

Presidential Address / Discours du président

# Mental Health in the Workplace: Towards Evidence-Based Practice

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## Abstract

The growing interest in workplace mental health programming has created an unprecedented opportunity for psychology. I describe a comprehensive approach toward workplace mental health incorporating a focus on prevention, intervention, and accommodation. I argue that practice in this area must move beyond advocacy to focus on evidence-based interventions designed to enhance mental health in the workplace.

*Keywords:* mental health, prevention, intervention, accommodation, workplace stress

I come from a long line of short-lived men. Although most of the women in my family live into their late 80s and 90s, the men mostly die before the age of 65. Almost invariably, consistent with heart disease being the leading cause of death in Nova Scotia (Statistics Canada, 2004), they die of coronary heart disease. I have the advantage, however, of being represented by a union and working for an employer that provides a comprehensive list of health care benefits. If, or when, my time comes to have a cardiac “incident” I know that my health care will be paid for, and that I will have access to every form of treatment and rehabilitation required. Moreover, I will use the resources without second thought and can reasonably expect that my colleagues and employers will support me in my journey back to health.

The prevalence rate for depression in Nova Scotia is also high (Latham, 2012). If I develop symptoms of depression, once again my employer and union are there for me with a comprehensive set of benefits that includes the availability of an employee assistance program (EAP), provisions for short- and long-term disability

leave if required and, of course, payment for psychological services. In this case, however, if I am like most employees I will not access these services. When it comes to mental health issues, the resources provided by organizations are typically underutilized (Linnan et al., 2008; Reynolds & Lehman, 2003). EAP programs, for example, are often underaccessed and underutilized (Canadian Medical Association, 2013). Moreover, the people who could often benefit the most from these resources are also the least likely to use them (Hunt & Eisenberg, 2010; Linnan et al., 2008).

Dimoff and Kelloway (in press) suggested several potential reasons for this underutilization of organizational resources: (a) individuals may not recognize that they require a program, service, or resource; (b) individuals may not be aware of what resources are available; or (c) individuals may not use available resources because of other concerns or fears (e.g., stigma). There are signs that at least some of these conditions are changing and, indeed, I go as far as to claim that we currently have an unprecedented opportunity to substantially change the mental health of Canadians for the better. A variety of policy and economic factors have resulted in a “perfect storm” that is changing the organizational landscape with regard to mental health issues. In short, organizations in Canada are getting involved with mental issues to an unprecedented extent and this movement creates both an opportunity and a challenge for psychology as a profession.

## The Perfect Storm

On a policy front, the storm has been brewing for a considerable time. Senator Michael Kirby began a series of investigations into Canadian health care with his initial report on the state of the health care system (Parliament of Canada, 2002). A subsequent report focused more specifically on mental health and mental health care in Canada (Parliament of Canada, 2006). Ultimately this work led to the creation of the Mental Health Commission of Canada (MHCC). Now in its second funding mandate the MHCC has focused on workplace mental health and with their corporate partners (e.g., the Bell “Let’s Talk” campaign) has done much to identify workplace mental health as an area ripe for intervention.

In 2013, the MHCC partnered with the Canadian Standards Association (CSA) to issue CSA Z1003—a Standard for Psychological Health and Safety in the Workplace (Canadian Standards Association, 2013). This is a voluntary management standard that provides guidance to organizations on how to develop a workplace mental health program—that is, the standard identifies what the authors believe are the core elements of such a program and the key considerations in implementing such a program. The MHCC

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has just completed the “case study” project in which 40 Canadian organizations agreed to serve as models during the implementation of the standard and to provide data on the process of implementing workplace mental health programs.

Along with the emerging policy agenda, economic considerations have increasingly pointed toward the need to focus on workplace mental health. The potential economic consequences of mental health problems are well documented and in organizations include consideration of absenteeism, presenteeism, reduced productivity, increased turnover, and host of other organizational behaviors (for a review, see Dimoff, Kelloway, & MacLellan, 2014). Perhaps most strikingly, insurers report skyrocketing rates of “mental health claims” in their long-term and short-term disability leave plans. Some estimates suggest that over 70% of the costs incurred by insurers are attributed to mental health issues.

