost-effective way to promote wellbeing and prosperity. The WHO-commissioned investment analysis for scaling up mental health treatment in 36 countries found strongly favourable benefit-to-cost ratios, ranging from 2.3-3.0 to 1 when only economic benefits are considered, and 3.3-5.7 to 1 when value of health benefits are included [27]. The average annual costs to scale up investment over 15 years and close the treatment gap for depression and anxiety were low, regardless of level of country income (Figure 1) [27].

> "There is a growing body of evidence demonstrating both the efficacy and cost-effectiveness of key interventions for priority mental illness in countries at different levels of economic development [58]."

A 2019 case study of a Canadian telecommunications company, Bell Canada, found investment in mental health programs over seven years [670] led to a 20% reduction in short-term disability claims and an annual return on investment of CAD $4.10

Figure 1. Average annual cost in USD to scale up investment over 15 years to close the treatment gap for depression and anxiety

> Every additional $1 USD spent on treatment for depression and anxiety results in a return on investment of $4 USD in better health and ability to work [27].

Research is proliferating in workplace settings. Public and private sector support for the development and dissemination of academically rigorous research is imperative in order to promote individual, organizational, and systemic change. Programs that focus research on workplace mental health and wellness, such as the Canadian Occupational Health and Safety Futures Program, which is inclusive of private sector involvement and engagement, can support more efficient translation of research findings into business practice.

New technologies as tools to support mental health. These include programs or applications (apps) for use on computers, tablets or smartphones, wearable wireless health trackers, and virtual reality programs. These technologies offer new approaches in health promotion and new avenues for reaching individuals on a wide range of sensitive health topics including mental health. These new technologies can take live health data and personalize it for the user, to better self-manage care. *Headspace* and *Calm* are examples of apps that support mindfulness and stress management.

Several apps in China support mental wellbeing including *WeChat*, a messaging, social media, and mobile payment mobile application with over 1 billion monthly active users. Psychological support features through *WeChat* include the popular *Jian Dan Xin Li*, a platform for online and in-person psychotherapy services, and *Know Yourself*, which organizes offline workshops and talks in addition to online articles. A start-up in Thailand, *Ooca*, offers online employee assistance programs and video-consulting by psychiatrists to its employee and corporate clients. A Canadian app, *IncludeMe*, focuses on workplace mental health. Using game play and evidence-based resources, *IncludeMe* helps business owners and supervisors to learn more about mental health and how to include and accommodate people with mental health concerns at work.

Example Policies and Programs

Several successful policies and programs are being implemented throughout the APEC region to promote and support mental health and safety in the workplace. Below we provide some examples that, while not exhaustive, demonstrates best practices from across the region which can help to inform enhanced action and investment across APEC economies.

Workplace Mental Health and Safety Policies

Government recognition, action, and enforcement of mental health promotion, prevention and treatment, as well as protective legislation and policy to combat mental health targeted stigma, prejudice, and violence, are essential to protecting the rights of people with mental illness and to promoting economic and social prosperity. Below are several examples of positive government action from the APEC region to support workplace mental health and safety.

Over the last decade, Canada has experienced an accelerated movement in the area of workplace mental health due to significant developments in legislation and standards, improved education and training, positive shifts in media coverage, increased research and growing business leadership [71]. Labour and health-related legislation has been enacted across multiple Canadian jurisdictions that provides additional protection and compensability for workplace mental illness or injury, including in relation to bullying, harassment, and post-traumatic stress disorder (Figure 2).

Figure 2. Examples of Canadian legislation addressing workplace mental illness or injury

Workers Compensation Amendment Act	*2011*
Workers Compensation Amendment Act (Presumption re Post-Traumatic Stress Disorder and Other Amendments)	*2015*
Sexual Violence and Harassment Action Plan Act (Supporting Survivors and Challenging Sexual Violence and Harassment)	*2016*
Supporting Ontario's First Responders Act (Post-Traumatic Stress Disorder)	*2016*

Japan, following a partial amendment to the Industrial Health and Safety Act, initiated an economy-wide occupational health policy in 1995: the Stress Check Program [72]. The policy focuses on raising awareness and preventing workplace stress-related illnesses with an emphasis on providing psychologically healthy workplaces. The program's Stress Check survey has been both evaluated and validated [73] and provides employees indicating high levels of stress with the opportunity to consult with a physician. Under the policy all workplaces with more than 50 employees are mandated by law to participate.

Standards, Guidelines and Measures

Developing free and voluntary guidelines, tools and resources can help guide organizations to successfully implement evidence-supported policies that support mental health and prevent mental illness.

