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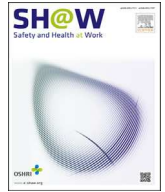
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Original Article

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.

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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,

the World Bank online Library, the Campbell Collaboration, Web of Knowledge (Web of Science), African Index Medicus, Health and Safety Science Abstracts, EMBASE, National Electronic Library for Health, and BMJ Group. The second part included electronic searches of the WHO's library, the University of Nottingham's (Nottingham, UK) library catalog, and Google Scholar.

2.1.3. Gray literature

Regarding the gray literature, electronic searches were performed through the National Technical Information Service, the OpenSIGLE, website, and Google Search Engine in order to identify available websites of promoted initiatives/tools. Relevant websites and databases including publications available within these sources were reviewed. In particular, websites from WHO, the International Labour Organization, the International Commission on Occupational Health, the UK Health and Safety Executive, Centers for Disease Control and Protection, the United States National Institute for Occupational Safety and Health, the European Agency for Safety and Health at Work, and the European Trade Union Institute were reviewed. Searches also included the European Commission Mutual Information System on Social Protection Comparative Tables on Social Protection, materials from conference proceedings and Internet pages of any additional relevant organizations identified through these searches.

2.1.4. Keywords

Specific keywords and terms were used throughout the search strategy which included: mental health, mental ill health, promotion, prevention, work-related stress, occupational stress, well-being, promotion, good practice, workplace, worksite, wellness, national, sectoral, level, social determinants of health, psychosocial, risk factors, hazards, risk assessment, risk management, community involvement, stress management, interventions, psychological, health, healthy, problems, burden, demands, working hours, work-life balance, conflicts, uncertainty, job insecurity, change, restructuring, working environment, working conditions, impact, (widely applied) organizational, emotional exhaustion, common mental disorders (CMDs), preventive tools, WHO, regions, member states, global, and country.

All the keywords were flexibly combined, altered, and/or truncated in order to serve the search needs. All the sources that came up due to these key terms were reviewed on the basis of their summary and/or abstract to check for relevance and compliance with the protocol. Additionally, reference lists were reviewed in order to identify any possible relevant citations and sources in support of the search strategy. The results of the scientific and gray literature review were cross-checked with those of another study conducted by members of the research team for the International Labour Organization [29]. This study involved a review and global survey with key stakeholders to identify initiatives of good practice in the area of WMHP at national level. It was encouraging to see that the findings of both studies showed considerable convergence. After carefully reviewing all results, the final choice of initiatives was made according to the predefined criteria of inclusion.

2.2. Semi-structured expert interviews

2.2.1. Participants

Seventeen semistructured interviews were conducted with occupational safety and health (OSH) experts across WHO regions who have good knowledge of the selected 11 initiatives by having been involved in their development, implementation, and evaluation. Purposive sampling was used, combined with snowball sampling at times, in order to ensure that the authors were able to interview people with the most suitable experience [31]. Due to

limitations with respect to tools' availability, as mentioned above, the number of experts for each WHO region was not equal (e.g., there are many more initiatives in Europe contrary to the African region). There was a fair balance between sexes as there were nine male and eight female participants. The participants came from the UK, Italy, Belgium, Spain, The Netherlands, Finland, Poland, Canada, USA, Australia, Thailand, Japan, and Ghana. They had 5–38 years of relevant work experience. The participants were highly knowledgeable experts with many years of experience in OSH and mental health in the workplace in the public and private sector. All experts were involved in the development, implementation and assessment stages of the tools.

2.2.2. Procedure

All the participants were recruited through an online process including an official contact letter/invitation. A standardized process was applied to minimize biases and ensure accuracy and consistency. All interviews were audio recorded and transcribed to avoid misinterpretations or missing data [31]. Ethics approval was seen before the commencement of data collection. All the participants were informed and debriefed about the purpose of the study, confidentiality, and data storage based on the Data Protection Act (1998) [33].

2.2.3. Data analysis

Thematic analysis helped to identify themes amongst collected data. An inductive or bottom-up approach was employed in order to explore and understand the data [34]. The transcription process was based on conventions for convenience and accuracy. Analysis was conducted in depth with a latent–constructivist approach, which ensured authenticity, transparency, and trustworthiness [31,34,35]. After summarizing the key points of all the transcripts, the creation of main codes was initiated [36,37]. The codes were clustered under primarily coherent themes [38,39].

For the readers' convenience, the groups of experts have been abbreviated as follows: experts with OSH experience of 5–10 years (female/male) = F/M1, experts with OSH experience of 10–20 years (female/male) = F/M2, experts with OSH experience of 20–30 years (female/male) = F/M3, and experts with OSH experience of > 30 years (female/male) = F/M4.

3. Results

3.1. Literature review

The search strategy included 20 databases, and concluded to a selection of 11 tools. Table 1 represents the list of the identified tools per country and WHO region while further details on each initiative are presented in Table 2.

3.2. Interviews

The thematic analysis highlighted four basic themes: (1) good practices for WMHP at national level; (2) responsibility for WMHP; (3) barriers; and (4) potentials for successful implementation. The themes consisting of subthemes and including their descriptors are presented in Tables 3–6.

3.2.1. Good practices

Good practices were indicated as the first theme with five subthemes: participation and social dialogue; science/research into practice; a clear action plan; shared knowledge; and evaluation (Table 3). All the responses, which indicated a level of success with respect to implementation, were coded as positive for this theme.

