Final Report for Scientific Research Project #17-02

Mindfulness-based intervention as a key component of successful workplace functioning and personal well-being for frequently absent employees

granted to Dr. Michael McIntyre, St. Boniface Hospital Research Centre

Document contents

Section i) Funding statement

The Project entitled “Mindfulness-Based Intervention as a Key Component of Successful Workplace Functioning and Personal Well-Being for Frequently Absent Employees” was funded by the Worker’s Compensation Board (RWIP #17-02).

Section ii) Project overview

2. Preface

The present study was derived from an examination of the work history of the employees at Actionmarguerite, which is one of the largest personal care homes in Western Canada. There are over 500 employees. Slightly more than 50 have a pattern of recurrent work-related injury, accidents, and illness. Personnel records show that this group, that we shall label as the "frequently absent," routinely exhaust all their benefits and have made a much higher percentage of claims for work-related accidents and injuries than their colleague employees. It may seem surprising that both illness and frequent accidents are comorbid for this group. However, the literature clearly shows that stress is strongly related to ruminative inattention and to diminished immune efficiency. Clearly, the activities undertaken in periods of work absence for the frequently absent are not developing resilience. Continuing susceptibility to accident, injury, and illness persists. We recruited participants for this study from the communities of care under the aegis of the Catholic Health Corporation of Manitoba. Our hypotheses were that Mindfulness Based Stress Reduction (MBSR) Program, as developed at the University of Massachusetts Medical School, would potentiate any physical healing that occurs in periods of recovery and that it would break the chronicity of stress-related malady. MBSR was chosen because it is the most thoroughly studied mindfulness intervention and because it is widely implementable due to the number of professionals who have been trained and formally certified in this protocol. In addition, it develops a sense of participatory health in which individuals take increased responsibility for their own well-being. We see this as a vital component of preventive medicine. For the most part, in what follows we shall concentrate on the MBSR literature and only occasionally examine consequences of other mindfulness-based interventions.

2.1 Literature review and study rationale

In recent years, there has been a great growth of interest in mindfulness as a psychological construct. The scientific literature that contributes to a deepening understanding of the construct and to an enhanced understanding of interventional efficacy is increasing geometrically. The presence of MBSR in the worlds of psychology and medicine derives largely from the work of Jon Kabat-Zinn (1982, 1990, & 1994). Of particular note is the fact that his early work brought effective treatment to individuals suffering with chronic, stress-related conditions – chronic pain and psoriasis, for example (Kabat-Zinn,1982). It is the chronicity and intensity of the stress response in the frequently absent that is believed to explain the persistent reoccurrence of malady. One early study mapped out the questions to be addressed by later research (Davidson, Kabat-Zinn, et al.,2003) and are directly relevant to the goals of the proposed study. It demonstrated that an evidence-based stress reduction intervention could reduce anxiety and negative emotions. The study demonstrated changes in brain

asymmetry in favour of left over right hemisphere activity – this pattern is associated with greater positivity and improved immune efficiency as measured by antibody counts. The reduction of anxiety, stress, and negative emotions; the induction of brain changes reducing negative autonomic responsiveness; and improvement of immune efficiency constitute a very succinct summary of the goals of the proposed intervention. Considerable progress has been made in the intervening years in each of the three areas.

Keng, Smoski, and Robins (2011) offer a meta-analysis of studies reporting effects of mindfulness on psychological health. Their summary concludes that mindfulness does indeed bring about some substantial, positive psychological change. Convergent evidence indicates increased subjective well-being, reduced symptoms of stress and anxiety, reduced emotional reactivity, and improved behavioural regulation. The improvement in behavioural regulation may be of special importance for the proclivity of the frequently absent group to be accident-prone. Lomas, Medina, Ivtzan, Rupprecht and Eiroa-Orosa (2017) examined mindfulness interventions in occupational settings and demonstrated a preponderance of positive results. Burton, Burgess, Dean, Koutsopoulou, and Hugh-Jones (2017) found that mindfulness can relieve stress in healthcare professionals but noted that the literature suffers from inadequate sample sizes. Luken & Sammons (2016) showed that mindfulness interventions were effective in treating burnout in healthcare workers. Gotnik, Chu, Busschbach, Benson, Fricchione, & Hunink (2015) conducted a systematic review of the literature on mindfulness based interventions and showed strong trends in the literature toward decreased negative traits and increased positive traits. Job satisfaction may be a very important influence on presence and performance. Hulsheger, Alberts, Feinholdt, & Lang (2013) demonstrated that a mindfulness-based intervention led to improved job satisfaction. Similarly, Durkin, Beaumont, Hollins Martin, & Carson (2016) demonstrated self-compassion – frequently reported as a consequence of mindfulness training – was associated with reduced burnout and increased job satisfaction for nurses. Baer, Lykins, and Peters (2012) noted that meditation experience predicted psychological well-being when measured by many of the tests in the proposed study. They also observed that mindfulness training and meditation experience also nurtures self-compassion. In a regression analysis, they noted that the relationship between meditation experience and well-being was completely accounted for by a combination of mindfulness and self-compassion. That mindfulness training nurtures self-compassion is particularly important for the proposed study. A recent study (Seppala, Hutcherson, Nguyen, and Doty, 2014) argued for an important connection between compassion, self-compassion and resilience in healthcare providers.

Explanations for several of the more important consequences of MBSR training may be found in the work of Barbara Fredrickson. Kabat- Zinn distinguishes between stress reactivity and responsivity. Stress responsivity involves the thoughtful selection of the appropriate response to exigent circumstances. Fredrickson's research (2013) demonstrates that creative choices occur significantly more often when affect is positively valenced. Her work also shows that the autonomic and hormonal arousal we all experience when responding to a stressful situation diminishes more quickly in the presence of more positive affect (Tugade & Fredrickson, 2007). Again, this finding is relevant to the proposed study as the stress response in those experiencing stress-

related symptoms does not dampen efficiently thus increasing the cumulative burden of stressful experiences. Clearly, an intervention that dampened stress reactivity would be of benefit to the frequently absent group.

Another type of change induced by mindfulness training is in attentional focus. Attentive awareness of the demands of the present moment would seem to be a key factor in accident and injury avoidance. Training of attention to focus on present moment awareness is one of the foundational objectives of MBSR training. Jha, Rogers, and Morrison (2014) have demonstrated that strengthening the core cognitive systems of attention and working memory through mindfulness training in high stress professions contributes to resilience. Moadab (2013) provides evidence that mindfulness training results in enhanced neural networks related to selective attention. She also reports that meditators showed improved self-monitoring of errors. The focus on the changes in neural networks in this study points toward other changes in the brain that are consequent on increasing mindfulness.

The sophistication of studies of brain changes associated with meditation experience and mindfulness training has grown enormously in recent years. Two developments have fueled this growth. The first is conceptual and involves great advances in understanding neuroplasticity. We now understand that the brain anatomy and physiology can be changed by experience and that these changes can occur across the lifespan. The second involves the great advances in neuroimaging techniques. Some of the most exciting work in neuroscience of mindfulness combines these two developments. Lazar, Kerr, et al., (2005) have demonstrated that meditation experience is associated with grey matter thickening in the cortex particularly with areas associated with attention, interoception and sensory processing. Luders, Toga, etal., (2009) demonstrated cortical thickening in areas associated with emotional regulation and response control. The MBSR course resulted in increased grey matter density in the left hippocampus after just eight weeks (Holzel, Carmody, et al., 2011). One other finding deserves mention. The default mode network is a set of midline structures that become active when the brain is not otherwise engaged. Activity in this network is associated with rumination, worry, and negative expectation. Brewer, Worhusky, et al. (2011) report that meditation experience decreases activation of this network. Brain plasticity is possible and MBSR training has induced it in a relatively short period of time. The nature of the changes reported above appear to be highly relevant to strengthened resilience and enhanced functioning in the frequently absent group.

Growth in understanding the relationship between mindfulness, immune function, and health continues to advance as well. One very important study (Rector, Dowd et al., 2014) linked psychological stress, viral presence, and antibody levels in a robust, large-scale study. Stress has also been linked to inflammation and the exacerbation of inflammatory illnesses. MBSR training was particularly effective in both reducing emotional reactivity and was of therapeutic benefit in chronic inflammatory conditions (Rosenkranz, Davidson, et al., 2013). The nature of these relationships may help us understand the relationship between stress, stress reduction, and illness.

Meditation training in general and MBSR training in particular appears to confer benefits on participants experiencing high levels of stress. There is abundant evidence that health care workers experience high levels of stress. In a recent study in our lab (Stoesz, 2014), it was determined that the health care workers had stress levels far

above the national norms. The participants in this study underwent MBSR training and showed substantial reductions in stress levels to levels equivalent to the population mean. Our lab has also demonstrated decreased burnout and fears of compassion, as well as increased work engagement and self-compassion in a project that was presented at the annual Mind & Life conference (McIntyre, MacDonald et al., 2018) and is being prepared for publication. Continuous work with individuals who are experiencing declining health and mental distress commonly results in psychological distress (Figley, 2002; Hannigan, Edwards, and Burnard, 2004). The stress of healthcare work may be especially acute when caring for patients who display aggression (Gascon, Leiter et al., 2013).

In summary, the literature demonstrates that mindfulness and MBSR alter behaviors in ways that might be effective in ameliorating patterns of accident, injury, and illness in a group of healthcare workers who appear to be suffering from the chronic stress endemic to their profession.

What is not known at this juncture is whether a very plausible intervention, MBSR training, will be as effective as predicted for a group that has experienced chronic stress and its debilitating consequences for an extended period of time. It is also not known whether the changes in attention to the present moment and improved behavioural regulation are of sufficient magnitude to reduce the frequency of accidents and injuries. Similarly, it is not known whether the improved immune efficiency that is related to the MBSR program will be sufficient to ameliorate long-standing ill health.

2.2 Relevance and significance of research

While it is established that MBSR can be effective in reducing stress and anxiety and promoting well-being in healthcare workers (Shapiro, Astin et al., 2005), it is not established that MBSR can be an effective component of altered work habits. At one of the facilities of interest, Actionmarguerite, over 50 percent of days off due to accident, injury, and illness are taken by 10 percent of the staff. The 10 percent of the frequently absent have distressing patterns of frequent accidents, re-injury, and recurrent illness. Clearly the time away from work may accompany a short-term amelioration in the condition that occasioned the time away; however, recurrence rates make it abundantly clear that underlying vulnerabilities have not been addressed.

Confirmation of the hypotheses in the current study would add a powerful addition to the range of experiences available to the frequently absent that foster both individual and organizational health. Such a development would contribute to the overall health and well-being of employees and also serve to stabilize human resources within organizations. Absences in healthcare often results in overburdened healthcare staff and diminished attention to patients. Therefore, this development would improve the efficacy of the investment by all parties in the processes of healing and prevention. These developments would be of value in Manitoba and beyond.

2.3 Research objectives

The research was designed to examine the efficacy of a program of MBSR to interrupt the existing pattern of recurrent work-related accidents, injuries, and illness,

and also to promote both psychological and physical well-being and to allow a more meaningful and successful return to work. It is our hypothesis that equipping workers with the skills needed to reduce chronic stress will enable increased attentiveness, reduce burnout, increase work satisfaction and personal well-being. In turn, we hypothesize further that patterns of recurrent accidental injury and frequent illness will improve.

Given the cost that recurrent accidental injury has for the government and employers, we believe that the proposed intervention and its scientific evaluation will have tangible benefits for employees, for employers, and for the taxpayer. The objectives of the WCB to foster successful rehabilitation and to support a productive and safe return to meaningful work are entirely consistent with our research objectives. The treatment condition for the study utilizes one of the most intensively studied intervention paradigms (MBSR). We hope to establish that MBSR can be an extremely useful component of program intended to reverse patterns of frequent absence. Our objectives are to do this by demonstrating a reduction of stress, anxiety and burnout; increases in measures of well-being and work engagement: and in altered patterns of work disruption.

Section iii) Review of work completed

The work completed for this Project was outlined in Progress Reports prepared for WCB. Here we provide each of the progress reports that detailed our activities over the duration of the Project.

WCB Progress Report #1

Introduction

Our activity has focused on five objectives. The first involved securing critical staff members for our research team. The second involved a review of the protocol prior to ethics submission to discern means of shortening the testing requirements and to identify possible improvements. Both of these tasks took advantage of the expertise of the new members of the research team. A third focus involved forming the Project Implementation Advisory Committee, meeting with members of the committee institution by institution because of vacation conflicts, and developing a recruitment strategy that satisfies the procedural and logistic needs of each of the participating institutions: Action Marguerite, St. Amant, and HEB. The fourth focus involved weaving the results of the previous three objectives into a completed Ethics Application and into recruitment materials and participant contact documents. Our intention is to have these documents submitted by the November 5th deadline for the November meeting of the Bannatyne Campus Research Ethics Committee. Our fifth objective is to have sessions booked, venues chosen, and recruitment procedures in place so that implementation may commence immediately after ethics approval.

Staffing

Two individuals have been identified that will play an extremely important role in the implementation of the project. During the negotiation of the terms of the grant a qualitative research component was added. Since qualitative research was not strongly represented in the research team, we needed to add expertise in this area. A search was conducted for someone willing to join our team in the supporting role required. We were able to identify and then retain Rebecca Martin (CV attached as Appendix 2). Rebecca works as a full-time contract researcher focusing on qualitative research. Her first task has been to prepare the qualitative component of the ethics application. She will also conduct and analyze the qualitative component of the project in the in the second year. The pivotal position funded by the grant is the full-time project manager employed over a two-year term. After a thorough search we chose Dr. Erin Buckels (CV attached as Appendix 3) who was just completing her doctorate at UBC. Dr. Buckels is experienced in implementing studies and is making prepossessing contributions to the personality literature. Her examination of our dependent variables in the context of the issues raised by members of the implementation advisory committee have already been

of significant benefit in tuning the design to be more responsive to the questions raised by the participating institutions.

Re-Examination of Protocol

At the point that the funding agreement was finalized, our lab completed a large-scale analysis of mindfulness-based interventions in healthcare workers. The results--along with the expressed desired found in the review of our protocol for a more compact set of measures--have led us in the direction of several changes. We have just recently completed a study of Mindfulness-Based Interventions in a large (>300) sample of Healthcare and Human Services workers with its attendant statistical power. The analysis of this data has allowed us to trim the measures we propose to be using in the study. Specifically, we failed to find informative results with Pommier's Compassion Scale and the Utrecht Work Engagement Scale despite the sample size. We, therefore, plan to eliminate those measures from the research design. We also noted growing reports of redundancy between the Positive and Negative Affective Scale (PANAS) and the Positive Affective Well-Being Scale and have decided to drop the PAWS.

A second change emerged through discussions with the Implementation Advisory Committee members. They articulated the view that some members of our proband group may be highly motivated to work despite their pattern of absences, while others may be less motivated. The second group of employees is perhaps best characterized as demonstrating "counterproductive workplace behavior." In considering the views expressed, the research team arrived at the conclusion that information on the presence (or absence) of counterproductive work behavior might assist in the interpretation of the data. Hence, we plan to include a measure of counterproductive work behavior (see Appendix 4).