In 2012, the Mental Health Commission of Canada, in partnership with the Canadian Standards Association (CSA Group) and the Bureau de normalisation du Québec (BNQ), championed the development and release of the *National Standard for Psychological Health and Safety in the Workplace* (the Standard), a set of guidelines, tools and resources that seek to support mental health and prevent mental illness [74]. The free and voluntary guidelines seek to mobilize action around 13 workplace psychosocial factors impacting employee mental health (Table 3) [75]. Monitoring these factors and providing support accordingly is important to support workplace mental health.

Table 3. The 13 factors of psychological health and safety in the workplace [75]:

1. Psychological Support: an environment that is supportive of employees' psychological and mental health concerns, and which responds appropriately.
2. Organizational Culture: a work environment characterized by trust, honesty, and fairness.
3. Clear Leadership & Expectations: effective leadership and support that helps employees know what they need to do, how their work contributes to the organization, and whether there are impending changes.
4. Civility & Respect: workplace interactions are respectful and considerate.
5. Psychological Competencies & Requirements: a good fit between employees' interpersonal and emotional competencies and the requirements of the position.
6. Growth & Development: encouragement and support for the development of employee interpersonal, emotional and job skills.
7. Recognition & Reward: appropriate acknowledgement and appreciation of employees' efforts in a fair and timely manner.
8. Involvement & Influence: employees are included in discussions about how their work is done and how important decisions are made.
9. Workload Management: tasks and responsibilities can be accomplished successfully within the time available.
10. Engagement: employees feel connected to their work and are motivated to do their job well.
11. Balance: there is recognition of the need for balance between the demands of work, family and personal life.
12. Psychological Protection: psychological safety is ensured, workers feel able to ask questions, seek feedback, report mistakes and problems, or propose new ideas without fearing negative consequences.
13. Protection of Physical Safety: appropriate action to protect the physical safety of employees.

Shortly after the launch of the Standard, *Assembling the Pieces: An Implementation Guide to the National Standard for Psychological Health and Safety in the Workplace* was released. This practical, hands-on guide helps organizations to implement the Standard in their workplace [76]. To date, this Standard has been downloaded more times than any other standard developed by the CSA Group. In a survey of over a thousand organizations, 26% of unionized workplaces, and 23% of non-unionized workplaces indicated that their organization was actively involved in the implementation or maintenance of the Standard [71].

Singapore's Health Promotion Board (HPB), a governmental organization, developed and implemented the *Singapore Mental Wellbeing Scale* based on extensive research with local stakeholders [77]. The scale is reflective of Singaporean values and beliefs about mental wellbeing (Table 4). The mental wellbeing factors informed the *Treasure Your Mind* program, a series of seminars and skills-based workshops that targeted improving employee mental health. After participation in Treasure Your Mind, employees had access to additional resources while employers were offered guidelines to support mental wellbeing in the workplace, including leadership training and information on helping employees to access services.

Table 4. The Singapore Mental Wellbeing Scale

Five aspects that define mental wellbeing among Singapore residents:

Self-esteem
Believing in your potential and engaging in lifelong growth and development

Social connectedness
Nuturing a good social support network

Emotional intelligence
Appreciating and understanding self, others and circumstances

Resilience
Handling life's challenges by being optimistic

Cognitive efficacy
Realistic thinking; thinking clearly and rationally

Extracted from: https://www.hpb.gov.sg/article/health-promotion-board-develops-first-mental-wellbeing-scale-reflective-of-asian-values-and-beliefs

Training, Education and Awareness Programs

There are several successful examples of training, education and awareness programs taking place in APEC member economies.

Mental Health First Aid (MHFA), is an Australian-developed program that is now available in multiple APEC economies. It is an example of a successful training program that seeks to enable individuals and workplaces to support people experiencing mental health crises. MHFA, like physical first aid, trains individuals with tools to support a person experiencing a mental health crisis until medical treatment can be obtained, or until the crisis is appropriately resolved. MHFA Australia offers tailored workplace courses that include online and face-to-face training components and offers a program to promote the inclusion of MHFA officers in workplaces. It also has an MHFA Skilled Workplace program, which offers three levels of formal recognition to organizations for their commitment to promoting mentally healthy workplaces and implementing MHFA.

In Canada, several free in-person and online evidence-supported workplace mental health resources, including educational opportunities such as webinars, workshops, online university certificates, have been developed over the last decade. For example, *Not Myself Today* and *The Working Mind* are education-based programs designed to increase awareness of mental health among the workforce and decrease stigma. These programs equip workers with tools and resources to manage and support themselves and employees who may be experiencing mental health issues. More than 450 companies have participated since 2013.

