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Development of guidelines for workplace prevention of mental health problems: A Delphi consensus study with Australian professionals and employees

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Abstract
The purpose of the research was to conduct a Delphi expert consensus study (with employer, health professional and employee experts) to develop guidelines for the workplace prevention of mental health problems. A systematic review of websites, books, pamphlets and journal articles was conducted; a 363-item survey developed; and 314 strategies were endorsed as essential or important by at least 80% of all three panels. The endorsed strategies provided information on: creating a positive work environment; reducing job strain; rewarding employee efforts; workplace fairness; provision of supports; supportive change management; provision of training; provision of mental health education; and employee responsibilities.

Introduction

The 2007 Australian National Survey of Mental Health and Wellbeing (NSMHWB) estimated that mental disorders affect as many as one in five people in a 12-month period (Slade, Johnston, Oakley Browne, Andrews & Whiteford, 2009). Depression, anxiety and related disorders are the most prevalent mental disorders and are among the leading causes of disability worldwide (World Health Organisation, 2008). In addition to social impact, mental disorders can significantly affect workplace productivity due to absenteeism and presenteeism (being sub-optimally productive at work) (Cocker, Martin, & Scott, 2011; Goetzel, Long, & Ozminkowski, 2004; Sanderson and Andrews, 2006).

The ability to work plays a critical role in mental and physical wellbeing (LaMontagne, Keegel, Louie, & Ostry,

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2010; Wilkinson & Marmot, 2003). Work is a primary determinant of socioeconomic position and plays a key role in social connectedness, the development of identity and self-esteem. However, there is strong evidence that a poor psychosocial work environment can increase the risk of mental health problems, particularly depression (Bonde, 2008; Stansfeld & Candy, 2006). Research in this area has focussed on job strain (LaMontagne, Keegel, Vallance, Ostry, & Wolfe, 2008), effort-reward imbalance (Siegrist, 1996) and organisational justice (Kivimaki, Elovainio, Vahtera, & Ferrie, 2003). Interventions that aim to increase employee control have been shown to have beneficial effects on mental health (Egan, Bambra, & Thomas, 2007), For example, problem solving or steering committees comprising employee representatives and managers have led to improvements in measures of mental health in a number of environments including US local government agencies (Landsbergis & Vivona-Vaughan, 1995), the UK Civil Service (Bond & Bunce, 2001) and Canadian hospitals (Bourbonnais, Brisson, & Vinet, 2006). There is evidence that job-stress interventions, particularly those that use a 'systems approach', that is, targeting both working conditions (e.g. task restructuring) and individual skills and behaviours (individual stress management and physical training) are most likely to result in health benefits (Egan et al., 2007; LaMontagne, Keegel, & Vallance, 2007).

Moreover, the workplace is increasingly recognised as an important setting for health promotion, not only to address health problems caused by work, but also to address non work-related problems that may become visible or be exacerbated within the working environment (LaMontagne, Noblet, & Landsbergis, 2012; Martin, Sanderson, & Cocker, 2009; Sanders & Crowe, 1996). Until relatively recently, much workplace health promotion activity has focussed on physical, rather than mental health promotion (Sturgeon, 2006) and the literature on the prevention of mental health problems in the workplace is relatively limited. In a recent systematic review of workplace (secondary) prevention studies that used control groups and assessment of depressive disorder with a validated screening instrument, Dietrich, Deckert, Ceynowa, Hegerl, and Stengler (2012) identified only one (French) study that met the inclusion criteria. This gap in evidence is particularly striking in the Australian context, as the majority of research has been carried out in Europe and the US, which have different health and occupational health and safety (OHS) regulatory frameworks. However, some evidence suggests that workplace interventions may produce improvements in mental health literacy (Kitchener & Jorm, 2004) and reduce depression and anxiety symptoms. In a 2009 study, Martin, Sanderson, Scott, and Brough (2009) systematically reviewed workplace interventions that aimed to reduce symptoms of depression and anxiety in participants, some of whom had diagnosed disorders. Over half the interventions used psychoeducation with cognitive behaviour therapy or training in coping skills within a stress management framework, while the others focused on physical activity, poor work environment and cardiovascular disease. A meta-analysis of 17 studies showed small but positive overall effects of the interventions on symptoms of depression and anxiety.

In addition, implementation of research findings in workplace policies and practices remains a significant challenge. While evidence of the effectiveness of interventions may be increasing, workplace health researchers often struggle to effectively communicate research findings to workplace decision-makers. In turn, workplace practices may not adequately inform research. Such knowledge exchange, which incorporates the idea of knowledge as a changing set of understandings shaped by both researchers and users, is increasingly recognised as an effective means of taking up research information (Greenhalgh, Robert, Bate, Kyriakidou, Macfarlane & Peacock, 2004). It involves engaging decision makers in all relevant sectors and represents a move towards viewing practice-based evidence as equally relevant as evidence-based practice (Marmot, 2004).

In this context, assessing expert consensus offers a way of bringing together available research evidence and best practice in order to enable recommendations and decisions to be made. Such methods have been widely applied in the development of clinical practice guidelines. The most commonly used consensus method is the Delphi process (Jones & Hunter, 1995), which has been used to develop mental health first aid guidelines using the expertise of professionals, consumers and carers (Jorm, Minas, Langlands, & Kelly, 2008; Kelly, Jorm, Kitchener, & Langlands, 2008; Langlands, Jorm, Kelly, & Kitchener, 2008). In a workplace setting, the Delphi consensus method has also been used to develop guidelines for organisations supporting employees returning to work after an episode of anxiety, depression or a related mental health problem (Reavley, Ross, Killackey, & Jorm, 2012).

This aim of the study was to develop guidelines for organisations wishing to implement a strategy for workplace prevention of common mental health problems (depression and anxiety disorders), encompassing mental health problems that may be caused by work, and also those that may become apparent in the working environment. Once established, the guidelines may be used to facilitate the development of preventive policy and practice in the workplace setting.

Materials and methods

The Delphi method

The Delphi process involves a group of experts making private ratings of agreement with a series of statements, feedback to the group of a statistical summary of the ratings, and then another two rounds of rating (Jones & Hunter, 1995). Statements about workplace strategies to prevent mental health problems were derived from a search of the lay and scientific literature, and these were presented to a panel of experts in three sequential rounds. Any additional strategies suggested by panel members were included in the subsequent round for all experts to rate. A summary of group ratings was fed back to the panel members after the first two rounds. Panel members could choose to either change or maintain their ratings. In this way, a list of statements that had substantial consensus in ratings was developed, and those statements with low or conflicting ratings discarded.

Panel formation

There were three separate panels. One comprised consumer advocates representing the employee perspective, who