Implementational details

The biggest risk for this study involves an inability to attract an adequate number of participants from the Frequently Absent Group combined with the need to devise recruitment and enrolment methods agreeable to all participants. This was addressed as follows:

1. We desire participants serving individuals who are in decline or who possess relatively stable impairments, Action marguerite and the St. Amant Centre were first choices. In the unlikely chance, given the size of these institutions, that additional participants were needed, an arrangement was made with HEB so that all Healthcare Workers serving our target populations could be invited to participate.
2. It was decided that our target population for the Frequently Absent Group would comprise individuals enrolled in the Attendance Support Assistance Program. These individuals will be contacted in confidence by their Human Resources Departments, informed of the potential benefits of MBSR, informed further of the relevance of MBSR to their status, and be invited to contact the Experimental

Coordinator for further information. They will also be told of the reimbursement available to participants that can be used to defray the costs of participation e.g. transportation or for other purposes.

3. Other individuals employed in the target institutions will receive a general notice including a brochure describing the program, its requirements, and compensation and invited to enrol. Posters may also be used.
4. This process will continue until the requisite classes are full.

Ethics application

The Ethics application is complete save for minor tuning of the contact and consent letters and final copies of a brochure and poster. It will be submitted to the Bannatyne Campus Research Ethics Board and to WCB by the REB's November 5th deadline.

Implementation

Two sections of the MBSR course will be offered in early winter. One will be located at St. Boniface Hospital in the Education Building Parlour and the other in St. Vital at St. Amant. Parking and good bus service is available at both venues. Scheduling will begin immediately following ethics approval. We plan on recruiting the second advisory committee – a knowledge transfer committee – as soon as the MBSR programs are underway. We have just finished a large – 315 participants – study on Mindfulness-Based Interventions in Healthcare and Human Services. We believe that th results are quite compelling. We have been invited to make an oral presentation of these results at Mind and Life – a major international conference. We'll also present this information to the local community as a means of enhancing knowledge of mindfulness, stress reduction, health promotion, and preventative medicine. It is our plan to also use this opportunity to introduce members of the Knowledge Transfer Advisory Committee to the nature and scope of the work included in the WCB project.

Project Implementation Committee

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WCB Project Report #2

We have mostly good news after having resolved several difficulties. Our ethics application was not approved as submitted. There were two issues that we regarded as serious and that went well beyond the usual changes in wording or referencing. The first was the imposition of the requirement that the study be submitted to the Canadian Clinical Trials Registry. This was troubling for three reasons. Prior studies using the same methods, dependent variables, and independent variables were approved so that this requirement appeared to disregard precedent. Secondly, clinical trials require random assignment of participants to experimental conditions. In our study, participants are assigned based on their status as frequently or typically absent rather than randomly. Thirdly, clinical trials are intended to assess the efficacy of two or more treatments. Our study assesses a single treatment administered to two groups. We attempted unsuccessfully to negotiate a change with the head of the REB. After consultation with the senior administration at the SBRC concerning impact beyond our study, we agreed to register the study.

In addition, our protocol involved the payment of $100 upon completion of the study as had a number of completed studies approved by the REB. Payment was disallowed. Again, precedents approved by the REB were disregarded as was the use of payments reported in the literature. We found this troubling as payment seemed to all of those involved in implementation to be especially important for especially for the Frequently-Absent Group. After somewhat protracted discussion a mechanism of payment was

approved. It involves payment of $50. After each of the eight classes, $10., after the retreat, and $50. upon completion.

Dr. Buckels, who is functioning as a co-principal investigator is taking on registration and development of a payment tracking mechanism so costs remain unchanged. Registration as a clinical trial will not reduce participation. We are concerned that the payment formula will reduce the incentive to complete the study and increase attrition. We have in place an arrangement with HEB that will allow recruitment over a larger number of potential participants if needed.

A revised ethics submission is complete and we expect the formal approval within days. The implementational group has been meeting and is ready to launch. We have settled on a schedule that avoids school breaks and will begin in April. Final drafts of recruitment documents with the implementation dates and payment procedures are prepared and ready to be sent as soon as formal review of the REB is in hand. We did not retain the first admin assistant hired and have found a new employee with whom we are very pleased. Small changes to documents reflecting changes in contact information have been made. A record keeping system has been designed and finalized.

In summary, we plan to recruit presently and commence classes in mid April and to begin a second set of two classes in the autumn. We have, while waiting, constructed the databases and trained our new assistant on data entry. I expect that we'll be on time with completion of the study. Obviously, the longitudinal comparison of attendance, accident, and leave data for the years prior to the intervention and the two years following the intervention being supplied by the participating institutions will be completed in due course. We have also tested our system with data from similar studies and have established that it is capable of the detailed and refined analyses planned for the present study

WCB Progress Report #3

The Implementation Committee met five times and developed the procedures for recruiting participants, record keeping, coordination with the HR departments at Action Marguerite and St. Amant, and ongoing administrative management of the WCB research and the MBSR course on which the research program is based.
As reported previously to Joanne Machado, Dawn MacDonald MSW RSW, who is an internationally recognized MBSR teacher and who was originally scheduled to offer the program has left the employ of St. Boniface Hospital. The Catholic Health Corporation of Manitoba, however, was able to secure Ms. MacDonald to offer the MBSR courses that are the major interventions in the study. Ms. MacDonald was budgeted first as an in-kind line in the budget. Teaching expenses transferred to the WCB budget and were offset by designating a portion of the second year's project manager's costs to CHCM. Approved Research Ethics Board permissions were obtained for the study and for all changes. The Ethics Committee felt that registering the study with the National Clinical Trials Registry was warranted. Thus, registration was completed and this fact was noted in the approved Ethics Protocol.

Dr. Jennifer Kornelsen has become Co-Principle Investigator for the project. Dr. Kornelsen is presently a professor in the Department of Radiology at the University of Manitoba. She is especially expert in research design and data analysis and is very well versed in the mindfulness literature and teaching practice. She is, in fact, a fully trained Mindful Self-Compassion teacher. She replaces Dr. Buckels.

We recruited, enrolled, and have offered the program and collected data from one of the four cohorts of participants. We also recruited, enrolled, and are offering the program to the second of the four cohorts of participants. We also have entered the Time 1 data for this cohort. We are just involved in recruiting and enrolling Cohorts Three and Four.
A possible difficulty with this study given the records of frequent absence is attrition. We are pleased that attendance rates were excellent and equivalent for the ASAP and Control Groups. Both were similar to that observed in other studies we have conducted. All of the questionnaire data for Cohort One has been entered, scored, and analyzed. Of course, the data from all cohorts will be amalgamated for the final analysis. Both descriptive and inferential statistics were calculated.

A comparison of the characteristics of the ASAP and Control groups at the outset of the study employed a conservative, 2-sided, $p<.05$ contrast. The ASAP group showed significantly (2-sided, $p<0.05$) lower non-judgment, and higher personal burnout pre-MBSR than the non-ASAP group pre-MBSR. It is noteworthy and important that these differences disappeared after the MBSR course. Thus, there were no significant between groups differences between ASAP and non-ASAP employees after MBSR training. We will continue with this analysis and extend it in two ways. We shall perform a one-sided analysis consistent with our a priori hypotheses and also compare the entrance characteristics of both groups in this study with the very large number of participants in similar studies that we have performed.

The most important data derives from a paired sample T Test pre/post scores for the entire group. Overall, for the pre/post contrast, significant improvements were observed in the Five Facet Mindfulness Questionnaire total score and in the Observation, Non-Judgment, and Non-Reactivity subscales. Thus, the mindfulness of both the experimental and control groups was strengthened. Along with the improved mindfulness, we observed statistically significant increases to positive affect and self-compassion. These were accompanied by statistically significant decreases in undesirable traits. Anxiety, negativity, and perceived stress all declined. Both groups manifested lower personal burnout as measured by the Copenhagen Burnout Inventory. In addition, two of the three measured Fears of Compassion, compassion for self and compassion from others decreased.

In addition to quantitative data, we acquired qualitative data (see Section iv). We regard these findings in a very positive light. They have encouraged us in our belief in the soundness of the experimental structure and of the intervention. We are strengthened in our belief that the studies funded by the grant will provide an evidenced-based program of benefit to healthcare and human services workers who have patterns of frequent

absence as well as those that have typical attendance. The data suggest that heterogeneous intervention groups that include both members of the experimental group and of the control group are viable and effective. Hence, we have recruited Group 2 and will be continuing with no changes.

WCB Progress Report #4

The Implementation Committee met twice with the primary goals of reviewing expenditures and identifying ongoing needs and also to schedule the third and fourth sessions. Recruitment for Session 3 was aborted with the onset of Covid 19 lockdown and the directive on the cessation of research (see appendixes).

The second MBSR session, again taught by Dawn P. MacDonald was successfully completed and data obtained.

Data showed a similar pattern of results from Group 2 to the results for Group 1. Thus. Groups 1 and 2 were combined. The combined analysis shows a very similar pattern of encouraging results to the results for Group 1 that were reported in the previous Progress Report. The following statistically significant changes are noteworthy: The combined analysis showed an even more widespread increase in mindfulness. The total FFMQ score as well as all five of the facets of mindfulness increased. As an aside, we note that the literature provides ample evidence of an inverse relationship between mindfulness and workplace injury. Thus, our results are very consistent with the institutional objectives of the WCB. In the combined analysis, the data also demonstrated an increase in positive traits. Positive affect and self-compassion both increased. Decreases were found in negative affect, anxiety, stress, and personal burnout. Participants also showed a greater receptivity to compassion in that fear of compassion from others and fear of self-compassion decreased. The decreases in the stress related tetrad of anxiety, stress, negative affect, and personal burnout. The interconnections between stress and physical malady are a cornerstone of the burgeoning field of psychoneuroimmunology. The World Health Organization has written emphatically on the critical role of stress reduction in the control of a panoply of illnesses and the promotion of well-being. As with mindfulness increases, the data provide promise of an intervention that is effective for workers in healthcare and human services even those with histories of frequent absence.

The qualitative data continue to indicate that participants are experiencing the MBSR program very positively. The following represent a sampling of the comments collected at the conclusion of the second session (see Section iv).

Scheduling and recruitment for Groups 3 and 4 was discontinued because of Covid restrictions and Covid's influence on the variables being studied. There appear to be changes in the support provided for frequently absent employees that may complicate the continuance of the research along with, of course, the uncertainties introduced by Covid 19. It is especially noteworthy since both St. Amant and Action Marguerite are continuing care facilities and require the very highest levels of precaution. Until

clarification for continuance develops, our plan is to perform a complete analysis of the data to ready it for both publication and for communication to those who might be interested in MBSR interventions for their employees. This will include Bonferroni analyses, examination of one-tailed differences consistent with a priori hypotheses, inter-correlation matrices, and factor analyses in so far as participant numbers permit. We also hope to convene the Knowledge Transfer Advisory Committee that may, now that we know we have compelling data, assist in magnifying its impact.

WCB Progress Report #5

The Implementation Committee met twice with the primary goals of reviewing expenditures and project progress.

Scheduling and recruitment for Groups 3 and 4 continues to be on hold due to changes in the support provided for frequently absent employees that may complicate the continuance of the research along with the uncertainties introduced by COVID19. St. Amant and Action Marguerite are continuing care facilities and therefore recruitment of employees from these centres is not currently possible. As noted in Progress Report#4, until clarification for continuance develops, our plan is to perform a complete analysis of the data to ready it for both publication and for communication to those who might be interested in MBSR interventions for their employees.

Data obtained from the first and second MBSR sessions, taught by Dawn P. MacDonald, continue to be analysed.

Data from Groups 1 and 2 are also being compared to data obtained from a prior, separate omnibus study conducted through the Compassion Project research arm. Participants in the omnibus study completed the questionnaire package at the same time points and with the same MBSR intervention as in the WCB study, but were not involved in a WCB program. Analysis of this comparable data will increase statistical power and afford the opportunity to answer questions such as how changes in scores within the WCB program participants compared to that of participants not in the WCB program.

Scripting of syntax for analysis of all data is in progress.

Compilation and assessment of the qualitative data is in progress.

Upon completion of the analyses, the intention is to convene the Knowledge Transfer Advisory Committee that may assist in magnifying its impact.

Section iv) Presentation of results and evaluation

Twenty-four participants completed the study. Of these, 10 participants were recruited via the ASAP program. The remaining 14 participants were recruited from the same workplaces but were not in the ASAP program. The following table provides the distribution of the participants in the ASAP program and from which workplace they were employed.

ASAP	STA	AM
No		x
No		x
No	x	
Yes		x
Yes	x	
No	x	
No		x
Yes	x	
No	x	
Yes	x	
No	x	
No	x	
Yes	X	
Yes	X	
No	X	
No	X	
Yes	X	
No		X
Yes	X	
Yes		X
Yes	X	
No	X	
No	X	
No	X	

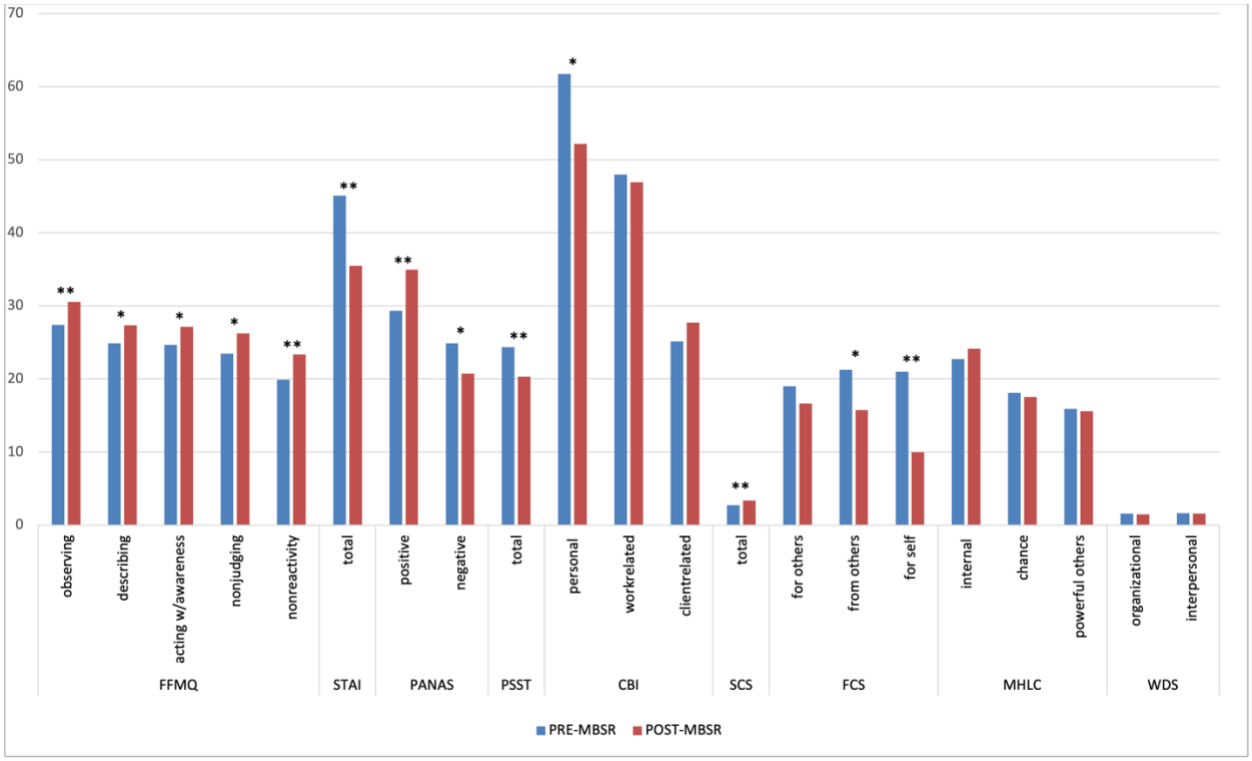
Seventeen employees enrolled and then withdrew from the study or failed to show up for the MBSR orientation or first class.

