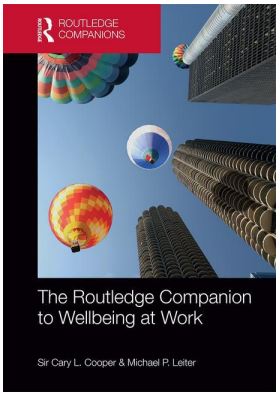

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Determinants of mental health in the workplace

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Determinants of mental health in the workplace

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Introduction

> [M]ental health in the mainstream of public policy have demonstrated, mental health policy is no longer limited to a segregated enclave under the direction of a specialized bureaucracy. It has moved into the mainstream across a wide range of public policy dimensions.
>
> *(Goldman, Sherry, & Alegria, 2009, p. 1215)*

Declining mental health is an endemic global phenomenon. The magnitude and nature of this affliction has societal, organizational, and individual implications, given that mental health has no geographic, cultural, or organizational boundaries. According to the World Health Organization (2013), at least 450 million people suffer from mental health problems in both developed and underdeveloped countries. The United Nations estimates that 25% of world's population experience a mental health episode during their lifetime, which is both a cause and a consequence of major socioeconomic problems such as poverty, compromised education, gender inequality, ill health, and violence, among others (United Nations, 2010). Globally, some 3%–4% of the Gross National Product is estimated to be spent on problems related to mental health within the workplace (World Health Organization, 2003). Eventually, the hidden cost of mental health in the workplace is likely to be far greater in terms of lost individual performance and organizational productivity. Clearly, urgent attention and action are essential to help curb this problem.

Dealing with poor mental health in society should be viewed equally as a policy and workplace problem. Typically, one in 10 employees are estimated to suffer from depression, anxiety, stress, or burnout in the European Union, United States, Canada, and Australia during their working lives (Gabriel & Liimatainen, 2000). Accumulated evidence suggests that work environments contribute to a range of mental ailments across a wide spectrum of employment settings (e.g., Lim, Kim, Kim, Yang, & Lee, 2010; Love, Edwards, & Irani, 2010; Pasca & Wagner, 2012; Puig et al., 2012; Travers & Cooper, 1993). Hence, a major responsibility of finding solutions to mental health afflictions inevitably rests with organizations where these arise. The real issue facing organizational decision-makers is not whether they have to deal with mental health issues but rather *how* they can best tackle this growing problem in the context of limited resources.

Whilst there is considerable literature indicating the problems are inherent within organizations, one promising avenue of research in explaining how to address mental health issues relates to how positive actions can yield both desirable individual wellbeing and effective organizational outcomes (e.g., Cameron, Mora, Leutscher, & Calarco, 2011; Gabriel & Liimatainen, 2000). Affirmative action in wider societal settings is known to help improve the mental health of individuals in the workplace (e.g., Hickie, 2004; Pirkis et al., 2005), suggesting similar organizational initiatives and interventions can help contribute to the wellbeing of those suffering mental health symptoms and disorders. Initiatives by organizations to improve the mental health of their workforce will have correspondingly positive societal ramifications. Healthy workforces signal a healthy society. Hence policy and managerial decision-makers both stand to gain through collective action designed to improve individual mental health in the workplace.

In this respect, policy and organizational initiatives are akin to two sides of the same coin. Accordingly, both policy and organizational stakeholders need to be cognizant of the impact mental health potentially has within and on each person's sphere of influence, in developing and implementing effective strategies directed at improving the situation. With that notion specifically in mind, the main aim of this chapter is to synthesize the literature to help contextualize the impact of mental health on and within organizations in light of policy decisions and/or actions pertaining to mental health. As mental health has no physical boundaries (Kitchener & Jorm, 2004), the variety of mental health afflictions will also permeate many facets of people's lives such as the workplace, societal institutions, and broader society. We develop a conceptual framework (Figure 5.1) that unravels the link between these and the four elements of mental health, namely personal wellbeing, coping, symptoms, and disorders. Based on our review of extant literature, we posit these four elements influence and are strongly influenced by aspects of organizations, governments, and wider society. To the best of our knowledge this is the first time such an approach has been adopted in the extant literature. Through this framework we are able

