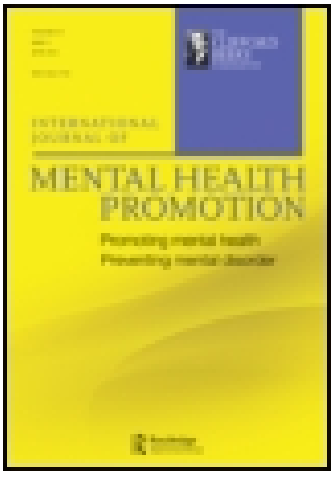

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An integrated approach to workplace mental health: an Australian feasibility study

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An integrated approach to workplace mental health: an Australian feasibility study

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We developed and implemented an integrated workplace mental health promotion intervention combining job stress reduction with a workplace mental health literacy program. The intervention was evaluated using an uncontrolled design, with organizationorganisation-wide census employee surveys of working conditions and mental health literacy pre-intervention, followed by a 1-year action planning and intervention period, then a post-intervention survey. All employees were invited to be surveyed, and all respondents were included in analysis, independent of participation in intervention activities or employment status (44% response rate at baseline, 37% at final). No significant changes were observed in the targeted psychosocial working conditions – job control, job demands, and social support at work. In contrast, significant improvements in some aspects of mental health literacy were observed, particularly in helping behaviours. Acknowledging the limitations of this being an uncontrolled pilot study, our results suggest that it is feasible to integrate job stress and mental health literacy intervention, as well as evidence of sustained improvements in mental health literacy and the need for more intensive and sustained efforts to improve psychosocial working conditions.

Keywords: Mental health, intervention, evaluation, mental health literacy, job stress, work.

Background

Mental health problems are the leading cause of non-fatal disease burden worldwide and in Australia. Mental health problems in Australia account for 24% of total years lost due to disability and are the third largest cause of overall disease burden (Begg et al., 2007; Mathers, Vos, & Stevenson, 1999). Depression and anxiety disorders are the most common mental health problems, with over three million Australians experiencing these in any 12-month period (Australian Bureau of Statistics, 2007). Mental health problems are common in the working population, and represent a growing concern in the workplace, with potential impacts on workers (e.g., discrimination), organisations (e.g., lost productivity) and workplace health authorities (e.g., rising job stress-related claims) (Organisation for Economic Cooperation and Development [OECD], 2012). The costs of major depression alone among working Australians have been estimated at $12.6B nationally per year (LaMontagne, Sanderson, & Cocker, 2010).

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Workplace interventions to address common mental health problems have expanded rapidly in the last decade, particularly as a means to prevent, detect and effectively manage depression and anxiety among employees (Martin, Sanderson, & Cocker, 2009; Sanderson & Andrews, 2006; Wang et al., 2007). In Australia, one of the largest workplace mental health programs was launched in 2004 by Australia's national not-for-profit depression and anxiety initiative, *beyondblue* (Highet, Shann, & Young, 2010). In general, *beyondblue*'s workplace program seeks to improve mental health literacy through education about how to recognise and respond to depression and anxiety disorders in the workplace, to improve knowledge of depression and anxiety disorders as treatable conditions, to destigmatise mental health problems and to develop skills and confidence in how to assist a work colleague or supervisee to seek professional help.

In parallel to the growing awareness of the impact of common mental health problems and the development of mental health literacy and early detection programs, there has been a growing body of international evidence demonstrating that stressful working conditions, such as high job demands, low job control, low social support and imbalance between efforts and rewards at work, have detrimental impacts on mental health (Bonde, 2008; LaMontagne, Keegel, Louie, & Ostry, 2010; Siegrist & Marmot, 2004; Stansfeld & Candy, 2006). Systematic reviews of international intervention studies suggest that improvements in psychosocial working conditions can improve workplace mental health (Bambra et al., 2009; Egan et al., 2007; LaMontagne & Keegel, 2012; LaMontagne, Keegel, Louie, Ostry, & Landsbergis, 2007).