ASAP	STA	AM	Date of Withdrawal	NOTES
No		X	No Show	Didn't show up for Orientation or first class. - no word from registrants
No		X	No Show	Didn't show up for Orientation or first class. - no word from registrants
No		X	No Show	Didn't show up for Orientation or first class. - no word from registrants
Yes		X	No Show	Didn't show up for Orientation or first class. - no word from registrants
Yes		X	2019-10-04	Only attended orientation, don't know the reason for withdrawal
Yes	X		2019-10-04	Only attended orientation, don't know the reason for withdrawal
No		X	2019-10-04	Only attended orientation, don't know the reason for withdrawal
Yes		X	2019-10-18	Only attended the first class, don't know the reason for withdrawal
Yes		X	2020-01-16	Withdrew day before course began
No	X		2020-01-20	Withdrew due to not being able to attend most classes / scheduling conflicts and vacations
Yes		X	2020-01-20	Withdrew – don't know reason
Yes		X	2020-01-24	Didn't show up for Orientation or first class. - no word from registrants
Yes	X		2020-02-08	Withdrew formal on Feb 24, only attended 3 classes, and hour orientation
Yes		X	2020-01-25	Didn't want to come in on their day off for class
Yes		X	2020-01-25	Didn't want to come in on their day off for class
No	X		2020-01-25	Approved/Withdrawn/ approved again, missed orientation -showed up first class, connected with supervisor and concluded that he won't be continuing as he'll be missing too many classes
No		X	2020-03-06	Didn't show up for last class, didn't answer email regarding completing post -Study forms

Most enrolled employees that withdrew from the study were from the ActionMarguerite location (13 of the 17). When speaking with the employees, we found that issues regarding transportation to and from the study location (St Amant) and the time that it took to travel generated sufficient additional stress that study participation was not favored. Slightly more than half of the enrolled employees (10 of 17) that withdrew were in the ASAP program. Differences between the job descriptions, work conditions, personnel characteristics, or unknown factors may account for this majority of withdrawals from one location, whereas participation in the ASAP program or frequently absent status does not appear to account for withdrawals.

When all study data was assessed (n=24), significant differences were observed for Pre-MBSR to Post-MBSR (Figure 1).

The results indicate:
- mindfulness increased in all categories
- anxiety decreased
- positive affect increased while negative affect decreased
- perceived stress decreased
- personal burnout decreased
- self-compassion increased
- fears of compassion from other and for self decreased
- work-related and client-related burnout did not improve
- health locus of control did not change
- workplace deviance decreased slightly but not significantly



Note: * denotes $p<0.05$ which is conventionally sufficient for publication; ** denotes $p<0.05$ Bonferroni corrected ($p<0.0023$) which reflects particularly robust results; repeated measures two-tailed T-test.

When the participants in the ASAP program were compared to those not in the ASAP program (controls), significant differences were observed (Figure 2, Table 1). Figure 2 provides a graphic representation of the scores across the two groups and two time points. Table 1 details the mean score per group and time point as well as the statistical result of the repeated measures test for each group. Statistically significant comparisons are displayed in bold font ($p<0.05$) and with an asterisk for p-values corrected for multiple comparisons ($p<0.0023$).

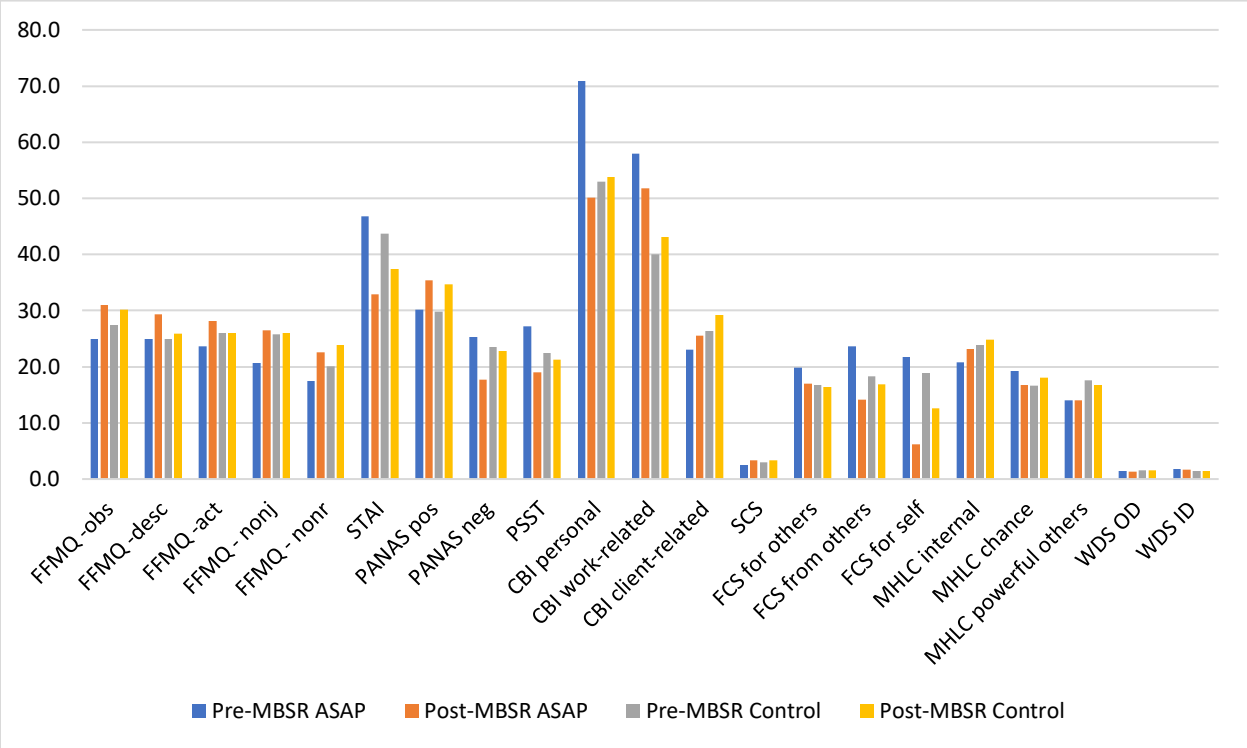


Table 1.

	ASAP Pre-MBSR	ASAP Post-MBSR	p-value	Control Pre-MBSR	Control Post-MBSR	p-value
FFMQ observation	25	31	**0.0093**	27.4	30.2	**0.0080**
FFMQ describing	25.0	29.4	**0.0212**	25.0	25.9	0.1794
FFMQ acting	23.6	28.2	**0.0123**	26.1	26.0	0.4821
FFMQ nonjudging	20.7	26.5	**0.0198**	25.8	26.0	0.4367
FFMQ nonreacting	17.5	22.6	**0.0087**	20.1	23.9	**0.0023**
FFMQ total	111.8	137.6	**0.0001***	124.4	131.9	**0.0296**
STAI	46.8	32.9	**0.0050**	43.7	37.4	**0.0054**
PANAS positive	30.2	35.4	0.0541	29.9	34.6	**0.0108**
PANAS negative	25.3	17.7	**0.0044**	23.6	22.9	0.3583
PSST	27.2	19.0	**0.0002***	22.5	21.2	0.1987
CBI personal	70.9	50.1	**0.0005***	52.9	53.8	0.4724
CBI work-related	57.9	51.8	0.1440	40.1	43.2	0.2040
CBI client-related	23.0	25.6	0.3607	26.4	29.2	0.2379
SCS	2.5	3.4	**0.0001***	2.9	3.3	**0.0132**
FCS for others	19.8	17.0	0.1523	16.7	16.4	0.3977
FCS from others	23.6	14.2	**0.0039**	18.3	16.9	0.2602
FCS for self	21.8	6.2	**0.0041**	18.9	12.6	**0.0333**
MHLC internal	20.8	23.2	0.0640	23.8	24.8	0.2907
MHLC chance	19.3	16.8	**0.0295**	16.6	18.1	0.1387
MHLC others	14.0	14.0	0.5000	17.5	16.7	0.1451
WDS organizational	1.49	1.36	**0.0478**	1.57	1.52	0.4462
WDS interpersonal	1.75	1.65	0.2527	1.43	1.47	0.1453

Table 1. Mean scores and p-values derived from independent samples two-tailed t-tests. P-values <0.05 are displayed in bold font and an * denotes p-values Bonferroni-corrected for multiple comparisons ($p<0.0023$).

The qualitative data reflected the participants' experience of the MBSR course. The following are statements made in response to open-ended questions in the questionnaire package.

Group 1 responses to post-intervention questions:

I found myself blessed to be a part of this course.

I believe it is very beneficial [in my work life] especially when I feel stressed – helps me to do my job better as well.

I was recommended by a friend who took this course last year. I would absolutely tell people about it. It is so beneficial and we don't realize that we don't look after ourselves. They should have this as a regular course to take for staff.

I have noticed the way I have been receiving information has changed and my responses have been trained to slow down and be more thoughtful – to see the larger picture.

Self-care is very important in order to be optimal to serve others.

The biggest challenge for me was finding loving kindness for others I deemed undeserving; however, it helped me find a deeper level of compassion without being tolerant of the behaviour that repelled me originally.

I notice I am calm more in workplace, do my job in a better way, thinking on different approaches in supporting the ladies, have patience with them, calm down with them when they are having behaviour issues.

There should be more people that take the course (some people could really benefit).

I feel more level-headed and able to make better decisions overall. My communication with others is improving.

Group 2 responses to post-intervention questions.

Yes I have [benefitted from this course], it has helped me stay grounded when something happens.

Absolutely [I have benefitted from this course] – I am now able to find an anchor without intrusive thoughts ruling my day! Breathing is easier, thought are calmer and kinder.

Yes [I have benefitted from this course] I have become more aware of how my body feels and how I can help it.

[In my work life I've noticed] More control over stress and changes.

[In my work life I've noticed] I am calmer and more present to the emotional experience behind the issues I'm supporting people with.

[In my work life I've noticed] Brings about in me much more patience with certain clients that can be very trying at the best of time.

[What surprised me about this course is that] It's not just fluff – even though you can't see what is going on in the brain your can feel it. Neuroplasticity, spirit connection, kindness to one's SELF translates to kindness towards others.

It's okay not to be perfect, there's still something to learn.

Yes [I intend to continue my practice], because being present to live your life is a beautiful thing.

I have been recommending this course to others in my field. They will probably join in when they are ready.

Take it [the course]. Its helpful. Very helpful.

It came into my life at a very critical time and has played a major role for coping.

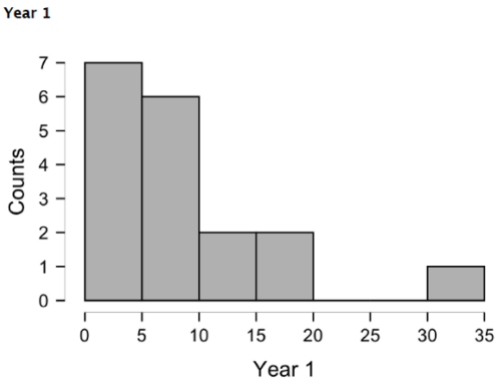
Data from employers regarding attendance of study participants. For years 2019, 2020, and 2021, the table below provides the percentage of total hours missed for their equivalent full time (EFT) position for the study participants. The percentages at the bottom of the table are average percentage of hours missed for their EFT for all employees in similar job positions for comparison. Because the years 2019 – 2021 include the COVID-19 pandemic, it is not possible to say if these values for the study participants or for all employees are generalizable, however absenteeism increased in each of the years for all employees.

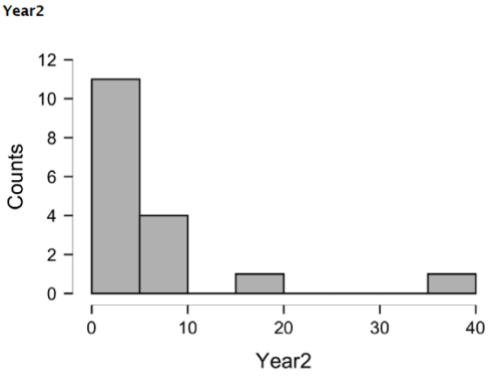
ASAP	STA	AM	2019	2020	2021	Notes
1st Class October – December 2019						
No		x				Information unavailable
No		x				Information unavailable
No	x		5.18%	8.33%	8.71%	
Yes		x				Information unavailable
Yes	x		8.05%	16.76%	21.73%	resigned October 18, 2021
No	x		3.03%	3.57%	9.59%	resigned March 12, 2021
No		x				Information unavailable
Yes	x		5.46%	6.53%	14.17%	
No	x		14.19%	4.48%	n/a	resigned September 24, 2020
Yes	x		19.85%	n/a	n/a	resigned January 16, 2020
No	x		3.08%	1.73%	9.54%	
No	x		31.64%	2.23%	6.28%	
2nd Class January – March 2020						
Yes	X		4.78%	5.55%	n/a	
Yes	X		8.59%	39.94%	15.69%	
No	X		0.30%	4.25%	1.67%	
No	X		18.92%	2.67%	6.21%	
Yes	X		14.09%	7.05%	n/a	resigned August 7, 2020
No		X				Information unavailable
Yes	X		5.87%	3.58%	5.40%	
Yes		X				Information unavailable
Yes	X		4.24%	3.58%	6.69%	resigned October 15, 2021
No	X		2.18%	1.71%	1.47%	
No	X		1.95%	2.49%	3.69%	
No	X		5.53%	1.25%	2.08%	
			4.07%	4.99%	6.62%	includes the following positions: Early Childhood Educators, Childcare Assistants, Support Workers, Keyworkers, Tutors

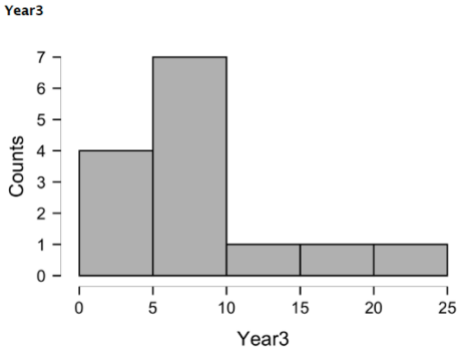
The following statistics include assumption checks which are done to evaluate our evaluation of our hypotheses. When data is not normally distributed different statistics are required. Because we were unable to study the full sample that we intended to study, we did a variety of statistical analyses that contributed to our surety about the data.