Not-for-profit organizations, as well as patient and support advocacy groups, play an important role in the reduction of stigma and health promotion. *The Green Ribbon Campaign* for example, run by the Obsessive-Compulsive Disorder (OCD) & Anxiety Support Group based in Hong Kong, seeks to raise awareness of mental health in workplaces. The aim of the campaign is to wear green or a green ribbon to show support for individuals and families managing mental health conditions, with the hope of reducing social stigma, as well as supporting the development of confidence and community for those experiencing mental health issues.

The Singapore HPB provides a range of programs to help employees cope effectively with stress and build their mental wellbeing. This includes experiential workshops such as mindfulness, sleep management and activities such as playing music to effectively manage stress. A workplace wellness roadshow is also available for companies, where employees can assess their individual stress levels and learn practical stress management tips. To encourage a supportive workplace for employees, HPB also conducts a training workshop for managers and human resource personnel to help them better support staff at work. Participants are taught to recognize signs and symptoms of common mental health conditions and burnout, and how to approach staff who may be in need to encourage them to seek help early.

Public and Private Sector Programs

Public and private sector leadership and endorsement is essential to the effective development, promotion, implementation, and enforcement of workplace mental health and safety programs and policies. Several initiatives led by both public and private sectors are underway in the APEC region.

The City Mental Health Alliance Hong Kong (CMHA-HK) is an extension of the City Mental Health Alliance that originated in the UK. The CMHA-HK is a collaboration of business leaders in Hong Kong, with the goal of promoting a positive mental health culture for workers in Hong Kong, of sharing best practices in workplace mental health and increasing awareness of mental health issues. The CMHA-HK is "business led and expert guided", with activities that include research and data collection, training sessions to corporate staff, toolkits and resources on workplace mental health, support to member organizations in the development and implementation of a workplace mental health strategy, and advocacy and media engagement.

> "We wish for mental health to be recognised as a boardroom issue and considered essential to maximise business performance, critical to managing business risk and vital to safeguarding organisations' people responsibilities. We believe that prevention should be recognised as equally as important as treatment to address mental health problems."
>
> - City Mental Health Alliance Hong Kong

The Korea Workers' Compensation & Welfare Service implemented an Employee Assistance Program (EAP) in 2009 to support workers' psychological difficulties in collaboration with EAP institutions through the 'workers' welfare net'. In addition, any worker in a company under 300 employees may sign up on *WorkDream.net* and receive online mental health services including a bulletin board, question-answer telephone and online consultations, as well as individual, group, and company-wide in-person consultations.

Additionally, Korea has a Comprehensive Intervention for Mental health promotion in workplaces (*CIM Care*), a three-phase intervention program for prevention management, early response and treatment, and post-treatment management. Phase 1 consists of online and offline education, guides and classes for maintaining mental health, and *CIM Care* mental health evaluation. Phases 2 and 3 consist of online and offline education, screening for high-risk individuals, crisis intervention, and industrial mental health consulting.

The Government of Canada's Joint Task Force on Mental Health, established in 2015 and comprised of an equal number of employer and employee representatives, released several reports to address mental health and to address challenges and opportunities for improving psychological health and safety in the workplace across the federal public service. The objective is to encourage federal organizations to align with the *National Standard for Psychological Health and Safety in the Workplace*. In 2017, the Centre of Expertise on Mental Health in the Workplace was launched to facilitate easy access to resources and tools for organizations, managers and employees.

The United States company Deliotte has taken several steps to promote workplace mental health. In 2015 the company hired a Chief Well-Being Officer, who launched a Mental Health at Work campaign, which provides Mental Health First Aid training along with resources and educational opportunities to support employee mental and physical health and well-being. The company also has a podcast called *Work Well* that explores topics related to well-being, including destigmatizing mental health.

Next Steps

This overview of model policies and workplace mental health and safety programs from the APEC region provides a snapshot of the innovative ways in which government, workplaces, community organizations and individuals can support and promote improved mental health in the workplace.

Existing programs can serve as best practice examples to inform the expansion of workplace mental health and safety programs in other jurisdictions. As awareness of the essential role of mental health in workplace wellness and economic productivity increases, several opportunities exist for further enhancement of these approaches. Digital technologies have emerged as an effective and accessible way to deliver mental health interventions and could be similarly effective to promote workplace mental health and safety.