In order to achieve the greatest population mental health benefits, workplace mental health promotion could integrate intervention on work-related risk factors with programs to improve mental health literacy and early detection (LaMontagne, D'Souza, & Shann, 2012; LaMontagne et al., 2014). This article describes the development, implementation and evaluation of an integrated workplace mental health promotion intervention combining job stress reduction with a workplace mental health literacy program.

Methods

Study context

This project was conducted as a partnership between *beyondblue* and a small group of researchers. As such, it was an effort to integrate practitioner and researcher strengths in the development of a workplace mental health promotion strategy. The partnership was formed in response to a call for proposals from an Australian territory government health promotion department (ACT Health, Canberra, Australia) for a 'new approach' to workplace mental health that encompassed the rapidly expanding mental health literacy and early detection programs with job stress prevention and reduction strategies. Representatives from *beyondblue* and a research group jointly prepared a response to the request for tenders and were awarded the contract. Importantly, the study was designed to test the feasibility of developing, implementing and evaluating an integrated workplace mental health program through a practitioner–researcher partnership, and to yield practice and policy as well as research value.

Study design and sample

Intervention effectiveness was evaluated using an uncontrolled design, with organisation-wide census employee surveys of working conditions and mental health literacy pre-

intervention, followed by action planning and intervention (up to 1 year), and a post-intervention survey 1 year after the baseline survey.

The location of the study sites was delimited by the jurisdiction of the funder to the Australian Capital Territory, a small territory that includes the Australian national capital of Canberra. Worksites were recruited to the project through advertisements in the most prominent Canberra-area newspaper (*The Canberra Times*), the Canberra Chamber of Commerce & Industry newsletter and Australian Public Service networks in February 2008. Over 30 organisations expressed interest or made enquiries about participating in the study, and 24 responded formally to the advertisement. Ten were selected for inclusion in April 2008 based on criteria specified by the funder for workplace size and sector: 3 government sector organisations of 200–300 employees, 3 non-government organisations of 200–300 employees and 3–4 small service sector organisations of <100 employees.

Data collection

All employees, regardless of full time, part time, short-term contract or casual/temporary status, in each participating worksite were invited to complete an anonymous survey which included questions on the main targets of the intervention [mental health literacy and psychosocial working conditions (or job stressors)], workplace descriptors and respondent socio-demographics. Surveys were self-administered on paper and returned in postage-paid envelopes directly to the researchers so as to clearly demonstrate the confidentiality and anonymity of the surveys (no individual-level data were shared with employers, and no identifying information was collected).

A post-intervention survey was conducted approximately 1 year after the start of the intervention. The final survey also elicited information on whether respondents had participated in any mental health literacy training or job stress intervention activities.

Measures

Mental health literacy was assessed using survey items developed by *beyondblue* (Highet, Hickie, & Davenport, 2002; Pierce & Shann, 2012) to assess knowledge of depression (three items), attitudes towards people with depression (eight items), knowledge of helping behaviours that could be helpful to someone with a mental health problem (four items), likelihood to enact helping behaviours (six items) and confidence with respect to enacting certain helping behaviours (six items) (these item groups correspond crudely to knowledge, attitudes, behavioural intentions and self-efficacy). Mental health literacy items were analysed individually.

Likert-scaled items from a brief version of Karasek and Theorell's demand-control model were used to measure psychological demand (three items), skill discretion (SD; six items) and decision authority (DA; three items) (Karasek, 1979; Mausner-Dorsch & Eaton, 2000). Data were also collected for supervisor and co-worker support (two items each). Psychological demand score were computed as the sum of the three items multiplied by two, and job control was computed as an equally weighted scale combining SD and DA as follows: [total SD + 2 (total DA)]. The social support at work domain was the sum of two subscales: support from colleagues (two items) and support from supervisors (two items).