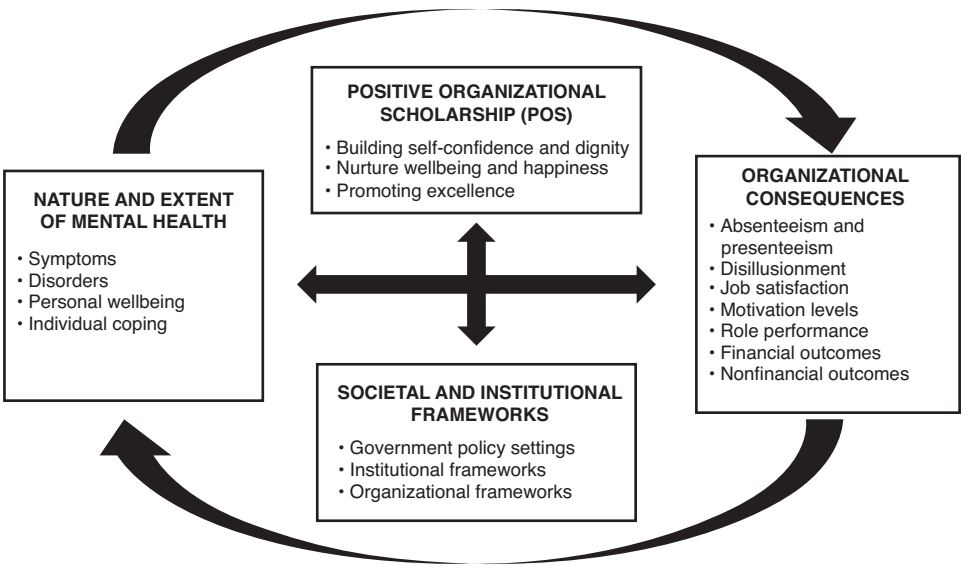

Figure 5.1 Interaction of Nature and Extent of Mental Health, Organizational Consequences, Positive Organizational Scholarship, and Societal and Institutional Frameworks

to infer how mental health problems in society have a range of consequences for organizations. Similarly, mental health problems in organizations impact on society. Within the framework, the potential links between these domains are suitable for testing. In all, the conceptual framework helps to provide a better understanding of the potential role that government, societal entities, and organizations can play in helping to deal with issues concerning mental health.

Our framework synthesizes the various strands of research and thinking about mental health in the workplace and identifies areas for testing constructs and their inter-relationships. Central to our argument is that the domains of Nature and Extent of Mental Health, Positive Organizational Scholarship (POS), Societal and Institutional Frameworks, and Organizational Consequences are intertwined. An understanding of the interactive effects of these domains will place decision-makers in an optimal position to find solutions to these growing workforce and societal mental health problems. In the sections that follow, we explore the magnitude and cost of mental health problems within society and the workplace; links between POS and mental health; the "happier-and-smarter" and "sadder-but-wiser" hypotheses; societal and institutional frameworks that impact on mental health; and finally the contribution, implications, and future research directions of mental health.

We used a simple methodology to identify the relevant extant literature suitable for analysis. Google® and Google Scholar® were scrutinized using the following keywords: mental health, public policy, conceptual, framework, organization, wellbeing, consequences, Positive Organizational Scholarship, workplace, world health organization. A substantial number of high-quality reports into mental health were identified from countries in Europe, the United Kingdom, the United States, Australia, and Canada. The websites of other credible international organizations concerned with mental health were also closely examined, including the International Labour Organization, World Health Organization, and the US Department of Health and Human Services. We now turn our attention to defining mental health before reviewing the relevant literature on mental health in society and the workplace.

Theoretical background

Defining mental health

From a macro perspective, "mental health" refers to the state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and an ability to adapt to change and to cope with adversity (US Department of Health and Human Services, 1999). This comprises four elements that reflect both positive (*personal wellbeing* and *coping*) and negative (*symptoms* and *disorders*) dimensions – influenced by individual factors, social interactions, societal structures and resources, and cultural values (Korkeila et al., 2003). Disorders are those health conditions characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning (US Department of Health and Human Services, 1999).