Public and private sector support for the development and dissemination of academically rigorous research is imperative in order to promote individual, organizational, and systemic change. Programs that focus research on workplace mental health and wellness, such as the Canadian *Occupational Health and Safety Futures Program*, which is inclusive of private sector involvement and engagement, can support more efficient translation of research findings into business practice. Research in this area from across the APEC region continues to grow, and enhanced research from all economies, including low- and middle-income economies, is essential.

Call to Action

The greatest asset we have is our people, and their mental and physical wellbeing are critical to our collective wellbeing as a global community. Concerted international effort is critically needed to support the dismantling of existing preventable barriers to improved workplace mental health.

We acknowledge that:

There is no health without mental health.
Mental and physical health and wellbeing are intimately connected and cannot be viewed as separate priorities.

Maintaining the current course is not sustainable.
As it stands, 25% of us will suffer from a mental illness in our lifetime but more than 50% of us will not seek or receive help. Left unaddressed, workplace environmental factors that contribute to mental health degradation have the potential to do serious harm. At $16 trillion USD (2011 to 2030) globally in lost economic output, this critical gap is too costly to ignore [26].

The workplace is an optimal location for mental and public health interventions.
We spend almost 60% of our waking hours and most of our lives working. Additionally, there is significant evidence to support that employment in a healthy environment can foster physical and mental health and wellbeing, while unemployment is correlated with poor health outcomes.

"Work can be therapeutic and reverse the adverse health effects of unemployment... The provisos are that account must be taken of the nature and quality of work and its social context; jobs should be safe and accommodating [78]."

Mental illness prevention and health promotion will not only improve the quality of life and health of employees, it can also improve your bottom line.
Supporting the mental health of employees can increase productivity and staff retention, while lowering presenteeism, ultimately decreasing costs associated with health care provision [42].

APEC Digital Hub for Mental Health calls upon leaders from all sectors to:

Be a champion for change.

Demonstrate sustained visible and active leadership, so that others can mirror your commitment and resolve. It is a journey of continual improvement that requires ongoing leadership, clear communication, and embedding the concepts of mental health and wellness into day to day decision making.

Provide the pathway for others to follow.

Identify the business, as well as moral, case for acting and provide others with tools to support long-term transformation. Take stock of what already exists, review and analyse data and evidence, and build the case for why this is a priority.

Be evidence-informed.

Seek evidence-based information about the effectiveness, feasibility and affordability of interventions that reduce mental illness and promote a mentally healthy work environment.

Empower cross-sector involvement.

Strengthen cooperation across private and public sectors, and across local, regional and international levels of government. Join innovative partnerships and common mandates to support workplace mental health. Address complex challenges through multi-sector alignment and collaboration.

To support leaders and organizations in their efforts to raise awareness and spark dialogue around workplace wellness and resilience, we make these **recommendations**:

Recommendations for Workplace Leaders

Inspire others within your organization.

No matter what your role at an organization or in society, you can motivate others to take action. Be a trailblazer and leader, and share your journey, approach and successes to drive widespread impact.

Talk openly about mental health in the workplace.

Clearly communicate the importance of mental health for the organization. Ensure that employees understand that everyone experiences challenges in maintaining their mental health.

Raise awareness about existing benefits, services and supports.

Offer help for those who are struggling or at risk for mental health issues. Promote the use of supports such as Employee Assistance Programs to increase access to services.

Support employees' efforts to get help.

Make it clear at all levels of the organization that the organization supports employees' efforts to take care of their mental health the same way they take care of their bodies. This may include flexible work arrangements, taking a mental health day, and ensuring that people are not penalized for taking care of their mental health.

Combat the stigma.

Help to normalize mental health by talking about stress management, self care, and mental health in meetings and communications. Encourage those in leadership roles who have experience with mental health issues to share their stories openly.

Recommendations for Workplace Organizations

Demonstrate commitment.

Clearly communicate that mental health is a priority. This may include adding the enhancement of workplace mental health as a key performance indicator for the organization, dedicating human and financial resources to advance this priority, writing a policy statement or some form of communication to all employees in support of workplace mental health, and supporting senior leaders in sharing their own personal stories.

Identify the organizational need.

Develop a good analysis of the situation in the organization and where improvement is needed. Review relevant data and information, and gather feedback from employees to ensure the organization has a clear baseline on which to set objectives and track progress.

Develop a strategy for a mentally healthy workplace.

Provide a clear plan and framework to promote workplace mental wellbeing, minimize workplace risks, support those who are experiencing mental health issues and reduce stigma.

Educate supervisors.

Train supervisors to identify the signs of mental health problems and how to appropriately respond. Ensure supervisors and managers have the literacy, tools and competencies to effectively support their employees.

Implement effective, evidence-based programs.