Demographic and employment data were collected on sex, age, highest level of educational attainment, level of occupational skill (three categories), duration of employment (less than 2 years vs 2 years of more) and status of employment (permanent full time, permanent part time vs casual, fixed term contract or labour hire).

Worksite intervention

As presented in Figure 1, the general logic of the intervention was that mental health literacy and job stress intervention would improve working conditions and mental health literacy (primary outcomes evaluated), which in turn would improve mental health and work performance (as secondary outcomes, not evaluated).

Following management approval of participation in the project, general staff were informed about the project in group information sessions outlining the project goals and approach before administration of the baseline survey.

Site-specific, tailored intervention action plans were developed for each workplace using participatory methods, including:

- intervention brainstorming and planning meetings with management;
- insight gained from general staff project information sessions;
- full-day Future Inquiry workshops for each workplace, to develop action plans to promote mental health and reduce job stress. The Future Inquiry workshops consisted of a series of facilitated group exercises culminating in the development of site-specific action plans outlining priorities for job stress and mental health promotion intervention (Blewett & Shaw, 2013);

Intervention activities included the following:

- The *beyondblue* National Workplace Program (NWP) was a mental health literacy program that was offered to all worksites. A 2-hour face-to-face workshop was delivered to general staff and a 3-hour workshop was delivered to managers. All sessions were facilitated by a mental health professional with experience delivering workplace training. Both workshops had two parts. The first part of the workshop was psycho-educational which presented the prevalence rates of common mental health problems, signs and symptoms in the workplace, effective treatment and management approaches and included short videos of real people describing their own experiences of managing their depression and anxiety in the workplace. The design of this section reflected other approaches to increasing mental health literacy and reducing stigma (Kitchener & Jorm, 2004). The second part of the workshop was focused on increasing participants' confidence and skills to have conversations

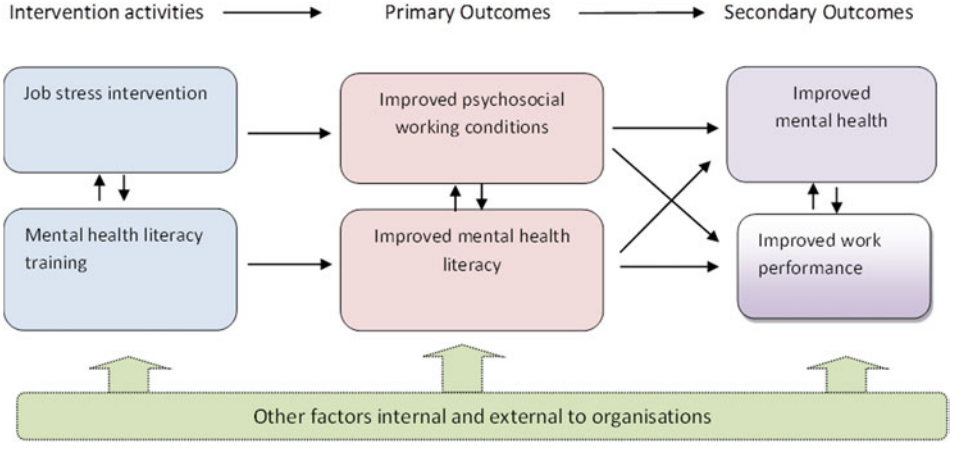

Figure 1. Intervention logic.

in the workplace with people they are concerned about. This utilised case study scenarios to give participants the opportunity to put what they had learnt into practice. The standard NWP sessions were adapted for the project to include expanded coverage of job stress to highlight the links between job stress, workplace mental health and mental health literacy. The manager sessions also covered important legal/regulatory aspects under OH&S, anti-discrimination and employment law.

- Site-specific activities as detailed in action plans;
- Periodic communications between site contacts and the researchers regarding action plan implementation.

Qualitative implementation evaluation

Approximately 6 months into the intervention period, the lead researchers (A.D. LaMontagne and C. Shann) conducted telephone or in-person updates with site contacts to discuss progress with *beyondblue* training and the implementation of action plans generated in the Future Inquiry workshops.