Table 1
Tool per country and World Health Organization (WHO) region

| Tool | Country | WHO region |
|--|---|-----------------|
| Management Standards for work-related stress [40,41] | UK, Italy | Europe |
| PSYRES: Psychological health & well-being in restructuring [42,43] | Finland, Poland, Denmark, The Netherlands | Europe |
| ISTAS 21 [44] | Spain | Europe |
| OSH Covenants & Catalogues [45] | The Netherlands | Europe |
| SOBANE strategy [46] | Belgium | Europe |
| National Standard on Psychological Health & Safety in the Workplace [47] | Canada | The Americas |
| Total Worker Health Strategy [48,49] | USA | The Americas |
| People at Work (P@W) [50] | Australia | Western Pacific |
| Mental Health Action Checklist (MHACL) [51] | Japan | Western Pacific |
| The Happy Workplace Concept [52] | Thailand | South-East Asia |
| Employee Well-being Programme [53] | Ghana | Africa |

ISTAS, Instituto Sindical de Trabajo, Ambiente y Salud; OSH, occupational health and safety; SOBANE, Screening, Observation, ANalysis Expertise.

The first subtheme, which is about participation and social dialogue for all the stakeholders, was prevalent among all participants. These actions incorporate the full engagement of all, “safety and health [experts], labor [employees], and representatives of labor, management of all level... put them all together in the same room and say we are all after the same main point” (M3, USA), “a cross-sectional engagement” (M4, Canada). Employees’ empowerment has been agreed as a vital element for success, “take their role in the company” (F4, The Netherlands); “top management [has] to give feedback... and [people need] to show empathy to each other” (M1, Japan).

The science/research into practice subtheme was agreed as a matter that raises difficulties, but as the only pathway to successful implementation. “Yes [organizations] may expect your [approach] to be based on a good psychological theory, but it is the application of that theory in the real world... and you have to be careful with terminology as stress is not [easily] recognizable [and understood]” (M1, UK). Correct understanding of science can be a challenge for organizations; misunderstanding leads to “missing information” (M3, Belgium). Scientific knowledge needs to be presented in an apt way without losing value; “have one ‘leg’ in science/knowledge and the other one in practice... knowledge activism” (M3, Spain).

A clear action plan includes elements such as “a development circle” (M1, UK), “careful planning” (F2, Australia) to avoid wasting money and the need for full awareness of the problem in order to choose actions that “meet the identified needs” (M4, Canada). It is helpful to focus on “a general methodology to be able to meet the majority of population” (M3, Spain), but “being specific” to solutions and “never transferring” solutions is dramatically significant (F4, The Netherlands). Tools need to be “tailored by sector” (M3, Italy).

“Continual improvement” and adaptation through evaluation have been outlined as important elements. When “a rational plan” does not work (F4, The Netherlands), adaptation is the way to solutions (M3, USA). All of the tools incorporate plans and actions of evaluation aiming at sustainability. Three out of 11 tools are going to be evaluated with all the rest having been already fully or partially evaluated including either formal or informal evaluations.

3.2.2. Responsibility

This theme was supported by three subthemes: current trends, drivers, and impact (Table 4). With respect to current trends, there was an agreement that “the emphasis has changed from organizational responsibility to individual responsibility” (M1, UK). The message currently coming out from many governments and organizations is that “individuals have the responsibility for their own mental health and they need to be more resilient” (M3, USA). Moreover, there is also the issue of “MH seen as a peripheral issue” (F3, The Netherlands) for organizations that “do not see why they

should be doing it” (M1, UK) and do not understand the high impact of primary prevention.

Drivers for WMHP mainly included the need of organizations to find ways to comply with the law as part of their social responsibility, but also tackle the persistent numbers of work-related injuries and illness. “Legal obligation... led companies to invest more in the prevention of workers’ mental health” (M3, Italy). Organizations will seek tools in order to “meet the needs” for a particular sector rather than doing “philanthropy” (M1, Ghana); “decline in productivity” (M3, Italy) creates a need for actions that will decrease the number of work-related illness and injuries.

The impact of organizational responsibility for WMHP has been stressed as more important concerning prevention and the level of success than individual responsibility; “it is OK to think about health risk assessment and what are the individual challenges”, but the responsibility should “not start from there” (M3, Belgium). The organizational environment will affect “every single employee, whether they know it or not, whether they have a health condition or not, and it is those organizational changes that have the greatest opportunity for primary prevention” (M3, USA).

3.2.3. Barriers

The theme of barriers was based on responses in relation to difficulties in developing and implementing WMHP tools. Therefore, all the answers referring to obstacles, resistance, difficulties, and constraints were coded positive for this theme (Table 5). The subthemes, which support this theme, are: knowledge deficiency; financial constraints; cultural gaps; time pressure; and fear.

Knowledge deficiency was supported by the fact that many middle managers have a lot of responsibilities, but they are not “best qualified to deliver” and this “blocks good practice” (M1, UK) because “low level of awareness of the impact of employees’ mental illness is the main barrier” (M3, Italy). People finish their education, but they “have never heard about OSH prevention” (M3, Belgium).

Financial constraints were illustrated through the burden of “upfront investments” (M3, USA), the financial prerequisite of continual improvement and the shift towards constant cost reduction without any added productivity value. There was a consensus on the fact that “insufficient investment” has an impact on processes and makes implementation “less successful” (F4, The Netherlands). In particular, when “there is not much money and the [financial] crisis is present”, organizations will “not put money [on evaluation]” (F2, Finland) and “every time there is a financial crisis... [WMHP] is the first to be cut, because organizations are not [obliged] to do it” (M1, Ghana).