The convergence of economic and policy considerations has resulted in what I would argue is an unprecedented concern for issues related to workplace mental health. Organizations, as never before in my memory, are looking for solutions, interventions, and programs focused on mental health issues. Consultants and experts of all types have rushed in to fill this void and there is a danger that “doing something” is being confused with “doing what is effective.” Despite extensive research into the causes and correlates of occupational stress and mental health problems, many of the interventions and programs being implemented are, at best, weakly supported by empirical data (Dimoff et al., 2014). In short, we have lots of practice and lots of evidence and very little evidence-based practice focused on mental health issues.

Promulgation of the CSA Z1003 standard in 2013 was a landmark event that provided organizations with a strategy for improving “psychological health and safety in the workplace.” Although the standard is voluntary, one can reasonably expect that adhering to the standard will provide employers with a “due diligence” defense in any potential legal actions and that organizations will have some motivation to implement the standard. Early adopters of the standard have indicated that they see a focus on mental health issues as a being “mission critical.” That is, a focus on mental health is seen as being central to the mission of the organization (e.g., in health care organizations) or as an embodiment of corporate values that focus on the health of employees.

The standard is based on four general principles, requiring organizations to have a corporate commitment to improving psychological health and safety, to have leadership commitment to the issue, to involve employees in the identification of workplace issues and the design of workplace programs, and to ensure the confidentiality of individuals. Beyond these principles the standard implements the “plan do check act” sequence familiar to occupational health and safety practitioners (Kelloway, Francis, & Gatién, 2013). That is, companies are asked to surveil the workplace to ascertain existing conditions, to formulate plans and strategies to improve conditions, to implement these plans, and to monitor progress and adjust as necessary.

The standard has focused the attention of organizations almost exclusively on workplace conditions. The standard identifies 13 environmental features, or workplace conditions, such as psychological support, workplace demands, work–life balance, recognition and feedback, and so forth. The standard does not present a theory of job stress or even define what is meant by psychological health and safety. Rather, the features identified were compiled

based on a review of the organizational literature and similar models have been advanced by the American Psychological Association under the label of a “psychologically healthy workplace” as well as by academics (see, e.g., Kelloway & Day, 2005; Warr, 1987).

Two problems are apparent in the flurry of mental health programming that is associated with promulgation of the standard. First, although many of these organizational efforts are well intended, there is not a strong evidence base that provides guidance as to what are the most effective workplace strategies. In essence, we have convinced organizations to act but are not well positioned to advise them as to what actions to take. Although there is a wealth of data supporting the association of workplace conditions with well-being (see, e.g., A. Day, Kelloway, & Hurrell, 2014), most of these data are derived from the weakest possible research evidence (i.e., cross-sectional, self-report surveys) and there is a marked lack of strong interventions studies showing that (a) we can change characteristics of the workplace and (b) doing so will positively affect employee well-being.

The second problem is that much of the focus has been on what occupational health psychologists refer to as primary prevention activities (e.g., Sauter, Murphy, & Hurrell, 1990). Almost exclusively, the focus has been on identifying and, eventually, changing organizational conditions with the ultimate goal of improving well-being. This is a laudable goal. I believe that the workplace is well suited to address issues of mental health. However, we also know that not all mental health conditions originate in the workplace. I suggest that comprehensive workplace mental health programming must address at least three basic issues—prevention, intervention, and accommodation.

### **The Three Pillars: Prevention, Intervention, and Accommodation**

#### **Prevention**

As previously noted, prevention efforts focus on changing workplace conditions in an effort to positively affect employee well-being. Although one can identify numerous potential areas for change, most of my work in recent years has been focused on changing organizational leadership and, in particular, improving the leadership styles of those who hold formal positions of leadership in organizations. That is, our focus has been on changing the way that organizational leaders treat, and interact with, those that they lead.