Invest in programs that are evaluated and address the key issues of your unique workplace. These can include awareness campaigns, education, anti-stigma and literacy programs for employees, and training for supervisors and managers about psychological health and safety. Review, enhance and expand health services and supports for employees (e.g, increase health benefits and add peer-support programs).

Acknowledgments

The Asia-Pacific Economic Cooperation (APEC) Digital Hub for Mental Health

In 2016, the Asia-Pacific Economic Cooperation (APEC), a multilateral forum representing 21-member economies, established the APEC Digital Hub for Mental Health (Digital Hub) in recognition of the need for a coordinating centre for APEC initiatives in mental health. The Digital Hub convenes government, public, and private sectors to share, develop, scale up and evaluate innovative evidence- and practice-based programs for mental health.

The Digital Hub is hosted in Canada by a collaborative partnership of the University of British Columbia, University of Alberta, Mood Disorders Society of Canada, and the Canadian Network for Mood and Anxiety Treatments.

Photo: The APEC Digital Hub for Mental Health 'Next Steps' Round Table Conference, Singapore (June 2019)

Workplace Wellness and Resilience Work Group

Given important links between economic productivity, development, and mental health, reducing workplace stress and promoting psychologically healthy work environments is a top priority for APEC economies. As such, Workplace Wellness and Resilience is one of the 7 Focus Areas of the Digital Hub. Other areas of focus include: data collection and standardization; integration with primary care and community-based settings; advocacy and public awareness; disaster resilience and trauma; Indigenous communities; and, vulnerable communities and children.

This White Paper comes as a response to the APEC Digital Hub for Mental Health 'Innovation in Action: Building the Digital Hub for Mental Health' International Conference, June 2017, where the need for a high-level position paper that could be used by APEC economies to rally and mobilize governments, decision-makers, employers and other stakeholders to recognize the value of investing in workplace mental health was identified. The members of the Workplace Wellness & Resilience Work group contributed to the authorship of the White Paper, including:

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Bibliography

1. World Health Organization. (2014, August). Mental health: a state of well-being . (World Health Organization) Retrieved November 2018, from http://www.who.int/features/factfiles/mental_health/en/
2. American Psychiatric Association. (2018, August). What Is Mental Illness? (American Psychiatric Association) Retrieved November 2018, from https://www.psychiatry.org/patients-families/what-is-mental-illness
3. Whiteford, H., Ferrari, A., Degenhardt, L., Feigin, V., & Vos, T. (2015). The global burden of mental, neurological and substance use disorders: an analysis from the global burden of disease study 2010. PLoS One, 10(2), e0116820.
4. Vos, T., Flaxman, A., Naghavi, M., Lozano, R., Michaud, C., et al. (2013). Years lived with disability (YLDs) for 1160 sequelae of 289 diseases and injuries 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. Lancet, 380, 2163-2196.
5. World Health Organization. (2001). Mental disorders affect one in four people. (World Health Organization) Retrieved November 2018, from http://www.who.int/whr/2001/media_centre/press_release/en/
6. World Health Organization. (2015). Mental health included in the UN Sustainable Development Goals. (World Health Organization) Retrieved November 2018, from http://www.who.int/mental_health/SDGs/en/
7. World Health Organization. (2008). WHO Mental Health Gap Action Programme (mhGAP). Retrieved from World Health Organization: https://www.who.int/mental_health/mhgap/en/
8. World Health Organization. (2013). Comprehensive mental health action plan 2013–2020. Retrieved from World Health Organization: https://www.who.int/mental_health/action_plan_2013/en/
9. Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., et al. (2018). The Lancet Commission on global mental health and sustainable development. Lancet, 392(10157), 1553-1598.
10. Whiteford, H., Degenhardt, L., Rehm, J., Baxter, A., Ferrari, A., Erskine, H., et al. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet, 382, 1575-1586.
11. Vigo, D., Thornicroft, G., & Atun, R. (2016). Estimating the true global burden of mental illness. Lancet Psychiatry, 3(2), 171-178.
12. Black, C. (2008). Working for a Healthier Tommorow: Dame Carol Black's Review of the Health of Britain's Working Age Population. Presented to the Secretary of State for Health and the Secretary of State for Work Pensions. London.
13. Harvey, S., Henderson, M., Lelliott, P., & Hotopf, M. (2009). Mental health and employment: much work still to be done. Br J Psychiatry, 194, 201-203.
14. Henderson, M., Harvey, S., Overland, S., Mykletun, A., & Hotopf, M. (2011). Work and common psychiatric disorders. J R Soc Med, 104, 198-207.
15. World Health Organization. (2018, March). Depression. (World Health Organization) Retrieved November 2018, from http://www.who.int/en/news-room/fact-sheets/detail/depression
16. Naylor, C., Parsonage, M., McDaid, D., Knapp, M., Fossey, M., & Galea, A. (2012). Long-Term Conditions and Mental Health: The Cost of Co-Morbidities. London: The King's Fund.
17. France, E., France, E., Wyke, S., Gunn, J., Mair, F., & McLean, G. (2012). A systematic review of prospective cohort studies of multimorbidity in primary care. Br J Gen Pr, 62, 297-307.
18. Gunn, J., Ayton, D., Densley, K., Pallant, J., Chondros, P., Herman, H., & Dowrick, C. (2012). The association between chronic illness, multimorbidity and depressive symptoms in an Australian primary care cohort. Soc Psychiatry Psychiatr Epidemiol, 47(2), 175-184.
19. Merikangas, K., Ames, M., Cui, L., Stang, P., Ustun, T., Von Korff, M., & Kesslet, R. (2007). The impact of comorbidity of mental and physical conditions on role disability in the US adult household population. Arch Gen Psychiatry, 64(10), 1180-1188.
20. Luppino, F., de Wit, L., Bouvy, P., Stijen, T., Cuijpers, P., Pennix, B., & Zitman, F. (2010). Overweight, obesity, and depression: a systematic review and meta-analysis of longitudinal studies. Arch Gen Psychiatry, 67(3), 220-229.
21. Eaton, J., McCay, L., Semrau, M., Chatterjee, S., Baingana, F., Araya, R., et al. (2011). Scale up of services for mental health in low-income and middle-income countries. Lancet, 378, 1592-1603.
22. Birnbaum, H., Kessler, R., Kelley, D., Ben-Hamadi, R., Joish, V., & Greenberg, P. (2010). Employer burden of mild, moderate, and severe major depressive disorder: mental health services utilization and costs, and work performance. Depress Anxiety, 27(1), 78-89.
23. Dewa, C., Thompson, A., & Jacobs, P. (2011). The association of treatment of depressive episodes and work productivity. Can J Psychiatry, 56, 743-750.
24. Goetzel, R., Carls, G., Wang, S., Kelly, E., Mauceri, E., Columbus, D., & Cavuoti, A. (2009). The relationship between modifiable health risk factors and medical expenditures, absenteeism, short-term disability, and presenteeism among employees at novartis. J Occup Environ Med, 51(4), 487-99.
25. Kowlessar, N., Goetzel, R., Carls, G., Tabrizi, M., & Guindon, A. (2011). The relationship between 11 health risks and medical and productivity costs for a large employer. J Occup Environ Med, 53(5), 468-477.
26. Bloom, D., Cafiero, E., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, L., Fathima, S., et al. (2011). The global economic burden of noncommunicable diseases. Geneva: World Economic Forum.
27. Chisholm, D., Sweeny, K., Sheehan, P., Rasmussen, B., Smit, F., & Cuijpers, P. (2016). Scaling-up treatment of depression and anxiety: a global return on investment analysis. Lancet Psychiatry, 3(5), 415-424.
28. Dewa, C. D. (2010). Examining the comparative incidence and costs of physical and mental health-related disabilities in an employed population. J Occup Environ Med, 52, 758-62.
29. Smetanin, P., Stiff, D., Briante, C., Adair, C., Ahmad, S., & Khan, M. (2011). The life and economic impact of major mental illnesses in Canada: 2011-2041. Prepared for the Mental Health Commission of Canada. Toronto: RiskAnalytica.
30. Bloom, D.E., Stanciole, A., Cafiero, E.T., Weiss, J., McGovern, M.E., Bakkila, S., et al. (2013). The economic impact of non-communicable disease in China and India: Estimates, projections and comparisons. IZA Discussion Paper No.7563. Bonn, Germany: Institute for the Study of Labor.
31. Chen, J., Liu, L., Zhao, X., & Yeung, A. (2015). Chinese international students: An emerging mental health crisis. J Am Acad Child Adolesc Psychiatry, 54(11), 879-80.
32. Han, J., Batterham, P., Calear, A., & Ma, J. (2018). Seeking professional help for suicidal ideation: A comparison between Chinese and Australian university students. Psychiatry Res, 270, 807-14.
33. Sado, M., Yamauchi, K., Kawakami, N., Ono, Y., Furukawa, T., Tsuchiya, M., et al. (2011). Cost of depression among adults in Japan in 2005. Psychiatry Clin Neurosci, 65(5), 442-50.
34. Sado, M., Takechi, S., Inagaki, A., Fujisawa, D., Koreki, A., Mimura, M., & Yoshimura, K. (2013). Cost of anxiety disorders in Japan in 2008: a prevalence-based approach. BMC Psychiatry, 13, 338.
35. Sado, M., Inagaki, A., Koreki, A., Knapp, M., Kissane, L., Mimura, M., & Yoshimura, K. (2013). The cost of schizophrenia in Japan. Neuropsychiatr Dis Treat, 9, 787-98.
36. Okumura, Y., & Higuchi, T. (2011). Cost of depression among adults in Japan. Prim Care Companion CNS Disord, 13(3), pii: PCC.10m01082.