Cultural gaps include barriers such as immature organizational cultures that lack the right mentality and background to engage in WMHP. For example, in some organizations “there is some form of hierarchy in getting things done” (M1, UK), and “workers do not

Table 2
Holistic tools relevant to workplace mental health promotion

| Tool* | Details |
|---|--|
| <i>Europe</i> | <i>For the European region, 5 initiatives were selected:</i> |
| Management Standards for work-related stress | The 1 st initiative is the Management Standards for work-related stress by Health & Safety Executive (HSE) in the UK, which has been adapted & is now also used in Italy. The Management Standards are voluntary & incorporate 6 key areas of work design, which can enhance health & wellbeing protection & promotion in the workplace (demands, control, support, relationships, role, & change). The Standards provide a step-by-step risk assessment & management approach in order to help organizations easily implement the process [40,41]. |
| PSYRES: Psychological health & well-being in restructuring | The 2 nd initiative chosen is the Psychological Health & Wellbeing in Restructuring (PSYRES) project in The Netherlands, Poland, Finland & Denmark. PSYRES is a research-driven initiative at national level, which aims to disseminate knowledge & good practice about workplace mental health protection & promotion during the organizational restructuring process [42,43]. |
| ISTAS 21 | The next initiative that was selected is ISTAS21 in Spain. ISTAS21 is based on the Danish Copenhagen Psychosocial Questionnaire (CoPsoQ) for assessing psychosocial risks. It is a voluntary methodology, based on risk assessment & risk management [44]. |
| Occupational safety & health (OSH) Covenants & Catalogues | The Work & Health Covenants & OSH Catalogues in The Netherlands were also identified as relevant sectoral tools. These initiatives essentially are social partner agreements on how to protect & promote a healthy work environment at sectoral level [5]. |
| SOBANE strategy | Lastly, the SOBANE strategy in Belgium was identified as a tool at national level for the assessment & management of psychosocial risks, which strongly supports a holistic approach. It is a voluntary initiative that can be used by any organization & sector aiming to comply with the law & protect/promote employees' wellbeing [46]. |
| <i>The Americas</i> | <i>For the region of the Americas, the National Standard on Psychological Health & Safety in the Workplace in Canada, & the Total Worker Health Strategy in the USA were selected.</i> |
| National Standard on Psychological Health & Safety in the Workplace | Canada's standard is part of the Mental Health Strategy for Canada, & the 1 st ever national standard directly targeting psychological health & safety in the workplace that is auditable. It is a voluntary standard & it is aligned with other existing standards to ensure healthy workplaces & support employees with mental ill health. It also aims to assist organizations by providing guidelines to employers in order to improve the psychological health in the workplace step-by-step. It encourages the executive leadership to set workplace mental health as a priority. Special training is provided & free monthly webinars are conducted to help people recognize, assess, manage, & deal with psychological health & safety in the workplace [47]. |
| Total Worker Health Strategy | Regarding the USA initiative, Total Worker Health is a voluntary strategy by the National Institute for Occupational Safety & Health (NIOSH), which encompasses occupational health & safety, injury, & illness prevention in order to advance employees' health & wellbeing. Mental health is allied to the strategy's pursuit of wellbeing through addressing stress & mental ill health of employees. Specific guidelines are provided to help organizations assess/manage OSH issues & promote employees' wellbeing. This initiative is heavily research driven & the Centres of Excellence, which are funded by NIOSH, conduct research on health risk factors & psychosocial stress hazard reduction in support of the Total Worker Health strategy [48,49]. |
| <i>The Western Pacific</i> | <i>For the Western Pacific region, the People at Work Project (P@W) in Australia, & the Mental Health Action Checklist in Japan (MHACL) were selected.</i> |
| People at Work (P@W) | The P@W is a voluntary psychosocial risk assessment process & it has been developed & managed by the University of Queensland as a collaboration between many initiators such as Safe Work Australia, the Australian National University, WorkSafe Victoria, etc. The process aims to provide reliable risk assessment to organizations by measuring job demands & job resources. It is available for all type of industries & sectors [50]. |
| Mental Health Action Checklist (MHACL) | Regarding the MHACL, it is also a voluntary worker participatory approach to improve mental health in workplaces. MHACL focuses on 6 technical areas, which are: sharing work planning; work time & organization, ergonomic work methods; workplace environment; mutual support in the workplace; & preparedness & care. The checklist aims to enhance workplace-level discussions on identifying various kinds of improvements in the workplace for any type of industry in order to promote workplace mental health [51]. |
| <i>South-East Asia</i> | <i>The Happy Workplace Project in Thailand was selected for the South-East Asia region.</i> |
| The Happy Workplace Concept | It is a project funded by the Thai Health Promotion Foundation. This voluntary initiative is a highly holistic approach regarding work-life balance & addresses health promotion in various ways such as physical, mental, spiritual, social, communal, & cultural. This project is heavily based on the concept of happiness & how employees experience it. Training is provided, but there is also the "Happinometer" assessment tool, which helps organizations measure employees' happiness in order to take further action. This voluntary initiative focuses more holistically on work-life balance in comparison to the rest [52]. |
| <i>Africa</i> | <i>For the African region, the Employee Wellbeing Programme in Ghana was selected.</i> |
| Employee Well-being Program | This is a collaboration between the Ministry of Health in Ghana & GIZ (Deutsche Gesellschaft für Internationale Zusammenarbeit). This voluntary initiative started with a focus on tackling HIV & further developed into a general wellbeing program, which includes aspects such as social protection (financial wellness & counseling, preparation for retirement, insurance), & efforts to support national systems & leadership that deliver environmental management. This initiative provides tools & policies to organizations & is heavily based on the WHO model for healthy workplaces. The psychosocial work environment is part of the model's health & safety aspect, however, the process of psychosocial risk assessment & management is at a considerably early stage in Ghana, & hitherto the actions are limited [53]. |

* For the Eastern Mediterranean WHO region no initiative or tool at national level for Workplace Mental Health Promotion was identified, therefore no further actions could be taken in order to explore any possible development or implementation.