Data analysis

Data from pre- and post-intervention questionnaires were analysed using STATA IC 12 (College Station, TX, USA). We compared pre- and post-intervention results (repeat cross-sectional data) using two-sample *t* tests. A two-sided *p*-value of less than 0.05 was considered statistically significant.

The study protocol was reviewed and approved by the Human Research Ethics Committee of the University of Melbourne (#0722302 and #0824788).

Results

A total of 719 workers from 10 worksites completed the baseline survey (44% response rate), and 640 workers across 9 worksites completed the follow-up survey (37% response rate). One worksite discontinued participation early in the intervention period following the Future Inquiry workshop. There were no significant differences (data not shown) in the baseline and final socio-demographics and employment characteristics measured (Table 1).

Participation in intervention activities varied considerably across sites. Of the 640 final survey respondents, 31% ($n = 199$) reported attending one or more project intervention activity, with the greatest number reporting participation in *beyondblue's* mental health literacy training ($n = 125$). Participation in one or more intervention activity (per respondent, as reported in final survey) ranged from a high of 73% in one site to a low of 17% in another.

Across all sites, a total of 28 mental health literacy training sessions were provided. Most sites ran a single, 2-hour general staff training session and a single 3-hour managers' training session. Larger sites tended to offer more training sessions (one site offered four sessions for general staff and two for managers) and one site did not offer any mental health literacy training, despite repeated offers.

The Future Inquiry workshops yielded site-specific action plans detailing priorities for job stress and mental health promotion intervention. Due to project funding constraints, workplaces were asked to implement their action plans using their own resources

Table 1. Baseline and final socio-demographics and employment characteristics

	Pre intervention		Post-intervention	
	n	%[a]	*n*	%[a]
Gender				
Male	277	39	243	38
Female	432	60	382	60
Age				
18–30	198	28	177	28
31–50	338	47	308	48
51 or older	180	25	153	24
Educational level				
Primary	193	27	147	23
Vocational training	55	8	52	8
Tertiary/postgraduate	465	65	440	69
Occupation				
Manager or professional work	338	47	300	47
Technician or trades worker, community and personal service, clerical worker	333	47	298	47
Machinery operators and drivers; labourers	45	6	40	6
Employment duration				
Less than 2 years	226	32	176	28
2 years or more	478	68	457	72
Employment status				
Perm full or part time	618	87	553	87
Casual, fixed term contract, labour hire	93	13	85	13

Note: [a]Percentages may not equal 100 as there are 'not answered' for some categories.

(excepting the mental health literacy training), supported by periodic telephone or in-person contact with the project investigators. Several of the action plans highlighted the importance of communication in the workplace, and some included aims to up-skill staff and examine how to achieve a more flexible work/life balance. A number of sites underwent restructures during the intervention period and one site (the one that dropped out following the Future Inquiry workshop) had undergone an intensive restructure in the year preceding the project.

Approximately half-way (6 months) into the intervention period, some sites were actively following up their action plans, some appeared to be doing relatively little and most were in between. Of particular note was the experience of a local government park and land management agency. This site illustrates both the challenges and positive impacts of the intervention. Early in the project, the site contact changed and the site wavered in its commitment to the project. After a number of communications between the project team (A.D. LaMontagne and C. Shann) and top management of the organisation, the site re-committed to the project and implemented *beyondblue* training for general staff and managers. The site contact reported that the timing of this training was extremely beneficial, as some trainees were responsible for the supervision of personnel deployed to fight the extreme bushfires in the Australian state of Victoria in February 2009, or were deployed as emergency responders themselves. This was a traumatic experience for these workers (173 Victorian residents died and 414 were injured in these fires), even before the tragic fatality of a Canberra firefighter (employed by the organisation participating in our study) on deployment to fight the fires in

