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Effectiveness of MH-Guru, a brief online mental health program for the workplace: A randomised controlled trial

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ABSTRACT

Background: Depression and anxiety interfere with an individual's quality of life and result in substantial economic costs to the workplace through lost productivity. The internet offers an unparalleled opportunity for the large scale, cost-effective delivery of mental health awareness and destigmatisation programs in the workplace. However, to date high quality assessments of the effectiveness of such workplace programs have been confined to health professional settings. The current study reports the effectiveness of Mental Health Guru (MH-Guru), a two-module online mental health workplace induction program.

Methods: A total of 507 employees from a large multi-departmental government workplace were randomised to a 2-week online depression and anxiety educational program (Mental Health Guru; MH-Guru), or a Wait List Control condition. Participants completed online surveys at baseline, 1 week post-intervention and at 6-month follow-up. Primary outcome measures included depression and anxiety literacy, personal stigma about depression and anxiety, and help seeking intentions for anxiety and depression at post-test. Secondary measures included help-seeking attitudes and self-reported help seeking behaviour. Satisfaction measures were also collected.

Results: Dropout at post intervention was 26.7% and 21.0% for the MH-Guru and Control conditions respectively. Relative to Control, MH-Guru participants showed significantly greater improvements in depression and anxiety literacy at post intervention. Between group standardized effect sizes at post-test and 6-months were 0.78 and 0.81 for depression literacy and 0.80 and 0.79 for anxiety literacy. Compared to the Control participants, the MH-Guru group also showed significantly greater reductions in depression and anxiety personal stigma. Between group effect sizes in stigma for depression were −0.56 and −0.47 at post-test and 6-months respectively and −0.42 at both time points for anxiety. The MH-Guru intervention was not associated with a differentially greater increase in anxiety or depression help-seeking intentions or improvement in help seeking attitudes compared to the Control group. However, self-reported help-seeking behaviour was significantly greater in the MH-Guru group at post-test. In addition, the MH-Guru group showed greater intentions to seek help for depression from the Internet at 6-month follow-up. Satisfaction items suggested that the program was acceptable to employees.

Conclusions: Brief online programs such as MH-Guru have the potential to play an important role in increasing mental health awareness and decreasing stigmatizing attitudes in the workplace, and by extension the general community.

1. Introduction

Mental disorders are the leading cause of disability burden worldwide accounting for 23% of all years lived with disability (Whiteford et al., 2015). Globally the cost of mental illness in 2010 was $US 2.5 trillion, a figure which has been projected to increase to $US 6 trillion by 2030 (Bloom et al., 2011). A major component of these costs is attributable to lost work productivity due to absences from work and 'presenteeism'. For example, lost work productivity and compensation claims due to mental illness have been estimated to account for $11 billion in Australia and $102 billion in the USA (Greenberg et al., 2015).

Currently mental illness is the subject of substantial stigma. For example, 20% of respondents in a national stigma survey in Australia reported that they would not employ a person with depression and a similar percentage indicated that they would not work closely with a person with depression (Griffiths et al., 2006). Stigma not only further compromises the mental health of people with a mental illness but also serves as a barrier to seeking help for mental ill-health (Barney et al., 2006). Poor mental health literacy (lack of knowledge about

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mental ill-health, its diagnosis, management, treatment and prevention (Jorm et al., 1997) also mitigates against help seeking (Gulliver et al., 2010).

In a recent meta-analysis we reported that online programs are as effective as face-to-face interventions in reducing stigma in the community (Griffiths et al., 2014). There is also evidence that online educational programs can improve mental health literacy (e.g., (Griffiths et al., 2004, Kiropoulos et al., 2011)) in the general community and there is increasing interest in the potential for online applications to promote help seeking for mental ill-health. Such programs are scalable in theory. However, the implementation of online programs among adults in the general community presents challenges given that there are few drivers to promote their uptake.

The workplace presents a unique opportunity to deliver public health programs which address stigma and mental health literacy and promote help seeking, for three reasons. First, a significant percentage of the adult population are members of the workforce. Secondly, since the employer pays the employee for their time, if the former determines that staff should undertake a work-place mental health awareness program it is likely that the employee will do so. Finally, the employer has strong financial motivation to engage with measures that might reduce the high economic cost of mental health problems in the workplace.