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talk free... there is an imbalance of power...so tailoristic and authoritarian [organizational culture]" (M3, Spain).

Time pressure and fear were reported to impact on WMHP implementation. With respect to time, benefits for mental health may take years to be seen in an organization and this is very "challenging" for them (M1, Japan) because OSH specialists cannot "solve all the problems in 1 day or 2 days" (M3, Belgium). Changes need time and organizations often want overnight solutions to their

problems. Despite companies' preference for "quick fixes" (M1, UK), successful outcomes come only with consistent "repetition" and work in the long term (F4, The Netherlands).

Fear of "unemployment and precariousness" makes people afraid of talking about work and mental health related issues and leads employees to accept bad working conditions and employers not to take care of WMH (M3, Spain). "A lot of people, including employers, are a bit afraid of it [mental illness and its

Table 3
Good practices theme

| Themes | Subthemes | Descriptors |
|----------------|---------------------------------|---|
| Good practices | Participation & social dialogue | Stakeholders' engagement Employees' empowerment Collaboration between countries, & between the public & private sector Feedback & support provision at all levels in the workplace |
| | Science/research into practice | Effective translation of science into practical steps & approaches Availability of appropriate expertise to organizations Accessible & user-friendly language |
| | Clear action plan | Stepwise approach of action Well-structured implementation process Specificity & clarity |
| | Shared knowledge | Dissemination of knowledge on good practice (workshops, internet, media) Material provision to stakeholders (booklets, guides, brochures) |
| | Evaluation | Continual improvement through assessments Adaptation to organizational changes |

Table 4
Responsibility for workplace mental health theme

| Themes | Subthemes | Descriptors |
|--|----------------|---|
| Responsibility for workplace mental health | Current trends | Mental health as a peripheral rather than a central issue Shift from organizational responsibility to individual responsibility Organizational responsibility works better for easily measurable problems |
| | Drivers | Legislation Numbers of work-related injuries & illnesses |
| | Impact | Organizational responsibility has a bigger effect Individual responsibility is not enough Higher impact when individual responsibility follows organizational |

Table 5
Barriers theme

| Themes | Subthemes | Descriptors |
|----------|-----------------------|---|
| Barriers | Knowledge deficiency | Lack of knowledge amongst managers, professionals, workers Nonscientific approaches Inaccurate use of data |
| | Financial constraints | Upfront investment Continual improvement needs investment Cost reduction |
| | Cultural gaps | More difficulties for small & medium-sized enterprises Difficult to communicate mental health issues Mature versus immature cultures The impact of unwritten rules |
| | Time pressure | Organizations prefer quick fixes Results/changes need time |
| | Fear | Afraid employers (time & money loss, business failure) Afraid employees (precariousness, lack of opportunities) |

Table 6
Potentials theme

| Themes | Subthemes | Descriptors |
|------------|----------------------|--|
| Potentials | Policies/legislation | Inform & update policies on workplace mental health Need for proper legislation Active labor inspection Preventive actions are more effective than reactive actions |
| | Better evidence | Clear short- & long-term cost-benefit relation Constant monitoring at all levels |
| | Educate people | Training for all stakeholders in the workplace Education on psychosocial risk identification National & international dissemination of good practice |
| | Holistic approach | Both organizational culture & community needs to promote mental health Direct & indirect actions Multidisciplinary approach & multilevel integration |

consequences]... that they prefer to get rid of those people instead of doing something to make them better" (F2, The Netherlands). Employers are scared that if they start with risk assessment and management, this might "open a can of worms" (F2, Australia), which will lead to time and money loss.

3.2.4. Potentials for future success

The theme of potentials for future success includes informing policies/legislation, working for better evidence, educating people on psychosocial risk identification, and applying a holistic approach (Table 6).

Policies/legislation have a huge impact on how organizations act towards WMHP and there was a common view that mental health can be protected and promoted only if "policies are informed" (M1, UK). WMH needs to be supported by legislation because organizations, in their majority, take actions due to legal pressures rather than personal choice (M1, Japan) and "it is disappointing that 40–50 years after the good work agenda [in the UK], we are still trying to propagate basic messages to organizations" (M1, UK). It would be very supportive for WMHP initiatives if "the labor inspection could include psychosocial [risks], not only physical... it could influence people... because [it] has great prestige and power" (F3, Poland). If the labor inspection becomes more active and includes psychosocial risks, WMHP will be easily identified, understood, and dealt with.

Constant "monitoring" (F2, Thailand) of the processes is the only way to achieve a better evidence base and convince organizations that there are practical reasons to take preventive actions. There is a need "to find the link between economic benefit for the company and prevention" (M3, Belgium) and "cost-effectiveness" (M4, Canada). If there is clear evidence and understanding about "economic internal investment and financial benefits... this will put programs in place" (M3, Belgium). There are "missed opportunities by swinging between the responsibilities of employers and employees rather than working more holistically" (M1, UK). A holistic approach is vital because "when you try to find the problem, the causes of the psychosocial problems are not often only psychosocial aspects" (M3, Belgium).

4. Discussion

4.1. Whose responsibility?

This paper aimed to shed further light in the area of WMHP by investigating key approaches that have been introduced in several countries to promote mental health in the workplace. On the basis of interviews with experts, it aimed to provide recommendations on key elements of good practice and key challenges that need to be tackled by appropriate policies and stakeholder actions.

