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Original Article

Examples of Holistic Good Practices in Promoting and Protecting Mental Health in the Workplace: Current and Future Challenges

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ABSTRACT

Background: While attention has been paid to physical risks in the work environment and the promotion of individual employee health, mental health protection and promotion have received much less focus. Psychosocial risk management has not yet been fully incorporated in such efforts. This paper presents good practices in promoting mental health in the workplace in line with World Health Organization (WHO) guidance by identifying barriers, opportunities, and the way forward in this area.
Methods: Semistructured interviews were conducted with 17 experts who were selected on the basis of their knowledge and expertise in relation to good practice identified tools. Interviewees were asked to evaluate the approaches on the basis of the WHO model for healthy workplaces.
Results: The examples of good practice for Workplace Mental Health Promotion (WMHP) are in line with the principles and the five keys of the WHO model. They support the third objective of the WHO comprehensive mental health action plan 2013–2020 for multisectoral implementation of WMHP strategies. Examples of good practice include the engagement of all stakeholders and representatives, science-driven practice, dissemination of good practice, continual improvement, and evaluation. Actions to inform policies/legislation, promote education on psychosocial risks, and provide better evidence were suggested for higher WMHP success.
Conclusion: The study identified commonalities in good practice approaches in different countries and stressed the importance of a strong policy and enforcement framework as well as organizational responsibility for WMHP. For progress to be achieved in this area, a holistic and multidisciplinary approach was unanimously suggested as a way to successful implementation.

1. Introduction

Mental health is incorporated as an important element in the definition of health provided by the World Health Organization (WHO): "A state of complete physical, mental and social wellbeing and not merely the absence of disease." [1]. This definition focuses on a holistic approach, which brings together physical, mental, and social health. It pertains to two main ideas: there is no health without mental health, and health is not just the absence of illness. Mental health has been conceptualized as *a state of wellbeing* where the individual realizes personal abilities, is able to cope with life's stressors, can be productive, and contributes to the community [2–6]. Work-related determinants of mental health are embedded in the physical and psychosocial work environment [7]. Psychosocial hazards in the workplace include aspects of work organization, design, and management such as a heavy workload, lack of control, unsuitable job roles, poor interpersonal relationships, and lack of career prospects and development [8]. Quality of life, optimal health, mental health and wellbeing in the workplace are critical issues, considering the fact that people spend 15.7–25.4% of their time per year at work (Organization for Economic Co-operation and Development statistical facts on working hours with a minimum of 1,381 working hours in a year for The Netherlands, and a maximum of 2,226 working hours in a year for Mexico) [9].

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As a result, WHO has stressed the urgency to advance mental health [10–12] due to the impact of mental ill health on individuals of any age [13,14], organizations, and society overall. However, addressing mental health in the workplace has not received enough prioritization and it has been concluded that there is a gap between knowledge and policies (where available) and real-life practice, which needs to be analyzed and managed [15,16]. Mental health in the workplace has been a *Cinderella subject* for a long time: phenomenally accepted but practically neglected [17]. In recent decades initiatives to address this gap have been implemented either through workplace health promotion programs or psychosocial risk management [16]. The WHO Comprehensive Mental Health Action Plan (CMHAP) 2013 states as implementation options to "Promote work participation and return-to-work programmes for those affected by mental and psychosocial disorders," and to "Promote safe and supportive working conditions, with attention to work organizational improvements, training on mental health for managers, the provision of stress management courses and workplace wellness programmes and tackling stigmatization and discrimination." [6].

Workplace health promotion (WHP) and psychosocial risk management are two overarching approaches to improve employees' health, safety, and wellbeing, which incorporate mental health promotion and mental ill health prevention [16,18]. WHP is a combination of various efforts from employers, employees, and the community in favor of maintaining wellbeing. These efforts include empowerment of individuals and resilience building, the development of personal health resources and the implementation of wellness programs [19]. Mental health promotion is a basic part of WHP, which needs to be addressed in order to ensure employee wellbeing [5,20,21].