The suggestion that the way your leader treats you has an effect on your physical and psychological well-being is hardly novel (data documenting such associations have been available for over 50 years; R. C. Day & Hamblin, 1964). Nor would such a claim come as a surprise to any working adult (Gilbreath, 2004). What may be more surprising is the nature and extent of these effects (Kelloway & Barling, 2010; Mullen & Kelloway, 2011). Leaders affect employee well-being both directly and indirectly. For example, negative interactions with leaders are associated with increased blood pressure during, and following, the work shift (Wong & Kelloway, 2016). Leaders have an indirect effect on employee well-being in that leaders may be a “root cause” of other forms of organizational stress (Kelloway et al., 2005). Thus, lead-

ers who assign excess work or tight deadlines to individuals may exacerbate feelings of role overload or work–family conflict.

We know quite a bit about the specific styles and actions of leaders that affect individual well-being. Having a leader who is abusive (i.e., engaging in “sustained display of hostile verbal and non-verbal behaviours”; Tepper, 2000, p. 178) is associated with increased employee strain (Harvey, Stoner, Hochwarter, & Kacmar, 2007), burnout (Grandey, Kern, & Frone, 2007), and diminished levels of self-esteem (Burton & Hoobler, 2006) and self-efficacy (Duffy et al., 2002). When leaders treat employees unfairly, employees may experience increased rates of psychiatric disorders (Ferrie et al., 2006; Kivimaki, Elovainio, Vahtera, & Ferrie, 2003). There is also a growing body of literature pointing to the negative effects associated with having a “passive” leader at work (for a review, see Skogstad, Einarsen, Torsheim, Aasland, & Hetland, 2007).

In addition to the evidence pointing to negative effects associated with poor leadership, there is also now research suggesting that positive forms of leadership are associated with enhanced well-being. Most of this research has focused on the notion of transformational leadership—the most widely studied leadership theory (Barling, Christie, & Hopton, 2011). Bono et al. (2007) found that transformational leadership behaviors were associated with employees’ sense of optimism, happiness, and enthusiasm. Arnold, Turner, Barling, Kelloway, and McKee (2007) found that employees with transformational leaders experienced their work as being more meaningful and this sense of meaning, in turn, was associated with enhanced well-being. Several subsequent studies have documented similar relationships (e.g., McKee, Driscoll, Kelloway, & Kelley, 2011; Nielsen, Randall, Yarker, & Brenner, 2008; Nielsen, Yarker, Brenner, Randall, & Borg, 2008). These findings led Kelloway and Barling (2010) to suggest that leadership training and development could be considered a health intervention in organizations.

In contrast to a more general lack of intervention studies, there is quite a bit of data supporting the proposition that leadership interventions “work.” Avolio, Reichard, Hannah, Walumbwa, and Chan (2009) provided a meta-analysis of over 200 studies. In the 62 studies that focused on leadership development, the data suggested that leadership skills could be improved. Consistent with these findings, we have consistently shown that transformational leadership can be developed through training (see, e.g., Barling, Weber, & Kelloway, 1996; Kelloway, Barling, & Helleur, 2000; Mullen & Kelloway, 2009). Importantly, this conclusion is based on field experiments in which leaders were randomly assigned to experimental condition with leadership style assessed by the direct reports of leaders. We have consistently shown that leadership training results in improved leadership. Moreover, Barling et al. (1996) showed that increasing leaders’ transformational leadership resulted in increases in employee affective commitment to the organization—a measure that can be considered an assessment of context-specific mental health (Warr, 1987).

Consistent with these data, we (McKee, Driscoll, Kelloway, & Kelley, 2011) recently used a wait-list control design to experimentally evaluate the effectiveness of leadership training on employee well-being. Our results show that when leaders were trained in transformational leadership, their employees reported enhanced psychological well-being. Serendipitously, we also noted that leaders’ own psychological well-being improved as a result of leader-

ship training. Although there is much work left to do, these results suggest that leadership—and potentially other organizational conditions—can be changed to positively influence employee well-being.