Many participants agreed on the fact that there is a mentality across organizations that mental health is a personal problem and individuals have to find a way out of it. Even if organizations take some actions, they are usually reactive such as counseling and training provision to make individuals *stronger* and more resilient. This mentality is held not only by organizations, but also by governments. This creates many challenges for seeing success in the domain of WMHP. However, it was argued that since the impact of poor mental health is already known, governments and organizations would inevitably end up shifting their viewpoints towards prevention. OSH legislation can be a powerful motivator where it exists [4,21]. However, since legal frameworks are lacking in many countries, this is not enough [54]. Hard data and evidence of the impact of poor mental health are currently the only overriding reason that triggers organizations to consider their organizational responsibility in this area from the perspective of prevention. There is a need for evidence-based policy making and the promotion of a multilevel intervention framework on the basis of a strong evidence base to drive progress in this area [15,54].

4.2. In line with the WHO GPA and MHW five keys

Regarding the GPA and the five keys for healthy workplaces, four out of the five GPA objectives have been discussed through the initiatives (devise and incorporate policies, protect/promote health, provide evidence) and all five keys of MHW have been covered. The study evaluated how the 11 tools support organizations to accomplish the five keys of the MWH in order to meet GPA's objectives. The objectives were met by all initiatives. However, some initiatives illustrated a better and stronger support of the objectives contrary to others. All of them were developed in order to protect and promote employees' health, mental health, and wellbeing. One of the key drivers, apart from compliance with the law, was the goal to eradicate the incidents of work-related injuries and illnesses from both a physical and mental perspective [6,55].

The objectives on devising and incorporating workers' health into other policies (the 1st and the 5th objective of the GPA), especially for mental health, were covered by the findings on opportunities for the identified tools. Stakeholder consensus on the need for more effective WMHP policies highlights the importance to inform and reform current policies [15]. There are policies and legislation for OSH prevention, but not all countries have legislation directed to WMHP. It was evident that European countries have more policies for employees' mental health [8,56]. Interestingly, even for the countries with a hitherto strong background in this area, difficulties were reported regarding the implementation of initiatives because organizations are not yet fully aware and educated on psychosocial risk assessment [23].

The GPA objective on the protection and promotion of workers' health (the 2nd objective) through primary prevention of occupational hazards, including psychosocial hazards, was supported by the findings on good WMHP practices, which include employee participation/social dialogue. Engagement of all stakeholders is a

vital part of success, which pertains to the first two keys of the MHW; the first key represents leadership commitment and engagement, the second key represents workers and their representatives' involvement. All levels in a working environment include top management, employees, employers, representatives of all stakeholders, OSH specialists, and collaboration between industries, sectors, and countries [3,19,24,25]. In particular, social dialogue and communication between all stakeholders are a substantial basis for effective implementation and improvement in the workplace. Employee empowerment in order to bridge the power gap between employers and employees was reported to be a central part of success. Charismatic leadership that empowers people through appreciation, showing trust, giving responsibilities, and providing feedback and support is a great strength for organizations and WMHP effectiveness [20,21,57–59].

Business ethics and legality (third key) were supported by organizations that had to comply with the law at first and then move on to the next step, which was to find ways to a successful implementation. The fact that psychosocial risks are not easily identified and measured was the main reason why organizations fail to see great results. People need to know what psychosocial risk means in order to deal with it. Lack of awareness and an appropriate policy framework allow organizations to superficially comply with OSH law but not seeing results with respect to mental health [3,26].

All the good practices work in a parallel way with the fourth key for healthy workplaces of the MHW. The initiatives unanimously incorporate and support the element of systematic, comprehensive process to ensure effectiveness and continual improvement through numerous actions as the only way to success for WMHP. All of the participants, regardless of the initiative's current evaluation status, have agreed on the importance of continual improvement through understanding suitable or less suitable practices and sustaining a systematic evaluation process [6,55,60]. Sustainability and integration in a multilevel way implying the application of a holistic approach is in line with the fifth key of the MHW. Multilevel integration represents proposed changes not only through single interventions in the workplace, but a broader approach to changes: integrating an appropriate mentality, with tasks, roles, approaches, and solutions [3,21]. A multidisciplinary holistic approach was identified as a robust solution for successful implementation. It has been understood that there are current efforts for a holistic approach and multilevel integration; looking at issues from many perspectives and different viewpoints does help in understanding not only economic aspects, but also cultural, personal, psychological, health, and productivity aspects and their connection [25,61]. It was common that cultures with a collectivistic mentality, such as Ghana, Japan, and Thailand embraced a community approach, mindfulness, and spirituality more heavily with respect to mental health than individualistic ones, which tend to have a business-oriented understanding. Attention to the values of family, community, and spiritual self was more discernible through collectivism [62–66]. However, the implementation of a holistic approach is still in progress in all countries covered.

4.3. In line with the WHO CMHAP

The initiatives included in this study have also been explored in order to identify the extent to which they are in line with the CMHAP [6]. The initiatives mainly cover the first, third, and fourth objectives (CMHAP has 4 objectives in total). The first objective suggests the strengthening of leadership and the increase of national policies and laws for mental health in line with international human rights standards; there is a need for more policies on WMH.

The third objective prompts mental health promotion through the implementation of multisectoral strategies at national level. All the identified initiatives are multisectoral workplace strategies at national level as pointed by the CMHAP. The fourth objective focuses on strengthening the evidence and research for mental health, which is part of the findings on potentials of this study. This objective aims to the collection and report of mental health indicators every 2 years, which could potentially be facilitated by a consistent monitoring process within organizations [6].