37. Lee, K., & Kim, I. (2018). Job Stress-attributable Burden of Disease in Korea. J Korean Med Sci, 33(25), e187.
38. Chong, S., Vaingankar, J., Abdin, E., & Subramaniam, M. (2013). Mental disorders: employment and work productivity in Singapore. Soc Psychiatry Psychiatr Epidemiol, 48(1), 117-123.
39. Aon Corporation. (2017). APAC Benefits Strategy Study 2017. Retrieved from AON: http://www.aon.com/apac/study/2017-apac-benefits-strategy-study.jsp
40. Ho, R., Mak, K., Chua, A., Ho, C., & Mak, A. (2013). The effect of severity of depressive disorder on economic burden in a university hospital in Singapore. Exp Rev Pharmacoeconom Outcomes Res, 13(4), 549-559.
41. Greenberg, P.E., Fournier, A-A., Sisitsky, T., Pike, C.T., Kessler, R. (2014). The economic burden of adults with major depressive disorder in the United States (2005 and 2010). J Clin Psychiatry, 76(2), 155-162.
42. Goetzel, R., Roemer, E., Holingue, C., Fallin, M., McCleary, K., et al. (2018). Mental Health in the Workplace: A Call to Action Proceedings From the Mental Health in the Workplace-Public Health Summit. J Occup Environ Med, 60(4), 322-330.
43. Valenstein, M., Vijan, S., Zeber, J.E., Boehm, K., & Buttar, A. (2001). The cost-utility of screening for depression in primary care. Ann Intern Med; 134, 345-360.
44. Stewart, W.F., Ricci, J.A., Chee, E., Hahn, S.R., Morganstein, D. (2003). Cost of lost productive work time among US workers with depression. JAMA. 289(23).
45. Nghi, T., Ngoc, N., & Buoi, L. (2004). Occupational stress and worker's mental health during the transitional economic period: Vietnam National Hospital of Psychiatry, National Institute of Occupational Health and Environment.
46. Dua, T., Barbui, C., Clark, N., Fleischmann, A., Poznyak, V., van Ommeren, M., . . . al, e. (2011). Evidence-based guidelines for mental, neurological, and substance use disorders in low-and middle-income countries: summary of WHO recommendations. PLoS Med, 8(11).
47. Henderson, C., Evans-Lacko, S., & Thornicroft, G. (2013). Mental illness stigma, help seeking, and public health programs. Am J Public Health, 103(5), 777-780.
48. Thornicroft, G. (2007). Most people with mental illness are not treated. Lancet, 370(9590), 807-808.
49. Public Health Agency of Canada. (2019). The Chief Public Health Officer's Report on the State of Public Health in Canada 2019: Addressing Stigma Towards a More Inclusive Health System. Retrieved from PHAC: https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-what-we-heard/stigma-eng.pdf
50. Pescosolido, B., Martin, J., Long, J., Medina, T., Phelan, J., & Link, B. (2010). "A disease like any other"? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. Am J Psychiatr, 167(11), 1321-30.
51. Canadian Medical Association. (2008). 8th annual National Report Card on Health Care. Canadian Medical Association.
52. Stuart, H. (2003). Stigma and work. Healthc Pap, 5(2), 100-11.
53. Corrigan, P., & Gelb, B. (2006). Three programs that use mass approaches to challenge the stigma of mental illness. Psychiatr Serv, 57(3), 393-8.
54. Yoshioka, K., Reavley, N., Rossetto, A., & Nakane, Y. (2016). Associations between beliefs about the causes of mental disorders and stigmatizing attitudes: Results of a mental health literacy and stigma survey of the Japanese public. Int J Ment Health, 45, 183-192
55. Ritsher, J., Otilingam, P., & Grajales, M. (2003). Internalized stigma of mental illness: psychometric properties of a new measure. Psychiatry Res, 121(1), 31-49.
56. Hsin Yang, L., Kleinman, A., Link, B.G., Phelan, J.C., Lee, S., & Good, G. (2007). Culture and stigma: Adding moral experience to stigma theory. Soc Sci Med, 1524-1535.
57. Fernandez, D. (2010). Legal protection for victims of workplace harassment in Chile. Comp Labor Law Policy J, 32(1), 91-108.