## Intervention

To the extent that we can help organizations create better or healthier work environments, we should certainly do so. However, we must also recognize that not all employee concerns originate in the workplace and a sole focus on prevention is not likely to have the kind of effects we are hoping for. Rather, I suggest that there is considerable value in seeing the workplace as a site for intervention. Thus, public health programs aimed at children (e.g., vaccination) may be administered through the school system because that is the easiest way to reach children. Similarly, there is value in targeting mental health issues in the workplace because many adults spend their days in the workplace.

In developing their resource utilization model, Dimoff and Kelloway (in press) proposed that organizational leaders could act as resource facilitators—assisting individuals who were struggling to (a) recognize that additional help was required, (b) identify the resources that were available to them in the organization, and (c) to access those resources. A central assumption underlying this model is that managers were able to identify when individuals were struggling.

As an initial test of this assumption, Dimoff (2016) conducted qualitative interviews with managers who had supervised at least one individual who was experiencing mental health difficulties. The managers identified four types of behavior as cues that an individual was struggling at work: (a) Individuals engaged in negative emotional expressions. They talked about feeling overwhelmed, wanting to quit work or being stressed. (b) Individuals withdrew from social interactions—they stopped going to coffee with others, or did not engage in social interaction in the workplace. (c) Individuals began to miss time at work, phoning in sick, being tardy, or leaving work early. (d) Finally, individuals who were struggling started missing performance targets—missing deadlines, not completing assignments, or turning in poor-quality work. In many cases it was not the behavior per se but, rather, the change in the behavior that signaled that an individual was having difficulties. Moreover, these behavioral manifestations of struggle were both observable by managers and within the managers’ scope of authority. Managers could address these issues not as mental health concerns but as performance/workplace issues. It was clear in the interviews that managers had no interest in diagnosis or in differentiating mental health issues from any other kind of personal struggle—they simply wanted to address the workplace issue and provide access to whatever resources the organization made available (e.g., employee assistance programs, benefits for psychological services).

One way in which organizations have been addressing mental health issues in the workplace is through the growing popularity of mental health or psychological first aid training. Kitchener and Jorm (2002) developed Mental Health First Aid training to teach the public to give initial help to a person who may be developing a mental health problem or experiencing a mental health crisis. Designed to help individuals recognize and provide support for individuals who might be suffering from a mental health condition,

over a decade of research (Kitchener & Jorm, 2002, 2004, 2008) now supports the effectiveness of Mental Health First Aid training in increasing mental health literacy and individual self-efficacy to provide support to others.

We (Dimoff, Kelloway, & Bernstein, in press) evaluated the effectiveness of a workplace-based mental health first aid program targeted at leaders in organizations. Based on our initial discussions with participating organizations, we designed a 3-hr training session designed to teach organizational leaders (a) about the most common mental health problems and issues and (b) what resources (i.e., policies, programs, benefits, contacts) were available through their organizations.

We focused on training leaders for several reasons. First, as previously reviewed we know that the supervisor–employee relationship is important to maintaining positive employee health and well-being (Caveen et al., 2006; Kelloway & Barling, 2010; Wong & Kelloway, 2016). Second, supervisors are typically in frequent contact with employees and in a position to notice variations in workplace behavior. Early detection and intervention improves the prognosis for mental health problems (Craig et al., 2004). Finally, Dimoff's (2016) qualitative data suggest that managers were motivated to help employees who were struggling.

We implemented the Mental Health Awareness Training (MHAT) program in two organizations. In one organization we were able to randomly assign leaders to either an experimental (training) or a wait-list control group. In the second organization, there were some geographic constraints but we were able to use block random assignment to treatment or wait-list control. Our design included pretest, immediate posttest, and delayed (8 weeks) posttests, to assess the effectiveness of the training.