Table 2. Changes in mental health literacy training from baseline to follow-up

	Baseline (%)	Follow up (%)	Change (%)	*p* value
What proportion of Australians do you think experience depression?				
(One in five correct answer)	55	58	3	0.24
Depression and stress are much the same thing (disagree/strongly disagree)	87	85	−2	0.44
Having a stressful job increases the likelihood of depression (agree/strongly agree)*	63	69	6	0.03
Responses to depression				
Keep out of their way and give them space (definitely/probably unhelpful)	75	78	3	0.12
Take them out to the pub for a few drinks to help (definitely/probably unhelpful)*	77	82	5	0.03
Tell them about your worries to help them put things in perspective (definitely/probably unhelpful)	80	78	−2	0.36
Encourage them to take time off work or go on a holiday (definitely/probably unhelpful)	23	25	2	0.48
How likely would you be				
To suggest they get hold of some self-help materials (likely/v likely)*	51	60	9	0.00
To suggest they go to a doctor or other health professional (likely/v likely)	82	84	2	0.20
To assist them to make an appointment with their doctor (likely/v likely)	52	56	4	0.09
To suggest they go to a psychologist/other mental health professional (likely/v likely)*	53	61	8	0.00
To go with them to see a doctor or other health professional (likely/v likely)*	26	31	5	0.02
To follow them up and make sure that they got professional help (likely/v likely)*	61	70	8	0.00
How confident would you be				
To initiate a conversation about how they are coping?	55	59	4	0.17
To disclose a personal experience of not coping?	54	55	1	0.59
To suggest they get hold of some self-help materials?*	45	52	7	0.01
To suggest they go to a doctor, psychologist or other health professional?	58	60	2	0.39
To persist with encouraging them to seek help even if they deny there is a problem*	35	50	15	0.00
To help them make an appointment?*	37	44	7	0.01

Note: *$p < 0.05$.

Victoria. The site contact reported that as a result of the *beyondblue* training managers felt that workers were more willing to discuss the emotional impacts of this experience, and furthermore managers felt better skilled in recognising workers who might be particularly affected, and were more confident about approaching and discussing those experiences with their employees.

Comparison of baseline to final mental health literacy outcomes (Table 2) showed significant improvement in only two of the seven knowledge and attitude items (e.g. that stressful jobs can increase the risk of depression, and that going out for a few drinks may not be helpful). However, there were a greater number of significant improvements in the higher-order helping behaviour outcomes (7/12).

Table 3 summarises observed changes in the psychosocial working conditions (job control, job demand and social support) from before to after the intervention. No significant improvements or negative changes in the measured working conditions were observed.

Discussion

This study demonstrates the feasibility of integrating job stress and workplace mental health literacy training. The intervention was associated with a significant and sustained improvement in mental health literacy, but we found no evidence of improvements in psychosocial working conditions. Given that the intervention was of relatively low intensity – particularly with respect to improving psychosocial working conditions – more intensive and sustained intervention is likely to further improve the impact of mental health literacy training, and could result in improvements in psychosocial working conditions.

We acknowledge certain limitations and strengths of this study. Most importantly, causal inference is limited by the uncontrolled study design (no control/comparison sites) and repeat cross-sectional analysis (did not assess within-person change); such a design, however, is justifiable for a feasibility/pilot study such as this study. Furthermore, the response rates were low. A corresponding strength of the study is that we conducted census surveys of all employees regardless of participation in intervention activities, and analysed the data according to an intention-to-treat approach. Finally, the workplaces that participated in the study were recruited through an advertisement in the local newspaper and as such are a self-selected sample of organisations that are ready and willing to implement workplace mental health programs, thus limiting generalisability. The action planning approach used allowed participating organisations to tailor their responses to general intervention objectives (Hawe, Shiell, & Riley 2004). This participatory approach helps to optimise the fit of the intervention to the context at hand and provides a means for integrating the participant's context expertise with the content expertise of external professionals involved in intervention development (LaMontagne & Keegel, 2012); this is crucial because organisations usually require unique solutions to job stress problems, even if the process of intervention may be based on generic principles and frameworks (Hurrell & Murphy, 1996).