Warr's Vitamin model (1986, 1987, 1994, 2007) provides a more focused description of mental health in relation to work. This model synthesizes prior research and theories about job-related mental health to develop an evidence-based integrated model of mental health in the workplace context. More recently, Warr (2007, p. 132) introduced 12 features of jobs and environmental categories that underlie job-related affective wellbeing: opportunity for control, opportunity for skill use, externally generated goals, variety, environmental clarity, contact with others, availability of money, physical security, and valued social position; and supportive supervision, career outlook, and equity. In this context, *stress* and *burnout* are used predominantly to describe afflictions linked

to work outcomes, whereas mental health and depression are context-free (see Hosie & Sevastos, 2010). In fact, *stress* is not generally regarded as a medical condition, whereas depression and anxiety are (Cooper, 2005). This illustrates that the mental health problem is quite complex to define and conceptualize, let alone address. We do not, however, propose to articulate the various forms of mental illness but rather to provide an overview of the nexus between the various afflictions, society, and the work environment. Therefore, our purpose is to provide a framework that encapsulates these aspects so employers and policy-makers can better contemplate their role in helping to reduce mental health problems in the workplace. In doing so, we aim to provide a suitable platform for future empirical research into this growing problem and subsequently provide potential solutions.

Cost of workplace mental health

Mental health problems in the workplace are not a new phenomenon. It is worth noting that hidden, or indirect, costs of mental health place additional burdens on the consequential public monies in areas of social care, education, housing, criminal justice, and social security systems (Knaap, 2003). Whether this is attributed to real increases in the incidence of such problems or simply improved reporting and documentation methods will always be a point for debate. What is not in dispute is that the direct as well as indirect costs of mental health have been on the rise for decades. In this regard, there is an unequivocal body of evidence that the global financial cost from negative aspects of mental health is debilitating for both industry and society. The estimated cumulative global economic output lost to mental disorders will amount to US$16.3 trillion between 2011 and 2030 (Bloom et al., 2011). This cost has increased significantly over the last few decades and is predicted to substantially increase into the future, and is not bound by geography.

For example, more than a decade ago, the cost of stress at work, and related mental health problems in the European Union alone was estimated to average between 3% to 4% of Gross National Product, amounting to a €265 billion cost annually (Levi, 2002). During 2000, a survey of the then-15 EU member states found over half of their total 160 million workers reported having a very high incidence of sick leave, citing stress and mental strain as the principal reason (World Health Organization, 2005). In United Kingdom, stress, depression, or anxiety was the largest contributor to the overall estimated annual days lost due to work-related illness (Tasho, Jordan, & Robertson, 2005). The British economy lost approximately 3.5% of Gross National Product per annum, equating to £40 billion per year on stress-related illness (Toohey, 1995). In the same period, work-related stress alone cost businesses and governments across the European Union about €20 billion in absenteeism and related health costs. These estimates do not even include the costs of lower productivity, higher staff turnover, and reduced ability to innovate (Konkolewsky, 2004).

Typically, in the United Kingdom time off work for stress related illnesses has increased by 500% since the 1950s. In 2003, more than half a million Britons believed they experienced work-related stress that made them ill (Jones, Huxtable, Hodgson, & Price, 2003). At least 5% of all British workers found their job either very or extremely stressful. These stress levels translated into an estimated average of 28.5 working days lost in each year per affected worker, making this type of ailment very costly for the British economy. More recent UK data indicates a growing problem in terms of both the overall economy and public costs. Typically, around 42% of people claiming work related benefits are diagnosed with mental health conditions, up from 28% since 1997 (Hay, 2010). The UK Royal College of Psychiatrists estimated that up to 30% of British employees experience mental health problems. The question of cause and effect on mental health in the workplace still remains largely unresolved. Despite this, about one in every 20 working-aged

Britons experience major depression at any given point in time (Gabriel & Liimatainen, 2000) and this evidently impacts on public funds and industry.

In an Australian context, mental health disorders are the third largest contributor to the overall cost burden of disease (Begg et al., 2007). Depression alone is very widespread, whereby 20% of Australians are estimated to suffer from the affliction (Beyondblue, 2008; Rosenberg & Hickie, 2013). In an earlier study, Goldie (2004) notes that time off work for mental illness–related compensation claims averaged 96.1 days of lost productivity, compared to 28.9 days for other health claims. Brammall (1999) reported work-related stress claims for compensation in Australia rose from 1.7% in 1985–1986, to 5.1% in 1997–1998. During the time of this study, work-related stress claims were estimated to double in the period 1992–1997, costing the economy in excess of AUD$200 million annually. An estimated $5.9 billion is attributable to workplace distress in Australia, with to cost of depression costing in the order of $12.6 billion (Fels, 2016).