In both organizations a similar pattern of results emerged. Relative to the control group, managers who received the MHAT program demonstrated increased knowledge about mental health issues (Evans-Lacko et al., 2010), improved attitudes toward individuals with mental health problems (Griffiths, Christensen, Jorm, Evans, & Groves, 2004), increased self-efficacy (Chen, Gully, & Eden, 2001) around dealing with mental health issues, and increased intent to promote mental health (Mullen & Kelloway, 2009) at posttest. All of these changes were sustained at the 8-week posttest. In the second organization we were also able to examine the frequency and duration of disability claims for “psychiatric” diagnoses. Although we could not tie these claims directly to the training, we know that posttraining claims were, on average, 18 days shorter with no change in frequency. Moreover, we were able to show that the decreased length of claims occurred in the Atlantic region where the training was implemented and corresponding change did not occur in regions where the training was not implemented.

Dimoff (2016) substantially replicated and extended these findings using a field experiment that showed both leaders and employees experienced more positive outcomes that were related to the intervention. There is, of course, always more work to do to assess intervention efforts in organizations. However, our results suggest that a relatively brief intervention focused on leaders and tailored to the specific resources and policies of the organization can have positive effects on how leaders view mental health disorders and how they intervene with employees who are struggling.

## Accommodation

Perhaps the area of workplace mental health programming that we know the least about is how organizations accommodate individuals with mental health problems. There are two major issues related to accommodation: (a) How do we bring people back to work after a period of disability leave resulting from a mental health disorder? (b) How do we keep people in the workplace rather than having them go off on disability leave? We have a great deal of work to do to figure out both return to work and stay at work interventions that are effective.

There is some guidance to be had from the extensive literature dealing with physical disabilities. A systematic review of the return to work literature (Franche et al., 2005) suggested several practices that lead to successful return to work programs. The availability of alternative work assignments or work accommodations, the use of a return to work coordinator, early and considerate contact with the employee when they go off on leave, and well-established channels of communication between the workplace and health care providers all appear to be related to early and successful return to work. As with other “invisible” injuries, concerns about stigmatization may result in workers not asking for, or taking advantage of, these arrangements. Francis et al. (2014) suggested that the stigma experienced by injured workers experience may be “anti-therapeutic” (Lippel, 1999) and contribute to both failed return to work and chronic disability (Eakin, 2005; Tarasuk & Eakin, 1995). Research in this area suggests that education programs can improve people's attributions about and attitudes toward people with psychiatric conditions (Pinfold et al., 2003). This appears to be an effective approach in the workplace (Dimoff et al., in press).

Thus, although there is a well-developed body of literature speaking to strategies that assist individuals to stay at, or return to, work, more research is required to determine whether these strategies are effective for individuals dealing with mental health concerns. I also note that many of these strategies place considerable onus on employers (e.g., to effect work accommodations or provide additional resources) and require an infrastructure that is may be beyond the means of small businesses. As in other areas of occupational health programming, strategies that are shown to be effective in large companies may not translate easily to small businesses (see, e.g., Kelloway & Cooper, 2011).

## Summary and Conclusion

In recent years organizations have increasingly recognized the need to develop and implement mental health programs in the workplace. This has created both an opportunity and a challenge for psychology as a profession. The opportunity is that organizations are willing, and maybe even eager, to implement programs that are aimed at enhancing their employees' well-being. The challenge is to determine what programs are most effective. I have suggested that a comprehensive approach to workplace mental health would encompass a focus on prevention, intervention, and accommodation and presented some evidence that such interventions along these lines have been effective. Much more remains to be done to establish evidence-based practices in the area of workplace mental health.



## Résumé

L'intérêt grandissant en programmation de la santé mentale en milieu de travail a créé une opportunité inouïe pour la psychologie. Je décris une approche globale en matière de santé mentale en milieu de travail axée principalement sur la prévention, l'intervention et l'accommodation. J'y souligne que la pratique dans ce domaine doit aller au-delà de la préconisation et se concentrer sur des interventions basées sur des données probantes conçues pour améliorer la santé mentale en milieu de travail.

**Mots-clés :** santé mentale, prévention, intervention, accommodation, stress en milieu de travail

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