Taking a closer look at the initiatives and their link to CMHAP, the Management Standards for work-related stress are based on psychosocial risk assessment to identify the cause and gather evidence (4th objective), implement prevention (3rd objective), and inform/engage stakeholders (1st objective). Psychological Health and Wellbeing in Restructuring (PSYRES) was research driven and aimed to gain insight and identify effective preventive actions for psychological wellbeing during restructuring (4th objective) and inform/engage/empower stakeholders (1st objective). The OSH Covenants/Catalogues are risk management projects to identify causes, gather evidence (4th objective), implement prevention (3rd objective), and engage all stakeholders in order to improve leadership for a healthy workplace (1st objective). ISTAS21 is a psychological risk assessment questionnaire aiming to identify risks and prevent (3rd objective), inform and share evidence (4th objective), and motivate/engage stakeholders (1st objective). SOBANE strategy is an occupational risk management tool including psychosocial risks, which aims to identify the problem by using evidence (4th objective), suggest preventive and/or treatment actions (3rd objective), and empower stakeholders in order to improve leadership for WMH (1st objective). The Canadian Standard is a systematic process to create psychologically safe workplaces by identifying and tackling psychosocial hazards (3rd and 4th objectives) and supporting the leadership by informing/motivating/engaging the people involved (1st objective). Total Worker Health focuses on psychosocial stress hazard reduction approaches (3rd objective), evidence provision (4th objective), and dissemination of knowledge in order to strengthen awareness and leadership for workplace wellbeing (1st objective). From a similar perspective, People at Work (P@W) and Mental Health Action Checklist (MHACL) work on the basis of psychosocial risk identification and management aiming to share knowledge, inform and engage all stakeholders and leadership (1st, 3rd, and 4th objectives). The Happy Workplace (met all 3 objectives) and the Employee Wellbeing Program (met 1st and 3rd objectives) aim to improve employees' wellbeing through various strategies, but without a clear-cut reference to psychosocial risks. In particular, the Employee Wellbeing Program is at a very early stage regarding WMHP and psychosocial risk management [6].

4.4. Constraints and opportunities

There are some differences in terms of the life cycle of the examined tools. For example, PSYRES, OSH Covenants, and the Management Standards have now stopped the process of continual improvement contrary to Canada's Standard, SOBANE, P@W, MHACL, Total Worker Health Strategy, Promotion of Wellbeing Program, ISTAS 21, OSH Catalogues and the Happy Workplace Concept. Even though organizations do seek advanced tools and improvement, it has been noted that the economic climate and recessions affect the continuation of actions [67,68].

Knowledge deficiency is a great problem not only because companies cannot identify the reasons behind poor mental health in their work environment, but they also cannot easily transform shared knowledge into effective practice [15,22]. Therefore, there is a great need to act in a two-way direction by educating people

about mental health/psychosocial risks and making science and good practice understandable to the wider audience [22,69]. With respect to cultural gaps, it is difficult to control differences between organizational cultures. Mature larger organizations with better awareness on mental health in the workplace accept and use tools more easily, but it is more difficult to implement them fully. This is in contrast with smaller organizations that are more difficult to penetrate, but easier to integrate fully. The solution is to be as specific as possible based on the given situation and context [70].

Fear was another constraint, especially in countries that are more affected by recessions. Employees are afraid of losing their job and having minimal opportunities, which make them accept any working conditions without any resistance. In this case, employers might choose not to integrate WMHP fully and avoid time and money expenditure, especially if there is no legislation forcing them to explicitly take actions [67]. There is also a gray area where OSH law exists, but evidently mental health is the missing bit. Participants interestingly suggested that this lacuna can be overcome with the use of labor inspection that includes psychosocial risk factors [21,22], although this is far from reality in most countries around the world.

4.5. Limitations and strengths of the study

The main limitation of the study is its selective, qualitative, and interpretative nature of it, which does not allow further generalizations. In addition, lack of tool availability led to an unequal number of experts for each WHO region, which may have affected evaluation due to cultural differences. Nevertheless, the tools were selected based on clear inclusion criteria across WHO regions (with the exception of the Eastern Mediterranean where no suitable tools were identified). Despite cultural differences, there clearly are similarities as concerns good practices, responsibilities, barriers, and opportunities, which also give credibility to the findings. Lastly, all the participants are highly knowledgeable experts with many years of experience in OSH and mental health in the workplace.

4.6. Conclusion

The findings of this study indicate that there is a lack of coordinated preventive action for WMHP. There is an urgent need for education, which will enable all stakeholders to understand the impact and cost of poor mental health. Findings suggest that a holistic approach for WMHP combined with informed legislation and active labor inspection is the best plan of action at national level for future success.

Practices, which comply with the WHO five keys for healthy workplaces, such as engagement of all stakeholders, social dialogue, proper translation of science into tangible practice, dissemination of good practices, and continual improvement are acknowledged to be effective ways to promote mental health in the workplace. Nonetheless there is a lot of space for improvement. One very significant potential for improvement is the holistic approach that fully incorporates psychosocial aspects and explores possible psychosocial risks in the workplace. Future research should identify and evaluate such holistic approaches across all WHO regions in order to map available expertise globally.

Conflicts of interest

All authors declare no conflicts of interest.