Current expenditure was almost AUD$6.9 billion (or $309 per person) for the 2010–2011 period, an increase from $238 per person since 2006–2007 (Australian Institute of Health and Welfare, 2013). Recently, an estimated 1.9 million Australians (9% of the population) received mental health services during 2010–2011, including 15 million mental health related general practitioner visits in 2011–2012 (Australian Institute of Health and Welfare, 2013). Similar patterns are observed in the United Kingdom, United States, and Canada.

In North America during 2009–2010, Oliffe and Han (2014) report that approximately 78% of short-term and 67% of long-term disability claims were mental health related. Clinical depression is one of the most common illnesses in the United States, with costs estimated to range between US$30 billion and $44 billion per annum to treat (Gabriel & Liimatainen, 2000). These authors also report that one in 10 working-age US adults became affected with the ailment each year, resulting in a loss of approximately 200 million working days. The overall cost from depression to US businesses amounts to around US$25 billion a year in absenteeism and low productivity, and a further $15 billion for treatment (Moskowitz, 1998).

Clearly, attitudes towards the problem need to change: a failure to take responsibility for employee wellbeing will have both a wider long-term as well as a more immediate range of negative consequences for organizations. In fact, employers have a duty to take care of their employees in the workplace to protect them from injuries derived through physical and/ or psychological wellbeing (Cooper & Cartwright, 1994). In this respect, it is largely immaterial whether poor mental health and associated costs were: (1) directly caused by the work environment, (2) brought into the work environment from preexisting conditions, or (3) a combination of both. Irrespective of the attribution, when viewed through the employer lens, reduced mental health levels within the workforce lead to losses in employee productivity and performance. From a productivity vantage, let alone a legal and moral stance, it makes perfect sense for organizations to play a greater role in helping find solutions to these seemingly intractable problems. Given the nature of the mental health challenge, it is evident that the best approach for them to take would be to ensure organizational policy and procedures concurrently serve the best interests of both organizations and their employees.

POS and mental health

Based on the previous discussion, we argue that shifting focus to explore the positive view of the mind (Cameron & Caza, 2004; Snyder & Lopez, 2002) has potential to contribute to explaining how organizations can respond to many mental health challenges. This approach should also help inform managerial actions designed to simultaneously serve organizational and employee interests. Our argument extends the POS domain, which helps explain and predict the

occurrence, causes, and consequences of issues concerning individual, group, organizational, and mental health. We reinforce the main thrust of POS in relation to mental health as it underpins the logic inherent in this chapter.

POS is the study of dealing with positive "outcomes, processes and attributes of organizations and their members" (Cameron, Dutton, & Quinn, 2003, p. 4). While not grounded in any particular theory, POS draws on theories, models, and constructs that help explain how human excellence within organizations can be encouraged. POS can help explain the positive actions that employers can take to improve the mental health of their employees. Typical examples of POS studies include recognizing the impact of positive affect, organizational citizenship behaviors, psychological capital, and prosocial behavior within organizations (Avey, Nimnich, & Pigeon, 2010; Baruch, O'Creevy, Hind, & Vigoda-Gabot, 2004; Castro, Douglas, Hochwarter, Ferris, & Frink, 2003; Mayfield & Taber, 2010; Sun, Aryee, & Law, 2007).

POS attempts to explore how individuals' quality of life can be enhanced, particularly those who work within and are affected by organizations (Roberts, 2006). POS is conceptualized in terms of caring, compassionate support, forgiveness, inspiration, fostering respect, integrity, and gratitude, as well as the creation of meaningful work (Cameron et al., 2011). It can help explain how organizational decision-makers can assist in the rehabilitation of individuals suffering from poor mental health, because the elements in POS identified by Cameron et al. (2011) cut across many of the areas in the literature depicted to help improve mental health and individual wellbeing. For example, the well-established positive association between workforce participation and elevated psychological wellbeing (Dooley, Fielding, & Levi, 1996; Mathers & Schofield, 1998) indicates the merit of adopting a POS approach to improving individual mental wellbeing.