Descriptive Statistics

	Year 1	Year2	Year3
Valid	18	17	14
Missing	0	1	4
Mean	8.719	6.806	8.066
Median	5.495	3.580	6.485
Std. Deviation	8.092	9.299	5.831
Shapiro-Wilk	0.822	0.559	0.908
P-value of Shapiro-Wilk	0.003	4.280e −6	0.146







The following one-sample t-tests were performed using the Wilcoxon test to account for the non-normal distribution of the data. The results show that the study participants had significantly higher percentages of total hours missed for Year 1 (2019) but not in Years 2 or 3 (2020 and 2021). Again, the attendance rates were likely impacted by the COVID pandemic.

	Test	Statistic	df	p	Location Estimate
Year 1	Student	2.438	17	0.013	8.719
	Wilcoxon	134.000		0.017	7.025

Note. For the Student t-test, location estimate is given by the sample mean. For the Wilcoxon test, location estimate is given by the Hodges-Lehmann estimate.
Note. For the Student t-test, the alternative hypothesis specifies that the mean is greater than 4.07. For the Wilcoxon test, the alternative hypothesis specifies that the median is greater than 4.07.

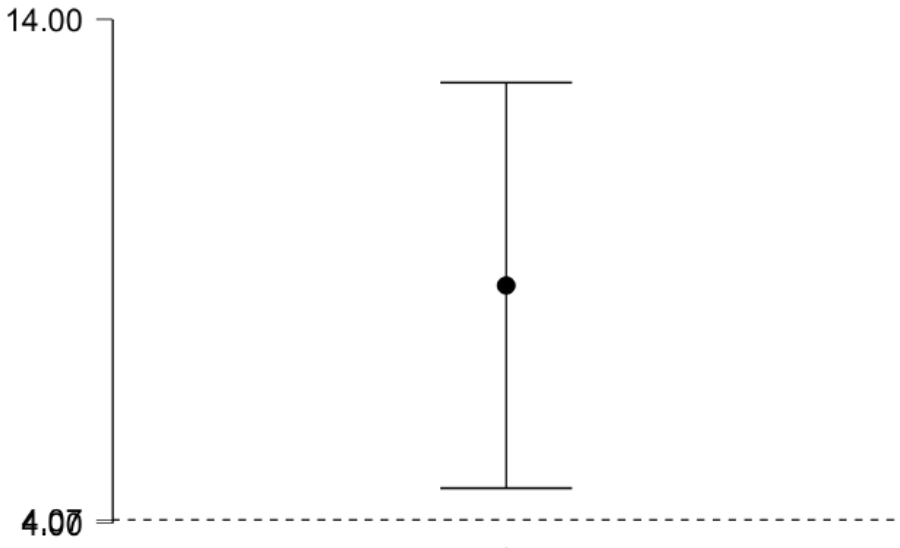
Assumption Checks

Test of Normality (Shapiro-Wilk)

	W	p
Year 1	0.822	0.003

Note. Significant results suggest a deviation from normality.

Year 1



One Sample T-Test

	Test	Statistic	df	p	Location Estimate
Year2	Student	0.805	16	0.433	6.806
	Wilcoxon	64.000		0.570	4.380

Note. For the Student t-test, location estimate is given by the sample mean. For the Wilcoxon test, location estimate is given by the Hodges-Lehmann estimate.
Note. For the Student t-test, the alternative hypothesis specifies that the mean is different from 4.99. For the Wilcoxon test, the alternative hypothesis specifies that the median is different from 4.99.

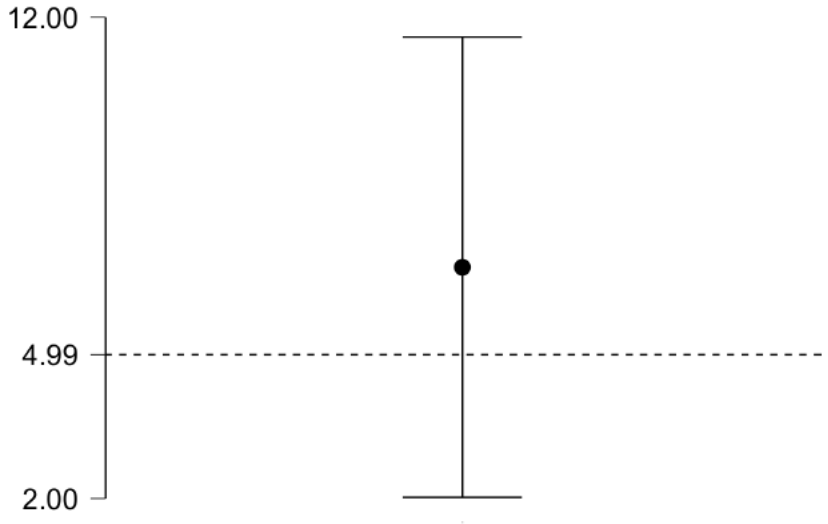
Assumption Checks

Test of Normality (Shapiro-Wilk)

	W	p
Year2	0.559	4.280e −6

Note. Significant results suggest a deviation from normality.

Year2



One Sample T-Test

	Test	Statistic	df	p	Location Estimate
Year3	Student	0.928	13	0.370	8.066
	Wilcoxon	59.000		0.715	7.495

Note. For the Student t-test, location estimate is given by the sample mean. For the Wilcoxon test, location estimate is given by the Hodges-Lehmann estimate.
Note. For the Student t-test, the alternative hypothesis specifies that the mean is different from 6.62. For the Wilcoxon test, the alternative hypothesis specifies that the median is different from 6.62.

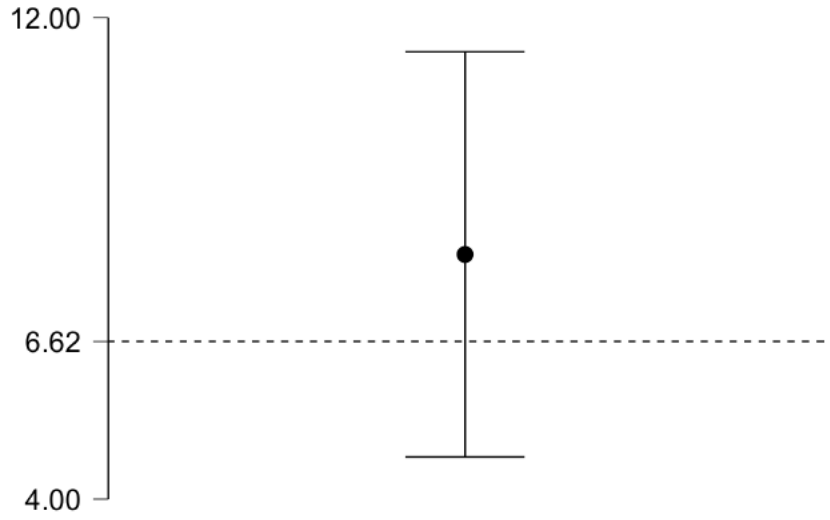
Assumption Checks

Test of Normality (Shapiro-Wilk)

	W	p
Year3	0.908	0.146

Note. Significant results suggest a deviation from normality.

Year3



Cases	Sphericity Correction	Sum of Squares	df	Mean Square	F	p	η^2
Year	None	7.446	2.000	3.723	0.068	0.935	0.005
	Greenhouse-Geisser	7.446	1.475	5.047	0.068	0.884	0.005
	Huynh-Feldt	7.446	1.619	4.600	0.068	0.901	0.005
Residuals	None	1425.295	26.000	54.819			
	Greenhouse-Geisser	1425.295	19.179	74.314			
	Huynh-Feldt	1425.295	21.043	67.733			

Note. Type III Sum of Squares

Friedman Test

Factor	Chi-Squared	df	p	Kendall's W
Year	4.000	2	0.135	0.603

Conover Test

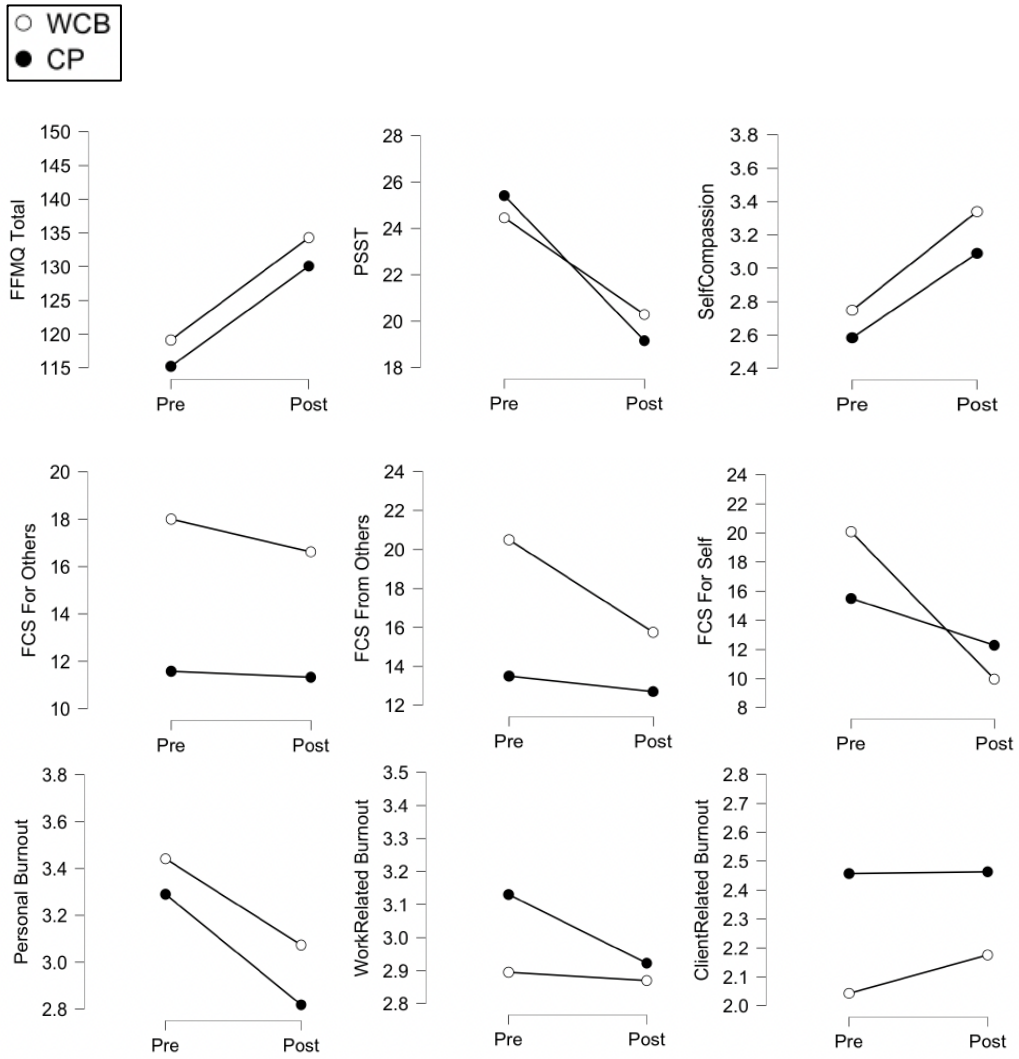
Conover's Post Hoc Comparisons - Year

		T-Stat	df	W_i	W_j	p	p_{bonf}	p_{holm}
2019	2020	0.378	26	26.000	24.000	0.709	1.000	0.709
	2021	1.512	26	26.000	34.000	0.143	0.428	0.285
2020	2021	1.890	26	24.000	34.000	0.070	0.210	0.210

Note. Grouped by JaspColumn_.subject._Encoded.

Data from the WCB Groups 1 and 2 were compared to data obtained from a prior, separate omnibus study conducted through the Compassion Project (CP) research arm. Participants in the omnibus study completed a questionnaire package at the same time points and with the same MBSR intervention as in the WCB study but were not involved in a WCB program. Omnibus study data was available for the FFMQ, PSST, SCS, FOC, and CBI questionnaires. Analysis of the comparable data increased statistical power and afforded the opportunity to answer questions such as how changes in scores within the WCB program participants compared to that of participants not in the WCB program.

Figure 3. Mean scores for the WCB and CP participants.



	WCB Pre-MBSR	WCB Post-MBSR	CP Pre-MBSR	CP Post-MBSR	F-val Group	F-val Observation	F-val Group * Observation
FFMQ total	119.1	134.3	115.2	138.1	0.564	**28.818**	0.003
PSST	24.5	20.3	25.4	19.2	0.002	**25.105**	1.076
CBI personal	3.44	3.07	3.29	2.82	0.894	**16.078**	0.196
CBI work-related	2.90	2.87	3.13	2.92	0.455	2.123	1.478
CBI client-related	2.04	2.18	2.46	2.46	2.720	0.675	0.265
SCS	2.75	3.34	2.58	3.09	1.086	**32.324**	0.320
FCS for others	18.0	16.6	11.6	11.3	**15.071**	0.791	0.355
FCS from others	20.5	15.8	13.5	12.7	3.227	**5.024**	3.158
FCS for self	20.1	10.0	15.5	12.3	0.112	**15.519**	3.472

Note: Repeated Measures ANOVA, F(1,23)

The data demonstrate that for most measures individuals in the WCB group were affected similarly to the individuals in the omnibus study. For all tests, changes were in the same direction.

Section v) Proposed recommendation(s)

The results of the project indicate that persons in the return-to-work program benefit similarly to those in the general population with reductions of stress and personal burnout, and improvements in mindfulness, self-compassion, and fears of compassion from other and for the self. These benefits may translate into return-to-work behaviours in frequently absent employees. We recommend that workplaces offer Mindfulness Based Stress Reduction programming which may improve absenteeism for employees trending toward frequently absent status and before entering compensation programs due to prolonged workplace absences and offer to employees already in compensation programs for absenteeism to facilitate return to work. Providing training in MBSR and related models within the workplace should continue to be explored and researched to provide evidence in how they can change the landscape of our organizations.

Section vi) Electronic copy of resources/presentations

Due to the limitations caused by the Covid-19 pandemic and the consequential cancellations of MBSR offerings, the number of participants for the Project was fewer than what is generally acceptable for peer-review publication. However, we were able to compare the data from the Project to the data obtained in a larger, independent study of members of the public who participated in the MBSR course and had completed some of the same questionnaires. It is possible to disseminate the findings of the Project in two ways. First, interested members of WCB may be invited to attend a presentation of the overall findings of the larger independent study and the Project. Second, a knowledge dissemination document may be generated in the form of a pamphlet, brochure, and/or poster of the larger independent study and the results of the Project. The knowledge dissemination document will be provided to the WCB in electronic format, and in hard copy if requested.

Section vii) Executive Summary of the Final Report

Recurrent accidental injury and frequent illness costs employers, employees, and taxpayers. This research was designed to examine the efficacy of an intervention to interrupt the existing pattern of recurrent work-related accidents, injuries, and illness, and to promote both psychological and physical well-being and to allow a more meaningful and successful return to work. Our hypothesis held that equipping workers with the skills needed to reduce chronic stress would enable increased attentiveness, reduce burnout, increase work satisfaction and personal well-being. In turn, we hypothesized further that patterns of recurrent accidental injury and frequent illness would improve. Our research objectives were consistent with the objectives of the WCB—to foster successful rehabilitation and to support a productive and safe return to meaningful work. The treatment condition for the study utilized one of the most intensively studied intervention paradigms (mindfulness-based stress reduction (MBSR)). Our aim was to establish that MBSR can be an extremely useful component of a program intended to reverse patterns of frequent absence. Our objectives were to do this by demonstrating a reduction of stress, anxiety, and burnout; increases in measures of well-being and work engagement, and in altered patterns of work disruption.