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References

- [1] World Health Organization, Constitution of the World Health Organization – *Basic Documents*, Forty-fifth edition, Supplement, October 2006 [Internet]. Available from: http://www.who.int/governance/eb/who_constitution_en.pdf.
- [2] Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR, Rahman A. No health without mental health. *Lancet* 2007;370:859–77.
- [3] World Health Organization. Healthy workplaces: a model for action: for employers, workers, policy-makers and practitioners. Geneva (Switzerland): World Health Organization; 2010.
- [4] World Health Organization. Mental health policies and programmes in the workplace. Geneva (Switzerland): World Health Organization; 2005.
- [5] European Agency for Safety and Health at Work (EU-OSHA). Mental health promotion in the workplace: a good practice report. Luxembourg (Luxembourg): EU-OSHA; 2011.
- [6] World Health Organization. Comprehensive mental health action plan 2013–2020. Sixty Sixth World Health assembly. Geneva (Switzerland): World Health Organization; 2013.
- [7] Marmot M, Wilkinson R. Social determinants of health. Oxford (UK): Oxford University Press; 2009.
- [8] Leka S, Cox T. The European Framework for Psychosocial Risk Management. PRIMA-EF: a resource for employers and worker representatives. Geneva (Switzerland): World Health Organization; 2008.
- [9] Organisation for Economic Co-operation and Development. Average annual hours worked per worker [Internet]. 2012 [cited 2013 Jul 24]. Available from: <http://stats.oecd.org/Index.aspx?DatasetCode=ANHRS>.
- [10] World Health Organization. Mental health: strengthening our response. Fact Sheet No. 220. Geneva (Switzerland): World Health Organization [Internet]. Updated August 2014. Available from: <http://www.who.int/mediacentre/factsheets/>.
- [11] McDaid D, Curran C, Knapp M. Promoting mental well-being in the workplace: a European policy perspective. *Int Rev Psychiatry* 2005;17:365–73.
- [12] Mykletun A, Harvey SB. Prevention of mental disorders: a new era for workplace mental health. *Occup Environ Med* 2012;69:868–9.
- [13] Yasamy MT, Dua T, Harper M, Saxena S. Mental health of older adults, addressing a growing concern. Geneva (Switzerland): World Health Organization; 2013.
- [14] Patel V, Flisher A, Hetrick S, McGorry P. Mental health of young people: a global public-health challenge. *Lancet* 2007;369:1302–13.
- [15] Langenhan MK, Leka S, Jain A. Psychosocial risks: is risk management strategic enough in business and policy making? *Saf Health Work* 2013;4:87–94.
- [16] Leka S, Jain A, Iavicoli S, Vartia M, Ertel M. The role of policy for the management of psychosocial risks at the workplace in the European Union. *Saf Sci* 2011;49:558–64.
- [17] Cox T, Leka S, Ivanov I, Kortum E. Work, employment and mental health in Europe. *Work Stress* 2004;18:179–85.
- [18] Mills PR, Kessler RC, Cooper J, Sullivan S. Impact of a health promotion program on employee health risks and work productivity. *Am J Health Promot* 2007;22:45–53.
- [19] Kirsten W, Karch RC. Global perspectives in workplace health promotion. Sudbury (MA): Jones & Bartlett Publishers; 2011.
- [20] Secker J, Membrey H. Promoting mental health through employment and developing healthy workplaces: the potential of natural supports at work. *Health Educ Res* 2003;18:207–15.
- [21] Western Pacific Regional Office (WHO). A training manual for health workers on healthy lifestyle [Internet]. 2009 [cited 2013 Aug 4]. Available from: http://www.wpro.who.int/philippines/publications/trainers_guide_healthy_lifestyle/en/index.html.
- [22] European Agency for Safety and Health at Work (EU-OSHA). Drivers and barriers for psychosocial risk management: an analysis of the findings of the European survey of enterprises on new and emerging risks (ESENER). Luxembourg (Luxembourg): EU-OSHA; 2012.
- [23] Leka S, Jain A. Health impact of psychosocial hazards at work: an overview. Geneva (Switzerland): World Health Organization; 2010.
- [24] Grawitch MJ, Trares S, Kohler JM. Healthy workplace practices and employee outcomes. *Int J Stress Manage* 2007;14:275–93.
- [25] Kelloway EK, Day AL. Building healthy workplaces: what we know so far. *Can J Behav Sci* 2005;37:223–35.
- [26] Robichaux C, Parsons M. An ethical framework for developing and sustaining a healthy workplace. *Crit Care Nurs Q* 2009;32:199–207.
- [27] Berkhout F, Hertin J, Gann DM. Learning to adapt: organisational adaptation to climate change impacts. *Clim Change* 2006;78:135–56.
- [28] Grawitch MJ, Gottschalk M, Munz DC. The path to a healthy workplace: a critical review linking healthy workplace practices, employee well-being, and organizational improvements. *Consult Psychol J Pract Res* 2006;58:129–47.
- [29] Leka S, Jain A. Work-related stress: identifying global actions and future needs. Geneva (Switzerland): International Labour Organization; 2015 in press.
- [30] Goodman LA. “Snowball sampling”. *Ann Math Stat* 1961;32:148–70.
- [31] Bryman A. Social research methods. Oxford (UK): Oxford University Press; 2012.
- [32] Levy Y, Ellis TJ. A systems approach to conduct an effective literature review in support of information systems research. *Informing Sci* 2006;9:181–212.
- [33] The British Psychological Society. Code of ethics and conduct: guidance published by the ethics committee of the British Psychological Society. Leicester (UK): British Psychological Society; 2009.
- [34] Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3:77–101.
- [35] Madill A, Jordan A, Shirley C. Objectivity and reliability in qualitative analysis: realist, contextualist and radical constructionist epistemologies. *Br J Psychol* 2000;91:1–20.
- [36] Boyatzis R. Transforming qualitative information. Cleveland (OH): Sage; 1998.
- [37] Mason J. Qualitative researching. London (UK): Sage; 2002.
- [38] Saldana J. The coding manual for qualitative researchers. London (UK): Sage; 2009.
- [39] Ryan GW, Bernard HR. Techniques to identify themes. *Field Meth* 2003;15:85–109.
- [40] Kerr R, McHugh M, McCrory M. HSE Management Standards and stress-related work outcomes. *Occup Med* 2009;59:574–9.
- [41] Health and Safety Executive. Managing the causes of work-related stress: a step-by-step approach using the Management Standards. London (UK): HSE; 2007.
- [42] European Agency for Safety and Health at Work (EU-OSHA). PSYRES: psychological health and well-being in restructuring: key effects and mechanisms [Internet]. 2008 [cited 2013 Jul 10]. Available from: <https://osha.europa.eu/sub/newosha/en/noe-research-programme/project-abstracts/psyres-psychological-health-and-well-being-in-restructuring-key-effects-and-mechanisms>.
- [43] Wierze N, Nielsen K, Pahkin K, Widerszal-Bazyl M, de Jong T, Mattila-Holappa P, Mockajlo Z. Exploring the link between restructuring and employee well-being. Warsaw (Poland): Central Institute for Labour Protection - National Research Institute; 2011.
- [44] European Agency for Safety and Health at Work (EU-OSHA). ISTAS 21 Methodology (CoPsoQ) [Internet]. 2002 [cited 2013 June 10]. Available from: <https://osha.europa.eu/data/risk-assessment-links/istas-21-methodology-copsoq>.
- [45] Bakhuys Roozeboom M, Shire P, Hoofman W, Houtman I, Klein Hesselink J, Arbobalans. Quality of work, effects and measures in The Netherlands. Hoofddorp (NL): TNO Work and Employment; 2008.
- [46] Malchaire J, Piette A. The SOBANE strategy for the management of risk, as applied to whole-body or hand–arm vibration. *Ann Occup Hyg* 2006;50:411–6.
- [47] Mental Health Commission of Canada. The road to psychological safety: legal, scientific and social foundations for a national standard for psychological safety in the workplace [Internet]. 2012 [cited 2013 Aug 7]. Available from: <http://www.mentalhealthcommission.ca/>.
- [48] Centers for Disease Control & Prevention. NIOSH program portfolio: total worker health [Internet]. 2013 [cited 2013 Jun 12]. Available from: <http://www.cdc.gov/niosh/programs/totalworkerhealth/>.
- [49] Sauter SL, Murphy LR, Hurrell JJ. Prevention of work-related psychological disorders: a national strategy proposed by the National Institute for Occupational Safety and Health (NIOSH). *American Psychologist* 1990;45:146–58.
- [50] Workplace Health and Safety Queensland. People at Work Project [Internet]. 2013 [cited 2013 Aug 7]. Available from: <https://www.worksafe.qld.gov.au/education/articles/people-at-work-project>.
- [51] Yoshikawa T, Kawakami N, Kogi K, Tsutsumi A, Shimazu M, Nagami M, Shimazu A. Development of a mental health action checklist for improving workplace environment as means of job stress prevention. *Sangyo Eiseigaku Zasshi* 2007;49:127–42.
- [52] Chawsthiwong B. Happy workplace. *J Soc Dev* 2007;9:61–93.
- [53] Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ). More than just good business: employee wellbeing programmes in Ghana. Bonn (Germany): GIZ; 2012.
- [54] Kortum E, Leka S. Tackling psychosocial risks and work-related stress in developing countries: the need for a multi-level intervention framework. *Int J Stress Manage* 2014;21:7–26.
- [55] World Health Organization. Workers' health: global plan of action [Internet]. 2007 [cited 2012 Jul 24]. Available from: http://www.who.int/occupational_health/publications/global_plan/en/index.html.
- [56] European Commission. European pact for mental health and well-being. In EU-High-Level-Conference “Together for Mental Health and Well-being”. Brussels; 2008. p. 12–3.
- [57] Davydov DM, Stewart R, Ritchie K, Chaudieu I. Resilience and mental health. *Clin Psychol Rev* 2010;30:479–95.
- [58] Joubert N, Raeburn J. Mental health promotion: people, power and passion. *Int J Mental Health Promot* 1998;(Inaugural Issue):15–22.
- [59] Liden RC, Wayne SJ, Sparrowe RT. An examination of the mediating role of psychological empowerment on the relations between the job, interpersonal relationships, and work outcomes. *J Appl Psychol* 2000;85:407–16.
- [60] Anand G, Ward PT, Tatikonda MV, Schilling DA. Dynamic capabilities through continuous improvement infrastructure. *J Operat Manage* 2009;27:444–61.
- [61] Sierchio GP. A multidisciplinary approach for improving outcomes. *J Infus Nurs* 2003;26:34–43.