Such practice and scholarly endeavors in relation to POS focus on understanding those dynamics associated with and leading to developing human strength that produces resilience, restoration, and vitality. Through this activity, employers can cultivate extraordinary individuals, units, and organizations. POS helps focus our attention on understanding how decision-makers can increase the *positive* rather than reducing all problem solutions to examining the *negative* within organizations (Caza & Caza, 2008). Based on studies and evidence cited, it is apparent that organizations are not only central to help finding societal mental health solutions but in doing so will also need to take a more proactive approach. This necessitates organizations take positive affirmative action. Whilst we do acknowledge the critics of POS (e.g., Fineman, 2006; Held, 2004), as research in this domain potentially yields individual and organizational benefits associated with managerial POS action, this body of knowledge simply cannot be ignored.

Work by Cameron et al. (2011) reveals that POS practices help enhance organizational performance levels, which they attribute directly to amplifying (creation of positive emotions), buffering (enhancing resilience, solidarity and efficacy) and heliotropic (attraction towards positive energy) effects of such managerial action. Psychological capital, defined as "an individual's positive psychological state of development," has a positive effect on an employee's role performance and job satisfaction levels, both of which are strongly associated with mental wellbeing, and this provides a further indication of the role of positivity within organizations (Luthans, Avolio, Avey, & Norman, 2007, p. 542). On a similar trajectory, earlier work by Bagnall (2004) observed that although unhappiness (which is intrinsically negative) may be a much more interesting phenomena to research, happy people do better in almost every sphere of life. For example, Lyubomirsky, King, and Diener (2005) found that happy people tend to acquire more favorable life circumstances that engender success – a condition that holds across multiple life domains, such as marriage, friendship, health, and job performance.

Clearly, there is merit in building programs within the work setting designed to stimulate and foster happiness and positivity among employees. The potential organizational benefits of

cultivating these are well documented (Pressman & Cohen, 2005; Seligman & Csikszentmihalyi, 2000), indicating that organizations should help to propagate happiness, wellbeing, courage, citizenship, healthy work, and healthy working relationships. We conceptualize such positive action within the workplace in terms of actions designed to enhance self-confidence and dignity, nurturing wellbeing and happiness, and to promote employee excellence. Collectively, these comprise elements of the POS domain within our framework (Figure 5.1). The literature strongly indicates that the key to unlocking an individual's full potential and subsequent mental wellbeing is through such forms of constructive managerial actions.

Critics argue that the POS approach is merely self-centered on the part of decision-makers (e.g., Fineman, 2006; Roberts, 2006), but we advocate this positive method has merit for a number of reasons. Any effort to help reduce individual suffering can, and should, be a prime organizational concern. Put more directly, it is time all the bad news about diminished mental health and consequences in the workplace is countervailed by good news stories. Such a viewpoint clearly falls under the auspices of POS. Initiatives such as beyondblue and Mental Health First Aid (MHFA), in Australia, are excellent examples of positive action taken within the wider community context. These efforts consistently show that increased mental health knowledge and decreased stigma contribute to individual empowerment to help others within the community (Hickie, 2004; Menhenhall & Jackson, 2013).

Indeed research in occupational psychology centers on incorporating happiness, wellbeing, courage, citizenship, and satisfaction with healthy work and healthy relationships (Cameron et al., 2003; Keyes & Haidt, 2003). There is growing resistance in psychology to be obsessing over the dark side of human existence – in favor of effort being directed towards a more positive view of the mind (Cameron & Caza, 2004; Snyder & Lopez, 2002). Such intense enthusiasm for POS is naturally balanced with the countervailing experience of emotional darkness (Jung, 1933), simply because nurturing a positive environment does not mean an absence or the total elimination from suffering. Both belong to the human narrative. Seligman (cited in Hosie and EIRakhawy, 2014, 122) tempers the case for POS by recognizing this potential duality: "By working on mental illness we forgot about making the lives of relatively untroubled people happier, more productive and more fulfilling. We didn't develop interventions to make people happier; we developed interventions to make people less miserable." Such conceptualization suggests that addressing mental health can be approached from either the "positive" or "negative" vantage as either is simply attempting to provide a remedy for either side of the same coin.

"Happier-and-smarter" and "sadder-but-wiser"

Herein it is posited that interest in "happier-and-smarter" ("enthusiasm-naivety") and the "sadder-but-wiser" ("depressive-realism") hypotheses (Staw & Barsade, 1993) is synonymous within the broader context of research efforts directed towards POS. In this regard, Staw and Barsade's (1993) "happier-and-smarter" and the "sadder-but-wiser" hypotheses are considered integral to any discussion pertaining to POS. These authors found a positive relationship between dispositional affect and employee performance. However, Weiss and Cropanzano (1996) contend these positive emotional responses are inclined to produce decrements in performance. These authors reason that activities resulting from a negative state are more extensive and constantly disruptive than those stemming from a positive emotional state. A "depression-realism" effect indicates depressed people may sometimes make more accurate judgments compared to their less-depressed counterparts. In this conceptualization, emotional behaviors have the potential to facilitate, to interfere, or simply to be unrelated with behaviors in the job domain (Weiss & Cropanzano, 1996). Indeed, reactions to negative events produce stronger reactions than the reactions to positive experiences (Taylor, 1991).