The results indicate that the MBSR intervention was beneficial to the study participants in multiple domains. Mindfulness increased, anxiety decreased, positive affect increased while negative affect decreased, perceived stress decreased, personal burnout decreased, self-compassion increased, and fears of compassion from others and for the self decreased. The results did not show significant improvements in work-related or client-related burnout, health locus of control, or workplace deviance. The open-ended feedback from participants was positive mirroring the results obtained via the questionnaires. Due to COVID, the data was inadequate for assessing the impact of the MBSR intervention on absenteeism. The data from the current study was comparable to that obtained in a previous study by our group in which a large sample of participants completed some of the same measures pre- and post-MBSR. Fears of compassion for others was significantly higher in the current study participants than in those from the larger study, whereas both groups showed similar decreases in fears of compassion from others and for self. Our results show that employees in the ASAP program benefit similarly to those in the general population with reductions of stress and personal burnout, and improvements in mindfulness, self-compassion, and fears of compassion. These benefits may translate into reduced workplace injury and return to work behaviours in frequently absent employees.

Section viii) References

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Section ix) Appendices

Appendix A) ASAP program document
Appendix B) Research Ethics Board approval
Appendix C) Study Consent Form
Appendix D) Questionnaires
Appendix E) University of Manitoba COVID-19 letter to researchers

Attendance Support and Assistance Program

(ASAP)

Guide for Managers

Contents

Definitions

This manual is intended to provide an overview the ASAP program, along with some helpful tools and models you might use when having conversations with staff.

Before you begin, it may be beneficial to review the following definitions.

Absence	Any time an employee, who is scheduled or otherwise expected to be at work, is not at work. Absences due to compensable injuries within the meaning of *The Workers' Compensation Act* are excluded from this definition
Attendance	Attending work, on time and remaining at work when scheduled including returning from breaks on time.
Culpable Absenteeism	Culpable absenteeism is an absence from work where the employee is at fault. Culpable absenteeism includes: • Lateness/leaving work early including break times without approval or suitable justification • Absence without approval or suitable justification Culpable absence is dealt with through a **disciplinary response.** It does not form **part of the Attendance Management process nor does it form part of ASAP.**
Non-culpable Absenteeism	Non-culpable, also called "Innocent Absenteeism", is an absence for which the employee is not at fault and may result from factors outside the direct control of the employee. Such absences are never dealt with through a disciplinary response nor do they ever form part of the progressive discipline process or the disciplinary record. Rather, **efforts to reduce these absences are dealt with through Attendance Management and/or ASAP.**
Excess Absenteeism	Excess absenteeism is identified as being above the norm for the employee comparator group. The comparator group is determined by the employer and may be the average of the facility, unit, floor, sector, classification, etc. On occasion, an individual staff person's attendance record will reach a level of concern that necessitates direct, individual interaction with that staff person. There is no magic number of absences that triggers this concern but the average level of absenteeism within the employee's comparator group is usually a good indicator. Each facility will determine appropriate comparators and Human Resources should be consulted to obtain this information.
Pattern Absenteeism	Pattern absenteeism is absences that may appear to be non-culpable when viewed in isolation; however, upon review of overall absenteeism, a pattern of absenteeism appears that suggests possible culpability.

Principles and Guidelines of ASAP

ASAP is a collection of strategies and efforts focused on building a program **specific to an individual** to assist that employee in his/her efforts to improve attendance.

ASAP is non-disciplinary and only addresses non-culpable absences

- We hire dedicated staff that are committed to their jobs and the people they serve
- All employees have a contractual obligation to attend work and will use sick leave only for its identified purpose.
- Staffing levels are based on the presence of staff as scheduled – person-centered care is affected by staff absence; additional workloads for co-workers result
- Without active management of attendance and communication of expectations for our staff, staff may not understand the importance of regular attendance
- Management of absence may reveal workplace variables that can be modified to improve attendance, staff wellness and improve productivity and for the people we serve.
- Management of absence may disclose opportunities to assist individual staff in their efforts to remove obstacles from their personal and/or work-lives that are acting to prevent regular attendance
- Absence from work results in substantial financial, operational and quality costs to the healthcare system
- Employees leaving our system due to an inability to improve attendance are a loss to the healthcare system
- The whole focus of managing attendance is on removing barriers to regular attendance and rewarding regular attendance
- Managing non-culpable absence is not a disciplinary process nor should it be geared toward termination of employment
- Each employee brings unique circumstances to the workplace and their attendance shall be looked upon individually and evaluated based on its own merits

The 3 R's – Roles, Rights and Responsibilities

Any successful approach to attendance management requires an understanding of, and respect for, the roles, rights and responsibilities of employees, employers, occupational health and safety, human resources, and unions.

Employer/Manager

- Managing attendance of staff reporting to them and communicating expectations.
- Informing employees about ASAP and addressing all employee questions and concerns or directing them to the appropriate department (e.g. Occupational Health and Safety, Human Resources, Employee/Labour Relations).
- Implementing appropriate steps under ASAP as required.
- Maintaining regular contact with and providing support to an employee who is absent from work.
- Ensuring that the provisions of the Collective Agreement(s) are followed.
- Respecting legislation related to employment e.g. Human Rights Code.
- Maintaining the confidentiality of employee information.

Employees

- Each employee has a contractual obligation to attend work regularly. Attending work for all scheduled shifts unless unable for legitimate reasons.
- Improving and maintaining personal health and adjusting lifestyle, where necessary, to enable regular attendance.
- Making every reasonable effort to attend to personal affairs and obligations (including medical appointments if possible), on their own personal time and not during normal working hours.
- Reporting all occurrences and/or absences from work in accordance with the employer's absence reporting procedure.
- Reporting work-related injuries and/or illness immediately as they occur directly to their manager and completing required forms.
- Providing appropriate and sufficient medical documentation
- Fully participating in early and safe return to work initiatives and workplace accommodations.
- To fully participate in efforts to identify and implement strategies to improve attendance.
- Maintaining regular communication with the manager and/or designate during absences and providing information on the expected duration of absence and possible return to work date.
- NOTE: Employees may be required to provide medical clearance stating restrictions, if any, prior to being permitted to return to work.

Human Resources

- Providing Managers and Employees with clear guidelines related to employee attendance.
- Providing training and advice to Managers as required, on Attendance Management and ASAP.
- Providing advice and support to managers and staff in the management of attendance.
- Ensuring that ASAP is administered consistently and equitably.
- Ensuring appropriate consultation with Unions.

Occupational Health and Safety

- Providing support to employees and managers.
- Providing advice on occupational safety and health issues as they relate to ASAP, as required.

The ASAP Process

ASAP has been developed to assist Managers in their efforts to work with individual staff to address concerns relating to absenteeism.

Following assessment of the attendance report sent to you quarterly through Human Resources, situations for which ASAP has been identified as appropriate are to be addressed by proceeding through the following steps:

Check In – Initial Conversation

Step 1 – Communicate the Concern/Start the program

Step 2 - Formal Attention to Attendance

Step 3 - Formal Attention to Attendance - Notice of Possible Termination

Step 4 - Formal Attendance Management: Assessment of On-Going Viability of Employment

There are two ways an employee can move through the ASAP Program.

1. Due to an unsatisfactory level of attendance at each review meeting, the employee will move forward to the next step. If attendance doesn't improve at each review meeting they will eventually move to Step 4 within a one year time frame

2. An employee enters the program and at one step or another they show improvement and reach a satisfactory level of attendance. They must show that they can maintain a satisfactory level of attendance twice before they will be taken off the program. If they cannot stay at a satisfactory level of attendance twice they will be moved forward to the next step.

**Employees will not go backwards through the steps.

Example: An employee starts the program at 12%, 12 weeks later they have a rate of 8%. We would recommend they still move forward to the next appropriate step. They have not reached a satisfactory level of attendance yet.

Check In

The intended purpose of this step is for managers to connect with their employees. This a chance to discuss their attendance and the increase in absences. Try to understand what is occurring that is affecting the above standard absences. Employees around 4-6% should be considered for a check in and decide if the attendance management program is needed for them.

Questions to consider when carrying out the check in:

- How are you?
- How are things going in your role?
- Do you enjoy your job? What are some positives of your position?
- Is this position a good fit for you?
- Anything I can do to help, or provide support?

Step 1

You have deemed it appropriate that they be placed on ASAP. At this stage it is important to communicate your concerns around their attendance and discuss the details of the program.

Step 2

Attendance has not improved from Step 1. At this stage it is important to discuss effective strategies to lower their attendance rate.

*This program is non-disciplinary, at step 1 and 2 employees should not be held back from transferring positions.

Step 3

Attendance has not improved. Review previous strategies, make alterations if necessary. Medical notes will be required for missed time.

At this stage the manager needs to communicate very clearly if satisfactory improvement is not achieved by the next meeting that an assessment will be made by the employer as to whether his/her employment will be continued or whether it will be terminated due to frustration of contract because of his/her inability to attend work on a regular basis.

Human Resources will attend all ASAP meetings if need be, however only step 3 meetings are mandatory.

Step 4

Prior to this meeting the manager needs to consult with Human Resources to determine if further opportunities to improve attendance should be offered or whether it is time to end the employment relationship due to frustration of contract.

It is important that we have clear documentation stating the employee has not been able to improve their attendance and prove their inability to maintain a satisfactory level of attendance.

<u>Key points to remember</u>

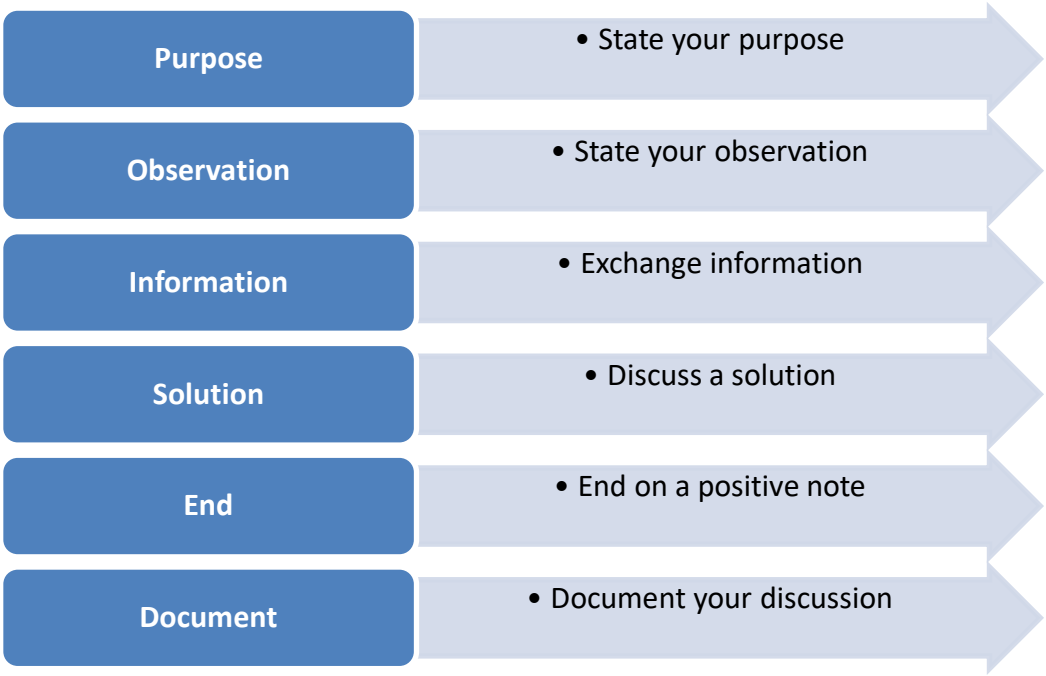
Take into account individual circumstances when assessing whether or not to proceed to the next step. Proceeding to the next step is not automatic in the ASAP process. The manager must maintain accurate documentation. This includes a written summary of all meetings with employees, as well as the supporting scheduling and payroll records. Ensure that copies for the employee's personnel file are provided to Human Resources as necessary and uploaded into Quadrant.

At every step we must clearly communicate if satisfactory improvement is not achieved by the end of the program (step 4) that an assessment will be made by the employer as to whether his/her employment will be continued or whether it will be terminated

Where an employee's absence record can be attributed to a medical condition this may constitute a disability under the Manitoba Human Rights Code. As a result, reasonable accommodation may be required. Where a medical condition exists, consult with Human Resources / Occupational Health. Please note ASAP may be put on hold until the medical concerns can be addressed.

How to Have a Difficult Conversation

Using the "POISED" principle means you are calm, confident and ready to "attend" to attendance. Try this approach when one of your employees experiences an absence from work:



Sample Conversation

Manager: I'd like to spend a few minutes talking about your attendance. You're an important member of this team and I'm concerned that the team/unit will be challenged to handle the workload if you are not able to regularly attend work. (*Purpose*)

Perhaps we could start with you telling me a bit about your recent absence from work? (*Observation*)

Employee: I haven't missed that much work. Which time are you referring to?

Manager: The attendance records show that you've missed 3 Fridays over the past 6 weeks -January 6, 20 and February 3. We can discuss each day separately if that would make more sense, or if it's easier for you, just discuss the absences in more general terms. (*Information*)

Employee: I won't need to be away in the future. I'll be able to get the work done, don't worry.

Manager: I'm not solely concerned about your past absences but I want to make sure you are OK. About the absences over the past few weeks, what do you need or what can we do to help you attend work regularly? (*Information*)

Employee: I've been having some trouble with my day care and there have been a few days when I couldn't find alternate day care for my kids. I've solved the problem and it won't happen again.

Manager: I know that finding suitable day care can be very difficult in this city. I'm glad to hear that you've found a solution. (*Information & Solution*)

Tips for Mindful Conversations

Be positive

- Make sure you are feeling positive and resourceful at the time of the meeting
- Know that your behavior will set the pace for the meeting
- Don’t expect the worse - or you might get it!

Listen actively

- Stop talking and really listen to the employee
- Paraphrase what the employee says - state it back in your own words: "So what I hear you saying is...."
- Empathize with the stated (or unstated) emotions: "I can see you are upset...."
- Confirm that you have clearly understood the employee's perspective

Separate perception from interpretation

- Ask for specifics/examples. If the employee says something like: "You don't care about me!" Rather than responding with a defensive remark like: "I do so!" inquire about how the employee came to that conclusion (interpretation). Say something like: "Can you give me an example of something I have done or haven't done that has communicated to you that I don't respect your work?" (perception of behavior)

Manage your own emotions

- Let the employee 'own' his/her own emotions. Taking on an employee's destructive emotions can be debilitating and limit your effectiveness as a supervisor.
- Take time out if you need it. It is better to call a 5 minute break - walk around the office to cool off, and then resume the meeting - than to risk losing credibility with your employee because you were not able to manage your own emotions.
- Practice deep breathing. You can do this on the way to the meeting and during the meeting. This practice actually results in a physiological change that allows you to be more resourceful and in control when you need to be.