- [62] Morling B, Lamoreaux M. Measuring culture outside the head: a meta-analysis of individualism—collectivism in cultural products. *Pers Soc Psychol Rev* 2008;12:199–221.
- [63] Koenig HG. Research on religion, spirituality, and mental health: a review. *Can J Psychiatry* 2009;54:283–91.
- [64] Seybold KS, Hill PC. The role of religion and spirituality in mental and physical health. *Curr Direct Psychol Sci* 2001;10:21–4.
- [65] Goleman D. Meditation and consciousness: an Asian approach to mental health. *Am J Psychother* 1979;30:41–54.
- [66] Grossman P, Niemann L, Schmidt S, Walach H. Mindfulness-based stress reduction and health benefits: a meta-analysis. *J Psychosom Res* 2004;57:35–43.
- [67] Kortum E. A need to broaden our perspective to address workers' health effectively in the 21st century. *Ind Health* 2012;50:71–2.
- [68] Landsbergis PA, Grzywacz JG, LaMontagne AD. Work organization, job insecurity, and occupational health disparities. *Am J Ind Med* 2014;57:495–515.
- [69] Czabala C, Charzyńska K, Mroziak B. Psychosocial interventions in workplace mental health promotion: an overview. *Health Promot Int* 2011;26:70–84.
- [70] Wong KY. Critical success factors for implementing knowledge management in small and medium enterprises. *Ind Manage Data Syst* 2005;105:261–79.