Individuals experiencing positive moods are more likely to engage in simplified heuristic processing when making judgments and decisions (Sinclair & Mark, 1992). In contrast, those individuals experiencing a negative mood are likely to be more prone to utilizing systematic information-processing strategies. Individuals reporting negative affect tend to focus attention on improving the quality of decisions made (Forgas, 2002; Schwarz & Bless, 1991). Perhaps this is because people with negative affect are more sensitive to organizational reality, where "depressive realism" effects depressive tendencies that avoid a range of biases, such as optimism (Lichtenstein, Fischoff, & Phillips, 1982; Martin & Stang, 1978) and the illusion of control (Langer, 1975). As such, individuals who are less positive exercise more accurate information processing (Weiss & Cropanzano, 1996). For example, a person with depressive tendencies is less likely to overestimate his or her capacity to deal with ambiguous task circumstances (Tabachnik, Crocker, & Alloy, 1983). Such a counterintuitive position regarding the possible decrements in performance resulting from the emotion-performance relationship is likely to be contentious. The pursuit of microconcerns of positive and negative affect in the workplace needs to be connected with the macroconcerns and initiatives of society.

Overall, a common theme has emerged from the experience of dealing with mental health policy, namely the critical importance of engaging a wide array of stakeholders in the development and success of national policy and frameworks. In Australia, for example, all three tiers of government have usually been responsible for mental health policy, program, and services. Moreover, there is considerable overlap between service provision between the government, private, and not-for-profit sectors. These services are delivered either directly or by outsourcing to private agencies capable of providing enduring holistic solutions (Rosenberg & Hickie, 2013). Evidence to date suggests that the most effective solutions are provided by community organizations, not government. Rosenberg and Hickie (2013) made the case for the emergence of collaborative and coordinated care in response to this challenging public policy issue. As with any consumer-based system, they argued that collaborative care needs to provide integrated options capable of providing effective delivery systems. In this scenario, new models of "joined-up services" delivery needs to informed by existing and emerging evidence of what is effective for consumers of mental health solutions. Mental health needs to overcome the existing "policy silos" to overcome a complex system that is "characterised by fragmentation and inconsistency" (Rosenberg & Hickie, 2013, p. 16).

Societal and institutional frameworks that impact mental health

There are personal and environmental determinants of poor mental health that include an individual's attributes and interactions; sociocultural, economic, political, and environmental factors, such as national policies, social protection, living standards, working conditions; and community support mechanisms (World Health Organisation, 2013). With these in mind, the World Health Organization developed the Mental Health Action Plan 2013–2020 to promote global mental wellbeing, provide care, enhance recovery, promote human rights, and reduce mortality, morbidity, and disability for persons with mental disorders (World Health Organisation, 2013). This plan is based on a number of recommended universal principles that can be tailored to member states to ensure consistency with their national priorities and specific circumstances. There is no universal grand plan to solve global mental health problems, as countries are at different stages in developing and implementing policy responses for this growing problem. For example, between 76% and 85% of people received no treatment for their mental disorder in low-income and middle-income countries, whereas this ranged between 35% and 50% for high-income countries (World Health Organisation, 2013).

Some governments have already taken steps through programs designed to promote the mental wellbeing of their citizens. For example, the Australian National Mental Health Commission Strategies and Action Plan 2012–2015 has been developed to monitor and report on the state of mental health in Australia. Although still in its infancy, the plan comprises a national reporting card, benchmark of performance, identification of key priorities and data gaps, and an evaluation mechanism to chart progress against a 10-year roadmap promoting improved mental health. One of the successful spin-offs of the strategy was the formation of the independent, not-for-profit public entity beyondblue, with key priorities that include: (1) increasing awareness of depression and anxiety; (2) reducing stigma and discrimination; (3) improving help seeking; (4) prevention and early intervention; (5) reducing impact, disability, and mortality; and (6) facilitating learning, collaboration, and research (beyondblue, 2013). At inception this national collaborative model was initially funded by the Federal and Victorian Governments, with $17.5 million each year over five years. Beyondblue now attracts funding from other state governments in partnership with a range of businesses, educational, and community organizations.