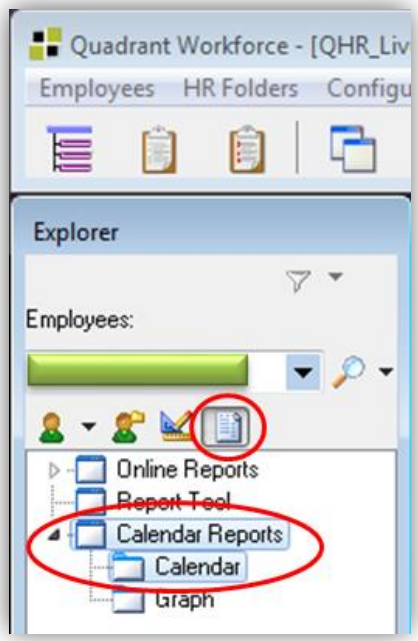
Reschedule if it seems appropriate

- Ask the employee to take some time to calm down, reschedule for another time

How to Access Calendar Reports

The Calendar Reports in Quadrant Workforce can be used to view trends and on-going activities in an employee's schedule. These calendars should be reviewed in conjunction with the employee's regular schedule.

1. In Quadrant Workforce, click on **Reports → Calendar Reports → Calendar**



2. Under **Calendar** select the data that you wish to review:
    a. **Attendance – Income Protection –** this will show you time off using Income Protection banks, including Personal, Family, Medical Appointments, and unpaid time.
    b. **Attendance – Vac, Sick, Stat** – this will show you time off using Income Protection, Statutory Holidays, Vacation, Sleepover Vacation, and unpaid time.
    c. **Attendance – Overall** – this will show you all hours schedule, including Regular & Overtime hours worked, Approved Leaves, Income Protection banks, WCB and MPI Leaves, and unpaid time.

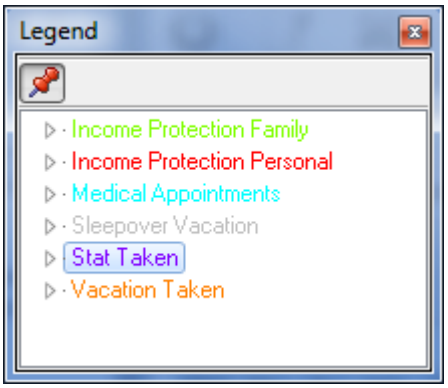
Note: Medical Appointments have been included for reference only, and are not included in attendance reports available through Quadrant reporting.

Note: Unpaid time includes instances where an employee does not have enough time in their benefit bank to cover an absence, or when an employee calls in sick on a picked up shift (MGEU CRP & MGEUS).

Select **Start Date** and **End Date** to specify attendance time frame. Click **View** to refresh the calendar.

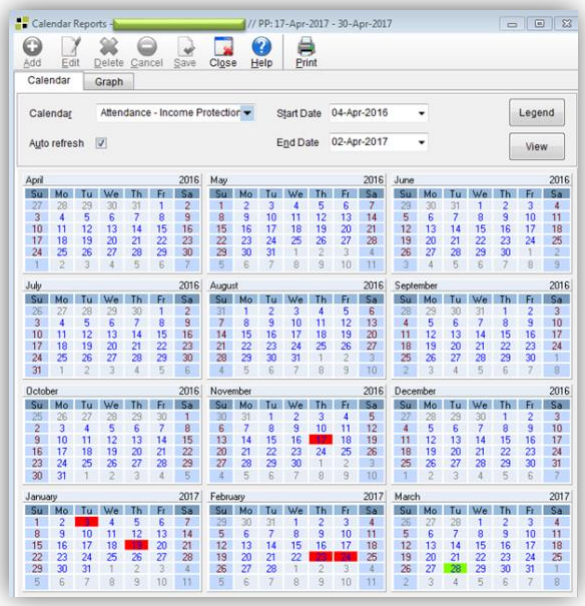
Note: The calendar will display a maximum of 12 months.

3. Click on **Legend** to view all codes and their meanings:
    a. **Pink** – Regular & Overtime
    b. **Blue** – Approved Leaves
    c. **Green** – Income Protection / WCB / MPI / LOAs
    d. **Light Blue** – Medical Appointments
    e. **Light Green** – Income Protection Personal
    f. **Red** – Income Protection Family
    g. **Orange** – Vacation
    h. **Grey** – Sleepover Vacation
    i. **Purple** – Stat Taken
    j. **Yellow** – Unpaid Time



Examples:

Attendance – Income Protection



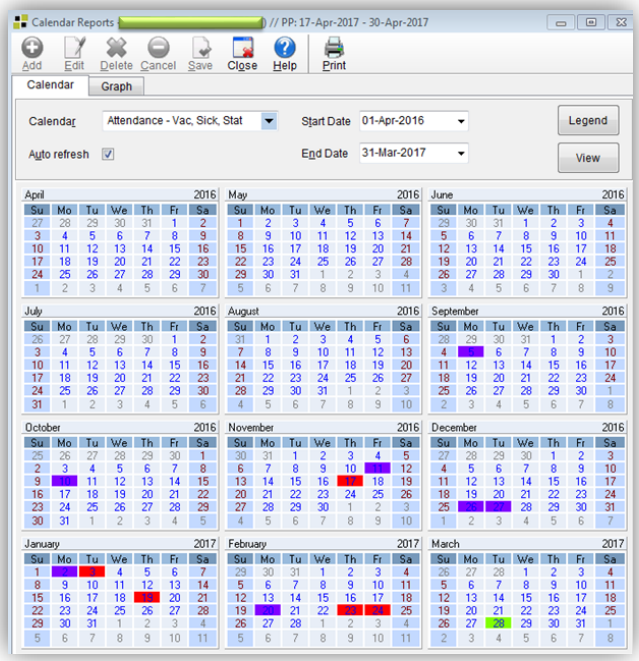
RED – Income Protection Personal

GREEN – Income Protection Family

TEAL – Medical Appointments

YELLOW – Unpaid

Attendance – Vacation, Income Protection, Stat



RED – Income Protection Personal

GREEN – Income Protection Family

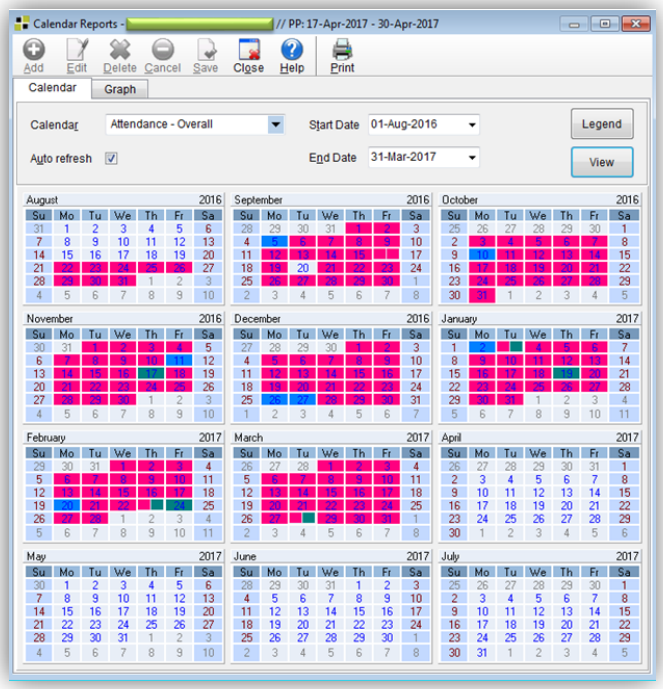
TEAL – Medical Appointments

ORANGE – Vacation Taken

GREY – Sleepover Vacation

PURPLE – Stat Taken

Attendance – Overall



PINK – Regular & Overtime Hours

BLUE – Approved Leaves

GREEN – Income Protection / WCB / MPI / LOAs

How to Read Attendance Reports

	A	B	C	D	E	F	G
1	**Summary Report on Sick Time Hours**						
2	**20-Apr-2017 10:46:35 AM**						
3	**Start:**						
4	*04-Apr-16*						
5	**End:**	1					2
6	*02-Apr-17*						
7	**Program**	**CC**	**Cost Centre**	**Name**	**Occupation**	**Hire Date**	**Type**
411	CRP	71627	CRP		SUPPORT WORKER CRP	12-Sep-2016	P
412	CRP	71627	CRP		SUPPORT WORKER CRP	05-Jan-2017	P
413	CRP	71627	CRP		SUPPORT WORKER CRP	05-Oct-2010	F
414	CRP	71627	CRP		SUPPORT WORKER CRP	08-Sep-2011	P
415	CRP	71627	CRP		KEYWORKER CRP	13-Jun-2013	F
416	CRP	71627	CRP		SUPPORT WORKER CRP	02-Dec-2010	P
725							
726							

H	I	J	K	L	M	N	O	P	Q	R
		3				4		5		
Status	**EE FTE**	**FTE Hours**	**Personal Sick**	**Family Sick**	**Unpaid Sick(All)**	**Total Sick**	**Total Worked Hours (excl OT)**	**Sick% on Total Worked Hours**	**Sick % of FTE Hours**	
Active	0.6	1248	0	0	304	304	311.22	97.68%	24.36%	
Active	0.6	1248	9.54	0	6.46	16	239.61	6.68%	1.28%	
Active	1	2080	80	12	10	102	2,096.25	4.87%	4.90%	
Active	0.93	1934.4	66	24	0	90	2,070.98	4.35%	4.65%	
Active	1	2080	24	16	1.5	41.5	2,110.75	1.97%	2.00%	
Active	0.93	1934.4	0	0	0	0	434.18	0.00%	0.00%	

1. **Start / End Dates:** Attendance reports are typically run on an annual timeframe, based on 26 pay periods. This will capture all hours worked and all absences within the reporting period.
2. **Type / Status:** Attendance reports will provide information on Part-Time and Full-Time employees who are currently Active. Employees currently on leave will not be included.
3. **FTE Hours:** During the annual reporting period, each employee will be projected to work a set number of hours based on their FTE (full-time equivalent).

   Example: 0.6 FTE x 2080 hours (annual maximum) = 1248 hours.

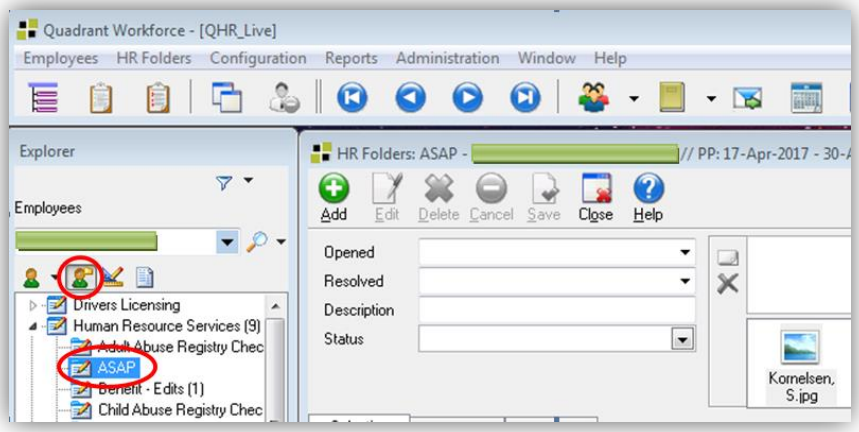
4. **Total Sick:** A combination of Personal, Family and Unpaid time using an employee's Income Protection banks. Unpaid time may include hours where an employee does not have enough income protection available, or if the employee has called in absent on a picked up shift (based on collective agreements).
5. **Sick % on Total Worked:** The attendance report will provide a percentage of absences, based on the total hours worked by the employee during the reporting period. The total hours worked includes all hours in an FTE position, picked up shifts and non-overtime hours.

    Example: 16 hours (total sick) / 239.61 hours (worked hours) = 6.68%.

The percentage presented in the attendance report is intended as a flag to identify possible issues, and should be used in conjunction with the calendar attendance reports available in Quadrant Workforce. This flag may warrant an initial conversation with an employee, may have been previously identified (in the case of a currently active employee who was on leave in the previous year), or may indicate ASAP follow-up is required.

How to Enter Letters into Quadrant Workforce

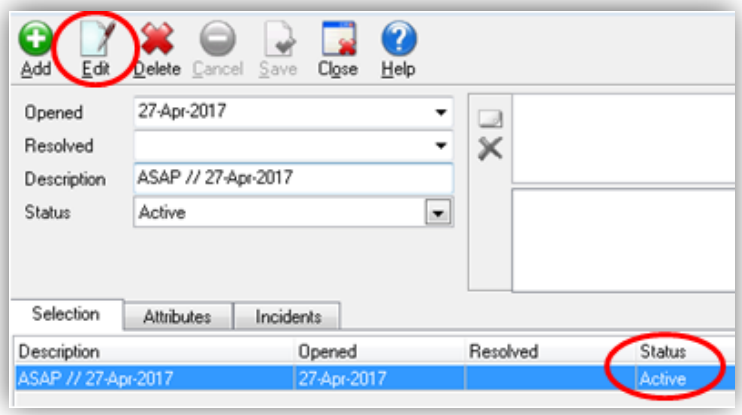
1. Scan and save completed ASAP form and save it as PDF file on your drive.
2. In Quadrant go to **Employee HR Folders → Human Resource Services → ASAP**



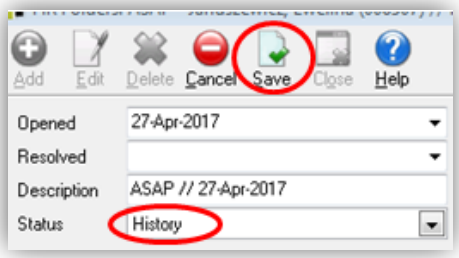
3. Click "**Add**"
    a. Under **Check-In** select the meeting date.
    b. Depending on the ASAP step, enter the meeting date under "**Step # Meeting**" – this will specify employee's current step on the ASAP program.
    c. Select next **Follow Up Date**
    d. Under "Notes" (right top corner of the screen), *right click* inside the second box and click **Insert File**

    e. Select the ASAP PDF file that you saved on your drive, and click **Open.**
    f. Click **Save**

4. To enter a follow up ASAP meeting, open employee's ASAP folder in Quadrant. Select the **Active** file, and click **Edit**



a. Change the **Status** of the previous meeting to **History.** Click **Save.**



NOTE: Always make sure that only one record has **Active status.**

5. Following Step #3, enter a new ASAP meeting by adding a new record. Make sure to enter **Check-In** date and **Step # Meeting** date in order to specify employee's current step on the ASAP program.

Medical Information

In all instances where the employer is contemplating the need for the provision of medical information, there is a need to strike a balance between the employer's right to know against the employee's right to privacy.

The majority of collective agreements in health care contain language that provide for some level of entitlement on behalf of the employer to request medical certificates to substantiate a claim for income protection and/or provide medical information in regard to fitness to return or medical restrictions. It is the managers' responsibility to become familiar with the language contained in collective agreements they are responsible for administering.