Despite the uncontrolled design, we would argue that the improvements observed in mental health literacy were likely attributable to the intervention because the items were based on the mental health literacy curriculum and there were no observed improvements in the one site that did not implement the *beyondblue* mental health literacy training program (data not shown). The observed improvements are of particular importance in

Table 3. Changes in psychosocial working conditions from pre- to post-intervention

	n	Mean (pre)	*n*	Mean (post)	*P*
Job demands	700	14.85	612	14.70	0.45
Job control	678	24.92	602	25.24	0.29
Coworker social support	712	3.07	636	3.14	0.29
Supervisor social support	710	3.10	635	3.08	0.78

that: (1) there was disproportionate improvement in higher-level helping behaviours over knowledge and attitude outcomes, which is consistent with the likelihood that the participating organisations were self-selected for relatively high awareness levels preceding intervention (i.e. that pre-existing high levels of awareness set the stage for improvements in helping behaviour outcomes); (2) the improvements were observed through a worksite census survey and intention-to-treat analysis (as opposed to pre-survey to immediate post-survey evaluation of training participants only); and (3) observed improvements were sustained at a significant level across most participating worksites for a period of months (training preceded the final survey by at least 3 months), suggesting that mental health literacy training effectiveness may have been reinforced by other intervention activities.

The lack of improvement in psychosocial working conditions was disappointing. This may be explained in part by the low intensity of intervention to improve working conditions. Due to project resource limitations, we only supported the participating organisations through a needs assessment and action planning process, but implementation was left largely to the sites themselves. The time required to effect change in psychosocial working conditions (organisational level change) is also longer than the time required to change knowledge, attitudes and behaviours at the individual level (LaMontagne et al., 2007); thus, it is possible that some positive changes were in train that may have manifested after the time of the final survey. Conversely, a number of participating sites underwent restructures preceding or during the intervention period; and restructures have been shown in most cases to exacerbate psychosocial working conditions and to adversely affect employee mental health (Egan et al., 2007). Furthermore, the intervention period included the onset of the 2008 global financial crisis, which may have also had a negative effect on psychosocial working conditions. Other recent job stress intervention studies with comparison groups have been shown to be effective only in retaining working conditions at baseline levels, with declines observed in comparison sites, as was observed in a study comparing 11 intervention sites to 10 non-intervention controls in a large US retail chain (DeJoy, Wilson, Vandenberg, McGrath-Higgins, & Griffin-Blake, 2010).

Through our recruitment and management consultation observations, we also noted that employers were primarily drawn to participate in the study by the prospect of receiving *beyondblue* training free-of-charge (normally offered on a cost-recovery basis) for their organisations (rather than being attracted by the prospect of job stress intervention). Thus, organisations may have been more 'ready to change' with respect to mental health literacy than job stress intervention, as reflected in our evaluation results (i.e. starting with high knowledge and awareness, but showing significant improvements in higher-order helping behaviours). Taken as a whole, the null findings with respect to working conditions suggest the need for longer follow-up periods to observe intervention-related changes in psychosocial working conditions and the need for more intensive and sustained intervention to achieve such outcomes, as well as the need for study designs to attempt to take into account the ever increasing likelihood of organisational changes that may affect intervention implementation as well as effectiveness (Olsen et al., 2008).

Conclusions and future directions

Improving mental health literacy in the workplace is feasible and often welcomed by workplace gatekeepers. While improvements in psychosocial working conditions may be more difficult to achieve than improvements in mental health literacy, we would argue that

efforts should continue to be made to develop integrated approaches to workplace mental health in order to be true to the Ottawa Charter for Health Promotion in this setting (to address all modifiable determinants of workplace mental health), to respond to legal and ethical mandates for both physically *and psychologically* safe work, and to reduce the burden of work-related mental health problems (Canadian Mental Health Commission, 2013; LaMontagne & Keegel, 2012; LaMontagne et al., 2014).

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