Another Australian initiative is the Mental Health First Aid (MHFA), which developed courses in 2000 that are offered by the Centre for Mental Health Research, Australian National University. The main reason for the program was to help those many suffers in workplaces who wait far too long before seeking help. MHFA aims to increase public recognition of the early warning signs and symptoms pertaining to anxiety, depression, psychotic disorders, and substance abuse disorders (see www.mhfa.com.au). It is a direct type of affirmative action and specifically targets sufferers. The course has been so successful that it is now replicated worldwide (Menhenhall & Jackson, 2013; Terry, 2010; Zilnyk, 2010). MHFA has also been shown to be quite versatile in terms of its adaptability to cater to a range of settings that include different countries and targeted employment initiatives (Jorm & Kitchener, 2011). MHFA has the capacity to be tailored to align with the various national and state level priorities and capabilities in each jurisdiction. Major MHFA outcomes include increased mental health knowledge, decreased stigma, and increased confidence in helping persons with a mental health crisis (Menhenhall & Jackson, 2013). By increasing mental health literacy through the course, members of the public (and work colleagues) can provide initial help in acute mental health crisis situations, as well as emotional support, for those experiencing mental illness before professional help can be sought.

Experiences of the role of national frameworks and platforms in the prevention of mental health such as beyondblue and MHFA are not unique to Australia. For example, during 2003–2004, Canadian health care experts and economic policy leaders declared their first-ever Business Year for Addiction and Mental Health forum. Through this forum a charter was developed that was aimed at mobilizing key stakeholders (namely trade unions and employers in the private and public sectors) through national and international efforts, and was aimed at preventing the debilitating effects of workplace depression, anxiety, and addiction. The Mental Health Commission of Canada has subsequently developed a national standard to provide a systematic approach to developing and sustaining a psychologically healthier workplace (Mental Health Commission of Canada, 2013). The Canadian plan comprises three strategic pillars – namely prevention, promotion, and resolution – designed to reduce the incidence of 13 workplace factors known to contribute to poor mental health. Similar to the Australian frameworks, this particular initiative also casts the net wide in terms of engaging stakeholders in the debate by including unions, employer groups, and employers, among others. Involvement from leaders of such entities are crucial to ensure the psychological wellbeing of the work force (Gilbert & Blisker, 2012). Inputs and support from these stakeholders are tantamount for such programs to gain traction.

Conceptual framework and contributions

Drawing upon existing frameworks described in previous sections, we posit that organizational actions, depicted through POS and various national policy frameworks and initiatives, and encapsulated by the Societal and Institutional Frameworks, are highly interdependent. The effects of these domains on one another and their moderating powers in the recursive relationship between mental health and organizational consequences are reflected in our conceptual framework. Through this we offer an overarching perspective on how to juxtapose mental health within organizations and wider society. Specifically, the escalating incidence of poor mental health in society permeates many facets of people's lives, creating numerous challenges. The individual's mental wellbeing has become analogous to the workplace and society. In an effort to help understand the problem, we have synthesized the literature and articulated a framework that contextualizes the nature and extent of poor mental health in the context of these domains. The main scholarly contribution of this approach is fivefold.

First, it offers a unique insight into mental health problems. Adopting this perspective has made it possible to juxtapose the institutional influencers of mental health. These were modelled in terms of domains comprising Nature and Extent of Mental Health, POS, Societal & Institutional Frameworks, and Organizational Consequences.

Second, the framework reveals the critical importance of understanding how the interactive effect of policy settings and managerial action plays a critical role in finding solutions to this problem. By inference, a joint government-organizational action has the potential for a greater impact on poor mental health than unilateral and/or independent efforts of either party. Such interaction is also envisaged to potentially comprise other stakeholders, such as employees, employer groups, industry bodies, and unions. We do not specifically discuss these stakeholder contributions in detail in this chapter, but the evidence shows how valuable their inputs are with respect to the many known mental health challenges (Hickie, 2004; Mental Health Commission of Canada, 2013).