The law surrounding the right to request medical certificates and the content of same is constantly changing. Therefore, questions regarding the right to ask for certificates, additional particulars, etc. should be discussed with your Human Resources department.

**NOTE: Generally speaking, the employer is entitled to medical information relating to prognosis of return, date of exam, temporary and permanent restrictions of relevance to the position and expected return date.*

If considering asking for a medical certificate related to use of family related income protection benefits, contact Human Resources.

UNIVERSITY OF MANITOBA | Research Ethics and Compliance

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P126-770 Bannatyne Avenue
Winnipeg, MB
Canada R3E 0W3
Phone +204-789-3255
Fax +204-789-3414

HEALTH RESEARCH ETHICS BOARD (HREB)

CERTIFICATE OF FINAL APPROVAL FOR AMENDMENTS AND ADDENDUMS

PRINCIPAL INVESTIGATOR:	INSTITUTION/DEPARTMENT:	ETHICS #:
Dr. Michael McIntyre	U of M and SBGH/Compassion Project Research	HS22370 (H2018:467)

HREB MEETING DATE (If applicable):	APPROVAL DATE:
	June 4, 2019

STUDENT PRINCIPAL INVESTIGATOR SUPERVISOR (If applicable):
NA

PROTOCOL NUMBER:	PROJECT OR PROTOCOL TITLE:
NA	A Mindfulness Based Intervention as a Key Component of Successful Workplace Functioning and Personal Well-Being (Linked to H2015:320)

SPONSORING AGENCIES AND/OR COORDINATING GROUPS:
Workers Compensation Board of Manitoba

REMINDER: THE CURRENT HREB APPROVAL FOR THIS STUDY EXPIRES: April 3, 2020

REVIEW CATEGORY OF AMENDMENT:	Full Board Review ☐	Delegated Review ☒
Submission Date of Investigator Documents: May 13, 2019	HREB receipt date of Documents: May 22, 2019	

THE FOLLOWING AMENDMENT(S) and DOCUMENTS ARE APPROVED FOR USE:

Document Name	Version(if applicable)	Date
Protocol:		
Protocol	V. 2	04/30/2019
Consent and Assent Form(s):		
Letter of Consent - Consent Form	V. 3	2019-04-30

Other:

CERTIFICATION
The University of Manitoba (UM) Health Research Board (HREB) has reviewed the amendment to the research study/project named on this ***Certificate of Approval*** as per the category of review listed above and was found to be acceptable on ethical grounds for research involving human participants. The amendment and documents listed above were granted final approval by the Chair or Acting Chair, UM HREB.

HREB ATTESTATION
The University of Manitoba (UM) Health Research Board (HREB) is organized and operates according to Health Canada/ICH Good Clinical Practices, Tri-Council Policy Statement 2, and the applicable laws and regulation of Manitoba. In respect to clinical trials, the HREB complies with the membership requirements for Research Ethics Boards defined in

Division 5 of the Food and Drug Regulations of Canada and carries out its functions in a manner consistent with Good Clinical Practices.

QUALITY ASSURANCE
The University of Manitoba Research Quality Management Office may request to review research documentation from this research study/project to demonstrate compliance with this approved protocol and the University of Manitoba Policy on the Ethics of Research Involving Humans.

CONFLICT OF INTEREST
Any Principal or Co-Investigators of this study who are members of the UMBREB did not participate in the review or voting of this study.

CONDITIONS OF APPROVAL:

1. This amendment is acceptable on scientific and ethical grounds for the ethics of human use only. ***For logistics of performing the study, approval must be sought from the relevant institution(s).***
2. This research study/project is to be conducted by the local principal investigator listed on this certificate of approval.
3. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to the research study/project, and for ensuring that the authorized research is carried out according to governing law.
4. **This approval is valid until the expiry date noted on this certificate of approval. A Bannatyne Campus Annual Study Status Report** must be submitted to the HREB within 15-30 days of this expiry date.
5. Any changes of the protocol (including recruitment procedures, etc.), informed consent form(s) or documents must be reported to the HREB for consideration in advance of implementation of such changes on the **Bannatyne Campus Research Amendment Form.**
6. Adverse events and unanticipated problems must be reported to the HREB as per Bannatyne Campus Research Boards Standard Operating procedures.
7. The UM HREB must be notified regarding discontinuation or study/project closure on the **Bannatyne Campus Final Study Status Report**.

Sincerely,

John Arnett, PhD. C. Psych.
Chair, Health Research Ethics Board
Bannatyne Campus

Hôpital St-Boniface Hospital
RECHERCHE • RESEARCH

CONSENT FORM

Title of Study: A Mindfulness Based Intervention as a Key Component of Successful Workplace Functioning and Personal Well-Being

Principal Investigators

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Sponsors: Workers Compensation Board and Catholic Health Corporation of Manitoba

Dear Potential Participant,

You are being asked to participate in a research study. It is unusual in that the study is embedded in a Mindfulness Based Stress Reduction (MBSR) course. This course meets for up to three hours per week and there will be one day of retreat. The actual study will occur in the first and last class. Please take your time to review this consent/information sheet. This consent/information sheet may contain material that you do not understand. You may ask the principal investigators, Dr. Michael McIntyre or Dr. Jennifer Kornelsen, any questions you may have. They may be contacted by phone or by email at the addresses listed above or consulted in person.

Purpose of Study: The research study is being conducted to explore how well-being, mindfulness, and health are nurtured and strengthened in health and human service organizations by MBSR training. We plan to do this by examining how changes in mindfulness, self-compassion, and compassion are related to changes in participants' thoughts about their well-being, and of their attitudes toward themselves and towards

their work. We also plan to study changes in workplace health and attendance records supplied anonymously by the Human Resources Department at your workplace. In addition, we plan to study whether the changes are affected by personality characteristics measured by a short questionnaire.

Study Structure: The study is contained in a MBSR class taught by a teacher certified by the Center for Mindfulness at the University of Massachusetts Medical School. The first class will include the "before" questionnaires and the final class the "after" questionnaires. Both the class and the data collection are integral parts of this study. You, of course, may withdraw from the class/study at any point for any reason. However, you must withdraw from both the class and the study at the same time.

If you agree to participate, you will first read and endorse this consent form. You will be given a participant code so that your name will not appear on any of the experimental materials. In the first session you will be given a set of questionnaires. You will be asked to complete them early in the first class. These questionnaires have been designed to provide data on your thoughts, beliefs, and opinions about your personality, mindfulness, compassion, work, and well-being. For the final step of the study, you will receive a second set of questionnaires in the last class. Data will not contain any identifying information. Your employer will also be asked to provide anonymous health and attendance records for up to two years prior to the MBSR class and up to two years following the class.

Summary of Research Findings: Upon completion of this study, group results will be mailed out to participants approximately seven months following completion of your course. Individual data will not be released.

Risks and Discomforts: The risks associated with MBSR are minimal. The heightened attention developed in the course may result in participants being more attentive to negative aspects of their situation. There is no known harm related to the completion of the experimental components of the study. However, if you feel at risk or wish to discontinue the study at any point in time, you are free to do so. You may also contact your teacher or Dr. McIntyre or Dr. Kornelsen. Likewise, if there are specific questions in the questionnaires you do not wish to answer, you may omit them. In the process of your participation, if you feel uncomfortable, please contact study staff who will refer you to the appropriate services.

Benefits: Participants will receive all the attendant benefits of MBSR training, which is offered without costs to participants. These include many physical and psychological health benefits that have been suggested in scientific research (e.g., increased awareness and concentration, enhanced well-being, and new ways to cope with your own situation), however there is no guaranteed health outcome. Participants may or may not experience therapeutic benefits from participating in the study.

Costs: Participating in the research study is of no cost to the participant.

Payment for participation: You will receive $5 for every class attended. You will receive $10 for attending the full-day retreat. You will receive $50 for completing the questionnaire package at the last class. Total payment for participation is therefore up to $100 and will be payable upon conclusion of the course.

Confidentiality: Information gathered in this research study may be published or presented in public forums, however your name and other identifying information will not be used or revealed. All information collected will be kept in a secure place (locked cabinet and password protected electronic database) for up to 7 years post-publication of the results and for an indefinite period in electronic form, in accordance with the guidelines of the University of Manitoba Research Ethics Review Boards. The master list linking your name and contact information to your participant code will be destroyed as soon as it is no longer needed, and study related documents will bear only your participant code from that point on. At no time will individual responses be reported. The only person who will have access to your name or other personal information is our administrative assistant, who will retain this information for the duration of the study to ensure your payment for participation. Participant names and contact information will be stored in a password-protected computer different from the computer that holds the actual data. The only people who will have access to the numerically recorded data are Dr. Kornelsen and her research assistants. Please understand that we will take all precautions necessary to keep all information collected during the course of this study confidential and your name will not be identified at any time and will not be associated with any published results. None of the test results will be shared with your employer except as fully-anonymous group data.

The University of Manitoba Health Research Ethics Board and/or the St. Boniface Hospital Research Ethics Board may review records related to the study for quality assurance purposes.

All records will be kept in a locked secure area and only those persons identified will have access to these records. If any of the records need to be copied, your name and all identifying information will be removed. No information revealing any personal information such as your name or contact information will leave the St-Boniface Hospital Research Centre.

Voluntary Participation/Withdrawal from the Study: Your decision to take part in this research study is voluntary. You may refuse to participate or you may withdraw from the study at any time with no negative consequences. **It is extremely important to recognize that your employment status IN NO WAY depends on your participation.**

We will tell you about any new information that may affect your decision to continue participation in this study, should that arise.

Questions: If you have any questions about the study as it proceeds, please do not hesitate to contact the study's Principal Investigator, Dr. Michael McIntyre, at mmcintyre@sbrc.ca or 204-235-3206 or Dr. Jennifer Kornelsen, at Jennifer.Kornelsen@umanitoba.ca or 204-787-5658. You may also call the University of Manitoba Health Research Ethics Board at 204-789-3389 if you have any questions about your rights as a research participant.

Public information about this study - *ClinicalTrials.gov* is a website that provides information about federally and privately supported clinical trials. A description of this clinical trial will be available on http://www.ClinicalTrials.gov. This website will not include information that can identify you. At most, the website will include a summary of the results. You can search this website at any time.

Statement of Consent: I have read this consent form. I have had the opportunity to discuss this research study with Dr. Michael McIntyre or with Dr. Jennifer Kornelsen. I have had my questions answered by them in language I understand. The risks and benefits have been explained to me. I believe that I have not been unduly influenced by any study team member to participate in the research study by any statements or implied statements. In addition, any relationship (such as employer, supervisor, or family member) I may have with the study team has not affected my decision to participate. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board and the St. Boniface Hospital Research Ethics Board for quality assurance purposes. This study is funded by a grant from the Workers Compensation Board of Manitoba to the St. Boniface Hospital Research Centre and by the Catholic Health Corporation of Manitoba. It has been approved by the University of Manitoba Research Ethics Board.

By endorsing this consent form, I have not waived any of the legal rights that I have as a participant in a research study. Please provide your consent by responding in the appropriate check box below and returning the form in the stamped return envelope included with this letter. You will be contacted and given information about the details of the course scheduling.

Thank you.

I consent to participate in this study. _____ Yes _____No

I agree to being contacted for future follow-up in relation to this study.
_____ Yes _____No

Name (Print) _____

Signature _____

For Office Use:

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent

Research Team Member: _____

Signature: _____ *Date* _____

Role in the study: [ ] Co-Principal Investigator [ ] Other (specify)_____

FFMQ

Instructions: Please rate each of the following statements using the scale provided. Write the number in the blank that best describes your own opinion of what is generally true for you.

1	2	3	4	5
Never or very rarely true	Rarely true	Sometimes true	Often true	Very often or always true

_____ 1. When I'm walking, I deliberately notice the sensations of my body moving.

_____ 2. I'm good at finding words to describe my feelings.

_____ 3. I criticize myself for having irrational or inappropriate emotions.

_____ 4. I perceive my feelings and emotions without having to react to them.

_____ 5. When I do things, my mind wanders off and I'm easily distracted.

_____ 6. When I take a shower or bath, I stay alert to the sensations of water on my body.

_____ 7. I can easily put my beliefs, opinions, and expectations into words.

_____ 8. I don't pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted.

_____ 9. I watch my feelings without getting lost in them.

_____ 10. I tell myself I shouldn't be feeling the way I'm feeling.

_____ 11. I notice how foods and drinks affect my thoughts, bodily sensations, and emotions.

_____ 12. It's hard for me to find the words to describe what I'm thinking.

_____ 13. I am easily distracted.

_____ 14. I believe some of my thoughts are abnormal or bad and I shouldn't think that way.

_____ 15. I pay attention to sensations, such as the wind in my hair or sun on my face.

_____ 16. I have trouble thinking of the right words to express how I feel about things

_____ 17. I make judgments about whether my thoughts are good or bad.

_____ 18. I find it difficult to stay focused on what's happening in the present.

_____ 19. When I have distressing thoughts or images, I "step back" and am aware of the thought or image without getting taken over by it.

_____ 20. I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.

_____ 21. In difficult situations, I can pause without immediately reacting.

_____ 22. When I have a sensation in my body, it's difficult for me to describe it because I can't find the right words.

_____ 23. It seems I am "running on automatic" without much awareness of what I'm doing.

_____ 24. When I have distressing thoughts or images, I feel calm soon after.

_____ 25. I tell myself that I shouldn't be thinking the way I'm thinking.

_____ 26. I notice the smells and aromas of things.

_____ 27. Even when I'm feeling terribly upset, I can find a way to put it into words.

_____ 28. I rush through activities without being really attentive to them.

_____ 29. When I have distressing thoughts or images I am able just to notice them without reacting.

_____ 30. I think some of my emotions are bad or inappropriate and I shouldn't feel them.

_____ 31. I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadow.

_____ 32. My natural tendency is to put my experiences into words.

_____ 33. When I have distressing thoughts or images, I just notice them and let them go.

_____ 34. I do jobs or tasks automatically without being aware of what I'm doing.

_____ 35. When I have distressing thoughts or images, I judge myself as good or bad, depending what the thought/image is about.

_____ 36. I pay attention to how my emotions affect my thoughts and behavior.

_____ 37. I can usually describe how I feel at the moment in considerable detail.

_____ 38. I find myself doing things without paying attention.

_____ 39. I disapprove of myself when I have irrational ideas

STAI

Instructions: Read each statement and select the appropriate response **to indicate how you feel right now, that is, at this very moment**. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

Not at all	A little	Somewhat	Very much so
1	2	3	4

_____ 1. I feel calm
_____ 2. I feel secure
_____ 3. I feel tense
_____ 4. I feel strained
_____ 5. I feel at ease
_____ 6. I feel upset
_____ 7. I am presently worrying over possible misfortunes
_____ 8. I feel satisfied
_____ 9. I feel frightened
_____ 10. I feel uncomfortable
_____ 11. I feel self confident
_____ 12. I feel nervous
_____ 13. I feel jittery
_____ 14. I feel indecisive
_____ 15. I am relaxed
_____ 16. I feel content
_____ 17. I am worried
_____ 18. I feel confused
_____ 19. I feel steady
_____ 20. I feel pleasant

PANAS

Instructions: This scale consists of a number of words that describe different feelings and emotions. Read each item and then list the number from the scale below next to each word. **Indicate to what extent you have felt this way over the past week.**

Very Slightly or Not at All	Slightly	Moderately	Quite a Bit	Extremely
1	2	3	4	5

_____ 1. Interested	_____ 11. Irritable
_____ 2. Distressed	_____ 12. Alert
_____ 3. Excited	_____ 13. Ashamed
_____ 4. Upset	_____ 14. Inspired
_____ 5. Strong	_____ 15. Nervous
_____ 6. Guilty	_____ 16. Determined
_____ 7. Scared	_____ 17. Attentive
_____ 8. Hostile	_____ 18. Jittery
_____ 9. Enthusiastic	_____ 19. Active
_____ 10. Proud	_____ 20. Afraid

PSST

Instructions: The questions in this scale ask you about your feelings and thoughts during **the last month**. In each case, please indicate your response by placing an "X" over the circle representing **how often** you felt or thought a certain way.