By contrast, psychosocial risk assessment and management are vital ways to identify and control psychosocial risks in order to protect employees' physical and mental health. Psychosocial risk management in the workplace is underpinned by legislation in many countries [22]. Appropriate and adequate policy formulation for mental health protection and promotion considerably enhances the level of success for initiatives that include psychosocial risk management [16].

The WHO Healthy Workplaces Model (MHW) has been developed on the basis of the WHO global plan of action on workers' health (GPA) and is in line with the WHO CMHAP [3,6]. Specifically, the MHW stresses the importance of effective leadership, workplace mental health promotion (WMHP)/mental ill health prevention, strengthening evidence and research (evaluation and assessment). The model additionally stresses the importance of tackling psychosocial risks as they are highly linked to poor workplace mental health (WMH) [23], the provision of personal health resources in support of mental health, and enterprise community involvement, with a view to promote employee wellbeing and work–life balance from a wider perspective [3,21].

The MHW is based on five keys: leadership engagement; workers' involvement; ethics; continual improvement; and integration. It proposes that the development of a healthy workplace should be underpinned by the engagement of key stakeholders including leaders, employees, and their representatives [3,24,25]. Attention is paid to the importance of ethics and compliance with legislation as the first step of good practice [26]. The importance of evaluation and continual improvement is highlighted since adaptation in relation to new needs increases effectiveness [27]. The last key element is coherent and comprehensive integration as a vital part of an effective implementation [28].

The current study is guided by the key objectives of the WHO model for healthy workplaces/the GPA for workers' health, and the CMHAP. The aim of the study was to identify initiatives/tools, which are aligned with the five keys and process of the MHW, and gather knowledge and expertise on good practices on WMHP. The aim was to summarize commonalities across countries, highlight barriers that need to be tackled, and conclude on opportunities for future improvement.

2. Materials and methods

The study was structured in two parts and lasted 5 months in total. The first part included scientific and gray literature reviews to identify the initiatives. The second part was based on semi-structured interviews with experts with good knowledge of the identified initiatives.

2.1. Selection of initiatives

The current study aimed to support the development and establishment of the MHW audit tool for the WHO in order to assess progression towards healthy workplaces following the GPA and CMHAP objectives. Only initiatives/tools in line with the MHW have been included. Eleven good practice initiatives/tools for WMHP were selected. The authors attempted to provide a balanced perspective across countries and WHO regions; however, that was not always feasible due to a lack of tools in some countries and/or WHO regions. The selection process was not exhaustive as tools at organizational level (single cases) were excluded. The aims were: to gather a sufficiently representative number of initiatives; identify good practices and commonalities amongst different countries in the WHO regions; and investigate the way of promoting and protecting workplace mental health [29,30]. The results of the scientific and gray literature review were cross-checked with those of another study [29]. The final choice of initiatives was made according to the predefined criteria of inclusion. A literature search protocol was used, based on selection criteria for addressing WMH [31,32] including: (1) initiatives in line with the MHW; (2) initiatives at national level; (3) initiatives at sectoral and interorganizational level (implemented by many organizations in the country); (4) focus on mental health promotion and mental ill health prevention; (5) workplace focus; (6) no single interventions but holistic initiatives; and (7) already implemented.

2.1.1. Search strategy

The search was conducted in two parts. The first part included electronic and library searches for the academic literature and both electronic and hard copies of the available material. The second part was the gray literature search, which was mainly performed by using online databases, search engines, and websites (see below). After gathering all the required sources and information, a data synthesis was conducted in order to identify initiatives across WHO regions based on the protocol. Initiatives were identified in the Americas, the European region, the African region, the Western Pacific region, and South-East Asia, but none in the Eastern Mediterranean region. In addition, we tried to reduce reporting biases by avoiding duplicating studies while searching through multiple databases. We also tried to prevent biases stemming from the language barrier by trying not to exclude information in languages other than English [31].

2.1.2. Academic literature

The academic literature search was conducted in two parts. The first part included electronic searches, which were performed by using the following online databases for relevant articles (including internet based searches): PubMed, Medline, Global Information Full Text (provided by the WHO), EBSCO, ApaPsyNET, ApaPsyInfo, Nexis, Applied Social Sciences Index and Abstracts, the Cochrane Library,