However, such programs, if they are to be implemented must be evidence-based. Surprisingly, to our knowledge, except for programs focused on educating health practitioners or health trainees (Rosen et al., 2002, Bayar et al., 2009, Irvine et al., 2012a, 2012b) there have been no randomised controlled trials of the effectiveness of internet-based passive educational interventions for delivering improved mental health knowledge, attitudes and help seeking outcomes in the workplace.

Accordingly the current study sought to investigate the effectiveness of Mental Health Guru (MH-Guru), a brief online universal workplace educational program about depression and generalised anxiety. Based on the empirical evidence cited above, MH-Guru was designed to increase anxiety and depression literacy, decrease negative attitudes to these conditions, provide advice to supervisors and colleagues to assist co-workers with mental ill-health and promote help seeking.

2. Method

The study employed a two-armed randomised controlled trial design with outcome measurements at baseline, post-intervention and 6-month follow-up. The trial was approved by The Australian National University Human Research Ethics Committee (Protocol 2013/387) and registered with the Australian and New Zealand Clinical Trials registry (ANZCTRN 12613001083785).

2.1. Participant recruitment and setting

Participants were 507 employees from a large Australian multi-department government organisation in Australia comprising 20,921 employees. The organisation provided its written consent to participate in the trial with approval provided by the Executive of the organisation. Employee interest in the trial was generated through a recruitment strategy comprising emails, in-house newsletter articles, presentations and "top-down" management encouragement and support. All advertising materials contained a link to the study website which provided detailed information about the scope and nature of the trial. Employees who opted to proceed completed a series of online questions to indicate informed consent after which the employee was enrolled in the trial and referred to the online baseline assessment survey. Recruitment of individual employees took place over a 5-month period from July 2014 to November 2014.

All employees of the organisation who were aged at least 18 years were eligible to enrol in the trial. There were no other exclusion criteria.

2.2. The trial conditions

Participants were assigned either to the online Mental Health Guru intervention or a Wait-List control.

2.2.1. Mental Health Guru (MH-Guru)

The intervention program is an online psychoeducation workplace induction program scripted by the first author and developed by the Australian National University. MH-Guru comprises two modules, the first focused on depression and the second on generalised anxiety disorder. Each module takes approximately 30 min to complete and is comprised of information about the condition including its prevalence, symptoms, how to identify if a person is depressed, a symptom checker, treatments, risk factors, myth busting, advice to supervisors, advice to colleagues of a person with depression/anxiety and sources of help. The program is presented in a simple multi-media, interactive format containing graphics and in-program exercises. Video vignettes of consumers with lived experience of depression or anxiety reinforce the program content and were incorporated as a proxy form of contact since there is some evidence that contact may be an effective intervention for decreasing stigma (Cooper et al., 2003).

Participants were invited to complete one module of MH-Guru per week.

2.2.2. Wait-List control (Control)

During the trial period, participants in the control condition were asked to complete the study online surveys only. This group was free to access professional mental health care during the wait-list period. Control participants were offered the opportunity to complete the MH-Guru program after the 6-month trial period.

2.3. Procedure

Participants completed the baseline measure online in week 1 after which they were allocated to either the MH-Guru or the Wait List Control condition (see randomisation procedure below). Those allocated to the intervention condition were invited by automated e-mail to access the MH-Guru Depression module in Week 2. A further automated email was sent in Week 3 inviting intervention participants to access the MH-Guru generalised anxiety disorder module although participants were required to complete the depression module before they could access the anxiety module. In Week 4 participants in both the MH-Guru and Wait List control conditions were invited by automated email to access and complete the post-intervention assessment. Invitations to complete the 6-month follow-up assessments were also sent via automated email to participants in both conditions. All emails contained a link to the study portal where the participant was able to log on using their username and password to access the relevant program module or assessment. Participants who failed to access the post-intervention or follow-up assessment within one week of the initial request were sent a reminder email, followed if necessary by a further reminder email one week later.

Participants were advised that their employer had agreed that they could complete the surveys and intervention during work hours. However, they were also provided the option of completing the study at home, if they preferred. The program was delivered from a server at the Australian National University. All assessment data were collected online on the ANU server.

Participants could seek technical support from the ANU research team. The protocol required the trial manager to contact an in-house clinical psychologist should a participant contact them in distress. One participant eventually randomised to MH-Guru was followed up by the psychologist as part of this process.