	Never	Almost never	Sometimes	Fairly often	Very often
	1	2	3	4	5
1. In the last month, how often have you been upset because of something that happened unexpectedly?	○	○	○	○	○
2. In the last month, how often have you felt that you were unable to control the important things in your life?	○	○	○	○	○
3. In the last month, how often have you felt nervous and "stressed"?	○	○	○	○	○
4. In the last month, how often have you felt confident about your ability to handle your personal problems?	○	○	○	○	○
5. In the last month, how often have you felt that things were going your way?	○	○	○	○	○
6. In the last month, how often have you found that you could not cope with all the things that you had to do?	○	○	○	○	○
7. In the last month, how often have you been able to control irritations in your life?	○	○	○	○	○
8. In the last month, how often have you felt that you were on top of things?	○	○	○	○	○
9. In the last month, how often have you been angered because of things that were outside your control?	○	○	○	○	○
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	○	○	○	○	○

CBO

Instructions: Please place an "x" over the response which is most applicable to you.

	Never	Seldom	Sometimes	Often	Always
1. How often do you feel tired?	○	○	○	○	○
2. How often are you physically exhausted?	○	○	○	○	○
3. How often are you emotionally exhausted?	○	○	○	○	○
4. How often do you think: "I can't take it anymore"?	○	○	○	○	○
5. How often do you feel worn out?	○	○	○	○	○
6. How often do you feel weak and susceptible to illness?	○	○	○	○	○

	To a very low degree	To a low degree	Somewhat	To a high degree	To a very high degree
7. Is your work emotionally exhausting?	○	○	○	○	○
8. Do you feel burnt out because of your work?	○	○	○	○	○
9. Does your work frustrate you?	○	○	○	○	○

	Never	Seldom	Sometimes	Often	Always
10. Do you feel worn out at the end of the working day?	○	○	○	○	○
11. Are you exhausted in the morning at the thought of another day at work?	○	○	○	○	○
12. Do you feel that every working hour is tiring for you?	○	○	○	○	○
13. Do you have enough energy for family and friends during leisure time?	○	○	○	○	○

	To a very	To a low	Somewhat	To a	To a very

	low degree	degree		high degree	high degree
14. Do you find it hard to work with clients?	○	○	○	○	○
15. Do you find it frustrating to work with clients?	○	○	○	○	○
16. Does it drain your energy to work with clients?	○	○	○	○	○
17. Do you feel that you give more than you get back when you work with clients?	○	○	○	○	○

	Never	Seldom	Sometimes	Often	Always
18. Are you tired of working with clients?	○	○	○	○	○
19. Do you sometimes wonder how long you will be able to continue working with clients?	○	○	○	○	○

SCS

Instructions: Please reach each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale.

Almost never				Almost always
1	2	3	4	5

_____ 1. I'm disapproving and judgmental about my own flaws and inadequacies.

_____ 2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.

_____ 3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.

_____ 4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.

_____ 5. I try to be loving towards myself when I'm feeling emotional pain.

_____ 6. When I fail at something important to me I become consumed by feelings of inadequacy.

_____ 7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.

_____ 8. When times are really difficult, I tend to be tough on myself.

_____ 9. When something upsets me, I try to keep my emotions in balance.

_____ 10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

_____ 11. I'm intolerant and impatient towards those aspects of my personality I don't like.

_____ 12. When I'm going through a very hard time, I give myself the caring and tenderness I need.

_____ 13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

_____ 14. When something painful happens, I try to take a balanced view of the situation.

_____ 15. I try to see my failings as part of the human condition.

_____ 16. When I see aspects of myself that I don't like, I get down on myself.

_____ 17. When I fail at something important to me I try to keep things in perspective.

_____ 18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.

_____ 19. I'm kind to myself when I'm experiencing suffering.

_____ 20. When something upsets me, I get carried away with my feelings.

_____ 21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.

_____ 22. When I'm feeling down I try to approach my feelings with curiosity and openness.

_____ 23. I'm tolerant of my own flaws and inadequacies.

_____ 24. When something painful happens, I tend to blow the incident out of proportion.

_____ 25. When I fail at something that's important to me, I tend to feel alone in my failure.

_____ 26. I try to be understanding and patient towards those aspects of my personality I don't like.

FCS

Instructions: Below are a series of statements that we would like you to think carefully about and then circle the number that best describes how each statement fits you. Please use this scale to rate the extent that you agree with each statement:

Don't agree at all	0	1	2	3	4	Completely agree
			Somewhat agree			

1.	People will take advantage of me if they see me as too compassionate	0	1	2	3	4
2.	Being compassionate towards people who have done bad things is letting them off the hook	0	1	2	3	4
3.	There are some people in life who don't deserve compassion	0	1	2	3	4
4.	I fear that being too compassionate makes people an easy target	0	1	2	3	4
5.	People will take advantage of you if you are too forgiving and compassionate	0	1	2	3	4
6.	I worry that if I am compassionate, vulnerable people can be drawn to me and drain my emotional resources	0	1	2	3	4
7.	People need to help themselves rather than waiting for others to help them	0	1	2	3	4
8.	I fear that if I am compassionate, some people will become too dependent upon me	0	1	2	3	4
9.	Being too compassionate makes people soft and easy to take advantage of	0	1	2	3	4
10.	For some people, I think discipline and proper punishments are more helpful than being compassionate to them	0	1	2	3	4
11.	Wanting others to be kind to oneself is a weakness	0	1	2	3	4
12.	I fear that when I need people to be kind and understanding they won't be	0	1	2	3	4
13.	I'm fearful of becoming dependent on the care from others because they might not always be available or willing to give it	0	1	2	3	4
14.	I often wonder whether displays of warmth and kindness from others are genuine	0	1	2	3	4
15.	Feelings of kindness from others are somehow frightening	0	1	2	3	4
16.	When people are kind and compassionate towards me I feel anxious or embarrassed	0	1	2	3	4
17.	If people are friendly and kind I worry they will find out something bad about me that will change their mind	0	1	2	3	4

18.	I worry that people are only kind and compassionate if they want something from me	0	1	2	3	4
19.	When people are kind and compassionate towards me I feel empty and sad	0	1	2	3	4
20.	If people are kind I feel they are getting too close	0	1	2	3	4
21.	Even though other people are kind to me, I have rarely felt warmth from my relationships with others	0	1	2	3	4
22.	I try to keep my distance from others even if I know they are kind	0	1	2	3	4
23.	If I think someone is being kind and caring towards me, I 'put up a barrier'	0	1	2	3	4
24.	I feel that I don't deserve to be kind and forgiving to myself	0	1	2	3	4
25.	If I really think about being kind and gentle with myself it makes me sad	0	1	2	3	4
26.	Getting on in life is about being tough rather than compassionate	0	1	2	3	4
27.	I would rather not know what being 'kind and compassionate to myself' feels like	0	1	2	3	4
28.	When I try and feel kind and warm to myself I just feel kind of empty	0	1	2	3	4
29.	I fear that if I start to feel compassion and warmth for myself, I will feel overcome with a sense of loss/grief	0	1	2	3	4
30.	I fear that if I become kinder and less self-critical to myself then my standards will drop	0	1	2	3	4
31.	I fear that if I am more self-compassionate I will become a weak person	0	1	2	3	4
32.	I have never felt compassion for myself, so I would not know where to begin to develop these feelings	0	1	2	3	4
33.	I worry that if I start to develop compassion for myself I will become dependent on it	0	1	2	3	4
34.	I fear that if I become too compassionate to myself I will lose my self-criticism and my flaws will show	0	1	2	3	4
35.	I fear that if I develop compassion for myself, I will become someone I do not want to be	0	1	2	3	4
36.	I fear that if I become too compassionate to myself others will reject me	0	1	2	3	4
37.	I find it easier to be critical towards myself rather than compassionate	0	1	2	3	4
38.	I fear that if I am too compassionate towards myself, bad things will happen	0	1	2	3	4

MHLC

Instructions: For each item below, indicate the number that represents the extent to which you agree or disagree with that statement. Please make sure that you answer **EVERY ITEM** and that you indicate **ONLY ONE** number per item. This is a measure of your personal beliefs; obviously, there are no right or wrong answers.

Strongly Disagree 1	Moderately Disagree 2	Slightly Disagree 3	Slightly Agree 4	Moderately Agree 5	Strongly Agree 6

_____ 1. If I get sick, it is my own behavior which determines how soon I get well again.

_____ 2. No matter what I do, if I am going to get sick, I will get sick.

_____ 3. Having regular contact with my physician is the best way for me to avoid illness.

_____ 4. Most things that affect my health happen to me by accident.

_____ 5. Whenever I don't feel well, I should consult a medically trained professional.

_____ 6. I am in control of my health.

_____ 7. My family has a lot to do with my becoming sick or staying healthy.

_____ 8. When I get sick, I am to blame.

_____ 9. Luck plays a big part in determining how soon I will recover from an illness.

_____ 10. Health professionals control my health.

_____ 11. My good health is largely a matter of good fortune.

_____ 12. The main thing that affects my health is what I myself do.

_____ 13. If I take care of myself, I can avoid illness.

_____ 14. Whenever I recover from an illness, it's usually because other people (for example, doctors, nurses, family, friends) have been taking good care of me.

_____ 15. No matter what I do, I'm likely to get sick.

_____ 16. If it's meant to be, I will stay healthy.

_____ 17. If I take the right actions, I can stay healthy.

_____ 18. Regarding my health, I can only do what my doctor tells me to do.

WDS

Instructions: Below are a number of behaviors that may occur in the workplace. Thinking back over the past year, indicate the extent to which you have engaged in each behavior using a 7-point scale:

Never			Occasionally			Daily
1	2	3	4	5	6	7

_____ 1. Made fun of someone at work.

_____ 2. Said something hurtful to someone at work.

_____ 3. Made an ethnic, religious, or racial remark at work.

_____ 4. Cursed at someone at work.

_____ 5. Played a mean prank on someone at work.

_____ 6. Acted rudely toward someone at work.

_____ 7. Publicly embarrassed someone at work.

_____ 8. Taken property from work without permission.

_____ 9. Spent too much time fantasizing or daydreaming instead of working.

_____ 10. Falsified a receipt to get reimbursed for more money than you spent on business expenses.

_____ 11. Taken an additional or longer break than is acceptable at your workplace.

_____ 12. Come in late to work without permission.

_____ 13. Littered your work environment.

_____ 14. Neglected to follow your boss's instructions.

_____ 15. Intentionally worked slower than you could have worked.

_____ 16. Discussed confidential company information with an unauthorized person.

_____ 17. Used an illegal drug or consumed alcohol on the job.

_____ 18. Put little effort into your work.

_____ 19. Dragged out work in order to get overtime.

QSQ

Pre-Intervention Questions:

1. What motivated you to take this course?

_____

_____

_____

2. What (if anything) do you expect to gain from this course?

_____

_____

_____

3. Do you have any prior experience with mindfulness and/or mediation? If so, please describe your past experience:

_____

_____

_____

_____

Post-Intervention Questions:

1. Do you feel that you have benefitted from this course? If so, in what way(s)?

_____

_____

_____

2. Have you noticed any changes in your work life? If so, what changes have you noticed?

3. What are 1-2 takeaway messages of this course, as you understand them?

4. What surprised you about this course?

5. What challenged you about this course?

6. Do you intend to continue your practice? Why or why not?

7. What would you say to a friend or colleague who was considering taking this course? Would you recommend it? Why or why not?

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From: vprio-researchers-bounces@lists.umanitoba.ca <vprio-researchers-bounces@lists.umanitoba.ca> on behalf of Digvir Jayas <Digvir.Jayas@umanitoba.ca>
Sent: 20 March 2020 16:57
To: VPRIO-Researchers@lists.umanitoba.ca
Subject: [VPRIO-Researchers] Research Communique #4: Suspension of Most On-Campus/Field Sites Research, Scholarly Works, and Creative Activities

Dear Researchers:

On March 16th, researchers were sent the first communique regarding the impacts of COVID-19 on research. In that communique principal investigators were instructed to:

- not start new experiments until April 15 and to complete any ongoing experiments with great care with respect to the safety of all research personnel;
- develop a plan to stop all research including field research, should it become necessary to do so; and
- have their plan in place by the close of business (4:30 PM) Wednesday, March 18th.

It is necessary to operationalize the suspension of most on-campus/field sites research, scholarly works, and creative activities during this pandemic that:

- cannot be conducted remotely;
- cannot ensure health and safety requirements of research personnel; and
- might introduce coronavirus (COVID-19) into a vulnerable population.

The expectation is that researchers will continue as much research as possible remotely but only limited research will continue in university research facilities, including off-campus research sites. Researchers who feel that they have exceptional circumstances, should direct their requests to Dr. Digvir Jayas, Vice-President (Research and International).

Requests for exceptions to continue any **Research, Scholarly Works and Creative Activities** in university research facilities, including off-campus research sites and field stations must address the following.

1 Describe why continuing this research is essential. What are the consequences of suspending this work (economic, social, etc.)? Note that you must have all of your ethics protocols and biosafety program approvals in place. New protocols for new research may not be processed except for COVID-19 related research. You should have your lab supplies, etc., in place as well since the purchasing department may not be able to process orders and suppliers may not be able to fill and deliver on orders.

2 Outline in detail your plan for ensuring employee(s) safety. How will the employee get to the lab/field work/research location? What are the procedures for decontaminating the lab after use by a given employee? What is the plan if this (first) employee becomes ill and cannot continue the work? What is the plan if that (first) alternate employee becomes ill and cannot continue the work?

3 Your department head and ADR/RLO must first approve your plan to continue research.

Your plan will then be reviewed by a committee designated by the VPRI and will include the two AVPs and a representative from Office of Risk Management team and/or the Environment Health and Safety Office.

The University understands the impact that this closure will have on your research programs and the granting agencies are aware of it too. The Granting agencies have provided some general updates on their response to COVID-19 and in the next few days they will be providing details of a package of measures to address upcoming grant competitions, ongoing payment of staff from grants, and the impacts of lab closures. They are currently developing mitigation strategies for all immediately scheduled grant competitions and considering approaches for awarded grants including the possibility of extensions.

Please complete the form found here and email it to Digvir.Jayas@umanitoba.ca.

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