58. World Health Organization. (2018, March 30). Mental health: strengthening our response . (World Health Organization) Retrieved November 2018, from http://www.who.int/en/news-room/fact-sheets/detail/mental-health-strengthening-our-response
59. World Health Organization. (2014). Mental Health Atlas 2014 . Geneva: World Health Organization.
60. Kessler, R., Berglund, P., Demler, O., Jin, R., Merikangas, K., & Walters, E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry, 62(6), 593-602.
61. Liang, L. (2019). China's tech giants under fire for long work hours; Workers complain of burnout as bosses push 9am to 9pm, six days a week schedule. Straits Times. Singapore, Singapore.
62. Wang, S. (2019, May 27). China's tech workers burn out mentally and physically in the '996' rat race. CNN. Beijing, China.
63. Katz SJ, K. R. (1997). Mental health care use, morbidity, and socioeconomic status in the United States and Ontario. Inquiry, 34, 38-49.
64. Bebbington, P., Brugha, T., Meltzer, H., Farrell, M., Ceresa, C., Jenkins, R., & Lewis, G. (2000). Psychiatric disorder and dysfunction in the UK National Survey of Psychiatric Morbidity. Soc Psychiatry Psychiatr Epidemiol, 35, 191-7.
65. Weich, S., & Lewis, G. (1998). Poverty, unemployment, and common mental disorders: population based cohort study. BMJ, 317, 115-19.
66. Kivimaki, M., Virtanen, M., Vartia, M., Elovainio, M., Vahtera, J., & Keltikangas-Jarvinen, L. (2003). Workplace bullying and the risk of cardiovascular disease and depression. J Occup Environ Med, 60(10), 779e783.
67. Escartín, J., Salin, D., & Rodriguez-Carballeira, A. (2011). Conceptualization of workplace bullying: gendered rather than gender neutral? J Pers Psychol, 10(4), 157e165.
68. Attell, B., Brown, K., & Treiber, L. (2017). Workplace bullying, perceived job stressors, and psychological distress: Gender and race differences in the stress process. Soc Sci Res, 65, 210-221.
69. Salin, D., & Hoel, H. (2013). Workplace bullying as a gendered phenomenon. J Manag Psychol, 28(3), 235e251.
70. Deloitte (2019). The ROI in workplace mental health programs: Good for people, good for business - A blueprint for workplace mental health programs Retrieved from Deloitte Insights: https://deloitte.com/content/dam/Deloitte/ca/Documents/about-deloitte/ca-en-about-blueprint-for-workplace-mental-health-final-aoda.pdf
71. Samra, J. (2017). The Evolution of Workplace Mental Health in Canada: Research Report (2007-2017). Fredericton: University of Fredericton.
72. Kawakami, N., & Tsutusmi, A. (2016). The Stress Check Program: a new national policy for monitoring and screening psychosocial stress in the workplace in Japan. J Occup Health, 58, 1-6.
73. Imamura, K., Asai, Y., Watanabe, K., Tsutsumi, A., Shimazu, A., Inoue, A., et al. (2018). Effect of the National Stress Check Program on mental health among workers in Japan: A 1-year retrospective cohort study. J Occup Health, 60, 298-306.
74. CSA Group. (2018, December 12). Psychological Health and Safety in the Workplace. Retrieved from CSA Group: https://www.csagroup.org/article/cancsa-z1003-13-bnq-9700-803-2013-r2018/
75. Guarding Minds @ Work. (2018). Know the psychosocial factors. (University of Waterloo) Retrieved from A Workplace Guide to Psychological Health and Safety: https://www.guardingmindsatwork.ca/about/about-psychosocial-factors
76. Collins, J. (2014). Assembling the Pieces - An Implementation Guide to the National Standard for Psychological Health and Safety in the Workplace. Retrieved from CSA Group: https://www.csagroup.org/documents/codes-and-standards/publications/SPE-Z1003-Guidebook.pdf
77. Fen, C., Isa, I., Chu, C., & Ling, C. (2013). Development and validation of a mental wellbeing scale in Singapore. Psychology, 4(7), 592.
78. Waddell, G., & Burton, K. (2006). Is working good for your heakth and well-being? London: The Stationery Office.

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