Third, in line with calls from the International Labor Organization and the World Health Authority and other entities, the framework indicates that an organizations response (or lack of) to the mental health challenge is central to finding solutions to this conundrum. Since organizations are seen to be both the *source* and proposed *solution* to the mental health problem, they need to shoulder more of the burden for finding solutions. In that regard, their actions can have positive or negative consequences for both the firm and wider society. Thus, the moderating effects of POS and Societal and Institutional Frameworks potentially enhance (dampen) the positive (negative) outcomes. Our synthesis of the literature reveals that a healthy workforce usually equated to a healthy society, and vis-à-vis, so affirmative action by organizations under the auspices of POS is depicted herein to have widespread benefits.

Fourth, available studies in this domain are largely descriptive in nature, thus developing and testing appropriate cause-effect models with pertinent constructs would be most beneficial. This is because research findings would potentially help policy and organizational decision-makers decide on *how* and *where* they can direct their limited resources to achieve maximum effect.

Fifth, there appears to be no systematic examination in the extant literature as to what types of workplaces (and role types) lead to the recursive relationship between mental wellbeing and organizational consequences. Since this nexus may vary across work settings, the blanket view taken in the literature to designate the link between poor mental health and the workplace is not ideal. Clearly, a typology comprising various professions and the mental health consequences of each work setting is worth exploring in more detail. This would help employers become more vigilant in ensuring its decision-makers are cognizant of mental health problems, their

likely consequences for the individual and organizations, and perhaps more importantly, what they can do about these problems. However, lessons still need to be learned on how to prepare organizations to deal with growing cases of aliments such as stress, depression, and anxiety in the workplace.

Ultimately, the framework developed in this chapter could be used to help decision-makers determine which job roles are more susceptible to mental health problems. This would enable them to identify high-risk employees and determine precisely what remedial action needs to be taken. Potentially this would minimize the wasteful use of limited resources in trying to develop programs for nonexistent problems.

Sixth, the framework indicates how affirmative action, under the semblance of POS, can help improve the mental wellbeing of employees. Various forms of "positive" action are cited in the literature but none appear to be specific to the context of mental health. Thus, identifying and testing an effective compendium of positive action specific to this setting that could help improve mental health within the workplace research-praxis priorities. The success of MHFA program shows the value in proactive action on mental health outcomes (Menhenhall & Jackson, 2013; Terry, 2010; Zilnyk, 2010) but since research may uncover a much wider range of policy and practice options in the repertoire of the framework for dealing with this line of inquiry merits further investigation.

On a final note, whilst the principal aim of this research was to provide a framework to help articulate mental health problems in the workplace, we have also uncovered a range of managerial implications. In the first instance, managers should recognize that the sheer scale and scope of poor mental health within society means that it will inevitably afflict their work environment. This means organizational decision-makers also need to play a role in formulating viable solutions to the problem. Executives and managers need to realize that they are in a unique position to influence key stakeholders because their actions can contribute towards and potentially help reduce mental health problems. On the basis of our synthesis of the literature, the most effective approach would be to take a proactive stance and develop positive action in conjunction with government and other stakeholders. Failure to do this would inevitably result in a further increase in the incidence of mental health in the workplace and this would ultimately put more pressure on the public funds. In order to take corrective action, policy-setters are then likely to take legislative measures that would have the effect of transferring the cost burden and responsibility of ameliorating mental health back onto the employer. Therefore, it is in organizations' best interests to take the leadership in breaking the vicious cycle between poor mental health, the workplace, and society.

Directions for future research

In addition to its scholarly contributions, our framework can serve as a platform for guiding future research. Potential trajectories include at least four avenues: First, the framework points to a recursive relationship between the incidence of mental health in society and consequences of this on organizations. These two domains are moderated by the interactive effects of actions stemming from policy and organizational decisions. Such links need to be empirically explored across a wide range of settings and jurisdictions. Second, the central role of organizations in contributing to solutions to the problem needs to be examined in more detail than in available studies. Third, our framework highlights the positive possibilities of various organizational actions for improving mental health, but empirically generalizable studies in this area are scant. As Sutton, Hocking, and Smythe (2012) noted, despite the view in the literature that

"occupation is beneficial for mental wellbeing, there is limited research exploring the experience and meaning of occupation in the context of the recovery process" (p. 143). Fourth, and finally, the direction and strength of the link between affirmative organizational action and its association with positive mental health outcomes needs to be empirically established across settings.

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